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Mutuality in nurse-caregiver relationships in pediatric nursing: A concept analysis

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ABSTRACT

Problem: Mutuality is often used in literature in the context of family-centered care and therapeutic relationship building. A therapeutic relationship is necessary to deliver family-centered care, strengthen family health and function, increase patient and family satisfaction, reduce anxiety, and empower decision-makers. Despite mutuality being such an important concept, it is not well defined in the literature.
Eligibility criteria: The Walker and Avant method for concept analysis was used. The databases Medline, PSYCHInfo, CINHAL and Nursing & Allied Health were searched for texts in English from 1997 to 2021 using specific search terms.
Sample: Of the 248 results, 191 articles were screened and 48 met inclusion criteria.
Results: Mutuality was found to be a process of dynamic reciprocity whereby the partners contribute uniquely to their shared goals, values, or purposes.
Conclusion: Mutuality is an important aspect of family-centered care and is used throughout nursing and advanced nursing practice.
Implications: The concept of mutuality should be incorporated into family-centered care policies, as without it, family-centered care cannot be established. Further research should be done to develop methods or educational techniques to establish and maintain mutuality in advanced nursing practice.

Introduction

In the context of family-centered care and therapeutic relationship building, *mutuality* is a concept that lacks a standard definition (Curley, 1997; McCarthy & Freeman, 2008; Mikkelsen & Frederiksen, 2011). Mutuality, a cornerstone of family-centered care and therapeutic relationships, contributes to strengthening family health and function, increasing patient and family satisfaction, reducing anxiety, and empowering the decision-makers (Byczkowski et al., 2016; McCarthy & Freeman, 2008; Mikkelsen & Frederiksen, 2011; Wennberg-Capellades et al., 2021). Mutuality is particularly important in pediatric nursing. Families have high anxiety levels when seeking care for their child at a hospital (Embong et al., 2020). Developing mutuality with families helps reduce their anxiety as they feel like a partner in their child's care, empowers them to participate in their child's care, increases their ability to cope with the hospitalization and increases their satisfaction with the care received (Byczkowski et al., 2016; McCarthy & Freeman, 2008; Mikkelsen & Frederiksen, 2011; Wennberg-Capellades et al., 2021). Each year millions of children are hospitalized worldwide (Kanecki et al., 2022).

Mutuality is often referenced in nursing literature concerning family-centered care and therapeutic relationships despite the lack of a clear, accepted definition. In a review of the literature, four concept analyses focusing on mutuality were identified (Brown, 2016; Curley, 1997; Henson, 1997; Potter-Dunlop, 2017). Only two, completed in 1997, discussed mutuality of the nurse-caregiver relationship within pediatric nursing practice (Curley, 1997; Henson, 1997). Since that time, pediatric nursing care has become more complex with new treatments, busier departments and innovative technology that impacts the relationship with families (Cohen et al., 2011; Taylor, 2006; Thimbleby, 2013). Satisfaction with care has become an important indicator of hospital care quality as it affects the family's likelihood of adhering to treatment guidelines, recommending the care facility, and returning for care at that facility (Andrew et al., 2014; Byczkowski et al., 2013; Ekwall

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et al., 2009). Establishing mutuality is essential for patient satisfaction (Byczkowski et al., 2016). Nurses know that relationship building is an important part of nursing care, and not being able to form adequate relationships contributes to nurse burnout. Having a clarified definition of mutuality and shifting the focus back to the roots of nursing, relationships, will contribute to improving nursing practice (Rozo et al., 2017). These reasons support the need for a concise and current concept analysis of mutuality within the nurse-caregiver relationship in a pediatric nursing context. This review aims to provide an up-to-date analysis of this concept, see how the use of the concept has changed over time, and discuss the practice implications for advanced practice nurses worldwide.

Methods

This concept analysis was conducted using the Walker and Avant (2011) method. Eight steps were followed: (1) choosing a concept, (2) determining the purpose of the analysis, (3) identifying all uses of the concept, (4) defining the attributes, (5) identifying a model case, (6) identifying a borderline, related and contrary case, (7) identifying antecedents and consequences, and (8) defining empirical referents (Walker & Avant, 2011; Weaver & Mitcham, 2008).

