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Interpersonal Communication Patterns Between Rehabilitation Instructors and Psychiatric Patients at Dr. Amino Gondohutomo Regional Mental Hospital

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Abstract

This study examines interpersonal communication patterns between rehabilitation instructors and psychiatric patients at Dr. Amino Gondohutomo Regional Mental Hospital, Semarang, Indonesia. A descriptive qualitative design involved five purposively selected instructors responsible for agriculture, occupational therapy, sandal-making, reading and painting, and sewing and bead-stringing. Data were obtained through in-depth interviews, field observations, and rehabilitation documentation, then analyzed using data reduction, data display, and conclusion drawing, supported by source and methodological triangulation. Findings identified adaptive verbal and nonverbal communication tailored to rehabilitation activities and patients' immediate needs. Instructors employed orientation, explicit task directions, persuasive encouragement, small rewards, and supportive reassurance. Gestures and facial expressions conveyed patients' requests and emotional reactions. A rehabilitation observation involving 29 patients documented introductory interactions before activity assignments. Communication barriers included medication-related drowsiness, reduced attention, disappointment when cigarette requests conflicted with hospital rules, and demands on instructors' emotional self-regulation. Reassuring explanations were accompanied by calmer observed body language, but long-term psychological or clinical outcomes were not measured. The study concludes that clear, responsive, and empathetic communication supports interaction and participation in structured rehabilitation activities; findings remain limited to instructors' reported and observed experiences. Further research should incorporate patients' perspectives and evaluate communication practices across different phases of recovery.

Keywords: *Interpersonal communication, Psychiatric patients, Psychosocial rehabilitation, Rehabilitation instructors, Therapeutic communication.*

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INTRODUCTION

Psychiatric rehabilitation represents an essential component of mental healthcare because recovery involves not only clinical stabilization but also the restoration of interpersonal functioning, emotional regulation, and meaningful participation in social activities. The therapeutic relationship has become an important focus of contemporary mental health research, particularly regarding how interactions between patients and healthcare personnel influence engagement with recovery-oriented services (Marchi et al., 2024). Patient-centered communication has also gained attention in psychiatric inpatient settings, where dialogic interaction and active patient participation are increasingly recognized as relevant components of mental healthcare delivery (Gerken et al., 2025). Within Indonesian psychiatric services, therapeutic communication has been investigated as an intervention associated with managing the risk of violent behavior among patients with schizophrenia, highlighting its relevance to interactions involving complex psychological and behavioral conditions (Aura et al., 2025). Research conducted in mental rehabilitation facilities further demonstrates the significance of therapeutic communication in relationships between patients with schizophrenia and healthcare personnel (Hidayah et al., 2024). These developments indicate that communication in psychiatric rehabilitation extends beyond the transmission of instructions and involves interpersonal processes through which patients interpret messages, express responses, and establish working relationships with rehabilitation personnel. At Dr. Amino Gondohutomo Regional Mental Hospital in Central Java,

interactions between rehabilitation instructors and psychiatric patients constitute a relevant setting for examining how communication patterns are organized within institutional rehabilitation activities.

Recent developments in mental health communication research have increasingly emphasized relational acceptance, professional competence, interpersonal responsiveness, and patient participation as interconnected dimensions of therapeutic interaction. Grounded-theory research examining acceptance within nurse–patient relationships has positioned acceptance as an interpersonal process that develops through therapeutic encounters rather than merely as an individual professional attitude (Aznar-Huerta et al., 2024). The concept of relational competence has similarly received attention in mental healthcare, reflecting the need to understand how professional communication practices contribute to the establishment and maintenance of constructive relationships with patients (Beyene et al., 2024). Research exploring patients' and facilitators' experiences of discovery group sessions based on the Tidal Model has extended this discussion toward facilitated interpersonal engagement in preparation for person-centered group interventions (Benzon & Jørgensen, 2024). Indonesian research examining communication patterns among former psychiatric patients in social rehabilitation institutions provides another analytical dimension by considering the organization of interaction within rehabilitation communities (Riadi et al., 2024). These studies collectively demonstrate a movement from understanding communication primarily as information delivery toward examining interpersonal relationships, participatory exchanges, and the organizational conditions shaping therapeutic interaction, although their research settings and professional participants remain heterogeneous.

The existing literature nevertheless reveals a contextual and interactional research gap concerning the interpersonal communication patterns specifically established between rehabilitation instructors and psychiatric patients during institutional rehabilitation activities. Research on therapeutic relationships in community mental health services provides substantial insight into patient–professional interactions, but its broader clinical orientation does not directly explain communication practices associated with the instructional responsibilities of rehabilitation personnel (Marchi et al., 2024). Studies investigating patient-centered communication within inpatient psychotic-disorders units similarly emphasize psychiatric treatment environments whose organizational structures and professional responsibilities may differ from those of rehabilitation instruction (Gerken et al., 2025). Indonesian research examining therapeutic communication in mental health foundations has addressed communication processes associated with caring for individuals experiencing psychiatric disorders, although its institutional setting differs from instructor–patient interaction within a regional psychiatric hospital (Wijaya et al., 2023). Research concerning group communication among former psychiatric patients also contributes to understanding rehabilitation-related interaction but does not specifically establish how individual instructors formulate messages, interpret patient responses, or adjust their communication during instructional encounters (Riadi et al., 2024). The resulting gap concerns the limited contextual explanation of how verbal and nonverbal messages, interpersonal responses, communication adjustments, and interactional barriers operate together within instructor-led psychiatric rehabilitation. Addressing this limitation requires an examination of communication as a situated interpersonal process rather than assuming that findings from nursing relationships, inpatient psychiatric treatment, or group-based rehabilitation can be transferred directly to the communication practices of rehabilitation instructors.

