VID
vitenskapelige
høgskole

Decision-making in Bipolar Disorder Care

Exploring the Nurse's Role through the Positive Health Model: A literature review

Bachelor thesis in Nursing

Candidate number: 133601

Campus: VID Oslo

Student cohort: Nursing, BASP3040

Number of words: 10.350

Submission deadline: 22 May 2025

VID

Abstract

Theme: Decision-making and communication in bipolar disorder care using the Positive Health model.

Aim: The aim of this study is to find out how nurses can help patients with a bipolar disorder make decisions in order to cope with their disease.

Research question: How can nurses help patients with bipolar disorder make decisions to cope with their disease?

Method: This thesis is made up of a literature review analysing five qualitative and quantitative research articles, substantiated by pre-existing theory, empiricism, and ethical and legislative considerations.

Results: The first three selected articles discuss supported decision-making in bipolar disorder, substantiated by the fourth article discussing the setting and the fifth article discussing the Positive Health dialogue tool. All articles underscore the importance of communication in shared decision-making, serving patient-centred care in bipolar disorder.

Conclusion: In conclusion, building and maintaining a therapeutic relationship between the nurse and the patient presenting with bipolar disorder is crucial in exercising shared decision-making. With the help of the Positive Health model and its dialogue tool in form of the spiderweb, patient values may become apparent, strengthening a sense of autonomy and enhancing positive patient outcomes through (shared) decision-making.

Keywords: Bipolar disorder, communication, shared decision-making (SDM), therapeutic relationship, Positive Health model, values

Table of content

1 Introduction

In medicine, a broken ankle makes a relatively easy fix, as opposed to psychiatric diseases presenting with more strenuousness in identifying the concern. One of such psychiatric disorders that requires a broad outlook on multiple health determinants is bipolar disorder (BD).

In 2019, an average of 1 in 150 adults (40 million people, or 0.53% of the global population) were living with BD (GBD, *2022*). BD is a mood disorder that affects and can oppose difficulties in all aspects of the patient's life, such as in relationships, school and work, or carrying out activities of daily life (ADLs). Because of this transfusion and the impact of BD, patients often present with comorbidity. In fact, the World Health Organization (WHO) (*2024*) argues that "bipolar disorder is one of the leading causes of disability globally as it can affect many areas of life". This causes the mortality gap between the general population and patients presenting with BDs to make up approximately 10-20 years of life (McIntyre et al., *2020*).

This broad outlook and required holistic assessment on psychiatric diseases that can be seen as constellations of interconnected factors [determinants] that mutually influence each other (Sabbe et al, *2024*), can be found in the Positive Health (PH) model (Huber, *2024*). This model is a conversation tool targeting six dimensions with a subdivision into 42 different aspects constructing an overall image of someone's well-being. The emphasis lies on what an individual is capable of doing and what they need for a meaningful life, instead of focusing on the limitations that come with their illness (Huber et al, *2016*). This encompasses the most important dimension of the model: *meaningfulness*, formerly described as the spiritual and existential dimension.

Neuroscientists and psychologists from NeuroLaunch (*2024*) argue that "the interplay between psychosocial and biological aspects of BD underscores the importance of adopting a holistic approach to treatment".

1.1 Background

While no specific statistics on bipolar disorder in Norway are available, 1.3% of the Dutch population is known to live with a BD (with little evidence of gender difference) (Nederlands Herseninstituut, *2023*; Beentjes et al., *2015*). I am currently studying in Norway as a nursing student from the Netherlands.

Before I came to Norway (previous semester), I was an intern in a homecare organization. One of the patients was a 36-year-old woman living with bipolar disorder. She was exceptional, as she was the only patient under our care that received mental health care (besides psychogeriatrics). She inspired me to write about this disease, as I can barely grasp what it means to live with this disorder. In the same internship, some colleagues used the Positive Health model on own initiative in identifying the care demand (in different cases). I was taught about the model in school, but now it came to life.

Since the research as thesis is part of the bachelor nursing studies the research is scientifically relevant for nursing. A specific aspect of a topic, in this case a specific aspect of Positive Health in relation to psychiatry, will be highlighted that has not yet been researched. Moreover, the research builds on suggestions for further research in previous studies (related to subtopics) from the research articles.

I have chosen to write about the PH model as it can help nurses and (psychiatric) patients themselves create a greater understanding of the clinical picture in regards to their (own) lives from a holistic view. In this thesis I want to investigate how the PH model can be employed through communication between nurses and patients suffering from BD in homecare.

A study from the Dutch Trimbos-institute indicates a strong increase in psychiatric disorders (including BD) among Dutch citizens (Luik, *2022*): 26% in 2022 compared to 18% in 2010. Persons living in institutions were excluded from the study. Interviews were conducted in the respondents' homes (NEMESIS, *2022*).

The increase means that the chances for a nurse working in home care to encounter a psychiatric patient increases, highlighting the relevance to the nursing profession. The prevalence of BD is underestimated and often mistaken for depression (Tugrul, *2003*). Tugrul (*2003*) states that "nurses have the ability to significantly impact the successful care

of these patients by recognizing and assessing BD, managing treatment with appropriate mood stabilizers and therapies, and educating patients and their families". As the patient's eyes and ears (as colleagues would often say in my internship), the nurse is responsible for effectively taking care of his or her patients according to the nurse's scope of practice.

Furthermore and therefore, the research has social relevance as the results aim to benefit nurses in home care working with patients with BD, and indirectly the patients they are taking care of. In that sense, patients move passively. However, social relevance is also found in the aim for patients with a BD to benefit from the research actively and directly by applying Positive Health in their own lives. This also makes the research practically relevant, because the thesis leads to suggestions or insights that can be used in health care.

1.2 Research question

How can nurses help patients with bipolar disorder make decisions to cope with their disease?

The research question will in answering shed light on the problem statement from different perspectives.

1.3 Limitations of the study

To prevent the research [question] from covering a too broad field of interest and losing track of the common thread, it is helpful to set up a set of limitations to the study. The limitations I have chosen to apply to this assignment regard the clinical picture, years of age and the setting in which the study is conducted.

First of all, the study will focus on patients with BD. The chronic character of BD lends itself to be subject to Positive Health, as the model targets chronic illnesses.

Secondly, the setting in which the psychiatric patients are found and the field the nurses are working in with those patients is in home care. I chose this setting, because the focus can be placed on the dimension of *meaningfulness*, assuming the other dimensions demand less attention at home than when admitted to a hospital or psychiatric ward. I want to focus on

meaningfulness, since it is the most important dimension of the PH model. Moreover, I want to investigate how meaningfulness attributes to decision-making in BD.

Thirdly, the age group I have decided to focus on concerns ages 19 up to and including age 44. This finds root in the demographic and epidemiologic relevance as mental health disorders often present in this age group (including BDs) (Ten Have, *2022*). People aged 19-44 often go through a lot of lifechanging events, which may influence their mental health. Moreover, this age group forms the largest part of the population.

Lastly, not every patient with BD can independently decide what is good for them when the disease imposes harmful behaviour that cannot be ceased with voluntary care and compulsory care is needed. However, the scope of this thesis is too small to cover those situations as well. Therefore, I have decided to assume consultative settings in which no harmful behaviour is exhibited and patients are in an enabling state of mind to exercise decision-making.

1.4 Clarification of key terms

To avoid misinterpretation of key terms flowing from the problem statement and research question, the following definitions are employed in the thesis:

- *Decision(s)*
  'A choice that you make about something after thinking about several possibilities.' (Cambridge Dictionary, *n.d.*).

- *Cope*
  'To deal with problems or difficulties, especially with a degree of success. It can also mean to struggle or contend with difficulties and act to overcome them.' (Cambridge Dictionary, *n.d.*)

- *Meaningfulness (as interwoven in the Positive Health model)*
  'The quality of showing or having meaning' (Cambridge Dictionary, *n.d.*).
  Meaning is about value and is a primary need. It gives purpose to our lives and moves us (Stevens, *n.d.*). It is a process of assigning personal value to experiences.

> "People who see meaning in their live have access to personal resources, such as resilience, hope, and self-efficacy. Meaningfulness, or meaning in life, leads to less general mental distress" (Schnell et al., *2022*).

A clarification of the concepts of *bipolar disorder*, *home care,* and the *Positive Health model* will be described in respectively chapters 2.1, 2.2.1, and 2.3.

1.5 Outline of the thesis

In the next chapter I will set forth important theoretical perspectives that will be used as guidelines for the discussion in chapter five. In chapter three, the methodology for this thesis will be described, and justification for the found articles through the search process will take place, including ethical review. Consequently, chapter four will consist of the definite selected articles that will be subject to the following literature review.

With those chapters, a foundation has been established for the discussion. In chapter 5, the discussion, I will discuss the research question in light of the theoretical perspectives in chapter two and the collected research articles in chapter four. By doing so, I will aim to find an answer to the research question as stated in chapter 1.2.

Finally, the threads will be tied together and the thesis comes to a completion in the conclusion in chapter six.

2 Theory

In this chapter I will present important theoretical perspectives that are relevant in shedding light on the research question. Firstly, an elaboration on BD is made, followed by an extract on the relevance to the nursing profession. The relevance to the nursing profession is also found in the nursing theories that are to be read in the third and fourth part of this chapter. The chapter ends with ethical and legislative considerations regarding what is to be studied: how nurses can help patients suffering from BD make decisions in order to cope with their disease.

2.1 Bipolar disorder

2.1.1 What is bipolar disorder?

Bipolar disorder is an incurable mood disorder presenting with extreme mood episodes; emotional highs (mania or hypomania) alternate with emotional lows (depression). The disorder is also known as manic-depressive episode. To properly perform good treatment, it is essential for the nurse to know with what clinical picture the patient is presenting. There are two types of BD: Bipolar I disorder and bipolar II disorder (Hersenstichting, *2024*). The classification is dependent on duration and severity of the episodes. Type I is characterized by having at least had one manic and (often, not necessarily) a depressive episode. Type II is characterized by depressive episodes alternating with hypomanic episodes. Hypomania is less severe than mania (Cleveland Clinic, *2025*). In my literature review I will focus on aforementioned two types of BD.

Cyclothymic disorder, also referred to as cyclothymia, is a rarer, milder form of BD with mood swings not meeting full criteria for BD-I or BD-II (Bielecki et al., *2023*). In the literature study this type of disorder will (implicitly) be taken into account.

