‘The working alliance between patients with bipolar disorder and the nurse: helping and hampering elements from the patients’ perspective’

Running title: The working alliance in bipolar disorder

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The authors declare that this study has not been published or submitted for publication elsewhere.

The authors state that the protocol for the research project has been approved by the VU-METc (protocol ID 2010/318) and conforms to the provisions of the Declaration of Helsinki in 1995 (as revised in Tokyo 2004). All participants gave informed consent and patient anonymity is preserved.

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Introduction

Bipolar disorder (BD) is a severe chronic mood disorder, characterized by recurring depressed and (hypo) manic episodes (1). Life-time prevalence for BD found in European studies range from 1.5% to 2.4% (2,3). Despite pharmacological treatment, the relapse rate into mania or depression in two years is estimated at 48.5% and in five years at 57.3%, with a relapse ratio of 2.5:1 for depression over mania (4,5). In many cases the treatment of BD is only partly effective, leaving the patient experiencing persisting subsyndromal symptoms between episodes with a 3:1 ratio for depressive over manic subsyndromal symptoms (4-6). Due to these persistent symptoms functioning and perceived wellbeing are impaired and patients report a lower quality of life (7-10). IsHak et al. (2012) reported that patients rate the depressive symptoms as most burdensome.

To enhance quality of care the Dutch Guideline for Bipolar Disorders (GBD) advises collaboration between patients, their relatives and involved specialists (11). At this moment a randomized controlled trial (CC-trial) is conducted in the Netherlands to determine the effectiveness of a collaborative care program (CC) for patients with BD (12). In CC a collaborative team is composed in which a nurse has a coordinating position in patient care. The treatment is systematically performed and decisions regarding treatment are made using shared decision-making. Earlier studies in the United States on collaborative care in patients with BD showed an improvement in treatment adherence, social functioning and quality of life (13).

The collaborative nature of CC contains several elements that resemble the working alliance (WA). Bordin defined the WA in three dimensions: the patients' and therapists' ability to agree on treatment goals, the assignment of tasks and the development of a bond between patient and therapist (14,15). A good WA is described in several studies as a mediating factor in enhancing treatment adherence and favorable patient outcomes in mental health (16-18). Research on effects of the WA, between patients with bipolar disorder and their care manager on patient outcomes is limited, yet revealed that a good alliance is associated with a decrease of time spent depressed (19,20), fewer suicidal ideations (21,22) and a better treatment adherence (22,23).

Problem statement

Depressive episodes in BD are frequent and vary in their severity and appearance and are perceived as most burdensome by patients. So far, treatment outcomes in depression can be improved. WA and CC both contain components that may contribute to enhanced patient outcomes. However, a precise understanding of the elements in WA that patients experience as helping or hampering in recovery of a depressive episode has not been investigated yet.

Aim

The aim of this qualitative study was to provide a basis for theorization, by enhancing the understanding of patients' experiences regarding elements of the WA with the nurse that contribute positively or negatively to recovery from a depressive episode. This information can lead to enhanced insight in the WA between patients with bipolar disorder and their nurse and to more awareness of patients' needs during recovery. This may enable nurses to adapt their attitude and support, in preventing further relapse and advance remission.

Research question

Which elements of the working alliance with the nurse experience patients as helping and which elements as hampering in the process of recovery of a depressive episode and how do these elements contribute to the process of recovery?

Methods

Design

A Grounded Theory (GT) approach was chosen as the appropriate design for this qualitative study, because it is considered appropriate to investigate the experiences of patients and to construct a theory that is grounded in the data (24). It provides a framework for a systematic yet flexible approach and helps to develop a theory about not only the elements that are helping and hampering in the WA during a depressive episode, but to exceed to a more abstract and conceptual understanding of the WA (25).

Sampling

Participants eligible for this qualitative study in the Netherlands were enrolled in the experimental condition of the Dutch CC-trial, in which seven mental health outpatient teams participated (12). One team was excluded in the current study, because of the possible acquaintance of the investigator (ES) with patients of that team. Eligible patients were aged 18 to 65 years, diagnosed with bipolar disorder according to DSM IV criteria (1), spoke and understood the Dutch language and had reported -2 or -3 (e.g. a mild to severe depressive episode) on the Life Chart (LCM-r) for more than four consecutive weeks during the CC- trial. The LCM-r has proven to be a reliable instrument to measure mood fluctuations in patients with depressive and manic symptoms (26,27).

