

# **Understanding the Therapeutic Alliance in Stroke Rehabilitation**

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# Interview Transcription Guide

The following symbols and formatting are used throughout the thesis when quotes from participant interviews or the literature are provided:

<b>Bold</b>	Indicates emphasis provided by the participant
<i>Italics</i>	Signifies the interviewer's speech
....	Indicates that words have been removed from the original transcript
[ ]	Denotes that additional words have been inserted by the researcher to clarify the meaning of the quote, or to provide contextual information (for example, gestures).
“ ”	Indicates a direct quote from a participant interview or the literature
‘ ’	Signifies a quote within a participant interview excerpt



## List of Abbreviations

ABI	Acquired brain injury
ACA	Anterior cerebral artery
AUT	Auckland University of Technology
CASP	Critical Appraisal Skills Programme
FIM	Functional Independence Measure
MCA	Middle cerebral artery
N	Number
NZ	New Zealand
OT	Occupational therapist
POCI	Posterior circulation infarct
PT	Physiotherapist
RN	Registered nurse
SLT	Speech-language therapist
SW	Social worker
TACI	Total anterior circulation infarct
TBI	Traumatic brain injury

## 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 institution of higher learning.

Signed:



Date: 02/10/2015

Megan Bishop

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## Ethics Approval

Ethical approval was gained from the Auckland University of Technology Ethics Committee on 25<sup>th</sup> of September 2012 (Ethics Application Number: 12/237).

## Abstract

This study identified and explored the core components of a strong therapeutic alliance and those factors perceived to influence its development within an inpatient stroke rehabilitation setting. The therapeutic alliance has been a consistent predictor of outcome in psychotherapy and mental health research and there is growing evidence that it may facilitate beneficial change in other health settings. A systematic review of the brain injury rehabilitation literature (completed as part of this research) identified associations between the therapeutic alliance and a range of rehabilitation outcomes including improved productivity, self-awareness and emotional regulation. However, the review highlighted very few studies specifically exploring the therapeutic alliance in stroke rehabilitation, and a lack of clarity around whether psychotherapy-based alliance concepts and measures apply to brain injury rehabilitation research.

The empirical study then undertaken used Interpretive Description methodology to explore client and clinician perceptions of their therapeutic alliances. Clients (n=10) with a range of stroke-related difficulties and clinicians (n=7) from a range of professional backgrounds (nurses and therapists) were recruited. Semi-structured individual (clients) and focus group (clinicians) interviews were the primary source of data collection. Interviews were transcribed and uploaded to NVivo data management software, and data analysed using thematic analysis with careful attention to rigour.

Two themes emerged from the data. The first theme, *everyone is different*, described the core components of a strong therapeutic alliance. These were: a personal connection, a professional collaboration and family/whānau collaboration. Client participants appeared to prioritise each component to varying degrees and these priorities could change over their rehabilitation stay. Further, a range of personal factors and competing demands seemed to influence alliance development. This meant that therapeutic alliances were often dynamic and complex. The second theme, *relationship disruptions*, outlined the factors that could compromise alliance quality. The strength of the pre-existing alliance and the management of the ‘disruption’ seemed to impact on whether client participants continued to engage in these alliances and therapy, or whether a relationship breakdown would occur and impact on future work with the practitioner.

The therapeutic alliance model proposed in this thesis extends current understandings of how alliances may be conceptualised and operationalised in an inpatient stroke rehabilitation service. Based on these findings and other relevant literature, a number of practice-based recommendations are discussed. These include the need for a person-centred, flexible approach to determine, regularly review and respond to each client's alliance needs and preferences, rather than assume what these may be. In this research, strong alliances were considered to alleviate distress and promote hope, rehabilitation engagement, wellbeing and progress. As such, explicit consideration of each person's therapeutic alliance needs and preferences should arguably be considered a crucial component of clinical work, in order to augment stroke rehabilitation processes and outcomes. Intervention studies testing different approaches to developing and maintaining therapeutic relationships are needed, with this work informing the key components of those interventions. Meantime, the study makes clear that the way clinicians connect with each client matters, and that how we might best connect varies between clients and over time.

## Chapter 1: Introduction

This qualitative study explores how people with stroke and their clinicians view their therapeutic alliances within an inpatient stroke rehabilitation service. Evidence in other health arenas suggests that the therapeutic alliance is an important and consistent contributor to outcome, but there has been limited examination of whether the concept is relevant to stroke rehabilitation. This research intends to advance current knowledge of the core components of a strong therapeutic alliance and the factors that may shape its development within this context. Armed with this knowledge, clinicians may consider ways to build and maintain optimal relationships with their clients. Researchers may also utilise these findings in their development of a conceptually sound therapeutic alliance model and outcome measure in stroke rehabilitation.

This chapter provides the background behind the study. It begins by reflecting on my personal interest of this topic, followed by an overview of the impact of stroke on individuals, their family and the New Zealand community. It highlights some of the process aspects of rehabilitation programmes that are considered to be beneficial, and introduces evidence supporting the therapeutic alliance in different healthcare settings. This leads into a description of the study's focus and significance. Finally, it outlines the structure of this thesis.

### 1.1 Personal reflections

In the early stages of my neuro-physiotherapy career, I focussed on developing my technical skills and knowledge in order to improve my clients' motor control and functional abilities. It quickly became apparent that clients responded differently to the same interventions, even if their impairments were similar. A bio-medical model formed the basis of my education, so if progress was sub-optimal I would alter the frequency or intensity of input, or try a different intervention. Success was variable.

Years later, I joined a team who followed a biopsychosocial, collaborative approach in rehabilitating clients with complex neuro-disability. This experience was pivotal in changing the way I thought about and worked with my clients and the interdisciplinary team. It encouraged me to contemplate the psychological and social factors

(as well as the biological) that may impact on a person's experience of a brain injury, and their recovery from it. The way I collaborated with clients varied depending on the information I gleaned from them and other health professionals. We held 'graduation ceremonies' as each person completed their rehabilitation programme. Often, there were plenty of reasons to celebrate. But it also left me with a number of questions. Why did I form more productive relationships with some clients and not others? Was it due to our personalities and backgrounds, their neurological difficulties or my competencies? Some team members consistently fostered a connection with clients with challenging behaviours; I wondered what their trade secrets were.

Treatment success certainly appeared to relate to the quality of the clinician/client relationship – at least to some extent. However, building and maintaining relationships could be challenging. When faced with 'difficult' clients, I (and other colleagues) sometimes sought support from others who possessed more clinical experience, a different set of skills or a similar cultural background to the client. Sometimes this was because we required professional guidance on how to manage a novel or complex case, but more often than not it was because we needed to find a 'way in' to effectively work with someone. I have helped to manage multiple situations where there has been a complaint from a relative or client against another clinician. Most of these related to a breakdown in communication or trust between the complainant and staff member rather than the therapist's clinical competence. It seemed that technical expertise alone did not necessarily achieve relationship harmony, but there was limited access to clinician-friendly information identifying the key ingredients for therapeutic relationship success.

As part of my post-graduate diploma, I completed a literature review of the factors that may influence the therapeutic alliance (or therapeutic relationship) between clinicians and clients in brain injury rehabilitation. I was struck by the depth of evidence in psychotherapy demonstrating associations between a strong alliance and treatment outcome, but the lack of quality evidence in brain injury rehabilitation. A number of stimulating discussions with my current supervisors convinced me of the need to gain qualitative information to better understand the therapeutic alliance concept in neuro-rehabilitation. An inpatient stroke rehabilitation environment was specifically chosen as this was where I was working on study commencement. I was also involved in local and national working parties designed to improve stroke rehabilitation processes.



Consequently, I had the optimal platform to undertake my research and later, to use my findings to enhance knowledge and service provision in this field.

## 1.2 Researcher's assumptions

As an experienced neuro-physiotherapist and novice researcher, I held knowledge and assumptions about this topic prior to study commencement. These were made explicit in a pre-supposition interview carried out on 14 September 2012 with another health professional (see Pre-supposition Interview Summary in Appendix A). It was anticipated that by acknowledging these assumptions in the interview and then sharing these with my supervisors, it would reduce their potential to influence the data analysis process (Thorne, Kirkham, & MacDonald-Emes, 1997). This is discussed further in *Chapter 3: Methodology and Methods*. Several of my assumptions were challenged during the research process; these are conveyed in *Chapter 5: Discussion* (see page 124).

## 1.3 The impact of stroke

Stroke occurs as a result of an infarct or haemorrhage, which interrupts the flow of blood supply to the brain causing damage to the surrounding brain tissue (World Health Organisation, 2002). Symptoms vary depending on which area of the brain is affected and the severity of the stroke, and may encompass physical, sensory, cognitive, communication and emotional changes. For many people, these changes persist at least three years later, causing a profound functional, psychological, social and economic impact on individuals and their families (Bonita, Solomon, & Broad, 1997).

In New Zealand, around 9000 individuals experience a stroke each year (Stroke Foundation of New Zealand, 2014) and the majority survive due to improvements in medical access and technology (Dyall, 2008). As a result, approximately 60,000 New Zealanders are currently living with the aftermath of stroke, which makes it the leading cause of adult disability in this country (Stroke Foundation of New Zealand, 2014). Three quarters of all strokes that occur in New Zealand affect people over 65 years of age (Stroke Foundation of New Zealand, 2014). These factors, combined with an aging population (Statistics New Zealand, 2014), place accumulating pressures on our health and care providers. Effective practices are required to promote maximal recovery and

alleviate the costly burden on individuals and the community (Stroke Foundation of New Zealand and New Zealand Guidelines Group, 2010).

New Zealand has a publicly funded health system with, in theory, an egalitarian approach to medical and rehabilitation access (McNaughton et al., 2011). Safeguards to promote cultural safety and reduce inequalities also exist at a government level, such as the Health Practitioners Competence Assurance Act 2003 (New Zealand Government, 2013). In spite of this, increasing numbers of non-European New Zealanders are experiencing stroke, often with poorer outcomes than Europeans. Compared with New Zealand Europeans, Māori recorded nearly one and a half times the rate of stroke and Pacific Islanders recorded almost double the rate between 2002 and 2003 (Carter, Anderson, & Hackett, 2006). Māori and Pacific Islanders are also likely to be 10-15 years younger at stroke onset and experience greater disability on standardised measures (McNaughton et al., 2011; McNaughton, Weatherall, McPherson, Taylor, & Harwood, 2002). There have been repeated calls to reduce these cultural disparities (McNaughton et al., 2002; Stroke Foundation of New Zealand and New Zealand Guidelines Group, 2010). Stroke rehabilitation researchers may be perfectly poised to improve our understanding of the cultural values that impact on rehabilitation processes in order to promote culturally competent services.

#### 1.4 Rehabilitation processes and the therapeutic alliance

Evidence-based treatment techniques and modalities across a range of functional and health domains are advocated to reduce the burden of disability post stroke (Foley, Teasdale, Bhogal, Speechley, & Hussein, 2013; Stroke Foundation of New Zealand and New Zealand Guidelines Group, 2010). There is also growing recognition of the non-technical features of rehabilitation - including the way clinicians work with individuals, families and each other - that may influence outcomes (Bright, Boland, Rutherford, Kayes, & McPherson, 2012; Cooper, Smith, & Hancock, 2008; Hills & Kitchen, 2007; Hush, Cameron, & Mackey, 2011; Jensen, Gwyer, Shepard, & Hack, 2000; Kayes & McPherson, 2012).

Health services are encouraged to view their patients as active health consumers and essential purveyors of the quality of care provided (Hush et al., 2011; Rademakers, Delnoij, & de Boer, 2011). An inter-disciplinary approach to rehabilitation recognises individuals and their families as integral members of the team (Stroke Foundation of

New Zealand and New Zealand Guidelines Group, 2010). Team members collaborate with each other to plan, problem-solve and make decisions around therapy and care provision and continuity (Bokhour, 2006). This ensures that input is individualised, coordinated and relevant. It also serves to educate family members in their informal but often vital roles in reinforcing desirable behaviour and supporting the client's ongoing adjustment and adaptation to their disability (R. L. Evans, Matlock, Bishop, Stranahan, & Pederson, 1988). For New Zealand Māori and Pacific Islanders, involvement of whānau (the wider family network) is essential for individual and whānau health and wellbeing and is a strategic aim in healthcare policies (Ministry of Health, 2014a, 2014b).

The quality of the relationship (or therapeutic alliance) between clinicians and clients may mediate different health and rehabilitation outcomes. The therapeutic alliance refers to the process of collaboration between the clinician and the client in order to address the difficulties that the client experiences (Horvath & Symonds, 1991). The therapeutic alliance has long been viewed as a catalyst for treatment success across different health populations, with the majority of evidence embedded in mental health and psychotherapy research. In a large randomised trial using a range of interventions for depression from medication through to cognitive-behaviour therapy, the therapeutic alliance was highly correlated with outcome and more strongly predicted recurrence of depression than any of the interventions (Krupnick et al., 1996). A meta-analysis of 24 studies in adult mental health demonstrated that the strength of the alliance accounted for at least 26% of the variation in psychotherapy outcomes across different approaches and conditions (Horvath & Symonds, 1991). Consequently, the therapeutic alliance is considered to be a 'common factor' that facilitates change across different theoretical and treatment paradigms (Weinberger & Rasco, 2007).

The therapeutic alliance also facilitates beneficial change in cardiac and musculoskeletal rehabilitation (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010) and diabetes management (Lee & Lin, 2009). Physiotherapists across the orthopaedic, neurological, geriatric and paediatric specialties perceive that the clinician-client interaction is the strongest contributor to outcome, rather than the therapy itself or client attributes (Stenmar & Nordholm, 1994).

From the client's perspective, reports indicate that positive treatment outcomes co-exist with strong working relationships (Hills & Kitchen, 2007; R. Johnson, 1993). Clients may even place a higher value on the interpersonal and process aspects of care, such as communication, empathy and joint decision-making, over their physical outcomes when rating healthcare provision (Hush et al., 2011; Rademakers et al., 2011). Establishing and maintaining a therapeutic connection is considered vital to the quality of any clinical interaction involving Māori and Pacific Islanders (Lacey, Huria, Beckert, Gilles, & Pitama, 2011; Ludeke et al., 2012; McLellan, McCann, Worrall, & Harwood, 2013). It is important that this relationship acknowledges cultural-specific beliefs and values in order to augment trust and receptivity to the input provided (Lacey et al., 2011; McLellan et al., 2013). Emerging evidence suggests that the quality of the therapeutic relationship between speech-language therapists and Māori individuals and their whānau impacts on perceived therapy success and satisfaction after stroke (McLellan et al., 2013).

More recently, brain injury rehabilitation researchers are realising the therapeutic alliance's potential to enhance client engagement and recovery (Bright et al., 2012; Kayes & McPherson, 2012). However, this field currently lacks a conceptual understanding of the therapeutic alliance and a relevant and reliable measurement tool (Kayes & McPherson, 2012). These points will be expanded on further under *Chapter 2: Literature Review*. Given its role in augmenting outcomes in other health arenas, it is only prudent that brain injury researchers explore the therapeutic alliance further.

## 1.5 Focus and significance of the study

Providing effective rehabilitation services require an awareness of the factors that may contribute to recovery. Evidence elsewhere suggests that the therapeutic alliance facilitates treatment success across different disciplines and health conditions, yet, as *Chapter 2: Literature Review* will demonstrate, a number of questions remain in relation to its concepts and role in stroke rehabilitation. In particular, there are few studies examining the therapeutic alliance in stroke rehabilitation and even fewer that incorporate stroke survivors' perspectives.

This study explores the views of people with stroke and clinicians (rehabilitation nurses and therapists) to address the following research questions:

- a) What are perceived to be the core components of a positive therapeutic alliance in stroke rehabilitation by people with stroke and their clinicians?
- b) What factors are perceived to influence the development of a strong therapeutic alliance?

For clinicians, the study aims to provide insights around how they may form and maintain strong therapeutic alliances. For researchers, the findings may help to determine whether existing conceptual model(s) apply, or whether an alternative model needs to be created. In turn, this may advance the development of a measurement tool that is contextually relevant to this field, from which researchers can evaluate the therapeutic alliance's impact on outcomes.

## 1.6 Structure of the thesis

*Chapter 2: Literature Review* will present and critically discuss the existing evidence relating to the therapeutic alliance or therapeutic relationship in brain injury rehabilitation. It will highlight the paucity of studies examining these concepts in stroke rehabilitation and provide a rationale for exploring the research questions above.

*Chapter 3: Methodology and Methods* will articulate why Interpretive Description is an appropriate methodology to answer the research questions. It will detail the participant recruitment, data collection and data analysis phases of the study and illustrate how rigour and ethical standards were maintained throughout.

*Chapter 4: Findings* will be divided into two themes. The first theme will identify the core relationship components that participants appeared to value to different degrees, and the factors that seemed to impact on relationship quality. The second theme will highlight participants' experiences of relationship disruptions.

*Chapter 5: Discussion* will discuss several key findings within the context of relevant literature. Implications for clinical practice will be considered throughout this chapter, in keeping with Interpretive Description recommendations (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). The study's limitations, suggestions for future research and conclusion will be conveyed.

## Chapter 2: Literature Review

This chapter identifies, critically appraises and synthesises stroke rehabilitation research that examines therapeutic alliance concepts and its impact on outcomes. Factors that may influence alliance quality are also explored. In order to provide context for the literature review, the chapter initially outlines relevant alliance theory and related constructs from psychotherapy research.

### 2.1 The therapeutic alliance: A theoretical overview

The therapeutic alliance has been investigated extensively in the field of psychotherapy over the past 30 years, with strong evidence consistently indicating that it is a predictor of client outcome (Horvath & Symonds, 1991; Krupnick et al., 1996; Martin, Garske, & Davis, 2000). This section summarises key alliance concepts and theories that underpin the evidence base in psychotherapy and mental health research.

#### 2.1.1 Definitions, concepts and theory

The therapeutic alliance's origins lie in psychodynamic theory, where it is referred to as the healthy, trusting components of the client-therapist relationship (Baldwin, Wampold, & Imel, 2007). Bordin's (1979) alliance definition appears the most dominant in the literature and refers to the degree in which the client-therapist partnership is engaged in collaborative, purposive work. Bordin's theoretical framework consists of three components: *goals* - refer to the consensus around the client's presenting problem and expectations of therapy; *tasks* - are based on agreement around what is required to achieve the goals, *bond* - relates to the trust, respect and attachment between the therapist and client. As the alliance supports and reflects the work of therapy, careful attention needs to be paid to the development, maintenance and repair of this collaboration (Bordin, 1979).

More recently, Hatcher and Barends (2006) clarified and extended Bordin's (1979) theory of working alliance in a couple of important ways. Firstly, they proposed that the alliance is a super-ordinate framework for therapy delivery:

“Alliance is actualized when technique engages clients in purposive work. Alliance cannot happen without technique. Good technique means good alliance.” (Hatcher & Barends, 2006, p. 294).

These assertions challenged researcher attempts to separate out the alliance from technique in determining their respective contributions to treatment outcomes (for example, Horvath, 2001; Lambert & Barley, 2001). Less successful outcomes may sometimes reflect the challenges in engaging clients in collaborative, purposive work rather than the treatment choice per se (Hatcher & Barends, 2006). Secondly, the bond needs to be robust enough to support the work of therapy (Bordin, 1979; Hatcher & Barends, 2006). By explicitly linking the bond dimension to the collaborative work, it suggests that building a bond needs to have a justifiable therapeutic purpose.

Pinsof and Catherall (1986) re-conceptualised the alliance to improve its applicability to marital and family therapy where therapists work with multiple clients simultaneously. These researchers propose two dimensions: the *content* dimension relates to the goals, tasks and bond elements outlined in Bordin’s theory of working alliance, and the *interpersonal* dimension. The latter dimension works at three levels by incorporating *individual* (with each family member), *sub-system* (such as with parents or siblings), *whole system* (family members as a group) and *within-system* (agreement within the therapy system) alliances. This systemic theory accounts for the formation of alliances with all relevant parties who may influence change, but also recognises that these alliances may vary in quality and impact on each other (Pinsof & Catherall, 1986).

### **2.1.2 Related constructs**

A number of terms are used interchangeably with, or referenced alongside, the alliance. The ‘therapeutic alliance’, ‘alliance,’ ‘working alliance’ and ‘helping alliance’ terms are often used synonymously (Horvath & Luborsky, 1993). There appears increased debate around whether and how alliance constructs and theory differ from the ‘therapeutic relationship.’ Many researchers view the therapeutic alliance as *one component of* the therapeutic relationship, with the latter also incorporating:

- a) Additional interpersonal components such as positive regard and empathy (Castonguay, Constantino, & Holtforth, 2006; Hatcher & Barends, 2006; L. N. Johnson & Wright, 2002); or
- b) Transference and countertransference (Gelso & Carter, 1994; Hill et al., 2008; Leibert, Smith, & Agaskar, 2011); and
- c) The ‘real relationship’ or personal connection between the therapist and client (Gelso & Carter, 1994).

Other researchers do not appear to distinguish the alliance from the therapeutic relationship (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998).

In view of the considerable benefits reported in psychotherapy, it is timely and appropriate that researchers have turned their attention to the alliance’s potential impact in stroke rehabilitation.

## 2.2 Literature review questions

This literature review brings to light and critiques evidence relating to the following questions:

- a) What are the key concepts that underpin the alliance in stroke rehabilitation research?
- b) How does the therapeutic alliance impact on outcomes in stroke rehabilitation?
- c) What factors influence the alliance in this field?

## 2.3 Literature search

### 2.3.1 Inclusion/exclusion criteria

#### 2.3.1.1 Population

Preliminary scoping of the literature identified that very few papers have studied the therapeutic alliance (or related terminology; see below) in the stroke rehabilitation population. Therefore, the search was expanded to incorporate all acquired brain injury



survivors. Acquired brain injury occurs as a result of traumatic causes, such as head injury and concussion, or non-traumatic causes, such as stroke and subarachnoid haemorrhage (Buhl & Pallesen, 2015).

### **2.3.1.2 Relationship terminology**

Early scoping also drew attention to the number of terms used to describe the alliance or relationship between clinicians and clients in this field. The database searches incorporated these additional terms (see Table 1).

### **2.3.1.3 Outcomes**

There were no restrictions on alliance outcomes to ensure that all potential benefits were explored.

### **2.3.1.4 Publication date**

Articles were included from 1990 to June 2013 as preliminary scoping of the literature demonstrated the paucity of relevant studies prior to 1990.

### **2.3.1.5 Language**

Only articles published in English were included for ease of interpretation and analysis of findings.

### **2.3.1.6 Study design**

All quantitative and qualitative study designs were included in order to explore alliance concepts, theory, relevance and outcomes. Narratives or commentaries were excluded to ensure that the review was based on empirical evidence.

## **2.3.2 Search strategy**

### **2.3.2.1 Database search**

The databases utilised were EBSCO Health Databases (including Cumulative Index to Nursing and Allied Health Literature, MEDLINE and Psychology and

Behavioral Sciences Collection); OVID (including Allied and Complementary Medicine database, all Evidence Based Medicine Reviews databases and PsychINFO) and SCOPUS.

**Table 1: Key words applied to the database search**

Population (OR)		Relationship term (OR)
'Brain injur*' Stroke	(AND)	'Therapeutic alliance' 'Working alliance' 'Therapeutic relation*' 'Working relation*' 'Therapist-patient inter*' 'Therapist-patient relation*' 'Clinician-patient inter*' 'Clinician-patient relation*' 'Helping alliance'

### 2.3.3 Procedures

#### 2.3.3.1 Screening for relevance

Titles and abstracts of papers identified in this search were screened for relevance. Those papers identified as potentially relevant had their references imported to an EndNote X 4.0.2 library and a copy of the full text saved to file. A manual search of reference lists identified further articles that appeared to meet the inclusion criteria. In-depth reading of all full texts determined each study's contribution to the literature review questions.

#### 2.3.3.2 Quality assessment

Articles were critically appraised according to the Critical Appraisal Skills Programme (CASP) checklist most relevant to each study's methodology (Critical Appraisal Skills Programme, 2013). CASP supports the evaluation of scientific articles to determine the validity of the study and the clinical importance and relevance of their results (Critical Appraisal Skills Programme, 2013). As there are no official descriptive quality ratings for these checklists, each article was scored out of the total number of criteria available. A higher score denotes more criteria were fulfilled, but researchers recommend caution when interpreting these scores, as each criterion is not weighted

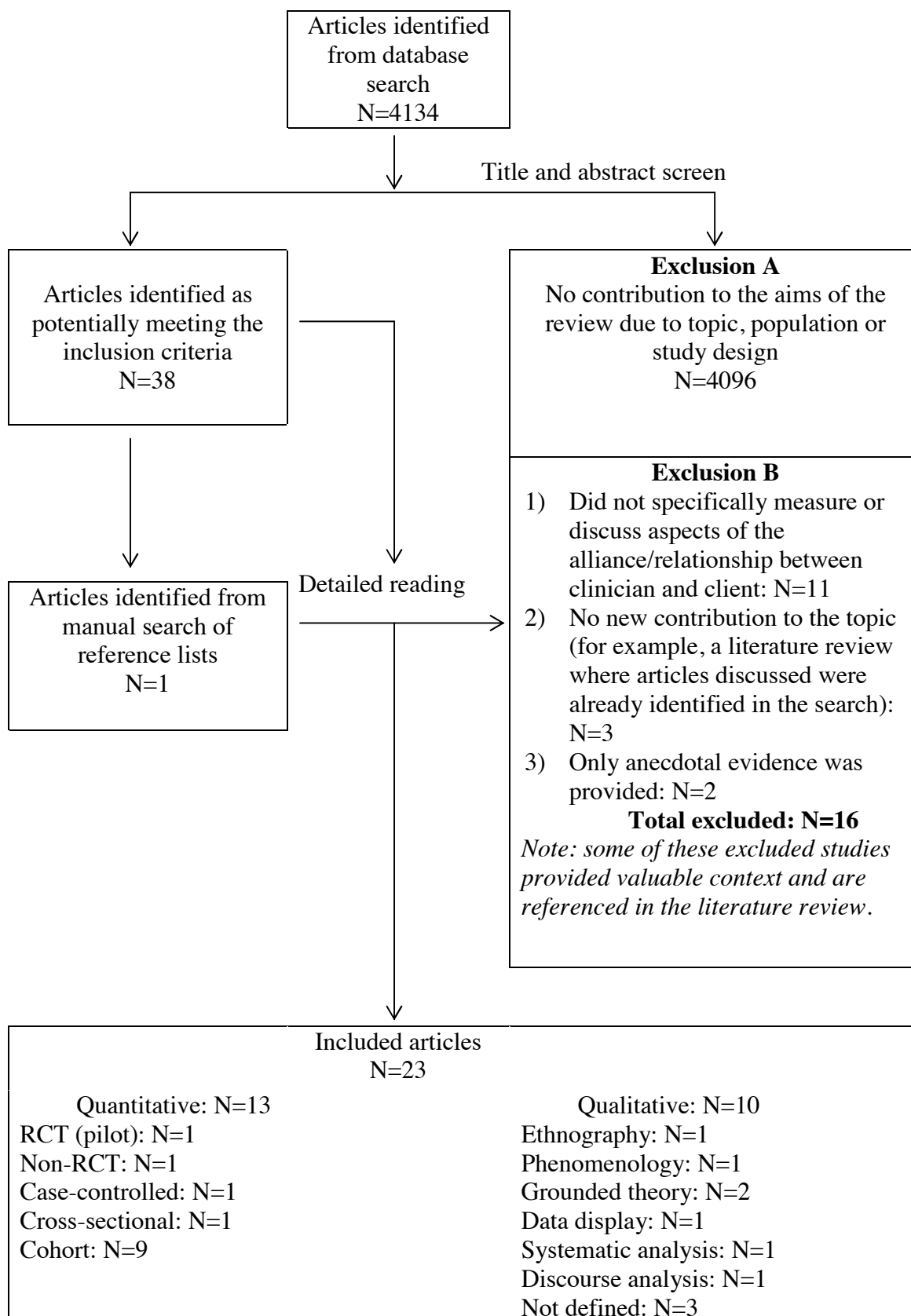
according to importance (Besley, Kayes, & McPherson, 2011b). CASP scores are reported in Table 2; so too are key methodological weaknesses in studies with lower CASP scores.

### **2.3.3.3 Data extraction**

Information relating to each study's design, purpose, participant characteristics, data collection method and finding(s) were extracted and are presented in alphabetical order in Table 2. Study findings are integrated and critically discussed in section 2.4 Findings. As one of the aims of the literature review was to improve conceptual understandings of the therapeutic alliance, data was extracted from all papers regardless of their quality (Morse, 2000).

### **2.3.4 Search results**

Figure 1 summarises the search process and results. The literature search produced 4,134 articles with 38 articles initially appearing to meet the inclusion criteria. One further article was identified via a manual search of reference lists. Following a full reading of each paper, 23 articles (13 quantitative and 10 qualitative) fulfilled the inclusion criteria. Studies were excluded following either the initial title/abstract screening or the full text review; reasons for their exclusions are detailed in Figure 1.



**Figure 1: Literature review search results**

**Table 2: Summary of key information extracted from each study**

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Chang and Wang (2009)	Qualitative: ethnography	To explore perceptions of the therapeutic relationship in a Taiwanese rehabilitation unit.	21 inpatients with stroke, spinal cord injuries and head injuries, 12 caregivers and 15 healthcare workers.	Observation of structured and unstructured rehabilitation routines; in-depth unstructured interviews; review of medical records.	Relationships were considered to be pedagogical in nature, which is congruent with traditional Chinese principles.	8/10
Darragh, Sample and Krieger (2001)	Qualitative: phenomenology	To identify important practitioner qualities and traits.	51 community-based participants with acquired brain injury (excluding stroke).	Open-ended in depth interviews.	Relationship quality impacted on perceptions of treatment efficacy; participants valued effective communication skills, support, respectfulness, empathy and participation in their rehabilitation decisions.	9/10

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Evans, Sherer, Nakase-Richardson, Mani and Irby (2008)	Quantitative: non-randomised, historical-controlled trial	To evaluate an intervention to improve alliance between clients and their clinical team.	Clients with TBI attending a post-acute brain injury rehabilitation service: 69 control group/35 treatment group	Questionnaires of alliance, awareness levels, depression, family functioning, and levels of independence; productivity status.	No significant between- group differences in alliance ratings; stronger team and clinician-rated alliances in treatment group were significantly associated with productivity on discharge, less emotional distress and more intact family functioning.	6/11 Alliance measures have not been psychometrically tested in this population; incorrect temporal relationship between several assessments and interventions.
Hersh (2010)	Qualitative: grounded theory	To explore clinicians' perceptions of therapeutic relationships and their endings in aphasia therapy.	30 speech pathologists working with patients with aphasia (mixed aetiologies) in acute, rehabilitation and community settings.	Semi-structured, in-depth interviews.	Close relationships needed to be balanced with varying degrees of professional distance; personal information was disclosed carefully due to the 'artificial' nature of relationships.	7/10

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Hsieh, Ponsford, Wong and McKay (2012)	Quantitative: pilot RCT	To evaluate the effectiveness of a 12-week anxiety treatment programme.	27 inpatients with moderate to severe TBI and at least one anxiety disorder.	Measures of anxiety, cognitive function, change expectancy and working alliance.	No significant between- group differences in working alliance ratings.	8/11
Jones, O'Neill, Waterman and Webb (1997)	Qualitative: grounded theory	To explore communications and relationships between staff and stroke patients.	10 stroke patients in a rehabilitation ward and their key relatives and 14 staff members (nurses, doctors and therapists).	Unstructured interviews.	Developing relationships appeared to be influenced by the roles and personal qualities (of clinicians and clients) and the organisational context.	3/10 Limited or no information provided around research aims, design, recruitment strategy, ethical issues, data analysis and credibility of findings.
Judd and Wilson (2005)	Qualitative: data-display method	To elicit practitioners' views and experiences of the challenges to forming an alliance with TBI survivors.	21 clinical psychologists who provide psychotherapy to clients with TBI (combination of inpatients and outpatients).	Anonymous postal return questionnaires containing semi-structured questions.	The main challenges related to cognitive, behavioural and emotional difficulties. Educational, psychosocial and cognitive strategies were perceived to overcome these barriers.	9/10

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Klonoff, Lamb and Henderson (2001)	Quantitative: observational cross-sectional design	To investigate productivity levels and their associations with participant characteristics and working alliance ratings.	164 participants with brain injuries who participated in an outpatient-based work/school re-entry programme.	Structured telephone survey covering productivity status at 3 months, 1,3,5,7,9 and 11 years post discharge; staff-rated working alliance scores during rehab programme.	Stronger working alliances were associated with better vocational/school outcomes.	7/12 Alliance and outcome classification scales have not been psychometrically tested; clients' alliance ratings were not elicited; large variance in time to follow-up; nearly a third of participants were lost to follow-up.
Klonoff, Lamb, Henderson and Shepherd (1998)	Quantitative: observational cohort design	To assess the relationships between programme outcomes and working alliance scores, compensation-seeking behaviour and cognitive functioning.	64 patients with brain injuries attending an outpatient-based work/school re-entry programme (note: same setting as for Klonoff et al., 2001).	Productivity at discharge (disability-adjusted); work readiness, work eagerness and working alliance measures.	Stronger working alliances were associated with better programme outcomes.	7/12 Alliance, functional severity and work/outcome rating scales have not been psychometrically tested; clients' alliance ratings were not elicited.



Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Klonoff et al. (2010)	Quantitative: observational cohort design	To explore the relationship of cognitive retraining performance to discharge driving status.	103 participants with brain injuries who participated in an outpatient-based work/school re-entry programme (note: same setting as for Klonoff et al., 2001).	Cognitive retraining scores, behavioural checklist ratings, working alliance scores.	Higher mean alliance scores were associated with driving clearance and an enhanced behavioural approach to cognitive retraining tasks.	6/12 Alliance and functional severity scales have not been psychometrically tested; clients' alliance ratings were not elicited; it is unclear the relative contribution of improved cognition or higher alliance scores in predicting driving clearance.
Klonoff et al. (2007)	Quantitative: observational cohort design	To explore the relationship of cognitive retraining performance to discharge productivity status.	101 participants with brain injuries who participated in an outpatient-based work/school re-entry programme (note: same setting as for Klonoff et al., 2001).	Review of medical chart data covering: cognitive training scores, cognitive retraining behavioural checklist ratings and working alliance scores.	Higher alliance scores significantly related to improved behavioural approaches to cognitive retraining tasks; no statistically significant associations between alliance and work/school outcome status.	5/12 Alliance, functional severity and outcome classification scales have not been psychometrically tested; clients' alliance ratings were not elicited; no outcome information provided for the 52 potential participants excluded due to lack of programme completion.

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Kovarsky, Schiemer and Murray (2011)	Qualitative	To examine group interactions between student speech-language pathologists and adults with TBI.	Four speech-language pathology students and six adults with TBI.	Transcribed video recording of group meeting.	Rapport was damaged due to successive instances of sexually explicit humour; the informal setting and the students' difficulties in managing the disinhibited behaviour may have contributed to the breakdowns.	3/10 Limited or no information provided around the recruitment strategy, relationship between researcher and participants, ethical issues, data analysis process, statement of findings and research value.
Lewinter and Mikkelsen (1995)	Qualitative	To explore therapists' views of the stroke rehabilitation process.	Two occupational therapists; three physical therapists; two nurses; one physician working on the rehabilitation unit.	Semi-structured in-depth interviews.	Professionalism and empathy are required to prevent excessive dependency in long-term therapeutic relationships.	3/10 Limited or no information around study design, recruitment strategy, relationship between researcher and participants, ethical issues, data analysis process, statement and credibility of findings and research value.

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
McLaughlin and Carey (1993)	Quantitative: observational cohort design	To determine the correlations between family-team conflict and patient outcome, family stress, programme satisfaction and family support/ education.	98 patients with brain injuries who attended an acute rehabilitation service and their family members.	Questionnaire, review of medical records	Greater family/team conflict was correlated with increased family stress and lower levels of programme satisfaction; younger patient age, longer lengths of stay and lower physical and cognitive functioning on admission.	6/12 Questionnaire that was used to measure family/team conflict, family stress levels and satisfaction with programme has not been validated and was only measured from the psychologist's perspective.
Peiris, Taylor and Shields (2012)	Qualitative	To explore patients experiences of physiotherapy and whether their experiences differ if they receive an extra day of therapy.	19 patients undergoing inpatient rehab for neurological and musculoskeletal impairments.	In-depth interviews.	Participants' personal interactions with physiotherapists were valued over the content or outcome of therapy; patients appreciated empathetic, caring and encouraging therapists.	9/10

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Prigatano et al. (1994)	Quantitative: observational case-controlled trial	To investigate the productivity status of patients who had undergone a neuro-psychological rehabilitation programme compared with an historical control.	38 TBI patients who underwent the current programme (treatment) versus 38 TBI patients who attended the hospital prior to the development of the specialty programme (historical control).	Telephone questionnaire to relatives regarding each patient's productivity status, clinician-rated working alliance scores of patients and their family members.	A good or excellent alliance with rehabilitation staff was significantly related to a positive productivity status.	5/11 Alliance and outcome classification measures have not been psychometrically tested; client alliance ratings were not elicited; alliance scores completed up to three years retrospectively; knowledge of outcome a potential confounder; functional abilities also possible (unmeasured) confounders.
Schönberger, Humle and Teasdale (2006a)	Quantitative: prospective cohort design	To examine the development and interaction of the alliance, patients' compliance and awareness during rehabilitation.	86 clients with brain injuries participating in a holistic neuropsychological outpatient rehabilitation programme.	Client and therapist ratings of the alliance, therapist ratings of client awareness and compliance.	A client's experience of their emotional bond with their therapist predicted awareness, which in turn fostered programme compliance.	8/12

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Schönberger, Humle and Teasdale (2006b)	Quantitative: prospective cohort design	To investigate the relationship between working alliance, compliance, awareness and subjective outcome of brain injury.	86 clients with brain injuries in a holistic neuropsychological outpatient rehabilitation programme (note: same setting as for Schönberger, Humle, et al., 2006a).	Therapist and client ratings of the alliance and programme success; therapist rating of programme compliance and client awareness; client completion of European Brain Injury Questionnaire.	Clients' experience of a good bond with their therapist mid-therapy was predictive of a reduction in subjective reports of depressive symptoms.	8/12
Schönberger, Humle and Teasdale (2007)	Quantitative: prospective cohort design	To examine the impact of patients' cognitive abilities on their working alliance with their therapist.	86 clients with brain injuries in a holistic neuropsychological outpatient rehabilitation programme (note: same setting and participants as for Schönberger, Humle, et al., 2006a).	Neuropsychological tests of attention, memory and higher cognitive functions, therapist and client ratings of the working alliance.	Weak relationships between cognitive tests and alliance ratings indicating that a good alliance is feasible even with clients with severe cognitive difficulties.	8/12

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Schönberger, Humle, Zeeman and Teasdale (2006)	Quantitative: retrospective cohort design	To examine the role of the alliance and compliance in different elements of a rehabilitation programme and in relation to psychosocial outcome.	98 patients with brain injuries in a holistic neuropsychological outpatient rehabilitation programme (note: same setting as for Schönberger, Humle et al., 2006a).	One physiotherapist's and one neuropsychologist's retrospective ratings of patients' compliance and their working alliance.	Both the neuropsychologist's and physiotherapist's alliance ratings were significantly related to employment at follow-up; low inter-rater agreement on the alliance scale; neuropsychologists more likely to form a 'good' or 'excellent' alliance with patients.	6/12 Alliance, patient compliance, employment and physical training measures have not been psychometrically tested; alliance and compliance assessments were completed retrospectively (up to four years post discharge) and only by therapists; both raters had knowledge of patient outcome.
Sherer et al. (2007)	Quantitative: prospective cohort design	To determine factors that may influence the strength of the alliance for patients with TBI and to examine the association of the alliance with outcome.	69 patients with TBI admitted to a post-acute brain injury rehabilitation programme.	Questionnaires: patient, family and clinician ratings of the alliance, client awareness and disability levels; clinician ratings of productivity status on discharge; family ratings of family functioning.	Higher levels of family discord were associated with lower alliance ratings; greater discrepancies between team and family ratings of patient functioning were associated with lower alliance ratings and poorer rehabilitation effort.	8/12

Author	Study design	Purpose	Participant characteristics	Data collection method	Key finding(s) relating to the alliance	Study quality (CASP scores and key weaknesses)
Talvitie and Reunanen (2002)	Qualitative: discourse analysis	To investigate how, through conversation, physiotherapists and stroke patients construct their treatment interaction.	10 physiotherapists and nine stroke patients in one rehabilitation centre, three health centres and one private clinic.	Videotaping and transcription of nine therapy sessions.	Lack of therapist regard for the patient's feelings and an unwanted power differential within therapy sessions appeared to create awkward interactions.	7/10
Walsh (2007)	Qualitative: systematic analysis	To identify small talk in interactions between speech-language pathologists and adults with communication disorders and the impact on therapeutic management.	Two speech-language pathologists and adults with communication disorders associated with stroke or chronic schizophrenia.	16 audio-recorded sessions.	Participating in informal discussions around therapy tasks and treating the client as an equal conversational partner improves rapport and enables the client to raise concerns that may otherwise interfere with the therapeutic relationship or progress.	7/10

## 2.4 Findings

This section begins by outlining the different terms used to describe the therapeutic alliance or its related constructs, and the definitions and concepts associated with these. It then presents and critically evaluates the potential benefits of a strong therapeutic alliance and the factors that may influence it in brain injury rehabilitation.

### 2.4.1 The therapeutic alliance terms and concepts

As the stroke rehabilitation setting currently lacks a conceptual model of the therapeutic alliance, this review included studies that explored constructs related to the alliance, such as the ‘therapeutic relationship’ and ‘rapport’. The purpose of this was to provide a comprehensive overview of the existing knowledge around the therapeutic alliance in this field. Throughout this review, the ‘therapeutic alliance’ term is often used in a broad sense to refer to the alliance and its related constructs.

The therapeutic alliance definitions and concepts that researchers ascribed to or explored in their studies are conveyed below and summarised in Tables 3 and 4.

#### 2.4.1.1 Terms, definitions and concepts

Twelve quantitative articles investigated the ‘therapeutic alliance’ or ‘working alliance’ between the clinician and client. These terms were often used interchangeably and/or shared a common definition. Of the nine studies that explicitly defined or conceptualised the client-clinician alliance, the majority referred to Bordin’s theory of working alliance, while one other proposed a novel definition and framework. A further study examined the ‘adversarial alliance’ between the clinical team and the client’s family. See Table 3 for an overview of these definitions and concepts, as well as the studies that referenced these. Outcome measures that are associated with these concepts are also presented in Table 3– these will be discussed further in section 2.4.2 (outcomes associated with the therapeutic alliance).

A central difference between the first two alliance frameworks outlined in Table 3 is that the inter-personal dimension is absent from the definition, concepts and outcome measure proposed by Prigatano and colleagues (1994). Instead, this latter model focuses on client awareness, acceptance and level of realism about their deficits



(Klonoff et al., 2010). McLaughlin and Carey's (1993) model differs from the previous two by outlining a *negative* alliance between *clinicians and family members*.

**Table 3: Quantitative studies: Alliance definitions, concepts and outcome measures**

Researcher(s)	Definition	Concepts	Associated Outcome Measures
<b>The therapeutic or working alliance</b>			
Bordin (1979) (Referenced by: C. C. Evans et al., 2008; Klonoff et al., 2010; Klonoff et al., 2007; Schönberger, Humle, et al., 2006a; Schönberger, Humle, et al., 2006b; Schönberger et al., 2007; Sherer et al., 2007)	The degree in which the client-therapist partnership is engaged in collaborative, purposive work.	The interpersonal bond. Mutual agreement of the goals and tasks of therapy.	Working Alliance Inventory Short Form. <sup>1</sup> Working Alliance Inventory – Short Form Revised. <sup>2</sup> California Psychotherapy Alliance Scales. <sup>3</sup>
Prigatano et al. (1994) (Referenced by: Klonoff et al., 2001)	The patient and therapist working together to achieve certain goals.	Therapy attendance and preparation. Level of agreement regarding the course of action. Level of appreciation for accomplishments and services provided.	Prigatano Alliance Scale. <sup>4</sup>
<b>The adversarial alliance</b>			
McLaughlin and Carey (1993)	A conflict-laden relationship between families and clinicians.	A mismatch between the client, families and team regarding the goals and expectations of rehabilitation.	Not documented.

<sup>1</sup> Based on content analyses of Bordin's alliance constructs (Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989).

<sup>2</sup> Based on content analyses of Bordin's alliance constructs (Hatcher & Gillaspay, 2006).

<sup>3</sup> Based on Bordin's (1979) framework and general psychodynamic theory (Elvins & Green, 2008; Gaston, 1991).

<sup>4</sup> Based on concepts proposed by Prigatano et al. (1994).

Table 4 presents the range of constructs that were the central phenomenon of interest in the qualitative studies. These included the ‘therapeutic relationship’ or ‘relationship,’ ‘rapport,’ ‘interaction’ and ‘therapeutic alliance’. The definitions and concepts that accompanied these constructs are also illustrated in this table. Of note, only two of the ten articles provided a definition. There also appears to be limited conceptual overlap between Tables 3 and 4, which may relate to the variant phenomena under review. Judd and Wilson’s (2005) study was the only qualitative study that specifically explored the therapeutic alliance, yet the alliance concepts considered by clinicians to be salient when working with survivors of traumatic brain injuries mostly deviate from those outlined in Table 3. Achieving goal congruence is one concept identified in their study that does align with all frameworks in Table 3. Collaboratively formed, short-term goals were perceived to facilitate self-reflection for clients with unrealistic future expectations, thus promoting the alliance (Judd & Wilson, 2005). While these researchers referred to Bordin’s (1979) alliance concepts, their findings also resonate with Prigatano and colleague’s (1994) framework.

The clinician-client bond is one constituent of Bordin’s (1979) framework. Client participants in two qualitative studies suggested that the quality of the interpersonal relationship with their clinician was more important than the therapy itself (Darragh et al., 2001; Peiris et al., 2012). Clients valued clinicians who demonstrated empathy (Darragh et al., 2001; Peiris et al., 2012) and care (Peiris et al., 2012); engendered trust (Darragh et al., 2001; Jones et al., 1997; Peiris et al., 2012); were therapeutically present (Darragh et al., 2001; Jones et al., 1997) or strict (Chang & Wang, 2009), and/or strived to meet their expectations and goals (Darragh et al., 2001; Jones et al., 1997). The majority of these concepts do not appear to have been captured in the frameworks outlined in Table 3.

**Table 4: Qualitative studies: Alliance/relationship definitions and concepts**

Researcher(s)	Definition	Concepts
<b>Therapeutic relationship or relationship</b>		
Chang and Wang (2009) Darragh et al. (2001) Hersh (2010) Jones et al. (1997) Lewinter and Mikkelsen (1995)	Not documented.	Empathy.  Therapeutic presence.  Trust.  Congruent expectations/ goals.  Strict.
<b>Rapport</b>		
Kovarsky et al. (2011)	The harmoniousness of interpersonal relationships between people (Spencer-Oatey, 2002).	Not documented.
<b>Interaction</b>		
Peiris et al. (2012) Talvitie and Reunanen (2002) Walsh (2007)	Not documented.	Empathy and care.  Trust.
<b>Therapeutic alliance</b>		
Judd and Wilson (2005)	The degree in which the client-therapist partnership is engaged in collaborative, purposive work (Bordin, 1979).	Therapeutic presence.  Trust.  Support/encouragement.  Maintaining hope.  Maintaining engagement in relationship and therapy.  Collaborative understanding.  Congruent expectations/goals.

### **2.4.1.2 The therapeutic alliance and rehabilitation delivery**

Different views exist around how the therapeutic alliance relates to rehabilitation delivery. One researcher suggested that the therapeutic relationship is “the vehicle of therapy itself” (Hersh, 2010, p. 31). Higher alliance scores in two studies related to an enhanced client approach towards their rehabilitation, including improved application of compensatory strategies (Klonoff et al., 2010; Klonoff et al., 2007). These combined findings support the proposition that the therapeutic alliance engages the client in *any* therapeutic work (Bordin, 1979; Hatcher & Barends, 2006).

In other articles, the therapeutic alliance and therapy technique are viewed as two discrete constructs. Hsieh et al. (2012) attempted to discern which anxiety treatment programme enhanced participants’ therapeutic alliance ratings. Results indicated that both treatment groups had similar alliance ratings at the end of therapy (Hsieh et al., 2012). Organisational expectations and processes may encourage clinicians to separate out the therapeutic alliance from assessment and interventions. For example, a speech-language therapy participant reported that an hour-long home visit was often divided in half between the delivery of formal therapy (documented for auditing purposes) and the necessary social interactions that supported it (Hersh, 2010).

Clarifying what the alliance consists of and how it relates to rehabilitation provision may then improve therapists’ ability to utilise it effectively in brain injury rehabilitation.

### **2.4.2 Outcomes associated with the therapeutic alliance**

Researchers have examined the therapeutic alliance’s potential impact on client productivity, function, cognition and mood following a brain injury. This section explores and critiques their findings.

#### **2.4.2.1 Productivity outcomes**

Seven studies investigated the therapeutic alliance in relation to productivity outcomes (see Table 2 for an overview of these studies). Several studies based their productivity criteria on a client’s level of engagement in paid or voluntary work or school, while accounting for modifications and support requirements (Klonoff et al.,

1998; Klonoff et al., 2007; Prigatano et al., 1994; Schönberger, Humle, Zeeman, et al., 2006). Other studies included household management as a positive productivity outcome, recognising the cognitive and physical demands this work entails (C. C. Evans et al., 2008; Klonoff et al., 2001; Sherer et al., 2007).

The majority of studies reported that a stronger clinician-rated alliance is significantly related to a higher productivity status at discharge or follow-up (C. C. Evans et al., 2008; Klonoff et al., 2001; Klonoff et al., 1998; Prigatano et al., 1994; Schönberger, Humle, Zeeman, et al., 2006). Sherer et al. (2007) demonstrated that client and family therapeutic alliance ratings significantly predicted productivity success, whereas the clinician ratings did not. One study failed to find a statistically significant association between the therapeutic alliance and productivity outcomes (Klonoff et al., 2007).

Superficially, the balance of evidence appears to support an association between the strength of the therapeutic alliance and successful productivity outcomes, yet there are a number of methodological flaws pervading many of these studies (see Table 2 for the variation in quality between studies). Some studies did not seem to account for potential confounding factors. For example, despite the possibility that a client's impairments or abilities are likely to be associated with their productivity status, three studies failed to explicitly measure these (Klonoff et al., 2001; Prigatano et al., 1994; Schönberger, Humle, Zeeman, et al., 2006). In addition, three studies measured productivity status between a maximum of three years (Prigatano et al., 1994; Schönberger, Humle, Zeeman, et al., 2006) and eleven years post discharge (Klonoff et al., 2001). It may be difficult to draw associations between the strength of the alliance during a rehabilitation programme and a client's work status many years later, as multiple factors may subsequently influence this outcome. Confounding variables could include post-discharge rehabilitation input, neural recovery, financial/compensation implications and social/work-place supports and flexibility. However, it is still of interest that a significant association existed in many studies as all participants would have been subjected to the same confounding variables.

There are also limitations in the alliance outcome measures applied. Six of the seven studies (excluding C. C. Evans et al., 2008) used the Prigatano Alliance Scale (see Footnote 4, page 28). The scale's criteria suggest that clients who play a more active role in rehabilitation or those with better meta-cognitive skills - either as a result

of these areas being relatively spared from organic damage or due to success in the cognitive retraining programme – are likely to achieve higher scores. The Prigatano Alliance Scale does not appear to have been psychometrically tested and its concepts bear little resemblance to those presented in psychotherapy research. Consequently, it is unclear whether alliance or neuropsychological constructs were under investigation in these studies.

Two studies employed the California Psychotherapy Alliance Scales to assess the alliance (C. C. Evans et al., 2008; Sherer et al., 2007). These scales focus on client and therapist contributions to the alliance and therapy, and reflect the interpersonal aspects of the relationship (Elvins & Green, 2008; Hatcher & Barends, 2006). Despite their alignment with existing alliance theory (see Footnote 3, page 28), clients and family members reported difficulties in understanding some of the scales' items and relating these to their rehabilitation programme during pilot testing (Sherer et al., 2007). Subsequently, Sherer and colleagues modified the scale but no studies appear to have investigated its original or modified reliability, validity or applicability in brain injury rehabilitation.

In terms of *who* determines alliance quality, five of the seven studies relied solely on clinicians' assessments of the alliance (see Table 2). However, it makes research and clinical sense to obtain client ratings. Researchers suggest that alliance perceptions are likely to be influenced by different factors, which may cause clinician and client ratings of their alliance to diverge (Schönberger, Humle, et al., 2006a; Schönberger, Humle, et al., 2006b). Therefore, a different set of alliance-outcome associations may have been detected and discussed if client perspectives were included. Psychotherapy researchers also recommend eliciting client ratings of the alliance as it may allow clinicians to proactively assess and address alliance ruptures (Castonguay et al., 2006).

The choice of *when* the therapeutic alliance was measured also appears to have compromised the integrity of some studies. Prigatano et al. (1994) and Schönberger, Humle, Zeeman, et al. (2006) used retrospective alliance ratings– some of these ratings were based on clients who had been discharged up to four years earlier (Schönberger, Humle, Zeeman, et al., 2006). This is likely to have distorted the accuracy of these assessments as it may be challenging to recall client attendance rates and adherence to advice many months or years later. Clinician knowledge of client outcome may be an

additional, potentially confounding factor.

While the quality of existing evidence makes it difficult to confirm any associations between the therapeutic alliance and productivity outcomes following post-acute rehabilitation programmes, the consistency of evidence suggesting that this relationship may exist makes it worthy of further exploration.

#### **2.4.2.2 Functional status**

Evidence varies regarding the impact of the alliance on function. Two studies failed to find any associations between the degree of therapeutic alliance and client functional status (including their communication, cognitive and motor skills) on discharge (C. C. Evans et al., 2008; Sherer et al., 2007). Klonoff et al. (2010) report that a higher mean and discharge alliance score, as measured by the Prigatano Alliance Scale, is associated with driving clearance. As discussed previously (see pages 32-33), this alliance measure's questionable conceptual basis limits the viability of these findings. The researchers also failed to account for the participants' visual, perceptual or physical difficulties, which are likely to have influenced driving skills. Overall, there is insufficient evidence demonstrating an association between a strong therapeutic alliance and functional change over time.

#### **2.4.2.3 Metacognitive and emotional change**

Several studies report that emotional and metacognitive benefits are associated with a robust therapeutic alliance. In one study, client perceptions of a strong emotional bond positively influenced awareness, which, in turn, predicted compliance with rehabilitation (Schönberger, Humle, et al., 2006a). Although the development of awareness has been linked to an increase in depression (Fleming, Strong, & Ashton, 1996), research suggests that a client's experience of a good emotional bond halfway through rehabilitation may be predictive of a reduction in emotional distress (Schönberger, Humle, et al., 2006b). As a result, the therapeutic alliance may not only enhance self-awareness – considered by some clinicians and researchers to be a pre-requisite for effective rehabilitation (Fleming et al., 1996), but may also manage the adverse emotional effects of the adjustment process. As the client's perception of the bond appears key, it also highlights the importance of developing *all* aspects of the therapeutic alliance in order to create a framework of acceptance and engagement in



therapy (Schönberger, Humle, et al., 2006a). This is congruent with Bordin's (1979) emphasis on the interpersonal, interactive and reciprocal nature of the alliance.

Contrary to findings illustrating that the therapeutic alliance enhances awareness, Sherer et al. (2007) failed to find any correlation between the two. A limitation of this study is that measures of alliance strength and client awareness were only obtained once – two weeks after admission. It may be challenging for clients, particularly those with cognitive and communication difficulties, to develop strong alliances so quickly. In comparison, the other studies measured these variables four times throughout the rehabilitation process, therefore capturing changing associations over time (Schönberger, Humle, et al., 2006a; Schönberger, Humle, et al., 2006b). Based on the finding that the strength of the emotional bond mid-therapy (but not at programme start or end) is predictive of a reduction in depressive symptoms, researchers suggest that it may be particularly pertinent for therapists to foster a strong alliance in the middle phase of rehabilitation (Schönberger, Humle, et al., 2006b).

In spite of the promising findings presented above, they remain compromised by the alliance outcome measure selected (the Working Alliance Inventory-Short Form; see Footnote 1, page 28). Whether Bordin's (1979) concepts and the measures based on these concepts are suitable for brain injury rehabilitation research remains under-explored. Physical rehabilitation researchers have stressed the need to re-contextualise and reword components of these scales to improve their acceptability and validity (Besley, Kayes, & McPherson, 2011a; Hall et al., 2012). Given that participants struggled to answer questions on two different alliance scales in this review (Hsieh et al., 2012; Sherer et al., 2007), it is conceivable that these measures also lack conceptual relevance in brain injury rehabilitation.

Arguably the biggest limitation of all of the research presented in this section is that each study focussed on measures of association between the therapeutic alliance and outcomes and therefore, causal inferences cannot be made. However, this is likely to relate to the complexities inherent in research aiming to understand the role of the therapeutic alliance in rehabilitation outcomes, where a randomised controlled trial would be ethically inappropriate and it would be difficult to control for the effects of contamination bias.

### **2.4.3 Factors that may influence the therapeutic alliance**

A range of factors appeared to positively or negatively impact on the therapeutic alliance. These included intrinsic relationship elements; professional, service and cultural factors; brain injury-related impairments and family/whānau.

#### **2.4.3.1 Relational factors**

Participants described different types of therapeutic relationships, from collaborative (Darragh et al., 2001; Hersh, 2010), to pedagogical (student-teacher) (Chang & Wang, 2009) or authoritarian (Talvitie & Reunanen, 2002). Variation appeared to exist even within a rehabilitation service:

“Relationships could be placed on a continuum ranging from the intensely participative, close and sustained to the intensely hierarchical, closed and detached.” (Jones et al., 1997, p. 102)

Clinicians’ perceptions of their role seemed to influence how their relationships developed. In two studies, clinician participants viewed themselves as experts and expected clients to adhere to their instructions and treatments (Chang & Wang, 2009; Jones et al., 1997). Client participants within these same rehabilitation services were reportedly happy to comply with their clinicians’ recommendations (Chang & Wang, 2009; Jones et al., 1997). These findings support the alliance model proposed by Prigatano et al. (1994) (see Table 3, page 28). In another study, client participants tried to assert a more active role in their relationships but were rebuffed, creating awkward encounters (Talvitie & Reunanen, 2002). Darragh et al. (2001) suggested that disparate views between clinicians and clients on how their therapeutic relationship should unfold could lead to power struggles that damage the relationship and client perceptions of the service. These latter findings align with Bordin’s (1979) collaborative alliance model.

Some clinicians forged collaborative relationships with their clients. An observation study of speech-language therapists’ clinical interactions reflected a symmetrical distribution of power including equal turn-taking and client initiation and dominance of topics (Walsh, 2007). Client participants experienced the freedom to discuss issues of concern to them – even if they were outside of the remit of the professional’s area of knowledge and expertise. These researchers concluded that if

such concerns are not discussed, they might impede the therapeutic relationship and client progress.

A collaborative or 'real' relationship sometimes relied on the controlled disclosure of small amounts of personal information. This encouraged clients to reciprocate and was perceived to contribute to relationship success and therapeutic gains (Hersh, 2010). There appeared a need to maintain professional boundaries within these relationships to prevent dependence and inappropriate intimacy (Hersh, 2010; Lewinter & Mikkelsen, 1995). However, contextual factors such as working in remote, small town locations meant that some clinicians found they were unable to separate their professional and personal lives (Hersh, 2010). Further research would be beneficial in examining clients' perspectives of the role of self-disclosures in augmenting relationships, as well as what level of information clinicians may disclose while maintaining professional standards.

#### **2.4.3.2 Professional factors**

Certain professional skills may improve therapeutic alliance quality. One study compared alliance ratings between a neuropsychologist and a physiotherapist and demonstrated that the neuropsychologist was more frequently able to form 'good' or 'excellent' alliances (Schönberger, Humle, Zeeman, et al., 2006). This may be explained by the nature and extent of psychology training schemes, which provide these clinicians with expertise in supporting clients' cognitive, emotional and inter-personal difficulties and establishing a clear framework for therapeutic collaboration. Unfortunately, this study failed to elicit the client participants' ratings of the therapeutic alliance, which may have provided a more client-centred foundation for researchers to explore this issue further.

Other professionals also report differential abilities in forming close working relationships. Speech-language therapists perceive that they are often able to develop a collaborative, intimate rapport with clients with aphasia due to their expertise in supporting clients to circumnavigate their communication difficulties (Hersh, 2010). Anecdotally, health professionals frequently seek support from speech-language therapists to facilitate interactions with clients with aphasia. It may be difficult to ascertain whether it is their clinical competence, personal characteristics or familiarity

with these clients that helps speech-language therapists navigate such encounters. As one clinician participant commented:

“It got to the stage where I knew him so well in the end that I could guess fairly quickly and it wasn’t skill as a speech path at all...and sometimes it was just sheer fluke you know!” (Hersh, 2010, p. 36).

Based on the research available in this review, there remains insufficient evidence articulating what competencies are required for *any* clinician to foster a strong therapeutic alliance, let alone what skills or qualities are required to repair alliance breakdowns. In addition, there does not appear to be research examining clients’ views on whether they have a closer affinity to some clinicians based on the clinicians’ professional skills.

### **2.4.3.3 Service factors**

Therapeutic relationships are sometimes considered to be artificial in nature as they are, in part, controlled by organisational requirements (Hersh, 2010). For instance, service restrictions such as time constraints and a discharge focus are thought to impede the ability to form personable, authentic relationships (Hersh, 2010). Environmental and temporal factors may also have a bearing on the alliance. Speech-language therapists described forming friendship-like relationships with clients who they treated over a prolonged period of time in their own homes and communities (Hersh, 2010). It appears that the quantity of input does not automatically correlate with the quality of the therapeutic relationship. Nurses in one study reported that they often spend more time with their clients compared with other clinicians, yet the nature of the public ward environment and focus on prioritising the short-term needs of several clients at once often negatively impacted on their ability to build up strong relationships (Jones et al., 1997).