A significant proportion of bipolar patients are affected by rapid cycling: lifetime prevalence ranges between 25.8%-43% (Carvalho et al., *2024*). Rapid cycling is not a diagnosis, but rather a feature of the disease referring to the presence of at least four mood episodes in the previous twelve months meeting the criteria for manic, hypomanic or depressive

episodes (Carvalho et al., *2024*). Episodes appear unexpectedly and are of relatively short duration.

2.1.2 Pathophysiology and etiology

Both the exact pathophysiology and etiology of BD are unable to be proven and therefor unknown (Jain & Mitra, *2023*). However, multiple researches have been conducted referring to (possible) genetical, biological and environmental determinants in the disease. For example, researcher Kevin O'Connell from the Centre for Precision Psychiatry at the University of Oslo states that BD is one of the most heritable psychiatric disorders with an estimated heritability of around 80% (*2025*).

Environmental factors, such as (stressful) life events, social support, childhood (adversities), birth complications, climate and health may either trigger or prevent the development or the manifestation of a psychiatric disorder. Circumstantial evidence is found for an association between environmental factors and the clinical course of BD (Aldinger & Schulze, *2016*).

2.2 Relevance to the nursing profession

2.2.1 What it means to provide or receive care at home

Home care refers to any diagnostic, therapeutic, or social support service provided at home (Levine et al., *2003*). From a very practical point of view, in home care the creativity of nurses is sometimes called upon, as they might not have all the means directly available which they need for executing their care activities (Gazzaroli et al., *2020*). Moreover, nurses in home care work solitarily and cannot easily fall back on a colleague in case of dire situations. Therefore, a nurse has to trust his/her competence and carry (appropriate) confidence in his/her professionalism.

Someone's home is often a meaningful, discrete place. Receiving homecare is as a subjective experience. For example, the familiar environment can be experienced as pleasant by the patient and nurses can provide personal attention. Homecare can also come with a loss of

private territory for the patient, as the sheltering place of public life also becomes a workplace for the professional (Tamm, *2009*). However, this is greatly affected by the professionalism of the nurse and how he/she conducts themself. This is based on ethical and legislative considerations, described in the last part of this chapter. In order to secure professional confines and a nurse's professional conduct tailoring the patient's needs, a key aspect that has to be taken into regard is communication.

2.2.2 Communication between nurses and patients

Communication is defined as an ongoing process in which at least two people exchange information, either subconsciously or consciously (Adriaansen & Caris, *2020*). Communication is highly dependent on one's frame of reference. Therefore, it is important to implement professional communication as foundation, with the intention of realizing a specific aim in the care situation.

A specific, important aim through communication is to build a trust-based, therapeutic relationship between nurse and patient (Ten Have & Gortworst, *2021*). The trust-based relationship is indispensable as it creates space for the patient to employ opportunities to regain control over his situation. Moreover, it enables the patient to mention a (possible) inability to follow certain instructions (therapy-adherence), so that the nurse and patient together can investigate the cause and what to do about it.

When communicating, both verbally and non-verbally, with a patient with BD it is important to know in which mood state the patient is. A therapeutic relationship and knowing the patient may help anticipate and judge the mood state. Based on the patient's mood, communication must be coordinated (Spek et al., *2021*). For example, from a patient in a depressive episode the nurse may expect reduced reciprocity, whereas a patient in a (hypo)manic episode may exhibit egocentrism, verbosity or transgressive behaviour. In the latter case, the nurse wants to limit stimulation, avoid confrontation, and have the patient continuously engaged in the conversation as the patient may be easily distracted. When in a depressive mood, it is important for the patient to have their feelings validated (by the nurse) and not be dismissed by exaggerated encouragement. The nurse may have to

exercise patience in engaging the patient in the conversation. Psychoeducation and decision-making should preferably happen when the patient is in euthymic state.

Important communication skills in conversing with patients with BD are listening, sharing emotional reflection, motivational and confirmational communication, providing concrete guidance where necessary and shared decision-making (GGZstandaarden, *n.d.*).

Shared decision-making is the process in which patient and healthcare provider together decide on the best fitting treatment for the patient (VGZ, *n.d.*). Pros and cons are weighed, and consequences, diagnosis, and aftercare are discussed. Decision-making not only applies to choices on medical treatment, but is also applicable to psychological or lifestyle interventions, palliative care, and other non-medical treatment choices.

For enabling shared decision-making, fostering a therapeutic relationship is important as it forms the basis for providing and gathering information through, for example, psychoeducation (Hamann et al., *2003*). The therapeutic relationship defines as the professional bond between a therapist and their patient, characterized by trust, respect, empathy, and collaboration (Dyson, *2024*). Extensive research has shown that forming a therapeutic alliance is one of the most important, effective factors in care for and treatment of psychological and behavioural problems (Keijsers et al., *2012*). This emphasizes the importance of good communication between a nurse and the patient with BD.

2.3 Positive Health

In this part of the theory chapter, an elaboration on Positive Health as to aforementioned in the introductory chapter will be made.

Positive Health is a vision to health and not a definition or a specific treatment method (iPH, *2022*). The focus is placed upon personal strength and resilience. Moreover, the Positive Health model is scientifically substantiated and therefore not to be confused with alternative medicine (iPH, *2024*).

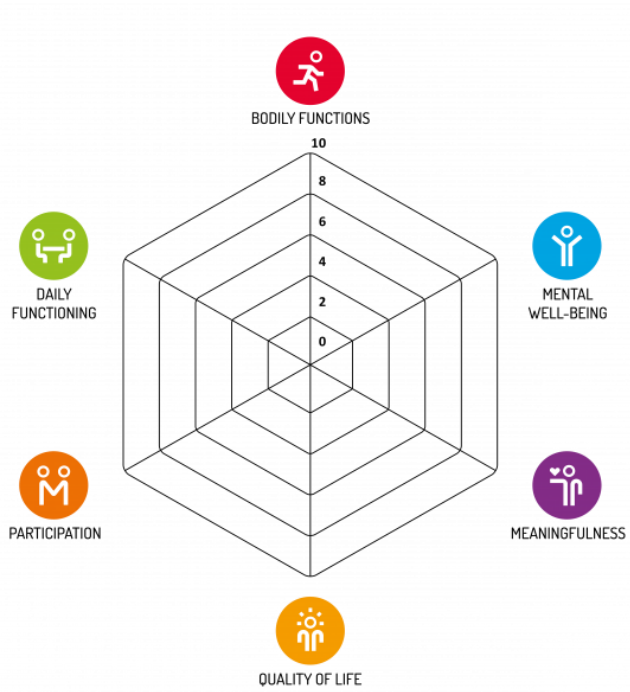

Figure 2 Positive Health model as conversation tool (iPH, 2024)

The Positive Health model as spiderweb seen in figure 2 can be used as a conversation tool to identify, both for the patient and for the healthcare provider, how one experiences their health welfare. This happens through assigning scores per dimension. The intention is for the patient to fill out the spiderweb, engaging self-reflection. This promotes self-management and allows the patient to decide what they find important in treatment (f.e. medical treatment), coping with their disease.

The scores express how the patient experiences their situation per dimension; the higher the score, the higher the satisfaction. Lower scores may make clear what areas in the patient's life demand attention. After filling out the spiderweb, the follow-up question to the patient is what element they give priority to work on.

As can be seen in figure 2, the dimension of *bodily functions* tops the spiderweb. The seven associated aspects concern feeling healthy, being fit, complaints and pain, sleep, nutrition, stamina, and exercise. *Daily functioning* is about taking care of oneself, setting boundaries, health literacy, coping with time, coping with money, being fit for work, and being able to ask for help. The dimension of *participation* regards social contacts, being taken seriously, enjoying fun activities with others as well as being able to receive their support, and sense of belonging. Moreover, it is about doing meaningful things and about having interest in society. *Quality of life* consists of seven aspects, known to be enjoyment, being happy, feeling good, feeling well-balanced, feeling safe, housing circumstances, and making (monetary) ends meet. Remembrance, concentration, communication, being cheerful, self-

acceptance, adaptability, and a sense of control belong to *mental well-being.* The most important dimension to this model, *meaningfulness*, is dedicated to having a meaningful life, zest for life, pursuing ideals, feeling confident, accepting life, gratitude, and lifelong learning.

Machteld Huber emphasizes *meaningfulness*, because research has shown that meaning brings people closer to their own power and makes them stronger (iPH, *2022*). This has to do with one's own intrinsic motivation, as described in the self-determination theory by Ryan and Deci (*2000*). Moreover, patients in mental health care value the dimension of *meaningfulness* more highly than patients in general health care (Van de Loo et al., *2022*). This makes the study of the Positive Health model revolving around the sixth dimension *meaningfulness* interesting and relevant in relation to psychiatry as well.

The dimension of *meaningfulness* is about creating a deepening in communication (Douma, *2022*). Huber was inspired by Viktor Frankl and Aaron Antonovsky, who were the firsts to argue on the importance of meaningfulness.

2.3.1 Antonovsky's Salutogenic model as foundation for Positive Health

Antonovsky (*1979*) came up with the Salutogenic Model of Health after he noticed that not every concentration camp survivor from World War II was traumatized, where many others would be (Ververda, *2005*). As opposed to the more common pathogenic approach, Antonovsky introduced a new concept: the salutogenic approach that focuses on the origin of health (salus = health, genesis = origin) (Vinje et al., *2016*).

Antonovsky describes a set of three constructs that together make up for what he called Sense of Coherence: comprehensibility, manageability and, most important, meaningfulness (iPH, *2020*). Moksnes et al., elaborate and state that "a strong sense of coherence helps the individual to mobilize resources to cope with stressors and manage tension successfully with the help of identification and use of generalized and specific resistance resources" (*2021*). The stressors and use of resources in coping show similarities with the Neuman Systems Model, presented in the next part of this chapter.

Huber was inspired by Antonovsky and partly adopted his theory as WWII was ubiquitous in her youth since she was born one year after the war. A friend of her father, survivor of a

German concentration camp, told Huber that the key to surviving was having an ideal, or a goal in life, and having friends (KRO-NCRV, *2023*). Having companions corresponds to Antonovsky's sense of coherence, as having an ideal corresponds to meaningfulness.

2.4 The Neuman Systems Model

The framework for this literature study is built on the Neuman Systems Model (NSM). The NSM is central to the nursing bachelor at the University of Viaa in the Netherlands, my home institution.

