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ORIGINAL ARTICLE

The therapeutic relationship from the perspective of patients and nurses in the first days of admission: A cross-sectional study in acute mental health units

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Abstract

The therapeutic relationship (TR) is essential in mental health nursing care and plays a fundamental role in the understanding and treatment of the patient's health status. Despite being a bidirectional construct, limited evidence is available to shed light on this issue in mental health units and even less so in the first days of admission. This study aimed to examine the association and differences between nurses' and patients' perspectives on the establishment of the therapeutic relationship in acute mental health units during the first days of hospitalization. A cross-sectional study was carried out in 12 Spanish mental health units. Data were collected from patients and nurses using the Working Alliance Inventory-Short (WAI-S) questionnaire. A total of 234 cases were analysed, including 234 patients and 58 nurses. The results showed a positive association between nurses' and patients' perspectives on the therapeutic relationship, but also revealed significant differences on each WAI-S dimension. Nurses assigned higher scores compared to patients on the perception of the quality of the therapeutic relationship. The dimensions with the greatest weight from the patients' perspective regarding the quality of the therapeutic relationship were the perception of greater agreement on goals and tasks among

nurses. This study demonstrates the importance of establishing shared goals and tasks with nurses from the first days of hospitalization to improve the quality of the therapeutic relationship as perceived by patients. These findings underline the need to consider the different perspectives of both parties to promote a high-quality therapeutic relationship.

KEYWORDS
acute inpatient units, cross-sectional study, mental health nursing care, therapeutic relationship

INTRODUCTION

The therapeutic relationship (TR) is an essential part of any nursing intervention and is the linchpin of effective person-centred care in the realm of mental health care (Hartley et al., 2020). This relationship involves an interaction between the nurse and the patient and is based on concepts such as partnership, empowerment, respect and trust (McAllister et al., 2019; McMillan et al., 2019; Zugai et al., 2015). It is a fundamental process for the holistic understanding and effective treatment of the patient's health condition. An adequate TR increases the effectiveness of any intervention in clinical nursing practice (McAndrew et al., 2014) and improves the health outcomes of the people who receive it (Hreńczuk, 2021; Kelley et al., 2014; Moreno-Poyato et al., 2017; Zugai et al., 2015). Hence, there exists a need to better understand the TR within mental health units by involving all key stakeholders, both patients and professionals.

BACKGROUND

The TR is essential in the practice of mental health nursing (Harris & Panozzo, 2019), and it has evolved along with the professionalization of nursing (Gabrielsson et al., 2016; McAndrew et al., 2014; Zugai et al., 2015). In 1950, Peplau had already defined the therapeutic component of the nurse–patient relationship (O'Brien, 2001). One of the main objectives of the TR is to understand the patient's perceptions and needs (Reynolds & Scott, 1999), enabling the nurse to empower the patient and promote skills to address and overcome their problems (Peplau, 1997). To this end, the empathy of mental health nurses is an essential aspect of the TR (Gerace et al., 2018; Moreno-Poyato, Rodríguez-Nogueira, et al., 2021). In this sense, the TR is defined as a relationship of help (Moreno-Poyato et al., 2017; Strandås & Bondas, 2018), where the nurse works to improve the health of the people served, establishing a meaningful relationship based on mutual trust and a therapeutic alliance (Moreno-Poyato et al., 2016). This alliance between the nurse and the patient, understood as a specific construct of the TR (Hartley et al., 2020; McAllister et al., 2019; Moreno-Poyato et al., 2016), is known to be composed of three dimensions (Bordin, 1979): firstly, the relational bond that is established between the professional and the patient; secondly, the agreement on the therapeutic objectives to be set in the relationship; and finally, the agreement between the professional and the patient on the necessary tasks to be performed in order to achieve these objectives (Bordin, 1979).

