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Shared Perceptions, Different Experiences: Therapeutic Alliance among Healthcare Professionals and Psychiatric Patients

Therapeutic Alliance in Psychiatry

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Abstract

Introduction: The aim of this study is to examine quality levels of the therapeutic alliance between healthcare professionals and hospitalized patients. The research is designed as a cross-sectional study.

Methods: The research was conducted at the Clinical Hospital Center Osijek, specifically at the Clinic for Psychiatry. A total of 184 respondents participated in the study, 132 of whom were hospitalized patients and 53 healthcare workers. All participants were provided timely information regarding the research objectives and methodology, they were given relevant materials, and they gave their consent to participate in the study. The same general demographic questionnaire was used as a research instrument for both healthcare workers and hospitalized patients. In order to assess the quality level of the therapeutic alliance, the *Scale to Assess the Therapeutic Relationship in Community Mental Health Care: STAR* questionnaire was applied, with acquired permission from the authors.

Results: Healthcare professionals rated positive cooperation significantly higher than patients (Fisher's exact test, P=0.01). They also experienced more emotional difficulties in comparison to the domain of positive clinical support for patients (Mann–Whitney U test, P=0.02). However, even though the healthcare professionals gave it a slightly higher grade, there is no significant difference in the overall assessment of the therapeutic alliance between healthcare professionals and patients.

Conclusion: The results of the study indicate that both healthcare professionals and patients perceive a favorable therapeutic alliance. Positive collaboration is rated higher among healthcare professionals than among patients, with professionals potentially experiencing more emotional challenges. On the other hand, patients grade higher the level of excellence, in terms of the positive clinical support they receive, than the healthcare professionals. However, both groups of respondents equally recognize a high level of positive clinical support.

INTRODUCTION

The therapeutic alliance, also referred to as the working alliance, describes the interaction between the healthcare professional and the patient. The therapeutic alliance is considered an important aspect of the therapeutic process and can influence treatment outcomes [1].

Most conceptualizations of the therapeutic alliance are based on Bordin's pantheoretical definition, which includes three elements: the emotional bond established between the patient and the therapist, mutual agreement on the goals of therapy, and the tasks required to achieve them. This definition has enabled extensive empirical research that has repeatedly demonstrated the therapeutic alliance as a consistent predictor of outcomes across different approaches to psychotherapy [2].

In order for a therapeutic alliance to be formed, the patient must have a directed need for recovery, a certain sense of helplessness or inadequacy, and a conscious need to cooperate with the therapist. The therapeutic alliance in psychotherapy differs from a consultative or advisory relationship and from interpersonal influence [3]. The strength of the therapeutic alliance is built through mutual consent to undertaken actions and the maintenance of a collaborative relationship. Indicators of change are the goals achieved through specific tasks, which is made possible by the bond created between the patient and the psychotherapist. The therapeutic alliance is considered an important determinant of psychotherapy success, as it provides a framework for various strategies and methods of the psychotherapist's work [3].

Previous studies indicate that a higher-quality therapeutic relationship is associated with improved recovery of mental health. When patients feel understood, respected, and supported, they are more likely to actively engage in the therapeutic process, follow treatment recommendations, and experience positive changes in their well-being [4, 5]. Assessing the quality of the therapeutic alliance between patients and healthcare professionals has become increasingly important for examining the outcomes and effects of healthcare services aimed at improving mental health [6, 7].

Some theorists have defined the quality of the alliance as "the most important integrative variable" of therapy, and it currently seems possible to claim that the quality of the alliance between patient and therapist is a consistent predictor of positive clinical outcomes, regardless of the psychotherapeutic approach or assessment criteria used [8, 9]. There are numerous validated instruments commonly used to assess the therapeutic alliance in psychotherapy research. Among the most well-known are: Working Alliance Inventory (WAI), Helping Alliance Questionnaire (HAq-II), California Psychotherapy Alliance Scales (CALPAS), Agnew Relationship Measure (ARM), Vanderbilt Therapeutic Alliance Scale (VTAS), and Kim Alliance Scale (KAS) [8]. These instruments assess different perspectives of the therapist–patient relationship, with their main aim being to examine the level of quality and strength of the alliance. Commonly assessed dimensions include agreement on goals, agreement on tasks, bond or relationship quality, collaboration and engagement, communication and feedback, and the working alliance [8].

