

The therapeutic relationship at the heart of nursing care: A participatory action research in acute mental health units

Diana Tolosa-Merlos RN, MSc¹  | Antonio R. Moreno-Poyato RN, MHN, MSc, PhD²  |
Francesca González-Palau RN, MHN, MSc³  | Alonso Pérez-Toribio RN, MSc⁴  |
Georgina Casanova-Garrigós RN, MSc, PhD⁵  | Pilar Delgado-Hito RN, MSc, PhD^{6,7}  |
on behalf of MiRTCIME.CAT Working Group

¹Institut de Neuropsiquiatria i Addiccions, Hospital del Mar, Barcelona, Spain

²Department of Public Health, Mental Health and Maternal and Child Health Nursing, Nursing School, Universitat de Barcelona, L'Hospitalet de Llobregat, Spain

³Hospital Santa Maria, Salut/Gestió de Serveis Sanitaris, Lleida, Spain

⁴Unitat de Salut Mental de l'Hospitalet, Gerència Territorial Metropolitana Sud, Institut Català de la Salut, L'Hospitalet de Llobregat, Spain

⁵Department and Faculty of Nursing, Universitat Rovira i Virgili, Tortosa, Spain

⁶Department of Fundamental Care and Medical-Surgical Nursing, Nursing School, Universitat de Barcelona, L'Hospitalet de Llobregat, Spain

⁷GRIN-IDIBELL (Nursing Research Group - Bellvitge Biomedical Research Institute), L'Hospitalet de Llobregat, Spain

Correspondence

Antonio R. Moreno-Poyato, Department of Public Health, Mental Health and Maternal and Child Health Nursing, Nursing School, Universitat de Barcelona, L'Hospitalet de Llobregat, Spain.
Email: amorenopoyato@ub.edu

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Abstract

Aims and Objectives: To explore the process of change within the clinical practice of nurses in mental health inpatient units in the context of a participatory process to improve the nurse–patient therapeutic relationship.

Design: Participatory Action Research.

Methods: Ninety-six nurses from 18 mental health units participated. Data were collected through focus groups and reflective diaries between March 2018 and January 2020. Data were analysed using inductive content analysis. The COREQ guidelines were used.

Results: The research process was carried out through two cycles of four stages each in which the nurses were able to identify the facilitating and limiting elements of their practice in relation to the therapeutic relationship. They then proposed two consensual improvement strategies for all the units, which they called reserved therapeutic space and postincident analysis. Finally, they implemented and evaluated the two strategies for change.

Conclusions: This study has shown that, despite the different cultural and structural realities of the participating units, it is possible to implement a collaborative process of change, provided the needs and expectations of both the participants and the organisations are similar.

Relevance to Clinical Practice: The results obtained through Participatory Action Research were directly transferred to clinical practice, thus having an impact on individual nurses and patients, as well as on the collective dynamics of the teams and aspects related to the management of the units.

No Patient or Public Contribution: Patient or public input is not directly applicable to this study. Patients were recipients of the changes that were occurring in the nurses as part of their daily clinical practice.

KEYWORDS

action research, clinical nursing research, mental health services, nurse–patient relationships, psychiatric nursing

1 | INTRODUCTION

The person-centred care model has emerged as the fundamental pillar to guarantee the quality of care provided by health services (McCormack & McCance, 2016). Specifically, in the field of mental health nursing, the therapeutic relationship is recognised as the axis of nursing care (Moreno-Poyato et al., 2020) and a fundamental part of person-centred care (Hamovitch et al., 2018). However, building and maintaining a therapeutic relationship in mental health inpatient units is complex (Moreno-Poyato et al., 2021). Therefore, improving the nurse–patient therapeutic relationship should be a goal to provide higher quality nursing care throughout the hospitalisation process.

1.1 | Background

The nurse–patient therapeutic relationship can be understood as the interpersonal interaction between the nurse and the patient, which is based on mutual trust, and which is focussed on providing therapeutic assistance (Moreno-Poyato et al., 2016). Although it is widely recognised internationally that the therapeutic relationship is the foundation of nursing care in acute mental health inpatient units (Hartley et al., 2020; McAndrew et al., 2014; Moreno-Poyato et al., 2016; Peplau, 1997), several studies still highlight difficulties regarding its establishment in clinical practice (Harris & Panozzo, 2019a; Kingston & Greenwood, 2020; Moreno-Poyato et al., 2021). Thus, in hospital settings, which are often chaotic and complex, certain barriers exist, including lack of time, communication problems (Harris & Panozzo, 2019a), administrative tasks, ratios (Kingston & Greenwood, 2020) and the physical structures of the units or care cultures (Moreno-Poyato et al., 2021). These aspects have emerged as factors that are external to nurses and that limit and condition the therapeutic relationship. If nurses do not become aware of the presence of these barriers, there is a risk that they will become entrenched and new ones will be created, and therefore patients will perceive their actions as lacking care, presence or involvement (Harris & Panozzo, 2019b). In addition, nurses believe that the practice environment, often with limited time and resources, affects their safety and that of their patients, as well as conditioning the therapeutic relationship by reducing the quality and quantity of interactions (Moreno-Poyato et al., 2021). Furthermore, the lack of availability of the nurse during hospitalisation contributes to patients not feeling listened to or involved in their own care (Rio et al., 2020). Ultimately, patients feel closer to their environment and to themselves when nurses spend time with them, carry out daily activities and recognise them as whole people (Eldal et al., 2019). Such is the case that patients consider their

What does this paper contribute to the wider global clinical community?

