

Journal of Social Intervention: Theory and Practice –
2011 – Volume 20, Issue 1, pp. 57–75
URN:NBN:NL:UI:10-1-101309

ISSN: 1876-8830

URL: <http://www.journalsi.org>

Publisher: Igitur publishing

Services in cooperation with Utrecht University of
Applied Sciences, Faculty of Society and Law

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Received: 10 September 2010

Accepted: 1 November 2010

Review Category: Research

ACTIVATING WELFARE RECIPIENTS WITH HEALTH COMPLAINTS: REASONS FOR FAILURE OF A COGNITIVE TRAINING PROGRAMME

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ABSTRACT

Activating welfare recipients with health complaints: Reasons for failure of a cognitive training programme

In western welfare states, a trend towards activation of welfare recipients has led to the development of interventions aimed at recipients with health complaints. Forms of coercion, such as mandatory participation, are increasingly applied within this activation policy. An example of this approach is the Dutch project "Healthy to Work (HtW)" ("Gezond aan de Slag") which developed and evaluated an intervention combining an exercise programme with cognitive training. Although HtW had been selected as an example of good practice, a randomized clinical trial did not show beneficial effects. This cognitive training programme based on rational-emotive therapy has not been studied separately as yet. Therefore, an in-depth qualitative study was conducted to examine reasons for failure. A purposive sample of six trainers were interviewed. The results indicated that trainers encountered problems with the heterogeneity of participants and different problems, expectations and labour market obstructions than expected beforehand. The mandatory nature of HtW had a negative effect on motivation of both participants and trainers. The discussion questions the assumption that coping style and cognitions of welfare recipients with health problems are the main obstacles to finding work, and the policy to ignore physical limitations of participants. We suggest that in this complex area of practice, improvement can be achieved by allowing trainers to adapt and learn during the process, while also reflecting on normative aspects, and by taking perspectives of welfare recipients themselves into account.

Keywords

Activation policy, cognitive therapy, health education, rational emotive therapy, qualitative research, social welfare

SAMENVATTING

Het activeren van uitkeringsgerechtigden met gezondheidsklachten: oorzaken voor het falen van een cognitief trainingsprogramma

Een groeiende nadruk op de activering van uitkeringsgerechtigden heeft in veel Westerse verzorgingsstaten geleid tot de ontwikkeling van interventies die gericht zijn op uitkeringsgerechtigden met gezondheidsklachten. Vormen van dwang, zoals verplichte participatie, worden meer en meer toegepast binnen dit activeringsbeleid. Een voorbeeld hiervan is het

Nederlandse project "Gezond aan de Slag", dat een interventie ontwikkelde en evalueerde waarin een fysiek trainingsprogramma gecombineerd wordt met cognitieve training. Hoewel HtW als "best practice" gold, liet een *randomized trial* geen positieve effecten van de interventie zien. Omdat het cognitieve trainingsprogramma, gebaseerd op rationeel-emotieve therapie, niet eerder afzonderlijk werd bestudeerd, werd een diepgaande kwalitatieve studie uitgevoerd. Getracht werd om de oorzaken van het falen van het programma in kaart te brengen. Zes, gericht geselecteerde, trainers werden geïnterviewd. De resultaten lieten zien dat de trainers problemen hadden met de heterogeniteit van de deelnemersgroep en op andere problemen, verwachtingen en arbeidsmarktobstakels stuitte dan vooraf verwacht. De verplichte aard van HtW had een negatief effect op de motivatie van zowel deelnemers als trainers. In de discussieparagraaf van dit artikel worden vraagtekens geplaatst bij de veronderstelling dat de copingstijl en cognities van uitkeringsgerechtigden met gezondheidsproblemen de belangrijkste hindernissen zijn voor het vinden van werk, en worden vraagtekens geplaatst bij het beleid om fysieke beperkingen van deelnemers te negeren. De auteurs suggereren dat met betrekking tot dit complexe praktijkprobleem, verbetering kan worden bereikt door aanpassen en leren van de interventie gedurende de toepassing daarvan toe te staan, en door expliciet te reflecteren op de normatieve aspecten van de interventie, en de perspectieven van de uitkeringsgerechtigden zelf.

