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Working alliance among mental health nurses in Indonesia: A comparative analysis of socio-demographic characteristics

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Abstract

Background: Working alliance between therapist and client in psychotherapy practice has become proven to compensate for a significant difference in various psychotherapy modalities. However, few studies have investigated the structure of alliance in the context of nurses working at mental health hospitals in Indonesia.

Objective: This study aimed to compare the working alliance of mental health nurses according to socio-demographic characteristics.

Methods: A cross-sectional research was performed at the Mental Health Hospital in West Java, Indonesia, as a referral hospital in Indonesia from May to December 2019. The inclusion criteria were nurses with a minimum of one year of working experience and a Diploma III certificate in nursing. Convenience sampling was used to recruit 120 nurses who agreed to join in this study. The working alliance was measured using Working Alliance Inventory-Short Revised-Therapist (WAI-SRT).

Results: The majority of the respondents were female (77.5%), holding a Diploma III degree in nursing (49.17%), having working experience ranged from 11 to 15 years (34.17%), and working at the chronic unit (32.5%). The mean score of the working alliance was 44.46 ($SD = 11.32$). The domain of agreement on goals had a higher mean score (17.65 ± 3.45), followed by the task domain (16.56 ± 5.81) and bond domain (22.10 ± 7.23). There was a significant difference in working alliance according to education level and working experience ($p < 0.05$), while no significant differences in terms of gender and working unit.

Conclusion: Mental health nurses with higher education levels and more vast working experience had higher working alliances. Thus, nurse managers and hospital policymakers should provide Continuous Nursing Education (CNE), working alliance training, and therapeutic strategies for nurses to improve their working alliances. It is also essential to cooperate with nursing schools to include working alliances as learning objectives.

Keywords

working alliance; mental health; Indonesia; psychiatric nursing; hospitals; demography

Working alliance between therapist and client has become proven in psychotherapy practice to compensate for a significant aspect of the difference in result throughout various modalities of psychotherapy (Norcross, 2011). The

practitioner-client relationship is also seen as enormously crucial in mandatory care. To investigate the significance of this relationship, many studies have extended the principle of alliance to the area of compulsory care

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(Menger, 2018; Polaschek & Ross, 2010). In general terms, the working alliance contains numerous elements relevant to the patient-clinician partnership (Flückiger et al., 2018). There are two forms of therapeutic alliance: (1) the Type I alliance, which is characterized by the patient's presumed support for him or her, and (2) the Type II, which consists of teamwork that includes both the patient and the therapist in resolving the patient's difficulty and distress (Luborsky, 1994). In the meantime, the working alliance has three elements: (1) the connection between both the client and therapist, which would be likely to be characterized and experienced in matters of love, faith, respect for one another, and a sense of shared responsibility and vision of the task, (2) the consensus between both the client and therapist on the objectives of psychotherapy, and (3) the commitment between both the client and therapist on the goals of psychotherapy (Bordin, 1994).

Alliance at general hospitals is different from that at mental hospitals. Alliance at psychiatric hospitals has unique characteristics, including the consumers requiring the nurse's expertise in interpersonal relations and empathy (Reynolds & Scott, 1999). Nurses are needed to be prepared for unpredictable situations at mental hospitals (Happell et al., 2003). Similarly, Ward (2013) found that fear is "part of the job and part of the unpredictable nature of caring for people experiencing complex distortions in thinking and behavior." Alliance at mental hospitals, there are three essential characteristics. First, alliance for mental hospital nurses requires adeptness to build an interpersonal relationship because the behavior of consumers is challenging to predict, such as how to communicate with people who are depressed, withdrawing themselves from others, committing suicide, threatening, and behaving aggressively (Del Piccolo & Goss, 2012). Second, there is an unpredictable situation for nurses at work, such as cooperating with patients when suddenly they become threatening because of hearing a voice or hallucination (Jacob & Holmes, 2011). Third, another characteristic is the presence of violent behavior that patients may likely do against nurses. However, although hospitals' settings are different, the alliance is an essential part of nurses' role as facilitators for patients to improve or as "facilitators for the patients to grow" (Hemsley et al., 2012).

Many factors influence alliance at psychiatric hospitals, including environment or workplace climate (Green et al., 2014), professional nurse's attitude, and patient's condition (Zugai et al., 2015). Working environment may take the form of supporting room atmosphere, a clear program, and guarantee of spontaneity are significant components for patient's alliance (Johansson & Eklund, 2006). A study at Canadian Medium-Security Forensic Psychiatric Facility concludes that nurses often distance themselves from ideal service under a particular condition. In contrast, nurse's attitude has been a predictor in a successful relationship between patients and therapists at psychiatric hospitals (Jacob & Holmes, 2011). Research by Mcsherry et al.

