

**Positive expectations and vitality
for healing insights in depression**

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ABSTRACT

Aim: To describe the characteristics of conversations that can alleviate the suffering of patients with mild or moderate depression.

Background: Depression is the most common disability in the world and is increasing alarmingly. One treatment option that has not yet been evaluated sufficiently is caring conversations with a nurse.

Design: Qualitative empirical research.

Method: Nine patients with experience of caring conversations in a depressive period were interviewed in 2012.

Findings: Depressed patients felt that nurses transmitted positive expectations and vitality during caring conversations. The caring process is described in three phases with three main categories and six subcategories:

Phase 1. The nurse invites the patient to share her/his experiences:

Main category 1. The nurse's commitment makes the patient feel valued.

Phase 2. The patient feels trust:

Main category 2. The patient feels trust and confidence thanks to the nurse's positivity and reliability.

Phase 3. The patient invites the nurse to share experiences:

Main category 3. The patient dares to open up and be guided to insights by the nurse.

Conclusion: Committed nurses transmitting vitality and positive expectations can use caring conversations as powerful tools to alleviate the suffering of patients with mild or moderate depression.

Key words: depression, caring conversation, psychiatry, vitality, positive expectations, confidence, trust, commitment, insights, nurses

INTRODUCTION

Background

Depression is the most common cause of disability worldwide. Some 350 million people suffer from depression and the number is expected to increase. The cause/s of depression can be complex and stem from biological, psychological and social factors (WHO, 2010). The depressed person often states social or cultural causes, such as conflicts and stress in family and relationships (Fu & Parahoo, 2009). Symptoms of depression are depressed mood, loss of interest and pleasure, and decreased energy. Many also suffer from insomnia, loss of appetite, difficulty in concentrating, feelings of guilt, low self-esteem (WHO, 2010), anxiety disorders (Devane, Chiao, Franklin, & Kruep, 2005) and also from pain and physical diseases which then have poorer prognoses (Socialstyrelsen, 2011). The severity of the symptoms will determine whether the depression is classified as mild, moderate or severe (WHO, 2010). At any level there is always a risk of deterioration that can even lead to suicide, which is the cause of about one million deaths per year. Accordingly it is important to initiate appropriate treatment early (Socialstyrelsen, 2011). The WHO recommends treatments like antidepressants, psychosocial support and psychotherapy. Many people receive inadequate treatment or none at all. This may be due to healthcare providers' shortage of resources and/or skills, or to social stigmatization (WHO, 2010). The relapse statistics of 50% for depression (Åsberg & Martinsson, 2010) also show that today's therapies are not enough. In this context the nurse is a resource not fully utilized (Blomberg & Hedelin, 2007) and according to Western experts in the field of depression we need guidelines and training for nurses working with this population (McIlrath, Keeney, McKenna, & McLaughlin, 2010; WHO, 2010). In psychiatric care, conversations are important tools and conversations that relieve the patient's suffering can be called caring conversations (Fredriksson, 2003). Caring conversations with a nurse can be a method to alleviate the suffering of patients with depression (Nygård, Nåden, Foss, & San, 2011) but this method has been poorly explored (Blomberg & Hedelin, 2007; Fredriksson, 2003).

THE STUDY

Aim

To describe the characteristics of conversations that can alleviate the suffering of patients with mild or moderate depression.

Design

Patients' experiences of conversations were explored through qualitative interviews with a reflective lifeworld approach. Each lifeworld is unique since each is the world as it is experienced by a unique person. A lifeworld approach means starting from the patient's experience of her/his lifeworld with its full everyday context. A reflective approach involves reflecting, trying to understand and penetrating deeper into the matter so that even what is hidden can come to the surface, such as unconscious feelings for example. In order to obtain new and unpredictable information, the interviewer has to put her/his preconceptions aside and be open and responsive to the patient's story.

At each interview, the informant was asked to describe experiences of good conversations with health professionals during the depressive period, conversations that led to their feeling better. Follow-up questions helped the informants to describe in more detail and to reflect more and more deeply so as to detect qualities they were sometimes not aware of themselves. Some examples of these questions are: "Can you explain this further, please?"; "How do you know?"; "How did it feel?"; "Can you please give an example?". Sometimes the interviewer's questions led to the recovery of memories: "Imagine you are entering the room, what happens?" (Dahlberg, Dahlberg, & Nyström, 2008).

