

Conceptualizing Health Assets in a Nursing

Context:

Synthesis of Findings from Multiple Perspectives

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FOREWORD

*Success is achieved by developing our strengths, not by eliminating our
weaknesses*

(Marilyn vos Savant)

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LIST OF PAPERS

Study I

Rotegård, A. K., Moore, S., Fagermoen, M. S., & Ruland, C. M. (2010). Health assets: a concept analysis. *International Journal of Nursing Studies*, 47(4), 513–525.

Study II

Rotegård, A. K., Fagermoen, M. S., & Ruland, C. M. (2011). Cancer patients' experiences of their personal strengths through illness and recovery. *Cancer Nursing*, May 9. doi: 10.1097/NCC.0b013e3182116497

Study III

Rotegård, A. K., Ruland, C. M., & Fagermoen, M. S. Nurse perceptions and experiences of patient health assets in oncology care: a qualitative study. *Research and Theory for Nursing Practice*, (Accepted).

Study IV

Rotegård, A. K., & Ruland, C. M. (2010). Patient centeredness in terminologies: coverage of health assets concepts in the International Classification for Nursing Practice. *Journal of Biomedical Informatics*, 43(5), 805–811. doi: 10.1016/j.jbi.2010.04.010

Unpublished study

Rotegård A. K. Health assets in nursing documentation of cancer care. Studies of Health Technology and Informatics (Submitted to International Medical Informatics Association, NI2012, The 11'th Nursing Informatics Conference).

ACRONYMS AND ABBREVIATIONS

CONNECT	Communication and Information Sharing between Patients and Their Care Providers
GRR	General Resistant Resources
ICNP	International Classification for Nursing Practice®
ICT	Information and communications technology
ISO/FDIS18104	The International Organization for Standardization, document number FDIS 18104
NCS	The Norwegian Cancer Society
NFR	The Norwegian Research Council
SOC	Sense of Coherence
VERDIKT	Core Competence and Value Creation in ICT (NFR's program for development and application of knowledge to enhance interaction, innovation and value creation in the ICT-based network community)
WHO	World Health Organization

SUMMARY

Health assets, or peoples' capacities and strengths, have been recognized by the World Health Organization (WHO) as being necessary to strengthen and maintain health and wellness. However, the concept of health assets has not been well defined in recent years and there is little consensus. The purpose of this doctoral dissertation was to synthesize findings about health assets based on conceptualization and knowledge from various perspectives: literature, patients and nurses, and the nursing terminology system International Classification for Nursing Practice (ICNP).

First, a concept analysis was conducted to examine the meaning of the concept, its underlying attributes, antecedents and consequences, and its uses in health care. A definition of health assets and a descriptive model of its components and possible relationships were proposed. Health assets were defined as the *“repertoire of potentials—internal and external strength qualities in the individual, both innate and acquired—that mobilize positive health behaviors and optimal health/wellness outcomes”* (Study I). Five strength dimensions were uncovered: relational, motivational, volitional, protective strengths, and mobilization. To further explore and describe the concept empirically, focus group interviews with 26 cancer patients and cancer survivors who were members of patient support groups (Study II), and 26 nurses experienced in cancer care were conducted (Study III). Patients reported a rich repertoire of personal strengths they used or wished for during their illness and recovery, resulting in seven themes and 12 subthemes of health assets. Most striking was their experience that care providers did not ask for, discuss, or build on patients' own strengths. Patients wanted to be involved, and they possessed a considerable number of potential strengths that they wished could have been mobilized with the help of care providers. Patients preferred a more active role in their care than they actually had or were invited to take.

Nurses in the focus groups were not very familiar with the concept of health assets, and realized that they did not focus much on patients' strengths in their care. The discussions and reflections on health assets directed their attention to the patient as an active agent contributing to his or her own health rather than a passive recipient of care. Three additional dimensions of health assets appeared from the nurses' focus groups: cognitive, emotional, and physical strength. Additionally, various themes and subthemes related to health assets were elicited. Furthermore, it became apparent that health assets were not static, but may

fluctuate between more or less of the same asset and/or between two or more health assets. Contextual and individual circumstances also affected what constitutes a health asset.

To explore and describe nursing documentation of health assets, cancer patient records were analyzed (unpublished study). A mean of 3.2 health assets was documented in 43 out of 100 patient records, and 61% of the descriptions of assets quoted patients. Health assets were found most often described in the admission notes (49%), but no information was found that described or indicated an intended use or follow up in the nursing documentation. Finally, the ICNP, a standardized professional nursing vocabulary, was assessed for its representation and suitability to represent health assets (Study IV). Based on the findings from the concept analysis, the focus group interviews with nurses and the analysis of patient records, health assets terms were cross-mapped with the ICNP. Of 76 health assets terms, 33 were represented in the ICNP. Several health assets categories and subcategories were missing or embedded in the descriptors of other ICNP concepts or terms. Many terms reflected clinicians' problem-oriented perspective rather than patients' strength perspective. ICNP has possibilities for providing clinical support for the documentation of health assets, but more research and development is needed before the ICNP can adequately represent health assets.

The findings of these studies suggest a need for a greater focus on patients' health assets; patients want their strengths to be utilized and to contribute to their own care. However, nurses do not fully utilize patients' strengths, but realize their importance when made aware of them and aspire to become more aware of this aspect of care.

This dissertation provides an improved understanding of health assets, particularly within cancer care, and contributes to knowledge about health assets from several perspectives. A synthesis of the findings from the five studies resulted in a refinement of the definition and conceptual model for health assets. However, further studies are needed to substantiate the model and test its suitability for research and teaching, and to develop support systems for patients and nurses that foster the use of health assets. Knowledge gained from this work can assist nurses in balancing the traditional problem-oriented approach with a health assets approach. In this manner, nursing care can help patients move from being passive recipients of care to becoming active agents of wellness and health, sharing power, and having more control over their illness.

1.0. Introduction

This doctoral dissertation arose out of my interest in patients' resources. One assumption and motivation behind this research was that a focus on the resources and strengths of the patient is central to nursing. My perspective on patients' resources was influenced by Virginia Henderson's nursing theory, which states that patients' resources are their strength, will, or knowledge (1997). Recent studies conclude that health care professionals do not fully see or utilize patients' potentials, resources, or contributions to health and wellness. Research has found that healthy people such as care providers and family also have a tendency to underestimate patients' internal resources and quality of life (Martensson, Carlsson, & Lampic, 2008) or lack the skills to identify and support patients' resources (Eloranta, Routasalo, & Arve, 2008). These challenges may be associated with the problem-oriented view of health. The disease and problem perspective of health has dominated and overshadowed the health and wellness perspective in health care (Hofmann, 2005). Health is more than the absence of deficit. Wellness has been described as the core of health, and as including the patient's perspective (Moore & Huerena, 2005; WHO, 2006). Furthermore, wellness has been described as the capacity for living and solving problems (Carlson, 2003). People's capacities for living and their own perceptions and viewpoints can therefore be considered as central in wellness. The importance of this perspective is reported in a Norwegian study where wellness and resources were central in people's conceptions of health (Fugelli & Ingstad, 2001). Health is described by the World Health Organization (WHO) in the Ottawa Charter as a positive concept that emphasizes social and personal resources (WHO, 1986). These descriptions of health and wellness are the central ideas and foundation of this dissertation.

Discussions on this issue with my advisor and colleagues from the faculty during my early studies at the Francis Payne Bolton School of Nursing, Case Western Reserve University, Cleveland, Ohio, USA challenged me to clarify the meaning of patients' resources and I was introduced to the concept of "health assets". A former nurse and faculty member at this university, Rozella Schlotfeldt, had developed a health-seeking nursing model during the 1970s that was used as a foundation for the doctoral and masters' programs at that school. In this model, Schlotfeldt used the concept of health as focused on people's strengths rather than on problems and pathology. The nursing mission was to assess and enhance people's health status, health assets, and health potentials (Glazer & Pressler, 1989). The person in her model was described as having health assets, and health assets were described as

comprising health-seeking behaviors and health-seeking mechanisms. An analysis and summary of Schlotfeldt's model concluded that these components needed more clarity (Glazer & Pressler, 1989).

However, the health assets concept has not been used well in nursing research and literature, and the understanding and uses of the concept across health care professions varies, as reported in the first study of the dissertation. Health assets was recently recognized by the WHO and the positive psychology movement as a necessary additional focus to the problem focus in health care, as a means to strengthen and maintain health and wellness (Harrison & Ziglio, 2003; Peterson & Seligman, 2004), but an explicit definition of health assets could not be found in either of these sources. In a personal telephone conversation with Dr. Antony Morgan (Associate Director, Centre for Public Health Excellence, National Institute for Health and Clinical Excellence, England), I was told that the concept of health assets was not defined in the program of health assets in WHO, but that it represented the abilities of individuals or communities to protect and/or promote health (Personal communication, November 10, 2006).

The health assets concept appeared to fit the positive perception of health, including people's resources, and I wanted to explore further the meaning and usage of the concept. Most of the literature on health assets has focused on their role in facilitating positive development in children and adolescents, while knowledge was lacking about the development and utilization of health assets in adults, especially in challenging situations like serious illness, and also in a nursing context. Therefore, this dissertation takes an inductive approach; first in a concept analysis and thereafter during conceptualization of health assets in a nursing context based on empirical studies from multiple perspectives, namely cancer patients, nurses experienced in oncology care, nursing documentation in cancer patients' charts, and a global nursing terminology system. The descriptions of health assets from these perspectives were synthesized, providing an expanded and refined definition and visualization (conceptual model) of health assets.

The present dissertation focuses on individual patients and their health assets in a nursing context. The concept analysis revealed that, from a public health perspective, salutogenesis was an underlying theoretical construct of health assets. This dissertation aimed at a conceptualization of the health assets concept that was not constrained by one specific theoretical framework, and used an inductive approach to explore and extend the understanding of the concept.

1.1. Clinical support systems for the positive aspects of health

According to a previous study, health care professionals tend to act for or against, rather than being with and engaging the patient (Oudshoorn, 2005). Hence, patients may become passive in their own care for health and wellness, not making good use of their resources or health assets. In Norway, as in many other countries, empowering patients to take a more active role in their own health through electronic support systems has been declared a high priority health policy goal (Helse- og omsorgsdepartementet [Ministry of Health and Care Services], 2009; Sosial- og helsedirektoratet [Norwegian Directorate of Health], 2004). Empowering and supporting patients' autonomy through participation and information sharing are central values and outcomes of eHealth, which aims at improving interaction and teamwork between health care providers, patients and next of kin, and between various actors within health and social care systems (Europe's Information Society, 2011).

This doctoral dissertation is part of a larger research project "CONNECT – Communication and Information Sharing between Patients and Their Care Providers" that aims to design clinical decision support systems for patient-centered illness management and provide collaboration in patient care (C. M. Ruland, Principal Investigator).

One example of a clinical decision support system in nursing is the system for planning, performing, and documenting nursing care, now done through electronic patient records (EPR) systems. However, support systems for those nursing activities that focus on the positive aspect of health, namely wellness, patients' resources and the patients' perspective, are lacking. Clinical decision support systems, and more specifically care plan systems and terminology systems, are based upon illness and deficit approaches (Feeley & Gottlieb, 1998; Meleis, 2007), or the problem-oriented nursing process (Moen, 2002). The reason for this may rely on descriptions of nursing care.

Nursing theories, such as those of Henderson (1997) and Orem and colleagues (Orem, Taylor, & Renpenning, 1995) have strongly influenced nursing in Norway (Kirkevold, 1998) and continue to be influential. These theories attempted to describe the focus of nursing and the nurse's responsibility, and were based on identifying the patient's needs and (capacity for) self-care. In these theories, health is described as the capacity for independent decisions and actions using one's physical and psychological resources, while nursing is needed when patients have problems because of their needs or when having self-care

deficits (Kirkevold, 1998). In parallel with these theories, the nursing process model was developed to describe and support nurses' work, decisions, and documentation to obtain the best possible outcomes for the patient's health. The nursing process reflected nursing as both a problem-solving and a relational process, and the individual patient's situation was fundamental (Fagermoen, 1980). However, the problem-solving part of the model became the focus of the adaptation and implementation of the nursing process into clinical care and education (Fagermoen, 1980). The lack of emphasis on the relational aspect in the nursing process may have contributed to the limited focus on the patient's perspective in documented nursing care. Research reports a lack of attention to patients' individual perspectives, preferences, and/or experiences in the documentation of their care (Adamsen & Tewes, 2000; Florin, Ehrenberg, & Ehnfors, 2005). It is acknowledged that personal experiences, preferences, and values need to be integrated and supported to optimize health decisions in the clinical encounter (Tonelli, 2006). Furthermore, it is argued that health and nursing care needs support systems that are more robust, enabling nurses to recognize patients' experiences and knowledge, to document these and provide more person-centered care (Biswas et al., 2008; Irving et al., 2006). Such knowledge is founded on a fuller understanding of health and wellness.

Even though the wellness perspective has been studied to some extent and is accepted as an important part of health, it has been concluded that the concept is still not clearly understood and that factors affecting or influencing wellness need to be studied (Corbin & Pangrazi, 2001). The lack of clarity about the wellness perspective and the factors influencing it may also explain the limitations of this perspective in electronic support systems. Many nurse researchers and theorists have criticized the needs based and self care tradition in nursing, including Rozella Schlotfeldt in the USA (Kirkevold, 1998) and Kari Martinsen in Norway (Martinsen, 1993). Health assets may be a factor contributing to a clearer understanding of health and wellness. However, more knowledge is needed to understand, assess, and use health assets in support systems for clinical nursing care, education, and research.

1.2. Purpose of this dissertation

The purpose of this dissertation was to synthesize findings about health assets based on conceptualization and knowledge from various perspectives: literature, patients and nurses, and the nursing terminology system, the ICNP.

The specific aims of the studies that comprise this doctoral dissertation were:

- To conduct a concept analysis of health assets, examining the meaning of the concept, its underlying attributes, antecedents and consequences, and uses in a health care context.
- To explore and describe cancer patients' experiences and perceptions of the health assets they use or desire through their illness and recovery.
- To explore and describe nurses' experiences and perceptions of cancer patients' health assets.
- To explore and describe nurses' documentation of health assets in cancer patients' records.
- To explore and describe the representation of the health asset concept in a standardized professional nursing vocabulary, the ICNP Version 2.0, and evaluate the suitability of the ICNP to support nursing documentation of health assets.

1.3. Overview of the studies in the dissertation

This dissertation started with a systematic literature review and a concept analysis of health assets and resulted in a preliminary definition and conceptual model of health assets (Study I). This was followed by four studies that explored and described patients' health assets: (a) as experienced by cancer patients and survivors, (b) as experienced by nurses in cancer care, (c) as documented by nurses, and (d) as represented in a nursing terminology system for use in an electronic patient record system (the International Classification for Nursing Practice®, ICNP).

Each study added breadth and depth to the knowledge and understanding of the health assets concept from different perspectives. An overview of the five studies comprising this doctoral dissertation is provided in Table 1.

Table 1. Overview of the five studies included in the doctoral dissertation

	Study I	Study II	Study III	Unpublished study	Study IV
Purpose	To examine the concept of health assets, including its underlying attributes, antecedents, consequences, relationships, and its evolution in a health care context.	To explore and describe cancer patients' experiences and perceptions of health assets they use or desire through their illness and recovery.	To explore and describe from the perspective of nurses, their perceptions and experiences of patients' health assets in the context of cancer care.	To explore and describe nurses' documentation of health assets in cancer patient records.	To explore and describe the representation of the health assets concept in the ICNP Version 2.0 and evaluate the suitability of ICNP to support documentation of health assets.
Method/design	Rodgers' evolutionary concept analysis method.	Qualitative: exploratory and descriptive.	Qualitative: exploratory and descriptive.	Retrospective chart review.	Manual, conceptual cross-mapping between the health assets concept and ICNP concepts and terms.
Sample and data sources	60 documents addressing health assets.	26 cancer patients and survivors.	26 nurses experienced in oncology care.	43 records of cancer patients, including when hospitalized and from outpatient clinics.	Target terminology: ICNP Version 2.0. Source terminology: the conceptual model of health assets (19 categories and 53 subcategories).
Data collection	<ul style="list-style-type: none"> Systematic database searches: CINAHL, MEDLINE, AMED, EMBASE, PsycINFO, PubMed, Google scholar. Reference lists. 	Focus group interviews.	Focus group interviews.	100 available cancer patient records, collected for the larger study.	The browser of the ICNP Version 2.0 (English) and BaTool, a tool for translating ICNP into Norwegian.

Data analysis	Inductive concept analysis.	Qualitative thematic analysis.	Qualitative content analysis.	Cross-mapping to determine conceptual match between health assets concepts and terms, and ICNP concepts and terms.
Results	<p>Definition and a preliminary conceptual model of health assets with attributes, antecedents and consequences.</p> <ul style="list-style-type: none"> Knowledge of health assets expanded and confirmed with: <ul style="list-style-type: none"> • themes and subthemes. • patients who wanted their health assets to be more appreciated and used. 	<p>Knowledge of health assets expanded and confirmed:</p> <ul style="list-style-type: none"> • Three new core dimensions of strengths/attributes identified. • balancing processes as a new defining attribute. • contextual and individual variations. 	<p>A mean of 3.2 health asset entries per record were found:</p> <ul style="list-style-type: none"> • 61% quoted the patients. • mobilization was the most documented health asset (43%). • protective strengths were the least documented health asset (4%). • health assets were most often documented in the admission note (49%). A further 25% were mentioned in status reports but lacked systematic follow up. 	<p>43% of health assets terms had a complete match, 38% had a partial match, and 18% had no match with ICNP:</p> <ul style="list-style-type: none"> • several health assets categories and subcategories were missing or embedded in the descriptors of other ICNP concepts and terms. • many terms reflected the clinician's problem-oriented perspective rather than a patient's strength perspective.

2.0. Methodological aspects

This chapter describes the researcher's qualifications and preconceptions, the samples, the methods chosen for data collection, and data analyses. Considerations of the rationale for these choices are provided. These include potential positive and limiting aspects of the methods, and steps we took to minimize the possible limitations and enhance the quality of the studies.

2.1. The researcher's qualifications and preconceptions

In qualitative research, the researcher is the instrument collecting and analyzing data (Patton, 2002). The researcher's qualifications and experiences for conducting good qualitative research are therefore of importance, but may also be sources of biases. Being aware of one's qualifications and preconceptions before the study is an important precaution related to subjectivity bias.

The experiences and qualifications that have enhanced my credibility as researcher are experiences from managing and leading groups as a nurse in management, teaching, and advisor positions in hospital nursing care. Moreover, I have undertaken courses in qualitative research and gained experience through previous research projects using similar methods of analysis and data collection (cross-mapping, qualitative interviewing, document analysis of patient charts).

My assumptions of health and wellness and my qualifications may have affected the research questions, data collection, and analyses. Ahead of the studies, I was inspired by Aaron Antonovsky's theory of salutogenesis (1987) in my perception of people's resources. However, I was aware of my standpoints and did not expect these to be the whole truth. I wanted to go into the research with an open mind to conceptualize health assets and grasp the knowledge in the data from different perspectives, without being limited by a single theory. I wanted to understand the concept of health assets from the standpoints of previous publications on the concept, which covered several health care perspectives, from the perspectives of cancer patients and survivors, and from the perspective of expert oncology nurses.

I was introduced to the term "health assets" during my studies in the United States. It was unfamiliar to me at that time and motivated me to start exploring it to see whether it contributed

to new knowledge and insight in nursing science. Not much research had been done on it in a nursing context.

The safeguards used to address subjectivity and strengthen credibility are further described and discussed in Chapter 3.

2.2. Data collection and sample

The sampling plan was designed to explore and understand health assets as fully as possible within the time and financial limits of the doctoral work. We planned to obtain richness and broadness of data, and to select sampling methods that were appropriate for the purpose of the dissertation.

Different methods were used for collecting data, comprising a concept analysis based on a systematic literature review (Study I), empirical data collected in focus group interviews with patients and nurses (Studies II and III), data collected from cancer patient records (unpublished study), and from ICNP (Study IV). A summary of the samples and methods from the published studies and additional unpublished information is displayed below.

2.2.1. Concept analysis (Study I)

The development and clarification of concepts has been regarded as an important element of scientific advancement within a discipline, and new or expanded concepts may be vital in a discipline's scientific process (Rodgers, 2000). The concept of health assets is rarely used within the context of nursing, even though it was introduced in Schlotfeldt's nursing model (Glazer & Pressler, 1989; Schlotfeldt, 1978, 1988). Rodgers considers concepts as changing and dependent on contexts, e.g., on various health care disciplines (Rodgers, 2000). The first study of this dissertation used Rodgers' evolutionary concept analysis method (2000), an inductive and descriptive method to clarify commonalities and disagreements in the uses of the concept across disciplines, in addition to its evolutionary background. Such inquiry is appropriate when little knowledge exists of a phenomenon, as was the case with the concept of health assets.

Rodgers' method proposes a rigorous sampling design to increase the probability of a credible sample of literature representing the concept (Rodgers, 2000). In this study, data (literature

findings) were collected from relevant literature sources about the concept among various health care domains including, but not limited to, nursing, medicine, psychology, psychiatry, public health, and social/behavioral sciences. Data were retrieved from CINAHL, MEDLINE, AMED, EMBASE, PsycINFO, PubMed, and Google scholar. To uncover the social, political, and economic contexts of the concept of health assets, health policy documents were also included in the search strategy (Economic Commission for Africa, 2001; World Health Organization, 2008).

An initial keyword search on “health assets” was conducted, resulting in 25 hits. To extend the search strategy and cover assets in a health perspective, a title search was conducted for “assets” only, resulting in 484 additional hits. The retrieved literature was therefore manageable. Criteria for inclusion were articles and web pages, not limited to research articles, in English or Scandinavian languages, published between January 1966 and March 2007, which described health assets on a personal level. The criteria for exclusion were documents or web pages referring to anonymous sources, unavailable documents, duplicates, missing abstracts, and articles that addressed health assets on a system level, e.g., staffing and technology.