The limited understanding of instructor–patient communication carries practical implications because psychiatric rehabilitation activities require communication that accommodates differences in patients' emotional conditions, interpersonal responsiveness, and capacity to interpret instructions. Research examining acceptance within therapeutic relationships indicates that interpersonal recognition and the development of constructive relational conditions warrant attention when investigating interactions between mental health professionals and patients (Aznar-Huerta et al., 2024). The literature on relational competence further establishes the relevance of professional communication abilities to interactions involving individuals with mental health conditions, suggesting that message delivery cannot be separated from the interpersonal circumstances in which communication occurs (Beyene et al., 2024). Indonesian research concerning therapeutic communication among patients with schizophrenia has also addressed its application to behavioral difficulties, demonstrating the practical relevance of communication in situations requiring careful interpersonal engagement (Aura et al., 2025). Studies undertaken in mental rehabilitation settings reinforce the importance of examining therapeutic exchanges between care personnel and psychiatric patients rather than evaluating

rehabilitation exclusively through clinical or administrative procedures (Hidayah et al., 2024). Without a context-specific understanding of instructor–patient interaction, rehabilitation services have a limited empirical basis for identifying how communication barriers emerge during instructional activities, how interpersonal responses influence mutual understanding, and which communication practices may require further evaluation.

The present study positions interpersonal communication within psychiatric rehabilitation as a relational process involving the delivery of messages, interpretation of patient responses, adaptation of communication practices, and negotiation of interpersonal understanding between instructors and patients. Previous research concerning discovery group sessions based on the Tidal Model has examined facilitated conversations within person-centered interventions, whereas the present investigation directs attention toward communication patterns arising in rehabilitation instructors' interactions with psychiatric patients (Benzon & Jørgensen, 2024). Research on interpersonal communication involving individuals with psychiatric disorders in a temporary shelter provides a related perspective on individualized interaction, although the social care environment differs from the organizational conditions of a psychiatric hospital rehabilitation service (Pohan, 2024). Studies exploring therapeutic communication in mental health foundations also offer relevant comparisons concerning communication during psychiatric care, but they do not establish the particular interactional arrangements operating between rehabilitation instructors and patients at the selected institution (Wijaya et al., 2023). The emphasis on interpersonal interaction is consistent with contemporary research identifying acceptance as a significant process within therapeutic relationships, while extending the analytical focus toward the specific responsibilities and communicative encounters associated with rehabilitation instruction (Aznar-Huerta et al., 2024). The proposed novelty lies in integrating the analysis of verbal and nonverbal communication, message-delivery strategies, interpersonal responsiveness, and communication barriers within a single institutional rehabilitation setting. This contribution is primarily contextual and analytical because it seeks to clarify communication patterns within a specific professional relationship without presupposing the effectiveness of particular communication strategies or claiming that the findings necessarily apply to other psychiatric institutions.

This study aims to describe and analyze interpersonal communication patterns between rehabilitation instructors and psychiatric patients at Dr. Amino Gondohutomo Regional Mental Hospital, Central Java. The investigation focuses on how instructors communicate during rehabilitation activities, how messages are conveyed through verbal and nonverbal interaction, and how interpersonal responses shape the communication process. Particular attention is directed toward communication strategies used to establish understanding, maintain constructive interpersonal relationships, and respond to differences in patients' psychological and communicative conditions. The study also seeks to identify barriers encountered during instructor–patient interactions and examine how these barriers relate to the communication processes occurring within the rehabilitation environment. Its scientific contribution is expected to strengthen the understanding of interpersonal communication as an interactional process within psychiatric rehabilitation, extending existing discussions beyond conventional nurse–patient relationships and group-based therapeutic activities. The practical contribution is to provide an empirically grounded basis for evaluating communication practices and informing the development of responsive, patient-sensitive interpersonal approaches among rehabilitation instructors in institutional mental healthcare services.

RESEARCH METHODS

This study employed a descriptive qualitative research design to examine interpersonal communication patterns between rehabilitation instructors and psychiatric patients at Dr. Amino Gondohutomo Regional Mental Hospital, Semarang, Central Java (Creswell & Creswell, 2018). The research focused on instructors' experiences and interpersonal interactions during routine psychosocial rehabilitation activities, particularly how communication was established and maintained with psychiatric patients. The investigation examined verbal communication, nonverbal expressions, and interpersonal responses as relevant dimensions of communication between instructors and patients (DeVito, 2019). Five rehabilitation instructors were selected through purposive sampling based on their direct involvement in patient rehabilitation, with selection considerations including length of service, gender, and rehabilitation assignments. The rehabilitation activities represented in the study included

agriculture, occupational therapy, sandal-making, painting and reading, and sewing and bead-stringing. Each informant was assigned an identification code from P1 to P5 to protect personal identity and maintain confidentiality throughout the research process (Lincoln & Guba, 1985).