Participants

Nine informants were recruited from primary care in western Sweden. Initially a written request was sent to the primary care manager to sort out potential informants. After receiving approval, three healthcare centres were contacted via a letter of information with a personal request to find informants. Nurses asked potential informants if they were interested in participating and thereafter the interviewer contacted those who accepted participation for further information and appointment arrangements. Nurses and interviewers together made strategic selections in order to put together as mixed a group as possible for maximal variation. This resulted in a group of six women and three men, aged 30-80 years and with varying family constellations (varying social status such as for example married, divorced or parent of small children) and varying professional fields. Eight informants had a long history of mental illness and experience of frequent conversations with psychologists, psychotherapists, physicians and other healthcare professionals. The inclusion criteria stipulated that the informants were to be adults who had regular conversations with a nurse at the primary healthcare centre when they had a mild or moderate depression in 2011. The exclusion criteria specified individuals with personal or caring relationships with the interviewer.

Data collection

The interviews were conducted during February and March 2012 by two of the co-authors (GMB and KL) during specialist nurse education in psychiatric care. By agreement with each informant all interviews took place at a primary healthcare centre. The interviews lasted 25-40 minutes and were recorded.

Ethical considerations

As the study was conducted during education a review by the Ethical Committee (Socialstyrelsen, 2010) was not required, but nevertheless the Declaration of Helsinki (World Medical Association, 2003) compliance and ethical considerations were strictly followed. The informants were informed orally and in writing about the confidentiality of the study, and that they could cancel the interview at any time. They were also informed that their personal healthcare would not be affected whether or not they participated in the study, or if they cancelled it. They received contact information for

the interviewer and the School of Health Sciences. Informants were also given the opportunity to ask questions before they signed an informed consent form. As deep conversation can cause repressed emotions to rise up to surface, interviewers were ready to dedicate extra time to informants needing support at that time, but none of them had this need.

Data Analysis

Each interviewer made a literal transcription and then they cooperatively carried out a qualitative content analysis with an inductive approach. This approach involves not assuming any theory or model, but analyzing the text unconditionally to illuminate the contents (Lundman & Hällgren Granheim, 2010):

- The interviews were read thoroughly to see the whole content.
- Meaningful units, i.e. sentences and words belonging together, were lifted out of the text.
- These meaningful units were condensed and their text shortened.
- These condensed meaningful units were then coded by content.
- Similar codes were merged into categories.
- Categories were divided into subcategories or united to create main categories.
- When the categories had been structured, we immersed ourselves even more deeply in the material and found a theme that permeated all the categories.
- Finally, three phases became apparent in the material.
- To adjust or confirm the categories and theme, the working process involved continually returning to the original interview texts.

Validity and reliability

The interviewers are nurses with experience in conducting caring conversations. Despite awareness of the importance of setting their preconceptions aside, there were still a few leading questions during the first interviews. With a focus on flexibility and openness to the informant's unique experience this should not however have had any effect on the outcome. Preconceptions were also an asset in capturing the depth and variety of the phenomenon of depression, since the nurses' different preconceptions led to a greater variety of requests to the informants to highlight different aspects of their experience in the caring conversations. In the analysis phase, there was good reliability between colleagues, which probably improved the quality of the work. It was also a strength that eight of the nine informants had extensive experience in conversations with healthcare professionals during periods of depression, enabled them to compare caring conversations to those that have been non-caring. The interviews reached relatively deep levels, providing many variations in the results, but they also showed a strong consensus. Nobody deviated from the pattern that emerged, which increases its credibility.

