Good health for all: an ethnographic study of frontline professionals in general and mental healthcare and social welfare

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GOOD HEALTH FOR ALL

An Ethnographic Study of Frontline Professionals in General and Mental Healthcare and Social Welfare

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Good Health for All

An Ethnographic Study of Frontline Professionals

in General and Mental Healthcare and Social Welfare

Goede Gezondheid voor Iedereen

Een etnografische studie van uitvoerend professionals

in de algemene en geestelijke gezondheidszorg en het sociaal domein

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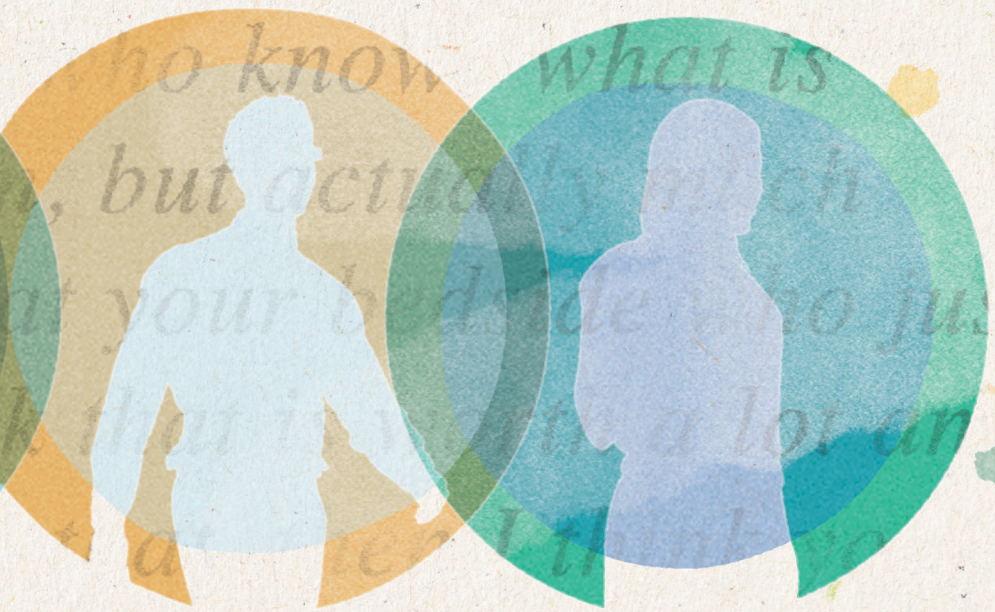
Chapter 1

General introduction



1.1 Introduction

> '*A silent tragedy is unfolding. It concerns the most vulnerable patients: chronically ill individuals, the elderly, psychiatric patients, and young people with mental health problems. Referring them quickly is often impossible [...] and there are long waiting lists for youth care and psychiatry. Precisely in these cases of [combined] problems, intensive collaboration between general practitioners and other healthcare providers is essential. However, the lack of collaboration in care stands in the way* (Valkenburg, 2019).'

The above-quoted Dutch newspaper article (Valkenburg, 2019) highlights that in the Netherlands, an increasing number of individuals face an accumulation of problems that cross professions and organizations, including physical, psychological and social difficulties. This issue is particularly evident among people with a low socioeconomic status (SES), who not only face poor health outcomes, but also face challenges such as unemployment, depression or low self-confidence and who have limited knowledge of alternative routes to health and care, as well as low health literacy or bureaucratic skills (SCP, 2023; WRR, 2021). In fact, one in six Dutch citizens faces a combination of problems across professional domains (SCP, 2023). These combined problems create a pressing need for collaboration across professional- and organizational borders. This interplay of issues and required collaboration occurs everywhere, but especially in large cities like The Hague, the Netherlands, where this study takes place and health inequalities are particularly evident. The newspaper quote highlights that collaboration in care and social welfare is as necessary as it is problematic when dealing with combined problems. Frontline professionals are expected to work together across professional- and organizational boundaries, but many incentives – such as policies, professional norms and finances – go against collaboration. General practitioners work with specialists, neighborhood nurses, debt counsellors and client supporters from social welfare in caring for clients with combined problems. These vulnerable clients require support from multiple professionals and organizations, which frontline professionals must navigate and coordinate. As such, the problem is not only about how professionals relate to other professionals, but also about how professionals relate to these vulnerable clients when they organize care. This indicates that the most vulnerable group suffers the most when care and social welfare are not well organized. In the Netherlands, a broad view of health and care, and a focus on collaboration across professions and organizations is used to address combined problems and to offer responsive care through initiatives such as neighborhood teams and case management (a.o. Ministerie van Volksgezondheid, 2016). Combined problems place pressure on frontline professionals through increasing caseloads, administrative burdens and various roles and responsibilities (Christensen, Arøe et al., 2020; Döring, 2021; Agresta, 2004). The need for collaboration across profes-

sions and organizations in care and social welfare raises questions about how frontline professionals in general healthcare, mental healthcare and social welfare work towards good health for everyone.

What intrigues me to conduct this research is both socially and scientifically motivated. From a societal perspective, I think it is important to contribute to insights that can help care for vulnerable people. Prior to starting this doctoral research, I explored broader health-related topics with professionals from various fields. I was also interested in broader societal discussions on inequality, diversity, and inclusion. Building on this interest, this dissertation explores the role of professionals in healthcare and social welfare, and more broadly, in supporting the health of vulnerable people. It is widely recognized that medical care alone is often insufficient to support vulnerable people. Therefore, I am eager to learn how frontline professionals from various professions and organizations relate to other professionals and clients. This research thus aims to contribute to a better understanding of how professionals relate to clients and other professionals in general healthcare, mental healthcare and social welfare. This dissertation addresses the collaborative processes not only across professionals and organizations, but also between professionals and clients — an increasingly important societal challenge both in and beyond healthcare. Populations increasingly face combined problems, therefore, collaboration across professions and organizations will be crucial. Consequently, studying how various frontline professionals relate to other professionals and clients is important. Such research can offer valuable implications for the health of vulnerable people and for interprofessional collaboration in the care for vulnerable populations (e.g. Valentine & Edmondson, 2015).

From a scientific perspective, studying professionals in care and social welfare presents a unique challenge, as this field of research is primarily dominated by public health scientists. Thereby, a similar problem arises: science itself is also fragmented. Apart for insights from public health, understanding this complex issue also requires insights from social sciences, as professionals are impacted by social, cultural and organizational factors and clients often face both medical and social challenges. Therefore, insights from public administration and public health are essential to understand how frontline professionals relate to other professionals and clients in caring for clients with combined problems. While extensive public health studies explore factors that influence people's health (a.o. Kikuchi et al., 2023), my research bridges two disciplines — public administration and public health. It focuses on frontline professionals from general healthcare, mental healthcare and social welfare in a care and social welfare context, and is guided by an anthropological lens that shapes the research approach. As a social scientist working in both public administration and public health, I see it as a necessity to study health through an interdisciplinary research approach and by combining expertise in an interdisciplinary collaboration between researchers from public administration and public health. Insights from public administration are essential to

understanding interprofessional collaboration and the role of frontline professionals. Furthermore, insights from public health highlight the need for frontline professionals to provide more than just medical care. In addition, insights from medical anthropology show that health conceptions go beyond health definitions, but also consist of beliefs about factors that affect people's health and practices that promote it. Moreover, the questions raised in this dissertation are of relevance to both public administration and public health, thereby, this research can enrich both disciplines. The use of an anthropological lens allows me to explore these dynamics of collaboration across professions and organizations, especially regarding the challenges of supporting vulnerable clients that I previously highlighted. Through this anthropological lens, this study adds to the public health and public administration literature by focusing on perceptions and behaviors of frontline professionals. Moreover, through an anthropological lens, culture is seen as a dynamic system of norms, values, beliefs, language, interactional patterns and social practices that people use to interpret their world (a.o. Geertz, 1974; Schwartz-Shea and Yanow, 2013; Spradley, 2016). As such, by looking at their conceptions and values, I gain insight into the ways in which frontline professionals make sense of their work with clients and with other professionals. This anthropological lens allows for a contextualized exploration of cultural aspects such as beliefs, conceptions and professional behaviors in general healthcare, mental healthcare, and social welfare. This lens goes beyond a purely public health perspective by exploring professionals' health conceptions, roles in collaboration and reasonings in their everyday work. The research specifically focuses on how frontline professionals relate to both professionals and clients, as seen from their own perspective. This anthropological lens also informs the diverse methods used in this study — such as ethnographic observation and in-depth interviews — which are less commonly applied in public health and public administration research, though they are increasingly gaining traction in the latter (see o.a. Brodkin, 2011; Cecchini, 2017; Cecchini, 2021; La Grouw et al., 2024; Maynard-Moody & Musheno, 2022; Zacka, 2017; Maynard-Moody, Longo & Zacka, 2019). These methods build on a longstanding tradition in medical anthropology, which has played a role in exploring the frontline professionals' perspectives of health and care (a.o. Singer, 1995). Grounded in various qualitative research methods, this study emphasizes the importance of context and it seeks to interpret professionals' work in complex care across professions and organizations (Barnard and Good, 1984).

1.2 General aim and research question

This research aims to analyze the health conceptions, roles in collaboration and reasonings about clients among various frontline professionals in general healthcare, mental healthcare and social welfare. Health conceptions help us to understand how frontline

professionals perceive health and how they understand their own and others' roles, shaping their expectations and approaches to health and care. Roles in collaboration reflect how frontline professionals perceive both their own roles and the roles of others. Reasonings about clients provide insight into the underlying considerations in professional decision-making. By studying these three aspects – health conceptions, roles in collaboration, and reasoning – this research deepens our understanding of how professionals relate to both professionals and clients. These insights can inform policy-making, teaching, and interprofessional collaboration. Ultimately, I assume that a better understanding of these dynamics may enhance the societal relevance of professional knowledge and inform context-sensitive approaches to care. Throughout the research, I consistently focus on frontline professionals working across professions and organizations, in caring for clients[1] with combined psychosocial problems. This research provides a deeper and more nuanced understanding of how various frontline professionals in care and social welfare collaborate. The overall research question that is central to this dissertation is as follows:

How do frontline professionals relate to other professionals and clients in caring for clients with combined psychosocial problems?

To answer this question, this dissertation is structured around four empirical sub-questions. To understand how frontline professionals relate to other professionals and clients, it is crucial to first understand how they perceive health, as their health conceptions guide how they perceive their roles and reasonings in care. Therefore, the first sub-question is as follows:

1. How can the health conceptions of frontline professionals in general healthcare, mental healthcare and social welfare be conceptualized?

To answer the question of how frontline professionals relate to other professionals and clients, it is furthermore important to understand frontline professionals' health promotion roles. This is essential because these roles shape how professionals position themselves in relation to both other professionals and clients and how professionals approach the care for clients with combined problems. Therefore, the second sub-question is as follows:

1 The introduction and conclusion chapters use the term 'client' to refer to people with combined psychosocial problems. In the empirical chapters of this dissertation, other terms are used such as citizen-client or patient, depending on the context of the empirical research.

2. What kind of health promotion roles do frontline professionals in general healthcare, mental healthcare and social welfare have and how are these shaped by their professional identity?

To answer the question of how frontline professionals relate to other professionals and clients, it is, moreover, important to understand what interprofessional collaboration looks like, particularly in fluid team contexts such as the research context in this dissertation. This is because collaboration shapes how frontline professionals play their roles and use their conceptions in interaction with others and how they position themselves in collaborative efforts to support clients with combined problems. Team fluidity means that teams have high degrees of change and difference in terms of membership (Kerrissey et al., 2020). By exploring interprofessional collaboration in such fluid team contexts, this chapter aims to explore how frontline professionals relate to other professionals when working across professions and organizations in caring for clients with combined problems. Therefore, the third sub-question is as follows:

3. What does interprofessional collaboration look like in a fluid team context?

To answer the question of how frontline professionals relate to other professionals and clients, it is also important to understand the reasoning behind frontline professionals' decision-making with clients with diverse socioeconomic statuses. This is because such reasoning reveals how frontline professionals interpret SES cues, which in turn shapes their interactions with clients and with other professionals. By exploring the reasoning of frontline professionals in healthcare regarding varying socioeconomic status cues, this chapter aims to understand the different ways in which professionals' interpretations of clients' status shape professional approaches to caring for clients with combined problems. Therefore, the fourth sub-question is as follows:

4. What reasoning do frontline professionals in healthcare use regarding cues associated with varying socioeconomic statuses?

1.3 Research setting: frontline care in The Hague, the Netherlands

In the Netherlands, healthcare and social welfare are organized through various statutory frameworks such as the Health Insurance Act (Zvw), the Long-Term Care act (Wlz), the Social Support Act (Wmo), and the Youth Act. Each of these laws determines its own funding, regulations, and responsibilities within specific care domains. This domain-specific approach can lead to fragmentation, making collaboration between professionals across different professions and organizations particularly challenging,

especially when caring for people with combined problems (Rijksoverheid, 2025). A multitude of professionals, organizations, laws, funding streams and regulations further increase the systems' complexity and may prevent people with combined problems from receiving adequate care (RVS, 2023). A growing focus on collaboration between frontline professionals across professions and organizations addresses these issues (Nivel, 2024).

This research is situated in The Hague, one of the largest cities in The Netherlands. This city is characterized by highly segregated neighborhoods, with low- income residents requiring considerable support. The growing proportion of people facing combined problems, such as a combination of medical issues, poverty and depression increases the need for collaboration across professions and organizations (Haaglanden, 2021). The Hague provides a research context which is relevant for studying collaboration in caring for vulnerable populations, because it requires frontline professionals, such as social workers, general practitioners and social psychiatric nurses, to work across organizations and professions.

This research involves frontline professionals working in general healthcare, mental healthcare and social welfare. The following is an overview of the various types of professionals involved in this study. First, general practitioners (GPs), along with other frontline professionals such as practice nurses, often have the task of gatekeeper when working with vulnerable clients with combined problems. This means that they often refer to and collaborate with other frontline professionals within or outside of the general practice. As GPs are the first point of contact for clients, they are also the first frontline professionals to interpret clients' problems and to build a relationship with them. Additionally, in the context of long waiting lines in mental healthcare, care demands on GPs have become more complex, and the pressure on general practice care has increased (Hadoks, 2024). GPs are paid by health insurers. Second, frontline professionals in mental healthcare in The Hague often work in interdisciplinary mental healthcare teams focused on specific neighborhoods, to ensure that professionals can offer care that is close to their clients. They work to help clients with more than one problem and some are specialized in clients with severe psychiatric disorders. Often, the care is a combination of medication, psychological treatment and social and community support (Parnassia, 2024). Mental healthcare is also paid by insurance companies. Third, a range of frontline professionals in social welfare is included in this research. Frontline professionals working in social welfare are very diverse and there are various forms of responsibility, governance and funding (among others the Social Support Act and the Participation Act), and, unlike with health insurers, it is managed by the municipality. Professionals in social welfare are among others: social workers or client supporters, case managers social support law, social psychiatric case managers, debt counsellors and community sports coaches, whose tasks vary considerably. Generally, professionals in social welfare are increasingly confronted with people with more severe and combined problems (Wijkz, 2022). Although officially working in the safety domain, police officers

are also included in the second chapter of this study as professionals in social welfare, as they work on the safety and well-being of people with combined problems (Politie, 2024), and they see an increase in reports of people displaying misunderstood behavior (ZonMw, 2025). Police officers work with municipal policies and funding regarding local responsibilities such as safety and nuisance, but they are also part of the national police (ZVHH, 2023).

1.4 Methodology

In both disciplines, public health and public administration, there is increasing attention for frontline professionals, their collaboration, their roles and decision-making (a.o. Kostelanetz, 2022; Valentijn et al., 2013; Green et al., 2021; Nutbeam & Lloyd, 2021; Hamilton et al., 2019; Harrits & Møller, 2014; Harrits, 2019; Raaphorst et al., 2018) and both disciplines benefit from an anthropological lens (o.a. Cecchini, 2021; La Grouw et al., 2024; Maynard-Moody & Musheno, 2022; Zacka, 2017). This anthropological lens wins terrain in both disciplines, because it enables researchers to get close to the everyday experiences and work practices of frontline professionals. The anthropological lens and ethnographic methods of this dissertation add to these research fields in the sense that they help to create an in-depth understanding of frontline professionals' conceptions, roles in collaboration and reasonings in care for clients with combined problems, based on the everyday experiences and practices of professionals. More specifically, applying an anthropological lens to the study of frontline professionals in caring for clients with combined problems adds to public administration literature on street-level bureaucracy by exploring not only what professionals do, but by also making sense of their work, their roles, and of other professionals and clients. In doing so, this research adds depth to the study of street-level bureaucracy by highlighting cultural dynamics of the complex reality of care and collaboration in everyday practices (ibid.). Moreover, this approach contributes to the literature on health promotion. While research on the effects of social determinants on health addresses structural factors driving health inequalities (a.o. Nutbeam & Lloyd, 2021), my research provides a more contextualized perspective including norms and role perceptions that shape professionals' efforts to address health inequalities, using an anthropological lens (Schwartz-Shea & Yanow, 2013; Spradley, 2016). This dissertation's approach thus helps to better understand how frontline professionals interpret health and health interventions in their work (Barnhoorn et al. 2020) with other professionals and clients.

In this dissertation, I use the anthropological lens with a particular focus on emic perspectives, meaning that the phenomenon under-research is studied from the perspective of respondents themselves (Mostowlansky & Rota, 2020). This anthropological lens required a specific selection of qualitative research methods, grounded in ethnographic

research, to understand the cultural aspects of this care issue. Answering the different sub-questions required various research methods. Regarding the first sub-question, since little is known about the health conceptions of different frontline professionals, a largely inductive study with deductive elements was necessary — one that included a wide variety of frontline professionals to capture a comprehensive understanding of their perspectives needed for conceptualization (Nowell & Albrecht, 2019). I did so by developing and carrying out 23 inductive semi-structured interviews with a broad variety of professionals in general healthcare, mental healthcare and social welfare. Based on these interviews, I analyzed frontline professionals' health conceptions through an iterative process of thematic analysis to identify health conception dimensions (Braun & Clarke, 2006). Regarding the second and third sub-questions, to study the actual behavior of frontline professionals in health promotion roles and in interprofessional collaboration it was necessary to conduct research within the professional setting using methods such as participative observation and various forms of reflective interviews. This ethnographic fieldwork allowed me to be present at the frontline professionals' work location and to observe how roles are practiced over a longer period of time where they unfold (Spradley 2016, Walshe et al., 2012; Zahle, 2012). I used various types of observations, participative and non-participative. Depending on the setting and how comfortable the professionals and clients were with my presence, I participated more or less. For example, in some team meetings and house visits I was urged to also ask questions, while in others it seemed more fitting to be non-participative like a fly on the wall. In the positionality statement on page 115 I further reflect on my positionality. I spend 150 hours or 34 days in the field doing observations and informal interviews and with every main respondent I held an additional formal semi-structured interview. Regarding the fourth sub-question, this dissertation pioneered with an in-depth qualitative interview study in street-level bureaucracy research as a way to explore how frontline professionals reason about their clients' SES at work. Most street-level bureaucracy literature on the role of clients' SES in decision-making focuses on one SES-indicator, while I explored how professionals use different SES dimensions together (a.o. Halling, Christensen et al., 2024, although see Raaphorst et al., 2018; Harrits, 2019). I used personas based on the ethnographic fieldwork for sub-questions two and three to stimulate conversations about real-life decision-making in order to examine how professionals assess the problems of clients with varying socioeconomic statuses in 15 qualitative interviews (Loyens & Paraciani, 2023). Throughout the whole study I used thematic analysis as method of analysis. I used sensitizing concepts and the analyses were predominantly inductive.

I position this dissertation as an anthropological study with an emic lens. This emic lens is most clearly used in chapter two, three and five. In addition, the focus on meaning-making runs as a central threat throughout the whole dissertation: in how

frontline professionals view health, how they interpret and shape health promotion, how they engage in interprofessional collaboration, and how they reason about the socioeconomic status of clients. Moreover, in this dissertation, I make use of the methodological variation that is well established within the anthropology tradition, while remaining explorative and context-sensitive.

Through the ethnographic methods, this dissertation emphasizes active collaboration with and engagement of research participants. By centering their perspectives through the research process, the study moves beyond interdisciplinarity toward a transdisciplinary approach (Féaux de la Croix, 2023). These elements of participation, collaboration and co-creation, central to anthropology, are also aspects of a transdisciplinary approach, promoting knowledge across domains and ensuring that research is closely connected to practice (Maguire, 2017). I collaborated with research participants in various stages of the research including research design, validation of the research methods, recruiting and engaging with participants, and reflecting on their work and providing feedback to research participants. For instance, I developed and aligned my research questions in dialogue with a mental healthcare organization, I collaborated with multiple care organizations to recruit respondents, I validated the personas and tested the interviews for empirical chapter four with general practitioners, I facilitated opportunities for respondents to reflect on their work during and after interviews and observations and I provided feedback by sharing a summary of my research projects and offering recommendations for professionals, their managers and policy makers.

1.5 Scientific relevance

This dissertation studies how frontline professionals relate to clients and other professionals in their work with clients with combined problems with an anthropological lens. This micro-level approach around everyday practices of frontline professionals offers a novel perspective in public health and public administration, where studies typically focus on the macro and meso levels, such as policy frameworks and institutional collaborations (a.o. Kikuchi et al., 2023; Tummers et al., 2012). Looking at the role of frontline professionals in care and social welfare through an anthropological lens, this dissertation anticipates to be relevant to literatures on health conceptions, health promotion, interprofessional collaboration, teamwork and street-level bureaucracy. This section outlines how the questions in this dissertation and the anthropological lens are relevant to these strands in the literature.

Health conceptions are typically studied within public health, which primarily focuses on lay perspectives and definitions of health. While not a formal subdomain, the literature on health conceptions forms an important strand within public health,

addressing how lay people and professionals understand health. There is however no insight in how health is understood by various frontline professionals in general healthcare, mental healthcare and social welfare themselves (Armstrong & Swartzman, 1999; Colombo, Bendelow, Fulford & Williams, 2003; Levesque & Li, 2014). By studying health conceptions held by frontline professionals from various professions and organizations, and by exploring dimensions beyond health beliefs, this dissertation is relevant to the literature on health conceptions.

The health promotion literature, which is rooted in public health, describes health promotion roles as perceived tasks and it focuses on medical professionals such as GPs and nurses (a.o. Geense et al. 2013, McAvoy et al. 1999, McKinlay et al. 2005, Brotons et al. 2005). There is however no insight into the health promotion roles of other frontline professionals involved in caring for clients with combined problems. This dissertation is relevant to this literature by exploring health promotion roles of a broad range of frontline professionals in general healthcare, mental healthcare and social welfare, involved in caring for clients with combined problems. Moreover, the dissertation also shows how these roles go beyond merely tasks.

The interprofessional care literature is interdisciplinary by nature, with foundations in public health and health sciences, and enriched by perspectives from disciplines such as public administration, sociology, and organizational studies. There has been much scholarly attention to the study of interprofessional collaboration in care in the context of hospitals (a.o. Valentine & Edmondson, 2015), however, less is known about how such collaboration takes place in complex care contexts outside of hospitals. This dissertation is relevant to both the literature on interprofessional care and literature on teamwork by focusing on how frontline professionals collaborate interprofessionally in less institutionalized settings. Moreover, where interprofessional care scholars (a.o. Schot et al., 2020) often do not explicitly address team fluidity — a concept originating from the literature on teamwork within management sciences — this study aims enrich the interprofessional care literature by exploring interprofessional collaboration in a context of team fluidity (a.o. Valentine & Edmondson, 2015).

The street-level bureaucracy literature, which is prominent in public administration, mostly focuses on typical street-level professionals such as teachers, pedagogues, cops and executive organizations and it studies *whether* SES plays a role in decision-making (Harrits & Møller, Raaphorst & Groeneveld 2018, Maynard-Moody et al., 2022). This dissertation is relevant to the street-level bureaucracy literature on the role of clients' SES in frontline decision-making by studying not only whether, but also *how* GPs interpret SES indicators in their judgments and by adding a less typical street-level bureaucrat to the study of street-level bureaucracy.

The anthropological lens and emic perspective in this dissertation are valuable tools as they bring deeper, micro-level contextual and cultural insights to the study of

frontline professionals in healthcare and social welfare, which are under-researched in both public health and public administration (but see a.o. Cecchini, 2021; La Grouw et al., 2024). In this dissertation, contextual understanding refers primarily to the specific social, organizational, and professional settings in which frontline professionals operate – such as fluid team settings or contexts with high socioeconomic diversity. Thereby, the empirical studies in this dissertation seek to contribute to theory-building by studying how frontline professionals relate to clients and other frontline professionals in caring for clients with combined psychosocial problems grounded in frontline professionals' interpretations. As such, the emic perspective contributes to the health conception literature by exploring what health means to frontline professionals themselves and by including contextual factors related to cultural and social dynamics. This approach thus allows me to study how professionals themselves interpret health. Moreover, the emic perspective in this dissertation is relevant to the health promotion literature as it helps to understand frontline professionals' actual roles from their own perspective and how these roles develop within specific professional contexts and workplaces with distinct sets of values, knowledge and skills (Barnhoorn et al., 2022). Furthermore, the emic perspective also adds relevance to the literature on interprofessional care and teamwork as it helps to understand interprofessional collaboration in a context of team fluidity through a contextualized approach from the perspective of the professionals themselves. Additionally, the emic perspective in this dissertation is relevant for the literature on street-level bureaucracy by studying equity and clients' social status from the professionals' perspective (Harrits, 2019; Harrits & Møller, 2014; Raaphorst et al., 2018; Raaphorst et al., 2024). Through this emic perspective, I look at frontline professionals' own interpretations of social status in differentiating between clients, which enables me to explore how professionals interpret and use status indicators in their daily work.

1.6 Societal and practical relevance

This dissertation's research is in line with the strategic agenda of my workplace Leiden University Medical Centre Health Campus The Hague, which aims to use various academic perspectives to contribute to a healthier life expectancy for all through among others accessible and context-sensitive care (LUMC 2025). By gaining insight into how frontline professionals in care and social welfare relate to vulnerable clients and other professionals, this dissertation aims to contribute to our understanding of health differences and to the role that frontline professionals may play in them. By studying the health conceptions, roles in collaboration and reasonings about clients, this dissertation seeks to provide insight into some of the mechanisms through which health inequalities are either enforced or mitigated in everyday professional work. Seeking to understand

how various actors relate to one another is essential for effectively addressing health differences in the long run.

This study also aims to offer insights that are directly relevant to current national policy initiatives that emphasize a transition towards interprofessional collaboration, integrated care and better alignment between care and social welfare, such as the Integrated Care Agreement (IZA) and the Health and Active Living agreement (GALA) in the Netherlands (NFU, 2025; RIVM, 2024). The dissertation seeks to support such efforts by offering insight into how care is shaped on the ground in everyday work between frontline professionals across professions and organizations. Such insights may inform the integration of such policy initiatives. Additionally, this research resonates with local initiatives such as The Hague Prevention Approach (Den Haag, 2023), which aim to strengthen integrated care at the neighborhood level. By exploring how frontline professionals perceive and experience the conceptions, roles in collaboration and reasonings in their daily work with clients with combined problems, this study seeks to contribute to shaping practical strategies for implementation of such programs on the ground.

1.7 Structure and outline of this dissertation

The overarching research question is divided into four sub-questions, each representing a distinct piece of the empirical puzzle, which collectively contribute to answering the research question. In this first chapter I introduce the research questions and I answer them in the next chapters. The narrative of the chapters in this dissertation is as follows: the chapters are built up around the idea that clients have combined psychosocial problems and that, therefore, more collaboration between frontline professionals from with various professions and from various organizations is needed. This context has implications for the way in which frontline professionals view health and care, how interprofessional collaboration works and how they interpret clients with various SES backgrounds in decision making. Therefore, in this dissertation, both clients' combined problems and interprofessional collaboration are central for how frontline professionals interpret and care for clients in general healthcare, mental healthcare and social welfare.

Chapter two addresses the beliefs about health and about how these should be pursued according to various frontline professionals in care and social welfare. By using an inductive research approach and a semi-structured interviewing method, this study aims to further conceptualize frontline professionals' health conceptions in care for clients with combined psychosocial problems.

Frontline professionals may face challenges in health promotion due to limited resources and clients' combined health conditions. Therefore, the third chapter seeks to explore how professionals behave in health promotion and how health promotion

roles are shaped by professional identities, focusing on behaviors they adopt in those complex care conditions. This chapter focuses on the interpretation and fulfillment of health promotion roles by gathering and analyzing hours of ethnographic fieldwork in various professional domains with frontline professionals caring for clients with combined psychosocial problems.

Frontline professionals often promote health together with other professionals in contexts where teams have high levels of membership change and difference. Therefore, chapter four explores how interprofessional collaboration works in a context of team fluidity. The chapter integrates literature on team fluidity and interprofessional collaboration in care with hours of ethnographic fieldwork to analyze how frontline professionals in general healthcare, mental healthcare and social welfare collaborate in a context of team fluidity, while addressing the needs of clients with combined problems.

While the fourth chapter was about interprofessional collaboration, the fifth chapter is also closely connected to the theme of caring for clients with combined problems that cross professional and organizational boundaries, as professionals' interpretations of clients may also shape how care is planned, offered or referred. As such, chapter five is an in-depth qualitative study that explores how frontline professionals in general healthcare reason about clients with varying socioeconomic backgrounds while working with individuals facing ambiguous problems. This chapter thereby seeks to create insight into how professionals' interpretations of SES play a role in shaping a care plan together.

Chapter six concludes this dissertation by answering the general research question and discussing the specific theoretical, methodological, societal and practical contributions. It describes the findings of the empirical studies and discusses empirical and methodological implications. Additionally, it outlines the dissertation's limitations, recommendations for future research, societal and practical implications. Table 1.1 summarizes the structure of the dissertation.

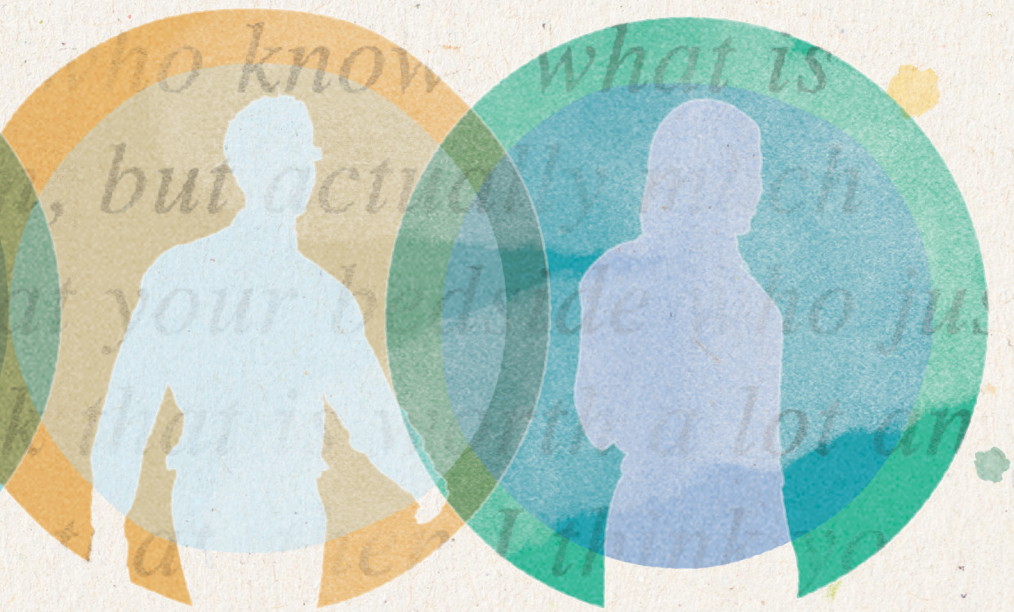
Table 1.1: Structure of the dissertation

Chapter	Research question	Data
Chapter 1	General introduction	-
Chapter 2	How can the health conceptions of frontline professionals in general healthcare, mental healthcare and social welfare be conceptualized?	Semi-structured interviews
Chapter 3	What kind of health promotion roles do frontline professionals in general healthcare, mental healthcare and social welfare have and how are these shaped by their professional identity?	(Participant) observation, informal interviews and semi-structured interviews
Chapter 4	What does interprofessional collaboration look like in a fluid team context?	(Participant) observation, informal interviews and semi-structured interviews
Chapter 5	What reasoning do frontline professionals in general healthcare use regarding cues associated with varying socioeconomic statuses?	Qualitative interviews with personas as conversation starters
Chapter 6	General discussion	-

Chapter 2

Professionals' health conceptions of clients with psychosocial problems: An analysis based on an empirical exploration of semi-structured interviews

Fia van Heteren, Nadine Raaphorst, Sandra Groeneveld, Jet Bussemaker



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Abstract

Background: Caring for clients with combined psychosocial problems involves diverse frontline professionals such as general practitioners, psychiatric nurses, police officers, social support consultants and debt counselors. As these professionals have different professional backgrounds and work in different organizations, their health conceptions, or beliefs about what constitutes health and how this should be pursued, may also differ. Having an understanding of various frontline professionals' health conceptions is relevant, as these may affect interprofessional collaboration in their work with clients with psychosocial problems.

Objective: To understand various frontline professionals' health conceptions.

Design: Inductive qualitative approach.

Setting: The Hague, the Netherlands.

Participants: Various frontline professionals from social welfare, general healthcare and mental healthcare, working with clients with combined psychosocial problems.

Methods: Between September 2020 and April 2021, 23 in-depth semi-structured interviews were conducted with frontline professionals in social welfare, general healthcare and mental healthcare. Based on these interviews, this paper analyzes frontline professionals' health conceptions. After transcription, all interviews were imported into ATLAS.ti for analysis. An iterative process of thematic analysis was used to identify health conception dimensions.

Results: The paper found that frontline professionals' health conceptions differ in three main aspects: 1) health definitions, 2) alignment with clients and 3) contextualization of clients' health.

Conclusions: The main implication of this research is that this inductive analysis of health conceptions provides a first building block in theorizing frontline professionals' health promotion practices.

