

Understanding barriers and facilitators to therapeutic relationships in state psychiatric hospitals

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Abstract

Objective(s): This qualitative study aimed to elucidate barriers and facilitators faced by individuals with serious mental illness in establishing positive therapeutic relationships within the public sector.

Method: Twenty-two individuals, receiving inpatient treatment and near discharge from three state psychiatric facilities, participated. The sample was diverse with respect to gender (60 % male) and race/ethnicity, with a mean age of 40 years (standard deviation = 12.91). Thematic analysis and a contextualist lens were used to analyze the data.

Results: Results indicated that inadequate meeting time, lack of clinically relevant communication, and discrepancies in client/provider perspectives, impeded positive therapeutic relationships. Facilitators to therapeutic relationships included feelings heard and understood by providers, comprehensive, timely discharge plans, and thinking broadly about aftercare.

Conclusions: Cultivating positive therapeutic relationships is especially difficult in resource-challenged settings. Enhanced client-provider communication and individually tailored aftercare planning can enhance inpatient therapeutic relationships, convey a greater sense of understanding of clients, and facilitate client-provider collaboration.

KEYWORDS

decision making in psychotherapy, patient preferences, serious mental illness, therapeutic relationship

Accumulating evidence suggests that the therapeutic relationship between a provider and consumer is integral to the experiences of mental healthcare for individuals with serious mental illness (SMI), as well as to their recovery (Denhov & Topor, 2011; Ware, Tugenberg, & Dickey, 2004). Indeed, extant research has found the therapeutic relationship to be associated with a host of positive treatment outcomes, as well as being paramount to the recovery process more broadly (Denhov & Topor, 2011; McCabe & Priebe, 2004; Topor et al., 2006). This study has found that the positive support of helping professionals can serve as a decisive factor for individuals with SMI in understanding what recovery means and how to achieve it (Denhov & Topor, 2011; Schön, Denhov, & Topor, 2009). Importantly, the perceived helpfulness of providers has not been linked to any specific professional group or treatment modality (Schön et al., 2009). Instead, “helpful” providers seem to be those who demonstrate a genuine investment in getting to know the individuals in their care as people, beyond their diagnoses and status as “patients” (Schön et al., 2009).

While this study has advanced our understanding of the integral role of therapeutic relationships in supporting positive treatment experiences and recovery, additional research is needed. Relative to the broader literature on treatment engagement and the therapeutic alliance, there has been less focus on understanding the role of therapeutic relationships specifically in the treatment of those with SMI (Denhov & Topor, 2011). This trend seems to be shifting in recent years, with increased awareness of the importance of exploring both consumers’ and providers’ perspectives of “what works” and “what doesn’t work” with respect to therapeutic relationships within SMI populations. In their review of the qualitative research on this topic, Ljungberg, Denhov, and Topor (2016) found that individuals with SMI perceived professionals as most unhelpful when they were pessimistic, held a predefined view of individuals in their care, and/or were highly critical and negative. The extant quantitative research in this area has also offered some support for the associations between the therapeutic alliance and decreased symptom severity, improved quality of life and social functioning, and reduced time spent in the hospital (McCabe & Priebe, 2004).

Most of the literature on the role of the therapeutic alliance in fostering positive treatment experiences—both within SMI populations and more broadly—has been conducted with outpatient samples. This may be, in part, due to the fact that investigating the inpatient therapeutic alliance is made uniquely complicated by multiple treatment modalities, caregivers, and staff roles (Blais, 2004). While there has been some research on the inpatient therapeutic alliance, to date, this literature has not focused specifically on SMI populations. Nonetheless, this broader research has highlighted the integral role of the inpatient therapeutic alliance in predicting individuals’ satisfaction with services and treatment compliance in acute-care settings (Martin, Garske, & Davis, 2000; Mitchell & Selmes, 2007; Olfson et al., 2000). This study has also found that the inpatient alliance is established early, remains relatively stable throughout treatment, and exerts a strong influence on clients’ evaluation of the quality of their care (Blais, 2004). In fact, individuals’ inpatient therapeutic relationships in acute-care settings are considered integral to shaping their hospitalization experiences (Walsh & Boyle, 2009). Finally, there is nascent supportive evidence that the inpatient alliance is associated with better outcomes not only upon discharge but also once individuals have transitioned back into the community (McCabe & Priebe, 2004; Olfson et al., 2000). This study suggests that individuals’ inpatient therapeutic relationships have the potential to be impactful beyond the inpatient stay itself.

The relative paucity of research on fostering positive inpatient therapeutic relationships among individuals with SMI is notable because past research has highlighted particular concerns about the quality and provision of inpatient care for this population (Ljungberg et al., 2016). Indeed, extant research has found that inpatient treatment for individuals with SMI is often characterized by either a perceived “lack of (therapeutic) relationship” or experienced as punishing, abusive, dehumanizing, and based in fear (Ljungberg et al., 2016). This literature has been limited in scope and is mostly based on exploring individuals’ past experiences in the hospital, with a particular emphasis on barriers to positive therapeutic relationships. While examining prior negative experiences in care is helpful and provides a useful foundation for future research, it limits our understanding of “what works” in terms of positively engaging individuals with SMI in their treatment during hospitalization.