The investigator of the CC-trial (TV) collected the LCM-r data in the CC-trial in an interview by phone with patients. All eligible patients were invited to join the current study. Consenting patients were approached by ES for further information by telephone and an information letter and to obtain final consent. Eighteen patients were eligible to participate in this study. Four patients declined. One patient declined due to the anticipated burden of the interview, two due to instability of the pathology and one patient did not want to be confronted with the depressive period.

Data collection and analysis

Each participant was interviewed for one hour in the privacy of their own home, to provide a secure environment in which they could speak freely. Interviews were conducted between February and May 2013. Participants were interviewed using a semi-structured approach using a topic list (appendix I). Sensitizing topics in the topic list were based on the Working Alliance Inventory scale, an instrument based on the three dimensions of Bordin (e.g. goals, tasks and bonds) to measure the quality of the WA (28), and characterizing features of CC regarding the alliance (e.g. the collaboration between patient and nurse, and the establishment and evaluation of goals and treatment plans) (12). In the course of the study

this topic list was adjusted according to preliminary findings and emerging theory. Data were analyzed using Nvivo 10, a software program for qualitative research (29).

According to the GT approach open, axial and selective coding were conducted. Through an inductive process of constant comparison, data continuously influenced the development of categories and arising theoretical concepts (25). The relationship between the core-category and other categories was constructed in a theoretical framework, to gain a conceptual understanding of the helping and hampering elements of the WA in recovery.

Trustworthiness of the data

To enhance the methodological quality of the study, quality-criteria of Lincoln and Guba (1985) were used (30,31). Interviews were audio taped, transcribed verbatim and analyzed by ES, to enhance the credibility and authenticity of the data. Member checks were performed during the interview and findings and interpretations of the researcher were affirmed by subsequent patients. Furthermore, bracketing was performed to enhance objectivity. To enhance the confirmability three interviews were analyzed separately by ES and TV, to discuss emerging categories and themes. The research process was carefully supervised by TV, BM and a peer-review group. Thick description, presenting various citations of patients, is inserted to enhance the credibility and transferability of the study. During the study process memos were made to enhance the confirmability (32). In each interview, observational memos to improve interpretation and understanding of the data were made. Methodological memos were made to recognize subjective attributions of the investigator and to guide the research process. Theoretical memos provided a clear view of the conceptual development of the study. All memos were regarded as data.

Ethical considerations

The study is approved by Medical Ethical Exam Committee of the VU medical centre (protocol ID 2010/318). Participants were informed that all interview information is confidential and that their treating clinicians were informed about the study, but to ensure anonymity, no information of their participation was revealed.

Results

Fourteen patients participated in this study, of which twelve female and two males. The mean age of the group was 48.7 years and the years of contact with the nurse were 1-16 years.

Patients expressed various elements in the WA that can help or hinder recovery of a depression. The data revealed three important themes that enable the nurse to make a contribution. In the first place it was vital that the nurse created a safe environment that empowered the patient to feel secure, understood and welcome. In this environment the nurse and patient collaborated to establish the two key points in recovery, e.g. clarifying thoughts and feelings of the patient and supporting patients to remain or become active (figure 1). Citations of patients are categorized by theme in table 1.

To what extend the nurse could contribute to the recovery, depended on several factors e.g. the perceived severity of the depressive symptoms and quality of the WA. Patients expressed various burdensome symptoms that affect their mental, physical and social functioning during a depressive episode. Most prominent features named were: a loss of energy and interest, fatigue, insecurity, low self-esteem and self-stigma and difficulties in thinking clear. Due to these symptoms, it was difficult for patients to find solutions to everyday problems and to remain active. Patients inclined to withdraw from contacts.