Articles were selected in two steps: (1) by title search, and (2) by reading abstracts. All titles were read to get an overview of the use of the health assets concept and its relevance to health care. Thereafter, all abstracts and web pages addressing health assets were read. After reading the abstracts, relevant articles were selected and read in full.

A total sample of 60 documents was retained for in-depth analysis, representing 30% of the total population of relevant literature ($n = 198$). Rodgers has recommended at least 20% of a total population of documents as necessary to facilitate a credible sample of data. Of the 60 documents, 10 were abstracts only, which were retained in the analysis because they provided precise descriptions of aspects of health assets.

A prerequisite for a complete concept analysis is to look for associated expressions to help clarify the concept. Hence, a second literature review was conducted, rendering 45 additional documents on the associated expressions “health resources”, “resourcefulness”, and “resilience”. To select articles based on these concepts we used the same title search strategy and selection procedure as described above.

2.2.2. Focus group interviews with patients and nurses (Studies II and III)

Empirical data about cancer patients' health assets or strengths were collected in focus groups from the perspective of expert nurses within oncology care and cancer patients/cancer survivors. The focus group interview as a method is suitable for generating knowledge about an issue that is little explored (Kitzinger, 1995). Focus groups are designed to gather in-depth information based on participants' understanding, perceptions and experiences about and use of a phenomenon (Kitzinger, 1995; Krueger & Casey, 2000; Rice & Ezzy, 2002) and thus fit the purpose of the studies.

A purposive sampling procedure was used to select information-rich participants for these studies. Group interviews were conducted with two samples: one sample comprised expert nurses in cancer care, the other comprised cancer patients and cancer survivors. To enhance broadness and richness of understanding and knowledge of health assets, participants were recruited from different sites located in southeastern Norway (Table 2). Managers at each facility (head nurses/the manager/NCS administrator) were asked to help recruit participants consistent with the inclusion criteria and to distribute informed consent letters that explained the study (Appendices I and II).

Table 2. Sites, inclusion criteria, and context of the focus group interview samples.

	Nurses	Patients and survivors
Sites	<ul style="list-style-type: none"> • Four satellite units of two university hospitals. • The Norwegian Cancer Society (NCS). 	The NCS's patient support groups.
Inclusion criteria	Minimum 5 years' experience in cancer care. ¹	<ul style="list-style-type: none"> • Had current or previous cancer diagnosis. • Were above 18 years of age. • Were able to speak and understand Norwegian. • Were willing to share and describe their experiences of health assets through the period of illness and recovery.
Contextual description	<p>The five groups of participants represented:</p> <ul style="list-style-type: none"> • the whole spectrum of cancer care: before, during and after cancer diagnosis and treatment. • a wide variety of settings: hospitals, outpatient clinics, day care and palliative care facilities. 	<p>Represented variation in experiences with regard to gender and diagnosis:</p> <ul style="list-style-type: none"> • two groups of women/breast cancer.² • one group of men/prostate cancer.³ • one mixed gender group/lymphoma.⁴

¹ Consistent with theoretical descriptions of expert nurses (Benner, 1984).

² Breast cancers are the most common cancer in Norwegian women and the Western world (Cancer Registry of Norway, 2011).

³ Prostate cancers are the most common cancer disease among Norwegian men (Cancer Registry of Norway, 2011).

⁴ Lymphoma is a common cancer diagnosis and the support group was chosen on advice from the NCS administrator because it was the fastest growing and most active group in the NCS.

The total sample of participants across the studies and groups consisted of 52 participants (26 nurses and 26 patients) distributed in nine groups (five groups of nurses and four of patients), with 4–7 participants (median = 6) in each group. A total of 41 women (including 26 nurses) and 11 men participated. The average age of the nurses was 45.4 years (range 27–61 years), while the patients' average age was 63.9 years (range 50–79 years). Within each group, the members were quite homogeneous and this facilitated comfortable group dynamics, allowing participants to feel at ease in sharing their views and experiences. It has been suggested that the

best groups have participants who share the same background but do not know each other (Patton, 2002). The participants in these focus groups had the following shared background: nurses working with cancer patients and patients sharing the same disease and engaged in the same support group. In most of the groups, some knew other participants more or less, while others did not.

The group interactions in focus group interviews should be positive in that people who do not easily share their thoughts may be encouraged and empowered to become heard (Rice & Ezzy, 2002). In some patient groups, some participants were more shy than others were, but they shared willingly when asked to, after having listened to the others' stories. Group interaction often produces insight and knowledge based on participants' comparison and contrasting of their experiences and views (Krueger & Casey, 2000; Rice & Ezzy, 2002). This occurred in all group interviews in these studies. Focus groups have also been found to provide positive experiences and to be enjoyable for the participants (Patton, 2002). The groups in these studies were characterized by much humor and enjoyment, especially the patient groups. Many nurses spontaneously summarized that the group session had given them time for important reflection and discussion, time they usually did not have at work.

Although being useful for their purposes, focus group interviews have disadvantages, which we made efforts to minimize. The focus group interviews were carefully planned, in terms of the roles of the moderator and co-moderator, the guiding questions, and conduct of the interviews. The plan also considered tape recording, note taking, and where moderators and participants were to be seated around the table. A guide for the discussions listed a series of intended questions: opening, introductory, transitional, key and closing questions, as recommended by Krueger and Casey (2000) (Appendices III and IV).

There is a limit on how much in-depth information about participants' experiences can be obtained in focus groups compared with individual interviews. These studies used an open, inductive approach, and the number of questions was few and controllable, to facilitate generation of in-depth data. A focus group aims to reach into the depths of group experiences, and discussing each other's input helps participants to interpret their own experiences and put them into perspective (Krueger & Casey, 2000).

2.2.3. Health assets in nursing documentation of cancer care (Unpublished study)

This study is not yet published, therefore a more comprehensive presentation of the methods and results in this study are provided. As part of the larger CONNECT study, 100 cancer patient records were available from two hospitals (the same sites used for two of the focus groups of nurses in study III). We selected one hospital unit and outpatient clinic at each site. A convenience sample of records was chosen for this study because of their availability, pre-approval by the Ethical Review Board for chart abstraction, and because they represented the same cancer diagnoses as some of the patients in the interviews.

Data were collected from admission assessments, progress notes, nursing care plans, and the discharge summary in the patient record. Of the 100 patient records, 43 met the inclusion criteria: (a) had readable handwritten or computerized nursing notes including one hospital stay; (b) at least one admission note; (c) six consecutive shift reports and/or available discharge notes or an outpatient clinic report; and (d) had health assets content. All the text was readable, and the documentation was primarily characterized by short text. The records analyzed included 16 belonging to women and 27 to men. Anonymity was assured because copies of paper records had already been de-identified in the larger study.

These records were retrospective data documented for clinical purposes before the study was introduced. Retrospective document analysis does not necessarily reflect the present reality, but it provides data and a picture of whether and how health assets were documented. This data set represented the nurses' interpretation of patients' health assets, but at the same time, they referred directly to what the patients said, required, or wanted, thus also reflecting a patient perspective although through the lenses of nurses' perspectives. This study therefore provided data about the use of health assets as it occurred in normal processes of cancer care at these sites without any contamination by the research process, thus the records were a valuable additional data source for the dissertation.

2.2.4. Patient centeredness in terminologies (Study V)

This study was conducted while the analyses of the focus group interviews with nurses (Study III) were ongoing. The samples for this study consisted of the ICNP and the health assets conceptual findings. The health assets conceptual model, here considered the “source terminology”, was developed based on findings from three sources: Study I (concept analysis of health assets), the results from the first step of the analysis in Study III (focus group interviews with nurses in oncology care), and the unpublished study (health assets in nursing documentation of cancer care). Findings from these studies were synthesized and organized as themes or terms representing the health assets concept, with 19 categories and 52 subcategories of health assets’ strengths, dimension, and mobilization (Appendix V).

The ICNP Version 2.0 was used as the “target terminology”. This terminology was chosen because it is a global, concept-based nursing terminology system. ICNP is a member of the WHO Family of International Classifications (WHO–FCI). It is also a reference terminology and ontology system that aims to facilitate cross-mapping (Bakken, Coenen, & Saba, 2004). The Norwegian Nursing Organization recently recommended ICNP as the terminology system for documentation of nursing care in electronic health records in Norway (Seland, 2009).

2.3. Analyses of data

2.3.1. Concept analysis (Study I)

Rodgers’ method promotes an analysis that takes form as an inductive thematic analysis of the concept based on the literature sampled. The purpose of the thematic analysis is to describe major aspects (antecedents, attributes, and consequences) of the phenomenon, thus mainly taking a theoretical form (Rodgers, 2000). The analysis was carried out in three phases: (1) investigating the health assets concept, (2) examining the associated concepts/terms (resources, resourcefulness and resilience), and (3) comparing the attributes of the associated expressions (Phase 2) to the health assets concept (Phase 1).

In Phase 1, the literature was read as a whole to get an impression of previous work and to identify the use of the concept. Literature was re-read to identify and extract content for each aspect of the concept separately and consecutively: attributes, antecedents, consequences, and contextual information (social, cultural, and political). A thematic analysis was conducted on the extracted text for each conceptual aspect, by comparing for similarities and sorting into themes and categories. The themes were examined for their meaning, patterns and similarities. Different words used to express the content were checked in several online dictionaries, e.g., *Compact Oxford English Dictionary* and *Merriam-Webster Online Dictionary*. Data were organized and reorganized until a consistent system of categories, dimensions, and relationships emerged for the attributes, antecedents, and consequences of health assets. To ensure a systematic analysis of the abstracted articles and strengthen the validity and reliability of the analysis and findings, an audit trail was developed and kept for the work processes, interpretations, and decisions. This analysis required moving back and forth between the extracted themes and the documents for clarification and follow-up analysis of interpretations and understandings.

In Phase 2, the same procedure as for Phase 1 was used, but focused mainly on the attributes of health assets.

In Phase 3, we determined whether an associated expression was a synonymous term or a related concept to the health assets concept. A synonymous term would share all of the central attributes of the main concept, whereas a related concept would only have a relationship to the main concept (Rodgers, 2000). The analytic steps and findings were discussed with two experienced researchers, and are described in more detail in paper I.

Rodgers' method describes the importance of identifying exemplars, rather than having the researcher construct them as is done in other methods of concept analysis, e.g., the Wilson method (Rodgers, 2000). In this study, we used several examples from various clinical contexts to illustrate the characteristics of the concept's actual and possible applications. A preliminary conceptual model was developed to describe the antecedents, attributes, and consequences of the health assets concept figuratively. Conceptual models assist the understanding of abstract concepts and may support their use in clinical practice. The health assets conceptual model is at a high level of abstraction and needs to be further developed to be clinically valid and useful.

Rodgers (2000) has encouraged further development of a concept based on empirical research such as interview data. In this doctoral study, the concept analysis was followed up with focus group interviews with nurses and patients.

2.3.2. Analysis of focus group interviews (Studies II and III)

Qualitative thematic analyses with an inductive approach were used in line with Kvale and Brinkmann's (2009) descriptions to analyze the transcribed text from the focus group interviews. The transcribed text consisted of a total of 328 pages (184 pages in the patient study and 144 pages in the nurse study). We used Kvale's method of qualitative interviewing and analyses, which is widely used and is the analytical method that is described in greatest detail (Dilley, 2004; Kvale & Brinkmann, 2009). First, an open reading was conducted to get an overall impression of the whole. The transcribed texts were read several times. Then the systematization and interpretation of the text was performed as an iterative and holistic process, included meaning coding, condensation, and interpretation. The meaning coding in this work involved breaking down the text into meaning units, comparing them, and conceptualizing the data into groups of similarities (Kvale & Brinkmann, 2009). The coding was driven by the data, reading the text openly, and looking for descriptions of strengths manifest in the material. Additionally, concept-driven coding was used on the data from the nurses' focus group interviews to code the data into the core dimensions of health assets.

Meaning condensation refers to compressing longer statements into briefer ones, keeping the sense of meaning with fewer words (Kvale & Brinkmann, 2009). Thematic analysis aims to compare and contrast similarities across cases (Polit & Beck, 2008). A theme is a recurring regularity emerging from the data that provides meaning and identity to an abstract entity (Polit & Beck, 2008). The statements were thematized from the participants' viewpoint as understood and interpreted by the researcher. The themes were then analyzed for interpretation of meaning, going beyond the manifest meaning, being more critical, uncovering underlying meaning of the text (Polit & Beck, 2008). This critical commonsense interpretation was validated with colleagues.

An audit trail was used to document the analytic process, including the thoughts and reflections of the moderator and central quotations from the participants.

2.3.3. Health assets in nurses' documentation of cancer care

(unpublished study)

The complete set of nursing documentation of each patient's record that had been de-identified in the larger study was photocopied verbatim and treated and stored with strict confidentiality. The coding and condensation of meaning was performed by two coders who read each document in the patient records independently. The second coder, who was familiar with content analysis, but not with health assets as concept, was informed about the results of the concept analysis of health assets (Study I).

A combination of a conventional directed and a summative analysis was conducted, as described by Hsieh and Shannon (2005). The main differences between these approaches are the coding schemes and origin of codes. Conventional content analysis starts out with observations of the text and codes derived from the data (Hsieh & Shannon, 2005). Our first step in the analysis of cancer patients' charts was a reading of the text in order to get an overview. An open-ended question to the transcribed text was used to identify and highlight all instances of health assets (strengths) documented: Is there any part of this text that appears to contain descriptions of the patient's strengths or health assets? The highlighted text was then organized into clusters based on shared meaning or similarities.

The text was then read, interpreted, and condensed within the predetermined instances of, respectively, relational, motivational, volitional and protective strengths, and mobilization. This represents a directed content analysis that uses predefined codes from related research or frameworks in order to extend a framework (Hsieh & Shannon, 2005). In this study the initial health assets model had been developed and the aim was to substantiate it with concrete knowledge and content of health assets.

To further analyze the use of health assets, the categorized content was counted and viewed in relation to the context of documentation; the part of the documentation system that the health assets were documented (income assessment, care plan, status report), and the form in which the health assets were expressed (from the provider's or patient's perspective). This part of the analysis represented a summative content analysis, which also included analysis of latent

content (Hsieh & Shannon, 2005). The same strength dimensions as described in the initial health assets model provided the keywords for this analysis.

After the coding, condensation, and initial interpretation of the texts, the two coders met to compare and discuss the results until consensus was reached. New tentative themes and categories of health assets were also discussed to establish credibility of the analysis. At the end of the analysis, a partial audit of the analysis was undertaken by two expert researchers.

2.3.4. Patient centeredness in terminologies (Study IV)

A conceptual cross-mapping (mapping) was conducted between the ICNP Version 2.0 and the concepts in the health assets model. A common meaning and understanding of nursing phenomena or concepts is important to enhance and secure information and communication exchange across time and populations (Goossen, 2006), for example between different electronic patient record systems. ICNP is consistent with the ISO/FDIS 18104, a formal model and upper ontology of nursing diagnosis and nursing interventions that, amongst others, aims at facilitating cross-mapping (International Standards Organization, 2003; Moss, Coenen, & Mills, 2003).

Cross-mapping is the determination of semantic correspondence of a concept in two systems, and thus can solve the problems of interoperability between different computerized systems (Hardiker, Bakken, & Coenen, 2006; Veltman, 2001). Mapping is also called matching or alignment, and tries to make source terminology (in this case the health assets model) and the ontology (ICNP) consistent and coherent with one another while keeping them separate (Mao, 2008). A bi-directional mapping procedure was used, starting out from both sources (Franklin, Jacobs, Tchervakov, & Beland, 2002), to strengthen the search for meaning across terms used and possible terms available.

The ICNP uses a multiaxial design, where the formation of relevant and useful concepts for nursing practices is facilitated through a combination of terms from several axes (Coenen, 2003). The focus axis, a required semantic element of a nursing diagnosis, provided the main entity for the mapping. The reason for choosing this axis is that the health assets approach embraces health assets as the focus of care for wellness outcomes. The health assets category, “mobilization of control”, conceptually involves an action element and therefore the action axis

was included as entity in these cases. Similarities were described accordingly to the following coding rules, previously used by Zielstorff (2003) and by Park and colleagues (Park, Lu, Konicek, & Delaney, 2007):

- A complete match is defined as the exact wording of the same term, a term that is conceptually the same but uses synonyms, or a combination of ICNP terms that express the concept.
- A partial match occurs when an ICNP term or combination of terms describe only parts of a health assets concept, or if the ICNP expression is either more precise (lower level/narrower expression), more abstract (higher level/broader expression), or uses similar but not synonymous terms. A mapping is also considered a partial match if a combination, including terms from an axis other than the focus axis, is used. The health assets category mobilization of control conceptually involves an action element and therefore both focus axis and action axis could give a complete match.
- No match is given if a health assets term cannot be found in the ICNP.

3.0. Methodological considerations: Trustworthiness

Trustworthiness is a scientific aim used to increase the credibility and legitimacy of qualitative research and which parallels the standards of reliability and validity in quantitative research (Polit & Beck, 2008). Trustworthiness is the most used criterion, regarded as a gold standard for qualitative research, and it includes the criteria of credibility, dependability, confirmability, and transferability (Guba & Lincoln, 1989). Hence, trustworthiness will be used in further discussion about the quality and integrity of this dissertation. The quality and integrity of this work were planned and considered throughout the project. In general, identifying, defining, and refining a concept may contribute to strengthen the trustworthiness of later research on the phenomenon (Morse, Hupcey, Mitcham, & Lenz, 1996). However, the steps made in defining and refining the concept also needs to be considered in terms of trustworthiness.

3.1. Credibility

Credibility is considered a primary valid criterion for qualitative research (Polit & Beck, 2008), and it parallels internal validity in quantitative research (Patton, 2002). To establish credibility and generate confidence in the truth and interpretation of the data, several considerations and safeguards were carried out. The process of collecting and analyzing data was a systematic process that was planned and followed thoroughly, and each new step or redirection was thoroughly discussed and agreed upon in the research team. One important part of this first step was to plan for sufficient time to collect and analyze data to be able to gain in-depth understanding. The focus group interviews were therefore planned to last up to two hours. In Study I, more information may have been provided if the full text had been available for the unobtainable documents that were excluded and the papers for which abstracts only were included in the concept analysis. In the unpublished study, more patient records would have given added depth to the nurses' documentation of health assets. More breadth may have been reached if records had been collected from more hospitals and also home-based care. In Studies II and III, breadth of the sample was aimed for by having nurses and patients represented in several groups from various contexts (various institutions and units, phases of the illness, and diagnoses). The time limit made it impossible to extend the studies. Comprehensive notes, audio taping, and verbatim transcribing enhanced credibility, while we strove for credibility in

data coding and analysis by rigorous transcription, debriefing between moderator and co-moderator, co-coding and auditing with experienced peers and researchers. Additionally, considerations and safeguards of credibility were conducted through the credibility of the researcher and triangulation.

3.1.1. Credibility of the researcher

Credibility of the researcher, “the instrument” of qualitative studies, is dependent on his or her preconceptions (described in 2.1.), and how he or she gained access to the research fields (described in 2.2.). The presence of a researcher and a research issue may cause a halo effect or an “instrumentation” effect. The researcher might influence the group interaction in focus groups, and therefore in Studies II and III this researcher took a more reserved position as a moderator, supported collaboration between participants, and ensured that everyone’s voice was heard. In order to reduce the halo effect, the participants were told that the researcher wished to hear their views and experiences of health assets, and that this knowledge was unknown to the researcher. It was highlighted that no answer was wrong or right, but rather the aim was to understand various experiences and thoughts about health assets. In one of the focus groups, the nurses knew the researcher professionally, and this could have affected their response and discussions, both positively and negatively. The conversation flow in all groups was easy and natural, and disagreements were raised, indicating free and honest discussions. Critical self reflection to avoid subjectivity bias was an ongoing activity of the researcher throughout the data collection and analyses.

3.1.2. Triangulation

Triangulation may be parallel to convergent validation in quantitative research (Polit & Beck, 2008). Triangulation reduces the biases from a single method or a single researcher, and enhances the credibility of the study by using multiple data sources, multiple methods of data collection and analyses, and multiple researchers. Triangulation contributes to a more comprehensive understanding of a concept like health assets (Polit & Beck, 2008). Various triangulation techniques were used in this dissertation and are described in Table 3.

We looked for contrasts and contradictions in the decisions and interpretations, and discussed the relevance of the findings related to the health assets focus. The search and selection strategy for the concept analysis was repeated and controlled numerous times through both analyses and writing. This approach was considered a thorough self-validation.

Table 3. Characteristics of the different triangulations across the studies.

	Data triangulation	Method triangulation	Investigator triangulation
Description (Polit & Beck, 2008)	Using multiple data sources.	Using multiple methods of data collection and analysis.	Using two or more researchers to make data collection, coding and analytic decisions.
Contents of triangulation in the studies	<p>A) Collecting data from a <u>variety of people and perspectives</u>:</p> <ul style="list-style-type: none"> theory/literature of health assets patients' and nurses' experiences ICNP–nursing terminology system. <p>B) Space triangulation – data on health assets were collected at <u>multiple sites</u> (focus group interviews):</p> <ul style="list-style-type: none"> four units of two university hospitals, 	<p>A) Methods used for <u>data collection</u>:</p> <ul style="list-style-type: none"> literature review of health assets and related concepts focus group interviews documents in patients records. <p>B) Qualitative methods for <u>analyzing data</u>:</p> <ul style="list-style-type: none"> concept analysis thematic analysis content analysis cross-mapping conceptual correspondence or match between health assets model 	<p>A) In most studies, decisions about data collection, coding and analyses were discussed with two peer researchers (except Study I and the unpublished study) and two expert researchers (three experts in Study I).</p> <p>B) Two coders independently analyzed the patient records of the study exploring health assets in nursing documentation of cancer care (unpublished study).</p> <p>C) Three coders independently coded and analyzed the match of meaning in the mapping study (Study IV).</p> <p>D) A partial audit was undertaken at the end of the analysis with an expert researcher</p>

	including both inpatient and outpatient clinics <ul style="list-style-type: none"> one cancer organization, with four patient support groups from various districts in southeast Norway. 	and the ICNP–nursing terminology system.	(three researchers in Study I).
Aims (Polit & Beck, 2008)	<p>A) Validation of conclusions /findings of health assets through multiple perspectives of health assets.</p> <p>B) Looking for consistency across sites.</p>	<p>A) Evaluate the internal consistency of health assets (Patton, 2002).</p> <p>B) Minimize the weaknesses of single source and approach with strengths of each method (Patton, 2002).</p> <p>C) Provide a more complete picture and understanding of health assets.</p>	<p>A) Reduce possibilities of biased decisions and idiosyncratic interpretations of data.</p> <p>B) Enhance the dependability and confirmability of the results.</p>

3.2. Dependability and confirmability

Triangulation is a strategy that also enhances the dependability and confirmability of the dissertation work. Dependability is a criterion that parallels the reliability aspects of stability in quantitative studies, i.e., whether data are stable across time and situations (Polit & Beck, 2008). Confirmability corresponds to objectivity in quantitative studies, i.e., whether the accuracy, relevance, and meaning of data are congruent between two or more people (Polit & Beck, 2008).