- This study confirms that the results obtained through Participatory Action Research are directly transferred to clinical practice, producing an impact not only on individual nurses and patients but also on the collective dynamics of the teams and on aspects related to the management of the units.
- This study shows that, despite the different cultural and structural realities of the participating institutions, it is possible to implement a collaborative process of change, provided the needs and expectations of both the participants and the organisations are similar.

interactions with nurses to be central elements in assessing their satisfaction with their admission (Molin et al., 2021), yet the literature shows that interventions to improve participation are scarce and ineffective (McAllister et al., 2021).

Studies are being carried out at the international level with the aim of developing interventions to improve the therapeutic relationship in mental health nursing (Hartley et al., 2020). Some of these studies point to the need for the involvement of managers and institutions as promoters of nursing foundations for quality care (Moreno-Poyato et al., 2021). Other studies focus on the convenience of designing studies with the participation of both users and professionals (Hartley et al., 2020). The interventions studied for improving the therapeutic relationship include training, reflective groups, psychological formulation, consultation and shared activity (Hartley et al., 2020). In addition, the most important interventions are the implementation of group reflection sessions for the professionals of the units (Moreno-Poyato et al., 2019), the creation of spaces for professionals and patients to carry out activities together, facilitating mutual commitment (Molin et al., 2018; Molin et al., 2019) or other more classic actions such as clinical sessions for staff on specific patients with the aim of facilitating case understanding (Berry et al., 2016).

Nonetheless, no specific interventions that have been shown to be effective (Hartley et al., 2020). This leads us to reflect upon the need to combine several approaches in clinical practice or to look for alternatives for the creation of interventions through participatory methods, such as Participatory Action Research or Appreciative Inquiry, which seek transformational change in group dynamics (Watkins et al., 2016). Specifically, Participatory Action Research (PAR) is a research methodology that allows us to understand and improve contexts through transformation (Kemmis &

McTaggart, 2008). It is useful for exploring the phenomenon under study because it makes it easier for participants to identify both the aspects to be improved and the most effective procedure to carry out such improvement (Casey et al., 2022). This research methodology has been introduced in recent years in the area of health sciences with successful results (Cordeiro & Soares, 2018) and, more specifically, in the nursing field (Effendy et al., 2022) as a pathway to implementing evidence-based practice (Munten et al., 2010). In this sense, the PAR process in the nursing discipline enables a better understanding of the study phenomenon to design improvement strategies, implement changes and transform clinical practice (Bradbury et al., 2019) through a cyclical and continuous interaction of different stages such as action, reflection and evaluation (Rowell et al., 2017). Specifically, in the area of mental health nursing, the literature indicates that PAR has shown positive results for aspects related to decision-making in daily clinical practice and also the development of care plans and care models (Chambers et al., 2013; Larkin et al., 2015; Salzmänn-Erikson, 2017; Vantil et al., 2020).

Participatory Action Research has proven to be useful in improving health care and services at the individual, collective and organisational levels (Cordeiro & Soares, 2018). Moreover, political administrations recommend the use of participatory methods that involve the various stakeholders concerned (Spanish Ministry of Health, 2022). However, no studies have been found in the field of acute mental health care that involve stakeholders from different institutions in a collaborative and participatory manner. This approach would enable the detection of difficulties and the development of improvement strategies. Most importantly, lines of action may be unified in a consensual manner with the aim of improving the practice of the nurse–patient therapeutic relationship in mental health units.

1.2 | Aim

The aim of this study was to explore the process of change within the clinical practice of nurses in acute mental health inpatient units in the context of their participation in an action research process to improve the nurse–patient therapeutic relationship.

2 | METHODS

2.1 | Design

This study is part of a three-phase, mixed-methods project involving 18 acute mental health units in Catalonia (Spain) (MiRTCIME. CAT). The first and third phases of the project were developed using quantitative methods. This study corresponds to the second phase, which aimed at responding to the aims described above, and was also carried out using qualitative methods. An approach based on the constructivist paradigm was proposed, contemplating the study phenomenon from its different realities in order to generate changes

and reconstruct using consensus (Lincoln & Guba, 1990). To this end, a PAR was proposed according to the model proposed by Kemmis and McTaggart (2008), designed with a two-cycle process of four stages each (planning, action, observation and reflection) (Figure 1). This work is presented in accordance with the consolidated criteria for qualitative research reporting (COREQ: Tong et al., 2007) (Supplementary File 1).