2.1 Introduction

Combinations of physical, social and psychological issues are referred to as psychosocial problems (Van Hook, 2004). People with such combined problems may, for example, have debts, and suffer from depression or stress, as well as chronic headache. The care for people with multiple and chronic conditions is becoming a major burden for frontline professionals from various domains (Grumbach & Bodenheimer, 2004). Clients with psychosocial problems therefore often receive care from many different professional disciplines, such as general practitioners, social-psychiatric nurses or social workers, who are to some extent working together across professions and organizations. Broad conceptions of health, referring to beliefs 'that guide health professionals in their attempts to understand, explain, make sense of, and respond to health-related phenomena' (Levesque & Li, 2014, p. 629: 629), are considered valuable in this context, since they have the potential to bridge gaps between medical healthcare, mental healthcare and social welfare, thereby possibly de-medicalizing societal problems (2011; M. Huber et al., 2016).

There is a lack of insight into the health conceptions held by frontline professionals in general healthcare, mental healthcare and social welfare (Armstrong & Swartzman, 1999; Colombo, Bendelow, Fulford, & Williams, 2003; Levesque & Li, 2014). Understanding professionals' health conceptions is relevant, as these may affect health promotion and interprofessional collaboration. Our study therefore develops a conceptualization of health conceptions grounded in the definitions expressed by professionals relating to health and the beliefs about required practices. The central research question is as follows: *How can the health conceptions of frontline professionals in (mental) healthcare and social welfare be conceptualized?*[2] To answer this question, we conducted a qualitative interview study among diverse frontline professionals in social welfare and general- and mental healthcare. These professionals all work with clients with psychosocial problems, and collaborate across professional and organizational boundaries.

This study contributes to existing scholarship in two ways. First, the literature on health conceptions mainly focuses on cultural differences in patient groups, and on how conceptual differences between health professionals and patients impede therapeutic processes (Armstrong & Swartzman, 1999; Levesque & Li, 2014; Pachter, 1994). We contribute by studying health conceptions held by professionals rather than lay health conceptions. Second, studies focusing on the health conceptions of health professionals (Huber et al., 2011) focus on physicians, while the health conceptions of diverse professionals involved may affect health-promoting practices, collaborative processes, and, in turn, patient outcomes. Involving other types of professionals than physicians

2 Health conceptions refer to the perceptions of the professionals themselves, and the conceptualization is the result of our analysis.

in the study of health conceptions is relevant in order to grasp a variety of insights. Furthermore, the literature suggests that health conceptions are broader than health definitions and that they consist of various dimensions. We will contribute by further conceptualizing these dimensions. In order to better understand how these frontline professionals work as an integrated body, it is necessary to understand their health conceptions.

In what follows, we first conceptualize health conceptions by drawing on health care literature. Our research context and mainly inductive methodology are then explained, followed by a presentation of our findings working towards a grounded conceptualization of professional health conceptions. We conclude with a discussion and avenues for future research.

2.2 Literature review: defining health conceptions

Notwithstanding some medical studies about what health conceptions include, such as the ability to achieve or exercise a cluster of basic human activities (Venkatapuram, 2013), only few social scientists clearly define what they mean by health conceptions. Levesque and Li (2014) refer to health conceptions as explanatory models 'of health and illness, which include beliefs about possible causes of illness, onset and evolution of symptoms, pathophysiology of illness, severity of illness, and possible treatments' (Kleinman, 1978). This definition primarily focuses on beliefs about illness, rather than health. While illness and health are related, existing research on how people define *health* has pointed out that it could be seen as more than the absence and, hence, treatment of disease (Hjelm, 2006). In addition, health conceptions may be classified not only by beliefs about what health is, but also by what should be done to sustain and improve health and how those involved should behave towards each other (Colombo et al., 2003). For this reason, we define health conceptions as beliefs about what health is, about the factors that affect people's health and about those practices that promote health (Colombo et al., 2003; Levesque & Li, 2014). Professionals' health conceptions thus include definitions of what constitutes health, beliefs about required practices of clients and their environment, and beliefs about how the professionals involved should behave towards clients, their surroundings and each other.

Health conceptions are dynamic (Bircher, 2005; Levesque & Li, 2014), which means that they not only shape how new knowledge and experiences are interpreted, but are also shaped *by* new knowledge and experiences. This implies that health conceptions serve as a frame through which experiences are interpreted and explained (Goins, Spencer, & Williams, 2011; Kleinman, 1978; Levesque & Li, 2014; Torsch, 2000). In our study this means that professionals' health conceptions affect, for instance, the information they pick up, deem important and act upon in interactions with clients. New infor-

mation and knowledge are assimilated 'to fit into existing cognitive structures or schemas' (Levesque & Li, 2014) and beliefs about health could be adapted by new experiences.

Research about health conceptions mainly focuses on clients' lay perspectives of health, and explores differences in health conceptions based on demographic factors (Barnes, Buck, Williams, Webb, & Aylward, 2008; Dubbin, Chang, & Shim, 2013; Robertson, 2006). Recently, however, there has been growing awareness of the importance of various stakeholders' health conceptions, including professionals. For instance, Huber and colleagues (2011; 2016) evaluated among stakeholders such as healthcare professionals, patients, policy makers and insurers, the support for their conceptualization of health as positive health: 'health as the ability to adapt and to self-manage in the face of physical, social and emotional challenges' (ibid., 2011). Positive health includes six dimensions: bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social and societal participation, and daily functioning. They found significant differences between groups, with patients valuing all dimensions equally, while physicians mainly assessed health biomedically (Huber et al., 2016). However, as frontline professionals in social welfare and mental healthcare were not included in this study, what is missing is clarity about how the broader range of professionals providing care define and pursue health in caring for clients with combined problems.

Following our definition of health conception and Huber and colleagues (2016), health conceptions consist of different dimensions. To be able to develop an empirically grounded conceptualization of health conceptions requires an inductive and explorative study including professionals from various professional backgrounds.

2.3 Research approach

The study takes an inductive qualitative approach (Nowell & Albrecht, 2019). The inductive logic fits with the focus on theory building, as empirical exploration is needed to be able to form a conceptualization. The design is fitting because the health conceptions of professionals are highly understudied. The data stem from a qualitative study focused on diverse frontline professionals working with clients with combined psychosocial problems in the Netherlands. The study focuses on the perceptions and interpretations of people themselves, which is important to research because professionals' perceptions are suggested to play a leading role in professionals' practices (Levesque & Li, 2014).

Research setting

The study was carried out with frontline professionals working in social welfare and (mental) healthcare in The Hague, which is a large city in the west of the Netherlands with a population of approximately 500.000. In some areas of this city, the number of years lived in good health is among the lowest in the Netherlands. Psychosocial prob-

lems are common, which is reflected in the occurrence of severe psychiatric conditions, confused behavior, a high risk of anxiety disorders and depression and the increase of dementia. Such problems are particularly common among low-income residents and are often found in combination with social and medical problems (Haaglanden, 2021). To deal with these problems, the city implements policy initiatives that require high levels of collaboration between various professionals and organizations. Hence, because this research needs a diverse sample of professionals to construct a conceptualization, psychosocial care in the Hague is a context that is well suited for this purpose.

Methods and data

Respondents were selected on theoretical grounds. All 23 respondents are frontline professionals in social welfare, mental healthcare or general healthcare working with clients with psychosocial problems in The Hague. This exploratory study aimed to gather a multitude of perspectives and experiences to be able to conceptualize, because different professionals may think differently about health. The sample therefore consisted of various kinds of frontline professionals, such as: out-patient attendants, psychiatric nurses, community police officers and general practitioners. Frontline professionals from different organizations and different neighborhoods in The Hague were interviewed. All respondents have been doing frontline work for years (respondent characteristics in appendix A1). Four respondents are professionals in general medicine, six are professionals in mental health and thirteen respondents are professionals in social welfare. The first author recruited the first respondents through contact with a gatekeeper in a network organization in the field of mental healthcare. Following this introduction to the field, the author used snowball sampling, based on referrals from initially sampled respondents, to recruit respondents with the above criteria in mind. The advantage of this sampling strategy is that it allows the researcher to reach populations that are otherwise difficult to sample (Johnson, 2014). Moreover, this respondent selection made it possible to study health conceptions in a frontline care context where professionals are all caring for clients with combined problems and where there is a major focus on interprofessional collaboration.

We used semi-structured interviews (see appendix A2) to gain insight into respondents' health conceptions. Interviews give insight into people's perceptions and the meanings they attach to situations (e.g. Maynard-Moody, Musheno, & Musheno, 2003). Our definition of health conception served as a sensitizing concept in constructing the interview questions. The concept is sensitizing rather than definitive, because it lacks a specification of attributes or benchmarks which would allow a clean-cut identification of a specific instance of its content. Instead, it gives a general sense of reference and guidance in approaching empirical instances (Blumer, 1954). Following Blumer (1954), the use of sensitizing concepts matches the inductive nature of this study, recognizing that what we are referring to by any given concept inspired by the existing literature

may shape up in different ways in each empirical instance. As such, open questions were asked about health views, pursuing health, why it is important, how they interact with other involved stakeholders. Respondents were also asked to give examples of daily work activities and to reflect on their experiences at work. The interviews, varying between 45-90 minutes in duration, were conducted between September 2020 and April 2021. Most interviews took place at a location chosen by the respondents, although some interviews were held online because of Covid-19 restrictions. They were all tape recorded, transcribed verbatim and imported into ATLAS.ti for analysis. Informed consent was given by all respondents. This study was registered and approved by the Medical Ethical Review Committee of Leiden, The Hague and Delft (N20.158).

The analytical process moved back and forth between transcripts, analytical memos, emerging themes, and theory. We used thematic analysis to identify key themes relevant to our research question, and followed different steps in our analysis outlined by Braun and Clarke (2006).The iterative and recursive analysis began with initial open coding, during which categories were assigned to the themes in the transcripts. We coded the content of the full transcripts in detail but paid special attention to codes that were relevant to our sensitizing concept of 'health conception'. We then searched for more abstract themes by comparing the codes within and between the transcripts and by organizing them into codes and more general code families (ibid.). These code families were subsequently refined by going back to the coded transcripts and rereading them to check whether the themes reflected the meanings found in them. After multiple rounds of coding, the general code families reflect our final health conception dimensions (code table in appendix A3). As our aim was to construct a conceptualization, we paid particular attention to the internal homogeneity and external heterogeneity of the dimensions (Braun & Clarke, 2006). This holds that data 'within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes' (Braun & Clarke, 2006). In the coding process, conflicts in the emerging patterns were explicitly looked for, which led to the accounts and interpretations being re-examined. Lastly, in the discussion stage, we looked back at the sensitizing concept and theoretical framework to reflect on how our interpretations differ from the existing literature.

To increase the validity and reliability of our research, we followed several procedures outlined by Krefting (1991): negative case analysis, keeping notes about our data collection and analysis and peer examination. Throughout the analytical process, we searched the data for insights that would disprove our emerging insights, we wrote memos and kept logs on the steps taken in the coding process and multiple researchers were involved in interpreting the findings.

For the purposes of presentation, quotes were translated into English with the intention of maintaining the original meaning. The quotes that were used in the analysis serve an illustrative purpose, best representing the themes found. Information that

could identify respondents is omitted from the findings. The remainder of this article presents and discusses the main themes and their interpretations.

2.4 Frontline professionals' health conceptions: a three-dimensional conceptualization

This section presents an analysis of health conceptions held by frontline professionals in social welfare and general- and mental healthcare. Based on the inductive analysis of the interview data, we found that health conceptions consist of three dimensions: (1) health definitions, (2) alignment with clients and (3) contextualization of health (see table 2.1). In what follows, the different health conception dimensions and their substantiations will be presented. Following examples from the data, we will conceptualize further by describing each dimension and its boundaries in more general terms. In the second part of the results section, we will address the interplay between the different health conception dimensions in our empirical data.

Table 2.1. Health conceptions: dimensions

Dimensions	Substantiations
Health definitions	The ways and extent to which a client is seen as healthy.
Competence and behavior	Health as the extent to which people can rely on themselves or their network to do what they want by being strong, vital and communicative.
Mental health	Health as the extent to which a person is mentally healthy and experiences stability.
Physical health	Health as the extent to which a person is without physical complaints and without threat to life.
Alignment with clients	The ways and extent to which horizontal and vertical distances in the professional-client relationship are kept to a minimum.
Being approachable	The extent to which the professional is close to a clients' lived experience.
Seeking alignment	The extent to which and the ways in which the professional invites the client to share their preferences and takes these into account in the treatment plan.
Contextualization of problems	The extent to which and the sources used by professionals to place clients in their broader context to understand what actions will be appropriate in helping them.
Assessing social context	The extent to which and how a client's social circle is assessed and connected with.
Assessing other problems	The extent to which and how problems emerging in other life areas are assessed.

Dimension A: Defining health

This first health conception dimension refers to the ways in which and the extent to which a client is seen as healthy. By defining health, frontline professionals equip themselves with ideas about when a client could be considered healthy and thus what they, both professional and client, should see as goals to work towards. Frontline professionals have varying ideas about whether certain aspects of health definitions should be considered as goals when working towards healthy clients. We found three distinct ways in which health definitions are substantiated by professionals, namely: competence and behavior, mental health and physical health, which will be discussed below.

Competence and behavior

Health as competence and behavior encompasses the extent to which a client can rely on themselves and their network to live as they wish. Accounts about competence and behavior are mostly about clients showing that they can live independently by using skills and knowledge such as being powerful, vital or health literate. Health literacy could help clients to make substantiated decisions about their health. In this view, healthy clients are thus knowledgeable and independent, and can communicate, self-manage and self-learn, they deal with problems, participate in society, and recognize their patterns and signals (of stress). The following examples show the importance of competence and behavior as a health definition for frontline professionals working with clients with combined problems:

> *'[…] [along with] all sorts of problems that someone […] [may have,] […]the coping capacity is the extent to which someone can, from themselves, have the power and tools to deal with that (respondent 1, social worker).'*

> And

> *'[…] this one man […] is much healthier in a way […], because he makes sure his house is tidy and that is some kind of resilience that the other kid doesn't have yet. […] He still uses cocaine, but he has more control […] and he doesn't have friends visiting him at 2 a.m.; […] He remains below the police radar and doesn't create a nuisance (respondent 3, police officer).'*

This definition of health as competence and behavior is a particular one. The examples show that a client is considered healthy if they are competent to deal with problems themselves or are able to ask others in their social circle for help. The examples show that health is not defined in a physical or mental way, but rather as the skill of being in control of your own and your social environment's behavior. As such, healthy clients have the individual potential to do well in society despite the many problems they may

have, because they are able to take control, set boundaries and know when and how to ask for help.

Mental health

Mental health, the second health definition, can be distinguished from competence and behavior. Whereas frontline professionals with a competence and behavior health definition see clients as healthy when they show great individual potential, professionals with a mental health definition stress that clients are healthy when they feel healthy in their own experience. As the following examples show, clients are seen as healthy when they can live life the way they prefer, without necessarily showing great potential or competent behavior. When clients have an illness, but they do not experience this as problematic in their lives, they can still be healthy in this health definition. This definition stresses that health is very personal and it is related to the client's perspective of life. The following examples show that respondents use different words to describe mental health, but their interpretations are similar.

> '*This [,health,] is very personal. [Clients are healthy] When [they] [...] have no complaints and don't experience barriers to being in balance'* (respondent 4, social case manager).'
>
> And
>
> '*The client perception is important, because they feel healthy when they experience few obstacles in daily life. [...] What we see helps here is to have a goal in life, for example through a job and daily structure. This kind of perspective could help clients not to fall into a depressive spiral* (respondent 5, client supporter).'

These examples show that mental health is personal and perceptive, which is argued by most respondents. However, some respondents make an exception when actors in the clients' surroundings experience the client to be unhealthy, for example through danger to themselves or others. Therefore, in their words, clients are mentally healthy when they '*don't stand out*' in society (respondent 22, police officer).'

Physical health

Physical health is the third kind of health definition in our data, which does not focus on client behavior or experience, but instead on a client's physical abilities, like being able to move your body, having a healthy weight or being without any serious physical illness. The following two quotes illustrate this conceptualization of a physical health definition.

> *'Clients are healthy when they are not in a life-threatening situation* (respondent 20, community sports coach).'
>
> And
>
> '*Objectively, someone with no physical complaints is healthier than someone who chronically needs a wheelchair.*(respondent 5, client supporter).'

These respondents, thus, define health as having good physical abilities. Nevertheless, even though they strive for good physical health, being perfectly healthy physically does not seem possible in the eyes of these respondents who work with clients with multiple problems.

Health definitions are particular in the sense that they reflect ideas about what goals professionals, clients and their environment should work towards. We have seen that these goals could relate to competence and behavior, mental health and physical health.

Dimension B: Alignment with clients

Alignment with clients, the second health conception dimension, can be distinguished from defining health. Whereas health definitions help respondents to make sense of which goals they could work towards, health definitions do not necessarily imply how they perceive that these goals should be achieved. As the following section shows, health conceptions are constructed not only by health definitions, but also by perceptions about the ways in which — and the extent to which — horizontal and vertical distances in the professional-client relationship should be minimized. We conceptualize alignment as professionals' intention to come close to a client's lifeworld, experiences and preferences by minimizing horizontal and vertical distances. Two sorts of alignment in the professional-client relationship are at play in frontline professionals' work with clients with psychosocial problems: seeking approachability and seeking alignment.

Being approachable

Approachability relates to the intent to connect with clients in a relationship of trust. This happens in different ways: first, the adjustment of speech and conversation are considered important connective aspects to build the trust needed to help a client. Second, when professionals experience the lifeworld of their clients as too distant, consequently prohibiting them from helping these clients, respondents try to be approachable by being physically present in the clients' living environment. The following quote is an example of the latter. The respondent in this example sets up an office close to their clients with the intention of being approachable to them physically:

> '*Once a week we [...] had this consultation office at the local housing association [...] in the neighborhood. [...] This was a consultation hour for the whole neighborhood [...]. [...] We [wanted] to do it here [...], in the neighborhood. And then they [, the youth,] came and did homework assistance [...] and that is that kind of steering, helping, advising, supporting and talking. Talking until you can hardly utter another word*[3] (respondent 3, police officer).'

The example shows that being approachable physically could open up the possibility to connect further through conversation and thereafter to potentially achieve health-related goals. Approachability is especially relevant to respondents when they are caring for clients who may normally not seek help easily.

The other quotes regarding aligning similarly show how respondents create and have a relationship of trust with clients that helps them to work towards health goals together.

Seeking alignment

Seeking alignment elicits a second kind of alignment with clients, which entails the extent to which and the ways in which a professional intends to invite clients to share their preferences and to take these into account when constructing the treatment plan. In the following quote, the frontline professional explains how she tries to get clients to open up in order to gain an understanding of what clients find important.

> '*Questioning, probing, investigating: sometimes it's also [the case] that they don't know, you know, ignorance* (respondent 11, mental health worker).'

This respondent asks questions to invite clients to share their preferences. Professionals take these preferences into account to a certain extent in constructing the treatment plan. Alignment about health definitions is important to respondents because when the client agrees with or brings up the health problem, they are found to be more eager to work towards health goals. However, respondents also argue that sometimes clients have to be educated first, before they should say what they find important. This is the case, for example, when respondents think that clients are not aware of what is good for them. Thus, even though professionals try to seek alignment by opening up towards clients' ideas about health and care, they sometimes decide to work with their own health definitions.

3 Freely translated from Dutch : 'Lullen tot je een ons weegt' (respondent 3, police officer).

Dimension C: Contextualization of problems

The data shows how, in the perception of respondents, alignment helps professionals to minimize horizontal and vertical distances to their clients, which may help to work towards health goals. However, alignment does not help professionals to gain insight into how clients' broader context may impact their health or their opportunities to become healthy. As the following section shows, to be able to reach health goals, respondents also need to assess various contextual sources — beyond the client themselves — that help professionals to understand what clients may be able to handle regarding being and becoming healthy, or which actions are appropriate when helping them. Professionals' examples about contextualization of clients' health are clustered around the two aspects: 'assessing social context' and 'assessing other problems', which will be discussed below.

Assessing social context

Respondents often explain that they need to assess clients' social context to decide what clients, together with their environment, could handle in becoming healthy. As such, frontline professionals assess personal social circumstances that may impact clients' preferences or may facilitate or hinder clients' potential health. When assessing the personal social context, frontline professionals try to get more information from clients about their social context, but also from their environment including family members, friends, or other professionals involved with the client. Professionals may gather such information with the client through house visits or conversations as well as by contacting other stakeholders directly. Respondents' examples show that such contextual information could help professionals to figure out whether a client has a strong enough environment to reach self-efficacy or other health goals. The following examples show why frontline professionals assess the client environment to figure out what health problems they could work towards.

> *'You also learn about the system surrounding them: how the children are, the partner, but also the bigger family. […] And the funny thing is that you recognize patterns. Who gets ill and how they deal with certain problems […]. You are a family doctor, and yes that has great added value* (respondent 16, general practitioner).'

And

> *'And the environment, I think that they also play a big role in health. Yes, I'm in an environment where people think this is important […], but [clients in] our target group […] are of course often alone, they live alone, have a small social network or none at all. Yes, if you have been an addict for years, than I think you are […] often kicked out by everybody […], you lie*

> *and you cheat. Yes, people with psychiatric problems, [...] they are labeled as crazy by their environment* (respondent 11, mental health worker).'

The first example shows how knowing about the client environment can help clarify a client's possible health problems. The second example shows how knowing about the client environment can also increase the knowledge about possible solutions which may be appropriate for a client, including which stakeholders, professionals or relatives may be involved in these solutions. In assessing the client's social context, frontline professionals in care and social welfare try to gather as much information as possible, because the care question often does not come from the client themselves, but from their social network and other professionals involved. Importantly, according to our respondents, involving other stakeholders could increase the possibility for more chronic care instead of constantly falling behind (respondent 16). In other words, clients can be helped faster and better. Even though involving the client's social context is argued to be important among all professions, respondents feel they do not always have the time and resources for this intensive work.

Assessing other problems

Apart from assessing clients' social context in trying to gain an understanding of their support system, frontline professionals sometimes also assess other problems than the ones presented by the client to work out what health goals they might be able to work towards. Professionals often do this in case of multiple or vague problems that often repeat themselves. The following example shows how professionals assess other problems.

> '*To assess a client's health and needs, you need to do good research, because when you have good diagnostics, you can give good treatment. Often, professionals only treat one aspect, like depression. And if you are placed out of your house or have financial or relationship problems, to make a qualitative diagnosis you have to look into someone's broader health. So, what I think is important is the mental, but also the physical health and the different life areas, like work, living, relationships and friends, these are often much more important. [...] All these kinds of things, to map these out* (respondent 11, mental health worker).'

This example shows that the respondent thinks it is important to look at multiple and underlying problems when thinking about the health of clients. All respondents believe that it is important to look at health broadly, because they argue that different aspects of health and different problems influence one another. Some put it more strongly, by saying that addressing only one health aspect is not useful. Even though they believe

this to be important, some respondents say they do not have the time, resources or professional role to look beyond the health area they are specialized in.

Interplay between dimensions of health conception

Based on our analysis, we have argued that frontline professionals' health conceptions consist of three dimensions, including health definitions, alignment with clients and contextualization of clients' health. In the section above, we have conceptualized these dimensions. However, the analysis shows that empirically these dimensions and their interpretations often appear in combination and consequently together form the health conceptions of professionals. The number of respondents in which the dimensions co-occur is presented in a co-occurrence table, which we produced in ATLAS.ti (appendix A4).

First, in our analysis, we noted that the different health definitions appear in combination with each other. Ten respondents consider mental health important together with health as competence and behavior. This co-occurrence may be due to the characteristics of the context in which frontline professionals work with clients with multiple problems. More specifically, when a client is mentally healthy, they feel stable, which may coincide with behaving in ways that are seen as competent. Similarly, when one is not able to be healthy in a competence and behavior sense, this may also cause suffering in terms of mental instability. Even though the two definitions seem often closely related in practice, they are different conceptually. Mental health is about health experience, and competence and behavior are about abilities and actions. A combination of all three health definitions is rarely present in our empirical data. This happens for example, when a client has severe physical problems and cannot walk, they may not be able to live the life that they want due to little social support. Clients may also experience this suffering differently mentally. At the same time, physical problems are often triggered by mental- and social problems, such as financial difficulties.

Second, we noted that five respondents who focus on seeking alignment, also find mental health definitions important. This may be because in the mental health definition, client preferences are argued to be relevant. Similarly, when seeking alignment, respondents actively try to find out what the client preferences are by asking them questions. Conceptually, seeking alignment differs from the mental health definition as seeking alignment is a more active dimension that respondents employ to find out what the client's preferences are. Moreover, four respondents think seeking alignment and health as competence and behavior are important. This mostly happens when professionals argue that clients should be capable of personally communicating their health needs, and professionals see a less active aligning role for themselves. A possible risk here is that not every client is able to communicate their own needs, and that consequently their problems are not seen and treated. At the same time, when client perceptions are abnormal and may be dangerous, or when it is difficult to determine whether clients know that the body and mind are connected, professionals often focus

less on alignment, but instead focus on what they think is important regarding their client's health.

Third, for eight respondents, seeking alignment co-occurs with contextualization of problems and for seven respondents with contextualization of social context. When a professional seeks alignment, they try to figure out the client's health perspective. In a similar line of thought, when a professional contextualizes, they try to find out what in the client context or which problems make it possible or impossible to work towards being healthy.

Fourth, the analysis shows that five respondents who define health as competence and behavior find that assessing social context is important. This could be because respondents assessing clients' social context may realize that not all clients have a social context that enables them to be healthy in the sense of competence and behavior. For example, clients without a family may be unhealthy not because they do not want to take care of themselves, but because they are not able to do this themselves or with the help of a social network. Moreover, assessing other problems co-occurs four times with mental health definitions, because when professionals treat mental health, they focus on health experience. They do not only focus on one problem that clearly presents itself, but may dare to look broader to unravel other problems clients experience.

The analysis not only shows how frontline professionals aim to combine health conception dimensions in practice by caring for clients with combined psychosocial problems, it also shows that frontline professionals may draw on more than one health definition at a time. This makes it challenging to disentangle health conception dimensions in frontline work. However, the conceptual differences should be taken into account when studying frontline professionals. In the following section, we elaborate on the distinctiveness of the three-dimensional health conception and discuss how it relates to the existing literature. We also present opportunities for studying health conceptions in frontline care further.

2.5 Discussion

The health conception literature has been silent on the health conceptions of professionals. In this article, we have addressed this lacuna by further conceptualizing the health conceptions held by professionals (Colombo et al., 2003; Huber et al., 2011; 2016; Levesque & Li, 2014) by exploring the health conceptions of frontline professionals in care and social welfare. Health conceptions refer to beliefs about health and the aspects that may help promote clients' health (Levesque & Li, 2014). In line with the health conception literature (on clients, medical professionals and other stakeholders), we argue that health conceptions consist of different dimensions (Armstrong & Swartzman, 1999; Huber et al., 2011; Levesque & Li, 2014; Pachter, 1994).

What we learn from this research is that in empirical practices, health conception dimensions and their substantiations are often connected. In line with Levesque and Li (2014), this means that professionals' health conceptions affect, for instance, the information they pick up, consider important and act upon in interactions with clients and that beliefs about health could be adapted by new experiences, such as when providing care.

These findings underline the importance of the competence and behavior health definitions and consequently the individual responsibility of clients, which run through the analysis as an apparent theme for many respondents. Professionals assume that clients should be able to express preferences themselves, to know what they want or to take care of themselves. This assumption is even held by most professionals who focus on assessment of the client's social context. Even though an assessment of social context may reveal clients' restrictive circumstances, some respondents argue that clients are still responsible for their own health. This focus on personal responsibility is not surprising in light of public views including the neo-liberal idea that ill health is primarily self-inflicted and is dependent on an individual's unhealthy behaviors, which are considered a matter of choice (Berg, Harting, & Stronks, 2021; Galvin, 2002; Hughner & Kleine, 2004). As these views are also present in the broader care sector in which our respondents work, they may play a role in their work through socialization in both professional and organizational settings (Moyson, Raaphorst, Groeneveld, & Van de Walle, 2018; Weis & Schank, 2002; Zarshenas et al., 2014).

This research makes a threefold contribution to the health conception literature. First, as the health conception literature suggests that health conceptions may consist of various dimensions, we explored dimensions of health conceptions by inductively investigating frontline professionals working with clients with combined problems. While positive health describes six dimensions of health, these do not do justice to the dimensions we conceptualized, which relate not only to beliefs about health, but also to what is expected of clients and other involved stakeholders. The inductive element was therefore useful in our analysis to further explore health conception dimensions and it may consequently enrich the literature on health conceptions. Second, this study is one of the first to examine health conceptions of professionals by involving frontline professionals from various professional backgrounds, who are involved in caring for clients with combined problems. Involving a diverse sample of respondents was necessary to construct a conceptualization. This conceptualization can be further validated by researchers studying larger samples of frontline professionals. They could find, for example, how the three dimensions are connected and combined in the actual work practices and behaviors of professionals and thus, what their health conceptions look like. This is especially relevant as health conceptions shape and are shaped by new knowledge and experiences (Levesque & Li, 2014 and others). Third, although health conceptions give insight into ideal practices, professionals stress that they are not always able to act upon them because of limited resources and combined health situations of

clients. More research is needed into how health conceptions manifest implicitly in actual health-promoting practices and through which mechanisms. In working with combined problems, health promotion practices may differ along professional and organizational lines, but may also relate to the tendency to work in an integrated group or to the social backgrounds of the clients with whom the professionals work (Baumann, 1961; George, 2017). This raises questions about how socialization processes may impact these frontline professionals' actual practices, how frontline professionals are able to collaborate across borders and how they decide to promote the health of clients with varying social backgrounds. Such research is especially relevant in this context in which health promotion requires that professionals understand each other and their clients. Our analysis of health conceptions thus provides a framework to study and nuance health conceptions and their use in care practice.

Furthering the study of professional health conceptions is relevant for the scientific literature, but also for discussions among frontline professionals, managers and policymakers on how health is understood and how good health can best be achieved. Knowing about and comparing professionals' health conceptions is important because professionals care for vulnerable clients together and misunderstanding may impact their abilities to do this. Therefore, we recommend that managers of frontline professionals in care and social welfare engage in dialogue about health conceptions and their use among professionals. Future research should therefore try to understand how frontline professionals use health conception dimensions in practice. Moreover, further conceptualization would make it possible for frontline professionals and their managers to reflect on their own work through the use of these dimensions.

2.6 Limitations

This research has limitations which need reflection. A limitation of this study is that it used only the method of semi-structured interviewing. Whereas the rich narratives yield insight into the health conception dimensions perceived as important by frontline professionals, they are less apt to study frontline professionals' actual health-promoting behavior. This study has provided insight into how health conceptions of frontline professionals in care and social welfare can be conceptualized in three dimensions. Future studies could complement this effort by conducting participant observations and experiments to study professionals' behaviors more explicitly. Another limitation is that our strategy of snowball sampling does not guarantee representativeness (Johnson, 2014). The reason for this is that our initial respondents may have nominated professionals they know well or thought would be interested in the topic of health conceptions. However, this sampling strategy was necessary to recruit respondents matching our specific

study focus, namely, professionals who work with clients with combined psychosocial problems and who are to some extent working together to care for clients. The goal of this research was to conceptualize health conceptions by exploring the health conception dimensions of various frontline professionals in social welfare and healthcare. We aimed for maximal variation in order to form conceptualizations; it was not our goal to make generalizable statements about different professional groups. The study's methodological approach allows for theoretical but not empirical generalization across contexts (Feldman & Orlikowski, 2011). It is possible that frontline professionals who are not working with this specific client group perceive health differently. It is nonetheless likely that the findings are relevant for other areas of frontline care work distinguished by high levels of complexity and prolonged encounters between professionals and clients. These health conceptions may go beyond professionals working with this specific client group, especially because our respondents are often more general care professionals who also work with clients without combined problems. Comparative research is needed to further develop and validate this conceptualization of health by frontline professionals. To this end, future research could compare the perception and use of health conception dimensions within different care organizations and between different types of frontline professions to advance the theory of this field of study. It was also beyond the scope of this study to evaluate whether and how the use of different health conception dimensions results in better or worse outcomes for clients (Møller, 2022). These are important questions for future research.

2.7 Conclusions

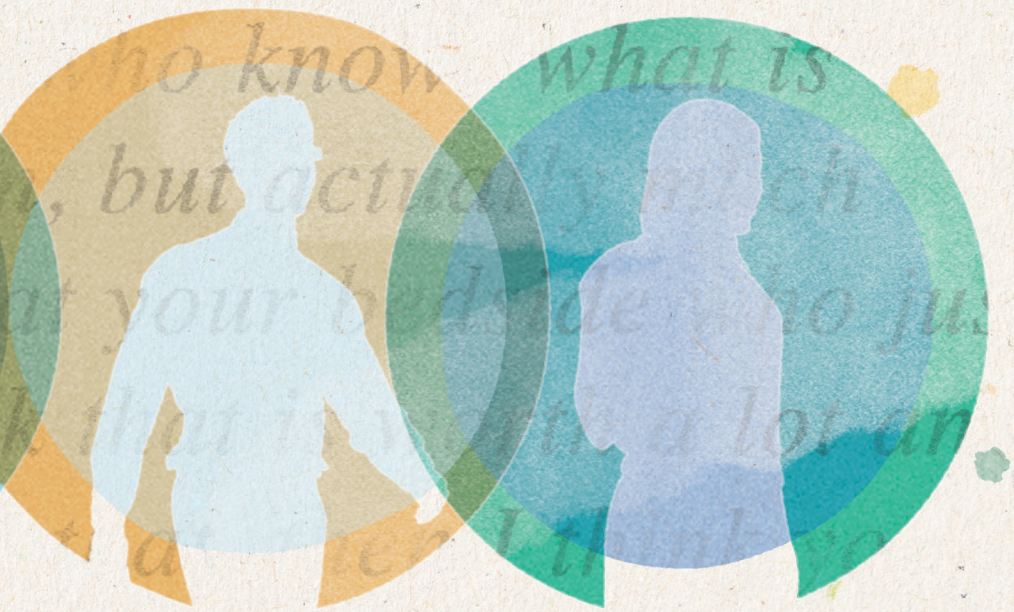
Drawing on qualitative in-depth interviews among frontline professionals in healthcare and social welfare working with clients with psychosocial problems, this research found that professional health conceptions can be conceptualized along three dimensions that go beyond health definitions such as those studied by others (Huber et al., 2016). First, frontline professionals in care and social welfare define health in different ways. Second, they aim to interact on the same level as clients to make the relationship equal. Third, professionals say to place clients in their broader contexts in order to understand what kind of health goals and care are appropriate.

This study also explored the interplay between the different health conception dimensions and has shown that frontline professionals in care and social welfare combine health conception dimensions and health definitions when treating clients with combined problems.