In acute mental health inpatient settings, the TR is critical for providing quality care (Moreno-Poyato et al., 2016; Zugai et al., 2015) and is the basis of nursing practice (McAllister et al., 2019). However, the existing clinical support tools are not always effective for restoring the therapeutic alliance and leading patients to improved outcomes (Coelho et al., 2021; Lambert et al., 2018). Therefore, it is important to understand the perspective of professionals and patients in order to analyse their agreements and disagreements regarding the TR (Beaudette et al., 2020; Flückiger et al., 2018; Igra et al., 2020; Lessard-Deschênes & Goulet, 2022; Penix et al., 2021; Tschuschke et al., 2020). Although the TR may be experienced differently by the participants (Atzil-Slonim et al., 2015; Hartmann et al., 2015; Kivlighan et al., 2016), the literature highlights that the agreement between professionals' and patients' estimates of the TR is fundamental in the assessment and outcomes of the care process (Hartmann et al., 2015; Igra et al., 2020; Lessard-Deschênes & Goulet, 2022; Tschuschke et al., 2020).

However, a conspicuous gap in our understanding persists, particularly concerning the factors that influence the differences in perspectives between patients and nurses regarding the establishment of the TR. In research on psychotherapy outcomes, variation is primarily associated with certain characteristics of practitioners such as experience, gender (Hartmann et al., 2015), insecurity, anxiety and negative feelings of irritation or frustration (Nissen-Lie et al., 2015) as aspects that negatively affect patients' estimates of the perceived TR. Likewise, some patient characteristics, such as hostility, irritability (Nissen-Lie et al., 2015), negative symptomatology of persons with psychotic disorders and cognitive functioning (Beaudette et al., 2020) may influence the differences in estimates made by the professionals. Conversely, to bridge perspectives, the evidence points to the importance of an adequate establishment of the TR in the first 24–72 h of hospitalization (Moreno-Poyato, El Abidi, et al., 2021),

as well as the need to improve the quality of the TR through greater empathy, collaboration and communication between both groups (Bachelor, 2013; Evans-Jones et al., 2009; Lessard-Deschênes & Goulet, 2022).

Nonetheless, despite the relevance of the phenomenon, there is a substantial knowledge gap regarding the difference between patients' and nurses' perspectives on the TR in mental health inpatient settings, particularly during the first days of hospitalization. Therefore, to enhance care in acute mental health inpatient settings, a deeper comprehension of both perspectives, the discrepancies between them and the factors influencing the bidirectional nature of the TR is not only crucial but also long overdue. Addressing this knowledge gap will pave the way for more effective, empathetic and patient-centred mental healthcare practices.

AIMS

To examine the association and differences between nurses' and patients' perspectives on establishing a TR in acute mental health units during the first days of hospitalization.

METHODS

Design

A cross-sectional study was conducted in which the data collection conformed to the first phase of a multicentre project entitled RTSMHNursing_Spain, which aims to evaluate the impact of a nursing intervention to improve the TR between nurses and patients in 12 acute mental health units in Spain.

Participants

The study population consisted of patients hospitalized in 12 acute mental health inpatient units and their responsible nurses. Eligible patients were adults hospitalized in mental health inpatient units who consented to participate in the study on a voluntary basis. Participants were excluded if, at the time of recruitment, they presented a language barrier, mechanical restraint, contraindication by the clinical referent, cognitive impairment or intellectual disability. Regarding the eligible nurses, the nurses assigned to the included patients and who voluntarily accepted to participate were enrolled in the study. Consecutive sampling was performed, and given the purpose of this study, the sample size achieved was considered appropriate considering that, for multiple linear regression, it is recommended to introduce one variable for every 10–15 individuals (Austin & Steyerberg, 2015; Green, 1991).

Data collection

Procedures

The research team member coordinating the study at each unit was responsible for informing the patients who met the inclusion criteria about the objectives of the study and obtaining informed consent. This occurred between 24 and 72 h from the time of admission. Once the first meeting or welcome interview with the patient by the nurse in charge of the unit had taken place, the nurse was provided with a dossier containing the assessment instrument, and in addition, the nurse coordinating the study at each unit, outside the patient's care process, was responsible for administering the patient's assessment. The remaining data were obtained from the patient's clinical history. Study data were collected and managed using REDCap electronic data capture tools (Harris et al., 2019).