The databases Medline, CINHAL, PSYCHInfo and Nursing & Allied Health were searched using database and search terms. The following terms and their variations were used: nurse-patient relations, nurses, patients, client, family nursing, family-centered care, patient-centered care, professional family/patient relations, interpersonal relations, interpersonal communication, and therapeutic relations. These search terms were combined with the term mutuality. The term mutuality was used instead of a truncated version because "mutual" is used too frequently in texts and failed to yield relevant results during the preliminary search. The search was limited to text in English from 1997 to present, as 1997 was the year the last comprehensive concept analysis on the subject was completed. Any text that included a definition of the concept of mutuality in the context of nurse-patient/family relationships was included. Any additional relevant texts found outside of the search or within the references of the found articles were included as well. Articles were excluded if the mutuality discussed concerned mutuality between personal caregivers, if the mutuality discussed was not nurse-family focused, or there was no explicit use of the word mutuality. Citation management and data extraction were done using a Microsoft Word document.

Results

In total 48 articles were included in this concept analysis. The search yielded 248 results, 244 from databases and four additional studies found by hand-searching the references of the included articles. Fifty-seven duplicates were removed, and out of the remaining 191 articles screened, 48 met inclusion criteria. See Fig. 1 for Flow Diagram.

Uses of the concept

Mutuality is a concept that underlies many nursing theories. The theory of human relatedness, created in 1993 but included here as several texts used its definition, describes mutuality as "the experience

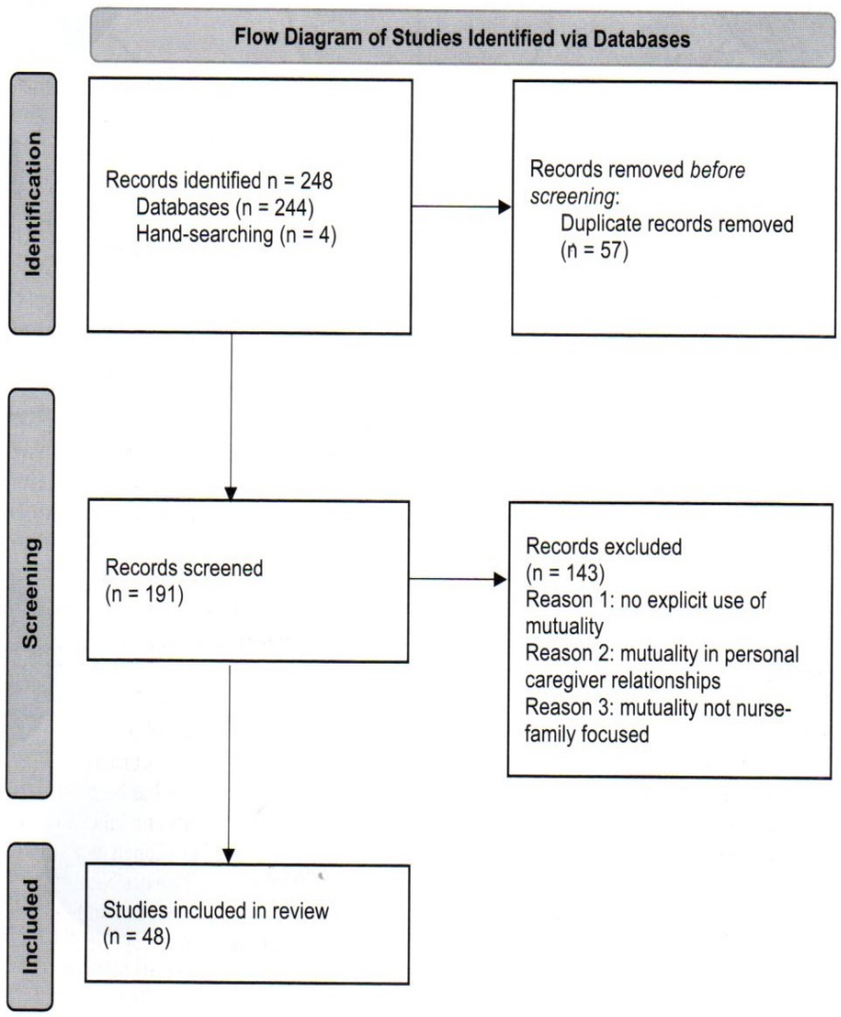

Fig. 1. Flow Diagram of Studies Identified via Databases.
Adapted from PRISMA flow diagram (Page et al., 2021).

