Neurorehabilitation: A Disciplined Disciplining Discipline

What discourses are brought into play when people with neurological conditions talk about their relationship with their rehabilitation practitioner?

A poststructural discourse analysis

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Abstract

Neurorehabilitation is an encompassing health service for individuals who experience impairments as a result of a neurological injury or disease. It aims to improve functioning, reduce disability and assist the individual to achieve a desired state. Contemporary perspectives of neurorehabilitation are underpinned by the belief that clients will actively engage in this process, collaborate with their rehabilitation practitioner and help themselves to achieve their desired goal. Client involvement is considered necessary for improved outcomes and as an ethical approach to service delivery. However, the extent and nature of this involvement appears equivocal.

To explore how clients make sense of neurorehabilitation and position themselves as its subjects a poststructural discourse analysis informed by Michel Foucault's theories of discourse and power was undertaken. Foucault's concept of discourse and his approach to power draws attention to the power of discourse to construct its objects, the subject positions made available by the discourse and what these enable or constrain. This discourse analysis explored text where six neurorehabilitation clients discussed their relationship with their rehabilitation practitioners to find out how they constructed their own subjectivity.

Neurorehabilitation was constructed as a discipline that selected a particular type of person to be its subjects and then acted on their behaviours. As a body of knowledge with techniques to shape behaviour, neurorehabilitation functioned as a technology of normalising power internalised by its subjects to address situations where function differed from what was considered normal. The participants were disciplined by, and disciplined themselves with the practices of the discipline to achieve their desired ends.

Foucault's concepts of governmentality and disciplinary power showed the productive way this normative power works to achieve particular ends. The participants became rehabilitation subjects in the hope they would achieve some kind of normality from the practices of the discipline. They were intertwined in strategic power relationships that involved obligations and responsibilities. Neurorehabilitation demanded their sacrifice and

commitment in return for independence and wellbeing. This power relationship was productive and benevolent. The current trends in neurorehabilitation that advocate for devolving practitioner dominated services, incorporating client perspectives and adopting a biopsychosocial model capitalise on this strategic relationship.

Viewing neurorehabilitation as a discipline revealed some of the strategies this technology used to achieve its ends. This can assist us to attend to the possibilities these strategies offer and be wary of the potential dangers.

Contents

Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institute of higher learning.

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Related publications

Cummins, C. Kayes, N. Payne, D. (2015) Taking another look: a reflection on the benefits and challenges involved in conducting a secondary analysis of qualitative data. Oral Presentation. *International Institute of Qualitative Methods Conference.* Crown Hotel, Melbourne. April 2015.

Cummins, C. Payne, D. Kayes, N. (2016) Neurorehabilitation a disciplined disciplining discipline. Oral Presentation. *British Sociological Association Medical Sociology Group Annual Conference.* Ashton University Birmingham. 7-9 September 2016. BSA Publications, Durham ISBN: 9780904569476

Introduction and Background

Neurorehabilitation is a practice and a health service constructed as concerned with promoting human flourishing (Gibson, 2016; Wade, 2015). Rehabilitation for people with disease or injury to their neurological system is considered important as such damage is generally not amenable to medical interventions and may account for a complex array of impairments. In the past, people experiencing this type of injury had a poor prognosis (Lanska, 2009). The last half century has seen a growing appreciation of the adaptive capacity of the nervous system to change following damage and a recognition of the place of rehabilitation to manipulate and guide this process to achieve optimal outcomes (Danzl, Etter, Andreatta, & Kitzman, 2012).

As a multidisciplinary service, neurorehabilitation seeks to improve individual functioning, promote social inclusion and assist the individual in the management of her or his own health to achieve their desired state (Royal Australasian College of Physicians, 2015; World Health Organisation, 2011). This service is targeted at those individuals identified as likely to benefit and requires sustained effort on the part of the individual client (Wade, 2015). Contemporary perspectives of neurorehabilitation are underpinned by the belief that clients will actively engage in this process and help themselves to achieve their desired goal (Wade, 2016b).

Recent trends in health service provision include moves to recognise the clients' expertise, incorporate their perspective and involve them as active partners in their own health care (Gzil et al., 2007; Holman & Lorig, 2000). These moves are suggested to address critiques of paternalistic practitioner dominated services and underpin client-centred approaches to rehabilitation (Leplege et al., 2007). For the neurorehabilitation client this active participation involves more than participating in therapy. They are also required to form a collaborative partnership with their practitioner to achieve their rehabilitation goals. This client involvement is considered both necessary to improve outcomes, and as an ethical

approach to service provision (Cott, 2004; Järvikoski, Puumalainen, & Härkäpää, 2015; Krupinski, Seccades, & Shiraliyeva, 2014).

The expectations for this client involvement and the nature of the collaboration with the rehabilitation practitioner is not always apparent. Discussions that classify client behaviour in terms of qualities such as the 'good', 'difficult', 'compliant', 'motivated' or 'unmotivated' suggest that there are certain desirable client behaviours (Kahil, 2009; Koekkoek, Hutschemaekers, van Meijel, & Schene, 2011; Potter, Gordon, & Hamer, 2003; Sutherland & Gilbert, 2008; van Hal, Meershoek, Nijhuis, & Horstman, 2013). These however frequently relate to compliance with practitioner advice, congruence with practitioner expectations and/or achieving practitioner defined goals rather than client collaboration, and appear to serve as reinforcement of practitioner authority (van Hal et al., 2013).

Academic literature appears to signal practitioner expectations for client behaviours however, these are at times contradictory and equivocal. For example, the notion of client – practitioner partnership is in tension with expectations for clients to follow practitioner advice. As a researcher involved in collecting and analysing qualitative data where participants discussed their experiences of neurorehabilitation services, I recognised that participants' expectations and constructions of rehabilitation were at times contrary to those portrayed in rehabilitation literature. Some of the participants understood themselves to be good clients by their attendance at rehabilitation sessions and compliance with practitioner authority, but did not recognise a requirement for on-going practice of prescribed tasks, while others considered they were good clients by the extent of their progress towards their rehabilitation goals. Some described a practitioner-dominated process, while others enthusiastically discussed the collaborative way they worked with their practitioner. This prompted for me an interest in the forces that shape client behaviour. The Marxist explanations of power I was familiar with did not seem to account for the effects I was noticing in the transcripts. According to this perspective, power is a possession of the dominant group who use it to exploit those in minority groups (Abercrombie, Hill, & Turner, 1988). In the transcripts I was analysing there appeared to be more subtle power

negotiations operating between the client and their practitioner. My aim was to conduct a secondary analysis of data using a poststructural discourse analysis approach guided by the theories of Michel Foucault to reveal the ways power operates in neurorehabilitation.

This study asked 'what discourses are brought into play when people with neurological conditions talk about their relationship with their practitioner?' It aimed to uncover the ways in which neurorehabilitation was constructed and the different subjectivities that the participants took up in the rehabilitation relationship. To address the question a literature review was undertaken that examined rehabilitation professionals' constructions of neurorehabilitation and how the client was positioned within those constructions. Following this, a poststructural discourse analysis explored text where neurorehabilitation clients discussed their relationship with their practitioner. The analysis explored how the participants, as neurorehabilitation clients, constructed rehabilitation and positioned themselves as its subjects.

This study involved a secondary analysis of a subset of data collected as part of a research project carried out in Aotearoa New Zealand by the Centre for Person Centred Research Centre (CPCR). The primary study entitled: Enhancing collaboration and connection in neurorehabilitation (EnCOR), aimed to explore the core components of the therapeutic relationship from the perspective of rehabilitation clients following a neurological event and was funded by an internal AUT grant. The semi-structured interviews generated from this study provided the text for this study. This Masters' study did not directly contribute to the aims of this main study. Rather the secondary analysis complemented the main study by offering a different methodological lens to show the tensions and complexity of the therapeutic relationship in neurorehabilitation.

Deliberating terminology

Language is important for poststructuralists who interrogate it for the way it is constituted by and constitutes the reality it seeks to represent (Cheek, 2000). When Foucault discusses bodies, he refers to both the social body, society; and the individual body (Rose, 1999). Included in this a reference to the person and their physical body. Poststructural writers

deliberately use words in this way to signal their double meaning and encourage us to think differently (Nichols et al, 2015). In his approach, Foucault encourages us to think of the physical body as influenced by the social body and vice versa. Gibson (2016) explains that persons "have bodies and are bodies at the same moment – the social is embodied and the body is social" (p. 14).

Throughout this thesis, I have referred to the recipient of rehabilitation services as the client. This word choice in part reflects trends to move away from the use of the word 'patient' in rehabilitation (Prior, 2009). Prior suggests this is because of the association the word has with an acute health setting and assumptions of acquiescence and passive docile bodies who are the object of medical treatment or recipient of services. The use of the word 'client' is also somewhat contentious in rehabilitation literature. For example, Whalley Hammell (2006) claims that the word 'client' can be misleading as it implies a choice to select services or that health practitioners are employed by and answerable to their clients as in a business relationship. Other terms such as consumer or service user are equally problematic. I recognise the problems associated with these terms, however, a term is required to communicate my thinking and I have chosen to use the word 'client' to describe the individuals receiving rehabilitation services. The use of this word also serves to trouble the power relations between client and practitioner.

Somewhat relatedly I have chosen to use the term 'client-centred' rather than the similarly meaning and often used interchangeably 'person-centred'. This decision is to ensure consistency it also recognises the subjectivity of 'client' within this term.

Disability is another contentious term frequently used in rehabilitation, with many rehabilitation academics using it to refer to the impact that impairment has on an individual's ability to function. These sources suggest that rehabilitation is 'a response to disability' and a service that aims to 'ameliorate disability', distinguishing between medical services that deal with disease and rehabilitation services that address disability (for example see Wade, 2016, p. 111). Disability advocates reject siting disability within the individual suggesting rather that disability is the social disadvantage that arises from

impairment (Hughes & Paterson, 1997). Acknowledging this tension, where the intention is to refer to impairment this has replaced the term 'disability' that may have been used in the literature.

Rehabilitation is a multidisciplinary service involving professionals from many disciplines. Again, for the sake of consistency throughout this thesis I have referred to these professionals as the 'practitioner' unless the specific disciplinary role is relevant.

The purpose of this thesis.

Unlike a traditional thesis, this study did not set out to suggest alternative ways neurorehabilitation can be, or signal specific practice implications, as to do so would be contradictory to poststructural scholarship. Foucault (1996) explained in an interview clarifying his position on the political effect of his ideas:

> *It is absolutely true that when I write a book I refuse to take a prophetic stance, that is the one of saying to people: here is what you must do-and also: this is good and this is not. I say to them roughly speaking, it seems to me that things have gone this way; but I describe those things in such a way that the possible paths of attack are delineated. Yet even with this approach, I do not force or compel anyone to attack. So then, it becomes a completely personal question… (Foucault, 1996, p. 262).*

The intention of poststructural discourse analysis is to challenge prevailing notions of the way things are and the assumptions that underpin ingrained principles (Cheek, 2004; Foucault, 1973). Poststructural discourse analysis provides opportunities for questioning the taken for granted as given, natural, normal. It provides frameworks for exploring everyday practice and the assumptions and understandings that shape behaviour and offers space for thinking otherwise (Gibson, 2016). Discourse analysis does not offer closure or suggest that this is the only possible way to interpret text; rather it acknowledges the partial and incomplete reading of one of multiple readings that could be made of the text.

Thesis structure.

Thus far, I have provided a rational for this study and for its methodology. In Chapter Two I discuss the methodological underpinnings. The starting point for carrying out this study was to come to grips with poststructural discourse analysis and Michel Foucault's theories of discourse and power. This chapter documents my understandings of the philosophical and methodological perspective that formed the basis for this discourse analysis. An overview of the relevant key concepts and terms relating to Foucault's theory of discourse and power are presented to provide a grounding for the analysis.

Chapter Three comprises the literature review. Concepts such as neurorehabilitation need to be examined within the theoretical system they constitute and what they mean for those who use them (Gibson, 2016). Therefore, I felt it was important to explore how a range of sources influential in the field constructed neurorehabilitation by examining contemporary academic literature and identifying how the client was positioned in these constructions. I then examined how this positioning was evidenced in the literature in the context of the client – practitioner collaboration to offer an understanding of client involvement in neurorehabilitation.

Chapter Four details the methods used for this discourse analysis. These are discussed together with key considerations for conducting a secondary analysis, the attention to ethical concerns and how I worked to maintain rigor. The in-depth explanation of methodology and methods allows the reader to judge the congruence of approach taken with the question asked, the interpretation argued in the findings chapter, and assess the quality of the research (Nixon & Power, 2007).

In Chapter Five I present the dominant findings from my interpretation of the text. The analysis is integrated with relevant aspects of Foucault's theories using excerpts from the texts to support the argument that neurorehabilitation was constructed as a disciplining disciplined discipline.

Chapter Six brings the thesis together, discussing the key findings in conjunction with Foucault's theories of power, particularly his concept of governmentality and develops the argument introduced in the analysis. This poststructural discourse analysis does not aim to offer suggestions for change but instead to use Foucault's theories of discourse and power to uncover what is taken for granted as 'normal'. Revealing the workings of power may help us understand that things may be otherwise.

Chapter Two: Methodology

This study used a poststructuralist approach to discourse analysis informed by the work of Michel Foucault's notion of discourse and power, to explore the way neurorehabilitation was constructed by its clients. In this chapter, I give a broad outline of the philosophical background that underpins poststructural research and then discuss the key concepts used in this project.

Foucault, like other poststructural philosophers believed there is no objective reality but that reality is constructed through a matrix of discourses that give meaning to the world (Cheek, 2000). This does not deny that the world exists but that as soon as we give meaning, attempt to describe, explain or understand the world we call into use language structures mediated by historical and cultural forces. Discourses are the vehicles that transport meanings, knowledge and beliefs within a cultural and social context (Mills, 2004). They structure how we think and act, and constrain what we think about and know. Discourses are produced by and produce power relations. Power for the poststructuralist is not a thing but a strategy, a relation between forces (Kendall & Wickham, 1999). The nature of these power relationships will be explored further below.

Postmodern or Poststructural?

Poststructuralism and postmodernism are two terms often used interchangeably within social science. Both terms become difficult because they lack consensus of meaning and can be applied to a range of theoretical positions (Cheek, 2000). Although they are both ways of thinking about the world and have many common tenets, they have a different emphasis

and focus (Cheek, 2000). Therefore, it is important for writers to state explicitly their position when using these terms. Postmodern is a term frequently used in the arts and social sciences with diverse interpretations. It can refer to beyond or ultra-modern, or an anti-modernism stance. In art and literature postmodern refers to practices that break with conformity and challenge traditional conventions such as the role of the author and reader. In social science, postmodernism does not refer to a progression from modernism, which puts its faith in science to discover absolute forms of knowledge and promises of progress; instead, the prefix 'post' here implies it is the anti-thesis of, and a response to modernity (Crotty, 1998). It is this opposition to the assumptions of modernity that unifies the diverse strands of postmodernism (Grenz, 1996). Some suggest that the prefix 'post' implies not a move away from, but a recognition of the relationship with the original movement (Grant & Giddings, 2002).

Postmodern theory rejects the possibility of objectivity and finding absolute truth, and views knowledge as socially constructed, relational and personal, fluid and unstable (Crotty, 1998). Postmodernism critiques the philosophical position and assumptions of modernism such as the progressive nature of history, or the prevalence of reason and the discoverability of scientific truth, and contests the humanistic view of the self as a coherent subject (Cheek, 2000). Postmodern theorists renounce the idea that grand narratives or totalising theories and notions of causality can capture human experience. Instead they favour plurality, fragmentation and multiplicity, recognising that knowledge is not neutral but is closely associated with power, and always culturally and historically contingent (Cheek, 2000). The goal of postmodern research is to focus on what is held to be true in a specific community, maintaining that these relative truths construct the ground rules that make possible the well-being of the community (Grenz, 1996).

Poststructuralism is a branch of the postmodern movement within social science that extends from and at times is an anti-thesis for structuralist ways of understanding and explaining social phenomena. Structuralists recognised that structures permeate our world and focused on the systems and institutions that create and govern social action

(Sturrock, 1986). Structuralism had its origins in the work of the linguist Saussure (1857-1913) who did not believe that meaning was held within an object but saw language as a structure and an abstract object in the possession of the collective consciousness of society (Sturrock, 1986). Language systems, which are structures of signs and significations and the rules scaffolding their use, provide the conceptual categories available to individuals (Traynor, 2006).

Structuralism attends to the systems and institutions within which individuals function such as systems like language and institutions like the family. Structuralism downplays the role of the individual agent and runs counter to the ideology of individualism. It puts the individual not as the superior element exercising an untoward power over economic, social and political or literary systems, but within the system and bounded by its rules (Sturrock, 1986, p. 167). The individual is a social concept defined in relation to the existence of others. Structuralism does not deny the individual has freedom or influence but tries to define the extent to which the individual is constrained by the system.

Many of structuralism's ideas once considered subversive have now been incorporated by mainstream western thought, or challenged and disregarded by poststructuralism. Interestingly some of the key thinkers associated with structuralism and responsible for its prominence did not wish to be associated with it. Michel Foucault was among those who apparently claimed they had arrived at their methods without prompting by the structuralist movement (Sturrock, 1986).

Poststructuralism can be considered a response to structuralism. It is a term generally used to denote the work of European philosophers and critical theorists who rejected the binary oppositions, stability and self-sufficiency of the structures posited by structuralism (Sturrock, 1986). While some aspects of Foucault's theories correspond to those of structuralism, he fundamentally disagreed with the structuralist search for definite underlying structures that can explain the human condition and argued that it is impossible to ever step outside of discourse and objectively survey the situation (Foucault, 2002). Foucault also rejected the

poststructuralist label, although this is where his writing is frequently positioned as his theories coincide with its general tenets.

Cheek (2000) suggests that the main distinction between postmodern and poststructuralism is that the former is a theory of society, culture and history and the later a theory of knowledge and language (Cheek, 2000, p 40). For poststructuralists, language is central for the constitution of reality. While they share this belief with structuralists, they do not believe in the existence of a stable core at the base of structures, but rather that these structures are historically and culturally contingent (Jackson & Mazzei, 2013). Poststructuralists focus on the way texts are structured and interrogate language for the way it is constituted by and constitutes the reality it seeks to represent (Cheek, 2000). Texts from a poststructural perspective are the means of representing reality and can be the written word, works of art, structures and practices. For the poststructuralist nothing can be outside language; we need language to convey the meanings that represent our reality. Meaning is always contingent, unstable, historical, contestable, and never fully present to us (Jackson & Mazzei, 2013).

Of particular interest for this study are poststructural explanations of the linkages between discourse and power, knowledge and the self. Poststructuralists assert that language is not neutral or innocent but imbued with power (Gavey, 1989). Power is viewed not as a force or a thing that can be possessed but a relation that operates within and via discourse, always moving and circulating among people. Knowledge is socially constructed through specific relations, is transient, inherently unstable, not neutral, and is closely connected with power (Gavey, 1989). Gavey explains that those in positions of power can regulate what counts as truth and are able to maintain their access to material advantages and power (1989, p. 472). Although in agreement with structuralists' understandings of the individual as a social concept and not the creator of meaning, for poststructuralists the self is a construct and function of discourse (Gavey, 1989). The poststructural self is fluid and fragmented, constituted by discourse, a site of disunity and conflict, always in process and produced within power relations (Jackson & Mazzei, 2013).

Poststructural research questions the normal everyday 'natural' truths and practices held by a social group; explores how these came to be constructed in a particular way and investigates the structures that keep them in place (Cheek, 2000). The goal of poststructural research is not to uncover facts or reveal a truth, instead it offers opportunities to analyse the socially constructed nature of human behaviour and assumptions within language and its power for producing subjectivities.

A poststructural discourse analysis analyses and interprets the operation of systems of signs as they relate to communication practices between humans (Traynor, 2006). It considers how discourses create subjects and subject positions and how these reproduce the relations of knowledge and power (Campbell & Arnold, 2004). Discourse analysis aims to chart the way that the phenomenon of interest is discursively constructed and the way these discursive structures map out subject positions (Mills, 2004). A discourse analysis of rehabilitation would investigate statements that construct rehabilitation and how these statements create the rehabilitation subject and attempt to make visible how power relations are operating in the rehabilitation context.

This study drew on Michel Foucault's concepts of discourse and power to explore how people with neurological conditions receiving rehabilitation services constructed themselves as its clients. To assist in assessing the quality of this discourse analysis the key guiding concepts used are discussed below.

Key concepts

What is discourse?

While the term discourse is often used in the social sciences, it can have a wide range of meanings; it can refer to verbal conversation or the formal treatment of a subject, a unit of speech, a selected text for analysis, or an authoritative voice (Mills, 2004). Generally, however for the poststructuralist, texts are anything that are open to a reading for meaning, with discourses referring to an organised system of concepts and language practices, including elements of practice and regulation (Mills, 2004). Mills explains that

'texts' include what has been said or written, as well as what is implied with actions or intention, or signalled with space. Actions, images and the construction of physical space can convey meaning and produce particular behaviour. For example, the layout of a hospital ward is embedded with meaning and regulates the way the patients and health professionals behave within the space. Discourses are clusters of statements, which are the basic unit of discourse that refer to the same phenomenon and the practices these statements bring about. Surrounding supporting, protecting or challenging discourses are practices and structures which keep a discourse in place or allow it to become replaced (Foucault, 2002). Discourses construct, reflect and are supported by institutions (Foucault, 2002). For example, the biomedical discourse generates and is generated by hospitals and universities. Discourses are contextual in that they are always historically and socially situated. For example, a discourse of masculinity from 1950's United States would be very different from one circulating currently in New Zealand. Discourses are also active in that they create or perform or cause something to happen (Mills, 2003). A discourse of masculinity may inspire men's groups to form, motivate clothing styles or perpetuate domestic violence.

Biomedicine is a discourse; a way of thinking and talking about health and illness that creates and is created by medical institutions. Biomedicine is the application of biological principles to human health. It is the dominant discourse shaping the understandings of illness and suffering and the organisational system of healthcare in western societies (Yuill, Crinson, & Duncan, 2010). It has the power to say what counts as truth and thus silence contradictory discourses. Biomedicine's view of health and illness and the power associated with its knowledge has become socially embedded and is generally accepted as the moral authority over clients who are the subjects of its practices (Lupton, 2003). Authority is conferred on its speakers who are able to state what counts as normal health function, as well as to identify and treat variances from normal or standardised states that it classifies as abnormal function.

