The working alliance between patients with bipolar disorder and the nurse: helpful and obstructive elements during a depressive episode from the patients’ perspective

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Abstract

Bipolar disorder is characterized by recurrent depressive and hypomanic or manic episodes. Despite pharmacological treatment, relapse rates are high and in many cases patients experience persistent (subsyndromal) depressive or manic symptoms. A controlled trial has been conducted in the Netherlands to determine the effectiveness of a collaborative care program (CC) for patients with bipolar disorder. This intervention program emphasizes the importance of a high-quality working alliance (WA), which can have a positive influence on treatment results.

The current paper addresses the following research question: Which elements of the WA with the nurse are experienced as helpful and which as obstructive by patients in the process of recovering from a depressive episode, and how do these elements contribute to the process of recovery?

A qualitative interview study with a grounded theory approach was conducted among 14 patients who participated in the experimental condition of CC.

Three core themes underpinned the nurses’ support during recovery: a safe and supportive environment, assistance in clarifying thoughts and feelings, and support in undertaking physical activity. Our study illustrates that the process of recovery from a depressive episode is mediated by the quality of the WA with the health care professional.
**Introduction**

Bipolar disorder (BD) is a severe chronic mood disorder characterized by recurrent depressive and manic or hypomanic episodes (1). Life-time prevalences for BD found in European studies range from 1.5% to 2.4% (2;3). Treatment for BD is only partly effective in a substantial percentage of patients, leaving the patient with persistent predominantly depressive subsyndromal symptoms between episodes (4-6) which are associated with impaired functioning and decreased quality of life (7-10). Patients rate depressive symptoms as the most burdensome (8).

During treatment, optimal collaboration between the patient, mental health care providers, and the patient’s family is important to enhance quality of care (11). Well-designed integrated treatment programs that reinforce this collaboration are needed. We developed a collaborative care program (CC) for patients with BD that puts a heavy emphasis on the quality of the working alliance. The effectiveness of this intervention program was studied in a randomized controlled trial. The major components of this program are summarized in table 1. Patients randomized to CC experienced a decrease both in the severity of depression and in time spent with depressive symptoms (12).

Mental health nurses occupy a central position in delivering care in our CC program, giving them the opportunity to create strong working alliances with patients. The WA has been defined across three dimensions: the patients’ and therapists’ ability to agree on treatment goals; the assignment of tasks; and the creation of a bond between patient and therapist (13;14). A good WA is described in several studies as a mediating factor in enhancing treatment adherence and promoting favourable patient outcomes in mental health (15-17). Research on the effects on patient outcomes of the WA between patients with BD and their care manager is limited, yet reveals that a good alliance is associated with a decrease in time spent depressed (18;19), fewer suicidal ideations (20;21), and better treatment adherence (21;22). Nevertheless, we have no precise understanding of the elements in the WA that patients with BD experience as helpful or obstructive. We therefore conducted a qualitative study to gain a better understanding of the value and impact of the WA in this patient group. Since persistent depressive symptoms are a particularly important problem in BD, this study focuses on the elements of the WA that contribute positively or negatively to recovery from a depressive episode. This information can enable nurses to adapt their professional attitude and behaviour in order to contribute effectively to the promotion of recovery and the prevention of relapse.
<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
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<tr>
<td>Formarrion of a Collaborative Care team</td>
<td>The formation of a Collaborative Care team, including at least the patient, the nurse, the psychiatrist and where possible a family member, in which all decisions concerning treatment and care are made. The team members met in the third, sixth and twelfth month.</td>
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<td>Coordination of care</td>
<td>Coordination of care was provided by the mental health nurse in his/her role as care manager.</td>
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<td>Contracting</td>
<td>A treatment plan formulated as a contract was introduced to achieve agreement within the CC team on the most important problems and treatment activities.</td>
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<td>Systematic assessment of care needs</td>
<td>The Camberwell Assessment of Needs provided a framework for the formulation of treatment plans. The execution and outcomes of the treatment plan were systematically monitored and evaluated in the CC team.</td>
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<tr>
<td>Psycho-education</td>
<td>Each patient and caregiver was invited to participate in six two-hour sessions of psycho-education.</td>
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<tr>
<td>Problem-solving treatment (PST)</td>
<td>PST was integrated into the intervention to enhance the patients' self-management skills.</td>
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<td>Life Chart Method (LCM)</td>
<td>LCM was used to help patients recognize mood patterns in daily life.</td>
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<td>Relapse prevention plan</td>
<td>Early warning signs of relapse and interventions were described in a relapse prevention plan.</td>
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<td>Pharmacotherapy and somatic care</td>
<td>Pharmacotherapy and somatic care were continued as appropriate. In addition, the CC team continuously monitored effects, paying specific attention to medication adherence.</td>
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Methods
Design
The Grounded Theory (GT) approach was chosen as the appropriate design for this qualitative study, whose main aims are to investigate the lived experiences of patients and to obtain a theoretical understanding of the factors within the working alliance that contribute to the patient’s recovery (24).