Feedback obtained from evaluating the quality of the therapeutic alliance empowers therapists to build strong therapeutic relationships, enhance patient engagement, improve treatment planning, and make informed decisions that contribute to positive treatment outcomes. Good alliance quality enriches the therapeutic process and facilitates a collaborative and supportive environment for patients to achieve their therapeutic goals [10].

The aim of this study was to examine the quality of the therapeutic alliance between healthcare professionals and hospitalized patients at the Psychiatric Clinic, assessing cooperation, emotional difficulties, and clinical support from both perspectives. The study contributes to understanding professional–patient relationships in psychiatry and highlights the alliance as a predictor of treatment outcomes.

METHODS

Study design: This research was designed as a cross-sectional study [11].

Setting and samples: A total of 184 participants were included: 132 hospitalized patients (80 men and 53 women) and 53 healthcare professionals (10 men and 42 women). Inclusion criteria for hospitalized patients were: age ≥18 years and hospitalization in one of the aforementioned departments, regardless of whether it was the first or a repeated hospitalization. Inclusion criteria for healthcare professionals were: age ≥18 years and employment in one of the aforementioned departments, regardless of total years of work experience.

Measurements and instruments: A general demographic questionnaire was used for both healthcare professionals and hospitalized patients, including nine items: age, sex, marital status, years of marriage, place of residence, housing status, education, employment status, and occupation. To assess the quality of the therapeutic alliance, the "Scale to Assess the Therapeutic Relationship in Community Mental Health Care: STAR" questionnaire was applied [12]. Permission to use the instrument was obtained from the original author. The instrument consists of 12 items for healthcare professionals (STAR-C) and 12 items for hospitalized patients (STAR-P). All participants rated items on a 5-point Likert scale ranging from 0 to 4 (0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Very often). The total score ranges from 0 to 48, with higher scores indicating better quality of the therapeutic alliance. Subscale ranges are as follows: Positive collaboration: 0–24; Positive clinician input: 0–12; Non-supportive clinician input: 0–12; Emotional difficulties: 0–12.

Data collection/procedure: Data were collected by administering the demographic questionnaire and STAR scales to both groups of participants during hospitalization or employment at the Clinic.

Ethical considerations: Permission to use the STAR questionnaire was obtained from the original author. All participants were informed in a timely manner about the objectives and procedures of the study, received an information sheet, and provided written informed consent prior to participation. The research was approved by the Ethics Committee of the University Hospital Centre Osijek (R1-318-2/2023) and by the Ethics Committee of the Faculty of Dental Medicine and Health Osijek (2158/97-97-10-23-34). The study was conducted in accordance with all applicable guidelines to ensure proper conduct and the safety of participants, including the principles of Good Clinical Practice, the Declaration of Helsinki, the Health Care Act of the Republic of Croatia, and the Act on the Protection of Patients' Rights of the Republic of Croatia. Participant anonymity and confidentiality were strictly maintained.

Statistical data analysis: Categorical data were presented as absolute and relative frequencies. Differences in categorical variables were tested using the χ^2 test or Fisher's exact test where appropriate. The normality of distribution of numerical variables was assessed with the Shapiro–Wilk test. Due to non-normal distribution, data were described using median and interquartile range. Differences in continuous variables between two independent groups were tested with the Mann–Whitney U test. All *P*-values were two-tailed, with the level of significance set at α=0.05. Statistical analyses were performed using MedCalc® Statistical Software version 20.218 (MedCalc Software Ltd, Ostend, Belgium; https://www.medcalc.org; 2023).

RESULTS

The study included 184 participants: 52 (28.3%) healthcare professionals and 132 (71.7%) hospitalized patients. Among healthcare professionals, 42 (81.0%) were women, with a median age of 41 years (range 24–63). Most lived in the city (n = 43,83.0%) and in their own home/apartment (n = 43,82.0%), and 24 (46.0%) had secondary or higher education. Among patients, 80 (61.0%) were men, with a median age of 50 years (range 18–78). Fifty-nine (44.7%) were married, and 79 (59.8%) lived in their own home/apartment.