Data collection employed three complementary techniques consisting of in-depth interviews, field observations, and documentation of rehabilitation activities. In-depth interviews explored instructors' experiences, interpersonal communication strategies, message-delivery practices, and communication barriers encountered during interactions with psychiatric patients. Field observations focused on face-to-face conversations, body language, emotional responses, and interpersonal interactions during rehabilitation activities, while field notes and activity records provided supplementary information for understanding the observed communication processes (Creswell & Creswell, 2018). Data were analyzed using the interactive analytical model comprising data reduction, data display, and conclusion drawing or verification to identify recurring communication patterns and interpret relationships between the collected information (Miles et al., 2014). Source triangulation was conducted by comparing information obtained from the five instructors, while methodological triangulation involved examining consistency across interview findings, observational records, and rehabilitation documentation. These procedures were applied to strengthen the credibility of qualitative interpretations, identify inconsistencies between information sources, and reduce potential researcher bias in analyzing interpersonal communication practices (Lincoln & Guba, 1985).

RESULTS AND DISCUSSION

Interpersonal Communication Patterns Between Rehabilitation Instructors and Psychiatric Patients

Interpersonal communication within the psychosocial rehabilitation unit of Dr. Amino Gondohutomo Regional Mental Hospital constitutes an interactional process through which instructors deliver guidance, interpret patient responses, and facilitate participation in structured rehabilitation activities. The qualitative findings derived from five rehabilitation instructors illustrate how interpersonal exchanges occur across agricultural activities, occupational therapy, sandal-making, reading and painting, and sewing and bead-stringing. These activities provide different social environments in which instructors communicate practical instructions while responding to patients' emotional conditions, cognitive abilities, and interpersonal behavior. The observed interactions involve verbal explanations, nonverbal expressions, personal encouragement, and adjustments to communication according to the immediate circumstances encountered during rehabilitation. DeVito (2019) conceptualizes interpersonal communication as a reciprocal process involving message exchange, interpretation, and feedback, providing an analytical basis for understanding communication beyond the unilateral delivery of instructions. Research examining interpersonal communication in the care of individuals with psychiatric disorders similarly emphasizes the importance of relational interaction in supporting communication between caregivers and service users (Pohan, 2024). The findings indicate that communication between instructors and patients should be interpreted through the relationship between instructional responsibilities, patient responses, and the social characteristics of rehabilitation activities rather than through a single standardized communication pattern.

The research involved five rehabilitation instructors who were purposively selected because their professional responsibilities required direct interaction with psychiatric patients during rehabilitation activities. Informants were identified using the codes P1 to P5 to maintain confidentiality while allowing the systematic organization and comparison of information obtained through interviews and observations. The participants represented different ages, genders, rehabilitation assignments, and lengths of employment, providing variation in the organizational circumstances associated with interpersonal communication. Three instructors were male and two were female, with their ages ranging from 28 to 57 years and their work experience extending from more than five years to more than twenty years. These characteristics provided a basis for examining communication practices across instructors with different occupational responsibilities without assuming that demographic differences independently determined their interpersonal behavior. Beyene et al. (2024) emphasize the relevance of relational competence in mental healthcare, supporting the analytical consideration of professional experience, interpersonal responsiveness, and situational demands when examining communication practices among rehabilitation personnel.

The distribution of rehabilitation responsibilities created distinct instructional situations requiring different forms of communication between instructors and psychiatric patients. Agricultural activities supervised by P1 involved practical assignments such as collecting dry leaves, watering plants, and hoeing, requiring verbal explanations that identified specific tasks and locations. Occupational therapy conducted by P2 involved encouraging patients to participate in therapeutic activities, while P3's sandal-making responsibilities included instructional interaction and communication during the organization of rehabilitation sessions. Reading and painting activities supervised by P4 provided opportunities for supportive communication in a comparatively calm environment, whereas P5's sewing and bead-stringing activities involved patient interaction during tasks requiring attention and manual coordination. These distinctions demonstrate differences in the immediate communication requirements of rehabilitation activities, although they do not establish that any particular instructional approach was exclusive to a single unit. Riadi et al. (2024) examined communication patterns among former psychiatric patients in social rehabilitation institutions, providing a relevant comparison for understanding how rehabilitation activities can organize interpersonal exchanges and group relationships. The present findings extend attention to the instructor–patient relationship by examining communication during specific activities rather than treating rehabilitation as a uniform organizational environment.

Informant characteristics were relevant to interpreting the diversity of interpersonal communication practices documented across the rehabilitation units. P1, P4, and P5 had worked for more than twenty years, whereas P2 and P3 had accumulated more than five years of professional experience in their respective assignments. The differences in experience and responsibilities provided contextual information for interpreting how instructors communicated instructions, responded to patient behavior, and maintained interpersonal interaction during routine rehabilitation activities. These characteristics should not be interpreted as evidence that longer employment necessarily produced greater communication effectiveness because the study did not measure communication competence or compare outcomes according to employment duration. Aznar-Huerta et al. (2024) examined acceptance within therapeutic relationships as an interpersonal process, reinforcing the importance of understanding professional interaction through relational practices rather than relying exclusively on individual characteristics. Table 1 presents the original demographic and occupational profiles of the five informants, providing the descriptive foundation for interpreting the communication practices documented in subsequent field observations.