(2012) reported that behavior and attitude have a strong relation with successful alliance; for example, making positive comments about the client and greeting the client with a smile. Spiers and Wood (2010) concluded that building an alliance consisted of three non-linear overlapping phases: "establishing mutuality," "finding the fit in reciprocal exchange," and "activating the power of the client." Those are important to prevent negative perception in a team when achieving a target because the three views will provide an in-depth understanding of the actual condition. However, few studies exploring comparing demographics characteristics with the working alliance in mental health hospitals. Thus it becomes clear that while the role of the working alliance in forming clinical outcomes is founded in the literature on psychotherapy, the work alliance has played an important role in other disciplines (Stagg et al., 2019). Understanding the working alliance of mental health nurses and compare it according to socio-demographic characteristics is important, as they offer critical insights into how health care professionals can influence the patient's outcome. Insights gained from comparing working alliances of mental health nurses according to socio-demographic characteristics can also help create and evaluate related strategies for mental health nurses to strengthen working relationships. This study aimed to compare the working alliance of mental health nurses according to socio-demographic characteristics.

Methods

Study Design

Cross-sectional research was conducted at the Mental Health Hospital in West Java, Indonesia, as a referral hospital in Indonesia from May to December 2019.

Samples

All the samples were recruited from all locations in the associated hospital. The inclusion criteria were nurses with a minimum of one year of working experience and a certificate of Diploma III in nursing. The nurses who took leave were not allowed. Convenience sampling was employed, with a total of 120 nurses agreed to join in this study.

Measures

The socio-demographic characteristics included gender (male versus female), level of education (Diploma III, Bachelor, and Master degree with Specialist), duration of work in years, and working units (polyclinic, acute room, chronic room, emergency room, drug addiction, and administration).

The working alliance was measured using Working Alliance Inventory-Short Revised-Therapist (WAI-SRT) for nurses developed by Adam O. Horvath (<http://wai.proffhorvath.com/>). The subscales of the working alliance are goal, task, and bond. This instrument consists of ten items with five Likert-scale from seldom (0) to always (5).

A higher score indicates a higher working alliance. Then, the working alliance level was categorized into low and high; low if score less than overall mean score, high if the score higher than the overall mean score. This instrument has been forward-backward translated and adapted into Bahasa Indonesia. The process includes four steps: forward translation, expert panel back-translation, pre-testing and cognitive interviewing, and final version and documentation (World Health Organization, 2016). This process aimed to get final language versions of the Indonesia instrument and conceptually equivalent for each target country or culture. The Bahasa version of WAI-SRT was subject to a content test (content validity) by a mental health nursing expert (Head of Department of Mental Health Nursing Universitas Padjadjaran Indonesia). The Cronbach's alpha in the current study was 0.947.

Data Collection

The data were collected using questionnaires containing items organized on the basis of variable indicators, which were distributed to the respondents to receive their responses to each item. The steps and the procedure must be compatible with the research questions. The approach used in this study involved the completion of questionnaires on experiences of sensitivity to violence and loyalty to the alliance. These tools took about five to ten minutes to complete. After completing the questionnaires, the participants could return them, and the researchers reviewed their completeness.

Data Analysis

The descriptive analysis and inferential statistics were performed where appropriate. The results or normality

testing showed that working alliance was normally distributed based on the nonsignificant Kolmogorov–Smirnov test. The standard deviation (SD) of the mean was added for continuous data, while frequency and percentage were used for categorical variables. ANOVA and post hoc analysis with Turkey's test adjustments were done to determine differences between demographic characteristics with overall and domain scores of working alliances. A confidence interval of 95 % was used. The *p*-value of less than 0.05 was considered significant. The data were recorded and analyzed using SPSS version 20.

Ethical Consideration

Ethical approval from the ethical committees of mental health hospitals in West Java was obtained prior to data collection (Approval number: 2399/UN6.L/LT/2016). Subsequently, the researcher requested data on nurses working in the hospital under review and told the head nurse of the qualifying requirements. Before completing the questionnaires, the detailed consent form was given to the nurses.

Results

The total number of respondents was 120 psychiatric nurses from mental hospitals in West Java Province, Indonesia. The majority of the respondents were female (77.5%) and holding a diploma III degree in nursing (49.17%). A few of them were master's graduates (10%), and the working experience duration ranged from 11 to 15 years (34.17%). Nurses were working more in the chronic rooms (32.5%) (Table 1).