Systematic and sequential data collection and analysis procedures were rigorously conducted in all studies, including recording of decisions taken and the steps of coding and analysis. An audit trail was developed and used through the studies, documenting the analytic process, and the focus group interviews were audio taped and transcribed verbatim. One threat to the data quality and bias was a problem occurring at the beginning of one of the interviews. The audio recorder stopped and approximately 30 minutes of the interview was missing from the tape. Details such as key words as expressed by the nurses and possible quotations were therefore missing. However, the co-moderator had taken detailed notes and these were read to the participants at the end of the interview to give them the possibility of adding important information.

The discussions and stories told in the focus group interviews reflect participants' behaviors and thoughts, but they are not necessarily what actually happened in the concrete situations they described. Additionally, there may be a chance that not all important knowledge and thoughts were uncovered, because of the group effects of conformity. Some people do not want to disagree openly with others, e.g., fearing that their view will not be accepted, and the sessions may be dominated by strong and talkative participants. We encouraged various experiences and disagreements, which also characterized the group discussions. These disagreements allowed us to discover that individuality and balancing processes were characteristics of health assets.

Confirmability was further pursued by using quotations from the participants to illustrate the findings and keeping the naming of the themes as close to the data as possible.

Transcripts were written down precisely word for word from the participants' statements in the focus groups (including, for example, the use of dialect) in order to enhance dependability and

confirmability. Expressions of emotion were noted when obvious, and nonverbal communication was noted during the interviews to validate the interpretation. The transcripts were checked by listening to the audio tapes a second time while reading them. Furthermore, other experienced peer researchers co-coded and partially audited the analysis to enhance the dependability and confirmability of the findings (see Table 3). The methods are further described in each study article.

To minimize possible biases of translation between Norwegian and English (and *vice versa*), themes and quotations were translated by a bilingual Norwegian–English-speaking person. Central issues were checked with Norwegian–English and English dictionaries to ensure we captured the intended meaning of an expression. Additionally, in Study IV, health assets were mapped with ICNP terms and concepts to enhance the confirmability. A bilingual browser and translation tool consisting of ICNP terms and concepts, including descriptions of terms in both Norwegian and English, was used. A final control and discussion was conducted with the advisers, who were both fluent in both languages, and a native English-speaking professional editor.

3.3. Transferability

Transferability involves the extent to which the findings can be transferred to or be applicable in other settings or groups (Polit & Beck, 2008). It is also called analytic generalization (Kvale & Brinkmann, 2009). Thus, transferability corresponds with generalizability, although a statistical generalization is not intended in qualitative research.

The participants and the contexts of the studies were richly described in terms of demographic data, in order to help readers to judge transferability. The experiences and processes observed throughout the interviews were described. These detailed descriptions may strengthen the transferability of the findings to similar settings and patients.

The extent of overlapping findings across these groups and studies, and the breadth and depth of data indicated the data were rich and sufficient to allow good understanding of health assets. Transferability of the themes and subthemes is limited to other cancer contexts with adults and Caucasian populations.

The conceptual attributes of health assets may be similar and may be applicable or appropriate for situations other than cancer care, and thus can be expected to be transferable to other contexts and significant for an international audience. Moreover, the finding of themes of health assets based on the studies within a cancer care perspective may be transferable under similar contexts, in line with qualitative, naturalistic inquiry (Patton, 2002). More research using different methods is needed to learn more about, explain, and develop the health assets of a larger population of cancer patients with different diagnoses, ages, genders, illness stages, and socioeconomic backgrounds.

To conclude, despite some limitations of the methods used in this dissertation, the multiple research approaches provided depth and breadth of data. The quality and integrity of the studies contributed to trustworthy and important new knowledge, and thus provides a solid contribution for further research into health assets.

4.0. Ethical considerations

Approval for the studies in this dissertation was obtained from the Regional Committee for Medical Research Ethics (REK) (reference number 6.2008.225), from the Data Inspectorate (personvernombud) (08/939), and from the protocol committee (protokollutvalget) at Radiumhospitalet (protokollutvalgsnr, 2006–33).

Informed consent was obtained from the participants in the focus group interviews following a verbal description stating the purpose, nature, risks and benefits of the study. Participation in the focus groups was voluntary, and no incentives were offered. The participants (nurses/patients) were given a copy of the consent form to keep.

The studies did not include any expected physical risk or harm. Some questions were considered as potentially personal, e.g., about spirituality, and were considered carefully. Possible inconvenience for the participants, e.g., the time spent in focus groups, may have outweighed the potential benefits for them. The benefits of participation may have included that focus group interviews empowered the participants, provided increased attention, awareness of, and participation in health assets.

Confidentiality was ensured by use of a preassigned sequential record number for the patient records, by de-identifying the data and ensuring the presentation of results did not contain any personal, identifiable information. Data were stored on a secure server while the other materials (tapes and signed consent forms) were kept in a locked file cabinet at Oslo University Hospital. All data sets and disks will be stored for 5 years after completion of the doctoral study.

5.0. Main findings of each study in the dissertation

In the following, a summary of the main results of each study in the dissertation is presented. The journal articles describe the studies in more detail.

5.1. Health assets: a concept analysis (Study I)

The purpose of this study was to examine the concept of health assets, including its underlying attributes, antecedents, consequences, and relationships, and its evolution in a health care and nursing context. Data were collected from relevant literature from various health care domains including but not limited to nursing, medicine, psychology, psychiatry, public health, and social/behavioral sciences. Rodgers' evolutionary concept analysis method was used.

A result of the concept analysis (Study I) was a preliminary definition of health assets:

“the repertoire of potentials—internal and external strength qualities of the individual, both innate and acquired—that mobilize power and control toward positive health behaviors and optimal health/wellness outcomes.”

In later works from the WHO health assets have been defined in a public health context as

“any factor (or resource), which enhances the ability of individuals, groups, communities, populations, social systems and/or institutions to maintain or sustain health and well-being and to help to reduce health inequities.” (Morgan & Ziglio, 2007, p. 18).

The differences between these definitions show their overlapping perspectives; the definition obtained from the concept analysis is based on analysis across health care professions, and is an individual perspective (related to the nursing perspective). The WHO definition is based on a public health perspective, including individual, groups, communities, populations, social systems, and institutions.

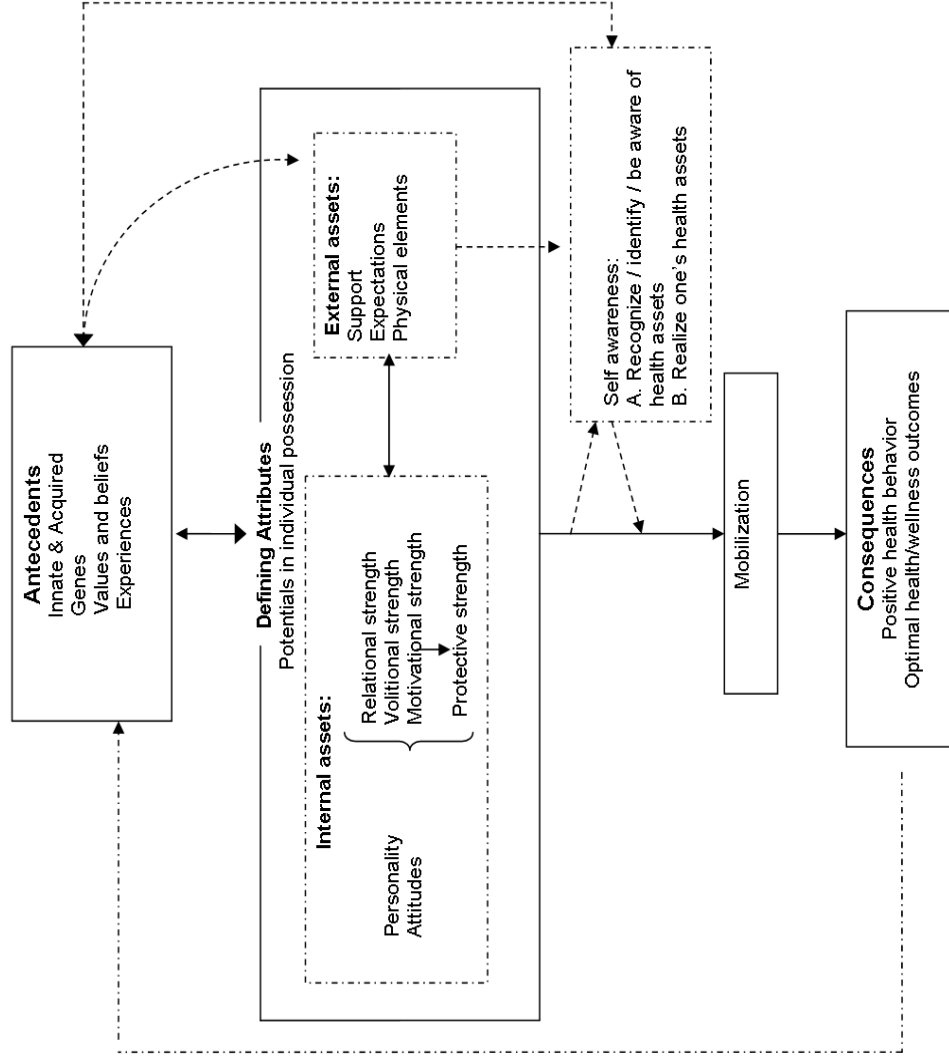
Another result of this analysis was the initial conceptual model for health assets, depicted in Figure 1. This figure depicts the concept diagrammatically to enhance understanding of the concept.

5.1.1. The initial conceptual model of health assets

The concept analysis described health assets as both innate and acquired, and based on the antecedent genes, values and beliefs, and previous experiences, that form and develop a person's health assets. Genes, or heredity, determine particular characteristics and personality and hence, a person's possibilities. How these possibilities are manifested depends on the environment and conditions for living. Internal health assets can be built, strengthened, and maximized through the integration of new life experiences, and are affected by values and beliefs from relational or cultural experiences with family, school, peers, and community. The defining attributes describe the characteristics of the concept or phenomenon and make it possible to identify it (Rodgers, 2000). Attributes of health assets include both internal and external components. Internal health assets are positive strengths inherent in a person and expressed through one's personality and attitudes, and include relational, motivational, volitional, and protective strengths. Examples of internal health assets described in the literature are optimism, good mood, hope, will, and goal directedness. The development of internal assets depends on external assets. The external assets that were identified are support and expectations from the person's social and cultural context such as family, neighborhood and institutions and in one's physical environment. All strength dimensions of health assets can be catalysts for mobilization, that lead an individual to take action, engage or change. This mobilization may include, for example, developing, getting involved in activities e.g., leisure pastimes, or adapting. Self awareness, identified as a moderator for mobilization, includes recognition, identification, self perception, and realization of oneself and one's own capacities. Mobilization of health assets may happen without the person being aware of it, but with self awareness, the person can more easily utilize his or her health assets and get into a position of readiness for action (e.g., fighting the illness or adapting to the situation). Mobilization can instigate positive health behaviors that in turn can lead to optimal health/wellness outcomes as consequences of health assets.

Further understanding and studies of the antecedents and consequences rely on knowledge of the attributes of the concept. More knowledge is needed to conceptualize health assets further. Therefore, the attributes and characteristics that are needed to be able to identify health assets were the primary focus in the subsequent empirical studies.

Figure 1. Conceptual model of health assets.



5.2. Cancer patients' experiences of their personal strengths through illness and recovery (Study II)

The health assets concept was not part of the normal discourse of clinical care for nurses or lay people in Norway. Therefore, it was decided to use the term “personal strengths” to represent the internal and external strength qualities that provided the central attributes of health assets as defined in Study I.

The purpose of this study was to explore and describe cancer patients' and survivors' experiences and perceptions of the strengths used or desired through their illness and recovery. Focus group interviews were carried out based on Krueger and Casey's method (2000) with a purposive sample of cancer patients, all enrolled in NCS's patient support groups. The 26 participants comprised two breast cancer groups, one prostate cancer group, and one lymphoma/leukemia group. A qualitative thematic analysis was used.

The cancer patients had a large repertoire of strengths they possessed, used, or said they could have used to help them live through the illness and recovery. Seven overall themes and 12 subthemes emerged from the data (Table 4). These themes and subthemes describe and extend the health assets attributes, both internal and external. Some of these themes overlapped with the findings from the concept analysis, while others were new and added more concrete themes.

Table 4. Themes and subthemes that emerged from focus groups with cancer patients.

Themes	Subthemes		
Good mood	Feeling useful, valuable, and at ease with oneself.		
Mindfulness	Positive thinking.	Self awareness: It's up to me.	
Positive relationships	Confidence and trust in health care providers.	Feeling seen and heard by health care providers.	Fellowship with peers.
Hopes and beliefs¹			
Protection	Self protection.	Protecting family and friends	
Will power	Being goal-oriented.		
Taking action and control	Being vigorous.	Asserting oneself.	Prioritizing/deciding.

¹ No subthemes of hopes and beliefs

An important finding from the patients' perspective was that they perceived that the care providers seemed unaware of, and did not ask for, discuss, or build their care on the strengths that the cancer patients possessed. Patients wished that care providers would appreciate and encourage them to use their strengths. They expressed that they themselves had much to contribute in their own care, they preferred a more active role in their care than they actually had, and requested more teamwork with their care providers.

5.3. Nurses' perceptions, experiences, and uses of patient health assets in oncology care (Study III)

The purpose of this study was to explore and describe from the perspective of nurses, their perceptions and experiences of patients' health assets in the context of cancer care. Data were collected in focus group interviews based on Krueger and Casey's method (2000). Five focus group interviews with a purposive sample of 26 expert nurses in oncology care were conducted. An inductive analysis of the interview transcripts was used to uncover the nurses' perceptions and experiences of health assets in general, that were then examined in the context of the five core dimensions of health assets as identified in the concept analysis: relational, motivational, volitional, protective strength, and mobilization. Finally, a thematic analysis of the nurses' discussions and reflections was undertaken inductively without the constraints of using the labels for strength dimensions from the concept analysis.

The findings from the nurses' general view of health assets revealed that the concept was unfamiliar. Through discussions and reflection, they expanded their understanding and the meaning of this phenomenon as something valuable and protective in the patient. The health assets concept drove their attention to the person, not the patient, as taking control and being engaged in their own health care instead of being the passive receiver of health care.

Based on the thematic analysis, three new core dimensions emerged from the nurses' focus groups: emotional, cognitive, and physical strength. Additionally, mobilization, which in the concept analysis study acted as a mediator between the attributes and consequences of health assets (Study I), was expanded with new themes and reformulated into mobilization of action and control. Mobilization was now recognized as an attribute. The themes and dimensions are described in Table 5.

Table 5. Dimensions and themes of cancer patients' health assets as experienced and perceived by nurses.

Core dimensions of health assets	Themes		
Cognitive strength	Acceptance. ²	Awareness.	Positive thinking.
Emotional strength	Feeling valuable.	Calmness (tranquility) ¹	Good mood and optimism.
Physical strength	In good shape.		
Volitional strength	Will to live.	Endurance	Courage.
Motivational strength	Hope.	Something to look forward to.	Predictability.
Relational strength	Trust.	Values and beliefs.	Openness. ¹
Protective strength	Self protection. ²	Protection of family and friends. ²	Physical protection. ²
Mobilization of action and control	Being vigorous and participating ² in treatment and care.	Living an ordinary and meaningful daily life.	

¹ Themes only raised in the open discussion.

² Themes only raised in the focused discussions.

Additionally, two overriding themes across all dimensions were revealed. First, health assets exist in *balancing processes*, there seems to be a movement or process within and among health assets. Second, *individual and contextual variations* are characteristics of health assets. This means that health assets are not in a steady state, but strength is derived from balancing different health assets against one other, or balancing within a single health asset. Health assets also vary depending on the individual, passage of time, culture, and context or situation.

Furthermore, although nurses in the focus groups considered a health assets perspective important, many nurses discovered that their identification, encouragement, and support of patients' health assets often was overshadowed by task- and problem-oriented care. Nurses identified lack of time, hospital policy and management as major obstacles and requested clinical

support that could encourage them to utilize (identify, encourage and support), and document patients' health assets. The nurses' perceptions and experience contributed more depth and detail to the health assets concept, and extended the understanding and knowledge base of health assets.

5.4. Health assets in nurses' documentation of cancer care (unpublished study)

The purpose of this study was to explore and describe nurses' documentation of health assets in cancer patients' records. A qualitative content analysis was conducted to analyze retrospectively the uses of health assets terms in documented nursing oncology care, building on Hsieh and Shannon's (2005) descriptions of qualitative content analysis approaches. Because this work is not yet published, a more comprehensive presentation of the results is provided here.

The 142 entries in the 43 patient records contained 177 health assets terms (some entries had more than one asset). This represents a mean of 3.2 health assets in each patient record. Of the 142 health asset entries, 89 (61%) quoted the patient, i.e., "*The patient says/expresses/wishes to...*". The findings in this study were similar to the findings from the nurses' focus groups. All themes related to health assets found in the nurses' focus groups were also found in the documentation of cancer care, except for the findings *courage*, *values and beliefs*, and *feeling valuable* that were only found in the focus groups. *Self protection* was not expressed directly in the material, but could be identified as an underlying message.

The largest proportion (49%) of health assets was described as background information in the admission notes, such as "*The patient is motivated for the new cytostatic treatment*" (motivational strength). Some health assets were mentioned in status reports (25%), such as "*The patient feels that he has received good information and has a good knowledge/understanding of the treatment after the information today. [He] is realistic*" (relational strength). No care plan or other information reflected an intended use or follow-up of the health assets. The distribution of the health assets in the patient records is summarized in Table 6.

Table 6. Health assets findings from nurses' documentation in the admission note or status report in the cancer patient records.

Health assets	Terms n	%	Example from the nurses' documentation
Relational strength	52	29.4	<ul style="list-style-type: none"> Says that the children are handling the illness of their father well, they have an open relationship and have talked a lot about the illness. She has told us what is required so she can trust the hospital unit.
Motivational strength	36	20.4	<ul style="list-style-type: none"> She is hoping that she will live until her son is grown up, because he is better qualified to manage on his own then. Says he is surprised over how calm he is. He believes he is prepared without being aware of it.
Volitional strength	9	5.1	<ul style="list-style-type: none"> Says that he is ready to fight and wants to survive. Manages to eat and drink despite the problems.
Protective strength	4	2.3	<ul style="list-style-type: none"> Says she has a great deal of gallows humor about her own situation. Is a bit worried for his wife, and he believes she is exhausted. I encouraged him to try to get some time together during the vacation and supported him to make appointment with her physician so she could take sick leave.
Mobilization	76	43	<ul style="list-style-type: none"> He brought the Fragmin with him and wanted to take responsibility for this medication himself. At his last hospitalization, there was a lot of hassle about how much food he had to eat. This made him tired and resigned. He wants to control this himself. The patient says that except for the tough days after the chemotherapy he lives like before; staying active, renovating the house, fixing the car, and so on.
Total	177	100	

5.5. Patient-centeredness in terminologies: coverage of health assets concept in the International Classification for Nursing Practice (Study IV)

The purpose of this study was to explore and describe the representation of health assets in the ICNP Version 2.0., and evaluate the suitability of ICNP to support documentation of health assets.

A manual conceptual cross-mapping was conducted between the health assets findings and the ICNP.

Of the 76 health assets concepts/terms, 33 were completely represented in the ICNP. The results of the mapping between ICNP and health assets terms/concepts are presented in Table 7, while further details are attached in Appendix V. A complete match describes terms that were conceptually the same, while a partial match occurred when an ICNP term or combination of terms only described parts of a health assets concept. No match occurs if a health assets term could not be found in the ICNP.

Table 7. Results of mapping between the health assets findings and the ICNP Version 2.0.

Health assets	Complete match	Partial match	No match
Relational strength	14/27	9/27	4/27
Motivational strength	4/13	5/13	4/13
Volitional strength	3/11	2/11	6/11
Protective strength	4/7	3/7	0/7
Mobilization	7/18	11/18	0/18
Total	33/76 (43%)	30/76 (39%)	14/76 (18%)

*The total number of 76 health assets terms is based on five themes (the strength and mobilization attributes), 19 categories, and 52 subcategories.

A number of ICNP terms reflected the objectivity of the clinician's perspective rather than the patient's strength perspective, such as labile personality (but not good mood), lack of trust or low trust (but not trust). The health assets model and the ICNP had a reciprocal relationship and informed each other.

Ideally, this study would have been built on a better foundation if it had been conducted after the final step of the analysis of focus group interviews of nurses and the analysis of focus group

interviews with patients. Therefore, new mapping of the end results from these empirical studies was conducted and followed the same procedure as described for the main mapping study. The additional findings from the analysis of focus groups of patients and nurses provided 16 new themes and dimensions that were not in the published paper. The result of the mapping of these themes with ICNP is described in the following paragraphs, and displayed in Tables 8 and 9.

The mapping of the additional findings from the end results of the empirical studies showed that six themes had full match, nine themes had partially match, while one theme could not be mapped with ICNP (see details in Table 8).

Table 8. Results of the mapping between additional themes (terms) of health assets from the empirical studies and ICNP Version 2.0.