The role of the nurse in relation to the patient and others in the patient's client system can and will be examined, as the Neuman Systems Model is particularly adaptable to interdisciplinary use (Memmott et al., *2000*). The NSM poses the nurse as partner in strengthening the client (system). The patient as expert of their life provides experiential knowledge, whereas the nurse provides with professional knowledge. With this, the NSM strengthens the tantamount character of nurse and patient in decision-making, and emphasizes the importance of building and maintaining a therapeutic relationship.

To be able to dive deeper in the spiritual and existential dimension of Positive Health, the NSM provides with a fitting view on health with its fifth variable being spirituality. The NSM offers a similar holistic and systemic view to health as Positive Health does. Besides spirituality the NSM describes a physiological, psychological, sociocultural and developmental variable (Verberk & Merks, *2021*). Those five variables are considered properties of the central core of the client system, bringing forth either stressors or resources for coping with the disease.

The client or client system is defined as an "individual, a family, a community, or a social issue, composed of the [aforementioned] core or basic structure of survival factors and surrounding protective concentric rings" (Neuman, *1995*, 45). Those protective rings make up the flexible line of defense (protects normal line from invasion of stressors), the normal line of defense (normal or usual level of wellness) and lines of resistance protecting the basic structure (central core).

Note: the term *client* derives from the theory, but translates to *patient*. In the continuation of the text, the term *patient* will be employed.

2.5 Ethical and legislative considerations

Nursing responsibilities and their scope find foundation in moral, ethical and legal guidelines as they establish how nurses are to provide responsible care.

The Dutch code of conduct for nurses is a moral and ethical guideline focussing on quality of life and well-being of the care recipient (V&VN, *2015*). The most important guidelines consist of having respect for patient's autonomy, doing well (providing good care) and doing no harm. Another guideline, specifically applicable to home care, is as follows: "As a nurse I respect and protect the patient's privacy" (§2.13). This also entails no unannounced entrance of patient's living environment and ensuring a minimum encroachment of the care recipient's privacy. Nurses must enter homes of their patients as guests and follow with their professional confines.

Moreover, professional confines are set forth in the (Dutch) Individual Healthcare Professions Act (Wet BIG) (CIBG, *2022*). The act provides rules for healthcare professionals, protecting patients from unqualified and inattentive conduct, ensuring quality and safety of healthcare.

In line of legislation, the Dutch Medical Treatment Agreements Act (WGBO) regulates the relationship between care provider and patient (RIVM, *n.d.*). It states that the patient 'behests for' treatment. The health care provider has to explain medical possibilities and the patient must be able to ask questions. The WGBO provides a legal foundation for shared decision-making.

For harmful behaviour compulsory care may be needed on grounds of the Compulsory Mental Healthcare Act (Wvggz) (Ministerie VWS, *2022*). With compulsory care, it is important to carefully consider ethical values, such as autonomy, paternalism, and rights and obligations (KNMG, *2018*). Not every person with BD per definition is unable to make decisions for themselves, on the contrary. Something nurses working with patients suffering from BD have to take into account is the insidious and ubiquitous (self-)stigma towards BD

(Hawke et al., *2013*). Negative consequences are experienced from stereotypes, prejudice and discrimination as result of their BD (Perich et al., *2022*). This can manifest in the patient (and their system), but also in the nurses themselves, considering different aforementioned frames of reference, possibly troubling the caring process. Awareness hereof is essential.

To meet psychiatric patient's wish for attention to *meaningfulness* (Van de Loo et al., *2022*) implementing meaningfulness is included in the core recommendation from the Dutch mental health care standard (GGZ Standaarden) in a recovery-oriented approach (*2024*). Especially for psychiatric patients, attention to meaningfulness is important as existential questions arise during periods of psychological disruption and/or recovery hereof (GGZ Standaarden, *2024*).

3 Method

In this chapter, I will describe how I have found the articles that will be used for this literature research. The chosen method of the study will be explained, and how the databases are employed through keywords and inclusion and exclusion criteria. Ethical considerations in regards to the thesis make up the last part of this chapter.

3.1 Literature study as a method

In this thesis, I use a literature study as a method for doing research. In literature, a literature study is more often referred to as a literature review. A literature review is defined as "a piece of academic writing demonstrating knowledge and understanding of the academic literature on a specific topic placed in context. A literature review also includes a critical evaluation of the material" (IAD, *2024*). Therefore, a literature review is a systematic way of collecting and synthesizing previous research (Baumeister & Leary, *1997*: 311). For this literature review, a total of five sources will be analysed.

For the nursing profession that is mainly practical, a literature study might seem irrelevant. However, in order to be able to carry out the practical part, nurses are trained in not only nursing technical procedures, but also in clinical reasoning (De Jong et al., *2016*). For that an analytic view is required. The literature study stimulates exercise in skill of observation, interpretation and clinical imagination. Moreover, when making health care decisions, professionals and patients aspire to be informed of the best available evidence, and literature reviews aim to answer their questions (Smith & Noble, *2015*). Literature reviews may influence policies in health care, and identify future research priorities.

In the literature review, I will come across different types of research. For example, cross-sectional studies, case studies or mixed methods studies. The latter is a combination of quantitative and qualitative research. The fundamental difference between quantitative and qualitative research is the underlying premise; for quantitative research applies that "the goal of knowledge is simply to describe the phenomena that we experience, and hence can observe and measure", drawing from the positivist paradigm, whereas 'subjectivity' is the premise of qualitative research (Cleland & Durning, *2015*). This entails that qualitative

research is more descriptive, focusing on interpretation, experiences and the meaning given to experiences, depicted in words (Tenny et al., *2022*). Deeper insights into real-world problems are provided. Quantitative research on the other hand is more about numbers and statistics, aiming to get behind facts. The positivist paradigm implies that knowledge can only be observed through objective, systematic and empirical observations (Horsten et al., *2007*).

In mixed-methods studies, qualitative research may help further understand and investigate quantitative data (Tenny et al., *2022*).

It is important to know the differences between different types of research, so that the research is organized and the search can be conducted in a targeted manner. The articles subject to my literature review will be made up of both qualitative and quantitative research papers. I chose to retrieve mainly qualitative studies, as the subjectivity of Positive Health is hard to grasp in numbers when it comes to experiences (in use), barriers or encouraging factors, or thoughts on the model. The effectiveness however, can be subject to quantitative studies. Measured can be numbers on behavioural changes (e.g. symptoms), causal relationships between implementation and health benefits, etc..

3.2 Search process

Here I will set forth how I found the research articles that are subject to my literature review. This entails setting up inclusion and exclusion criteria before proceeding with searches in CINAHL with Full Text, Medline and PsycINFO. Moreover, the Snowball method has come to use. I will describe how I conducted the searches. The included articles are presented in a table in chapter 3.1.3.

3.2.1 Inclusion and exclusion criteria

To narrow down the search, I have employed a set of inclusion and exclusion criteria for the literature throughout all queries. For the criteria, see table 1 below:

Included	Excluded

Written in English	Non-English
Publication date 2014-2025	Publication date <2014
Peer reviewed	Non-peer reviewed
Ages 19-44 and nearby ages	Children (<18), elderly (>65)
	Articles focusing on nurses as main target group instead of patients

Table 1 – Inclusion and exclusion criteria for eligibility

It is important to apply date limit filters as a lot may change over time, influencing relevance today. Besides applying the 'peer review filter', confirmation is retrieved through Kanalregisteret. Peer review ensures that published information in articles is as truthful, valid and accurate as possible (Steer & Ernst, *2021*).

3.2.2 Systematic representation of the search process

I performed my queries based on my first research question which I adjusted during the writing process to the current research question as stated in chapter 2.1. The queries were also applicable to this research question.

With the research question in mind, I wanted to find out how my queries would be most fruitful. Simply inserting all key terms would lead to no results. In fact, any term related to my research in combination with "Positive Health" or (Machteld) Huber resulted in a dead end with 0 hits. I had to break up the question and group terms.

The terms I used from scratch to form groups were 'communication', 'bipolar disorder' and 'home care'. The term 'nurses' or nurs* was only employed in PsycINFO to broaden the scope. In other databases, the term was left out as it would be covered in home care.

To find appropriate terms to conduct the searches with, I retrieved Mesh-terms that could help me further. However, in CINAHL with Full Text (CINAHL) and Medline, the Mesh-terms did not comply with my aim and presented too distinctly. Therefore, in CINAHL and Medline I used suggested subject terms that would cover the scope of the topics I wanted to find articles on. For PsycINFO I used subject headings, consequently choosing narrower or broader terms that would cover my scope. I tried different combinations, a process of trial

and error. In table 2 (- *Search process*) found in the appendix, the used terms and combinations are presented.

The first search, conducted in both Medline and CINAHL, gave different numbers of results. One of the articles in Medline was assessed fitting for my literature review. The same article, the first included, on supported decision-making came up in CINAHL. A similar search was conducted in PsycINFO, targeting the same word combinations from scratch; 'bipolar disorder' and 'communication'. Terms concerning 'nurses' were added in PsycINFO as the previous combination gave too many results (642). No useful results were found.

From search 1.f in PsycINFO, one relevant, but not useful (type of) study came up. Finding 26 citing articles for this study (limited to English, Article and 2014-2025) and reading the headlines led to "A qualitative exploration of patient and family views and experiences of treatment decision-making in bipolar II disorder", the second included article.

Combining search 1.d and 1.e in PsycINFO, a query was performed on home care personnel/ or home visiting programs/ AND interpersonal communication/ or active listening/ or conversation/. This led to 11 hits. On one of the 11 hits, cited articles were retrieved and 19 results came up. On two of those 19 articles, the snowballing method was applied. Unfortunately, this led to no useful results.

Furthermore, I decided to conduct searches with word combinations deriving from the terms 'bipolar disorder' and 'home care'. Again, all three databases were employed. This resulted in the third included article, found in CINAHL, on the effects of home nursing care.

The fourth included article was found in Medline. With the word combination as presented in the table, seven results were found. Four abstracts and two articles that were potentially relevant were read before deciding on the included article.