Trefwoorden

Activerend beleid, cognitieve therapie, gezondheidseducatie, rationeel-emotieve therapie, kwalitatief onderzoek, bijstand

ACKNOWLEDGEMENT

The authors thank trainers for sharing their experiences and opinion with us. We also thank Chris H. Z. Kuiper, PhD., for his critical comments on a previous version of the manuscript and for his advice.

INTRODUCTION

In the Netherlands, as in other European countries, encouraging welfare recipients to re-enter the labour market has become a central element of welfare reform programmes. This development has been called an "activating-welfare-states" trend (Van Oorschot, 2002). Welfare reforms have stimulated local community initiatives, and emphasize the obligations of recipients by putting

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work before welfare. The reforms have led to the development of numerous welfare-to-work programmes, as well as those addressing health and life style issues.

Given that during the end of the 1990s the level of unemployment was low (about 3%), there remained a relatively large proportion of long-term welfare recipients who were considered difficult to integrate (Van Oorschot, 2004). Health problems form an important obstacle for approximately 60% of these long-term welfare recipients (Hoff, Jehoel-Gijsbers & Wildeboer-Schut, 2003).

Therefore, interventions have been developed to alleviate or diminish health problems in this group. The Netherlands Institute for Health Promotion (NIGZ; Ploeg, 2005) identified 84 projects aimed at the activation of long-term welfare recipients by focusing on health promotion or diminishing health-related obstacles. Twenty projects were selected as "models of good practice". One of these is the project "Healthy to Work (HtW)" ("Gezond aan de Slag") (Schuring, Burdorf, Voorham & Der Weduwe, 2007), which was carried out in the period 2003–2006 and funded by the city of Rotterdam.

HtW builds upon the project "Exercise as warming-up for reintegration" (Schellekens, 2003), a 12-week exercise programme to improve both physical condition and thereby mental health to create a better starting-point for reintegration. Schellekens (2003) reported positive effects on physical condition and well-being, as well as a small increase in the number of hours worked by those individuals receiving disability benefits who were considered fit for work and who had volunteered for the programme.

HtW added cognitive training as the exercise programme alone was considered to be insufficient. The target population were initially long-term welfare recipients with non-specific back complaints combined with potential depressive complaints. Both a physician and an ergonomist had assessed whether a complete work resumption was possible and that there were no barriers preventing participation in HtW (Ploeg, 2005; Der Weduwe *et al.*, 2006). Due to the low inflow of eligible participants during the project the inclusion criteria were extended to all recipients with physical and mental health problems. Groups of a maximum of 18 persons were formed comprising both men and women from different backgrounds and cultures (see Ploeg, 2005, p. 51).

HtW aims to improve participants' functioning: the assumption is that chronic physical complaints and accompanying behavioural health problems such as depression negatively reinforce each other. HtW assumes that the intervention is necessary for correcting inadequate coping behaviour, so the client will subsequently be able to successfully complete a follow-up trajectory aimed at finding a regular job. The cognitive training programme was aimed at increasing insight into symptoms and problem-solving capacity and used elements of Rational Emotive Therapy (RET; Ellis, 1962). RET assumes that it is not events which determine how you feel, rather the meaning that is attributed to the events. According to RET psychological problems may be alleviated by

changing irrational or dysfunctional beliefs. In addition, the project also employed the Goldstein-method (Goldstein, 1973) aimed at improving the social skills of clients from lower social-economic classes. The main topics in the cognitive training programme are: relaxation, negative and positive thinking, doing pleasant activities, asking social support, and setting and maintaining limits (Der Weduwe, 2006).

The Department of Social Affairs of the city of Rotterdam invited participants to take part in the HtW project as a compulsory part of their reintegration. As a result of this the invitation letter stated that refusal may have consequences on individual's social security benefits. Many participants experienced difficulties with the strict regime and the mandatory nature of the course during the intervention. The cognitive training programme did not seem to appeal, and trainers were not able to assess what participants were doing with the information. Motivation for the exercise programme appeared to be better (Der Weduwe *et al.*, 2006). In most cases, the link to the follow-up trajectory, i.e. actual reintegration into work, failed.