Instruments

Therapeutic relationship

The Working Alliance Inventory-Short (WAI-S) patient version and professional version adapted in Spanish by Andrade-González were used (Andrade-González & Fernández-Liria, 2016). This is an instrument for measuring the working alliance and, thus, the TR between professional and patient (Horvath & Greenberg, 1989). The short version of the WAI has 12 items, each item being rated by the professional and the patient on a Likert scale ranging from 1 (never) to 7 (always). This instrument is conformed of three dimensions: bonding, agreement on goals and agreement on tasks. In our sample, the instrument presented Cronbach's alpha values of 0.93 for the total instrument and 0.89, 0.71 and 0.91 for each of the dimensions in the patients' version. For the nurses' version, Cronbach's alpha value was 0.91 for the total scale and Cronbach's alpha values of 0.74, 0.74 and 0.92 for each of the dimensions.

Sociodemographic and clinical variables

The following variables were collected from the patients: age, sex, diagnosis, admission modality and previous knowledge of the nurse in charge. The following variables were collected from the nurses: age, sex, time worked in the unit, specialized training in mental health, academic training and type of contract.

Ethical considerations

Approval was obtained from all the Research Ethics Committees of the participating centres. Participants were informed that their participation in the study was voluntary and that they could withdraw at any time.

The questionnaires were anonymous, and personal identification was not disclosed.

Analysis

Quantitative variables were expressed as the mean and standard deviation. Categorical variables were expressed as frequency and percentage. The reliability of the instruments in our sample was verified using Cronbach's alpha test. In the bivariate analysis, the association between quantitative variables was assessed using Pearson's correlation coefficient: The differences between the mean scores of the different dimensions of the WAI-S were analysed using Student's *t*-test for paired data and Cohen's *d* for the calculation of the effect size. To determine the relationship between the different dimensions of the WAI-S from the nurses' perspective with the global perspective of the TR from the patient's perspective, three different multiple linear regression models were performed including as independent variables: "Nurse's perspective on bond," "Nurse's perspective on goals" and "Nurse's perspective on tasks" in each of the models. In addition, other clinical and sociodemographic variables of nurses and patients were included as covariates. Previous analyses that jointly included the three domains of the nurses' perspective in the multivariate model showed a high collinearity among them, and therefore, independent models were developed. A confidence interval of 95% was established, and statistically significant results were considered with a p-value <0.05. Statistical analyses were performed with the SPSS V 27.0 statistical package (SPSS Inc., Chicago, IL).

TABLE 1 Nurses' sociodemographic and professional characteristics ($n=58$).

Variable	*n*	%
Mean age in years (SD)	35.9 (11.01)	
Sex		
Male	10	17.2
Female	48	82.8
MH nursing training		
Yes	24	41.4
No	34	58.6
Highest education		
Bachelor's degree	45	77.6
PhD or Master's degree	13	22.4
Employment contract		
Permanent	21	36.2
Temporary	27	46.6
Substitute	10	17.2
Mean years of MH experience (SD)	7.6 (7.1)	

Abbreviations: MH, mental health; SD, standard deviation.

TABLE 2 Association between patients' and nurses' perspectives on the therapeutic relationship.

	Patients' perspective			
Variable	**Bond**	**Goals**	**Tasks**	**WAI-S**
Nurses' perspective				
Bond	0.281***	0.237***	0.258***	0.284***
Goals	0.479***	0.525***	0.506***	0.551***
Tasks	0.506***	0.501***	0.566***	0.577***
WAI-S	0.490***	0.492***	0.520***	0.550***

Abbreviation: WAI-S, Working Alliance Inventory-Short.
***$p<0.001$.

RESULTS

A total of 234 valid cases consisting of 234 patients and 58 nurses were analysed. The mean age of the patients was 41.1 years (SD = 15.2), with 53.4% female and 43.3% male. One-third (31.7%) of the patients had a diagnosis of psychosis/schizophrenia, 25% of the patients had a mood disorder and the remainder represented other mental problems to a lesser extent. Up to 56.4% of patients were admitted involuntarily. Only 15.6% had been attended by the nurse in other previous admissions. The sociodemographic and professional characteristics of the nurses are described in Table 1.