2.2 | Participants

The project was presented to the nursing management of the 21 acute mental health units of the Catalan Mental Health Network ($n = 21$), of which 18 decided to participate. The management of each unit chose a nurse with leadership and credibility to coordinate the study and recruit the nurses in their unit. Subsequently, at an informative meeting at each centre, all nurses working in the acute units ($n = 235$) who met the following characteristics were invited to participate: (a) belonging to the permanent or interim staff, (b) assigned to the acute unit at the time the study was initiated, (c) not in training for 'formal mental health nursing qualification' and (d) not planning to be on sick leave or leave of absence during the study. A total of 157 nurses started the PAR; the remaining invited nurses did not wish to participate, citing personal reasons or professional demotivation. The nurse coordinator of each unit, together with the nurses who agreed to participate, formed the different support groups at each unit (SG). In turn, all the nurses coordinating the project formed the core group that met through focus groups (FG) to reach a consensus and direct the process. Finally, 96 nurses completed the two PAR cycles in their entirety.

2.3 | Data collection

Several techniques were used for data collection, which were integrated within the different stages of the two PAR cycles (Figure 1). In the initial context analysis stage, data were collected through an ad hoc observation guide prepared by the research team and completed by the coordinating nurses of each unit. This was recorded by means of an observation script prepared by the same team, which included a description of the physical structure, the nursing teams and the nurse–patient relationship in each of the units (Tolosa-Merlos et al., 2021). The reflective diaries of the participating nurses were the main data collection tool used in both PAR cycles (Tolosa-Merlos et al., 2023). The objective was to individually monitor the expected process of change, based on the nurses' reflection and understanding of their clinical practice (Price, 2017). The research team provided the participating nurses with a guide for self-observation of their clinical practice and a template for the preparation of the reflexive diary in which they were to record the self-observation data. Likewise, to stimulate collective reflection, group techniques were also carried out throughout the process. Thus, the coordinating nurses were the link between the participating nurses and the research team. The different stages of the