These findings raise a number of further questions: Do rehabilitation services and the wider health system influence how the alliance manifests in practice due to length of stay or caseload targets associated with fiscal restrictions? Or is it feasible to still develop a quality alliance over several short clinical interactions? Whether and how the local and national health system impacts on individual alliances is worthy of further exploration.

#### **2.4.3.4 Cultural factors**

While other studies conveyed the importance of forming a collaborative, client-centred relationship (Darragh et al., 2001; Hersh, 2010), findings from one study contradicted such concepts. Chang and Wang (2009) extensively observed and interviewed 21 clients, their caregivers and health professionals in a neuro-rehabilitation unit in Taiwan and identified that underlying Chinese ideologies influenced all aspects of the relationship. Therapeutic relationships transformed into pedagogical relationships, which were characterised by the compulsory nature of therapy, an authoritative approach and belief that pain will support recovery (Chang & Wang, 2009). Such findings highlight cultural differences in what professionals, clients and families may value in the therapeutic alliance. It has important implications for clinicians and rehabilitation services in New Zealand, where the Asian population constitutes the third largest ethnic population group after European and Māori (Statistics New Zealand, 2015). Whether rehabilitation professionals adapt their relationship-based approach depending on a client's cultural background and ideologies is yet to be determined by local or international researchers.

#### **2.4.3.5 Brain injury-related factors**

Compared to other populations, a different set of neuro-behavioural factors may limit alliance development in brain injury rehabilitation. A study exploring interactions in an informal setting captured video-recorded evidence of rapport breakdown between people with brain injuries and student speech-language therapists (Kovarsky et al., 2011). It appeared that the informal setting (a café) and the students' inconsistent and inexperienced responses to displays of sexually disinhibited behaviour contributed to these breakdowns. On the other hand, even seasoned experts report difficulties in forming a therapeutic alliance with clients with brain injuries. Clinical psychologists in one study experienced anger, fear and anxiety as a result of their clients' disinhibited behaviour (Judd & Wilson, 2005).

Impairments in memory, insight and flexibility of thought are also perceived to be particularly problematic in forming a strong therapeutic alliance (Judd & Wilson, 2005). Clinical psychologists apply a range of strategies to overcome these alliance barriers, including reality testing and supporting a client's self-reflection of their deficits

(Judd & Wilson, 2005). However, empirical evidence has demonstrated only weak correlations between a range of scores on cognitive tests and the therapeutic alliance, further strengthening the view that a good alliance may be feasible even for clients with cognitive deficits (Schönberger et al., 2007). It remains unclear what type and level of cognitive (or other) impairments may significantly interfere with the strength of the alliance, or how these clients view their therapeutic alliances. Further clarification is also required regarding the skills and attributes needed to overcome neuro-pathological impediments to the therapeutic alliance - particularly for those clinicians without a psychology background. It appears that some clinicians apply a professional, equitable approach (Hersh, 2010) whereas others avoid working with 'challenging' clients or recruit other staff members for support (Jones et al., 1997).

#### **2.4.3.6 Family/whānau factors**

Researchers have argued that the extent to which a therapist can form an effective alliance with the client not only depends on the neurological consequences and psychological impact of the brain injury, but also the client's social context (Lewis, 1991). Findings from several studies indicate that family-related factors may positively or negatively affect the alliance. Quantitative evidence suggests that low levels of family discord and similar perceptions between the family and clinicians of the client's abilities are associated with a stronger therapeutic alliance between clinician and client and more active programme participation by the client (Sherer et al., 2007). C. C. Evans et al. (2008) confirmed these findings by finding a positive correlation between the strength of team's alliance with the client/family and intact family functioning. However, it is difficult to determine the direction and temporal interactions of these correlations as scoring only occurred at one time point in both studies.

Conversely, high levels of family discord and differing perceptions between the family and clinicians of the client's abilities are significantly associated with poorer clinician-client therapeutic alliances (Sherer et al., 2007). Family stress and poor adjustment also correlates with increased conflict between the family and team, potentially leading to an adversarial family-team alliance (McLaughlin & Carey, 1993). McLaughlin and Carey did not evaluate whether this adversarial alliance then affected the clinician-client alliance.

In spite of the mounting evidence that family may impact on multiple relationships and client engagement in their rehabilitation, researchers have proffered few models or strategies for working with family in order to optimise the family-team alliance. Pinsof and Catherall's (1986) alliance framework referred to earlier in this chapter (see page 9) may have merits in rehabilitation services as clinicians often work with family – and each other - to help facilitate client progress and adjustment. In this review, no studies referred to or examined the alliance using this model. C. C. Evans et al. (2008) piloted an intervention to improve family function and alliance quality, and compared findings with an historic control group. The family intervention consisted of an hour-long brain injury education and discussion session that seemed to occur *after* clinician, client and family alliance ratings had been obtained. Perhaps as a result of this brief intervention and design flaw, no between-group differences for family functioning or alliance ratings were reported (C. C. Evans et al., 2008). Given the rationale for involving family in rehabilitation in order to support client recovery and optimise family wellbeing (see *Chapter 1: Introduction*, page 5), more empirically based guidance is required to manage relationships with them.

## 2.5 The therapeutic alliance in stroke rehabilitation: Current knowledge and knowledge gaps

The literature search highlighted the paucity of studies examining the therapeutic alliance in stroke rehabilitation. Of the 23 articles in this review, only three focused exclusively on the stroke rehabilitation population while 13 others included participants with stroke alongside other types of brain injuries or health conditions (see Table 2 for the different participant characteristics). People with stroke often require different rehabilitation approaches to other neuro-disorders such as traumatic brain injuries, spinal injuries and brain tumours, so it is possible that they have a unique set of relationship needs as well. Out of the 13 studies above, only two explored differences between participants with stroke and other conditions in their findings (Schönberger, Humle, Zeeman, et al., 2006; Walsh, 2007). Schönberger, Humle, Zeeman, et al. (2006) found no statistically significant differences between different injury types (traumatic brain injury versus stroke versus other) and alliance strength. These researchers used the Prigatano Alliance Scale to assess both the alliance (from the therapists' perspectives only) *and* patient compliance, further challenging this alliance measure's content validity and the quality of these findings. Walsh (2007) examined clinical discourse

between speech-language therapists and people with stroke or schizophrenia. A key finding was that small talk facilitates communication success and positive therapeutic relationships across these two conditions (Walsh, 2007). In the absence of qualitative or quantitative data exploring either party's relationship perceptions, this latter statement may be a tenuous conclusion to draw.

Of the three stroke-based studies, only one elicited clinician *and* client perspectives of the relationship (Jones et al., 1997). This article was part of a larger research project exploring communication on a stroke ward, and reports a number of factors that influence the relationship formation and type (see pages 36-40). While these are useful insights, they are compromised by the quality of the study (see Table 2) and would benefit from a contemporaneous update. The remaining two studies also focused primarily on non relationship-related rehabilitation processes. Lewinter and Mikkelsen (1995) sought therapists' perspectives on goal setting, outcome measurement and discharge planning, and included several additional questions encompassing rehabilitation quality and relationships. Subsequently, there is little information pertaining specifically to therapeutic relationships, and the quality of these findings is sub-optimal (see Table 2) and potentially outdated. Talvitie and Reunanen's (2002) discourse analysis of interactions between physiotherapists and their stroke patients was part of a larger project aiming to develop physiotherapy services in Finland. Again, there is a dearth of information relevant to the aims of this literature review.

Based on the literature review and a search update conducted in April 2015 (see pages 10-12 for the search parameters) no qualitative studies appear to have specifically examined what clinicians and people with stroke perceive to be the most important aspects of their therapeutic alliances. It is important to accrue this information for several reasons. Firstly, some participants with brain injuries have indicated that the quality of the clinical partnership is more important than the content of therapy or its outcomes (Peiris et al., 2012) and affects their perceptions of rehabilitation success (Darragh et al., 2001; Schönberger, Humle, et al., 2006b). Given the value placed on therapeutic alliances and the conceptual ambiguity that currently exists around these, it would be prudent to explore what constitutes a strong therapeutic alliance and what purpose it may serve to individuals, teams and rehabilitation programmes. Understanding the factors that may influence these alliances would also be highly beneficial. For clinicians, this combined knowledge



would assist in illuminating the competencies and attributes required to create, maintain and repair therapeutic alliances. For researchers, it may advance the development of a measurement tool that is contextually relevant to this field, from which researchers may more effectively (and credibly) evaluate interventions that strengthen the alliance and its consequent impact on outcomes.

## 2.6 Summary

This chapter has presented and critically evaluated the current evidence base relating to the therapeutic alliance in brain injury rehabilitation. It has brought to light the limited research examining this concept or its related constructs in stroke rehabilitation, further justifying the current study's aims. Chapter three discusses the methodology and methods applied to address these aims.

## Chapter 3: Methodology and Methods

This chapter provides a theoretical overview of Interpretive Description and justifies the selection of this methodology to address the study's aims. It elaborates on the research methods used to recruit participants and collect, prepare and analyse the data whilst ensuring adequate rigour. The final section describes the ethical considerations pertinent to this study.

### 3.1 Methodology

A qualitative study design was selected for several reasons. The preceding literature review outlined the paucity of studies exploring the conceptual underpinnings of the therapeutic alliance in stroke rehabilitation. In order to deepen understandings of the alliance, this research aimed to gather real-world evidence from the experiences and practices of individuals and teams within a stroke rehabilitation environment. Drawing on quantitative approaches were considered inappropriate given: a) a questionnaire or rating scale may limit our ability to capture the complexities and dynamic nature of the therapeutic alliance; b) a more structured approach to questioning may limit the participation of potential participants with cognitive and/or communication difficulties following their stroke; and c) the unavailability of an alliance measure specific to this field (see pages 32-35). As such, a qualitative approach was considered more appropriate to explore this phenomenon rather than evaluate it using measures that had not been contextualised or validated within stroke rehabilitation.

A qualitative approach using Interpretive Description methodology was used to address the following research questions:

- a) What are perceived to be the core components of a positive therapeutic alliance in stroke rehabilitation by people with stroke and their clinicians?
- b) What factors are perceived to influence the development of a strong therapeutic alliance?

### **3.1.1 Interpretive Description: A theoretical overview**

Interpretive Description is an inductive approach designed to explore clinically relevant phenomena and develop novel insights that yield implications for practice (Hunt, 2009; Thorne et al., 1997). This approach is philosophically aligned with naturalism (Thorne et al., 2004). Guba and Lincoln (1982, pp. 237-239) identify five axioms that characterise naturalistic inquiry:

- a) There are multiple, intangible realities. These realities can only be studied holistically and in their natural environments. Further inquiry into each reality will create more questions than it answers.
- b) The researcher and the respondent interact and influence each other.
- c) The purpose of a naturalistic inquiry is to generate a body of knowledge that is context-bound and focussed on differences (as well as similarities).
- d) Numerous processes, factors and conditions may shape and be an inherent part of the phenomena. Researchers can draw inferences from the patterns that shape the phenomena.
- e) The inquiry is value-bound and influenced by the researcher, the research process and the context.

The existing body of knowledge provides the starting point for an Interpretive Description inquiry. Knowledge may be derived from practice-based experience and a critical analysis of the evidence base (Thorne et al., 1997). This preliminary framework justifies the research aims and boundaries, and exposes the theoretical and empirical assumptions that guide the study's design and analysis (Morse, 1991). It is common practice for pre-study understandings to be challenged and refined during the analysis (Thorne et al., 1997). For Interpretive Description researchers, clear articulation of their methods for interpreting data and critically examining emerging insights is required.

Interpretive Description studies are often smaller scale explorations of a clinical phenomenon, with a focus on illuminating themes, patterns and characteristics within subjective experiences, while accounting for differences between individuals (Thorne et al., 2004). The findings of an Interpretive Description study should be arranged into a "coherent professional narrative that experts in the area will acknowledge as persuasive" (Hunt, 2009, p. 1286). The in-depth exploration of meanings and generation of knowledge that is accessible to those engaged in practice are two features that

separate Interpretive Description from traditional qualitative descriptive approaches (Thorne et al., 2004).

### **3.1.2 Rationale for choosing Interpretive Description**

Interpretive Description was selected for several reasons. Firstly, it guides the exploration of experience-based, complex health questions that may be of particular interest to a discipline or clinical context (Thorne et al., 2004). It also advocates that its findings have relevance, meaning and applicability in order to augment practice knowledge (Thorne et al., 1997; Thorne et al., 2004). As a clinician and educator in neuro-rehabilitation, this methodology supported my professional interest in examining and untangling some of the nuances and challenges associated with the therapeutic alliance in this field. In addition, it facilitated the creation of knowledge and recommendations that I can readily share with others.

While other qualitative methodologies require a formal pre-existing conceptual framework, Interpretive Description is considered suitable for research where there is limited empirical data (Hunt, 2009; Thorne et al., 1997). This aspect is relevant for the current study due to a lack of research evidence (see *Chapter 2: Literature Review*). Interpretive Description's recognition of experiential knowledge as a means of orientating the research creates a more tenable foundation for the current study than other approaches may offer.

Finally, Interpretive Description encourages multiple, dynamic approaches to both data collection and analysis (Hunt, 2009). This enabled a level of responsiveness to individual participant need, including tailoring interview questions to suit those with receptive communication difficulties in order to promote their participation in this research. Regularly moving between and critiquing collateral data sources has created a plausible and holistic framework for explaining the commonalities and variances that have emerged out of this inquiry. For these reasons, Interpretive Description was considered to be suitable for this study's exploration of the alliance in stroke rehabilitation.

## 3.2 Research methods

### 3.2.1 Participant selection and procedures

Qualitative interviews occurred between November 2012 and June 2014 and included individual client interviews and a clinician focus group interview. All participants were recruited from a regional inpatient rehabilitation service. Clients post stroke are transferred to this service once the acute stroke team determines that they are medically stable and able to participate in rehabilitation. The duration of rehabilitation stay varies from several weeks to several months. Clients have regular, on-site access to medical professionals (including a rehabilitation consultant), registered nurses and health care assistants, physiotherapists, occupational therapists, speech-language therapists, social workers, dietitians and allied health assistants.

#### 3.2.1.1 Client participants

##### 3.2.1.1.1 Eligible participants

Client participants were eligible if they had sustained a recent stroke and:

- a) Had received a minimum of two weeks of inpatient rehabilitation to ensure they had had the opportunity to form and consolidate several therapeutic relationships;
- b) Were over 18 years of age and able to provide informed consent in order to meet ethical obligations; and
- c) Were able to communicate in English without the need for an interpreter due to the limited funding resources available for this research.

Participants were excluded if:

- a) They had pre-existing cognitive deficits such as those associated with dementia; and/or:
- b) Their stroke was not their main cause of impairment.

This study aimed to explore the experiences of people whose stroke was their primary diagnosis. Therefore, those with another primary health diagnosis or pre-existing changes in cognition may have provided a different level of complexity that was outside of the scope of this research. As I initially worked within the rehabilitation ward where client participants were recruited, my own clients were excluded to reduce the potential for a clinician-client conflict of interest.

#### 3.2.1.1.2 Sampling

Purposive sampling (Carpenter & Suto, 2008) identified participants who had the potential to offer meaningful and diverse insights in relation to the study's aims (Thorne et al., 1997). To that end, sampling characteristics for the first eight client participants included those with a range of:

a) Physical, cognitive and communication difficulties

The Functional Independence Measure (FIM) is a standardised outcome measure assessing physical, cognitive and social skills across a range of day-to-day behaviour (Dodds, Martin, Stolov, & Deyo, 1993). The FIM is routinely recorded for each client on admission and discharge from this service. If a FIM score had not been recorded within two weeks of the interview date, then the clinical team recompleted this measure to reflect the participant's current levels of ability and independence at the time of the interview. Total and sub-componentry FIM scores were used to ensure heterogeneity in stroke severity and functional difficulties in the sample.

Stroke rehabilitation research often limits the involvement of participants with moderate to severe impairments in cognition and communication (examples include Almborg, Ulander, Thulin, & Berg, 2009; Peiris et al., 2012). This may be due to the potential complexities associated with hypothesis testing and generating accurate, comprehensive data from this sub-group. To better represent and glean knowledge from this sub-group of stroke survivors, this study purposefully incorporated the views of participants with moderate to severe cognitive and communication deficits (provided they met the eligibility criteria outlined above). These participants were supported to participate by using strategies and information provided by their speech-language therapist and/or occupational therapist (see pages 60-61).

b) Ethnicities

*Chapter 1: Introduction* (see pages 4-5) highlighted the over-representation of Māori and Pacific Islanders in New Zealand stroke statistics and the emphasis that members of these cultural groups place on relationships. These combined factors make this study particularly relevant and potentially beneficial for these cultural groups. It is possible that Māori or Pacific people have culturally specific perspectives regarding what matters most to the therapeutic alliance in the inpatient stroke rehabilitation setting. As such, while this research was not seeking a representative sample, it was considered important to capture perspectives of these cultural groups through the purposeful sampling process to inform developing practice insights.

c) Stages in rehabilitation

Psychotherapy researchers recommend assessing the alliance in the first third of treatment due to its stronger associations with outcomes (Horvath, 2001). In spite of these recommendations, it could be argued that it may be more time consuming to develop a therapeutic alliance with some clients with cognitive and communication impairments. Further, assessing the alliance only in the initial weeks of rehabilitation may have failed to incorporate experiences of relationship change over time for intra-personal, inter-personal or rehabilitation process reasons. Investigating perceptions of people who were at different stages of rehabilitation had the potential to provide additional insights regarding the alliance journey.

Theoretical sampling (Marshall, 1996) was employed as the study progressed to address areas of the study that required further clarification or development, as advocated by Hunt (2009). Concurrent data collection and analysis highlighted the dearth of relationship experiences with social workers, therefore the remaining two client participants were recruited who had received substantive social work input to further explore these perceptions.

This study aimed to recruit 10 client participants as this sample size was considered to be sufficient to provide a meaningful portrayal of the phenomenon under investigation (Thorne, 2008). This number of participants was also considered to allow for adequate diversity within the sample in relation to the sampling criteria described.

### 3.2.1.1.3 Recruitment

Regular liaison with members of the rehabilitation team identified the characteristics of prospective client participants who met the eligibility criteria. A member of the clinical team not involved with the client's care provided potential participants with a study information sheet and explanation tailored to meet their cognitive and communication needs (see Appendices B and C for the Standard and Simplified Client Participant Information Sheet). Interested clients were encouraged to discuss their possible involvement in the study with family/whānau before providing written consent for their name to be passed on to me for further information (see Appendix D for the Consent to Provide Name Form).

### **3.2.1.2 Clinician participants**

#### 3.2.1.2.1 Eligible participants

Eligible clinicians had at least one year of work experience with clients post stroke with the anticipation that these clinicians would have consolidated their technical skills and be able to provide insights regarding their therapeutic alliance experiences. Clinicians included therapists and registered nurses based on the rehabilitation ward.

#### 3.2.1.2.2 Sampling

Purposive sampling aimed to include clinicians with a range of:

- a) Professional qualifications;
- b) Years of experience in stroke rehabilitation and in other healthcare settings;  
and
- c) Gender and ethnicity.

The rationale behind this was to seek diverse personal and professional views of the therapeutic alliance.



### 3.2.1.2.3 Recruitment

Presentations of the proposed study and sampling strategy were given to potential participants at monthly therapy and nurse meetings, and poster advertisements were displayed in central staff areas. Interested clinicians approached me directly or had the option of contacting one of my supervisors if they wished to discuss their participation with someone outside of their workplace (given that I was a colleague). All interested clinicians received additional written and verbal information about the study (see Appendix E for the Clinician Participant Information Sheet).

## 3.2.2 Data collection

Interpretive Description encourages multiple approaches to data collection (Thorne, 2008). To achieve this, the current study utilised individual and focus group interviews with accompanying field notes, and obtained demographical information from each participant.

### 3.2.2.1 Demographical information

The following information was obtained from each client participant and/or their medical files: socio-demographic information; stroke location, type and time since onset; length of rehabilitation stay at interview; and FIM scores (within two weeks of the interview).

Clinician participants completed a form outlining their gender, age, ethnicity, qualification(s) and level of clinical experience (total years of experience as well as experience within neuro-rehabilitation). Summaries of relevant demographical characteristics for both sets of participants are available in Tables 5 and 6 in *Chapter 4: Findings* (pages 69-72).

### 3.2.2.2 Semi-structured interviews

The primary data source was derived by in-depth, semi-structured interviews with open-ended questions following a topical guide. This encouraged rich descriptions of experiences and ideas and allowed the line of questioning to be responsive to each participant, whilst providing a broad interview structure (Nicholls, 2009). Individual

interviews were considered to be suitable for client participants as they could be adapted according to each person's cognitive and communication needs, fatigue levels and preference for family/whānau support during these interviews. For clinician participants, focus groups were employed as they are an efficient data collection technique where discussion within a group is used as a prompt for identification of key concerns, and where shared experiences can encourage deeper thinking and debate on a topic (Kitzinger, 1995; Krueger & Casey, 2000).

The client participants partook in individual interviews that lasted between 34 and 84 minutes. Following a brief introduction, the opening question was: "Can you think of a therapist or nurse on the ward with whom you have a particularly good therapeutic relationship?" to explore their experiences of a strong alliance. Follow-up questions were used to encourage detailed and concrete responses. Examples of these questions included: "What would you say the key things are that make this a good relationship?" and: "How does this relationship impact on your rehabilitation?" Broad questions encompassed the therapeutic alliance's core components, relevance and value as well as factors that impede or support the formation and maintenance of one.

For participants with more limited abilities to express themselves or where a more specific line of questioning was perceived to be beneficial, direct questions were utilised such as: "What do you think are the three key things that help clinicians and people with stroke work well together?" and: "What can people with stroke do to contribute positively to these relationships?"

The clinician focus group was co-facilitated with my primary supervisor. Again, a topical guide with open-ended questions promoted responses around alliance components and influencing factors. Occasional facilitation was used, such as to compare views between different disciplines and to elaborate upon poignant topics raised.

The terminology used in the interview questions was deliberately kept broad for two reasons. First, from a pragmatic perspective, the phrase 'therapeutic alliance' is a jargon with specific theoretical roots that may not be easily understood by client and clinician participants. Second, the literature review findings (see *Chapter 2: Literature Review*) highlighted a) that an in-depth conceptual exploration of this phenomenon had not been undertaken in a stroke rehabilitation setting before; and b) that the

conceptualisation of the therapeutic relationship in stroke rehabilitation may not necessarily be confined to those constructs referred to in Bordin's theory of working alliance. As such, I wanted to remain open to the possibility of uncovering important concepts that may or may not be congruent with 'therapeutic alliance' as it is currently understood. Therefore, the broader phrase of 'therapeutic relationship' was adopted during the interviews and will be used throughout *Chapter 4: Findings* and *Chapter 5: Discussion*.

All interviews were audiotaped and transcribed verbatim, with the exception of the final client interview as this audio-file became corrupted during computer upload. For this interview, a report recalling as much detail as possible was completed that evening. Field notes accompanied all data collection episodes to capture key points and non-verbal information such as strong facial expressions and gestures, in order to support concept-context links.

### **3.2.3 Data preparation and analysis**

Prior to data analysis, there was a need to gain an overall perspective of each participant's views, rather than simply identifying and collating numerous discrete data units (Thorne, 2008). To this end, once each transcript was transcribed, preliminary macro-analysis occurred by proofing the transcripts against the audiotaped interviews and repeated re-immersion into the data.

A reflective summary of distinguishing points, interview barriers and facilitators, and an action plan was completed following each interview to provide a coherent overview and superficial interpretation (see Appendix F for an example of this summary). This promoted a responsive interaction between data collection and analysis, in line with recommendations by Thorne et al. (1997) and Hunt (2009), and informed the augmentation of the preliminary interview guide for subsequent interviews. For example, when a client participant emphasised the value of involving their loved one in their alliances with clinicians, or experienced an in-depth, friendship-like relationship with a clinician, future interviews sought other participants' views to clarify, validate or challenge these notions. A copy of a Revised Interview Guide is provided in Appendix G.

Following the clinician focus group interview, clinician perspectives of important therapeutic alliance constituents were also incorporated into future client participant interviews. An illustration of this is the benefits proposed by a couple of clinician participants of spending time developing a rapport with a new client on the rehabilitation ward *before* commencing formalised assessments and treatments. Several client participants were then questioned around their perceptions of this, such as: “when you arrive on the rehabilitation ward, what do you think is the right balance between clinicians initially spending time getting to know you as a person, versus commencing assessments and treatments?” The purpose of this was to broaden potential conceptual connections (Thorne et al., 2004).

### **3.2.3.1 Identifying and managing relevant data**

Despite orientating client participants and their family/whānau to the aims and context of the study, at times the views were provided by family; or related to client experiences in a different health setting (such as the acute ward); or with staff other than nurses and therapists; or with the technical/process aspects of rehabilitation. This may reflect some of the challenges associated with striving to compartmentalise a client’s rehabilitation experiences, especially in the presence of stroke-related difficulties.

Data derived from family/whānau was separated out during the coding process and was only included in analysis if the client participant had verbally or non-verbally indicated that they shared these views. This approach was taken as this study specifically sought clinician and client perceptions of the therapeutic alliance (and not family/whānau views). As alliance research in stroke rehabilitation is in its infancy, this study focused its attention and resources on exploring client and clinician perceptions of their alliances. Simultaneously eliciting and analysing family/whānau views – although vital in the development of our understanding of the alliance in this context – was considered to be outside the scope of this small exploratory study. However, family members attending the interviews often provided cognitive or communication support to the client, so data was incorporated that appeared to trigger or reflect the client’s own perspectives. Information relating to alliance experiences with other staff or in the acute neurological setting was still analysed, with additional contextual information provided when used as supporting evidence in the findings.

Separating out the technical or process aspects versus the relational aspects of rehabilitation proved to be more challenging. Examples included comments relating to the promotion of independence, information literacy and ecologically valid interventions. As conveyed in *Chapter 2: Literature Review* (see pages 8-9), psychotherapy researchers report that the alliance is a superordinate concept that manifests itself in - as opposed to being separate from - therapeutic technique (Hatcher & Barends, 2006). This interpretation of the alliance may go some way to explain the complexities around trying to untangle these concepts in research. Such data was managed by keeping the key focus of analysis on the phenomenon of interest (the therapeutic alliance) and through careful attention to rigour (see pages 57-59).

It is also worth noting that the majority of data was derived from the client participant interviews rather than the clinician focus group. Subsequently, the findings generated are often more reflective of the client participants' experiences of the therapeutic alliance. Attempts have been made to balance these by illustrating both parallel and discrepant clinical viewpoints in *Chapter 4: Findings*.

### **3.2.3.2 Approaches to data analysis**

Interpretive Description recommends an iterative approach to data analysis, with a focus on concurrent data collection and interpretation, and constant comparison (Hunt, 2009; Thorne et al., 2004). For the current study, structured analytical approaches included the identification and formation of codes, categories and core themes, and use of memos and diagrams. Illustrations of these techniques can be located in Appendices H – J. Each stage of data analysis involved regular collaboration with my supervisors.

#### **3.2.3.2.1 Codes, categories and memos**

Whole transcripts were reviewed and data (phrases and sentences) initially coded manually across three categories: 'key components,' 'influencing factors' and 'family views'. The first two categories directly related to the aims of this research and the final category supported the identification and management of relevant data, as described above. Wherever possible, codes remained in the participants' own words or were derived from a list of 'common codes' formed inductively. Thorne et al. (2004) advises against using pre-formed codes to ensure more accurate representation of the

data from where it was derived. Within each transcript, the categories were then examined separately and codes checked against each other and the raw data.

A 'memo' column was added alongside the categories to enable concurrent documentation of thoughts and queries triggered by the data during the coding process. It also incorporated data that did not appear to initially correspond with the existing categories, but was considered potentially valuable. Sandelowski (1995) highlights the risk of failing to re-organise the data in a more coherent way due to strict adherence to preliminary frameworks and pre-study viewpoints. Thorne et al. (2004) also recommends forming data collection procedures that challenge the immediately obvious - which may prove to be contradictory or exceptional perspectives on re-examination - in order to expand conceptual associations.

Codes were then applied to the NVivo 10 computer software package to support preliminary data organisation (*Qualitative research analysis software: NVivo10 for Windows*, 2015). Parent, child and grandchild nodes (i.e., categories) and memo links were created inductively by analysing data across participants. Nodes were regularly and critically reviewed to ensure congruence within and between them.

#### 3.2.3.2.2 Thematic development

Patterns were identified as well as themes and relationships between data sources, with initial ideas repeatedly assessed and challenged (Thorne et al., 1997). This involved continuously moving between the raw and coded data, analytical recordings and relevant literature (Thorne, 2008), alongside discussions within the research team. Multiple data sources provided triangulation and broadened the scope of the phenomenon (the therapeutic alliance) under study (Hunt, 2009, Thorne et al., 1997).

An inductive approach was used to support thematic development. This ensured that the relationships between codes, categories and themes were driven by the data. An example of this is provided in Appendix I. Diagramming, memos and written summaries were used as strategies to support the conceptualisation of key messages. An example of the use of diagramming is provided in Appendix J.

### 3.3 Ensuring rigour

Interpretive Description explicitly recognises the influence of the researcher's assumptions and practical knowledge on the research development (Hunt, 2009). For this study, attention to rigour was achieved by acknowledging and managing reflexivity, review and refinement of the interview technique, checking for robust interpretation of the data and supporting transferability.

#### 3.3.1 Acknowledging and managing reflexivity

As detailed on page 3 in *Chapter 1: Introduction*, I was mindful that I had pre-study empirical and theoretical understandings and assumptions about the therapeutic alliance concept through my clinical experiences, discussions with colleagues and academics, and through knowledge of the literature. These were acknowledged in a transcribed pre-supposition interview prior to recruitment in order to better recognise the potential for this knowledge to shape the data collection and analysis processes (Mays & Pope, 2000). A summary of my initial assumptions derived from this interview is presented in Appendix A.

One such assumption that had the potential to influence the findings was the role and impact of goals on the therapeutic alliance (for information relating to this presupposition, see *Chapter 2: Literature Review*, pages 28-30 and Appendix A). References to goals were still incorporated into the coding process, but interpretation of this concept was cautiously managed through the repeated examination of raw data, use of memos and supervisory discussions. This helped to prevent premature study closure following adherence to preliminary conceptualisations (Thorne et al., 2004).

The following two rigour-enhancing strategies outlined below also assisted in preventing my preconceptions from excessively influencing the findings.

#### 3.3.2 Review of interview technique

The interview guide was formulated in collaboration with my primary supervisor who is skilled at facilitating qualitative interviews with participants with neurological impairments. Further, a practise interview with another experienced qualitative interviewer occurred prior to data collection. Both of these experiences

provided me with valuable, independent feedback on choice of terminology and interview structure. They also highlighted strategies for guiding optimal data collection, such as redirecting participants back to the study's aims and managing family members' interjections. Copies of the first two de-identified transcripts were sent to both supervisors to seek further feedback on interview technique.

### **3.3.3 Checking for robust interpretation**

Ensuring that findings are grounded in the data is an inherent part of Interpretive Description (Thorne et al., 2004). Both supervisors supported the robust interpretation of data through:

- a) The collateral coding of two transcripts;
- b) Reviewing the NVivo-derived summary of nodes;
- c) Appraisal of the initial findings draft, which contained high levels of raw data (both supportive and potentially contradictory); and
- d) Regular critical discussions around emerging thematic development.