Table 1. Research Informant Profiles

Code	Gender	Age	Rehabilitation Role / Unit	Work Experience
P1	Male	55 years	Agriculture	> 20 years
P2	Male	34 years	Occupational therapy	> 5 years
P3	Male	28 years	Sandal-making	> 5 years
P4	Female	54 years	Reading and painting	> 20 years
P5	Female	57 years	Sewing and bead-stringing	> 20 years

The information presented in Table 1 establishes the diversity of instructor characteristics, while the observational findings provide more direct evidence concerning how communication was implemented during rehabilitation activities. An observation conducted on Monday, August 3, 2026, involving 29 psychiatric patients documented an initial orientation process facilitated by P3 before participants entered their respective rehabilitation activities. After patients gathered from their wards, P3 repeated the attendance check and invited individuals to introduce themselves by stating their names and places of origin. The introductory exchange preceded the assignment of patients to rehabilitation activities according to the psychologist's recommendations, indicating that communication was incorporated into the organizational transition from inpatient care to structured activity participation. Asking patients to identify themselves verbally provided an opportunity for interpersonal engagement and basic cognitive stimulation, although the available evidence does not establish measurable improvements in cognitive functioning. Benzon and Jørgensen (2024) examined facilitated group interactions within the Tidal Model, demonstrating the relevance of introductory communication in creating opportunities for participation and engagement in person-centered mental health interventions.

The orientation observed in the present study illustrates a structured communication pattern in which the instructor initiated interaction, established an identifiable sequence of participation, and encouraged patients to respond before beginning their assigned rehabilitation activities.

Agricultural rehabilitation activities demonstrated a relatively structured instructional communication pattern in which P1 distributed practical responsibilities and provided direct verbal guidance to patients. Participants were organized into groups responsible for collecting dry leaves, watering plants, and hoeing, indicating that task allocation was communicated through explicit assignments rather than leaving individual responsibilities undefined. When two patients requested permission to drink, P1 responded with a specific location-based instruction: "If you want a drink, go inside; there are glasses near the sewing machine." The response illustrates how concrete spatial information can be incorporated into interpersonal communication when patients require practical guidance within an unfamiliar or structured environment. Gerken et al. (2025) examined patient-centered communication in psychiatric care, supporting the relevance of communication practices that respond to individual informational needs while maintaining a coherent therapeutic interaction. The documented exchange indicates that P1's communication combined task-oriented direction with responsiveness to patient requests, although the available observation does not establish whether this approach was consistently applied throughout every agricultural rehabilitation session.

Communication practices in reading, painting, sewing, and bead-stringing activities displayed a comparatively supportive and persuasive interpersonal orientation in the observational descriptions. P4 supervised reading and painting activities, while P5 guided sewing and bead-stringing, with both instructors engaging patients through relatively gentle verbal interaction and personal attention. The original field account indicated that most participants in these activities were women and that the rehabilitation atmosphere was comparatively calm, allowing instructors to emphasize patient comfort and interpersonal engagement during practical tasks. The communication approach was characterized by patience, supportive explanations, and efforts to accommodate patients' emotional responses rather than relying exclusively on rigid instructions. Hidayah et al. (2024) examined therapeutic communication involving patients with schizophrenia in a mental rehabilitation facility, providing a relevant basis for interpreting supportive interpersonal interaction as an important dimension of psychiatric rehabilitation services. Research concerning therapeutic relationships in mental healthcare also identifies acceptance as a relevant relational process, suggesting that the manner in which instructions are communicated deserves consideration alongside their practical content (Aznar-Huerta et al., 2024). The observed differences between the agricultural and creative rehabilitation settings indicate variation in communication style and instructional circumstances, although the evidence does not permit attributing these differences exclusively to instructor gender, patient gender, or the specific rehabilitation activity.

Nonverbal communication constituted another identifiable component of interpersonal interaction between rehabilitation instructors and psychiatric patients, particularly when patients expressed requests through gestures rather than explicit verbal statements. During activities associated with P1 and P3, some male patients placed two fingers near their mouths to communicate a request for cigarettes, demonstrating the use of recognizable bodily gestures to convey personal intentions. Both instructors declined these requests because the hospital maintained a smoke-free policy, and the patients subsequently displayed facial expressions indicating disappointment. The observed interaction illustrates how nonverbal expressions can communicate patient needs and emotional responses while requiring instructors to interpret gestures within the institutional rules governing rehabilitation activities. Knapp et al. (2014) explain the importance of bodily movement and facial expression in human interaction, providing a conceptual foundation for interpreting these gestures as communicative behavior rather than incidental physical movements. The findings demonstrate that interpersonal communication in the rehabilitation unit involved structured verbal instructions, supportive exchanges, and nonverbal expressions, with instructors responding to patient communication while maintaining the practical and institutional boundaries of rehabilitation services.