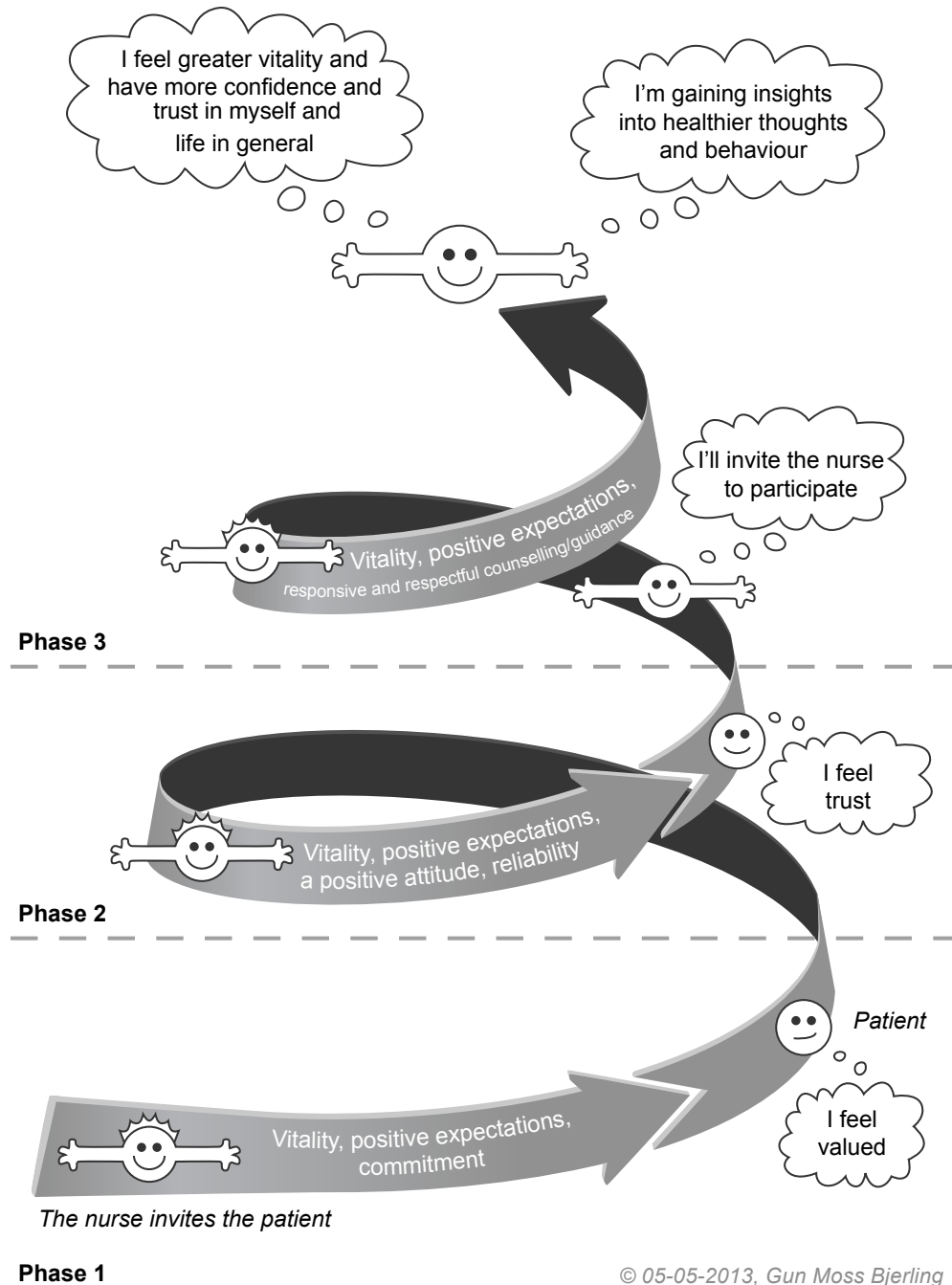
FINDINGS

The study participants were six women and three men with an age range of 30-80 years and with many differences in family, social and economic status. In the results section, all quotes end with a code (bracketed) referring back to the informant concerned.

Positive expectations and vitality strengthen patients

The overall theme is that patients with mild or moderate depression experience conversations as caring when the positive expectations and vitality of the nurse makes them feel strengthened, during a process of gradual transmission from the nurse to the patient. Six subcategories were distinguished, grouped into three main categories, which were then divided into three phases. This process is illustrated in a process model, below:

PROCESS MODEL FOR CARING CONVERSATION For patients with mild or moderate depression



Caring conversations for healing insights

Figure 1

Phase 1. The nurse invites the patient to share her/his experiences:

Main Category 1. The nurse's commitment makes the patient feel valued.