Study population
Eligible patients were those participating in the experimental condition of the Dutch Collaborative Care trial (CC), conducted by seven mental health outpatient teams (12). One team was excluded from the current study owing to the principal investigator’s (ES) possible acquaintance with that team’s patients. Eligible patients were aged 18 to 65 years, were diagnosed with BD according to DSM IV-TR criteria (1), and had sufficient command of the Dutch language to participate in the interview. Eligible patients were also those reporting a score of -2 or -3 (i.e. a moderate to severe depressive episode) on the retrospective Life Chart Method (LCM-r) scale 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 BD (25;26).

The principal investigator in the CC trial (TV) collected the LCM-r data during phone interviews with the patients as part of the main trial. All eligible patients (N=18) were invited to participate in the current study, with fourteen patients consenting. Four patients declined due to the perceived burden of the interview. Participants were informed about the study’s content and procedures by telephone and letter, and signed the informed consent form.

Data collection and analysis
Each participant was interviewed in their own home to ensure a secure environment in which they could speak freely. Interviews were conducted between February and May 2013. Participants were interviewed for an average of one hour using a semi-structured interview with topic list. This topic list was based on two sources: 1. items of the Working Alliance Inventory scale, based on Bordin’s three dimensions (goals, tasks and bonds), to measure the quality of the WA (27), and 2. typical features of the working alliance in CC, such as the specific nature of the collaboration between the patient and the nurse and the structured identification and evaluation of treatment goals (23). The topic list was adjusted over the course of the study in line with preliminary findings and emerging theory. Data were analysed using NVivo 10, a software program for qualitative text analysis (28).

In accordance with the GT approach, open, axial, and selective coding was conducted. An inductive process of constant comparison allowed categories and theoretical concepts to be developed based on coded interview text fragments (29). The inductive process led to the
identification and description of the core category. The relationship between the core category and
other categories was elaborated within a theoretical framework, providing a conceptual
understanding of the specific nature of the WA between patients and their primary nurse, including
the elements that help and obstruct the establishment of a good WA and its contribution to the
patient’s recovery.

Trustworthiness of the data
To enhance the methodological quality of the study, the researchers used Lincoln and Guba’s quality
criteria (30). Interviews were audiotaped, transcribed verbatim and then analysed. The researchers
performed member checks during the interviews by summarizing the information, asking the
participants to review its accuracy, and presenting it to them for validation in subsequent interviews.
Any potential preconceptions by the principal investigator were assessed and discussed during
regular supervision sessions and in personal memos to enhance objectivity. To enhance
confirmability, ES and TV analysed the first two interviews and the sixth interview separately. The
research group discussed selected code words, emerging categories and theoretical concepts until it
reached consensus. TV, BM, and a peer-review group supervised the research process. We include
various patient citations in this article to clarify the nature of the theoretical concepts. During the
study process, observational memos were drawn up to improve data interpretation and
understanding. Methodological memos were drafted to address methodological issues that emerged
during the study. These issues were then discussed during the supervision sessions, which steered
subsequent choices in the research process. Theoretical memos made the progressive evolution of
theoretical constructs and their interrelationships transparent.