Provisional findings were also clarified and checked for resonance with selected and consenting participants. Member checking involved one face-to-face and one email discussion with two client participants and a group discussion with eight clinician participants. See Appendices K and L for the written and pictorial information used to facilitate these discussions, for client and clinician participants respectively. When relevant quotes from these discussions have been incorporated into the findings, it has been made explicit that these were derived during member checking.

Member checking followed the naturalistic approach of ensuring that findings resonate with the sample of participants from whom the data was derived (Guba & Lincoln, 1982; Thorne et al., 1997). It also offered another source of critical evaluation to refine and challenge the themes and characteristics of the therapeutic alliance. For instance, a client participant perceived that relating to his clinician at a human level had relevance to all aspects of the therapeutic relationship (rather than being solely based within the *personal connection* core component as initially proposed). Further discussion and debate within the research team and re-immersion back into the raw data assisted in redefining these relationship constructs.



### **3.3.4 Supporting transferability**

In order to ensure that the findings have meaning for individuals in similar situations and contexts (Mays & Pope, 2000), participant characteristics (see Tables 5 and 6, pages 69-72) and rehabilitation setting characteristics (see page 47) have been described. Purposeful and theoretical sampling produced heterogeneity in participant characteristics to further promote transferability of findings (Thorne et al., 2004).

## **3.4 Ethical considerations**

Approval to conduct this research was granted by the Auckland University of Technology Ethics Committee (see Appendix M). Ethical principles applied to this study are discussed below.

### **3.4.1 Voluntary participation**

Potential client participants were informed of the study via written and verbal information provided by a member of the clinical team not directly involved with their care. This was designed to avoid any perceived coercion and to prevent invited participants from feeling awkward if they decided not to participate. Clients had the opportunity to discuss their possible involvement with family/whānau and consider their options for a couple of days before they were re-approached. Interested client participants then signed a Consent to Provide Name Form (see Appendix D) stating that they were happy for me to contact them and arrange a time to further discuss the study and sign the consent form (for willing participants). Client participants were encouraged to bring a support person(s) to this meeting.

Potential clinician participants were informed of the study via oral presentations and poster advertisements in their workplace. Interested clinician participants had the opportunity to discuss their participation with one of my supervisors or could approach me directly, which supported voluntary participation and reduced the risk of coercion.

For all potential participants, an information sheet (see Appendices B, C and E) and verbal information outlined the following:

- a) The purpose of the study, including anticipated benefits and potential risks for people with stroke and stroke clinicians;
- b) The voluntary nature of participation, including that they may withdraw their consent at any stage (prior to the completion of data collection) without explanation and, for client participants;
- c) That their decision to participate would not compromise their access to, or provision of, rehabilitation and care.

Prior to the interviews, I once again reiterated the purpose of the study and participants' rights and clarified any further queries raised by the participants. There was no evidence throughout the study of participants feeling obliged to participate, nor any withdrawals. In fact, the majority of participants stated that they found the interviews to be a beneficial experience.

### **3.4.2 Respect for the vulnerability of some clients**

For client participants, particular care was taken to ensure that consent was informed and voluntary, especially in view of possible cognitive and communication impairments. This included ensuring that the participant had the capacity to provide informed consent, tailoring the provision of information and support to meet their needs, and seeking assent from the participant's next-of-kin (when required).

#### **3.4.2.1 Capacity to provide informed consent**

During regular discussions with the clinical team to identify potentially suitable participants, I sought and documented the rehabilitation consultant's opinion (and where applicable, the treating occupational therapist's and/or speech-language therapist's views) on a client's ability to provide informed and voluntary consent regarding study participation. Clients who did not have the capacity to consent to study participation were not recruited.

#### **3.4.2.2 Information provision and support**

A simplified information sheet was available for client participants with cognitive or communication deficits (see Appendix C). The rehabilitation ward's senior occupational therapist and speech-language therapist were involved in refining this

information sheet prior to recruitment. For each participant presenting with cognitive or communication difficulties, advice was sought from their treating occupational therapist and speech-language therapist to determine their support requirements. This included client-specific strategies to augment (where applicable) their receptive and expressive communication skills and information retention. Guidance was also sought around whether it may be beneficial to involve the speech-language therapist in the interview. The facilitation of discussions around the study's processes and the interview itself was adapted according to each participant's needs.

### **3.4.2.3 Seeking assent from next-of-kin**

For client participants with moderate to severe cognitive and/or communication difficulties (in accordance with FIM scores and information from treating clinicians), assent was obtained from a participant's next-of-kin by involving them in the recruitment and information provision processes. The next-of-kin had the opportunity to ask questions, discuss any concerns and, when applicable, agree a plan to mitigate these concerns, prior to signing the Next-of-kin Assent Form (see Appendix N).

### **3.4.3 Respect for rights of privacy and confidentiality**

Confidentiality and privacy was maintained for all client participants in accordance with the Code of Health and Disability Services Consumers' Rights (Health & Disability Commissioner, 2009). Clinician participants involved in focus groups were reminded at the start of the session to avoid, where possible, providing examples which identified specific client(s) or family/whānau. If this did inadvertently occur, clinician participants were prompted to consider their professional and workplace obligations in maintaining confidentiality and privacy by not sharing client-related information outside of the focus group. They were also encouraged to refrain from repeating participants' views and experiences outside of the focus group. In spite of these strategies, confidentiality and privacy could not be guaranteed due to the group context and, as such, this was made transparent in the information and consent processes for those clinician participants involved.

Each participant (client and clinician) was allocated a study code following which participant identifiers were removed from all data collection sources and during reporting. This was made explicit to all participants in written and oral formats.

Pseudonyms have been and will continue to be used when using participant quotes in publications or other study reports. Personal information such as consent forms have been kept separate from data and both are stored in a secure, off-site location and in password-protected computer files. After 10 years, a secure document destruction service will be used to destroy hard copies of data and computer files will be deleted.

At times, it has been necessary to share pertinent participant data and de-identified transcriptions with the rest of the research team to enhance the quality of the research process such as sampling decisions and to aid interpretation.

The data will not be used beyond the reporting of this study without ethical approval and consent from participants. Findings may be used to inform the development of clinical guidelines to enhance the quality of the therapeutic alliance between people with stroke and their clinicians. It may be that supporting quotes – with no identifiable information - will be used for training purposes and guidelines in the future.

#### **3.4.4 Minimisation of risk**

It was not anticipated that there would be high levels of discomfort arising from the interview questions. However, it was recognised that they may cause some distress for client participants who were adjusting to their new diagnosis and difficulties encountered as a result of their impairments, as well as the unfamiliar ward environment, staff and routines. It was considered unlikely that clinician participants would experience discomfort or embarrassment during the focus group.

To counter possible adverse emotional reactions, all participants were advised via the information sheet, during the initial meeting and prior to the interview/focus groups that:

- a) They did not have to answer any questions that they did not wish to;
- b) They may terminate or reschedule the interview if they experienced any detrimental effects, including emotional distress or fatigue;
- c) Free AUT counselling services were available for any participant who experienced distress as a result of taking part in this research. The use of open-ended questions allowed the participants to have some control over the direction of the interview; and

- d) Clinician participants were advised to liaise with their clinical supervisor or manager if discomfort or distress occurred.

In addition, client participants were encouraged to have family/whānau support during the interviews. None of the strategies listed above were required as there was no evidence of psychological distress or significant fatigue for any participant during the interviews.

### **3.4.5 Avoidance of conflict of interest**

As at the outset of research I worked within the rehabilitation ward where client and clinician participants were recruited, there was potential for conflicts of interest. These included the possibility of professional conflicts with prospective client participants who I was clinically treating, and social/work-place relationship conflicts with prospective clinician participants within my team.

To reduce the potential for conflicts of interest, a third party approached prospective client participants, and clients who I was treating personally were not recruited into the study. The following points reduced the possibility of a power imbalance with clinician participants:

- a) Interested clinician participants directly approached me to volunteer for the study;
- b) I held no managerial or supervisory relationships with clinicians in the rehabilitation service;
- c) Clinician participants were offered the opportunity, both in writing and verbally, to have an individual interview with another member of the research team who was not based within the clinical team, if this was preferable. None of the clinician participants requested this option.

### **3.4.6 Cultural and social sensitivities**

Biculturalism is an important aspect of New Zealand society and is based on the partnership created by the Treaty of Waitangi between indigenous Māori and the government. New Zealand health organisations, practitioners and researchers have a responsibility to adhere to the Treaty's principles in order to strive towards equitable

healthcare for Māori (Ministry of Health, 2014). In line with these principles and Te Ara Tika - the Māori Ethical Framework (Hudson, Milne, Reynolds, Russell, & Smith, n.d.), regular consultation with Māori advisors, committees and research supervisors guided the research methods and application to ensure that they were culturally sensitive and appropriate to the needs of Māori. Individuals involved in the consultation process have been acknowledged at the start of this thesis. I also attended local Tikanga Māori Research training and was granted research approval from the hospital's Māori Research Advisory Group. The following Treaty of Waitangi principles of partnership, participation and protection and their relevance to this study are discussed below.

#### **3.4.6.1 Partnership**

Partnerships were fostered through the study design, informed consent process and involvement of whānau and traditions. The qualitative design of the study and use of interviews that followed an open-ended format encouraged and recognised the importance of allowing participants to share their stories and views freely. During the focus group, facilitators ensured each participant was given adequate opportunity to share their views and guided the group process with care.

In Māori culture, the informed consent process may relate not only to the individual Māori participant, but consent may also be required from the wider community. This was managed by encouraging whānau/support person(s) attendance at our initial meeting, and/or participants being encouraged to discuss their possible study involvement with whānau/iwi/hapu prior to providing informed consent. Māori participants were made aware of the availability of Māori clinical advisors to support the provision of study information in a manner that met their cultural and information literacy needs. The study's information sheet also provided clarity regarding the potential benefits, risks and future use of data.

Participants were encouraged to invite whānau to the interviews if they wished to. There was opportunity for the sharing of a karakia prior to interview commencement as well as kai (food) at the end of the interview, dependent on participant preference. Participants and their whānau were thanked for their involvement in the study and will be provided with a summary of the study's findings.

### **3.4.6.2 Participation**

Participants contributed to the research by sharing their experiences of the therapeutic alliance, with one Māori participant having the opportunity to provide feedback around these findings to support further refinement (as part of the member checking process described above). Māori participants were encouraged to use Te Reo Māori words or concepts to facilitate their expression of views. The findings have led to clinical recommendations regarding how clinicians in stroke rehabilitation may optimally form and sustain a strong therapeutic alliance with clients from a range of backgrounds and impairments post stroke (see *Chapter 5: Discussion*).

It was anticipated that some Māori participants may defer to another member(s) of their whānau who may be a designated spokesperson for the whānau, or the participant may experience a sense of whakamā or embarrassment as a result of their stroke and vulnerabilities. These factors had the potential to limit their ability to actively contribute to the interviews. Participation was maximised by establishing a rapport and fostering trust with Māori participants and their whānau in the pre-interview meeting. My knowledge of Māori customs, beliefs and values, including whakawhanaungatanga (making a connection) guided this relationship-building process. Interviews occurred in a private room or in the participant's home and participants were reminded that the information that they provided was confidential and would only be shared with members of the research team with personal identification features removed.

### **3.4.6.3 Protection**

Māori consider the head to be tapu (sacred), which is particularly relevant following a neurological impairment such as a stroke. The body is also considered tapu during periods of ill health. I remained cognisant of this and how the effect of their stroke may have provided additional distress for Māori participants. Due to my work experience and training, I was also aware of the Te Whare Tapa Whā framework and the potential need for other dimensions of health and wellbeing to be incorporated into the interview process, for example, a Karakia to nurture the participant's spirituality. This was discussed during the initial meeting and person-specific strategies incorporated into the interview process. Throughout the research process, I remained alert and responsive to different cultural groups, beliefs and practices.

The following approaches were utilised to mitigate the potential power imbalance when working with Māori:

- a) Involvement of family/whānau was encouraged in all interactions;
- b) Participants and family/whānau had the choice over when the meetings and interviews occurred;
- c) Incorporation of cultural practices (when applicable) into the interviews;
- d) A semi-structured interview approach;
- e) Responsiveness to signs of unease, distress and/or fatigue; and
- f) The sharing of preliminary findings with participants to support the refinement process.

### 3.5 Summary

This chapter has provided an overview of the research methodology and methods selected, as well as the reasoning behind them. There has been detailed elaboration of the ethical principles that relate specifically to participants in this study. The following chapter will explore the findings derived from these procedures and methodological approach.



## Chapter 4: Findings

Two themes emerged following data analysis. The first theme, *everyone is different*, presents the core relationship components that participants seemed to value to varying degrees. These components are: *a personal connection*, *a professional collaboration* and *family/whānau collaboration*. Additional factors that appeared relevant to relationship quality are also described. Theme two, *relationship disruptions*, illustrates why some relationships appeared to deteriorate to the point of breakdown, while others survived or were even enhanced following adverse events. Both themes use data (as quotes from participants) and interpretation to convey the findings.

The chapter initially outlines the participants' characteristics, before presenting these two themes.

### 4.1 Participant characteristics

Twelve client participants were invited to participate in this study. Two declined without identifying specific reasons. Of the remaining participants, all were eligible and consented to study participation. In total, 10 individual client participant interviews were conducted. Client participant details (using pseudonyms to maintain confidentiality) are summarised in Table 5 below and presented in order of participant age. Diversity in the sample was attained in relation to demographic and stroke-related variables (see pages 47-49).

One clinician focus group was conducted. Seven clinician participants self-referred and consented to participate - their details using pseudonyms are summarised in Table 6 and presented in order of years of rehabilitation experience. Clinicians with a range of ethnicities and years of clinical experience were represented. The sample lacked representation from physiotherapists and male clinicians. These limitations will be discussed in *Chapter 5: Discussion* (page 128).

For brevity, the findings will refer to client participants as 'clients' and clinician participants as 'clinicians'. Client quotes will have their pseudonym in brackets after the

quote (e.g. Toby), while clinician quotes will have their pseudonym and discipline abbreviation (e.g. Lynn, RN).

**Table 5: Client participant characteristics**

Pseudonym	Gender	Age	Ethnicity	Type of stroke	Time post stroke <sup>5</sup> (weeks)	Primary impairments	FIM score <sup>6</sup>		
							Total /126	Motor /91	Cognitive /35
Amanda	Female	29	NZ European	Right MCA infarcts	6	Mild left sided weakness Cognitive changes - information processing, problem solving, memory	111	80	31
Toby	Male	36	NZ European	Left midbrain haemorrhage	9	Moderate-severe right sided weakness Ataxia Cognitive changes – initiation, planning, problem solving, memory Dysarthria Fatigue	71	42	29
Huia	Female	52	Māori	Right POCI	10	Ataxia Visual deficits Cognitive changes – impulsivity, impaired divided attention Fatigue	114	86	28

<sup>5</sup> Refers to the time interval between stroke onset and the interview

<sup>6</sup> Higher FIM scores (total and componentry) indicate an increased level of ability and independence

Pseudonym	Gender	Age	Ethnicity	Type of stroke	Time post stroke (weeks) <sup>5</sup>	Primary impairments	FIM score <sup>6</sup>		
							Total /126	Motor /91	Cognitive /35
Miriama	Female	55	Cook Island Māori	Right pontine haemorrhage	17	Mild-moderate left sided weakness and reduced sensation Visual changes	112	78	34
Margaret	Female	57	NZ European	Right ACA and MCA infarcts	16	Moderate-severe left sided weakness Cognitive changes - information processing, initiation, planning and sequencing, attention Fatigue	67	37	30
Masina	Female	64	Samoan	Right TACI	4	Moderate left sided weakness Cognitive changes – problem solving, planning, information processing Fatigue	78	55	23

<sup>5</sup> Refers to the time interval between stroke onset and the interview

<sup>6</sup> Higher FIM scores (total and componentry) indicate an increased level of ability and independence

Pseudonym	Gender	Age	Ethnicity	Type of stroke	Time post stroke (weeks) <sup>5</sup>	Primary impairments	FIM score <sup>6</sup>		
							Total /126	Motor /91	Cognitive /35
David	Male	66	NZ European	Left temporal lobe infarct	5	Mild expressive aphasia Cognitive changes - memory, attention, information processing	118	91	27
Andy	Male	68	NZ European	Left parietal lobe haemorrhage	20	Moderate-severe right sided weakness Cognitive changes – distractibility, tangential conversation Fatigue	91	65	34
Heke	Male	72	Māori NZ European	Left MCA infarct	8	Moderate right sided weakness Mild receptive and moderate expressive aphasia	98	70	28
Carol	Female	76	NZ European	Left lacunar infarct	3	Mild right sided weakness Dysarthria Cognitive changes – memory, information processing Fatigue	103	75	28

<sup>5</sup> Refers to the time interval between stroke onset and the interview

<sup>6</sup> Higher FIM scores (total and componentry) indicate an increased level of ability and independence

**Table 6: Clinician participant characteristics**

Pseudonym	Gender	Discipline and abbreviation	Ethnicity	Rehabilitation experience (years)	Additional healthcare experience (years)
Ngaire	Female	Registered nurse (RN)	Tongan	3	17
Kiri	Female	Social Worker (SW)	NZ Māori	4	0
Vailea	Female	Registered nurse (RN)	Samoan	6	7
Bridget	Female	Speech-language therapist (SLT)	British/European	6	1
Lynn	Female	Registered nurse (RN)	NZ European	7	30
Kerry	Female	Occupational therapist (OT)	NZ Māori	7	1
Susan	Female	Social worker (SW)	European	9	20

## 4.2 Theme one: Everyone is different

“Like most things, it's down to the individual.” (Toby)

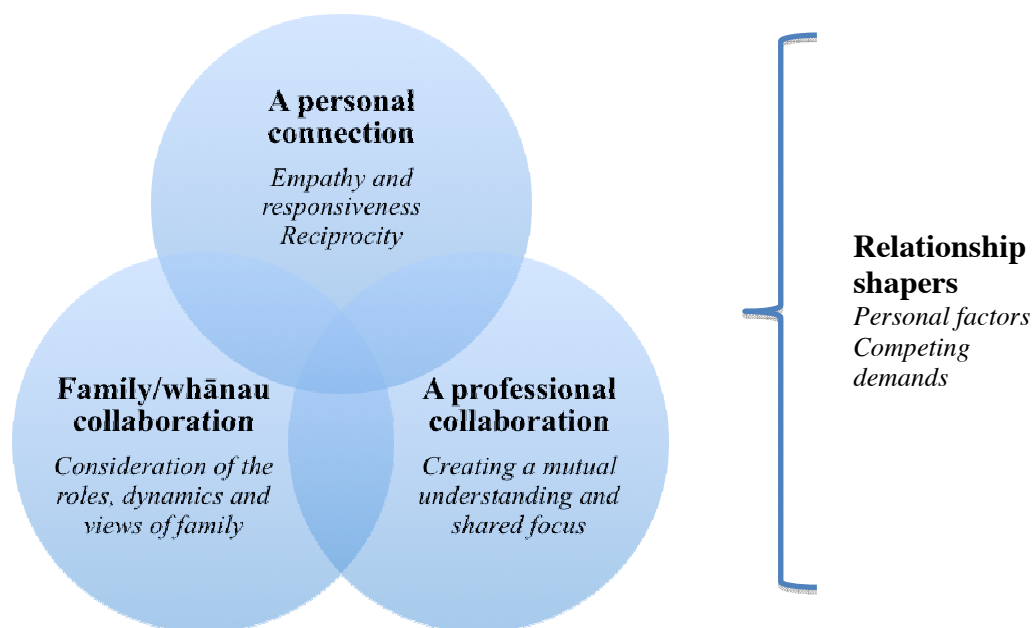
Theme one is divided into two categories. Category one presents the three core components of a strong therapeutic relationship and category two outlines factors that were perceived to shape relationship quality. Table 7 provides a structural overview of theme one.

**Table 7: Structure of theme one: Everyone is different**

Category		Questions the data prompted
Core components of a strong therapeutic relationship	A personal connection	What is the right degree of personal connection?  What is the optimal way of developing a strong personal connection?
	A professional collaboration	What is the right degree of professional collaboration?  What is the optimal way of developing a strong professional collaboration?
	Family/whānau collaboration	What is the right degree of family/whānau collaboration?  What is the optimal way of collaborating with family/whānau, while maintaining a strong therapeutic relationship with the client?
Relationship shapers		What facilitates or impedes the development of strong therapeutic relationships?

The rationale behind the use of questions to frame these findings is two-fold. Firstly, the data emphasised the importance of considering how *everyone is different* in building strong therapeutic relationships. Secondly (and as discussed in *Chapter 3: Methodology and Methods*), Interpretive Description encourages findings that are of clinical utility. The questions encourage the reader to remain cognisant of these two factors throughout the chapter.

Figure 2 depicts these combined categories. Inside each sphere are the clinical skills and personal attributes that appeared important for each component.



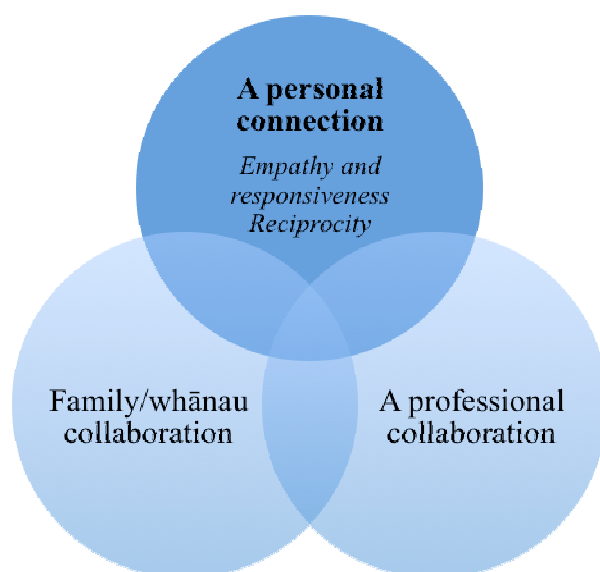
**Figure 2: Core components of a strong therapeutic relationship and relationship shapers**

#### **4.2.1 Category one: Core components of a strong therapeutic relationship**

Participants appeared to experience a strong therapeutic relationship in different ways. These experiences could be synthesised into three core relationship components: *a personal connection*, *a professional collaboration* and *family/whānau collaboration*. Participants prioritised each component differently depending on their needs and preferences. These priorities had the potential to change over time, which meant that therapeutic relationships were often dynamic and complex. Category one elaborates on each of these core components.



#### 4.2.1.1 Core component one: A personal connection



**Figure 3: A personal connection**

Connecting at a personal level appeared to be a central feature of the therapeutic relationship for some participants. Clinicians perceived that this core component was operationalised by “being yourself” (Vailea and Ngaire, RNs). Clients often expressed similar views: “It’s being real, as a human and a therapist” (David, during member checking). This seemed to help participants understand and respond to the person behind the stroke or uniform, creating an emotional co-investment in each other.

##### 4.2.1.1.1 What is the right degree of personal connection?

Some clients prioritised a connection that extended beyond what might be considered the traditional client-health professional partnership. When asked to describe a particularly strong relationship, the following clients responded:

“It was pretty like in-depth one, yeah. We were like friends.” (Margaret)

“[RN’s name] and [second RN’s name] were like family. Funny thing to say.” (Andy)

These relationships were often reported to form instantly and provided personalised interactions.

“I actually felt that she cared for me, you know? And that I was in her best interests and I weren’t just a patient, you know, that has to be done in a certain amount of time.” (Margaret)

Other clients held a more detached outlook regarding the need for a close bond: “It’s just another relationship... you can’t be **that** intimate” (Toby). Focusing on the therapeutic work itself seemed more of a priority for these participants.

“In an ideal world, I would see it working like... I guess the... physio just working out what needs to be done and just going for it. Yeah. I don’t... speaking for myself, but I don’t think you’d need to worry about who the person [client] is so much.” (Toby)

Both Toby and Heke likened the rehabilitation ward to a prison. A focus on the ‘escape’ was considered more important than connecting at a personal level.

“Because the goal of everyone should be to get out as quickly as possible. Hopefully they’ve got their own friends. Yeah. And don’t need to make friends on the inside, ’cos that’s what it’s like, it’s like a prison [laughter].” (Toby)

These findings indicate varying views around whether a personal bond is inherent or superfluous to one’s therapeutic relationship needs.

#### 4.2.1.1.2 What is the optimal way of developing a strong personal connection?

“It’s more than their professional capacity, it’s their persona.” (David, during member checking)

The data suggests that the *empathetic, responsive delivery of rehabilitation and reciprocity* supported the development of a strong personal connection. A clinician’s ability to use their personal attributes therapeutically appeared hallmarks of both approaches.

## *Empathy and responsiveness*

“At times they’ve cared for me, and **how** they care for you.” (Huia)

Empathy seemed to manifest through a clinician’s sensitivity and understanding of their client’s personal situation. In particular, clients often reported emotional turmoil after their stroke, which left them feeling vulnerable within these relationships and to the trials and tribulations of rehabilitation. Being aware of and sensitive to one’s emotional needs was often valued:

“The team were sensitive to where I was with my illness, my mental state, I think they were onto that, on the button.” (Huia)

“I knew straight away that she knew damn well what I was thinking, you know. That I hated it, I didn’t want to have a stroke, I want to go home, I want to do better, I want things to happen quickly, and things ain’t gonna happen that quickly. And that is a huge frustration...” (Andy)

Empathy towards one’s affective state had the potential to foster a sense of wellbeing, progress and relationship trust.

“It’s good to have that sense [of compassion], it gives you a sense of wellness, security with who’s looking after you, which contributes to your wellness, how well you get and how well you do.” (Huia)

Andy felt “totally at ease revealing myself” as a result of his physiotherapist’s sensitive, non-judgemental manner when he became upset. This contrasted with his reserve around another clinician, part of whose role involved counselling.

“I was...sort of standing back a little bit...maybe I thought that she [his SW] was one of the officials at Kenepuru [laughter]. That I would be on trial because of this [interaction], you know?” (Andy)

For clients like Andy, trust in their clinician’s human rather than professional qualities and intentions appeared to be a higher relationship priority. This may be particularly pertinent when reflecting on the magnitude of change following a stroke. However, clinicians recognised the challenges in reconciling their own emotive responses when interacting with distressed clients.

“...being able to sit through and hear someone kind of grieve and acknowledge what they’ve been through is actually quite hard. I think lots of people [clinicians] don’t feel comfortable with that.” (Kerry, OT)

As well as therapeutically discerning a client’s emotional state, the way a clinician responded appeared equally important. Margaret described how her physiotherapist acknowledged the anniversary of her mother’s death by releasing balloons in the hospital foyer during one of her acute re-admissions to Wellington Hospital:

“I’m thinking, ‘this is their time they’re giving up for me. Just for that’.... it was an incredibly special thing they didn’t have to do....you know they gave me that respect so I gave **them** that respect.” (Margaret)

Margaret reported this to be one of several “beautiful things” her physiotherapist did that signified care had extended beyond the call of duty. Even simple care behaviours were considered poignant, such as clinicians who spent time with clients who they weren’t specifically assigned to.

“...even if she wasn’t looking after me that night, she’d still come and see me...it was **pretty amazing**.” (Andy)

Through spontaneous and ‘non-routine’ care behaviours, these clinicians were seen to morph beyond their professional persona. For some clients, it engendered trust, respect and emotional engagement in their therapeutic relationships.

### *Reciprocity*

“She shared part of her with you” (Margaret)

Being personally vested in each other appeared to involve a degree of reciprocity. Participants discussed reciprocity in relation to the disclosure of relevant personal information and shared emotions and humour.

Huia perceived the reciprocal sharing of oneself to be an important benchmark for the quality of her relationships.

“...it’s in the kōrero [story/discussion] we share, you give a bit of yourself, somebody gives a bit of themselves, you know? And I think that’s the gauge to the relationship and the rapport and I think it’s very, very special in the healing.” (Huia)

This quote highlights the value Huia placed on her therapeutic relationships and their potential to influence her sense of wellbeing and recovery.

A clinician’s self-disclosure of personal information, such as sharing family photos and reports of weekend activities, were often perceived to dismantle expert-patient barriers and provide “confirmation that life goes on” (Andy). Some clinicians purposefully disclosed personal information to help reduce the power imbalance in particular situations.

“But there’s a definitely a shower conversation, you have to share, the person’s very vulnerable, it’s not appropriate, you-them. There’s definitely a sharing. Trying to put them at ease.” (Kerry, OT)

These findings indicate that self-disclosure may have therapeutic value beyond its use as a ‘tool’ for rapport building; it may also comfort and promote hope for some.

At times, reciprocity was reflected at an emotional level. One participant commented “it would hurt her [PT] if I were hurting” (Margaret). Another client’s bond flourished with a nurse who evidently shared his distress following an adverse experience: “[RN’s name] just couldn’t believe it, she was so upset, she was amazing.” These comments illustrate some clients’ heightened awareness of their clinician’s views and emotions as well as the value placed on complementary behavioural responses.

Shared humour was valued by many client- including Toby and Heke who earlier indicated that a strong personal connection was perhaps less relevant in their therapeutic relationships (see page 76). This illustrates the nuanced nature of these relationships, where a common personality trait like humour may sometimes foster a more appropriate personal connection than sharing other elements of one’s lives and emotions.

Humour could set the scene for the interaction ahead.

“I used to give her cheek every day... She’d come in every morning and she’d say ‘wake up’ and I’d say ‘no, you go away’ and things like that, there’s always something like that. She was just so wonderful.” (Andy)

For a number of clients, it also played an important role in lifting one’s mood.

“I needed it to be able to laugh, otherwise I would have done a lot of crying.” (Andy)

At times, reciprocity was referred to as an important constituent *and* product of a strong personal connection. This is evidenced on page 78 where Margaret’s sense of being respected fostered respect for her clinicians. A couple of clients also discussed mutuality of effort.

“...oh they’d move heaven and earth for you...I’d move heaven and earth for these people too.” (Huia)

When a strong bond existed, these clients reported going the extra mile with their therapy efforts in order to not let their clinician down.

Empathetic, responsive care and reciprocity appeared to promote emotional and behavioural synchrony for those who valued a strong personal connection. As a result, it invoked trust and respect and supported engagement in rehabilitation for some clients. It also had the potential to provide valuable rehabilitation ‘survival’ tools such as hope for the future.

### *Boundaries*

Despite the important role that empathy and self-disclosure seemed to play in promoting a strong personal connection, the need for boundaries was acknowledged by both clients and clinicians. Clinicians identified that their level of personal sharing was guided by a myriad of factors. These included their trust in the client, the situation and their experience, skill or intuition.