3.2.3 Definite selected articles

Article and Title	Author	Year	Search Engine

Supported decision-making from the perspective of mental health service users, family members supporting them and mental health practitioners	Kokanović, R., Brophy, L, […] and Herrman, H. (+3)	2018	CINAHL with Full Text and Medline
A qualitative exploration of patient and family views and experiences of treatment decision-making in bipolar II disorder	Fisher, A., Manicavasagar, V., […] and Juraskova, I. (+2)	2018	PsycINFO Snowballing
Communication and decision-making in mental health: A systematic review focusing on Bipolar disorder	Fisher, A., Manicavasagar, V., […] and Juraskova, I. (+1)	2016	CINAHL with Full Text
Effect of Home Nursing Care on the Severity of Symptoms in Patients With Bipolar I Disorder: A Randomized Clinical Trial	Zeighami, R., Raeisolhagh, A., & Ranjbaran, M.	2021	CINAHL with Full Text
Positive Health dialogue tool and value-based healthcare: a qualitative exploratory study during residents' outpatient consultations	Bock, L.A., Noben, C.Y.G., […] and Van Mook, W.N.K.A. (+4)	2021	Medline

Table 3 – Definite selected articles

3.3 Source criticism

Since Positive Health (in context of my thesis) is a relatively new, Dutch concept, English sources are limited. Therefore, I had to retrieve sources that would cover aspects, separately and sometimes combined, of the research question. In the discussion data will be transposed to PH.

The systematic review by Fisher et al. (2018) uses sources dating between January 2000 and March 2015. This potentially affects relevance and validity. However, the authors decided the data was relevant in 2016 for they did publish their article. Therefore, I considered outdated source findings inconsequential to relevancy.

Relevancy is also influenced by context. The study from article three was conducted in Iran. The cultural differences may pose a distorted image in comparison to the other four articles based on Western cultures (Australia (3) and the Netherlands). Notwithstanding, I chose to include the article as it covers two main topics flowing from the research question, strengthening relevance. Moreover, the cultural differences are negligible.

Close to relevancy is representativeness. None of the articles have high representativeness, because of their qualitative character. They offer thematic, detailed insights, but cannot be generalized. This is also the case with the quantitative research by Zeighami et al., since only 90 patients from the same hospital participated in the research.

Besides BD not being the main topic in article one, I decided to include the article as relevance is also found in psychiatric context and in the topic of supported decision-making.

Article two does not clearly answer for how the influence of BD itself (as the patients were respondents) on the outcome of the studies have been addressed for or manipulated (as opposed to article three). This may have resulted in distorted results, potentially detracting validity.

Article two, three and four (Fisher et al., 2018; Fisher et al., 2016; Zeighami et al., 2021) all refer to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This asks for criticism, as the DSM-5 was the most controversial in the manual's history (Wakefield, *2016*). Fisher et al. (2018) themselves pose critique to one of the criteria of the DSM-5 as it is largely arbitrary and not of clinical significance (Parker & Fletcher, *2014*). Zeighami et al. and Fisher et al. (2016) on the contrary, seem to unquestioningly take on information from the DSM-5. This given fact did not impair including the articles, as the description of the disease is not what the study is ultimately about.

Article five is conducted among specialised residents. This depicts more discrepancies than initially thought with the more broadly oriented nurse. Nonetheless, the healthcare activities investigated in form of consultations can be translated to nursing. Besides that, the implementation of the Positive Health model is subject to Bock et al.'s study, aligning with my study.

3.4 Ethical considerations

All articles included in my literature review have already been approved by an ethics committee. All of my personal experiences written about in this paper have been anonymised to ensure privacy of patients, colleagues or others involved.

My own experiences, among other things, make bias inevitable. While writing the thesis, I have tried to circumnavigate my own bias by critically reflecting on my interpretations of texts.

In the process of writing my thesis, I have employed the language model GPT-4-turbo-model (OpenAI, 2024) for refinement of the structure of the text and for brainstorming about aspects of the research question. All interpretation of the articles and substantiating sources, analysis, and further writing are exclusively my own work.

To the best of my knowledge, this is the first paper examining and providing insight into the implementation of the Positive Health model in patients with BD at home. I declare I have committed no plagiarism throughout this thesis and all sources are cited according to the APA7 rules.

4 Results

The fourth chapter of the thesis presents the selected articles which are subject to this literature study. The main findings and relevance for the research question is presented. Included are the introduction, methodology, results, and discussion parts of the articles.

4.1 Research article 1

Title: Supported decision-making from the perspectives of mental health users, family members supporting them and mental health practitioners

Author, year of publication and journal: Kokanović, R., Brophy, L., McSherry, B., Flore, J., Moeller-Saxone, K., Herrman. 2018. Australian & New Zealand Journal of Psychiatry.

Aim: The study aims to explore from several perspectives the barriers and facilitators to supported decision-making in an Australian context. Supported decision-making was considered in terms of interpersonal experiences and legal supported decision-making mechanisms.

Introduction: Supporting the decision-making of mental health service users fulfills professional, ethical and moral obligations of mental health practitioners. It may also aid personal recovery. Previous research on the effectiveness of supported decision-making is limited.

Method: 90 Narrative interviews about experiences of supported decision-making were conducted and analysed. Participants were mental health service users who reported diagnoses of schizophrenia, psychosis, bipolar disorder and severe depression; family members supporting them and mental health practitioners. The data were analysed thematically across all participants.

Main findings: People with psychiatric diagnoses, their families and mental health practitioners all noted negative interpersonal experiences in decision-making, concomitant with stigma and discrimination in services. Enabling supported decision-making can be

facilitated by (1) support for good communication skills in mental health practitioners and (2) introducing legal supported decision-making mechanisms.

Relevance for the research question: Multiple perspectives are taken into consideration; that of patients, their family members or friends and mental health practitioners. The importance for good communication skills in (supported) decision-making is elaborated on.

4.2 Research article 2

Title: A qualitative exploration of patient and family views and experiences of treatment decision-making in bipolar II disorder

Author, year of publication and journal: Fisher, A., Manicavasagar, V., Sharpe, L., Laidsaar-Powell, R., Juraskova, I. 2018. Journal of Mental Health.

Aim: To explore patient and family perspectives of treatment decision-making in BPII.

Introduction: Treatment decision-making in bipolar II disorder (BPII) is challenging, yet the decision support needs of patients and family remain unknown.

Method: Semistructured, qualitative interviews were conducted with 28 patients with BPII-diagnosis and 13 family members with experience in treatment decision-making in the outpatient setting. Participant demographics, clinical characteristics and preferences for patient decision-making involvement were assessed.

Main findings: Four inter-related themes emerged: (1) Attitudes and response to diagnosis and treatment; (2) Influences on decision-making; (3) The nature and flow of decision-making; (4) Decision support and challenges. Views differed according to patient involvement preferences, time since diagnosis, and patients' current mood symptoms. Findings will inform the development of BPII treatment decision-making resources that better meet the informational and decision-support priorities of end users.

Relevance for the research question: Multiple perspectives regarding decision-making in bipolar II disorder are taken into consideration; that of patients, their family members or friends and mental health practitioners.

4.3 Research article 3

Title: Communication and decision-making in mental health: A systematic review focusing on Bipolar disorder

Author, year of publication and journal: Fisher, A., Manicavasagar, V., Kiln, F., Juraskova, I. 2016. Patient Education and Counseling.

Aim: To systematically review studies of communication and decision-making in mental health-based samples including BP patients.

Introduction: Given medical uncertainty underlies BP treatment decisions, and the potential link between patient involvement and outcomes, patients should participate in treatment decisions. Patient involvement is particularly important in BP, as patients are responsible for actively self-managing their illness to prevent further relapse and/or recurrence.

Method: Qualitative systematic review of studied using PsycINFO, MEDLINE, SCOPUS, CINAHL, and EMBASE (January 2000-March 2015). Of 519 retrieved articles, 13 studies were included (i.e. 10 quantitative/1 qualitative/1 mixed-methods).

Main findings: Overall BP patients, like others, have unmet decision-making needs, and desire greater involvement. Clinician consultation behaviour influenced patient involvement: interpersonal aspects (e.g., empathy, listening well) fostered therapeutic relationships and positive patient outcomes.

Relevance for the research question: The article provides with a significant amount of in depth data on communication and decision-making in bipolar disorder.

4.4 Research article 4

Title: Effect of Home Nursing Care on the Severity of Symptoms in Patients With Bipolar I Disorder: A Randomized Clinical Trial

Author, year of publication and journal: Zeighami, R., Raeisolhagh, A., Ranjbaran, M. 2021. Home Health Care Management & Practice.

Aim: Investigating the effect of home nursing care on the severity of symptoms of bipolar I disorder.

Introduction: Bipolar I disorder is a common, chronic, and recurrent disease in which improper and inadequate follow-up of patients after discharge leads to increased hospitalization.

Method: Clinical trial performed on 90 patients admitted to an Iranian specialized psychiatric hospital. Sampling was done using random allocation of six blocks in experimental and control groups. In the experimental group, after leaving the hospital, the intervention was performed for 3 months in the form of two telephone calls and one face-to-face meeting per month.

Main findings: The severity of bipolar I symptoms before and after the intervention in the experimental and control groups were respectively showing a statistically significant difference. According to the results, the home nursing care for patients leads to a reduction in the severity of symptoms and a reduction in the rate of re-hospitalization of patients.

Relevance for the research question: The article briefly depicts the intervention of home nursing care and how it may or may not be beneficial to patients suffering from bipolar I disorder. Among other things, the intervention is made up of family- and patient support and education, providing insights in the implementation of communication.

4.5 Research article 5

Title: Positive Health dialogue tool and value-based healthcare: a qualitative exploratory study during residents' outpatient consultations

Author, year of publication and journal: Bock, L.A., Noben, C.Y.G., Yaron, G., George, E.L.J., Masclee, A.A.M., Essers, B.A.B., Van Mook, W.N.K.A. 2021. BMJ Open.

Aim: To explore how residents experienced the application of the Positive Health Dialogue tool (PH-tool) during outpatient consultations and its influence on the delivery of value-based healthcare (VBHC).

Introduction: Traditionally, physician-patient communication is primarily grounded on a paternalistic model, that is, medical authority. In the last decade, PH has been widely embraced in the Dutch public sector, as means to a further patient-centred approach.

Method: Qualitative study using non-participant observations of outpatient consultations during which residents used the PH-tool, followed by longitudinal individual, semistructured interviews. To analyse data from observations and interviews, observational form notes' summarisation and categorization, and an iterative-inductive thematic approach was used.

Main findings: Residents had ambivalent experiences with using the PH-tool. Three main benefits and three main barriers became apparent. For particular patients and problems, using the PH- tool seems a promising strategy to increase VBHC delivery.