Ethical considerations
The study was approved by the Medical Ethical Committee of the VU University Medical Centre
(protocol ID 2010/318). Participants were informed that all interview information would remain
confidential.

Results
Introduction
Fourteen patients (12 women and 2 men) participated in this study. Patient characteristics are
described in table 2.
The nature of the nurse’s contribution to the process of recovery depended on several factors, including the perceived severity of the depressive symptoms and the quality of the WA. Patients (N=12) who perceived their depression as severe felt more dependent on the nurse, describing him or her as their ‘safety net’. Patients (N= 2) who perceived their depression as moderate used the nurse mainly as a coach during recovery.

Patients expressed various burdensome symptoms that affected their ability to function mentally, physically, and socially during a depressive episode. The most common symptoms named were loss of energy and interest, fatigue, low self-esteem, self-stigma, and cognitive problems such as difficulty thinking clearly. These symptoms made it difficult for patients to solve everyday problems and remain physically active. Although most patients were inclined to withdraw from social contacts, the majority said that contact with the nurse remained or even increased in frequency.

We found three important themes underpinning nurses’ contribution to the recovery process. First, the nurse created a safe environment, helping the patient feel secure, understood, and welcome. In this safe environment the nurse performed two main activities that contributed to the patient’s recovery and are related to the second and third themes, i.e., clarifying the patient’s thoughts and feelings, and supporting patients become or remain physically active (figure 1). The three main themes are elaborated in the following sections.
**Theme 1: A safe and supportive environment**

According to patients, the most important basic requirements for creating a safe and supportive environment are: being there when needed; being empathic to the patient; knowing the patient beyond the illness; and equality in the collaboration.

**Being there when needed**

Patients felt secure, knowing that when they needed to, they could reach out and the nurse would be there to support them. Although most patients perceived the support of the nurse as helpful, some emphasized their wish to be as independent as possible. Most patients valued the nurse’s ability to balance active support for the patient against respect for the patient’s desire for autonomy.

*I need the nurses’ support when I am incapable of managing the depression on my own, but as soon as possible I do want to manage on my own. This is a clear wish and so I don’t feel dependent on her. There is a lot that I can do myself, but there are moments when I think “help me” and then I’m glad she’s around.*

Important factors that enhanced the patient’s sense of commitment of the nurse were: feeling welcome and accepted despite all current problems and needs (and regardless of their content); having the nurse’s undivided attention without the fear of overstraining her; and the idea that the nurse thinks about the patient even when there is no direct contact.

*I don’t have to hide anything from her or present myself as better than I am, because I don’t burden her by being myself, which is the case with other people. I burden them if I let them know that I’m depressed or unstable or anything.*  

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*Figure 1. Patients’ experience of the helpful elements of the working alliance when recovering from a depressive episode*
Continuity in conversations, with the nurse remembering topics discussed in the past, were mentioned as vital to the quality of the WA, as well as keeping earlier agreements. For example, one patient said that the nurse repeatedly forgot agreements, contributing to the patient’s perception of her as unreliable, and interfering with the collaboration. Although overall patients stated that nurses offered enough assistance, three patients felt that outreach was lacking, e.g. house calls when the depression was so severe that even a trip to the clinic became an insurmountable barrier. The possibility of email contact was noted as helpful in making the nurse more accessible. Patients appreciated when the nurse liaised between them and other professionals during depressive episodes. This helped them conserve energy and avoid having to explain their situation repeatedly.

**Being empathic**

Having an empathic nurse encouraged patients to discuss all their problems. Such openness is important in providing nurses with information vital to assessing the severity of the depression and deciding on corresponding interventions. When feelings of vulnerability increased, patients needed nurses who were extra friendly, caring, thoughtful, and attached.

‘She is kind and caring, and that makes it possible to tell her everything. I would have even told her if I had had suicidal ideations; even if I had had concrete plans, I would have told her.’