of real or symbolic shared commonalities of visions, goals, sentiments, or characteristics, including shared acceptance of differences, that validate the person's world-view" (Hagerty et al., 1993, p.294). Peplau's theory of interpersonal relations describes mutuality as an essential part of the therapeutic relationship and is characterized by the mutual sharing of information and shared decision-making toward mutual goals (Wills, 2010). Habermas's intersubjective mutuality from the communicative action theory is defined as reciprocal understanding, shared knowledge, and mutual trust that relies on comprehensibility, truth, sincerity, and legitimacy (Gingrich, 2006; Porr, 2005; Sumner, 2001).

In the previous concept analyses, Henson described mutuality as a "connection with or understanding of another that facilitates a dynamic process of joint exchange between people" (Henson, 1997, p.80). It was characterized by an "action that is shared..., a sense of moving toward a common goal, and a sense of satisfaction for all involved (Henson, 1997, p.80). Curley defined mutuality as a "synchronous, co-constituting relationship that stimulates the process of personal becoming" (1997, p.210). Brown argued that mutuality and social capital needed to be viewed together but did not offer an original definition of either (2016), and Potter-Dunlop (2017) used the definition Hagerty et al. (1993) provided.

Since the concept analysis was published in 1997, uses of the term mutuality have changed slightly. Within nursing, terms used to describe mutuality are presented in Fig. 2. The most commonly used descriptors are individuality, respect, trust, reciprocity, and shared goals and values (Cegala, 2005; Conger, 1997; Curley, 1997; Dennis & Neese, 2000; Donnelly, 2013; Forsyth et al., 2011; Gunther, 2001; Hartrick, 1997; Hedelin, 2003; Heliker & Nguyen, 2010; Henson, 1997; Holopainen et al., 2019; Jeon, 2004; Jerzak, 2001; Lane & Serafica, 2013; Mikkelsen & Frederiksen, 2011; Nowak et al., 2018; Paterson et al., 2012; Patusky, 2002; Sanders et al., 2014; Sinkfield-Morey, 2018; Vatne & Hoem, 2008; Wills, 2010). The focus remains largely on the dynamic nurse-family/patient relationship as evidenced by the following

Fig. 2. Uses of Mutuality: A Concept Map.

definitions of mutuality: a dynamic interaction characterized by intimacy, contact and understanding (Sahlsten et al., 2007); a responsive relationship that is a negotiated process between nurse and patient (Tarlier, 2004); interdependence and influence in the relationship with others (HaCohen, 2019; Hedelin, 2003); and a relationship with fluctuating give and take (Falk-Rafael, 2001). However, recent definitions have emphasized the importance of being present and available. Holopainen et al. (2019) and Spiers and Wood (2010) define mutuality as when presence and recognition transform into the availability of both individuals. They have also focused more on treating each other with dignity and respect (Heliker & Nguyen, 2010; Lane & Serafica, 2013; Mikkelsen & Frederiksen, 2011).

Within pediatric nursing, mutuality discussed in the literature focused on the caregiver and the child to a much lesser extent (Curley, 1997; Mårtenson & Fägerskiöld, 2007). Within pediatric nursing, family-centered care means that the nurse must provide care to the whole family unit rather than just the child (Registered Nurses' Association of Ontario, 2015). With a child, it is essential to facilitate a connection and maintain respect. Mutuality with a child is described as pleasant behaviour, sharing of feelings, and reciprocal interactions (Mårtenson & Fägerskiöld, 2007). With caregivers, it is more complex as the family needs to be seen with respect and dignity and as equal partners in their child's care. The caregivers' competency in caring for their child needs to be acknowledged and supported (O'Halloran & Doody, 2013). Developing this mutuality will support the nurse caring for the child and maintain the family's wellness (Curley, 1997). Based on the current uses of the concept, an updated definition of mutuality could be a process of dynamic reciprocity whereby the partners contribute uniquely to their shared goals, values, or purposes.

