

1 **TITLE:** Improving the therapeutic relationship in inpatient psychiatric care: assessment  
2 of the therapeutic alliance and empathy after implementing evidence-based practices  
3 resulting from participatory action research

4 **ABSTRACT:**

5 *PURPOSE:* To examine how evidence about the therapeutic alliance gleaned from  
6 participatory action project affected the level of this alliance and the degree of empathy  
7 of psychiatric nurses.

8 *DESIGN AND METHODS:* Quasi-experimental study in two psychiatric units. In one  
9 group, evidence-based practices that affected the therapeutic alliance were  
10 implemented; in the comparison group, there was no such intervention.

11 *FINDINGS:* The nurses from the intervention group improved their degree of empathy  
12 and factors such as agreement on objectives and tasks with the patient.

13 *PRACTICE IMPLICATIONS:* The results confirm the possibility of measuring and  
14 improving the therapeutic relationship in psychiatric care.

15 **KEY WORDS:** Evidence-based practice, mental health, nurse-patient relations,  
16 psychiatric nursing, participatory action research

17

18 **INTRODUCTION**

19 The therapeutic relationship (TR) is one of the most important tools available to  
20 nurses, especially in mental health nursing (Scanlon, 2006). The concept of the TR  
21 emerged in parallel to the professionalization of nursing care (O'Brien, 2001) and is  
22 considered the cornerstone of psychiatric and mental health nursing (Scanlon, 2006).

23 The TR is also called the helping relationship, the nurse-patient relationship, the trusting  
24 relationship, and the therapeutic alliance (Moreno-Poyato et al., 2016). Nevertheless,  
25 the central focus of all these concepts is the helping/working relationship that is

1 established between nurse and patient. An appropriate TR increases the efficacy of  
2 nursing interventions in the acute mental health setting (McAndrew et al., 2014).

3 The literature discusses various aspects of the meaning of TR for nurses and patients  
4 in the clinical practice of psychiatric units. Psychiatric nurses are aware of the concept  
5 of TR and its importance (Clark, 2012; Cleary et al., 2012; Dziopa & Ahern, 2009;  
6 Hawamdeh & Fakhry, 2014). However, they are also aware that specific skills are  
7 required to develop and maintain a TR with patients (Dziopa & Ahern, 2009). Factors  
8 such as consistency, empathy, the ability to listen, making a positive first impression, a  
9 safe and comfortable environment, and teamwork are the basic pillars on which the  
10 development of a TR is based (Cleary et al., 2012).

11 For their part, patients perceive that attitudes, values and a trusting relationship are  
12 more important in the TR than technical skills (Schroeder, 2013). Service users expect  
13 to receive individual attention as part of their treatment plan (Hopkins et al., 2009). A  
14 feeling of control and self-determination is highly important, and this is provided by  
15 interpersonal relationships (McCloughen et al., 2011). So much so, that what patients  
16 want most are empathetic nurses: i.e., those able to identify what the patient expects or  
17 needs from the nurse at any given moment (Schroeder, 2013). Patients value nurses who  
18 are patient and imaginative and have a sense of humour (Cleary et al., 2012), who listen  
19 and are empathetic (Moreno-Poyato et al., 2016).

20 So, for both nurses and patients the TR is at the core of nursing care in psychiatric  
21 units (Cleary et al., 2012; Hopkins et al., 2009). However, nurses and patients have  
22 different expectations about the TR in clinical practice and different ideas about its  
23 significance. In this regard, although nurses consider that features such as empathy and  
24 listening to patients are fundamental to the TR, patients often feel that they have very

1 few opportunities to work together with their nurses and that their opinions are not  
2 taken into account. On occasion they perceive nurses as authoritarian, or condescending  
3 and unsure (Hopkins et al., 2009; Schroeder, 2013). This makes it necessary to assess  
4 the distance between the two standpoints and try to bridge the gap so that clinical  
5 practice can be improved in psychiatric units (Moreno-Poyato et al., 2016).