Therapeutic alliance – STAR questionnaire

Healthcare professionals' responses (STAR-C) indicated frequent positive collaboration: 34 (45.4%) reported very often listening to patients, 40 (76.9%) often perceived good interaction, and 35 (67.3%) reported shared trust. Patients' responses (STAR-P) showed that 39 (29.5%) very often had a trusting relationship with professionals, and 72 (54.5%) often discussed personal goals and treatment with them.

Domain comparisons

No significant difference was observed in Positive Collaboration scores between healthcare professionals and patients, although professionals rated it as excellent more frequently than patients (Fisher's exact test, *P*=0.010) (Table 1).

Table 1. Distribution of respondents according to the assessment of positive collaboration between healthcare professionals and patients

Positive collaboration	Healthcare professionals n (%)	Patients n (%)	Total n (%)	*P*-value
Good (5–12)	0 (0.0)	14 (10.6)	14 (7.6)	
Excellent (13–24)	52 (100.0)	118 (89.4)	170 (92.4)	0.010
Total	52 (100.0)	132 (100.0)	184 (100.0)	

Note: *Fisher's exact test

Emotional difficulties (professionals) were rated significantly higher than Positive Clinician Input (patients) (Mann–Whitney U test, *P*=0.020) (Table 2).

Table 2. Difference in emotional difficulties among healthcare professionals and positive clinical support among patients

	Median (IQR)	Difference (95% CI)	*P*-value*
Emotional difficulties among healthcare professionals	9 (8–10)	–1 (–1 to 0)	0.020
Positive clinical support among patients	8 (6–9)		

Note: *Mann–Whitney U test

Similarly, Fisher's exact test showed that professionals rated Emotional Difficulties as good more often than patients rated Positive Clinician Input (*P*=0.030) (Table 3). No significant differences were observed between Positive Clinician Input (professionals) and Non-supportive Clinician Input (patients).

Table 3. Distribution of respondents according to the assessment of emotional difficulties among healthcare professionals and positive clinical support among patients

Assessment	Emotional difficulties among healthcare professionals n (%)	Positive clinical support among patients n (%)	Total n (%)	*P*-value*
Poor (0–3)	0 (0.0)	2 (1.5)	2 (1.1)	
Good (4–9)	39 (75.0)	72 (54.5)	111 (60.3)	0.030
Excellent (10–12)	13 (25.0)	58 (43.9)	71 (38.6)	
Total	52 (100.0)	132 (100.0)	184 (100.0)	

Note: *Fisher's exact test

Overall therapeutic alliance

Total STAR scores ranged from 0 to 48. Although professionals gave slightly higher scores, no significant difference was found between groups (Table 4).

Table 4. Difference in the overall assessment of therapeutic alliance

	Median (IQR)	Difference (95% CI)	*P*-value*
Healthcare professionals	37 (34–39)	–1 (–3 to 1)	0.230
Patients	35 (31–40)		

Note: *Mann–Whitney U test

Overall, 89 (48.4%) participants rated the alliance as good and 86 (46.7%) as excellent, with no significant differences in distribution between groups (Table 5).

Table 5. Distribution of respondents according to the overall assessment of therapeutic alliance

Overall assessment	Healthcare professionals n (%)	Patients n (%)	Total n (%)	*P*-value*
Poor (12–24)	0 (0.0)	9 (6.8)	9 (4.9)	0.110
Good (25–36)	24 (46.2)	65 (49.2)	89 (48.4)	
Excellent (37–48)	28 (53.8)	58 (43.9)	86 (46.7)	
Total	52 (100.0)	132 (100.0)	184 (100.0)	

Note: *χ^2 test

DISCUSSION

The therapeutic alliance serves as a critical factor influencing treatment outcomes, as it shapes the quality of interaction and collaboration between healthcare professionals and patients. The present study confirmed that the overall quality of the therapeutic alliance among hospitalized psychiatric patients and healthcare professionals is generally high, consistent with prior findings [12, 13].