For Foucault, the term discourse was a central concept in his work, although he often used it in various ways treating it sometimes as the "general domain of all statements, sometimes as an individualised group of statements, and sometimes as a regulated practice that accounts for a number of statements" (Foucault, 2002, p. 90). Discussing discourse and applying the theories of Michel Foucault generally involves overlaying these three definitions.

Within his definition, Foucault included a broad meaning of discourse referring to "all utterances or texts which have meaning and which have effects in the real world" (Mills, 2004, p. 6). For example, as used by Foucault (2002) in the statement: "the subject is produced through discourse, is subjected to discourse and cannot reside outside of discourse" (p. 90). However, Foucault used the term in other more specific ways as well. When he referred to "groups of utterances which are regulated in some way and seem to have coherence and a force in common to them", he was referring to clusters of related statements and practices produced together within power relations (Foucault, 2002; Mills, 2004). For example, the collection of statements related to gender inequality referred to as feminism.

Foucault (2002) also spoke of discourse as "a regulated practice which accounts for a number of statements" (p. 90), which refers to the institutions and practices that produce, reinforce and circulate these statements, and the rules and processes which produce and support particular discourses while denying others. Here Foucault is referring to a discipline such as medicine that includes the associated body of statements and the institutions that generate and utilise those statements, and the practices connected with the discipline. The biomedical discourse constructs and governs the way medical topics can be meaningfully talked and reasoned about. Alternate health practices such as homeopathy are denied credence within a biomedical discourse. Truth claims related to the discourse must be established using authorised methods (Kendall & Wickham, 1999). What can be considered as truth or knowledge in medicine must be proven with scientific techniques and subjected to its rigour checks (Morse, 2015). The discourse also creates

structures that confer authority to specific people. In medicine a hierarchy of authority operates, where generally the registered specialist is the sanctioned authority on medical matters (Lupton, 2003).

Discourses create objects; they name phenomena and bring them into our understanding. There can be more than one discourse about a phenomenon but each discourse will construct the object in different ways (Foucault, 2002). The selected discourse governs how to think about and act towards the phenomenon. For example, a biomedical discourse describes phenomena observed as a *cerebrovascular accident* and classifies this as a '*stroke*' which then suggests that hospital treatment and certain rehabilitation practices are necessary, while a religious discourse may describe the same phenomena as an act of God and therefore prayer and repentance may be proposed.

Discourses construct subjects who are also subjected to the rules and conventions of the discourse. They also produce places for the subject to position themselves within (Traynor, 2006). These positions can be taken up, or imposed upon the subject. The biomedical discourse constructs the individual who experienced the cerebrovascular accident as a stroke patient, and the people who are designated to assist the stoke patient in their recovery as the rehabilitation specialists.

Foucault and the subject

The 'subject' was a general theme of Foucault's work which aimed to uncover the making of the contemporary self (Dreyfus & Rabinow, 1983). However, like the structuralists he did not hold with conceptions of the self as an autonomous stable entity, an independent authentic source of action and meaning. For Foucault the self is not a natural given essence but the dynamic result of events and changing circumstances (Wetherell, Taylor, & Yates, 2001). Foucault was interested in discovering the different ways by which human beings were made subjects. He examined the fields of knowledge centred on human action that attempt to understand, assist and guide social human beings and the institutional

arrangements that sustain human conduct to reveal the effect these activities had on human possibilities (Foucault, 2001).

For Foucault a subject is someone who is subjected to someone else's control and dependent or tied to his own identity by a conscience and self-knowledge (Foucault, 1994). Discourse creates the subject and subjects the subject to its practices. The subject of discourse cannot stand outside discourse (Foucault, 2002; Hall, 2001). Discourses produce subjects by using particular forms of knowledge to define attributes which individuals who personify these attributes are associated. For example, biomedicine uses its knowledge to examine the person who has experienced the phenomena classified as a cerebrovascular accident, identifies the associated symptoms and labels them as a stroke client. The stroke client becomes someone who will be the subject of biomedical attention, the target of rehabilitation practices. The stroke client cannot exist independent of a biomedical discourse.

Discourse also produces places where it makes sense for the subject to locate themselves and thus become subjected to its meanings and regulations (Hall, 2001). The biomedical discourse produces hospital wards, guidelines, procedures and practices for stroke rehabilitation. Discourses offer possibilities to the subject; ways of being, understanding and identifying with, which may vary in terms of the power they offer the individual (Gavey, 1989). The subject position of client becomes available in a biomedical context.

Foucault suggested the phrase *grids of specification* to refer to the classification system used to define subjects of a discourse, and *authorities of delimination* for those in positions of authority who classify and name the subjects of the discourse (Foucault, 2002). The Glasgow Coma Scale is an example of a *grid of specification*, it is a measure used by health professionals (*authorities of delimination*) to assess a client's level of consciousness following an injury to the head. The rating contributes to the classification of the patient as someone with a mild, moderate or severe traumatic brain injury, predicting certain behaviours and determining the type of care the client becomes subjected to.

Subject positions are produced through multiple often contradictory and unstable discourses (Cheek, 2004). For example, the person with stroke can be a health consumer and client, a patient and a docile recipient of hospital care. The individual may be cast into subject positions because of history or the actions of others or can select the discourses they will be subjected to or how they position themselves in relation to various discourses (Mills, 2004). However, this choice may not be rational or conscious as discourses battle for subjectivity that can result in fragmented or contradictory positions in play at one time (Gavey, 1989).

Subjectivity

The discourse that creates the subject and the subject positions for the subject to occupy also specifies the behaviours associated with the position that becomes their subjectivity. Subjectivities are constructed by discourses within power relations (Jackson & Mazzei, 2013). The subject position creates a vantage point for the subject, a place to view the world from (Willig, 1999). From this position, the subject will have a variety of experiences, conscious and unconscious thoughts and feelings, which form their subjectivity and contribute to a sense of self and ways of understanding their relation to the world (Weedon, 1987, in Gavey 1989). This sense of self is not stable but fluctuates in response to everyday practices and in relationship with others (Jackson & Mazzei, 2013). This is why Foucault was against using fixed characteristics such gender and race to describe subjectivity as though they may be subject positions that contribute to notions of self, they may not always be called into play in response to some situations. For example, the individual who takes up the position of neurorehabilitation client while attending therapy sessions may in other situations, take up the subjectivity of Maori author or heterosexual male.

Notions of Power

Foucault did not conceive power as a thing, or something that could be possessed, but a strategy that is practiced, not a force but a relation between forces (Foucault, 2001; Mills, 2003). He saw power as a relation that exists everywhere in every interaction; not central

or unidirectional but operating in webs of relationships(Foucault, 1983). Foucault critiqued conventional notions of power as a repressive force possessed by particular individuals or groups. He suggested that such a notion of power is essentialising, making one party always the oppressor and the other the oppressed, which disregards the freedom and agency people have to resist or use power for constructive purposes (Jackson &Mazzei, 2013).

Foucault's vision of power is as an unstable constituent subject to resistance or challenge and enacted in every interaction (Mills, 2003). Such power relations are reciprocal; they can be unequal, with points of confrontation, instability and conflict, but are always moving and circulating among people (Foucault, 1991). We accept power, Foucault explained because of "the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (Foucault, 1991, p 61). Foucault was interested in the productive effects of power as it circulated through the practices of people in their everyday world. Power relations between supervisor and student within an academic discourse are behind the production of this thesis.

Power/knowledge

Foucault recognised the intimate relationship that power has with knowledge and the subject. Through his work, he demonstrated how knowledge about people is constructed as a function of power (Jackson & Mazzei, 2013). The knowledge that the health professional has acquired through their academic training gives them power to assess, diagnose and treat the client. This formal knowledge is reinforced through their practice and leads to the acquisition of further knowledge. The power relation between the rehabilitation professional and the client produces particular kinds of knowledge about the client and induces certain actions. The physiotherapist performs various assessments to gain knowledge of their client's functional capabilities which in turn form the basis of the treatment plan.

Technologies of power

Foucault was not interested in who exercises power but in *how* power is exercised, in its functions and effects. He explained that:

> *In thinking of the mechanisms of power, I am thinking rather of its*
> *capillary form of existence; the point where power reaches into the very*
> *grain of individuals, touches their bodies and inserts itself into their*
> *actions and attitudes, their discourses, learning process and everyday*
> *lives. (Foucault, 1980, p. 39).*

He recognised the need to study the strategies, networks and mechanisms – what he called 'technologies' that are employed as devices of power (Foucault, 1988a). He was interested in the interaction between the self and others and the devices that individuals use to exercise power over themselves and others. In his work, he identified discourses that functioned as technologies of power that determined the conduct of individuals and submitted them to certain ends or domination (Rabinow & Rose, 2003).

Governmentality

Governmentality was the term Foucault used to describe the techniques and procedures for directing human behaviour (Foucault, 2003; Rose, O'Malley, & Valverde, 2006). He was not only referring to the political structures but all the strategies called into play "to control the possible field of action of others" (Foucault, 1983, p. 221). Foucault explained that governmentality is the interaction between technologies of power and those of the self. Technologies of the self are those practices and procedures which "permit individuals to effect operations on their own bodies, souls, thoughts, conducts, and ways of being so as to transform themselves in order to attain certain states of happiness, purity, wisdom, perfection or immortality" (Foucault, 1988, p. 18). For example, practices of self-examination, reflection, dieting or confession are actions Foucault would describe as technologies of the self.

Foucault explained that the tactics of governmentality - the rendering of the individual to the control by others, are not only the macro control strategies or laws, but also the minute

techniques which control the behaviour of a population (Foucault, 2003). Like others before him, he recognised two distinct forms of power that a society uses over its citizens: *juridical* and *normative power*. The first, *juridical power* operates through prohibitions and punishments and is exercised upon individuals by official agents of the state (Foucault, 1994). This is the type of governmental power generally thought of, however there are other more subtle micro mechanisms that operate as *normative power*. *Normative power* is a productive force that operates through official and unofficial agents throughout society and functions through opinions or social norms. The two types of *normative power* that Foucault was interested in were *disciplinary power* which works on individual bodies to optimise capability and is enforced through internal surveillance, and *bio-power* which aims to optimise the life of the population and uses statistics to monitor and manage its subjects (Foucault, 2003).

Disciplinary power

Disciplinary power is a form of self-regulation encouraged by institutions that permeates throughout society (Foucault, 2003). It trains rather than punishes. It 'makes individuals'; it separates, analyses and differentiates its subjects and makes them the objects and instruments of its exercises (Foucault, 1991, p. 188). *Disciplinary power* comes from the outside but works by pressuring the self to work on the self (Mills, 2003). *Disciplinary power'*s training processes involve observing, examining and comparing to a standard of what is classified as 'normal'. Examinations accumulate global data which document differences and create norms (Foucault, 2003). Neurorehabilitation assesses impairment by measuring a client's function and comparing this to normal function, its practices then work to address the gap between abnormal and normal.

Foucault (2003) believed that the power exercised through disciplines and the discourses conceived from disciplines are responsible for what he described as a *normalising society*. He contrasts this kind of society with one where an absolute ruler or sovereign exercised power over the land and its people. This sovereign power is a top down form of power and dominated the systems of right -the juridical codes of a society. Foucault claimed in

contemporary society, power is bound up with science and specifically medicine. Scientists are the experts deployed to produce and reinforce its truths. In this *normalising society,* rules of natural law based on knowledge produced by the human sciences that are perceived as neutral and sacred, have challenged and superseded the juridical systems of sovereignty (Foucault, 2003).

Bio-power

Bio-power exists on a different level and scale but dovetails, integrates with and modifies *disciplinary power*. With its focus on man (sic) as a species, *bio-power* is concerned with collective phenomena that are contingent and unpredictable and have economic and political effects that become pertinent at the mass level (Foucault, 2003). The mechanisms of bio-power include forecasts and statistical estimates that are used to assist regulatory mechanisms to establish equilibrium to compensate for the random element of populations in order to optimise a state of life. Medicine while caring for the individual also works as a form of *bio-power.* It is concerned with illness as phenomena affecting a population Neurorehabilitation contributes statistical data that form norms with which to calculate risk factors, direct policies and inform practices to ameliorate these risks.

Foucault's concept of discourse and his approach to power allows for an understanding of the way knowledge is produced and transmitted through language and practices, and the way discourse is put to work to regulate the behaviour of others (Willig, 2004). A poststructural discourse analysis guided by the theories of Michel Foucault draws attention to the power of discourse to construct its objects, the subject positions made available by the discourse and what these enable or constrain. This discourse analysis explores text where neurorehabilitation clients discuss their relationship with their rehabilitation practitioner to find out how they construct their own subjectivity and experiences and how these constructions are then lived through their associated practices to generate insights that are potentially applicable within a health care context.

The next chapter will explore how a range of sources influential in the field construct neurorehabilitation by examining contemporary academic literature and identifying how the client was positioned in these constructions. I then examine how this positioning was evidenced in the literature in the context of the client – practitioner collaboration to offer an understanding of client involvement in neurorehabilitation.

Chapter Three: Literature Review

Neurorehabilitation is a service for individuals who experience impairment due to neurological injury or disease and aims to maximise their recovery and minimise the impact of impairment on their function. As a customised service targeted at those individuals identified as likely to benefit, it involves their consensual and active participation. The exact nature of this service and the extent of the expected involvement of the individual is unclear. This chapter has two parts and begins with an exploration of constructions of neurorehabilitation from a range of sources influential in the field to understand the way rehabilitation professionals conceptualise this service and their expectations for client involvement. Foucault (2002), suggested that structures operate to control and support the circulation of discourses, and include those that give certain authors the authority to speak on certain subjects. Within a biomedical discourse these structures include academic journals, database search engines, libraries and universities which operate to confer authority on particular speakers. (Fadyl, Nicholls, & McPherson, 2013). An initial search of EBSCO health databases using the terms "neuro*" AND "rehabilitation" with a date range of 2005 -2016 was run. Sources were considered influential by considering the authors professional position and publishing influence (for example professors of rehabilitation or rehabilitation journal editors, and their citation history). Following this, the positioning of clients in these constructions is discussed. Descriptions of rehabilitation rather than just neurorehabilitation were considered when there was an implicit inference to rehabilitation for people who had experienced an injury or disease that affected the neurological system. In the second part of this chapter I examine how this positioning is evidenced in the literature in the context of the client – practitioner collaboration to gain a better understanding of client involvement in neurorehabilitation. This exploration assisted with answering the thesis question that sought to explore the discourses that were brought into play when people with neurological conditions talked about their relationship with their practitioner and make visible how power relations were operating in neurorehabilitation.

A: How is neurorehabilitation constructed in the literature?

A range of opinions of neurorehabilitation can be identified in the academic literature. While there is some overlap, they fit into two broad categories: those that view rehabilitation as a health service concerned with optimising function (Wade, 2015), and those that take a holistic view and conceive rehabilitation as a passage or journey (Whalley Hammell, 2015). An example of the first perspective is evident in the following definition:

> *Rehabilitation is a comprehensive interdisciplinary and biopsychosocial process aimed at enabling people with conditions that impact on health and function to reach and maintain their optimal physical, sensory, intellectual, psychological and social abilities in order to live a meaningful life. Rehabilitation, when delivered at its best, provides people with the tools they need to attain maximal health, function, independence and self-determination. […] [R]ehabilitation facilitates improvement in people's ability to function even when there is persistent impairment or disease. It works to help people obtain or resume, as far as possible, optimal roles in society and to limit preventable secondary impairments. […] to allow those whose lives have been saved by acute medical care to regain a life worth living (Royal Australasian College of Physicians, 2015).*

This contemporary definition characterises the predominant health service approach that views rehabilitation as a restorative process provided by an encompassing health service for particular individuals. This process involves the implementation of a set of multifaceted measures designed to assist individuals who experience, or likely to experience, disability due to injury or disease to achieve optimal functioning in interaction with their environment.

Rehabilitation as a response to impairment

Current rehabilitation practices reflect trends in rehabilitation theory and social attitudes. Medical historians locate our modern rehabilitation services as emerging in the middle of the twentieth century originating from advances in understanding of biomechanical principles of movement and neuropsychological mechanisms (Conti, 2014; Lanska, 2009). These developments were stimulated by the 'World Wars': WW1 & WW2, the poliomyelitis epidemic in Europe, North America, Australia and New Zealand, and the advance of the

private automobile. The availability of antibiotics and advances in surgical treatments increased survival from these events but left many people living with significant impairment. This prompted the recognition that more assistance was required to facilitate recovery and restore function for those whose wounds were treated by medical services (Lanska, 2009). From these beginnings, rehabilitation has developed into a health service responding to a wide range of impairments associated with congenital or acquired conditions including those associated with aging processes (S. Davis & Madden, 2006; Pryor & O'Connell, 2009).

Generally rehabilitation refers to the strategies developed (Wade, 2015), or the use of an array of interventions delivered by a service or therapist (Langhorne, Bernhardt, & Kwakkel, 2011; World Health Organisation, 2011) to reduce the disabling consequences of those with impairments associated with acute medical conditions, chronic disease and injury, and to increase social participation (Siegert, Taylor, & Dean, 2012). Earlier conceptions of rehabilitation portray a normative process of restoration, that focused on interventions to improve functional possibilities and performance (Gzil et al., 2007; Lanska, 2009; Laxe, Cieza, & Castaño-Monsalve, 2015; McPherson & Sobsey, 2003; Siegert et al., 2012). An example of this perspective is evident in this extract from a neurology conference where rehabilitation was described as:

> *[T]he planned attempt under skilled direction by use of all available*
> *measures to restore or improve health, usefulness and happiness of*
> *those who have suffered an injury […] its further object is to return them*
> *to the service of the community in the shortest time (Riddoch, 1942 in*
> *Laxe, 2015)*

However social movements including the disability rights movement have influenced the assumptions underpinning this health service and broadened its scope to include psychological and social functioning, emphasising the need to consider the contribution of social and environmental factors when providing rehabilitation services (Leplege et al., 2007; Siegert et al., 2012; Ward, 2012).

Recent changes in approaches to rehabilitation include a move away from a biomedical model, which refers to a way of thinking about disability as a feature of the person, directly

caused by disease or injury and requiring medical care provided by health professionals (Gzil et al., 2007; Lanska, 2009). A functional model of rehabilitation, which emphasised the limitations impairments impose, challenged this biomedical curative model. However these models were criticised by disability rights groups among others because they neglected the person who had the illness or injury, and failed to recognise the role of social and environmental factors (Lanska, 2009; Mayes, 2009). These models were also critiqued for being grounded in paternalism and fostering a culture of pity, dependence and segregation of disabled people (Cott, 2004; Gzil et al., 2007; Leplege et al., 2007; Wade, 2015). The currently endorsed biopsychosocial model integrates biomedical and social frameworks that centre on the needs of the individual and recognise that personal and environmental factors influence the experience of disability (Lanska, 2009; Wade, 2015). Part of this shift involved the move towards viewing individuals as capable of participating in their own health care decisions (Collis Pellatt, 2004; Cott, 2004; Gzil et al., 2007). More recently, there is an expectation that the public will be involved in health care processes and the management of their own health (Holman & Lorig, 2000; Mudge, Kayes, & McPherson, 2015; Rickard & Clarke, 2015)

One example of this shift towards a biopsychosocial model is the International Classification of Functioning, Disability and Health (ICF) introduced in 2001 by the World Health Organisation (WHO). Designed to integrate the biomedical and social models of disability, this classification system focuses on the impact of impairment rather than the cause; classifying the consequences of disease and identifying interventions as they pertain to impairment (Lanska, 2009). This system is endorsed for use by rehabilitation professionals and researchers for assessing and addressing rehabilitation needs and for reporting outcomes (Dahl, 2002). However it has been criticised by disability advocates for its potential to endorse marginalisation of certain groups (Whalley Hammell, 2004). The ICF emphasises health and function rather than impairment and provides a standardised language to describe and discuss function and impairment (Siegert, Ward, Levack, & McPherson, 2007).

Rehabilitation is part of a larger spectrum of services that aim to optimise health and promote human flourishing (Gibson, 2016; Holman & Lorig, 2000; McPherson & Sobsey, 2003). Derick Wade, a consultant in neurological rehabilitation and editor of the journal *Clinical Rehabilitation,* explains that like medicine, rehabilitation aims to maximise quality of life and safety, and minimise pain and distress. However the focus of rehabilitation is on activities and social participation rather than disease (Wade, 2015). Although Wade suggests that rehabilitation should run in parallel to medical services, it is often constructed as a transition stage between acute medical care which works to save lives, and 'a return to living a life worth living' (Lanska, 2009). Thus suggesting that rehabilitation is concerned with more than just the health of the individual.

Rehabilitation focuses on understanding and ameliorating the impact of impairment rather than disease and involves solving complex multi-factorial problems using transdisciplinary teams that include the client and their family (Lanska, 2009; Wade, 2015). These problems are addressed with rehabilitation interventions designed to improve, maximise, achieve, maintain, prevent, slow rate of loss, restore optimal bodily or social functioning or compensate for loss of function(Hart & Ehde, 2015; Pryor, 2015; Royal Australasian College of Physicians, 2015; World Health Organisation, 2011). Included in some interpretations of rehabilitation are strategies associated with the ongoing management of the presenting health condition and comorbidities, and the necessity to monitor for potential complications (Pryor, 2015; Royal Australasian College of Physicians, 2015).

A slightly different emphasis comes from rehabilitation nursing which contrasts acute nursing care with care provided on rehabilitation wards, where the focus is on promoting self-care and independence, and enabling clients to cope with and adapt to functional limitations (Pryor & O'Connell, 2009). However, Julie Pryor the editor of the *Journal of Australasian Rehabilitation Nurses Association,* accentuates a distinction between 'rehabilitation' and 'rehabilitation care' and suggests that what is often referred to as rehabilitation is actually a type of health service (Pryor, 2015). 'Rehabilitation care' Pryor explains, is not a place or a phase of health care, but a health service with a specific focus.

She supplies a definition from the Australian Institute of Health and Welfare (2015) explaining that:

> *Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition (in Pryor, 2015, p. 2).*

These constructions of rehabilitation are primarily concerned with function and making amends for the impaired body. They position the practitioner as expert and provider of this health service.