Phase 2. The patient feels trust:

Main Category 2. The patient feels trust and confidence thanks to the nurse's positivity and reliability

Phase 3. The patient invites the nurse to share experiences:

Main Category 3. The patient dares to open up and be guided to insights by the nurse.

The nurse's commitment makes the patient feel valued

The first phase of a caring conversation starts when the patient experiences the nurse's welcoming attitude and genuine commitment. This means that the nurse wants and is supposed to be able to help, and that he/she has positive expectations concerning the patient's ability to change her/his thinking and behaviour patterns. This may initially stimulate anticipation and vitality in the patient that later develop into confidence and trust in the patient's own ability to change her/his life:

"... Suddenly I understood that maybe I'm stronger than I think and a little bit better than I think ... I left feeling much stronger and just then I could deal with it [the problem]." (i8)

Patients experience the nurses' commitment as genuine interest and personal support, described in the subcategories below:

Patient perceives the nurse's genuine interest

The patient feels valued as a person and that her/his experiences are endorsed by the nurse's interest, shown by listening, understanding, being responsive and asking how the patient feels. The nurse's interest is thus shown by body language, attentiveness and feedback. There is continuous contact even during silences:

"Even when she doesn't say anything there is still contact. ... Eye contact and body language as well, listening ... Yes, she is open somehow. Not like this." (arms crossed over chest). ... it felt like she really wanted to know what I had to say. (i3)

Patient receives personalized support

Nurses committed to this work described providing personal support according to need and situation, making the patient feel valued, pampered and safe. This support may involve elementary nursing actions such as giving the patient a glass of water, a handkerchief, or a hug. Availability is adjusted to need with regard to frequency of visits, visiting time to be completed and the patient's permission to call "anytime" and even be offered personalized appointments:

"... So I called and told her that today I could not come because then I was afraid of falling down .. then [the nurse] said 'I'll meet you, so we can take a walk, get you some air and have a talk' ... "(i9)

Informants also describe this personal guidance as help and advice to focus on the essential, and if necessary robust supervision by the nurse setting limits, putting on the brakes and making decisions for the patient. Depression often means paralysis and difficulty in thinking rationally, so this treatment allows patients to relax and rely on the

carer. Sometimes patients are given tasks, such as setting their own goals, training certain things or doing something enjoyable.

The patient feels trust and confidence thanks to the nurse's positivity and reliability

Phase two of a caring conversation is when the patient trusts the nurse. This trust may increase gradually after several visits or occur at once:

"... And we talked for five to ten minutes and after a week or two I did not feel ashamed anymore. ... And then I also got like a damn kick, and why I do not know, but I experienced her as very positive, so I longed to go and talk for a few minutes "(i7)

Trust is based on the patient's experiencing the nurse as positive and reliable, as described in the subcategories below.

Patient experiences nurse's positivity

By means of encouraging words, humour, body language, facial expressions, tone of voice and hugs, nurses can convey a positive mood and joy to strengthen patients, increasing their self-esteem and giving them new strength, hope, inspiration and confidence in themselves and the future.

Several informants also report the nurse's special charisma that made them relax and feel safe, and that gave them new vitality to endure or to deal with things. This charisma is described as being full of positivity, confidence, compassion, naturalness, warmth, love, joy and energy. When comparing with non-caring conversations they note the absence of this positive charisma:

"...it's just this enormous warmth that she spreads she passes on good, very good energy ... warm energy. You enjoy her company. Just being around her makes me happy and I'm sure that she communicates something very special. ... The other I've had, there has been... she understood me, but it was still somehow cold. Then I just left: Well, now I've been here today. Nothing more."(i9)

Patient perceives nurse's reliability

The patient must feel that he/she can trust the nurse. Professionalism is specified as an important criterion and informants define professionals as being impartial, objective, reliable and experienced in helping people with depression. This increases confidence. Similarly, confidence increases when the nurse recognizes knowledge gaps and consults colleagues or explores research on the subject. However, mere professionalism is not enough. A trusting relationship needs something more:

"Well, the first one I went to, it was more.. she was somehow difficult to get close to. We never got to know each other. I found it a bit awkward. Maybe she could.. I came into the room and she sat there quietly and it was up to me to start the conversation. "(i1)

Another basis for reliability may be experiencing fellowship with the nurse. It is described as personal chemistry, being on the same wavelength, talking the same language, having similar values, interests and/or experiences. Patients feel that the

nurse is an understanding and trustworthy friend. This feeling of fellowship often occurs spontaneously from the very first meeting:

"It felt like I had known her a long time somehow and yet not. ... I looked forward to just [doing the sampling] and talking for a few minutes. It was unbelievable."(i7)

The patient dares to open up and be guided to insights by the nurse

In the third phase of the caring conversation, the patient is strengthened by positive expectation, vitality and trust, and thus confident enough to dare to look more deeply into her-/himself and also to invite the nurse to participate in this process. By focusing on the patient's experiences through respectful cooperation and flexible guidance, insights leading to increased wellbeing are achieved. This process is described in the subcategories below.

Respectful cooperation

Although patients do not see the nurse as an authority, they respect and trust her/him. They also feel that the nurse respects and appreciates them as fellow human beings, and that their opinions are given due attention, which strengthens their self-esteem and confidence. Patients can talk about what is important for them at any given moment, and the nurse follows the story and asks appropriate questions. Thus the process continues through cooperation.

If the conversation does not reach this third phase, in which the nurse and patient cooperate, it does not matter if the nurse is skillful finding the crux of the problem, since it is the patient who must learn new ways of thinking and reach new insights. This is illustrated by a "non-caring conversation":

"... Practically every time I left I was angry and disappointed and never experienced getting the opportunity to talk about my problems, because she always repeated the story about the lion and the cave – I always escaped. So principally I knew what she would say before she opened her mouth. "(i7)

Flexible guidance focusing on patient's experiences

Informants feel conversations as caring when they can spontaneously share their experiences and issues currently important to them. Just talking about these issues can relieve internal pressure and heaviness, thus alleviating the patients' suffering, as the example below demonstrates:

Informant: *"... it's okay to be who you are. Well, she breathes security and compassion and warmth she gives out a kind of warmth, making you open up. ..."*

Interviewer: *"But what does it mean when you open up?"*

Informant: *"That you can talk about stuff you think is really tough. ... I felt useless ... I did not go there to keep up some kind of mask and limit what I told her, but I was just like this (outward gesture)."*

Interviewer: *"You poured it all out?"*

Informant: *"Yes, and it was just a relief, to be able to do it."(i4)*

Caring conversations for healing insights

Nurses focus on positive aspects and highlight traits in the patients that can be valuable in helping them to develop a more positive self-image, and to release negative thoughts and feelings of guilt that create suffering. Follow-up questions encourage the patient to go more deeply into their experiences and sometimes to discover forgotten things.

These memories can help them to understand the context and causes of suffering and to discover new perspectives:

"And when she put her finger on these things, it was really an eye-opener. ... So I can say she made the pieces fall into place. "(i3)

Going through this deep process and then coming up to the surface again enables patients to work through problems and make progress in personal development. It can lead to insights that create new patterns of thought and behaviour, which may be about accepting situations or about acting and influencing situations. Thus the caring conversation can become the turning point on the path to increased wellbeing.

Interviewer: *"When did it change? When did you become better?"*

Informant: *"When I stopped taking medicine and talked to [the nurse]. "(i3)*

CODES: Content	CODES: Meaning	SUBCATEGORIES	MAIN CATEGORIES	PHASES	THEME
Interest Pos. expectations Interaction Confirmation	Valued Strengthened Safe	Patient experiences nurse's genuine interest	1 Nurse's commitment makes patient feel valued	1 Nurse invites patient to share experien ces	Patient is strengthened through positive expectations and vitality
Caring Availability Support	Pampered	Patient receives personalized support			
Pos. body language Pos. attitude Verbally positive	Strength Self-esteem Confidence Faith	Patient experiences nurse's positivity	2 Nurse's positivity and reliability make patient feel confidence	2 Patient trusts nurse	
Fellowship Fellow human Professional		Patient perceives nurse's reliability			
Respect Cooperation	Strength Self-esteem Confidence	Respectful cooperation	3 Patient dares to open up and be guided to insights by nurse	3 Patient invites nurse to share experien ces	
Talking Positive focus Guidance Adherence	Insight Relief New thinking	Flexible guidance focusing on patient's experiences			