Health asset (HA) concept and terms	ICNP term	ICNP parent term	Closest match/alternative in ICNP	Match between HA and ICNP
Cognitive strength	Cognition [10004485] + effective [10014956].	Psychological process [10015961] + Positive judgment [10010981].		Complete match.
Positive thinking	Positive cognition [10028351].	Positive process [10014918]+ Cognition [10004485].		Complete match.
Positive relationships	Positive status [10014960] + Relationship	Status [10018793]+ Diagnostic and outcomes phenomenon[10005895]		Complete match.
Taking action and control	Patient activity[10014145] + Self-control [10017690].	Action [10000386] + volition [10020855].		Complete match.
Prioritizing and deciding	Prioritizing [10015736] + Effective decision making [10028731].	Planning [10014648] + Positive cognition [10028351] + Decision making process [10005594].		Complete match.
Emotional strength	Emotion [10006765] +	Psychological process [10015961] + Positive		Complete match.

	Effective [10014956].	judgment [10010981].		
Asserting oneself	Assertive behavior [10002660].	Behavior [10003217].		Partial match.
Mindfulness	Mindful.		Self-awareness [10029446]	Partial match
In good shape	In shape.		Physical well-being [10014514].	Partial match.
Predictability	Predictability (predictable). Expectability.		Expectation [10023679].	Partial match.
Feeling seen and heard by health care providers	Attentiveness. Notice (being noticed). Show interest.		Care provider role [10003991] + Attention [10002924].	Partial match.
In good shape			Physical well-being [10014514].	Partial match.
Feeling valuable			Dignity [10005979] + Emotion[10006765].	Partial match.
Feeling at ease with oneself			Comfortable [10025574].	Partial match.
Fellowship with peers	Friendship. Partnership. Companionship.		Social cohesion [10018362]	Partial match.
Feeling useful	Helpful.			No match.

Compared with the published findings of the mapping study, these additional themes and subthemes from the final results for the focus groups of nurses and patients resulted in approximately the same percentage of matching with ICNP. The lack of match decreased from 18% to 16%, while partial match increased from 39% to 42 %. There was a slightly decrease in complete match from 43% to 42% (Table 9). Thus, the addition of health assets terms provided almost the same final results.

Table 9. Match of health assets to ICNP comparing results from Study IV with updated results including themes from nurses' focus group interviews (Study III) and patients' focus group interviews (Study II).

	Findings of Study IV n (%)	Updated findings including themes from Studies II and III n (%)
Complete match	33/76 (43%)	39/92 (42%)
Partial match	30/76 (39%)	39/92 (42%)
No match	14/76 (18%)	15/92 (16%)

6.0. Synthesis of the studies

A qualitative synthesis was carried out to aggregate the findings across the studies to gain in-depth understanding of the health assets concept. Syntheses of findings across studies are useful because they may develop conceptual understanding, conceptual models and clinical practice, and can be used for developing nursing terminologies/standards (Rodgers, 2000).

The synthesis of the studies with multiprofessional perspectives in the concept analysis (Study I) resulted in an initial definition and conceptual model of health assets with defining attributes, antecedents and consequences. These findings were confirmed and further developed based on data from the four subsequent studies and represented verbal and formal perspectives of nurses and patients' perspectives (Studies II, III, IV, and unpublished study).

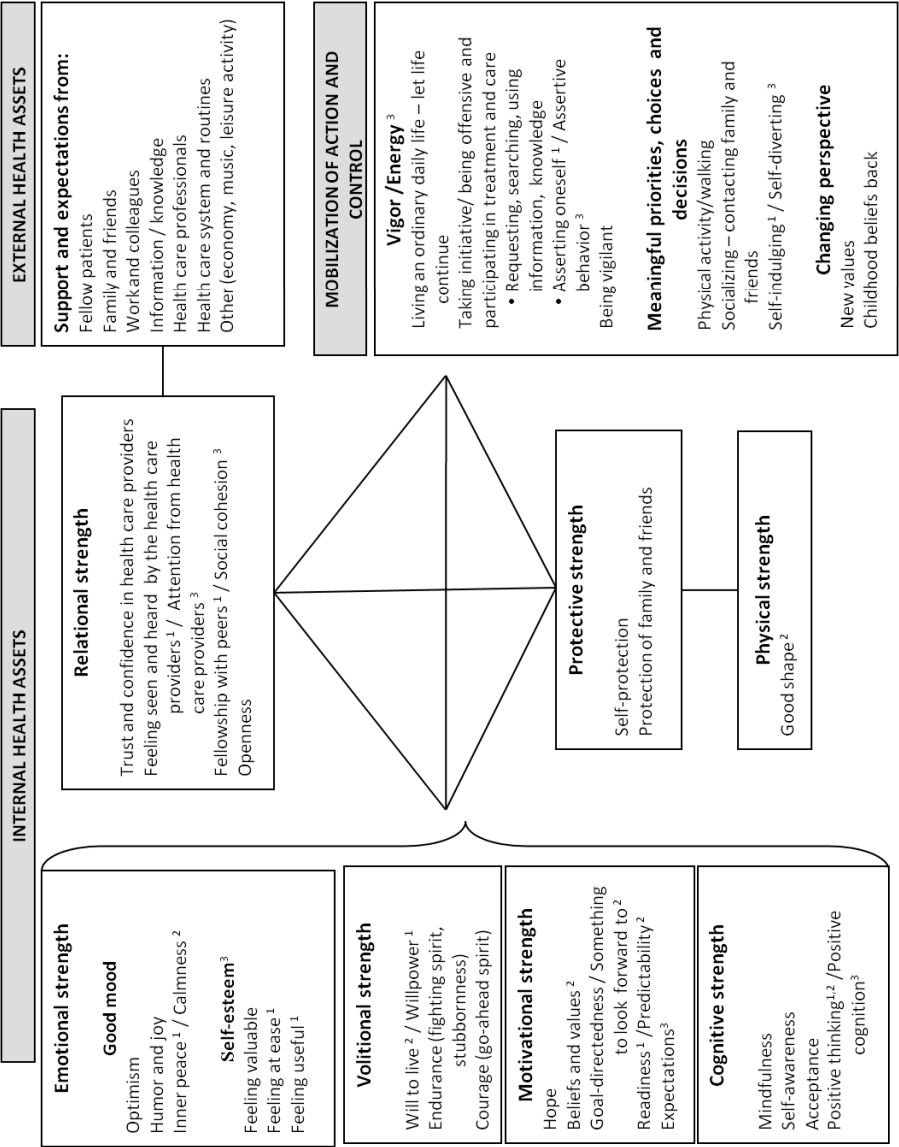
6.1. Expanded and refined definition and conceptual model of health assets

The findings across all studies contributed to identifying additional characteristics of the health assets concept; this included an understanding of health assets as a balancing process, influenced by individual, contextual and time variations, and mobilization as a strength that encompasses action and control and identified as an attribute. Hence, the definition of health assets was reformulated based on these additions:

“Health assets are the repertoire of balancing potentials—internal and external strength qualities of the individual, both innate and acquired, influenced by preferences and contexts — that mobilize action and control toward positive health behaviors and optimal health/ wellness outcomes.”

Compared with the initial model identified in the first study, the model was substantiated and refined and now includes three new strength dimensions: emotional, cognitive, and physical strength; and new themes of health assets related to the strength dimensions. The refined conceptual model is depicted in Figure 2.

Figure 2. The substantiated and refined model of health assets.



¹ Expressions from the patients' experiences. ² Expressions from the nurses' experiences. ³ Term/concept from ICNP.

Some of the strength dimensions in the initial conceptual model were reconceptualized in the refined model. Self awareness, which in the first model was described as a moderator between internal health assets and mobilization, was considered to be a cognitive strength after the empirical studies. Moreover, the concept analysis provided information that made us ponder about whether relational and protective strength had a more central position than the other strengths in the conceptual model (Paper I). The synthesis revealed that protective and relational strengths were central health assets balancing with other strengths and moderating the mobilization of patients' health assets. Therefore, these two strength dimensions were given a central position in the revised model.

The development and utilization of internal assets appears to be influenced by external assets, as described in the concept analysis (Study I) and as found in this synthesis. External health assets were described in the concept analysis study as one's social and cultural context and support, such as family, neighborhood, institutions, and physical environment (Study I). The synthesis of the studies revealed that health care providers and systems, together with fellow patients, were important external health assets. The cancer patients' work and colleagues, nature and everyday activities were also described as important external health assets.

The antecedents and consequences of health assets found in the concept analysis (Study I) are not depicted in the revised model. Antecedents are the precursors, or episodes, that must take place before the concept occurs, while consequences are the outcomes of the occurrence of the concept (Walker & Avant, 2005). These conceptual elements, including a focus on the relationships between the attributes and the antecedents or consequences, would have required a more advanced study and was considered to be too extensive for this dissertation work. The concept of health assets and its attributes was also considered too immature in a nursing context to conduct such studies. Therefore, the empirical studies in this dissertation work focused on the attributes of health assets, and on revising and substantiating these attributes.

6.1.1. Relational strength

In the concept analysis study, relational strength was revealed as a central attribute of health assets and was described as social, cultural, and/or spiritual connectedness, belonging and having bonds, and as a sense of close, empathetic, supporting, and/or positive relationships, where trust was a core quality (Study I). The relational strengths were often described in the context of family and friends. In the study of cancer patients' and survivors' perceptions and experiences other important relational strengths that were found were *confidence and trust in health care providers* and *being seen and acknowledged by health care providers*, together with *fellowship with peer patients* (Study II). Nurses also described *trust* and *close interactions*, but they perceived that close interactions were related to *family, friends, and network* as important health assets in patients (Study III).

6.1.2. Protective strength

In the literature, health assets were described as a buffer or prevention against challenges or undesired health aspects, and the more health assets a person possessed the stronger the protection (Study I). In the focus groups of both patients and nurses, protective strength was described as an active process of *self protection* and *protection of family and friends*. Both patients and nurses talked about distancing oneself from information as positive self protection. Patients described protective strengths more extensively, i.e., using humor, withdrawal from others, focusing on everyday life, and putting the illness in the background. They also described protection of family and friends in terms of holding back information about the illness, as well as their feelings and thoughts. However, the nurses questioned whether protection of family was a health asset because some had experienced that patients used too much energy in protecting their loved ones, even though they realized that patients themselves might find this to be a strength. Protecting fellow patients was also often described strength by the patients. Protecting or taking care of their partner and family was also an issue documented by nurses in the records as a health asset.

6.1.3. Emotional strength

Emotional strength was not identified in the concept analysis, but emerged in the analyses of nurses' experiences of cancer patients' health assets. The three themes of emotional strength were *feeling valuable*, *calmness*, and *good mood and optimism*. Furthermore, the characteristic of the patient as being positive and optimistic was frequently documented. The patients talked about and demonstrated *good mood* and of *feeling valuable*. They also described *feeling at ease* and *feeling useful* as strengths, which together with *feeling valuable* was interpreted as *self esteem*.

Revising the findings from the content analysis of the patient records in this synthesis revealed that some of the health assets documented by nurses could be better placed within the new dimensions of strengths as had evolved through the other studies and the synthesis. An example of emotional strength was: "*Says that she is not afraid of what is going to happen.*"

6.1.4. Volitional strength

Volitional strength was described in the concept analysis and in nurses' and patients' focus groups. The concept analysis of health assets described a wish or desire with regard to determination and commitment to worthy goals (Study I). Patients and nurses both described the will to live as fighting spirit and go-ahead spirit. Endurance was discussed and described well by the nurses, and while it was not described by the patients, it was demonstrated through their stories. Patients talked about willpower in terms of stubbornness and being tough, while nurses talked about patients' courage as a health asset. In the nurses' documentation of health care willpower was indicated related to being active and managing to eat and drink despite the consequences/symptoms of the cancer illness.

6.1.5. Motivational strength

Motivational strength was identified in the concept analysis as a desire for investment in or belief about the future, a wish to learn and integrate knowledge and to find purpose in a challenging situation (Study I). The nurses described motivational strength as a health asset, often as a general drive or zest, but also more concretely described as hope, and having something to look forward

to. The latter was more concretely described by patients and survivors as being goal-oriented. Both talked about hope as a central health asset. Additionally the nurses discussed predictability, i.e., being prepared for treatment and possible negative outcomes. A novel finding from some of the nurses' experiences, probably based on health care providers' explanations, was that patients sometimes described infection as confirming that the treatment was working and thus giving them hope and motivation. Having plans for the future was a health asset documented mostly within this strength dimension.

6.1.6. Cognitive strength

Cognitive competencies have been mentioned in previous health assets studies, but did not provide enough information to be included as a strength dimension in the initial health assets model. However, additional understanding and new themes from the empirical material contributed to the evolution of cognitive strength as an added core dimension of health assets. Cognitive strength, also conceptualized as *mindfulness*, became more prominent especially in the nurses' focus groups, but it was also described in the patient groups. Cognitive strength consisted of *acceptance*, *positive thinking*, and *vigilance towards health care providers*. Acceptance was described by nurses as patients' acceptance of their cancer and its consequences, including whether they accepted help/relief from others and how they reconciled with their new reality. Patients talked about realizing the possibility of death, but despite this realization, hope and belief were considered to be important. Mindfulness, understood as bearing in mind, being regardful, attentive, heedful, and/or observant (www.freedictionary.com), was described by many patients. Patients especially described positive thinking and self awareness, often based on heightened self reflection and discovery of their own potentials, values, and responsibilities; a type of strength they often used to hold negative thoughts at bay and to maintain a clear focus. Male patients especially considered it a strength when they managed to remain rational in their thoughts and actions. Nurses also described self awareness e.g., by being conscious about self as a person, not only the illness. Nurses also described positive thinking and focusing, or seeing possibilities, as health assets.

Re-analyzing the findings from the analysis of nurses' documentation of cancer care showed that cognitive strength was documented, e.g., *"Says she has reconciled with the situation and thinks the everyday life works well."*

6.1.7. Mobilization of action and control

In the concept analysis, health assets were uncovered as an empowering force that mobilized positive and meaningful engagement and change (Study I). More details were found in the empirical data. Nurses and patients both described being vigorous as mobilizing health assets. Vigor included becoming active in treatment and care, and in everyday activities. Nurses experienced that most patients wanted to do something to contribute to their own healing and health, and more concretely, the vigor included taking initiative, being responsible and being offensive. Several of the patients' stories reflected the vigor of asserting themselves in the context of health care. Furthermore, patients mobilized action and control by meaningful priorities, choices and decisions. Nurses and patients described physical activity, especially walking, as a meaningful activity and strength. Nurses highlighted social activities with family, friends, and colleagues. Mobilization also included living an ordinary life, although sometimes adjustments were needed. Many female patients prioritized themselves in terms of indulging or rewarding themselves, often including their loved ones, which also provided feelings of ease. Several men described doing things on their own terms and desires, often on their own and not including family or friends. Nurses and patients both described new values as a health asset, indicating the changed perspectives that were being mobilized. Patients also told about childhood beliefs coming back to them through the illness.

6.1.8. Physical strength

Physical strength was described in Schlotfeldt's model of nursing (Glazer & Pressler, 1989), but was not described in the remaining literature on health assets. Therefore, it was not prominent enough to be included in the initial model of health assets. However, the empirical material from the nurses' focus groups showed that several nurses considered cancer patients' physical strength a health asset. Some claimed that being in good shape and having lived an active life helped patients better endure the treatment and its side effects. Yet, physical strength was indicated as

secondary to the internal strengths; patients highlighted the social aspects of physical activity as more important than the exercise itself, and nurses also expressed the importance of internal strengths over physical. Analyzing the findings of nurses' documentation in cancer patient records revealed that physical strength was documented, e.g., *"Does not have the energy to walk long walks, but stays active in other ways. Says he is in good shape."* Therefore, physical strength was added in the revised conceptual model of health assets.

6.1.9. Variations in and balancing processes of health assets

In the initial concept analysis, health assets were seen as a balance against health problems (Study I). Analyses of the empirical data, especially the nurses' stories and their discussions, provided information that revealed two new and different modes of balancing processes: balancing within and between health assets. One nurse expressed this as *"Don't let your strength become your weakness."* In the synthesis, it became clear that the balancing characteristics and the individual, contextual and time variation of health assets were also represented in the patient data. The expression *"finding one's limits"*, may represent balancing one's health assets. A balancing process within health assets means that a health asset may have both negative and positive aspects; i.e., too much or too little of a strength may not be an asset. A necessary balance within a health asset was clearly expressed by this patient who used his willpower, trying to get back to work: *"When I had finished [the treatment] ... I wanted to be back in full employment. But it wasn't that easy and ... I used so much willpower; wanting, wanting, wanting. It took a lot of my energy."* This quotation also indicates that the timing was wrong for using willpower for the desired purpose, and it may also indicate balancing motivation for going back to work with accepting the situation of not being ready yet (acceptance). Another example of a balancing process within a health asset is openness; as indicated by some nurses being too open or not open enough may not be a health asset.

A balancing process between health assets was also found. For example, sometimes holding back, not being open, would be a strength. Holding back (protection) towards family may be necessary to maintain the self and to protect their loved ones. Contextual variations could affect the need to hold back, mostly because others were afraid or had emotional problems because of the cancer illness or the possibility of death:

“... we will not keep this [the cancer illness] a secret,” I said, “so if anyone asks what it is we will tell them.” “That is nonsense,” he said (her husband), “because no one will care about that.” “Oh, just you wait and see” I said.... Then later he came back and said, “you were right; you can certainly see the cross [death] in their eyes when I told them you had cancer. So you are in fact on your way down to the cemetery right now (laughing).”

Another example of variation in health assets was patients’ beliefs. A wide range of beliefs (and doubts) were described by the patients in the focus groups, and were affected by individual preferences (e.g., belief in God, humanism, fatalism, superstition), and context (e.g., Christianity was brought to the consciousness by official flag-flying days or church holidays, and by special parts of the illness course). Belief may also be affected by age (time variation):

“The older you get, the more you experience and see... So, I am open to that there are more things under the sun than I can explain with my own knowledge.”

7.0. Discussion

This dissertation started with a concept analysis of the concept of health assets, resulting in an initial conceptual model and definition. The model was further substantiated based on findings from empirical exploration of patients' and nurses' perspectives of health assets within cancer care. Furthermore, clinical utilization and documentation of health assets and the health assets' representation in the ICNP were examined.

The findings show that the concept of health assets represents the inherent personal strengths and resource perspective that have the potential to mobilize patients towards health and wellness. It also shows that health assets can be better utilized if health care providers and patients become aware of them and support patients in utilizing them.

7.1. Understanding health assets: from an initial model based on literature review to an expanded and revised model based on empirical studies

The initial model of health assets was based on a systematic literature review and concept analysis, and described health assets on a more or less abstract level (Study I). The literature consisted of research and experiences from various health and psychosocial sciences and contexts. Because little research has been conducted about health assets within nursing care or from patients' perspectives, this dissertation substantiates knowledge of health assets in a nursing context, and is the first to analyze and develop a conceptual model of the health assets concept in general. Conceptual models are important because they represent some aspects of reality, a symbolic representation of a conceptualization to facilitate the understanding of abstract concepts (Polit & Beck, 2008). They also constitute a necessary scientific step for a concept to be accepted and used properly (Cowen, 2001). The conceptual model of health assets can assist nurses and health care providers in rethinking their care and developing support systems towards more patient centered care, with a shift of focus from deficits to strengths and wellness.

Qualitative analysis of people's experiences is an important element in the further clarification and development of a concept (Rodgers, 2000). The two empirical studies explored patients' and

nurses' perspectives on health assets in cancer care to extend the understanding and knowledge of the concept. Patients' experiences and perceptions of health assets represented an internal and personal perspective, while nurses who had experience based on observations and communications from many patients, represented an external perspective.

Nurses and patients both described a large repertoire of health assets that overlapped and complemented each other. This is the first study that systematically explores and describes cancer patients' and cancer survivors' health assets, together with nurses' experiences of cancer patients' health assets. For the most part, health assets research has been conducted from a developmental perspective in children and adolescents, or in a public health context, while this dissertation focuses on adult patients' experiences of their strengths in an illness situation. Hence, a more comprehensive repertoire of strengths was revealed, advancing the understanding and definition of the health assets concept in a way that is particularly relevant in cancer care, and which contributes to an elaboration of the health assets model and its representation. The model of health assets was substantiated with new themes and strength dimensions, and new characteristics of the concept.

In addition to the new findings, the empirical studies overlapped the findings in the concept analysis that was mainly based on work in other disciplines. This reinforces the conceptual model and definition of health assets and provides empirical strength and validity to the conceptualization and the model representing it.

7.2. Similarities and differences between health assets and related concepts

Several terms and concepts seem to overlap or be complementary to the health assets concept. Self management has similarities to the health assets mobilization of action and control. Furthermore, in the concept analysis we found that salutogenesis was an associated and underlying theoretical construct of health assets (Study I). Salutogenesis was also found as a precursor for positive psychology (Cowen & Kilmer, 2002), and positive health and salutogenesis are used interchangeably (Ciliers, 2010). Therefore, the main findings of this dissertation will be

further discussed in light of overlapping concepts and approaches, and the importance of health assets.

7.2.1. Self management and health assets

Self management has been central in nursing theories and has been defined as the activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being (Orem, Taylor, & Renpenning, 1995). In recent years, self management, like the health assets concept, has focused on the patient as an active agent of own care and on wellness rather than illness (Lorig & Holman, 2003). An essential focus of self management is the patient's skills and confidence to change and manage his or her health problems (Bodenheimer, 2011; Lorig & Holman, 2003; McCorkle et al., 2011), and to develop skills for health and wellness (Barr et al., 2003). While self management focuses on people's skills and confidence, the health assets concept provides the prerequisites and internal strengths, for mobilizing actions and control, e.g., the skills needed to manage. This may indicate that these two concepts are not overlapping, but are complementary. Action and control in health assets include vigor and energy, meaningful priorities, choices, decisions and actions, and changing perspectives. Within a self management perspective, mobilization of action and an increased responsibility to participate actively in one's own care may enhance positive outcomes of care (Gruman et al., 2010), and taking control over one's life is important in order to live well with long-term illnesses (Koch, Jenkin, & Kralik, 2004). In both the self-management concept and the health assets concept, patients' own mobilization may contribute to positive health outcomes.