This article seeks to add to the growing body of literature on barriers to and facilitators of establishing positive therapeutic relationships among individuals with SMI. We chose to focus specifically on exploring these questions in an inpatient context as this remains an underexplored area of research. We also sought to address some of the aforementioned methodological limitations in the literature by conducting prospective, qualitative research on both facilitators and barriers to therapeutic relationships for individuals receiving treatment in state psychiatric facilities. To our knowledge, there has not yet been any research that examines inpatient therapeutic relationships in longer-term care facilities, as the limited inpatient research has been restricted to acute-care settings. Of note, longer-term care facilities, including state psychiatric hospitals, serve a disproportionately higher percentage of individuals with serious mental illness and are, thus, uniquely suited to exploring these types of questions.

1 | INPATIENT EXPERIENCE IN STATE PSYCHIATRIC FACILITIES

There are important systems-level differences between state psychiatric facilities and acute-care settings that merit explanation. Especially in the era of managed care, state psychiatric facilities have been uniquely confronted with providing quality healthcare to the most challenging consumer populations despite increasing operating costs and financial constraints (Agency for Healthcare Research & Quality, 2010; Fisher, Geller, & Pandiani, 2009; National Association of State Mental Health Program Directors, 2014). Generally dependent on local, state, and federal funding sources to provide services, state hospitals play an integral role in the healthcare safety net, providing healthcare services to patients who might have limited access and/or cannot be safely and effectively treated elsewhere, including a large proportion of individuals from lower socioeconomic backgrounds (Agency for Healthcare Research & Quality, 2010), as well as those with criminal justice backgrounds (National Association of State Mental Health Program Directors, 2014).

In most cases, only individuals who cannot be safely and effectively treated in another setting are considered for admission to state psychiatric facilities (National Association of State Mental Health Program Directors, 2014). As such, “difficult-to-discharge” patients are disproportionately represented in state psychiatric facilities, including individuals with comorbid medical conditions, “inappropriate behaviors,” and those reluctant to leave the hospital and re-enter the community (Fisher et al., 2009; National Association of State Mental Health Program Directors, 2014). This, typically, results in lengths of stay that are considerably longer than acute hospital stays, such that individuals might remain in treatment for months or years at a time. In fact, individuals are often transferred directly to state psychiatric facilities from acute-care inpatient settings. It is evident that mental health providers at state hospitals face notable challenges in providing quality care for populations with high clinical need, despite limited resources. Given that individuals with SMI may already be vulnerable to negative experiences in care, it is critical to focus on their treatment in these types of high-acuity, low-resource settings. Though the literature has pointed to a relative “lack of relationship” between consumers and their inpatient providers (e.g., Hughes, Hayward, & Finlay, 2009; Ljungberg et al., 2016; Tidefors & Olin, 2011), it is possible that longer lengths of stay offer greater opportunity to develop positive therapeutic relationships in these contexts.

2 | CURRENT STUDY

Therefore, the aim of this qualitative study is to explore the inpatient-treatment experiences of individuals near discharge from three state psychiatric facilities in the Northeast. In particular, we focus on elucidating the barriers and facilitators faced by individuals with serious mental illness in establishing a positive therapeutic relationship within this public-sector context.

3 | METHODS

3.1 | Participants

Participants were 22 individuals receiving psychiatric inpatient treatment in three separate state psychiatric facilities in New England (see Table 1 for sociodemographic characteristics). Sociodemographic and clinical data were obtained from participant self-report. All of the participants were transferred directly to each of these state hospital from either acute/short-term inpatient settings ($n = 11$), forensic hospital settings ($n = 6$), or incarceration ($n = 5$). All of these facilities serve the economically disadvantaged and provide extended-care for “hard to treat” consumers (MA Executive Office of Health and Human Services, n.d.). Each of the inpatient units housed within the state psychiatric facilities was run by a multidisciplinary team of providers that offered a range of clinical services to clients. Individual clients were assigned to “mini teams” that consisted of a psychiatrist, social worker, and often a psychologist. Mini team meetings typically occurred every 2 weeks, with the exception of one participant, who reportedly met with her team daily due to ongoing medication monitoring and adjustment. Therapy was offered mostly in a group context, though some clients ($n = 7$) received individual sessions with the unit psychologist and/or psychology intern. The average length of stay for the individuals in our sample was 9.6 months; the shortest length of stay was 2 months, and longest length of stay was 2 years. Of note, these lengths of stay do not account for the amount of time spent in prior hospital settings and/or incarceration.