Defining attributes

Mutuality's defining attributes include respect, trust, the sharing of goals/values, and recognizing individuality and the unique and dynamic contributions of both the nurse and caregiver (Curley, 1997; Gunther, 2001; Henson, 1997; Potter-Dunlop, 2017). Respect is an essential part of healthy relationships and refers to valuing the thoughts and feelings of others (Curley, 1997). Without valuing the other person's contributions, it is impossible to be open to their input or trust the information being shared. Respect and trust are closely intertwined, as trust cannot be developed without respect (Gonzalez, 2017). Trust refers to being able to rely on the character, ability, strength or truth of someone (Gonzalez, 2017). It is essential for establishing mutuality, and therapeutic relationships (Gonzalez, 2017). To establish trust, there must first be an openness and willingness to trust (Gonzalez, 2017). In nursing practice, the nurse must respect the patient's and family's beliefs, values and opinions. In return, the patient and family must respect the nurse as a professional with skills and valuable input (Curley, 1997; Gonzalez, 2017). Once respect has been established, the family must develop trust in the nurse. They need to be confident that the nurse is working in their best interest and being honest (Lane & Serafica, 2013). In turn, the nurse must trust the patient and the family that they are sharing accurate information about the patients' health condition, factors that may impact it and their engagement with the care plan.

Sharing goals/values refers to establishing common ground concerning the patient so that the nurse and caregiver can work together to achieve optimal patient health outcomes (Heliker & Nguyen, 2010; Sahlsten et al., 2007). It is the important connection point for the nurse and the caregiver on which the foundation of the relationship is built (Lane & Serafica, 2013). Most commonly, the shared goal is the improvement of the patient's health condition; however, the way of attaining that goal may differ between the nurse and caregiver (Spiers & Wood, 2010). Establishing a mutually agreed upon way to meet their shared goal is important when establishing mutuality (Henson, 1997). For example, the Jehovah's Witness religion prohibits the acceptance of blood products (Park et al., 2019). Though the patient, family, and the nurse wish to improve the patient's health condition, the nurse must respect the patient and family's beliefs and work with the care team to establish a care plan that encompasses their beliefs.

The nurse and caregiver are unique individuals, and each contributes differently to the relationship and the common goal. These contributions can vary depending on the patient's or caregiver's needs, and it is not always an equal exchange (Henson, 1997; Sahlsten et al., 2007). Nursing professional boundaries must be maintained and the nurse is responsible for building and stabilizing the relationship (Henson, 1997; Sahlsten et al., 2007). The give and take in the relationship changes with the participation and autonomy of the caregiver. It is a dynamic process. For example, at the beginning of the relationship, the family may not have enough information about the health condition and how to care for the patient to participate fully. The nurse must contribute more to build the caregiver's confidence and competency in caring for the patient. The caregiver and the nurse both contribute to the relationship in unique and important, but not equivalent ways (Curley, 1997; Gunther, 2001; HaCohen, 2019; Hedelin, 2003; Henson, 1997; Nowak et al., 2018; Paterson et al., 2012; Sahlsten et al., 2007; Sanders et al., 2014).

Model case

Jack, a 6-year-old boy, and his mother Julie, present to a pediatric emergency department because Jack is having abdominal pain. Jack is diagnosed with appendicitis. After the diagnosis, the nurse, Erin, goes into the room to see how the family is coping with the news. Julie appears anxious, she is pacing the room, and her shoulders are tense. Erin sits down with Julie and asks how she is feeling. She explains that she is nervous about the operation and leaving Jack alone. Erin offers the option to stay with Jack until he gets to the operating room and assures Julie that parents are not visitors and she is welcome to stay with Jack for the whole hospital stay. Erin then explains to Julie that she needs to start an intravenous (IV) before surgery and that there are some techniques, she can use to decrease anxiety and pain related to the IV insertion. Erin explains comfort positioning and the distractions available and asks Julie what she thinks would work best for Jack out of the options provided. After drawing on Julie's expertise as the mother, Erin discusses the IV insertion with Jack using age-appropriate language. She offers him the same options she presented to Julie. Erin then uses her expertise and the shared decision-making process to insert the IV in a minimally distressing environment.

This case contains all the attributes of mutuality. Erin and Julie approach each other with respect, with Erin initiating the interaction. Erin asks Julie what is important to her. Together they make a plan that incorporates their shared values, reducing anxiety in the parent and the child. Erin recognizes that Julie has unique expertise about her child's needs and Julie recognizes Erin as having expertise in nursing care. Julie trusts Erin with the care of her child and Erin trusts Julie to know her child best.