The supporting role of health care providers is important for learning and practicing self-management skills (Barr et al., 2003). Support appears to attend to self management, but is not part of the concept. Support is part of the external health assets concept, characterized by affecting a person's internal relational strength and reinforcing mobilization of action and control towards health and wellness. Thus, relational strength is part of the health assets concept as a core dimension. The concepts of health assets and self management therefore appear to complement each other. This may be supported by earlier nursing research that described the importance of resources as part of self-care management (Kirkevold, 2002). Self management may contribute to health assets through the concrete skills needed to manage and feel confident. The health assets

concept may contribute to self management with a more person-centered approach that focuses primarily on the person's existing potentials and strengths.

7.2.2. Positive psychology and salutogenesis

Commonalities with the health assets model may be found in the character strengths and virtues in positive psychology and general resistance resources (GRR) in salutogenesis. In salutogenesis, sense of coherence (SOC) is the vital determinant of health and the capacity to use GRRs (Antonovsky, 1987). It may therefore parallel the health assets components of mobilization of action and control.

Some of the strengths and resources in these two approaches are similar to or overlap those in the health assets model, e.g., openness, bravery, and self control in positive psychology, and the cognitive and emotional phenomena in salutogenesis. Other strengths and resources are different from the health assets model, for example, honesty, gratefulness and discretion in positive psychology, and the biochemical and artifactual material phenomena in salutogenesis. However, the strengths and resources in these concepts are organized differently than in the health assets model.

Using salutogenesis as a framework, many studies have based their research on the salutogenic theory of SOC (Bronikowski & Bronikowska, 2009; Edbom, Malmberg, Lichtenstein, Granlund, & Larsson, 2010; Freire, Hardy, & Sheiham, 2002; Langeland, Wahl, Kristoffersen, Nortvedt, & Hanestad, 2007). An international review concluded that future research required a focus on resources, using qualitative approaches to expand and clarify dimensions of salutogenesis (Eriksson & Lindstrom, 2007). Furthermore, the authors concluded that other concepts were needed to expand the understanding of salutogenesis (Eriksson & Lindstrom, 2007). This doctoral study of health assets may inform salutogenesis on the content and its possible relationships to resources or health assets. The positive psychology and salutogenesis approach may also contribute to further development of the health assets model.

7.3. Utilization of health assets

The application of a concept in clinical practice contributes to further understanding and development of the concept (Rodgers, 2000). This dissertation explored the uses and representations of health assets in clinical practice, documentation, and nursing terminology, and revealed that the patients' health assets were not utilized sufficiently. This is the first study that has explored and described nurses' documentation of health assets in cancer patients' records, and is also the first to evaluate the representation of health assets in a standardized professional nursing vocabulary.

Patients would have preferred to use and receive support for their health assets in a better way, and wanted to contribute to their own care and wellness. The reasons why their health assets were not adequately utilized was also indicated in this work.

Even though the patients in this doctoral study identified positive relationships with health care providers as a needed asset, many described lack of trust in health care providers and health care systems and did not find nurses to be a significant asset to them. Trust is the core of relational strength, and trusting health care providers is important in an illness situation. However, as several patients said, they would have trusted nurses more if they better nourished their relationships with patients and if they used their knowledge better by providing patients with more information and concrete advice independent of physicians. Building trusting relationships has also been described as vital for person-centered care and self management (Hobbs, 2009).

Furthermore, we found that nurses did not build on patients' health assets. At the beginning of the focus group interviews with nurses, most of them found the health assets concept unfamiliar; however, when reflecting on and discussing the concept they found it to be important to nursing. The large repertoire of health assets described by these nurses underscored its importance.

Findings in the nursing documentation also revealed a lack of utilizing cancer patients' health assets as a focus of care (unpublished study). Information about patients' health assets was found, but the information indicated a lack of systematic utilization and follow-up in nursing care. Nurses' care was overshadowed by a task and problem orientation, as shown in both the verbal and written sources. Others have also found that nurses' planning and documentation of care is incomplete and inaccurate (Adamsen & Tewes, 2000; Ehrenberg & Ehnfors, 2001). Furthermore,

nurses identified lack of time, hospital policy, management, and organizational support as major obstacles to optimum health assets utilization in clinical care.

Better clinical support is needed to increase awareness and knowledge in both patients and nurses to improve utilization of health assets, and further research is also needed. Despite its shortcomings, ICNP is a nursing terminology system that partly supports health assets, but it has the potential to do this more extensively. ICNP could include more health assets terms and concepts, together with both professional and lay language terms that represent patients' health assets.

7.4. Implications of health assets and its conceptual model for practice and research

This dissertation elucidated the health assets concept in nursing care, and its importance to patients. Several implications can be drawn from this research.

The patients and nurses in this dissertation had rich experiences and knowledge about health assets. However, this knowledge seems to be untapped and could be made more accessible for clinical use. Nurses have the potential to become more aware of the important role they play in facilitating effective use of patients' strengths. In addition to being professional partners, nurses could take the initiative to coach patients in becoming aware of and using their health assets. However, nurses are not trained for this role and responsibility. Therefore such training could be included in nursing education. In addition to acting on behalf of or for patients, and resolving their problems and deficits, nurses have the potential to nourish patients' health assets and make them better able to use their power, become active and take control of their situation. The conceptual model of health assets may help nurses realize this potential and communicate clearly and demonstrate their support by building trust in their relationships with patients.

Clinical support is needed to make better use of patients' health assets. Previous studies have described how clinical support systems based on patient participation and self assessments are effective in facilitating involvement of cancer patients while contributing to improved communication between patients and providers, and to higher patient satisfaction (Ruland et al., 2010; Stacey, Samant, & Bennett, 2008).

The eHealth strategy of the Norwegian health authorities calls for greater involvement of patients and support for them to mobilize their own resources for improved health outcomes (Helse- og omsorgsdepartementet [Ministry of Health and Care Services], 2009). The development of support systems is in line with the aims of the overall larger project to which this dissertation is linked: “Communication and Information Sharing between Patients and Their Care Providers” (CONNECT). The aims of the CONNECT project, addressed in this doctoral study, were to explore clinicians’ and patients’ needs for documentation and information sharing to support shared decision making, patient-centered care, and illness management. Health assets are important in communication, information sharing and documentation. The health assets model can provide a foundation for nursing and patient education, and for rethinking clinical practice. This doctoral study took the first step in building a shared understanding of a concept, and when this happens, the concept can be represented by explicit language, terminology, and classification systems (Rodgers, 2000). Support systems that build on knowledge about health assets, expressed as a “common language,” may be one solution to bring the concept of health assets to nurses’ attention and for possible clinical implementation and use. ICNP is a promising vocabulary system for use in electronic health records for representing health assets, although it lacks terms and concepts. ICNP is a concept-based nursing terminology system that allows inclusion of synonym expressions for the same conceptual meaning, with the flexibility to include lay terms. Integrating health assets in both professional and lay language may provide better clinical support for patient centered communication, information and documentation of patients’ health assets. More research and development is needed before ICNP can adequately represent health assets. ICNP needs to be enhanced to be clinically useful and provide support for such use.

The findings in this dissertation that health assets involve a balancing process affected by individual, contextual and cultural variations suggest a need for support to be tailored and adapted for each individual. Various tailored communicative interventions are described in the literature, but many are tailored to behavioral change and risk assessment, and it is recommended that information in future needs to be tailored to patients’ personal characteristics (Albada, Ausems, Bensing, & van Dulmen, 2009). Patients’ health assets are examples of personal characteristics. Tailored information can be used to enhance patients’ control by involving them in planning care, especially in self assessment and identifying desired goals of care and self-management activities. Patients’ own resources have been considered important enough to be

included in care plans (McCorkle et al., 2011). It can be assumed that health assets are also important. Tailored communications and shared care plans in electronic health records contribute to coordinated treatment and care, and are thus in line with the political strategies of the collaborative care reform in Norway (Helse- og omsorgsdepartementet [Ministry of Health and Care Services], 2009). Tailored support that includes patients' health assets may strengthen the expected purpose of this reform.

Further research is needed on health assets content, relationships, and strategies, and also in other patient groups and nursing contexts and samples. Important research questions may include how health assets can be implemented into practice and into nursing documentation/care planning. Another interesting and needed focus would be to explore which professional and personal strategies can best support patients in using their health assets to mobilize action and control.

It would be interesting to investigate whether strategies used in approaches building on similar concepts, such as self management, salutogenesis, and positive psychology, provide ideas or could be transferred for the development of strategies within a health assets perspective.

Examples may include communicative and cognitive strategies focusing on internal strengths and assets, such as the empowering dialogues based on salutogenesis (Langeland et al., 2007), integrative health coaching, and cognitive strategies like mindfulness training that may lead the focus away from negative thoughts (Wolever et al., 2011).

By building on the health assets concept, optimal health and wellness and positive health behaviors may be achieved, e.g., mastery, behavioral change, pleasure, and joy. By placing the patient's perspective in the forefront, as promoted and represented with the health assets concept, this dissertation may be an important step in enabling individuals, groups, and society to develop health policy that enables them to attain high quality goals of health and wellness. It would be worthwhile to explore if such outcomes were also associated with lower costs, as indicated in research on self management (Bodenheimer, 2011).

7.5. Limitations and strengths

This dissertation has limitations. The studies are exploratory and descriptive and are based on convenience samples. Thus, findings cannot be generalized to the wider population. However, according to Rodgers (2000), the phenomenon of health assets can be recognized by its defining attributes, and can be validated across various contexts. Moreover, conceptual models can be used to develop theories that explain or describe phenomena as they exist and are rooted in participants' experiences (Rodgers, 2000). Even though a wide range of health assets was described in this dissertation, more research is needed to confirm or expand content, structure and relationship of the elements in the conceptual model of health assets. Relational links are indicated in the model but research is needed to confirm these and to develop relational statements, an essential step of validating the results within and across populations and in hypothesis testing and theory development.

Limitations of the separate studies and considerations on how to meet these were described in Chapter 3. Personal biases and selection of participants may possibly have distorted the responses, and established personal and social values that may have affected the responses are difficult to detect (Polit & Beck, 2008). There are multiple ways of analyzing and interpreting data and findings, and other methods may have detected alternative themes and explanations for health assets to those described in this study.

Other contexts and settings may reveal other health assets, e.g., speaking with nurses in home-based care or community nursing. Among nurses, males and less experienced participants could have provided other information than that obtained from our sample. In addition, the sample of patients or survivors of cancer could have been extended to include younger participants and those with other diagnoses, and less educated participants. Other cultures and countries with different political structures and life conditions that may have an impact on the development and use of health assets should also be studied. However, this would have required more time and resources than were available for this dissertation. The relatively small sample of patient records represents a weakness. The population of cancer patient records may be variable in quality and completeness. The records in this study lacked care plans and detailed information. This may or may not be representative within the present setting or across settings. This study was conducted

to give some indication of health assets documented by nurses. A larger sample of records would provide more trustworthy information for generalizations.

In general, other lifestyle and chronic diseases are also contexts where the health assets model may be further studied. Trustworthiness could have been further strengthened if all studies had two or more researchers coding and analyzing all data independently. This was not feasible with the limited resources available, however it was done with some of the data and a comprehensive validation process was aimed for and described.

Further steps should be taken. Health care professionals would probably benefit by giving priority to developing and implementing strategies to nourish patients' health assets that aim at mobilizing patients' control and actions. Such mobilization, powered by patients' internal strengths, may be an important contribution to obtaining high quality health and wellness outcomes in individuals, groups, and societies. Further investigations should be done to explore strategies for mobilizing health assets. Communicative, cognitive and behavioral interventions or strategies are mentioned in this dissertation. Further development and research of health assets may help patients to take action and control in their life and help nurses to make patients the central actors in their life and illness situations. Today, the balance of power lies in favor of health professionals. The health assets model may help counterbalance this power.

8.0. Conclusions

This dissertation has contributed to a better understanding of health assets that could help cancer patients and their nurses in an improved utilization of patients' health assets. The significance of adult patients in utilizing their health assets in an illness situation was revealed. We have shown that the concept of health assets is not limited to psychosocial development in children and adolescents, in which context the concept had been primarily used in previous research and literature. The studies in this dissertation uncovered that both patients and nurses have a large repertoire of knowledge and experiences of patients' health assets, but that there is also a lack of health care providers' utilization of them. There is a need for increased awareness of patients' health assets in health care. Nursing is not only needed to help solve patients' problems, but also to support patients in becoming aware of and utilizing their health assets. Such a focus in nursing and in support systems for nursing may contribute to increasing the individual perspective, preferences and experiences of patients in care, and mobilizing patients' own positive engagement, by sharing power with care providers and feeling in control, and hence become active agents for their wellness and health.

These are the first studies to analyze the health assets concept and develop a conceptual model of its representation in a clinical setting. This dissertation is also the first study to investigate nurses' documentation of health assets and possible terminology support for such documentation.

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Nurse Perceptions and Experiences of Patient Health Assets in Oncology Care: a Qualitative Study

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work.

Abstract

Health assets, a term that refers to patients' strengths and potentials, has emerged as an important aspect of health care. A conceptual analysis of health assets revealed five core dimensions: mobilization and motivational, relational, volitional, and protective strengths. How nurses experience and use patients' health assets, however, is unknown. In this qualitative study, 26 expert nurses in cancer care participated in focus group interviews. The nurses had a large repertoire of experiences with cancer patients' health assets. When the data were subjected to thematic analysis, three new core dimensions were revealed: cognitive, emotional, and physical strengths. Balancing processes within and among health assets, identified as an overriding theme, appeared to be affected by individual and contextual variations. The nurses realized that patients' health assets could be better utilized and voiced a need for the clinical and organizational support to do so. New issues about health assets raised in this study may be due to its novel context, e.g., expert nurses in oncology care. More research is needed on health assets in other contexts, such as patients with different health problems, and of possible strategies to support nurses' use of health assets.

Keywords: Focus group interviews, health assets, nurse experience, patient participation, patient strengths, qualitative analysis.

Patients' resources and strengths are central in nursing theory, as well as in the concept of health, an important aim of nursing care. However, health care providers tend to underestimate patients existing internal resources (Martensson, Carlsson, & Lampic, 2008) and lack the skills and abilities to identify and support them (Eloranta, Routasalo, & Arve, 2008). Further, there are few, if any, systematic support for clinical practice that focuses on health, wellness, competencies, and strengths. Increased attention to patients' internal resources may improve nurses' ability to make correct assessments and provide for individualized care (Martensson et al., 2008).

Personal strengths have been part of nursing theories ever since Florence Nightingale stated that "*health is not only to be well but to use well every power we have*" (Nightingale, 1860, p. 298). Later nursing theorists like Virginia Henderson and Dorothea Orem addressed patients' strengths but used different concepts (Orem, 1991). Orem included in her theory the capacity and agency of self, which may be conditioned by available resources (Hoy, Wagner, & Hall, 2007). However, these theories are based on a problem-oriented approach rather than one promoting strengths and health (Meleis, 2007). Existing theories and models need further development to better support patients' strengths and resources and, thereby, improve patient-centred care.

Salutogenesis is an example of a theory and approach that emphasizes a perspective on wellness rather than deficits and problems, and the determinants of health. Despite the amount of research conducted on salutogenesis, it is concluded that other concepts are needed to expand the understanding of determinants of health, especially including people's resources (Eriksson, 2007; Langeland, 2003). Also, qualitative inquiries are encouraged (Eriksson, 2007). The concept of health assets is recently recognized and recommended greater attention in clinical practice and research (Peterson & Seligman, 2004; World Health Organization, 2008). However, the concept of health assets is not often studied in a nursing context. In order to gain knowledge and understanding of the concept of health assets, the purpose of this paper is to describe nurses' experiences and perceptions of patients' health assets in the context of cancer care.

Background

We have conducted several studies to extend knowledge and understanding about patients' health assets. We began with a literature review and concept analysis of health assets (Rotegård, Moore, Fagermoen, & Ruland, 2010).

This work uncovered that the concept of health assets was initiated in Rozella Schlotfeldt's nursing model, in which the focus is mainly on people's strengths, rather than their problems and pathology (Glazer, 1989; Schlotfeldt, 1988). The health assets concept has gained increased attention across many disciplines emphasizing different aspects of the concept, but is lacking within nursing research. The disciplines of psychology and psychiatry have focused on the psychosocial and promotive aspects of the health assets concept (Pergadia, 2002; Peterson & Seligman, 2004). In public health and social work, youth, child, family, and community were used as contexts within the developmental, environmental, and religious aspects of the health assets concept (Cochrane, 2006; Jones-Mckyer, 2005; Kegler et al., 2005; Kretzmann & McKnight, 1993; Sanderson, 2000; Yanicki, 2005). Recently health assets have been used in discussions of the economic and social determinants of health across populations (World Health Organization, 2008) and of human capital within a focus on the fight against poverty (United Nations, 2009).

Based on our literature review and concept analysis, we defined the concept of health assets as *"the repertoire of potentials—internal and external strength qualities in the individual's possession, both innate and acquired—that mobilize positive health behaviors and optimal health/wellness outcomes"* (Rotegård, et al., 2010, p.514). These potentials included the following core dimensions: relational, motivational, protective, and volitional strengths.

In the literature reviewed, however, there was almost no mention of health assets as related to adult persons, the utilization and importance of health assets in illness situations, and in a nursing context. A health assets approach in nursing care is promising and may foster health

and wellness (Rotegård et al., 2010) with outcomes like resilience and increased positive health behaviors (Rogers, Muir, & Evenson, 2003), mastery (Cochrane, 2006; McGuire, 2001; Murphey, Lamonda, Carney, & Duncan, 2004), and self-actualization (French et al., 2001; Glazer, 1989; Scales, Benson, Roehlkepartain, Sesma, & van Dulmen, 2006).

Therefore, we proceeded to explore real-life experiences of health assets from the perspective of nurses, thus obtaining information representing an internal as well as external view of health assets.

In Norway, and probably throughout Scandinavia, the most common term used is patient resources. Resources were found synonymous with assets in a health perspective (Rotegård et al., 2010), however health resources as a term mainly addressed resources on a systems level, e.g. staffing and technology, rather than on the personal level. Personal resources and internal resources were conceptually synonyms, but on a lower level of abstraction. Personal resources are part of or interchangeably used with coping resources (Lampic et al., 2003). This indicated health assets as an umbrella term and concept on a higher level of abstraction, and thus the focus for further investigation.

The clinical context chosen for these studies was cancer patients in different phases of illness. Cancer is a complex illness that often requires a long-lasting course of treatment, care, and rehabilitation. Hence, an examination of the use of health assets in a cancer care context seemed promising in terms of gaining insights and knowledge. Following the lacks of previous research and literature, the research questions were:

- (1) What perceptions do the nurses have of the concepts health assets and patient resources?
- (2) What experiences do nurses have of cancer patients' health assets, needed or used during treatment and care of cancer illness?

Method

Design

We used an exploratory and descriptive qualitative approach, conducting focus group interviews to collect data. We chose this method because focus group interviews facilitate interactivity and dialogue among participants, which would help us retrieve their experiences, understanding, and perceptions (Denzin & Lincoln, 2000). The researcher stays in the background during interviews, facilitating collaboration among and empowerment of the participants (Patton, 2002). Data were collected from October 2007 through December 2007.

Participants and Context

A purposive sampling procedure was used to select information-rich participants. To gain a broad understanding and knowledge of health assets in the context of cancer care, we varied our recruitment sites; the five focus groups we recruited came from four clinical areas at two university hospitals, in addition to one cancer organization. The head nurse/manager at each facility asked nurses to participate in a focus group interview and distributed the informed consent letter that explained the study. To obtain as much in-depth knowledge as possible, the inclusion criterion for nurses was a minimum 5 years of experience within cancer care. Thus, we were able to capture the experiences and knowledge of expert nurses representing the whole spectrum of cancer care, including before, during, and after cancer diagnosis and treatment, as well as a wide variety of settings (hospitals, outpatient clinics, and day and palliative care facilities).

Each group had 4-7 participants, for a total of 26 nurses, all women. Twenty-one nurses had post-basic education: 15 in oncology care, 4 in pedagogy/coaching, 3 in administration/management, three were clinical specialists, and 5 had other post-basic education. Eight nurses had two or more types of post-basic education. Seventeen nurses had fulltime positions, while eight nurses had 50-80% positions. More background information is given in Table 1.

INSERT TABLE 1 ABOUT HERE

Table 1
Background Information on Participants Age and Work Experience

	<i>Mean</i>	<i>Range</i>
Age (years) (<i>n</i> =26)	45.3	27-61
Years of work as a nurse (<i>n</i> =26)	20.0	3-39
Years of work within oncology care (<i>n</i> = 26)	13.3	0-32

Not every nurse met our inclusion criterion, however; one had only 3 years of oncology experience, while another had just started working in oncology. These nurses were recruited by the head nurse because of their broad experience and engagement in care. The reason for recruiting them despite their lack of experience within oncology care was the lack of sufficient available nurses that fit the inclusion criteria in their unit. These nurses belonged to two different focus groups at two different hospitals consisting of 5 participants each in total.

Procedures

We convened the groups in conference rooms at their respective clinical settings. The interviews were audio taped. Before starting the interviews we made small talk to create an open and safe atmosphere. We read aloud the information from the informed consent letter to each group, including rules for anonymity, and then collected demographic data. This paper’s first author acted as moderator, guiding the interview process. Using an inductive approach based on Krueger and Casey’s (Krueger & Casey, 2000) method, we then began eliciting the nurses’ perspectives of and experiences with their cancer patient’s health assets. We asked the following:

- 1. What are you thinking when you hear the expression *health assets*?
- 2. What are you thinking when you hear the expression *patients’ resources*?

3. Are these two expressions giving you different associations?
4. What health assets are you looking for when caring for cancer patients?
5. What health assets are the patients communicating or using during treatment and care?