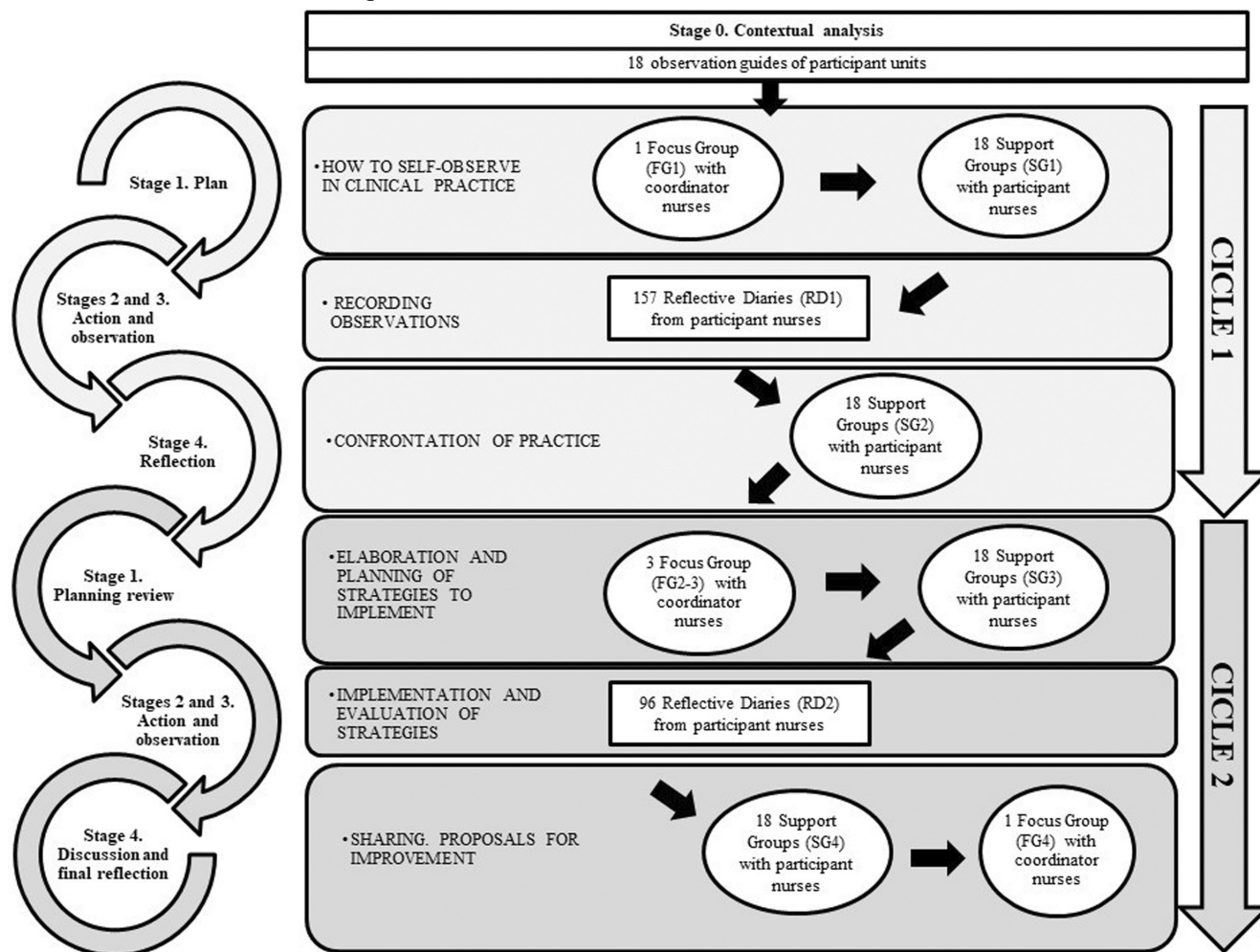


FIGURE 1 Study cycles, stages, actions and data collection techniques

PAR were articulated through support groups (SG) and focus groups (FG). The groups were moderated by the principal investigator and observed by another member of the research team. Field notes were taken and audio-recorded. The SGs were carried out in each of the units and lasted 90minutes. In these sessions, the coordinators and participating nurses from each unit reflected together, validated the results of the diaries and proposed strategies for improving the therapeutic relationship. The FGs were held at the Mar School of Nursing in Barcelona and lasted 120minutes. In these FGs, the core group integrated by all the coordinators of the study, discussed and agreed on the steps to be followed in each stage of the PAR. The data collection period was from March 2018 to January 2020.

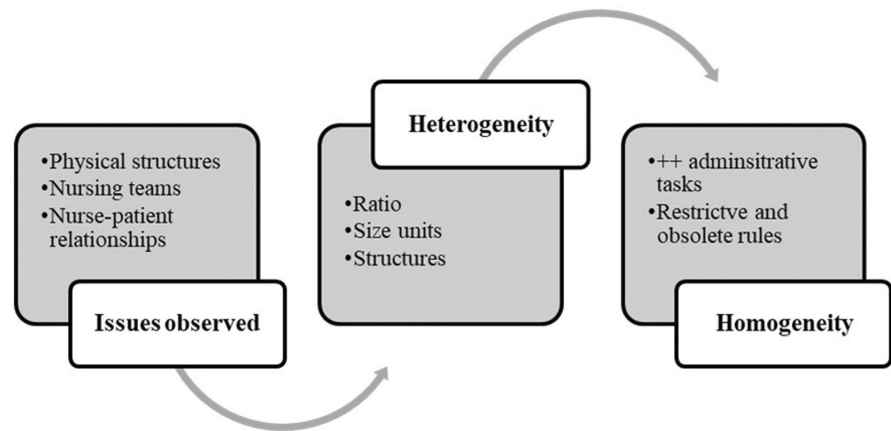
2.4 | Data analysis

Data analysis began with data collection. It was carried out by means of thematic content analysis of the transcriptions of the observation guides, the reflective and field diaries, the SGs and the FGs. A process of identification, coding and categorization of the main axes of meaning of the discourse was followed for each stage of the research. After an initial panoramic reading of the data obtained,

the text was fragmented into descriptive codes assigned by semantic content. These codes were then grouped into more analytical subcategories according to the meaning of the linguistic units and combinations. These subcategories were subsequently grouped into more specific categories that provided a greater understanding of the text. The process was carried out through researcher triangulation, namely by the lead author and another team members, who verified the results in a consensual, reflective, critical and collaborative manner. This was the backbone of a rigorous codification process. (Merriam & Tisdell, 2016). The QRS NVivo 12 program was used as data analysis software throughout the process.

2.5 | Rigour

All qualitative research processes require quality and methodological rigour, which were considered in this study according to the approach by Lincoln and Guba (1990). The research team comprised members with expertise in mental health (clinical team) and members trained in qualitative research and with experience in similar studies (methodological team). Thus, it was a broad research team with different ontological positions, which furthered the criterion of

FIGURE 2 Contextual analysis of the participant units

neutrality by welcoming the proposals of all its members. Consensus, openness and a critical spirit were present throughout the process. For the reliability criterion, the way in which the information was collected was documented, and continuous feedback was given to the participants, since at the beginning of each stage, a document was sent to all the participants with the results of the analysis for validation. These steps conferred authenticity and credibility to the data, as well as confirming them. Furthermore, the simultaneity of data collection techniques and researchers guaranteed triangulation. Finally, reflexivity was the criterion underlying the whole process, and critical analysis was present throughout. The researchers' awareness, self-knowledge and careful thinking allowed them to avoid influencing the dynamics of the research. Finally, the context of such a broad and participatory study ensures that the transferability of the results is valid for all participating centres.

2.6 | Ethics Statement

The Research Ethics Committees of all participating centres approved the study. All nurses signed an informed consent form and agreed to participate voluntarily. Likewise, they did not receive any compensation or incentive for participating in the study. Nurses were assigned a code to keep track of their diaries and to maintain anonymity and confidentiality of the data obtained. In addition, a generic study e-mail account was created for managing the diaries, accessible only to the principal investigator. The research ethics committee of coordinator centre approved the study with reference: 2017/7381/I (Comité de Ética de la Investigación con medicamentos del Parc de Salut Mar de Barcelona).

3 | FINDINGS

Ninety-six of the 157 nurses who started the study completed the PAR process. The mean age of the nurses was 33.3 years, ranging between 22 and 62 years. 67.7% ($n = 65$) were female and 22.9% ($n = 22$) of the total nurses had the official title of specialist in mental health nursing. The participating nurses had a mean experience of

7.6 years in mental health and had been working in the participating unit for an average of almost five years. Nurses from all work shifts were represented in the study.