Adaptive Communication Strategies for Establishing Therapeutic Relationships

Interpersonal communication strategies employed by rehabilitation instructors at Dr. Amino Gondohutomo Regional Mental Hospital demonstrated adjustments to patients' psychological conditions, cognitive functioning, emotional responses, and participation in therapeutic activities. The

research findings indicated that instructors combined verbal guidance, persuasive encouragement, emotional reassurance, and supportive interpersonal interaction according to the circumstances encountered during rehabilitation sessions. These communication practices were reflected in the different approaches adopted by instructors working in occupational therapy, agricultural activities, sandal-making, painting, reading, sewing, and bead-stringing. The variation in instructional approaches suggests that interpersonal communication within psychiatric rehabilitation requires sensitivity to patients' immediate responses rather than exclusive reliance on standardized verbal instructions. Beyene et al. (2024) conceptualized relational competence in mental healthcare as an important dimension of professional interaction, emphasizing the relevance of interpersonal responsiveness and communication abilities in establishing constructive therapeutic relationships. The documented interactions indicate that instructors adapted their communication to the practical requirements of rehabilitation while attempting to maintain patient participation and interpersonal understanding.

Persuasive communication was particularly evident in occupational therapy activities supervised by informant P2, who employed repeated verbal encouragement to stimulate patients' willingness to participate in assigned therapeutic tasks. Interview information indicated that the instructor frequently used supportive expressions to motivate patients who demonstrated reduced initiative, limited concentration, or fluctuating willingness to complete rehabilitation activities. The instructor also provided small rewards, including candy, as a form of immediate positive reinforcement accompanying verbal encouragement during occupational therapy sessions. These practices demonstrated an interactional approach in which instructional communication was combined with tangible incentives intended to encourage patient engagement rather than relying exclusively on authoritative commands. Benzon and Jørgensen (2024) examined patients' and facilitators' experiences of person-centered group interventions, highlighting the relevance of supportive engagement and communication processes in facilitating participation within mental health services. The combination of persuasive messages and symbolic rewards can be interpreted as an effort to associate participation with positive interpersonal experiences, although the research did not measure changes in motivation or treatment adherence resulting from these practices. The findings illustrate how instructors may incorporate encouragement and immediate recognition into rehabilitation communication while maintaining a distinction between the documented instructional strategy and its unmeasured therapeutic effectiveness.

Communication adjustments were also observed when instructors encountered patients experiencing physiological conditions that affected their ability to participate actively in rehabilitation activities. The original research account indicated that morning administration of psychotropic medication was sometimes followed by pronounced drowsiness, which affected patients' alertness and responsiveness during rehabilitation sessions. In the painting unit, informant P4 responded to this condition without employing harsh reprimands and instead encouraged affected patients to visit the bathroom and wash their faces. This practical instruction reflected a supportive communication approach that acknowledged patients' immediate condition while attempting to maintain their involvement in the scheduled activity. Lee et al. (2024) examined factors associated with person-centered care among psychiatric nurses, providing a relevant basis for interpreting communication adjustments as part of professional sensitivity to individual patient circumstances. The observed response demonstrates the incorporation of patient condition into instructional communication, although the available evidence does not establish whether washing the face consistently improved alertness or rehabilitation performance.

Emotional reassurance represented another communication strategy identified during rehabilitation activities, particularly when patients encountered unfamiliar environments or experienced anxiety concerning their institutional circumstances. Informant P3 described situations in which patients entering rehabilitation for the first time demonstrated confusion, substantial anxiety, and an expressed desire to leave the treatment environment. The instructor responded by providing verbal reassurance and explaining that patients could return home following authorization from the physician responsible for their treatment. This explanation communicated institutional conditions while attempting to reduce uncertainty concerning the patients' anticipated discharge and their immediate rehabilitation experience. The original observation described calmer body language and a more comfortable interactional atmosphere following the reassurance, although these responses cannot establish a sustained reduction in anxiety without additional clinical assessment. Gerken et al. (2025) examined patient-centered

communication within inpatient psychiatric services, supporting the relevance of dialogic interaction and understandable explanations when communicating with individuals experiencing psychotic disorders. The documented communication approaches adopted by the five rehabilitation instructors are summarized in Table 2 to illustrate differences in instructional strategies and their application during rehabilitation activities.

Table 2. Interpersonal Communication Strategies Applied by Rehabilitation Instructors

Instructor	Communication Strategy	Documented Practice
P1	Direct verbal instruction	Task allocation and specific spatial guidance during agricultural activities
P2	Persuasive encouragement	Repeated verbal motivation and small rewards, including candy
P3	Orientation and reassurance	Patient introductions and explanations to anxious patients
P4	Supportive communication	Practical guidance for patients experiencing drowsiness
P5	Personal and persuasive interaction	Supportive guidance during sewing and bead-stringing activities

The communication strategies presented in Table 2 demonstrate variations in how instructors conveyed messages and responded to patient needs across different rehabilitation activities. P1 emphasized clear verbal directions and specific information concerning task responsibilities, whereas P2 incorporated persuasive encouragement and small rewards to support participation in occupational therapy. P3 employed orientation and reassurance to facilitate initial interaction and address anxiety associated with unfamiliar rehabilitation circumstances. P4 adopted supportive practical instructions when patients experienced drowsiness, while P5 emphasized personal and persuasive communication during creative and manual activities. These approaches illustrate differences in instructional emphasis rather than independently verified differences in therapeutic effectiveness, since the research did not employ standardized assessments of communication quality or patient outcomes. Aznar-Huerta et al. (2024) examined acceptance as a process within therapeutic relationships, providing an analytical foundation for understanding how responsive interaction and recognition of individual circumstances may contribute to the development of constructive relationships between mental health personnel and patients.