Table 2 shows the results obtained regarding the association between nurses' and patients' perceptions of the TR in the first hours of admission. The results show that there is a positive and significant association between patients' and nurses' perspectives both on the overall TR and on each of its dimensions, with the strongest associations being found for goals, tasks and the total scale. Furthermore, a low association was observed in the bonding dimension, with a value of $r=0.281$.

Table 3 shows the results obtained regarding the differences between nurses' and patients' perceptions of the TR in the first hours of admission. According to the results obtained, nurses assign higher values than patients for the overall perception of the TR. Furthermore, the data reveal the existence of statistically significant differences in all dimensions and in the total WAI-S scale. However, the effect sizes obtained are of small-to-moderate magnitude, with Cohen's *d* values ranging from 0.13 to 0.37.

To identify the key factors in the establishment of the TR from the patient's perspective, three multivariate models were constructed (Table 4). One model with each of the WAI-S dimensions from the nurse's perspective, in which sociodemographic and clinical variables of interest to both nurses and patients were also included as covariates (Table 4). In model 1, a significant positive association

TABLE 3 Differences in the therapeutic relationship between patients and nurses.

Variable	Patient	Nurse	*p*-Value*	Cohen's *d*
Bond	20.6 (6.3)	22.8 (3.6)	<0.001	0.35
Goals	18.2 (5.8)	18.9 (4.4)	0.045	0.13
Tasks	18.4 (7.3)	19.2 (5.3)	0.040	0.13
WAI-S	57.2 (17.7)	60.9 (11.8)	<0.001	0.37

Abbreviation: WAI-S, Working Alliance Inventory-Short.
**T*-test pairs.

was obtained between the nurse's perspective of the link with the global perspective on the patient's TR (β=1.26, CI=0.62–1.90). The covariates that were significant in this model were the patient's diagnosis (anxiety disorder vs. psychotic disorder (ref.); β=16.16, CI=2.31–30.0) and the age of the nurse (β=−0.41, CI=−0.59 to −0.23). In the second model, a significant positive association was obtained between the nurse's perspective of agreement on objectives and the patient's overall perspective on the TR (β=2.00, CI=1.53–2.47). In model 2, only the nurse's age covariate

TABLE 4 Relationship between the different dimensions of the WAI-S from the nurses' perspective with the global perspective of the TR from the patient's perspective.

	Model 1 Adj R^2=0.18		Model 2 Adj R^2=0.34		Model 3 Adj R^2=0.38	
Independent variables	β	95% CI	β	95% CI	β	95% CI
Nurse's perspective on bond[a]	1.26***	0.62; 1.90	–	–	–	–
Nurse's perspective on goals[b]	–	–	2.00***	1.53; 2.47	–	–
Nurse's perspective on tasks[c]	–	–	–	–	1.78***	1.41; 2.16
Patient's admission modality[a,b,c]						
Voluntary	Ref.		Ref.		Ref.	
Involuntary	−1.06	−6.10; 3.98	−0.10	−4.59; 4.40	−1.17	−5.54; 3.20
Patient's age[a,b,c]	0.08	−0.08; 0.25	0.13	−0.01; 0.28	0.08	−0.06; 0.23
Patient's sex[a,b,c]						
Male	Ref.		Ref.		Ref.	
Female	1.84	−2.84; 6.53	0.65	−3.56; 4.85	1.51	−2.57; 5.58
Patient cared for by the nurse in previous admissions[a,b,c]						
No	Ref.		Ref.		Ref.	
Yes	4.34	−0.67; 9.36	2.82	−1.63; 7.27	1.95	−2.40; 6.31
Patient's diagnosis[a,b,c]						
Psychotic disorders	Ref.		Ref.		Ref.	
Bipolar disorder – Mania	5.23	−1.59; 12.04	4.42	−1.68; 10.51	5.02	−0.90; 10.94
Depressive disorders	−4.47	−12.77; 3.83	−5.12	−12.54; 2.30	−4.43	−11.64; 2.77
Anxiety disorders	16.16*	2.31; 30.0	12.42	0.02; 24.83	12.86*	0.81; 24.92
Personality disorders	5.48	−1.72; 12.69	5.21	−1.23; 11.66	4.86	−1.40; 11.13
Substance use disorders	−0.05	−8.69; 8.60	−4.32	−12.14; 3.49	−5.96	−13.61; 1.69
Nurse's age[a,b,c]	−0.41***	−0.59; −0.23	−0.24**	−0.41; −0.08	−0.26**	−0.42; −0.09
Nurse's sex[a,b,c]						
Male	Ref.		Ref.		Ref.	
Female	−2.50	−10.45; 5.45	−2.63	−9.72; 4.46	−0.51	−7.43; 6.41
Mental health nurse's training						
No	Ref.		Ref.		Ref.	
Yes	3.65	−1.22; 8.52	1.88	−2.51; 6.26	0.48	−3.82; 4.78