“...it’s not enough just to be empathetic, I have to be skilled at what I do. And that helps me maintain boundaries to a degree.” (Lynn, RN)

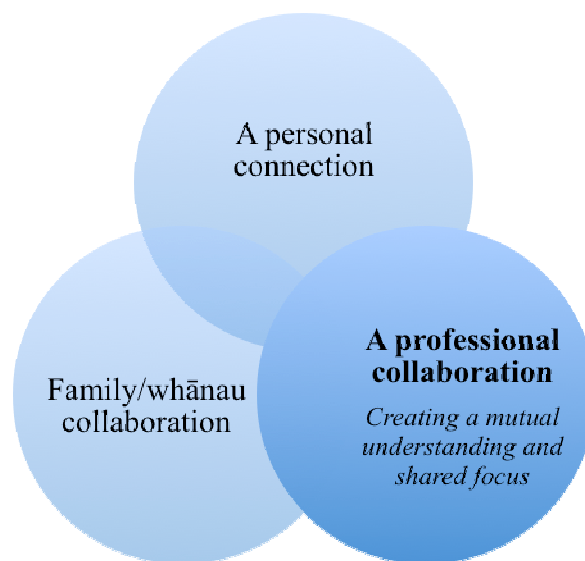
“Bridget [SLT]: It kind of becomes a bit more clear when you, when you are approaching- or hitting- that boundary, so I guess it’s a bit of an experience thing as well that you just, you get to know-  
Kerry [OT]: -your tummy tells you, you’re like ‘oh this is feeling rather uncomfortable.’”

Clients recognised that clinicians needed to manage their time between building relationships and performing clinical duties.

“Boundaries probably are still needed... If they’re going to be good nurses, if they’re going to be caring nurses and...efficient, they’ve got to draw, there’s got to be a line. They can’t spend all their time chatting to people.” (Andy)

These findings indicate a need for clinicians to balance the expression of their personal qualities and life with their professional skills and requirements. This may enable them to simultaneously foster strong therapeutic relationships, maintain personal and professional boundaries *and* deliver an effective service.

#### 4.2.1.2 Core component two: A professional collaboration



**Figure 4: A professional collaboration**

A strong professional collaboration appeared to be based on creating a *mutual understanding* of the client’s personal and clinical contexts, and striving towards a

*shared focus*. Responding to a client's preferred degree of participation in their therapeutic relationships and rehabilitation also seemed important.

#### 4.2.1.2.1 What is the right degree of professional collaboration?

Clients often held specific views around their preferred degree of power and involvement in these partnerships. Discerning these views was considered important.

“Staff have to decide individually the level each person is going to be, want to be involved [in their relationships], you can't say they're all black and white and the same.” (David)

Some favoured leading their programme with relevant guidance from clinicians.

“The physio fits in and directs and guides and suggests multiple paths and more effective paths, but it's ultimately down to the patient to... to be able to indicate.” (Toby)

“I've played a leading role, but it's only leading so far as letting them know where I'm at or what's happening; not leading in what needs to be done, they-that's their job.” (Huia)

Others preferred the experts to assume leadership responsibility.

“They'd know better than I do, they've seen hundreds of people who've strokes.” (David)

Clients and clinicians noted the influence of neurological impairments on relationship participation.

“Their ability to be involved in that relationship can be [pause] available to them at different degrees.” (Susan, SW)

Clinicians discussed utilising their skills or additional resources – such as recruiting input from families - to ensure that partnerships with severely impaired clients were both productive and personalised. *Collaborating with family/whānau* (core component three) sometimes became a focus of these therapeutic relationships and will be discussed further on pages 87-91.



There are a couple of important caveats to these findings. Firstly, clients who favoured lower levels of power still wished to have their aspirations heard and to understand the proposed therapy. This suggests a minimum level of relationship participation may be appropriate for clients, within the limits of their capabilities. Secondly, these capabilities or preferences changed for some clients over their rehabilitation period. For example, as David's confidence in his communication skills improved, so too did his perceived ability to participate in therapeutic relationships. Responding to these varying degrees of collaborative predilections for each individual and over time seemed to help maintain healthy relations.

“...certainly they make you feel valued, they listen... you might be thinking about a type of activity or therapy, and I would question it. They would **let me** question it, they would **ask** for further suggestions and it's not that the patient knows all the time because the therapist does know what group of muscles etcetera need working. But at least you are given the opportunity to air it and get it out there and it was the accepting of that.” (Huia)

#### 4.2.1.2.2 What is the optimal way of developing a strong professional collaboration?

“Get the right people with the right skills doing the right job.” (Huia)

The data indicated that three processes were conceivably required to generate a mutual understanding. These processes included listening mindfully, observing mindfully and conveying professional knowledge in a way that was easily understood. A mutual understanding had the potential to unite views and direct efforts towards a person-centred, transparent outcome.

#### *A mutual understanding*

“...and therapeutic, what is that in both worlds?” (Huia)

*Listening mindfully* often facilitated an awareness of a client's personal values, beliefs and priorities. Huia explained how she knew that her clinicians had listened intently by the way they referred back to previously disclosed personal information.

“...yes they did listen, they do know who I am. You know, I don't mind working with this lot, 'cos they listen and acknowledge and value what you have to say, it was valued that enough for them to remember it.” (Huia)

Clinicians also perceived that prioritising the time to listen encouraged a deeper understanding of their clients as people. It had the added benefit of augmenting goal-planning processes.

“...if you can just have that just general ‘get to know you’ conversation, person to person...and I think it does set the scene for what comes afterwards... and I think it can be stronger in terms of goal setting... whereas if you go and do an assessment, go out, you don’t really know an awful lot within a score, on a piece of paper, it doesn’t necessarily reflect on what the person is-who the person is.” (Bridget, SLT).

Some clients preferred the ‘listening’ to precede the ‘doing’ of rehabilitation.

“I think it would be useful [to have a discussion] at the start because it gives them a game plan.” (Huia)

Others perceived the two could occur concurrently. This was considered a valuable way of developing therapeutic relationships whilst maximising the limited resources available, so “you’re not wasting time” (Toby).

*Mindfully observing* client behaviour enabled some clinicians to select, pace and review the technical aspects of the programme. Adept clinicians were often perceived to have an awareness of a client’s emotional, cognitive and physical response to a task. Programmes and feedback could then be tailored to maximise rehabilitation potential. Toby considered this to be one of his physiotherapist’s most “attractive” relationship attributes.

“...you know where you can get away with so much, but there is a line in the sand that you don't push it beyond. Um, I think a lot, a lot of specialists could benefit from a similar sort of approach. I just think that it's a good thing to be able to hit those notes, to be able to be firm, you know, like, 'cos we naturally just as human beings, we go for the easier route, and it's better if we have somebody that just pulls us up.” (Toby)

Clients also appreciated a clinician’s awareness and responsiveness to fatigue, ill health and low mood. This included providing encouragement or a pause in active therapy. Achieving a “firm but fair” (Huia) approach seemed to require sufficient relationship duration as well as skilful observation.

“...we've been together longer, so she knows, she would prod it and I would react to this in a way.” (Toby)

These findings highlight a dynamic interaction between listening, observing and responding. Clinical skills, personal attributes and relationship factors appeared to underpin these elements. Achieving the ‘right’ clinical response had the potential to strengthen the partnership, optimise a client’s participation in therapy and promote hope.

“...she listened to me and she dealt with the problem and we did and that was ‘wow’ you know? I felt that that one time I felt I could do anything.” (Margaret)

Understanding the clinical issues and processes improved therapeutic relationship perceptions for some clients. This seemed to require *knowledge conveyance* in a way that accommodated both neurological and information literacy needs. David’s strongest therapeutic relationship was with a clinician who “has put lots of hours in helping me to understand what has been happening.” Andy experienced “absolute, total confidence” in his physiotherapist who simplistically conveyed the theory behind their rehabilitation plan.

“She was very straightforward... ‘we can do it this way’...well I can be sure now that I was going to be safe, because I knew there was someone there like [PT’s name] who wanted to help me and wanted to do it properly.” (Andy)

Andy described how her communication skills conveyed her depth of experience and helped to create an instant, powerful and trusting relationship.

Clinicians also acknowledged the importance of providing transparent information and involving clients in decision-making processes. Kiri (SW) noted that this approach, “as opposed to just going in and doing things for them...that helps the relationship with them.” Such findings infer that explanatory interventions may play an important role in augmenting understanding and developing relationship trust.

#### *A shared focus*

“...we could actually shoot for something that we could both see.” (Toby)

A mutual understanding seemed to enable technical skills and expertise to dovetail with a client's needs and preferences. For several clients, this led to the development of a person-centred rehabilitation plan and optimal relationship.

“It meant that they were listening. That's that connection. It wasn't just getting pulled out of the sky and saying 'this is the best for you, because this has what's happened to you.' No way. When you're included in the solution and are able to participate in the solution, I think that's a great thing.” (Huia)

Clinicians were aware that facilitating goal attainment could enhance the therapeutic connection.

“...when [Bridget, SLT], I know when you've got people eating again they've changed, you've had the moment and they're like...you walk in the room and they're like, 'you gave me the pie!'” (Kerry, OT).

Yet for many clients, the creation of a mutually agreed, transparent rehabilitation blueprint—rather than goal achievement itself—was enough to develop a constructive partnership.

“I have a close working relationship with both [PT's name] who's the physio and [OT's name] who's the OT... um [PT's name]'s is certainly more I would say productive, purely because it's easier to see the plan.” (Toby)

A common aim appeared to provide clients with windows of hope and tangible evidence that their clinicians were working with them to achieve what mattered most.

“[They] took me to a place where I wanted to be...and...never drew a picture particularly but in our talking of the steps that were required to get me there.” (Huia)

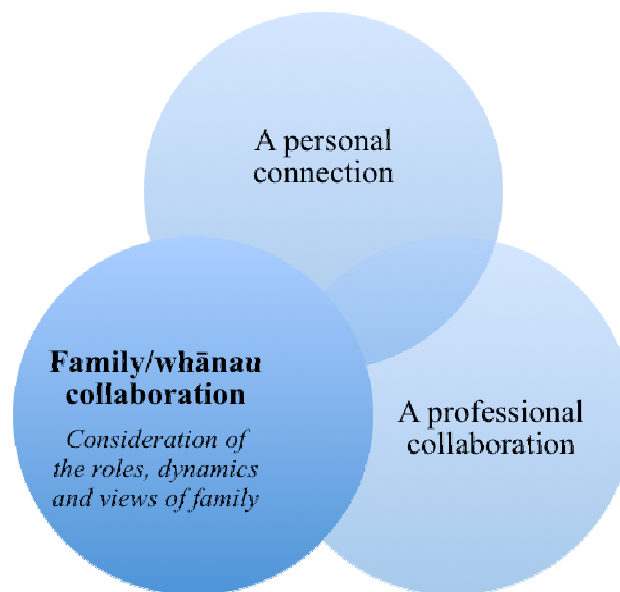
Spending time discussing rehabilitation objectives helped to align expectations. It made Andy realise that achieving his desired outcome might not occur within an inpatient relationship timeframe. Rather than quashing his hopes, he seemed to draw inspiration from this discussion. He considered it a “vital” part of his collaboration with his physiotherapist.

“It helped me in the sense that I realised that I would be able to walk again. But also, more importantly to realise **that it was going to take a long time...** yes

and if we hadn't done that then I would still have been questioning what she was saying.” (Andy)

These extracts highlight how clients wanted to have a *sense* of progress. However, the combined findings suggest that a successful professional collaboration was represented more by the groundwork put into creating a shared, person-centred focus, than necessarily achieving the end result.

#### 4.2.1.3 Core component three: Family/whānau collaboration



**Figure 5: Family/whānau collaboration**

A client's wish or need to involve family in their rehabilitation and relationships with clinicians was revealed in a wide variety of responses. In contrast, clinicians seemed to prioritise a family-centric approach due to its potential rehabilitation and therapeutic relationship benefits. *Family/whānau roles, dynamics and views* seemed to influence participants' decisions around the preferred degree and nature of this coalition.

##### 4.2.1.3.1 What is the right degree of family/whānau collaboration?

As mentioned above, clinicians described the importance of consistently engaging with relevant family/whānau.

“...it’s really important in our work with every patient...is the involvement of their really important support networks.” (Susan, SW)

Six out of the ten clients interviewed also conveyed the need to involve their family/whānau in their rehabilitation - and by extension, in their relationships with relevant clinicians. For example, Heke communicated that the involvement of his wife was the most important constituent of a strong therapeutic relationship with his clinicians, as “everything goes back to my wife.”

Forming an *exclusive* therapeutic relationship with their clinician appeared a priority for other clients. They preferred that their family/whānau remained on the sideline from these interactions.

“I am the main conduit and everything goes through me...I do know what works for me...and I know I would rather be getting the physio from the experts...so its better that they [my family] are left well alone...they are only a support team for me.” (Toby)

These comments suggest that family members still played a valuable role in Toby’s rehabilitation life, but their participation in his therapeutic relationships was perhaps unnecessary.

Family functioning appeared a mitigating factor in a couple of clients’ decisions. Miriama described excluding her whānau’s involvement in her therapeutic relationships in order to preserve their collective health: “I didn’t want to worry them...I didn’t want to be a burden.” A surprise finding here relates to Miriama’s Cook Island Māori ethnicity and the value she placed on maintaining whānau wellbeing by *not* involving them in her therapeutic relationships. As will be discussed under *Chapter 5: Discussion* (see page 113), rehabilitation research and guidelines encourage clinicians to consistently collaborate with whānau from Pacific Island and Māori cultures in order to optimise individual and whānau health. In contrast, Huia (a New Zealand Māori) emphasised the importance of a strong clinician-whānau collaboration (see page 89). These discrepant views may be explained by each participant’s sense of identity. When asked to describe a particularly strong therapeutic relationship, Huia reported the following:

“...it has been really valuable them [clinicians] being sensitive to and understanding and valuing and acknowledging Māori values and beliefs, because I am a Māori.” (Huia)

Miriama preferred to be viewed as a person first and a Cook Island Māori second. These findings re-iterate that clinicians may need to consider how *everyone is different*- even within cultural groups - before routinely collaborating with family/whānau.

#### 4.2.1.3.2 What is the optimal way of collaborating with family/whānau (while maintaining a strong therapeutic relationship with the client)?

Building optimal family/whānau collaborations seemed to require consideration of the various roles, dynamics and views of family members. These factors had the potential to impact on the clinician-client therapeutic relationship.

#### *The roles of family/whānau*

A number of participants highlighted the central role loved ones may play in a client's life, including as principal decision makers, rehabilitation partners and advocates. Identifying and involving relevant family/whānau within these roles was often perceived to be an essential component of the therapeutic relationship.

“Ask or clarify early in the piece, especially when working with Māori: ‘who are the key decision makers? Who should we speak with?’ Because in my world...they're whānau [wider family networks] and they are very key to everything.” (Huia)

Some family members were considered important rehabilitation partners who could assist with skill development and provide holistic and enduring support for the client. Susan (SW) emphasised the need to collaborate with these members, as well as with her clients.

“...**that** interaction of **that** family with **that** patient, is going to be in an ongoing way **crucial**, so our relationship with the family is also important to build.” (Susan, SW)

David reported a particularly close therapeutic relationship with his speech-language therapist, in part, due to her proactive collaboration with his wife. He evidently

had insight into his memory and communication difficulties, as well as the rehabilitation benefits of involving his wife.

“...if [wife’s name] was there and is part of the process we can talk about it together, this part of my rehabilitation I guess... the more I say things again, the more I think things again, the more I internalise them...if I didn’t have [wife’s name] that involved...it would be much more difficult for me.” (David)

Through their advocacy role and sharing of client-specific information, it appeared that family could also bring out the ‘human-factor’ for their loved ones. This seemed particularly salient for clients with marked cognitive and communication difficulties.

“...that’s where the family speak up and make a statement and they are an advocate for their relative...that’s the role of the family, they strengthen that, that kind of relationship that that patient has with us because they speak out.” (Lynn, RN)

Family advocates sometimes helped clinicians to reprioritise and build stronger *personal connections* with clients, rather than being consumed by a utilitarian approach in managing the day-to-day ward operations and processes.

Strong relationships between the team and family had the potential to improve a client’s engagement in their relationships with staff, through the delivery of consistent messages.

“...whānau also supported me to stay...so it was everybody talking to me really...so I wouldn’t rebuff against it, you know, keeping that engagement alive and trusting.” (Huia)

The above findings suggest that some family/whānau may enhance the *clinician-client professional collaboration* by helping to align views and expectations. In other situations, family may strengthen the *personal connection* dimension of the therapeutic relationship.

#### *Family/whānau dynamics and views*

The data indicates that adverse family dynamics could affect relationships within the clinician-client-family triad. Clinicians were aware that intra-family conflict



sometimes caused clients to behave differently when loved ones were around. This could influence how well a client engaged in their therapeutic relationships and rehabilitation.

“...if there are other people there who can sometimes be, you know, family who can be influencing in some way, it’s just not as straight forward because the patient themselves isn’t necessarily going to be the same because there is someone else there who either previously or currently has some impact on them and how they are, that can make a difference [to the relationship] as well.”  
(Bridget, SLT)

Prior to collaborating with families, one client suggested that clinicians explore any “uncomfortable interplay” (David, during member checking) between members. David argued that this would ensure optimal collaboration with the most relevant loved ones.

Divergent views between the team and family members of what was considered to be safe and effective practice could alter the clinician-client collaboration.

“...he [the client’s husband] was so forceful in terms of what his views were... there was a time when there was quite a risk that that was going to possibly make her unsafe and limit her progress and limit the way we could sort of work with her.” (Bridget, SLT)

In these instances, family involvement appeared to require careful management. Utilising others - such as translators, cultural advisors or other family members - was reported to be beneficial in attempting to achieve a shared focus. However, the efforts involved could take its toll on clinicians.

“In some ways it was also actually very necessary to bring other people in to help that, to help support that, because um it appeared that we were not all working in the same direction. So it sort of just dissipates, it has the risk of dissipating your energy in some ways.” (Susan, SW)

Findings in this section illuminated apparent discrepancies between clinicians’ and clients’ views on the need to regularly collaborate with family/whānau. Clients’ decisions seemed to relate to the unique role and variable influence of loved ones in their life. Clinicians appeared to consider the needs of the client from a rehabilitation or

therapeutic relationship perspective before deciding how to optimally engage with family/whānau.

## 4.2.2 Category two: Therapeutic relationship shapers

Analysis of the data revealed a number of factors that did not appear integral to strong therapeutic relationships, yet had the potential to influence their quality.

### 4.2.2.1 What facilitates or impedes the development of strong therapeutic relationships?

Factors that were seen to help or hinder the formation or maintenance of strong therapeutic relationships are outlined in Table 8 with interview extracts then presented.

**Table 8: Relationship facilitators and impediments**

Facilitators	Impediments
<i>Personal factors:</i>	<i>Personal factors:</i>
A cultural connection.	A cultural disconnection.
Receptivity to other cultures.	<i>Competing demands:</i>
Personalities.	Institutional and healthcare constraints.

#### 4.2.2.1.1 Personal factors

Working alongside clinicians from a similar cultural background automatically enhanced the therapeutic relationship for some clients. This appeared particularly relevant for New Zealand Māori and Pacific Island participants who reported a strong sense of cultural identity.

“I found a real whānau [wider family] connection, it’s more than just...and that’s just through the talk we’ve had, we’ve shared whakawhanaungatanga [process of establishing relationships], share a bit about each other, at times they’ve cared for me, and **how** they care for you. They understand taha wairoa [spiritual health] all what’s included in that square of Te Whare Tapa Whā’ [Māori Healthcare Model].” (Huia)

Huia's comments indicate that staff from similar cultural backgrounds may intuitively understand how to develop a strong *personal connection* (through the reciprocal sharing of personal information) and *professional collaboration* (a shared understanding of beliefs, values and healthcare approaches).

Conversely, working with clinicians from different cultural backgrounds negatively impacted on the perceived quality of some relationships. Several clients experienced a sense of cultural exclusion: "You're just **there**, you know, you're not one of them" (Margaret). Forging close links with these clinicians was considered more challenging, but still possible:

"But you get through that by talking about their culture, you know, talking about them. And then you become more of a person [to them]." (Margaret)

This suggests that mutual receptivity to and interest in each other's cultures may assist in overcoming these barriers and strengthen the *personal connection*.

Several clients reported using their easy-going personality to manage multiple relationships on the ward. In particular, it helped to lessen the impact of staff discontinuity (see *competing demands* below).

"...you're not allocated to the same staff member...every day...and so you got to be, get along with everyone." (Heke)

These findings infer that clients sometimes use their own personal resources to overcome perceived relationship barriers.

#### 4.2.2.1.2 Competing demands

Clinicians reported being acutely aware of changes in the healthcare environment with a perceived focus on shorter rehabilitation stays. Spending time fostering therapeutic relationships versus contributing to discharge planning processes created tension for some clinicians.

"I think that getting to know someone aspect of it and, and them knowing you a bit is...just spending that time, and I think often there's pressure to sort of get in and do your assessment and get an answer quickly." (Bridget, SLT)

The majority of clients indicated that clinicians – and in particular nurses - endure heavy caseloads and that this impacted on their therapeutic relationship quality.

“I wanted to be able to have a good sociable communicative relationship but I knew they had a job to do.” (Andy)

Nurses also raised concerns regarding the reduction in “hands-on” interaction time with their clients as a result of the changing nature of service delivery. Lack of staff continuity –again, particularly with nurses - was also perceived to impact on the establishment of strong therapeutic relationships for several clients.

“If I had a new person involved tomorrow, I would have to build up to a degree of relationship with that person that I felt confident and go ahead. So it would slow things down a little bit.” (David)

While the factors discussed above did not appear to be viewed as the core components of a strong therapeutic relationship, they seemed to potentially impact on the formation or maintenance of them. Each factor may have had an independent or interactive effect on relationship strength. Once again, these findings reflect the nuances within therapeutic relationships.

#### **4.2.3 Summary of theme one: Everyone is different**

These findings emphasised the importance of considering how *everyone is different* when building strong therapeutic relationships. Consequently, there appeared a need for relationship plasticity to accommodate each client’s unique and fluid priorities. A clinician’s ability to use their personal attributes therapeutically and professional skills flexibly seemed crucial to relationship success.

### 4.3 Theme two: Relationship disruptions

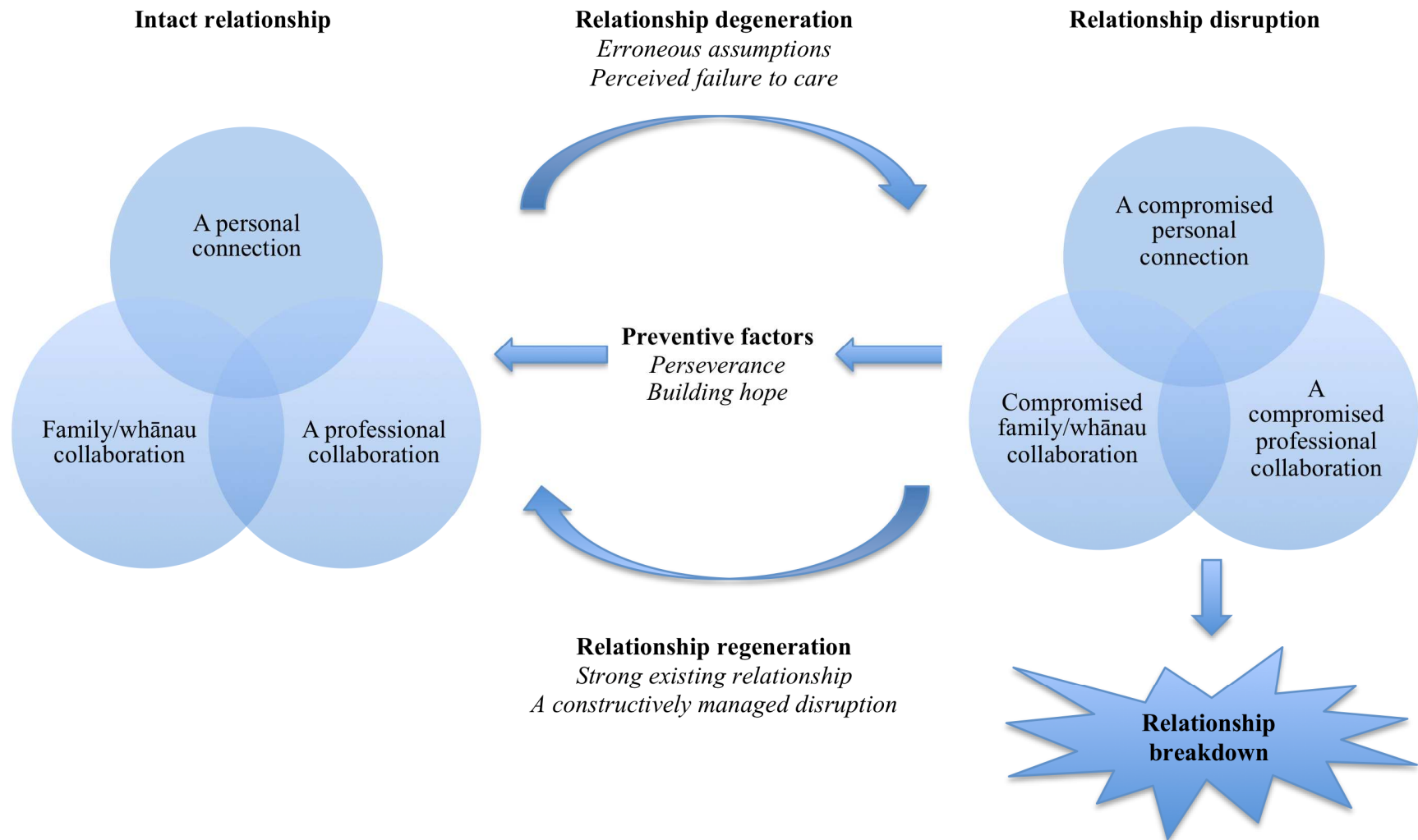
On occasion, participants struggled to form or maintain positive therapeutic relationships. Findings suggested that erroneous assumptions or a perceived lack of responsiveness to one's needs could lead to a relationship disruption. The outcomes of these varied. Some appeared to result in a relationship breakdown where the client disengaged from their relationship or care, and seemed to suffer emotionally. Other relationships appeared to be able to withstand relationship disruptions, or were even enhanced following these.

This theme presents findings relating to therapeutic relationship disruptions under the following categories (see Table 9):

**Table 9: Structure of theme two: Relationship disruptions**

Category
Manifestations and (mis)interpretations
Contributing factors
Preventive factors
Outcomes

Figure 6 represents the proposed factors leading to the degeneration and potential regeneration of therapeutic relationships.



**Figure 6: Diagrammatic representation showing the proposed degeneration and regeneration of therapeutic relationships**

### 4.3.1 Category one: Manifestations and (mis)interpretations

Analysis of the data highlighted few examples of challenging relationships reported by clinicians. In comparison, more than half of the clients conveyed specific or cumulative experiences that led to a marked deterioration in at least one therapeutic relationship. These relationship disruptions were characterised in different ways. For example, two clients recalled an overt confrontation with a clinician.

“...the blow up...that was at the end of a number of sessions where I had, you know, tried, I basically just said ‘yeah yeah yeah yeah yeah’ and, but in my head I was thinking this: ‘What is the point of this?’... And, so, when I blew up, I basically, and challenged the plan, I was at the end of my tether anyway.”  
(Toby)

In these situations, the treating clinician may have been fully aware that a relationship disruption had occurred. In contrast, the remaining client participants described their weakening relations by their adverse but potentially suppressed emotional reactions.

“...it’s hurt my feelings... I didn’t say anything, but is to me I’m **nearly** saying something to her.” (Masina)

Some clinicians appeared to be tuned into these subtle expressions of relationship dissatisfaction. One nurse identified a client’s reluctance to engage in some relationships by her non-verbal signs.

“The others [clinicians] she used to roll her eyes at... and pretend to be asleep.”  
(Vailea, RN)

Other clinicians seemed less observant or rationalised such behaviour in different ways. For example, Huia’s clinicians assumed that she was depressed following a period of disengagement from her rehabilitation and relationships.

“Because I was in my room, you know in darkness, ‘I was getting depressed not socialising’” [Huia uses a speech marks gesture as if indicating that others felt that she was becoming depressed].

Huia explained that her frustration with some clinicians related to their insistence that she participate in a social rehabilitation situation, which would have compromised her Māori values and beliefs. Her experience outlines the potential for clinicians to attribute 'resistant' or 'disengaged' behaviour to non-relationship factors. This creates a risk that the underlying relationship issue may not be addressed if team efforts are directed towards managing an assumed client 'problem'.

### **4.3.2 Category two: Contributing factors**

Two main factors appeared to contribute to relationship atrophy. These included erroneous assumptions and/or a perceived lack of responsiveness to one's needs and preferences. These factors had the potential to impact on the integrity of the core components of a strong therapeutic relationship (as outlined in Theme One) and are detailed under each of these below.

#### **4.3.2.1 A compromised personal connection**

Occasionally clinicians seemed to incorrectly judge a client's preferred level of personal connection, or failed to fully connect at a personal level with those who valued it. An example of the former case is Carol's recollection of a clinician who disclosed superfluous personal details.

“Carol: I'm not very keen on [RN's name] but she's meant well. Talks too much [laughter].

*Interviewer: Ok...how does this impact on you, her talking a bit much?*

Carol: Like, 'get on with the job someone, get to do.' She... told us her age and told us this and that...it's unnecessary, I felt.”

Other clients reported similar sentiments. One of Heke's clinicians shared a lengthy story about her dog, potentially at the expense of delivering care.

“...you could see with her that she was more looking in the mirror at herself...and nothing with my requirements were met there.” (Heke)



Carol and Heke seemed to favour the *professional collaboration* aspect of their relationships. Their clinicians may have compromised the therapeutic relationships by incorrectly assuming the need to develop a close personal bond. Alternatively, the type and level of information disclosed may have detracted from, rather than enhanced, the personal connection.

Some clients experienced an emotional division with a clinician when the personal connection was not nurtured. Margaret felt more like a “stroke victim” than a human and Andy declared one nurse “a nasty, vicious person” when there was a perceived paucity of interest in their wellbeing and needs.

“I ring the bell probably an hour or so after and she came in and stood there and stared at me: ‘Yes?’ [demanding, gruff tone] like that. It absolutely terrified me...I muttered ‘I need a bottle’ and it was though I had demanded the crown jewels!” (Andy)

When recounting these types of experiences, clients frequently insinuated that their clinician had failed to respond to them as sentient beings. Sometimes this feeling resulted from a lack of empathy or responsiveness in the delivery of care. At other times, a clinician was seen to have deficiencies in qualities that may support a personal connection, including the sharing of personal information or humour for those who benefited from it.

“...for most people it's having a bit of a joke, having a bit of a laugh, you know, and if they don't want to, on a consistent basis then, you know, we're probably going to have some problems.” (Toby)

A personal connection appeared to be jeopardised by some clinicians who were perhaps less attuned to or unable to calibrate their approach to meet their client’s relationship and emotional needs.

#### **4.3.2.2 A compromised professional collaboration**

Professional collaborations sometimes suffered when there was a lack of mutual understanding, as outlined by Huia’s experience on pages 97-98. Assumed versus actual agreement around the preferred degree of collaboration or rehabilitation focus could also lead to relationship friction. Toby’s “blow up” seemed to arise from a power struggle and goal conflict with one of his clinicians.

“I didn't blow up for no good reason and perhaps [PT's name] was labouring under one set of goals, one set of results, but you've got to understand I was in the process of saying ‘no, we are shifting the goal posts.’” (Toby)

Margaret recalled a disparity in desired outcomes for a washing and dressing task, as her own preferences did not seem to be accommodated.