3.1 | Stage 0: Contextual analysis of the participant units

In this stage, prior to the start of the nurses' participatory process, which lasted two months, the aim was to obtain an initial 'snapshot' of the study context, which would confirm the feasibility of the process of change in the units and serve as a starting point for the process. After analysing the reports of the participating units, and despite the heterogeneity of size, ratios and physical structure of the units, a similar model of care and similar limitations were present in all units for the establishment of the therapeutic relationship (Tolosa-Merlos et al., 2021) (Figure 2).

4 | CYCLE 1

4.1 | Stage 1—plan

During this stage, which lasted one month, the first cycle of the PAR began with a first focus group (FG1) in which the coordinators of each unit met. The results obtained in Stage 0 were validated and guidelines for self-observation of the nurses' clinical practice were designed for three common situations in the context of the therapeutic relationship decided by the nurse coordinators: (a) admission welcome, (b) pre-agitational state and (c) voluntary approach by the professional.

'A good moment to observe could be upon admission, which is where the nurse begins to build the therapeutic bond'. (07FG1) 'Interaction when the nurse detects a pre-agitational state and we have to perform verbal de-escalation'. (15FG1) 'I believe that in any approach promoted by us, whether or not there is intervention'.

(14FG1)

Once these guidelines were designed, the first support group (SG1) was held at each unit where the coordinators informed the nurses how they should carry out the self-observation of clinical practice. To this end, they were provided with a guidance document on how to carry out the observation and how to record the data using a reflexive diary (RD) (Tolosa-Merlos et al., 2023).

4.2 | Stages 2–3: Action and observation

In these stages, which took place over three months, the nurses observed their practice according to the guidelines agreed upon in Stage 1 and recorded their observations in their reflexive diaries (RD1). A total of 157 diaries were collected, revealing that, for nurses, the attitudinal component was central to the therapeutic relationship. Thus, their attitude to communicate, adapt and open up to the relationship with the patient, as well as believing in themselves, were key factors for them. Through the diaries, the nurses described the essential activities in the therapeutic relationship, as well as the contextual factors of their practice that affected the therapeutic relationship. The analysis identified that reflection on the nurses' actual practice in the mental health units contributed to greater understanding of the therapeutic relationship phenomenon (Tolosa-Merlos et al., 2023).

4.3 | Stage 4: Collective reflection

At this point in the process, the results of the previous stage were discussed as a group by the nurses in each unit through the second support group (SG2). This stage lasted three months. During this stage, the nurses validated the results of the diaries, proposing and agreeing on two strategies to establish a better therapeutic relationship in their clinical practice. The coordinators of each unit submitted their proposals for improvement to the research team, who carried out an initial analysis grouping them into four main categories: improvement of the training of professionals, improvement of the physical spaces of the units, improvement of the nursing teams and improvement of nursing interventions during clinical practice.

5 | CYCLE 2

5.1 | Stage 1: Replanning

The second cycle of the PAR began with the objective of reaching a consensus on the strategies to be implemented in all the units based on this first analysis of the data obtained in the previous phase. This stage was developed over a two-month period. The process was carried out through a workshop involving the 18 nurse coordinators. In the first part of the workshop, two simultaneous focus groups (FG2) were used to discuss the proposals for improvement that the research team had compiled in a working document. In these FGs,

the coordinating nurses reflected and discussed the different categories and selected the following strategies for the improvement of the therapeutic relationship: (a) creation of a personalised nursing intervention space for each patient on a regular basis throughout their hospital stay, (b) updating facility regulations towards a more humanising and less restrictive model of care, (c) training for newly recruited professionals, (d) having an adequate space to be able to carry out the reception and interventions with greater intimacy and (e) conducting reflection groups with the nursing teams in order to explain situations, share experiences and vent or decompress after tense situations or stressful moments.

In the second part of the workshop, the 18 nurse coordinators met in a new focus group (FG3) where they agreed and designed the two final and unified strategies for all the units, as well as their implementation schedule. First, in the context of self-improvement of the professionals, the nurses developed the term 'post-incident analysis' (initially referred to as 'reflective groups'), to denote the need to generate critical-constructive spaces, improve the self-knowledge of professionals and practice emotional ventilation collectively in the team after complex situations and incidents in clinical practice. These situations were qualified as sentinel events and were as follows: a physical or verbal violent behaviour, a psychomotor agitation, a movement restriction, a suicide of a patient in the unit, an elopement or a vital emergency. Second, in the context of improving interventions with the patient, the nurses defined the initial strategy (a) under the label of 'reserved therapeutic space' addressing the lack of time, lack of adequate physical space and lack of professional recognition. It aimed at improving the interventions and the therapeutic relationship with the patient through regular, programmed spaces, free of interruptions.

'I really liked the two proposals that came out. And so, *a priori*, I think they are quite feasible to carry out in the unit, which is why also... according to what things... they are very reluctant'. (17FG3) 'Both proposals are very cool, and I think they are doable. You must respond to the needs of what nurses are asking for. One, the post-crisis space, is to name and shape what you do. And the other is that they're going to love it. To have a space for you...for the patient...if they get it...'