Relevance for the research question: One of the topics that I assign greatest value to is covered: the Positive Health model. Not only does it cover the topic, it also discusses its implementation. This is important for my research question, as I want to learn how nurses could operate the PH-model.

5 Discussion

In this chapter I will discuss the research question of my thesis: "*How can nurses help patients with bipolar disorder make decisions to cope with their disease* ?" This will be done in light of the five articles, the theory chapter, empiricism and a modicum of substantiating sources. Three main themes emerged and will guide the discussion, founded on the Neuman Systems Model.

5.1 Rethinking Decision-making: Who Pulls the Strings?

Traditionally, healthcare provider-patient communication is primarily grounded on paternalistic reasoning (Bock et al., 2021, article 5). This means that the healthcare provider would often 'pull the strings' and decide over treatments for the patient. However, the paradigm has shifted and a focus on shared decision-making (SDM) has risen, in which patients gain control. Article 1 mentions that SDM "shifts power from clinicians to mental health service users (MHSUs)". All selected articles agree that SDM is becoming of increasing importance in mental health care.

It is important to know why practicing shared decision-making is important in bipolar disorder care, besides GGZstandaarden (n.d.) mentioning it is an important communication skill in conversating with a patient with BD. Because of the complexity BD presents with, patients, their significant others and health care providers are faced with a multitude of treatment options (Renes et al., *2024*). Renes et al. (2024) argue that collaborative care models in BD, such as SDM, "have shown better health outcomes compared with care as usual".

According to Fisher et al. (2016) key elements of shared decision-making include: providing patients with treatment option information, checking patient understanding of options and involvement preferences, and incorporating both patient and clinician perspectives and preferences into final decisions.

Supported decision-making as Kokanović et al. employ the concept, is a form of communication that empowers and encourages the patient to be actively involved in their

health care process. Supported decision-making is distinct from shared decision-making, as it emphasizes patient autonomy over the more collaborative shared decision-making. This points in the direction of the Positive Health model that encourages patients to actively engage in their health care process by means of self-reflection through filling out the spiderweb tool.

Decision-making may also include family members (Kokanović et al., 2018; Fisher et al., 2018), or in terms of the NSM; (parts of) the patient system, next to the nurse. For example, Fisher et al (2016) argue that "family involvement in treatment discussions was perceived as mostly supportive". This is in line with article 2 that describes how "patients' family members facilitate medical decision-making, by providing emotional, informational, practical decisional support and/or advocacy to the patient, and by being their sounding board". In the end, patients are viewed as the ultimate decision-maker. Article 2 illustrates a patient's response for autonomy: "I'll always talk to other people and see what they think, but ultimately I'll always make the decision myself". When consulting with both patient and their family, it is important to make sure family does not feel overlooked (Kokanović et al., 2018) and is involved according to the patient's and family's wishes (regarding confidentiality, perceived family burden or distress (Fisher et al., 2018)).

Article 4 (Zeighami et al., 2021) does not mention shared decision-making, but in the home care intervention, goals on family- and patient support and education are formulated. For example, encouraging the patient to express thoughts and feelings is also understood in the definition of shared decision-making. Family may, among other things, "help [patients] accept reality and not deny the disease". This is in line with an aspect of the most important dimension of the PH model *meaningfulness*, namely *accepting life*. Acceptance in terms of PH is about inner submission that provides space for reorienting possibilities in coping with the disease (iPH, *2020*). It helps patients find meaningfulness, despite loss or suffering. Besides helping to accept life, an appeal is made to the family in regards to numerous other goals as part of the intervention, demonstrating the importance of involvement of the family. Moreover, being in the familiar home environment - that is also part of the client system as set forth in the NSM - may cause the patient to speak more freely enhancing SDM.

The patient I was working with in my home care internship lived with her mom as they fled from the war in Ukraine. Her mom could provide us, the nurses, with additional information about the course of the disease as she knows her daughter best. For her daughter, she was a stabilizing figure.

For example, when the patient was in a manic episode she was often not home when she was supposed to be home as home care came for assistance with medication intake. Her mother informed us that she had been overspending on clothes and that she was seeing a friend that would lead her to Jesus. Her mother would than later that night assist with medication intake on our behalf. The mother of the patient was often worried and fatigued, since she carried great responsibility for the care of her daughter, even with the help of the home care organization. This illustrates the importance for a nurse to not only focus on the patient, but also on their system. When the system 'fails', the patient will have weaker ground and be more prone to interference of symptoms in their daily lives.

However, it is ill-judged to opine that SDM suits every patient with BD. When it comes to involvement preferences, articles agree that mental health service users, including the patient systems dealing with BD, wish to be involved – more – through shared decision-making (Kokanović et al., 2018; Fisher et al., 2018). On the other hand, Fisher et al. (2016) nuance and note that when BD patients experience more severe symptoms, they are more likely to prefer clinician-led decision-making. Therefore, the decision-making, and the preference for share therein, is dependent on the patient's mood state.

When thinking of the patient from my internship, SDM would not even be considered as her symptoms were hindering clear communication. SDM should be practiced when the patient is in a state of euthymia. The BD diagnosis in itself is unlikely to explain preferences for autonomy. Moreover, the initiating and facilitating of SDM is moderated by the complexity of decisions being made (Fisher et al., 2016): Greater SDM was associated with more complex decisions.

In addition, discordance between preferred and experienced roles in SDM predict lower patient satisfaction with psychiatric consultations (Fisher et al., 2016). Two categories of patient involvement were identified in article 3: instrumental and interpersonal.

Instrumental involvement is objectively referring to the clinician practicing their deal in SDM: presenting treatment options, etc. Interpersonal involvement is subjectively referring to how the patient feels “heard and acknowledged, and being responded to with sensitivity and empathy”. This depicts both ‘being’ and ‘feeling’ involved, contributing to the patient’s own evaluation of autonomy. Article 1 one is more gloom-ridden and takes on referral of Bee et al. (2015) arguing that any involvement is commonly driven by tokenism.

5.2 The Power of Communication in the Therapeutic Alliance

As aforementioned, shared decision-making shifts power to the patient, emphasizing their autonomy. Fisher et al. (2016) further suggest enhancement of patient autonomy can foster the therapeutic relationship and thereby positive patient outcomes.

From the perspective of the NSM, the patient and the nurse may understand they are equal in the therapeutic relationship dealing with BD, each with their own experiential or professional share. Stressors have to be identified and dealt with, both internally and externally. Those can be counteracted with identified resources.

A strong, collaborative therapeutic relationship appears particularly important in chronic mental illnesses like BD[II] where treatment decision-making is subject to ongoing review (Fisher et al., 2018). An ongoing healthy therapeutic relationship augments continuity of care. “In contrast, inadequate continuity of care reportedly led to patients feeling unsupported and lacking knowledge to manage their illness.” Article 1 argues that participant often commented on the value of the professional relationship established with the health care provider who helped them make decisions (Kokanović et al, 2018). Moreover, article 1 emphasizes the importance of interpersonal skills and relationships in enabling SDM. According to Fisher et al. (2018), the therapeutic relationship is linked to various outcomes, including patient satisfaction with care, […] , more open communication and, in turn, improved clinician understanding of the patient's treatment preferences. This is in line with article 3, stating that “patients who perceived their therapeutic relationship as strong, positive and collaborative were more likely to indicate improved medication

adherence, reduced suicidal ideation, and greater patient satisfaction with psychiatric visits". Importantly, having a good therapeutic relationship made patients comfortable to defer decisional control when experiencing reduced decisional capacity (Fisher et al., 2016). "SDM appeared more common within a longstanding therapeutic relationship, […], and when patients' family had attended consultations" (Fisher et al., 2018).

For the nurse it is important to have a good therapeutic relationship with the patient, because it helps anticipate in what state the patient is in and, for example, perform risk assessment. When the patient from my internship was not at home as she told her mom she was going to see Jesus, it was hard to estimate signification of this statement. It could have meant she was with her friend, or it might have been interpreted as a suicidal ideation. I had a hard time figuring this out, since I did not know the patient too well. My internship was too short to get to know each other that well.

A therapeutic alliances enforces a sense of coherence as the patient has a beacon in the health care provider to fall back on. This is consistent with Antonovsky's theory, stating that a strong sense of coherence helps the patient to mobilize resources when coping with their disease (*manageability*). They find life worth engaging with (*meaningfulness*) and understand why coping with their disease is necessary (*comprehensibility*). Psychoeducation is part of the first stage of SDM as described in article 3, namely 'information exchange'. It can help patients understand their experiences, minimising fearful emotions.

This is especially important in BD as the mood antitheses may cause the patient to be hesitant to rely on themselves. However, not only may they not rely on themselves, they may not rely on the health care provider either as they may feel suspicion, distrust or fear when their perception of reality is distorted. Trust as prerequisite is therefore very important in the therapeutic relationship.

When the patient is in an (hypo-)manic episode, the nurse wants to (educate (family) about) limit stimulation (Zeighami et al., 2021; 83), avoid confrontation and have the patient continuously engaged in the conversation as the patient may be easily distracted. When in a depressive episode, the nurse must exhibit validation of feelings and continuously engage the patient in the conversation. In both cases listening, summarizing and asking follow-up

questions are good techniques to make the patient feel seen and heard (Ten Have et al., *2021*). The Positive Health models' spiderweb tool can be used in a conversation with a patient experiencing mood symptoms. It may function as an engaging tool and give direction to the conversation. On the other hand, the PH dialogue tool may work counterproductive as it lacks demarcation in clinical practice (Bock et al., 2021), meaning the holistic approach may cause lack of focus, once again distracting the patient.

Having a strong therapeutic relationship is especially important in home care, as the patients home is potentially their only safe place, sheltered from the outside world. Their home is the nurses workplace. If denied entrance, the nurse stands no chance of being able to carry out her job, which may lead to frustration. Not only the Dutch code of conduct and the WGBO protect the patient, only the constitution states that trespass is indictable.

5.3 Values as Core Principle in Bipolar Disorder Care

Besides a beating heart, values, either cultural, moral or personal, drive our behaviour. Recurrent themes in the articles and in theory reflect on values and can tell us more about how nurses can help patients with bipolar disorder makes decisions to cope with their disease.

In the Neuman System Model (NSM), values are found in the core of the system (patient) and play a fundamental role in how a person experiences and assesses their life, and thereby, their health (Verberk & Merks, *2021*). The normal line of defense (stable condition in health) is affected by values, where values are considered critical internal resources.