Patients appreciated when nurses took their side unconditionally as they struggled with severe feelings of depression and when seeking relief. One patient mentioned that when the nurse took her partner’s side, it negatively impacted their WA.

**Knowing the patient beyond the illness**

Patients experienced the nurse as helpful when the nurse was well informed about BD in general, but also about the specific characteristics and vulnerabilities of the patient as a person. This was reinforced when patients felt that the nurse acknowledged their feelings and their illness. Patients felt that this allowed them to speak freely, without having to mask their real feelings. It also increased the patient’s trust in the nurse’s treatment recommendations because the nurse was able to effectively combine theoretical insights concerning the mental disorder with the patient’s individual needs. One patient spoke about the prescribed medication that interfered with the daily routine she had adopted to stay in control of her depression:

‘I am so glad that I can discuss my experiences and that my nurse acknowledges them by saying “As a result of the current medication, your rhythm has changed, and you benefitted from the rhythm that you had developed yourself before, so I understand why it isn’t working for you.”’
Patients differed in their preferences regarding the nature and content of nursing care during the process of recovery from depression. For instance, some patients needed help in structuring their daily activities, while others explicitly rejected the nurse’s interference in their daily life. The nurse’s capacity to tailor nursing care to the patient’s individual problems and needs is an important prerequisite for promoting the working alliance and recovery. Most patients said that they appreciated the nurse offering them advice without pressuring them to comply.

**Equality in the collaboration**

Although most patients felt they were able to express their thoughts and feelings openly and honestly, it was challenging for them to discuss difficulties they were having in their collaboration with the nurse. Most patients expressed the need for collaboration based on equality, with a reciprocal opportunity to discuss problems in the collaboration. Patients who were dissatisfied with the quality of the WA did not discuss their difficulties with the nurse. The majority of patients with a good WA said that they had little or no trouble discussing their preferences and difficulties that had arisen in the collaboration, but they rarely talked to their nurse about actual problems that had occurred in the collaboration, for various reasons. One patient felt that the problem she had experienced was relatively small and therefore was not worth mentioning. Another patient mentioned the fear of negatively influencing the collaboration.

‘No I have never told him. I suppose I’m afraid. I would feel awkward telling the nurse, because in general we collaborate well. I should not be commenting about this… I don’t want to risk disrupting our collaboration.’

Mutual trust was described as important for discussing existing problems openly and on an equal footing, for instance suicidal thoughts, intentions, and behaviours. It gave patients more scope to remain independent, because there was a mutual agreement that when problems arose, the patient would inform the nurse and ask for her support.

**Theme 2: Clarifying thoughts and feelings**

Mental problems caused by the depression, such as restlessness, worrying, lack of concentration, self-inflicted guilt, low self-esteem, and insecurity, influenced the way patients assessed themselves and their situation.

‘I find myself more easily confused… imagining things to be more difficult than they are and judging my positive contribution to be smaller than in fact it is.’
Nurses helped patients deal with these mental problems by clarifying the patient's thoughts and feelings. Patients mentioned this as making a vital contribution to the quality of the WA and the recovery process.

**Elucidate and unravel**
Nurses assisted patients in clarifying their thoughts and helped them to get a clearer view of reality. Nurses listened and motivated the patient to look beyond the boundaries of the depression and to perceive everyday situations in a different light. The nurse helped elucidate situations by recognizing and naming specific expressions and behaviours that were characteristic for the patient's depression. Patients valued the information about BD that the nurse provided, because it helped them understand their symptoms. It gave them hope that future relief of symptoms would lessen the problems they currently experienced.

‘I think that the nurse helps me to see it in a different way, approach it in a different way, suggesting ideas... making me aware of how things happen. You can’t see the immediate cause of the problems you’re having at that moment by yourself, because they’re constantly accumulating... The nurse helps me take a step back and look at things more objectively.’

Patients felt supported when nurses helped them clarify situations and used a practical approach to help them find solutions to problems. The nurse helped clarify situations not only by listening actively and offering alternative interpretations of reality, but also by steering the conversation and making sure that important topics were discussed.