Borderline case

The previous example would be considered a borderline case if when Julie expressed anxiety about the operation and leaving Jack, Erin did not offer for Julie to go with Jack to the operating room but instead validated Julie's fears and continued the conversation with active listening. There is no exploration of a mutual solution that shares the nurse's and caregiver's values.

Related case

The previous example would be a related case if when Erin went to insert the intravenous (IV), she did not explain the importance of comfort positioning and distraction in reducing anxiety and pain. Erin assumed that Julie had prior knowledge and would understand why comfort positioning and distraction were needed without further explanation. This would be using collaboration, assuming the mother has adequate knowledge to collaborate effectively rather than mutuality.

Contrary case

Erin enters the room and says, "I need to start an IV for surgery." When Julie expresses concerns about the IV start, Erin says, "I need to do this now so he can get his pre-operative antibiotics." She then starts the IV. She doesn't acknowledge Julie's anxiety, doesn't offer any opportunity for shared decision-making and doesn't approach the encounter respectfully.

Antecedents

There are several antecedents to establishing mutuality. First, there is a need to be addressed (Curley, 1997; Gunther, 2001; Henson, 1997; Mårtenson & Fägerskiöld, 2007; Potter-Dunlop, 2017; Sahlsten et al., 2007). This means that there is a problem present that affects both the nurse and the caregiver. For instance, in the example above, the need to be addressed involves family-centered pre-operative care. The nurse needs to start an IV and administer antibiotics before the surgery. To address this need, the nurse and caregiver need to have developed a style of communication they are both comfortable with (Curley, 1997; Gunther, 2001; Henson, 1997; Mårtenson & Fägerskiöld, 2007; Potter-Dunlop, 2017; Sahlsten et al., 2007). This means that they can exchange information clearly and understandably while expressing their needs and feeling heard (Kourkouta & Papathanasiou, 2014). The nurse and caregiver must be available and present in the encounter (Hedelin, 2003; Holopainen et al., 2019, Spiers & Wood, 2010). This is part of communicating effectively. If both parties are distracted, information is not exchanged clearly. If the nurse and family cannot communicate effectively, it will be difficult to establish trust, address needs, or establish mutual goals. The nurse and caregiver must also have the desire and openness to understand the other's perspective (Curley, 1997; Gunther, 2001; Henson, 1997; Mårtenson & Fägerskiöld, 2007; Potter-Dunlop, 2017; Sahlsten et al., 2007). Without this, trust cannot be established. Finally, both the nurse and caregiver must participate in the relationship. One person cannot establish mutuality. (Curley, 1997; Gunther, 2001; Henson, 1997; Mårtenson & Fägerskiöld, 2007; Potter-Dunlop, 2017; Sahlsten et al., 2007).

Consequences

Implementing mutuality in the nurse-caregiver relationship increases the family's ability to cope with illness and preserves their dignity. When the nurse includes the family in the child's care and incorporates what is important to them, caregivers have an increased sense of control. This empowers them to actively participate in their child's care (Gunther, 2001; Henson, 1997; Jack et al., 2005; Potter-Dunlop, 2017; Zoffmann & Kirkevold, 2005). When the caregivers are involved in the decision-making process and making the care plan, they are more likely to adhere to it (Byczkowski et al., 2013). They are also more invested in the plan of care since they were partners in its development and ensured it would fit with their preferences, values and beliefs. This leads to decreased length of stay in the hospital since caregivers actively participate in the care and build their confidence in managing the illness. This, in turn, leads to better management at home and decreases readmissions. (Curley, 1997; Gunther, 2001; Zoffmann & Kirkevold, 2005). Establishing mutuality also increases family satisfaction with the care provided (Byczkowski et al., 2013). Furthermore, mutuality increases nurse satisfaction with the care provided (Curley, 1997; Gunther, 2001). Inability to establish mutuality can increase nurses' stress levels and lead to emotional exhaustion. Both of which play a role in nurse burnout. Evidence suggests that establishing mutuality with families may decrease moral distress, role strain and nurse burnout (Curley, 1997; Gunther, 2001). See Fig. 3 for a visual representation of the antecedents, attributes and consequences of mutuality.