(14FG3)

Once the two final proposals for improvement and their schedule for implementation had been defined, the third support group (SG3) was held at each centre, in which each nurse coordinator informed the nurses of what they had to do to implement them.

5.2 | Stages 2–3: Action and observation

After being informed by the coordinators, the nurses implemented the two strategies that had been agreed upon in phase 1 of cycle 2 in their clinical practice and evaluated them by means of reflexive

diaries (RD2) that the research team designed for this purpose, as well as the guide on how they should prepare them. These stages were carried out over four months. Ninety-six reflective diaries were collected in which nurses described and reflected on the improvement strategies implemented. In the case of the *postincident analysis*, the nurses reflected on the type of incident they had analysed by describing what had occurred. Most of them described situations of violent behaviour or psychomotor agitation of the patients that ended in restriction of movement or absconding. The nurses identified the most common interventions they had carried out prior to the incident, the aspects that needed to be improved, the elements that had facilitated the implementation of the strategy and how they had felt. Regarding the *reserved therapeutic space* intervention, the nurses reflected that it was a space for sharing the patient's objectives and expectations regarding admission. The nurses described the aspects they worked on most in the therapeutic spaces, as well as the barriers and facilitating elements they had encountered in their implementation. In addition, they expressed the emotional impact that accompanied the development of the intervention and, its usefulness in general (Table 1).

5.3 | Stage 4: Final reflection and conclusions

In this final stage, which was carried out over five months, after implementing the two improvement strategies and recording them in the reflexive diaries (RD2), the fourth support group (SG4) was held at each centre, where the nurses reflected on and evaluated both the implementation of the two strategies in their clinical practice and the entire PAR process. Regarding the strategies implemented, the nurses confirmed and validated the results obtained from the diaries and agreed on their usefulness for improving the therapeutic relationship at the units.

It has been useful for improving teamwork, finding improvement strategies for similar future situations and to see the mistakes made more easily.

(06DR206)

Regarding the group reflection of the process, the nurses described that, as part of this study, they had learned to trust themselves more, to consider their own emotions and to become aware of the importance of their interventions.

Thinking about the feelings that come up for me when conducting the interview makes me understand a bit better how the patient might be feeling during the interview.

(13DR207)

The nurses explained that they incorporated some changes into their clinical practice by adopting a more open attitude to therapeutic relationship. Although they agreed that participating in this

study had been a very gratifying experience for them, they also recognised that it was difficult to complete the whole process due to its considerable demands and its long duration. In addition, they also expressed doubts as to whether the two improvement strategies could be maintained in the future, due to lack of time and lack of involvement of the rest of the professionals. Finally, the nurses were interested in acquiring new knowledge and highlighted the need for training in therapeutic relationship, de-escalation techniques and communication skills.

During the last focus group (FG4), the coordinating nurses shared the feedback from the units, drew the final conclusions and closed the process as a whole. At the individual level, in their respective units, the coordinators were confident that the nurses who had participated in the study would maintain everything they had learned about therapeutic relationship throughout the process, but at the collective level, they also had doubts as to whether the improvement strategies could be maintained as designed.

The actions that were proposed were useful and the therapeutic relationship with the patient is very important. This is a good measure to work on, but there is a lack of consistency to regulate it and to do it in a more regulated and formal manner on behalf of the institution.

(17FG4)

Moreover, at the institutional level, they emphasised that the study had contributed to implementing some changes in the unit regulations, updating them and further adjusting them to the patients' needs. For example, the use of street clothes instead of pyjamas or the regular use of mobile phones. They also recognised that the management of some centres had shown some sensitivity to the results reported by the coordinators, especially in relation to ratios and staff shifts.

'The nurses really believed in the study and that change is possible'. (03FG4) 'I value the study very positively because I think the topic is very appropriate for our sector and I think we have to continue talking about the therapeutic relationship. The fact that people from all over Catalonia came gives us the option to see other opinions and to be able to discuss them'.

(15FG4)

6 | DISCUSSION

The aim of this study was to explore the process of change in the clinical practice of nurses working at acute mental health inpatient units in the context of their participation in an action research study aimed at improving the nurse-patient therapeutic relationship. It should be noted that, as in most studies that have used similar methods in the health area, the participatory process

TABLE 1 Stages of action and observation of the second cycle: Results of the implemented strategies collected in the nurses' reflective diaries