Throughout the articles not all values as I interpret them are marked being values. Not only did I retrieve values, but also aspects that arise from or substantiate values. What I describe here is therefore subject to bias.

What is important to patients concerning care provision can be deduced from the articles. Kokanović et al. mention "personal recovery principles emphasizing hope, identity and personal responsibility", as well as respect for inherent dignity, individual autonomy including the freedom to make one's own choices […]. Those aspects are described to be

grounds for how personhood for a mental health service user (MHSU) is preferably approached. This is in line with article two, Fisher et al's (*2018*; 73), in which a patient respondent illustrates the value autonomy. For a nurse, respect for autonomy means having respect for the patient's opinions, choices and lifestyle (KNMG, *2017*). Autonomy also implies being able to express wishes and preferences (SDM) (Kokanović et al., 2018; Zeighami et al., 2021).

Values can be expressed or perceived (through norms) distinctly in times of (hypo)manic or depressive episodes. However, values root deeper as they are generally unassailable making up part of one's personality. On the other hand, the effective exhibition, but also interpretation, of ones values are liable to, amongst other things, the mental state and mood. Euthymia provides a clear basis for expression of values.

For example, in interaction with the patient with BD in my internship, in appropriate moments I would use humor to convey a message or to encourage her to take her medication. Here, the word 'appropriate' is subjective. As it might have been appropriate to me, it might have felt derogatory or patronizing for the patient. And so on. The value we assign to certain aspects in communication (interaction) is dependent on our frame of reference. This frame of reference is for a great deal formed by values (Mainwaring, *2001*), and may be as complex as the constellation of a psychiatric disorder.

Fisher et al. (2016) mention that SDM is well-suited to treatment decisions that are sensitive to patient values and preferences as in BD. The (possible) etiology of BD found in environmental factors underscores the importance of assessing the disease from a holistic point of view. This makes the PH model applicable, as it covers most aspects of life. In her PH model, Huber translates sense of coherence (Antonovsky) to sense of belonging (participation). Sense of coherence is not a value in itself as it is more of an orientation to life that endorses values like 'participation' and 'involvement', such as needed in SDM. The PH model in conversation can be used to identify patient values through the assigning of the scores. It will visualize what the patients value most and what they decide they want to work on.

Meaningfulness as set forth by Huber touches on seven aspects that all let the patient assign value to something in their lives, through their values. For example, having zest for life exists because someone assigns value to something in their life. Bock et al. (2021) argue that in problem treatment the PH-tool can induce residents to identify what patients deem most valuable. Moreover, it helped the healthcare providers more deliberately consider 'values' when making decisions.

Fisher et al. (2016) state that in SDM "patients […] [perceiving] their therapeutic relationship as strong (e.g., feeling understood), positive (e.g., having a good relationship), and collaborative (e.g., jointly resolving problems)" showed more positive clinical outcomes. Feeling understood, having a good relationship and jointly resolving problems find ground in values, for example, respectively being autonomy and respect, trust and authenticity, and collaboration and responsibility.

In my experience, besides symptomatic influences, personal values have a significant influence on whether a patient prefers and benefits from greater autonomy or a more paternalistic approach. Therefore, the question to what extents patients with BD want to be empowered in their autonomy is important.

A very practical case for implementation of the PH model: Since psychiatric illnesses such as BD have a relapsing and debilitating nature (Fisher et al., 2016;, Fisher et al., 2018; Zeighami et al., 2021), follow-ups after discharge from the hospital or mental health institutions in form of home nursing care are crucial. However, follow-ups are costly and "several participants highlighted difficulties in accessing psychiatrists and psychologists due to high costs, […] (Fisher et al., 2018). Costs form a potential stressor (NSM) and should be paid attention to, as article 5 illustrates, by using the PH model, so that can be decided where costs are to be spend. The PH model may provide value clarification in regards to coping with money (*daily functioning*) to consider preferences and deliberate on the varying benefits/costs of the different treatment options.

6 Conclusion

In this finalising chapter, I will work towards an answer for the research question in light of the discussion. The aim of my thesis was to identify how nurses can help patients with bipolar disorder make decisions to cope with their disease.

Throughout the queries aimed at communication, it became apparent that nurses should exercise shared decision-making (SDM) in conversing with patients with BD. SDM is most efficacious when the patient is euthymic, but can also be tailored to situations in which the patient is exhibiting symptoms of the antitheses moods, depending on preferences and earnestness of the decision to be made. Family plays an important role in SDM, functioning as sounding board and source of essential information.

A prerequisite for SDM is to build and maintain a trusting, therapeutic relationship, especially in the home care setting. In communication with the patient with BD moods may deflect and distort their interpretation of reality. Patients with BD want to be able to rely on the nurse and the professional relationship is linked to more positive patient outcomes.

The PH dialogue tool can help build the therapeutic relationship by assessing values, like autonomy, and visualising what should be decided to work on. *Meaningfulness* encompasses values, which is particularly interesting as they tell us more about possible unseen connections attributing to the complex constellation of the psychiatric disease. Not only is meaningfulness presented by Huber as the most important dimension of the model, but also patients in mental health care assign greater value to meaningfulness than patients in general healthcare.

Nurses are pivotal in helping the patient find comprehensive, manageable and meaningful ways to live with bipolar disorder.

References

Adriaansen, M., & Caris, J. (2020). *Waarnemen en interpreteren.* In: *Elementaire Sociale Vaardigheden.* (4e ed.). Bohn Stafleu van Loghum.

Antonovsky, A. (1979). *Health, stress, and coping*. San Francisco: Jossey-Bass.

Aldinger, F. & Schulze, T.G. (2016, September 21). *Environmental factors, life events, and trauma in the course of bipolar disorder*. Retrieved 13-04-2025 from https://pmc.ncbi.nlm.nih.gov/articles/PMC7167807/

Baumeister, R.F., & Leary, M.R. (1997, September). *Writing Narrative Literature Reviews*. *1*(3). Retrieved 02-04-2025 from https://doi.org/10.1037/1089-2680.1.3.311

Beentjes, T.A.A., Goossens, P.J.J., Jongerden, I.P. (2015, March 13). *Nurses' Experience of Maintaining Their Therapeutic Relationship With Outpatients With Bipolar Disorder and Their Caregivers During Different Stages of a Manic Episode: A Qualitative Study*. Retrieved 15-05-2025 from https://doi.org/10.1111/ppc.12109

Bielecki, J.E. & Gupta, V. (2023, July 17). *Cyclothymic Disorder*. Retrieved 13-04-2025 from https://www.ncbi.nlm.nih.gov/sites/books/NBK557877/

Bock, L.A., Noben, C.Y.G., Yaron, G., George, E.L.J., Masclee, A.A.M., Essers, B.A.B., Van Mook, W.N.K.A. (2021, November 1). *Positive Health dialogue tool and value-based healthcare: a qualitative exploratory study during residents' outpatient consultations*. Retrieved from https://bmjopen.bmj.com/content/bmjopen/11/11/e052688.full.pdf

Cambridge Dictionary. (n.d.). *Cope*. Retrieved 14-05-2025 from https://dictionary.cambridge.org/us/dictionary/english/cope

Cambridge Dictionary. (n.d.) *Decision*. Retrieved 14-05-2025 from https://dictionary.cambridge.org/dictionary/english/decision

Cambridge Dictionary. (n.d.). *Meaningfulness*. Retrieved 14-04-2025 from https://dictionary.cambridge.org/dictionary/english/meaningfulness

Cartwright, C., Greenhill, B., Griffiths, A.W., Harrison, J. (2024, September 27). *A meta-ethnography of shared decision-making in mental health care from the perspective of staff and service users*. In: BMC Health Services Research (24). Retrieved 26-04-2025 from https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-11540-9

Carvalho, A.F., Dimellis, D., Gonda, X., Vieta, E., McIntyre, R.S., Fountoulakis, K.N. (2014, June). *Rapid cycling in bipolar disorder: a systematic review*. Retrieved 13-04-2025 from https://pubmed.ncbi.nlm.nih.gov/25004199/

CIBG Ministry of Health, Welfare and Sport. (2022, May 2). *BIG-register > Registration > Procedures > Legislation*. Retrieved 14-04-2025 from https://english.bigregister.nl/registration/procedures/legislation

Cleland, J., & Durning, S.J. (2015, July 15). *Exploring versus measuring: considering the fundamental differences between qualitative and quantitative research*. Retrieved 02-04-2025 from https://doi.org/10.1002/9781118838983.ch1

Cleveland Clinic. (2025, March 19). *Hypomania*. Retrieved 13-04-2025 from https://my.clevelandclinic.org/health/diseases/21774-hypomania

De Jong, A., Legius, M., De Maesschalck, L. (2016). *8 Kennis toepassen*. In: Onderzoekend vermogen voor verpleegkundigen – Leerboek voor kritisch en methodisch probleemoplossend denken. Groningen, BSL. Retrieved 02-04-2025 from https://mijn.bsl.nl/onderzoekend-vermogen-voor-verpleegkundigen/10359072

Douma, L. (2022, February 28). *'Zingeving is ingewikkelder dan de concrete wetenschap waarin wij zijn opgeleid'*. Retrieved 13-04-2025 from https://www.ggztotaal.nl/nw-/nieuws/zingeving_is_ingewikkelder_dan_de_concrete_wetenschap_waarin_wij_zijn_opgeleid.html

Dyson, H. (2024, August 27). *Understanding the Therapeutic Relationship: The Heart of Effective Therapy*. Retrieved 15-05-2025 from https://www.drhdysonpsych.com/post/understanding-the-therapeutic-relationship-the-heart-of-effective-therapy#

Eger, E.E. (2018, October 23). *De Keuze – Leven in vrijheid*. Lev.