Note: *p<0.05; **p<0.001; ***p<0.001.
Abbreviations: CI, confidence interval; TR, therapeutic relationship; WAI-S, Working Alliance Inventory-Short.
[a]Independent variables introduced in model 1.
[b]Independent variables introduced in model 2.
[c]Independent variables introduced in model 3.

was significant (β=−0.24, CI=−0.41 to −0.08). Finally, model 3 included the nurse's perspective on task agreement as an independent variable (β=1.78, CI=1.41–2.216). In this model, the patient's diagnostic covariate (anxiety disorder vs. psychotic disorder) was also significant (ref.); β=12.86, CI=0.81–24.92) together with the nurse's age (β=−0.26, CI=−0.42 to −0.09).

DISCUSSION

This study aimed to provide an in-depth analysis of the association and differences between nurses' and patients' perspectives on the TR. The results indicate that, during the first days of admission, there is a positive association between nurses' and patients' perspectives on the TR they establish. However, there are differences between the perspectives of both groups on the TR, both in general terms and for each of its dimensions. Remarkably, only one study has been found that analyses the perspective of nurses and patients in acute mental health units. This study stand out for its qualitative perspective, which centers on involuntary treatment orders. It is worth noting that this study alings with our findings, shedding light on the distinct disparities that exist between nurses' and pacients' perspectives on the TR (Lessard-Deschênes & Goulet, 2022).

More specifically, and according to the results obtained, the nurses' scores were significantly higher than those of the patients in all dimensions of the WAI-S scale. These results are consistent with another study conducted in the mental health inpatient setting where physician ratings were higher than those of patients (Beaudette et al., 2020). However, in the community setting, the opposite has been found, with higher scores assigned by patients compared to therapists (Andrade-González et al., 2017; Hartmann et al., 2015; Igra et al., 2020; Penix et al., 2021). These differences could be attributed to the specific care environment under examination. It is possible that the development of the TR takes time, with initial days of hospitalization marked by its nascent stages, subsequently leading to an improvement in perceptions of TR quality over time (Andrade-González et al., 2017; Tschuschke et al., 2020) and a consequent reduction in differences between professional and patient assessments (Coyne et al., 2018). In addition, patients were found to perceive low therapeutic communication, reflecting poor empathy on behalf of the nurses (Saavedra Chinchayán et al., 2021) and emphasizing the importance of establishing a bond of trust during the first 24–72 h of hospitalization to understand their needs and expectations (Moreno-Poyato, El Abidi, et al., 2021).