6 Because of the conceptual complexity of TR, there are hardly any validated  
7 instruments for evaluating it. One of the most studied and measured constructs in the  
8 framework of TR is the therapeutic alliance. According to Horvath and Greenberg  
9 (1989), the therapeutic alliance is the relational attribute that is a feature of all relations  
10 that attempt to bring about a change. This alliance is constructed through the connection  
11 between the professional and the patient, who reach an agreement on objectives and on  
12 activities they must do together. It is, therefore, an extremely important factor in the  
13 overall nurse-patient relationship. On the basis of the theory on the therapeutic alliance,  
14 a measuring instrument was constructed: the Working Alliance Inventory (WAI;  
15 Horvath & Greenberg, 1989). This tool has been studied primarily in the community  
16 health setting, mostly among professional psychologists (Andrade-González &  
17 Fernández-Liria, 2015; Urbanoski et al., 2012). However, it has hardly been used in  
18 nursing and even less in psychiatric units. Cookson et al. (2012) used it to relate the  
19 interpersonal styles of nursing teams with psychiatric symptoms and the coercion  
20 perceived by patients in psychiatric units. The results showed that an authoritarian style  
21 by the team predicted a bad therapeutic alliance and an increase in the possibility of  
22 health professionals being the object of aggression. They only administered the scale to  
23 patients and the version administered was adapted to the measure of therapeutic alliance  
24 between the patient and the unit's team.

1     Empathy, regarded as the ability to understand the patient, is a critical component of  
2     the therapeutic nurse-client relationship in psychiatric nursing (Moreno-Poyato et al.,  
3     2016). In his conceptualization of empathy, Davis (1983) distinguished between  
4     cognitive empathy and affective empathy. For him, cognitive empathy is the attempt to  
5     understand the perspective of other people and the ability to adopt various roles that are  
6     useful to the situation. Affective empathy, on the other hand, is a tendency to react  
7     emotionally to the experiences observed in others. It is clear, then, that the most  
8     important sort of empathy for a good TR is of the cognitive type, while a high level of  
9     affective empathy would limit the therapeutic relationship of professionals with their  
10    patients (Davis, 1983). We have been unable to find any literature that assesses the  
11    change in empathy after interventions in nurses working in psychiatric units.  
12    Nevertheless, it has been reported that it is very difficult to increase the degree of  
13    empathy in participants in other contexts (Webster, 2010). Even so, the study of  
14    empathy in parallel to other constructs could clarify relationships, and reveal possible  
15    channels for change and improvement.

16    Finally, in terms of the improvement of care, for years now evidence-based practice  
17    has been a leading international trend. However, this empirical approach is not easy to  
18    apply in the complex clinical reality of health care services (Stevens, 2013). One of the  
19    methods used to incorporate evidence-based practice is participatory action research  
20    (PAR) (Abad-Corpa et al., 2012). The goal of PAR is to resolve or modify specific  
21    problems in communities, in this case in acute care nursing teams. PAR is a dynamic  
22    method consisting of an open, holistic and egalitarian process among researchers and  
23    participants (Delgado-Hito, 2012); the action needs to be filtered through experience  
24    and reflection before it can improve or change practices. In PAR, the generation of  
25    knowledge is viewed as a collaborative process, in which the skills and experiences of

1 each participant are essential to the outcome of the project. This method has had  
2 positive effects on nurses' knowledge, their professional performance, the structural  
3 context and patient outcomes (Munten et al., 2010).

4 The aim of this study was to evaluate the effectiveness of implementing evidence-  
5 based practices in the clinical psychiatric setting in terms of their impact on the  
6 therapeutic alliance and empathy perceived by nurses through PAR.

7

## 8 **METHOD**

### 9 **Design**

10 Quasi-experimental design with pre-test and post-test control group

### 11 **Study domain**

12 The study was carried out with nurses from acute psychiatric units in two hospitals in  
13 Barcelona. They were all on the permanent staff and had to have a contract of at least 21  
14 hours a week. The nurses who were in the comparison group belonged to a unit that  
15 cared for a total of 39 acute psychiatric patients. The nurse-patient ratio was 1:11. On  
16 the other hand, the nurses in the comparison group belonged to a unit with 44 acute  
17 psychiatric patients. The nurse/patient ratio in this comparison site was 1:12. The two  
18 units were in different hospitals but depended on the same institution and shared  
19 protocols, clinical guidelines and regulations. The two hospitals were in urban areas,  
20 specifically in Barcelona and its metropolitan area, the patient profile and their care  
21 needs are similar because the respective catchment areas contain districts of similar  
22 socioeconomic and cultural levels.