“...they're standing there making sure you've done it all right and then if you haven't and they go ‘oh hang on you've got a crease here’ [pointing to her collar] you know? And it's like, ‘well if I was at home, I wouldn't really give a damn.’ You know? It's like ‘oh you've got to do this properly’ and it's like, ‘well, all my life I've worn a sarong, so there's every likelihood when I go home, I'll just have a bit of material around me.’” (Margaret)

Margaret suspected that these clinicians were adhering to pre-set performance criteria (“I actually feel like I'm passing an exam with them”) and their own ideals, which created tense interactions. Other clients also worked with clinicians who arguably failed to stop and consider their individual situation.

“If they don't listen, if they just go ahead and do things by rote anyway, you know it then, I very quickly see that, and very quickly turn off from that person.” (Toby)

Clinicians concurred, “some people just rush in and do their jobs or whatever, and that's it” (Vailea, RN). Various factors were perceived to drive this task-focussed and assumption-laden approach. These included the need for a coping strategy for managing difficult clientele and adherence to professional rules and regulations.

Clinicians reported that relationships had been compromised when another team member was perceived to insensitively crush a client's focus and hopes for the future.

“...number of times where the therapeutic kind of relationships with **all** of us would be absolutely destroyed by one comment from a medical team who would say ‘oh well it looks like you probably won't walk and you're going to go hospital level care.’” (Kerry, OT)

This suggests that tangential rehabilitation aims may occur within *and* across relationships on a rehabilitation unit. Furthermore, a differing focus in one therapeutic relationship may have repercussions for others.

### 4.3.2.3 A compromised family/whānau collaboration

The data indicated that assumptions around the role of family members endangered some therapeutic relationships. For one participant, assumptions compromised the partnership between the clinical team and the key decision makers in her whānau.

“...what’s really important when working with whānau - I can’t help but stress - is get them to find out **who** are the key decision makers ’cos that’s how it can get messy, you know? I think, what I’ve experienced is they’ve being involved but I think some assumptions were made in my case, you know? ...When there’s a number of whānau, **ask whānau**, you know? It mightn’t be the only ones that are turning up that are the key, they are only the soldiers – foot soldiers – you know what I mean?” (Huia)

Erroneous assumptions sometimes extended to the practical role of family/whānau in a client's rehabilitation programme. Masina experienced this when she sought assistance to transfer into bed one evening.

“...she [the RN] said ‘why didn’t you ask your family to put you on the bed?’ But...it’s hurt my feelings eh? Oh, that’s not my...family’s job. They just come and visit, eh? And then they go home. But the nurses who are working here, that’s their job, to put the patients to bed.” (Masina)

This particular nurse may not have effectively collaborated with Masina and her whānau to clarify these expectations. The above findings infer that family/whānau role confusion may also lead to disharmonious relations.

### 4.3.3 Category three: Preventive factors

Perseverance and building hope seemed to protect some relationships from breaking down completely. For example, clinicians were cognisant of the capricious nature of some therapeutic relationships and the need to persevere through the highs and the lows.

“...being able to hang on in there, maintain that relationship, know that things may change for that person and that because they were um quite dismissive or whatever in week one and two doesn’t necessarily mean to say that in week three or four that their reaction is going to be the same.” (Susan, SW)

The resilience of some clients to fluctuations in relationship quality between different team members is also noteworthy. A couple of clients had considered the option of terminating less satisfactory partnerships but recognised the value in persevering. These clients were often focused on the bigger picture.

“...if I was a different sort of person, I’d be going ‘nah,’ you know, ‘on your bike’. But I do know that those things have to be done to get where I want to go.” (Margaret)

Sometimes clients tolerated single relationship transgressions, particularly if they viewed these as being out of character for a clinician with whom they shared a relatively strong therapeutic relationship.

*“Interviewer: OK, and so you said, you know, I can understand it hurt your feelings a bit when the nurse said that last week, did that impact on how you viewed your relationship with the nurse? Did it make you feel any differently towards her?”*

Masina: Umm no, but she’s a good one. But that’s the only time she can say to me about that. But all the times since I’ve been here, she’s a good one.”

Other clients perceived that they possessed the skills and personal attributes required to optimise each relationship.

“I could say ‘look, I don't want you [referring to his OT] anymore, I want someone else to work with me’ but I haven't and I think I know what I want out of both of my... well, out of both of my physios [referring to his OT and PT].” (Toby)

These participants reported having at least *one* strong therapeutic relationship, so could perhaps endure others that were less robust or valued.

Another perceived protective factor against relationship breakdowns involved building hope. This seemed particularly important for clients whose prognosis was considered sub-optimal.

“...let’s talk about the small things or the things that we want to work on this week or...so that’s what kind of keeps those one’s going, builds on that relationship that are quite doom and gloom.” (Kerry, OT)

This suggests that developing a *shared focus* may help to resuscitate ailing relationships.

#### **4.3.4 Category four: Outcomes**

A surprise finding was that not all relationship disruptions appeared detrimental. The underlying strength of the relationship and how well fractured relations were managed had the potential to influence relationship outcome following a disruption. This category presents situations that exemplify both positive and negative consequences after a relationship disruption.

##### **4.3.4.1 Negative outcomes**

Following a relationship disruption, the data suggests that some clients experienced a relationship breakdown whereby they terminated their relationship, actively distanced themselves physically or emotionally from their clinician, or declined therapeutic input. All relationship breakdowns appeared to adversely affect the client's mood or emotions. For example, Andy reported profound emotional ramifications following his interactions with a nurse whom he had not met before (see page 99): "I was terrified, you know I am still frightened of that woman." He also indicated that she – or anyone else – failed to explain or repair their damaged relations: "I did see her sometimes again, but always, always she walked past and she never apologised, ever." Consequently, he ended his relationship with her by seeking her removal from his case.

Andy's experience has similarities to that of Heke's who felt "bloody pissed off" with a newly allocated nurse who did not return to shower him as agreed. Heke also indicated that he did not wish to work with this nurse again. Both of these breakdowns occurred when the therapeutic relationship was in its infancy. This suggests that some new relationships may have insufficient foundations (or unfulfilled core components) to withstand such transgressions. In these examples, the rationale for and subsequent management of each nurse's behaviour appeared absent, which may also have affected outcomes.

Several clients disengaged from their relationship as a coping strategy when viewpoints deviated and the rapport degenerated: "You can do what I did which is just switch off and just do what they say" (Toby). Others, such as Margaret, declined input

based on her lack of understanding of a proposed procedure and impaired trust in her clinician.

“...where I was saying about the injections they says ‘oh we’re going to put in a PICC [peripherally inserted central catheter] line.’ Well that scared the hell out of me just the word! And I was like, ‘eh?! No you’re not putting in one of those!’ And then I found out that I should of, which of course made me feel pretty ‘oh [looks dejected] maybe I should of.’” (Margaret)

Such experiences may affect the quality and sustainability of a therapeutic relationship and also lead to a sub-standard delivery of care.

#### **4.3.4.2 Positive outcomes**

Connections could be preserved and even strengthened if a relationship disruption was therapeutically managed *and* coexisted with a robust relationship, as Toby experienced.

*“Interviewer: So how would you have described your relationship with [PT’s name] before the blow up?”*

Toby: I would say it was strong.

*Interviewer: And then since the blow up, has it changed?”*

Toby: It is even stronger.

*Interviewer: It's even stronger. So sometimes you need these ruptures-?”*

Toby: -yeah, certainly. I mean I didn't I didn't blow up for no good reason...but I mean, yeah, in the end, we got there and it's better.”

Toby reported an instant connection with this physiotherapist and had worked consistently with her for several months before the “blow up” occurred. His respect for her knowledge and experience was evident, all of which may have created a safe platform for him to vent his frustrations.

The management of Toby’s altercation with his physiotherapist appeared to pave the way for a more collaborative relationship. Realigning the power balance and the co-

creation of a more detailed and effective rehabilitation focus appeared to have multiple benefits.

“I think in the process of doing that...I would say we'd go, OK well I can say what I want and it's going to be listened to...all I wanted to do was make sure that we are on the same page and we're working together in the same way and the next day I just felt a little bit more empowered.” (Toby)

However, these benefits did not seem to affect his perceived progress:

*“Interviewer: And what difference has that actually had on your rehabilitation and progress and so forth?”*

Toby: Well, I mean, I don't suddenly start seeing better results.”

This infers that some clients value and benefit from a strong or strengthened therapeutic relationship even in the absence of obvious functional improvement.

#### **4.3.5 Summary of theme two: Relationship disruptions**

Relationships appeared to falter as a result of incorrect assumptions and/or a clinician's perceived lack of personalised response to a client's needs. Both party's efforts and abilities to achieve relationship congruence *or* tolerate incongruence may have influenced outcomes. A strong therapeutic relationship appeared to provide a foundation to enable conflict to be constructively addressed, which could ultimately preserve and strengthen this connection.

#### **4.4 The combined findings**

This chapter aimed to shed light on the research questions under review:

- a) What are perceived to be the core components of a positive therapeutic alliance in stroke rehabilitation by people with stroke and their clinicians?
- b) What factors are perceived to influence the development of a strong therapeutic alliance?

Table 10 presents a summarised response to these questions by synthesising key findings from themes one and two. It illustrates the core relationship components and factors that were perceived to enhance or detract from these.

The following chapter (*Chapter 5: Discussion*) will evaluate key findings within the context of relevant research and discuss the clinical implications of these findings.



**Table 10: Summary of combined findings**

Core relationship components	Relationship enhancers	Relationship detractors
	<i>Processes: Attunement and responsiveness</i>	<i>Processes: Erroneous assumptions and a perceived lack of responsiveness</i>
A personal connection	<p>A compatible degree of emotional connection</p> <p>Rehabilitation delivery: Empathetic and responsive</p> <p>Appropriate reciprocity: Self-disclosure, humour and shared emotions</p>	<p>An incompatible degree of connection</p> <p>Rehabilitation delivery: Lack of empathy and responsiveness</p> <p>Inappropriate self-disclosure or insufficient humour</p>
A professional collaboration	<p>Suitable levels of power and collaboration</p> <p>A mutual understanding</p> <p>A shared focus</p>	<p>Unsuitable levels of power and collaboration</p> <p>A lack of mutual understanding</p> <p>Divergent aims or a task focussed approach</p>
Family/whānau collaboration	<p>The right degree of collaboration</p> <p>Clarity around the role of family</p> <p>Consideration of family dynamics and views</p>	<p>An unsuitable degree of collaboration</p> <p>Role confusion</p>

## Chapter 5: Discussion

The purpose of this research was to identify and explore the core components of a strong therapeutic alliance, and the factors perceived to influence its development within an inpatient stroke rehabilitation context. Two themes surfaced from the interviews of clients with stroke and members of the clinical team. The first theme, *everyone is different*, proposed three core relationship components that client participants valued to varying degrees. It outlined the attributes and skills that appeared to optimise each component and additional factors that were seen to impact on relationship development. The second theme, *relationship disruptions*, suggested that erroneous assumptions or a perceived lack of clinical responsiveness contributed to relationship disruptions. The strength of the pre-existing relationship and the repair process appeared to impact on whether these relationships deteriorated to the point of breakdown, or recovered.

Many interesting findings emerged from this study. This chapter will focus on three key findings with specific attention paid to what this study adds and how it challenges previous understandings of the therapeutic alliance. Considerations for clinical practice are highlighted within each discussion point and collated towards the end of the chapter. The final sections convey the study's limitations, propose suggestions for future research and draw conclusions.

### 5.1 Developing strong therapeutic relationships

The participants' diverse perceptions of a strong therapeutic relationship were synthesised into a model (see Figure 2, page 74) consisting of the following core components: *a personal connection*, *a professional collaboration* and *family/whānau collaboration*. Each component was prioritised differently and priorities had the potential to change over time. These core components, and their contributions to the development of strong therapeutic relationships, are discussed alongside existing therapeutic alliance and brain injury rehabilitation research. In particular, comparisons are made with Bordin's theory of working alliance due to its dominance in psychotherapy and brain injury rehabilitation research (see *Chapter 2: Literature*

*Review*). The final section explores the nuances and practical implications of collaborating with family/whānau.

In line with this study's findings, an intimate or *personal connection* has been identified as an important therapeutic relationship concept in nursing and occupational therapy literature (Kirk, 2007; McGilton & Boscart, 2007; Morrison & Smith, 2013; Phillips-Salimi, Haase, & Kooken, 2012). The current study's conceptualisation of this relationship component has some similarities with Bordin's (1979) *bond* dimension. Bordin proposed that the type of bond required depends on several factors, including the client's level of vulnerability. In the present study, many client participants who expressed considerable distress and powerlessness appeared to seek and report emotional benefits from a strong personal connection with their clinician. These findings are supported by brain injury rehabilitation research demonstrating that clients with higher levels of depressive symptoms tended to form stronger alliances (Sherer et al., 2007) and the strength of a client's bond with their clinician mid-therapy was predictive of a reduction in depressive symptoms at programme end (Schönberger, Humle, et al., 2006b).

Bordin (1979) defined the *bond* dimension as the degree of alignment between the therapist and client's respective personalities. While some participants in the present study valued common personality traits such as humour, a strong *personal connection* also appeared to require clinicians and clients to enter into one another's personal worlds and connect at a human level. These concepts are less evident in Bordin's definition. Also specific to this study, a strong *personal connection* sometimes appeared to play an important role in influencing rehabilitation engagement and perceptions of recovery - as well as supporting one's emotional adjustment. These findings contribute new knowledge around how clinicians may actively enhance the personal connection (beyond relying on similar personality traits as Bordin's definition would imply) and the range of potential benefits that a strong personal connection may yield in stroke rehabilitation.

Understanding what mattered most to each person - including one's values, expectations, hopes and participation preferences - appeared to scaffold a strong *professional collaboration*. When personal and clinical information was discussed and integrated, a shared focus for the future could be co-created. Interestingly, this focus did not necessarily need to be *achievable* as many client participants were aware that

realising their hopes and goals might not occur within the inpatient stay (if at all). However, they spoke highly of clinicians who explicitly discussed a pathway and adapted their approach to work towards their hopes and goals. Other stroke rehabilitation researchers report that clients often hold broad goals that are blurred with their hopes and have no defined end-point (Bendz, 2003; Brown et al., 2014), but require a process to act on these (Bright, Kayes, McCann, & McPherson, 2011). Further, health professionals may be an important source of hope (Bright et al., 2011). In view of these combined findings, clinicians may need to be mindful of incorporating each client's hopes into goal setting processes to validate these hopes, direct efforts towards them and strengthen the therapeutic relationship.

Although a transparent rehabilitation plan appeared to be one output of a strong *professional collaboration*, this core component differs from Bordin's (1979) *tasks* and *goals* dimensions. Bordin reported that the type of goals and tasks are determined by the 'mode' of psychotherapy. For example, behaviour therapy often requires concrete goals around modifying a specific aspect of a client's life, whereas psychoanalytic therapy encompasses broad treatment aims around identifying and changing the client's contributions to their negative emotions and experiences (Bordin, 1979). In comparison, the present study suggested that relationship quality was enhanced when the type, specificity and purpose of goals (and tasks) were differentiated according to what was meaningful for each person, rather than what was required purely from a technical perspective. Again, it highlights that Bordin's model may not cover all aspects of this component that appear to be important within the stroke rehabilitation context.

This research proposed that *family/whānau collaborations* were sometimes an essential element of therapeutic relationships. Participants often viewed family/whānau as key decision makers, advocates and rehabilitation partners, so preferred that their therapeutic relationships incorporated relevant loved ones. In turn, loved ones had the potential to strengthen the client's *personal connection* or *professional collaboration* with clinicians. This core component is notably absent from Bordin's theory of working alliance. Other psychotherapy researchers categorise the family system as an extra-therapeutic factor (Leibert et al., 2011), where this research identified them as potentially a core and indeed, significant factor *within* therapeutic relationships. These different conceptualisations of the alliance may be explained by the unique needs of the population and context. For example, a family-centred approach is considered to be

important in stroke rehabilitation (see page 114) but may be less pertinent in certain counselling-based interactions. It is also possible that the current findings reflect the importance many New Zealanders (and in particular, Māori and Pacific Islanders) place on family connectedness (see page 113).

The adherence to Bordin's (1979) dyadic model in psychotherapy may be perpetuated by the paucity of studies exploring clients' alliance priorities. It is plausible that some clients receiving psychotherapy may also value or require family involvement in their alliances. A primary finding from one study was the excessive emphasis that psychotherapists and mental health workers placed on their therapeutic relationships with the client (Furlong, 2008). By generally viewing their clients as autonomous beings - as opposed to interdependent, relational entities - these therapists appeared to pay limited attention to the family system's role in supporting client wellbeing (Furlong, 2008). The present study's novel suggestion that some therapeutic relationship boundaries may need to expand and include relevant family members could be applied to health genres outside of stroke rehabilitation. For example, it may also have relevance in intellectual disability services, as family of adults with severe intellectual disability have been observed to enhance the quality and frequency of successful interactions between their loved ones and paid workers by sharing effective communication strategies and pertinent history (H. Johnson, Douglas, Bigby, & Iacono, 2012).

Interestingly, some client participants preferred limited family involvement in their therapeutic relationships. That participants valued the *family/whānau collaboration* component (and other core components) to varying degrees inferred that an optimal therapeutic relationship did not necessarily require *all* components to be strong, but rather, each component emphasised according to the person's priorities. These priorities could change over time, indicating a need for *relationship plasticity* within and between clients. In contrast, Bordin (1979) suggested that a robust alliance requires each dimension to be strong in order to support the work of therapy. His theory appears to be based on the assumption that a therapist-directed approach is required to develop strong alliances, which may be influenced by his conception of a client-centred therapeutic approach:

“the very ideology of client-centred therapy tends to mute the responsibilities of the therapist and highlight those of the patient.” (Bordin, 1979, p. 255)

Interpretation of the current study's findings indicate that rather than assume, a key responsibility for clinicians was to consider (and regularly review) each client's relationship needs and preferences first and adapt *how* they worked with each individual and potentially their family/whānau. This is consistent with Leplege et al.'s (2007) view of person-centredness as an individualised and holistic approach that acknowledges variability within and between individuals. Contextualising the 'right' therapeutic relationship appeared to require an accurate appraisal of each person and each situation, so that clinicians could tailor their personal resources and clinical skills accordingly. Such skills seemed to extend beyond technical abilities to include inter-personal and emotional competencies (McCormack, Karlsson, Dewing, & Lerdal, 2010).

### **5.1.1 Practice implications**

There is a lack of clarity in rehabilitation research around how clinicians might follow a person-centred *and* family/whānau-centred approach to developing strong therapeutic relationships. Instead, studies have concentrated on the team-family (rather than team-client-family) partnership and recommend that clinicians share decision-making, knowledge and expertise with family (Foster et al., 2012; McLaughlin & Carey, 1993; Sohlberg, McLaughlin, Todis, Larsen, & Glang, 2001; Visser-Meily et al., 2006). The present study's unique promotion of the client's perspectives of family/whānau involvement in their therapeutic relationships and rehabilitation raised some interesting points for clinicians to consider prior to routinely engaging with significant others. Due to the potential complexities associated with client-clinician-family/whānau relationships, these practice implications specifically focus on this aspect of therapeutic relationship development.

#### **5.1.1.1 Understanding the client's priorities: New contributions to research**

Prior to discussing its similarities with family-based rehabilitation research, this section first outlines how this thesis broadens this knowledge base. Exploring the factors that underpinned each client participant's preferred level of family involvement appeared important in the present study. These preferences were individual, nuanced and sometimes seemed to differ from what stereotypical assumptions might be. For clinicians working in this setting, gleaning this information may enable them to adjust their relationship-building approach to enhance or protect family functioning and

wellbeing, optimise the decisional and rehabilitation support that family offer the client, and strengthen the clinician-client relationship.

Maintaining family/whānau wellbeing and functioning appeared to influence several client participants' therapeutic relationship priorities. In certain cultures, functioning as a family collective is an inherent part of everyone's identity and wellbeing (Foster et al., 2012; Liu et al., 2005; Phillips-Salimi et al., 2012). New Zealand-based health policies and rehabilitation guidelines refer to the concept of 'whānau ora' (family wellbeing), which emphasises the importance of engaging with the family of Māori and Pacific Island healthcare recipients (Ministry of Health, 2014a, 2014b). Two clients of Māori ethnicity in the current study prioritised the team's involvement of the key decision makers within their whānau to enhance their collective health. Several client participants of other ethnicities also placed a high value on maintaining family health by involving loved ones in their therapeutic relationships as decision makers and rehabilitation partners. This suggests that the whānau ora concept may be applicable across cultures. It also complements C. C. Evans et al.'s (2008) finding that stronger team-client alliances were significantly correlated with higher levels of family functioning.

Interestingly, one Cook Island Māori client preferred to exclude her whānau from her therapeutic relationships in order to *preserve* whānau wellbeing. Other researchers have assessed associations between family functioning and alliance quality but have done so from the perspective of family members (C. C. Evans et al., 2008; Sherer et al., 2007) or the client's psychologist (McLaughlin & Carey, 1993). These processes appeared to render the client a passive bystander, rather than a valued commentator and potential influencer, of family dynamics and function. The present findings highlight the need for clinicians to explore how one's cultural identity, values and intimate knowledge of family/whānau functioning may contribute to their relationship needs in different ways.

Other client participants preferred to limit family involvement in order to retain sole control of their therapeutic relationships. Therefore, clinicians may be prudent to clarify with every client whether there is a key person(s) whom they wish to involve in their therapeutic relationships and in what capacity, rather than make assumptions around these priorities. Allowing the client to decide whether a therapeutic relationship needs to be co-constructed with important others may ultimately enhance the

relationship (see *Chapter 4: Findings*, page 90) and enable clinicians to ration and prioritise their resources accordingly.

### **5.1.1.2 The potential benefits and risks of collaborating with family**

As well as their potential to augment the clinician-client therapeutic relationship, collaborating with family may also enhance rehabilitation outcomes. Clinician participants in this study and rehabilitation researchers advocate for a family-centric approach as stroke is considered a family disease or illness (Brocklehurst, Morris, Andrews, Richards, & Laycock, 1981; Clark & Smith, 1999; Visser-Meily et al., 2006), and loved ones often play a role in supporting a client's behaviour and adjustment post stroke (R. L. Evans et al., 1988; McMillan & Sparkes, 1999). Family-related variables also have the potential to impact on the client's rehabilitation engagement (see *Chapter 2: Literature Review*, page 40). These holistic benefits infer that there may be valid reasons for involving families in therapeutic relationships and rehabilitation that add to – or potentially conflict with – the client's preferences.

On the other hand, some family/whānau collaborations in the present study were perceived to undermine the client's engagement in their therapeutic relationships, or impact on their progress and safety. Reasons for these sub-optimal partnerships related to possible intra-family dysfunction and divergent expectations around the process or goals of therapy. Other studies report that family discord (C. C. Evans et al., 2008; Lefebvre, Pelchat, Swaine, Gélinais, & Levert, 2005; McLaughlin & Carey, 1993; Sherer et al., 2007) and/or a family member's unrealistic expectations of rehabilitation outcomes (Lefebvre et al., 2005; Levack, Siegert, Dean, & McPherson, 2009; McLaughlin & Carey, 1993) could hinder the clinician-client or family-team working relationship.

As detailed on page 41 in *Chapter 2: Literature Review*, few strategies have been proposed around how to optimally collaborate with family in these situations. Clinician participants in this study discussed using external supports (such as translators or cultural advisors) to try and align understandings and expectations. One client participant inferred that clinicians could refrain from collaborating with certain members who contribute to intra-family tension. Clinicians in other studies sometimes excluded family members from goal planning processes when goals diverged (Levack et al., 2009) or avoided interacting with 'demanding' relatives (Lindhardt, Hallberg, &



Poulsen, 2008). Restricting family participation contrasts with the benefits of a systemic rehabilitation approach as discussed above.

Perhaps when clients prefer limited family involvement or where an adversarial family-team alliance risks compromising client safety or progress, clients and clinicians may need to determine the relationship and service delivery parameters. In these situations it may still be relevant or even essential to form an independent partnership with these family members to support their adjustment and ultimately, to enhance client wellbeing. Clearly, this is an area of complexity requiring further exploration (see page 131 of this chapter).

## 5.2 Detecting and managing relationship disruptions

More than half of the client participants experienced at least one relationship disruption in this study. These were perceived to stem from a clinician's incorrect assumptions or lack of responsiveness to their relationship and rehabilitation needs. The outcome of disruptions varied; some appeared to result in a relationship breakdown which adversely affected the client's emotions and continued engagement in their relationship or care, while other relationships recovered. This section focuses on detecting and managing relationship disruptions in order to restore relationship health.

The findings indicated that a clinician's response (or lack of response) to a relationship disruption impacted on its perceived outcomes. Regaining relationship health appeared to require reparation of whichever core relationship component(s) had been compromised. For one participant, this involved re-negotiating power levels and goals in order to repair the compromised professional collaboration component. These findings are supported by psychotherapy research that encourages therapists to identify and address whichever relational element(s) (such as the interpersonal or task-related alliance) has ruptured (Richards, 2011; Safran & Muran, 2000). In counselling settings, a responsively managed relationship rupture also appears to be an important factor in strengthening the therapeutic relationship (Hill et al., 2008; Rhodes & Hill, 1994).

Addressing relationship discontent may be particularly pertinent in the early phases of relationship formation. A couple of participants experienced relationship breakdowns with clinicians they had only recently met, with one requesting that the staff member be removed from his care. Other studies illustrate that some clients choose

to end their clinical partnership based on their initial impressions of their clinician (Elkin et al., 2014; Knobloch-Fedders, Pinsoft, & Mann, 2004). Elkin et al. (2014) demonstrated that a clinician's responsiveness and promotion of a positive therapeutic atmosphere within the first two sessions is predictive of the clients' perceptions of the relationship and engagement in therapy. Relationship development and maintenance may need to be integrated from the very first interaction(s) in order to facilitate continued relationship and rehabilitation engagement.

The current findings provided original insights around the challenges that stroke clinicians may experience in identifying that a relationship *has* been compromised - a pre-requisite for the reparation process (Bennett, Parry, & Ryle, 2006; Castonguay et al., 2006). Client participants often suppressed their concerns rather than raise these with staff, resulting in potentially covert or ambiguous signs of relationship dissatisfaction. These included withdrawing from the clinician or elements of their rehabilitation programme, or declining care, which are markers of relationship issues in psychotherapy and mental health (Priebe, Watts, Chase, & Matanov, 2005; Safran & Muran, 1996). An important point of difference from previous research is that some client participants perceived that their dissatisfaction was erroneously attributed to a stroke-related problem, such as fatigue or depression. This suggests there is a risk that clinicians may sometimes misjudge their client's relationship experiences.

Existing brain injury research may implicitly encourage clinicians to conceptualise a rehabilitation or relationship engagement issue as a neurological one. For example, qualitative researchers report that a client's neuropsychological, communication or motivational difficulties are the main barriers to forming or maintaining a strong alliance or therapeutic relationship (Jones et al., 1997; Judd & Wilson, 2005; Kovarsky et al., 2011; Lefebvre et al., 2005). Quantitative studies have predominantly focused their investigations on client-related factors that may influence rehabilitation compliance and/or alliance quality. These have included injury variables (Schönberger, Humle, et al., 2006a), metacognitive or cognitive skills (Schönberger, Humle, et al., 2006a; Schönberger et al., 2007; Sherer et al., 2007), emotional distress (Sherer et al., 2007) or self-reported difficulties (Schönberger, Humle, et al., 2006b). Client participants within these quantitative studies were asked to rate only one alliance, precluding analyses of the multiple alliances they would have formed in a rehabilitation service. Such aims and methods perhaps assume that the client is the 'common factor'

impacting on, if not impeding, alliance strength, with little consideration given to the role of the clinician.

The present study's design differed from previous studies examining therapeutic relationship quality or disharmony in that it also explored client perspectives of the challenges *they* experienced when engaging with clinicians across different professions. Based on these reports, the clinician's responsive management of their discontent appeared to influence their perceptions of the therapist and engagement in therapy.

### **5.2.1 Practice implications**

The following clinical implications explore ways that clinicians and teams might detect and manage relationship dissatisfaction.

#### **5.2.1.1 Detecting relationship dissatisfaction**

In order to identify early indications of rupture, psychotherapy researchers advocate using alliance measures (Castonguay et al., 2006; Safran, Muran, & Eubanks-Carter, 2011). This option may be less tenable in stroke rehabilitation given the absence of a conceptually sound measure of relationship quality in this field (see *Chapter 2: Literature Review*, pages 33 and 35) and the likely practical issues associated with supporting clients to rate *all* of their therapeutic relationships. On the other hand, regularly obtaining clinicians' ratings of alliance quality may serve to draw their attention to any relationship issues (C. C. Evans et al., 2008). This seems a valid proposition, but relies solely on the clinician's perception of relationship quality.

Other researchers insist that it is the client's responsibility to assert their concerns (Hill & Knox, 2009; Rhodes & Hill, 1994). Once again, this may be unrealistic after a stroke due to the inherent power differential in clinical relationships (Lefebvre et al., 2005; Palmadottir, 2003) and the challenges many clients face with their emotional and cognitive expression (Johansson, Carlsson, & Sonnander, 2012; O'Halloran, Worrall, & Hickson, 2012).

Another option may be for clinicians (or at least a key worker) to undertake intermittent relationship 'health checks' to identify any issues and changing relationship priorities. These could involve discussions around whether the most appropriate family

members are involved and to the right extent, revisiting the client's hopes and their preferred level of involvement in rehabilitation decisions, and skilfully eliciting any concerns. Within each session or care task, clinicians may need to mindfully listen and observe their client's reactions and to try and refrain from making assumptions when clients decline or disengage from their therapy or relationships.

### **5.2.1.2 Developing competencies to resolve relationship disruptions**

The clinical skills and attributes that were considered to help facilitate relationship recovery in the present study are similar to those discussed in psychotherapy research. These included exploring the client's perception of the issues, re-negotiating the therapeutic relationship parameters and taking ownership of one's own contributions to the breakdown (Castonguay et al., 2006; Hill & Knox, 2009; Safran & Muran, 2000). Richards (2011) suggests that these skills rely on metacommunication (to openly discuss emerging relationship issues) and reflexivity (to not assume that client-related issues caused the rupture). Compared with psychotherapists, many stroke rehabilitation clinicians may be less familiar with these techniques. This may explain previous reports of clinicians disengaging from clients when they struggled to either form a productive relationship or manage the client's frustrations on a stroke ward (Jones et al., 1997). While this was not a finding in the present study, it is conceivable that clinicians who feel ill equipped to manage a relationship disruption may avoid the 'issue'.

C. C. Evans et al. (2008) investigated several promising interventions designed to improve clinicians' knowledge and skills in developing and maintaining strong alliances in a brain injury rehabilitation service. These included in-services to improve the team's psychotherapeutic skills and regular, solution-focused team discussions of any alliance problems. The results demonstrated no significant differences in programme drop-out rates or alliance strength between this intervention group and an historic control, although there was a trend toward stronger alliance ratings with clients enrolled in the latter part of the study (C. C. Evans et al., 2008). In spite of these findings, the study's team approach towards developing relational competencies and managing problematic relationships may be easily applied to other rehabilitation services. It would be interesting to consider whether simply bringing the term 'alliance'

or 'therapeutic relationship' into everyday rehabilitation discourse may function to promote and protect this aspect of rehabilitation provision.