With respect to clinical characteristics, interviews revealed that the majority of participants in our sample had been previously hospitalized and, in many cases, multiple times ($n = 16$). There were only four individuals for whom

TABLE 1 Self-reported sociodemographic and clinical characteristics of study participants ($N = 22$)

Characteristic	N	%
Gender		
Male	13	59
Female	8	36
Other	1	5
Hispanic or Latino origin		
Yes	4	18
No	18	82
Race		
Asian	1	5
Black or African American	5	23
White	12	54
Other	4	18
Participant views self as having a mental illness		
Yes	11	50
No	9	41
Choose not to answer	2	9
Marital status		
Single	18	82
Married	1	5
Divorced	2	9
Choose not to answer	1	5
Education		
Less than high school	4	18
High school or GED	8	36
Some college or associates degree	9	41
Advanced degree past college	1	5

Abbreviation: GED, general educational development.

this help-seeking episode was their first hospitalization experience. Half of the sample ($n = 11$) endorsed having a mental illness and chose to describe their psychological difficulties in a variety of ways: some with diagnoses (i.e., depression, anxiety, bipolar disorder, schizophrenia, schizoaffective disorder, and posttraumatic stress disorder); others according to symptoms (e.g., hearing voices and hallucinating). There were nine participants who did not feel they had a mental illness; however, only a handful of these participants elaborated on their response. For example, one participant preferred to discuss her mental health challenges in terms of a “mental, physical, and developmental disability,” rather than as a mental illness because that “scares people.” Another participant noted, “They say I do,” with respect to his providers’ opinions of his mental health status.

3.2 | Materials

The current project utilizes data from 22 individuals currently receiving treatment in a state psychiatric setting. In this article, we report findings from our analyses of the predischarge qualitative interviews conducted with individuals on their inpatient units, with a particular focus on discussing themes pertinent to individuals’ therapeutic relationships.

After providing informed consent, all participants completed a demographic questionnaire before starting the interview. Interviews lasted approximately 45 min and covered a range of topics, including participants’ perceived reasons for hospitalization, causal illness beliefs, relationships with inpatient providers, and ideal aftercare treatment plans. With respect to the focus of this article, there were a number of ways in which the interview guide explored individuals’ therapeutic relationships with their providers (e.g., “mini teams”). For example, participants were asked to discuss what their providers had said about their need for hospitalization and the potential causes of their mental health challenges. Individuals also talked about their prior experiences with mental health services—What had been helpful and had gone well, and what providers could have done differently to improve their care. Participants tended to compare/contrast their previous treatment experiences with their current inpatient stay and therapeutic relationships. Finally, participants were asked to comment on the process of planning for discharge with their providers.

3.3 | Procedure

Participants were largely recruited with the help of their inpatient-treatment teams, who had been briefed about the study and agreed to support recruitment. Providers identified individuals who were “discharge-ready” and clinically stable on their respective inpatient units and facilitated their introduction to research staff to hear more about the project. Inclusion criteria included being 18 years or older and identified by the clinical staff as ready to be discharged. Exclusion criteria included status as a forensic patient undergoing short-term evaluation and assessment, as well as individuals who refused to be audio recorded during the interview process.

All individuals provided written informed consent before participating. Consenting and enrollment was completed by the first author and took place in private conference rooms on patients’ respective inpatient units to ensure confidentiality. Though capacity to consent was not formally assessed, the principal investigator collaborated with inpatient clinical staff and used clinical judgment when determining individuals’ appropriateness for research. None of the individuals introduced by inpatient staff to the research team failed to demonstrate the capacity to consent. For those individuals with legal guardians, the first author completed the consent process by phone, and signed documents were transmitted by fax or secure email. All demographic and necessary contact information was obtained through participant self-report. Participants also agreed to be audio recorded during the interview process. Finally, individuals were paid \$10 for their completion of the interview. All research materials and procedures were reviewed and approved by the Institutional Review Boards at Clark University and the Massachusetts Department of Mental Health and Public Health.

3.4 | Data analysis process

We used thematic analysis to analyze the interviews, a theoretically flexible, stand-alone qualitative method for identifying patterns or themes within the data (Bogdan & Biklen, 2003; Boyatzis, 1998; Braun & Clarke, 2006). Following data collection, interviews were transcribed verbatim before data analysis. We used Dedoose, Version 5.3.12 (2015) (www.dedoose.com), a qualitative and mixed-methods analysis program, to aid in our sorting and retrieving of data throughout the coding process. Pseudonyms were assigned to protect confidentiality.

Data analysis proceeded according to the six phases of analysis outlined by Braun and Clarke (2006). The first author was the primary coder for this study, though a second coder (third author) analyzed a subsample of the data set to ensure that multiple interpretations were considered. Both the first and third authors were involved in the transcription process and were engaged in active discussion about potential codes and patterns before formally analyzing the data. We then began the coding process together by engaging in line-by-line coding of two transcripts, which allowed us to begin organizing the data meaningfully into initial categories (Braun & Clarke, 2006). Both coders then independently coded four interviews and compared findings via in-depth discussions of similarities and discrepancies regarding identified codes. This analytic triangulation ensured that both coders' perspectives were taken into consideration when expanding and collapsing initial codes (Patton, 2002). We resolved coding differences during ongoing meetings throughout the analysis phase. The first author continued coding the remainder of the transcripts, creating new codes based on emerging theoretical categories. Earlier transcripts were reread and analyzed again to ensure that any newer codes were applied to all relevant excerpts of the data.