Thereafter, the five core dimensions of health assets identified in the concept analysis (Rotegård et al., 2010) guided the last part of the interview. The purpose was to obtain more concrete and in-depth descriptions and to extend our understanding of patients' strengths from a nursing perspective. An identical question was asked for each core dimension: "Can you give examples from your practice describing cancer patients' (e.g., relational) strengths?"

The moderator was assisted by a co-moderator, who noted non-verbal communication and core content and monitored the tape recorder and time. The interviews ended when no new information was attained, which occurred after 1.5-2 hours. A debriefing between the moderator and co-moderator took place after each interview to reduce possible bias, and discussions on the initial interpretation of the focus group interviews lead to consensus. We discussed and documented the main issues and impressions (group dynamics, discrepancies) of the interviews. The moderator then transcribed the interviews verbatim. Data were de-identified and stored in a locked file cabinet.

Ethical Considerations

The study received approval from the Regional Committee for Medical Research Ethics. Potential participants were informed about the study with an informed consent notice further explaining the study and their rights (voluntary nature of participation, confidentiality, right to withdraw from the study at any time) and asking for their signature if accepting to participate. Participation in the focus groups was voluntary, and no incentives were offered. Confidentiality was ensured by de-identifying the data and storing them on a secure server. The other materials (the tapes and signed consent forms) were kept in a locked drawer.

Data Analysis

The first author conducted a qualitative analysis based on an inductive approach. The analysis started with open-ended observations to uncover themes and subthemes (Polit & Beck, 2008). The systematization and interpretation of the text was performed as an iterative and holistic process, including meaning coding, condensation, and interpretation, as described by Kvale and Brinkmann (Kvale & Brinkmann, 2009). An audit trail documented the analytic process, including the thoughts and reflections of the first author as well as noteworthy quotations. A critical, common-sense understanding of the content was sought, going beyond the self-understanding of the individuals’ experience and beyond the manifest, direct, descriptive meaning of the text, looking for strengths embedded in the text (Polit & Beck, 2008). An example of the analysis is described in Table 2.

INSERT TABLE 2 ABOUT HERE.

Table 2
Examples of Inductive Meaning Coding, Condensation, and Interpretation of Health Assets

<i>Meaning coding - Extracted text</i>	<i>Meaning condensation</i>	<i>Meaning interpretation</i>	<i>Sub- theme</i>	<i>Theme*</i>	<i>Health assets dimension</i>
Nurse 4: “The nurse’s task is sometimes to put the patient into bravery. Fly out in the world again, dare to take those steps – but it is a job, a demanding job.” Nurse 3: “[they] feel it’s unsafe, because in the hospital it was in safe hands.” Nurse 1: “...it takes a bit of life courage to meet a different life after discharge.”	Bravery to fly out in the world again, daring to take steps,	Bravery to start the new life after discharge	Everyday bravery	Courage	Volitional strength
	demanding job, feeling “unsafe,” a different life after discharge.	From safe life inside the hospital to unsafe life after discharge	Prepared for facing everyday life after treatment and discharge	Predictability	Motivational strength

** Each theme had more sub-themes than the ones displayed in the table.*

In the next analytic step the nurses’ responses to the questions regarding the five core dimensions were read as a continuous text with an inductive approach “to let their voice be heard,” i.e., we listened without the constraints of labels from the concept analysis. The text

across interviews was read with these questions in mind: What strengths are embedded in the material? What characterizes these strengths?

In this thematic analysis, new core dimensions of strengths were identified. The wording of the final themes was formed as close as possible to the participants' expressions.

Trustworthiness

Several steps were taken to ensure this study's trustworthiness. The first author coded and condensed the meaning. Two peer researchers experienced in qualitative analysis then validated the meaning condensation, as well as preliminary and tentative findings. At the end of the analysis, two different expert researchers conducted a partial audit of the analysis to enhance the dependability and conformity of the study. The interpretation step and results were further reviewed with the expert researchers and discussed until consensus was reached.

Results

Nurses' perceptions of the concepts of health assets and patient resources

In this study, the nurses were asked to reflect upon the terms *assets* versus *resources*. The overall reaction from the nurses was that the assets concept (Norwegian: *aktiva*) was unknown. Most nurses related their understanding of assets to economics, stocks, and the politics of saving money, which had an underlying meaning of poor(er) practice and conditions for the patient, and not enhancing the quality of care. However, during the discussions the majority of the nurses found the concept *health assets* to have positive meaning. The difference in the discussions about the concepts *assets* and *resources* was that the health assets concept was more associated with the healthy part of the person, something valuable and protective, and a driving force for taking control and being engaged in one's own health.

Adding the term *health* to modify resources or assets helped enlighten the nurses. One of them expressed: “...it makes me think of the person and not the patient.” Further, the analysis within and across the groups revealed that, from the nurses' point of view, the terms health assets and health resources were considered synonyms.

Expressing their thoughts and sharing their experiences in focus group discussions facilitated the nurses' reflection on their own knowledge, practice, and attitudes. They realized that they often assessed patients from their own perspective rather than from the patients' and that they needed clinical system support to help them to become aware of, assess, and utilize patients' health assets more systematically.

Nurses cited lack of time as a major obstacle to awareness of and support for their patients' health assets. Lack of time was well illustrated by two nurses:

Nurse 5: *“It's faster to do things for the patient than let them participate, right? ... In the unit you have many routines that have to be done.”*

Nurse 2: *“When it is busy the health assets are not in focus, because I get more task oriented; they are having chemotherapy and what side effects have they had since last time? Then I do not ask around- then I become very task oriented.”*

Many argued the need for a conscientious policy about patient health assets and more acceptance from managers to effectuate individualized care plans. Some nurses indicated that health assets might be better utilized if the nurses got to know the patient and if they were better organized.

Nurses' experiences of cancer patients' health assets

The nurses' reflections and descriptions represented a large repertoire of experience with and knowledge about cancer patients' health assets and strengths. The characteristics of findings in the open discussion on health assets before focusing on the specific ones were that the nurses emphasized physical activity /walking, self-respect, keeping ones identity, openness, and being calm and patient. Also, information and knowledge was more concretely highlighted in the open discussions, as well as physical activity.

After introducing the specific questions of the strength dimensions, the responses were more in depth, and provided more concrete knowledge. When the data were subjected to thematic analysis, three new core dimensions were revealed: cognitive, emotional, and physical strengths. The results are summarized in Table 3.

INSERT TABLE 3 ABOUT HERE.

Table 3

Dimensions and Themes of Health Assets as Experienced by Nurses

Core Dimensions of Health Assets		Themes	
Cognitive strength	Acceptance ⁽²⁾	Awareness	Positive thinking Good mood and optimism
Emotional strength	Feeling valuable	Calmness (Tranquillity) ¹	
Physical strength	In good shape		
Volitional strength	Will to live	Endurance	Courage
Motivational strength	Hope	Something to look forward to	Predictability
Relational strength	Trust	Values and beliefs	Openness ¹
Protective strength	Self-protection ²	Protection of family and friends ²	Physical protection ²
Mobilization of action and control	Being vigorous and participating ² in treatment and care	Living an ordinary and meaningful daily life	

¹ Themes only raised in the open discussion. ² Themes only raised in the focused discussions.

Also health assets was found to be characterized by balancing processes and affected by individual and contextual variations.

Additionally, mobilization was expanded to include mobilization of action and control.

Cognitive strength.

Many nurses described and discussed patients' acceptance of their cancer and its consequences, including whether they accepted help/relief from others and how they reconciled with their new reality. Many nurses experienced that patients' health assets differed with the course of illness as accepting: having cancer, the changes that follow (especially living with fatigue and possible death), and being well after finishing their treatment. One nurse described it like this:

"The patient must not let the cancer or the fear of relapse overrides his life- he must not 'drive with the parking brake on,' but put it down, accept the situation, and live life."

Awareness was also raised as a theme of patients' health assets. One nurse shared a common story about a patient they all knew:

"She always talked about the well part of herself...she was a mother of three children and a singer...She focused on her wholeness, she was very conscious about that".

Positive thinking was also discussed a health asset by several nurses, and issues like patients having a positive attitude, focusing on the things they managed and possessed, as well as seeing possibilities.

Emotional strength.

The nurses brought up calmness as a theme when discussing acceptance and reconciliation with reality as strengths. The nurses described calmness as "having inner peace" and reflecting a feeling of safety. The nurses perceived patients with calmness as living a better life than the ones without it.

Several nurses talked about the health asset of "feeling valuable." They described it as conditioned by being seen and validated. Some nurses had experienced that when patients, throughout their illness, communicated about their thoughts and experiences, this could contribute to family and friends' reflections and realization of important values in life.

Humor, good mood, and optimism were also considered health assets in their patients. One nurse said:

"I could hear the seriously ill patient next door had visitors. And I heard that they laughed out loud and had a lot of fun, and I was thinking that it was fantastic; there and then all of them had a good moment. They managed to have fun"

Physical strength.

Nurses across groups talked about physical strength as a health asset. They said that patients in good shape, who had lived an active and healthy life, endured the physical side effects of cancer and its treatments better. Many patients talked to them about physical activity, especially walking, which was considered a particularly meaningful activity. Physical exercise, some nurses claimed, helped the patients through periods in an isolation ward and with recuperation afterwards.

Volitional strength.

Nurses experienced the volitional strength "will to live" in many patients and found it important in all phases of the illness. Nurses expressed this as "go-ahead spirit" and "readiness to fight," and saw it even in the palliation phase, when patients knew the time they had left was short.

Endurance was illustrated in these expressions: "never give up, but rather push themselves," "having a staying power," and "fighting challenges they met." More figuratively, endurance was expressed as "*to clench one's teeth*." One nurse said:

"Some get up in the morning with nausea, get in to the shower and vomit, continue throughout the day vomiting, eat, vomit, and read magazines about food while they eat and vomit."

Many nurses described the health asset courage as “having the guts” and “being brave.” Bravery was considered a necessary strength when meeting people and answering their questions and meeting expectations after receiving the diagnosis, because “*society creates a picture of how it should be.*” Further, nurses considered the courage to decline information as a strength in cancer patients, since many people pushed information on the patients, e.g., about alternative treatments and “cures” for cancer.

Motivational strength.

Hope was an obvious health asset in their patients, and nurses described hopes about surviving, comfort, and not being alone. A nuance of the theme “hope” was seen as a motivating strength; nurses said that patients often viewed getting an infection as a confirmation of the treatment’s effectiveness, thus providing hope for survival.

Another theme of motivational strength described was having something to look forward to. That included having plans and expectations, as well as having a motivation or drives to engage. One nurse explained:

“...to have important things to look forward to...for example going to the cabin again...That may be the motivation for living; that the patient can plan that trip.”

Predictability was also a health asset needed in their patients. Predictability made the situation more tangible for the patients, knowing what was going to happen and being confident that the hospital could be contacted if needed:

“Things must be predictable...as predictable as possible for the patient...Then you see that the patient handles [the situation/illness] better and perhaps improves”

Relational strength.

The nurses described trust as a core health asset enabling patients to use their other health assets. Trust and confidence was addressed to the patients' social network and family, as well as to health care providers. One nurse said:

"...I believe you can get much more out of the patients' health assets if you have a good foundation [of relationship]. So I believe that trust is a core concept for the patients to use their own strengths in a treatment situation"

Values and beliefs were mentioned by many nurses, however superficial. They talked about the importance of having a strong faith, spirituality, believing that one would manage the illness and its consequences, and believing in the future. Furthermore, health assets were described as a "value bank" and "foundation of values".

Many nurses described openness as the patients' ability to talk about their illness, thoughts, feelings, and needs. This included expressions of frustration and sorrow, which the nurses said enabled patients to mobilize new health assets like motivation and hope. Nurses viewed a focus on one's values in life, whether new or old, to be a health asset.

Many nurses found close relationships with family and friends an important asset that might provide company, support, understanding, comfort, and love. Close relations may therefore be external health assets that nourish relational strengths:

"We are seeing that the [social] network means a lot. We need to reduce our role,... we [nurses] mean something, but the environment that the patient comes from is the thing that really lifts them through. And we should be humbled because of that."

Protective strength.

Several stories were told about patients' protective strengths after being introduced to the term. Self-protection focused on patients sheltering themselves against other people's curiousness and against information:

"I have met patients who did not want any information... One [patient] did function very well. She worked in between the treatments and she was calm: "No, save me from information...I do not want it. I know what I am going to get and when to get the treatment, that's enough".

By resigning from everyday tasks and expectations, one nurse said, patients could allow themselves a break to regain energy.

Also, physical protection was mentioned as an important health asset to avoid infections.

Protection of others was also mentioned a health asset, although one nurse questioned whether it was a strength or not. She said that health care providers often found that patients used too much energy in protecting their loved ones. However, she experienced that patients often considered it a strength and necessity.

Mobilization of action and control.

Several nurses told that although most patients wanted to do something to contribute to their own health, some were careful of being (too) vigorous because they feared being labelled as "problematic." However, as one nurse said: *"It is a health asset to know the difference between being a burden and taking responsibility for one's own health."*

Patients' mobilization of action and control in terms of being vigorous and participating in treatment and care were described. This included taking initiative and taking the offensive, being vigilant to healthcare providers' advice and actions, obtaining and using knowledge and using ones own experiences, making decisions and following up hospital treatment and care plans.

Additionally, mobilization of action and control involved living an ordinary and meaningful life in terms of restoring everyday life routines and doing meaningful social and physical activities.

Balancing processes.

The stories the nurses shared about on patients' health assets revealed that the assets may even counter each other in an individual patient, indicating balancing processes. Two different modes of balancing were uncovered: balancing among diverse assets and within a single health asset. A balancing process, as we define it, is a movement to and from, as if to compare two objects, to estimate their relative weight or importance

(www.dictionary.reference.com). Balancing among health assets was found when two assets appeared contradictory but their interaction resulted in a positive outcome. An example is the contrast between the motivational strength "hope to live a normal life" (subtheme of hope) and the cognitive strength "reconciliation with reality" (subtheme of acceptance). A patient may have and use both strengths, but reconciliation with reality and a new life may influence and adjust (another health asset) the hope to live a normal life, e.g., to live as normally as possible with the changes wrought by the disease and its treatment. The combination of two health assets may therefore generate or mobilize other health assets (living an ordinary and meaningful life).

An example of balancing within a health asset is demonstrated by one nurse's comment:

"There is something called "don't let your strength become a weakness."

In other words, a health asset or its aspect may not be seen as such if it is exaggerated (too much of it) or lacking (too little of it). Also, the nurses' experiences indicated that the same health asset might have both positive (a strength) and negative (a problem) aspects. For example, trust was considered a relational strength by the nurses, but taken to either extreme (either exaggerated or lacking), could have a negative impact on the patient.

Individual and contextual variations.

Nurses across groups said that health assets vary among individuals. What is considered a health asset in one person may not be considered as such in another. For example, "openness" was considered a health asset, but conversely, in those patients who did not want to be open about everything, their reserve was also considered a health asset, at least for these specific

patients. It was suggested by some nurses that variations might be rooted in experience and/or personal characteristics or influenced by various cultural and family backgrounds.

What they considered a health asset also varied by context or situation, e.g. being home or hospitalized, and by time (i.e., phase of illness). All groups concluded that a variety of health assets are needed and change during different illness phases. For example, nurses highlighted “predictability” and “restoring everyday life” as important during the discharge phase and “fighting spirit, endurance, hope, and motivation” during the relapse phase. What is considered a health asset probably also depends on a patient's age and day-to-day variations of the illness and recovery. One nurse experienced that while adults had a greater repertoire of health assets, younger patients (adolescents and children) were easier to motivate.

Discussion

Many interesting aspects of cancer patients' health assets were brought up in the focus group discussions by these experienced nurses. The most prominent issues will be discussed; how nurses relate to the unfamiliar concept of health assets, new strength dimensions, variation in and balancing processes of health assets, and the implications these findings have for theory and practice.

How Nurses' Relate to the Unfamiliar Concept of Health Assets

Many nurses found that their use of patient health assets was often implicit due to the dominant task- and problem-oriented approach to clinical care. By providing a new concept like health assets, however, we may have contributed to their expanded understanding and knowledge; and the use of new words may affect practice too. It is known from philosophy, psychology, and linguistics that the language and terms we use affects our thinking and cognition (Marlowe, 2004). In the focus group, the nurses' perceptions changed from a

negative or sceptic attitude to realization and discovery of its value by one or two person(s) in the group, and/or by comparing what other situations they had heard about it (e.g. financial context). Furthermore, use of new concepts may affect perceptions too. Rodgers (2000) has claimed that personal interactions may significantly contribute to the formation and development of concepts. The discussions in our focus group interviews may therefore have nourished and contributed to the discovery of new knowledge and understanding. The health assets concept may impact a perceptual shift in the nurses and possibly lead to more useful, appropriate, and effective ways of caring about and acting toward their patients.

New Strength Dimensions and Content

This study identifies cognitive, emotional, and physical strengths as new core dimensions of health assets. These dimensions were indicated by some publications in the literature review and concept analysis (Rotegård, et al., 2010). However, they were more prominent in this empirical material, which focused on a new context; therefore, we marked them as dimensions in their own right. The issues that led to the discovery of these dimensions were central in the nurses' discussions and experiences of nursing care for cancer patients.

Patients may be unaware of their health assets. Nurses, however, may more easily observe these strengths; therefore, it is important that they help patients recognize and utilize them. To be able to assess and recognize these strengths in their patients, concrete knowledge must be available and, e.g. visualize in a conceptual model may support the nurses.

Other reasons as to why the new core dimensions of health assets were found in this study but not others may be the unique characteristics of the sample. Experienced oncology care nurses were interviewed, and such a sample has not been used in earlier research on health assets. Furthermore, cancer is a serious illness, often defined as a chronic disease, which possibly challenges patients' strengths and health assets. Caring for a patient over time gives deeper insight into the patient's life and uses of health assets. These nurses also had broad experience with several patients in the same situation, which may bring certain issues to the

forefront of their perspective, and may account for the variations and nuances that contributed to our discovery of the new characteristics of variations in and balancing processes of health assets found.

Variation in and Balancing Processes of Health Assets

Nurses suggested that individual variation in health assets is important and is related to a patient's experiences, culture, point in time, and/or context/situation. An example of the individual and cultural variations in health assets that can occur was found in a study comparing the coping styles of Asians, who tend to use "fighting spirit" as a strategy, versus Caucasians, who tend to use "adaptation" (Roy et al., 2005). Both strengths were found in our study, although fighting back could be perceived as negative from the health care provider's perspective.

Our findings also suggested that passage of time affects health assets. This is supported by research reporting that protection is used at an early stage (after diagnosis) and at a late stage (terminal) of cancer to reduce anxiety (Kreitler, 1999). Also, the use of protective strength may vary according to the age of the patient; young cancer patients have been found to use denial more than elderly cancer patients (Kreitler, 1999). Thus, it appears that health assets may change across the illness span and used in varying amounts depending on the patient's age and level of maturity.

The nurses' stories provided significant evidence of balancing processes, which were likely found due to their broad, cross-cutting experiences of many patients. Other studies have contended that health assets or strengths represent a balancing against health problems (Rotegård et al., 2010) and that the more health assets a person possesses, the stronger his or her protection against illness and the more that person will thrive (Atkins, Oman, Vesely, Aspy, & McLeroy, 2002; Cochrane, 2006; Scales, Leffert, & Vraa, 2003). However, our findings revealed that balance is not a steady state or only relevant to health problems. For instance, the nurses experienced that patients mobilize different strengths to attain a sense of control. Mobilizing toward health, thriving, and wellness did not reflect the number of health

assets a patient had per se but rather derived from a balancing of various health assets or even within a single health asset. These balancing processes are in line with and expand the understanding of previous descriptions of health as “finding balance” (Mendelson, 2002) and of mental health and wellness as a balancing of mind, body, spirit, and context (Hodge, Limb, & Cross, 2009).

Implications for Theory and Clinical Practice

The nurses in this study had a large repertoire of experiences with cancer patients' health assets, and the analysis revealed three new core dimensions of health assets; cognitive, emotional, and physical strengths. However, the nurses realized that patients' health assets could be better utilized and voiced a need for clinical and organizational support to improve their practice. Nursing theories would benefit from including a health assets perspective in what is currently dominated by a problem orientation. However, this requires a different approach to clinical and theoretical nursing, which may necessitate a paradigm shift. If nurses are to add health assets, i.e., the patients' strengths, as a core of nursing care, as described by Schlotfeldt (Glazer, 1989), we need conceptual models and theories to support such an approach.

Thus, nursing may better succeed at contributing to improved health care outcomes if they can learn to engage their patients more in their own health and wellness and encourage them to become “an agent of self,” i.e., fully use their capacities. This does not mean, however, that responsibility and care are left entirely to the patients, but rather that they are considered equal agents in their health care, with shared power. Patients will continue to need nurses to help them solve their problems, but all patients have health assets that can be utilized and strengthened. Such a perspective is consistent with idea of patient-centered care and patient-provider partnership (Hubbard, Kidd, Donaghy, McDonald, & Kearney, 2007) and is necessary for high-quality nursing care (Radwin & Alster, 2002).

Individual and contextual variations of health assets, as well as the balancing processes within and among them, call for flexibility in nursing care and its support systems. Clinical support

systems that include patient-specific information and help have produced positive patient outcomes (Ruland, White, Stevens, Fanciullo, & Khilani, 2003). Thus integrating and building on patients' health assets appears to be of significance. An approach built on individual preferences and tailored care may also contribute to greater value on a cost-effectiveness level as compared to health care decision making at a group level (Basu & Meltzer, 2007). Further, a health assets focus would require patients playing a more active role in their assessment, planning, documentation, and conduction of care.

Moreover, succeeding with a health assets approach may require a reorganization of institutions to provide the time required for one-on-one contact between patients and nurses. Relatively few studies have previously focused on the experiences of oncology nurses with health assets or -resources. More research on health assets using different methods and settings needs to be conducted. Future studies should explore how nurses can support patients in balancing their health assets and what strategies are best with regard to different individuals, illness phases, and contexts. Patients' health assets can be mobilized for them to assume (co-) responsibility and participate in their own care. Thus, they may be able to maintain or regain control and power in the health care system and in everyday life, thereby improving their health and wellness.