Rehabilitation *'a fundamentally human enterprise'*

Other constructions of rehabilitation view it in broad holistic terms. These metaphysical perspectives recognise the ongoing experience of living with the consequences of injury or illness and that dimensions other than health are involved. They generally describe rehabilitation, as a journey, or passage of self-mastery after disruption from chronic illness or impairment (Cott, 2004; Ellis-Hill, Payne, & Ward, 2008; Pryor, 2015; Whalley Hammell, 2015). Occupational Therapy Professor Karen Whalley Hammell (2015) describes rehabilitation as "a process of enhancing well-being and of attaining – or regaining – a meaningful life in the context of disease illness or impairment" (p49). According to Whalley Hammell, rehabilitation is for those with problems such as stroke, spinal cord injury, or severe and persistent illness and involves assisting people to learn "to live well in the context of one's own environment, with potentially life-altering problems" (Whalley Hammell, 2015, p. 50).

Other authors portray impairment as a life disruption and construct rehabilitation as one tool in the reparation (Bourke, Hay-Smith, Snell, & DeJong, 2015; Ellis-Hill et al., 2008). Pryor (2015) defines rehabilitation as "a journey undertaken by the person who is the subject of a type of health service" (p. 2). She explains that "rehabilitation is about a person regaining control over their body and their life" and for some people this entails "the holistic reconstruction of the self" and suggests that this is a unique journey for each person that is

"informed by the significance they assign to their situation" (Pryor, 2015, p. 2). In this definition, Pryor advises the journey is undertaken by those who are receiving 'rehabilitation care', and involves putting themselves back together and regaining control over their body and life. This vision of rehabilitation removes the health professional from being the direct provider of rehabilitation although implies their involvement in facilitating the client's journey towards self-reconstruction.

Another perspective comes from Cheryl Cott (2004) who describes rehabilitation as "a status passage in a career of chronic illness and disability" (p. 1413). This approach is similar to the one presented above by Whalley Hammell (2015) who constructs rehabilitation as assisting the person whose life is disrupted by chronic illness to adjust to living with impairment and Ellis-Hill (2008) for whom rehabilitation assists in the reconstruction of the self. Cott emphasises the role of rehabilitation in assisting the individual to regain meaningful life roles and reconcile the pre-injury self with the post-injury self. These definitions recognise the ongoing nature of living with impairment (Cott, Wiles, & Devitt, 2007), however Cott appears to propose disability as an identity or selfhood. This contradicts perspectives that view disability as outside of the individual and experienced as a result of impairment (Hughes & Paterson, 1997). As well, in these constructions of neurorehabilitation, the notion of reparation and reconciliation that entails a shift of the pre-injury self to the post injury suggests a coherent self. This is counter to poststructural conceptions of the fluid self, always in a state of discontinuity and conflict (Cheek, 2000).

Quality of life is a discursive construct running through many of these perspectives. Rehabilitation's concern with quality of life reflects an encompassing way to view health and the experience of illness or impairment (Gibson, 2016). This term relates to social ideas of what constitutes a good life however, it also indicates that life has degrees of quality. Disability ethics scholar Colleen McClain (2005) suggests that quality of life is "the extent to which a person's hopes are matched by experience" (p. 56). She holds the belief that health care professionals are concerned about their client's quality of life and want to assist them to accomplish their life goals. McClain suggests that: "the purpose of rehabilitation is to

augment an individual's physical, psychological and social potential to help the patient accomplish life goals" (p. 56). This concern for promoting wellbeing and enhancing human flourishing constructs rehabilitation as a benevolent service.

Rehabilitation researchers, Richard Siegert and colleagues (2007) explain "rehabilitation is a fundamentally human enterprise, one in which humans help other humans or themselves", and is based on core values of altruism, empowerment, choice, equality and individualism (p. 1606). They suggest that the principles of autonomy, independence, and social participation reflect basic assumptions about what it is to be human, and underpin rehabilitation and drive its interventions (Siegert et al., 2007). These principles are evidenced in the way rehabilitation is constructed and in the processes described as key to rehabilitation.

Since its early days as a response to concerns of people living with the effects of war and epidemics, rehabilitation has evolved. Contemporary writings in rehabilitation bring to the surface two dominant views – one more focused on function and the other more focused on the existential. However while these two views depart in terms of the focus for services and the role of the health professional, the human capacity for growth, change and adaption is a key principle underlying both perspectives (Siegert et al., 2007).

Key rehabilitation processes

With its aims of decreasing the effects of impairment and enhancing function, participation and quality of life, rehabilitation involves a number of key processes. The emphasis placed on these depends on the perspective taken. For example, Wade (2015) explains that due to the nature of the problems neurorehabilitation addresses, where in many instances medical recovery is not attainable, rehabilitation is designed to engender behavioural and attitudinal adaption. In a review exploring evidence to support interventions used in stroke rehabilitation, Langhorne, Bernhardt, and Kwakkel (2011) use a deficit model of rehabilitation and explain that stroke recovery is a complex process involving a combination of spontaneous and learning dependent processes of restitution, substitution and compensation (Langhorne et al., 2011). Adaption, adjustment, problem solving and learning

are considered the key rehabilitation processes by some authors (Krupinski et al., 2014; Wade, 2015; Young & Forster, 2007). However, others who take a holistic approach emphasise enabling, negotiating and client empowerment which suggests different expectations for client involvement in rehabilitation (for example Cott, 2004: Pryor, 2015: Ward, 2012: Whalley Hammell, 2015).

Other authors are more specific. For example, Young and Forster provide key purposes for stroke rehabilitation which they refer to as the four 'R's of rehabilitation (Young & Forster, 2007). These include: *1) realisation of potential* which requires that therapy has continued long enough to achieve a plateau phase in recovery; 2) *re-enablement* which focuses on promoting independence in daily living skills such as walking and dressing; 3) *resettlement* referring to discharge from hospital that helps the person feel safe, well supported and confident; helping the person to *re-establish* their status and personal autonomy; and 4) *readjustment* helping the person to adapt and accept a new lifestyle (Young & Forster, 2007, p. 86).

These processes can be associated with different phases or transitions in the rehabilitation process. Young and Forster (2007) explain that in stroke rehabilitation there are two phases where the early phase involves the use of techniques to influence the potential neuroplastic changes. Readjustment strategies form the later phase. This phase focuses on adaptive responses and coping strategies, and therefore requires rehabilitation interventions that help the clients to perform instrumental activities of daily living and accept their changed abilities (Young & Forster, 2007). Donnelly and colleagues (2004) suggest that in spinal cord injury, rehabilitation extends beyond the usual inpatient time frames and initially focuses on immediate self-care tasks and mobility, and later moves to empowering clients to take charge and become experts in their own care (Donnelly et al., 2004).

The inclusion of rehabilitation processes such as 'enabling' and 'empowering' signals a shift in client participation in health care where rehabilitation provides 'the tools' to enable the client to achieve their desired goals. This comes with a recognition of the individual's rights for self-determination (Laine & Davidoff, 1996). It also indicates a transfer of responsibility

to the client and supports an agenda for promoting the client to take on tasks for self-management of their health condition (Anderson & Funnell, 2005). For poststructuralists empowerment is a troublesome concept as it suggests individual freedom and agency rather than acknowledging the constraints that restrain human behaviour (Cheek, 2000). However, the inclusion of these processes recognises that rehabilitation involves more than restoration of, or compensation for loss, of physical function, it also involves the active involvement of the client.

Underlying the provision of rehabilitation are its specific procedures. According to Wade (2015), these include *assessments* that set out to understand the nature and cause of the impairment and involve exploring all the factors that impact on activities (including those external to the client) especially those that can be influenced to improve performance. Other activities are: *planning and goal setting*, both of which require collaboration between many different groups and need to take into account the context and goals of the client; *interventions,* which can provide care and support to maintain wellbeing and safety, or *treatments* designed to reduce impairment and improve function; and *evaluating progress* against goals set (Wade, 2015). The nature of the assessments or intervention varies according to the specific service. However, this pattern of events is generally a common approach in rehabilitation settings. The rehabilitation professional is assumed to be responsible for coordinating and conducting these procedures although client-led service provision is also possible in some situations (Collis Pellatt, 2004).

The position of the client in neurorehabilitation

In earlier constructions of rehabilitation, the client was positioned as a passive recipient of therapy and sometimes a burden on their family (Lloyd, Roberts, & Freeman, 2014; Pryor & O'Connell, 2009). However contemporary perspectives are underpinned by the assumption that the client will engage actively in the interventions and be prepared to help themselves (Lanska, 2009; Lloyd et al., 2014; Siegert et al., 2007). The stipulation for participation associated with eligibility is sometimes explicitly stated. For example, the Australian Institute of Health and Welfare's (2015) definition of rehabilitation included the statement:

'The patient will be capable of actively participating' (in Pryor, 2015, p. 2). The nature and extent of this active involvement however is not always apparent.

Some rehabilitation academics state their expectations for client participation. Langhorne, Bernhardt, and Kwakkel (2011) for example, explain that there is various evidence supporting the principles underpinning stroke rehabilitation including high patient (and family) motivation and engagement, setting goals, and task-specific and context-specific high intensity training (Langhorne et al., 2011). They position the client (and the family) as a 'tool' in this process. The client is required to be motivated to participate in the interventions and contribute information about their personal context to facilitate the setting of treatment goals and enable context-specific training.

Recognising the importance of client involvement in treatment decisions, Martin van den Broek (2005) a consultant clinical neuropsychologist, discussed neurorehabilitation from a behaviour change perspective. He described neurorehabilitation as a goal-directed, client focused problem-solving process. The therapist's role in this process is to assist the client to identify their problems and facilitate their move through a change process. According to van den Broek, successful outcomes are achieved through effective negotiation, goal definition and setting processes that enhance the clients' intrinsic motivation to change, and an emphasis on placing the client in the centre and attending to her or his wishes rather than therapist perceived needs (van den Broek, 2005).

This approach which places the client 'in the centre' fits with client-centred principles of rehabilitation (Cott, 2004; Leplege et al., 2007). Although an ambiguous concept which has become a catch phrase in rehabilitation, it emerged in recognition of the place of the client in medical decisions and moves towards increasing their involvement in health settings (Cott, 2004; Laine & Davidoff, 1996; Sullivan, 2003). This approach signalled attempts to move away from clinician-dominated, disease-focused services towards more individualistic and holistic models that strive to incorporate client perspectives into service provision and position the client as the active agent in the process (Leplege et al., 2007; Mayes, 2009).

In contrast to van den Broek's suggestion for placing the client in the centre, Christopher Ward (2012), a professor in rehabilitation in the UK, advocates for a relational approach. In such an approach, the focus is not on the individual, but rather includes the web of relationships that are part of the client's context. Ward used a human systems model to explain how problems arise when only one individual's interests are considered. He illustrated the importance of considering families as part of the therapeutic system. Ward explained that in rehabilitation the problems are not owned by one individual but by all concerned in the therapeutic process (Ward, 2012). He challenged perspectives that position the rehabilitation client in the centre as the person with the problem, but rather argues the health practitioner to become a coordinator, negotiator or 'collaborative enabler' in order to navigate the various competing interests (Ward, 2012). With this, Ward acknowledges the possibility that the parties involved may hold opposing rehabilitation goals.

Viewing the client as either the centre of care or as part of a web of care, along with the shift in philosophies that view the client as capable of participating in their own health care decisions, suggest that the client is required to participate in a partnership with the health professional (Laine & Davidoff, 1996; Mayes, 2009). However, client involvement is not just limited to making decisions about the direction of their rehabilitation, they are also required to be actively involved in therapy tasks and learn new skills.

In a recent series of articles advocating for changes to the way rehabilitation is positioned within health service provision, Wade (2015) stressed that in contrast to medical care, therapy is only a small part and rehabilitation involves the client participating in a process of learning. He explained that as well as contributing to the goal setting process, the client is required to display a willingness to put in effort, accept the hard work involved in the interventions and associated learning processes, and take responsibility for their own learning and motivation (Wade, 2015). According to Wade, the rehabilitation client needs to "learn how to undertake an activity that was previously undertaken or that is now wanted" the client is required to "want to learn" and "understand the link between learning basic

skills and being able to undertake the wanted activity" (pp. 1151-1152). Wade explained that practice-intensity is the effective component and therefore the client is expected to continue to practice the prescribed tasks outside of their therapy sessions (Wade, 2015). He continued, explaining that the client "must practice" and understand that "practice does not in and of itself require a therapist to be present" they must also "take responsibility for learning" (p. 1152). Wade continued:

The patient needs to be reminded that success requires their full engagement and that 'therapy' in itself can achieve little. The patient needs to understand that they must practice, that it is hard work, that an activity may take longer and that it may involve failure. (Wade, 2015: p. 1153).

Aside from this learning, hard work and practice, and participating in planning processes and treatments, rehabilitation clients also appear to be expected to display particular behaviours. Pryor and O'Connell (2009) explored rehabilitation nurses' understandings, perceptions and expectations of rehabilitation. They reported that the nurses believed the rehabilitation client needed to be positive, motivated and make an effort to participate in their own rehabilitation, possess the will to work towards self-care, and be ready to work cooperatively with rehabilitation staff (Pryor & O'Connell, 2009).

Client involvement in rehabilitation processes was considered necessary for functional outcomes. Krupinski and colleagues (2014) described the need for specific client behaviours:

Neurorehabilitation […] involves patient engagement for greater neuroplastic changes and functional outcomes. Engagement is motivation, passion, desire, dedication, trust, attitude about treatment and active participation of the subject (Krupinski et al., 2014 P1).

They explained that neuroplasticity, which is the capacity for the reorganisation and adaption of the nervous system, is enhanced by the client's engagement (Krupinski et al., 2014). They use the term '*neurotherapist*' to describe the role of the clinician as a teacher who guides the client through the rehabilitation process. Krupinski and colleagues considered a clinical interaction focused on building rapport, promoting client participation

and 'empowerment', and setting client centred goals as crucial to the neurorehabilitation process. With their description, Krupinski and colleagues are inferring clients are accountable for their behaviours desire and passion in return for functional outcomes. The descriptions for ideal client behaviours propose the existence of a moral criteria for 'the good client'.

These constructions of rehabilitation suggest that the client has an active role in neurorehabilitation beyond merely participating in therapy. Although there are differences in emphasis, these authors suggest that a key feature of this role is the collaboration between the client and practitioner in therapeutic decision making and goal setting processes. Many of these perspectives were advocating for a move away from positioning the health practitioner as expert who was 'rehabbing the patient' (Pryor, 2008), towards placing the health practitioner as partner, coordinator, broker, facilitator or 'collaborative enabler' (Alve et al., 2013; Collis Pellatt, 2004; Cott, 2008; Ward, 2012). This client – practitioner collaboration has been defined in different ways by various authors with some describing these as human technologies (Kayes & McPherson, 2012), emphasising the importance of the relationship between client and practitioner. Others have focused on aspects of client-centredness which is a health care practice that strives to incorporate client perspectives into service provision and promotes client 'empowerment' and participation (Cott, 2008; Järvikoski et al., 2015; Leplege et al., 2007).

B: Collaboration between client and practitioner in neurorehabilitation

These descriptions of neurorehabilitation that construct it as a process requiring consensual client involvement and collaboration with health professionals prompted an exploration of how this is evidenced in the literature. A review of academic literature that discussed the client – practitioner collaboration in neurorehabilitation was carried out to explore how this relationship was constructed and the client was positioned within it. This began with a search of EBSCO health databases which included CINAHL, MEDLINE and SPORTDiscus, using the terms 'rehabilitation' AND 'client' OR 'patient' AND 'collaboration' OR 'cooperation' NOT 'mental' NOT 'substance' NOT 'criminal'. The date limit was from 2000

onwards as this appeared to be when the shift in emphasis of the collaboration between client and practitioner was occurring in neurorehabilitation (Cott, 2004). A further filter to identify relevance to neurorehabilitation was applied. Items were screened for relevance and disregarded if the focus was on interagency or interdisciplinary collaboration or for paediatric populations. The decision not to include paediatric populations was taken to keep this review manageable and with an appreciation that there may be different discursive formations operating in relation to children that warrant their own investigation. The articles identified as relevant were studied to identify the different ways the client was positioned, as well as the justification for and the expected outcome of this client – practitioner collaboration. Where the literature discussed work considered seminal by the authors that had not been identified by the search strategy these articles were also retrieved and incorporated in the discussion.

Although there was considerable overlap, the literature identified in the search highlighted three broad categories of collaboration including: 1) collaboration as a component of the therapeutic relationship; 2) collaboration as a philosophy of client-centred care; 3) or collaboration as part of the goal setting process. A number of studies set out to find evidence of these practices. Others involved interventions to test the effect of this interaction on rehabilitation outcomes or to test ways to improve this collaboration. Each of these broad categories are discussed in more detail below.

I. The therapeutic relationship

A number of the articles identified in the search discussed client – practitioner collaboration in relational terms as an aspect of the therapeutic relationship. The therapeutic relationship refers to the relationship between client and practitioner that exists for a therapeutic purpose. It is ideally conceived as an interpersonal, interactive, reciprocal and contractual relationship that recognises the rights and obligations of both parties (Kayes & McPherson, 2012; Laine & Davidoff, 1996; Leplege et al., 2007). This broad term is sometimes referred to as the 'therapeutic' or 'working' alliance. Although these terms are frequently used interchangeably with 'therapeutic relationship', they more correctly refer to different

components of the therapeutic interaction. The therapeutic relationship involves interactive and relational elements and generally refers to the interaction and affective bond between the client and therapist, the communication style used in the interactions, and the rapport and trust that is established. Kayes and McPherson (2012) note that this relationship is more than one of caring but rather involves the explicit interactions between client and practitioner designed to advance the therapeutic process. They describe this relationship as a 'human technology' and advocate for considering it as a key contributor to outcomes in rehabilitation.

Much of the research and theories relevant to the therapeutic relationship come from psychotherapy, however the nature and role of the relationship in neurorehabilitation appears to be of growing interest. The elements of the relationship theorised as important in the counselling relationship have historical roots in the works of Freud (1856-1939) and later Rogers (1902-1987) whose work was developed by researchers who recognised that this relationship was common across a broad range of therapeutic practices and responsible for a large portion of healing effects (Horvath, 2005). Edward Bordin (1913-1992) proposed a conceptualisation of the therapeutic relationship and described it as a "conscious here and now" bi-directional relationship that involves agreement and collaboration between the therapist and client (Horvath, 2000 p. 167). According to Bordin, the relationship is made up of three interlocking components: *bonds* – referring to interpersonal attachments such as liking and trust; *tasks* – agreement or consensus of what is to be done and how these tasks will contribute to problem resolution; and *goals* – agreement on the outcome expectations of therapy (Horvath, 2000). While these theorists' work underpins many definitions of the therapeutic relationship, there are various interpretations, which place different emphasis on these core components and interactional styles, with others including components that acknowledge the role of specific client or practitioner behaviours (Bachelor & Horvath, 1999; Doran, 2016; Gelso, 2013; Horvath, 2001). Fundamental to the relationship according to Horvarth (2001), is the client positioning themselves as active collaborator and their endorsement of activities.

Inconsistency regarding the terminology applied to this relationship and lack of agreement on the core components account for some of the contentions in this field. For example, the therapeutic alliance is described as representing "interactive collaborative elements of the relationship in the context of an affective bond or positive attachment" (p. 271) (Castonguay, Constantino, & Holtforth, 2006). Psychotherapist Charles Gelso (2013) argued that the working alliance is frequently used as a proxy for the therapeutic relationship but claimed this fails to capture the totality of the therapeutic relationship. He conceptualised the therapeutic relationship as separate from, but interacting with technical components of the therapeutic interaction and included a 'real relationship' where both parties are genuine and hold positive realistic perceptions of each other (Gelso, 2013). Gelso considered this real relationship basic to all human encounters and the foundation of the therapeutic relationship. However, he viewed the working alliance that was specific to the therapeutic encounter and represented the working collaboration between practitioner and client as the catalyst that 'gets the work done'.

Some authors appear to separate the bond between client and practitioner from the interactive components of the relationship and differentiate between the alliance and the relationship. Matthew Leach (2005) discussed the importance of establishing rapport with clients and suggested the therapeutic alliance is "the conscious and active collaboration between the patient and therapist", distinguishing it from therapeutic relationship which he defined as "the trusting connection and rapport established between the client and therapist, through collaboration, communication, therapist empathy, mutual understanding and respect" (p. 262). Leach rather nebulously defined patient rapport as "a harmonious relationship". He suggested that due to the underlying principles of reciprocity and collaboration, the terms are interchangeable (Leach, 2005).

Linda Tickle-Degnen (2002) is more specific in her description of rapport, which she explained: "is formed as individuals grow to like one another and experience the other as genuinely warm, respectful and understanding" (Tickle-Degnen, 2002, p. 470). She likewise suggests that the therapeutic relationship is a combination of rapport and the working

alliance, explaining that the working alliance is formed "as individuals collaborate with one another to develop common goals and as they develop a sense of shared responsibility for working on tasks that are involved in achieving these goals" (Tickle-Degnen, 2002, p. 470). Drawing from these definitions one might arguably conceptualise working alliance as a subset of the therapeutic relationship.

Recognition of the relevance of this relationship related factor in neurorehabilitation has resulted in increasing discussion on the topic. For example, advocating for utilising it to encourage engagement to support treatment effectiveness (Krupinski et al., 2014), to promote motivation (Maclean, Pound, Wolfe, & Rudd, 2002), encourage the client to contribute information to set contextual goals (Bright, Boland, Rutherford, Kayes, & McPherson, 2012), and assist in the adjustment process (Schönberger, Humle, & Teasdale, 2006). Others have been interested in measuring the effect of relationship on outcomes (Klonoff, Lamb, & Henderson, 2000; Sherer et al., 2007) or testing interventions that sought to enhance it (Evans, Sherer, Nakase-Richardson, Mani, & Irby, 2008). The apparent appreciation of the value of this relationship in neurorehabilitation has led to increasing efforts to encourage and support its development.

The therapeutic relationship in neurorehabilitation can be challenging due to the involvement of multidisciplinary teams, the inclusion of partners and family members in the treatment dyad (Evans et al., 2008; McLaughlin & Carey, 1993), and the cognitive, communication, neurobehavioural and emotional consequences frequently inherent in the context of neurological impairment (Berg, Rise, Balandin, Armstrong, & Askim, 2015; Judd & Wilson, 2005; Schönberger, Humle, & Teasdale, 2007). These factors, it is proposed, can impair relationship building and goal elicitation resulting in practitioner led encounters (Lloyd et al., 2014; O'Callaghan, McAllister, & Wilson, 2012; Rohde, Townley-O'Neill, Trendall, Worrall, & Cornwell, 2012). However, the presence of these factors does not necessarily prevent a therapeutic relationship forming. For example, Schonberger and colleagues (2007), sought to explore how impairment factors such as reduced insight influenced the working alliance. Although they failed to find a relationship between the therapeutic

relationship, as measured by the Working Alliance Inventory (WAI), and their outcomes of interest, they did not find that impaired awareness or insight significantly impeded the relationship (Schönberger et al., 2007).