Once initial coding was complete and the codes were appropriately collated, both coders sorted the codes into potential themes. The research questions and interview guide questions, as well as the use of a contextualist lens (discussed further below), aided our efforts in considering how different codes might inform an overarching theme (e.g., therapeutic relationship) and/or corresponding subthemes (e.g., desire for more one-to-one time). The first author and primary coder for this study were primarily responsible for reviewing and defining the final thematic scheme. Of note, themes that appeared to overlap in content were collapsed, whereas those that were irrelevant to the rest of the data set and/or to our research questions were excluded. Our findings below reflect part of the refined, final thematic scheme—Each theme we introduce aims to 'tell a story' that is linked with the broader research questions pertaining to individuals' relationships with their inpatient providers.

3.4.1 | Methodological lens

We used a contextualist approach to guide our analysis, which allows researchers to consider the broader social context in making sense of individuals' experience and meaning-making (Braun & Clarke, 2006). Though merit is given to individuals' statements and expressions, they are understood relative to participants' surrounding context, from which they can never be isolated (Bronfenbrenner, 1986; Pettigrew, 1985). As such, contextualism is primarily concerned with "the event in its setting," acknowledging that as the context of an event changes, the knowledge will need to change as well (Pettigrew, 1985, p. 6). Thus, throughout the analysis process and in refining our thematic scheme, we were attuned to how our participants' treatment context informed their responses to our questions and understood their narratives relative to this context. In particular, we considered how the systemic challenges faced by public-sector hospitals might influence aspects of individuals' hospitalization experiences, including their relationships with the inpatient-treatment team.

4 | RESULTS

In examining the factors that may impact the therapeutic relationship in the context of treatment at state psychiatric hospitals, several salient themes emerged. It is important to note that participants rarely discussed their

relationships with providers in explicitly positive or negative terms. Rather, our findings underscore the complexity of establishing therapeutic relationships, such that barriers and facilitators can and often do coexist in the context of a single consumer–provider dyad. We begin our discussion by identifying those factors that may hinder the development of a positive therapeutic relationship in this unique treatment context. We then turn our attention to elucidating facilitative factors that support the development of a positive therapeutic relationship.

4.1 | What factors may hinder therapeutic relationships in state psychiatric hospitals?

4.1.1 | Inadequate individual meeting time

Half of the participants in our sample ($n = 11$) pointed to insufficient individual meeting time as a source of frustration. Individuals explained that they were assigned a team of cross-disciplinary clinical providers, but bi-monthly meetings were often short, and there were some providers present with whom patients rarely had direct contact. It is important to note that only one of these individuals had been engaged in individual therapy for the duration of his treatment. Otherwise, participants relied solely on team meetings and/or had been assigned an individual therapist for a relatively brief period of time ($n = 2$).

Timothy, a 65-year-old White male, noted that his inpatient experience could have been improved had his providers “met with [him] on a more regular basis, one-on-one.” He thought it was “sort of odd” that some of his providers, including the unit psychologist and occupational therapist, were only present for biweekly team meetings, which often did not include clients. Though Timothy had more frequent contact with his social worker, he still expressed dissatisfaction with their limited time together. He stated, “Today he came in and said, ‘Can we talk for a couple of seconds?’ The hospital setting is set-up to talk to patients for a few seconds, there’s not much (communication) that goes on.” Timothy’s assertion is noteworthy given that he had been hospitalized for 1 year and 3 months at the time of his interview. Another individual, Raphael, a 24-year-old biracial male, who had been in the hospital for 9 months, expressed similar sentiments regarding his very-limited time with providers. He poignantly expressed,

When I first got here, they didn’t listen to me. They didn’t care what I had to say...it would be good if they could actually listen to the patients and have the patience. Like when I’m in team, I’m only in there for 5 minutes, and then they kick me out. I’m only in there for a few minutes. You should be in there for at least 10 or 15 min to, you know, talk...they don’t have people do that. They’re quick, you know? In and out, in and out.

Even those participants who were able to establish positive relationships with their providers acknowledged the inherent limitations of receiving care in resource-challenged settings. For example, Linda, a 48-year-old biracial individual, expressed discouragement and concern about how other consumers were being treated as a result of limited time and resources. Linda had been in the state hospital for 2 months at the time of her interview. She stated,

Sometimes the person is not in the best state of mind and sometimes the doctor doesn’t really take them seriously as a human being, and kind of talks down to them or won’t reach out to help them. Like, right now we have 30-something patients and two doctors. And they just keep adding more and more patients. And I’ve noticed that not too many patients actually leave this place. Just more and more (patients)...this hospital doesn’t care. It’s like a factory.

4.1.2 | Lack of communication regarding clinically relevant topics

Almost half of the participants in our sample ($n = 9$) pointed to a lack of open communication with their providers as negatively impacting the therapeutic relationship. Only three of these individuals had been given the opportunity to

work with an individual therapist over the course of their hospital stays. Individuals explained that their inpatient providers had failed to provide them with clinically relevant information pertaining to their diagnosis, medication management, and discharge planning. This is despite an average length of stay of 9 months among these participants. For example, Steven, a 43-year-old White male, expressed frustration about his lack of knowledge regarding his assigned diagnosis of schizoaffective disorder, having already been hospitalized for 3 months. He stated,

It's like, you know, I ask them on what basis? What do you have to go on with this? Tell me. I ask them, and they didn't say anything. At least that's my impression—I asked them for examples, and they wouldn't give me any.