The results also show that the nurse's perspectives on bonding, objectives and tasks, along with the nurse's age, are important factors influencing the patient's perspective on the quality of the TR. In fact, agreement on tasks and goals on behalf of the nurses is the most influential variable on the patient's perception of the quality of the TR. In this regard, the literature indicates that shared decision-making is strongly aligned with the principles of person-centred care and user participation in a TR of trust (Huang et al., 2021; James & Quirk, 2017). Conversely, the lower association found within the bonding dimension could be attributed to its inherent complexity and the challenges it poses in terms of assessment, especially during the initial phases of the relationship, producing greater variability in perceptions between nurses and patients (Atzil-Slonim et al., 2015). These results are in line with other studies in psychotherapy, which found significant associations between tasks and/or goals (Andrade-González et al., 2017; Beaudette et al., 2020; Evans-Jones et al., 2009; Luong et al., 2020). Moreover, the age of the nurse has a negative impact on the patients' perception of the quality of the TR, possibly due to professional burnout and its negative consequences on the TR and quality of care (Friganović, 2017; Torres Campuzano, 2018). Contrary to our results, other studies have shown that age and mental health experience are positively associated with better patient-perceived quality of the TR (Moreno-Poyato, Casanova-Garrigos, et al., 2021; Moreno-Poyato, Rodríguez-Nogueira, et al., 2021). This difference is probably because in these studies the TR is assessed in a very general manner, whereas the present study evaluated the TR according to specific patients, where nurses who are older were perceived in a worse light.

Finally, it is noteworthy that patients with a diagnosis of anxiety disorder have a more positive outlook on the quality of the TR. This suggests that anxiety disorder may positively influence patients' perspectives, especially when there is greater agreement on tasks and goals. In this regard, the literature indicates that the TR is essential for therapy in patients diagnosed with an anxiety disorder (Luong et al., 2020), as they need a safe and welcoming space where they can express their concerns and receive the necessary support (Arcaro et al., 2017). These results are in line with previous studies in the field of psychotherapy, which have shown that an increased patient–therapist alliance can improve the severity of anxiety symptoms (Buchholz & Abramowitz, 2020; Luong et al., 2020) and promote successful experiences with therapeutic exposure (Luong et al., 2020). Therefore, this could positively influence the perception of the quality of the TR. However, in contrast to other studies in psychotherapy (Beaudette et al., 2020; Hartmann et al., 2015; Nissen-Lie et al., 2015), no significant effects were found for nurse gender and experience, as well as admission modality, specific diagnosis, patient age and gender.

Limitations and strengths

This study has some limitations that should be considered. First, as this is a very new study in this

field, it was not possible to compare the results with other previous studies. In addition, as this is a cross-sectional study, only associations can be established; however, causality between the variables could not be demonstrated. As for the participants, although random sampling was not used, the sample is considered to be representative of the general population, and therefore, the results could be extrapolated. Finally, it is important to note that although the TR is a complex assessment construct, this study has been able to incorporate the perspectives of both nurses and patients.

CONCLUSION

The results obtained in this study revealed that, in the first days of admission to mental health units, there are differences in the perspective of the quality of the TR between nurses and patients. The nurses' ratings were higher than those of the patients. However, no clinically relevant factors were identified in the patients' characteristics, except for a better appreciation of the quality of the TR by those with anxiety problems; neither were there relevant nurse factors, with the exception of age as a negative factor. In the first days of admission, what patients value most in the TR is shared decision-making, both in the case of agreement on goals and agreement on tasks.

RELEVANCE FOR CLINICAL PRACTICE

The findings highlight important implications for clinical practice and improving quality of care in the health care setting. Also, they point to the importance of considering the perspectives of both groups in the TR and highlight the need for additional research to better understand these results and their implication for clinical practice. In addition, this study provides valuable information to improve the understanding of the dynamics of the TR between patients and nurses. The results indicate that the establishment of the relationship should be improved, and these differences should be reconciled, as nurses are still rating above the patient's evaluation. This could be an opportunity for healthcare professionals to consider these findings and focus on improving those aspects that can influence the patients' perspective in order to provide care that is more efficient and of higher quality.

AUTHOR CONTRIBUTIONS

ARMP, JFRM and KEA made substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data for the work. CEL and ARMP contributed to the main part of the data analysis. KEA, MCR, JAGS, EMR, JJPM, JPV, GRR, AMRL, LJG and CSP assisted in the collection of data from each of the participating centres. ARMP, JFRM, KEA, MTLC and MPL helped in drafting the work or revising it critically for important intellectual content. ARMP, JFRM, KEA and CEL contributed to the final approval of the version to be published. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved by ARMP.

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CONFLICT OF INTEREST STATEMENT

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.

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