Patients with a good relationship with their nurse (N= 12) noted that the nurse contributed to their recovery in different ways, whereas patients with a moderate relationship (N=2) perceived no contribution. Patients who expressed having a severe depression appeared to feel more dependent of the nurse during their recovery, describing the nurse in terms such as their 'safety net'. Patients who perceived their depression as moderate seemed to use the nurse more or less as an assistant during their recovery.

Theme 1: A safe and supporting environment

Patients named important basic needs with respect to the attitude of the nurse, which are outlined in the following themes: Being there when it is needed, being emphatic to the patient and knowing the patient beyond the illness.

Being there when it is needed

Patients described the security they experienced in knowing that when they needed it, they could reach out, and the nurse was there. Important aspects that enhanced the feeling of availability when needed were: feeling welcome, undivided attention of the nurse, without fear of straining the nurse and the feeling of patients that the nurse keeps the patient in her thoughts even when they are not in direct contact. The possibility of email was noted as extra

helpful, strengthening the accessibility of the nurse. Continuity in conversations, where the nurse remembers which topics were mentioned and attention for agreements were vital to experience involvement of the nurse. One patient told that the nurse repeatedly forgot agreements, which was one of the reasons that the collaboration was tampered. Although patients overall stated that nurses offered enough assistance, three patients missed a more outreaching contact like house calls when the depression impeded them so much that even the trip to the clinic became an insurmountable barrier.

Being emphatic

According to patients an environment where they feel secure and safe enough to speak open and honest about all problems that occur during the depression was important to provide the nurse with vital information to map the severity of the depression and to decide on corresponding interventions. The nurses' attitude adapted to patients' needs during a depressive episode: being extra friendly, caring, thoughtful, and attached.

For most of the patients it was important to perceive the nurse as emphatic to their situation and feelings. The notion of recognition and acknowledgement of being ill and being understood were important for the WA. One patient felt that the nurse took the side of the partner, what negatively impacted the WA and the contribution the nurse made in the recovery. Negative experiences with professionals or persons in the past, where actions of the patient as a result of the illness were treated as condemnable behavior, contributed to the need to experience empathy from a non-judgmental nurse. Some patients expressed that they valued it that the nurse took the time to listen and emphasized with their feelings, yet, at the same time motivated them not to dwell in the depressive feelings and to become active.

Knowing the patient beyond the illness

Patients experienced the nurse as helpful when they were confident that the nurse had knowledge of BD as well as knowing the patient as a person. This contributed to the sense of being able to speak freely, without having to mask the real feelings they experience, and the feeling of trust in the suggestions the nurse made in the treatment.

Although most patients expressed the possibility to be honest about their situation and feelings, discussing difficulties in the collaboration appeared to be challenging. Patients with a moderate WA did not discuss their difficulties and even patients with a good WA expressed reluctance. One patient mentioned the fear of negatively influencing the collaboration.

Theme 2: Clarifying thoughts and feelings

Mental problems caused by the depression like: trepidation, worrying and concentration problems, self-inflicted guilt and insecurity influenced the way patients valued themselves and their surroundings. Some patients mentioned that they underestimated positive contributions they made, and were unable to distinguish the essential from the ancillary.

Elucidate and unravel

Nurses could support patients by assisting them in clarifying their thoughts and help them to get a clearer view of reality. Nurses listened and motivated the patient to look beyond the boundaries the depression created and to perceive situations in a different light. The nurse helped to elucidate situations by summarizing the patients' story and added her own perception of the situation, or helped the patient to unravel the situation by thorough querying. Patients described that at moments it was sufficient when the nurse reminded them that some difficulties they experienced were a result of the depressive symptoms. Patients felt helped when the nurse did not pressure them to dig in the past and kept questioning why they felt depressive, but looked at the problems they experienced in the presence.

Empowering the patient

Nurses motivated patients who experienced difficulties in noticing positive aspects in their situation, to give the situations they described a moment's thought to become aware of the positive aspects. Efforts made to enhance the patients' own capabilities are perceived by patients as more helpful than instant solutions, because it provides them with skills to regain control over their own situation. The problem solving treatment method (PST) was named by patients as an important method to regain confidence in their own ability to change the way they perceived problems and to start solving them. At the same time it created a good collaboration between patient and nurse, providing a framework in the appointments where problems and thoughts were discussed systematically. Although PST was perceived as helpful, some of the patients experienced difficulties in applying the method to their own situation.