Chapter 3

Health promotion roles shaped by professional identity: an ethnographic study in the Netherlands

Fia van Heteren, Nadine Raaphorst and Jet Bussemaker



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Abstract

How frontline professionals in care and social welfare interpret and fulfill their health promotion roles is of great importance for the health of the vulnerable clients they work with. While the literature on health promotion is limited to describing the roles of healthcare professionals, this study examines the health promotion roles held by various frontline professionals when working with clients with combined psychosocial problems and how this is associated with professional identity. Based on ethnographic data from Dutch frontline professionals in social welfare, general healthcare, and mental healthcare, this article shows how various frontline professionals promote health by reframing and customizing health problems and that this is associated with how they identify as pragmatic or holistic professionals.

3.1 Introduction

Given their position at the frontline of care, how professionals in social welfare, general and mental healthcare fulfil their responsibilities is of direct importance to the clients they work with (Zacka 2017, Von Greiff, Skogens et al. 2020). The health of the population is influenced by social determinants throughout the life course. This implies that efforts aimed at promoting health has in recent decades become a collective responsibility, needing a comprehensive approach involving various sectors and diverse partners, rather than being solely the purview of the (mental) healthcare sector (Shields- Zeeman 2021). It is therefore important to look not only at the health promotion roles, including prevention and changing behaviors of individuals with respect to their health, of medical professionals such as general practitioners (GPs) and practice nurses, but also at the roles of other types of professionals (McAvoy 2000, Geense, Van De Glind et al. 2013, Kemppainen, Tossavainen et al. 2013). Insight into the different health promotion roles of professionals is relevant because this may help them to work together to promote the health of vulnerable clients suffering from combined problems.

A professional role embodies the perceived professional tasks and functions that are specific to a professional group. The role that professionals play, or what professionals value and how they behave, is shaped by the ways in which they are socialized in different professional contexts (Weis and Schank 2002, Møller 2021). We are aware of the literature on professional logics (Abbott 2014, Cecchini and Harrits 2022), but in this paper, we adopt the approach of examining professional identity. Professional socialization is a process of learning, interacting, developing and adapting (Dinmohammadi, Peyrovi et al. 2013), and contributes to the formation of identity. Identity is someone's self-definition, which answers the question "*Who am I?*" or "*Who are we*?" (Ashforth and Schinoff 2016). In turn, professional identity is defined as 'the attributes, values, knowledge, beliefs and skills shared with others within a professional group' (Adams, Hean et al. 2006). As such, we expect that professional identity, or subjective self-conceptualization associated with the work role (Adams, Hean et al. 2006), shapes professionals' health promotion roles (Agresta 2004).

Our research question is therefore as follows: *What kind of health promotion roles do professionals in healthcare, mental healthcare and social welfare have, and how are these shaped by their professional identity?* This question will be answered through an ethnographic study of various frontline professionals in social welfare, mental healthcare, and general healthcare who work in health promotion with clients who have psychosocial problems.

This study contributes to the professional health promotion literature in two ways. First, earlier health promotion studies focus on medical professionals such as GPs and nurses (a.o. Geense, Van De Glind et al. 2013). Our research includes various types of frontline professionals, in mental healthcare and social welfare, but also in general

healthcare, all of whom are involved with clients with psychosocial problems. Second, while empirical studies on health promotion have offered descriptions of different professional health promotion roles (e.g. Geense, Van De Glind et al. 2013), these are only described as tasks. In this research, we offer a conceptualization of health promotion roles and how these are shaped by professional identity. As professional roles develop within specific professional contexts and workplaces with distinct sets of values, knowledge, and skills (Barnhoorn, Nierkens et al. 2022), we examined the professional embeddedness of health promotion roles. Understanding how health promotion roles are shaped by professional identity is furthermore relevant for discussions among professionals, managers, and policy makers on how to ensure quality and continuity in care. To this end, we studied professionals over a longer period of time to examine how and why professionals take on health promotion roles.

In the following sections we will present our theoretical framework delineating the core concepts of this study, after which we will describe our ethnographic methodology and research context. We will then present our findings and conclude with theoretical and practical implications.

3.2 Theoretical framework

Professional health promotion roles

Health promotion is a community-based and collaborative practice based on social and health policies (Baisch 2009), which includes prevention and behavioral change (Kemppainen, Tossavainen et al. 2013) with the aim of giving people control over their own lives (Labonte 1994). It is also seen as preventing or minimizing risks or risky behavior (Cecchini 2021) pertaining to the health risks of clients construed as high risk, while professionals working in health and social welfare are seen as "risk-minimizing agents" (Cecchini 2018). In line with this, professional health promotion is regarded as promoting clients' action competences to minimize risk (ibid.). A professional role is understood as the perceived professional tasks and functions that are characteristic of a professional group (Agresta 2004). In our study, health promotion roles are understood as how professionals perform their role in relation to the client through different activities, responsibilities and tasks that are performed aimed at improving the health of clients (Tannahill 1985, Geense, Van De Glind et al. 2013).

Professional health promotion roles have been studied for medical professionals such as GPs (McAvoy, Kaner et al. 1999, Geense, Van De Glind et al. 2013), and nurses (see McAvoy, Kaner et al. 1999, McKinlay, Plumridge et al. 2005, Geense, Van De Glind et al. 2013, Kemppainen, Tossavainen et al. 2013), with studies exploring professionals' perceived approaches and attitudes towards health promotion without observing their actual roles. Their health promotion tasks (that together make up a role) range from

making an enquiry about a client's lifestyle, prevention, providing information, advising, referring, and actively screening for a disease (McAvoy, Kaner et al. 1999, McKinlay, Plumridge et al. 2005, Geense, Van De Glind et al. 2013) to modifying behaviors (Brotons, Björkelund et al. 2005). Existing literature on professional health promotion roles is highly descriptive in character and lacks analytical precision. Based on an analysis of this literature, we found that health promotion roles differ on three dimensions related to the type of involvement, perceived abilities, and perceived importance in health promotion.

Type of involvement

The literature shows that health promotion consists of several types of involvement, namely, working *reactively* and working *proactively*. Reactive involvement means that professionals respond to clients' clearly expressed or specific symptom or problem (McAvoy 2000, Kemppainen, Tossavainen et al. 2013). As such, during illness visits or conversations regarding specific symptoms, professionals educate or advise their clients about behavior, lifestyle or possible risks (McAvoy, Kaner et al. 1999). Reactive health promotion among nurses is focused on risk-specific practices related to disease in favor of behavioral, disease-focused, lifestyle-oriented determinants of health. Such strategies may fail to incorporate broader societal dimensions of health promotion (Runciman, Watson et al. 2006, Whitehead 2006, Casey 2007). *Proactive* involvement is concerned with assessing risks and counseling, for example during routine check-ups (McAvoy, Kaner et al. 1999, Kemppainen, Tossavainen et al. 2013). In proactive involvement, professionals aim to work as teachers to educate their patients (McAvoy, Kaner et al. 1999). The main difference with reactive is that in proactive involvement, it is not necessary for clients to have any worrying symptoms to react on.

Perceived abilities

Perceived *abilities* in health promotion hold that professionals relate to their abilities and responsibilities in health promotion. On the one hand, professionals feel that health promotion is part of their job and they are *able*, *skilled,* or *responsible* to help clients to stay or become healthy. Professional knowledge about health promotion activities helps to make them feel that they are able and/or responsible. On the other hand, professionals may feel that they are *unable*, unskilled and/or irresponsible for health promotion (Geense, Van De Glind et al. 2013). As Geense and colleagues (2013) mention, unable professionals could ignore health promotion activities, because it is up to other stakeholders to take responsibility. Moreover, some professionals only feel able to promote health when they can do so in collaboration with other stakeholders. For example, by confirming or supporting the plans made between the client and a colleague (ibid.), or by empowering individuals or communities (Kemppainen, Tossavainen et al. 2013).

Perceived importance

Perceived *importance* in health promotion means that professionals relate to whether health promotion is a worthwhile part of their job. Professionals may *emphasize* health promotion as a key component of their work (McAvoy 2000). They are motivated or willing to promote health, which can be shown by offering support to other professionals working on health promotion. Professionals may also be *skeptical* about health promotion and its results and effects (Geense, Van De Glind et al. 2013), because they expect it will not make a difference. For example, while they try to motivate clients as much as they can, they may, due to low expectations, not refer them to other professionals that could further help (ibid.).

Professional identity

Drawing on identity theory, the individual's sense of self consists of a personal identity with characteristic attributes such as gender or age and a social identity including categories of people that may include nationality or a team member. A person is therefore a unique individual and socially they are part of a group (Ashforth 2000). Individuals give meaning to their identity through interaction with others (Weick 1995). Identity is thus a relational concept and is formed, among other things, through comparison (Ashforth, Harrison et al. 2008). Identity construction is the process through which actors come to define who they are, and identification is the extent to which one internalizes an identity as a — partial — self-definition (Ashforth and Schinoff 2016). Professional identities are often robust due to clear standards (Ashforth and Schinoff 2016). For example, a professional category such as doctor becomes meaningful in relation to other professionals in the category of social worker or bureaucrat (Ashforth 2000). Such well-defined groups tend to be exclusive, concrete, and context specific with clear goals, norms, member interdependencies, and interactions between them (ibid., Ashforth 2000, Adams, Hean et al. 2006, Pratt, Rockmann et al. 2006). Professional identity is constructed in interaction with others as it relates to 'how people compare and differentiate themselves from other professional groups' (Adams, Hean et al. 2006: p. 56). Professional groups may possess various professional identities (Brown and Humphreys 2006, McDonald, Harrison et al. 2008). Based on this literature we expect that professional identities often align with professional groups, but how they do so must be empirically studied.

In this study, a professional identity refers to an individual's self-definition as a member of a profession (Ibarra 1999, Adams, Hean et al. 2006, Chreim, Williams et al. 2007), and it includes how one interprets one's professional goals, values, beliefs, norms, and interaction styles (Burke and Stets 2009). Every action, speech, or thought we engage in can be a manifestation of how we define ourselves as professionals (Alvesson, Lee Ashcraft et al. 2008), and how we behave in practice with others can give rise to professional identity (Weick 1996, Chreim, Williams et al. 2007, Touati, Rodríguez et al. 2019). Moreover, individuals assign different meanings to their identity, and professionals can

have multiple identities (Ashforth, Harrison et al. 2008, Ashforth and Schinoff 2016), depending on the context and their multiple professional roles (Mak, Hunt et al. 2022). We acknowledge that connections exist between professional identities and other identities, though we do not discuss them in this paper.

Literature on identity of professionals involved in health promotion shows distinct professional identities for various types of professionals. GPs are said to include patient-centeredness, conceiving of the patient as a whole person and being an active participant in a relationship of equals, which might encompass delivering personalized healthcare (McDonald, Harrison et al. 2008). Compared to GPs' strong professional identities, social welfare professionals' identities have been exposed to ambivalence towards recognition of their occupations enabled by New Public Management (NPM) and gendered presumptions emerging as factors in undermining the stability of professions in social welfare (Healy 2009). Especially in interprofessional settings, their professional identity is unstable, thereby challenging their health promotion contributions (Bark, Dixon et al. 2023). Professionals in mental healthcare prefer dialogical approaches for embracing their sameness with clients, which is seen both as an opportunity to connect deeply as well as a risk of exposing the limitations of professional expertise in health promotion (Schubert, Rhodes et al. 2021).

Based on identity literature, we expect that professional identity is central to how professionals interpret and play their roles in health promotion (i.e. Weick 1996, Weis and Schank 2002, Chreim, Williams et al. 2007, Touati, Rodríguez et al. 2019, Møller 2021). The professionals in our sample comprise a heterogenous social group when looking at their educational background, work tasks, terms of employment and income (Bourdieu 1984, Ilsvard and Møller 2015). Theoretically, we therefore assume that professionals with different professional backgrounds identify differently and consequently promote health differently.

3.3 Methodology

Research setting

The study was conducted with frontline professionals in social welfare, and general and mental healthcare in the Dutch city of The Hague with a population of approximately 500,000 people. In this city, psychosocial problems are disproportionally common, particularly among low-income residents (Haaglanden 2021). A Dutch Health Policy Document addresses health issues from a comprehensive standpoint, transcending domains, embracing the 'Health in All Policies' approach. Both the national and local governments collaborate over an extended period, prioritizing prevention and well-being (Shields- Zeeman 2021). In line with these developments, The Hague municipal health service and the municipality work with local partners towards ambitions in health

promotion concerning stimulants and health and mental resilience and psychological health (Den Haag, 2020, Milieu, 2020). In this action program, several types of frontline professionals are asked to work with many stakeholders to care for the population. The program suggest that a local approach is useful and that frontline professionals have broad health views and knowledge, and that they exhibit creativity and entrepreneurship (Den Haag, 2020, p. 3, 4). Hence, this setting in which much is asked of several types of frontline professionals concerning health promotion is well suited for empirically studying professional health promotion roles.

Research strategy and data collection

This research is ethnographic, which means that it is a study about a group of people and their lifestyle studied in their natural environment (Ybema and Kamsteeg 2009, Cecchini 2018). The goal of this study is to uncover how frontline professionals perceive and act on health promotion roles and professional identity. With an ethnographic strategy we can observe these professionals' behavior (Geertz 1974, Cecchini 2018), which is necessary to gain insight into how professionals give substance to their role.

This study uses abductive logic, which combines deductive and inductive reasoning in an iterative process. It moves back and forth between theory and empirical observations (Schwartz-Shea and Yanow 2013, Meyer and Ward 2014). In this study, abduction starts with an empirical question about professional identity theory and leads to expectations about health promotion roles. Moreover, abduction involves describing and understanding the world from the respondents' perspective and then deriving a scientific explanation (Meyer and Ward 2014).

Respondents are frontline professionals in social welfare, and mental and general healthcare working with clients with psychosocial problems in The Hague. Theoretically, this selection is relevant to study because these professionals are said to work together in an interprofessional setting and their health promotion roles may complement, conflict or overlap. These professionals were chosen, because they are all encouraged to engage in health promotion in their work through the 'health in all policies' approach (Shields- Zeeman 2021). All respondents handle many cases per day, resulting in a considerable number of observed interactions. All fieldwork was conducted by the lead author. This study aimed to gather in-depth and context specific insight into frontline professionals in care and social welfare. We used a sample consisting of six main respondents working in three organizations: two GPs, two professionals in social welfare and two mental healthcare professionals to ensure valuable insights into the complexities and nuances of professional identities and professional roles in health promotion in their specific organizational settings (Møller 2018). We studied them intensively in interaction with their colleagues and stakeholders. All professionals have been performing frontline work for many years (see appendix B1). We studied frontline professionals at work with clients where the professional identified or suspected combined problems (i.e., problems

for which professional help traverses professional fields). Our aim was not to generalize to a wider population of frontline professionals, but to gain an in-depth understanding of how professional identity shapes their health promotion roles.

The lead author gained access to these professionals by using their network built up during earlier research. Potential respondents or their supervisors were emailed requesting discussing participation in this research. The professionals were eager to learn from reflecting on their work and welcomed us openly.

The lead author conducted ethnographic fieldwork including participant observation, informal conversations, and semi-structured interviews to gain insight into respondents' health promotion roles and professional identities. Fieldwork allowed the researcher to be present at the professionals' work location and observe the phenomena of interest where they unfold (Spradley 2016). While perceptions about health promotion roles have been grasped by interviews before (Geense, Van De Glind et al. 2013), how roles are practiced can be tacit and hard to articulate. Roles are therefore best observed over a longer period of time in their natural setting (Walshe, Ewing et al. 2012, Zahle 2012). The lead author conducted two rounds of observations during which the operationalized health promotion roles (see section 2.1 and appendix B2) as well as our definitions of health promotion roles and professional identity were used as sensitizing concepts.

During observations, interest was taken in how professionals behave in health-promoting consultations with clients and how they reflect on their behavior. During informal conversations and interviews, follow-up questions were asked that give insight into how professionals identify, what they value and how they interpret their interaction styles. During the fieldwork, the researcher was able to talk with the main respondents' colleagues and others involved in the care process. Before starting each round of data generation, the observation guide and conversation scheme based on sensitizing concepts were updated (see appendix B1 and appendix B4) to plan and steer the process, while still allowing for inductive findings and adjustments. The observations and interviews were conducted between January 2022 and January 2023 at the work location of the respondents (i.e., consulting rooms, house visits, team rooms). Field notes were taken during the observations and were written out in detailed reflections after or in between observations (i.e., when professionals did administrative work). Later, field notes were re-written digitally by filling in the gaps of the first descriptions (Spradley 2016). Semi-structured interviews were audiotape-recorded and transcribed verbatim. All data were imported into ATLAS.ti version 9 for further analysis. All respondents gave informed consent. This study was registered and approved by the medical Ethics Committee of Leiden, The Hague and Delft (N20.158).

The role of participant observer was taken with varying degrees of participation. This means that sometimes the researcher would be more participative, for example by joining in the conversation during lunch. At other times, the context would allow for

a more distant position, such as during a client consultation. This means that the researcher had to be flexible and act in accordance with signals given by the respondents. The researcher is thereby an instrument of data generation and data analysis (Bernard 2017). The researcher spent a considerable amount of time in the field (34 days or 150 hours, appendix B3) with the goal of decreasing the reactivity of those observed to the presence of the researcher (ibid.), and the researcher wrote reflections about their positioning in the field.

Analysis

The lead author first developed stories for each respondent based on the health promotion roles observed during fieldwork. A story consists of excerpts of field notes taken on health promotion during one consultation between a client and a professional, sometimes these are accompanied by respondents' reflections.

After open coding and discussions with the second author, the lead author further specified the initial themes that were close to the empirical data. During more focused coding, the first author explicitly looked for health promotion roles and professional identities. During the abductive thematic analysis (Braun and Clarke 2006) the authors confronted the initial findings with the definitions of health promotion roles, and professional identity and used them as sensitizing concepts. The authors then built a typology. By taking an overarching view, constant comparison (Schwartz-Shea and Yanow 2013) between and within professional groups has been central in our analysis. The lead author used conversations with the main respondents and their colleagues to member check and search for alternative explanations. The respondents reacted to what the author observed and triangulation took place by comparing observational and conversational data (Schwartz-Shea and Yanow).

The final result shows two types of health promotion roles and two types of professional identities. The authors disentangled professional identities and professional roles in order to study the mechanisms between them. Our code table (appendix B5, on personas) gives insight into how respondents from various professional groups differ in their professional identities and how they fulfill their health promotion roles.

The next section outlines the main types of professional identity and professional roles in health promotion. Examples are based on the empirical data, with references made to the theoretical framework in italics.

3.4 Findings

Health promotion roles

Role 1: reframing health promotion

In general, in the health promotion role of *reframing a client's care needs* professionals are observed to reframe clients' needs into something specific which they can work with by setting boundaries. Even though the respondent may observe the complexity of the problem, they demarcate the problem into a specific aspect which is prioritized. Ultimately, health promotion may be focused on problems for which clients did not plan an appointment or ask for help with, and it remains unclear whether clients see the prioritized aspect as a problem. In this role we see that when professionals do not necessarily react to the worries as presented by the client, they are mostly involved *proactively*. However, these professionals work *reactively* with problems that they observe themselves. Moreover, when reframing, professionals have in common that they find it *important* to act in a health-promoting way and that they experience the *ability* to promote health when a problem is close to their professional expertise. When professionals are aware of the broader problems presented by the client, they may not go into aspects of these problems right away and/ or they may refer clients to another professional, as is shown in the empirical examples below.

> ***'Then back to contraception, it would be very problematic for you to get pregnant again*** (respondent A, GP)**.'**
>
> Before the client comes in, the respondent explains that the client did not want to tell the assistant why they are here today. However, the respondent knows that the client had an unwanted pregnancy and an abortion a while ago. Respondent: '*What can I do for you?*' Client: '*I'm angry and lonely and it cannot go on like this. It is very private, but I came here anyway. I'm so tired and I cannot sleep. Do you see these bags under my eyes? I have a problem.*' Respondent: '*Do you want to tell us about your problem?*' Client: '*Yes, I'm renting this house together with a friend (…). But she left and I have to pay our rent. Now sometimes I do not have enough money to feed my child. I do not know what to do. My kids suffer from it, they are not doing well at school. (…) It hurts that I cannot take good care of them.*' Respondent: '*I understand that you don't feel good and that is not a good situation for your children. (…) Stress all day, they also feel that. And I heard you had an abortion recently? Do you now use contraception?*' Client: '*Yes, but no….*' Respondent: '*We could talk more about this later. How can I help you now?*' The client stresses that her financial situation is very

> important for her, as is the urgency of cheaper housing. The respondent explains that a colleague, a practice nurse, has more time to help her with that. '*She knows about different money streams, because you know that medicines will not help in this case.*' The client nods understanding. '*Then back to contraception, it would be very problematic for you to get pregnant again.*' The respondent proposes a coil as the best option and asks if the client wants to think about it at home. After the consultation, the respondent told me that the client is '*at high risk of unwanted pregnancy*', which could increase her problems.

In this example, respondent A reframes social and financial problems as expressed by the client into a lifestyle or contraception problem. Therefore, this respondent decides to *proactively* take the lead in the conversation by focusing on contraception. Contraception is something medical which he is *able* to fix and it is close to his professional expertise. Fixing this is *important* because it could, in the respondent's opinion, prevent more problems from developing.

Professionals performing a reframing health promotion role seem to understand the complexity and broadness of the problems presented by clients, but they do not feel able or motivated to help with problems beyond their expertise.

Role 2: customized health promotion

Customized health promotion happens in close relationship with the client and their environment. In this role, the client is given the opportunity to take the lead and the responsibility in expressing the problems. As such, we see that in this role professionals tend to work *reactively* since they react to the very problems that are expressed by clients. However, professionals could still be *proactive*, when they propose solutions and try to educate patients. A central aspect of customized health promotion is that professionals ask in-depth follow-up questions because they find it *important* to listen and to avoid steering away from what clients express as important. Professionals are *able* to be responsive by crossing professional boundaries. In short, client autonomy is central and professionals follow the clients' needs and solutions (responent E, social worker).

> '***I work differently with every client*** (respondent D, mental health worker)**.**'
>
> Respondent D brought an SOS tracker for the client, who seems pleased with it. With this, the client can call the mental healthcare emergency line when needed. The professional and client test the device together. A burden seems to fall off the client. Respondent to client's partner: '*Do you want to have a look?*' Last week the partner messaged that the client was not doing well. '*He heard voices and saw delusions, but now he is a*

bit calmer. When she [client's partner] messages, then something is really wrong.' By using a color system, the professional discusses with the client how he feels and how they can try to prevent him from feeling that bad again. Before we leave, the respondent asks the partner how she thinks he's doing. After the house visit, the respondent explains that they work very differently with every client. '*With this man I was childish, which is what he needs for his fears.*'

The above example of customized health promotion is exemplary of respondents who find it *important* to *react* to client preferences by listening closely, by collaborating with other involved professionals and in teamwork with the client environment. Professionals are *able* to take the care question seriously by taking time to figure out together with the client environment what else may play a role and how to prevent future crises.

Additional health promotion role dimensions

Our analysis provides reason to distinguish additional dimensions in health promotion roles alongside the three dimensions operationalized based on existing literature. Professional health promotion roles differ based on the following dimensions: 1) dealing with complexity, 2) patient versus professional autonomy, and 3) involving client context in health promotion. First, in reframing, professionals clearly demarcate problems, while in customized health promotion the complexity of problems is embraced. Second, in reframing, professionals take the lead in deciding which problems are most appropriate to solve, while in customized health promotion professionals encourage clients to determine the direction of health promotion. Third, in customized health promotion involvement of the client context is more clearly observed.

Professional identity

Professional identity 1: the pragmatic professional

Pragmatic professionals are professionals who see themselves as a fixers, who like to see impact of their work and who value setting boundaries around what they can and cannot do for a patient. Moreover, they value that they can do their job in ways they prefer, possibly by involving other professionals with different expertise. Additionally, these professionals respect clients' solutions, but they also want clients to know about and to respect their professional suggestions.

'***[I have] a focus on more pragmatic, hands-on work*** (Respondent A, GP).'

'I think I am an all-round general practitioner, with a focus on more pragmatic, hands-on work. […] I am relatively more inclined to do things and

> *less to have long conversations. [...] Which means that I often do the more urgent care like injections and treatments and I think I'm also stronger in the musculoskeletal system. [...] I like extreme medical cases. So, I can relish someone who's living in a dirty house with rats and pus coming out of their ankle. There may be some general practitioners who think, 'Yuck, do I have to go there?'. But there is often relatively a lot to do there, so there's a relatively high impact of what you do.'*

This story is exemplary of pragmatic professionals, who *value* doing the type of work that they are trained for. They *believe* that they can reach their *goal* of making great impact.

Respondents with a pragmatic professional identity mainly use reframing health promotion roles and the data shows how this identity and this role interact. Respondents perform the reframing role as follows: first, by fixing something that they understand and that is manageable and preferably close to their professional strength. Second, by setting clear boundaries regarding what is and what isn't their responsibility and professional scope. Aspects of the pragmatic professional identity, such as a drive to solve problems by using their professional expertise, are mobilized in taking up a reframing role. Respondents with a pragmatic professional identity sometimes use customized health promotion roles. This happens when their professional knowledge seems insufficient to understand the problem.

The pragmatic professional idenity transcends the professions, and it occurs with professionals in social welfare and in general practice (see appendix E for more examples of health promotion roles from our data).

Professional identity 2: the holistic professional

A holistic professional is someone who is involved, listens, and is motivated to take (extra) time and to extend the boundaries of their profession when this helps them to better help the client, especially those with combined problems. Therefore, this professional appreciates the collaborative aspect with the client on how to approach health promotion.

> ***'much nicer [is] that someone is at your bedside who just cares about you*** (Respondent F, mental healthcare)'

> *'What I find most important in my work is helping people who have a difficult life and that there is care and attention for them, also for people who may fall outside [...] of what we think you should be as a citizen. [...] I think that I would also want that when I would need care, that I would have a connection with [the caregiver]. I think that I would like to have a*

capable doctor, who knows what is technically the problem, but actually much nicer, that someone is at your bedside who just cares about you. I think that is worth a lot and if you find a balance in that, then I think you are the best care provider.'

This story is exemplary of holistic professionals, who *value* being loyal caregivers with a present attitude towards their clients. Their *goal* is to be their authentic self, while being responsive in their interactions with clients.

Respondents with holistic professional identities perform the customized health promotion role as follows: 1. They emphasize that their solution does not necessarily have to align with the client's solution. 2. They prioritize being accessible to clients and work with tailored treatment rather then focused solely on diagnosis. 3. They stress that boundaries can be complicated and that they sometimes go beyond what their role requires. For instance, respondent B (GP) enjoys that she now spends '*more time with clients that need it*', she even holds longer conversations herselves, while other GPs usually delegate these to a practice assistant. Aspects of the holistic professional identity, namely taking time, being accessible, being flexible in how one approaches the task and being willing to shed boundaries, align with how these professionals play the customized health promotion role.

The holistic professional identity also transcends professions, as it occurs with professionals in social welfare, general practice, and mental healthcare (see appendix B5 for more examples of professional identities from our data).

Two respondents with a holistic professional identity (respondent C and E, social workers) have scattered professional identities, which means that they identify as both holistic and pragmatic and that their professional identities are not very strong. This observation seems to results in the takeup of both professional roles (see appendix E for examples of professional identities and health promotion roles).

3.5 Discussion and conclusion

Discussion

This research makes a threefold contribution to the health promotion literature. First, health promotion scholars do not acknowledge how professional identity shapes health promotion roles (Geense, Van De Glind et al. 2013). What we learn from our research is that the health promotion roles of various professionals are more layered than descriptions of attitudes towards tasks, but that the actual roles performed relate to how one identifies as a professional, what one values and how one interprets one's interaction styles. Insight into professional roles and professional identity brings the literature a step further in understanding why frontline professionals promote health of clients

in certain ways. Moreover, in line with identity literature (Weick 1995, Ashforth 2000, Ashforth, Harrison et al. 2008), identity is a relational concept which is formed by promoting health with clients and other professionals. When and why various aspects are prioritized in health promotion in interaction with clients and other stakeholders are issues for future research.

Second, this research gives insight into the health promotion roles of various professionals instead of just those with medical backgrounds. This is relevant considering various frontline professionals collaborate to solve combined problems. Our findings indicate that both health promotion roles and professional identities transcend professional groups. This means that professional background does not determine one's professional identity and health promotion role. This finding suggests that when collaborating across professions, professionals should potentially not be hindered by their different backgrounds. However, how these professionals are able to work together across professions goes beyond the scope of this research. Notwithstanding these findings, professional identity aligns with health promotion roles and some aspects of the professional background seem to play out in health promotion. First, consistent take-up of health promotion roles of professionals in social welfare seems to be challenged by their scattered professional identities emerging from factors such as NPM and gendered presumptions (Healy 2009). Second, professional identities of professionals in mental healthcare align with their historical nature to focus on an authentic connection with the client (Schubert, Rhodes et al. 2021). Third, GPs, who are highly professionalized and are generally focused on the whole person, seem to have strong professional identities (McDonald, Harrison et al. 2008), which plays out in clear adoption of health promotion roles. Additionally, in line with the literature on holistic general practitioners, general practitioners are holistic by nature. Holistic general practitioners focus on conventional methods when this is deemed more practical, for instance when they interpret that the situation, such as a life-threatening situation, requires them to do so (Raaphorst and Houtman 2016).

Third, based on our findings, we argue that health promotion roles can be conceptualized in more abstract ways than suggested in earlier research. Besides descriptions of tasks, health promotion roles in earlier literature differ based on the dimensions: type of involvement, perceived abilities and perceived importance of health promotion. The types of health promotion roles in our study, however, differ based on how professionals manage complexity, client autonomy and how they involve the client context in health promotion. These empirical findings resonate with broader developments in healthcare from reactive to proactive care, from cure to care and from disease-centered to patient-centered care as described for GPs (De Valck, Bensing et al. 2001, Waldman and Terzic 2019).

Health promotion roles pose several risks and advantages for clients and professionals. First, reframing health promotion is risky when working with a problem

that a client does not see as a problem. This could mean that clients do not feel taken seriously, which could negatively impact the client-professional relationship and lead to unmet health needs of vulnerable clients (Salmon, Dowrick et al. 2004). A potential advantage of reframing health promotion is that professionals who work in line with their professional expertise and skills are able to help clients. This could be valuable for clients and it could motivate professionals to solve clients' problems. Second, a risk of power-sharing related to customized health promotion is that professionals put much trust in client autonomy, while not every client may be able to communicate their needs, and thus to take this responsibility. However, an advantage could be that clients feel heard, valued or even empowered and that they are helped in ways that align with their needs. Clients may experience empowerment to help themselves better. As such, our findings on the dimension of patient versus professional autonomy are in line with Larsen and Cecchini's (2023) argument that professionals in healthcare need to be able to play dual roles, acting as traditional knowledge authority and also connecting on equal terms with clients' views.

Limitations

This research has limitations which need reflection. The goal of this research was to describe how professional identity shapes the health promotion roles of various professionals in social welfare, in mental and general healthcare. We aimed for a diverse sample with various professional backgrounds to unravel how professional identity, possibly triggered by professional background, shapes health promotion roles. The study's methodological approach allows for theoretical rather than empirical generalization (Feldman and Orlikowski 2011). To gain insight into possible patterns within and between the different professional groups, larger-scale research is recommended. Moreover, notwithstanding the strategy of snowball sampling does not guarantee representativeness (Johnson 2014), this strategy was necessary to recruit respondents matching our theoretical selection: frontline professionals who work with clients with psychosocial problems. Thereafter, in the decision to use a specific health promotion role, other – contextual-factors may also play a role. Therefore, how health promotion roles are linked to personal identity, interprofessional collaboration and power sharing with clients, should be further studied. Finally, future research should explore how clients experience health promotion.

Conclusion

We have researched how professional identity shapes the health promotion roles of various professionals through an ethnographic study of frontline professionals promoting the health of clients with combined problems. This study contributes to the existing literature by describing professional identities and how they relate to practiced health promotion roles. Our expectation was that professionals with different professional

backgrounds would identify differently and would therefore have different health promotion roles. Instead, we found that professionals' health promotion practices are related to professional identities, which transcend professional backgrounds. Specifically, our findings indicate that frontline professionals in social welfare, general healthcare and mental healthcare promote health according to two roles: reframing health promotion and customized health promotion and that they identify as pragmatic and as holistic professionals. Even though the pragmatic professional identity is predominantly observed in professionals utilizing the reframing role and the holistic professional identity is prevalent among those engaged in customized health promotion, this relationship is not deterministic.

Chapter 4

Interprofessional collaboration in fluid teams: An ethnographic study in a Dutch healthcare context

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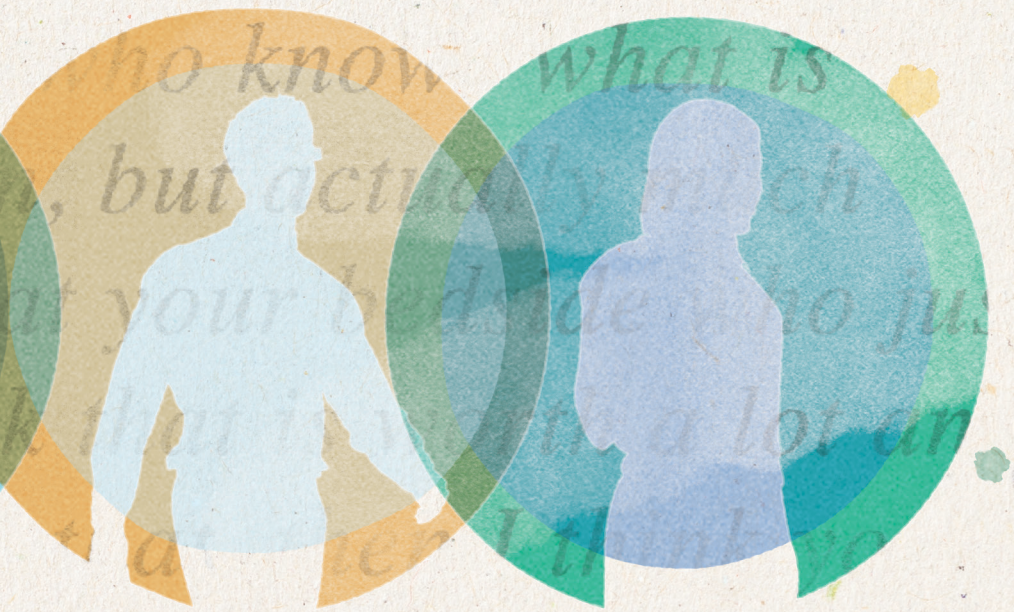

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Abstract

In caring for clients with combined problems, various professionals are encouraged to work together in new ways. Collaboration is often fluid, and professionals are expected to seek other professionals and organizations to solve combined problems. This type of collaboration is not institutionalized; it may therefore be hard to develop routines compared to fixed teams. Knowledge about how frontline professionals work together in non-institutionalized forms of fluid collaboration is lacking. This article addresses this gap by studying how professionals from various disciplines work together in fluid collaborative contexts when caring for clients with combined problems. To this end, this empirical research has an iterative design and uses ethnographic fieldwork in studying these hard-to-grasp contexts. In the analysis, we explore whether and how interprofessional collaboration manifests in fluid teams in general practice, mental healthcare and social welfare a Dutch city and how team fluidity plays a role.