Another participant, Jordan, a 38-year-old African American male, expressed concern that he had not yet discussed with his psychiatrist what he understood as a problematic medication side effect. Jordan had transferred to the state hospital from a forensic setting, where he had resided for 4 years; he had been on the inpatient unit for 5 months at the time of his interview. Jordan noted, "I will have urges, urges to swing on people...I'm holding it back. It's an everyday struggle...I mean, I think it's the medication, that's why I want to go to my doctor." Jordan worried that his treatment team might penalize him if he were to express concerns about his current medication regimen openly. He explained, "So it's like, you can't really (speak up), you gotta do what they said or else they might get mad and stuff like that. I don't wanna offend nobody, you know what I'm saying?" Thus, as a result of his concerns about the potential negative implications of "speaking up," Jordan did not feel empowered as the client to raise this topic in the team.

4.1.3 | Perceived discrepancies in client and provider perspectives

Given a perceived lack of adequate meeting time and open communication, it is perhaps unsurprising that the majority of participants did not feel that they were on the same page as their providers. These perceived discrepancies between clients and their providers existed across three domains including causal illness beliefs, diagnosis, and treatment. We discuss each briefly, in turn.

Despite being hospitalized and accepting medications, fewer than one-third of participants ($n = 7$) endorsed an understanding of their mental health challenges that was consistent with the traditional biomedical model. Those individuals who did, noted that their "genetic predisposition" to illness and/or a "chemical imbalance" might have played a role in the onset of their mental health challenges, together with significant psychosocial stress. These participants tended to have been hospitalized for longer periods of time, such that the average length of stay among these individuals was just over 1 year. In contrast, almost all the participants in our sample ($n = 20$) highlighted the centrality of psychosocial stressors in causing their mental health challenges. The most frequently endorsed psychosocial cause of the illness was past trauma, including childhood abuse and domestic violence. Individuals also cited such contextually sensitive causal factors as unemployment, feeling overworked, dropping out of high school, institutionalization, and experiences of discrimination. For example, Joe, a 55-year-old multiracial male, who had been hospitalized for 2 years, endorsed experiencing psychosis but understood his symptoms as resulting from "racial profiling" and rejected the biological model of illness. Joe explained, "I've been discriminated against...all different forms of racial profiling and hate crimes—I've gotten assaulted three times." Joe believed that these experiences of discrimination "most likely" contributed to him developing psychosis and becoming mistrustful of others. Joe described,

I'm the type of person, I can socialize with anybody...but certain people I don't know that well, and I don't know who would try to do the (hate) crimes. That could be part of my illness, like hearing somebody said

this about me, or I thought someone said that...then it kind of turns into my illness...(but) I don't hear voices, I'm talking about people talking (negatively about me).

In addition to differences in opinion about what had caused their mental health challenges, a few individuals ($n = 4$) also noted that they disagreed with their providers about their assigned diagnosis. Of note, three of these individuals had been in the hospital for a few months (i.e., 3–5 months) at the time of their interviews, and none of them had been assigned an individual therapist. For example, Taylor, a 23-year-old White female, believed that she had posttraumatic stress disorder as a result of childhood trauma, whereas her inpatient psychiatrist had diagnosed her with bipolar disorder. Taylor had been engaged with the mental health system via residential treatment facilities and/or group homes since the age of 18. She had been in the hospital for 5 months when she stated,

I don't have a chemical imbalance or anything, it's just what I went through when I was a kid...The doctor here, he once said that I was bipolar and I told him, "Listen, I know myself. I'm not bipolar—I've never been manic, I've never had or felt euphoric or elated or anything. I've always been depressed." So I disagree with him on that.

Last, a significant minority of individuals ($n = 5$) explained that sometimes as a result of the aforementioned discrepancies, they disagreed with their providers around treatment planning. These participants had been hospitalized for an average of 1 year at the time of their interviews. These disagreements occurred almost exclusively in the context of discussing medications and/or electroconvulsive therapy, both biological agents. For example, Jose, a 21-year-old Latino male, who had been in the hospital for 7 months, had reportedly told his treatment team that he did not want to take medications, as he did not feel he needed them. Jose explained, "I don't like taking pills...They (my doctors) said it helps me relax. They suggested that I should take them...or I won't be healthy, I won't be acting right." After receiving this feedback from his providers, Jose opted not to "push the issue" and takes his medications as prescribed despite his own reservations. He was one of the few individuals in the sample to be assigned an individual therapist for the duration of his inpatient stay.

4.2 | What factors may contribute positively to therapeutic relationships in state psychiatric hospitals?

4.2.1 | Feeling heard and understood by providers

There was a significant minority ($n = 5$) of individuals who explained that their therapeutic relationship was strengthened by providers who were compassionate and led individuals to feel cared for, listened to, and understood. It is somewhat surprising that none of these individuals had been assigned to work with individual therapists on their respective inpatient units. For example, Mary, a 47-year-old White female, who had been in the hospital for just over 1 year and had long struggled with depression and suicidality, explained that the most helpful thing her providers had done was "talk to [her], listen to [her], and give advice" that she found "eye-opening." The trusted and nonjudgmental conversations she had with her inpatient providers aided Mary to better understand how her own self-injury could negatively impact her children; this was a turning point in her recovery. Another individual, Chris, a 46-year-old White male, who had been hospitalized for the first time, also valued the genuine connection he had shared with his providers as an integral component of his recovery. Of note, Chris had only been in the hospital for just over 3 months at the time of his interview. He stated,

The conditions are what they are, it's a 50-year-old facility, that's state-run, doesn't have a lot of money... but once I got past how horrible the conditions were, the people who work here were very easy to talk to... and I didn't feel like they were here to analyze me...as they were to listen...unlike a lot of other places that I've been in the last year, they were human and sometimes it's really hard to find that.