Theme 3: Supporting patients to remain or become active

Fear of losing grip and becoming more depressed were reasons to try to stay active. Become or maintain active also provided distraction from the situation, some feeling of accomplishment and the possibility of expanding borders. However, due to depressive symptoms it was an ongoing battle for many patients, in which nurses played an important role.

Collaborating in creating successful activities

Some patients expressed difficulties in overseeing tasks they wanted to undertake and the road to achieve activation. Nurses assisted by helping the patient to figure out which goals they wanted to reach. Nurses motivated the patient to break up each goal into practical manageable steps, thereby making them achievable, contributing to the feeling of accomplishment. Goals were evaluated in following appointments, which motivated patients, because it functioned as a big stick to comply with agreements. Patients expressed that positive reinforcement provided them with the safety to attempt to reach the goals they set. Nurses maintained this safety, by looking forward without a criticizing and dismissive attitude when goals were not reached.

Providing suiting activities

Patients expressed different wishes regarding the activities the nurse could offer. For instance, some patients needed help to structure daily activities, while other patients expressed that the nurse should not interfere with that. Knowing the patient as a person enhanced the chance of a successful collaboration between patient and nurse in the exploration of measures to maintain or expand activities. Most patients expressed that they valued the possibilities the nurse provided without pressuring them in using them.

Discussion

To our knowledge the current study is the first to examine the perspective of patients with a bipolar disorder on the working alliance with their nurse during a depressive episode. The three emerging themes e.g. a safe and supporting environment, clarifying thoughts and feelings and support to remain or become active, confirm findings of earlier studies in mental health, which confirms the transferability of the findings.

The patients' basic needs regarding the nurse like empathy and being there when needed, enabling them to be honest and open about their situation, meet the criteria of the 'holding environment, firstly described by Winnicot (1965). He stated that the holding environment' of the client-therapist relation resembles the care of the 'good enough' mother for her infant (33). The therapist is reliable, present, emphatic and accepting and uses a gentle and non-judgmental approach in the care for the patient (33,34). By understanding the patient, the therapist can provide the aid needed to get a grip on his situation and to clarify what is confusing for the patient. Furthermore, these and other personal attributes like knowing the patient as a person and the need to become active in solving the problems patients experience were also described in other qualitative studies of the WA in mental health services (35,36).

CC emphasizes the cooperation between patient and nurse (12). Characterizing elements of CC that patients confirmed to be an important attribute in the WA were: the active approach of the nurse to adapt treatment to the patient's needs and the nurse as coordinator in care, liaising with other professionals involved in treatment. The problem solving approach is described in several studies as an important strategy of the care manager in treatment and WA (35,36). The current study confirms problem solving treatment to be an effective method to create a good collaboration.

The findings of this study suggest that nurses attempt to create a functional level of equality in the alliance as described in a literature review about equality as a central concept in nurse ethics (37). Nurses provide patients with information, attune their support to individual needs of patients and maintain a balance between temporarily taking over control when necessary and empowering the patient in self-management. Nevertheless, although patients felt safe to speak freely with their nurse and experience a sense of equality, some patients chose not to inform their nurse about difficulties they experience in the collaboration. While fear of damaging the collaboration is one of the mentioned reasons, inequality in the patient-nurse relationship perhaps can further explain the reluctance to discuss the collaboration.

Limitations

This study has several limitations. One limitation is that all patients eligible were included; therefore theoretical sampling could not be performed and saturation is not reached. The results give an impetus to a grounded theory, yet more research is needed. A better understanding of the hampering elements of the WA could be revealed by interviewing more patients with a moderate WA. Furthermore, more detailed information regarding patients' reasons not to evaluate difficulties in the collaboration, could contribute to a better understanding.

Conclusion

Three core themes characterize the support that nurses offer during recovery. Firstly it is vital that nurses create a safe and supporting environment. This environment builds a foundation on which nurses can provide support in the two remaining themes; the support of the nurse in getting psychologically active and support in getting physical active. In this process it is essential that nurses enable patients to manage their recovery them-selves.