4.1 Introduction

When providing care for clients whose problems cross domains, and due to the growing complexity of problems in today's context more generally, professionals from various disciplines are increasingly collaborating to achieve their goals (Edmondson & Harvey, 2018). This trend is on the rise as diverse groups, from various functions, organizations, and sectors unite to address combined challenges in rapidly changing configurations (Kerrissey et al., 2020). The added value of interprofessional collaboration is now widely recognized and a significant amount of research has been conducted on this topic (Petrakou, 2009; Schot et al., 2020; Wei et al., 2022). Regardless of the value of this research, it primarily pertains to fixed teams. Traditional or fixed teams have binary team membership, based on either belonging or not belonging to a team with clear boundaries (Mortensen & Haas, 2018), meaning that their membership is stable. However, the composition of teams is often subject to change (Kerrissey et al., 2020), meaning that cross-boundary collaborative work is characterized by variation and constant change over time (Dow et al., 2017; Morgan et al., 2015; Schot et al., 2020). Moreover, the nature of the issues they work with leads professionals to work interdependently, because it may be unclear who may be required and at what point they may be needed to do the work (Kerrissey, 2018). This paper focuses on interprofessional collaboration in psychosocial care which is often characterized by such team fluidity.

Following Kerrissey and Satterstrom (2020), team fluidity means that teams have a high degree of change and difference in terms of membership. Understanding team fluidity in healthcare is important because it may give insight into how care is changing from fixed to fluid teams, which can aid in fostering improved interprofessional collaboration among professionals (Wei et al., 2022). This paper therefore explores how team fluidity plays a role in interprofessional collaboration in care. The research question is as follows: *What does interprofessional collaboration look like in a fluid team context?* To answer this question, an ethnographic research design was used. We selected teams that are characterized by fluidity and thus in which frontline professionals have to interact and coordinate their work with other professionals with varying forms of membership and differences between members. The methods used are participant observations and interviews and the respondents are frontline professionals from social welfare and general and mental healthcare. These professionals all work with clients with combined psychosocial problems. This context enables us to answer this research question, because these respondents by definition have to collaborate across professional and organizational boundaries to care for their clients.

This study contributes to the existing scholarship in two ways. First, literature on interprofessional collaboration in care does not address team fluidity (Schot et al., 2020; Williamson et al., 2012; Xyrichis & Lowton, 2008), while fluid teams exhibit distinct charac-

teristics that may play a role in how interprofessional collaboration takes shape (Bagayogo et al., 2016; Dow et al., 2017; Schot et al., 2020). Our research therefore contributes to the knowledge base on interprofessional collaboration in care as we explore how behaviors in interprofessional collaboration are potentially shaped by team fluidity, using the analytical framework as developed by Kerrissey et al. (2020) and Edmondson and Harvey (2018).

Second, while literature on teamwork in management science takes a solid initial step in conceptualizing and empirically studying fluid teams (Kerrissey et al., 2020), it predominantly relies on data about hospitals (e.g. Valentine & Edmondson, 2015) and ad hoc disaster response teams (Rashid et al., 2013). Our study contributes by examining how team fluidity plays a role in the context of frontline professionals in psychosocial care. This is relevant because, while in hospitals, professionals work in fluid teams for delineated tasks such specific operations with fluid personnel (Kerrissey et al., 2020; Rashid et al., 2013; Valentine & Edmondson, 2015), in psychosocial care, frontline professionals structurally work in fluid teams.

In what follows, this article conceptualizes team fluidity and interprofessional collaboration, by relying on literature on team fluidity in management sciences and interprofessional collaboration in care, it describes the study context, and the study design, before presenting and discussing the empirical findings.

4.2 Conceptualizing team fluidity and interprofessional collaboration

In this analytical framework, we draw a connection between team fluidity and behaviors in interprofessional care.

Team fluidity

This paper addresses team fluidity based on its characteristics outlined by Kerrissey (2018), which refers to new adaptive and dynamic forms of collaboration characterized by high levels of change and difference (Edmondson & Harvey, 2017; Kerrissey et al., 2020). Team fluidity is continuous, recognizing that individuals can participate in a team to varying degrees, at varying times, with varying other participants, and in varying roles (Mortensen & Haas, 2018). Following Kerrissey and colleagues (2020), factors of change or temporal instability arise in teams facing complexity due to the need to accommodate emerging demands, which makes anticipating required roles difficult. '*These teams shift their membership, change their goals and tasks, rapidly form or disband, or interact infrequently over long time periods* (Kerrissey, Satterstrom et al. 2020).' Furthermore, individual and situational difference in teams are increasingly evident in complex work context. These contexts are more diverse because combined challenges cannot be solved by a single organization (Alexander and Van Knippenberg 2014, Kerrissey, Satterstrom et al. 2020).

First, '*change*' means the dynamic evolution of team membership over time (ibid., 2020, p. 64). With membership changes, aspects such as goals and tasks automatically also change (ibid.). As such, the composition of the team may change frequently as individuals join to contribute their expertise and leave when their role is completed (Edmondson, 2012; Matthews et al., 2012; Mortensen & Haas, 2018). For example, temporary teams in hospitals fall into this category (Valentine & Edmondson, 2015). Second, '*difference*' refers to individual and situational disparities among individuals working together. With membership differences, aspects such as skills, language, culture and geographical locations also differ (Kerrissey et al., 2020; Mortensen & Haas, 2018), such as in situations when combined challenges have to be solved (Edmondson & Harvey, 2017). Teams with high levels of change and difference are thus called fluid teams (Gersick, 1988; Kerrissey et al., 2020).

Interprofessional collaboration

In this study, interprofessional collaboration is defined as an active and ongoing partnership between people from diverse professional backgrounds with distinctive professional cultures and possibly representing different organizations or sectors, who work together to solve problems or provide services (Morgan et al., 2015; Schot et al., 2020). Research often sees interprofessional collaboration, where various frontline professionals work together to care for clients, as contributing to good care (Bosch & Mansell, 2015). Based on a systematic review, Schot and colleagues (2020) identified three distinct behaviors essential to interprofessional collaboration in care: creating spaces, bridging gaps, negotiating overlaps. In what follows, this section will discuss these.

Creating spaces

Following Schot and colleagues (2020), the first behavior in interprofessional collaboration, *creating spaces*, is necessary for interaction in collaboration. Creating spaces holds that professionals establish spaces for interaction with external stakeholders (Nugus & Forero, 2011), by creating or recreating organizational arrangements to facilitate collaboration, and by circumventing existing organizational structures and establishing alternative, informal channels of information exchange (Gilardi et al., 2014). It is linked to the concept of organizing, which includes professionals organizing case treatment through interprofessional collaboration and fostering innovation rather than just treating patients within a healthcare organization (Noordegraaf, 2015). Creating spaces also resembles articulation work (Postma et al., 2015) and knot working (Lingard et al., 2012) in healthcare, which mean integrating tasks, responsibilities, and improvisation to negotiate everyday challenges.

Bridging gaps

The second behavior, *bridging gaps,* involves professionals actively overcoming four distinct types of gaps that exist between themselves and other professionals. The initial gap arises from varying *professional perspectives* on the optimal approach to client treatment. Bridging thus requires proactive efforts to familiarize oneself with the knowledge bases, professional values, and norms of other professionals (Chreim et al., 2013; Falk et al., 2017). The second gap involves professionals addressing *social gaps*. This pertains to informal and tactful interaction that considers the diverse personalities of individuals. Third, professionals bridge *communication divides* caused primarily by geographical fragmentation. Bridging, in this context, entails actively transferring knowledge or information between professionals and being accessible to others (Schot et al., 2020). Fourth, professionals bridge gaps related to *task division* by undertaking responsibilities that extend beyond their formal roles and provide assistance to other professionals (ibid., 2020). This concept is associated with boundary spanning, which refers to key agents managing interorganizational collaboration, interpersonal relationships and networks, creating innovative solutions and having knowledge of various cultures acquired through listening and understanding various professionals' positions and interests (Bakken & van der Wel, 2022; Williams, 2002).

Negotiating overlaps

The third behavior, negotiating overlaps, involves managing the overlapping aspects of professional work that arise due to collaborative demands that can potentially lead to conflicts. First, professionals negotiate between work roles and responsibilities in general, as collaboration can create ambiguous overlaps in determining tasks and responsibilities (Lingard et al., 2012; Schot et al., 2020). Second, professionals engage in negotiating overlaps within individual care processes, particularly when they collaborate in patient treatment, leading to the identification of noticeable overlaps (Schot et al., 2020). Member role clarity is considered important for interprofessional collaboration (Barnard et al., 2020; Wei et al., 2022), because, while in some organizations, membership changes induce creative ideas, for most organizations membership changes could be problematic if they threaten members' sense of belonging and trust (Cristancho et al., 2022; Mortensen & Haas, 2018).

Our general expectation is that professionals in fluid team contexts will experience tensions in interprofessional collaboration due to change and difference, because professionals with various backgrounds meet each other more on an ad hoc basis and collaboration is based on fragile interpersonal relationships.

4.2 Data and methods

Research design and data collection

This article is based on data from an ethnographic study including participant observation and interviews. The role of the participant observer was taken with varying degrees of participation, requiring the researcher to be flexible and responsive to respondents' signals (Bernard 2017). The approach adopted in this article is abductive (Schwartz-Shea & Yanow, 2013), which combines induction and deduction. The study uses theoretical insights on team fluidity and interprofessional collaboration in care as sensitizing concepts to steer the fieldwork and analysis, while still allowing for inductive findings and adjustments (Schwartz-Shea & Yanow, 2013). The sensitizing concepts in this study are behaviors in interprofessional collaboration (Schot et al., 2020) and change and difference (Kerrissey and colleagues, 2020), which holds that these concepts are sensitizing rather than definitive, because they lack specification of attributes or benchmarks that would allow for clean-cut identification in the context of interprofessional collaboration in care (Blumer 2017). Specifically, how change and difference play a role in behaviors in interprofessional care is unknown; which is inductive, regardless. Despite what we know of change and difference in other contexts, we thus recognize that these concepts may shape up in different ways in each empirical context. This qualitative research expands the literature by including different professional disciplines working with the same client group (Schot et al., 2020). Qualitative approaches over extended time periods are suitable to answer our research question, because a new phenomenon like interprofessional collaboration in a fluid context may change quickly and ad hoc and may not be prearranged (Edmondson & McManus, 2007; Kerrissey et al., 2020). Ethnographic fieldwork thus provides broader and more flexible approaches to collecting data that are advantageous in achieving a deeper understanding of fluid teams (Kerrissey et al., 2020; Kolbe & Boos, 2019).

The observational data consists of three months or 150 hours of observations of interactions between frontline professionals in psychosocial care and other frontline professionals who are part of the team, their clients and others involved in the care process. During observations, the researcher was allowed to be present during patient consultations, in lunch rooms, in professionals' offices and during collaborative meetings. To give insight into how respondents reflect on what the first author had observed, follow-up questions were asked during many informal conversations and three formal interviews during the fieldwork. The data generated through participant observation were written down as field notes (Spradley, 2016). During observations, interest was taken in how professionals behave in interprofessional collaboration in fluid teams. Two rounds of observations were performed, with preliminary analysis in between. After three months per research site, the researchers noticed that the same themes were recurring (saturation). Then, the first author conducted three more formal interviews to

check and reflect on what was observed (see observation guide and interview guide in appendix C1 and C2). The authors use triangulation by drawing on data generated with multiple methods (interviews and observations), which helped to increase our ability to interpret interprofessional collaboration in fluid teams (Thurmond, 2001). This study was registered and approved by the Medical Ethical Review Committee of Leiden, The Hague and Delft (N20.158).

Research setting and implication

The empirical study includes six main respondents in three professional groups who bear responsibility for clients with psychosocial problems. Respondents were selected on theoretical grounds: the professionals all work in fluid teams in social welfare, mental healthcare or general healthcare. Professionals have to collaborate across professional domains, because their clients' problems cannot be solved within one domain. Within this sample, a convenience sampling strategy is used, which means that we included who wanted to take part in the research and who was available.

The Dutch healthcare system emphasizes a broad view of health and care, acknowledging the interaction between physical, mental, and social health. This approach, combined with focus on patient-centered care that caters to individual needs and integrated care around people with combined problems, reinforces the necessity for frontline professionals to work on various health aspects and in various team settings (Standaarden n.d., Ministerie van Volksgezondheid 2016). In the Netherlands, the trajectory of a client with psychosocial problems always begins with the general practitioner (GP) who possibly collaborates with various types of organizations through referrals and other types of contact. Professionals in these organizations are working in general healthcare, social welfare, mental healthcare and beyond. Therefore, professionals working with the same clients do not always work within the same organization and may have different objectives. As a result, the teams they work in are dynamic, and there can be differences among the included professionals.

A fluid team is defined as a new and dynamic form of collaboration characterized by high levels of change and difference (Kerrissey et al., 2020). High levels of change create entitativity challenges concerning data collection, which means that it is harder to know whom to count and when to observe (Kerrissey et al., 2020). The functioning and character of the team, including their goals and tasks, may change over time (Tannenbaum et al., 2012). Considering these challenges related to team definition, the authors opted to study six main respondents. Each of the main respondents and those stakeholders they interact with to care for a client are considered part of the team. The main respondents remain on the team, while other professionals and stakeholders may shift on and off the team. The lead author consistently shadowed the respondents' interactions focused on promoting the health of shared clients. To be able to interpret

interprofessional collaboration and to get a grip on what team fluidity looks like, the first author used follow-up questions as a means of reflection and contextualization.

Analysis

The analysis took place in Atlas.ti. The lead author first selected data excerpts related to interprofessional collaboration as defined above. Second, during focused coding, the lead author confronted the data excerpts with the sensitizing concepts (change and difference) to explore how respondents collaborate interprofessionally in fluid teams and how team fluidity plays a role. Our approach thus involves examining whether we observe interprofessional collaboration, if so in what form, and finally identifying any additional elements compared to the analytical framework. Constant comparison between and within teams has been central in our analysis, as have member checking and searching for alternative explanations (Braun & Clarke, 2006; Schwartz-Shea & Yanow, 2013).

4.4 Results

This section outlines how professionals operate and talk about interprofessional collaboration in a fluid team. Examples are based on the empirical data, with references made in italics to the theoretical framework. The paragraph structure aligns with the seven behaviors in table 4.1, including reflections on the interprofessional care literature and on team member change and difference. Empirical findings are summarized in table 4.1.

Interprofessional collaboration in a fluid team context

Creating spaces

Creating alternative communication lines

Respondents create alternative communication lines in between professional domains in order to *bridge knowledge* gaps and partner matching gaps (see next sub-section). Respondents create new ways to discuss cases and exchange information that go beyond professionals' expertise and/or role.

Respondents create communication lines by inventing new positions within an organization or by temporarily inviting professionals from another professional domain to gain a grip on what their clients may need from other professionals, which is illustrated below.

> ***'But luckily we have […] [our practice assistant]*** (fieldnote, RA, general healthcare)'
>
> 'Respondent A explains that they are lucky to have this new practice assistant, who works on maintenance psychiatry, who knows everything about psychosocial care and '*the social domain is quite complicated to oversee, it changes all the time. But […] I use her expertise [to gain a better understanding of the social domain] when I want to have a quick discussion, or I [ask her to have] a conversation with that patient*'.

With the *creation* of this new type of general practice nurse practitioner, general practitioners (GPs) create an alternative connection with professionals in and knowledge of social welfare and mental healthcare. This guides respondents in identifying collaboration partners and managing workload by delegating tasks to practice nurses. This finding adds to the work by Schot and colleagues (2020), who emphasize connections with external actors but do not delve into intermediary roles created to connect internal and external actors across domains. Respondent A's team is characterized by membership change in various ways. First, the position of the new nurse practitioner is fragile due to insecurity about sustainable funding. Second, our data show that frequent changes in the social welfare domain regarding who works in which position are challenging, especially when respondents do not oversee the different frontline professionals in other domains. Membership change creates tensions in terms of who to reach and how to reach them, necessitating the creation of alternative communication lines as respondents cannot depend on fixed ones.

Organizing valued spaces

To assess individuals' contribution to a team, respondents arrange both structured and ad hoc formal meetings, inviting professionals from various domains. This effort helps professionals in coordinating mutual introductions and understanding each professional's role in relation to the client.

> ***'[We want to know] what she can mean for us and our [clients]***
> (fieldnote RE, social welfare).'
>
> 'After discussing several cases, the professional said that they invited a professional '*from "safe at home" [to get acquainted and] to have her explain a bit about her goals and tasks and to discuss what she can mean for us and our [clients].* The meeting ended with the exchange of phone numbers.'

By organizing biweekly interprofessional meetings, GPs regularly invite professionals from social, general and mental healthcare. In this example, they extended an invitation to someone from another organization for an introduction. This form of acquaintance during formal meetings allows professionals to collaborate more informally when necessary. Through such meetings, professionals aim to explore mutual offerings, understand each other's roles, and comprehend individual values.

More actual organizing or coordinating is required in a fluid team context, compared to what is mentioned in the interprofessional care literature (Nugus & Forero, 2011; Schot et al., 2020) on professionals creating spaces in relation to external actors. In our data, professionals not only create spaces to approach other professionals, but also create spaces to find out who to potentially reach, how to reach them in physically distant organizations and how to facilitate valuable collaboration. Respondent E's team is characterized by membership change. Which professionals are present at meetings changes, depending on who is invited to the meetings and who are acquainted with one another. What is challenging, according to respondent E, is that they cannot depend on those who are already acquainted. Respondents therefore invite other professionals to team meetings to find out who would be valuable to the team. Moreover, this team is characterized by membership difference, because professionals are often in the dark about each other's similarities or differences before meeting one another. Respondents manage membership changes and differences by organizing valued spaces. However, it can be challenging to determine who to invite or not to invite to team meetings, which sometimes results in potentially relevant professionals being left out (fieldnote RE).

While both creating alternative communication lines and organizing valued spaces appear highly formalized, our study aligns with Schot and colleagues (2020) in highlighting that much of the space creation is based on informal personal relationships. Notably, our study emphasizes that professionals often dedicate their personal time to creating these spaces, rendering them fragile and potentially less sustainable.

Bridging gaps

Bridging knowledge gaps

Frontline professionals bridge *knowledge gaps* with external actors, complementing each other's expertise to enhance client care in fluid teams. Respondents thus get a grip on the problem by leveraging differences in professionals' expertise within and between organizations. Respondent D, a mental healthcare worker, clarifies the client's needs to a municipal worker to safeguard the client, addressing concerns regarding the latter's overly positive perception.

'***I make sure that the municipal worker has the right knowledge*** (fieldnote RD).'

'Respondent D has an appointment with a client and a municipal worker in order to assess the eligibility for benefits. The respondent explains that she first invites the client for a preliminary discussion before adding the municipal worker. She calls the client and says that the municipal worker wants to ask her questions and that he has to give consent. Then she explains what she may and may not tell the municipal worker and asks if that's okay with him. The client agrees and the respondent adds the municipal worker. [...] The municipal worker says that she wants information on his phobia and what considerations she should take into account regarding the activities he can undertake as a counterpart for his benefits. [...] After the respondent explains the client's disorders, the municipal worker says that she will now explore how work can contribute to his recovery [...]. The respondent emphasizes the importance of proceeding cautiously in small steps and being critical of the environment for the client's long-term wellbeing. The client acknowledges this, expressing appreciation for her remarks. The municipal worker affirms that it is therefore crucial that they have this conversation.'

The respondent calls the municipal worker to make sure that she has the necessary mental healthcare knowledge to properly decide on the vulnerable client's case.

Similar to an emphasis on establishing a common narrative between *professional perspectives* within fixed teams, as suggested by a review of the literature on interprofessional care (Schot et al., 2020), our respondents reconcile diverse professional perspectives on client treatment by complementing each other's knowledge. Thereby, respondents seek the best way to treat clients. Nevertheless, our respondents actively seek diverse perspectives to better assist clients, not just overcoming gaps in professional perspectives. Respondent D's team shows membership differences, creating varied mental healthcare knowledge among professionals. Professionals leverage different professionals' background to their advantage by complementing each other. Additionally, the changing composition of the team per problem further plays a role, because familiarity aids in bridging knowledge gaps (RD).

Bridging communication gaps

Professionals bridge *communication gaps* by leaving notes for colleagues whom they do not see due to different work schedules and/or different physical workplaces. The following fieldnotes show how professionals do so within and between organizations.

Respondent E explains that she never sees '*the assistant, because [their] working hours don't correspond. This issue really needs to be caught up on, so I'll leave a note for her.*' Moreover, respondent C explains that she puts a note under the door of the professional responsible for the day program in a nearby organization. In this way she lets her know without speaking to her directly that the client still needs to get his medicine. The examples show how differences in work schedules, routines and workplaces necessitate the bridging of communication gaps by leaving notes for each other.

Our analysis shows that communication gaps are not solely caused by geographical dispersion, as suggested by Schot and colleagues (2020). Member differences, especially in work routines, also contribute when professionals lack physical collaboration opportunities. Bridging communication gaps thus involves collaboration among professionals with different professions, work schedules and work locations. When reaching out to professionals from other organizations becomes challenging, additional effort or creative strategies may be necessary to establish personal contact.

Bridging partner matching gaps

For different problem aspects, respondents turn to professionals in various organizations to identify the appropriate professional for client assistance, when they perceive their own capacity to help a client is insufficient. The gap holds that it is not consistently evident from the outset which professional they should ask for assistance. The following fieldnote shows how respondents bridge partner matching gaps:

> ***'[I try] to match the right partner*** (RF, mental healthcare).'
>
> '*To find the right partner and to do my job, I need a good social map. I depend on my network, especially in the neighborhood. I need good connections for smooth care. Given our large caseload, it also entails a lot of forwarding cases, organizing, facilitating access to, involving organizations, instead of handling all of that care provision oneself. It's simply quickly identifying what the problem is, and then matching it with the right partner. […] When I want to involve a partner, I try to be present in the neighborhood to become a familiar face. Sometimes I need to convince them that we have a shared interest in assisting the client. For example, with the housing association, I had to convince them that right now focusing of wellbeing is in the best of everybody's interest.'*

Respondents thus actively work to bridge partner matching gaps by going into a neighborhood to strengthen and engage their social network. In addition, they seek to convince other professionals of the mutual interests of collaborating with them to care for a client. Bridging partner matching in this fluid context differs from bridging

task division gaps in the interprofessional care literature (Schot et al., 2020). Unlike task division gaps, it involves actively seeking others to undertake tasks respondents cannot fulfill themselves. Respondent F's team is characterized by membership change and difference. In terms of membership change, the respondent has to change which professional or organization they engage with per problem aspect to temporarily join his team. Moreover, membership difference plays a role, as respondents contact professionals in different organizations and with different professions to help care for a client. As this section shows, respondents put in much work to find and match the right professionals for different tasks.

Negotiating overlaps

Negotiating responsibility overlaps

Frontline professionals negotiate overlaps between work roles when collaborating with professionals with their own focus and tasks, but where there is considerable overlap. While most respondents experience '*respect for each person's roles because we stand with our feet in the same clay*' (RF, mental healthcare), they find negotiating overlaps challenging when collaborating with professionals from external organizations. This is illustrated in the following interview excerpt from respondent A (general healthcare).

> ***'Getting angry doesn't help.'***
>
> *'I had to visit a man with a severe illness. Well, there's a nurse there who is terribly concerned and wants me to do all sorts of things, not trusting my knowledge and skills. I explain the situation, but she insists it's different and discusses it with the family and the patient without involving me, while I know that I'm right. She's a less educated lady [...]. How do you deal with that? [...] Getting angry doesn't help. At some point I said 'Now it's enough', this is how it is and if it doesn't improve, I'll come back another time. I was called back, went there again, and nothing had changed. [...] Then we got into a 'yes, no' discussion and it doesn't make sense getting upset about it nor calling her supervisor or something. What I could do is to notify the family next time. [...] But well, the family deals with that caregiver every day, and with me only once every three, four weeks, so it's an unequal situation.'*

In this example, both professionals think they know best and want to take responsibility for the client. While professionally, the GP may have authority, the nurse creates authority by being there for the client and their family very intensively. The respondent experiences difficulty negotiating taking back some authority and professional status.

Professionals thus experience tension when they negotiate overlapping roles and responsibilities to make sure that their clients are cared for properly.

Similar to a review of the literature on interprofessional care (Schot et al., 2020), our data show that collaborating can lead to unclear responsibilities (Lingard et al., 2012; Nugus & Forero, 2011). In contrast to this literature, our research in a fluid team context highlights these tensions. Respondent A's team is characterized by membership differences concerning professional background, physical work location and closeness to the client environment. These differences intensify the need for negotiating professional roles and responsibilities. Furthermore, membership changes, as highlighted by respondent F in mental healthcare, contribute to the challenge. High turnover and changing team composition make it increasingly challenging to identify appropriate partners for negotiations.

Negotiating safe work environments

Professionals negotiate who is admitted to the team and when to establish a safe work environment. The subsequent fieldnote from respondent F (mental healthcare) illustrates how professionals accomplish this.

> ***'It would be weird to have them listen in on how we work.'***
>
> '*Involving people from [another organization] to join our team meetings once a week is [...] important, because we need their input in difficult cases and we need to be able to rely on them. What is difficult, though, is that we already have too little office space and [...]*' the respondent's colleague adds that: '*it would be weird to have them listen in on how we work in all our cases, instead of those they are actually working on. We agreed that they only join when we talk about cases in which they are directly involved.*'

By negotiating, professionals agree on the attendance at team meetings. Through this negotiation, professionals aim to get to know each other slowly, rather than abruptly as it has been organized by their superiors. By doing this, they aim to protect themselves and their clients. Such negotiations are different from the types described in the interprofessional care literature (Schot et al., 2020). Professionals not only negotiate overlaps between work roles and responsibilities, but they also negotiate who may be part of the team and when. Respondent F's team is characterized by membership change, because the arrival of new members creates the need to negotiate their membership. Regarding these tensions, it does not seem to matter that they are different (which they are professionally), but it is mostly that their arrival changes the team.

Table 4.1. Interprofessional collaboration in a fluid team

	Membership change	**Membership difference**
Creating spaces		
Creating alternative communication lines	Inventing new positions & inviting temporary professionals	
Creating valued spaces	Inviting potentially valuable professionals	Inviting potentially valuable professionals
Bridging gaps		
Bridging knowledge gaps	Complementing each other's professional knowledge	Complementing each other's professional knowledge
Bridging communication gaps		Employing creative strategies to establish contact
Bridging partner matching gaps	Engaging with changing professionals per problem aspect	Contacting professionals in varying domains to find a match
Negotiating overlaps		
Negotiating responsibility overlaps	Identifying appropriate partners for negotiations	Negotiating professional roles and responsibilities
Negotiating safe work environments	Negotiating team membership	

4.3 Discussion and conclusion

Discussion

This research asks what interprofessional collaboration looks like in a fluid team context. This study finds that the taxonomy introduced by Schot and colleagues (2020) is functional for the analysis of interprofessional collaboration in fluid teams, but that there are distinct manifestations in fluid contexts. While team fluidity refers to the simultaneous presence of change and difference in team membership, we find that change is the primary driver for the specification of Schot and colleagues' (2020) taxonomy. This research makes a twofold contribution to the literature. First, by analyzing what team fluidity requires from professionals who engage in interprofessional collaboration (Schot et al., 2020; Wei et al., 2022). In doing so, we emphasize how challenges differ between fixed and fluid teams and how the teams' responses differ. We find that in fluid teams, there is a need to establish alternative communication lines that bridge internal and external interactions due to constantly changing membership and differences in membership. Professionals create valued spaces for collaboration, often based on fragile interpersonal connections. The reason being that professionals are unable to depend on established internal and external communication lines like in fixed teams (Nugus and Forero 2011, Gilardi, Guglielmetti et al. 2014). Furthermore, while fixed teams prioritize bridging perspectives, social differences, communication styles and task divisions (Falk, Hopwood et al. 2017, Schot, Tummers et al. 2020), fluid teams, however, encounter challenges in aligning communication lines, integrating diverse and changing work routines, and accommodating professionals from various professional domains who may not always match the typical profile or are unfamiliar to or intermittently part of the team. As a result, potentially relevant professionals may unknowingly be excluded from the team and professionals may need to invest additional effort in identifying and reaching out to appropriate professionals for the task. Moreover, fixed teams address potential conflicts and overlaps in roles and responsibilities that affect members' sense of belonging and trust (Mortensen and Haas 2018, Cristancho, Field et al. 2022). Fluid teams, however, also emphasize the importance of effective partner matching and ensuring safe work environment despite changing team compositions.

Our second contribution is the addition of empirical evidence from a frontline care context to research on team fluidity in management sciences (Kerrissey et al., 2020; Majchrzak et al., 2007; Valentine & Edmondson, 2015). Frontline care-settings are known for their direct engagement with clients, presenting distinctive challenges regarding team coordination, communication, and decision making that may diverge from those encountered in hospitals and disaster response teams. Additionally, frontline care often entails close collaboration between disciplines, including medical, social and mental healthcare professionals. Furthermore, frontline care demands prompt and adaptable responses to unforeseen situations. This means that in comparison to structured envi-

ronments such as hospitals, professionals may need to rely on improvisation and ad-hoc collaboration. The frontline care context of this study thus increases our theoretical understanding of the varied challenges and practices that are relevant when talking about team fluidity in teams across diverse professional contexts.

Limitations

The goal of this research was to describe what interprofessional collaboration in care looks like in a context of team fluidity. As such, the respondents were selected on theoretical grounds and the study's methodological approach allows for theoretical rather than empirical generalization (Feldman & Orlikowski, 2011). Further research should use other designs including larger study populations and various care systems to grasp possible differences between professional groups involved in care. Knowledge about professionals' health conceptions (Agresta, 2004; van Heteren et al., 2023), professional identities (Adams et al., 2006; Chreim et al., 2007; van Heteren et al., 2024) and professional-client interactions may help to understand possible differences and similarities in interprofessional collaboration between professionals. Moreover, in the decision to behave in a specific way in interprofessional collaboration in care, other factors may also play a role. Therefore, how interprofessional collaboration in a fluid team is linked to collaboration with the client environment should be further studied. Finally, future research should explore how clients experience interprofessional collaboration in fluid teams.

Conclusion

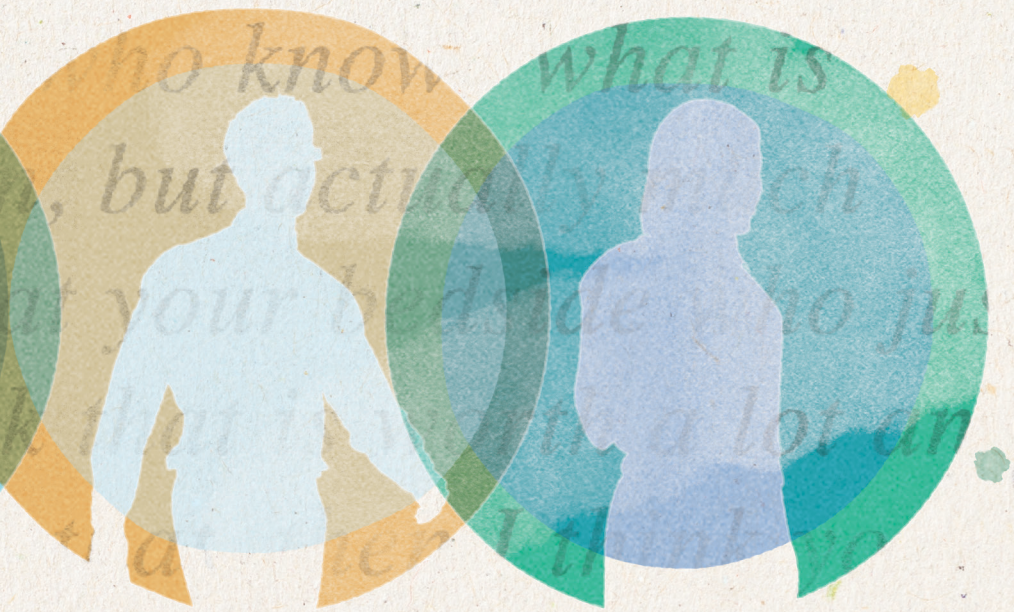
This study found that most interprofessional collaboration takes place informally through fragile interpersonal relationships in which membership change and difference create tensions. Even though professionals want to collaborate interprofessionally, this is difficult because membership in the team often changes and there are great differences between members.

The findings indicate that while some behaviors in fluid teams are similar to those observed in fixed teams, other behaviors are different because of different challenges. Different manifestations of interprofessional collaboration in fluid teams are particularly relevant given the prevalence of combined issues in today's context. This focus is especially pertinent because previous literature on interprofessional care (Schot, Tummers et al. 2020) has not consistently addressed team fluidity. In light of these combined issues, we recommend professionals to create awareness about the role of team fluidity in interprofessional collaboration. By doing so, future professionals in care and social welfare can be better prepared to navigate the challenges and capitalize on the opportunities presented by fluid team structures. In terms of training, future frontline professionals in care and social welfare should gain competencies such as quick adaptability to new communication styles and channels with diverse and changing team

members, as well as becoming empathetic and respectful listeners appreciating different perspectives and backgrounds, a fostering safe and inclusive team environment, and strong decision-making skills to navigate the complexities.