Table 1 Socio-demographic of nurses by the level of working alliance (*N* = 120)

| Socio-Demographic | Working Alliance | |
|-----------------------------------|----------------------|-----------------------|
| | Low (<i>n</i> = 55) | High (<i>n</i> = 65) |
| Gender | | |
| Male | 12 (44.4) | 15 (55.6) |
| Female | 43 (46.2) | 50 (53.8) |
| Education Level | | |
| Diploma III | 46 (78.0) | 13 (22.0) |
| Bachelor | 8 (16.3) | 41 (83.7) |
| Master degree with Specialist | 1 (8.3) | 11 (91.7) |
| Working Duration, Mean ±SD | 15.56± 7.65 | 18.43± 8.73 |
| Less than ten years | 16 (61.5) | 10 (38.5) |
| 11-15 years | 22 (53.7) | 19 (46.3) |
| 16-20 years | 15 (46.9) | 17 (53.1) |
| More than 20 years | 2 (9.5) | 19 (90.5) |
| Working Unit | | |
| Polyclinic | 4 (66.6) | 2 (33.3) |
| Acute Room | 13 (37.1) | 22 (62.9) |
| Chronic Room | 20 (51.3) | 19 (48.7) |
| Emergency Room | 12 (66.7) | 6 (33.3) |
| Drug Addiction | 4 (44.4) | 5 (55.6) |
| Administration | 2 (15.4) | 11 (84.6) |

The mean score of the working alliance was 44.46 ($SD = 11.32$), with a minimum score was 30, and the maximum score was 50. For each subscale, agreement on goals had

a higher, with a mean of 17.65 ($SD=3.45$), followed by task (16.56 \pm 5.81) and bond (22.10 \pm 7.23) (Table 2).

Table 2 Detail Exploration of working alliance among mental health nurses in Indonesia ($N = 120$)

| Domain | Mean \pm SD | Range |
|---------------|-------------------|---------|
| Overall score | 44.46 \pm 11.32 | 30 – 50 |
| Goal | 17.65 \pm 3.45 | 8 – 20 |
| Task | 16.56 \pm 5.81 | 8 – 20 |
| Bond | 22.10 \pm 7.23 | 15 – 25 |

Table 3 shows differences between socio-demographic characteristics with overall score and domain scores of working alliances. Findings showed a significant difference in the overall score of the working alliance and all subscales, including goal, task, and bond domains, according to the educational level ($p < 0.05$). Nurses with bachelor level had working alliance than those with master

and diploma. In addition, there was a significant difference in working alliance according to working duration ($p < 0.05$), in which nurses who worked 11 to 15 years had higher working alliance than those who worked for more than 16 years or less than ten years. There was no significant difference in working alliance according to gender and working division.

Table 3 Differences in working alliance of mental health nurses by socio-demographic characteristics ($N = 120$)

| | Overall Score Mean \pm SD | t/F (p-value) | Goal Score Mean \pm SD | t/F (p-value) | Task Score Mean \pm SD | t/F (p-value) | Bond Score Mean \pm SD | t/F (p-value) |
|----------------------------------|--------------------------------|------------------|-------------------------------|------------------|-------------------------------|------------------|-------------------------------|------------------|
| Gender^a | | 1.19 | | 2.47 | | 1.85 | | 1.36 |
| Male | 43.91 \pm 10.35 | (0.281) | 17.32 \pm 3.84 | (0.410) | 16.73 \pm 5.23 | (0.535) | 22.74 \pm 7.23 | (0.120) |
| Female | 44.31 \pm 09.42 | | 18.57 \pm 4.72 | | 16.04 \pm 5.81 | | 23.12 \pm 7.23 | |
| Education Level | | 5.32 | | 4.49 | | 4.12 | | 3.79 |
| Diploma III | 42.21 \pm 11.71 | (0.007) | 17.62 \pm 3.84 | (0.041) | 14.61 \pm 4.63 | (0.021) | 20.56 \pm 5.76 | (0.03) |
| Bachelor | 46.82 \pm 12.32 ^b | | 19.04 \pm 4.72 ^b | | 17.24 \pm 6.47 ^b | | 25.78 \pm 6.92 ^b | |
| Master degree with Specialist | 43.16 \pm 11.58 | | 18.42 \pm 4.72 | | 15.11 \pm 5.04 | | 23.05 \pm 7.35 | |
| Working Duration | | 5.49 | | 5.63 | | 5.58 | | 6.18 |
| Less than ten years | 41.56 \pm 11.71 | (0.021) | 16.91 \pm 6.84 | (0.013) | 14.73 \pm 6.53 | (0.01) | 20.56 \pm 5.76 | (0.001) |
| 11-15 years | 47.34 \pm 12.32 ^b | | 19.04 \pm 7.49 ^b | | 16.56 \pm 7.90 ^b | | 25.78 \pm 6.92 ^b | |
| >16 years | 45.78 \pm 11.58 | | 17.35 \pm 5.31 | | 14.53 \pm 6.64 | | 23.05 \pm 7.35 | |
| Working Unit | | 1.98 | | 2.01 | | 1.73 | | 1.76 |
| Polyclinic | 43.31 \pm 11.75 | (0.613) | 16.56 \pm 6.13 | (0.549) | 16.73 \pm 5.23 | (0.549) | 23.60 \pm 5.25 | (0.425) |
| Acute Room | 44.56 \pm 10.32 | | 18.53 \pm 4.32 | | 16.04 \pm 5.81 | | 22.71 \pm 6.62 | |
| Chronic Room | 43.71 \pm 12.05 | | 17.38 \pm 5.47 | | 16.04 \pm 5.81 | | 23.18 \pm 7.14 | |
| Others | 44.32 \pm 11.42 | | 17.45 \pm 4.42 | | 16.04 \pm 5.81 | | 24.73 \pm 6.95 | |