Empirical referents of mutuality

There are very few objective signs of mutuality, and no tool used to measure the mutuality in nurse-caregiver relationships. To date, mutuality between the nurse and caregiver has been explored through a qualitative lens. The presence of mutuality is subjective, and a qualitative approach allows an in-depth exploration of the experiences of the nurse and caregiver. Objectively, the positioning (eye level), body language (open posture and eye contact) and environment (few distractions) of both participants can show that both individuals are relaxed, comfortable and with someone they trust (Mårtenson & Fägerskiöld, 2007). As for conversations, words of agreement, the give and take of ideas, expressed satisfaction, and a friendly tone of voice can be indicators that mutuality is present (Curley, 1997; Heliker & Nguyen, 2010; Henson, 1997; Mårtenson & Fägerskiöld, 2007). However, there is a need to develop an objective tool for evaluating mutuality in nurse-caregiver relationships (Curley, 1997). There is a Mutuality Scale that measures the mutuality between patients and their personal caregivers (*i.e.* spouses) (Archbold et al., 1990; Pucciarelli et al., 2016). This scale was developed in 1990 (Archbold et al., 1990) and has been used in the context of examining mutuality's impact on patient and caregiver outcomes (Pucciarelli et al., 2016). For instance, studying the impact of mutuality on caregiver stress when caring for an older adult (Archbold et al., 1990) or studying the impact of mutuality on patients' and caregivers' quality of life (Pucciarelli et al., 2016). It is composed of a 15-item scale, with items including "how often do you laugh together?" and "how often does he or she [the patient] help you [the caregiver]?"

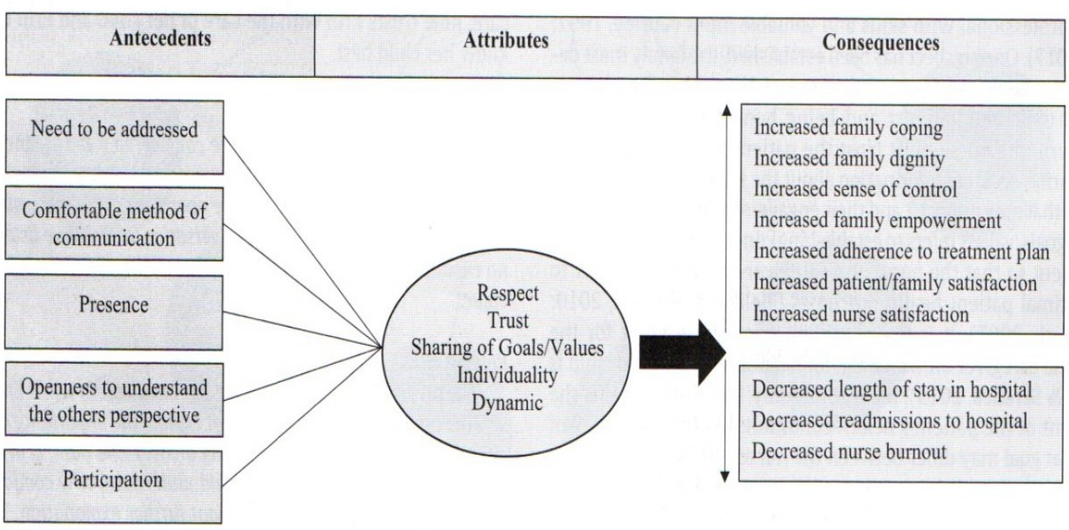

Fig. 3. Visual Representation of the Antecedents, Attributes and Consequences of Mutuality.

(Archbold et al., 1990; Pucciarelli et al., 2016). While the items on this scale are not translatable to the nurse-caregiver relationship, there are shared theoretical values behind the scale such as "shared values" and "reciprocity" (Pucciarelli et al., 2016). A new or adapted scale could be developed that examines the impact of mutuality on nurse and patient/family outcomes such as nurse burnout or patient/family satisfaction similar to this scale.