Recommendations

This study underlines the importance of a good WA in the recovery of a depressive episode. Although nurses are expected to possess the personal attributes to create a safe and sustaining environment, education programs should incorporate these attributes to train nurses to be self-reflective on this topic, thereby enabling them to use themselves as an attribute in enhancing treatment-outcomes.

The contribution of the nurse to recovery from a depressive episode implies to be dependent on the strength of the WA. This association could not be thoroughly investigated because of the limited number of patients that had a moderate WA, and should be further investigated. A periodical evaluation of the collaboration in which the nurse encourages patients to disclose possible problems in the WA is recommended. This can create an opportunity to resolve the reluctance of patient to discuss the dyad. Moreover, it can strengthen the WA or to find other solutions like delegating care to another nurse, in order to enable the patient to make energetic use of the helping attributes of the nurse.

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Table 1: *Citations of patients categorized by theme*

Theme	***Citation (Characteristics of participants)***
Safe and sustaining environment	
• Being there	"When it is not going well, when you are in full panic, you think: "it's all wrong"… Then I realize: "now I need the nurse as my safety net" and as soon as I talk with her on the phone a feeling of calmness arises, "oh it's going to be okay" *(Female, 58 years of age, participant 3)*
	"For her I don't have to hide anything, or present myself better than I am, because I don't burden her by doing so, which is the case with other people. I burden them if I let them know that I'm depressed or unstable, or anything.. I don't burden her and she understands it, I don't have to feel ashamed". *(female, 51 years of age, participant 2)*
	"I remember that I thought: "I wish that the nurse would come to me, that I don't have to go there". When you are seriously physical ill the doctor pays a house-call, why can't that be the case for me?" *(female, 51 years of age, participant 2)*
• Being empathic	"She is kind and caring, and that makes it possible to say anything. I would even have told her if I had suicidal ideations, even if I had concrete plans, I would have told her". *(female, 53 years of age, participant 10)*
	The nurse has a different attitude and believes me… and validates my feelings more when I struggle: he understands that I need it to survive, that I need to go outside en to be among people. He understands this more than my husband… who believes that I do these things just for myself, which is true, but also to be able to cope with life" *(female, 54 years of age, participant 13)*
• Knowing the patient beyond the illness	[A patient talks about problems she experienced with medication] "I am so glad that I can discuss what I experience with myself and that my nurse acknowledges this, stating: "your rhythm has changed and you benefitted from that rhythm which you developed, so I understand that it does not seem to work." *(female, 53 years of age, participant 10)*

Clarifying thoughts and feelings	"I find myself easier confused… estimating things to be more difficult than they are and value my positive contribution smaller than it in fact is". *(female, 53 years of age, participant 10)*
• Elucidate and unravel	I think that they are there for me and help me to see it in a different way, approach it in a different way, suggesting idea's… making me aware of how things happen. You yourself can't see the immediate cause, because it's constantly accumulating. *(female, 45 years of age, participant 5)*
• Empowering the patient	"being impatient with yourself and recovery, it helps when someone clearly states: look where you are now, a few weeks ago you were there and now you are so much further... simple things that can help and that bit of optimism and help to recollect yourself." *(female, 53 years of age, participant 10)* "Sometimes she offers things that really help me, every two weeks I make a PST-assignment. This is a way to make me think in a different way, she makes me think another way… I know that this will never go away [the bipolar disorder] so I need to enable myself as good as possible in order to try to decrease the change of reoccurrence… eventually she can't help me, I need to do it myself" *(female, 37 years of age, participant 14)*
Supporting patients to remain or become active	"I'm so afraid that when I let go the routine and I don't force myself... that I will relapse even further. I don't know how far I will relapse and where I end up, so I remain in my safe routines" *(female, 45 years of age, participant 5)*
• Collaborating in creating successful activities	The nurse said; "Try to vacuum the living room when your daughter cleans the house". Not everything all at once, just one thing in which you succeed" *(female, 50 years of age, participant 6)* [Patient speaks about the activities she undertook, after a conversation with the nurse] "…Because you have promised it and next time, he will ask about it, and then I want to tell him that I have done it… Not only tried to do it, but have done it. I remember the first time I went to the store, all I wanted to do is to turn around and go home… but then I thought about the conversation and persevered" *(female, 58 years of age, participant 2*