Similarly, Jade, a 35-year-old African American female with a long history of psychiatric treatment, indicated that the care and patience demonstrated by her providers allowed her to get the most out of her hospital stay over the last 6 months. Jade explained,

I understood why I was here (in the hospital), but I didn't care because my voices were running rampant. I just sat all day, talked to myself, talked out loud, negative outbursts...things like that. They (the doctors) were patient with me, they didn't push me...they just sat there and waited with me. The doctors took their time with me, didn't rush me or push me out the door. They didn't push me to take medication, and they listened. I just felt safe, like I was in a secure place.

4.2.2 | Facilitating a comprehensive and timely discharge plan

There was also a significant minority of individuals ($n = 5$) who noted that their providers' efforts to facilitate a timely discharge and access to social services were most helpful. The average length of stay for these participants was 9 months. Individuals appreciated their providers' efforts to help move them toward discharge, explaining, "I don't want to be here, and they want to get me out of here, too...so that feels good," or, "They are helping me get my discharge and find the proper treatment." For example, when describing the "positive relationship" she shared with her social worker, Mallory, a 49-year-old White female who had been hospitalized for just under one and a half years, stated,

He sets the rate of things, and he's moving me forward...and he did it right. I'm going to go to a program outside (of the hospital) again, and how can I deny it?... I have nothing to say—I'm so bored that I can't wait to go. I wish today was (discharge date) so I can go.

Participants were also quick to acknowledge their gratitude for providers' efforts to help them secure employment, housing, access to education, transportation, and so on. This is perhaps unsurprising given that participants largely understood their hospitalization as a means by which to "get back on their feet." For example, Jose, who was homeless at the time of his admission, expressed how helpful it was to work with his social worker to find housing postdischarge and establish new habits to support his success. He noted,

He helps me to get better and to get out of the hospital...we actually signed up for housing. They gave me the sheet to sign, and I sent it in myself, so that was helpful. We just talk about getting me out of here and how I'm gonna do...and we talk about how I need to stop the habits I had, so that has been helpful.

Jordan, who had also been homeless on admission, felt similarly about the ways in which his inpatient providers had been most helpful to him. He explained, "They work hard to get me out of here, they worked real hard...to get my license certificate, (they're) trying to get me an ID, trying to give me social security, and stuff like that." Both Jose and Jordan had been engaged with inpatient treatment for about 6 months at the time of their interviews.

4.2.3 | Thinking broadly about aftercare

In considering their "ideal aftercare," most participants ($n = 17$) indicated a strong preference for maintaining their wellness in ways that extended beyond formal psychological services. Thus, while individuals wished to continue engaging with formal psychological services, they viewed treatment alone as limited and insufficient. This highlights an additional avenue by which inpatient providers can foster the therapeutic relationship and ensure effective, client-centered discharge-planning. Some of the alternative ways of maintaining health and wellness espoused by

participants included such activities as exercise, creative expression (e.g., art, music, and dance), meditation, and journaling. Additionally, several individuals emphasized the importance of establishing social connections and experiencing social support throughout the recovery process. For example, Chris explained that he was looking forward to joining an athletic group not only to stay active and reduce stress but also to spend time with his friends. He noted,

I would go out and shoot some hoops, you know, play softball with some friends...I think that's just such an easier way to not just relate, but to relieve any tension that's going on...you know, you get it all out your system, and then once it's over with, go somewhere and sit down with your friends and joke and pick on each other and do all kinds of things.

Other participants expressed hopes for future interpersonal connection that included cooking meals for family members, “grabbing a cup of coffee” with new friends at a group home, reconnecting with friends and family from whom participants were disconnected, and starting a romantic relationship that would, hopefully, lead to marriage and a family.

5 | DISCUSSION

This study aimed to address prior gaps in the literature on treatment engagement by conducting in-depth qualitative interviews with individuals near discharge at three state psychiatric facilities in the Northeast. Our consumer-centric data allowed us to more comprehensively explore factors impacting the therapeutic relationship between individuals with serious mental illness and their providers in the state hospital context. Although participants rarely discussed their relationships with providers in an entirely positive or negative term, they did comment on barriers to developing a positive therapeutic relationship more often than they discussed facilitators. This imbalance perhaps shows how difficult it can be to establish strong therapeutic relationships in these resource-challenged settings, despite average lengths of stay lasting several months and sometimes years. Consistent with how we presented our results, we delineate our discussion of findings based on factors commonly endorsed across participants that hindered versus facilitated a positive therapeutic relationship.