### 23 **Study period**

1 The pre-test data of the participants were collected between September and December  
2 in 2014. The intervention (implementation of evidence-based practices through PAR)  
3 lasted for 10 months in 2015. The length of the intervention was due to the method used  
4 and the need for a two-stage process so that the changes could be suitably implemented.  
5 The post-test data of the participants were collected between October and December  
6 2015.

## 7 **Participants and recruitment**

8 The population under study were the nurses from the psychiatric units of the two  
9 hospitals selected. Because of the type of intervention and the method of implementing  
10 the evidence-based practices in the study design largely through focus groups (PAR), it  
11 was decided that each group should consist of nine participants (Jayasekara, 2012). The  
12 participants in each group were intentionally selected in such a way that they  
13 represented as many of the different nurse profiles in the unit as possible (Patton, 2002).  
14 All the nurses from the two units were informed of the objectives and the methodology  
15 of the study by the nursing director and email. All the nurses who were interested in  
16 taking part were given an informal interview during which they were provided with  
17 more information about the study. Those who most closely matched the profiles  
18 established for the sampling process were selected (Table 1).

## 19 **Data collection**

20 The following variables and measuring instruments were included.

21 *Variables:*

- 22 1. Sociodemographic and occupational variables
- 23 2. Dependent variables

1 - Level of therapeutic alliance, from the nurse's perspective, evaluated using the WAI-S  
2 scale, therapist version (Horvath & Greenberg, 1989)

3 - Degree of empathy, from the nurse's perspective, evaluated using the IRI scale (Davis,  
4 1983).

5 3. Independent variables:

6 - Implementation of evidence-based practices using PAR

7 *Instruments:*

8 1. The Working Alliance Inventory (WAI short). This inventory measures the  
9 therapeutic alliance and, therefore, the nurse-patient relationship (Horvath & Greenberg  
10 1989). The short version of this scale contains 12 items, and each item is evaluated by  
11 the health professional using a scale ranging from 1 (never) to 7 (always). This  
12 questionnaire is made up of three subscales: (i) bond: the bond between patient and  
13 nurse, which includes aspects such as empathy, mutual trust and acceptance: (ii) goals:  
14 the agreement between patient and nurse in terms of the objectives (that is to say,  
15 mutual acceptance about what the intervention aims to achieve), and (iii) tasks or  
16 activities: the agreement between patient and nurse about the tasks or activities that  
17 have to be carried out. The higher the score, the greater the therapeutic alliance. The  
18 Spanish version of the WAI-S has good reliability and validity, with a Cronbach alpha  
19 of .93 (Andrade-González & Fernández-Liria, 2015).

20 2. The Interpersonal Reactivity Index (IRI). This inventory measures the nurses' own  
21 perception of their empathic tendency with patients (Davis, 1983).

22 The instrument consists of 28 items with a Likert scale (1 = *does not describe me well*  
23 and 5 = *describes me very well*) and is made up of 4 subscales: (i) perspective taking:

1 measures the spontaneous attempts by nurses to put themselves in somebody else's  
2 shoes (adopt the point of view of others); (ii) fantasy: measures the tendency of nurses  
3 to feel useful in the relationship with the other and assesses their imaginative capacity,  
4 (iii) emphatic concern: measures the response of nurses in terms of sympathy, concern  
5 and affection for others, particularly when they are in trouble; and (iv) personal distress:  
6 evaluates the feelings of anxiety and distress that nurses experience when they observe  
7 others having negative experiences.

8 The higher the score, the greater the emphatic tendency in the therapeutic relationship.  
9 This instrument has been validated in Spanish (Pérez-Albéniz, Paúl, Etxeberria, Montes  
10 & Torres, 2003) and the Cronbach alpha values for the Spanish version vary between  
11 .63 and .71 among the four factors.