Chapter 5

What reasoning do frontline professionals use around citizen-clients' socioeconomic status: Exploring the mechanisms



Van Heteren, F. Raaphorst, N. J., Groeneveld, S., & Bussemaker J. M. (2025). What Reasoning Do Frontline Professionals Use Around Citizen-Clients' Socioeconomic Status: Exploring the Mechanisms. *Public Administration*. https://doi.org/10.1111/padm.13065

Abstract

This paper examines socioeconomic status (SES) as indicator for decision-making among frontline professionals in healthcare, focusing on general practitioners (GPs). Aside from research on stereotypes, we know little about how frontline professionals reason about SES in decision-making. This study addresses this gap by investigating how GPs use SES to develop care for patients with varying SES backgrounds. Based on qualitative interviews, the study identifies three SES reasonings which are closely intertwined with the status of patients: (1) status preservation reasoning describes how GPs interpret SES cues and status stability in relation to what needs to be preserved, (2) social distance reasoning helps explain how social distance creates a reference point when helping the patient, and (3) together reasoning describes how GPs use patients' busyness and educational level to develop treatment plans together with the patient. This study contributes to the existing literature by distinguishing SES reasonings in frontline professionals' decision-making.

5.1 Introduction

In caring for citizen-clients with combined psychosocial problems, frontline professionals work with people with different socioeconomic statuses (SES). The literature on street-level bureaucracy examines the role of SES in decision-making by frontline professionals, arguing that it is socially undesirable for people with different SES contexts to be treated differently in comparable situations (Harrits and Møller 2014, Raaphorst and Groeneveld 2018). People in certain social categories are more likely to have access to socially valued positions. For instance, children with lower social status tend to be devalued in school, not because they are less smart, but because teachers perceive them as less smart (van der Waal and de Koster 2015, van der Waal 2022). Notwithstanding the research into the use of stereotypes in decision-making, within street-level research in public administration (Raaphorst and Groeneveld 2018, Harrits 2019), there is still too little understanding of how professionals themselves work with differences in status among citizen-clients. Health sociology literature, on the other hand, addresses how frontline professionals use socioeconomic status as a category to justify differentiating among patients with specific needs (FitzGerald and Hurst 2017). Insights into the use of SES by GPs (General practitioners) are considered relevant for the work of SLBs (street-level bureaucrats) in general, because GPs operate at the frontline of service, making impactful decisions in direct interaction with citizen-clients, and having considerable discretion in doing so.

There is still a lack of understanding of the role of citizen-clients' SES in healthcare decisions. Therefore, our research question is as follows: *What reasoning do frontline professionals in healthcare use regarding cues associated with varying socioeconomic statuses?* This question explores the mechanisms through which frontline professionals, specifically GPs, interpret socioeconomic status cues when formulating treatment plans with their patients. By researching how GPs make judgments about patients with different socioeconomic statuses, we can deepen our insight into the role of SES in decision-making. We answer the research question by means of a qualitative interview study with GPs who, as frontline professionals, work directly with patients with combined psychosocial problems and encounter differences in SES on a daily basis. In our findings, we identify three SES reasoning mechanisms related to 1) status preservation, (2) the role of social distance in care, and (3) the ways in which professionals develop a treatment plan together with patients based on patients' busyness and educational level. Based on these findings, conversations can be initiated around the desirability of this approach.

This study makes three key contributions to the scientific debate. First, this study adds to existing research on the role of citizen-clients' SES in frontline decision-making (Harrits 2019, Harrits and Møller 2014, Raaphorst et al. 2018, Raaphorst et al. 2024). Existing research typically focuses on only one SES-indicator, such as citizen-clients'

level of education, or occupation, while the concept of SES consists of economic, social and cultural dimensions. Isolating one of the dimensions allows for assessing independent effects, but does not capture how different SES dimensions *together* are used to inform decision-making. Decision-making research often uses between-person designs and quantitative data (a.o. Halling, Christensen et al. 2024, although see Raaphorst et al. 2018 and Harrits 2019). While useful for uncovering biases, these methods do not reveal how SES indicators inform judgments about individual needs. Our pioneering qualitative within-person study in SLB research uses various SES indicators to achieve an in-depth exploration.

Second, street-level bureaucracy literature often highlights the downside of differentiating based on SES in similar situations (Harrits 2019, Raaphorst et al. 2018), while healthcare literature focuses on the positive side of responsiveness to different needs (Hamilton, Henderson et al. 2019, Hagger and Hamilton 2021). In fact, existing discrimination research provides indications that differences in citizen-clients' SES, such as level of education, in otherwise similar cases, *does* make those cases different for frontline professionals, indicating potentially different needs (e.g. Raaphorst et al. 2018, Raaphorst et al. 2024). This underlines that what constitutes 'equal cases' and 'different cases' is in the eye of the beholder. However, our understanding of the latter aspect remains limited. The present study aims to fill this gap by studying how GPs interpret different SES indicators in their judgments.

Third, much of the research on the role of SES in decision-making has focused on the differentiation mechanisms deployed by teachers, pedagogues and executive organizations (Harrits and Møller 2014, Raaphorst & Groeneveld 2018). This study focuses on the reasoning around SES among professionals who work with a diverse range of patients in terms of SES and place a strong emphasis on personalization: GPs working with patients with psychosocial problems. Focusing on GPs, who are primarily responsible for addressing patient needs, provides valuable insights into the role of SES in decision-making. In a highly professionalized context with significant autonomy, GPs may take SES into account in their decision-making — an area that remains under-researched.

In the following sections, we first present our theoretical framework, we then delineate the core concepts of this study, after which we describe our methodology and research context. We then present our findings and conclude with some theoretical and practical implications.

5.2 Differentiation on the basis of socioeconomic status

In this theoretical framework, we draw from literature on both street-level bureaucracy and health sociology to develop a theoretical understanding of the differentiation on the basis of socioeconomic status that frontline professionals bring to their decision-making. This theoretical framework uses the term 'frontline professional', because GPs are seen as professionals in frontline service, with the freedom to decide on appropriate care to meet their patients' needs (Lewis et al., 2003, McKenzie 2016).

Conceptualizing socioeconomic status

This study follows Van der Waal and De Koster (2015) in conceptualizing the separate dimensions of socioeconomic status. The authors argue that the existing literature is not always explicit as to what socioeconomic status entails, and that it is much more than education or income alone. In this study, socioeconomic status is conceptualized as a combination of economic, social, and cultural dimensions. Including these three dimensions in our conceptualization enables us to study how SES is used as a way to differentiate citizen-clients' needs.

The conceptualization centers on the distribution of economic, cultural, and social resources. In Bourdieu's approach on capitals (1984), professions are hierarchically ranked based on their labor market value. Indicators of *economic status* include whether someone is employed, how well they are paid, and whether they have economic resources (Vrooman, Boelhouwer et al., 2023) such as money. *Social status* is defined as the total of existing or potential resources as a result of possessing a more or less institutionalized network of social relationships. Social networks are never a given, and relationships and networks require ongoing investment and maintenance (Bourdieu, 1984, Engbersen, 2003). More social resources could be potentially valuable, and they could therefore also be hierarchically ranked. A person's *cultural status*, includes lifestyle, knowledge, cognitive capacities and education, which can be hierarchically ordered in terms of prestige. Cultural status can be used to obtain and maintain social privileges. A specific lifestyle is expected from people belonging to a certain cultural group (Weber 2009, van der Waal and de Koster 2015). The lifestyles of certain cultural status group are displayed, embraced and propagated by those belonging to other cultural groups. However, while some people may recognize other lifestyles as 'the way things should be', these lifestyles are not necessarily internalized by other cultural groups (Bourdieu 1984, Brinkgreve, van den Haak et al. 2011, van de Waal and de Koster 2015).

SES as ground for discrimination of otherwise similar cases

Two different fields in the literature consider how frontline professionals take citizen-clients' SES into account. First, street-level bureaucracy literature specifically focuses on the role of SES in decision-making by street-level professionals. It is considered so-

cially undesirable for people with similar situations but different SES backgrounds to be treated differently (Harrits and Møller 2014, Harrits 2019, Raaphorst et al. 2018). Second, health sociology literature addresses how frontline professionals justify making desirable distinctions between citizen-clients based on SES. The underlying assumption of this field of literature is therefore that individuals from different SES backgrounds potentially have different needs, and require distinct approaches. This type of research is particularly prominent in healthcare, because SES indicators influence how interventions play out, and healthcare researchers argue that we need to differentiate between citizen-clients based on SES indicators (Hamilton, Henderson et al., 2019 Hagger and Hamilton 2021). However, we still have limited understanding of the latter phenomenon.

Street-level bureaucracy research into SES mainly focuses on how similar situations are treated differently based on, among other things, stereotypes related to SES. These studies are designed using comparable personas and manipulating SES indicators to investigate differences in evaluation (Harrits, 2019, Harrits and Møller 2014, Raaphorst et al. 2018). These studies also indicate that SES indicators are sometimes explicitly used to gain insight into, for example, the competencies and intentions of citizen-clients that are relevant for decision-making. This suggests that differences in SES, such as level of education, in otherwise similar cases, *does* make those cases different for frontline professionals, indicating potentially different needs (e.g. Raaphorst et al. 2018, Raaphorst et al. 2024).

Street-level bureaucracy research shows diffuse patterns as professionals sometimes more positively evaluate clients with higher SES, and sometimes those with lower SES (Harrits and Møller 2014, Harrits 2019, Raaphorst et al. 2024). For instance, using a vignette experiment, Raaphorst, Ashikali and Groeneveld (2024) find that citizen-clients with higher educational levels are assumed to have more knowledge of the rules than those with lower educational levels. In line with this, Raaphorst, Groeneveld & Van de Walle (2018) find that higher educated citizen-clients avoiding contact are evaluated more negatively than lower-educated citizen-clients avoiding contact. These studies indicate reverse forms of discrimination, whereby the citizen-client with a lower level of education is evaluated more positively than higher educated citizen-clients. Other research indicates that frontline professionals explicitly reference social categories when describing their concerns about citizen-clients (Harrits and Møller 2014). Harrits and Møller (2014) show how frontline professionals' worry about citizen-clients seems to increase when social distance between the professional and citizen-client increases.

SES as ground for responsiveness to potentially different needs

Health sociology studies on the role of SES indicators show that they are used to differentiate between patients, potentially indicating different needs (Hamilton, Henderson et al. 2019). This research does not usually use the concept of SES, but refers instead to sep-

arate dimensions, such as lifestyles. This research is characterized by a growing interest in personalized healthcare. According to this literature, which mainly originates in the Netherlands, healthcare personalization operates from the principle of responsiveness to provide citizen-clients with the best assistance possible (De Blok, Meijboom et al. 2013, Bartels, Meijboom et al. 2021). In healthcare, the approach to categorizing patients based on their attributes has evolved with the emergence of personalized and precision medicine. These advancements aim to mitigate disparities among populations by considering individual lifestyles, thereby aligning with patient-centered care principles. Research in health sociology examines the interplay between lifestyle behaviors, social variables such as age, educational level, gender and income, genetics, environmental factors, and personalized healthcare strategies. This literature indicates that various SES dimensions relate to health behavior through lifestyle, offering normative recommendations on the best approaches for addressing these factors (Noordman, Verhaak et al. 2010, Berenguera, Pons-Vigués et al. 2017, Hamilton, Henderson et al. 2019, Hagger and Hamilton 2021). For example, Hamilton (2019) discusses how GPs take responsibility for discussing lifestyle with their patients. The decision to discuss lifestyle during a consultation is reported to be ad hoc and unsystematic, which means that there is no standard procedure regarding lifestyle advice or when to refer a patient to other professionals for lifestyle interventions. It is therefore unclear which reasoning GPs use to decide whether to offer lifestyle advice. Nevertheless, the literature suggests that patients' lack of understanding and low levels of health literacy may lead to professionals being more or less likely to bring up lifestyle changes (Hamilton, Henderson et al. 2019). Most of the literature in this field does not address how these lifestyles are then used to determine an appropriate healthcare plan (Lin, Chen et al., 2017).

Despite extensive exploration of socioeconomic dimensions and GP-patient interactions in health sociology research, most of these studies point to one or two SES indicators to explain patient-physician interactions. For instance, Willems et al. (2005) show that patients from lower SES elicit less positive socio-emotional communication and more directive and less participatory consulting styles from their doctors. Doctor's communication styles are influenced by the communication patterns of patients from high and low SES groups. In addition, such studies often do not explain why these particular indicators, such as educational level, income or occupation, are the relevant SES dimensions (Willems, De Maesschalk et al, Allen, Rogers et al. 2019). Health sociology literature posits that the premise of personalized healthcare is based on GPs' responsiveness to patients' lifestyle, which is an integral component of SES. Although some studies report positive and negative effects of personalized and customized approaches in healthcare, there is too little insight into the specific dimensions through which SES is used to inform judgments about needs (Minvielle, Fourcade et al., 2021). There is still a gap in our understanding of the reasoning GPs use when addressing SES and how social,

cultural and economic dimensions play a role in their decision-making (Bourdieu 1984, van der Waal and de Koster 2015). This study therefore investigates the reasoning GPs use around SES cues to identify potential differences in needs. In other words, we aim to understand how SES is used by frontline healthcare professionals to differentiate and recognize varying needs. This approach underscores the role of SES dimensions in personalization, identifying how GPs tailor their care based on their patients' diverse SES backgrounds.

This study generally defines reasoning as the mental process of drawing conclusions, making inferences, or evaluating arguments based on available information and logical principles (Mercier 2011, Mercier and Sperber 2011, Toplak, West et al., 2014). In this study, the authors focus on the latter by inductively examining the reasoning of professionals about individuals, and how SES dimensions are used in this reasoning to decide on treatment plans that match the patients' needs.

5.3 Methods

The issue of the reasoning used by professionals around cues associated with variations in socioeconomic status is best explored using a qualitative within-person design. The data in this study stem from qualitative interviews with GPs using personas as a method of data collection and analysis (Harrits and Møller 2021).

Context and research focus

The Dutch healthcare system is known for its accessibility, quality, and efficiency. GPs act as the first point of contact within the Dutch healthcare system. Patients have to first consult their GP before they can be referred to specialized care. In the Netherlands, GP is a highly professionalized profession with a lot of autonomy. This is due to the fact that GPs undergo a minimum of 9 years of training, it is a protected profession and there is a dedicated disciplinary board that oversees the conduct of practice of GPs (General Practitioner Training, 2025[4]). The idea is that GPs provide continuity of care, which means that they guide patients for long periods of time and have an overall understanding of their medical history, which in turn ensures a personalized and effective treatment. Apart from treating illnesses, GPs are also responsible for preventive care. They offer advice on healthy lifestyle, and screen for early detection of diseases (NHG, 2025).

This study was carried out in The Hague, the third largest city in the Netherlands. This was a strategic decision because psychosocial problems are disproportionally

4 This is an informative website by the General Practitioners Training the Netherlands aimed at providing official information about general practitioner training.

common in some parts of the city, particularly among low-income residents, and there are substantial differences in the socioeconomic status of the population (Haaglanden 2021). To guarantee internal validity, this study focused on GPs working in neighborhoods in which combined psychosocial problems were most apparent. Moreover, GPs increasingly have to deal with psychosocial problems, or a combination of physical, psychological and social problems, which are multiple, diffuse and can be seen as ambiguous. This expansion of health problems places greater pressure on GPs (Hadoks 2023) and these problems can often be interpreted differently and subsumed under various care domains. Importantly, GPs are the first frontline professionals to interpret patients' problems and build a relationship with patients with high levels of discretion. This happens in a context of personalization in healthcare in which GPs share the objective of collaboratively organizing care as much as possible within primary care (Hadoks 2024a). Given the variation in patients' SES backgrounds and the growing emphasis on personalization, there are good reasons for examining the SES reasoning of GPs. GPs in our sample have between 1 and 35 years of experience in this profession and their ages range between 30 and 65 years old. Most GPs identify with higher SES groups, while some have backgrounds in lower SES groups.

Methods and data

Interview study approach

In order to examine how professionals assess the psychosocial problems of citizen-clients with varying statuses, a qualitative interview study was conducted with GPs to mimic real-life decision-making by using personas to which respondents were asked to react. Similarly to vignette research, the authors used personas as stimulus material to start a conversation about attitudes, values, perceptions and judgements in decision-making, thus using them as tools for an in-depth analysis of these processes (Loyens and Paraciani 2023). Persona refers to text, images or other expressions used to describe a situation or individual that can be used as stimulus to prompt responses to interview questions (Hughes and Huby 2002). Personas also elicit 'second stories', meaning that if we know what topics are worth telling a story about, the next question triggers storytelling, also beyond the persona (van Hulst and Ybema 2020). Second stories emerge because first stories remind respondents of previous experiences (ibid.). Personas are hypothetical but realistic descriptions of situations that resemble the respondents' daily experiences (Wilks 2004). The personas in this study all somatically describe the same problem, but their SES context is different, which may lead respondents to conclude that their problems are different, also somatically.

For this study, three personas (see Appendix D1) were constructed during ethnographic fieldwork by the lead author, which strengthened the internal validity of the personas (van Heteren et al. 2024). The personas are therefore hypothetical, although

they are based on real GP-patient interactions (Hughes and Huby 2004). Respondents were asked to reflect on the three personas, all of which represented patients with a combination of psychosocial problems. All personas presented the same expressed health problem, namely pain in the chest, but with slightly different socioeconomic status cues. The high SES persona was a male lawyer who, due to stress-related complaints, did not spend as much time with his friends as he would have liked to (Engbersen 2003). He had a well-paid and highly educated job (Abel 2008). The low SES persona was an uneducated male who was temporarily on sick leave, was insecure about his financial situation, and was an informal caretaker for their partner (Abel 2008). He frequently cooked his meals in an air fryer, a choice often associated with lower SES individuals (Kamphuis, Jansen et al. 2015), and did not have a stable social network (Engbersen 2003). The mixed SES persona was a male with a mix of high and low SES indicators. This person worked as a freelance handyman, was close to his family, had a busy life, and sometimes smoked marijuana with friends to fall asleep more easily. This persona combined lower and higher SES cues, since smoking is often associated with lower cultural status individuals (Mariël, Schrijvers et al. 2002), while having friends and family is linked to higher social status (Engbersen 2003), and having a job is economically valued (Vrooman, Boelhouwer et al. 2023). He is also financially successful in his business, but he did not finish high school (Abel 2008). The authors assume that since SES cues are interrelated, they all affect how the persona, their health and the required healthcare plan are interpreted (Abel 2008). To avoid hierarchically ranking people's cultural lifestyles as researchers, the authors let the respondents decide what the SES cues pertained to and whether they concerned a high or a low status. Neither the researcher nor the persona explicitly stated this during the interviews; this was merely implied, for example, by referring to the type of work someone did, their educational background, their social network, or their lifestyle. To further enhance the personas' internal validity, they were tested in three pilot interviews with GPs and in conversations with GP colleagues from the lead author's department. The latter ensured that the personas elicited the type of response the authors were interested in, and that participants were triggered by the cues integrated in the personas. In other words, the resulting personas were plausible, authentic, and engaging, and they elicited vivid responses (Harrits and Møller 2021). After consulting experts, the authors concluded that chest pain could be interpreted in various ways, and that the level of concern and the development of a treatment plan could be directed at different aspects of the problem. Among males aged 40 to 50, chest pain could be a physical problem, but it could also be interpreted differently, as a stress-related problem. The problem is ambiguous enough to study potentially different interpretations based on patients' SES backgrounds. Another element that contributes to the transparency and traceability of our findings is the code table provided in Appendix D2.

In the analysis of this study, reasoning included the professionals' initial interpretation of the complaint, the interpretation of cues in reaching a decision about the

patient, the level of concern, and the development of a treatment plan. Reasoning about SES information may lead to a certain level of concern for the patient. The level of worry a GP experiences about a patient and the aspects of the persona they are most worried about are relevant: is the GP worried about the patient in general, or about specific aspects in or beyond the persona, and what kind of further decisions regarding a specific treatment plan do these worries lead to (Harrits 2019)? Existing research often focuses on the final decision, but in our study, reasoning revolved around the process of interpretation rather than the final level of concern (Harrits 2019). This study was registered and approved by the Medical Ethical Review Committee of Leiden, The Hague and Delft (N20.158) and consent was given by all respondents.

Data collection

Data collection took place in 2023. Prior to the interview, respondents were asked to share some information about themselves: In what circumstances did they grow up and how would they describe their own social status? How do they see themselves as a professional? What do they find important in their work? How do they view their work context? (see interview guide in Appendix D1). Respondents were then asked to read the different personas and the researcher asked them some open questions about each persona. The interview finished with reflection questions to help understand how the respondent arrived at their reasoning and how they compare their interpretation of the three personas. Why did the respondent choose different strategies for different patients? And how and why did their level of concern differ? These open questions helped respondents to think aloud and talk freely about their interpretation of the personas from their own perspective.

All 15 interviews lasted from 45 to 90 minutes, and they were audiotaped, transcribed verbatim, and coded using thematic analysis, including open, initial, and closed coding (Braun and Clarke 2006, Charmaz 2006). We translated all the quotes below from Dutch, and in doing so tried to reflect the original wording as accurately as possible. We used pseudonyms to protect the respondents' privacy and omitted any reference to the neighborhoods where they worked. Respondents were recruited by contacting GPs within the lead author's research network. All were purposefully selected as GPs working in neighborhoods where combined problems are most apparent. Additionally, the snowball sampling method played a key role in recruiting further respondents.

Analysis

This research study uses an abductive approach, moving back and forth between theory and data (Schwartz-Shea and Yanow 2013, Tavory and Timmermans 2014). We therefore approach the empirical world with theory on socioeconomic statuses and frontline professionals' standards for evaluating citizen-clients. Our analysis did not focus on comparing responses to the various personas, but rather on the reasoning about the

individual personas based on respondents' values and interpretations of SES cues. The problems experienced by the personas were similar, but the SES dimensions differed. We coded the interviews using constant comparison (Glaser and Strauss 2017) and sensitizing concepts relating to the three dimensions of socioeconomic status to identify relevant aspects of the data. The first step was to look at which cues respondents used in their reasonings. In their reasoning, respondents could for instance refer to status cues when talking about their initial interpretation of the persona. The second step was to look at how respondents reason around status cues, and what kind of reasonings they use. For example, their reasoning towards a specific level of concern and treatment plan. The third step was to look at which socioeconomic dimensions the respondents use in their reasoning. How did they differentiate between socioeconomic status dimensions and how did they refer to these dimensions in their reasoning about the citizen-client explicitly or implicitly? (See appendix B for quotes and initial interpretation). This type of analysis is relevant in this context, because GPs are highly professionalized in the Netherlands, but they also use their intuition or gut feeling in working with patients. The authors used the empirical insights to further explore the relevant literature and refine the analysis accordingly. We conducted peer validation during the coding process and the second author was closely involved in the coding process.

5.4 Findings

Conceptualizing SES reasoning

The authors conceptualized three different types of SES reasoning and explored their mechanisms: The findings focus on how reasoning occurs, taking into account status preservation, social distance and developing a treatment plan together with the patient through various mechanisms. An overview of these findings can be found in table 5.1.

Status preservation reasoning around SES

The first type of reasoning, status preservation, focuses on how GPs try to preserve their patients' status dimensions based on their SES. This type of reasoning is characterized by how GPs use various status cues to assess which dimensions need to be preserved.

The following example from respondent 4 shows what status preservation reasoning around SES looks like:

> ***'Suppose he relapses [with his burnout], he will lose a lot.'***
>
> *'The second [high SES] one is really in big trouble, and it will take a long time before he gets out of it, I think. He might be the most difficult, the most time-consuming, to get back on his feet. [...] With a bit of luck, the*

third [low SES] patient can move on with a minor intervention. If he can be reassured and find his strength again. [...]And if he can get some guidance on how to handle [his partner][...], it might be possible for him to return to a stable situation. [...] The first [mixed SES] man just keeps going. So far, he hasn't hit any obstacles. If we can get him to calm down a bit, he might make it much further without any problems. Socially, he has no issues... his work is going well. I don't see a decline happening here. With the second [high SES] man, his work is not going well, which is worrisome for a lawyer. And with the third man, his work is also not going well. But that is not the most important thing here. The difference between working and not working is not very significant for him in terms of income. So, in that respect, you can easily create some space and calm by keeping him on sick leave a little longer if necessary. Until the other issues are resolved. [The high SES man has risk of] social decline. Suppose he relapses [with his burnout], he will lose a lot. And then many small things can start to unravel. He might get into trouble with his partner, or at the very least, his self-esteem will take a huge hit.'

Respondent 4 therefore shows that in practice, the status preservation reasoning is a combination of SES indicators and perceived stability. GPs therefore look at various SES cues to decide what patients might lose if they become unstable, and they try to assess whether patients are stable.

GPs emphasize the importance of preserving various SES dimensions to prevent overall decline. They highlight the need to maintain social status, including relationships with friends and family, as well as economic status, such as having a stable income. GPs argue that cultural lifestyle cues, such as hard work and care responsibilities, have an impact on patients' stability. At the same time, GPs emphasize the importance of preserving cultural lifestyle, including self-esteem through work alongside other dimensions. In other words, GPs argue that certain patients should be able to hold on to their higher cultural lifestyle, possibly making it harder to solve their issues. In doing so, GPs often mention the cultural lifestyle indicator as being important, because it could determine whether a patient can keep living the way they do without losing other status dimensions.

Social distance reasoning around SES

Social distance reasoning around SES is about how the GPs' and patients' SES affect the development of treatment plans. Characteristic of social distance reasoning is that some GPs use their own status or a status they are familiar with as reference points in developing treatment plans. The social distance reasoning mechanism means that the GPs' reasoning from a small social distance show identification with the patients' needs,

due to recognition of or feeling closeness to a similar status group. Small social distance reasoning is illustrated in the example below by respondent 1:

'***And I think of myself. As I said, I'm also quite active [...].***'

'*Sometimes it's not entirely [...] logical, but it's about the part where he says: "What I find unfortunate is that I can no longer do fun things in the evening with friends, like play badminton or go to a party. I enjoy spending time with my friends." So, then I think: it's not okay that that's not possible. And I think of myself. As I said, I'm also quite active and I get a lot of energy from it. But sometimes I also feel that my life is a bit too busy, so I can easily imagine that it causes stress if you have such a full schedule. When other people look at my schedule, they often say: "How do you do it? It would stress me out." I don't know. Somehow, I'm suddenly thinking about that... [...] But there is something that makes me think: No, I don't think it's right that all that is no longer possible, so I find it alarming. I don't even necessarily know whether that means he has a heart condition.*'

Respondent 1 therefore shows that in practice, this mechanism means that GPs who recognize a patients' cultural lifestyle as similar to their own aim to help the patient to get their life back in order. GPs personally understand the importance of helping this patient, because they are able to identify with the patient.

While the first example of small social distance reasoning focused on the high SES persona, this mechanism also arises in situations where both the GP and the patient have or have experience with being in other than high SES positions, as illustrated by respondent 10:

'***I do know what it's like to be different [...].***'

'*At some point, we lost our expat status and then we just became foreigners [in the Netherlands]. [...] We were placed in a Dutch school and gradually moved out of that [expat] world. [We] survived here as best we could. [...] I was also on the receiving end of prejudice and all sorts of things. So, I'm a bit between two worlds in that respect. [...] I do know what it's like to be different and I know what it's like not to always have it easy, I know what it's like to have to fight for where you want to get to. But I've come a long way... [...] In general, in patient care, I try to take on a more empowering role. I want to give people more power over their own health, so they can take care of themselves, and we don't always have to do everything, because that's not necessarily realistic either. [So,] providing a lot of information,*

a lot of explaining, always saying why we do or don't do something. [...] I like to take the time, where I can, for someone, if they need it. And I think I also look – but I think that's part of the job – but I look more broadly. So, I take into account... I mean, you often see that it's not just the illness, but a lot of other things too.'

Respondents thus recognize the feeling of being 'different' because of their own status background. Identification with the patient makes it easier for GPs to get patients the treatment they deserve, similar to those in higher SES situations. GPs thus see a clear course of action ahead. This social distance reasoning is therefore not only activated by GPs' current status, but also by experiences in other SES positions from the past.

As this section shows, in small distance reasoning around SES, GPs mostly consider cultural status as an important dimension in recognizing their patients' status. GPs recognize the importance of this dimension for their patients, because they also find it important in their own life.

Together reasoning around SES

Together reasoning around SES is about how caring develops, and it describes how GPs use different approaches to working more or less collaboratively with a patient, based on their SES characteristics. Characteristic of together reasoning is that GPs use different approaches for formulating a plan with the patient. Specifically, GPs may decide to formulate a plan together with some patients, while with others, they may decide to formulate a plan for the patient, or let the patient decide about the plan. The core of together reasoning around SES is that GPs respond to the patient's perceived self-sufficiency, based on how busy their life is and their perceived cognitive capacity. In this mechanism, how busy a patient's life is affects the GP's perception of their self-sufficiency and, consequently, the treatment plan. However, this reasoning only arises in combination with the GP's interpretation of the patient's educational background, because a patient's educational level could determine whether the patient understands the type of care they may need.

The following quote from respondent 11 illustrates how together reasoning around SES works.

'That also really influences how you assess someone's health.'

'This [...] [low SES persona] understands very little, so you really have to take him by the hand. That also really influences how you assess someone's health. [...] The other man, he's a lawyer, he's also very cognitively engaged. [...] He will understand me when I make a plan, he's also probably articulate enough to talk back.'

In together reasoning, busyness is therefore mobilized to decide whether a patient's problems need to be resolved quickly so they can get on with their lives. More specifically, this occurs when patients who are understood to have a high educational level. In other words, when being busy and having a high educational level are combined, the patient's ideas on the treatment plan are given priority, and the patient is invited to take the lead concerning the direction in which they want the treatment plan to go. However, when a busy life is not combined with a high educational level, GPs often see busyness as a factor that can cloud the patient's judgement, making it impossible for them to decide on the treatment plan themselves. Therefore, GPs are likely to decide that these patients need more guidance in developing a treatment plan.

GPs refer to a combination of cultural cues to explain their reasoning around the extent to which a patient is able to devise a treatment plan or needs assistance in doing so. The together reasoning mechanism is therefore triggered by a combination of two different cultural cues.

Table 5.1. Three types of SES reasoning and their mechanisms

SES reasoning of GPs		
SES reasoning	**Substantiation**	**Mechanism**
Status preservation reasoning around SES	How status is preserved in relation to SES dimensions	How the need for status preservation is determined by combining SES indicators and interpretations of patients' stability
Social distance reasoning around SES	How social distance is used to develop a treatment plan for patients	How small social distance creates recognition and a reference point when helping the patient
Together reasoning around SES	How approaches to creating a treatment plan are explored together with the patient	How patients' busyness and educational level is used to determine the development of a treatment plan

5.5 Concluding discussion

This study explored the reasoning used by frontline professionals in healthcare regarding cues associated with varying socioeconomic statuses. Our findings are that GPs use three types of SES reasoning in shaping their approach to patient care. The first type of reasoning, status preservation, refers to the way GPs determine the need for status preservation by combining SES indicators and interpretations of patients' stability. The second type of reasoning, social distance, refers to the way in which small social distance creates recognition and a reference point when developing a treatment plan for

patients. Third, together reasoning around SES reveals how GPs use patients' busyness and educational level to determine the extent to which they develop treatment plans together with the patient. This last finding helps to explain how SES plays a role in the extent to which and the ways in which professionals invite citizen-clients to share their preferences and take these into account in formulating a treatment plan (van Heteren et al, 2023).

This study contributes to the existing street-level bureaucracy literature on SES in decision-making, which shows limited insight in SES reasoning, by providing insight into grounds for differentiating between citizen-clients. Our study contributes to this literature, conceptualizing SES reasoning among GPs by examining what reasoning GPs use when considering cues associated with varying socioeconomic statuses. Our conceptualization of status preservation reasoning around SES is useful for theory development on the role of SES in decision-making because it enhances our understanding of the reference points that may impact professionals' deservingness judgments and resource allocation. Our conceptualization of social distance reasoning adds to the literature on social distance (Groeneveld and Meier, 2022;, Harrits and Møller, 2014) by showing how differences in social status between professionals and citizen-clients matter for decision-making. Harrits and Møller (2014) find that the larger the social distance between professional and citizen-client, the more worry is expressed and interventions suggested. Corroborating these findings, our study shows how social distance is also a type of reasoning, where frontline professionals draw on their own status positions to identify with citizen-clients in similar positions. Our conceptualization of together reasoning highlights a potential bias in decision-making whereby citizen-clients with higher SES may receive more collaborative care compared to those with lower SES. These insights contribute to theory development on the role of citizen-clients' SES in decision-making by frontline professionals.

Our conceptualization of different types of SES reasoning could also be relevant to the literature on administrative burdens. The literature on administrative burdens explains how status background influences citizen-clients' experiences and their responses to these burdens (Christensen, Aarøe et al., 2020; Döring 2021; Masood and Azfar Nisar, 2021). The varying resources individuals possess for coping with administrative burdens stemming from interactions with the state may affect them differently (Döring, 2021). Existing research has shown how street-level bureaucrats play a key role in perpetuating social inequity by enforcing seemingly neutral rules that disproportionately burden certain groups (Maynard- Moody and Musheno, 2012; Moynihan, Herd et al., 2015; Nisar, 2018). However, our findings show that SES also plays a role in how professionals take citizen-clients' background in account in determining the type of assistance citizen-clients may need, and the grounds on which they may need this. For instance, while GPs see some patients as self-sufficient, other patients are more likely to elicit a desire to relieve them of the burden of figuring out how to solve their problems. In practice, however,

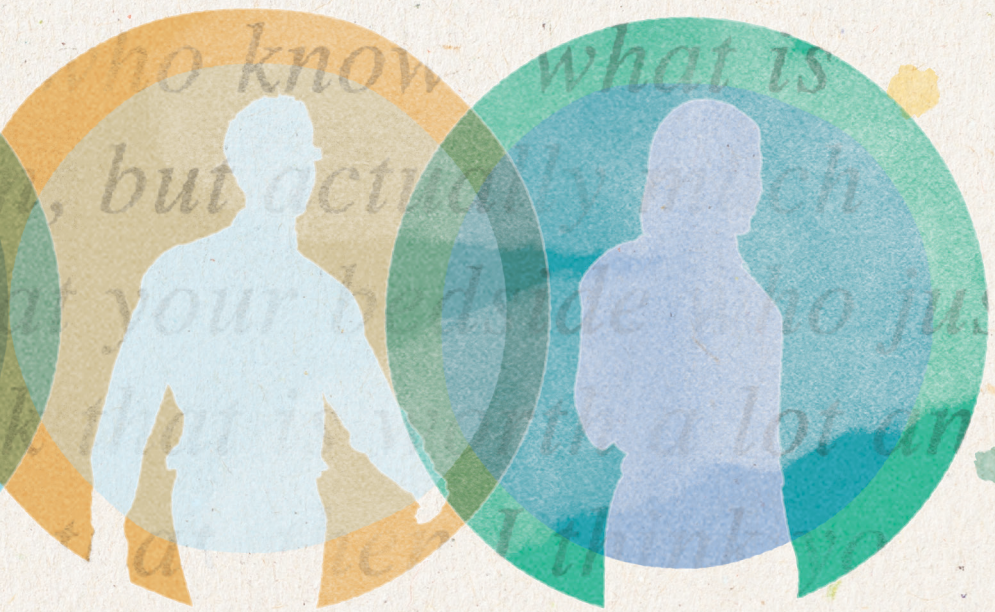
the patient perceived as being self-sufficient may actually experience this as a burden, while the other patient may want to think for themselves.