Table I

DISCUSSION

The informants describe being strengthened in various ways by the nurse's vitality and positive expectations in conversations. That the patients so clearly and coherently could describe the pervasive attitude of the nurse with its great significance for their experience of progressing beyond sadness, negative thinking and lack of energy, constituted a somewhat surprising result. The attitude of the nurse was imbued with genuine interest, enabling her/him to provide personalized support in a positive atmosphere.

Positive expectations

In a caring conversation, patients can feel the nurse communicating positive expectations. This means that nurses trust both their own ability and the ability of the patients – that together they can promote the increased wellbeing of the patients. The nurses' trust in the patients' ability to handle their own situations is important for the healing process (Rydenlund, 2012). Nurses also have to be able to put aside their own issues, and to have reached a certain level of personal development and self-knowledge, so as not to be influenced by their own projections, weaknesses and judgemental attitudes (Halldórsdóttir, 1996). The trust of a nurse may increase the confidence of a patient, inspiring hope. Hope in general, as well as in a particular situation, is a source of power, meaning and faith in the future (Benzein, 2012). Hope and faith for a better life are spiritual resources and valuable during crisis, but are often ignored (McLaughlin, 2004). It appears that the confidence and trust in the patient as shown by the nurse are decisive in starting a caring process.

The nurse's positive expectations are expressed through commitment to the individual patient, making her/him feel valuable. Being seen and appreciated as a human being by the nurse is often the first step for the patient towards recovery, since it involves recognizing oneself as a person worthy of respect (Lloyd & Carson, 2012). Only when the nurse is fully available will there be a meeting without roles and conditioned responses (Fredriksson, 2003). Complete focus and interaction are thus essential and will be evident in the nurse's body language. Research shows that the higher the degree of nonverbal interaction between interlocutors, the less risk there will be for the patient of relapsing into depression (Bos, Bouhuys, Geerts, Van Os, & Ormel, 2006). It is important to interact with the whole of one's person – body, mind and spirit – in order to create a transpersonal caring relationship and to help one's suffering fellow human being (Rydenlund, 2012). The nurse and the patient join forces at a higher level, enabling the nurse to perceive the patient's feelings and to endorse them. This helps the patient to release suppressed energy and to find an inner power, which supports self-healing and personal growth (Watson, 2008). As can clearly be seen from the above, a primary precondition for a caring conversation is the focused commitment of the nurse.

Vitality

The results show how patients experience that their nurses convey vitality/positive energy that strengthens them, even during short conversations. If psychiatric care aims

to be a truly effective form of care, then nurses must take on an empowering role rather than an authoritarian role towards the patient (Barker & Buchanan-Barker, 2011). Several health scientists emphasize the importance of supporting and strengthening the patient's life force to promote healing progress (Dahlberg & Segesten, 2010; Rodwell, 1996). The concept of empowerment in health science is comprised of the following elements: energizing, creating hope, enabling creative changes to take place and helping patients to grow and realize their full potential (Rodwell, 1996). There are also health scientists (Leddy, 2003; Newman, 2008; Rogers, 1991; Watson, 2008) and natural scientists (Gerber, 2000; Oschman, 2003; Tostar, 2004) who go one step further, claiming the life force or life energy to be the foundation of health, since humans beings are creatures whose energies are influenced by each others' energy frequencies. Thus the healing process involves progressing from low frequency to higher frequency vibrations, leading to personal development and improved health (Gerber, 2000). Nursing manuals describe how nurses can strengthen patients' life force or vital energy, also by including the use of treatments developed by energy medicine (Dossey, Keegan, Guzzetta, & Kolkmeier, 1995; Egeland, 2008; Leddy, 2003). Initial research has shown that such treatments can reduce depressive symptoms significantly (Shore, 2004). Thus health scientists and natural scientists confirm the informants' experiences of their nurses transmitting vitality and energy to them.