## 12 **The intervention**

13 The intervention consisted of implementing scientific evidence-based practices  
14 through PAR (Abad-Corpa et al., 2012). The process that was carried out during this  
15 intervention is described below and is presented in schematic form in Figure 1. After an  
16 initial self-observation of clinical practice by the nurses participating in the intervention  
17 group, they were provided with some scientific evidence: the nursing best practice  
18 guideline "Establishing Therapeutic Relationships" published by the Registered Nurses  
19 Association of Ontario (RNAO, 2002). The nurses were asked to compare their own  
20 practice with this text. They designed strategies to improve the TR with their patients on  
21 the basis of the evidence provided and their health-care context. More specifically, they  
22 designed, implemented and assessed three strategies for improving the TR (see figure  
23 1). It is important to note that the three strategies decided by the nurses should be



1 standard in some psychiatric wards, but they were not in the wards that we studied at  
2 that moment:

3 1. *Individual patient care*: This strategy consisted of dedicating a part of every  
4 working day to individual interactions with patients. The main aim of the  
5 interaction was to understand the patients' situations and try to help them by  
6 carrying out the three phases described in the text they had been presented with.  
7 As a result, the group agreed that the aim was to understand the caring  
8 requirements of the patients, to agree on objectives and to make joint decisions  
9 about the interventions to be carried out. The next interaction was scheduled to  
10 assess the work that had been done.

11 2. *Reflective groups*. This strategy consisted of setting up group sessions for the  
12 participants in which they could put their concerns and worries about clinical  
13 practice into words. In these forums they could share and discuss all sorts of  
14 cases and situations in terms of the TR. The purpose was for the members of the  
15 group to vent their emotions through constructive criticism among professionals.  
16 During the study period, two group sessions were scheduled.

17 3. *Study of other evidence (two scientific texts)*. As the initial evidence suggested,  
18 the group decided to gain more in-depth knowledge by reading two scientific  
19 articles they selected themselves (Scanlon, 2006; McAndrew et al., 2014). The  
20 nurses decided that the principal investigator should propose five articles from  
21 indexed peer review journals. Then they read the abstract of each article, and  
22 voted to decide on which two documents were the most appropriate.

23 The comparison group took no part in any intervention between nurses and patients that  
24 was not part of their unit's daily practice.

## 1 **Analysis of data**

2 The data analysis focused on the numerical differences that were obtained on the  
3 WAI-S and IRI scales, before and after the evidence was incorporated into practice  
4 through PAR. The groups were compared with Wilcoxon's test, which accurately  
5 calculated the p value using permutations. Also, to measure the strength and direction of  
6 association between variables under study in the intervention group, Spearman's  
7 correlation coefficient was calculated. The results were interpreted with a level of  
8 significance of  $p < 0.05$ . The process of analysis was carried out using the computer  
9 program IBM SPSS Statistics 21 and the statistical package R (version 3.3.1).

## 10 **Ethical considerations**

11 The Project was approved by the Institution's Ethics Committee of Clinical Research.  
12 All the participants were volunteers who had given their informed consent and who  
13 could withdraw from the study whenever they liked. The confidentiality of the personal  
14 and family data was guaranteed

## 15 **RESULTS**

16 Initially, a total of 26 participants were part of the research, enough to allow for some  
17 drop out. During the study 4 participants did actually withdraw from the intervention  
18 group: two for personal reasons, 1 for lack of professional motivation and 1 for the  
19 workload required by the study. In the comparison group, 2 participants did not fill in  
20 the questionnaires when the data was collected. Therefore, 20 participants completed  
21 the study, of whom 9 were in the intervention group and 11 in the comparison group.  
22 Given the size of the sample and to make the interpretation of the data more  
23 straightforward, the mean score and the 25th and 75th percentiles are presented for all  
24 the quantitative variables.

1 Table 2 shows the main sociodemographic and employment characteristics of the  
2 participants, and also provides the scores from the WAI-S and IRI before the  
3 intervention. The sample mainly consisted of women and all three work shifts were  
4 represented. Most of the nurses who participated were not specialists in mental health  
5 and had worked in the field for less than 10 years. As can be seen in table 2, the two  
6 groups presented similar characteristics before the intervention.