The randomized controlled trial evaluating HtW (Schuring, Burdorf, Voorham, Der Weduwe & Mackenbach, 2009; Schutgens, Schuring, Voorham & Burdorf, 2009) showed no beneficial effects. The intervention had no effect on mental and physical health or on work resumption. In the experimental group 2.2% started a paid job compared to 2.0% in the control group. No differences were observed in job-seeking behaviour and attitudes towards work, or in psychological measures of mastery, self-esteem, and pain-related fear of moving.

Projects such as HtW are taking place as part of a trend in many western welfare states towards activating welfare recipients. Welfare recipients with health problems are also being encouraged to find and accept work. This is occurring more and more within a context stressing benefit claimants' legal obligation to participate in activities that might lead towards work, and forms of coercion are increasingly being applied within this approach. Projects such as HtW have been implemented within this legal context and without the ethical constraints that are generally applied to treatments and experiments taking place within medical institutions. Welfare recipients are not asked to provide informed consent for these welfare interventions, and yet are obliged to participate with the possibility of cuts in social security payments if they refuse, as was also the case for HtW. In addition, participants were also able to choose whether they wanted to participate in the randomized clinical trial evaluating the effect of HtW. This randomized clinical trial had been approved by the medical ethics committee of the University Medical Center Rotterdam Erasmus MC (Schuring *et al.*, 2007; Schuring *et al.*, 2009). Welfare recipients who did not want to participate in this trial, were nevertheless obliged to participate in the intervention, under the regime of the new Dutch Law Work and Welfare (LWW).

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Although it is important for individuals with health complaints and physical limitations to participate in society, including paid work, the trend observed towards activation with use of coercion may have negative consequences, if, for instance, health limitations are underestimated, or if interventions are not well-tailored. Furthermore, such interventions typically focus on individual factors, yet it has been noted (see e.g., Zabkiewicz & Schmidt, 2007) that the mechanisms involved in long-term unemployment are complex, and cannot always be attributed to individual factors such as a poor motivation or a lack of effort in job searches. Other social factors in the labour market might play a role, and therefore Zabkiewicz and Schmidt (2007) argued that welfare-to-work programmes should be directed at the unique constellations of problems that recipients face.

The current study intended to learn from the HtW project by asking: What went wrong in this project, and particularly during the cognitive training? Since the quantitative study that evaluated the effect of HtW (Schuring *et al.*, 2009; Schutgens *et al.*, 2009) gave no insight into these issues, an independent qualitative study by researchers who had not previously been involved in HtW (IB, IT, and HM) was conducted to identify the positive and negative aspects of the cognitive training programme. More knowledge about what happened during cognitive training from the perspective of the trainers may contribute to improvements in professional practice aimed at work rehabilitation of the long-term unemployed with health problems. The study was carried out at the request of one of the developers (TV).

We hypothesized that an examination of the following questions might provide more in-depth insight into the reasons for failure of the programme and might open up directions for improvement:

1. What was the level of fit between the contents of the intervention and the characteristics and problems of the participants?
2. Where there any effects due to the recruitment method, particularly the mandatory nature, and the in- and exclusion criteria?
3. Did the clinical methods chosen, i.e. Rational Emotive Therapy and the Goldstein-method, have any effects on the failure of the cognitive training?

METHODS

In order to answer our research questions, semi-structured interviews were held with a purposive sample of trainers. The semi-structured interview format was chosen to ensure that all topics

considered relevant were addressed. However, it was also possible for trainers to address additional topics.

Trainers: Purposive sample

Since not all trainers could be interviewed, a purposive sample (Boeije, 2005) was composed consisting of six out of twelve trainers, allowing different backgrounds to be represented. The coordinating trainer was included, as was the only trainer from an ethnic minority background. Two men and two women were chosen from the other trainers, so the two organizations providing the trainers as well as male and female gender were equally represented in the final group.