Health sociology research on health inequalities argues that cultural capital is used to translate social inequality into health inequality through individuals' behaviors, attitudes and choices (Abel 2008), but there is a lack of research into how lifestyle approaches are implemented in healthcare (Minvielle, Fourcade et al., 2021). Our findings contribute to this literature by providing insights into how cultural status and other SES dimensions play a role in decision-making processes, with the aim of helping those in need. Central to our findings is that GPs focus on lifestyle indicators to tailor their personalized interventions. While such personalization in care seems crucial for some individuals, it is potentially problematic in that what one person perceives as personalized care may be interpreted by another as discrimination.

This research study has limitations that require reflection. One limitation is that we relied exclusively on qualitative interviews, using personas as conversation starters. While these rich narratives provide insights into the thought processes of frontline professionals and their reflections beyond the personas, they are not suitable for studying the professionals' reasoning in actual practice. This study sheds light on how GPs reason around SES in formulating healthcare plans with citizen-clients. However, this study does not give insight into how GPs mobilize professional — and other types of — knowledge in their reasoning. More specifically, in our findings, we show the mechanism of social distance reasoning, but we do not know where it comes from. Therefore, why respondents use this social distance reasoning could be because of motivation or personalized care, but it could also have to do with bias. Future studies could build on this by incorporating participant observations and experiments for studying professional behavior in various situations and to gain insight into knowledge mobilization (Møller 2022). Another limitation is the study's focus on a specific type of frontline professional, the GP. We chose GPs because they work specifically to address patients' needs, and they have significant autonomy in decision-making, as well as discretion, and extensive information about patients through personalized and often long-term relationships. This highlights the multifaceted and impactful nature of GPs' work, and distinguishes them from other street-level professionals, who may not have such an extensive range of characteristics. Future research should compare SES reasoning across different types of professionals in various domains to develop a general theory on SES reasoning among frontline professionals. Moreover, future research on administrative burdens could delve into how the use of SES reasonings by frontline professionals relates to the experienced burdens of citizen-clients' with different status backgrounds. Finally, this research study was carried out in a specific country context, and we wish to acknowledge that if this research was to be done in another country, different personas, inductively based on this alternative context, would be more appropriate.

Chapter 6

Conclusion and discussion



6.1 Introduction

The conceptions, roles and reasonings explored in this dissertation together shape how frontline professionals relate to other professionals and to their clients with combined psychosocial problems. The introduction of this thesis indicated that in The Hague, the Netherlands, many people live with combined psychosocial problems. Furthermore, there are inequalities between people living with and without problems such as medical issues, poverty and depression, and, such problems are mostly evident among people with a lower socioeconomic status (SES) (SCP, 2023). Furthermore, these combined problems among vulnerable clients create a need for collaboration between frontline professionals across professional and organizational borders, whereas many incentives go against such collaboration.

My main motivation was to increase our understanding of how frontline professionals relate to clients with combined problems and other professionals, because it can contribute to awareness in or around the aspects of persistent combined health problems and health inequalities. Efforts to address such combined problems in public health are mostly focused on studying effects of social determinants on health (a.o. Kikuchi et al., 2023; Nutbeam & Lloyd, 2021), while the role of frontline professionals in caring for clients is often not taken into account. Therefore, throughout this dissertation, I focused on studying frontline professionals in care and social welfare, which includes questions that are relevant for both public health and public administration. Combining insights from public health and public administration is relevant to understand the organizational- and professional aspects of interprofessional collaboration and street-level professionals. Moreover, drawing on an anthropological lens and emic perspective allowed for studying health conceptions, roles in collaboration and reasonings from the professionals' perspective. This approach was essential in uncovering implicit norms, values, and interpretations that guide professionals' work in care, including their interaction with each other and with clients. Frontline professionals' work, in turn, is relevant to promoting equitable health outcomes for clients with combined psychosocial problems. In this chapter, I answer the following overarching research question:

RQ: *How do frontline professionals relate to other frontline professionals and clients in caring for clients with combined psychosocial problems*?

By answering this question, the dissertation has aimed to understand the frontline professional's perspective in caring for people with combined problems. To answer the research question, this dissertation focused on frontline professionals working in organizations in general healthcare, mental healthcare and social welfare who work across professions and organizations in caring for clients with combined problems (a.o. Haaglanden ,2021; Actieprogramma Preventie, 2020; RVS 2020).

In this concluding chapter, I discuss the main findings of the empirical studies in relation to each other and to the literature to date. Furthermore, I answer the overarching research question and how the anthropological lens contributes to this question relevant for public administration and public health. A summary of the empirical findings of each empirical chapter will be presented in section 6.2. After that, in section 6.3, an answer to the general research question will be provided. In section 6.4 the theoretical and methodological implications will be discussed. In section 6.5, the limitations and recommendations for future research will be outlined and lastly, in 6.6 the societal and practical relevance of the findings will be discussed.

6.2 Summary of empirical findings

This section presents the conclusions of each empirical chapter separately. Each chapter addressed a distinct sub-question using different methods, thereby exploring different aspects of the same phenomenon – how frontline professionals in care and social welfare relate to other professionals and clients in caring for clients with combined psychosocial problems.

Health conceptions

Chapter two conceptualized the health conceptions held by various frontline professionals in general healthcare, mental healthcare and social welfare by focusing on how frontline professionals view and approach health. This chapter answered the following research question: *How can the health conceptions of frontline professionals in general healthcare, mental healthcare and social welfare be conceptualized?* I used an inductive semi-structured interviewing approach, with various types of frontline professionals who all work with clients with psychosocial problems, and who collaborate across professional and organizational boundaries. In doing so, this chapter conceptualized professionals' health conceptions and it emphasized the importance of these conceptions in care.

This chapter has found that frontline professionals' health conceptions differ in three main dimensions: 1) health definitions, 2) alignment with clients and 3) contextualization of clients' health. Thereby, this study shows that professionals' health conceptions not only consist of what professionals think constitutes health, but also include beliefs about what clients are expected to do and how professionals should support them in becoming or staying healthy. Additionally, the findings showed that frontline professionals have beliefs about what should be expected of other stakeholders in the client's broader context when determining appropriate health goals and care approaches. These findings are a first building block in theorizing frontline professionals' health conceptions. This study furthermore explored the interplay between the different health conceptions and found that frontline professionals in care and social

welfare combine health conception dimensions — health definitions, alignment with clients and contextualization of problems — in various ways when caring for clients with combined problems.

This chapter focused on the health conceptions of frontline professionals, the next chapter went into how health conceptions translate into practice – by exploring how health promotion roles are shaped by professional identity.

Frontline professionals' identities and roles

Chapter three focused on health promotion roles and professional identity of frontline professionals in caring for clients with combined problems by answering the following research question: What kind of health promotion roles do frontline professionals in general healthcare, mental healthcare and social welfare have and how are these shaped by their professional identity? I used ethnographic fieldwork to explore professionals' health promotion roles.

The findings of the study indicated how various frontline professionals promote health according to two roles: reframing and customizing health promotion and that this is associated with how they identify as pragmatic or holistic professionals. Even though the reframing role often co-occurred with the pragmatic identity and the customized role with the holistic identity, this relationship is not deterministic. My findings also showed that professionals' health promotion roles and professional identities transcend professional backgrounds.

Moreover, resonating with broader developments in healthcare from reactive to proactive care (De Valck et al.. 2001; Waldman & Terzic, 2019), the types of health promotion roles in this study differed based on how professionals *manage complexity*, *client autonomy* and how they *involve the client context* in health promotion. Thereby, health promotion roles are more layered than the fixed attitudes and tasks described in the health promotion literature (Geense et al., 2013), because they are shaped by professional identities and they are situational. The latter means that frontline professionals do not follow a single, static role; instead, they shift between roles, based on how they manage complexity, client autonomy and how they involve the client context.

This third chapter focused on how various frontline professionals in care and social welfare identify professionally and which health promotion roles they use. Chapter four then explored how these professionals collaborate across professions and organizations to care for clients.

Interprofessional collaboration in fluid teams

Chapter three demonstrated how identity is a relational concept, formed through promoting health with clients and other professionals (a.o. Weick, 1995; Ashforth, 2000). Therefore, it was relevant for chapter four to explore how frontline professionals promote health together with other professionals.

Chapter four focused on how team fluidity plays a role in interprofessional collaboration in care for clients with combined problems by answering the following research question: *What does interprofessional collaboration look like in a fluid team context?* I used ethnographic fieldwork to explore interprofessional collaboration in a context of team fluidity among frontline professionals in general healthcare, mental healthcare and social welfare who work across professional and organizational boundaries in caring for clients. A key focus of this study was how team fluidity, and thereby, differences and changes in membership, plays a role in interprofessional collaboration (Kerrissey et al., 2020).

The chapter found how frontline professionals collaborate interprofessionally in a context of team fluidity and how they experience this based on seven behaviors in collaboration; *creating alternative communication lines*, *organizing valued spaces*, *bridging knowledge gaps*, *bridging communication gaps*, *bridging partner matching gaps*, *negotiating responsibility overlaps* and *negotiating safe work environments*. These behaviors were identified using sensitizing concepts, as identified by Schot and colleagues (2020), which guided the analysis. The empirical research showed that most interprofessional collaboration takes place informally through fragile interpersonal relationships in which membership change and difference create tensions. Primarily, membership change, but also differences between members, increase the difficulty regarding interprofessional collaboration in fluid team contexts.

SES reasonings

Chapter five highlighted how frontline professionals relate to other professionals, but the other chapters also showed that in collaboration in care and social welfare, it is relevant to know more about how frontline professionals relate to the clients they care for.

This fifth chapter found how frontline professionals interpret their clients by exploring how frontline professionals in general healthcare take socioeconomic status (SES) into account in their daily decision- making with clients by answering the following research question: *What reasoning do frontline professionals in healthcare use regarding cues associated with varying socioeconomic statuses?* By means of a qualitative interview study with general practitioners (GPs) who work directly with clients with combined problems and who encounter differences in SES on a daily basis, I explored the mechanisms through which frontline professionals in general healthcare interpret SES cues when developing treatment plans with clients. In doing so, this study deepened existing insight into the role of SES in decision-making (Harrits & Møller, 2014; Raaphorst & Groeneveld, 2018).

In this chapter, I identified and conceptualized three SES reasonings in shaping GPs' approach to patient care. First, *status preservation reasoning*, refers to how GPs determine the need for status preservation by combining SES indicators and interpreta-

tions of patients' stability. Second, *social distance reasoning*, refers to the way in which small social distance creates recognition and helps GPs prioritize when developing a treatment plan for clients. Third, *together reasoning* refers to how GPs use patients' busyness and educational level to determine the extent to which they develop treatment plans together. Conceptualizing these different SES reasonings shows how GPs interpret and use various SES cues in their decision-making when developing treatment plans with patients. SES cues thus shape their approach to patient care in ways that impact patient care by aiming for *status preservation*, *prioritization* and *togetherness*.

6.3 General conclusion

Within this section the overarching research question will be answered by combining the findings of the different empirical studies. The overarching research question is:

How do frontline professionals relate to other frontline professionals and clients in caring for clients with combined psychosocial problems?

This general research question will be answered in two parts. The first part of the research question is about how frontline professionals relate to other frontline professionals in caring for clients with combined psychosocial problems. The second part of the research question is about how frontline professionals relate to clients with combined psychosocial problems.

First, I outline my findings on how frontline professionals relate to other frontline professionals in caring for clients with combined psychosocial problems. How frontline professionals relate to other professionals is shaped not only by characteristics of the team context – change and difference – but also by professionals' health conceptions and their professional identities. I have explored how frontline professionals work in a context of team fluidity. This focus is particularly relevant because there is a high prevalence of frontline professionals working with clients facing combined psychosocial problems and they inherently work in settings characterized by high levels of membership change and difference. This dissertation shows that in contexts of team fluidity, frontline professionals engage in seven behaviors related to interprofessional collaboration, including *creating alternative communication lines*, *bridging knowledge and communication gaps*, and *negotiating responsibilities*. These behaviors, in which change is the main driver, show many similarities but also some differences compared to the behaviors in interprofessional collaboration of professionals working in fixed teams (Schot et al., 2020). The differences are especially relevant given the prevalence of combined issues nowadays. What is different in contexts of team fluidity is that pro-

fessionals by definition have to work in diverse and constantly changing contexts, as a result of which they work with many different people. The dissertation showed that this, for instance, means that professionals in fluid team contexts experience unclarity regarding who to approach and when. Moreover, it can be difficult to know who to trust and to know who is responsible. Therefore, interpersonal relationships are fragile, but crucial to foster interprofessional collaboration. Notwithstanding the advantage of the ability to complement each other with different professional backgrounds, high turnover and changing team composition increase the challenge of identifying and reaching appropriate partners for collaboration in fluid team contexts.

Apart from team fluidity, I have also explored how frontline professionals see health and how they want to work towards this in collaboration with other professionals. The way in which professionals give meaning to health and care is strongly connected to how they relate to other professionals. Health conceptions are not only individual understandings, but are shaped in interprofessional collaboration. In fluid team contexts, interprofessional collaboration is therefore not only about dividing tasks, but it is also a negotiation of professionals' values and perspectives inherent to health conceptions. Moreover, when frontline professionals care for vulnerable clients together, misunderstanding due to varying health conceptions may impact their abilities to do so. For instance, *health definitions* are relevant, because having different ideas of what health means may impede the ability to work towards (similar) goals together. To be able to understand each other and reach health goals together, professionals also emphasize the importance of assessing contextual sources. By *assessing the social context* of the client, frontline professionals emphasize that they do not only try to get more information from clients about their social context, but also from their larger environment including other professionals involved with the client. Frontline professionals may gather such information through clients or by contacting other professionals directly. Frontline professionals view relating to other professionals as important, especially because they also *assess other problems* than the ones presented by the client. However, professionals see obstacles in practice such as limited time and resources to engage in time consuming relational work with professionals beyond their own specialty.

Besides contextual sources, the dissertation has also found that professionals relate to other professionals in the way they interpret their own role in care and, thereby, how they identify as professionals. For instance, those who identify as *pragmatic professionals* value the ability to carry out their work in ways they prefer and they value setting boundaries around what they can and cannot do for a client. Pragmatic professionals often use the *reframing* health promotion role, primarily using collaboration by involving other professionals with different and complementing expertise to safeguard the boundaries of their own expertise.

I now turn to the findings regarding how frontline professionals relate to clients with combined psychosocial problems and their health and care. How frontline professionals relate to clients is shaped not only by health conceptions, but also by their health promotion roles and their SES reasonings towards clients. First, when professionals define clients' problems in terms of a *mental health definition*, they actively *seek alignment* with the client. This means that professionals aim to establish an equal relationship with clients, allowing space for clients' experiences and preferences regarding health. Second, frontline professionals who define health as *competence and behavior*, argue that clients should be responsible and able to communicate their own health needs and these frontline professionals see a less active role for themselves. Only when they think the situation might get dangerous, those professionals take over with what they think is important for the clients' health. Third, frontline professionals who assess the clients' *social context* in caring for the client emphasize that not all clients may be able to take care of themselves, even with the help of their social network. What is central in these findings, is that frontline professionals emphasize the importance of personal responsibility through competence and behavior, but they also acknowledge the possible impact of contextual aspects.

Exploring professionals' health promotion roles, the research has suggested that frontline professionals relate to clients through two health promotion roles. First, in *reframing* health promotion, professionals take the lead by reframing clients' needs into something they can address within their professional boundaries. Within this role, it remains unclear whether the professionals' practices really focus on the problem which is prioritized by de client. This finding is in line with how professionals with a *pragmatic* professional identity value setting boundaries around what they can and cannot do for the client. Second, frontline professionals *customize* health promotion and determine the direction of care in close relationship with the client. The client is given the lead and responsibility in expressing which problems should be dealt with. This finding aligned with how professionals with a *holistic* professional identity appreciate collaborative efforts with clients. These health promotion roles show, among others, how professionals deal with client autonomy.

Frontline professionals in general healthcare relate to clients' SES in terms of *status preservation, social distance and togetherness* in developing a treatment plan with clients with combined psychosocial problems. This finding suggested that how professionals relate to the SES of clients with combined problems and how they intend to develop treatment plans with them is shaped by social and relational positioning. First, general practitioners relate to clients by emphasizing the need to preserve clients' status by combining SES indicators and interpretations of clients' stability. Second, general practitioners relate to clients to whom they perceive as having a small social distance, using recognition as a reference point when developing the treatment plan.

Third, general practitioners base their approaches to creating a treatment plan together with clients on clients' busyness and educational level.

The findings of this dissertation thus pointed out how various frontline professionals relate to other professionals and to clients with combined psychosocial problems in relevant ways. They do so in the way they see health and healthcare, in the expectations they have of themselves, of other professionals and of clients, in the way they behave in relation to other professionals and to clients and in the way they reason about clients' SES.

6.4 Implications

This dissertation contributes to public health and public administration by using an anthropological lens and emic perspective to study how frontline professionals relate to other professionals and clients in caring for clients with combined psychosocial problems. Thereby, the dissertation has implications for the literature on health conceptions, health promotion, interprofessional collaboration in care, teamwork and street-level bureaucracy, particularly on the role of clients' SES in frontline decision making. The combination of the public health and public administration disciplines and the anthropological lens enabled me to primarily take a formative approach towards conceptualization and theory building.

This dissertation contributes to the literature on health conceptions, which is an important strand within public health, by addressing the currently limited conceptualizing of professionals' health conceptions, which tends to mainly focus on differences in health beliefs and it only includes medical professionals such as GPs and nurses (Armstrong & Swartzman 1999, Colombo, Bendelow, Fulford and Williams 2003, Huber et al. 2016, Levesque and Li 2014). By including frontline professionals from various backgrounds in the context of caring for clients with combined problems, this dissertation offers a broader understanding of health conceptions among frontline professionals in care and social welfare. More specifically, this dissertation contributes to the conceptualization that frontline professionals' health conceptions, besides multiple *health definitions*, also consist of beliefs about *how to pursue* health together with clients, their context and with other professionals. Thereby, this dissertation advances the literature on health conceptions by changing the focus from individual beliefs to a more relational conceptualization that is situated in everyday practices of professionals working in complex care contexts. This dissertation opens the door for other researchers who could test these health conception dimensions among other professionals, in various care contexts and in actual care practices. This would offer insight into whether these dimensions conceptualized in this dissertation can be observed across different care contexts and how they can inform everyday professional practice.

This dissertation, furthermore, contributes to the health promotion literature in public health by addressing the currently limited conceptualization of professionals' health promotion roles as attitudes towards specific tasks (Geense et al., 2013). What this dissertation contributes is a conceptualization of broader health promotion roles as *reframing health promotion* and *customized health promotion*. I find that these health promotion roles go into what professionals do, but also into *how* they do this and *what* they find important in doing so. This finding is relevant to health promotion, because a professionals' role is determined by how they see and value themselves. By exploring a possible causal link with professional identity, I also find how health promotion roles are shaped by professionals identify as *pragmatic and holistic* professionals. This finding adds a novel theoretical layer to the literature on health promotion: rather than seeing health promotion roles as profession-specific tasks, this dissertation finds that health promotion roles are relational and they emerge through how professionals identify as professionals, what they value and how they interpret their interaction styles. This finding paves the way for other researchers to further explore why and when frontline professionals prioritize certain health promotion roles in interaction with clients and other stakeholders. This dissertation shows how health promotion roles are associated with how professionals identify as professionals. This finding deepens our understanding of why frontline professionals promote health in particular ways. The findings also raise new questions: for instance, why do professional identities and roles transcend professions? A possible explanation is that, when professionals in such complex contexts constantly collaborate with various professionals and organizations, they develop similar values and ways of working through socialization. These findings also open new directions for theory building. The dissertation's indication of a causal link between health promotion roles and professional identity invites further empirical testing and conceptual development of health promotion roles. Researchers could, furthermore, study how professional identity and health promotion roles interact in other professional care contexts.

This dissertation similarly contributes to the literature on interprofessional collaboration in care and the literature on teamwork by exploring the link between interprofessional collaboration and a fluid team context, while focusing on complex care outside of hospitals. The literature on interprofessional collaboration, which is inherently interdisciplinary, does not explicitly include team fluidity in its analysis and mostly focuses on fixed teams (Schot et al., 2020). This dissertation finds that, in a fluid team context, frontline professionals collaborate according to seven behaviors and that *change* is the main driver differentiating these behaviors from those behaviors found in fixed teams (ibid.). For instance, constant change in team members prevent professionals from relying on established lines of communication, as is possible fixed teams (Gilardi et al., 2014; Nugus & Ferero, 2011). Instead, professionals establish *alternative communication lines* to create safe and *valued spaces* that are often based on fragile in-

terpersonal connections. Moreover, potentially relevant professionals may unknowingly be excluded from the team as they encounter challenges accommodating professionals from various organizations and with various professions in the team. These findings are also relevant to the literature on teamwork from management sciences, which typically focuses on data about hospitals and ad hoc disaster response teams (Kerrissey et al., 2020; Valentine & Edmondson, 2015; Rashid et al., 2013). Instead, this dissertation adds empirical evidence to the literature on teamwork from a frontline professionals' context with tasks that are less delineated than in hospitals (Kerrissey et al., 2020; Rashid et al., 2013). The frontline care context in this dissertation thus increases our theoretical understanding of the challenges and practices that are relevant for frontline professionals in fluid team contexts. These findings create room for researchers to further explore the possible causal link between interprofessional collaboration and team fluidity by testing my findings among other frontline professionals in fluid team contexts beyond this one. Literature on interprofessional collaboration in care has so far given little attention to the difference between fixed and fluid team contexts. This dissertation offers a starting point in studying the implications of these differences.

This dissertation also contributes to the street-level bureaucracy literature on the use of SES in decision-making (Harrits, 2019; Raaphorst et al., 2018; Harrits & Møller, Raaphorst & Groeneveld, 2018), which is prominent in public administration. While existing research often focuses on the outcomes of SES-based differentiation, this research contributes by shifting the focus to *how* professionals differentiate. It uncovers the mechanisms behind this differentiation and conceptualizes the reasonings — *status preservation*, *social distance*, and *together reasoning* — that guide general practitioners' differentiation when developing treatment plans with clients. These reasonings help explain the grounds upon which frontline professionals differentiate between clients in practice. For instance, *status preservation reasoning* around SES enhances our understanding of frontline professionals' reference points that may impact their deservingness and resource allocation judgments (Bothfeld & Rosenthal, 2018). Moreover, by shedding light on the subtle mechanisms through which frontline professionals interpret and use socioeconomic cues, this research contributes to the literature on equity in decision-making. Furthermore, *social distance reasoning* around SES contributes to the literature on social distance (Groeneveld & Meier, 2022; Harrits & Møller, 2024) by showing how recognition regarding social status of the client matters for professional decision-making. In social distance reasoning, recognition is thus a form of informal expertise which guides decision-making. This raises questions regarding the extent to which personal identification is a legitimate base for differentiation in care. These findings imply that decision-making is not only about how much discretionary room professionals have, but that frontline professionals' interpretations of clients' SES are also very relevant for how they work with clients and for what they see as good care for a specific client. These findings also have implications for other researchers on the use

of SES in decision-making, who could, for instance, use these reasonings to test them among other frontline professionals both in- and outside of care. They could explore whether similar reasonings emerge, especially in different professional- and organizational contexts, and how they shape actual decision making in frontline work. Moreover, I cannot elaborate on how these findings contribute to (in)equality, because it was not the focus of this research. However, I expect that these professionals' reasoning about clients' SES may have implications for how professionals address clients, how they lead to differential or tailored treatment in frontline work and, in turn, for the health outcomes of vulnerable clients.

The anthropological lens and ethnographic methods in this dissertation also have implications for the depth of the findings on how frontline professionals relate to other professionals and their clients in caring for clients with combined problems, which is relevant for both public administration and public health. Although ethnographic methods are increasingly used in public health and public administration (see o.a. Brodkin, 2011; Cecchini, 2021; La Grouw et al., 2024; Maynard-Moody & Musheno, 2022; Zacka, 2017; Long & Zacka, 2019), it is still a rather novel approach is both disciplines. This dissertation is based on ethnographic research, which followed the everyday work of frontline professionals in general healthcare, mental healthcare and social welfare who work with clients with combined psychosocial problems. These methods are grounded in medical anthropology, which has long explored how people themselves understand and navigate health and care practices (a.o. Singer, 1995). Ethnographic research is particularly well-suited for this study, as frontline work is essentially something that happens in everyday, on the ground interactions. Ethnography allows for the observations of how frontline professionals relate to both other professionals and clients in multiple and changing situations (Van Hulst et al., 2017). Moreover, in a broader sense, ethnography is essential for research in the care context, because it shows the micro-level interactions, values, experiences and perspectives in care practices, that are otherwise hard to grasp. This is especially relevant in care settings, where much of what shapes behavior, interaction and decision-making is embedded in tacit knowledge and everyday routines.

The anthropological lens allowed me to inductively study how frontline professionals relate to other professionals and clients from the professional's perspective. In the second chapter, the anthropological lens allowed me to study professionals' health conceptions. What we learn from this inductive, emic analysis — based on professionals' own perspectives is that frontline professionals' health conceptions do not only consist of various dimensions of health beliefs, but that they also consist of beliefs about how to pursue health together with clients and with other professionals. In the third chapter, the anthropological lens has furthermore helped me to understand professionals' actual health promotion roles and how they are shaped by professional identity (Barnhoorn et al., 2022; Geense et al., 2013). The emic perspective, in particular, allowed me to explore and conceptualize how frontline professionals themselves interpret and enact

health promotion and how this is embedded in everyday practice, which may differ from formal role descriptions or policy expectations. Similarly, in the fourth chapter, the emic perspective captures how interprofessional collaboration is shaped in practice through formal arrangements, but especially through informal routines, negotiations, and meaning making that might otherwise not be observed. As such, the emic perspective enabled me to create new insight into what interprofessional care actually looks like for frontline professionals in a fluid team context. In the fifth chapter, the emic perspective allowed me to grasp how frontline professionals interpret socioeconomic status in their decision-making process. By asking open-ended questions and engaging with their prior experiences in the workplace, I was able to uncover and conceptualize the mechanisms through which frontline professionals reason about their clients' status indicators in developing treatment plans with clients.

6.5 Limitations of the study and recommendations for future research

There are some recommendations that arise from constraints related to the research approach. When starting this research, the intention was to include both the professional's and the client's perspective. However, it soon became clear after starting the doctoral research that include the client's perspective was not feasible due to time constraints. I then decided to create a comprehensive picture from the professional's perspective. However, in line with this limitation, I recommend other researchers to shed light on the clients' perspective to find out how care and interprofessional collaboration are experienced by those who are on the receiving end of care. Studying the client perspective is important because clients, often vulnerable, may also shape care together with the professionals. Understanding how they do so from their perspective is relevant. Researchers could for instance ask how clients experience health promotion and how health promotion roles are linked to power-sharing with clients. In line with this, future research could study how SES reasonings of frontline professionals relate to the experienced burden of clients. Another avenue for future research linked to the clients' perspective is to explore other potential stakeholders within the context of clients. In doing so, researchers could explore how both frontline professionals and clients relate to other stakeholders in the broader client context, such as informal caregivers, family, and friends.

Another constraint in this research is that the anthropological fieldwork is highly impacted by unforeseen circumstances, such as the murder of a frontline professional in a potential observation location and the Covid-19 pandemic. These external circumstances prevented me from carrying out my fieldwork as planned, leading to long periods (weeks and months) of waiting and uncertainty regarding if, when and how I would be able to begin and continue data collection for this dissertation. One of the changes

that was made because of these circumstances is that I did observations at another GP practice and at another mental healthcare location than planned initially and interviews were done months later than planned beforehand. Another challenge during Covid-19 was that some parts of the fieldwork shifted to online settings behind computers, whereas interviews and fieldwork meetings would have mostly have taken place in person before the pandemic. Doing observations online, or even over a respondent's phone on speaker mode, meant that I could not always grasp everything that was being said. Is also made it more difficult to observe non-verbal and implicit communication between professionals, to notice contextual details, and to reflect on them with respondents immediately after. However, as part of the professionals' work also moved to digital means, doing ethnographic research online became less of a limitation, because professionals got used to it. Additionally, an advantage of partly doing fieldwork online was that it was feasible to attend a large number of meetings and hold a large number of interviews from the comfort of my home office. However, in the later stages of my fieldwork, both the respondents and I were fortunately able to be physically present more frequently, although some meetings remained online. Moreover, the physical location of the researcher in the field influences what can be observed and accessed (Trangbæk and Cecchini 2023). I realize that I could have included different respondents or observed different interprofessional meetings had this research not taken place during Covid-19, or if I had I met different respondents in the beginning of my fieldwork. These circumstances likely influenced the specific form and detail of the findings. However, since my selection of respondents was theory driven and I followed qualitative research standards (a.o. Nowell & Albrecht, 2019), I am confident that the mechanisms identified in this research would still have emerged, even under slightly different circumstances. Such challenges are inherent to anthropological research, because you have to be there to do the fieldwork. Future researchers could do comparable research into the changes in interprofessional care, with attention to the impact of technology during and after the pandemic.

While almost all the empirical data in this dissertation is on frontline professionals including those in general healthcare, but also in mental healthcare and social welfare, the fourth empirical study, discussed in chapter five, only includes general practitioners. I chose to only include general practitioners in this empirical study, because they are the first professionals to interpret clients and to make a decision regarding a treatment plan based on that interpretation. Their reasoning could thus be relevant for how SES plays a role in frontline decision-making in care. However, this type of research into SES reasonings could also be relevant among other frontline professionals, because various professional groups interpret clients with varying SES backgrounds in their decision-making. Other professionals, such as nurses or professionals in social welfare, could have other considerations. Comparing SES reasonings between frontline

professionals from different professions could create valuable insight into how SES is observed and integrated in the work of frontline professionals in and beyond care.

There are also some recommendations for future research that arise from the findings of the dissertation. In this dissertation, I have developed conceptualizations and I have explored potential causal mechanisms. Whereas I have not tested these mechanisms, I leave room for future research to do so. For instance, the three SES reasonings are conceptualized based on in-depth interviews with GPs. Future research could test these reasonings in several ways. One approach is to observe GPs' actual decision-making practices. Another is to compare their reasoning with those of other frontline professionals, in order to develop a theory on SES reasoning among frontline professionals more generally. Additionally, experimental methods such as vignette studies could be used to access how SES cues impact their reasoning. Moreover, surveys could be used to explore how recognizable the reasonings are for frontline professionals. Future research could also explore how frontline professionals' SES reasonings are relevant for how they relate to other professionals in caring for clients with differing SES backgrounds. Insight into how differing SES reasonings may shape expectations about roles, responsibilities, and appropriate care strategies of other professionals could help to better understand how holding different SES reasonings can impact their ability to understand each other's perspectives and consequently to provide care together.

While I have studied the actual work practices in health promotion and in interprofessional collaboration, I have not tested the conceptualized health conception dimensions in those work practices. What further study should explore is how the three health conception dimensions are connected in actual work practices and thus how health conceptions shape and are shaped by socialization processes in for example professional training, work experiences and in interprofessional collaboration (Levesque & Li, 2014; Dinmohammadi et al., 2013). Moreover, to test the validity of the health conceptions of frontline professionals in care and social welfare and to further conceptualize them, comparative research is needed – for instance, comparing professionals across domains, regions or organizational contexts. This dissertation focused on how frontline professionals relate to other professionals and clients in caring for clients with combined problems. To explore whether and how the uncovered mechanisms actually play a role in the health of clients, participative action-based research with interventions is needed, in which clients and professionals work together towards change. Such change could involve raising awareness among frontline professionals about their reasonings around SES. It could also include fostering reflection on how professional identity and health conceptions shape care practices. Finally, it may require facilitating interprofessional dialogues in which professionals make their underlying assumptions about health, care, clients and collaboration explicit.

Finally, the dissertation finds that interprofessional collaboration often happens informally, based on fragile interpersonal relations in which change and difference in

team membership create tension. This raises the question of what can support such fragile forms of interprofessional collaboration. Future research could explore how various forms of leadership may shape the conditions for effective collaboration, and how it can connect policy paradigms that work in terms of collaboration across professional and organizational boundaries.

6.6 Societal and practical implications

Understanding how frontline professionals relate to other frontline professionals and their clients in care for clients with combined psychosocial problems is essential for understanding and improving care for clients with combined problems. This section offers both the societal implications for the care and health of vulnerable people and the practical implications for improving interprofessional collaboration and addressing the needs of those with combined problems.

The insights from this dissertation underline the societal importance of relational practices within public health, especially in light of the transition and transformation in care. Policy frameworks such as integrated care agreement (IZA) and the Health and Active living agreement (GALA) in the Netherlands ask a broad, integral health view, in which interprofessional collaboration between various domains is central (NFU, 2025; RIVM, 2024). Such a transformation thus requires more than policy change alone. It also calls for changes in how frontline professionals are socialized in their perspectives and approaches to care, their identities and roles in collaboration and their reasoning towards clients. These deeper layers of transformation receive little attention in current policy discourse. This dissertation highlights that addressing how frontline professionals relate to other professionals and clients in transformation is essential to realizing the ambitions of integrated care. Considering these policy developments, frontline professionals working with clients with combined problems should know how to relate to other professionals and to clients in contexts of team fluidity. The findings in this dissertation show that frontline professionals who work with other professionals and clients with combined problems, such as health problems, combined with debts and psychological problems, do need relational and reflective knowledge and skills that are different from professionals in less complex contexts. The findings also provide practical insights for frontline professionals and other stakeholders on how they should relate to other professionals and clients. For instance, frontline professionals working with combined problems need quick adaptability to changing and diverse team members and unforeseen situations and empathy to ensure a safe and inclusive work environment is essential. Furthermore, understanding professionals' health conceptions may affect health promotion through how professionals relate to clients and other professionals. This implies that knowledge of health conceptions and health promotion roles in care

for vulnerable people is relevant practically, because this adds to awareness of possibly different ideas about and approaches to health and care between professionals. Specifically, by explicitly conceptualizing these possible differences, this dissertation creates room for dialogue and collaboration among professionals, their managers and clients by enabling alignment of goals, roles and responsibilities in care practices. Understanding how professionals relate to other professionals and clients furthermore facilitates professionals and managers to question their own assumptions about professionals and about clients with varying SES backgrounds. Such reflection potentially supports professionals to make better use of each other's expertise and to better align with their clients' needs.