7 Table 3 shows the differences in the scores between the two groups after the  
8 intervention. It should be pointed out that improvements in the total score for the level  
9 of therapeutic alliance were statistically significant with a mean difference of more than  
10 7 points between the two groups ( $p=0.010$ ). Comparing the differences between groups,  
11 improvements were also significant in goals factors ( $p=0.025$ ) and tasks ( $p=0.004$ ).  
12 Likewise, the intervention group significantly improved their degree of empathy both  
13 for the whole scale, with a mean difference of more than 6 points with respect to the  
14 comparison group ( $p=0.026$ ), and for the factor Fantasy, with a difference in mean  
15 scores of more than 5 points ( $p=0.002$ ).

## 16 **DISCUSSION**

17 The aim of this study was to evaluate the effectiveness of using evidence-based  
18 practices in the clinical psychiatric setting in terms of the impact on the improvement of  
19 the therapeutic alliance and the empathy perceived by nurses through PAR. Although  
20 the changes may be due to the fact that the nurses themselves took part in the study, the  
21 results indicate that improvements were brought about in highly specific factors that are  
22 closely related to the intervention, the type of method used and the strategies that  
23 emerged from it. In this respect, the level of the therapeutic alliance increased in nurses,  
24 particularly in terms of agreeing on objectives and tasks with patients. The results with

1 respect to the total degree of empathy also revealed statistically significant differences.

2 It should be noted that nurses significantly improved their sense of usefulness in the

3 context of patient care. This aspect was measured using the factor Fantasy because of

4 the importance of self-awareness in establishing the TR.

5 It should be pointed out that the level of the therapeutic alliance was already high in

6 the pretest results of both groups (Andrade-González & Fernández-Liria, 2015). This

7 may be due to the presence of nurses specializing in mental care and the high degree of

8 experience of the participants. Whatever the case may be, the aspect that improved

9 significantly in the intervention group after the intervention was the joint determination

10 of objectives and tasks with the patients. This finding is in accordance with the

11 evidence-based practice that was initially implemented, which advocated the importance

12 of establishing objectives with patients and going through the stages of the TR with

13 them (Registered Nurses Association of Ontario, 2002). It is habitual clinical practice

14 for patients not to be involved in the care schedule with nurses (Biering, 2010; Stegink

15 et al., 2015; Voogt, Nugter, Goossens & van Achterberg, 2016). The results of our study

16 show that, after the intervention, the nurses had improved their perception about the

17 need to include patients in formulating the objectives of their care and the joint decision

18 about the interventions that needed to be made to improve their health. It is clear that

19 involving patients with mental health problems in their own care schedule empowers

20 them. By building bridges of this sort, inpatient psychiatric care becomes more like the

21 person-centered approaches characteristic of the WHO's health policies (2007).

22 It is necessary to emphasize that the high scores obtained by the nurses before the

23 intervention in terms of the bond confirm that they were able to establish a close bond

24 with patients before the evidence-based practice had been implemented. In fact, the

25 literature shows nurses have always given vital importance to confidence in the TR

1 (McCloughen et al., 2011; Moreno-Poyato et al., 2016). For this reason, the nurses who  
2 took part in the study did not significantly improve their connection with their patients,  
3 because at the start of the study it was already high.