The trainers varied in age from 28 to 56 years with between 4 to 39 years work experience. The educational level attained varied from intermediate vocational training (nursing) to higher vocational training (social work, teacher training) or university (psychology, school health education). Before their current role as prevention officials, they had diverse roles varying from nursing, refugee worker, or welfare officer to teacher, researcher or ergonomist.

Procedures

One of the researchers (IT) visited a trainers' meeting to provide information about the study. All trainers indicated they were willing to participate in the study. Informed consent and permission to audiotape the interview was sought and provided by the participating trainers.

Measurement

The semi-structured interview covered the following topics:

1. *Personal situation before HtW*: demographic information, education/profession, job experience.
2. *Experiences with HtW*: preparation, target population, health situation of participants, motivation for HtW, consequences social security payment, exercise programme, meetings about healthy living (= cognitive training).
3. *Impediments to accessing the labour market and the role of HtW*: obstacles to finding work, support, HtW as support for work rehabilitation, advice of the interviewee.

Each topic was introduced with an open question, and if necessary additional probes were made, for instance to ask for clarification or for additional information.

Data analysis

All interviews were transcribed verbatim and then divided into fragments. The fragments were assessed to determine whether they were relevant to the research questions. Relevant fragments were labelled (Baarda, De Goede & Teunissen, 1998; Boeije, 2005), and the labels entered into the Atlas-ti computer program (Muhr & Friese, 2004). All fragments and labels were assessed by two researchers (IB and IT). Differences in judgements were discussed until a consensus was reached. Subsequently, quotations were grouped per subject and families of labels were determined (Muhr & Friese, 2004). For instance, all labels describing characteristics of the target population in relation to the programme, e.g. diversity, cultural differences, educational level, language skills, were grouped together into one family. Families of labels that were relevant to the research questions were selected and summarized by content, whilst ensuring that all opinions were reflected as best as possible. We also noted differences in opinion when they occurred. For privacy reasons, quotations are given without a link to a person, and in addition, trainers have been described as a group, and not as individuals.

RESULTS

Research question 1. Fit between programme and participants

The following families of labels were considered to be relevant for this research question:

- characteristics of participants in relation to the programme;
- the concept of the programme;
- expectations of the participants;
- perceived obstacles to the labour market.

We have described the perspectives of the trainers for each family of labels.

Characteristics of the participants in relation to the programme

A subject that often arises while describing the fit between programme and target population is the diversity of participants: "young, old, bright, unintelligent, black, white, man, woman, all mixed. So much more varied than we had imagined". The heterogeneity hinders the execution of

the programme: "one can adapt the handbook, but every time a new group starts it appears to be different".

The educational level of most participants was low. For this group, the level of abstraction of those parts of the programme based on rational-emotive theory seemed problematic. And the programme appears "too difficult" for this population that "is not used to sitting at a school-desk".

Also, many participants had problems with Dutch language. For some people "it was difficult to participate because they could not [...] put things into words, and particularly (not) [...] emotional things". And, "with some people [...] it is better to use an interpreter" and "not to think dogmatically" or "otherwise you should give Dutch language lessons instead of such a complex cognitive behavioural therapy". The programme also relied on writing skills, but "participants did not have enough skills at their disposal".

Many participants had an immigrant background, and the programme did not take into account cultural differences. An example often mentioned was the intervention topic "assertiveness" that has a different meaning in Dutch culture compared to other non-western cultures. But it is also noted that the programme was not "at right angles to" other cultures, and that immigrants should "adapt themselves to the (Dutch) labour culture" and (thus) "should understand what 'assertiveness' is".

Programme concept

During the interviews with trainers it became clear that the initial concept of the programme changed in response to both the widening of the inclusion criteria and the reality within the groups. The trainers recounted that the initial concept was that the target group suffered from depression and back complaints, but that gradually the inclusion criteria were extended:

First depression with back complaints, then depression with all sorts of complaints to the loco motor system, then no longer depression but only complaints involving the loco motor system and then even that no longer per sé at a later stage.