Implications to practice

Based on the results of the analysis, mutuality can be represented by using the theory of interpersonal relations (Peplau., 1997). Mutuality is an aspect of this theory as it relates to forming relationships with the patient and family. Peplau describes three phases of the nurse-patient relationship: the orientation phase, in which the nurse initiates a relationship; the working phase, in which the patient and nurse both work meaningfully toward a shared goal and the relationship changes based on the needs of the patient and family; and the termination phase, where the nurse-patient relationship is terminated (Peplau., 1997). All three stages require mutuality to be established to obtain therapeutic outcomes. With a clearer definition of mutuality within the nurse-caregiver relationship, Peplau's theory of interpersonal relations could offer a framework from which future research could be developed and from which practice could be based.

For instance, mutuality is a concept that advanced practice nurses (APN) worldwide use in every aspect of their practice because it is the basis for building therapeutic relationships and delivering family-centered care. It can be employed in the key competencies areas of an APN: direct patient care, health system optimization, education, leadership, consultation and collaboration (Canadian Nurses Association, 2019; International Council of Nurses, 2020). An APN may use the theory of interpersonal relations to guide their practice while working within their key competencies. For example, an APN working in pediatric palliative care provides *direct patient care* when *consulting* with a new case. The APN will work within the orientation phase when developing a therapeutic relationship using mutuality to establish mutual goals for providing the child with the best quality of life. With those mutual goals established, the APN will *collaborate* with other healthcare team members to reach those goals. The APN can also act as a *leader* for other nurses working with that family by modelling and *educating* on mutuality to ensure the nurse and family are satisfied with their care. The APN can provide the theory of interpersonal relations (Peplau., 1997) as a framework to help guide other nurses' practice. Nurse satisfaction, as discussed previously, can decrease moral distress and burnout and can lead to increased nurse retention, thus *optimizing the health system* (Curley, 1997; Gunther, 2001).

Future research could focus on developing an objective tool for measuring mutuality in nurse-caregiver relationships. This could be a valuable adjunct to measuring the successful implementation of family-centered care. It is also recommended that therapeutic relationship building and establishing mutuality be incorporated into nursing education. Relationship building is a core part of nursing practice (Allande-Cussó et al., 2022). The Registered Nurses' Association of Ontario (2002) recommends that hospitals offer professional learning opportunities to improve relationship-building skills. This can be achieved through group workshops, role modelling, case studies or clinical supervisors. Mutuality should be built into those learning opportunities as an essential part of relationship building.

Furthermore, mutuality cannot be established if nurses do not have the resources to care for patients properly (Registered Nurses' Association of Ontario, 2002). In addition to offering professional learning opportunities to nurses, the hospitals must also ensure that nurses have the resources to create good relationships with families. Such resources include adequate staffing, and safe nurse-to-patient ratios.

Limitations

This research was limited by using only four databases to complete the search and by limiting texts to only results available in English. Additionally, omitting the concept "mutual" in the search may have led to some texts being missed.

Conclusion

Mutuality is essential to family-centered care and therapeutic relationships, which are important concepts in pediatric nursing care. This paper provides an up-to-date analysis of the concept within pediatric nurse-caregiver relationships. It proposes a new definition of mutuality. *Mutuality is a process of dynamic reciprocity whereby the partners (patient/family/nurse) contribute uniquely to their shared goals, values, or purposes.*

Following concept clarification, further research is needed specific to tool development or education to assist nurses in establishing mutuality. Future research would benefit from being guided by the theory of interpersonal relations (Peplau., 1997) to explore these topics. Mutuality should be incorporated into family-centered care models to help guide practice. The implementation of advanced practice nurses as mentors could help incorporate mutuality into everyday nursing practice.

Author contributions

SB and JT made substantial contributions to conception and design. SB contributed to the acquisition of data, analysis, and interpretation of data. SB, JT and JC were involved in drafting the manuscript and revising it critically for important intellectual content; and gave final approval of the version to be published. SB is 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.

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Impact statement

Mutuality is often used in literature in the context of family-centered care, and therapeutic relationship building but it is not clearly defined. In pediatric nursing especially, a therapeutic relationship is necessary to deliver family-centered care, which contributes to strengthening family health and function, increasing patient and caregiver satisfaction, reducing anxiety, and empowering the decision makers. Analyzing the concept of mutuality within a pediatric nursing context will assist stakeholders to incorporate this concept into nursing practice, thus improving nursing care and patient/caregiver satisfaction.

Conflict of interest statement

No conflict of interest to declare.

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