Investigating the nature of the therapeutic relationship in neurorehabilitation has led some researchers to explore relationship styles and discuss this relationship in terms of paternalism (Collis Pellatt, 2004; Rickard, 2015). Other researchers construct this relationship as a tool to improve client compliance with the health practitioner's advice and thus enforce practitioner authority and their position as expert (Evans et al., 2008; Schönberger, Humle, Zeeman, & Teasdale, 2006). For example, Schönberger and colleagues suggest that rehabilitation treatments are only effective if clients comply with the therapeutic regime and actively engage in treatment, therefore they advocate for attending to the therapeutic relationship to enhance this compliance.

To test the effect of this relationship on rehabilitation outcomes, Schönberger and colleagues (2006) conducted a series of studies testing aspects of this, one being a retrospective review of patient records from a rehabilitation programme for people with acquired brain injuries. In this study two therapists, one a physiotherapist, the other a neuropsychologist, were asked to rate their past clients on a series of factors which the authors identified as constituting the working alliance (Schönberger, Humle, Zeeman, et al., 2006). These included verbal agreement, patient appreciation of accomplishment, patient engagement (defined as an outward display of activity), patient acceptance, and patient following therapist advice. These ratings were combined with assessments of client attendance at sessions over the rehabilitation period (Schönberger, Humle, Zeeman, et al., 2006). Schonberger and colleagues looked for an association between these ratings of the working alliance and patient compliance, with outcomes of work placement and participation in physical training activities up to four years post discharge. These authors interpreted the working alliance as following therapeutic advice, participating, actively engaging and independently taking responsibility for their own therapy and thus depended on motivation (Schönberger, Humle, Zeeman, et al., 2006). They reported a range of

difficulties with inter-rater agreement but concluded a high correlation between therapist-rated working alliance, compliance and employment. The retrospective nature of this study and the lack of blinding to outcomes by the raters weakens the results of this study. However, it does illustrate the diverse conceptualisations of the therapeutic relationship and the various motivations for using this 'human technology'.

The literature suggests there is an increasing focus on the importance of this therapeutic relationship in neurorehabilitation. This at face value is consistent with client-centred collaborative approaches. However, the way in which the therapeutic relationship is being conceptualised in some cases (e.g. compliance) is fundamentally in tension with the imperatives behind this approach.

II. Client-centred rehabilitation

Client – practitioner collaboration is a core component of approaches to rehabilitation that strive to incorporate client perspectives into service provision and position the client as an active agent in the process. Linda Tickle-Dignen (2002) suggests the therapeutic relationship is closely related to the client-centred model frequently used in occupational therapy. She explained that this model comes from a social justice and rights framework and is based on the principles of respect for and partnership with the client receiving services. It involves aspects of affective bond between client and therapist, the therapist's liking, understanding, warmth and respect for the client, and working alliance components of collaborative working towards common goals and a shared responsibility (Tickle-Degnen, 2002). This collaborative model comes under an umbrella of approaches to rehabilitation otherwise referred to as person-centredness (Leplege et al., 2007).

Client-centred or person-centred rehabilitation is a multi-dimensional concept that covers a number of ideas (Leplege et al., 2007). Person-centredness evolved from a shift that was taking place in the second half of the twentieth century in medicine that advocated for trying to understand the subjective experience of the client, to see their world and how their illness it affected it (Leplege et al., 2007). This coincided with moves to involve clients

in decision making processes and activities of health care (Cott, 2008; Gzil et al., 2007; Rose, 2006).

The civil and disability rights movements that were emerging in North America and Europe at a similar time were responding and contributing to this emerging person-centred philosophy (Leplege et al., 2007). These movements which were based on principles of social justice were rallying against disempowerment, and exclusionary policies and practices that traditionally saw disabled people segregated and excluded from participating in mainstream activities (Shakespeare, 2006). They contested the biomedical essentialist notions that viewed disability as a product of impairment, identified through diagnostic methods and treated with medical interventions (Hughes & Paterson, 1997). From a disability rights perspective the goal of rehabilitation is not to remedy impairment but to modify behaviours and social structures that produce oppression, exclusion or stigmatisation (Hughes & Paterson, 1997; Leplege et al., 2007).

The approach to psychotherapy by Carl Rogers known as 'the client-centred approach' has contributed to the current notion of person-centredness (Leplege et al., 2007). This approach aims to enhance the autonomy of the client who, according to Rogers, knows best what they require, and therefore therapy should activate the client's personal resources to assist them to find their own remedy for their difficulties. This activation requires an authentic relationship between client and practitioner (Leplege et al., 2007). For this, the practitioner is required to show the client unconditional esteem, display a benevolent attitude, show sensitivity and empathy, and develop a genuine person-to-person relationship (Leplege et al., 2007). This approach is considered individualistic because it addresses the specific needs of the client and individualising because it avoids reducing individuals to their impairment and reinforces the autonomy of the subject. For Rogers, the aim of this client-centred approach is to make the client the subject of their own therapy (Leplege et al., 2007).

The central notion of 'person' in this approach according to Leplege and colleagues (2007) stems from cultural trends that assign responsibilities for the own actions and behaviours

to a subject – the person. This 'person' is viewed as competent and able to participate in decisions that affect or concern them (Leplege et al., 2007). However, there appear to be a variety of terms applied to this philosophy and a range of interpretations emphasising different aspects of the underpinning theories. The terms are frequently used interchangeably with others and include for example: patient-centred, person-centred, client-oriented and client-led, which could otherwise indicate the different emphasis in approach (Järvikoski et al., 2015; Leplege et al., 2007).

Several authors have described different versions of this approach that place different emphasis on the autonomy and position of the client and the priorities addressed. These include:

- emphasising the individual client's specific, unique context, recognising the physical, emotional and spiritual needs, and providing an individualised tailored approach
- emphasising participation in society, using interventions that reflect the client's participation needs and focus on daily living activities
- emphasising decisional autonomy and self-determination, viewing the client as an expert in their own rehabilitation (this is often termed client-led or client driven)
- emphasising the partnership with service providers and actively involving clients in managing their care and rehabilitation
- emphasising respect and dignity and seeing the person behind the disability or impairment

(Collis Pellatt, 2004; Cott, 2008; Järvikoski et al., 2015; Leplege et al., 2007). Although there can be a degree of overlap, these various versions can result in diverse and sometimes conflicting approaches claiming to be client-centred.

This combination of seeing the perspective of the client, acknowledging their rights and responsibilities, preserving respect and dignity, empowering and facilitating participation and autonomy are evidenced in rehabilitation aims and philosophies of care such as those presented earlier. However the various interpretations of these principles can account for conflicts and misunderstandings that have arisen about client-centred working (Clapton &

Kendall, 2002; Järvikoski et al., 2015; Leplege et al., 2007). For example, prioritising participation where therapy may focus on self-care tasks is considered client-centred in that it recognises the clients' unique context and promotes independence. Other interpretations of this model would encourage the client to make their own decisions about what services they receive and support their choice to use their resources to enable them to participate in social roles (Mortenson & Dyck, 2006). These conflicting interpretations add to the equivocal nature of this approach.

Some perceive that practicing in a client-centred way challenges traditional ways of working. According to Cott (2004), it can be perceived to be incompatible with evidenced-based practice models that encourage therapists to choose interventions based on the best available evidence rather than the preference of clients. Attempts to adopt this approach can also be challenged by institutional goals. For example, when hospital rehabilitation services objectives are reported "to speed up discharge and rarely to increase patient autonomy unless that is the only way to transfer a patient from the medical setting" (Wade, 2016a, p. 112). Trade-offs to adopting this way of working include compromising the measurability of effectiveness or feasibility of approaches when client goals challenge existing measurement strategies and forfeiting family involvement over centring client preferences (Prescott, Fleming, & Doig, 2015).

Practitioners' intentions to work in ways they perceived to be client-centred have been reportedly thwarted by organisational cultures and reductionist processes (Hunt, Le Dorze, Trentham, Polatajko, & Dawson, 2015). Challenges have been reported when team members from other disciplines holding opposing therapy goals overrode practitioners' attempts to promote client preferences (Mortenson & Dyck, 2006). Services with limited resources or their own predetermined objectives have also hampered practitioner intentions to apply client-centred approaches (Hunt, Le Dorze, Trentham, et al., 2015). Practitioners have also reported that risk prevention and safety concerns frequently influenced decision making and were used to limit client autonomy and prioritise choice of interventions (Mortenson & Dyck, 2006).

Barriers to working in a client-centred way can also account for the equivocal evidence demonstrating implementation or effectiveness of this approach. Mortnenson and Dyck (2006) explored barriers to occupational therapists working in ways that promoted client empowerment. They suggested that client-centred practice was challenged by power imbalances in the therapeutic relationship which was created by differences in knowledge, social position and charisma, the values and beliefs of the client, and the reluctance of therapists to give up their power (Mortenson & Dyck, 2006). However other authors note the inevitability of this power imbalance and suggest that it is up to the clinician to be aware of this and constructively use it to advance the needs of their clients (Alve et al., 2013; Clapton & Kendall, 2002; Järvikoski et al., 2015).

Mixed evidence supports the use of client-centred approaches in rehabilitation. This could be attributed to various interpretations of this model, or challenges with measuring the expected outcomes. Cheryl Cott (2008) links client-centred care with client's perceived quality of care. She suggests that when clients are involved in determining progress in rehabilitation through participation in goal setting, when their physical comfort needs are recognised and addressed, when they are treated with respect and dignity as a person not an object of care, and they are given information about how to manage their condition; clients are more satisfied with the level of care they have received (Cott, 2008).

Evidence linking client-centred care to improved outcomes is equivocal. A large randomised control study trialling a client-centred care model in occupational therapy service delivery for people with multiple sclerosis, found that clients in the intervention group who participated in the power sharing client-centred model reported improved satisfaction with the service but did not have any better functional outcomes than those in the control group (Eyssen et al., 2013). Eyssen and colleagues suggested that time spent negotiating goals wasted time that could have been used in therapy. They concluded that client-centred practice should be discontinued because of the lack of evidence supporting this way of working (Eyssen et al., 2013). These findings could point to the challenge of evaluating client-centred approaches using outcome measures that do not reflect the specific goals of

the client. It could also highlight that some health practitioners may evaluate their services based on the effectiveness of achieving service or clinician goals rather than prioritising client satisfaction.

Involving the client in rehabilitation assessments that set out to understand the nature and causes of impairment is purported to make sense. Wade (2015) explained that clients are able to contribute useful information that assists the practitioner to explore all the factors that impact on activities, especially those that can be influenced to improve performance. Other authors advocate for client-centredness as good rehabilitation practice due to the ethical principles of human dignity, respect and self-determination that it is based on, with increased motivation and task performance an added bonus of this style of working (Järvikoski et al., 2015).

The belief that all clients should have opportunities to be heard and participate in rehabilitation decision making underpinned an investigation into the experiences of rehabilitation service users in Finland. This study explored how clients with severe impairments perceived themselves in terms of participation and 'being heard', and to identify what factors were associated with better possibilities to participate (Järvikoski et al., 2015). They surveyed a stratified sample of long term or permanent disability service users who applied for assistance during a calendar year. They selected the questionnaires that the service user themselves had participated in answering (n=704) and analysed the results to identify collaboration styles typically experienced. The respondents were asked about their involvement in their rehabilitation planning, and to what extent they felt they were listened to and their opinions and wishes were taken into account. The researchers found that collaboration between client and professional seldom occurred, with practitioner dominated planning the most common model. They believed that the plans were generally prepared on the basis of ordinary medical examinations rather than discussion of goals, with the professionals taking centre stage as planner and the client as an object or outsider (Järvikoski et al., 2015).

In their study Järvikoski and colleagues (2015), explored client attributes associated with participating and feeling heard in rehabilitation planning. They suggested that those participants who experienced communication, learning or intellectual difficulties, including those associated with cerebrovascular disease, had a weaker possibility of participating or being heard. However, those who had longer-term experience of their condition such as those with congenital conditions were more often perceived to be experts in their own impairment and as such had greater perceived competence and awareness of alternatives. As a result, they were more likely to express their opinion in the planning process and negotiate services.

Working in partnership with clients may present challenges to the traditional ways practitioners have viewed their roles. In anticipation of policy initiatives promoting client empowerment and involvement in health care, Glynis Collis Pellatt (2004), explored client and professionals' perceptions and experiences of client participation in team decision making processes in a spinal cord rehabilitation unit. The professionals in this study viewed partnership as implicit to their practice and claimed to involve clients in goal planning (Collis Pellatt, 2004). Collis Pellatt defined partnership as "an alliance where people work together in mutual respect" (p. 949), however she recognised that often what was described as partnership was actually paternalism where the professionals were making the decisions for their clients. She distinguished between hard and soft paternalism where the former involved the imposition of values and judgements on people "for their own good"; and the latter as interference, with practitioners believing that clients were not ready or fit to make informed decisions (Collis Pellatt, 2004, p. 950). Collis Pellatt concluded that health professionals often believed they were allowing their clients to make decisions without recognising the control they exercised over these decisions and that for the active participation of clients, professionals need to re-evaluate their interpersonal skills.

In summary, client-centred care is endorsed as an ethical approach to rehabilitation that acknowledges client competence and expertise, and strives to incorporate client perspectives into the provision of service and prioritises outcomes of importance to the

client. However, challenges come from those who question the utility of the approach preferring traditional ways of working and outcomes designated by health services. The multiple definitions and conceptualisation of this approach can account for some of the criticisms applied to it. Client characteristics such as impairment factors that limit client involvement and practitioner attitudes that operate as forms of paternalism also operate as barriers to incorporating client perspectives in rehabilitation planning.

III. Collaborative Goal Setting

Collaboration between the client and practitioner on setting the tasks of the therapy is an important component of both the therapeutic relationship (Horvath, 2001), and client-centred approaches to rehabilitation (Prescott et al., 2015). The involvement of the client in goal setting is considered important for a number of reasons. Wade (2015) suggests that because rehabilitation activities generally involve changing client behaviours, their participation in goal setting promotes their engagement and is considered central to the success of rehabilitation. Client contribution to goal setting reportedly enables context specific training (Langhorne et al., 2011), enhances adherence (Sugavanam, Mead, Bulley, Donaghy, & van Wijck, 2013), and ensures clients' wishes and interests are central and that relevant goals are agreed upon (Turner-Stokes, Rose, Ashford, & Singer, 2015; Wade, 2009, 2015, 2016b). Involving clients in goal setting processes is suggested to be a key to supporting self-regulation for people after traumatic brain injury (Doig, Fleming, Cornwell, & Kuipers, 2009; Ylvisaker, McPherson, Kayes, & Pellett, 2008). Prescott and colleagues (2015) suggest that client motivation can be enhanced by or be a by-product of participation in goal setting. Others explain that for rehabilitation to achieve its aim of improving quality of life, its interventions must be based on the values and preferences of the client (McClain, 2005; Siegert & Taylor, 2004).

Goals negotiated with the client, their family and the rehabilitation team can lead to increased engagement and satisfaction with the overall outcome of the rehabilitation (Turner-Stokes et al., 2015). However client involvement in determining rehabilitation goals is not a routine procedure with practitioners generally reported as taking charge of goal

planning and setting (Rickard & Clarke, 2015; Rosewilliam, Roskell, & Pandyan, 2011; Sugavanam et al., 2013). Evidence linking collaborative goal setting practices with improved functional outcomes however is inconclusive, inconsistent or difficult to interpret (Levack, Dean, Siegert, & McPherson, 2011; Prescott et al., 2015).

A considerable body of academic literature discusses goal setting in neurorehabilitation. Some exploring the various approaches to goal setting and the complexity involved (Levack et al., 2011; Turner-Stokes et al., 2015), the barriers to practice (Lloyd et al., 2014; Parry, 2004), the discrepancy between practice and perception, or whether it happens at all (Parry, 2004; Prescott et al., 2015; Schoeb, Staffoni, Parry, & Pilnick, 2014; Sugavanam et al., 2013; Talvitie & Reunanen, 2002; Wohlin Wottrich, Stenström, Engardt, Tham, & Von Koch, 2004). Although endorsed as a desirable practice it appears collaborative goal setting presents a number of challenges.

Collaborative goal setting involves traversing a range of barriers relating to the client, the practitioner or the service environment (Hunt, Le Dorze, Polatajko, Bottari, & Dawson, 2015; Levack et al., 2011; Sugavanam et al., 2013). Parry (2004) observed physiotherapy sessions in a stroke unit and reported that client-therapist interactions were brief and it was more common for therapists to suggest a goal for which the client generally agreed upon (to some extent). She suggested that a number of factors could explain the lack of client involvement in goal setting. These include therapists' perception of using up therapy time, being wary of eliciting problems that were irrelevant or not amenable to physiotherapy, wanting to work in a positive way and avoid exposing problems, or inferring that progress was possible, as well as the suggestion that involvement in these decisions was not what every client wants (Parry, 2004). Levack and colleagues (2011) also in a stroke rehabilitation setting, reported a privileging of some goals over others, especially those of a short-term nature, oriented to physical function, and the preference of the clinician. The belief that the practitioner has a responsibility to assist in ensuring the setting of realistic appropriately challenging goals, and if necessary "influence the person's attitude and expectations" (Wade, 2015, p. 1153) could account for practitioners dominating the goal setting process. Practitioners also are

tasked with accounting for community resources and providing cost effective services with limited resources, which could account for their caution for prompting client goals they perceive as less efficacious and generating a tension they are required to manage (Levack, 2009).

The various forms goal-setting takes can also contribute to the confusion around client involvement in goal setting. Wholin Wottrick and colleagues (2004) who carried out an observational study in a stroke rehabilitation setting, suggested that practitioners did not appear to know how to actively involve clients in goal setting and that the clients often did not recognise involvement opportunities (Wohlin Wottrich et al., 2004). They reported that some clients commented they did not like being asked 'what do you want to do today?' interpreting this as suggesting unpreparedness on the part of the practitioner rather than a goal setting opportunity (Wohlin Wottrich et al., 2004). Sugavanam and colleagues (2013) suggested that clients were unclear about the meaning of 'goals' and their role in the process. They noted that clients generally formulated hopes and broad goals, whereas practitioners selected short-term functional goals that were discipline specific.

Organisational culture, dominant ways of working, a reductionist focus on processes, resource restrictions and reporting requirements also allegedly drove goal-setting activities. Practitioners reportedly perceived a pressure to produce what they believed to be acceptable goals, viewing goal setting as a mechanistic reporting activity rather than recognising it as an opportunity for interpersonal communication and client involvement (Bright et al., 2012; Hunt, Le Dorze, Polatajko, et al., 2015; Lloyd et al., 2014). This limited view of goal setting appeared to restrict client – practitioner collaboration.

A recent study suggested that practitioner assumptions and knowledge expectations can limit client involvement in goal setting (Schoeb et al., 2014). Schoeb and colleagues video-recorded physiotherapy consultations with 37 consenting clients in a mixed population outpatient clinic. In the majority of encounters there were no explicit goal setting processes observable and when observed they fell into two styles. The first involved the therapist directly asking clients what they wanted from therapy. In response, the majority of clients

appeared unable to articulate a goal and were hesitant to contribute. The second style, which was observed in only five cases, involved the client presenting goals without being prompted (Schoeb et al., 2014). The study authors concluded that questioning styles used by the practitioners closed off goal negotiation. They felt this style of questioning implied practitioner assumptions about client knowledge, or that the client had a goal and knew how to articulate it. They believed that social barriers were also operating with some clients assuming treatment goals to be the practitioners' domain and not theirs, or that they were not entitled to claim knowledge of therapy and therefore downplayed their knowledge of the situation (Schoeb et al., 2014).

Other client factors thought to contribute to lack of collaborative goal setting include perceived readiness, age, communication or cognitive impairments, or family members not being available for goal setting sessions (Sugavanam et al., 2013). Wholin Wottrich and colleagues (2004) acknowledged that sometimes the clients did not understand or recall receiving information suggesting cognitive impairments attributed to stroke may have been limiting client involvement. Lloyd (2014) reported that physiotherapists in his study of goal setting after stroke, found it easier to collaborate on goal setting with patients with good insight, limited communication or cognitive impairments, previous experience of disability and 'realistic expectations'. However Berg and colleagues (2015) who explored practitioner experience of involving people with stroke-induced aphasia in clinical decision making during rehabilitation suggest that practitioner skills were important in enabling client participation in goal setting activities (Berg et al., 2015). While client factors may contribute to the challenges of collaborative goal setting, it seems there needs to be support from all parties involved for this form of client – practitioner collaboration.

Despite the intentions behind advocating for client involvement in goal setting, the practice appears challenging for both clients and practitioners. Beliefs and perceptions of the client role in rehabilitation may be contributing to this lack of involvement and restrictive view of client participation in rehabilitation goal setting.

Reviewing client – practitioner collaboration in neurorehabilitation

In spite of the endorsement of client-practitioner collaboration by many rehabilitation professionals, the biomedical model still appears to overshadow much neurorehabilitation provision, generating environments that appear in conflict with this call for collaboration (Wolf, Ekman, & Dellenborg, 2012). This environment structures and reinforces the roles of both client and practitioner. Anderson and Funnell (2005) suggest health professionals do not want to give up their role as experts and feel a responsibility for their clients. On the other hand, they believed clients were willing to surrender varying amounts of control to health professionals in order to gain their expertise, technology and compassion (Anderson & Funnell, 2005). Physiotherapists Mudge and colleagues (2014) also recognised a clash with their biomedical roots and client-centred approaches, acknowledging a natural tendency to paternalism. They suggested some clients also struggled with collaboration however, they believed that practitioners had a professional responsibility to incorporate strategies that enabled client – practitioner collaboration (Mudge, Stretton, & Kayes, 2014).