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TABLE LEGEND

Table 1: Background Information on Participants' Age and Work Experience

Table 2: Examples of Inductive Meaning Coding, Condensation, and Interpretation of Health Assets

Table 3: Dimensions and Themes of Health Assets as Experienced by Nurses

Health Assets in Nursing Documentation of Cancer Care.

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Abstract

Patients' experiences, knowledge and preferences, as well as more person-centered care need to be implemented in clinical support systems and are central values and outcomes of eHealth. Health assets represent such information. The concept of health assets was explored and described based on analysis of nursing documentation in cancer patients' records.

A convenience sample from 100 records, available from a larger study, resulted in 43 records that met the inclusion criteria. These were analyzed using content analysis methods.

A mean of 3.2 health assets was documented in these records, and 61% of the descriptions of assets quoted patients. Assets were found most often in the admission notes (49%), but no information was found that described or indicated an intended use or follow up in the nursing documentation.

Introduction

Empowering and supporting patients' autonomy through participation and information sharing are central values and outcomes of eHealth, which aims at improving interaction and teamwork between health care providers, patients and next of kin, and between various actors within health and social care systems¹. However, support systems for those nursing activities that focus on the positive aspect of health, namely wellness, patients' health assets and the patients' perspective, are lacking. Clinical decision support systems for care planning and terminology are developed from an illness / deficit perspective^{2,3}, and/ or the problem-oriented nursing process⁴. Research reports a lack of attention to patients' individual perspectives, preferences, and/or experiences in the documentation of their care^{5,6}. It is acknowledged that personal experiences, preferences, and values need to be integrated and supported to optimize health decisions in the clinical encounter⁷. Furthermore, it is argued that health and nursing care needs support systems that are more robust, enabling nurses to recognize patients' experiences and knowledge, to document these and provide more person-centered care^{8,9}.

Health assets represent personal experiences, perceptions and values. Health assets have been recognized by the World Health Organization (WHO) as being necessary to strengthen and maintain health and wellness. However, the concept of health assets has not been well defined and there is little consensus. Health assets was described a core of nursing in Rozella Schlotfeldts nursing theory¹⁰. Schlotfeldt used the concept of health as focused on people's strengths rather than on problems and pathology. The nursing mission was to assess and enhance people's health status, health assets, and health potentials¹⁰. The person in her model was described as having health assets, and health assets were described as comprising health-seeking behaviors and health-seeking mechanisms. An analysis and summary of Schlotfeldt's model concluded that these components needed more clarity¹⁰.

A concept analysis based on literature from several health care disciplines resulted in a definition of health assets and a descriptive model of the concepts' components¹¹. Health assets were defined in this study as:

“the repertoire of potentials—internal and external strength qualities of the individual, both innate and acquired—that mobilize power and control toward positive health behaviors and optimal health/wellness outcomes.”

This was one of five studies of a dissertation work exploring the meaning and uses of health assets in a nursing context. This dissertation work explored health assets based on conceptualization and knowledge from various perspectives: literature, patients and nurses, and the nursing terminology system, the International Classification for Nursing Practice (ICNP).

This paper reports on one of these studies; the nurses' perspective of health assets as documented in cancer patients' records.

Purpose

The purpose of this study was to explore and describe nurses' documentation of health assets in cancer patient records.

Method

Data collection.

We used a retrospective chart review of 100 available cancer patient records, collected for a larger study. These records included documentation of hospitalized patients and patients from outpatient clinics. A convenience sample was chosen. Data were collected from admission assessments, progress notes, nursing care plans, and the discharge summary in the patient record. Of the 100 patient records, 43 met the inclusion criteria: (a) had readable handwritten or computerized nursing notes including one hospital stay; (b) at least one admission note; (c) six consecutive shift reports and/or available discharge notes or an outpatient clinic report; and (d) had health assets content, in terms of relational-, volitional-, motivational-, or protective strength, or mobilization towards health and wellness. These were dimensions revealed in a concept analysis¹¹. The text was readable, and the documentation was primarily characterized by short text. The records analyzed included 16 belonging to women and 27 to men. Anonymity was assured because copies of paper records had already been de-identified in the larger study. These records were retrospective data documented for clinical purposes before the study was introduced. Retrospective document analysis does not necessarily reflect the present reality, but it provides data and a picture of whether and how health assets were documented. This data set represented the nurses' interpretation of patients' health assets, but at the same time, they referred directly to what the patients said, required, or wanted, thus also reflecting a patient perspective although through the lenses of nurses' perspectives. This study therefore provided data about the use of health assets as it occurred in normal processes of cancer care at these sites without any contamination by the research process.

Data analysis.

The complete set of nursing documentation of each patient's record was photocopied verbatim and treated and stored with strict confidentiality. The coding and condensation of meaning was performed by two coders who read each document in the patient records independently. The second coder, who was familiar with content analysis, but not with health assets as concept, was informed about the dimensions of health assets as mentioned in the inclusion criteria.

A combination of a conventional, directed, and a summative analysis was conducted, as described by Hsieh and Shannon¹². The main differences between these approaches are the coding schemes and origin of codes. Conventional content analysis starts out with observations of the text and codes derived from the data¹². Our first step in the analysis of cancer patients' charts was a reading of the text in order to get an overview. An open-ended question to the transcribed text was used to identify and highlight all instances of health assets documented: Is there any part of this text that appears to contain descriptions of the patient's strengths or health assets? The highlighted text was then organized into clusters based on shared meaning or similarities.

The text was then read, interpreted, and condensed within the predetermined codes, the dimensions of health assets, in a directed content analysis.

To further analyze the use of health assets, the categorized content was counted and viewed in relation to the context of documentation; the part of the documentation system that the health assets were documented (income assessment, care plan, status report), and the form in which the health assets were expressed (from the provider's or patient's perspective). This part of the analysis represented a summative content analysis, which also included analysis of latent content¹². The same strength dimensions as described in the initial health assets model provided the keywords for this analysis.

After the coding, condensation, and initial interpretation of the texts, the two coders met to compare and discuss the results until consensus was reached. New tentative themes and categories of health assets were also discussed to establish credibility of the analysis. At the end of the analysis, a partial audit of the analysis was undertaken by two expert researchers. In addition to this, we strove for credibility in data coding and analysis by rigorous coding, co-coding and auditing. Other experienced peer researchers co-coded and partially audited the analysis to enhance the dependability and confirmability of the findings. Systematic and sequential data collection and analysis procedures were rigorously conducted. An audit trail was developed to document the analytic process.

Results

142 entries, pieces of information (sentences or paragraphs) documenting health assets in the 43 patient records contained 177 health assets terms (some entries had more than one asset). This represents a mean of 3.3 entries and 4.1 terms of health assets in each patient record. Also, it could be seen that there was 20 health assets terms in the 12 health assets entries in the 5 outpatients' records. Thus, the average of health assets terms is 4 in the outpatient record.

The patients were quoted in 89 (61%) of the 142 health asset entries, i.e. "*The patient says/expresses/wishes to...*". Eight (66%) of 12 entries quoted the patient in the outpatient records.

The largest proportion (49%) of health assets was background information in the admission notes, such as "*The patient is motivated for the new cytostatic treatment*" (motivational strength). Some health assets were mentioned in status reports (25%), such as "*The patient feels that he has received good information and has a good knowledge/understanding of the treatment after the information today. [He] is realistic*" (relational strength). No care plan or other information reflected an intended use or follow-up of the health assets. The distribution of the health assets in the patient records is summarized in Table 1.

Table 1. Health assets findings from nurses' documentation in the admission note or status report in the cancer patient records.

Health assets	Examples of entries in the nurses' documentation	Health asset terms	# of health asset terms	
			(n)	%
Relational strength	<ul style="list-style-type: none"> Says that the children are handling the illness of their father well, they have an open relationship and have talked a lot about the illness. She has told us what is required so she can trust the hospital unit. 	<ul style="list-style-type: none"> Open communication and relationship in the family Open communication between patient and provider Trust 	52	29.4
Motivational strength	<ul style="list-style-type: none"> She is hoping that she will live until her son is grown up, because he is better qualified to manage on his own then. Says he is surprised over how calm he is. He believes he is prepared without being aware of it. 	<ul style="list-style-type: none"> Hope to live Protecting children Calmness Awareness Being prepared 	36	20.4
Volitional strength	<ul style="list-style-type: none"> Says that he is ready to fight and wants to survive. Manages to eat and drink despite the problems. 	<ul style="list-style-type: none"> Ready to fight Will to live 	9	5.1
Protective strength	<ul style="list-style-type: none"> Says she has a great deal of gallows humor about her own situation. Is a bit worried for his wife, and he believes she is exhausted. I encouraged him to try to get some time together during the vacation and supported him to make appointment with her physician so she could take sick leave. 	<ul style="list-style-type: none"> Gallows humor Concerned about his wife- wanting to help her 	4	2.3

Mobilization	<ul style="list-style-type: none"> • He brought the Fragmin with him and wanted to take responsibility for this medication himself. • At his last hospitalization, there was a lot of hassle about how much food he had to eat. This made him tired and resigned. He wants to control this himself. • The patient says that except for the tough days after the chemotherapy he lives like before; staying active, renovating the house, fixing the car, and so on. 	<ul style="list-style-type: none"> • Want to take responsibility for medication • Want to control eating • Live everyday life like before 	76	43
Total			177	100

The dimensions of relational and motivational strength were the only ones documented in the outpatient records, as well as mobilization. These records contained health assets like support from and socializing with family, friends, and work, being future oriented, taking initiative and having a conversation partner.

Discussion

The application of a concept in clinical practice contributes to further understanding and development of the concept¹³. The findings in this study were similar to the findings from another study where nurses' experiences and perceptions of health assets were explored and described in focus group interviews¹⁴. All themes related to health assets found in the nurses' focus groups were also found in the documentation of cancer care, except for the findings *courage*, *values and beliefs*, and *feeling valuable* that were only found in the focus groups. Together with the other studies conducted about health assets this study may contribute to expanded conceptual understanding, conceptual models and clinical practice, and can be used for developing nursing terminologies/standards¹³. The uses and representations of health assets in clinical practice documentation revealed that information about patients' health assets was found, but the information indicated a lack of systematic follow-up in nursing documentation of nursing care. Without follow up, patients' health assets may be ignored and not utilized sufficiently. Knowledge of health assets seems to be untapped and could be made more accessible for clinical use. A previous study found that the International Classification for Nursing Practice (ICNP) is a promising vocabulary system for use in electronic health records for representing health assets, although it lacks terms and concepts¹⁵. Nurses have the potential to become more aware of the important role they play in facilitating effective use of patients' health assets and strengths. The findings in this study may reflect that nurses' care are dominated by a task and problem orientation, as shown in both the verbal data from patients¹⁶ and nurses¹³. Others have also found that nurses' planning and documentation of care is incomplete and inaccurate^{5, 17}. In addition to acting on behalf of or for patients, and resolving their problems and deficits, nurses have the potential to nourish patients' health assets and make them better able to use their power, become active and take control of their situation. Mobilizing patients' health assets may contribute to optimal health and wellness and positive health behaviors, e.g., mastery, behavioral change, pleasure, and joy¹¹. A conceptual model of health assets, as previously described¹¹ and further built on in this study, may help nurses realize this potential and communicate clearly and demonstrate their support. The eHealth strategy of the Norwegian health authorities calls for greater involvement of patients and support for them to mobilize their own resources for improved health outcomes¹⁸. Better clinical support is needed to increase awareness and knowledge in both patients and nurses to improve utilization of health assets, and further research is also needed. This is the first study that has explored and described nurses' documentation of health assets in cancer patients' records. This study was conducted to give some indication of health assets documented by nurses. The relatively small sample of patient records represents a weakness. The population of cancer patient records may be variable in quality and completeness. The records in this study lacked care plans and detailed information. This may or may not be representative within the present setting or across settings. A larger sample of records would provide more trustworthy information for generalizations.

Further research is needed on health assets content and strategies, and also in other patient groups and nursing contexts and samples. How to assess and document support and mobilization of patients' health assets should be further studied.

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APPENDICES



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Forespørsel om deltagelse i en diskusjonsgruppe om helseressurser hos pasienter med kreft

Du blir herved forespurt om å delta i en diskusjonsgruppe i forbindelse med en doktorgradsstudie ved Medisinsk Fakultet ved Universitetet i Oslo og Senter for Pasientmedvirkning og Sykepleieforskning ved Rikshospitalet-Radiumhospitalet. Doktorgradsstudien er tilknyttet et større prosjekt, "CONNECT - Informasjons- og kommunikasjonsutveksling mellom pasient og helsepersonell gjennom felles pasientjournal", under ledelse av dr.Cornelia Ruland som også er min hovedveileder.

Hensikten med denne studien er å utvikle et system som hjelper helsepersonell å styrke kreftpasienters egne ressurser/styrker. I denne forbindelse ønsker vi å spørre om pasienters opplevelser og erfaringer med kommunikasjon og bruk av styrker / ressurser underveis i sykdomsforløpet og hvilke ressursene dere opplever viktig for å håndtere situasjonen og hverdagen.

Dersom du sier ja til å delta i diskusjonsgruppen sammen med andre (tidligere) pasienter blir dere samlet gruppevis, 5-8 i hver gruppe. Intervjuet vil ta ca 1,5-2 timer.

Dine / gruppens innspill og erfaringer vil bli tatt opp på lydbånd og behandlet strengt konfidensielt. Studien er godkjent av Regional etisk komité for medisinsk forskningsetikk og av Datatilsynet. Rikshospitalet HF er også ansvarlig for å ivareta sikkerheten til personopplysninger som behandles i studien og vi vil behandle opplysningene i samsvar med gjeldende lovverk. Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. All informasjon vil bli lagret og presentert uten personidentifikasjon og blir beskyttet gjennom strenge sikkerhetstiltak. Data vil bli avidentifisert, og ingen svar vil kunne tilbakeføres til deg som person. Pasientopplysninger som eventuelt kommer fram når resultater av studien skal presenteres vil også bli anonymisert. Alle data vil bli oppbevart i et låst arkivskap på prosjektleders kontor/ Rikshospitalet HF.

Deltagelse i studien medfører ingen kostnader for deg. Det er ingen risiko forbundet med denne studien. Studien vil gi helsepersonell økte kunnskaper og systemer for å fange opp kreftpasienters ressurser. Videre kan studien være med på å gi helsevesenet et redskap som kan sikre pasienter individuell oppfølging, informasjon og støtte på vei mot et mer helhetlig og pasientvennlig helsevesen. Hvis du sier ja til å delta ber vi deg fylle ut og undertegne "Skjema for informert samtykke" (side 2) og levere det til undertegnede ved første møte.

Selv om du sier ja til å delta i studien nå, kan du trekke deg når du måtte ønske det, uten å oppgi noen grunn, og uten at det vil ha noen konsekvenser for deg. Dine data vil da bli slettet.

Vi regner med at studien i sin helhet vil være avsluttet etter 2015. Alle data vil være slettet senest etter 10 år, dvs. før 31.12.2019.

Om du har spørsmål om deltakelse eller selve studien kan du ringe stipendiat Ann Kristin Rotegård på telefon 23 07 54 59 eller min hovedveileder dr. Cornelia M. Ruland på telefon: 23 07 54 60.

Samtykkeskjema

Jeg samtykker i å være med i studien slik den er beskrevet ovenfor. Jeg er informert om at min deltakelse i studien er helt frivillig. Selv om jeg sier ja til å delta i dag, kan jeg trekke meg fra studien eller avbryte intervjuene når jeg måtte ønske det, og uten at det vil ha konsekvenser for meg.

Dato: _____

Navn: (blokkbokstaver):

Signatur

Prosjekt: Pasientens helse aktiva

Fokusgruppeintervju :PASIENTER

Åpning (Ca 5 min)	<ul style="list-style-type: none">● Presentasjon: med moderator og ass. moderator rollen. Fyll ut informert samtykke (levere inn forhåndsutfylt) – gjennomgå muntlig.● Hensikten med intervjuet: Studien jeg holder på med tar for seg erfaringer med og opplevelser av egne styrker / ressurser, og her er det en del jeg lurer på. Det jeg ønsker er om dere kan si noe om/ dele med hverandre de opplevelser og erfaringer dere har gjort dere gjennom tiden med kreftsykdom; <p>Vi ønsker å lære av den enkeltes erfaring og tanker om temaet. Alles historie og bidrag er viktig og enighet er ikke målet. Om dere har forskjellige erfaringer og meninger ønsker vi at det kommer fram. Ingen svar er rett eller feil. Har de spørsmål eller kommentarer vil vi gjerne høre disse.</p> <ul style="list-style-type: none">● Om å ta samtalen opp på bånd – sikring av konfidensialitet. Vi trenger en lydbåndopptaker for å få med det dere sier. Selv om en av oss noterer, vil vi ikke klare å fange alt dere sier. Når vi senere publiserer fra studien, vil det ikke være mulig å spore bestemte personer tilbake til individuelle utsagn. Lydopptakene vil bli slettet når forskningsrapporten foreligger.● Regler for samtalen. Vi vil forsøke å la en person snakke om gangen for å få det med godt på tape.● Deltakerne presenterer seg.
Introduksjon spørsmål (Ca 20 min)	<p>Åpningsspørsmål (bryte isen): småprat om bakgrunn, interesser</p> <ol style="list-style-type: none">1. Jeg tenker at det vil være greit at dere først snakker om og kan dele med hverandre: om det noe dere mener [eller selv har opplevd] at er en styrke i hverdagen med kreftsykdom?<ul style="list-style-type: none">- Det hadde vært fint om vi kan ta runden og si noe om dette en og en. Kan du starte?
Nøkkelspørsmål I (Ca 20 min)	<ol style="list-style-type: none">2. Hvilke styrker/ressurser i deg selv eller i omgivelsene dine var eller kunne vært nyttige å bruke for å hjelpe deg gjennom hverdagen / kreftsykdommen?

(Jeg hører du nevner ... Kan du si mer om det? Kan du forklare nærmere? Kan du gi eksempler? Hva mener du/dere andre? Hvilke erfaringer har dere med dette?)

Prosjekt: Pasientens helse aktiva

Nøkkel-spørsmål II (Ca 15 min)	<p>3. Nå skifter vi tema: jeg ønsker å dreie samtalen mot helsepersonell og de erfaringer dere har med hvordan styrke og ressurser er en del av/inngår i kontakt og samtaler med helsepersonell. Kan dere si noe om dette?</p>
Oppfølgings spørsmål	<p>(“Noe dere ikke har snakket om men som jeg lurar på er om....”):</p> <p>1. Hvis vi tenker oss dine indre ressurser /styrker: Har noen av dere eksempel på om</p> <ol style="list-style-type: none"> tilhørighet (sosiale, kulturelle og åndelig) viljestyrke beskyttelse personlighet og livserfaring kan være/har vært en styrke gjennom hverdagen med sykdommen? Var det noe som spesielt som motiverte dere gjennom hverdagen med kreft? Opplevde dere situasjoner der dere tok handling, ble engasjert eller forandret dere (meninger, atferd) (en om gangen)? <p>Til alle: Hvordan? I hvilke situasjoner var dette spesielt nyttig?</p> <p>2. Hvis vi tenker oss ressurser dere har i omgivelsene:</p> <ol style="list-style-type: none"> Har noen eksempler på at familie og venner var /er en styrke for deg gjennom sykdommen og hverdagen? På hvilken måte? Er det noe eller noen rundt deg som har gitt deg styrke eller i seg selv vært en styrke (støtte)for deg gjennom sykdommen og hverdagen ? På hvilken måte? Har noen eksempler på at fysisk styrke og aktivitet var/er en styrke gjennom sykdommen og hverdagen? Hvordan?
Avslutning (Ca 5-10 min)	<p>Avslutte (dra konklusjoner av diskusjonen):</p> <p>4. Dere har virkelig gitt mange nye gode innspill om styrke og ressurser dere har erfart eller mener kan taes i bruk når man har en kreftsykdom. Før vi avslutter; er det noe mer dere ønsker å si om dette? Er det noe vi ikke har snakket om som dere mener er viktig?</p>

(Jeg hører du nevner ... Kan du si mer om det? Kan du forklare nærmere? Kan du gi eksempler? Hva mener du/dere andre? Hvilke erfaringer har dere med dette?)

Prosjekt: Pasientens helse aktiva

	<p>Informasjon om hva du vil gjøre med dataene videre. Muligheten til individuell samtale eller sende e-post om man har kommentarer, ideer, spørsmål man ser i etterkant.</p> <p>Takk delakerne og slå av lydbåndet</p> <p>FYLLE UT DEMOGRAFISKE DATA OM DET IKKE ER GJORT PÅ FORHÅND.</p> <p>Debriefing: En refleksjonsrunde mellom moderator og observatør (på bånd): Hva var de viktigste temaene som ble diskutert? På hvilken måte skilte disse seg ut fra det vi forventet? På hvilken måte skilte de seg fra det som skjedde i tidligere grupper? Hvilke punkter skal med i rapporten? Hvilke sitater må vi ta med? Var det uventede funn? Skal noe endres til neste gruppe?</p>
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Moderators rolle: lede diskusjonen, spørsmålene styrer diskusjonen. Kan gjerne trekke seg litt tilbake når spørsmålet er stilt. Viktig å få frem gruppediskusjon og gruppeprosess. Når spørsmålene stilles, så pass på at det ikke er den samme som svarer først hver gang .

Observatørs rolle: notere om det skjer noe spesielt; "nikking" fra mange, kroppspråk etc. Ta stikkordsnotater. Plassering overfor moderator. Følge med på tiden og styre den og båndopptakeren.

Intervjuguide er utarbeidet etter inspirasjon fra Jane Mikkelsen Kyrkjebø (2004). Learning to improve: Integrating continuous quality improvement learning into nursing education. Department of Education /Research Centre for Health Promotion, Faculty of Psychology, University of Bergen, Norway.

(Jeg hører du nevner ... Kan du si mer om det? Kan du forklare nærmere? Kan du gi eksempler? Hva mener du/dere andre? Hvilke erfaringer har dere med dette?)