This development "made it very difficult to come with an offer that's appropriate". Also, the target group was "completely different" than they had thought: the people were not depressed, but did have significant problems with language and education. Moreover, the group had been "sent", leading to a lack of motivation in a large part of the group.

One trainer disagreed, and found that "most hypotheses" did come true, except for "the hypothesis concerning depression". According to this trainer, the target group suffers mainly from

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problems “that are not directly related to a physical condition, probably mental health problems play a role” such as “an external locus of control”.

The view on the main health problems of the target group did not change in the initial and revised concept. The trainers describe the main health problems of the target group as: being in a bad shape, an unhealthy lifestyle (bad eating habits, obesity, smoking), “batteries of medicines”, and illnesses that are “not clearly identifiable”. Some observed mainly psychological or psychosomatic complaints. Participants appeared to complain a lot, and trainers described them as passive, focusing on what they were unable to do, and adopting a victim role.

The policy is not to go into the health complaints and physical limitations, but to focus instead on what participants can do. However, this attitude leads to distrust among participants: “Don’t you believe that I really can’t do it?”

Expectations of the target group

The trainers had the impression that participants had none or very low expectations of the training and blamed this partly on the bad provision of information in advance: “for most participants it was completely unclear what the intention was”. One trainer attributes this to the top-down development of the programme, and said: “No, the entire project does not meet (the expectations) [...] because the participants were never asked a thing”. One trainer remarked that some participants thought that the training would lead to a job, but that “(these) expectations were not realized”, and another trainer described how participants reacted to the course: “(..) again such a course, and... what do they think, that we are crazy? Give us rather a job at last, instead of... course after course, interview after interview”.

Obstacles to entering the labour market

The trainers mentioned lack of training as an important obstacle. One trainer disagreed and played down this factor and finding a lack of social skills the major problem. Two trainers mentioned physical limitations as an impediment to finding a job, with one of them stating: “Well, unskilled, unemployed for years and you can’t use your back... well, invent a cunning plan, and then? ...how can we find a job for him?”. He still finds that many “just don’t have the energy to work for 40 hours whatever job they do” and that these people “receive more justice” by limiting their hours than “implying all sorts of physical limitations”. Another trainer often observed an accumulation of problems because “these people are very capable of making the wrong choices”.

Furthermore, impeding factors such as language mastery, higher age, lack of motivation or job experience, and personal circumstances such as care for children, were also identified.

Some also discerned external factors, such as the legislation that sanctions instead of motivates or that is vague, as well as bureaucracy that creates obstructions, and the services-oriented economy which offers fewer places to the lower educated. They observe that people had sometimes been ignored for many years and that they had become used to the situation. One trainer found that all members of the target group had wrongly received “a disability status as a kind of bonus” which they use “sometimes rightly [...] and sometimes as an excuse” for their unemployment.

Summarizing and analyzing the above information, it appeared that the fit between the programme and the participant group was not optimal. There were problems with the heterogeneity of the target group, and education and language deficiencies. The initial expectation that the target group would suffer particularly from depressive complaints and other mental health problems seemed not to be true. There seemed to be other and more important problems and obstacles to entering the labour market, such as training, education, and language deficiencies, a higher age, and physical limitations. Participants were not well informed, and had no or very low expectations. Expectations that the training would lead to a job were not realized.

Research question 2. The recruitment method

The labels concerning the mandatory nature, the in- and exclusion criteria, and motivation of participants were examined for this research question.

The mandatory nature

The trainers find that the mandatory nature of the course predominantly led to negative responses such as anger, resistance, and mistrust, and this influenced motivation negatively. On the other hand, they believed that nobody would come without some coercion.

The mandatory nature also influenced their own motivation and pleasure in working with the groups. Most had little or no experience in working “with unmotivated people”. Some explicitly stated that they found it unpleasant or difficult to work with people who were not motivated: “this course was never (my) favourite”. But they had mixed feelings, as they also wanted to mean something for this group: one expressed this ambiguity by saying that he had an affinity “with diversity” but not with “the mandatory nature”.