The insights form this dissertation can also support local and regional initiatives that aim to foster new forms of collaboration — such as improving mutual understanding and learning each other's language and roles — as well as the implementation of policy in organizations working with clients with combined problems. By researching how frontline professionals relate to other professionals and clients across professions and organizations, this research provides valuable insight for translating policy initiatives into the everyday work of frontline professionals in care and social welfare. Based on the findings, I recommend managers to actively create the conditions for interprofessional collaboration, by not only encouraging it in policy, but by enabling it in practices on the ground. This includes facilitating shared physical spaces where professionals from different organizations and professions can meet and build trust. My research for example showed an organization where professionals were expected to collaborate with professionals from another organization, but the lack of physical workspace hindered opportunities to meet and interact outside of formal case consultations. This situation seemed to play a role in competitive feelings regarding the ability to use actual workspaces and feelings of distrust when caring for clients together. Possibilities for informal contact are especially important in collaboration across professions and organizations. It is therefore also important that managers, together with frontline professionals, and professionals across organizations, take the time to reflect on how the intended collaboration is experienced. Such reflection is especially relevant considering frameworks for frontline professionals, which are often focused on organizational aspects like task redistribution (Zorginstituut Nederland, 2012), but increasingly recognize the value of normative reflection regarding professionalism including leadership and interprofessional collaboration (NFU, 2020).

This dissertation further demonstrates that care, even when it is tailored towards clients, cannot be seen apart from value judgments related to aspects of SES, such as lifestyle. Although reasoning around SES often happens implicitly, it may play a role in the decision-making of frontline professionals. The findings underline the importance of studying how frontline professionals relate to both clients and other professionals, as what one person sees as the right care, might be perceived as wrong or even stigma-

tizing to another. In their daily work, frontline professionals, therefore, should reflect on normative assumptions, for instance around status preservation and social distance towards clients. Such reflection and awareness of underlying assumptions are not only relevant for relating to clients, but also for self-awareness and for relating to other professionals. Through professional's awareness of assumptions about SES, professionals could realize how they, often unconsciously and possibly unintentionally, shape their reasoning towards clients. Since reasoning around clients' SES can affect the kind of care clients receive, it may also impact their actual health outcomes. Additionally, reflecting on their own assumptions about SES could help frontline professionals to better understand other professionals, especially when collaborating with professionals with different reasonings and standpoints. Such reflections could thus help prevent misalignment in collaboration and it could reduce the risk of implicit discrimination. This refers to the risk that professionals' interpretations of clients' SES subtly shape how they interpret needs and involve clients in developing a treatment plan, potentially leading to unequal treatment, even when seen as personalized care. Thereby, seeking to understand how professionals and clients relate to one another is essential for addressing health inequalities.

Altogether, the findings of this dissertation offer valuable input for health promotion practice by encouraging frontline professionals to reflect more on their own health conceptions, how they pursue health together with clients and other professionals, and how they use assumptions about SES. In daily routines, such reflection may receive little attention, as professionals indicated they rarely take time for it, but also found it useful and meaningful when we engaged in it during our conversations. I therefore recommend creating space for reflection, for example in team meetings or professional development, potentially linked to broader initiatives such as appropriate care programs. In this way, the findings of this dissertation can contribute to strengthening reflective health promotion practices in everyday care.

The dissertation's findings are relevant for policymakers and professionals, but also for clients and client representatives, such as client councils (a.o. Rijksoverheid, 2025a). For client councils advocating for the voices of clients to be heard in the care process, this dissertations' findings are relevant as they shed light on how professionals interpret their role in care and clients' health and needs. As such, the dissertation highlights the importance of understanding the professionals' perspective in their decision-making, which can empower client representatives to advocate for openness about the reasoning used in decision-making to ensure that decisions made by professionals align with the best interest of clients. In doing so, this dissertation also creates insight into broader discussions on equality, diversity, inclusion and values in decision-making of other frontline professionals who work with clients with combined problems in and beyond care.

Positionality statement

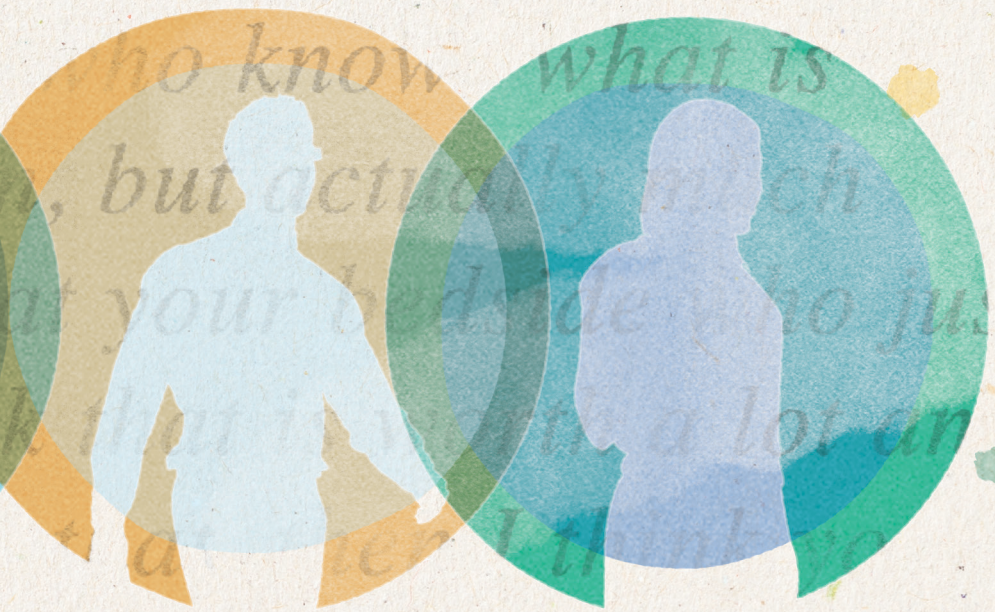
Bibliography

Appendices

Summary

Nederlandse samenvatting

About the author



Positionality statement

Reflections on my position in the research field

I acknowledge that I, as a scholar, with my own personal story, shape the research process and my perspective on the social world (Schwartz-Shea & Yanow, 2013; Ybema, 2009; Trangbæk and Cecchini 2023), which is why the knowledge I produce in this dissertation will always be a partial view (Schwartz-Shea, 2014). I entered the research field as a trained anthropologist and public administration scholar. I have a strong background and interest in research into health in a broad sense of the word, which means that I had been doing research into topics related to inclusion, gender and well-being during the years before the research for this dissertation. However, I am not medically trained, while most of my respondents are. Knowing that health is an important theme in my research and that I work at a public health department, at rare moments, respondents confused me for a medically trained 'insider'. Such situations meant that they would forget that I was only a researcher, and share information that they may also have shared with colleagues or trainees.

I entered the field with a relatively privileged position, due to my educational background, my considerable health, and familiarity with institutions. At the same time, I was an outsider, depending on building a network with trust en reciprocity in the research field. Not being medically trained, it was all the more valuable that I could spend considerable time in the research field to get familiar with the various frontline professionals, their work and especially their professional jargon. This time spend at the workplaces of respondents enabled me to ask questions and to become familiar with their daily work.

My background in themes like diversity, inclusion and gender shaped my focus in the beginning of the research. I was curious how care and social welfare work in practice, while hoping to better understand what this could eventually mean for people in vulnerable situations. I would describe my position as that of a familiar outsider, whose curiosity encouraged reflection among research participants. Being an outsider and relatively unfamiliar with the research setting was valuable at first, as it allowed me to question things that others might take for granted. This position led me to ask questions about everyday routines and assumptions that were reflected upon by respondents. Over the course of the PhD trajectory, however, my view of care gradually changed. I developed a deeper understanding of the complexities and dynamics that frontline professionals experience in their daily work. At the same time, my position in the field also changed, as I gained more knowledge of the context and became more embedded in practice. This growing familiarity helped me to better understand the context in which the research took place, which was helpful in developing, conducting and interpreting the later stages of the research.

More specifically, my position as a familiar outsider inevitably shaped both the data collection and the interpretation of the findings. First, this positionality allowed me to see practices and ask critical questions that might have remained unquestioned by insiders. Second, my background and personal interests may have shaped what I found salient of further exploration. I have aimed to strengthen the validity and interpretation of the findings by remaining reflexive throughout the research process, by actively considering my own assumptions, alternative explanations, and seeking feedback from research participants and peers.

Reflections on conducting interdisciplinary research

My research as well as my role is interdisciplinary: I research how frontline professionals collaborate across professions and organizations, and my own work crosses academic disciplines. Doing interdisciplinary research brought valuable insights, but it also brought challenges. In the beginning of this doctoral research, it was challenging to find a fitting academic journal to publish my work in, as many academic outlets are still discipline oriented. After finding the right journal for the first empirical chapter, it became clear to me that the value of what I was doing was being acknowledged by the academic community.

Moreover, as an anthropologist and public administration scholar in a mainly medical and public health oriented context, I had to adapt to different communication styles, especially when it came to productively discussing epistemological assumptions and methodological approaches. This meant that I had to actively claim my space, not only by listening and adapting, but also by demonstrating the value of my approach and qualitative methods. Although qualitative research is increasingly recognized in public health, especially within my department, I still experienced clear differences — particularly at the beginning of my research in 2019 — in how knowledge was constructed. One recurring theme of discussion was the use of socioeconomic status (SES) in research. Some epidemiological or public health colleagues used SES as a socio-demographic variable, either as a control variable or as one of the main independent variables in a multivariate model, while I approached it as a socially embedded category (Wright et al., 1999). I think the approach in this dissertation is valuable in the sense that I unpacked how SES was understood and used by respondents in their everyday work context. This, however, requires unpacking the concept and clearly understanding what it constitutes of, rather than working with it as an umbrella term without clarity about its actual meaning (Van der Waal & De Koster, 2015). Different perspectives like these led to valuable interdisciplinary discussions within the department. One of the ways in which I felt able to add value with my approach was through my involvement in co-hosting a qualitative research platform at the Leiden University Medical Centre (LUMC) and initiating an interdisciplinary network that brought together scholars from public administration and public health.

Within my supervisory team, which was inherently interdisciplinary, I initially found it challenging to steer the research direction, especially since my background lies mostly in anthropology and public health was a new domain. While the freedom I was given was demanding at times, I gradually grew into a more leading role in shaping the research projects. Working in this interdisciplinary team became increasingly valuable, as our contributions to the collaboration grew to complement and inspire each other clearly.

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Appendices

Appendix A1: Table with respondent characteristics

Respondent ID	Job position	Professional discipline
R1	Out-patient attendant	Social
R2	General practitioner	Medical
R3	Community police officer	Social
R4	Social case manager municipality	Social
R5	Client supporter	Social
R6	Out-patient attendant	Social
R7	Practice nurse mental healthcare	Medical
R8	General practitioner	Medical
R9	Recovery coach mental health	Mental
R10	Recovery coach mental health	Mental
R11	Mental health worker with police	Mental
R12	Manager multidisciplinary approach at municipality	Social
R13	Social psychiatric case manager	Social
R14	Community sports coach	Social
R15	Community sports coach (and dietician)	Social
R16	General practitioner	Medical
R17	Case manager social support law municipality	Social
R18	Prevention officer mental health	Mental
R19	Mental health worker	Mental
R20	Community sports coach	Social
R21	Community gardener	Social
R22	Police officer, specialist on people suffering confusion	Social
R23	Social psychiatric nurse	Mental

Appendix A2: Interview guide[5]

Overarching topics	Goal	Topics interview questions & probes
Before the interview	Explaining nature and aim of research, reassuring confidentiality, handling of data, and seeking permission and consent	· Explaining aim of research project · Explaining handling of data · Asking for permission to audio record interview · Asking for informed consent
Introduction	Acquiring contextual knowledge Setting the scene of the interview and role expectations	· Professional background and experience · Current job and daily activities
Health views	Acquiring knowledge about health views	· Kinds of health views held · What is done to achieve this · Why is this important · Other desired outcomes · Changes over time
Health views in collaboration with other professionals	Acquiring knowledge about working with other professionals	· Kinds of professionals and organizations they work with · How forms of collaboration are organized · How the types of collaboration mentioned are experienced · How health views may align · Importance of collaboration for reaching health views

5 The interview guide was adapted to the specific professional contexts and after the first few interviews. The interview guide differed slightly for those working in different specializations.

Appendix A2: Interview guide6 *Continued*

Overarching topics	Goal	Topics interview questions & probes
Health view in interaction with clients	Acquiring knowledge about working with clients	· Importance of client values and ideas · Situation in which client could be helped well > Why and how · Situation in which client could not be helped well > Why and how · How health views may align with clients > Weighing importance of client preferences · Experience of interaction with clients
Closing	Exploring other themes left unmentioned but of potential importance for the research Explaining overall planning of research project and thanking respondent for participation	· What are important values in their work? · Any other themes that respondents would like to address · Explaining further planning of the project

6 The interview guide was adapted to the specific professional contexts and after the first few interviews. The interview guide differed slightly for those working in different specializations.

Appendix A3: Code table of generic description of health conception dimensions

	Mental healthcare Gr=211; GS=6	Medical healthcare Gr=137; GS=4	Social welfare Gr=464; GS=13	Totals
Contextualization of other problems Gr=41	8	12	24	44
Contextualization of social context Gr=40	9	8	20	37
Defining_ competence Gr=66	20	4	39	63
Defining_ mental Gr=35	10	6	18	34
Defining_ physical Gr=10	3	2	5	10
Alignment_ being approachable Gr=13	3	5	5	13
Alignment_ seeking alignment Gr=62	17	18	28	63
Totals	70	55	139	264

The number of quotes coded with a health conception dimension per type of professional.

Appendix A4: Co-occurrence code table of health conception dimensions

	Contextualization of other problems Gr=41	Contextualizatoin of social context Gr=40	Defining health competence Gr=66	Defining health mental Gr=35	Defining health Physical Gr=10	Being approachable Gr=13	Seeking alignment Gr=62
Contextualizationof other problems Gr=41	0	4	2	4	2	0	8
Contextualization of social context Gr=40	4	0	5	2	1	1	7
Defining competence Gr=66	2	5	0	9	2	0	4
Defining health mental Gr=35	4	2	9	0	2	0	4
Defining health physical Gr=10	2	1	2	2	0	0	2
Being approachable Gr=13	0	1	0	0	0	0	2
Seeking alignment Gr=62	8	7	4	4	2	2	0

Co-occurrence is established when respondents mention two dimensions in the same story within an interview.

Appendix A5. Table with (main) respondents' tenure

Respondent number	Domain	Profession	Educational level
A	Healthcare	General practitioner	University
B	Healthcare	General practitioner	University
C	Social welfare	Social worker or client supporter	Higher education
D	Mental healthcare	Mental health worker and social worker in mental healthcare	Higher education
E	Social welfare	Social worker with elderly people	Higher education
F	Mental healthcare	Social psychiatric nurse	Higher education

Appendix B1: Observation guide with operationalization

Health promotion role dimensions	Operationalisation	Example from fieldwork
Type of involvement: reactive health promotion	Observe any text on a situation in which a frontline professional perceives a problem or symptoms to be clear and demarcated enough to respond to directly. During illness visits or conversations regarding specific symptoms, professionals educate or advise their patients about behavior, lifestyle or possible risks (McAvoy, Kaner et al. 1999). Reactive health promotion is firmly focused on disease risk-specific practices in favor of behavioral, disease-focused, lifestyle-oriented determinants of health. Such strategies fail to incorporate broader societal, economic, ecological, and political dimensions of health promotion (Runciman, Watson et al. 2006, Whitehead 2006, Casey 2007).	A client has clear symptoms of allergies and asthma and the GP reacts to this by prescribing medicine that should be used when specific symptoms appear.
Type of involvement: proactive health promotion	Observe any text on a situation in which a frontline professional proactively performs an intervention without specific worrying symptoms in this direction expressed by the client. Professionals could even interfere in case of seeming high risk. Proactive health promotion could, for example, include proactively changing the problem in a way that the professional thinks is more relevant to the client (McAvoy, Kaner et al. 1999). Or by proactively trying to figure out what an underlying problem is.	1. GP giving advice that does not directly fit with the problem the client came with. The GP thinks this is more relevant to the client or that this is what the client could mean. 2. GP interfering in someone's life by giving unsolicited advice about, for example, the use of birth control for someone at high risk of unwanted pregnancy.

Appendix B1: Observation guide with operationalization *Continued*

Health promotion role dimensions	Operationalisation	Example from fieldwork
Perceived ability health promotion role: able	Observe text on frontline professionals who feel able, skilled and/or responsible to promote health of their clients. They feel they have the right knowledge and facilities to do so and they perceive it to be their task.	'It is my task to help with anything in the social environment. You can ask me anything, because it is my job to help you. Don't hesitate.' (social worker)
Perceived ability health promotion: unable	Observe any text on frontline professionals who don't feel able or skilled and/or not responsible for health promotion.	1. 'It is not my role, to write such nonsense statements, but no one else will do it.' (GP) 2. 'It is not our role to help you so comprehensively. It is your own responsibility to get to know how your phone works and how to use it for your finances.' (Social worker)
Perceived ability health promotion: collaborative	Observe any text on frontline professionals who do take on health promotion activities, but only when they can collaborate with other stakeholders.	'I think this client has real problems but I'm not sure how we can help them apart from listening to them. I refer them to the practice nurse so they can help find an experience expert to connect with.'
Perceived importance health promotion: emphasize	Observe any text on frontline professionals who emphasize the importance of health promotion activities. They are motivated and willing to promote health.	'One thing that really motivates me in my work is to help people get healthy, to care.' (GP)
Perceived importance health promotion: skeptical	Observe any text on frontline professionals who are skeptical about health promotion and its results. They expect that it won't really help and are thus neither motivated nor willing.	'If I help them with this task, then they will never learn to do it independently and they will come back over and over again.' (Social worker)
Professional identity aspects	Operationalization	Examples from fieldwork
An individual's self-definition	Observe any text on an individual's self-definition as a member of a profession (Adams, Hean et al. 2006, Chreim, Williams et al. 2007).	'I identify as a real caregiver in heart and soul.' (Mental healthworker).

Appendix B1: Observation guide with operationalization *Continued*

Health promotion role dimensions	Operationalisation	Example from fieldwork
Professial uniqueness	Observe any text on what makes the professional unique on their own and how they become meaningful relative to others through clear goals, norms, beliefs, values, interaction styles and member interdependencies that are associated with a role in work situations (Ashforth 2000).	'Its is my goal that when people leave here they they feel lighter. It makes no sense to judge, therefore I go into what people find important.' (Mental healthworker).
Cultural expectations	Observe any text on the cultural expectations about how to behave in a social position (Burke and Stets 2009).	'I like to indicate boundaries around my professional expertise, towards clients and towards other professionals. I would rather do what I am good at.' (Mental healthworker).

Appendix B2: Table with hours of observation per respondentgroup

Respondent group	Hours of observation	Days of observation	Formal semi-structured interviews
Mental healthcare	65 hours	14 days	1
General healthcare	45 hours	11 days	1
Social welfare	40 hours	9 days	1

Appendix B3: Conversation/interview guide

Briefing/appointments
Discussing confidentiality, anonymity and introduction to interview
Professional roles
What is your professional background?
What is your work experience like?
What are your core professional roles?
Health promotion
What are health promotion roles (or not) according to you?
What does heatlh promotion mean to you?
Do you believe health promotion is a core task as a professional? Why/ why not? What is more important?
Professional identity
How would you describe yourself as a professional?
How do you value these roles and tasks (or not)?
What meaning do you give to these roles and tasks?
What do you find most important in your work with clients with combined psychosocial problems?
What are you good at, what do you contribute to your job?
Do you think you are competent/ the right stakeholder to work on health promotion? Why/ why not?

Appendix B4: Persona

	Persona
Respondent A, professional in general healthcare	
Observed health promotion roles	I use a *reframing health promotion* role
This is how I fulfill my role	I would rather just fix something that I understand and that is manageable and preferably medical, which aligns with my professional strengths. Otherwise, I can refer a patient so someone else who can offer help. I fulfill my health promotion role by setting boundaries regarding what is and isn't my scope of responsibility and I consider it important to focus on the aspects that align with my professional strengths.
Example of how I fulfill my professional role in health promotion	*'If I disagree with [a patient about wanting antibiotics], I sometimes still prescribe antibiotics, but at least I have had my say. I provide advice based on what I consider important, but I am accommodating. I don't engage in constant debates, as work should also remain enjoyable.'*
My professional identity is	***The pragmatic professional*** I am a pragmatic general practitioner, a fixer, I like extreme medical cases, I value setting boundaries around what I can and cannot do for a patient and I value that we can manage our general practice as a business.
Example of my professional identity	***The pragmatic professional*** *'Yes, I think I am an all-round general practitioner, with a focus on more pragmatic, hands-on work. That means that I am relatively more inclined to do things and less to have long conversations. […] Maintenance of psychiatry, I have somewhat less affinity with that. […] Which means that I often do the more urgent care like injections and treatments and I think I'm also stronger in the musculoskeletal system. […] I like extreme medical cases. So, I can relish someone who's living in a dirty house with rats and pus coming out of their ankle. Yes, so I feel like, nice. There may be some general practitioners who thinks, 'Yuck, do I have to go there?'. But there is often relatively a lot to do there, so there's a relatively high impact of what you do. It's a combination of wonder, the bizarreness of the syndrome, or the extreme aspects, I find that interesting and intriguing. How someone ended up in such a situation and what the background is. Yes, so that, and the same goes for when people are really seriously ill, I often find that fascinating. It just becomes more medically interesting, I think. So someone who says, 'No, I'm not feeling quite right in my well-being," I find less interesting than someone who is really in the midst of a big psychosis, constructing entire theories about how they are going to improve the world… I find a genuine first psychosis to be a very, very interesting medical picture."*

Appendix B4: Persona *Continued*

	Persona
Respondent D, professional in mental healthcare	
Observed health promotion roles	I use a *customized health promotion* role
This is how I fulfill my role	I fulfill my health promotion role by prioritizing being accessible to patients through platforms like WhatsApp. I furthermore do so by working with tailored treatment rather than focused solely on one diagnosis. I help patients in the way that works for them. The goal is that people leave here feeling like a heavy burden has been lifted off of them.
My professional identity is	***The responsive professional → holistic*** I am an accessible, responsive professional who values adapting to what the patient needs and who intends to foster a strong therapeutic relationship. The *caring professional → holistic* I am someone who truly wants to assist people that are really in need.
Example that shows my professional identity	**The holistic professional** The respondent is undergoing training as a Cognitive Behavioral Therapist, and she finds it very informative. She expresses that this should be mandatory, stating, '*My conversational techniques are now very different. Instead of just skirting around issues, I now have more knowledge to really address and assist. It's transformative. What I find important is to be there for people, especially those with multiple diagnoses. While there is a lot of stigma about our patient group, I think we can really help them here. In finding a solution I think it is really valuable that we can work on finding a fitting treatment here instead on just focusing on one diagnosis like depression. […] I will try to go with what works for the patient, it doesn't have to be my solution. […] Thereby, I try to protect the patient, both from themselves and from other professionals.*'
Respondent F, professional in mental healthcare	
Observed health promotion role	I use a *customized health promotion* role
This is how I fulfill my role	I fulfill my health promotion role by letting the patient know that I am there as a consistent support for them instead of wanting to fix things. The essence of my work lies in ensuring that everyone has someone who cares for them, looks out for them, and shows concern. And by building a connection without immediately wanting to judge or solve things. The reason being that '*every individual's journey in receiving care is unique. I might tidy up here, but that would not be helpful for her. We are working on recovery in different ways*'.

Appendix B4: Persona *Continued*

	Persona
My professional identity is	The *caring* professional → holistic I am a natural-born caregiver. The *present* professional I value being present for my patients and their needs. Thereby, I bring genuineness, authenticity and loyalty into my interactions.
Example that shows my professional identity	***The holistic professional*** *'The presence approach, yes […]. That's actually kind of the basis of what I do, within the pressure of business and management. We have a big caseload with complex cases. But being there for people and keeping a part of my agenda free to map out the worrying cases, to have some sort of free space to ring the doorbell three times. It is not possible teamwise, but Ideally I reserve a few hours a day for this. This way I can really invest in a relationship without immediately providing assistance, but based on being there for people and listening to what someone needs and just radically being there for them without judgment. Presence theory is thus the basis of providing good care, by getting to know someone well first. Based on that understanding and that very strong relationship, you can get very far.'* *'I'm not different as a human than as a professional, only the profession sits over it like a layer. And of course a few things that I am or I am not in my private life, you obviously don't take with you in your profession. But that authenticity and that I make contact with people and this authenticity they feel that. And the loyalty and being there for someone. […] So I'm always myself, I'm the nurse and the care provider at work, while I'm at home I'm also normal. Well, in my private life I also take care of other people and then you can say that in any case I'm a social person, I don't know how to say it, but it is not that different from how I am in real life, but I think that is quite necessary because the [clients] then feel that it is serious, and that you are not coming to pretend, or play a game or something. […]*

Appendix B4: Persona *Continued*

	Persona
Respondent B, professional in general healthcare	
Observed health promotion roles	I use a *customized health promotion* role
This is how I fulfill my role	I fulfill my *customized* health promotion role by having informal conversations, *building a relationship*, and trying to *understand the patient's environment*. For instance, 'I ask many questions to the patient to gain a better understanding of the situation and to clarify any uncertainties that may be related to the problem. This way, I aim to uncover the true nature of the issue at hand and the right approach by taking the patient and their concerns seriously. I provide them with the opportunity to (re)gain control over the care process.' I fulfill my customized health promotion role by doing more when this is necessary. For example, by 'engaging in conversations while someone waits for specialized psychological help.'
Example of customized health promotion role in data	The client's mother explains that the doctor's file says it is jaundice, but that this '*is not the case […]. [The child] suffers from a painful stomach and ribs, and has thin stools every day*'. The professional asks if there are things that the child cannot do because of her complaints. The child suffers during gymnastic class, where she cannot participate without pain. The respondent asks follow-up questions to figure out when and how the child suffers and how the mother observes this. Then the respondent explains that it is difficult to figure out what is going on based on what they know. There are many complaints but there is no clear pattern. They agree to do serveral more tests during the next appointment. Respondent to client and mother: '*It's always a matter of weighing up together what is more annoying, all these tests or the complaints.*' This story is exemplary of customized health promotion in which professionals find it *important* to work closely with clients and their enviroment by asking questions to figure out what is important to the client regarding their physical complaints, but also in other life areas.
My professional identity is	***The holistic professional*** I am an involved professional who listens, and who is motivated to and interested in solving complex issues. I am willing to extend the boundaries of my profession when this helps me to better help the patient.

Appendix B4: Persona *Continued*

	Persona
Example that shows my professional identity	***The holistic professional*** '*That I let people take control themselves. Yes, I think that also reflects a bit on how I approach life. Of course, that says something about me as well. […] That's the interesting aspect of our general practitioner profession- where does the boundary lie between what is within the realm of a general practitioner, and where does the line between societal responsibility and your role interpretation lie? I think that's the beauty of our profession; every general practitioner has to determine that for themselves. There's no right or wrong, but it varies for everyone. I can easily imagine that there are colleagues who say 'You come here with back pain, so I only treat the request present to me'. That is also very legitimate. For me, it's slightly different if it turns out that the person keeps coming back with that back pain and apparently isn't helped with the answer I give to the initial request. Then I want to explore further. […] [What I find enjoyable about my job here is that] it's about the whole concept of humanity, I think. […] It is clear that health, for me, is not only physical. It's also about how people function in other life domains. In that sense, the holistic nature of the general practitioner profession is what I chose many years ago. […] That is the basis of the general practitioner profession, I believe. The strength of our profession is that we have the opportunity to get a much broader view of those life domains because each domain influences health*.'
Respondent E, professional in social welfare	
Observed health promotion roles	I use *customized and reframing health promotion* roles
This is how I fulfill my roles	I fulfill the *customized* health promotion role by making sure that '*my solution doesn't have to be theirs*.' '*However, boundaries can be complicated, and sometimes I go beyond what is strictly required for a client. When a client comes here in distress, I will not turn them away. At the same time, I find it important that clients take responsibility and initiative*.' I fulfill the *reframing* health promotion role by helping with everything related to the social aspect. For instance, '*this woman came here with pain issues, but I think she is actually afraid and lonely and she should start volunteering again. […] We are from prevention, so these are things that we should take notice of*.''

Appendix B4: Persona *Continued*

	Persona
Example of reframing health promotion role from data	The professional and I greet the woman who sits in her mobility scooter when we arrive outside her building. She had forgotten that the social worker would visit today, but she says that she is happy that we are here. We walk and talk together for more than an hour. The client says that she: '*would like to keep walking with her until […] [she] can walk independently again.*' Later, the professional tells me that: '*She will probably never walk independently again and I cannot help with the instability in her legs. […] I think this is actually a loneliness issue. When I have not visited her for a week I can really see that she is lonely, depressed and sad and she really feels better after I came by. Walking with her is a way for me to talk with her and to monitor her social isolation*'. In this example, respondent E reframes a physical problem of not being able to walk independently due to a sore leg into a problem of social isolation. The respondent understands that the client experiences insecurity when walking due to pain in her legs. As a social worker, the respondent is not able to help with the legs, but she can help with a related social problem: loneliness.
My professional identity is	The *proactive* professional → pragmatic I am a doer, which means that I am driven to get things done. I go the extra mile for a client and I push boundaries to make things happen for a client. The *respecting* professional → pragmatic I value respecting the clients' solution, but they should also respect my professional suggestions. The *flexible* professional → holistic What I appreciate about this job is the flexibility to shape how I approach each task and focused on which domain […].

Appendix B4: Persona *Continued*

	Persona
Example that shows my professional identity	***The pragmatic professional*** *'I work on everything related to the social. Sometimes I think, if you put in a little extra effort, you can get people over a hurdle, to something, and then you can actually help people. […] Well, people don't need to get down on their knees or bring flowers, like, 'oh, thanks.' Just seeing how people progress or when they say 'you've really helped me overcome my fear of public spaces, you know, by taking me out with someone,' then I find it okay. But don't take me for a ride [when I have put a lot of work in your care].'* ***The holistic professional*** *'In that sense, I can really empathize with how it is for people, that you can really feel lost. Well, and that does create a bond. […] If I know it helps, I mention [that I have been ill too and how I dealt with that]. […] Well, I think I'm a good listener. I find it important to pay attention to the client. I try not to force my solution down their throat, so I listen to their problem and my solution doesn't have to be the client's solution.'* *'And this was not my task, but I think this is also social work. That's what I appreciate about this job, that I can shape my role the way I want to.'*
Respondent C, professional in social welfare	
Observed health promotion roles	I use *customized and reframing health promotion* roles
This is how I fulfill my roles	I fulfill the *customized* health promotion role by having longer conversations during one on one appointments with clients who are able to express their problems. '*Then, I enjoy assisting with psychosocial issues*.' I fulfill the *reframing* health promotion role by assisting people in addressing their material concerns to the extent of our capabilities. '*During the open office hours, we only do short social questions. Then, professional boundaries are central to me, otherwise, I end up dealing with minor tasks that are not within the scope of my education*.' However, often, '*I cannot really fix their problems, but all I can do is listen*.'
My professional identity is as follows	The eager professional → pragmatic I am eager to help when I can truly make a meaningful impact for a client who takes ownership of their own wellbeing. The eager professional → holistic What motivates me is when I can help people by having longer conversations about their problems that go beyond just material stuff. What I really like is to listen, when I know I can really mean something by empowering them.

Appendix B4: Persona *Continued*

	Persona
Example that shows my professional identity	***The pragmatic professional*** *'I can't help someone who doesn't take ownership of solving their own problems. Otherwise, I end up doing small tasks that I haven't studied for. It's important for me to set boundaries on what is and isn't my responsibility. When a client pressures me, I won't work harder. I want to help, but only if I feel like I can truly make a difference. [...] This profession is not what it has been, I don't feel taken seriously anymore. I feel like I can't do the work that I want to do.'* ***The holistic professional*** *'Addressing relationship issues is a significant aspect of my work because it can have a profound impact on someone's life, relationship problems.'*

Appendix C1: Observation guide dimensions of collaboration

Collaborative dimensions by schot, Tummers et al. 2020.	**Operationalization**	**Example from fieldwork**
Creating spaces	1. Note down any observations on a situation in which a frontline professional creates spaces in relation to *external actors* such as managers and other institutions (Nugus & Forero, 2011).	GPs and social welfare professionals set up and participate in interprofessional meetings.
	2. Note down any observations on a situation in which a frontline professional creates spaces *internally* by (re)creating the organizational arrangements for collaboration.	
	3. Note down any observations on a situation in which a frontline professional works around existing organizational arrangements by *creating alternative, informal information* channels (Gilardi et al., 2014).	
	4. Note down any observations on a situation in which a frontline professional creates another type of space	

Appendix C1: Observation guide dimensions of collaboration *Continued*

Collaborative dimensions by schot, Tummers et al. 2020.	Operationalization	Example from fieldwork
Bridging gaps	1. Note down any observations on a situation in which a frontline professional bridges a gap between *professional perspectives* on how to best treat clients (Chreim et al., 2013; Falk et al., 2017).	A GP calls a sports coach in the hope that she can persuade him of the benefits of the exercise program.
	2. Note down any observation on a situation in which a frontline professional overcomes s*ocial gaps* by strategic communication in light of diverse personalities and communication preferences (Timmons & Tanner, 2005).	
	3. Note down any observation on a situation in which a frontline professional bridges c*ommunication divides* by actively transferring and translating professional knowledge or information from one professional to another, as well as about making oneself available to others (Dahlke & Fox, 2015; Schot et al., 2020; Williamson et al., 2012).	
	4. Note down any observation on a situation in which a frontline professional bridges *task division* gaps by conducting tasks that are not part of their formal role and help other professionals (ibid.).	
	5. Note down any observation on a situation in which a frontline professional bridges another type of gap.	
Negotiating overlaps	1. Note down any observation on a situation in which a frontline professionals negotiates *between work roles and responsibilities in general* (Lingard et al., 2002; Schot et al., 2020).	A GP explains that she cannot wait to start with a new program, but, according to her, it is not her role, but the role of municipality to start it.