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E-post: firmapost@rikshospitalet.no
Org.nr.: NO 987 399 708 MVA
www.rikshospitalet.no

Deres ref:
Vår ref:
Dato: 11.10.2007

Forespørsel om deltagelse i studien:

"Kreftpasienters helseaktiva / ressurser"

Skjema for Informert samtykke

Du blir herved forespurt om å delta i et forskningsprosjekt i forbindelse med en doktorgradsstudie ved Medisinsk Fakultet ved Universitetet i Oslo og Senter for Patientmedvirkning og Sykepleieforskning ved Rikshospitalet-Radiumhospitalet. Doktorgradsstudien er tilknyttet et større prosjekt; "Communication and Information Sharing between Patients and their Care Providers", under ledelse av dr.Cornelia Ruland. Hun er også min hovedveileder.

Hensikten med denne doktorgradsstudien er å (1) kartlegge kreftpasienters helseaktiva /-ressurser for planlegging av behandling /sykepleie og (2) sammenligne disse med eksisterende standardiserte vokabularer til eventuell videreutvikling av elektronisk pasientjournal.

Deltakelsen innebærer at dere blir intervjuet gruppevis, ca 6-7 i hver gruppe. Intervjuet vil ta inntil 2 timer. Vi ber deg fylle ut og undertegne "Skjema for informert samtykke" (side 2) og levere det til undertegnede ved første møte.

Dine / gruppens innspill og meninger vil bli tatt opp og lagret på lydbånd og behandlet strengt konfidensielt. Studien er tilrådd av Regional etisk komité for medisinsk forskningsetikk og godkjent av Datatilsynet. Rikshospitalet HF er også ansvarlig for å ivareta sikkerheten til personopplysninger som behandles i studien og vi vil behandle opplysningene i samsvar med gjeldende lovverk. All informasjon vil bli lagret og presentert uten personidentifikasjon og beskyttet gjennom strenge sikkerhetstiltak. Alle data vil bli aidentifisert, og ingen svar vil kunne tilbakeføres til deg som person. Pasientopplysninger som eventuelt kommer fram når resultater av studien skal presenteres vil også bli anonymisert. Lydbånd og andre data vil bli oppbevart i et låst arkivskap på prosjektleders kontor/ Rikshospitalet HF.

Deltagelse i studien medfører ingen kostnader for deg. Det er ingen risiko forbundet med denne studien. Studien vil gi sykepleiere økte kunnskaper og systemer for å fange opp og støtte kreftpasienters ressurser (styrker). Videre kan studien være med på å gi helsevesenet et redskap som kan sikre pasienter individuell oppfølging, informasjon og støtte på vei mot et mer helhetlig og pasientvennlig helsevesen.

Selv om du sier ja til å delta i studien nå, kan du trekke deg når du måtte ønske det, uten å oppgi noen grunn, og uten at det vil ha noen konsekvenser. Dine data vil da bli slettet.

Vi regner med at studien i sin helhet vil være avsluttet etter 2009. Alle data vil være slettet senest etter 10 år, dvs. før 31.12.2019.

Om du har spørsmål om deltakelse eller selve studien kan du ringe stipendiat Ann Kristin Rotegård på telefon 23 07 54 59 eller min hovedveileder dr. Cornelia M. Ruland på telefon: 23 07 54 60.

Samtykkeskjema

Ta vare på første siden av dette samtykkebrevet.



Jeg samtykker i å være med i studien slik den er beskrevet ovenfor. Jeg er informert om at min deltakelse i studien er helt frivillig. Selv om jeg sier ja til å delta i dag, kan jeg trekke meg fra studien eller avbryte intervjuene når jeg måtte ønske det, og uten at det vil ha konsekvenser for meg.

Dato: _____

Navn: (blokkbokstaver):

Signatur

Prosjekt: Pasientens ressurser – helse aktive – Nov. 07

Fokusgruppeintervju: Sykepleiere

Åpning (ca 5 min)	<ul style="list-style-type: none">• Presentasjon: med moderator og ass. moderator rollen. Fyll ut informert samtykke (levere inn forhåndsutfyllt) – gjennomgå muntlig.• Hensikten med intervjuet: Årsaken til at jeg har samlet dere til dette fokusgruppeintervjuet er at jeg holder på med en doktorgradstudie hvor jeg ser på pasientressurser eller "Health assets". Health assets kan oversettes med pasientenes helse aktive. Det finnes ikke systematisert kunnskap som avdekker om disse begrepene egentlig er det samme og hva innholdet i dem er. Samtidig vet vi at disse elementene er sentrale i sykepleierteori og praksis. Det jeg trenger og som dere kan hjelpe meg med er å få tak i den erfaring dere har om pasientressurser og helse aktive i praksis for å få frem meningen og innholdet i disse begrepene slik dere forstår og erfarer dem. Hensikten er todelt: 1) først ønsker jeg at dere gjennom denne runden snakker sammen og bidrar med tanker og erfaringer, gjennom generelle refleksjoner. 2) deretter ønsker jeg diskusjoner og erfaringer rundt noen foreløpige resultater som har kommet fram gjennom et teoretisk arbeid (begrepsanalysen) jeg har gjort og hvilken betydning dette har i og for praksis. Vi ønsker å lære av den enkeltes erfaring og tanker om temaet. Alles historie og bidrag er viktig og enighet er ikke målet. Om dere har forskjellige erfaringer og meninger ønsker vi at det kommer fram. Ingen svar er rett eller feil. Har de spørsmål eller kommentarer vil vi gjerne høre disse.
Ikke båndopptaker	<ul style="list-style-type: none">• Om å ta samtalen opp på bånd – sikring av konfidensialitet. Vi trenger en lydbåndopptaker for å få med det dere sier. Selv om en av oss noterer, vil det alltid være med en form for filter/forforståelse, og det kan være viktige nyanser vi ikke får frem. Når vi senere publiserer fra studien, vil det ikke være mulig å spore bestemte personer tilbake til individuelle utsagn. Lyddopptakene vil bli slettet når doktorgradsarbeidet er avsluttet.• Regler for samtalen. Vi vil forsøke å la en person snakke om gangen for å få et best mulig lydbåndopptak og for å følge hverandres innspill bedre.• Deltakerne presenterer seg.

Prosjekt: Pasientens ressurser – helse aktive – Nov. 07

Introduksjon (ca 15 min)	<p>Åpningsspørsmål (bryte isen): småprat om bakgrunn, interesser</p> <p>A) TANKER OG ERFARINGER – GENERELLE REFLEKSJONER</p> <p>1. Introduksjonsspørsmål (begynne diskusjonen rundt temaet)</p> <p>Når dere hører begrepet</p> <p>a) "pasientens aktive"</p> <p>b) "pasientens ressurser"</p> <p>– hva tenker dere da?</p> <p><i>(Kanskje du kan begynne?)</i></p>
Overgang (ca 15 min)	<p>2. Overgangsspørsmål (link til nøkkelsspørsmål)</p> <p>a) Gir disse to ordene, pasient ressurser og pasientens helseaktive til forskjellige assosiasjoner?</p> <p>b) Bidrar ordet "pasientens helse aktive" til andre nyanser eller annet innhold?</p> <p><i>Hvorfor? Hvordan?</i></p>
Nøkkel-spørsmål A (ca 20-30 min)	<p>3. Hvilke pasientressurser / aktive observerer (ser) <u>dere</u> <u>etter</u> som sykepleiere i praksis med kreftpasienter? Kan dere gi meg eksempler på pasientens ressurser /aktive dere ser etter hos pasientene i praksis?</p> <p>4. a) Hvilke pasientressurser /aktive uttrykker / formidler eller tar pasienten i bruk gjennom behandling og pleie? (verbalt og non-verbalt)</p> <p>b) Kan dere gi meg eksempler på ressurser / Aktive pasienten formidler/kommuniserer?</p> <p>Oppsummering etter A: Hva er det viktigste vi nå har diskutert?</p>
5min pause	

(Jeg hører du nevner ... Kan du si mer om det? Kan du forklare nærmere? Kan du gi eksempler? Hva mener du/dere andre? Hvilke erfaringer har dere med dette?)

Prosjekt: Pasientens ressurser – helse aktiva – Nov. 07

<p>Nøkkel-spørsmål B</p> <p>(ca 20- 30 min)</p>	<p>B) DISKUSJONER OG ERFARINGER OM KARAKTERTREKK / Kjemnetegn</p> <p>5. En pasientressurs /aktiva må inneha følgende karakteristika/Kjemnetegn (se foiler):</p> <p>A) Individuell eiendom/besittelse /kontroll (en del av personen selv – utviklet gjennom erfaring/verdier, oppdragelse etc og medfødte egenskaper)</p> <ul style="list-style-type: none"> - Potensial /mulighet - Styrke (motivasjons-/ mobiliserende /vilje og / eller beskyttelse) <p>6. a) Hva betyr disse elementene i praksis?</p> <p>b) Eksempler på pasientressurser / Helseaktiva som representerer disse karakteristika (en og en? alle 4 er til enhver tid definisjonen på helse aktiva)?</p> <p>7. Hvilke andre ord eller nyanser kunne vært brukt for å gjenspeile disse karakteristika/ kjemnetegn? (konkret)</p> <p>Oppsummering etter B: Hva er det viktigste vi nå har diskutert</p>
<p>Avslutning</p> <p>(ca 20 min)</p>	<p>8. Avslutte (dra konklusjoner av diskusjonen):</p> <p>a) Hvor viktig er det at pasientressurser /Helseaktiva fokuseres på i sykepleie?</p> <p>b) Er det spesielle faser i sykdomsforløpet hvor pasientens ressurser/aktiva er mer viktig enn andre faser?</p> <p>c) Er det spesielle/forskjellige pasientressurser/aktiva som er viktig i de forskjellige fasene av sykdomsforløpet?</p> <p>1). inkomst ny pasient 2) behandlingsfase 3) Utskrivningsfase 4) mellom kurene (hjemme / poliklinikk) residiv fase / infeksjon o.l. (innleggelse) 5) erklært frisk – er hjemme /poliklinisk kontroll 6) palliasjonsfase.</p>

Prosjekt: Pasientens ressurser – helse aktive – Nov. 07

	<p>9. Avslutning -endelig (sikre vitale aspekter ikke er oversett):</p> <p>Hensikten med samtalen / diskusjonen vår i dag har vært å få frem deres kunnskap om pasientens helse aktive slik dere forstår dem og har erfaring med. Dere har gitt mye verdifull tilbakemelding!!</p> <p>Til slutt, er det temaer i denne forbindelse dere syns mangler i diskusjonen eller som dere mener vi burde snakket om?</p> <p>Muligheten til individuell samtale eller sende e-post om man har kommentarer, ideer, spørsmål man ser i etterkant.</p> <p>Takk deltakerne og slå av lydbåndet</p>
	<p>Debriefing: En refleksjonsrunde mellom moderator og observatør (på bånd): Hva var de viktigste temaene som ble diskutert? På hvilken måte skilte disse seg ut fra det vi forventet? På hvilken måte skilte de seg fra det som skjedde i tidligere grupper? Hvilke punkter skal med i rapporten? Hvilke sitater må vi ta med? Var det uventede funn? Skal noe endres til neste gruppe?</p>

APPENDIX V.

Table 1

Results of the Mapping Between Motivational Strength (Categories and Subcategories) and ICNP Version 2.0.

Health Assets Term	ICNP Focus Axis	ICNP Parent Term	Closest Match/ Alternative in ICNP
Motivational strength	0 ¹		Hope Impulse [10009903]
A. Hope	Hope [10009095] ²	Emotion	
• Optimism	Optimist - 0 Possibility - 0 Opportunity (option) - 0 Hopeful (cheerful, confidence)-0		Hope [10009095]
• Hope of surviving	Hope [10009095] Survive -0 Live/life-0	Emotion	Hope [10009095]
• Hope about comfort	Hope [10009095] Comfort [10004655]	Emotion Status	
• Hope about not being left alone	Hope [10009095] Avoiding (action) [10003077] Loneliness [10011417]	Emotion Preventing Negative emotion	Visit [10020817] (time: event or episode) Relationship [10016684] Social cohesion [10018362]
• Hope about managing work	Hope [10009095] Managing (action)[10011625] Work role [10021150]	Emotion Action	Coping [10005208]
• Hope about managing everyday tasks	Hope [10009095] Managing (action)[10011625] Everyday life-0	Emotion Action	Self-care [10017661] Family support role [10026998] Family member role [10007605]
B. Goal-directedness	0 Look forward to (anticipate, hope for, expect, wait for, long for)- 0 Having goal(aim, purpose in life, intention, motive, reason) - 0		
• Having something valuable to look forward to, plan and carry through	Planning [10014648] (action) Progressive-0 Future oriented-0 Valuable-0	Coordinating	Potentiality (10015151) Future (10008299) Value (10020599) Pleasure [10014682] Hope [10009095]
C. Drive/motivation	Drive-0 Motivation-0 Zest (glow, interest, spark,wish, desire, wants, involve, engaged)-0		Impulse [10009903]
• Motivation/drive for treatment	Motivation-0 Treatment -0 Therapy (many therapies)		Motivating (action)
• Motivation/drive for finding/using one's strengths	Motivation -0 Using-0 Strength-0 Identifying [10009631] Applying [10002464]	Evaluating Distributing	Energy [10006899] Attending [10004002] Managing (action) [10011625]

¹ 0(cero) denotes no match ²Number in brackets denotes the code of the ICNP term

Table 2

Results of the Mapping Between Relational Strength Concepts and Terms (Health Assets Model v. 1.2) and ICNP Version 2.0.

Health Assets Concepts and Terms	ICNP Term in Focus Axis	ICNP Parent Term	Closest Match/ Alternative in ICNP
Relational strength	0 ¹		Relationship [10016684]
A. Acceptance	Acceptance [10000329] ²	Coping	
• Acceptance of the situation	Acceptance [10000329] Situation (time axis) [10018202]	Coping Process	Acceptance of health status [10023499] (focus)
• Acceptance of help /relief	Acceptance [10000329] Relief /help-0	Coping	Relieving [10016716] (action)
• Adherence	Adherence [1001756]	Status	
• Reconciliation to reality	Reconciliation-0 Reality-0		Acceptance of health status [10000338] Thinking [10019663] Reality orientation therapy (means) [10016451] ProvidingRealityOrientationTherapy [10024515] Acceptance [10000329] Actual [10000420] Situation (time axis) [10018202]
B. Expectations	Expectation [10023679]	Belief	
• Self-expectations		Expectation [10023679]	Determining [10005824] (action) Cognition (focus) [10004485]
• Expectations about health care (providers)	Expectation [10023679] Care provider role [10003991] Health service 10008795 (means)	Belief ndividual role Service	
C. Self-respect	Self-esteem [10017724] Positive self-image [10014925]	Self-image Positive self image (diagnose)+self-esteem ³	
D. Awareness	Awareness [10003083]	Cognition	
• Readiness for treatment and possible side effects	Readiness [10016414] Therapy (means) [10019628] Possible-0 Potentiality [10015151] Side effect [10024057]	Status Collection of acts State Phenomenon	Readiness for - effective coping [10001469] - ability to manage regime [10001448] -effective decision making [10025278]
• Readiness for possible death	Readiness [10016414] Possible-0. Potentiality [10015151] Death - [10005560]	Status State Event or episode	
• Readiness for everyday life after treatment and discharge	Readiness [10016414] Everyday life-0 Therapy (means)[10019628] Discharge (time) [10006000]	Status Collection of acts Event or episode	Readiness for coping [10001469]
• Insight into and knowledge of the treatment and its consequences	Insight-0 Knowledge [10011042] Therapy (means)[10019628] Side effect (time) [10006000]	Status Collection of acts Phenomenon	
• Self-awareness	Self-awareness [10017642] Self-awareness (diagnose) [10029446]	Awareness Effective cognition + Awareness	
E. Connectedness	0		Attachment [10002897] Relationship [10016684] Belonging [10003238]
• Existential connectedness (love, spirituality)	0		Spiritual Belief [10018577] Value [10020599] Cultural Belief [10005427] Religious Belief[10016728]
• Tranquility (Peace of mind)	0		
• Social connectedness	Rapport [10023124]	Relationship	Social cohesion [10018362] Belonging [10003238]

F. Trust	Trust [10025934]	Emotion	
• Self-confidence	Confidence-0 Self-reliance -0 Self-assurance-0 Self-esteem [10017724]	Self-image	
• Confidence in healthcare system	Trust [10025934] Health service [10008795]	Emotion Service	
G. Openness	0		Communication [10004705] Effective ability to communicate [10025025] Effective verbal communication (diagnose) [10028230]
• Expression of feelings	Ability to communicate feelings [10026587]	Ability to communicate	
• Expression of feelings about death	Ability to talk about dying process [10026573]	Ability to communicate	
• Open communication of one's knowledge and needs	Effective communication [10014828] Knowledge [10011042] Need-0	Communication and positive process Status	Self-care [10017661] Caretaking [10004002]
• Expression of humor and pleasure	Communication [10004705] Laughing [10011192] Pleasure [10014682] Humor-0	Interactive behavior Focus Emotion	

¹ 0(cero) denotes no match ²Number in brackets denotes the code of the ICNP term ³ + denotes a combination of two or more parent terms

Table 3

Results of the Mapping Between Volitional Strength (Categories and Subcategories) and ICNP Version 2.0

Health Assets Term	ICNP Focus Axis	ICNP Parent Term	Closest Match/ Alternative in ICNP
Volitional strength	Volition [10020855] ²	Attitude	
A. Will to live	Will To Live [10021113]	Volition	
• Will to survive, get well	Will To Live [10021113] Health [10008711] Well being [10021047]	Volition Status Health	
• Will to live a normal life, put the illness behind one	Will To Live [10021113] Normal-0 Put illness behind-0	Volition	Maintaining (action) [10011504]
B. Readiness to fight / fighting spirit	0 ¹		
• Persistence	Persistence-0 Stayer-0		
• Perseverance	Perseverance-0		
• Endurance	Endurance [10006875]	Status	
C. Courage/guts	0		
• Go-ahead-spirit	0		
• Life-spirit	0		

¹ 0(cero) denotes no match ²Number in brackets denotes the code of the ICNP term

Table 4

Results of the Mapping Between Protective Strength (Categories and Subcategories) and ICNP Version 2.0

Health Assets Term	ICNP Focus Axis	ICNP Parent Term	Closest Match/ Alternative in ICNP
Protective strength	Ability to protect [10000215] ²	Ability	Protection (action)
A. Self-protection	Ability to protect [10000215]	Ability	Effective ability to protect [10028276] (positive diagnosis)
• Self-protection	Effective protective ability [10028276] (Diagnosis)	Ability to protect+ Positive diagnosis and outcomes+ ³ Positive status	
• Emotional protection	Cautious -0 ¹ Prudence-0 Emotion [10006765] Ability to protect [10000215]	Psychological process Ability	
• Physical protection (against infections)	Ability to protect [10000215] Physical-0	Ability	Physical response [10014505]
• Social protection	Withdrawal-0 Socialization [10018391] Ability to protect [10000215]	Interactive behavior Ability	Avoiding (action) [10003077]
• Protection against information	Information processing [10010158] Ability to protect [10000215]	Cognition Ability	
B. Protection of family and friends against suffering	Ability to protect [10000215] Extended family [10007410] Suffering [10019055]	Ability Family Negative emotion	Emotional support [10027022] Emotional support role [10027005] Family support [10023680] Family support role [10026998]

¹ 0(cero) denotes no match ²Number in brackets denotes the code of the ICNP term ³ + denotes a combination of two or more parent terms

Table 5

Results of the Mapping Between Mobilization of Control (Categories and Subcategories) and ICNP Version 2.0

Health Assets Term	ICNP Focus Axis	ICNP Parent Term	Closest Match/ Alternative in ICNP
Mobilization of control / power	Mobilization-0 ¹ Control [10005135] ² Self control [10017690]	Status Volition	
A. Vigorous	Vigor (ous)- 0	Interactive behavior	Energy [10006899]
• Doing something	Engage(Involve(d),Commitment) -0 Action [10000386]	Intentional process	Participation (action) [10014099]
• Taking responsibility	Responsibility-0		Managing [10011625]
• Initiating	Initiating [10010221]	Regulating	
B. Participating in treatment and care of illness	Self performing activity 10017805 Illness-0 Treatment-0 Therapy [10019628] Situation [10018202]	Patient activity+ Performing	Health seeking behavior [10008782]
• Being alerted of health care providers' advice and actions	Alertness [10002144] Effective alertness (diagnose) [10028346] Care provider [10003989] Action [10000386] Advising [10001917]	Status Alertness + Positive diagnosis and outcome +Positive status ³ Individual playing role Intentional process Guiding	Supervising [10019093] Checking [10004189]
• Obtaining and controlling information	Obtaining [10013572] Controlling [10005142] Checking [10004189] Information-0	Managing Organizing Cognition	Alertness [10002144] Information processing [10010158]
• Participating in decision making	Participation [10014099] Decision making process [10005594]	Interactive behavior Cognition	Effective decision making process [10028731]
C. Being active in daily life	Self performing activity [10017805] Daily life / living)-0 Activities of daily living-0	Performing + patient activity	Routine [10017384]
• Restoring daily life	Self-care [10017661] Restoring [10017140]	Intervention + self performing activity Treating	Self diverting [10017711]
• Being socially active	Socialization [10018391] Social process [10018406]	Interactive behavior Process	
• Being physically active	-0 Walking [10020886] Exercising [10007315]	Mobilizing Exercising process + Performing	Physical recovery [10014496] Physical well-being [10014514] Self-performing activity
D. Adapting	Adaptation [10001741]	Coping	
• Steering life in a new direction/ Reorganizing life	Managing [10011625] Adjusting [10001760] Organizing [10013806] Daily life/living-0	Action Organizing Managing	
• Prioritizing what is meaningful	Prioritize [10015736] Meaningful-0Purpose-0 Value [10020599]	Planning Belief	
• Adjusting one's expectations (realistic)	Adjusting [10001760] Expectation [10023679] Realistic -0	Organizing Belief	
• Adjusting to new appearance	Adjusting [10001760] Appearance-0 Look-0 New/changed-0	Self-image	Body image [10003405] Altered perception [10001242]

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