Studies seeking evidence of services that promote client collaboration also reported on the challenges the biomedical model presented to this approach. An ethnographic study of a hospital ward explored how structures such as routines and the design of the environment influenced client – practitioner relationships (Wolf et al., 2012). Wolf and colleagues believed that the biomedical perspective operating in the ward generated feelings of client invisibility and inferiority, noting that the client was viewed as a source of information rather than a partner in the care process. They reported that the environment was organised to meet medical needs with surveillance activities dominating. They observed that routines which structured and limited client – practitioner interactions, were predominantly information gathering activities and restricted client-centred processes (Wolf et al., 2012).

Processes that included clients in treatment decisions and assumed to address paternalism in health care provision and promote client-centred ways of working were found to have the opposite effect. Anne Opie (1998) for example, explored client involvement in treatment planning meetings that claimed to enhance client 'empowerment'. Opie concluded that

rather than operating as devices for knowledge exchange and collaboration these processes actually had the opposite effect, positioning the client as subordinate, marginal and passive in contrast to the therapist as expert (Opie, 1998). Alvie and colleagues (2013) endorsed this finding in a more recent study.

Exploring long term rehabilitation service users and their practitioners' experience of collaboration in service planning, Grete Alve and colleagues also found that some planning process were restrictive and limited collaboration opportunities (Alve et al., 2013). For example, they cited clients who reported feeling vulnerable and weak in large group planning sessions where their shortcomings were discussed. Others were concerned about their difficulties being discussed in a gathering of experts, or reported feeling fraught with realising how much assistance they needed (Alve et al., 2013). Alve and colleagues suggested that the challenge for practitioners was to find strategies that suited the individual needs of clients that enabled them to participate in rehabilitation decision making and understand that what can work for some clients may not work for others.

Including clients in rehabilitation decision making is endorsed as a means for promoting client involvement and a reciprocal relationship of shared responsibilities. It is also considered necessary as a part of the client practitioner collaboration to ensure that context-specific meaningful rehabilitation goals are set. However, institutional practices and cultural barriers operate that limit the extent of this collaboration and at times reassert traditional roles of the client as passive recipients of care.

Chapter summary

Exploring constructions of neurorehabilitation in academic literature revealed two dominant perspectives: One more focused on addressing functional deficits resulting from neurological injury or disease and the other focused on the overall impact this has on the life of the individual and their family. These perspectives differ in emphasis, however both suggest the client has an active role in neurorehabilitation beyond participating in therapy and suggest a key feature of this role is the collaboration between the client and practitioner.

This client – practitioner collaboration has been explored in rehabilitation research literature that suggest this practice to be a fundamental component of the therapeutic relationship, the basis for client-centred ways of working, and necessary for defining and setting treatment goals. Evidence suggests however that this collaboration is not as widespread or straight forward as the rhetoric for client involvement suggests.

Working collaboratively appears challenging, complex and multifaceted, requiring skill and effort from both the client and practitioner. With this collaboration comes increased expectations of client actions and emotions. Institutional practices dominate ways of working and reinforce traditional client – practitioner roles where practitioners are positioned as experts who control the rehabilitation process and the client as the object and subject of their care and practices. Practitioners reportedly felt responsible for their clients and for solving client problems. Clients reportedly were prepared to give up some of their autonomy in return for the health practitioners' expertise and technical assistance. These habitual ways of interacting and the structures that support them appear to challenge the adoption of client-centred practices.

This review has considered the way rehabilitation professionals position the client in neurorehabilitation and the academic evidence that discusses this positioning. Imperatives that drive client-centred practice require the perspective of the client added to this for a fuller understanding. Applying an alternative explanation of how power operates in neurorehabilitation and exploring how neurorehabilitation clients construct rehabilitation and position themselves within this construction may uncover what is hidden in the everyday taken for granted world and provide another perspective.

The next chapter will detail the methods used to conduct the discourse analysis that explored client constructions of neurorehabilitation.

Chapter Four Methods

> *The real voyage of discovery consists not in seeking new landscapes but in having new eyes* (Marcel Proust 1871-1922)

This study used a poststructural discourse analysis guided by the theories of Michel Foucault to answer the question: *What discourses are brought into play as people with neurological conditions talked about their relationship with their practitioner?* This analysis required data in the form of text where the phenomenon of interest was discussed. For this thesis, I chose to use found text (data collected for another purpose) in the form of interviews.

Data collection: Secondary analysis

As discussed in the introduction, this study involved a secondary analysis of a subset of data collected as part of a research project carried out by the Centre for Person Centred Research entitled: *Enhancing collaboration and connection in neurorehabilitation (EnCOR).* Secondary analysis involves the use of existing data to pursue research questions other than the primary purpose for which it was collected (Heaton, 2008). It is increasingly advocated as a pragmatic use of data, an accelerated approach to answering a research question, and as a way of relieving the burden of participating in research for vulnerable, hard to reach or over researched participant groups (Corti & Thompson, 2006). Secondary analysis also allows for an additional in-depth analysis than was taken in the primary study. It can provide an opportunity to explore topics not central to the original research, combine data sets from similar studies with the same population, examine health issues across illness groups, time and space, or allow data to be viewed from a different conceptual lens (Heaton, 2008).

The secondary analysis of qualitative data poses philosophical, ethical and practical challenges for the qualitative researcher (Heaton, 2008; Irwin & Winterton, 2012). Epistemological assumptions about what counts as evidence and how knowledge is acquired affect the type of data that is suitable for secondary analysis. The ethical and practical concerns are linked with the philosophical position taken. To ensure these concerns

have been addressed, it is important details about the primary study be included in the write up of the secondary study (Heaton, 2004).

The primary study in this case used a qualitative descriptive methodology (Sandelowski, 2000), to explore the core components of the therapeutic relationship from the perspective of rehabilitation clients following a neurological event. The study aimed to contribute to the development of a conceptual model and a tool for measuring the therapeutic relationship. It used purposeful and theoretical sampling to capture a breadth of experience. Clients were eligible to take part if they had received at least four neurorehabilitation sessions with the same practitioner within the last six months.

Semi-structured interviews were used to gain the participants perception of what mattered most in their relationship with their neurorehabilitation practitioner. Questions and prompts focused on what the participants perceived to be the key features of this relationship (see appendix). The interviews were conducted by myself in my role as research officer employed by the Centre for Person Centred Research at AUT University, and by a male fourth year physiotherapy student carrying out a summer studentship project who was seeking a cultural perspective of the topic. Some of the participants attended a neurorehabilitation clinic run by the university. While many of the interviews were conducted in the participant's home, some were carried out on clinic premises prior to the participants attending their therapy sessions, while others were carried out in a residential rehabilitation setting. The interviewers introduced themselves and their role prior to the commencement of the interview and preceded data collection with rapport building conversation. Written consent was obtained. The interviews were audio recorded and transcribed verbatim by the researchers.

Concerns for conducting a secondary analysis

The concerns raised about the use of data collected for other studies focuses on three key points (Heaton, 2008). Each of these are described below with an explanation of how they relate to the current study.

Data fit

The first concern relates to the fit of the data and involved questioning if the data would adequately meet the needs of the secondary analysis (Heaton, 2004). This included considering compatibility of data collection and sampling methods between the two studies. The semi-structured interviews of the primary study aimed to capture the participants' perspective of the phenomena in question who were free to go into details about areas they were comfortable talking about. This type of data is suitable for a discourse analysis as it can use any text addressing the phenomena in question (Cheek, 2000).

Ethics

The second key concern for conducting a secondary analysis relates to the moral and ethical responsibility to the participants and the original researchers (Heaton, 2008). These concerns include questions of informed consent, privacy and anonymity, data ownership and the professional reputations of the primary researchers.

Ethical approval for the primary study was gained from the AUT University Ethics Committee (AUTEC: Reference number: 13/257). This Masters' thesis was referenced in that ethics application. Participants were informed about and invited to consent to their interview data possibly contributing to this Masters' thesis. Only data from consenting participants were included in this secondary analysis.

Another caution raised is use of broad consent statements to enable the reuse of data in other studies (Heaton, 2008). Ethical approval is usually granted on the understanding that the data will be used for a particular purpose and the researcher conducting the secondary analysis needs to ensure that the data is used in a way that still fits with this intention or seek consent of the participants to use their data in this new way. (Heaton, 2004). Although this secondary analysis explores the data from a different perspective and the participants may not recognise my interpretation, this analysis is within the intention for which the data was originally collected.

Maintaining an ethical standing is the responsibility of the researcher, this forms part of the rigor process and involves a judgment of researcher integrity. The major ethical considerations for this Master's study was to continue to maintain the confidentiality of the participants, to treat the data with respect and ensure that it was used for the purpose for which consent had been given. To maintain confidentiality, identifying features were removed from quotes and pseudonyms are used in the study write up. Maintaining privacy and anonymity of researchers is another ethical concern generally raised in regards to secondary analysis (Heaton, 2008). This concern does not apply in this instance nor does concern for researcher reputation, as the principal investigator for the primary study was a supervisor on this secondary project.

Another concern raised by Heaton (2008) for conducting secondary analysis refers to the importance of contextual knowledge, which she considered a strength of qualitative research because it allows for recognition of the effects of the particular context in which the data was collected during analysis. This concern is less relevant for discourse analysis that looks at discourses operating at the macro level. As the principal investigator and research officer involved in the primary study were also involved in this secondary analysis, the issue of contextual knowledge is not a concern. Discourse analysis requires minimal contextual detail as the focus of the analysis is on the discourses employed and not the particular context of the individual. However the context of the interview may direct the focus of the discussion and the topics raised, poststructural research recognises the role the researcher plays in constructing data with the participant and accounts for this in the discussion of the findings (Jackson & Mazzei, 2013).

Data selection

Of the 14 participants from the primary study all 14 consented for their data to be included in this Masters study. There is no specific formula for determining the sample size in qualitative research. The goal is to reach a balance between incorporating enough rich data that will allow an in-depth exploration and facilitate searching across the data set for discourses in play (Braun & Clarke, 2013). It was not feasible for this study to incorporate

the complete data set of the primary study in this secondary analysis due to size of the primary data set and time constraints for this Masters study. The interviews averaged one hour and had generated rich data therefore it was decided that six transcripts would provide enough data for this current study.

Sampling is not congruent with this methodology as a poststructuralist discourse analysis does not look for similarities of experiences or representational characteristics usually associated with qualitative studies that attempt to explore the depth or range of experiences. Another criticism levelled at secondary analysis is the "juicy quote syndrome' referring to the suspected temptation to select transcripts on the basis that they contain rich information supporting a particular point that the researcher is pursuing (Heaton, 2008). To prevent this criticism and to overcome the problem of transcript selection it was agreed to use a third party to randomly select six transcripts to be incorporated in this project. Numbers were literally drawn from a hat.

The data set

Six transcripts were selected randomly to form the data set - to be the texts for this discourse analysis. These texts were generated by interviews conducted with one woman and five men; they were aged between 43 and 65. Time since diagnosis ranged from six months to eight years. The participants were all currently receiving rehabilitation for a neurological impairment and included two people with stroke, two people who had experienced a traumatic brain injury, one person with a spinal cord injury and one person with motor neurone disease. Three of these interviews were conducted by myself as researcher on the primary study and the fourth year physiotherapy student conducted the other three. Three interviews were conducted in the participants' homes; two were conducted in outpatient rehabilitation clinic settings and one in a residential rehabilitation facility.

Analysis

This poststructuralist discourse analysis involved the systematic and explicit exploration of the interview transcripts to identify the subjects and objects constructed in them (Cheek,

2004). This study was guided by the theories of Foucault however there is no specific prescriptive formula for conducting such an analysis. The researcher uses the chosen theoretical base to formulate questions with which to interrogate the data, then the texts are read with a view to answering the research question in conjunction with the theoretical texts (Jackson & Mazzei, 2013). The questions that guided the analysis were:

- What subject positions are talked about here?
- What kinds of selfhood or subjectivity do these subject positions bring about?
- Can we identify the discourses that the participant is using to construct their notion of self?
- Do different contexts discussed bring about different kinds of selfhood?
- Can we see evidence of power relations in the interviews?
- What is the effect of these power relations? Is there resistance, struggles, shifting or competing relations?
- How is rehabilitation being constructed by the clients?

The texts were read and re-read systematically searching for the way the participants constructed themselves and rehabilitation. The transcripts were annotated with excerpts of data that addressed these questions highlighted, following which tables were built within MS Word for storage and retrieval of illustrative quotes. Tables were created for each transcript and then were merged to examine commonalities and differences across the texts. The developing analysis was regularly discussed with the project supervisors. An iterative process of exploring the texts and revisiting readings discussing the theories underpinning the research allowed for a developing understanding of the key concepts and how they were evidenced in the data.

Rigour

Quality assurance mechanisms of trustworthiness or rigour in qualitative analysis refers to the steps taken to ensure that the researcher has practiced good science and that new knowledge will be taken seriously (Nixon & Power, 2007). Debate exists about the terms

for these processes and the misappropriation and misconceptions frequently associated with rigour strategies quoted by qualitative researchers (Morse, 2015; Nixon & Power, 2007). The terms such as validity, reliability, transferability, dependability and confirmability generally refer to attempts to demonstrate the worthiness of the research (Morse, 2015). Commonly these are strategies to demonstrate accuracy and support truth claims as well as indicate the possibility for replicating findings. Discourse analysis involves an interpretation of the data from a perspective held by the researcher. Processes traditionally recommended for ascertaining research quality are not relevant as the findings are not presented as a form of truth but an exploration of the topic by the researcher to offer an alternate explanation for observed phenomena (Nixon & Power, 2007). However, other alternative quality assurance processes are recommended that are more compatible with the ontological and epistemological groundings of this methodology.

The primary measure of research quality is the ability to demonstrate that this poststructural discourse analysis is consistent with the epistemological position taken and that the method and analytical decisions are congruent. Nixon and Power (2007) suggest six essential elements to assess the quality of discourse analysis: 1) a clear research question that is appropriate for discourse analysis; 2) the definition of discourse adopted for the study and the style of discourse analysis is explicitly stated; 3) statements relating to the theoretical framework and the epistemological and ontological position; 4) transparency in text production and selection, and of analysis methods and application of theory; 5) a clear description of the concepts which guided the analysis; and 6) whether the research question has been adequately answered. The in-depth explanation of methodology and methods is provided to allow the reader to judge the congruence of approach taken with the question asked and the interpretation argued in the findings and discussion.

Other relevant quality strategies include prolonged engagement with the data, spending time on the analysis process which can be evidenced by the thoroughness of the analysis

and the quality of the interpretation, and providing a clear articulation of assumptions held by the researcher in the thesis write up (Morse, 2015). These elements allow the reader to assess the researchers interpretation and follow the reasoning process (Nixon & Power, 2007).

Researcher reflexivity enhances the quality of the research by calling for a conscious and deliberate effort on the part of the researcher to be attuned to the effect of the personal contextual and circumstantial aspects on the process and maintain awareness of their own involvement in the world they study (Berger, 2015). As such, reflexivity is a major quality control strategy in qualitative research and hence important that the researcher's interests are stated explicitly (Berger, 2015).

Other forms of qualitative inquiry attempt to address researcher bias with methods that include interrater reliability, standardised coding systems and random sampling (Morse, 2015). However, poststructural conceptions of research recognise that the researcher brings their cultural understandings and experiences with them into the analysis and that it is not possible to remove the researcher from the research process (Jackson & Mazzei, 2013). The interviewer affects how the participant responds in the interview – how comfortable they are to share their stories and from which angle they will portray the events they are relating. The interviewer's interest also shapes the way the interview proceeds and which questions are asked, which prompts used, and which comments are followed up on (Berger, 2015). When conducting the analysis, the experiences and world view of the researcher effects what is noticed and of interest to be researched, it directs their gaze towards particular phenomena and away from others. Therefore, it is necessary for the researcher to account for their values beliefs, knowledge and biases so that the reader can evaluate the potential effect this may have on the analysis.

My interest in conducting this exploration came about in my work as a research assistant on a group of studies exploring patient engagement in rehabilitation services. I am not a registered health professional. I attended Teachers College in 1975 and worked for less than three years as a primary school teacher. Subsequent to this, I trained and worked as an

Orientation and Mobility instructor for people with visual impairments during the 1980's working in and later managing a residential rehabilitation unit for newly blinded adults run by the Royal New Zealand Foundation for the Blind (RNZFB). Following this, I enjoyed a period of parenting combined with various types of employment including as a Visual Rehabilitation Coordinator in the Eye Clinic at Auckland hospital. During this time, I studied for a Bachelor of Arts degree majoring in sociology. Sociology interested me as it explores how society and social structures shape human behaviour. The position of research assistant in the Centre for Person Centred Research allowed me to combine my previous life experiences with my new academic qualification.

Not being a health professional, or someone with first-hand experience of neurorehabilitation services, makes me an outsider in the research process (Berger, 2015). My lack of familiarity with the phenomenon being researched does not give me an advantage or disadvantage. Rather, it affects what I notice and find interesting, as well as what I might ignore or take for granted.

In this chapter, I have explained the approach taken to conduct this discourse analysis. The findings from this are presenting in the following chapter.

Chapter Five: Findings

A disciplined disciplining discipline

This chapter presents the findings of my analysis of the texts that looked for the ways neurorehabilitation was constructed by participants and the different subjectivities they took up in their rehabilitation. A poststructural discourse analysis acknowledges that various interpretations of the texts can be proposed, therefore in this chapter I present the dominant findings of my analysis and my interpretation of these.

The overarching finding was that neurorehabilitation appeared to be constructed by the participants as a material and discursive practice: a *disciplined disciplining discipline.* Neurorehabilitation appeared to be a space and a practice for people deemed eligible to become both its subjects and objects. Using special equipment and specialist staff with particular knowledges, traits and skills, neurorehabilitation involved performing specific practices that focused on abilities, working on and with the body. Neurorehabilitation was an individualised service that used standardised practices and population norms to identify and address the needs of its subjects. Constructed as a discipline that demanded discipline, neurorehabilitation used discipline to protect and enhance the capabilities of its clients. Here I use discipline in its multiple senses referring to both the body of knowledge and the regulation of behaviour. The participants became subjects of neurorehabilitation through being identified as capable and worthy of investing in, and were submitted to its observation, examinations, practices and control to optimise their capabilities and achieve their desired state. As subjects of the discipline, they were required to work on themselves and became particular kinds of people.

In this chapter, I discuss these findings in more detail, describing the different aspects of Foucault's concept of disciplinary power and how it applied to the texts. I firstly discuss neurorehabilitation as a discipline, and introduce the mechanisms of the discipline. Then I illustrate how neurorehabilitation as a discipline used these disciplinary strategies to select and discipline the participants who became its subjects. I then explore how the discipline acted on and produced the disciplined subject.

Neurorehabilitation is a discipline – a body of knowledge and a set of practices

Neurorehabilitation is a discipline that draws on a biomedical discourse. It named the phenomena of neurological damage and constructed the practices by which those subjects identified as experiencing these phenomena were subjected to. Neurorehabilitation acted with its knowledge to select the individuals who would be the focus of its practices and who would use these practices to work on themselves to achieve a desired state.

Western medicine with its supporting institutions is based on a set of understandings or discourses about how the body works, these inform the strategies it takes to identify and address dysfunction or illness. For example, one participant said:

> *I recognised early on that this was something I wasn't going to be able to fix myself, I needed some help. […] I just, it was just blind faith, that these guys know better, know what's best for me and I just want to get things working again [Leonard].*

Leonard recognised his situation required specialist knowledge and skills if he was 'to get things working again'. He accepted the rehabilitation practitioners as having expert knowledge that he did not have but would be required to help him 'fix' his body. Leonard was willing to do what needed to be done in order to improve his situation and acknowledged the need for assistance and direction from neurorehabilitation. The biomedical discourse suggests the body needs assistance to heal and that a particular body of knowledge is required to address neurological damage. The roles of experts and their expertise are central (Lupton, 2003). These understandings are the basis of the medical disciplines.

Foucault described discipline as an "art of the human body" (Foucault, 1984, p. 181). He viewed discipline as a technology of power that creates subjects who are the objects of its practices (Foucault, 1977/1984). In common usage, the word 'discipline' has two meanings, the first as a branch of knowledge or field of inquiry, or a subject area of learning or instruction and includes a set of rules of practice *(collinsdictionary.com).* The second meaning of discipline concerns training, correcting, regulating and controlling behaviour.

Foucault combines these two meanings and describes discipline as a form of self-regulation encouraged by institutions (Mills, 2003). Sarah Mills explains that for Foucault "discipline is a set of strategies, procedures and ways of behaving which are associated with certain institutional contexts and which then permeate ways of thinking and behaving in general" (p. 44). With this perspective, discipline is a body of knowledge that moulds thoughts and creates objects, and techniques that shape behaviour. These two interpretations of the word discipline work in conjunction with each other. The body of knowledge and the associated institutions are created by and create the discourse that forms the discipline. These discourses in turn create and support the discursive practices that discipline the behaviours of the subjects of the discourse.

As a way of thinking about illness and the required health care strategies, neurorehabilitation has a specialist language, equipment and practices that accompany it. This quote from one of the participants illustrates this:

> *They got me to do the, it was interesting that like the toileting and showering and **oral care** and all that […]. They've been concentrating on **the upper limb** and strengthening **the lower limb** so on the **motor mead and arm grinder and leg press.** […] and talking about yourself it's not like they um it's not the bung side or the bad side but try and think positive about it you know calling it using terms like the **affected side** (laughs) [Brian].*

The participants adopted the language of the discipline, viewing their body in the technical terms of the discipline. While Brian was encouraged to think about his impairment in positive language, the term 'affected' still identifies that his body is constructed as 'different' through neurological disease.

Foucault argued that disciplinary power is productive. It identifies individuals who can benefit from its practices and makes them subjects of its discourse. The chief function of disciplinary power is to train. It separates, analyses and differentiates individuals. This disciplinary power is not a major repressive force but a subtle procedure with simple instruments of examinations, normalising judgments and observation (Foucault, 1984).

These disciplinary mechanisms operate to select, classify, train and supervise the subjects of the discipline. The instruments combine forces to operate however; each mechanism has specific functions in neurorehabilitation practices and were identified in the text.

Disciplinary mechanism: the examination

> *The examination is highly ritualised. In it are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth. […] For in this slender technique is to be found a whole domain of knowledge, a whole type of power* [Foucault 1984, p. 197].