### 5.3 The judicious use of self-disclosure

A clinician's disclosure of personal information could facilitate or impede therapeutic relationships in this study. Debate also exists in the literature around the benefits, risks and ethics associated with clinician-led self-disclosures. This section will explore these complexities and provide suggestions to support the judicious application of self-disclosures in stroke rehabilitation.

The current findings reported that a personal connection often developed through the mutual sharing of personal information. This finding bears similarities to a subcomponent of the therapeutic relationship theorised by Gelso (2009). These researchers described the personal or 'real relationship' whereby clients perceive their psychotherapist as a person with preferences and imperfections. The 'genuineness' element of this relationship develops from discussions and self-disclosures that aren't directly related to the therapeutic work itself (Gelso, 2009).

In the present study, self-disclosures had the potential to reduce expert-patient barriers and promote comfort, cultural responsiveness and an emotional investment in each other. Other studies support the views that appropriate self-disclosures may balance the symmetry of power (Audet & Everall, 2010; Hanson, 2005), demonstrate cultural competence (Lacey et al., 2011) and strengthen engagement (Audet & Everall, 2010; Hanson, 2005) within relationships.

Participants identified another benefit associated with self-disclosures that is less prominent in the literature. Hope could be nurtured when clinicians shared stories of their lives outside of the rehabilitation ward, as these stories provided confirmation that life continues after a stroke. Relationship-based strategies previously reported to foster hope include empathy (O'Hara & O'Hara, 2012) and validating a client's future hopes (Judd & Wilson, 2005), with limited attention paid to the possible role of self-disclosures. Developing understandings of the different ways that clinicians can use their personal attributes to generate hope is important, as a recent systematic review identified that hope is perceived to play an important role in supporting recovery after stroke (Bright et al., 2011).

Clinician-led disclosures seemed to enhance relationships for many participants, but detracted from others. This finding is consistent with other studies (Audet & Everall, 2010; Hanson, 2005). In the present study, the type and frequency of disclosures appeared to matter. Those that were considered too elaborate (such as discussing a personal story at length) or unnecessary (such as revealing one's age), were perceived to monopolise time away from care and weakened perceptions of their clinician's competencies. Extensive and irrelevant disclosures similarly impeded the therapeutic relationship and therapy process in another study (Audet & Everall, 2010). Inappropriate self-disclosures may suggest that a clinician lacks the skills required to tune into or respond to their client's relationship needs. This is congruent with research indicating that the clinician's skill (or skill deficit) in sharing personal information determined whether their disclosures were perceived to help or hinder the relationship (Hanson, 2005).

On balance, self-disclosures seemed to play an important role in augmenting therapeutic relationships in the current study *provided* they were responsive to one's relationship and care needs. In contrast, controversy surrounds the application of therapist disclosures in psychotherapy from ethical and theoretical standpoints (Gutheil & Gabbard, 1993; Peterson, 2002). Studies demonstrate that these disclosures may breach intimacy/sexual boundaries (Audet & Everall, 2010; Hanson, 2005), create a role reversal where the client feels obliged to 'manage' the relationship (Audet & Everall, 2010; Hanson, 2005), contaminate the therapy process (Peterson, 2002; Wachtel, 2011) and cause an alliance/relationship rupture (Gutheil & Gabbard, 1993; Hanson, 2005). After critically evaluating the evidence and ethical principles associated with self-disclosures, Peterson (2002) recommended the following:

“In general, the uncertainty inherent in determining the ethicality of self-disclosure is precisely the reason that therapists should exercise extreme caution before sharing information about themselves.” (p. 30)

Many of the issues outlined above were not identified in the current study, which may reflect the different health conditions, therapy contexts and subsequent therapeutic relationship needs. Following a stroke, a person's vulnerabilities may be magnified due to the nature and extent of their deficits, confinement (metaphorical if not physical) to a medicalised environment and sudden exposure to a high volume of clinical partnerships. Consequently, all client participants appeared to require a degree

of human connection with their clinicians to promote comfort and trust in their relationships and rehabilitation. Appropriate self-disclosures could facilitate this process and provide a welcome distraction from their difficulties – the same distraction that may be considered a hindrance in psychotherapy (Wachtel, 2011). It could be posited that failure to disclose *any* personal information may be ethically unsound if the client requires this. Evidence in this study and others suggests that non-disclosures may interfere with the formation of a personal connection (Hanson, 2005; McGilton & Boscart, 2007).

The current study and many others acknowledge the need for professional boundaries to ring-fence the disclosure of personal information (Audet & Everall, 2010; Gardner, 2010; Hanson, 2005). Professional boundaries are considered to be essential in maintaining a connection that is both professional and therapeutic (Gardner, 2010). Rather than refraining from disclosing personal information due to their potential to cross relationship or professional boundaries, the evidence outlined above suggests that self-disclosures could be viewed as a valuable clinical tool in developing relationships in stroke rehabilitation.

### **5.3.1 Practice implications**

Prior to applying self-disclosures, clinicians may wish to contemplate the following in order to foster the right degree of personal connection while maintaining professional standards:

#### **5.3.1.1 Potential contribution to the relationship or therapy**

Considering the client's needs and preferences first and foremost may help clinicians to decide whether to disclose personal stories, experiences or opinions. Prior to disclosing personal information, Peterson (2002) suggests that therapists reflect on whether the information is likely to benefit the client or themselves. It could be argued that reports of inappropriate self-disclosures in the present study perhaps served the clinician's interests ahead of the client's. An example of this is when Heke perceived that a clinician was "more looking in the mirror at herself" when she shared a personal story. Such disclosures could be considered to 'exploit' the clinician's captive audience (Peterson, 2002). Heke may have felt particularly disempowered in this situation due to his considerable expressive communication difficulties. By viewing self-disclosures as a

therapeutic strategy, it may encourage clinicians to think about its potential to augment the personal connection or support the work of therapy. If it is unlikely to achieve either, then clinicians could utilise their skills and attributes in other ways to develop the relationship.

### **5.3.1.2 A person-centred approach to disclosing personal information**

Based on the variable influence that self-disclosures have on therapeutic relationships, the following factors may guide the clinical reasoning process:

- a) The disclosure's content: for example, its congruence with what has been previously shared by the client. Other research demonstrates that reciprocal disclosures have relevance and significance to clients (Audet & Everall, 2010; Barrett & Berman, 2001).
- b) The context: for example, whether disclosures may ease a client's vulnerability and discomfort associated with specific tasks and encounters (such as during personal cares).
- c) The client: for example, their cultural identity (in particular, Māori clients may value the responsive disclosure of a clinician's personal background to build a connection – see *Chapter 4: Findings*, pages 92-93 and Lacey et al., 2011), personality (Peterson, 2002) and their preference for a close personal connection.

In some instances, minimal or impersonal disclosures may forge a more appropriate personal connection. At other times, clients may require their clinicians to reveal themselves a little further before they commit to the relationship. Again this requires and reflects a clinician's ability to tune into and respond their client's relationship needs, which is supported in other studies (Audet & Everall, 2010).

### **5.3.1.3 Maintaining professional boundaries/territories**

The role of boundaries in guiding a clinician's disclosure is widely discussed in counselling-related literature, yet clinician participants in the present study often relied on intuition and experience to establish these. Community speech-language therapists similarly identified that negotiating boundaries are done implicitly and are difficult to explain (Hersh, 2010). These combined findings suggest that education or work-based



training may not fully prepare clinicians with the requisite knowledge, skills and confidence to achieve both emotional proximity and professional distance with their clients. In stroke rehabilitation, this may be particularly contentious when working with clients exhibiting disinhibited behaviour and/or during interventions and care tasks that are intimate by nature.

One option may be for clinicians to contemplate in advance what information they feel personally and professionally comfortable sharing with their clients, and in what situations. This may pre-empt instances where clinicians suddenly find themselves at a decision-making juncture, such as a client asking them about their family or residential details. Researchers suggest that clinicians with clear beliefs and rationale for disclosing are less likely to impede the relationship or therapy when they share information (Peterson, 2002). Newly qualified staff may benefit from training highlighting the potential risks and benefits of disclosures through facilitated discussions around common clinical scenarios. Such training may improve clinicians' reasoning, comfort levels and professional safety when expressing their personal identities.

It may also be useful to reconsider how professional boundaries are conceptualised. Researchers have argued that the term 'boundary' indicates a rigid, pre-determined demarcation separating out ethical from unethical behaviour, which does not reflect the context-dependent nature of therapeutic relationship boundaries in practice (Austin, Bergum, Nuttgens, & Peternelj-Taylor, 2006). These researchers proposed 'therapeutic territory' as an alternative metaphor as it denotes a shared space that clients and clinicians may enter and monitor. In keeping with the present findings, it suggests that therapeutic relationship 'territories' may be adapted to the individual, rather than the other way around.

#### 5.4 Summary of discussion and clinical implications

This chapter has highlighted both similarities and differences in the way therapeutic relationships were conceptualised, developed and maintained in this study compared with what has previously been identified in the literature. Consistent with other studies, this research reported that:

- a) A personal connection and working towards shared goals/hopes appeared to be important elements of a strong therapeutic relationship;
- b) Developing, monitoring and maintaining relationships often needed to be integrated throughout the duration of the partnership; and
- c) The combination of personal attributes and professional judgement appeared to augment relationship quality.

The present study contributed to the body of knowledge around this topic by suggesting that:

- a) Family/whānau were often a core component of therapeutic relationships;
- b) A person-centred approach and relationship plasticity seemed to enable clinicians to assess and respond to variation in therapeutic relationship priorities within and between individuals (rather than to assume what these were); and
- c) Strong therapeutic relationships were perceived to enhance hope, wellbeing, therapy efforts and progress.

Each section within this chapter offered practice-based suggestions to support the integration of new and existing evidence into rehabilitation practice. Table 11 collates these discussion points and clinical implications.

The researcher's pre-suppositions were referred to in the initial chapters (see pages 3 and 57) and summarised in Appendix A. The following pre-suppositions were challenged during this research:

- a) Core components of a strong alliance: The inclusion of family/whānau as a core component of some therapeutic relationships contrasted with my expectations.
- b) Factors impacting on the alliance (client's perceptions): Achieving goals did not appear to be a salient factor for most client participants; instead, working towards a shared focus seemed more important.
- c) 'Surprise' findings: That some client participants preferred low levels of involvement in their rehabilitation and decision-making challenged my expectations; so too, did those who preferred minimal family/whānau input.

**Table 11: Summary of discussion and clinical implications**

Discussion point from this research	Clinical implications	Page no.	Supporting evidence
Developing strong relationships requires a person-centred, and sometimes family/whānau-centred, approach.	Appreciate that clients experience a strong therapeutic relationship in different ways and that their relationship priorities may change over time.	111-112	
	Where possible, avoid making assumptions about a client's therapeutic relationship needs and preferences.	112	
	Discerning and responding to relationship priorities is likely to require inter-personal, emotional and clinical competencies.	112	McCormack et al. (2010)
	Incorporating one's hopes into goal planning may serve to validate them, unite efforts towards a shared focus and strengthen the therapeutic relationship.	109-110	Bright et al. (2011)
	Exploring each client's preferences for involving family/whānau in their therapeutic relationships is advised, but be mindful of other benefits (and risks) when collaborating with significant others.	112-115	C. C. Evans et al. (2008) Sherer et al. (2007) McLaughlin and Carey (1993)
	Strong therapeutic relationships may contribute to a client's emotional and psychological wellbeing, and enhance their rehabilitation efforts, engagement, perceived progress and family functioning/wellbeing. It is possible that rehabilitation outcomes may be optimised as a result.	109-115	Schönberger, Humle, et al. (2006a) Schönberger, Humle, et al. (2006b) C. C. Evans et al. (2008)

Discussion point from this research	Clinical considerations	Page no.	Supporting evidence
Maintaining relationship health requires a proactive approach to detect and manage relationship disruptions	Therapeutic relationship development, monitoring and maintenance may need to be integrated and revisited over the period of care to support relationship and rehabilitation engagement.	115-116	Elkin et al. (2014) Knobloch-Fedders et al. (2004) Safran & Muran 2000
	Clinicians and clients may hold different perceptions of the quality of their therapeutic relationships.	116	
	Relationship dissatisfaction may manifest subtly and present in such a way as to be easily misattributed to a common stroke-related issue.	116	Priebe et al. (2005) Safran & Muran (1996)
	Clinicians need to be aware of their own possible contributions to a relationship disruption and acknowledge responsibility if this is the case.	118	Richards (2011) Safran & Muran (2000)
	Consider a team approach to developing therapeutic relationship competencies and to problem-solve relationship issues.	118-119	C. C. Evans et al. (2008)

Discussion point from this research	Clinical considerations	Page no.	Supporting evidence
The judicious use of self-disclosure may achieve emotional proximity and professional distance	Clinician-led self-disclosures may help or hinder therapeutic relationship perceptions. Helpful self-disclosures reflect the skilled use of one's personal attributes and professional judgement.	119-120	Audet and Everall (2010) Hanson (2005)
	Sharing relevant personal information may promote comfort, signal cultural attunement, foster hope and strengthen the personal connection.	119	Audet and Everall (2010) Hanson (2005) Lacey et al. (2011)
	Prior to disclosing, justify its purpose from an ethical and therapeutic relationship viewpoint: is it likely to benefit the client?	121-122	Peterson (2002)
	Newly qualified staff may require training to improve their rationale and success when sharing personal information.	123	Peterson (2002)

## 5.5 Study limitations

This chapter has discussed the study's contributions to the current knowledge base of therapeutic relationships with people after stroke, yet it is important to acknowledge its limitations. This section examines how the participants' characteristics, the interview approach and the therapeutic relationship concept itself may have impacted on the findings generated.

Firstly, participants were recruited from one rehabilitation ward. Therefore, their relationship experiences are likely to have been affected by the competencies, characteristics and access to a limited range and number of clinicians (for clients) and system processes and pressures that may have been unique to this particular service (for all participants). One mitigating factor was that interviews occurred over a 20-month period, during which time there was considerable staff turnover and changing service priorities. In spite of this, it is important to acknowledge the challenges that may exist in applying these findings to other rehabilitation units with different client and clinician characteristics and service idiosyncrasies.

Participants reported that therapeutic relationships were a "two-way process" and were affected by the other party's willingness and capacity to contribute to the relationship. This study purposefully selected client participants with moderate to severe cognitive or communication difficulties, with these participants able to be supported to express their relationship perspectives to some extent. Consequently, these findings lack the views of clients with more profound deficits who may have different relationship needs.

Physiotherapists and male clinicians were not represented in the clinician participant sample. Instead, two experienced physiotherapists were recruited to attend the member checking discussion for clinicians and their views supported the refinement of these findings. Unfortunately, there were no male clinicians working on the rehabilitation ward at the time of the focus group interview or member checking discussion who met the eligibility criteria. While perspectives from male clinicians were missing, none of the participants discussed the role of gender in relation to their therapeutic relationships and it did not appear to be an influencing factor in the studies reviewed during this research.

The interview approach may also have influenced the findings. Interviews occurred at one time point for each client, so data is unlikely to have detected all the relationship nuances over time, particularly for those with memory deficits. It was evident that several participants struggled to recall their initial interactions with staff when they entered rehabilitation whereas others had only recently commenced a prolonged rehabilitation stay. As a result, it is difficult to determine whether there were common relationship patterns over an entire rehabilitation journey and if/how these were affected by pivotal events such as discharge planning or key staff turnover.

Interviews were not separated into client-clinician dyads due to the likely methodological challenges associated with identifying and recruiting the most relevant clinician(s) for each client. This is likely to have oriented the data and subsequent findings to primarily reflect the clients' relationship perceptions. For example, the 'culpable' clinician's perspective of a relationship disruption reported by a client was not elicited and may have provided further contextual information.

The study aims and interview approach predominantly excluded family/whānau perspectives of the therapeutic relationship. Despite the involvement of family members proving a core relational component for many participants, their loved ones' limited contributions to these interviews may have diverted the findings away from a more family system-orientated therapeutic relationship concept and approach.

The majority of interviews were conducted whilst I was employed as a physiotherapist on the same rehabilitation ward as the participants (but was not a treatment provider for any client participant). Therefore my discipline-specific background and role on the team may have influenced some of the questions and responses. Of note, many clients identified having strong relationships with their physiotherapist and nearly half were reportedly satisfied with *all* of their relationships with clinicians. There is a possibility that a researcher external to the organisation or from a different rehabilitation discipline may have elicited different responses. However, the final three client interviews occurred after I had resigned from the service and three interviews also occurred soon after the client had been discharged. Further, a couple of clients who had received substantial input from other disciplines were recruited in the latter stage of data collection (see page 49). Together, these approaches and events may have reduced the potential for my professional background and role to excessively impact on the findings generated.

Finally, many participants struggled at times to differentiate between their therapeutic relationships and their general rehabilitation experiences. Other researchers have similarly observed that these perceptions are often difficult to separate (Peiris et al., 2012). Consequently, there is potential that the present findings also incorporate perspectives on what makes rehabilitation successful for some participants and less so for others.

In spite of these limitations, this study provides novel insights around the core constructs and factors that may enhance or impede therapeutic relationships for clinicians and clients in stroke rehabilitation services. Due to this study's seemingly unprecedented exploration of these aims within the inpatient stroke rehabilitation context, further research would provide additional clarity and guidance for clinicians working in this field.

## 5.6 Future research

A number of questions arose during the formation and refinement of the findings, which may provide the following directions for further investigations:

*Are these findings transferable to the wider stroke rehabilitation population?*

As discussed, while this study appears to be unique in its aims, approaches and population characteristics, it only explored the perspectives of 17 clients and clinicians derived from one rehabilitation service. A larger-scale study with similar aims would hopefully shape the proposed relationship constructs, barriers and facilitators. However, the participants represented a diversity of stroke-related difficulties, ethnicities, genders and ages (for client participants) and professional backgrounds and experience (for clinician participants). In addition, according to Thorne (2008), this sample size is considered to be sufficient to provide a meaningful portrayal of the phenomenon under investigation.

*How may multiple relationships be optimally managed?*

Future studies may explore whether it is necessary for all members of the team to have a strong or 'good enough' therapeutic relationship with the client to impact on outcomes, or whether some relationships may be more important than others. This is of interest given the high numbers (and different characteristics) of therapeutic



relationships that clients are likely to encounter over their rehabilitation stay. It may also be important to examine whether there are certain rehabilitation structures (such as sufficient staff to support relationship continuity) and processes (such as person-centred goal planning practices) that support the development of therapeutic relationships within a service.

Research may also examine whether one relationship disruption impacts on other therapeutic relationships in the team. One clinician participant reported that a staff member's insensitive comments to a client could have repercussions for therapeutic relationships across the team, but it was unclear whether clients held similar perceptions.

Eliciting family/whānau perspectives of these relationships may also address some of this study's limitations and gaps in research. There are some promising practice guidelines and models proposed for engaging with families following an acquired brain injury (for example, Foster et al., 2012; Sohlberg et al., 2001), but as discussed on page 41, there appear to be few studies providing clarity on how to manage the complexities of this collaboration. Individual psychotherapy researchers also provide few clues as their alliance theory and research has been mostly confined to the clinician-client dyad (Bordin, 1979; Horvath & Symonds, 1991). Viewpoints from multiple relationship stakeholders may help to clarify how relationships with relevant family members may best be prioritised, initiated and managed, whilst balancing the needs and preferences of the client (and, at times, the clinician). This includes whether the therapeutic relationship with the client is of prime importance and needs preserving at all costs. Or perhaps, whether a systems approach may be more appropriate given the enduring nature of stroke-related deficits and influencing role of some family in a client's life.

*Is the therapeutic relationship a potential catalyst for rehabilitation change?*

Due to the qualitative nature of this inquiry, there were no formalised assessments undertaken of relationship quality or its impact on rehabilitation 'success'. As such, while there were anecdotal reports regarding the benefits of a strong therapeutic relationship, further research is needed to explore the association with outcome. This research may provide the basis for the development of a conceptually sound, valid and reliable relational measure, which will further support research aiming to explore the impact of the therapeutic relationship on outcome.

### *How is relationship-fostering competence instilled?*

Further evidence is required to determine how best to instil essential and desirable relationship-promoting qualities and skills in rehabilitation clinicians. An important feature of this study's findings was that both professional *and* personal competencies might be required. Interestingly, around half of the 1000 American Occupational Therapists surveyed in one study felt ill equipped to use themselves therapeutically to facilitate the therapeutic relationship (Taylor, Lee, Kielhofner, & Ketkar, 2009). This study has helped to operationalise these competencies but further work is required to translate them into clinical practice.

## 5.7 Conclusion

This research contributes new knowledge around how people with stroke and rehabilitation clinicians experience their therapeutic relationships in a post-acute stroke rehabilitation service. It is novel in its explicit exploration of the therapeutic alliance in the inpatient stroke rehabilitation setting, and of the views of clinicians from a range of disciplinary backgrounds and clients experiencing a range of difficulties post stroke. The findings suggest that the personal connection, professional collaboration and family/whānau collaboration appear the most salient core components of these relationships. Clients may preferentially 'weight' these components differently, and each component may move to the relationship foreground or background over the course of their inpatient stay. Developing and maintaining strong therapeutic relationships appears to require a person-centred (and sometimes family/whānau-centred) approach and relationship plasticity to accommodate each client's unique and fluid priorities. This may involve a level of emotional and intellectual awareness, as well as an ability to use one's personal attributes and professional competencies therapeutically. Participants suggested that strong therapeutic relationships could enhance their emotional and family/whānau wellbeing, facilitate hope, promote rehabilitation engagement and improve the perceived sense of progress. As such, determining and addressing or even prioritising each client's therapeutic relationship needs and preferences may augment rehabilitation processes and outcomes.

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## Appendix A: Pre-supposition Interview Summary

### **Core components of a strong alliance:**

In congruence with existing alliance research, the quality of the interpersonal bond and high levels of agreement around the goals and tasks of therapy are likely to be the main constituents of a strong alliance in stroke rehabilitation.

### **Factors that may positively impact on the alliance:**

From a client's perspective:

- a) Meeting expectations (therapy dosage, timeliness of input and outcomes);
- b) Fostering hope;
- c) Sound communication between clinician, client, family and within the team;
- d) Improving/achieving goals quickly;
- e) May form stronger alliances with 'hands on' therapists and those that provide more frequent, regular input (such as physiotherapists, occupational therapists and possibly key workers).

From a clinician's perspective:

- a) Low levels of cognitive and communication difficulties;
- b) Receptivity to clinical input;
- c) Cultural/background alignment;
- d) Family members' personality and 'fit' with the team.

### **Factors that may negatively impact on the alliance:**

From a client's perspective:

- a) Inconsistent clinical input (due to staff discontinuity);
- b) Receiving poor prognostic information;
- c) Expectations of outcome that diverge from clinicians/the team.

From a clinician's perspective:

- a) 'Challenging' family members;
- b) Clients with moderate to severe difficulties in their cognition (e.g. memory) or behaviour.



**Alliance formation and trajectory:**

The length of time taken to form a strong alliance and its trajectory over the rehabilitation period is likely to vary between clients and may be dependent on stroke-related impairments, changes in insight and congruency of expectations.

**Beneficial clinical skills and attributes:**

- a) Experience – to enable clinicians to consolidate their technical skills and be able to ‘focus’ on engaging with clients in a relationship sense;
- b) Active listening and psychotherapeutic skills to support goal achievement;
- c) Naturally having the ‘right’ personality and skill set.

**Possible ‘surprise’ findings:**

Such findings would include clients who do not value being involved in their rehabilitation programme and decision-making processes and those that do not wish for their families to be involved in these either.

## Appendix B: Client Participant Information Sheet (Standard)



# Participant Information Sheet

### **Date Information Sheet Produced:**

27 August 2012

### **Project Title**

Understanding the Therapeutic Alliance in Stroke Rehabilitation

### **An Invitation**

You are invited to take part in a research study called '*understanding the therapeutic alliance in stroke rehabilitation*', which is being undertaken by Megan Bishop, Dr. Nicola Kayes and Professor Kath McPherson, who are researchers at AUT University. Megan Bishop is also a physiotherapist at [rehabilitation provider]. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason and it won't affect the care that you receive. If you do want to take part now, but change your mind later, you can pull out of the study at any time (prior to the completion of data collection) without having to give a reason.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. If you would like to participate or find out further information, we will arrange an initial meeting to discuss the study and answer any questions you may have. We expect this initial meeting will take about 30 minutes. You may want to talk about the study with other people, such as family, whānau, friends, or your healthcare provider. Feel free to do this. If you agree to take part in this study, you will be asked to sign a Consent Form at this meeting and will be given a copy to keep.

This study has been approved by the Auckland University of Technology's Ethics Committee and Post-graduate and Research Committee. The primary researcher (Megan Bishop) is undertaking this study as part of her Master of Health Science qualification. Please see below for who you can contact if you have queries or concerns.

### **Why are we doing the study?**

We would like to find out about your experience of the therapeutic relationship that you have with your therapists and nurses on the rehabilitation ward. We are seeking to understand what key factors make up this relationship and what may help or hinder it. We will also be finding out therapists' and nurses' views of these relationships as well who are based in [rehabilitation provider].

### **How was I chosen for this invitation?**

You were chosen because we are wanting to talk to people who have experienced a stroke and are currently receiving rehabilitation and care at [rehabilitation provider]. We understand that you will be able to participate in an interview, with support as required.

### **What will happen in this research?**

If you consent to take part in this research, you will be invited to take part in an in-depth interview. You are welcome to have family/whānau present to support you in the interview. If you are Māori, you are welcome to have a Māori clinical advisor join us as well. The interview will take place in a private room at [rehabilitation provider] and last around 60 minutes. It will be audiotaped by the interviewer and then transcribed for analysis. We would also like to collect information about your stroke and relevant medical history from your medical file.

The study is expected to take around 18-24 months to complete. During the analysis phase of the study, you may be contacted again to give you the opportunity to provide feedback in relation to these findings. We are anticipating that we would require a total of around two hours of your time, which includes our initial meeting, interview and feedback session.

### **What are the benefits?**

Benefits to you: People often report that talking about their experience of stroke and the rehabilitation they have received is a positive experience.

Benefits to others: We are hoping that this study will help us understand how we can form and maintain strong therapeutic relationships with people receiving inpatient stroke rehabilitation. Your views and experiences will contribute to the development of recommendations for rehabilitation staff, to improve the way we work with people like you. We hope that this may improve quality of care, which should, in turn, have an impact on outcomes from stroke rehabilitation.

### **What are the discomforts and risks?**

We do not expect there to be any risks to you from participating in this study. However, it is possible you may find talking about some experiences difficult. For example, you may be experiencing difficulty in adjusting to the effects of your recent stroke and being in an unfamiliar ward with unfamiliar people and routines. We hope that you will feel comfortable during the interview, however if you feel that any question or topic may cause you distress, you do not have to answer or discuss it. If you find the interview tiring we can take a break or stop if you wish. If sensitive or distressing issues do arise for you during the interview and you would like to discuss this with someone, please let us know so we can help connect you with some support. You may want to talk with

services available through the Stroke Foundation. We have provided their details below. Alternatively, some free counselling sessions are available at AUT University if participation in the research causes you distress. You can contact the AUT University Health, Counselling and Well-being services directly on (09) 921 9998 if you wish to access these services.

### **What are the rights of participants in the study?**

Your participation in the study is voluntary, which means that you may choose not to participate or you may withdraw from the research at any time prior to the completion of data collection, without explanation. You will not experience any disadvantage if you choose not to take part or withdraw. You have the right to access information that has been collected as part of the study.

### **How will my privacy be protected?**

Your information will be confidential to the research team. Only the investigators of the study and research assistants will see the transcripts of the interviews. All transcripts and demographic data will be de-identified i.e. all personal information will be removed.

Personal information will be kept in a separate location and you will not be identified in any way in the written report. While some of your quotes from the interviews may be used in reports, your details will be altered so you cannot be recognised.

### **What happens at the end of the study or if you pull out?**

The findings will be written up as a thesis (as part of the primary researcher's Masters qualification) and will be presented at relevant conferences and published in professional journals. If you wish to receive a summary of the findings please supply your name and address or email address to the researcher.

Information from the study will be stored for 10 years in a secure database at AUT and will be permanently deleted after this time. The research team will be responsible for the safe storage of this information. If you choose to withdraw from the research project, all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

### **What are the costs of participating in this research?**

There are no costs associated with this research except your time. We will arrange a time to meet that is convenient to you and your support person/whānau. This meeting will occur in a private room in [rehabilitation provider].

### **How do I agree to participate in this research?**

You are welcome to contact the research staff directly to find out more about the study, or to volunteer to take part. Please ask for help from a staff or family member to contact them if required. Their contact details are at the bottom of the page.



## Appendix C: Client Participant Information Sheet (Simplified)



# PARTICIPANT INFORMATION SHEET

## Understanding the Therapeutic Alliance in Stroke Rehabilitation

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### An invitation

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You are invited to take part in a **study** of people's **experiences** of their **relationships** with their **therapists** and **nurses**.

**You can choose** if you want to take part in the research. It is entirely **voluntary** (your choice).

If you decide to not take part, **it will not affect care or treatment** you are receiving.

If you do take part, **you can change your mind later**. You do not have to give a reason.

This information sheet will give you **information about the study**. It may help you decide if you would like to take part. Please **tell us** if it is **difficult to understand** or if you have any **questions**.

This study is coordinated by researchers at AUT University in Auckland. It will take place between 1 November 2012 and 31 December 2013.

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### Who can take part in the study?

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We are inviting **10 people with stroke** who are in **[rehabilitation provider]** to take part in this study.

---

### What are the aims of this study?

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We are trying to learn more about **people's experience** of their **relationships** with their **therapists** and **nurses**.

In particular, **we will ask you** about:

- What were the **important parts** of these relationships
- **What helped** these relationships
- **What** made these relationships **more difficult**

---

### What happens if I decide to take part?

---

You will be asked to take part in an **interview**.

You are welcome to have a **family member/whānau** or **friend present** to help you communicate. Support from your **Speech-Language Therapist** can also be arranged.

Each interview will take about **60 minutes**.

We would like to **tape record** the interviews to make sure we don't miss important details. We would also like to get **relevant medical information** from your file.

The **interview** will take place in a **private room** in [rehabilitation provider]. There should be **no cost** to you, apart from your **time**.

---

### How will the study affect me?

---

Taking part will take some of your **time**.

#### Benefits to you:

You may find it **helpful** to **talk** about your **experience**.

#### Benefits to others:

This study will help us **understand** how to **improve our relationships** with people receiving rehabilitation for their stroke. This should help **improve** their **outcomes** from rehabilitation.

#### Risks:

There should **not be any risks** from taking part in the study.

You may find the interviews **tiring**. If you are tired, we can **take a break**.

Some people may find it **difficult to talk about their experiences**.

**If you feel distressed** by any questions, **you do not have to answer** and we can **stop** the interview.



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## Confidentiality

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What you say is **confidential (private)**.

Only the members of the research team will know what you say. **You will not be identified** in research findings.

If you are **Māori**, we may ask our Māori advisor to **join us** in our meetings.

Your information will be **securely stored away from the hospital**. Computer files will be password protected. If you choose to **withdraw** from the study, all of your **information** will be **destroyed**.

Your information will be stored for **10 years**. All future use of information will be strictly controlled and is bound by the Privacy Act.

---

## What happens with the results of the study?

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The results will form part of the Primary Researcher's **Master's qualification**. It will be presented at **conferences**. Results will also be published in **professional journals**.

We can give you **a copy** of the **results** if you would like.