Appendix C1: Observation guide dimensions of collaboration *Continued*

Collaborative dimensions by schot, Tummers et al. 2020.	Operationalization	Example from fieldwork
	2. Note down any observation on a situation in which a frontline professional negotiate overlaps in *individual care processes* (Schot et al., 2020).	
	3. Note down any observation on a situation in which a frontline professional negotiates another type of overlap.	

Appendix C2: Interview guide semi-structured interviews interprofessional collaboration

Themes	Questions
General introduction	General/introductory question: what does interprofessional collaboration mean to you in your work?
Interprofessional collaboration: *bridging gaps* 1) Professional perspectives 2) Social gaps 3) Communication divides 4) Task division	Thematic questions: 1) (How) do you experience knowledge gaps between you and other professionals when working with clients with combined problems? How do you deal with this? 2) How do you experience social gaps? And how do you try to overcome these? (personalities, communication preferences) 3) How do you experience communication gaps? And how do you try to overcome these? (knowledge, information, availability) 4) How do you experience gaps related to task division? (help each other beyond formal role etc)
Negotiating overlaps	1) How do you experience negotiating overlaps between *work roles and responsibilities in general?* a. Does working together create ambiguous overlaps into who does what, and who is responsible for what? And in individual care processes?
Creating spaces	1) How do you experience creating spaces in relation to *external actors* such as managers and other institutions? (non-clinical/ management related issues/relationship building). 2) How do you experience creating spaces *internally?* (by (re) creating the organizational arrangements for collaboration, working around existing organizational arrangements by *creating alternative, informal information* channels).

Appendix C2: Interview guide semi-structured interviews interprofessional collaboration
Continued

Themes	Questions
Professional values/professional identity	How would you describe yourself as a professional? a. What are you good at?- what do you contribute to your job? b. What is important to your work? c. What is the best thing about your job- can you give an example? d. Can you say what is the worst/toughest part of your job- example? e. Can you remember why you chose to do what you do? Do you still feel like that today?
Notions of role as a health-promoting professional	What does health mean to you? a. What do you associate with the word health? b. What about your work? How is health part of your daily work? How do you try to work towards this idea of health for clients with combined problems? c. Do you believe that health-promotion is one of the key tasks as a professional? Why/why not? What is more important?

Appendix D17: Personas and interview questions

Introduction questions

1. How did you grow up? How would you describe your own social status?
2. How would you describe yourself as a general practitioner?
3. What do you find important in your work?

Personas

Patient 1

A 45-year-old man comes to your consultation at the general practice. From his file, you know that he has been here before for sleep problems. To relax in the evening, he regularly smokes a joint with friends. He has a group of friends he has been close to since childhood and is very attached to them. Today, he comes in with complaints of chest pain. When he enters, it feels like a whirlwind has come in. After a short conversation with the patient, the following information comes to light: the man has had a lot of energy lately, which prevents him from sleeping well. He also experiences significant chest pain and doesn't understand the cause. He often worries about his pain in the evening when he is home and notices it especially when he feels very busy. He feels hyper and tired at the same time. Due to poor sleep, he doesn't feel refreshed. The patient indeed looks visibly tired, which you can see from the bags under his eyes. Sometimes, intense training at the gym helps him fall asleep, but he cannot do this every day because of his work. Upon further questioning, the patient also reveals that he has seen the mental health nurse for his sleep problems. The nurse suggested he talk to peers who are also hyper, which he is considering. Due to his sleep and pain issues, he cannot always make it to work on time. Fortunately, his own construction busyness is doing well, so he doesn't have to worry about money. Since dropping out of school early, he has worked in construction and, after gaining years of experience, has had his own company for a few years. His brother works with him in the company, and he is also close to other family members. His family means a lot to him. The patient is curious about your opinion on the chest pain and if you have a solution for it. The man look nervous. Furthermore, he has a blank medical history regarding heart abnormalities in the family, and you find no abnormalities during the physical examination.

Patient 2

A 46-year-old man comes to your consultation at the general practice. Before calling him in, you check his file. He was here last year when he had a burnout and temporarily stopped working at his own law firm. He is now back at work and has never had

7 Note that the vignettes and interview questions have been translated from the original Dutch.

to worry about income. You know that he is educated, articulate, and often asks many questions. You see that he is here for chest pain. After a short conversation with the patient, the following information comes to light: the man feels miserable. He cannot find balance. He had a burnout a while ago, which still affects how he can perform his job. Now he is experiencing chest pain and wonders where it comes from. The man has clearly thought a lot about it and, upon further questioning, reveals: 'I was always very actively involved in everything. Now I'm back at work, but it's still not going well. I'm seeing my psychologist again. She has held a mirror up to me, and I think I need to let go of my old, very active life. She also recommended relaxation exercises, which help somewhat. But what I regret is that I can no longer do fun things with friends in the evening, like playing badminton or going to a party. I value spending time with my good friends.' When you ask him why he can't do these activities anymore, he says it is mainly because of the chest pain. Because of this pain, he is afraid of overexerting himself. When he recently went to a friend's birthday party, the chest pain made him leave early, which he found very unpleasant. He feels like an outsider when he has to leave early. The patient is worried and wants to know what you think about his chest pain. He looks tired. From his file, you know that he has no family history of heart abnormalities, and your physical examination finds no abnormalities.

Patient 3

A 45-year-old patient comes to the general practice for a consultation. You know from his file that he has struggled in the past to find balance in his energy levels. You sometimes doubt whether this patient fully understands what you discuss with him, as he does not always seem to follow you advice regarding the regular intake of medications. After a short conversation about his situation, the following information emerges: the man has made an appointment today due to persistent chest pain. The pain is so severe that he is really worried about what it could be. After further questioning, the patients also reveals that the pain is hindering him. He needs all his energy for his sick partner, who cannot take care of herself at the moment. His partner wants him to leave her because she feels she can no longer be a good partner. At the same time, she is very controlling and jealous. The man has no family, friends, or neighbors who are concerned about them, and they have no children. Additionally, he does not want to burden others with their problems. The man is very tired. This has been the case since the accident he had while working at the cleaning company where he was employed. Since contracting Covid, he has been on sick leave. Last week, the company doctor called, and they will call him back soon after he has spoken with the general practitioner. The man is now afraid that they will want him to return to work. What makes him even more nervous is that he does not fully understand where his income currently comes from. If his income were to stop, he would be in serious trouble. It is already a struggle to make ends meet but he knows how to live with little. He has an air fryer and knows what fast food he can make

in it every day. What is wearing him down is not knowing what to expect, as he simply cannot work right now due to the chest pain. The man wants to know what is causing his chest pain. You find that the patient looks nervous and confused. He has no family history of heart abnormalities, and you physical *examination* finds no abnormalities.

Questions asked each time after the respondent reads one of the personas

1. What is your first impression of this patient? And why do you have this impression? What is it based on?
2. What would you like to ask this patient? Follow-up: What would you do if you knew this?
3. What alarms you? (only if something seems alarming to you)
4. What is your level of concern for this patient?
5. What could be influencing the patient's pain symptoms?
6. What kind of treatment plan would you develop based on what you know? Follow-up: I understand from previous conversations that it is impossible to rule everything out (medically), but are there specific things that take priority in this case? And what has less priority? Why? Can you give an example? What would be your preference, regardless of what the patient may want or find important? What would you like to convey or advice to the patient?
7. Under which circumstances would you take more action?

Additional questions asked after discussing the last persona

1. Can you reflect on how you compare your impression of these patients?
2. (Why) are you more concerned for one patient than for the other?
3. Why do you choose one treatment plan for one patient and a different plan for another?
4. Are these personas very different situations for you? What makes them different? To what extent do you recognize this in your own work?

Appendix D2: Code table8

Table D2. Examples of quotes and initial interpretation per reasoning

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
Status preservation reasoning		R1, r2, r3, r4, r5, r8, r10, r11, r13, r15
	'With the second [high SES] man, his work is not going well, which is worrisome for a lawyer. And with the third man, his work is also not going well. But that is not the most important thing here. The difference between working and not working is not very significant for him in terms of income. So, in that respect, you can easily create some space and calm by keeping him on sick leave a little longer if necessary. Until the other issues are resolved. [The high SES man has risk of] social decline. Suppose he relapses [with his burnout], he will lose a lot. And then many small things can start to unravel. He might get into trouble with his partner, or at the very least, his self-esteem will take a huge hit.' (R4) → Respondent four argues that patient three does not have much to loose right now in terms of money. He is in a bad situation, but, according to him, this situation is stable bad. → Helping the second patient is more urgent to this respondent, because his situation is less stable and the risk of decline regarding various SES dimensions is big.	
	'Sometimes it's not entirely... It's not entirely logical, but it's about the part where he says: "What I find unfortunate is that I can no longer do fun things in the evening with friends, like play badminton or go to a party. I enjoy spending time with my friends." So, then I think: it's not okay that that's not possible.' (R1) → Respondent one argues that the social status of patient two should be preserved.	

8 Note that the quotes from the interviews have been translated from the original Dutch.

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
	'*But yes, that social circle… Look, if you say, 'He wants to quit that, 'then it's difficult to competely abandon your friends as well, because, in my opinion, that actually causes more stress and more problems. […] So you need to be able to maintain that social bond and then see whether he can, well, whether he can possibly leave cannabis use out of it. If that is at least part of what he's asking for help with, of course. Because, yes, I don't want to give him advice or force him into something he's not open to.*' (R2) → Respondent two argues that the first patient his social status should be preserved, because his friends and family are an important part of his life. If he looses that, that may cause even more stress and more loss regarding his overall health. The respondent thus sees the social dimension as more imporant than the fact that the patient smokes cannabis within this social circle.	
	'*But this man will be called back by today or tomorrow by the occupational health service, and he wants an answer now. […] Yes, but also [more pressure] on himself. There's less oversight. There are also actually […] more issues at play. I mean, it's very unfortunate if you can't go play badminton with your friends, but if your partner is threatening, or at least making statements like this, this it's a bit of a different caliber*' (R10). → Respondent 10 argues that patient three is in an unstable situation and that it seems that there is a lot to lose for this patient in terms of social status. The patient may lose their partner if problems are not solved soon.	

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
Social distance reasoning		R1, r3, r4, r5, r7, r10, r 11, r12, r13, r14, r15
	'This is really my natural habitat, so to speak. I come from a working-class background, you could say. And I think I can relate very well... Well, I don't even have to adapt myself to it. I fit into this setting and speat the same language as the people here. I think I understand them. I think I can grasp and recognize many of their problems. [...] I also notice that the people I see more frequently are the ones I can help better.' (R14) → Respondent fourteen argues that the patients who he can understand better are the patients who he can help better.	
	'I pictured a patient with a somewhat similar story. [My first impression is] ADHD. Or at least hyperactive. This is definitely someone who's always going at full speed. And the fact that he used joints to calm down fits with that. That he's doing well in construction- I can completely see that too, because you can really go full throttle there.' (R4) → Respondent four recognizes another patient's situation in the first patient. The respondent uses this recognition to reason around the patient.	
	'I automatically tend to get people from a lower social background, people with psychiatric issues, alcohol problems, financial issues- this is the group that naturally crystallizes around which GP they feel comfortable with, and I notice that I get a large part of that group. [...] I can really stand beside someone and help them further, and I definitely enjoy the medical aspect as well, but it's mainly the relationship, the long-term connection you have with someone, that makes the work so enjoyable and special (R7).' → Respondent seven argues that they make the social distance smaller by connecting with the patient, which ensures that they can help patients further.	

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
	'*I consciously have no expectations. I want to know more first. […] To be honest, probably because I know how many times I've dealt with healthcare providers who had a conclusion before I even entered the room* (R10).' → Respondent ten identifies with patients with bad experiences with prejudiced professionals. Therefore, the respondent tries to work with patients without any prior expectations.	
Together reasoning		R1, r2, r3, r4, r5, r7, r8, r9, r11, r12, r13, r14
	'But he's quite a smart guy, and I think he probably realizes that both your work and your mental state could contribute to these kind of complaints. So, I would really want to know, why did you make this appointment today?' (R1) → Respondent one interprets patient two as a smart guy who has a busy job. The respondent seems to think that this patient knows that his mental and physical state are connected.	
	'And then you look at what he needs to make this situation bearable. Because no one can sustain being a caregiver continuously without support. And also: what do you want, cleaning accident? So, we really need to look at how we can help this man. Apparently, there are also concerns about his income.' (R3) → Respondent three interprets patient tree (low SES) as someone who needs their help as he cannot help himself. The respondent uses the lower educated cleaning job as an argument.	
	'Yes, I'm not going to ask exactly how things work in his office […]. But he's an intelligent man, so that story should come up on its own, and I honestly expect that. He'll probably know himself why he has a burnout. So, the conversation about that will naturally come up.' (R4) → Respondent four interprets patient two (high SES) as someone who will know what is going on, because he is intelligent.	

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
	'My experience with these kinds of patients is that you can make an appointment with the cardiologist, but they either don't show up or they don't understand what was said [...]. But then you can do a lot from the practice, but the best thing is if sometimes is first addressed in the social and societal aspect, like having a mentor or buddy, or someone who can guide them in those other areas.' (R8) → Respondent eight interprets patient three (low SES) as someone who his lower educated and may not understand his care and the care system. Therefore, he needs to be taken by the hand.	

Summary

Introduction

In this dissertation, I studied *how frontline professionals relate to other professionals and to clients in caring for clients with combined psychosocial problems.* This is relevant, because a high number of individuals face a combination of problems that cross professions and organizations. These problems create a pressing need for collaboration across professional and organizational borders in care and social welfare. This collaboration is complex and can become problematic, because many incentives- such as policies, professional norms and finances- go against interprofessional and interorganizational collaboration. This is why in this dissertation I analyzed how frontline professionals, in this complex context, work with other professionals and with clients. The research context is a large city in the Netherlands.

Findings

To answer the research question, I have explored four sub-questions, each representing a distinct piece of the empirical puzzle, which together answer the research question. First, in **chapter two,** I conceptualized frontline professionals' health conceptions based on an inductive qualitative interview study with frontline professionals in general healthcare, mental healthcare, and social welfare in The Hague, The Netherlands. Caring for clients with combined psychosocial problems involves various frontline professionals such as general practitioners, psychiatric nurses, police officers, social support consultants and debt counselors. As these professionals have different professional backgrounds and work in different organizations, their health conceptions, or beliefs about what constitutes health and how this should be pursued, may also differ. Having an understanding of various frontline professionals' health conceptions is relevant, as these may affect interprofessional collaboration in their work with clients with psychosocial problems. I used an iterative process of thematic analysis to identify health conception dimensions, that differ on three main aspects: 1) *health definitions*, 2) *alignment with clients* and 3) *contextualization of clients' health*. The main implication of this chapter is that this inductive analysis of health conceptions provides a first building block in theorizing frontline professionals' health promotion practices.

Second, in **chapter three**, I studied how frontline professionals in care and social welfare interpret and fulfill their health promotion roles, which is relevant for the care and the health of the vulnerable clients they work with. For this study, I used ethnographic data from Dutch frontline professionals in social welfare, general healthcare, and mental healthcare to show how various frontline professionals promote health by *reframing* and *customizing* health problems and how this is associated with how they identify as *pragmatic* or *holistic* professionals. While the literature on health promo-

tion is limited to describing roles as tasks of healthcare professionals, in this study, I examined the broader health promotion roles held by various frontline professionals when working with clients with combined psychosocial problems and how the roles are associated with professional identity. Moreover, in caring for clients with combined problems, various frontline professionals are encouraged to work together in fluid contexts, in which professionals are expected to seek other professionals and organizations to solve combined problems. This type of collaboration is not institutionalized; it may therefore be hard to develop routines compared to fixed teams. Knowledge about how frontline professionals work together in non-institutionalized forms of fluid collaboration is lacking. Therefore, third, in **chapter four**, I studied how frontline professionals from various professions and organizations work together in contexts of team fluidity, with high levels of membership change and difference. To this end, I used an iterative design and ethnographic fieldwork in studying these hard-to-grasp contexts. In the thematic analysis, I explored whether and how interprofessional collaboration manifests in fluid teams in general healthcare, mental healthcare and social welfare and how team fluidity plays a role. I aimed to further grasp how frontline professionals relate to their clients by examining socioeconomic status (SES) as indicator for decision-making among frontline professionals in healthcare, focusing on general practitioners (GPs). I did so in **chapter five**, by conducting and thematically analyzing qualitative interviews. I identify three SES reasonings in shaping GPs' approach to patient care, which are closely intertwined with the status of patients: (1) *status preservation reasoning,* (2) *social distance reasoning* and (3) *together reasoning*. These reasonings show how GPs interpret and use various SES cues in their decision-making when developing treatment plans with patients.

General conclusion

The findings of this dissertation show how frontline professionals relate to other professionals in a context of clients with combined problems and team fluidity, in which membership change and member difference create challenges. Such collaboration across professions and organizations is challenging because of unclarity about roles, responsibilities and mutual trust, while opportunities are taken to make use of each other's complementary expertise and skills. Frontline professionals develop collaborative behaviors, which are different from those found in fixed teams, mainly because interpersonal relationships are more fragile and potentially less sustainable. Apart from these behaviors, health conceptions also play a role, as collaboration is also about bridging ideas about what is health and how this should be pursued. Additionally, frontline professionals' professional identities play a role in how professionals fulfill their health promotion roles and how they coordinate this with other professionals.

The findings of this dissertation also show how frontline professionals relate to their clients with combined psychosocial problems, in which health conceptions,

health promotion roles and SES reasonings play important roles. While some frontline professionals actively seek alignment with clients from an mental health definition, others make the clients responsible and only intervene when the risks are higher. Frontline professionals also differ in how they see their roles: while some reframe clients' care questions into something that matches with their own expertise, others let clients decide on the care plan. Furthermore, GPs reason about their clients' SES in ways that impact the development of the treatment plan, such as through status preservation or developing the treatment plan together, based on mechanisms related to recognition and experienced social distance. This dissertation thereby shows how frontline professionals relate to other professionals and clients from various perspectives, roles and reasonings in working with combined psychosocial problems.

Nederlandse samenvatting

Introductie

In dit proefschrift onderzocht ik *hoe uitvoerend professionals in het sociaal domein en de (geestelijke) gezondheidszorg zich verhouden tot andere professionals en tot cliënten met gecombineerde zorg- en psychosociale problemen*. Dit is relevant, omdat veel mensen te maken hebben met combinaties van problemen die verschillende beroepsgebieden en organisaties overstijgen. Voor het aanpakken van dit soort problemen is samenwerking over professionele en organisatorische grenzen binnen de zorg en het sociaal domein nodig. Deze samenwerking is complex en kan problematisch zijn, omdat verschillende factoren – zoals beleid, professionele normen en financiën – samenwerking juist in de weg staan. Ik analyseerde in dit proefschrift hoe uitvoerend professionals, binnen deze complexe context, werken met andere professionals en met cliënten in Den Haag, een stad in Nederland die gekenmerkt wordt door maatschappelijke uitdagingen.

Bevindingen

Om de onderzoeksvraag te beantwoorden onderzocht ik vier deelvragen die elk een apart stuk van de empirische puzzel representeren en die tezamen de hoofdvraag beantwoorden. In **hoofdstuk twee** conceptualiseerde ik opvattingen over gezondheid gebaseerd op een inductieve kwalitatieve interviewstudie met uitvoerend professionals in de gezondheidszorg, de geestelijke gezondheidszorg en het sociaal domein. Bij de zorg voor cliënten met gecombineerde psychosociale problemen zijn verschillende uitvoerend professionals betrokken, zoals huisartsen, sociaal-psychiatrisch verpleegkundigen, politieagenten, cliëntondersteuners en schuldhulpverleners. Deze professionals hebben verschillende professionele achtergronden en ze werken in verschillende organisaties waardoor hun gezondheidsconcepties – hun ideeën over wat gezondheid is en hoe dit nagestreefd moet worden – ook kunnen verschillen. Inzicht in deze verschillende gezondheidsopvattingen is belangrijk, omdat ze impact kunnen hebben op interprofessionele samenwerking rondom cliënten met psychosociale problemen. Ik gebruikte een iteratieve thematische analyse om gezondheidsconcepties te identificeren die verschillen op de volgende drie aspecten: 1) *gezondheidsdefinities*, 2) *de mate van aansluiting bij cliënten* en 3) *de mate waarin de context van de gezondheid van cliënten wordt meegenomen*. Deze bevindingen laten zien dat uitvoerend professionals gezondheid niet alleen op verschillende manieren definiëren, maar dat ze er ook naar streven om de relatie met de cliënt gelijkwaardig te maken en ze plaatsen de cliënt in een bredere context om passende gezondheidsdoelen en zorg te bepalen. Deze inductieve analyse vormt een eerste bouwsteen voor theorievorming over gezondheidsbevordering van uitvoerend professionals in het sociaal domein en de (geestelijke) gezondheidszorg.

In **hoofdstuk drie** deed ik diepgaand etnografisch onderzoek met uitvoerend professionals in het sociaal domein en de (geestelijke) gezondheidszorg waarmee ik laat zien hoe uitvoerend professionals zich identificeren als professionals en hoe ze hun rol in gezondheidsbevordering vormgeven. Kennis over professionele identiteiten en rollen in gezondheidsbevordering is van belang voor de zorg voor en de gezondheid van kwetsbare cliënten. Waar de bestaande literatuur gezondheidsbevordering vooral beschrijft in termen van taken van zorgprofessionals, laat dit onderzoek zien hoe uitvoerend professionals brede gezondheidsbevorderende rollen op zich nemen in het werk met cliënten met gecombineerde problemen, en hoe deze rollen samenhangen met professionele identiteit. In tegenstelling tot de verwachting dat professionals met verschillende professionele achtergronden ook uiteenlopende professionele identiteiten zouden hebben, en dus verschillende rollen zouden op zich zouden nemen, vond ik dat gezondheidsbevorderende rollen juist gerelateerd zijn aan professionele identiteiten die die professionele grenzen overstijgen. Concreet vond ik dat uitvoerend professionals, ongeacht of zij werkzaam zijn in het sociaal domein of in de (geestelijke) gezondheidszorg, gezondheid bevorderen aan de hand van twee rollen: 1. *Herformuleren van gezondheidsproblemen* die cliënten zelf presenteren, tot iets specifieks waarmee zij binnen hun eigen kaders kunnen werken. 2. *Gezondheidsvragen op maat maken* door samen met de cliënt en diens omgeving passende doelen en zorg te bepalen. Daarnaast identificeren zij zich doorgaans op twee manieren, die eveneens niet aan een enkel beroepsgebied zijn gebonden als: 1. Pragmatische professionals: oplossingsgericht en duidelijk in het stellen van grenzen aan wat zij wel en niet voor een cliënt kunnen doen. 2. Holistische professionals: betrokken en bereid om te luisteren, extra stappen te zetten en soms buiten de eigen professie te treden voor een cliënt.

Daarnaast wordt in de zorg voor cliënten met gecombineerde problemen van professionals verwacht dat zij, over de grenzen van beroepsgroepen en organisaties heen, gezamenlijk tot oplossingen komen. Dit soort samenwerking is niet institutioneel ingebed, maar fluïde, waardoor het moeilijk is om routines te ontwikkelen zoals dat in vaststaande teams vaak wél mogelijk is. Er is weinig kennis over hoe uitvoerend professionals samenwerken in deze fluïde teams. Om deze reden onderzocht ik in **hoofdstuk vier** hoe uitvoerend professionals met verschillende professionele achtergronden en uit verschillende organisaties samenwerken in fluïde teams die gekenmerkt worden door een grote mate van veranderlijkheid en verschil met betrekking tot lidmaatschap tot het team. Door middel van etnografisch veldwerk bestudeerde ik deze fluïde contexten. Door middel van thematische analyse onderzocht ik of en hoe interprofessionele samenwerking zich manifesteert in fluïde teams in de gezondheidszorg, de geestelijke gezondheidszorg en in het sociale domein en hoe team fluïditeit daarin een rol speelt. De bevindingen laten zien dat samenwerking plaatsvindt via fragiele interpersoonlijke relaties, waarbij voortdurende veranderingen en verschillen in teamsamenstelling

voor uitdagingen zorgen in het vinden van geschikte samenwerkingspartners. Hoewel sommige gedragingen lijken op die in vaste teams, ontstaan in fluïde teams ook andere spanningen die de samenwerking beïnvloeden. Deze inzichten rondom de verschillende manifestatie van interprofessionele samenwerking in fluïde teams is extra relevant gezien de aanwezigheid en toename van complexe, domeinoverstijgende problemen in de huidige praktijk.

In hoofdstuk 5 bestudeerde ik, om beter te begrijpen hoe uitvoerend professionals zich tot cliënten verhouden hoe sociaaleconomische status (SES) geïnterpreteerd en gehanteerd wordt in besluitvorming van uitvoerend professionals in de gezondheidszorg, met een focus op huisartsen. Hiervoor voerde ik diepte-interviews uit met huisartsen en analyseerde deze thematisch. Daaruit leidde ik drie typen SES-redeneringen af die gebruikt worden bij het opstellen van behandelplannen en die sterk samenhangen met de status van patiënten: 1) *redenering gericht op statusbehoud* – hoe huisartsen SES-indicatoren combineren met hun inschatting van de stabiliteit van de patiënt om te bepalen in hoeverre het belangrijk is de huidige status te behouden, 2) *redenering gericht op sociale afstand* – hoe een kleine sociale afstand tussen huisarts en patiënt fungeert als referentiepunt bij het willen helpen van de patiënt en 3) *redenering over gezamenlijk zorgen* – hoe huisartsen interpretaties van het drukke leven en het opleidingsniveau van de patiënt gebruiken om te bepalen in welke mate het behandelplan samen met de patiënt wordt ontwikkeld. Deze redeneringen laten zien hoe huisartsen verschillende SES-signalen interpreteren en gebruiken in hun besluitvorming wanneer zij behandelplannen ontwikkelen met patiënten.

Algemene conclusie

In Nederland heeft één op de zes inwoners te maken met een combinatie aan fysieke, psychische en sociale problemen, met name mensen met een lage sociaaleconomische status. Deze kwetsbare groep vraagt om ondersteuning van meerdere uitvoerend professionals en organisaties tegelijk. Juist daar wringt het: samenwerking is hard nodig, maar beleid, professionele normen en financiering werken vaak belemmerend. Hierdoor lijden de meest kwetsbaren het meest wanneer zorg niet goed is georganiseerd, wat de urgentie van dit onderzoek onderstreept. De bevindingen van dit proefschrift laten daarom zien hoe uitvoerend professionals zich verhouden tot andere professionals en tot kwetsbare cliënten in het organiseren van zorg voor cliënten met gecombineerde problemen die professionele domeinen overstijgen.

Uitvoerend professionals in de zorg voor cliënten met gecombineerde psychosociale problemen maken gebruik van zeven interprofessionele gedragingen in fluïde teamcontexten, zoals het creëren van alternatieve communicatielijnen en het overbruggen van kennis en communicatiegaten. Deze gedragingen verschillen van interprofessionele gedragingen in vaststaande teamcontexten en zijn relevant gezien de toenemende aanwezigheid van gecombineerde problemen. Interprofessionele samenwerking blijkt niet

alleen samen te hangen met hoe professionals zich verhouden tot andere professionals, maar ook met het afstemmen van onderliggende perspectieven over gezondheid, zoals de mate waarin de context van de cliënt meegenomen dient te worden. Verschillende gezondheidsopvattingen kunnen goede samenwerking en gezamenlijke doelrealisatie in de weg zitten, terwijl het nodige relationele werk met professionals buiten hun eigen specialiteit tijdsintensief is. Uitvoerend professionals verhouden zich ook tot andere professionals door de manier waarop ze hun eigen rol in zorg interpreteren en hoe ze hun professionele identiteit vormgeven. Bijvoorbeeld, pragmatische professionals herformuleren vaak de gezondheidsproblemen van cliënten en zij gebruiken samenwerking met andere professionals vaak als een manier om zelf dicht bij hun eigen expertise te kunnen blijven. Tot slot laten de bevindingen zien hoe uitvoerend professionals SES-redeneringen gebruiken in het opstellen van behandelplannen, bijvoorbeeld door het belang van statusbehoud of het gezamenlijk opstellen van een behandelplan te benadrukken, rekening houdend met herkenning en ervaren sociale afstand, en leefstijl.

Dit proefschrift laat zien hoe uitvoerend professionals zich vanuit verschillende perspectieven, rollen en redeneringen verhouden tot andere professionals en cliënten in de zorg voor cliënten met gecombineerde psychosociale problemen.

Implicaties

De inzichten in deze dissertatie dragen allereerst bij aan de literatuur over gezondheidsconcepties door niet alleen in te gaan op gezondheidsdefinities, maar door ook te beschrijven hoe uitvoerend professionals gezondheid willen nastreven samen met cliënten, hun context en andere professionals. Ten tweede, dragen de inzichten bij aan de literatuur over gezondheidsbevordering door rollen in gezondheidsbevordering breder te conceptualiseren en door te exploreren hoe deze samenhangen met professionele identiteit. Ten derde draagt deze dissertatie bij aan de literatuur over interprofessionele samenwerking in de zorg en de literatuur over teamwerk door interprofessionele samenwerking expliciet te bestuderen in een fluïde teamcontext buiten het ziekenhuis. Dit proefschrift biedt een startpunt voor het bestuderen van de implicaties van de verschillen tussen interprofessionele samenwerking in fluïde en vaststaande teams. Ten vierde draagt deze dissertatie bij aan de street-level bureaucracyliteratuur over het gebruik van SES in besluitvorming, door de aandacht te verschuiven van de uitkomsten van verschillen op basis van SES naar de manier waarop professionals differentiëren op grond van SES-redeneringen.

Deze inzichten dragen niet alleen bij aan de theoretische ontwikkeling van de literatuur over gezondheidsconcepties, gezondheidsbevordering, interprofessionele samenwerking, teamwerk en uitvoerend professionals. Daarnaast hebben ze maatschappelijke implicaties voor de zorg voor en gezondheid van kwetsbare mensen, en praktische implicaties voor het verbeteren van interprofessionele samenwerking en het tegemoetkomen aan de behoeften van mensen met gecombineerde problemen. Ten eerste zijn

deze inzichten maatschappelijk relevant, omdat zij direct aansluiten bij recente beleidstransities, zoals het Integraal Zorgakkoord (IZA) en het Aanvullend Zorg- en Welzijnsakkoord (AZWA) in Nederland. In het IZA staat een integrale kijk op gezondheid centraal, waarin interprofessionele samenwerking tussen zorg- en het sociaal domein noodzakelijk is. Het IZA vraagt meer dan alleen beleidsverandering, maar ook verandering in hoe uitvoerend professionals zijn gesocialiseerd en in hun perspectieven en aanpak in de zorg, hun identiteiten en rollen in samenwerking en hoe ze redeneren over cliënten. Het AZWA vult dit verder aan door sterker in te zetten op preventie en samenwerking tussen het medisch en sociaal domein en te voorkomen dat mensen (zwaardere) zorg nodig hebben. Ten tweede vergt het werken met mensen met gecombineerde problemen flexibiliteit, empathie en het vermogen om goed samen te werken met diverse teamleden in onverwachte situaties. Inzicht in de verschillende gezondheidsconcepties, identiteiten, rollen en redeneringen van professionals kan uitvoerend professionals helpen om effectief samen te werken met andere professionals en met cliënten door met elkaar af te stemmen. Dit vergroot het bewustzijn van verschillen, stimuleert reflectie op de eigen aannames en ondersteunt professionals om elkaars expertise beter te benutten en beter aan te sluiten bij de behoeften van cliënten.

About the author

Fia van Heteren

Fia van Heteren was born on the 30th of November in Dordrecht, the Netherlands. During secondary school she was a competitive speed skater. After completing secondary school at Lyceum Oudehoven in Gorinchem, she started studying Commercial Economics at The Hague University of Applied Sciences. After competing her propaedeutic year and spending a year travelling, she started studying Social and Cultural Anthropology at the University of Amsterdam. During her bachelor, she conducted a research internship at TransCape, an NGO focused on HIV/AIDS education in Canzibe, South Africa. After graduating in 2015, she worked on an urban anthropology project with the municipality of Lansingerland and completed two master's programs: Anthropology of Policy in Practice at Leiden University and Public Management and Leadership at Leiden University. Her thesis research included projects on cultural participation (CultuurSchakel) and on women in high military leadership positions at the Dutch Ministry of Defense. Alongside her studies, Fia worked as a homework tutor, as well as a fieldworker for a research agency. After graduation she worked as a lecturer in Public Administration at Leiden University.

In 2019 (5 years, 0.8 fte), Fia started as a Ph.D. candidate at the Leiden University Medical Centre (LUMC) Health Campus The Hague and the department of Public Administration at Leiden University. Within her Ph.D. project she focused on frontline professionals in care and social welfare and how they relate to other professionals and to clients with combined psychosocial problems. She used an anthropological approach to study how frontline professionals relate to other professionals and clients. During her Ph.D. Fia has published her work in international peer-reviewed journals in public health and public administration. Her main research interests include health, inequality, diversity and inclusion.

Fia was co-chair of the qualitative research platform at the Leiden University Medical Centre and initiator and co-chair of an interdisciplinary network 'Healthcare Governance' that brought together scholars from public administration and public health. She tutored different work groups within the bachelors' program in Medicine at the LUMC on non-medical competencies for future physicians, including leadership skills. She was also part of a committee aimed at improving this educational program. She also gave several guest lectures in Public Administration, focusing on qualitative methods and her research findings. From September to December 2023, she was a visiting researcher at the department of Political Science at the Aarhus University, to present and discuss her work with various scholars. She has participated in several international conferences such as the European Group of Public Administration, the International Research Society for Public Management and the Street Level Bureaucracy Research Conference. She has also acted as reviewer for various peer-reviewed journals.

As of August 2025 Fia works as a postdoctoral researcher at the Section of Medical Decision Making at Leiden University Medical Centre. Fia is part of the Digital CACTUS project, which explores the role of digitalization in care pathways of people with multiple chronic conditions.

List of publications

International Publications

Peer reviewed publications

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Van Heteren, F. (2018). Is kunst voor iedereen? *Cultuur + Educatie*, 17(49), 29-44.