Note: ^astatistics test using independent t-test | ^bresults from post hoc with Turkey's test

Discussion

This study found that the majority of nurses working at mental health hospital has a good working alliance. The importance of the partnership between nurses and patients with mental illness is becoming an important topic (Thurston, 2003). However, conflicting opinions and different conclusions have been stated by Rise and Steinsbekk (2015) that the relationship between patients and nurses reported no significant effects on patients outcome. This is because the workload of psychiatric nurses is very high, and the treatment of mentally ill patients varies in the general hospital (Khalaila & Cohen, 2016; Suro & Weisman De Mamani, 2013). On the

contrary, Roche and Duffield (2010) found that, compared to nurses in general settings, nurses in mental health hospitals had scored higher in nurse-patient relationships, although the burden for engaging with patients was very high. Therefore, it is vital to establish the importance of the alliance between nurses and patients since the alliance has been confirmed to reduce the high burden of psychiatric nurses associated with complete patient dependency on nurses (Suro & Weisman De Mamani, 2013).

There was a significant difference between education level and working alliance. The lower the education level, the lower the working alliance would be. Furthermore, with regard to the partnership in psychiatric hospitals, the standard of education is becoming an important cause.

First, the mental hospital nurses' alliance allows the nurses to develop interpersonal relationships with the clients, primarily to interact with individuals who are depressed, withdraw from others, commit suicide, attack, and behave aggressively (Del Piccolo & Goss, 2012). Second, there is a condition that is utterly uncertain for nurses, such as cooperating with patients when they are unexpectedly threatened by hearing a voice or hallucination (Jacob & Holmes, 2011). Another trait is the involvement of patients with aggressive behavior, which is likely to occur towards nurses. This situation involves a specific competence, in particular through education and training.

Another view is that nurses are trained to face the various characteristics of mentally ill patients. Regardless of how difficult the experience is, it will continue to be professional (Trenoweth, 2003). The study concludes that nursing professionals have the expertise and the ability to assess patient abuse easily and intuitively. Caregivers can minimize the risk of abuse by being able to recognize circumstances and work as a team. Happell et al. (2003) show that nurses appear to leave or resign after abuse from the hospital. Furthermore, nurses in the acute room have been reported to be suffering from distress; they dispute with their families and want to leave their jobs (Daneault et al., 2006). In reality, trauma and violence exposures can adversely impact nurses and even hinder patient involvement.

To cope with the burden, specific training and education in psychiatric hospitals are very important. The pressure is a concern not only at home for the family but also at the psychiatric institution for nurses (Ennis & Bunting, 2013). It leads to a rise in occupational distress for nurses (Khalaila & Cohen, 2016). That's because the distinction is that patients with emotional and mental wellbeing suffer from a lack of productivity and capacity to help. This can be justified by the argument. This is exacerbated by the unique state of the mentally ill patient, such as hallucination, depression, self-isolation, suspicion, and risk to himself and the environment. In short, it can be said that a high level of education to promote a nurse's alliance with the patient would reduce the strain on the nurse (Happell et al., 2003).

Limitations of this study might include the low number of samples. Ideally, to generalize the findings and represent the national study, the samples should include all mental hospitals in all Indonesian provinces.

Conclusion

Our study revealed that the working alliance of mental health nurses in Indonesia was good, including the domains of agreement on goals, tasks, and bonds. The nurses with higher education and more ample working experience showed higher working alliances. Therefore, it is suggested to hospital policymakers and nurse managers to provide Continuous Nursing Education (CNE), working alliance training, and therapeutic strategies for nurses, especially in unpredictable situations. It is also essential to

cooperate with nursing schools to include working alliances as learning objectives.

Declaration of Conflicting Interest

The authors declare no conflict of interest in this study.

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Authors' Contribution

IY and HS contributed equally to the conception and study design, data collection, data analysis, data interpretation, drafted and revised the manuscript. LL contributed to data collection, data analysis and interpretation, and critically drafted and revised the article. All authors agreed with the final version of the article.

Data Availability Statement

The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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