Verbal communication within psychiatric rehabilitation was accompanied by nonverbal expressions that provided additional information concerning patients' immediate needs, emotional responses, and interpersonal engagement. The research documented situations in which patients communicated requests through bodily gestures, including placing two fingers near their mouths to indicate a desire for cigarettes during activities associated with P1 and P3. Both instructors interpreted the gestures and declined the requests because the hospital maintained a smoke-free policy, demonstrating the need to respond to nonverbal communication while observing institutional requirements. The patients subsequently displayed facial expressions of disappointment, indicating that nonverbal interaction also conveyed emotional responses to the instructors' decisions. These encounters illustrate the importance of interpreting verbal and nonverbal information together, particularly when communication involves patient expectations that cannot be accommodated under existing institutional rules. The instructors' responses also demonstrate that therapeutic communication does not necessarily require fulfilling every request but may involve maintaining appropriate interpersonal boundaries while recognizing the patient's expressed intention. Tolosa-Merlos et al. (2023) examined therapeutic relationships through reflective nursing practice in acute mental health units, providing a relevant perspective for understanding the professional judgments involved in emotionally sensitive interpersonal encounters.

Communication approaches also varied according to the characteristics of rehabilitation activities and the forms of participation required from psychiatric patients. Agricultural rehabilitation supervised by P1 involved direct instructions for practical tasks, while occupational therapy conducted by P2 incorporated repeated encouragement to support participation in structured activities. Sandal-

making activities associated with P3 included orientation and reassurance when patients required assistance in understanding their rehabilitation circumstances or managing anxiety. Reading and painting activities supervised by P4 emphasized supportive verbal communication, whereas sewing and bead-stringing activities guided by P5 involved personal interaction and persuasive encouragement during creative tasks. The variation indicates that communication strategies were connected to the immediate requirements of rehabilitation activities, although the qualitative evidence does not establish a causal relationship between particular activity types and specific communication styles. Piñar-Rodríguez et al. (2025) examined mental health professionals' perceptions of interpersonal approaches within therapeutic relationships, reinforcing the relevance of adapting professional interaction to relational circumstances without assuming that a single communication technique is appropriate for every patient.

The findings demonstrate that adaptive interpersonal communication within the rehabilitation unit involved a combination of practical instruction, persuasive encouragement, emotional reassurance, and sensitivity to patients' immediate physiological and psychological conditions. The strategies documented among the five instructors reflected different attempts to support patient participation while maintaining the organizational responsibilities and institutional boundaries associated with rehabilitation activities. Repeated verbal encouragement and small rewards were used to stimulate engagement, while supportive instructions were employed when patients experienced drowsiness or difficulties maintaining attention during scheduled activities. Emotional reassurance provided by P3 was accompanied by observable changes in patients' body language, offering qualitative evidence of an immediate interpersonal response without establishing a longer-term therapeutic effect. Marchi et al. (2024) examined therapeutic relationships in community mental health services, providing a relevant foundation for interpreting professional responsiveness and relational interaction as significant elements of mental healthcare. The research did not include standardized measures of patient satisfaction, communication effectiveness, or clinical recovery, limiting conclusions to the interpersonal practices and immediate responses documented through interviews and observations. These findings support an understanding of therapeutic communication as an adaptive process in which instructors must interpret patient needs, select appropriate forms of interaction, and maintain constructive relationships while responding to the practical and emotional demands of psychiatric rehabilitation.

Interpersonal Communication Barriers and Psychosocial Implications of Rehabilitation Activities

Interpersonal communication between rehabilitation instructors and psychiatric patients at Dr. Amino Gondohutomo Regional Mental Hospital encountered several barriers associated with patients' psychological conditions, physiological responses, emotional expectations, and the demands of rehabilitation activities. The qualitative findings identified medication-related drowsiness, reduced attention, limited verbal responsiveness, and differences between patients' personal expectations and institutional regulations as circumstances affecting interpersonal exchanges. These barriers emerged during routine rehabilitation activities in which instructors were required to communicate practical instructions while responding to variations in patients' emotional and behavioral conditions. Communication difficulties were also associated with the need to repeat instructions, interpret nonverbal expressions, and maintain constructive relationships with individuals experiencing fluctuating levels of concentration and engagement. Such conditions indicate that communication barriers in psychiatric rehabilitation cannot be understood exclusively as failures in message delivery because patients' psychological and physiological circumstances also influence how information is received and interpreted. Xiang et al. (2025) examined communication in acute psychiatric care from nurses' perspectives, providing a relevant analytical basis for understanding the complexity of professional interactions involving patients with psychiatric conditions. The findings demonstrate that rehabilitation instructors must manage interpersonal communication while accommodating individual differences in patient responsiveness and maintaining the practical requirements of structured therapeutic activities.