Strategies implemented	Level and focus of action	Aspects that condition the action	Emotional impact of the action	Usefulness of the action	Quotations
Post-incident analysis	- Action at the individual level - Situations of violent behaviour or psychomotor agitation with restriction of movement or escapes	- Infrastructure and staffing - The team's training - Coordination and consensus in the team - Relaxing regulations - Informing, increasing observation, and agreeing on interventions with the patient	- Identifying negative emotions: tension, frustration, helplessness, feelings of being out of control or of being bad professionals - Positive reinforcement: peace of mind, confidence, self-assurance, and satisfaction with a good result	- Improving the quality of care - Awareness of the importance of the interventions - Professional growth - Consolidates, provides cohesion, and strengthens the team - Facilitates emotional ventilation, sharing coping strategies and encouraging self-criticism and reflection	- We realised that guilt and fear only blocked us. We concluded that this experience would be useful for future interventions. It was helpful to be able to share it with the rest of our colleagues (01DR201) - On some occasions the workload did not make it easy to talk about it and we are not in the habit of doing so either (12DR201) - Together we were able to identify actions that could be improved. It was a space to let off steam, a moment of reflection and to share emotions-sensations (06DR203). - The usefulness of this intervention is indisputable because it helps to take into account steps or interventions that are deduced and not carried out. Nursing intervention would be much easier if each of the crisis situations that occur on a daily basis in the acute unit were analysed in time (07DR202)
Reserved therapeutic space	- Action at the collective level - Management of emotions - Coping strategies - Illness awareness - Pharmacological adherence - Consumption of toxic substances - Symptom identification	- Workload - Interferences from the environment, the lack of intimate spaces, the favourable environment of the unit - Team and patient collaboration - Nurses' training and experience - The previously established relationship of trust	- Identification of frustration or disappointment when intervention is not effective - Positive reinforcement: calm, comfortable, self-confident, and professionally fulfilled.	- On a personal level: to become aware of the importance of their interventions and to reflect on their daily clinical practice. Empowered - At the professional level: the intervention allowed them to get to know and understand patients better, empower them, work together with them, individualise care and strengthen the bond with them, giving them confidence and closer care	- It strengthened the bond with the patient, I think he felt more listened to and cared for. He had the opportunity to talk about his feelings regarding the admission and his expectations. We were able to establish together how to help him (07DR201) - The feeling during the whole process was enriching on a personal and work level. In many cases, I was able to empower the patient in the situation he/she was going through. (18DR201) - My personal satisfaction increased, and my fears and insecurities decreased (03DR206) - The client felt comfortable being listened to and understood. I felt good to see how the patient reflects on the event and trusts me to express herself (04DR206) - It has helped the patient to feel well cared for and with the necessary attention, promoting their wellbeing. It has strengthened the therapeutic bond so that we can achieve the objectives set (03DR205)

produced improvements both at the level of the nurses' individual clinical practice, as well as collective changes in the team, and even had an impact at the organisational level (Cordeiro & Soares, 2018; Cusack et al., 2018).

First, it is important to point out that in all the centres, there was support and interest in the change at the organisational level prior to the start of the study. However, it was important to carry out an adequate diagnostic analysis and examination of the field in the different participating units in order to assess the joint viability of the change process (Kemmis & McTaggart, 2008). The results of the initial diagnostic stage confirmed that, despite the heterogeneity of the different participating units, there were common elements in all units that were linked to the care model and the nurse–patient therapeutic relationship, susceptible to improvement in the context of a participatory process (Moreno-Poyato et al., 2021). This contributed to generate greater collective awareness of the need for change among nurses. These results were confirmed later on in the process, when the nurses individually self-observed themselves in those clinical practice situations where the therapeutic relationship was fundamental. This self-observation stage contributed to the nurses' individual and collective awareness of the meaning and usefulness of the therapeutic relationship, which gave them confidence and reassurance in their practice (Bekkema et al., 2021; Cusack et al., 2018). The use of diaries facilitated the individual reflexivity of the nurses that led them to identify that their attitude was essential for the change and improvement of the therapeutic relationship, thus fostering individual commitment to solve the problem (Bolg et al., 2020). Moreover, the FGs contributed to the collective reflection that allowed the nurses to identify the factors that helped them and those that prevented them from having an adequate therapeutic relationship, which are essential aspects to be able to later reach a consensus regarding strategies for improvement (Bekkema et al., 2021; Casey et al., 2022; Cusack et al., 2018).

As in other studies that have used participatory methods, the nurses proposed changes at the individual level aimed at improving the training (Karam et al., 2021; Minaya-Freire et al., 2020) and the incorporation of specific nursing interventions into practice (Salzmann-Erikson, 2017; Vantil et al., 2020). They also proposed changes at the collective level to improve teamwork, such as reflection groups (Chen et al., 2021; Moreno-Poyato et al., 2019) and organisational changes related to a more humanised care model (Chambers et al., 2013; Chandley et al., 2014). In this planning stage, the participation and representation of nurses from all units allowed them to assess the viability and feasibility of the proposals. Thus, the nurses were able to prioritise and agree on the implementation of two strategies to improve the therapeutic relationship at all the centres. An individual strategy to improve the direct intervention with the patient and a collective strategy to generate critical-reflective spaces, proposals similar to those generated in other participatory studies (Moreno-Poyato et al., 2019; Salzmann-Erikson, 2017; Vantil et al., 2020).