The Positive Collaboration subscale of the STAR questionnaire, reflecting mutual trust, shared goals, and openness, emerged as a key element in the therapeutic alliance. This aligns with previous research emphasizing that effective collaboration fosters a strong working relationship, promotes patient engagement, and facilitates the achievement of therapeutic objectives [14, 15]. In this study, patients frequently reported discussing personal treatment goals with healthcare professionals, underscoring the relevance of collaborative goal setting in enhancing patient motivation and active participation [19, 20]. These findings suggest that structured collaboration may contribute to improved adherence and treatment outcomes.

The Positive Clinician Input subscale highlights the importance of clinician behaviors, including support, respect, and empathetic listening. Results indicate that healthcare professionals provide high levels of positive clinical support, consistent with previous studies linking clinician responsiveness to patient satisfaction and therapy effectiveness [12, 28, 29]. This reinforces the notion that clinicians' emotional engagement and expression of positive emotions can enhance treatment outcomes, especially in patients with limited social support [30, 36].

Emotional difficulties among healthcare professionals, such as compassion fatigue, burnout, vicarious

traumatization, and challenges in maintaining appropriate emotional boundaries, are recognized as potential factors that may interfere with the therapeutic alliance [22–27]. In this study, healthcare professionals reported relatively low levels of emotional difficulties, suggesting that positive emotions and effective coping strategies are maintained, which likely supports the quality of the therapeutic alliance. This finding highlights the potential for interventions aimed at fostering positive emotions in clinicians to further enhance alliance quality and treatment outcomes [28–30].

The results also emphasize the broader implications of a strong therapeutic alliance for patient care. A robust alliance has been consistently shown to predict overall patient satisfaction, symptom reduction, improved functioning, and adherence to both psychotherapeutic and pharmacological interventions [31–35]. Moreover, for patients lacking social support, the therapeutic alliance can partially compensate for these deficiencies, illustrating its unique role in enhancing treatment outcomes in vulnerable populations [36].

Limitations of the study include its cross-sectional design, which limits causal inference, and the reliance on self-reported measures, which may be influenced by social desirability. Future research should consider longitudinal designs to examine the temporal dynamics of the therapeutic alliance and incorporate multi-method assessments, including observational and clinician-rated measures, to provide a more comprehensive understanding. Additionally, exploring interventions aimed at enhancing clinicians' emotional well-being and positive emotions may offer practical strategies to strengthen therapeutic alliances and optimize patient outcomes.

In clinical practice, these findings underscore the importance of fostering positive collaboration, clear communication, and mutual trust. Training programs for healthcare professionals should emphasize skills in goal setting, empathetic engagement, and emotion management, which may enhance both alliance quality and treatment efficacy. In educational settings, integrating these competencies into curricula could prepare future clinicians to establish and maintain strong therapeutic alliances, ultimately improving mental health outcomes.

CONCLUSIONS

The study indicates that both healthcare professionals and hospitalized patients perceive a positive therapeutic alliance, with consistent assessments across groups. Higher levels of collaboration and clinical support suggest that a strong therapeutic alliance may serve as a curative predictor, enhancing patient engagement, adherence to treatment, and overall treatment effectiveness. Emotional challenges among healthcare professionals do not appear to compromise the quality of the alliance, highlighting the potential of a well-maintained therapeutic relationship to positively influence therapeutic outcomes.

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Author Contributions

Conceptualization, D.K., Š.M. and I.B.; Methodology, D.K., I.J., M.M. and A.M.; Software, D.K., I.J. and M.M.; Validation, D.K., Š.M. and I.B.; Formal Analysis, D.K., M.M. and I.B.; Investigation, D.K., I.J.; Resources, D.K.; Data Curation, D.K., A.M.; Writing – Original Draft Preparation, D.K.; Writing – Review & Editing, D.K., I.J., A.M., Š.M., M.M. and I.B.; Visualization, D.K., I.J. and I.B.; Supervision, Š.M. and I.B.

Declaration of Conflicting Interest:

The author declares no conflict of interest.

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