The examination is a procedure specific to disciplinary power and involves the combination of observation and normalising judgement (Foucault, 1984). It is a disciplinary mechanism, by which the individual is judged, measured, compared with others and described (Foucault, 1984). This procedure creates the subjects of the discipline. Medicine uses its knowledge to examine and select the candidates who will become the subjects of neurorehabilitation. Those affected by a pathological neurological event are identified with tests, observations and assessments. Foucault (1988) suggested that biomedicine requires the body to be examined to reveal its secrets in order to be healed. The individual's abilities are categorised based on these examinations. *Grids of specification* classify individuals by their particular symptoms into illness groups. These include for example, stroke, traumatic brain injury, multiple sclerosis, Parkinson's, and spinal cord injury. Knowledge about the individual client is also generated by these examinations. Foucault (1995) believed that these classification systems are a technology of power and a procedure of knowledge. They enable separation and grouping of individuals, assist with their supervision and intelligibility, and allow for predictions to be made (Foucault, 1995).

The participants were subjected to a set of assessments that identified particular characteristics and allowed them to qualify as subjects of the discipline. The practitioners

used their knowledge and 'ceremonial practices' of assessment to produce the subjects of neurorehabilitation:

> *I was in ward 23 and they were doing the assessment thing before I went and did anything. And they sort of had to go and sort out whether I needed a hoist or one or two who assists and all that sort of thing for the nursing staff [...] they (the physiotherapists) came in and said "we are going to do an assessment for you for the nurses here and we will get you started on a programme in the next day or two" [Leonard].*

Leonard was subjected to the disciplinary gaze of the physiotherapists who examined, assessed and classified him. This process marked him out as being a certain type of object – the subject of the observation (Foucault, 1977/1984). The assessment gathered information about Leonard and made judgments by identifying differences from standardised norms. The practitioners who carried out the assessment used the authority and skills of their discipline to determine the practices that the participants would be subjected to and the rehabilitation services they would qualify for. The practitioner's disciplinary knowledge enables them to make calculations about the individual client based on their disciplinary knowledge of population standards, and estimate the amount of assistance that the individual subject would require to perform specified tasks, and predict recovery.

Neurorehabilitation looks for certain types of people to become its subjects. For New Zealanders, the public health system covers the immediate medical needs of those citizens who require assistance. For those who experience their pathology due to illness, neurorehabilitation services are funded by district health boards, which specify the criteria by which it selects its subjects. For example, the Counties Manukau District Health Board defines eligibility for their neurorehabilitation services as: living within the district, aged over 16, medically able with medical potential for full participation in a rehabilitation programme, willing to participate in an individualised rehabilitation programme and with potential for improvement and good rehabilitation outcomes (Counties Manukau District Health Board, 2014).

The assessment classified the participants as suitable subjects for neurorehabilitation, individuals with the capabilities to participate in and benefit from the techniques and knowledge of the discipline. The person with a pathological neurological event who had been classified as eligible for neurorehabilitation became a subject of its discipline, a project to be worked on; the object of its practices.

Once classified as a suitable candidate for neurorehabilitation, the participants became subjected to the practices of the discipline:

> *I had to be hoisted in and out of bed and one morning I just swung around and sat up on the edge of the bed myself and I was completely paralysed down the right side – I got a big telling off for that (laughs) they could see that they could do more things with me than what they were. [Leonard]*

Leonard who was hemiplegic related how one morning in hospital he was admonished for not waiting for assistance to sit up. Although he is reprimanded for his actions, this excerpt suggests there was a specific programme of rehabilitation based on his diagnosis and expected recovery trajectory.

Neurorehabilitation is disciplining

> *The body that is manipulated, shaped, trained; which obeys, responds, becomes skilful and increases its forces. […] Thus discipline produces subjected and practiced bodies* [Foucault, 1984, p 180].

The eligibility criteria for neurorehabilitation services not only creates subjects it also affects the behaviour of the subject. The neurorehabilitation client is required to actively participate in their rehabilitation programme and benefit from it. The discipline exercises a subtle coercive force turning the docile, analysable body into the manipulable body (Foucault, 1984).

Neurorehabilitation aimed to improve the participants' abilities by imposing its rules and practices. It worked on the body and the person. The practitioner physically manipulated the participants' body and the participants exercised their own body.

> *I said […] you had these […] ladies on a plinth that you were actually bending their arms and straightening them, straightening them, you know, their limbs [Brian].*

Brian observed how the practitioners worked the bodies of their clients. He has commented on how physiotherapy often involved hands on manual treatment. The practitioner manipulated the client's body to get it to act in a particular way. The disciplinary practices worked on the body as it re-learned to make the desired movements. The subject's body was an object of the discipline of neurorehabilitation.

The discipline trained the person as well as the body. I noted earlier (see page 66) how Brian was disciplined into rethinking his body and his impairment. The *affected side* was the encouraged perspective rather than *bad* or *bung side*. An everyday activity of brushing his teeth had become 'oral care'. The participants' language and thinking was influenced and disciplined by the discourses they were subjected to. Thus, the discourse affected how the participants came to know their body.

Systematic training and the practice of skills are important rehabilitation activities:

> *(My physio) was always saying always move your, keep your left hip going and on the leg press to bend this knee by itself, and tell me why the benefit of the quads, and that when you are walking by yourself it'll be strengthened; you'll be able to move it more confidently. […]He would always explain the things he was going to do and what benefit that would come from it that […] really clear about the exercises he was doing and what benefit was to come from it and also the things I could do myself when he wasn't doing it [Brian].*

The physiotherapist educated Brian about his body and trained him in the methods and techniques of the discipline. Not only was the body trained, but also the person, as Brian learnt about the benefits to expect from performing the set exercises. The participant's body

was subjected to the disciplinary practices and was gradually manipulated, shaped and trained; improved, corrected and strengthened, the object and target of disciplinary power (Foucault, 1984). The drilling of the exercise worked the body but the practitioner was also teaching Brian about the mechanical workings of his body, in this way he became a knowing subject. Foucault (1984) explained that disciplinary practices aim to increase the forces of the body and the mastery of each individual over their own body.

Individual responsibility was a discourse promoted by neurorehabilitation. There was an expectation that the participants would continue to work on their own bodies in the prescribed way:

> *They were clear about what they wanted me to do […] they gave me a*
> *whole exercise programme […] for me to just to not to wait for them*
> *[Brian].*

The practitioner indicated to Brian the expectation for him to practice the prescribed exercises on his own. The disciplinary power interacted with and promoted a technology of self, encouraging a particular kind of subject, someone who was willing to correct or regulate himself or herself for the sake of improvement, or in other words, be self-disciplined.

The participants generally expected to be corrected and disciplined by their practitioner:

> *I expect them to be honest with me […] if I have issues, posture, I'm*
> *doing an exercise wrong, - just be straight and explain to me say "you are*
> *doing that wrong it should be done this way" [Calvin]*

Calvin hoped to benefit from the disciplinary practices and therefore submitted to be educated and trained by his practitioner. Part of the disciplining involved being observed, corrected and instructed on how he needed to alter his behaviours and act on his body. Calvin and his body were trained.

Biomedical understandings of ways to address neurological damage and the discipline of physiotherapy have determined that there is a precise way for the exercises to be executed. In his observation of military discipline, Foucault (1984) described how the individual's body

was "exercised according to a codification that partitions as closely as possible time, space, movement" (p. 181). This appears similar to that described by the participants who explained how they were taught to exercise their body:

> *(My physio) he actually got himself filmed with his cell phone that had a*
> *camera on it and he managed to get it on a USB stick so I got photos of it*
> *and the explanation of it but I also got what it actually looks like as well*
> *[Brian].*

Brian explained how the practitioner created a video to remind him of the exercises he was to practice and to specify the correct way they were to be performed. His practitioner showed him the way the exercises looked when they were performed correctly, thus equipping him with the knowledge of how to complete the exercises properly. With this information, Brian became a particular seeing, knowing subject.

Risk appeared to be another discourse associated with neurorehabilitation. The participants learnt safe practices and absorbed the need to be concerned about their own physical safety. The notion of reducing risk and being cautious constructed neurorehabilitation as concerned about the safety of its clients:

> *One of the things they gave me was how to get myself off the floor if I fell*
> *over [Brian].*

> *Safety is a biggie if I don't feel safe then I don't… I don't want to fall*
> *down and break my leg [Emma].*

Brian and Emma had become aware of and shared the cautions and safety concerns of the neurorehabilitation discipline. For Foucault (2003), the calculation and management of risk is a governmental strategy generally associated with populations and bio-politics. However, the economy and efficiency of body movements are a disciplinary concern. Neurorehabilitation as a discipline seeks to increase the client's capabilities and management of their own body, therefore teaching clients to manage risk and avoid causing further damage is part of the discipline's practices. This caution shaped the participants' thoughts and influenced their behaviours.

The practitioner's disciplinary knowledge was a source of power and authority that the participants submitted to in the hope of achieving their goals:

I asked her "what muscle is that and what does this do and why can't I do this and why is my arm so sore and why can't I move it?" She took her time and explained it all to me and that made it easier for me to try and help her out, try and do the things she wanted to do. You know I would have crawled over hot coals for her. [Leonard]

Leonard sought knowledge from his practitioner so that he could assist her work on his body. The practitioner used her disciplinary knowledge to educate and train Leonard about his body and in the techniques proposed by the discipline to address his impairment. He was prepared to do whatever he could to come to understand his body in a particular way and achieve his desired state. This knowledge assisted Leonard to work on his own body and become self-disciplined.

Foucault used the power/knowledge combination to explain how knowledge works in conjunction with power (Mills, 2003). Power and knowledge depend on each other. Power sanctions what can be classified as fact or truth or can count as knowledge. Institutions like universities produce and sanction knowledge then act to circulate and maintain it. This authorised knowledge engenders power. The medical disciplines use the sanctioned power of science to produce knowledge and shape their practices and expertise, this power/knowledge combination reinforces its truths and endorses their rightness (Foucault, 2003). This is the basis of the practitioners' disciplinary knowledge, which gave them power to help the participants in their efforts to recover their abilities and teach them to improve themselves.

The knowledge/power relationship is played out as the practitioner demonstrated her status as someone with superior and valued knowledge. Foucault (1983), in his analysis of power relations suggested that a system of differentiations is required to permit one to act on the actions of others. He explained that these differences can be determined by law, status, knowhow and competence (Foucault, 1983) . The practitioners have their disciplinary

knowledge, the support of the medical institutions and regulations that govern their practices and sanction their authority.

The biomedical discourse has created specialist discursive practices designed to address particular areas of dysfunction. Thorne (2014) explains: "when we think of core disciplinary knowledge, we are most typically referring to the intellectual structures within which the discipline delineates its unique focus of vision and social mandate" (p. 1). Each specialist discipline has its own areas of expert knowledge, technical skills and scope of practice. The disciplines create speaking positions that focus the practitioner's view of the problems presented by the client. The solution may be individualised to the specific needs of the client, however the knowledges and practices of the specific discipline frame the view of the problem for the practitioner.

The specialist discipline's scope of practice and approach to addressing neurological pathology needed to match the participant's understandings of their recovery needs:

> *The name for a starter you know, "occupational therapist" I think well what sort of occupation am I going to be able to do you know? How is she going to teach me this? But I got to, basically I can see the need for them that they can show you things, how to do things that you have forgotten how to do or not capable of doing, or there is a better way of doing it. But for me it was all just common sense [Leonard].*

Leonard did not believe that the occupational therapist (OT) had any specific expertise to offer him 'just common sense', which is knowledge generally available and not superior to his own. This discipline appeared not to have any specific knowledge he perceived necessary to assist his recovery. Rather, Leonard prioritised his physical recovery and sought the expert assistance of the physiotherapists for this as he perceived they had the technical knowledge and skills that he needed to achieve his aims.

Disciplinary mechanism: observation

> *Thanks to the techniques of surveillance, the 'physics' of power, the hold over the body, operates according to the law of optics* [Foucault, 1984, p. 193].

Surveillance is a disciplinary mechanism used to select the subjects of the discipline and ensure its practices are effective. The practitioner observed and monitored the participant performing the prescribed practices to ensure they were performed correctly:

> *She had her eye everywhere at all times and would yell out across the gym that, you know if you happened to be stretching your ankles passively instead of … [Emma].*

Emma was mindful that the practitioner was observing and monitoring her performance in the gym. She knew there were correct ways of performing the exercises – she needed to be stretching 'actively' and not 'passively'. For Foucault, observation is a key disciplinary technique. The physical layout of the rehabilitation clinic or ward facilitates this observation. Foucault commented "stones can make people knowable and docile" (1984, p. 190) to indicate how buildings work to allow this kind of surveillance. He used the concept of *panopticism* to explain how the intentional design of physical structures facilitates self-surveillance. These mechanisms continue to perform as a disciplinary device when the observer is not present because the subject absorbs and internalises the disciplinary gaze (Foucault, 1984). In this way, the subject learns to monitor her or his own behaviour.

In the hospital, the participants were subjects of more than one disciplinary practice that could reinforce different desired behaviours. For example, Leonard recalled one of his experiences:

> *I felt that I could do better, I could do more than what I was being allowed to do sort of thing. Like very, I was quite close to discharge, so probably about six weeks or so I started being able to walk around unaided without a stick. And we had a barbeque or something, they had a barbeque there once a month or something and the physio's and the*

OT's and everybody all come to the dining room and we'd have this barbeque lunch and I got off the seat and walked over to the water cooler and got a drink. Well the charge nurse she came over and said, "What do you think you are doing?" [I thought] "Ooh geez I'm in a bit of trouble here!" and of course she had never seen me walking you see without assistance or in the chair and so I said, "(the physio) said it was alright."- A pathetic excuse - I couldn't think of anything else at the time. [Leonard]

The charge nurse, who appeared concerned with ensuring the physical safety of her patients, observed and then chastised Leonard who was impatient to be more mobile than was currently allowed. Although he was pushing the boundaries of accepted activity, Leonard still recognised the authority of the charge nurse and the 'trouble' he was in. The physiotherapist, whose disciplinary knowledge gives them authority to determine physical capacity, was called upon to sanction the indiscretion. People are subjects of more than one disciplinary practice and can position or align themselves with one or the other depending on the context (Cheek, 2004). The charge nurse's focus of care is in conflict with the participant's determination to be independently mobile. In this instance, it suited Leonard to align himself with the physiotherapist.

The hospital context facilitated disciplinary control and surveillance. Once discharged, Leonard was freer to choose which discursive practices he engaged in and worked on his recovery at his own pace.

She [the physio] wouldn't take any risks with me […] with my walking or balancing and that sort of thing you know. I felt, it was in the early stages they were overly cautious. I know why and I don't, it's not a criticism but I couldn't understand it at the time and I felt that I could do better I could do more than what I was being allowed to do sort of thing […]. We only had short sessions of it because it was supposed to tire you out, but it never did. In fact I bought a TENS machine for when I got home and fixed the pain in my arm and woke my foot up [Leonard].

Leonard struggled with the practitioner's concern for caution and the restrictions placed on him in the hospital. He wanted his practitioner to take risks, be more adventurous with him

and push the boundaries. This caution also suggests neurorehabilitation's concern with controlling and determining the pace of recovery. Away from the direct observation of the hospital staff, the practitioner's discipline was still working on Leonard. Although he was resisting some aspects of the caution imposed on him as he worked on his own recovery, he used the disciplinary treatment techniques he had learnt as an inpatient.

Resistance is an integral part of a power relationship. Foucault's theory of power suggests that without the freedom to resist, the client – practitioner relationship would be one of oppression rather than a relationship of power (Foucault, 2001). Sometimes this resistance occurred under the observation of the practitioner and as a direct challenge to their control. For example, Ben described how he managed his rehabilitation sessions at the gym:

> *Yeah I argue one more minute, I'll say – one more minute at this and they will argue only one minute and then I distract them and I, see yesterday the student, and I was on the treadmill and I said, 'Now crank it up' and she said 'oh you can't', I said 'come on I'll be fine'. 'Alright she said 'only two minutes'. But we were supposed to finish at twelve minutes and when it was coming up I said 'how many kids have you got?' And I knew that if you ask someone about their family or their interests – we went on for fifteen minutes and then [someone] came across and said 'you're on that a long time!' and I laugh and she said 'oh you bugger you so and so' – so but just those little techniques you have [...] so I manipulate them [Ben].*

Ben explained how he manipulated his sessions so that he could achieve the targets he set for himself that were contrary to those of the practitioner. Ben is not resisting the discourse of risk or the disciplinary practices but negotiating some of its controls.

Disciplinary mechanism: normalising judgements

> *Normalising judgement [...] refers individual actions to a whole that is at once a field of comparison, a space of differentiation and the principle of a rule to be followed. It differentiates individuals from one another, in terms of following overall rule: that the rule be made to function as a minimal threshold as an average to be respected or as an optimum*

Normalising judgements are a significant disciplinary technique, which can involve examination and observation, but these do not need to be formal procedures for normalising judgements to occur. Norms are standards of proper or acceptable behaviours associated with a social group, traits or established patterns of behaviour taken to be typical, set standards of development or achievement, widespread usual practices or the average performance of a significantly large group (L. Davis, 2010). For Foucault normalising judgments are powerful mechanisms for controlling populations (Foucault, 1984). In neurorehabilitation, the assessments that are carried out to identify eligibility use statistical norms of population health to compare function and define abnormal function in terms of the gap between or a departure from normal functioning (Whalley Hammell, 2006). These statistical standards classify clients by their abilities and calculate progress towards a desired state – of attaining being 'normal'.

Neurorehabilitation appeared to be operating as a normalising practice and enforcing a discourse of 'normal'. Because of the disciplinary knowledge, neurorehabilitation has the authority to say what is normal. In this way, the body and the experience are normalised:

They will give me advice and say, "no that's normal" or "you are doing really well" […] issues like that that they said were "normal in your case" [Calvin].

The practitioner's expert knowledge enabled them to pass such judgements, and reassure Calvin that his experience was normal for someone in his situation. What is considered 'normal' is situated and individualised by neurorehabilitation identifying patterns of behaviour taken to be typical for a particular group that for Calvin is someone with his particular condition. The person is separated out from the mass as an individual although with different capabilities, and is given an expectation of what is supposed to happen as normal or commonly occurring in this situation.

Neurorehabilitation is a medical response to neurological illness or injury and is typically associated with notions of restoration, recovery and repair. Dictionary definitions of rehabilitation suggest it is the 'act of restoring something to its original state' with the prefix 're' meaning again, and 'habilitate' coming from the Latin meaning to make fit (www.vocabulary.com/dictionary/rehabilitation). Connected with this definition is the intention of restoring someone to a 'useful place in society' or to a 'satisfactory state'. Medical dictionary definitions refer to rehabilitation as a 'process of reversing disabling conditions caused by injury or illness that cannot be reversed through surgical interventions'. The aim of these processes is reportedly to 'restore to normal or as near normal as possible' (http://medical-dictionary.thefreedictionary.com/rehabilitation).

The participants talked about their rehabilitation practices as being to '*make things work again*', to '*keep the body working*' or to improve or maintain their capabilities:

> *I do the tasks set for me and regularly because my rehabilitation will*
> *make me better [Calvin].*

> *I'm more capable now [Emma].*

> *I always said I wanted 100% recovery [Leonard].*

By engaging in the prescribed rehabilitation practices on a regular basis, Calvin understood his abilities would improve. Emma believed that she had benefited from neurorehabilitation by increasing what she was physically capable of doing. Leonard wanted a full physical recovery and actively engaged in his rehabilitation in the hope of achieving this. The individual nature of the pathological event determined expectations for recovery however, the participants hoped to gain a desired state by participating in the disciplinary practices.

Not all the participants expected recovery from participating in neurorehabilitation. Ben had a degenerative neurological condition but hoped that neurorehabilitation would slow the disease process:

> *I might be panting on the bike but I'm doing the exercises …I have*
> *increased my lung capacity…I should not be walking… my neurologist she*
> *is astounded by what I have been able to achieve [Ben].*

Ben wanted to challenge normal expectations for his diagnosis by using neurorehabilitation's disciplinary practices. By performing the exercises and being self-disciplined, he had retained important abilities. Ben valued his ability to walk and pushed himself to maintain this. Gibson (2016) notes that our society values walking as a normal and treasured human activity and it is often the focus of rehabilitation practices. Ben was attempting to push the boundaries of the established patterns of what was normal for his particular condition by wanting to retain his capability of walking - a behaviour considered normal for a larger social group to which he also belonged. Ben hoped neurorehabilitation would assist him to maintain his status of 'normal'.

The expectation for achieving a 'normal' state from participating in rehabilitation practices appeared at times to be imposed by the practitioners:

> *[The practitioner said] 'Oh we got Brian up to 50%' and sister said 'I need*
> *him at 80% normal', I think she wanted me at 100% [Brian].*

Here Brian described a conversation he was part of where his practitioner calculated the achievements of his rehabilitation programme in terms of a percentage towards a desired state of 'normal'. The participants' abilities and achievements were compared against population standards – an ideal of 100%. This need to restore Brian to 'normal' appeared connected to a notion of independence.

Achieving functional independence was promoted as a desirable neurorehabilitation outcome:

> *I did an independence programme which tries to get you the patient to*
> *do as much as he or she can. […] It was always with the idea that I might*
> *be going to live by myself again, so they would teach me, or do*
> *independence things that would be kind of easy one handed or use*
> *apparatus that you'd be able to. You know, like do things in terms of*
> *open and closing fridges and drawers, and all that, and cutting things*
> *and buttering toast and all that, that you can actually do with one hand*
> *and you'd do by yourself […] I was put on the independence program so I*
> *could fit in here [Brian].*

Brian explained the types of rehabilitation activities that were part of his independence programme which he 'was put on' with the aim that he might live on his own again, or to make him 'fit' for a particular living situation. For Brian, doing things by himself and being independent was constructed by his practitioners as desirable and 'normal'. However, Brian had to learn a new 'normal' that for him meant adapting and re-adjusting to doing things everyday things one handed, to enable him to live independently as much as he was able. 'Normalising' in this instance was not about restoring abilities but to give this participant the ability to 'fit in' to a particular social setting.

Being independent and doing things by oneself was associated with more than being fit for certain situations. It was also associated with socially valued personal attributes:

> *There always seemed to be a thing about because the person needs to acquire their independence or their self-worth again of finding as many ways as possible to be able to get them to do it themselves [Brian].*

Being independent was considered by Brian's carers who had managed to get him to '80% normal' a desired state but also important for his 'self-worth'. Independence and 'doing things by yourself' was constructed by neurorehabilitation as a desirable, 'normal' and essential for an individual's social value. Nicholas Rose (1998) explains that psychological norms have transformed the ways we interpret, judge and reform ourselves. He suggests that notions of individual worth and value connected to notions of autonomy and normality are attached to a political ethic associated with liberalism and rationality (Rose, 1998). The ability to be an autonomous citizen is valued by this type of society and another is discourse connected with rehabilitation (Gibson, 2016).