Increasing the scope of the in- and exclusion criteria

As previously mentioned, the in- and exclusion criteria were widened during the project. The trainers experienced this as problematic:

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Then the criteria were so vague, that it did cause problems in the group. The heterogeneity was so large that, in fact, it became quite unmanageable.

And: "The danger (was) that it became a sort of reservoir for people with all kinds of complaints" and that "no-one looked any more, then, to what the programme had initially been established for".

Motivation of participants

The trainers noted that although some participants appreciated the programme, the majority was not motivated. The main source for motivation appeared to be extrinsic, participants came in because they had to, and this resulted in much resistance and negative behaviour: "rage, anger, incomprehension, because this was the next of so many reintegration routes [...] without it leading somewhere". Some experienced the project as disrupting their daily routine. Additionally, participants appeared to be calculating, waiting/passive, aggressive, rejecting, suspicious, or socially desirable. Some found that they were doing very well without a job, or did not see a need to change, according to the trainers.

However, some participants were intrinsically motivated, for instance because they wanted a job, but this expectation could not be realized. Exercise was also mentioned as an intrinsic motivator: "some reacted very positive, particularly to the exercise part [...], because normally spoken they could not afford to sport". Another source for intrinsic motivation was the social contacts during the programme.

In summary, the aspects of the recruitment method described seemed to have had negative effects on the motivation of both participants and trainers. Motivating aspects of the training included the exercise component, the social contacts, and a job perspective.

Research question 3. Clinical methods chosen

For this research question, two labels were considered relevant: RET-method and Goldstein method. It should be noted that some of the fragments described above, particularly those on the characteristics of the participants in relation to the programme, also referred to the difficulty of the RET-method for this population.

RET-method

The trainers found the RET-method too difficult and too abstract for most participants. However, the underlying idea, that "what you think influences how you feel", seemed useful for this group, but the elaboration should be different, more practical. Also the view was expressed that the RET

method had good underpinnings and had been correctly applied, but that its significance for the participants depended on their motivation.

Goldstein-method

The trainers labelled the Goldstein-method as “unexpectedly successful”. On the one hand, they criticized the method: “very out-of-date material” and “explained too simple [...] as if it really goes that way”. But: “the images were clearly recognizable, since the participants found it, however, nice. This was above expectation”.

In summary, the RET method was found to be less suitable for this target group and this contrasted with the Goldstein method which was unexpectedly successful.

Additional Findings

Trainers gave the following suggestions for improving the cognitive training: make it more simple by focusing less on theory and more on practice; more use of here-and-now experiences; more influence for the participants themselves; smaller groups, more tailoring, and individual guidance; combining the programme with an internship.

DISCUSSION

Although HtW had been selected as a “model of good practice”, the results were disappointing (Schuring *et al.*, 2009; Schutgens *et al.*, 2009). The current study tried to explain why the cognitive training aspect of HtW had failed by interviewing trainers. The most important finding was that the target group of long-term welfare recipients with health problems is more heterogeneous than had been expected. It was clear that this group needed help to get a job. But, it was also clear that a tailor-made approach is necessary, and that the cognitive training did not fulfil this need.

Perhaps this finding is due to the widening of the inclusion criteria. However, this was also undertaken as welfare recipients fulfilling the original criteria were not present in sufficient numbers in the target population. The assumed uniform psychological problems of a depressed mood and passivity, which the training was intended to change, were not generally present. Not all members of the HtW target group shared the same characteristics, problems and labour market obstacles. Rather, varying combinations of contributing factors were observed. Sometimes health problems were the main factor, for instance when a former job could no longer be

performed, and sometimes other factors were more prominent, such as language mastery or training deficits, or a higher age. If psychological problems were present, they were diverse as well.

The current study has strengths and weaknesses that should be taken into account. First, in this article we only presented results on interviews held with trainers. Originally, we also wanted to interview a representative sample of participants, but due to practical and time constraints, only four participants were reached (Tomesen, 2008). This sample was too small to include, also because it was clear that this sample was not representative, and since not all relevant opinions had been sampled. A strength is that we obtained a purposive sample of trainers, and they informed us about the groups as a whole. They presented a good picture of the pluses and minuses of the training.