• Providing suiting activities	[patient tells about the nurse offering her creative therapy] “She asked: “what do you need, what could help you?”. When I told her about the creative therapy, she already knew that I liked painting and said: “I heard there is a vacancy and the first one I thought of was you” *(female, 52 years of age, participant 11)*

Figure 1: *The helping elements of the working alliance in the recovery of a depressive episode*

Dutch summary

‘De therapeutische relatie tussen patiënten met een bipolaire stoornis en de verpleegkundige: De door patiënten ervaren helpende en belemmerende factoren in het herstel van een depressieve episode’

De bipolaire stoornis wordt gekenmerkt door terugkerende manische en/ of depressieve episodes. Ondanks medicamenteuze behandeling is de kans op terugval groot en kampen patiënten regelmatig met subsyndromale verschijnselen tijdens stabiele periodes. Om tot betere behandelreslutaten te komen wordt momenteel het ‘Zorg in Samenwerking’ (ZIS) programma onderzocht op effectiviteit. Een belangrijk onderdeel van dit programma is de samenwerking tussen de verpleegkundige en de patiënt.

Het doel van het huidige onderzoek was het ontwikkelen van een theorie over de helpende en belemmerende factoren van de therapeutische relatie (TR) in ZIS en hoe deze elementen bijdragen aan het herstel van een depressieve episode. Deze informatie draagt bij aan de kennis over de TR bij patienten met een bipolaire stoornis en geeft verpleegkundigen handvatten in de zorg voor patiënten die aan het herstellen zijn van een depressieve episode.

Een kwalitatief onderzoek met een grounded theory benadering is toegepast. 14 patiënten die deelnemen in de experimentele arm van het ZIS-onderzoek zijn geïnterviewd.

Drie thema’s kenmerken de hulp door de verpleegkundige tijdens het herstel: een veilige en ondersteunende omgeving bieden, de patient ondersteunen in het verhelderen van gedachten en motivatie tot fysiek in beweging komen. Essentieel in dit proces zijn de mogelijkheden die de verpleegkundige de patiënt biedt zelf om te leren gaan met de depressie.

Uit de resultaten blijkt dat patiënten moeite hebben moeilijkheden in samenwerking bespreekbaar te maken. Omdat de kwaliteit van de TR en de bijdrage die vpk kunnen bieden aan het herstel met elkaar verbonden zijn is het belangrijk dat verpleegkundigen met regelmaat dit onderwerp bespreekbaar maken, om de zorg te optimaliseren.

Trefwoorden: therapeutische relatie, bipolaire stoornis, collaborative care, verpleegkundige, psychiatrie.

Abstract

‘The working alliance between patients with bipolar disorder and the nurse: helping and hampering elements from the patients’ perspective’

Bipolar disorder is characterized by recurring depressed and/or manic episodes. Despite pharmacological treatment, relapse rates are high and in many cases patients experience persisting subsyndromal symptoms. At this moment a study is conducted in the Netherlands to determine the effectiveness of a collaborative care program (CC) for patients with bipolar disorder. The collaborative nature of CC contains several elements concerning the working alliance (WA), which can have a positive influence on treatment results.

The aim of this study was to develop a substantive theory that answers the following research question: Which elements of the WA with the nurse experience patients as helping and which elements as hampering in the process of recovery of a depressive episode and how did these elements contribute to the process of recovery? This knowledge can provide enhanced insight in CC and opportunities for nurses to adapt their attitude and care.

A qualitative study with a grounded theory approach was conducted. 14 patients, who participate in the experimental condition of CC, were interviewed.

Three core themes characterize the support that nurses offer during recovery: A safe and supporting environment, assistance in clarifying thoughts and feelings and support in getting physical active. In this process it is essential that nurses enable patients to manage their recovery them-selves.