Disciplinary mechanism: individualising and standardising

> *The power of normalisation imposes a homogeneity; but it individualises by making it possible to measure gaps, to determine levels, to fix specialties and to render the differences useful by fitting them to one another [Foucault 1984; p.196-197].*

Foucault observed that despite separating out individuals, these disciplinary mechanisms of examination, surveillance and normalisation also impose a sameness on their subjects. Neurorehabilitation used its body of knowledge to develop its standard practices. Through its assessments, it gathered knowledge about the individual to create the subject and with its disciplining and normalising practices it supported standards of a larger social group. Neurorehabilitation worked with the participants to meet their specific needs using a recognised uniform, standardised approach:

> *They (the physiotherapists) must do it from the same script because they*
> *are the same almost in terms of explaining and then doing [Brian].*

While the individualised programmes were designed to meet the specific needs of the client, the uniform approach of the discipline 'using the same script' was adapted for the participants' needs identified through its assessment processes. The programme was customised for the participants but there was a standardised 'correct' way of performing the exercises. The exercises were also standardised ways of addressing specific problems.

The practitioners' disciplinary knowledge allowed them to assess and treat the individual and gain more knowledge that they used to tailor their approaches to meet the specific needs of its subjects. The practitioners also appeared to have a special knowledge of the participants. The participants believed their practitioner:

> *Knew how I felt [Leonard].*
>
> *Knew what I needed [Andrew].*
>
> *Knew more about me than I did [Andrew].*
>
> *Know what they can get out of me without me telling them [Calvin].*
>
> *Knew what I was going through better than my own family [Leonard].*

This special knowledge was generally related to the specific knowledge of their discipline and gave the practitioner access to other more personal or intimate knowledge of the individual client:

There was a lot of personal touches. [...] (The physio) could relate to what
I was going through and my wife couldn't [...] knew what I was feeling
[...] I had no clue then that it was fatigue making me grumpy [Leonard].

Knowledge of the medical explanations for Leonard's unusual emotions - how fatigue which was a consequence of the stroke affected his moods enabled the practitioner to appear to have insight into his personal dilemmas.

The assessment provided opportunities for the practitioner to gain knowledge of the individual client. However, this knowledge increased over the course of the time spent with their client:

I'm finding with my new physio it's taking her a while to know what my
limitations are and also get in rhythm with my body like in my walking
pattern and things like that [Emma].

As the practitioner came to know the limitations and abilities of their client, the participants appeared to become more willing to trust and follow their advice:

You end up building up a trust sort of thing with them and yeah there's
not that many people I trust or would divulge information to. They're
pretty good [...] say if they ask any personal questions about, you know,
they want to know something about, oh anything that might be
untoward - I would think twice about answering anything like that, but I
always, they explain everything to me [Andrew].

Andrew felt comfortable giving out information about himself that he generally kept private because his practitioners had demonstrated their expert knowledge explaining things to him. He trusted them and believed they were working in his best interest. Giving out personal information about oneself is an 'act of confession' that Foucault (1981) suggested was a widespread social practice and a central strategy to the outworking of power. Confessing intimate details about oneself to an employer, insurance company, or medical professional, for example, is one of the rituals that produces truth because of the proximity of the one who speaks to the subject of the confession (Foucault, 1981). Foucault explained that confession within a relationship of power gives the authority a tool with which to assess and

deal with the confessor. The participant confessed personal information to the practitioner because they had committed to assist him.

This intimate knowledge combined with their disciplinary knowledge enabled the practitioner to work with the individual client.

> *I find them pretty honest, straight up and down, and competent. I have got a lot of faith in them. [...] I could quiz her on issues and she comes straight back with answers and the right answers. Things that only I would know and she is telling me about it. [...] If I've got pains or issues or something like that and she will say to me "oh yeah, you are getting that pain there and sometimes you can get a pain in this area of your leg or your hip" and it's like I haven't even told anybody about that and that impresses me. Just in what she picks out. She picks up on me with my posture when I'm doing exercises or whatever. And she explains it to me so I understand why they are getting me to do exercises and everything she gets me to do [Calvin].*

Calvin was impressed with his practitioner's professional expertise because she appeared to have a special knowledge of him. He believed she had access to the truth about him – she knew the right answers. The practitioner's apparent insight into the participants' individual experience was a result of their standardised disciplinary knowledge. This knowledge appeared to help Calvin to accept the disciplinary practices and the practitioner's authority.

The disciplined subject

> *This form of power applies itself to immediate everyday life, which categorises the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognise and which others have to recognise in him. It is a form of power, which makes individual subjects* [Foucault in Dreyfus & Rabinow 1983, p. 212].

The selection processes that recognised eligibility and created neurorehabilitation subjects provided the participants with a subject position of 'neurorehabilitation client'. This subject position influenced their behaviours, affected their actions, and offered certain kinds of subjectivities. Dominant discourses, such as the biomedical discourse, frame understandings of issues and create viewing platforms for the subjects (Cheek 2000). Stuart Hall (2001) explained that subjects are figures who personify the particular forms of knowledge that the discourse produces and display the attributes defined by the discourse. Discourses produce a place for which the subjects position themselves within and from which the discourse has most meaning, is most easily understood and takes effect (Hall, 2001). Adopting a certain subject position is a type of action which has consequences and is set within particular contexts of action (Jackson & Mazzei, 2013). The participants, as neurorehabilitation clients, believed they had to act a certain way to retain their eligibility and benefit from the disciplinary practices. Neurorehabilitation also created the subject position of 'neurorehabilitation practitioner'. The practitioner's behaviour was also influenced by their discipline and the related discourses.

The neurorehabilitation client

Neurorehabilitation required its subjects to be particular kinds of people. The participants perceived the need to have particular personal characteristics as subjects of neurorehabilitation to achieve their desired state. They shaped themselves into the kinds of people they considered the discipline required them to be - to be compatible with the task. Leonard was prepared to do what was needed to achieve his desired state, he explained:

> *I could see that if you didn't have a positive connection with your physio*
> *it would affect you at rehab, it would affect your recovery I think.*
> *Motivation was the big difference […] I saw other people in there that*
> *just did not get on with their physio at all and so I don't know what it is. I*
> *still think there was probably a fair bit of, for me the motivation was to*
> *walk out of there unaided, and I did that [Leonard].*

Leonard recognised that certain behaviours were necessary for him to achieve his recovery goal. He needed to be motivated and 'get on' with his physio. Leonard acknowledged that

his relationship with his practitioner was important for his rehabilitation. Motivation is a poorly defined but highly valued attribute generally perceived to involve an outward demonstration of willingness to participate in the required activities (Maclean et al., 2002). Leonard believed he could portray this willingness by his positive attitude, connecting with and relating to his practitioner, and making the desired progress.

The discipline of neurorehabilitation acted on the participants' behaviour but they also acted on themselves. Foucault was interested in the way human beings were made subjects and particularly the way human beings turned themselves into subjects (Foucault, 1983). Leonard described the specific actions he took to prepare himself for his rehabilitation sessions:

> *My physio, she was the reason I got out of bed and had a shave every morning because I had my gym session at 9 o'clock in the morning so it was get up, have a shower and shave and breakfast and trod along down to the gym [...] I just wanted to please her (laughs). I knew if I did things right I would move onto the next bit and make progress and I didn't want to disappoint her. [...] I was prepared to try anything to get the repair work going and help it out [Leonard].*

Leonard was willing to do what was needed to regain the capacities he had before his stroke, and so disciplined himself, being reliable, turning up to his sessions, being punctual and compliant; a docile body doing the exercises the physiotherapist had directed. Leonard made himself into the right type of person in order to benefit from the practices of neurorehabilitation.

Neurorehabilitation requires a sustained effort from the client. The participants recognised the requirement for 'hard work' and their active involvement:

> *I have to go with my game on. [...] You work your butt off. [...] I don't go 'yeah I'm going to physio'. [...] You go with a particular attitude [...] just try my best I should just go with a good attitude I think that's what I should do just go and try my best and I think that's all you can expect from anyone just go. You turn up I think you I think that absolutely um*

you should be expected to turn up if you can and if you can't you should
be expected to ring [Emma].

Emma explained how she believed she needed to be prepared to work hard, and as for her going to physio was not always a pleasant experience, she needed to discipline her thinking and go with the 'right attitude'. She also needed to regulate her behaviour attend her sessions, carry out her exercises and actively engage in her rehabilitation. Both of these excerpts show a commitment and dedication to attending these appointments. The participants were prepared to modify their behaviours for the sake of their self-improvement.

The neurorehabilitation practitioner

The participants appeared to require their practitioner to be a particular type of person. Neurorehabilitation practitioners are subjected to the controls of their discipline. They gain their status of practitioner following participating in prescribed training and demonstrating they possess the knowledge and skills deemed necessary for their practice. They are required to attend to their disciplinary regulations to maintain their registration as health practitioners.

The participants expected their practitioner to have the necessary skills and knowledge of their discipline:

They are competent in what they do, that's important […] I look at her
and think "how well is she doing her job?" And she is doing it
exceptionally well. And that's all I expect of somebody, that they give it
everything. And that's what I am getting. [Calvin].

Calvin explained how he expected his practitioners to be 'competent', 'to give it everything' and do their job to a high standard. The practitioners needed to be able to demonstrate they had the necessary disciplinary knowledge, and do their job successfully. Competency denotes more than capability, it also suggests proficiency and efficiency. These traits are associated with discipline which Foucault (1984), explains endeavours to utilise abilities in

the most efficient manner. The participants evaluated the practitioner's behaviour against standards they perceived as necessary for someone in their position.

The neurorehabilitation practitioner was expected to use the skills and practices of their discipline to assist the participants enhance their abilities and achieve their goals:

> *And there was one thing that I don't think she was too happy about, was that the consultant I had asked the physios to do FES (functional electrical stimulation) on my arm and on my drop foot too, and I got the distinct feeling that (the physio) did it, and she was good at it - she got my wrist a bit working, but I got the feeling that she didn't like the machinery. She didn't like doing the electrical stimulation [...] I made sure I got my treatment, I think if she could have found the excuse to not do it she would have [...] but she could see I wanted it and she did it [Leonard].*

Leonard's medical specialist had suggested a treatment that he believed his practitioner did not support. Leonard made sure the practitioner conformed to the direction of the specialist whose position within the hierarchy of *authorities of delimination* of the biomedical discourse is superior to hers. However, Leonard respected the fact that despite her apparent reluctance the physiotherapist did the treatment because it was what he wanted. In complying with this, the practitioner was perceived to be working in the best interest of the client.

The participants also expected their practitioner to be accountable and disciplined:

> *That they are punctual when they say they are going to be there [Calvin]*

> *They are paid a reasonable amount of money by ACC [accident compensation corporation], you know, and I think ACC or whoever is the funder should get their money's worth and so should I as a client and that's really important to me that they take it seriously that a therapist takes it seriously [...]. I've had a physio that would swan in late, like ten minutes of ACC money and ten minutes of my time that's therapy I'm not getting [Emma].*

Calvin expected punctuality and dependability from his practitioners. Punctuality involves being disciplined by time and suggests self-discipline. Emma also wanted her practitioner to

turn up on time so that she could get the treatment she was expecting and believed she was entitled to, that the funder was paying for. The practitioner has an obligation to the state and the client. Time was linked to money and time was also linked to the client's recovery.

The eligibility criteria that selected the participants as subjects of neurorehabilitation also appeared to influence the behaviour of the practitioners:

> *She was a little bit inventive in her reporting as well because she used to under report sometimes so to ACC so that next time you always looked like you were progressing. [...] she kind of played the game but she did it because she cared so that you would always get your next programme. [...] that was pretty nice of her, she did do it because she, there was only one reason why she did it not because she was naughty but because she wanted you to be able to keep progressing [Emma].*

According to Emma, her practitioner was aware that to maintain her entitlement for neurorehabilitation, Emma needed to continue to appear to benefit from its practices and make progress. Emma perceived that her practitioner manipulated the reporting to the funding agency so that her client could continue to receive services. Emma supposed this to be an expression of the practitioner's commitment to her although this arrangement may have been mutually beneficial, as Emma's continued engagement ensured that she had a subsidised client.

The participants scrutinised the practitioners' behaviour:

> *And that's all I expect [...] If I wasn't I would confront them about it [Calvin].*

Calvin declared that he would challenge his practitioners if they did not meet his expected standards. Although the participants were subjected to the surveillance and disciplinary gaze of the practitioners, this observation was bidirectional. The practitioners were also expected to present themselves in a particular way:

> *I will politely tell the student – 'hey don't have garlic the day before you see me' if I'm doing a stretch – what the hell is that? - You woof it. I*

won't say it in an offensive way - I hate it; […] but it's quite common -
whether it be dandruff, personal hygiene, grooming etcetera [Ben].

Ben attended a clinic that operated as a tertiary training facility. At times, he positioned himself in an educator role offering advice to the student practitioners on their interpersonal skills, presentation and grooming standards, which he associated with their profession. In this way, Ben was voicing often-unstated social norms expected for a particular social group.

In addition, the clients expected the practitioners to meet certain ethical standards:

What I expect from them is that they will do the right thing for me […] I
was good with my customers and I always looked after the customer and
went out of my way to keep them happy and be honest with them and
straight up and down. I expect that from other people that deal with me
so I expect that from medical staff or rehabilitation people [Calvin].

Calvin expected his practitioners to demonstrate the same ethical standards he held. To make an effort to please him. To do what was right for him and communicate with him honestly – to tell him the truth about himself.

The participants also expected their practitioners to have particular character traits. These included empathy, patience, genuineness, tolerance, caring, respect, and understanding. As Leonard explained, some of these traits were particularly necessary for practitioners working with neurorehabilitation clients:

Because we can say some way out things sometimes [Leonard].

The practitioners were also required to have particular attitudes about their clients and their profession:

Being passionate about finding those different ways, […] just being in to
it pretty much. You can tell when somebody's not into their job […] as a
client, and that's really important to me that they take it seriously […]
passion and a drive, somebody that's caring and cares about the
outcome, cares about the patient [Emma]

I found them great people and always willing to help you, you know it's not like a hospital or anything; sort of more personal than that. I found and they're quite caring people you know. [...] They're concerned about your welfare [...] They're not taking you for a fool or anything, you know they tend to be genuine sort of people so, they tend to be most of them, so yeah I find them very understanding [...] you're talking to someone who is genuinely interested who wants to help you. [...] They're there to help people you know. So that makes a big difference they're just not paid, there to collect their pay you know [Andrew].

The practitioners were expected to be concerned about the participants' welfare, be dedicated to their work, self-sacrificing 'not there for the money', to be 'genuinely interested' in, understand and act in a respectful way towards their clients. These behaviours were considered by the participants to be necessary for the practitioner to display as part of their professional role in addition to their disciplinary knowledge.

In summary

This chapter used Michel Foucault's theories of power and discourse to explore how the participants constructed neurorehabilitation and the different subjectivities that they took up in their rehabilitation. Neurorehabilitation was constructed as a discipline that created and disciplined its subjects with the assistance of its mechanisms of examinations, observations and normalising judgements. Discipline works as a productive technology of power that creates subjects who were the objects of its practices. Neurorehabilitation identified individuals with certain capabilities who could benefit from its practices and made them subjects of its discourse. Through assessments, neurorehabilitation practitioners gathered knowledge about the individual and with exercises, disciplining surveillance and normalising practices, neurorehabilitation supported standards of a larger social group. Neurorehabilitation and its discourses of individual responsibility, normal, independence and risk acted on the behaviours of the participants and their practitioners. The discourses produced a place for the participants to position themselves within and from which the discourse had meaning and took effect. As subjects of neurorehabilitation, the participants were required to work on themselves and became particular kinds of people. The

practitioners' disciplinary knowledge gave them power to help the participants strive to recover their abilities and learn how to improve themselves. The disciplinary power interacted with and promoted a technology of self, encouraging a particular kind of subject - someone who was willing to correct or regulate herself or himself for the sake of improvement. These disciplinary practices aimed to increase the capabilities of the participants and their mastery over their body.

In the following chapter, I take these findings and discuss them in relation to Foucault's notion of power.

Chapter Six: Discussion

In this discussion chapter I develop the arguments introduced in the analysis discuss these in terms of Foucault's notion of power specifically the concept of governmentality.

Governmentality in neurorehabilitation

Examining how the participants constructed neurorehabilitation and the subjectivities they took up suggested this health service was operating as a governmental strategy that Foucault described as disciplinary power. Disciplinary power is a productive normative power that uses subtle strategies to control its subjects who internalise the discourses of the discipline and govern themselves (Foucault, 2003). As a tactical social practice concerned with the conduct of conduct, disciplinary power includes practices of self-government of one's thoughts and actions and aims to secure the wellbeing of each and all. This discipline operated within a complex matrix of power in neurorehabilitation where care and control coexisted within the one context. This construction of neurorehabilitation and the implications are discussed in relation to Foucault's theory of governmentality and other relevant rehabilitation literature.

Neurorehabilitation as a normalising discipline

The participants became subjects of neurorehabilitation with the expectation they would benefit from its practices. They were subjected to the disciplinary practices that worked on their bodies and shaped their behaviour. In contrast to top down versions of power, Foucault (2003) described disciplinary power as capillary, involving a diffuse web of power relations with no one central controlling force. The medical institution and its disciplines, the state as funder and regulator of health services, the neurorehabilitation client, and their family and practitioner are all involved in this web. This does not mean the practitioners do not hold powerful positions of authority; rather it suggests that subtle strategies of power are operating.

The coercive disciplinary mechanisms of examination, surveillance and normalising judgement discussed in the analysis, support this normative power that Foucault (2003)

described as a specific kind of power over life that normalises bodies. In this study, neurorehabilitation was viewed as normalising by the clients who used its resources to address situations where function differed from what was considered 'normal'. As shown in Chapter Five, the discursive practices such as the systematic training, drilling of exercises and adaptive techniques for daily living tasks, focused on ways to assist the participants to achieve a state of normal functioning. These normalising practices can be problematic when they endorse standards of normal function that may be unachievable for some individuals and thus perpetuate social exclusion for people who experience impairment. For example, the normal human activity of walking can be challenging for many neurorehabilitation clients. However it can be a prioritised goal endorsed by social expectations of normal behaviour and possibly pursued at costs greater than the potential rewards (Gibson, Carnevale, & King, 2012).

Neurorehabilitation serves individuals and society. It helped the participants achieve a state of 'normal' that for them was a return to previous levels of functioning, holding on to abilities they valued, or learning new ways of functioning that allowed them to achieve social acceptability. The standards used to assess this functioning came from scientific explorations of population data amassed into classification systems, and socially sanctioned standards of acceptable behaviour endorsed by social scientists and promoted by cultural groups (Whalley Hammell, 2004). Rehabilitation models that advocate for advancing client autonomy and independence promote these as socially desirable behaviours. While the neurorehabilitation client may share these aspirations, Whalley Hammell (2006) recommends recognising that these behaviours are socially and culturally endorsed norms that can discriminate against and marginalise those who do not fit in.

Foucault (2003) proposed that in a normalising society the disciplines define a code of normalisation and support this in their normative practices. Whalley Hammell (2006) notes that the classification and categorisation of physical, cognitive and mental deviations from an assumed norm is the cornerstone of rehabilitation. The concept of the norm comes from statistics and suggests an average position in a bell curve mapping certain traits. This average,

middle ground position can be celebrated as democratic, and is often associated with a desirable middle class, a collective social body and as a homogenising notion (L. Davis, 2010). This idea promotes an illusion of sameness, equality and objective neutrality (Whalley Hammell, 2006). The middle position is calculated by ranking traits and involves identifying outliers - the exceptions at either side of the middle. These outliers, or deviations from the norm, are classified as being more or less desirable by social processes (L. Davis, 2010). Lennard Davis explains that making decisions about what is normal and desirable is an assessment made by those who hold positions of authority. Services that promote independent living, for example, are suggesting that this is a desirable behaviour. Such desirable standards reflect the value systems of the dominant group but are promoted as natural, neutral and objective.

Foucault was interested in the dividing practices that created the abnormal and what they can tell us about social expectations of normal (Dreyfus & Rabinow, 1983). He claimed that norms are powerful social processes that reinforce professional authority. Through his explorations of madness and criminality he demonstrated how social judgements categorised human behaviour (Chambon, Irving, & Epstein, 1999). Neurorehabilitation uses classification systems such as the ICF constructed based on norms of culturally accepted standards of behaviour (for example, participation) to identify deviance from these standards (Whalley Hammell, 2006). (See Chapter Three page 25 for a discussion of ICF.) These *grids of specification* hierarchize individuals by their abilities based on assessments, cataloguing deficits and abnormal functioning; serving to reinforce the power of those who get to define what qualifies as normal (Whalley Hammell, 2006). Independent self-care and certain physical capabilities were normal goals some of the participants in this study strove to achieve.

Post-critical rehabilitation scholars advise practitioners to be wary of using classification tools like the ICF without recognising whose assumptions of normal desirable function underpin them (Gibson, 2016, Whalley Hammell, 2006). They warn of the dangers of marginalising those who cannot achieve the socially desirable standards of normalcy.

Practitioners hold powerful positions deciding what counts as normal, who is normal, and accessing the desirability of certain forms of performance. From the analysis, the practitioners were able to reassure the participants that their progress and behaviours were 'normal' for individuals in their situation based on their knowledge of population standards. However, the participant Brian seemed to be suggesting that the practitioners who 'put him on an independence programme' wanted him to achieve a standard of normal that may not have been valued as highly by Brian himself. Independence is a goal frequently cited in rehabilitation that endorses norms valued by specific cultural groups although other groups value interdependence (Gibson, 2016).

Advocates of the social model of disability who believe that society has a responsibility to reduce disability experienced as a result of impairment, would argue that society's expectations for normal behaviour should change rather than efforts made to change the individual to fit in and achieve social expectations of normal (Oliver, 2013). This may seem beyond the powers of the rehabilitation practitioner. Understanding that normalcy is socially constructed, fluid, and flexible and can change over time, and recognising the power experts have in its endorsement; can help practitioners to be more critical of the way norms are applied. Client-centred ways of working that prompt questioning the underlying objectives for particular goals, and explore what works best for the individual client in their context, can encourage practitioners to challenge normalising tendencies that do not work in the best interests of the client. This may also serve to challenge and change society's expectations of normal by making spaces for alternatives.