Medication-related drowsiness constituted a prominent physiological barrier identified in the rehabilitation activities observed at the hospital. The research description indicated that some patients experienced pronounced sleepiness following the administration of morning psychotropic medication, affecting their alertness and ability to participate actively in scheduled rehabilitation sessions.

Drowsiness was accompanied by slower verbal responses, reduced eye contact, and difficulty maintaining attention when instructors communicated directions or explained practical assignments. These conditions created situations in which instructors needed to consider patients' immediate level of alertness before expecting them to understand or implement instructional messages. Informant P4 addressed this difficulty by encouraging drowsy patients in the painting unit to visit the bathroom and wash their faces rather than responding through harsh verbal reprimands. Drayton et al. (2026) reviewed communication strategies in mental health settings, providing a relevant foundation for interpreting the adjustment of professional communication to the needs and capacities of individuals receiving psychiatric care.

Another communication barrier emerged when patients' expectations conflicted with institutional regulations governing permitted behavior during rehabilitation activities. During interactions involving P1 and P3, several male patients used a two-finger gesture near the mouth to communicate their desire to smoke cigarettes. Both instructors recognized the meaning of the gesture but declined the requests because the hospital implemented a smoke-free policy that prohibited smoking within the institution. The patients responded with visible facial expressions of disappointment, indicating that the refusal generated an emotional response communicated through nonverbal behavior. These encounters required instructors to acknowledge the patients' expressed intentions while maintaining institutional boundaries without unnecessarily intensifying interpersonal tension. Defourny et al. (2024) examined experiences of recovery, stigmatization, and interpersonal difficulties in mental healthcare, offering a relevant perspective on the importance of recognizing patients' experiences when interpreting interactions within institutional treatment environments.

Psychological demands experienced by rehabilitation instructors represented another dimension of communication difficulty because interactions required sustained attention, patience, and responses to varying patient behaviors. The original research materials indicated that instructors encountered situations involving repeated questions, slow task performance, unpredictable responses, and difficulties maintaining patients' attention during rehabilitation activities. These circumstances required instructors to regulate their own emotional reactions while communicating instructions and preserving a supportive interpersonal atmosphere. The need for emotional regulation was particularly relevant when patients did not immediately understand instructions or displayed behavior that differed from the expectations associated with scheduled rehabilitation activities. The research account emphasized that instructors needed patience when responding to such situations, although it did not document standardized assessments of emotional exhaustion, occupational stress, or psychological burnout. Hidayah et al. (2024) examined therapeutic communication involving patients with schizophrenia in a mental rehabilitation institution, supporting the relevance of communication practices that accommodate complex psychological and interpersonal circumstances. Table 3 summarizes the principal communication barriers documented in the research materials and the corresponding instructor responses, distinguishing observed situations from broader psychological or clinical outcomes that were not independently measured.

Table 3. Interpersonal Communication Barriers and Documented Instructor Responses

Communication Barrier	Documented Condition	Instructor Response
Medication-related drowsiness	Reduced attention, slower verbal responses, and limited eye contact	P4 encouraged patients to wash their faces
Institutional smoking restriction	Cigarette-request gestures and visible disappointment	P1 and P3 declined the requests
Anxiety in unfamiliar rehabilitation settings	Confusion and attempts to leave the ward	P3 provided reassurance and explained discharge conditions
Variable patient responses	Slow task performance and repeated questions	Instructors needed patience and emotional self-regulation

The communication barriers presented in Table 3 demonstrate that instructors encountered difficulties requiring different interpersonal responses according to the immediate circumstances of rehabilitation activities. Medication-related drowsiness primarily affected patients' attention and verbal

responsiveness, whereas cigarette requests involved differences between personal expectations and institutional behavioral restrictions. Anxiety associated with unfamiliar rehabilitation environments required explanatory and reassuring communication, while repeated questions and slow task performance placed demands on instructors' patience and emotional control. These differences indicate that communication barriers were not uniform and could not be addressed through a single instructional approach applied identically to every patient. Research by Aura et al. (2025) examined therapeutic communication in managing the risk of violent behavior among patients with schizophrenia, highlighting the clinical relevance of communication approaches that consider patients' behavioral and emotional conditions. The present findings support the importance of adapting communication to identifiable barriers, although the evidence does not establish that the documented instructor responses independently prevented behavioral escalation or produced measurable clinical improvements.