Encyclo.nl. (n.d.). *Thuiszorg definities*. Retrieved 12-04-2025 from https://www.encyclo.nl/begrip/thuiszorg

Fawcett, J., & Gigliotti, E. (2001, October). *Using Conceptual Models of Nursing to Guide Nursing Research: The Case of the Neuman Systems Model.* In: Nursing Science Quarterly, *14*(4) p:339-345. Retrieved 29-03-2025 from https://journals.sagepub.com/doi/epdf/10.1177/089431840101400411

Fisher, A., Manicavasagar, V., Kiln, F., Juraskova, I. (2016, July). *Communication and decision-making in mental health: A systematic review focusing on Bipolar disorder.* Retrieved from https://doi.org/10.1016/j.pec.2016.02.011

Fisher, A., Manicavasagar, V., Sharpe, L., Laidsaar-Powell, R., Juraskova, I. (2018, February). *A qualitative exploration of patient and family views and experiences of treatment decision-making in bipolar II disorder*. Retrieved from https://pubmed.ncbi.nlm.nih.gov/28084845/

Gazzaroli, D., D'Angelo, C., Corvino, C. (2020, December 10). *Home-Care Workers' Representations of Their Role and Competences: A Diaphanous Profession*. Retrieved 14-04-2025 from https://pmc.ncbi.nlm.nih.gov/articles/PMC7758209/

GBD 2019 Mental Disorders Collaborators. (2022, February). *Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2029: a systematic analysis for the Global Burden of Disease Study 2019.* Retrieved 12-04-2025 from 10.1016/S2215-0366(21)00395-3

GGZStandaarden. (2024, November 28). *Zingeving in de psychische hulpverlening.* Retrieved 14-04-2025 from https://www.ggzstandaarden.nl/zorgstandaarden/zingeving-in-de-psychische-hulpverlening/over-het-belang-van-zingeving-in-de-psychische-hulpverlening

GGZStandaarden. (n.d.). *Verpleegkundig handelen bij patiënten met een bipolaire stoornis – samenvattingskaart voor verpleegkundigen*. Retrieved 13-04-2025 from https://www.ggzstandaarden.nl/api/v2/tools/e4c253ea-4e32-496b-8c08-f20a37d54524/file

Haarman, B.C.M., Riemersma-Van der Lek, R.F., Burger, H., Drexhage, H.A., Nolen, W.A. (2018, February 1). *Het ontregelde brein; consequenties van ruimtelijke en temporele complexiteit van het brein voor pathofysiologie en diagnostiek van de bipolaire stoornis.* In: Tijdschrift voor Psychiatrie, *Volume 60 – Issue 2 p.*(105-113). Retrieved 13-04-2025 from https://repub.eur.nl/pub/105455/RePub_105455_OA.pdf

Hamann, J., Leucht, S., Kissling, W. (2003, May 15). *Shared decision-making in psychiatry*. In: Acta Psychiatrica Scandinavica. *107*(6), p403-409. Retrieved 14-05-2025 from https://doi.org/10.1034/j.1600-0447.2003.00130.x

Hawke, L.D., Parikh, S.V., Michalak, E.E. (2013, September 5). *Stigma and bipolar disorder: A review of the literature*. In: Journal of Affective Disorders, Volume 150(*2*). Retrieved 14-04-2025 from https://doi.org/10.1016/j.jad.2013.05.030

Hersenstichting. (2024, September 3). *Bipolaire stoornis*. Retrieved 13-04-2025 from https://www.hersenstichting.nl/hersenaandoeningen/bipolaire-stoornis/

Horsten, L., Douven, I., Weber, E. (2007). *Wetenschapsfilosofie*. Koninklijke van Gorcum, Assen.

Huber, M, A. S. (2014, January 1). *Towards a new, dyamic concept of heath: Its operationalisation and use in public health and healthcare and in evaluating health effects of food*. Retrieved 18-03-2025 from https://cris.maastrichtuniversity.nl/ws/portalfiles/portal/1486697/guid-ca35cef5-7513-4963-8666-dfed020b66ac-ASSET2.0.pdf

Huber, M., Van Vliet, M., De Kleijn, M., Van den Brekel-Dijkstra, K., Huijts, T., Van Hogen-Koster, S., Jung, H.P. (2024, March 16). *Rapid Review of the Concept of Positive*

Health and Its Implementation in Practice – Healthcare 12(6), 671. Retrieved 17-03-2025 from https://doi.org/10.3390/healthcare12060671

Huber, M., Van Vliet, M., Giezenberg, M., Winkens, B., Heerkens, Y., Dagnelie, P.C., Knottnerus, J.A. (2016, January 12). *Towards a 'patient-centred' operationalisation of the new dynamic concept of health: a mixed methods study*. Retrieved 18-03-2025 from https://pubmed.ncbi.nlm.nih.gov/26758267/

IAD Institute for Academic Development. (2024, February 26). *Literature review – A general guide on how to conduct and write a literature review*. In: The University of Edinburgh. Retrieved 02-04-2025 from https://institute-academic-development.ed.ac.uk/study-hub/learning-resources/literature-review#:~:text=A%20literature%20review%20is%20a,rather%20than%20a%20literature%20report.

Institute for Positive Health (iPH). (2020, December 9). *Sense of Coherence helpt mensen gezond houden*. Retrieved 14-04-2025 from https://www.iph.nl/kennisbank/sense-of-coherence-helpt-mensen-gezond-houden/

Institute for Positive Health (iPH). (2022, January 19). *3 Conferentie Positieve Gezondheid Uitwerking naar Positieve Gezondheid Machteld Huber*. [Video]. YouTube. Retrieved 27-03-2025 from https://www.youtube.com/watch?v=mN0ctjV1TUs

Institute for Positive Health (iPH). (2024, April 2). *Rapid review brengt wetenschappelijke kennis Positieve Gezondheid in kaart.* Retrieved 24-04-2025 from https://www.iph.nl/kennisbank/rapid-review-brengt-wetenschappelijke-kennis-positieve-gezondheid-in-kaart/

Institute for Positive Heath (iPH). (2024, May 13). *Wat is Positieve Gezondheid?* Retrieved 27-03-2025 from https://www.iph.nl/kennisbank/wat-is-positieve-gezondheid/

Jain, A. & Mitra, P. (2023, February 20). *Bipolar Disorder – Pathophysiology*. Retrieved 13-04-2025 from https://www.ncbi.nlm.nih.gov/books/NBK558998/

Keijsers, G.P.J., Vossen, C., Keijsers, L. (2012). *Helpen veranderen: Motiveringsstrategieën in de ambulante psychotherapie*. Boom.

KNMG. (2017, April 7). *Ethische toolkit – Respect voor autonomie*. Retrieved 26-04-2025 from https://www.knmg.nl/ik-ben-geneeskundestudent-1/ethische-toolkit/dilemmas-begrippen/respect-voor-autonomie

KNMG. (2018, February 14). *Ethische toolkit*. Retrieved 14-04-2025 from https://www.knmg.nl/ik-ben-geneeskundestudent-1/ethische-toolkit/verdiepen/begrippen-2

Kokanović, R., Brophy, L., McSherry, B., Flore, J., Moeller-Saxone, K., Herrman, H. (2018, June 28). *Supported decision-making from the perspective of mental health service*

users, family members supporting them and mental health practitioners. Retrieved from https://doi.org/10.1177/0004867418784177

KRO-NCRV. (2023, February). *De Verwondering – Machteld Huber*. [Video]. NPO Start.

Levine, S., Boal, J., Boling, P.A. (2003, September 3). *Home Care*. Retrieved 14-04-2025 from https://jamanetwork.com/journals/jama/article-abstract/197192

Luik, A. (2022, December 1). *Sterke toename psychische aandoeningen bij volwassenen.* Retrieved 13-04-2025 from https://www.trimbos.nl/actueel/nieuws/sterke-toename-psychische-aandoeningen-bij-volwassenen/

Mainwaring, L. (2001, September). *Environmental values and the frame of reference*. Retrieved 24-04-2025 from https://doi.org/10.1016/S0921-8009(01)00175-6

McIntyre, R.S., Berk, M., Brietzke, E., Goldstein, B.I., López-Jaramillo, C. Vedel Kessing, L., ..., Mansur, R.M. (2020, December 5). *Bipolar disorders*. Retrieved 12-04-2025 from https://pubmed.ncbi.nlm.nih.gov/33278937/

Memmott, R.J., Marett, K.M., Bott, R.L., Duke, L. (2000). *Use of the Neuman Systems Model for Interdisciplinary Teams* – Online Journal of Rural Nursing and Health Care, *1*(2). Retrieved 18-03-2025 from https://doi.org/10.14574/ojrnhc.v1i2.489

Nederlands Herseninstituut. (2023, January 26). *Bipolaire stoornis*. Retrieved 12-04-2025 from https://herseninstituut.nl/over-het-brein/bipolaire-stoornis/#:~:text=In%20Nederland%20komt%20een%20bipolaire%20stoornis%20bij%20%C3%A9%C3%A9n,eerste%20manie%20kan%20pas%20vele%20jaren%20later%20optreden.

NEMESIS. (2022, September 30). *Aantallen Nederlanders met een 12-maands aandoening.* Retrieved 13-04-2025 from https://cijfers.trimbos.nl/nemesis/kerncijfers-psychische-aandoeningen/aantallen-12mnds-aandoeningen/

Neuman, B. (1995). *The Neuman systems model.* In: The Neuman systems model (3rd ed., p:3-61). Retrieved 29-03-2025 from https://doi.org/10.1177/089431849600900207

NeuroLaunch. (2024, August 15). *Understanding the Pathophysiology and Psychopathology of Bipolar Disorder*. Retrieved 13-04-2025 from https://neurolaunch.com/pathophysiology-of-bipolar-disorder/#google_vignette

O'Connell, K. (2025). *The genetic key to bipolar disorder*. Retrieved 13-04-2025 from https://www.med.uio.no/klinmed/english/research/news-and-events/news/2025/the-genetic-key-to-bipolar-disorder.html#:~:text=%22Bipolar%20disorder%20is%20one%20of%20the%20most%20heritable,for%20Precision%20Psychiatry%20at%20the%20University%20of%20Oslo.