Critical physiotherapists argue for alternative approaches to the dominant biomedical model that endorses normalisation, advocating for reducing negative judgements associated with concepts such as dependency which they suggest should be viewed as a morally neutral choice (Gibson et al., 2012; Nicholls et al., 2016). They contest rehabilitation goals for independence proposing instead a 'connectivity' approach to rehabilitation that allows for creative ways of addressing impairment. By 'connectivity', they refer to the use of mediating technologies that assist individuals to engage meaningfully in the world. (Nicholls

et al., 2016). This approach includes re-visualising the various fluid connections between individuals and objects used to achieve outcomes that matter to the client.

Using Foucault's concept of governmentality to view neurorehabilitation shows the productive way that this normative power works to achieve particular ends. The participants became rehabilitation subjects in the hope they would achieve some kind of recovery through the practices of the discipline. However, Foucault warns that any practice can be dangerous; exploring the normalising nature of neurorehabilitation exposes the arbitrary nature of these distinctions.

Neurorehabilitation as a technology of the self

As subjects of neurorehabilitation, the participants learnt strategies to assist them to achieve their goals and absorbed the discourses of the discipline. The discipline of neurorehabilitation functioned as an internalised power strategy. Foucault proposed that in a normalising society everyone can exercise their own sovereignty as power over themselves (Foucault, 2003). In the current study, discipline shaped the bodies (thoughts and behaviours) of the participants while at the same time it showed them how to work on their own bodies. As subjects of neurorehabilitation, the participants were also required to be self-disciplined and prepared to work towards their own improvement. In the practitioner's absence, they perceived the expectation to practice their assigned exercises in the prescribed manner and modify their behaviour in line with the practitioners' expectations. In this way neurorehabilitation worked as a self-steering mechanism which Foucault referred to as a technology of the self (Foucault, 1988b). By this, Foucault is referring to the ways in which human beings come to understand and act upon themselves within certain regimes of authority and knowledge, and the use of certain techniques directed towards self-improvement (Rose, 2006, p. 99). These technologies of the self, include techniques to care for oneself which, according to Foucault, are always practiced under the actual or imagined authority of a system of truth and an authoritative individual (Rose, 1998). In neurorehabilitation the biomedical discourse provides the system of truth and the authoritative individuals in the form of the practitioner (Lupton, 2003).

The practitioners' explanations and advice assisted the participants to understand how their body functioned and helped them learn procedures to perform to assist them to achieve their goals – 'to get things working again' or 'keep them working'. The participants perceived an expectation to continue to practise these prescribed exercises and procedures after their rehabilitation session was over. It has been argued that this practice is essential for treatment effectiveness, claiming that it is impractical for practitioners to oversee the number of hours training that is required (Wade, 2015). Neurorehabilitation trained the participants to discipline themselves to achieve their desired state.

Foucault suggested that the modern state, with its advanced liberal political rationalities and drives for autonomy, consent and individual rights, governs health from a distance with its governmental technologies (Rose et al., 2006). The state secures the conditions for the health of the population through the provision of services, but tries to relieve itself of the responsibility for the security of the individual. The participants selected as eligible to receive rehabilitation services were required to work towards their recovery and participate in the prescribed activities. Rose (2006) explains that citizens become partners in the drive for wellbeing through accepting the responsibility for managing and monitoring their own health in the name of the wellbeing of the nation.

Identifying neurorehabilitation operating as a technology of the self supports rehabilitation goals for promoting functional independence, client autonomy and supporting self-management strategies where individuals learn to manage and take responsibility for their own health under the guidance of their practitioner (Holman & Lorig, 2000; Morgan et al., 2016). According to Rose and colleagues (2006), governmentality of the self involves the freedom of choice, autonomy, self-responsibility and obligation to maximise ones' life as a kind of enterprise (p. 91). This obligation to the self is consistent with neurorehabilitation requiring the active consensual participation of the client and the participants' perceived need to be self-disciplined. The participants learnt to take responsibility for exercising their bodies, to perform self-care tasks in the context of impairment, keep themselves safe and

prevent further injury. By taking care of themselves, the participants were acting as responsible moral citizens (Gibson, 2016).

Some interpret this imperative for self-management as an economically driven aspiration as services struggle to cope with the demands of meeting the long-term health needs of people experiencing chronic illness (Miller, Lasiter, Bartlett Ellis, & Buelow, 2015). This forms part of an economic discourse associated with provision of rehabilitation services, which promotes the financial and social benefits for both the client and society. For example, the more the participants were able to manage their self-care tasks, the less assistance they required from family members and formal caregivers, thus relieving society of the financial burden that could otherwise be associated with providing this assistance.

Assisting clients to learn to care for themselves can signal a devolving of clinician dominated services as clients have the opportunity to influence their own recovery. The self-governing subject can bring challenges to neurorehabilitation. Rose and colleagues (2004) explain that subjects fulfil themselves rather than being merely obedient. This is seen in the analysis when Ben, who was determined to maintain his ability to walk, resisted the restraints from his practitioners and set his own targets to achieve when he practiced his exercises. This tendency has also been observed by other researchers who reported that clients, who were able to take control of their own health decisions, often made decisions contrary to health professional's advice as they adapted regimens to fit with their individual circumstances (Thorne, 2008). As shown in the analysis by Ben, the self-governing client has the potential to challenge the position of practitioner as expert and aspirations for clients to comply with their advice. However, as the participants demonstrated, although they challenged the practitioners' authority at times, they were still subjects of the discipline of neurorehabilitation and under its influence.

The eligibility criteria that selected the participants as suitable neurorehabilitation subjects implied they were required to display particular characteristics. The participants believed it was necessary for them to be self-disciplined and motivated to improve their situation. Motivation is a concept frequently referred to in rehabilitation. Maclean and colleagues

(2002) describe motivation as the outward demonstration of willingness to participate in therapy tasks. In Chapter Five, (see page 85) Leonard described the efforts he made to appear motivated to his practitioner. However, this requirement for displays of enthusiasm suggests that those who are unable to demonstrate motivation or evidence of self-discipline may be denied continued eligibility as subjects of this service. On the surface, this may seem a rational decision as neurorehabilitation is constructed as a process that requires the active consensual involvement of the client. However, there may be those whose ability to display these characteristics is impaired by their pathology, for example, lack of affect following stroke (Skidmore, Whyte, Butters, Terhorst, & Reynolds Iii, 2015). There may also be cultural barriers operating that limit an individual's understanding of the expected behaviours that are considered qualifying as demonstrating self-discipline. For example, from the findings, Emma believed turning up on time for her session to be a sign of her motivation. Not everyone may share this belief. In addition, factors outside the control of the individual can account for low motivation. For example, the quality of services, mixed messages from rehabilitation professionals about expectations for proactivity or compliance as the desired behaviour, or a failure to see the relevance of prescribed activities towards achieving desired goal (Maclean et al., 2002). Leonard commenting on the tasks set for him by the occupational therapists illustrated this in the analysis.

Motivation, although considered by practitioners as necessary for clients to display (Krupinski et al., 2014), may present challenges to practitioner authority. In the findings, we observed some of the forms of resistance to practitioner authority the participants adopted. For example, Leonard described himself as highly motivated and believed that this was essential if he was to achieve his recovery goals. He indicated he was willing to do whatever it took to achieve his desired goal. Although he considered this involved pleasing his practitioner, he was impatient with the caution placed on him and attempted to push the boundaries of the expected pace of recovery. He challenged his practitioner's expertise by seeking advice from other medical specialists and adopted his own treatment methods when he was discharged from hospital. This is similar to findings presented by Maclean and colleagues (2002), where practitioners observed that highly motivated stroke clients often

'failed to comply' with treatment advice, rejected standard procedures for performing rehabilitation exercises, and allegedly took risks in therapy.

Governmentality of the self involves finding equilibrium between conforming to the directives of those in authority and the obligation to care for oneself (Foucault, 2011). Foucault explained that an important element of the governing of actions of 'men by other men' (sic) includes the element of freedom (Foucault, 2001, p. 138). By this, Foucault means that in power relationships individuals are faced with a field of possibilities in which there can be more than one way of behaving available. The individual is free to select from this field of possible actions. Governing the conduct of others is not a confrontation of adversaries but the management of possibilities (Foucault, 2001).

Despite the challenges to its authority, neurorehabilitation helped the participants help themselves to achieve their desired ends. As a discipline and a technology of the self, neurorehabilitation functioned as an internalised power strategy assisting the participants to discipline themselves according to the discourses of the discipline. By working towards improving their health and wellbeing, despite some incidences of resistance, the participants were accepting the obligations associated with their position as rehabilitation subjects.

Neurorehabilitation: functions of caring and control co-existing within one context

My findings show that a complex matrix of power was working in neurorehabilitation to form and mould the clients to think and act towards themselves in a particular way and assist them to achieve their desired state. The practitioners' disciplinary knowledge appeared to give them power to help their client recover their abilities. The participants appeared to appreciate the caring concern their practitioners demonstrated towards them. For example, Andrew was impressed by what he described as a genuine, caring attitude and his practitioners' dedication to their work. This is consistent with evidence from the literature review that suggested practitioners felt a sense of obligation for their clients' recovery (Anderson & Funnell, 2005). Practitioners as health professionals are charged with the wellbeing of their client and committed to helping enhance people's lives (Gibson, 2016).

Their position and knowledge gives them status and authority. The neurorehabilitation client enters into a relationship with their practitioner because of the practitioners' expertise that the client wishes to employ to achieve their ends. This strategic power relationship is productive and benevolent. This client – practitioner relationship involves obligations and responsibilities in return for achieving desired ends.

The current trends in neurorehabilitation that advocate for devolving practitioner dominated services, incorporating client perspectives and adopting a biopsychosocial model (Cott, 2008), capitalise on this strategic relationship. The biopsychosocial model requires the social, cultural and environmental implications of the disease or injury be addressed as well as biological factors (Wade, 2015). Expanding on this model of care are client-centred approaches which incorporate the perspective and give voice to the client who is no longer viewed as a diseased biological entity but an individual with the opportunity to participate in medical decision making (Sullivan, 2003). This approach was proposed to address concerns of paternalistic power relations and clinician dominated medical encounters (Leplege et al., 2007). The client – practitioner collaboration promoted by this approach has the potential to bring about different power relationships (Mayes, 2009).

The biomedical model relies on its objective biotechnical practices to reveal truths through the examination of clients' bodies (Sullivan, 2003). Sullivan describes this as the body speaking for the client. Moves towards client-centred approaches and a biopsychosocial model require access to other forms of knowledge. The practitioner needs to understand the context and meaning of illness for the individual client. For this, practitioners need to discover information about the psychosocial context of their client that cannot be learnt from examining the client's body. Consequently, clients are required to disclose personal information to their practitioner to facilitate individualised service provision and the setting of meaningful client-centred goals (Mayes, 2009; Wade, 2016a). Andrew illustrated this in Chapter Five when he explained how he divulged personal information to his practitioners that he would normally keep private.

This disclosure resembles confessional practices that Foucault (1981) described as a technology of the self where the individual comes to know himself or herself through the guidance of an authority figure. Foucault explained that confessing in front of an authority figure entails a cost and a reward. The confession or divulging of secrets about yourself holds certain anxieties including the fear of embarrassment. However, Foucault suggested that confessing also involved pleasurable aspects. The opportunity to reduce anxiety about possible dangers, validate experiences, have them interpreted and resolved, generates a desire to know the truth about oneself (Foucault, 1981). In turn, the knowledge the practitioner gains from the client increases the power they have to help the client achieve their rehabilitation goals (Mayes, 2009).

The participants appeared to want to learn the truth about themselves from their practitioners. Calvin, for example, described how he wanted his practitioner to tell him if he had any issues or was doing something wrong. (See page 70.) Dreyfus and Rabinow (1983) explain that the individual is encouraged to believe that to know the truth about themselves they need to subject themselves to examination, expert elicitation and interpretation (p. 175). The practitioner 'liberates the truth' about the individual client by encouraging a revelation of hidden secrets that the practitioners through their expertise are able to interpret and then guide the client towards self-understanding (Foucault, 1998). In this way, the practitioner gets to know the client and the client gets to know herself or himself. Leonard, for example, revealed his 'grumpiness' to his practitioner who was able to explain that this was caused by fatigue and a symptom of his stroke. (See page 81). Leonard, who did not know that he was experiencing fatigue until the practitioner explained it to him, gained self-knowledge.

This confessional act is also a power strategy associated with a web of practices and relationships Foucault (2003) termed *pastoral power*. Mayes (2009) claims that the doctor-patient relationship in client-centred models of care resembles a version of pastoral power as described by Foucault. Foucault appropriated the metaphor of the shepherd caring for the flock from Christianity, to describe the web of power strategies that the agents of the

state use to care for the welfare of the population. He likened this approach to that used by the Judeo-Christian doctrines to protect and ensure salvation of their subjects. Foucault suggested that in the modern state the strategies of this religious pastoral power combine with political practices of governing, with the end goal of salvation transformed to one of health, wellbeing, security and protection (Foucault, 2003). From the findings, neurorehabilitation as constructed by the participants appeared to perform as a pastoral power.

Foucault (2003) believed that this modern form of *pastoral power* that involves a web of practices, relationships and power strategies dispersed throughout institutions, aims to create, enable and produce governable subjects. He identified four key characteristics of this form of power: it is directed towards particular ends – that of salvation or 'health, wellbeing and security of the population; it is prepared to sacrifice itself for the life of the 'flock'; it is equally concerned for the individual as well as the whole population; it involves an intimate relationship that requires knowledge of the conscience – 'the inside of people's minds' (Foucault, 2003 p. 132). From my findings, these practices and relationships appeared to be operating in neurorehabilitation.

Pastoral power could describe the power relationship between the client and practitioner in neurorehabilitation. The practitioner is placed in the role of pastor by the biomedical discourse that is charged with the health and wellbeing of the population. The practitioner is encouraged to create an environment where the client feels safe to disclose details about themselves and cooperate with the practitioners' advice through establishing rapport and building a therapeutic relationship (Tickle-Degnen, 2002). The client is encouraged to reveal details about their personal lives to allow the practitioner to assist them achieve their desired ends (Mayes, 2009). The participants divulged details about their personal lives because they believed it would assist their practitioner to help them achieve their goals. Such access to intimate knowledge of the client may assist the practitioner to provide an individualised approach and attend to the needs of the particular client.

The participants constructed their practitioners as prepared to sacrifice themselves for their clients. For example, Leonard was impressed that his practitioner continued with a treatment regime that he believed she did not approve of but was willing to provide to satisfy his needs. Emma related how her practitioner manipulated the funding system to ensure her ongoing access to rehabilitation services. The participants believed that their practitioner was prepared to do whatever it took to assist them to achieve their rehabilitation goals including advocating for services on their behalf, being dedicated to their role and not 'in it for the money'. The practitioner as pastor cares about the individual client, and provides for them, a benevolent authority working in the best interest of the client.

It is important to acknowledge here that the therapeutic relationship required for accommodating the individual needs of each client has the potential to place each practitioner in a web of obligations that can be problematic as they balance their own professional obligations and external demands (Levack, 2009). The practitioner as pastor cares for and addresses the needs the individual client and their wider caseload (their 'flock'). The practitioner although in a position of authority is also disciplined by the discipline. The participants demanded standards of service from their practitioner wanting their 'money's worth' suggesting that the practitioner was also accountable to the state as funder. The practitioner as provider of a health service is answerable to other authorities.

Client-centred ways of working involve the practitioner and client in a strategic power relationship that can be a tool for mastery of one over the other; it can also assist the client to achieve their desired ends. Recognising power as a relationship rooted in the whole social network and co-extensive with every social relationship helps us realise the productive potential of this relationship and be alert to possible problems that may arise.

Strengths and Limitations

This study involved an exploration of text where neurorehabilitation clients discussed their relationship with their practitioner. The data was collected primarily to answer another research question. This situation had benefits specifically related to economic use of

research resources, as well as limitations related to the construction of the data and the analysis process. This secondary analysis that applied Michel Foucault's theories of power and discourse provided an opportunity for a different view of the text. This re-viewing has revealed an alternative interpretation of the phenomena uncovered in the primary study contributing to a broader understanding of the workings of power in the relationship between neurorehabilitation client and their practitioner.

A qualitative interview is a constructed artefact produced by the interviewer and participant for a particular purpose (Jackson & Mazzei, 2013). The resulting text is historically and socially situated and generalisations cannot be made. The analysis attempts to discuss the text within these boundaries, recognising the limitations while taking the opportunity to uncover what is taken for granted.

From the analysis, neurorehabilitation appeared to focus primarily on the physical body despite current rhetoric calling for the use of a biopsychosocial model to guide its interventions and to recognise the impact impairment has on the context of people's lives (Wade, 2016a). This may be a limitation of the data and the context of its construction where a fourth year physiotherapy student who may have indicated a preference for experiences of physical therapy conducted half of the interviews. However evidence from reviewing the literature suggests that practitioners often found it easier to set and work towards physical goals (Levack, 2009), with others reporting that despite attempts to incorporate psychosocial aspects, the biomedical model which privileges a focus on the biological body still dominates neurorehabilitation (Nicholls et al., 2016).

Methodological reflections

Despite an awareness of the cautions associated with conducting a secondary analysis these did not address the difficulties I experienced. In the beginning the analysis process was challenging for me. This related to conducting a secondary analysis of data that I had previously been involved with the collection and primary analysis of. Stepping away from the questions and findings of the primary study, the individual participants and their context to focus instead on the discourses was difficult. Initial analysis attempts focused too closely

on the minute particulars rather than at a macro level, thinking of the larger scale discourses that were operating. It was also difficult to challenge my existing explanations for phenomena recognised in the transcripts from the primary analysis and identify alternate explanations. This difficulty was eventually resolved through repeated attempts analysing the texts and engagement with the writings of Michel Foucault. Each iteration bought me closer to answering my research question.

I have presented the dominant findings of my analysis of the text and my interpretation of these. The features that were of interest to me were influenced by my experiences. The text were read with the intention of exploring how power operated in neurorehabilitation to answer the research question. This has focused my viewing and the interpretation presented here. I acknowledge that my findings are limited, partial, provisional and always open to interpretation.

Practice implications

As stated in the introduction, this thesis does not set out to make specific practice implications. However, the role of an academic is to scrutinise beliefs and assumptions that underpin practices and promote reflexive thinking about how things could be otherwise (Gibson, 2016; Said, 2003; Whalley Hammell, 2006). Poststructural research offers opportunities to analyse the socially constructed nature of human behaviour, the discourses that are operating, and their power for producing subjectivities (Cheek, 2000). It provides openings for questioning entrenched social practices, to examine what we are doing and why we do something (Gibson, 2016). This discourse analysis has attempted to make visible how power relations are operating in neurorehabilitation. It identified the normalising practice inherent in rehabilitation and the arbitrary nature of the norms endorsed by practitioners as desirable rehabilitation outcomes. This suggests that practitioners hold powerful positions reinforcing standards of 'normal'. Practitioners can be more critical of the standards they endorse and reflect on how their practices can be marginalising for those deemed to be outside of these norms.

This study has also highlighted how eligibility criteria constructs rehabilitation subjects as certain types of people and endorses particular behaviours, suggesting that those who cannot display these behaviours may be considered unsuitable for rehabilitation services. When devising and applying eligibility criteria, rehabilitation practitioners and administrators should be mindful of the effect of these criteria to exclude certain groups who may benefit from rehabilitation practice.

Finally, this study has highlighted the potential tensions involved in the therapeutic relationship required for practicing in a client centred way. If considered a valued practice, these tensions need to be openly discussed and strategies developed to navigate the tensions in ways that maintain a client centred approach and can enhance client/ practitioner collaboration.

Conclusion

Foucault's theory of governmentality assists us to identify and describe forms of power that operate within neurorehabilitation and shows the productive way that this normative power works to achieve particular ends. As a disciplined disciplining discipline, neurorehabilitation constituted the participants as its subjects and employed strategies of power to work on them to make themselves into subjects. Neurorehabilitation identified the participants as suitable subjects by its assessment processes then subjected them to its practices. The participants modified their behaviour according to the discourses of neurorehabilitation and became self-governing subjects.

These constructions suggest that neurorehabilitation was operating as a governmental strategy that involved aspects of self-government where clients had freedom and responsibility to themselves, and an obligation to do what was required to improve their abilities. The clients and practitioners were involved in a complex web of power relations to achieve particular ends.

The neurorehabilitation client entered into a relationship with the practitioner to achieve particular goals. This strategic power relationship is productive and benevolent. The

practitioners' skills and knowledge assisted the participants to learn the practices and discourses of neurorehabilitation to work on themselves. The participants exercised power over their own bodies but this was influenced by the strategies they had absorbed from the discursive practices of neurorehabilitation. This client – practitioner relationship involved obligations and responsibilities in return for achieving desired ends

Neurorehabilitation was constructed as normalising by the participants who used its resources to address situations where function differed from what was considered normal. This can be a desirable objective for those who have the potential to achieve these standards, but can be problematic in neurorehabilitation where normal function has been impaired. Norms are powerful social forces that can marginalise groups who do not fit with social expectations of normal behaviour.

Viewing neurorehabilitation as a discipline reveals some of the strategies this technology uses to achieve its ends. Such analysis can assist us to pay conscious attention to the possibilities these strategies offer and be wary of the potential dangers.

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Appendix

ENCOR interview guide (version 1: September 2013)

Note that these are simply prompts to guide the interviewer. In addition, we will refine questioning as the interviews progress to help really explore and target our phenomenon of interest.

- Can you describe for me the relationship you have with one of your current rehabilitation practitioners?
    - What is good about the relationship?
    - What is not so good?
    - What do you think would make it better?

- In your view, what would be the key features of a good working relationship between yourself and your rehabilitation practitioner?
    - What features of the relationship matter most to you?
    - What qualities do you think a rehabilitation practitioner would need to have to help create this kind of working relationship?
    - How would they need to act?
    - What qualities do you think you would need to have to help create this kind of working relationship?
    - How do you think you need to be around your rehabilitation practitioner?

- What features of the relationship do you think matter most in terms of achieving your rehabilitation goals?

- Is there anything else you would like to add that we have not covered?