4 As far as changes in empathy were concerned, unlike other studies, this study shows  
5 that the nurses substantially improved their degree of fantasy (Avasarala, Whitehouse &  
6 Drake, 2015), which reflects a greater sense of usefulness in patient care (Davis, 1983).  
7 This is particularly important because it shows that such an important factor as a nurse's  
8 self-awareness when establishing therapeutic relations with their patients can be  
9 changed (Dziopa & Ahern, 2009; Van den Heever et al., 2013). Also, the fact that  
10 nurses feel useful increases their self-confidence, which, in turn, improves the quality of  
11 the care they provide (Biering, 2010; Hopkins et al., 2009; McCloughen et al., 2011;  
12 Schröder, Ahlström, & Larsson, 2006). In terms of perspective taking, nurses already  
13 had high levels before the intervention (Davis, 1983), which shows that they were able  
14 to put themselves in the patients' shoes when they established the TR. In fact, nurses  
15 have always stressed that this is an essential feature of the TR (Dziopa & Ahern, 2009;  
16 Van den Heever et al., 2013; Van Sant & Patterson, 2013). Both the factor "perspective  
17 taking" and the factor "fantasy" belong to the cognitive part of empathy and, for this  
18 reason, they are more sensitive to change. However, those factors related to affective  
19 empathy such as "emphatic concern" and "personal distress" underwent no  
20 modifications because from a theoretical point of view they are less susceptible to  
21 change (Davis, 1983). This is extremely important and confirms the need to create more  
22 specific strategies aimed at improving affective empathy.

## 23 **LIMITATIONS AND STRENGTHS OF THIS STUDY**

1 The findings need to be considered in the context of the following limitations and  
2 strengths. First, the sample was small. For this reason, the comparison of both study  
3 groups was not adjusted for any of the variables with different distributions in the  
4 intervention and comparison groups. However, it took place in two hospitals and two  
5 different units were analyzed. Of course, including more psychiatric units from other  
6 centers would enable the sample to be extended so that the results could be generalized  
7 to contexts other than those that are similar to the ones studied. Secondly, there are also  
8 some sampling limitations. The participants in the study were not randomly selected;  
9 they were, in essence, a purposive sample. However, given the qualitative nature of the  
10 method for the intervention and that the aim was to be able to evaluate the changes and  
11 improve the initial TR in this context, maximum variance sampling gave the greatest  
12 guarantee of using the scientific evidence appropriately in the intervention unit.  
13 Although there was a comparison group, the assignment to this group was not  
14 randomized. Randomization was unfeasible because the intervention could affect the  
15 overall running of the unit. One of the strengths of the intervention, however, was that  
16 the unit where the intervention was carried out and the control unit were at some  
17 distance from each other and employed different nurses. This prevented possible  
18 information biases.

## 19 **IMPLICATIONS FOR NURSING PRACTICE**

20 The findings of the present study have important implications for practice, education,  
21 and research. In the first place, the study is innovative in that it attempts to quantify the  
22 improvement in the therapeutic relationship after an intervention. Without doubt, the  
23 positive results of this study could be the starting point for further, more in-depth work  
24 on this issue, which is of such importance and so necessary for mental-health nursing.  
25 There is a clear need for further research. The sample needs to be extended by including

1 more hospitals and more participants. Besides, patients are an important component of  
2 the TR because they are the recipients of nursing practice. Future research into patients'  
3 perspectives is also crucial. Also, future research should make a qualitative evaluation  
4 of the impact of the changes in nursing practice in the medium term. Likewise, studies  
5 need to be made on whether staff's self-reported changes lead to changes in practice and  
6 ultimately changes in outcome.

7 Whatever the case may be, the study has improved the therapeutic relationship between  
8 nurses and patients in the psychiatric unit where the intervention was carried out and  
9 has had a clear positive effect on the clinical practice of the nurses. It has also  
10 incorporated aspects of evidence-based practice into mental-health nursing. Likewise,  
11 the study reveals the importance of using participatory methods for integrating  
12 knowledge and learning in psychiatric nurses. In this regard, PAR should be promoted  
13 by unit managers as a common method for integrating empirical knowledge into  
14 practice, and strengthening the autonomy and participation of nurses.

## 15 **CONCLUSIONS**

16 Our study has shown that by incorporating evidence based practices into their work,  
17 nurses were able to increase their level of empathy and improve factors that contribute  
18 to establishing a therapeutic alliance with patients. Bearing in mind the importance of  
19 the TR in mental-health nursing, the main conclusions of the study are that clinical  
20 practice itself can be used to improve the TR and that this improvement can be  
21 quantified. We can also confirm that participatory methods such as PAR can be  
22 effectively used to improve the TR, and implement and develop evidence-based  
23 practice.

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