OpenAI. (2024). *ChatGPT* (GPT-4-turbo) [Large language model]. Retrieved from https://chat.openai.com/

Parker, G., Fletcher, K. (2014, January). *Differentiating bipolar I and II disorders and the likely contribution of DSM-5 classification to their cleavage.* Retrieved 21-04-2025 from https://pubmed.ncbi.nlm.nih.gov/24446541/

Perich, T., Mitchell, P.B., Vilus, B. (2016, February 16). *Stigma in bipolar disorder: A current review of the literature*. Retrieved 14-04-2025 from https://pubmed.ncbi.nlm.nih.gov/35172630/

Renes, J.W., Metz, M.J., Nolen, W.A., Hoogendoorn, A.W., Kupka, R.W., Regeer, E.J. (2024, August 28). *Shared decision-making in the treatment of bipolar disorder: findings from a nationwide naturalistic cohort study in everyday clinical practice*. Retrieved 15-05-2025 from https://link.springer.com/article/10.1007/s00127-024-02761-8

RIVM. (n.d.). *Wet geneeskundige behandelingsovereenkomst (WGBO)*. Retrieved 14-04-2025 from https://www.rivm.nl/cpt/kwaliteit-wet-en-regelgeving/wetgeving/wgbo

Ryan, R.M., & Deci, E.L. (2000). *Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being.* In: American Psychologist, *55*(1) p:66-78. Retrieved 28-03-2025 from https://doi.org/10.1037/0003-066X.55.1.68

Sabbe, B.G.C. & Giltay, E.J. (2024, March 6). *Psychopathologie als zelforganisatie van complexe dynamische systemen*. Retrieved 18-03-2025 from https://www.tijdschriftvoorpsychiatrie.nl/nl/artikelen/article/50-13345_Psychopathologie-als-zelforganisatie-van-complexe-dynamische-systemen/

Salvadore, G., Quiroz, J.A., Machado-Vieira, R., Henter, I.D., Manji, H.K., Zarate, C.A. (2010, December 10). *The Neurobiology of the Switch Process in Bipolar Disorder: a Review*. Retrieved 13-04-2025 from https://pmc.ncbi.nlm.nih.gov/articles/PMC3000635/

Schnell, T., & Krampe, H. (2022, April 21). *Meaningfulness protects from and crisis of meaning exacerbates general mental distress longitudinally*. BMC Psychiatry *22*(285). Retrieved 27-03-2025 from https://doi.org/10.1186/s12888-022-03921-3

Smith, J. & Noble, H. (2015, April). *Issues of validity and reliability in qualitative research*. Retrieved 28-03-2025 from https://pubmed.ncbi.nlm.nih.gov/25653237/

Spek, A., Kiep, M., Bronwasser, C., Snouckaert, V., Visser, H., Bayat, N., Swets, M. Schulte, R. (2021, September 3). *Whitepaper autisme spectrum stoornis ASS en/of bipolaire stoornis.* Retrieved 14-05-2025 from https://www.kenniscentrumbipolairestoornissen.nl/nieuws/2021/09/03/nieuw-whitepaper-autisme-spectrum-stoornis-ass-en-bipolaire-stoornis/

Steer, P. J. & Ernst, S. (2021, February). *Peer review – Why, when and how*. In: International Journal of Cardiology Congenital Heart Disease, *V*(2). Retrieved 20-04-2025 from https://doi.org/10.1016/j.ijcchd.2021.100083

Stevens, J. (n.d.). *Zingeving; nut en betekenis in jouw leven zoeken*. Retrieved 25-04-2025 from https://www.desteven.nl/persoonlijke ontwikkeling/autonomie/behoeften/zingeving

Tamm, M. (2009, July 7). *What does a home mean and when does it cease to be a home? Home as a setting for rehabilitation and care*. Retrieved 13-04-2025 from https://doi.org/10.1080/096382899297963

Ten Have, E.C.M., & Gortworst, R. (2021). *De verpleegkundige als communicator*. (7e ed.). Bohn Stafleu van Loghum.

Ten Have, M. (2022, December 1). *Cijfers: psychische gezondheid*. Trimbos Instituut. Retrieved 27-03-2025 from https://www.trimbos.nl/kennis/cijfers/psychische-gezondheid-ggz/

Tenny, S., Brannan, J.M., Brannan, G.D. (2022, September 18). *Qualitative Study*. Retrieved 02-04-2025 from https://www.ncbi.nlm.nih.gov/books/NBK470395/

Tugrul, K. (2003, December). *The nurse's role in the assessment and treatment of bipolar disorder*. In: Journal of the American Psychiatric Nurses Association, Volume 9(*6*) p180-186. Retrieved 13-04-2025 from https://doi.org/10.1016/j.japna.2003.10.005

Van de Loo, D.T.M., Saämena, N., Janse, P.. Van Vliet, M., Braam, A.W. (2022, February). *De waardering van de zes dimensies van positieve gezondheid in de GGZ*. In: Tijdschrift voor Psychiatrie (*64*)p:87-88. Retrieved 27-03-2025 from https://www.iph.nl/assets/uploads/2022/02/64-2022-2-artikel-loo.pdf

Verberk, F., & Merks, A. (2021). *Verpleegkunde volgens het Neuman systems model*. (7e ed.). Uitgeverij Koninklijke Van Gorcum.

Ververda, C. (2005, January). *Jongleren met Salutogenese*. Retrieved 14-04-2025 from https://www.salutogenese.nl/Site%202/salutogenese.html

Vinje, H.F., Langeland, E., Bull, T. (2016, September 3). *Chapter 4 Aaron Antonovsky's Development of Salutogenesis, 1979 to 1994.* Retrieved 14-04-2025 from https://www.ncbi.nlm.nih.gov/books/NBK435860/#ch4.CR8

V&VN. (2015, January). *Beroepscode van Verpleegkundigen en Verzorgenden* - §2.13 – Als verpleegkundige/verzorgende respecter en bescherm ik de privacy van de zorgvrager. Retrieved 13-04-2025 from https://www.venvn.nl/media/042ooa1u/de-nationale-beroepscode-voor-verpleegkundigen-en-verzorgenden.pdf

Wakefield, J.C. (2016, March). *Diagnostic Issues and Controversies in DSM-5: Return of the False Positives Problem.* Retrieved 21-04-2025 from

https://www.annualreviews.org/content/journals/10.1146/annurev-clinpsy-032814-112800

World Health Organization (WHO). (2024, July 8). *Bipolar disorder*. Retrieved 12-04-2025 from https://www.who.int/news-room/fact-sheets/detail/bipolar-disorder#:~:text=Key%20facts%201%20Bipolar%20disorder%20is%20a%20mental,difficulties%20in%20many%20areas%20of%20life.%20Meer%20items

Zeighami, R., Raeisolhagh, A., Ranjbaran, M. (2021, May). *Effect of Home Nursing Care on the Severity of Symptoms in Patients With Bipolar I Disorder: A Randomized Clinical Trial*. Retrieved from https://doi.org/10.1177/1084822320969122

Appendix

Search nr	Database	Search date	Search words and combinations	Limitations	Results	Read headlines	Read abstracts	Read articles	Included articles
1.a	Medline	22.04.25	(bipolar disorder or bipolar i or bipolar ii or manic depression or bipolar affective disorder or bipolar depression) AND (“nursing communication” or “communication skills”)	Peer reviewed; Publication Date: 20240101-20251231; English language; Language: English	9	9	2	1	1 (Same article as found in CINAHL with Full Text)
1.b	CINAHL with Full Text	22.04.25	(bipolar disorder or bipolar i or bipolar ii or manic depression or bipolar affective disorder or bipolar depression) AND (“nursing communication” or “communication skills”)	Peer reviewed; Publication Date: 20240101-20251231; English language; Language: English	5	5	1	1	1 (Same article as found in Medline)
1.c	CINAHL with Full Text	22.04.25	communication AND bipolar disorder	Peer reviewed; Publication Date: 20240101-20251231; English language; Language: English	122	16	1	1	1
1.d	CINAHL with Full Text	22.04.25	(bipolar disorder or bipolar i or bipolar ii or manic depression or bipolar affective disorder or bipolar depression) AND	Peer reviewed; Publication Date: 20240101-20251231; English	17	17	0	0	0

			(conversation* or conversation skills)	language; Language: English					
1.e	PsycINFO	22.04.25	(bipolar disorder/ or bipolar i disorder/ bipolar ii disorder/ or cyclothymic disorder/ or mania/) AND exp Communication/ AND (exp Nurses/ or exp Nursing/ or exp Psychiatric Nurses/ or exp Health Care Services/)	peer reviewed journal and english language and english and yr="2014 - 2025"	35	35	3	3	0
1.f	PsycINFO	22.04.25	(bipolar disorder/ or bipolar i disorder/ or bipolar ii disorder/ or cyclothymic disorder/ or mania/) AND (interpersonal communication/ or communication/ or interpersonal interaction/ or conversation/)	peer reviewed journal and english language and english and yr="2014 - 2025"	21	21	1	0	0
2.a	CINAHL with Full Text	22.04.25	(bipolar disorder or bipolar i or bipolar ii or manic depression or bipolar affective disorder or bipolar depression) AND (home care services or home health care or home healthcare or home	Peer reviewed; Publication Date: 20240101-20251231; English language; Language: English	43	32	2	1	1

			nursing) NOT “nursing home”						
2.b	Medline	22.04.25	(bipolar disorder or bipolar i or bipolar ii or manic depression or bipolar affective disorder or bipolar depression) AND (home care services or home health care or home healthcare or home nursing) NOT “nursing home”	Peer reviewed; Publication Date: 20240101-20251231; English language; Language: English	113	57	1	0	0
2.c	PsycINFO	22.04.25	(bipolar disorder/ or bipolar i disorder/ or bipolar ii disorder/ or cyclothymic disorder/ or mania/) AND (home care personnel/ or home visiting programs/)	-	0	0	0	0	0
3.	Medline	23.04.25	“Positive Health” AND (Huber or Machteld Huber) AND (tool or assessment or assessment tool)	Peer reviewed; Publication Date: 20240101-20251231; English language; Language: English	7	7	4	2	1

Table 2 – Search process

1. https://doi.org/10.1177/0004867418784177
   Supported decision-making from the perspectives of mental health service users, family members supporting them and mental health practitioners
   Found in both CINAHL and Medline (search 1a and 1b)

2. https://pubmed.ncbi.nlm.nih.gov/28084845/
   A qualitative exploration of patient and family views and experiences of treatment decision-making in bipolar II disorder
   Found from snowballing citing articles (from search 1f)

3. https://doi.org/10.1016/j.pec.2016.02.011
   Communication and decision-making in mental health: A systematic review focusing on Bipolar disorder
   Found in CINAHL (search 1c)

4. https://doi.org/10.1177/1084822320969122
   Effect of Home Nursing Care on the Severity of Symptoms in Patients With Bipolar I Disorder: A Randomized Clinical Trial
   Found in CINAHL (search 2a)

5. DOI: 10.1136/bmjopen-2021-052688

   Positive Health dialogue tool and value-based healthcare: a qualitative exploratory study during residents' outpatient consultations.

   Found through Medline (search 3)