‘It’s good that conversations are structured. Sometimes I am so full of something that it’s hard to think of the things that are important too. I linger on a specific topic. My nurse is very good at this.’

**Encouraging and empowering the patient**
The patients who had trouble seeing the positive side of their personal situation appreciated when the nurse motivated them to give their situation a moment’s thought, to explore and become aware of the positive aspects.

‘Being impatient with yourself and your recovery, it helps when someone clearly says look where you are now, a few weeks ago you were there and now you are so much further... simple things like that, that bit of optimism and a reminder can help to recollect yourself.’

An important factor in empowering patients was that the nurse was able to cheer them up on the road to recovery. Phrases such as ‘You’re doing a good job’ and recognition of their struggle contributed to patients’ self-confidence. Instead of nurses offering instant solutions, patients found it more helpful when they made an effort to enhance the patient’s own ability to explore these
situations. Learning self-management skills allowed them to regain control over their own situation. Several patients regarded the problem-solving treatment method (PST), a central component of the CC program, as important for regaining confidence in their own ability to change their perceptions of problems and to start solving them. Some patients mentioned that it gave them a clear framework for discussing problems and thoughts systematically during appointments.

‘Sometimes she offers things that really help me. Every two weeks I do a PST assignment. This forces me to think in a different way. I know this will never go away [the bipolar disorder] so I need to prepare myself as well as possible to try to lower the risk of relapse.’

**Theme 3: Supporting patients in becoming or remaining physically active**

A minimal level of physical activity appeared to be important in helping patients maintain control over their situation, preventing further depression, and contributing to the recovery process. Everyday activities offered patients distraction. It gave them a sense of accomplishment and created opportunities to push past their boundaries. However, the depressive symptoms made physical activity an uphill battle for many patients. Nurses played an important role in activating the patients by repeatedly reminding them of the importance of remaining active and encouraging them, nonjudgmentally, to engage in activity.

‘She said “Try to shop for groceries.” I took that as an assignment and went to the store with a pounding heart and cold sweat on my back. It helped me get on my bike and get moving... I made a promise and I wanted to tell her next time that I had done it... Each time she extended the assignment, it helped broaden my world.’

**Collaborating in planning and executing activities**

Some patients had trouble managing the activities they wanted to undertake and the path towards completion. Nurses assisted by helping the patient figure out the concrete goals they wanted to reach. Nurses encouraged them to divide each goal into manageable steps, thus contributing to their feelings of competence.

‘The nurse said: “Try to vacuum the living room when your daughter cleans the house. Don’t try to do everything all at once, just one thing that you can finish successfully.”’

Nurses and patients evaluated goals during subsequent appointments, motivating patients to work on these goals actively and to comply with the agreements made. The nurses’ positive reinforcement made patients feel safe experimenting with these goals. Nurses encouraged this sense of safety by looking forward without criticizing or being dismissive when patients failed to achieve goals.
Discussion
To our knowledge, the current study is the first to examine how patients with bipolar disorder see the working alliance with their nurse during a depressive episode. The three emerging themes, i.e. a safe and supporting environment, clarifying thoughts and feelings, and support in becoming or remaining physically active, confirm the findings of other studies (31;32). When nurses meet patients’ basic needs during the recovery process by expressing empathy and being there when needed, patients are able to speak honestly and openly about their emotions, thoughts and behaviour. The nurse thus creates a ‘holding environment,’ as first described by Winnicott (33), who said that the holding environment created within the client-therapist relationship resembles the care of the ‘good enough’ mother for her infant. The therapist is reliable, present, empathic, accepting, and takes a gentle and non-judgmental approach to caring for the patient (33;34). This attitude supports patients in their attempt to obtain a better understanding of what is happening in their life, to sort out the confusion of living with depression, and to get more grip on the recovery process. To build a strong WA, patients need to feel that the health care provider connects with them (31;32). Providers can do this by communicating (restating, summarizing, clarifying and questioning) and with personal attributes (being non-judgmental, patient and genuine)(32). Several studies have indicated the importance of providers being there when needed, indicating that to achieve a good WA, patients need to feel that the health care provider is taking the time to get to know the person beyond the illness (31;32).