The findings concerning the diversity of problems of the target group are in line with other research. Steenbeek & Jettinghoff (2008), for instance, summarized the literature and found that unemployed who are older, disabled, have an immigrant background, or a lower education have a (much) smaller chance of returning to work. Comparing ill and healthy unemployed, they found a higher age to be the most important obstacle to work resumption. It seems reasonable to assume that those with more than one of these unfavourable characteristics will have the highest chance of being part of the target group of HtW. The passivity observed by the trainers may therefore represent a reaction to the powerlessness experienced (Seligman, 1975; Bracke, 2000). This population with complex and often accumulated problems will, even with proper support, encounter many difficulties in finding and keeping a job, because the demand side and the competition on the labour market play a role, as well as social factors that cannot be easily changed (see e.g., Van Oorschot, 2002; Zabkiewicz & Schmidt, 2007). This means that professionals working with this group not only have to deal with feelings of powerlessness of the target group, but also with their own feelings of powerlessness.

The RET-method appeals to high levels of abstraction ability and language mastery, and was therefore too difficult for most participants. The Goldstein-method appeared unexpectedly successful in contrast. The Goldstein-method which was especially developed for the lower social classes, also appeared suitable for these lower educated welfare recipients.

Trainer and participant motivation appeared strongly influenced by the compulsory nature of HtW. It is also notable from the trainers' descriptions that this creates a negative image of participants. The obligatory character may have caused or reinforced this negative image, because this approach led to resistance and negative behaviour, so that positive characteristics of the target group could not, or less likely, come forward. Additionally, the resulting lack of trust and safety in the group meetings made it difficult for participants to disclose their problems.

The intervention HtW also included a number of stimulating aspects such as the exercise component, the social contacts, and the provision of structure and a purpose. A future intervention should perhaps emphasize these positive elements more strongly in order to enhance motivation.

We additionally reflected on several implicit assumptions of HtW that may also be relevant for understanding its failure. These are: the implicit assumptions of the RET method, the policy of ignoring physical limitations, the mandatory nature of HtW, and the research methodology. We also discussed alternative approaches that might be considered in future projects.

The main assumption of the RET-method is that many psychological problems originate from irrational or dysfunctional beliefs. A pitfall of the RET-method is, therefore, that it tends to ignore external factors relevant for understanding emotional reactions. This may lead, unintentionally, to a neglect of the situational or societal context that may inevitably evoke certain emotional reactions.

The policy not to pay attention to physical limitations and to look primarily at what participants are able to do, may have had negative effects for some participants. Also the name "Healthy to Work" may perhaps indicate that, unintentionally, real, irreversible, physical limitations were neglected, or were assumed to disappear with exercise and "positive thinking". This is illustrated by the account of participants who needed a job that was adjusted to their physical limitations (Tomesen, 2008). During the meetings, however, this issue could not be addressed. Therefore, they felt not taken seriously. Additionally, trainers did not get information from participants about this topic, and may have developed a so-called "blind spot". One trainer observed that this policy led to mistrust.

Accurate empathy, authenticity, and respect are necessary conditions for a good trusting working alliance between practitioner and client (see e.g. Egan, 1982). Acknowledgement and validation of physical limitations is, therefore, needed first before remaining capabilities can be addressed. Also, unresolved feelings about the loss of potential may hinder adjustment (Horowitz, 1992), including the search for alternative job possibilities. For this reason also, explicit attention to physical limitations and how they influence daily life is deemed necessary.