Trust/relationship

To develop a caring conversation the patient must trust the nurse. Professionalism is important, but the personal characteristics of the nurse appear to be at least as important. In a caring conversation, the nurse is both a professional and a fellow human being (Rydenlund, 2012). The nurse's ability to be genuine enables the patient to feel sufficient faith to open up and reveal her/his suffering (Carlsson, 2010). A caring relationship can influence and relieve a patient's suffering (Kasén, 2002). A caring conversation implies a relationship characterized by attentiveness, listening and touching (Fredriksson, 2003). The relationship between the interlocutors seems to be more important than the type of therapy or conversation (Cuijpers, van Straten, Andersson, & van Oppen, 2008) and psychiatric care is focusing increasingly on a meaningful therapeutic commitment that creates good relationships (Lloyd & Carson, 2012; Merritt & Procter, 2010). A trusting relationship is probably created by the nurse's ability to be genuine.

The patient opens up

According to this study, the guidance in a caring conversation should be responsive and respectful. Fredriksson also claims mutual respect as the foundation of the caring conversation's ethical aspect (Fredriksson, 2003). The dialogue should be a respectful interaction where both are valued for their key expertise (Dahlberg & Segesten, 2010; Lloyd & Carson, 2012). Nurses may be considered as travelling companions, guides and sometimes as an encyclopaedia helping patients to find the words and explanations for their internal disharmony (Merritt & Procter, 2010). Through genuine cooperation,

during which the nurse guides without controlling, the real meaning will be caught (Newman, 2008).

A caring conversation highlights behaviours and thoughts that do not benefit health. This triggers the "expanded consciousness" of the healing process, enabling the patient to change patterns towards increased wellbeing (Newman, 2008). Fredriksson also argues that the narrative part is the caring part of the conversation (Fredriksson, 2003). Literature and nursing theory seem to confirm that a responsive and respectful conversation can lead the patient to healing insights. However, these insights differ radically from the type of insight sometimes reported in healthcare, involving adaptation to the nurse's ideas and to the treatment offered (Hamilton & Roper, 2006). Instead the insights gained through caring conversation extend the patient's horizon of understanding of their life experiences (Rydenlund, 2012).

Limitations

The nine informants represented a relatively diverse but still small patient population. Also the majority had experience of repeated depression and most of them were women, so the results may not be representative of everyone with depression.

CONCLUSIONS

A caring conversation can raise the patient's mood and provide a powerful tool through a committed nurse transmitting vitality and positive expectations. For depression, this seems to be particularly important to start the caring process.

It is likely that the quality of conversation is dependent on the nurse's expertise, both in terms of personal maturity and anchoring in the health sciences. Accordingly it is important to organize tutorials, education, training and continuing research on how the nurse's approach and attitude can be crucial to the health process. Continued research in this field could profitably include intervention studies aimed at evaluating the process model for caring conversation that is the result of this study.

SUMMARY STATEMENT

Why is this research needed?

- Depression is the most common cause of disability in the world and is increasing alarmingly, which indicates that available forms of treatment are in some ways insufficient.
- Conversations with a nurse may be a method to alleviate the suffering of patients with depression but this option has been poorly explored.

What are the key findings?

- A nurse with genuine commitment can win the trust of a depressed patient, thus creating the initial potential for a caring conversation.
- The positive expectations and vitality of a nurse can gradually be transmitted to the patient, strengthening and enhancing her/his confidence and making it easier to talk about difficult issues.

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- The respectful and flexible guidance of a nurse can help patients with mild or moderate depression to change their thinking and behaviour patterns, enabling them to gain insights to relieve their suffering and increase their wellbeing.

How should the findings be used ?

- More emphasis in tutorials, education and training should be put on the importance of the nurse's approach and attitude in promoting depressed patients' healing processes.
- Continuing research on caring conversations in depression should also consist of intervention studies aimed at evaluating the process model for caring conversation demonstrated in this study's results.

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