With respect to factors impeding positive therapeutic relationships, our results indicated that half of the individuals in our sample did not feel they were meeting regularly enough with their providers. It is important to consider that this theme emerged mostly among participants in our sample who had not been assigned therapists during their hospital stay. As a result of inadequate individual meeting time, the kinds of conversations and exchange of information that individuals desired were hindered. Thus, individuals perceived a lack of open, reciprocal exchange of communication regarding clinically relevant content—For example, assigned diagnosis, medication side effects, and aftercare planning. Research on the healing role of patient-provider communication suggests that enhancing individuals' knowledge about clinically relevant topics facilitates their understanding of their illness, its associated risks, and various available treatment options (Street, Makoul, Arora, & Epstein, 2009). This exchange of information between patients and their providers can also lead to a shared understanding and sense of collaboration, enhancing consumer satisfaction, the therapeutic alliance, and individuals' commitment to treatment (Street et al., 2009). It is plausible that, given their extensive treatment histories, the individuals in our sample may have engaged in conversations about their diagnoses and medications in the past. Nonetheless, our results indicate that ongoing reciprocal communication is still essential to establishing positive therapeutic relationships and supporting continued treatment engagement. This may be especially salient when accounting for the fact that most of the individuals in our sample had been in the hospital for almost 1 year. Importantly, these findings illustrate a notable way in which this unique treatment context can exacerbate individuals' sense of disconnection from their providers. Indeed, some of the participants themselves acknowledged the explicit ways in

which these resource-challenged settings—referred to as ‘factories’ in one case—contributed to feeling dismissed and invalidated by their treatment teams. Perhaps had these participants been given the opportunity to work with a therapist on the unit, these gaps in communication could have been more easily bridged between individuals and their treatment teams. Of note, though it is plausible that other inpatient psychiatric facilities face similar difficulties, the individuals in our sample are nonetheless providing valuable information about how the therapeutic relationship was influenced by this specific treatment context.

Perhaps unsurprisingly given these aforementioned barriers, several individuals in our sample did not feel they were on the same page as their providers with respect to how they understood their mental health challenges nor their treatment preferences. Most notably, though participants were regularly prescribed psychiatric medications as a first-line approach to the treatment of their illness, the majority of individuals endorsed causal perceptions of illness that were incongruent with the biomedical model. It is interesting to note that the individuals who did endorse biological causal beliefs also tended to have been in the hospital for more than 1 year. It is plausible that, given their longer lengths of stay, these participants had more opportunity to develop insight into their mental illness and/or receive psychoeducation about the causes of SMI.

Extant research has highlighted that perceived discordance in client versus provider understandings of illness can impede the therapeutic alliance (Rüdell, Bhui, & Priebe, 2009). Given this, it is critical from an engagement perspective that providers facilitate explicit conversations with their clients about how they make sense of their psychological distress and their preferred treatments (Kleinman, 1980; Lauber, Nordt, & Rössler, 2005; Petrie, Broadbent, & Kydd, 2008; Rüdell et al., 2009). It may be difficult for consumers in state hospitals to receive ample opportunity to explore the myriad ways in which they understand their challenges, particularly outside the context of individual therapy. Nonetheless, the research supports that this kind of dialogue facilitates collaboration, enhances the therapeutic alliance, and results in client-centered practice, all of which positively impact engagement (Callan & Littlewood, 1998; McCabe & Priebe, 2004).

Importantly, though many individuals offered insights about what factors negatively impact the therapeutic relationship, they also illuminated noteworthy facilitators. Our results suggest that perhaps the most powerful action providers can undertake to strengthen the therapeutic bond is to develop a collaborative working relationship. The participants in our sample experienced active listening by their treatment providers as particularly important, as it made them feel cared for and understood. Indeed, there is considerable support for the facilitative role of adopting a “nurturing” stance to treatment, in which providers strive to be nonjudgmental, listen attentively, and convey a sense of understanding the patient (Ackerman & Hilsenroth, 2003; Bachelor, 1995; Sexton, Hembre, & Kvarme, 1996). These findings suggest that, among a group of individuals with SMI, feeling heard and understood by their providers appears to be integral to fostering connection. It is noteworthy that, above other in-session therapeutic techniques and/or providers’ theoretical orientations, participants highlighted the power of active listening. These results are encouraging given that prior qualitative research has characterized inpatient settings by a relative “lack of therapeutic relationship” for individuals with SMI (Ljungberg et al., 2016). Our findings suggest that it is not only possible to foster these types of positive therapeutic relationships in longer-term inpatient settings, but it is also achievable outside the context of a traditional psychotherapy dyad (i.e., within multidisciplinary team meetings).

In addition to listening and conveying a sense of understanding, inpatient providers can also strengthen the therapeutic relationship by working collaboratively with their clients toward discharge. In describing how discharging planning had been experienced as helpful, participants reflected on a sense of congruence between their goals and those of the treatment team (e.g., “getting back on track”), as well as feeling included as active participants in the process. Thus, ‘effective’ discharge-planning resulted when individuals and their providers worked together toward shared goals. This is consistent with a client-centered model of care, wherein consumer preferences and participation are central to discharge-planning (Anthony & Hudson-Barr, 2004; Hesselink et al., 2012). Our results suggest that effective discharge-planning includes addressing consumers’ preferences for housing and desired social services, in addition to securing traditional outpatient appointments (e.g., aftercare).