The Collaborative Care program emphasizes the importance of collaborating and creating good working alliances within the CC team (23). The patients in our study confirmed the main elements of CC in relation to the WA: the nurse’s active efforts to tailor treatment to the patient’s needs; the position of the nurse as care manager, with the nurse clearly being available to the patient in the treatment process; and the nurse’s responsibility for the coordination and continuity of care. Patients appreciated problem-solving treatment (one of the intervention modules in the collaborative care program). Aimed at helping them regain a sense of control, this approach supported the establishment of a good WA, offering nurse and patient the opportunity to collaborate on solving personal problems. In a number of cases it clearly led to the patient feeling more optimistic and empowered. The value of the problem-oriented approach for the quality of the working alliance has been confirmed in other studies (31;32).

The findings of this study suggest that nurses attempt to create a functional level of equality in the working alliance, as described in a literature review about equality as a central concept in nurse ethics (35). Nurses provide patients with information about BD, attune their support to patients’ individual needs, and maintain a balance between temporarily taking over control when necessary and empowering the patient to self-manage. Nevertheless, although patients generally felt
safe to speak freely with their nurse and experienced a sense of equality, some patients chose not to inform their nurse about difficulties they were experiencing in the collaboration. While fear of damaging the collaboration was stated as one of the reasons, perceived inequality in the patient-nurse relationship may perhaps also explain the patients’ reluctance to discuss the collaboration.

**Strengths and Limitations**

This study increases our understanding of the patient’s perspective on important elements in the WA with the primary nurse. We were able to include 14 out of 18 eligible patients in the study, thus minimizing the risk of selection bias. The interviews took place in the privacy of the participants’ homes, so that they felt comfortable and safe enough to openly discuss their perspectives on the working alliance. This increases the credibility and trustworthiness of our findings.

This study has some limitations. Given the relatively small number of eligible patients, i.e. patients with moderate to severe depressive symptoms during the randomized clinical trial, we were not able to apply the principle of theoretical sampling, thus limiting our ability to fully develop our theoretical model and reach data saturation. Our theoretical model is therefore tentative in nature and more research is needed to further complement it. Future research may achieve a better understanding of the obstructive elements of the WA by including interviews with more patients whose WA is of moderate or low quality.

**Conclusion**

Three core themes characterized the support that nurses offered during recovery. First, it is vital that nurses create a safe and supportive environment. This environment builds a foundation on which nurses can provide support. Second, nurses provide support by clarifying confusing thoughts and feelings associated with depression. Third, nurses can support patients in becoming or remaining physically active. Throughout this process, it is essential that nurses attune their support to the needs of the patient, finding a balance between temporarily taking over control and empowering the patient’s self-management.

**Recommendations**

This study underlines the importance of a good WA during recovery from a depressive episode in patients with BD. Nurses need to be aware that their attitude and professional behaviour are vital to achieving favourable treatment outcomes. Nurses training programs should pay ample attention to the acquisition of required competencies for establishing good working alliances with patients and train nurses to be self-reflective on this topic.

Our research contributes to the hypothesis that the process of recovery from a depressive episode is mediated by the quality of the WA with the health care professional. Our conclusions and
the theoretical framework we developed are provisional in nature. More research in this area in different contexts of care provision is thus needed, with a larger number of patients, including more patients with a poor or moderate WA with their nurse.

It is advisable to repeatedly evaluate the quality of the collaboration between nurses and patients, with nurses encouraging patients to disclose possible problems in the WA. Doing so makes it possible to overcome patients’ reluctance to discuss possible problems encountered in the relationship with the nurse. If collaboration is ineffective and there is no prospect of improvement, consideration should be given to delegating care to another nurse, putting the patient in a better position to use the nurse’s support.