Emotional reassurance played a particularly relevant role when patients experienced anxiety or uncertainty about their rehabilitation circumstances and the possibility of returning home. The research described situations in which patients entering rehabilitation for the first time demonstrated confusion, expressed a desire to leave the treatment environment, and required explanation concerning their institutional circumstances. Informant P3 responded by communicating that patients would be permitted to return home following authorization from the physician responsible for their treatment, providing information intended to reduce uncertainty without promising immediate discharge. The observed interaction was accompanied by calmer body language and a more comfortable rehabilitation atmosphere, indicating an immediate interpersonal response to the instructor's explanation. Such observations suggest that understandable information and supportive communication may contribute to patients' perceived security during unfamiliar rehabilitation situations, although their effects on sustained anxiety reduction or clinical recovery were not assessed. Gerken et al. (2025) examined patient-centered communication in an inpatient psychiatric setting, supporting the relevance of understandable explanations and dialogic interaction when addressing patients' concerns within institutional mental healthcare. The documented exchange illustrates how rehabilitation instructors can combine institutional information with interpersonal reassurance while maintaining appropriate boundaries concerning clinical decisions and patient discharge.

Rehabilitation activities also provided opportunities for patients to practice basic interpersonal behaviors through repeated engagement with instructors and other participants in structured tasks. Agricultural activities involved listening to instructions, receiving task assignments, asking permission to meet personal needs, and responding to verbal guidance concerning the location of equipment or facilities. Sandal-making, painting, reading, sewing, and bead-stringing similarly created circumstances in which patients were expected to follow directions, maintain attention, and communicate with instructors during practical activities. The orientation session involving 29 patients on August 3, 2026, demonstrated how introductory communication could provide opportunities for individuals to state their names and places of origin before entering assigned rehabilitation units. These interactions constituted observable opportunities for interpersonal engagement, although the research did not employ standardized instruments to measure improvements in social functioning, cognitive performance, or readiness for community reintegration. Riadi et al. (2024) investigated group communication patterns among former psychiatric patients in a social rehabilitation institution, offering a relevant comparison for understanding the relationship between structured rehabilitation environments and opportunities for social interaction. Research by Yosep et al. (2025) also addressed psychosocial interventions for individuals with schizophrenia, reinforcing the relevance of structured interpersonal engagement within mental healthcare while not establishing the clinical effectiveness of the particular activities examined in the present study.

The findings indicate that interpersonal communication barriers within the psychosocial rehabilitation unit involved physiological limitations, emotional responses, institutional restrictions, and the interpersonal demands associated with guiding psychiatric patients through structured activities. Instructors responded through practical guidance, verbal reassurance, patient interpretation of nonverbal gestures, and efforts to maintain patience during interactions involving reduced attention or variable responsiveness. The documented communication practices illustrate how rehabilitation instructors balanced task-oriented responsibilities with sensitivity to patients' immediate psychological and communicative circumstances. These observations contribute to interpersonal communication research by identifying specific interactional challenges within instructor-led psychiatric rehabilitation, a

professional relationship that differs from conventional nurse–patient communication in clinical treatment settings. The evidence supports the practical relevance of clear instructions, responsive interpersonal engagement, emotional self-regulation, and sensitivity to nonverbal behavior, but it does not establish causal relationships between communication strategies and long-term psychiatric recovery. Further research involving patients' perspectives, repeated observations, and appropriate measures of rehabilitation outcomes would be necessary to determine whether particular interpersonal communication practices contribute to sustained improvements in social functioning, therapeutic engagement, and readiness for community participation.

CONCLUSION

This study identified adaptive interpersonal communication patterns between rehabilitation instructors and psychiatric patients at Dr. Amino Gondohutomo Regional Mental Hospital, shaped by rehabilitation activities and patients' psychological conditions. Communication began with orientation, attendance checks, and verbal introductions, followed by direct instructional approaches in agricultural and sandal-making activities. Reading, painting, sewing, and bead-stringing activities involved more personal, supportive, and persuasive communication to accommodate differences in patients' attention and emotional responses. Nonverbal communication, including bodily gestures and facial expressions, provided additional means for patients to express their needs and emotional reactions. Instructors employed repeated encouragement, small rewards, practical guidance, and verbal reassurance to facilitate participation and maintain constructive therapeutic relationships. Reassuring communication was accompanied by calmer observed body language among anxious patients, although sustained psychological improvements were not independently measured. These findings demonstrate that effective interpersonal interaction in psychiatric rehabilitation requires instructional clarity, emotional sensitivity, adaptive communication, and appropriate professional boundaries.

The principal communication barriers included medication-related drowsiness, reduced attention, delayed verbal responses, conflicts between patients' expectations and institutional smoking restrictions, and the emotional demands experienced by rehabilitation instructors. These difficulties required instructors to maintain patience, regulate their emotional responses, and adjust communication strategies according to patients' immediate psychological and physiological conditions. Rehabilitation activities also provided opportunities for patients to practice listening, expressing personal needs, requesting permission, and participating in structured social interactions. Hospital management should consider regular training in therapeutic communication, emotional self-regulation, patient-centered interaction, and de-escalation techniques to strengthen instructors' professional communication competencies. Rehabilitation instructors should maintain clear verbal guidance, supportive interpersonal engagement, and appropriate positive reinforcement while respecting patients' individual conditions and institutional regulations. The study was limited to five rehabilitation instructors within a single psychiatric hospital and did not quantitatively assess communication effectiveness or long-term rehabilitation outcomes. Future research should incorporate patients' perspectives and compare interpersonal communication patterns across acute and recovery phases to examine their relationship with therapeutic engagement, social functioning, and rehabilitation outcomes.

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