Within our sample, individuals remained hospitalized for an average of 9 months to 1 year. We might infer from this that achieving clinical stability and developing comprehensive, individualized discharge plans in this treatment context are often time-consuming and arduous tasks. Nonetheless, as effective discharge-planning can reduce individuals' likelihood of being rehospitalized (e.g., Nelson, Maruish, & Axler, 2000), inpatient-treatment teams might consider routinely adopting a client-centered model of care wherein individuals are invited to participate and share their perspective.

Lastly, our results offered important insights about the diverse ways in which individuals' preferences for "ideal aftercare" include nonpsychiatric means of maintaining wellness. Most notably, several participants cited social support and connection as integral to recovery and coping with longstanding mental health challenges. Indeed, prior research has pointed to social support as an integral source of psychological health and a specific aid to recovery (Hendryx, Green, & Perrin, 2009). This study suggests that clinicians would do well to encourage social engagement and work with clients to identify meaningful social activities to support their recovery (Hendryx et al., 2009). The discharge-planning process represents a unique opportunity to explore individuals' social support network and preferred ways of engaging more actively with loved ones.

It is important to note that clinicians working in state psychiatric facilities are likely already well-informed about the importance of client-centered treatment and ensuring that their clients' voices are heard. Nonetheless, our findings suggest that though client-centered guidelines are likely to inform clinical care in theory, implementing these guidelines in practice may be more difficult. It is plausible, for example, that clinicians find it especially challenging to collaboratively plan for discharge with individuals who experience cognitive impairment and/or may not be able to articulate their preferences. Moreover, having these potentially difficult conversations with every client is time-consuming. There is also no guarantee that clinicians can ensure access to the types of services clients ultimately feel they most need. Thus, although relatively straightforward and perhaps unsurprising, these results underscore the inherent systemic challenges of providing consumer-driven services in these settings. Nonetheless, though potentially more labor-intensive on the front end, involving clients in preparing for discharge (to the extent possible) is likely to bolster their commitment to ongoing treatment, hence reducing the burden on the system in the long-term.

5.1 | Limitations and strengths

There are several limitations to this study worth noting, the first two of which relate to our sample selection. First, because the field has limited consumer-centric data on individuals receiving treatment in state psychiatric settings, we chose to focus our inquiry on this treatment context. We were unable, however, to compare and contrast our findings to the experiences of individuals in private and/or acute-care hospital settings. Future research would do well to consider how these other contexts might differentially inform findings related to the inpatient-treatment experience. Second, our sample consisted solely of individuals who were identified as discharge-ready by their treatment team and may have been told so by their providers. It is plausible that this knowledge influenced their perception of their hospital stay, including as it related to their relationship with inpatient providers. A more thorough exploration of individuals' treatment experience might also include consumers who were recently admitted and/or have been receiving treatment for similar lengths of time, though are not yet considered discharge-ready.

There are additional limitations to consider with regard to this study's methodology. A more comprehensive examination of the therapeutic relationship might do well to include providers' experiences in delivering care. A better understanding of how practitioners make sense of their clients' experiences in treatment, for example, may help determine possible mismatches in providers' versus clients' perspectives of the therapeutic relationship. Additionally, gathering insight from providers on the barriers and facilitative factors to delivering effective treatment, especially in resource-challenged settings, could inform policy and improve care. Lastly, it is possible that participants felt uncomfortable discussing challenges in their relationships with providers, particularly as the power dynamics inherent in the research interview may have mirrored their negative experiences on the unit. Perhaps participants would have been more comfortable exploring these sensitive issues in a focus group with fellow clients,

with whom they are more likely to have shared lived experience. The focus group setting could also allow participants to build upon ideas that other individuals introduce into the conversation.

Despite these limitations, this study has several notable strengths. One of the strengths of this study was its use of qualitative methods, an approach that provided rich, nuanced data about the complexities of establishing a positive therapeutic relationship in the context of an under-resourced treatment setting. Moreover, this article contributes to the existing literature in several meaningful ways. Of note, our purposeful recruitment of an especially vulnerable and historically inaccessible consumer population gave voice to an otherwise under-represented group of individuals. This novel perspective has important implications for future intervention research, as well as policies regarding mental health services delivery.

6 | CONCLUSION

This study was among the first that we know of to offer insights about the inpatient-treatment experiences of individuals with serious mental illness hospitalized in state psychiatric facilities. Cultivating a better understanding of what impedes a positive inpatient therapeutic relationship will aid providers in delivering more effective, client-centered care. This may have particular significance in the context of the transition to aftercare given accumulating evidence that individuals' therapeutic relationships with inpatient providers not only impact their evaluation of their hospital stays but also inform postdischarge service engagement (Blais, 2004; McCabe & Priebe, 2004; Olsson et al., 2000).

Taken together, our findings suggest that enhanced patient-provider communication, adequate individual meeting time, and comprehensive, individually tailored aftercare planning, can all meaningfully enhance inpatient therapeutic relationships for the better. These facilitators aid in conveying a sense of care and understanding for patients and facilitate client-provider collaboration, particularly in the context of resource-challenged settings.

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