The nurses evaluated the impact of the implementation of the improvement strategies again both individually and collectively. In

this manner, through the diaries, they were able to reflect individually and confirm a greater level of confidence and self-assurance as professionals, but also the importance of knowing themselves and identifying the role of emotions in clinical practice (Price, 2017; Vaughan, 2017). Through the FGs, those nurses who did not keep the diaries or who had naturalised or were less aware of the change that had occurred were able to reflect on and corroborate the findings from the diaries. In general, although the nurses reported that the process had been demanding and time-consuming (Moreno-Poyato et al., 2019), they acknowledged that the process had enabled them to substantially improve their clinical practice, mainly due to individual changes (Alomari et al., 2020; Bekkema et al., 2021; Cusack et al., 2018) and also organisational changes (Cordeiro & Soares, 2018). However, although there had also been changes at the collective level (Afshar et al., 2020; Chen et al., 2021), the nurses were hesitant to maintain these changes as these were dependent on other people in the team.

6.1 | Strengths and limitations

This study has certain limitations and strengths. It should be noted that this is one of the first studies in the area of mental health nursing that proposes the use of a participatory methodology with such a large number of participating centres and nurses. Thus, there are studies in the area of mental health nursing with similar methods in which a large number of people have participated, although not from different institutions (Larkin et al., 2015; Onnela et al., 2014). This posed major methodological challenges that deserve consideration and discussion.

The first issue worth reflecting on is the possible difference in contextual reality between the participating centres. To this end, the team considered it essential to carry out a detailed reconnaissance of the field. An analysis of the culture of care in the units was carried out (Tolosa-Merlos et al., 2021), and organisational interests and realities were assessed (Molineux, 2018). To assess organisational interest, in the stage prior to the start of the study, a working group was formed consisting of representatives of the management of each organisation. Together, we assessed whether there was a need to improve the therapeutic relationship in their institutions and, above all, we discussed the feasibility and the support that the organisations would provide to the study and the results that would emerge from it.

The second aspect that warrants reflection is that, once the institutional commitment had been agreed upon, the management of each centre selected a nurse to act as a representative and coordinate the study in their centre as part of the clinical research team. In this regard, the methodological team insisted that the person coordinating the study at each centre should have specific leadership and credibility characteristics within the institution (Kemmis & McTaggart, 2008). However, the needs of each institution meant that the coordinating nurses were chosen with different profiles. This could have conditioned the involvement of

the remaining nurses at each centre and the implementation of some of the strategies proposed. Thus, the role of the nurse coordinators could also explain part of the dropout rate. Nonetheless, in our study, most of the dropouts were due to the duration of the PAR and to the transfers of some participating nurses to other services.

The third aspect to be considered was the large volume of data to be managed. To this end, the nurse coordinators of each centre were included as part of the research team and were trained in methodology through several initial work sessions and, subsequently, there was a process of constant mentoring by the principal investigator and the rest of the methodological team. In addition, for data management and storage, a secure on-line space was built with unique access by the principal investigator of the project. All data were collected electronically. For data analysis, a subgroup was set up to work collaboratively, led by an expert researcher from the methodological team (Merriam & Tisdell, 2016).

Finally, it should be kept in mind that although the initial evaluation suggests that the improvements have been integrated into clinical practice, further evaluations are needed in the medium and long term to assess the maintenance of the changes in daily clinical practice (Cordeiro & Soares, 2018). Similarly, it should be noted that in this study, given the initial approach proposed to implement the change, patients were not included as stakeholders (Effendy et al., 2022; Wiles et al., 2022). In future studies, it would be interesting to consider the patients' perspective.

7 | CONCLUSION

This study has provided insight into the participatory process through which nurses in acute mental health units of 18 hospitals have been able to improve aspects of the nurse–patient therapeutic relationship considering the individual, collective and organisational areas. In turn, this study has shown that, from a constructivist paradigm, despite the different cultural and structural realities of the participating institutions, it is possible to implement a collaborative change process if the needs and expectations of the participants and the organisations are similar.

8 | RELEVANCE TO CLINICAL PRACTICE

In relation to the implications of this study, given the nature of PAR as a knowledge-generating method, the results imply an improvement in the nurses' training, incorporating new knowledge, consolidating their skills and reinforcing attitudinal aspects of their practice. Thus, the results obtained through PAR are directly transferred to clinical practice, producing an impact not only on individual nurses and patients but also on the collective dynamics of the teams and on aspects related to the management of the units. To assess whether the changes produced are sustained over time, further research is needed. Therefore, future studies should incorporate the

participation of patients not only as participants but also as part of the team. Similarly, in subsequent studies, it is necessary to evaluate the impact of the changes on patient health outcomes.

AUTHOR CONTRIBUTIONS

ARMP and PDH designed the study. APT, FGP and GCG were responsible for data collection. DTM was responsible for the data analysis team. DTM, ARMP and PDH drafted the final report. ARMP supervised the process of data collection and analysis and provided support and feedback during all study phases. All authors have contributed to the manuscript. Also, all authors read and approved the final manuscript.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Diana Tolosa-Merlos  <https://orcid.org/0000-0001-7668-0557>

Antonio R. Moreno-Poyato  <https://orcid.org/0000-0002-5700-4315>

Francesca González-Palau  <https://orcid.org/0000-0001-9187-9089>

Alonso Pérez-Toribio  <https://orcid.org/0000-0002-8962-974X>

Georgina Casanova-Garrigós  <https://orcid.org/0000-0002-3652-9745>

Pilar Delgado-Hito  <https://orcid.org/0000-0001-7077-3648>

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