Recently, a new third generation of so-called acceptance and mindfulness-based behaviour therapies have been developed such as Acceptance and Commitment Therapy (ACT; Segal, Williams & Teasdale, 2001; Hayes, 2004). These therapies are less vulnerable to the pitfall described above for the RET-method to ignore valid grounds for emotions, because they consider emotional reactions to be part of a larger context, emphasize acceptance of negative feelings and situations, and aim at teaching people to cope more effectively with negative emotions and cognitions *without changing or judging them*. These therapies also use experiential techniques

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and therefore also match with the recommendation of several trainers to work more with direct experiences in the “here-and-now”. However, what is perhaps even more important is that these methods enable trainers and participants to look without prejudice at the job and welfare-dependent situation within the societal context. In this way, they can work towards appreciation and acceptance of possible negative feelings such as powerlessness and anger. From there, they can examine if and how their situation can be changed.

The mandatory nature of HtW had a greater impact than expected beforehand. HtW was offered within the regime of the new Dutch Law Work & Welfare (LWW). Thus, there was a legal obligation to participate and a strongly limited freedom of choice, leading to a situation of formal coercion. This use of coercion fits in with an ongoing societal trend towards discipline (Rovers & Scheepmaker, 2008) with quasi-compulsory and compulsory elements that are increasingly applied. The justification of coercion within the LWW context is that receiving welfare brings with it the obligation to actively participate in programmes aimed at finding a job or at removing obstacles towards this end.

With an increasing number of health care interventions carried out within this new legal context, it seems necessary to consider certain legal and ethical aspects (Van Ooijen-Houben, Roeg, De Kogel & Koeter, 2008). Health care interventions are principally delivered on a voluntary basis and upon request of the individual concerned. Keeping in mind the right to self-determination, mandatory health interventions should satisfy strict requirements of due care. This issue deserves special attention with experimental health care interventions that have not yet proven to be effective. Furthermore, the seriousness of the problem and the physical and mental violation involved, should be carefully weighed. In addition, use of coercion, particularly in a formal, legal, context, is always an “ultimum remedium”. Finally, mandatory health interventions should be in agreement with the “individualization principle” of the LWW that states that obligations linked to welfare should be adjusted to the circumstances and capabilities of the beneficiary. Finding ways to do justice to this individualisation principle deserves special attention. For instance, motivating communication techniques may be applied combined with taking time to clarify participants' wishes and problems, so that an informed choice can be made for a health care intervention together with recipients (Van Heerwaarden, Hofs & Walraven, 2008). It is crucial that the intervention matches with those problems that, according to the participant, are most strongly related to problems with finding and keeping a job. This may also increase the effectiveness of this type of health intervention: Scientific research has shown that treatment under external pressure should stimulate the internal motivation of the client as much as possible (Van Ooijen-Houben *et al.*, 2008). In HtW, participants' motivation was far from optimal, perhaps particularly so because the offer did not match the needs of the target group.

One purpose of HtW was to facilitate empowerment (see Ploeg, 2005, p. 51). According to Jacobs (2005), participation of the target group is crucial for attaining this goal, but is often difficult to achieve. Also in HtW, the target group had not been involved in the development of the intervention. Its development is characterized by a top-down approach, that was reinforced by the obligatory character that took away control from participants.

Participation by the target group in intervention development, for instance via interviews or focus groups, seems desirable to achieve empowerment. Also the degree of coercion applied, and methods used, deserve special attention. To tailor an intervention to the most important needs, it seems worthwhile to conduct first a confidential and individual assessment, that together with the beneficiary identifies the most important labour market obstructions. In developing health care interventions, special attention should be given to the expectations and needs of the target population.

The research methodology applied in developing and testing HtW by a Randomized Controlled Trial required a high level of standardization, and the intervention was given to large numbers of welfare recipients. Therefore, during the study, it was not possible to learn from experience and adapt the programme accordingly. Also, this methodology did not stimulate (moral) reflection. During the interviews, trainers made suggestions about adaptations that would make it possible to react more directly to the problems presented by participants. In fact, in this type of practice-oriented research, trainers could be given the role of co-researcher and co-developer. This would, however, require another type of research methodology. Perhaps, a *modus-2* approach (Gibbons, Limoges, Nowotny, Schwartzman, Scott & Trow, 2005) described as context-driven and problem-focused can be useful in combination with "*modus-3*" research described by Houweling, Kuiper and Letiche (2010) as an approach which also considers the normative aspects of professional practice.

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