The results provide an impetus to a grounded theory; more research is needed. Patients often are reluctant to discuss difficulties in the collaboration. Since the quality of the WA seems to be interconnected with the support nurses can offer in the recovery, it is recommended that nurses systematically evaluate the WA to enhance the support they can provide.

Keywords: working alliance, bipolar disorder, collaborative care, nurse, mental health.

Appendix 1: Topiclist Bevorderende en belemmerende elementen in de samenwerking

Depressie

- Hoe kijkt u terug op de periode dat u depressief was?
- Hoe voelde u zich?
- Welke invloed had de depressie op uw leven?

Factoren van herstel

- Wat heeft u geholpen om beter te worden?
- Hoe heeft dit bijgedragen aan uw herstel?
- Waren er specifieke personen in uw leven die hierbij hielpen?
- Hoe hebben zij u geholpen om te herstellen van de depressie?

Aspecten in de samenwerking met de verpleegkundige *(Eerste exploratie van de rol van de verpleegkundige tijdens het herstel, hierbij richtend op hoe de participant dit ervaren heeft en wat de hij/zij belangrijk vindt in het contact)*

Verpleegkundige genoemd als factor

U heeft aangegeven dat het contact met de verpleegkundige invloed heeft gehad op uw herstel van de depressie. Ik zou hier graag wat dieper op in willen gaan.

Verpleegkundige niet genoemd als factor

- Hoe ervoer u het contact met de verpleegkundige toen u depressief was?
- Wat was er belangrijk in dit contact?
- Waren er ook punten in dit contact die u juist niet hielpen in het verminderen van uw depressieve klachten?

Als er geen contact is geweest met de verpleegkundige

- Hoe verloopt het contact over het algemeen?
- Wat zijn de punten in het contact met de verpleegkundige die u helpen tijdens het beter worden? Op welke manier heeft u hier baat bij?
- Zijn er punten in het contact die u moeilijk vind? Hoe werkt dit?
- (als het contact tot op heden volgens de participant geen bijdrage leverde aan het herstel) Hoe kan het contact met de verpleegkundige in uw ogen bijdragen aan uw herstel?

Verdieping van de helpende en belemmerende elementen in de samenwerking

- Hoe werkte dat precies? Wat deed de verpleegkundige? Hoe reageerde u hier op?
- Hoe merkte u dat het u hielp/ belemmerde in het beter worden? Waar merkte u dit aan? Hoe ging de verpleegkundige hier mee om?

Topics WAI en CC

- De samenwerking tussen de patiënt en verpleegkundige en eventuele andere betrokkenen bij de behandeling (psychiater familie etc.)
  - Het begrip van de verpleegkundige over de doelen van de patiënt
  - Het verschillen van mening ten aanzien van de te bereiken doelen en de manier waarop daar aan gewerkt wordt.
  - Het begrip van de verpleegkundige over de doelen van de patiënt
  - Gewaardeerd worden als persoon door de verpleegkundige
  - Wederzijds vertrouwen tussen verpleegkundige en patiënt
  - Het vertrouwen in de verpleegkundige als de persoon die behulpzaam kan zijn in de behandeling
  - Aardig gevonden worden door de verpleegkundige
  - Begrepen worden door de verpleegkundige
- Shared decision making in het vaststellen van doelen en daaruit volgende acties.
  - De gezamenlijke overeenkomst over doelen en acties (shared- decisionmaking in collaborative care) die de patiënt kunnen helpen zijn situatie te veranderen.
  - Het krijgen van nieuwe inzichten door de behandeling
  - Het gezamenlijk werken aan de gestelde doelen
  - Het verschillen van mening ten aanzien van de te bereiken doelen en de manier waarop daar aan gewerkt wordt.
- De geprotocolleerde evaluatie van de doelen, acties en samenwerking.
  - Wordt op de afgesproken manier aan de afgesproken doelen en acties gewerkt? (Wat blijkt uit evaluaties)
  - Zijn de patiënt en verpleegkundige het eens over de juistheid van de gekozen werkwijze?
  - Is de samenwerking tussen de patiënt en verpleegkundige een onderwerp van gesprek tijdens de behandeling?