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## How can I volunteer to take part in this study?

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You can **contact the researchers** directly to **find out more** about

the study or to **volunteer** to take part. They may also **contact you** if you are **happy** for them to do so.

**Megan Bishop** (Primary Researcher) [workplace number]  
**megbis11@aut.ac.nz**

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## Your concerns

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If you have **concerns** about the **conduct** of this study, you can contact:

**Dr Rosemary Godbold** Executive Secretary, AUT Ethics Committee

**Phone:** (09) 921 9999 x 6902

**Email:** *rosemary.godbold@aut.ac.nz*

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## Support services

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If you **experience distress** from taking part, **please let us know** so we can help arrange support for you.

You may wish to talk with someone at the **Stroke Foundation**.

Stroke Foundation: (04) 472 8099

Alternatively, you can access **free counselling** at **AUT University** if taking part in the research causes you distress:

AUT Health, Counselling and Well-being: (04) 921 9998

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## Finally

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This study has received **ethical approval** from **AUT University**.

If you would like **more information** about the study please feel free to contact a member of the research team:

**Megan Bishop (Primary Researcher)**

**Phone:** [workplace number]

**Email:** [megbis11@aut.ac.nz](mailto:megbis11@aut.ac.nz)

Masters Student, AUT University

*Alternatively, you can contact:*

**Dr. Nicola Kayes (Project Supervisor)**

**Phone:** (09) 921 9999 Ext 7309

**Email:** [nkayes@aut.ac.nz](mailto:nkayes@aut.ac.nz)

Person Centred Research Centre, AUT University

**Please keep this brochure for your information.**

**Thank you for reading about this study.**

Approved by the Auckland University of Technology Ethics Committee on 25/09/12 AUTEK Reference number 12/237.

## Appendix D: Consent to Provide Name Form



### Consent to Provide Name

*Project title: Understanding the Therapeutic Alliance in Stroke Rehabilitation*

*Project Supervisor: Dr. Nicola Kayes nkayes@aut.ac.nz  
(09) 921 9999 x 7309*

*Researcher: Megan Bishop megbis11@aut.ac.nz  
[workplace number]*

**I have been given information** about the study of therapeutic relationships in stroke rehabilitation.

I am **interested in knowing more** about the study.

I agree that the charge nurse/therapist (name) \_\_\_\_\_ can **give my name to the researcher** named above.

Participant's signature: .....

Participant's name:.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 25/09/12  
AUTEK Reference number 12/237

## Appendix E: Clinician Participant Information Sheet



### Participant Information Sheet: Clinicians

#### **Date Information Sheet Produced:**

27 August 2012

#### **Project Title**

Understanding the Therapeutic Alliance in Stroke Rehabilitation

#### **An Invitation**

You are invited to take part in a research project designed to explore your views of the therapeutic relationship with your stroke patients/clients. This project is being undertaken by Megan Bishop (Physiotherapist in [rehabilitation provider] and Master of Health Science Student at AUT University) and Dr. Nicola Kayes and Professor Kath McPherson (researchers at the Person Centred Research Centre at AUT University).

Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time (prior to the completion of data collection) without having to give a reason.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. You may want to talk about the study with other people, such as family, whānau or your manager. Feel free to do this. If you would like to participate or find out further information, we will arrange an initial meeting to discuss the study and answer any questions you may have. We expect this will take about 15 minutes. If you agree to take part in this study, you will be asked to sign a Consent Form at this meeting and you will be given a copy of this to keep.

This study has been approved by the Auckland University of Technology's Ethics Committee and Post-graduate and Research Committee. Please see below for who you can contact if you have queries or concerns.

#### **Why are we doing the study?**

Evidence in other areas of health suggests that the strength of the therapeutic relationship between a person with a health condition and their clinician/doctor, improves health outcomes. However, this idea has not been fully investigated in stroke rehabilitation. The purpose of the study is to deepen our understandings of *what key factors make up and influence the therapeutic relationship* from the perspectives of people with stroke and clinicians (therapists and nurses) working in an inpatient stroke rehabilitation setting. Based on these findings, recommendations will be made to health care workers and managers around *how* we can best form and maintain strong therapeutic relationships. This will hopefully have a beneficial impact on stroke outcomes.

### **How was I chosen for this invitation?**

You were chosen because we are wanting to talk to therapists and nurses working in an inpatient stroke rehabilitation unit who have had at least one year of experience in working with clients post stroke.

### **What will happen in this research?**

If you consent to take part in this research, you will be invited to take part in a focus group consisting of around five therapists and nurses working in your rehabilitation unit. The focus group will last around 60-90 minutes and will be audiotaped by the interviewer. It will then be transcribed for analysis.

The study is expected to take around 18-24 months to complete. During the analysis phase of the study, you may be contacted again to give you the opportunity to provide feedback in relation to these findings. The total time required for participants is around two hours and 15 minutes. This includes around 15 minutes for the initial meeting, up to 90 minutes for the focus group and 30 minutes for the sharing and refinement of provisional findings.

### **What are the benefits?**

Benefits to you: It may be useful to reflect on your own clinical practice and to hear other clinicians' views of their therapeutic relationships with stroke clients. Recommendations from the research may guide your ability to form and maintain strong therapeutic relationships with people with stroke in the future.

Benefits to others: Improving the way clinicians create strong therapeutic alliances has the potential to result in improved rehabilitation outcomes.

### **What are the discomforts and risks?**

We do not expect there to be any risks to you from participating in this study. However, it is possible you may find talking about some experiences difficult. We hope that you will feel comfortable during the interview. However, if you feel that any question or topic may cause you distress, you do not have to answer or discuss it. If sensitive or distressing issues do arise for you during the interview, we encourage you to discuss these issues with your supervisor/manager or alternatively, there are some free counselling sessions (including on-line services) available at AUT University. You can contact the AUT University Health, Counselling and Well-being services directly on 09 921 9998 if you wish to access these services. The primary researcher will be known to some participants but confidentiality will be maintained at all times (see below for

‘How will my privacy be protected?’ and ‘What do I do if I have concerns about this research?’).

### **What are the rights of participants in the study?**

Your participation in the study is voluntary, which means that you may choose not to participate or you may withdraw from the research at any time prior to the completion of data collection, without explanation. You will not experience any disadvantage if you choose not to take part or withdraw. You have the right to access information that has been collected as part of the study.

### **How will my privacy be protected?**

All efforts will be made to ensure information shared during focus groups will be kept confidential, including reminding participants to maintain confidentiality and respect of information outside of the group setting. However, complete privacy cannot be guaranteed due to the nature of the group context. The research team will keep your information confidential. Only the investigators of the study and research assistants will see the transcripts of the interviews. All transcripts and demographic data will be de-identified i.e. all personal information will be removed.

Personal information will be kept in a separate location and you will not be identified in any way in the written report. While some of your quotes from the interviews may be used in reports, your details will be altered so you cannot be recognised.

### **What happens after the study ends or if you pull out?**

The findings will be written up as a thesis and will be presented at relevant conferences and published in professional journals. If you wish to receive a summary of the findings please supply your name and address or email address to the researcher.

Information from the study will be stored for 10 years in a secure database at AUT and will be permanently deleted after this time. The research team will be responsible for the safe storage of this information. If you choose to withdraw from the research project, all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

### **What are the costs of participating in this research?**

There are no costs associated with this research except your time. We will arrange a time to meet that is convenient to you and your colleagues also involved in the focus group. This meeting will occur in a private room at your workplace.

### **How do I agree to participate in this research?**

If you would like to participate in this study, please contact the research team within two days of receiving this invitation. As the primary researcher is known to participants, please feel free to contact one of the project supervisors if you would prefer to discuss the study or arrange for an independent interview with another member of the research team. Their contact details are at the bottom of the form.

### **Will I receive feedback on the results of this research?**

Yes. If you would like to receive a summary of findings you can indicate this on the consent form. If so, we will send you a written summary on completion of the study (this is likely to be around Nov/Dec 2014). If you wish to discuss the summary findings with one of the research team, we are happy to meet with you or discuss them with you over the telephone.

### **What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Nicola Kayes, [nkayes@aut.ac.nz](mailto:nkayes@aut.ac.nz) (09) 921 9999 x 7309

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Dr Rosemary Godbold, [rosemary.godbold@aut.ac.nz](mailto:rosemary.godbold@aut.ac.nz) (09) 921 9999 x 6902.

### **Whom do I contact for further information about this research?**

#### Researcher Contact Details:

Megan Bishop          [megbis11@aut.ac.nz](mailto:megbis11@aut.ac.nz)          [workplace number]

#### Project Supervisor Contact Details:

Dr Nicola Kayes          [nkayes@aut.ac.nz](mailto:nkayes@aut.ac.nz)          (09) 921 9999 x 7309

Prof Kath McPherson [katmcp@aut.ac.nz](mailto:katmcp@aut.ac.nz)          (09) 921 9999 x 7110

#### *Support Services*

AUT Health, Counselling and Well-Being Services (09) 921 9998

Approved by the Auckland University of Technology Ethics Committee on 25/09/2012  
AUTECH Reference number 12/237.



## Appendix F: Post Interview Reflective Summary

Participant: Margaret

Date of interview: 14/12/12

### *Demographic summary:*

57 y/o female with left sided weakness and cognitive difficulties post right TACI requiring decompressive craniectomy; previously working, lives alone but supportive local community and son. History of/ongoing depression.

Keyworker: PT; Therapists primarily involved: PT> OT>SW

Length of time in rehab: 49 days; interrupted by three acute hospital admissions due to health complications.

Discharge date: TBC

### *Interview facilitators:*

- Mild cognitive and communication impairments and eager to share views – I was able to apply open ended, loosely guided questioning with diversions into new, relevant topic areas as they arose.
- Margaret was able to reflect on a range of relationships with therapists and nurses and could tolerate a longer interview

### *Interview barriers:*

- Occasional delay in information processing, distractible and reduced ability to express more complex thoughts – some impact on response to questions.
- Most recent experiences occurred on acute wards –may require separating of acute versus rehab experiences in coding/data analysis.

### *Impressions of emerging ideas:*

#### Key components of strong relationships:

- How connected she feels at a personal/human level to her clinicians impacts on how she feels about herself (line 27,43,68-70, 72-73, 86-87, 548, 569-571, 745) and how much effort she puts into her rehab (114, 120-1)
- Friendship-type relationship (10) requires openness (13), caring/empathy (26, 54, 56), reciprocity- ‘she’d share her photos, her life sort of thing, shared part of her with you’ (83-84, 93); recognising important events in her life (224-229); mutual respect (237-246)
- Having goals/focus supported, regardless of whether they are achievable/realistic (354-66, 610-624) or not; requires ‘can-do’ attitude by staff (342, 370). Essential for maintaining hope/preventing slide into depression (599-608).

- Process of *how* tasks are carried out: including need for empathy/care/human elements (as above); the right staff attitude (135); ‘done in the right way’ (677-80); allowing sufficient time to participate/complete tasks (27-36, 234). In turn, this supports motivation (114-118, 131-133); not letting the therapist down (120); speed and sense of task achievement (125-6); personal satisfaction (126); and faith in clinician’s skills (678).
- Need to understand the purpose behind therapy/procedures (20)– ‘if it doesn’t connect in your head...that experience is really wasted’ (164-165). Explaining health care at an appropriate level - to increase understanding (13-21, 167-180), reduce fear (480-494, 634-640), increase acceptance of procedures/tasks (634-40). Supported by staff approachability (501-7).
- Being listened to – to manage issues, (186-192) reduce depression (204-217)
- Appropriate level of encouragement and honesty– enough to foster hope but not excessive amounts (577-589)
- Professionalism – respecting patient’s ‘bad’ days (732-43) and rising above these.
- Stronger relationships with clinicians who are seen more frequently – reduce patient vulnerabilities (701-5)/ encourages reciprocity of kindness (713-5).

#### How clients contribute positively to these:

- Not playing the stroke victim role – pushing self to be as independent as possible (720-728).
- Communicating with staff as humans – instigating conversation (138), demonstrating interest in their lives (255-257, 261-2); overcoming cultural differences (537-8), being nice (159-161) – staff in turn treat patient better/more as a human (257, 273-4, 538).
- Recognising different staff approaches/attitudes (142-144) and experience levels (162-163).

#### Components that may hinder these relationships:

- Staff complaints e.g. back pain/overworked (304-318); grumpiness (422-426)
- Different cultures – difference in way patients are treated/expectations (524-532)
- Limited recognition of patient’s expertise in own body (282-297) – makes patient feel worthless.
- Disrespect of patient’s values (e.g. visitors)/inflexibility for task completion (682-693).
- Poor timekeeping (646-7, 667-72),
- Risk of excessive information inducing anxiety (466-469) or excessive honesty impacting on mood/hope (552-557).
- Focus on task completion (53-62, 100-105).

Different roles of professionals:

- OTs: vanity (454-55), placing their views on the patient (433-35, 439, 451-53), 'passing an exam' (418, 429-32)
- PTs: physicality (454), objective 'they're not...personalising it' (446-48), 'work *with* you and get the job done' (419)
- Nurses: variability; sterile (458), cause pain (459-463), prescriptive at times 'the nurses think they are doctors' (642-52).

***Further actions required:***

1. Incorporation of these emerging ideas into future interviews, including the preferred nature of relationships, the balance between fostering hope but setting realistic goals, possible differences in relationship perceptions between disciplines.

## Appendix G: Revised Interview Guide

The interview guide below is an updated version of the original interview guide. This version was developed following data collection and co-occurring analysis with three client participants and the clinician focus group. Each subsequent client participant interview explored only several of these areas (i.e. not all questions were asked) to encourage detailed responses to topics raised.

### **Broad questions**

I'm trying to better understand the relationship between a person with a stroke and their therapist or nurse and what might be the most important aspects of that. I would like to hear your thoughts on this. Can you think of a therapist or nurse with whom you have a particularly close working relationship?

Can you describe this relationship?

What are the key things that make this a good relationship?

How does this relationship impact on you? On your rehabilitation?

Did it take long to establish a strong relationship?

Has the relationship stayed the same throughout your rehabilitation stay? (What factors have caused it to change?)

What have you done to help make this a strong relationship?

Can you think of a relationship with a staff member that perhaps isn't as strong? Tell me about this relationship.

What do you think has made it more difficult to form a strong relationship with this therapist or nurse?

How does this relationship impact on you?

Does anything make it easier?

Did the relationship change over time? (What factors have caused it to change?)

### **Specific questions**

#### **Bond**

What kinds of things are important for clinicians to understand about *you* as a person?

What is the best way for them to get to know you as a person?

What do you think is the right balance between clinicians doing their assessments and delivering therapy, versus spending time listening and talking to you?

How important is it for you to *like* your clinicians?

What kind of personality traits impact on the strength of your bond with a clinician?

What effect does it have on your working relationship if a clinician is from a similar cultural background?

How is your relationship with a clinician influenced by how frequently you see them?

How does the nature of *your* specific difficulties following your stroke affect your ability to form strong working relationships with staff?

### **Power**

What level of involvement have you had in driving/directing your rehabilitation programme?

What is the best way for clinicians to get to know what *you* want out of your working relationships on this ward?

Are you able to talk about a time when you have had different views or priorities to one of your clinicians? How did this manifest itself?

Can you tell me about how important it is for you to know and understand all the specific details of your therapy programme? What do you find is the best way for clinicians to share this information with you?

### **Outcomes**

What are the most effective ways for clinicians to help you towards achieving your goals/milestones?

How is your relationship with a clinician affected by your speed of progress towards a shared goal?

Does it matter *who* helps you to walk/dress yourself/talk etc. or just that *someone* does it?

What kind of feedback is most helpful in relation to your progress towards milestones?

### **Momentum/support**

What do you find is the right balance between staff pushing you as hard and as far as you can go or letting you go at your own pace?

How would they know what your limits are?

What works best in terms of helping you to become independent?

### **Professional skills and roles**

Which professional skills do you think are required to enable clinicians to work effectively with you?

Can you tell me about any differences in your relationships with staff as a result of their job role?

### **Family**

What is the best way for clinicians to work with your family/whānau during rehabilitation? What impact does this have on you/your relationships with clinicians/progress?

How does this impact on their role as family/whānau?

### **Expectations**

What are the best ways for clinicians to prepare you for what you can expect to happen in rehab?

## Appendix H: Coding

The first few pages of Margaret's interview transcript provide an example of how initial codes were formulated and applied to the 'Key Components' and 'Influencing Factors' categories. The 'Family Views' category was not applicable here. The memo column also indicates my initial thoughts and queries triggered by the data during coding.

	<b>Key Components</b>	<b>Influencing Factors</b>	<b>Memo</b>
<p>MB: So thanks very much for agreeing to talk to me Margaret, um, so I'm really interested in hearing about your relationships with your therapists and nurses out in rehab. First of all, is there is a therapist or nurse with whom you have or had a particularly close working relationship and can you tell me a little bit about that? Margaret: Um, yeah I did have one, but she's gone.</p> <p>MB: OK. Can you, can you describe what that relationship was like?</p> <p>Margaret: Ah it was pretty like <u>in-depth</u> one, yeah. We were like <u>friends</u>.</p> <p>MB: Yeah.</p> <p>Margaret: And um could talk, she was very...um...what's the word? Not attachable...um, you know, <u>you could tell her anything</u>. And um, <u>she could give you advice and reasons why</u>, which you need.</p> <p>MB: What sort of advice around what sort of things would she give you?</p> <p>Margaret: Oh, as to <u>why things have to be done in certain ways</u>. And cos a lot of it <u>you don't understand</u>, <u>you just get told</u>, you know that <u>you have to do this and you have to do that</u>. And I like to <u>know why</u> it has to be done like that. And um, yeah.</p> <p>MB: How does that help you in knowing the reasons why behind things?</p>	<p>In-depth Friendship-like</p> <p>Tell her anything Understanding why</p> <p>Knowing why</p>	<p>Advice Explains why</p> <p>Not understanding why You just get told Have to do it</p>	<p>Like David and his wife, Margaret describes a strong therapeutic relationship as being friendship like.</p> <p>I am finding it difficult to determine whether some words/phrases are key components or influencing factors e.g. 'understanding why'.</p>

<p>Margaret: Well it's <u>understanding it all</u>. I'm <u>quite happy to do it</u> if you can <u>understand it</u>.</p> <p>MB: It makes sense to you why you're doing it?</p> <p>Margaret: Mmm. Yeah.</p> <p>MB: Were there other really core components of your relationship, other than that you got on well, kind of a friendship-like relationship and that she explained what you were doing and why? Were there other things that were really important?</p> <p>Margaret: Well I actually felt that she <u>cared for me</u>, you know? And that <u>I was in her best interests</u> and <u>I weren't just a patient</u>, you know, that has to be done in a certain amount of time. You know like there are some that... you know you sort of feel like they are on <u>a timeframe</u> and so they like 'right <u>we've got to do this</u> and we've got to do that' and you're on a timeframe and it's like...the other one was, you know, sort of like, '<u>no, we'll get it done when it has to be done...but it will get done</u>' and so that helped heaps.</p> <p>MB: So was it done at a speed that was suited to you or-?</p> <p>Margaret: Yeah, well it was done in a sense that, like, it'll get done, but... um...yeah, it'll get done because <u>we can do it</u>, you know, not because it's a timeframe for finishing it, it's cos <u>we can do it</u> and <u>we will do it</u>. And <u>I'll be here for you to do it</u>.</p> <p>MB: So were there some shared things that you wanted to work on together?</p> <p>Margaret: Yeah.</p> <p>MB: Yeah, what sort of things?</p>	<p><b>Key Components</b></p> <p>Understanding why Happy to do it</p> <p>Caring In her best interest More than a patient</p> <p>Getting the job done</p> <p>Doing it together Being there for me</p>	<p><b>Influencing Factors</b></p> <p>On a timeframe</p> <p>Done no matter what</p>	<p><b>Memo</b></p> <p>There seems to be a link between understanding and engagement</p> <p>Re: Timeframes – I am not sure whether she is talking about a session-based timeframe or a goal based timeframe. She may be referring to achieving goals when they need to be achieved and not just ticking off a 'to-do' list.</p> <p>She seems to be talking about the relationship being a team effort in achieving things together, feeling the pain together etc.</p>
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	Key Components	Influencing Factors	Memo
<p>Margaret: Oh basically, um, just to get going. You know get things moving.</p> <p>MB: Yep. And what sort of impact did your relationship with this person have on you as a person?</p> <p>Margaret: Ooooh, she made <u>me feel like I was a person</u>, you know, <u>not just a thing</u>. <u>Not just something like, something that um...has to be done you know, 'this is my job so I've got to get it done.'</u></p> <p>MB: That's good, and and what sort of impact did it then have on your rehabilitation?</p> <p>Margaret: Well, <u>it made you wanted to do it</u>. You know, because <u>she was there with you</u>. And...must say <u>I'm losing that sort of attitude with one other person</u>, which is a bit of a shame...cos I know she's probably got <u>the same thoughts</u>, but the <u>attitude is different</u>.</p> <p>MB: So can you describe the difference in attitude given that it's quite a stark contrast for you?</p> <p>Margaret: Well, one is that <u>she's got a job to do</u> and it's gonna <u>be done no matter what</u> and sometimes she does <u>hurt, you know</u>, I feel like she <u>doesn't seem to care that much</u>.</p> <p>MB: Ok okay. Whereas the other, as you said was-</p> <p>Margaret: Oh, <u>it would hurt her if I was hurting</u>.</p> <p>MB: Yeah</p> <p>Margaret: You know which is the biggest difference, you know like...yeah, I got hurt the other day and...it was sort of like <u>'well, it's got to be done, because, you know that's the way we're going to get your muscle working'</u>. But it <u>really, really hurt</u> and um, but it got the muscle working, you know <u>it did the job</u>. But I thought it could have been <u>done a lot nicer</u>.</p> <p>MB: OK, so it was the way in that it was done?</p>	<p>Feel like a person Feel more than a thing</p> <p>Want to do it Being there for me Attitude</p> <p>My pain is her pain</p> <p>Done a lot nicer</p>	<p>Feeling like a job</p> <p>Attitude Same thoughts, different attitude</p> <p>Getting the job done Done no matter what Causes pain Uncaring</p> <p>Done no matter what Getting the job done</p>	<p>Being treated like a person and not just a thing/job/patient has already come up several times.</p> <p>Having to do it versus wanting to do it</p>



## Appendix I: Thematic Development

These two tables demonstrate how raw data from several participant interviews was combined to form codes and categories. Of note, some of the data presented in table two appears incongruent with data in table one. An inductive approach to data analysis supported the identification and management of data that seemed to reinforce *or* conflict with existing data; in this example, it led to early conceptualisations of ‘Theme one: Everyone is different.’

**Table One**

Raw data	Code	Category	Thematic development ideas
<p>it was pretty like in-depth one, yeah. We were like friends (Margaret)</p> <p>as if she’s known me a long time (Carol)</p> <p>(Nurse A) and (Nurse B) were like...family (Andy)</p> <p>sometimes there are those special people that we sometimes sort of feel that we’ve build a more special relationship with them (Susan, SW)</p>	Friendship-like	Relationship characteristics: A human connection	A strong therapeutic relationship appears to be characterised by a close or human connection – one that transcends the clinical partnership.
<p>Well I actually felt that she cared for me. You know, and that I was in her best interest (Margaret)</p> <p>I get a deep sense of the caring (Huia)</p>	Caring		These care behaviours seem simple and easily applied– spending time, listening– yet provide emotional nourishment.
<p>it makes you feel that you are someone. You know that’s valued, I should say, and valued enough to share that...even that bit of time with (Margaret)</p> <p>I felt respected, heard and valued (Huia)</p>	Valued		

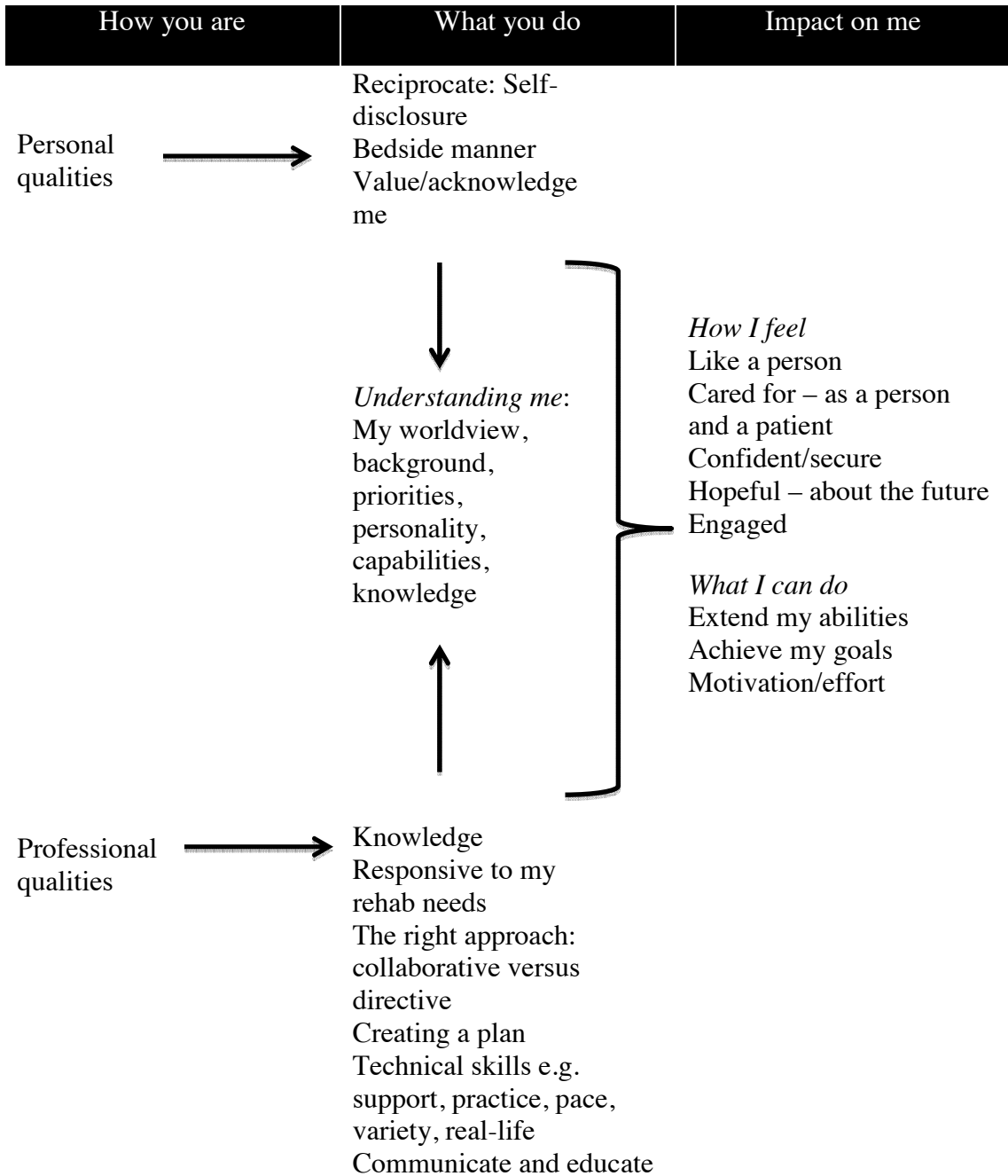
Raw data	Code	Category	Thematic development ideas
I weren't just a patient, she made me feel like I was a person, you know, not just a thing (Margaret)	Treated as a human		
she's got that...way about her. You know of seeing a person (Carol)			
then I know, yes they did listen, they do know who I am (Huia)			
Knowing them as a person, not just as a patient (Lynn, RN)			
just have that just general 'get to you know you' conversation, person to person (Susan, SW)			
she'd share her photos, her life sort of thing, shared part of her with you (Margaret)	Knowing them/ knowing you	Reciprocity: self-disclosure	Reciprocity may help to reveal each other's humanness - seems an important rapport-building tool across cultures.
it's in the kōrero [story/discussion] we share, you give a bit of yourself, somebody gives a bit of themselves (Huia)			
always, you know she would tell me what she was doing on her day off, taking the grandchildren out to the river to go swimming (Andy)			
if you're accepting that you're going to have that element of a two-way sharing of, of information (Bridget, SLT)			
it would hurt her if I was hurting (Margaret)	Vested in each other	An emotional co-investment	
I've had wonderful, wonderful people, nurses working on the ward...ohh they'd move heaven and earth for you...I'd move heaven and earth for these people too (Huia)			

**Table Two**

Raw data	Code	Category	Thematic development ideas
<p>you know you can be friendly but you can't be friends (Toby)</p> <p>I can't see the point in making friends [with clinicians] because that involves a level of...just a level of intimacy that most of the interactions that I had, you can't, you can't be that intimate (Toby)</p> <p>I'd say she's just um...um, professional (Heke)</p>	Being professional	Relationship characteristics: a professional relationship	<p>Client participants appear to want and need different things out of their therapeutic relationships.</p> <p>What is the right type of relationship for each person? A personal/close relationship versus a professional relationship?</p>
<p>I'm not very keen on [nurse B] but she's meant well. Talks too much (Carol)</p> <p>you could see with her that she was more looking in the mirror.... she was telling everybody about the bo- do- dog- dog (Heke)</p>	Sharing too much	Maintaining boundaries	<p>How much do they wish to know their clinicians as people versus focus on the therapeutic work itself?</p>
<p>I just like if they're going to do their job, just get on with it you know (Carol)</p> <p>In an ideal world, I would see it working like..I guess the... physio....just working out what needs to be done and just going for it. Yeah. I don't... speaking for myself, but I don't think you'd need to worry about who the person is so much (Toby)</p> <p>just do the thing, get the thing done and then move on (Toby)</p>	Getting on with the job	A shared rehab focus	<p>Some – like Carol and Huia – appear to want to combination of both</p>
<p>I guess what is attractive about [PT] is that she knows well...she seems to know what she's talking about (Toby)</p> <p>you respect their knowledge and value their...their knowledge and wisdom (Huia)</p>	Technical skills and knowledge		

## Appendix J: Using Diagrams as an Analytic Tool

This diagram attempted to delineate a clinician's personal qualities from their professional qualities. It represents client participants' (potential) perspectives.



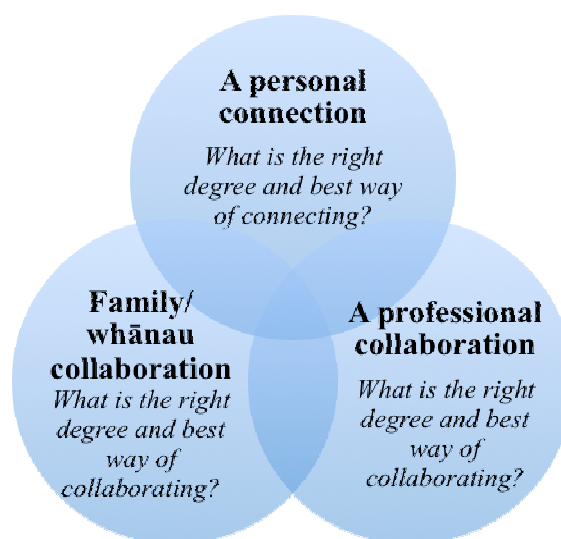


### Understanding Therapeutic Relationships in Stroke Rehabilitation

*What we have found so far:* Two key themes have emerged from our study exploring what clients with stroke and their clinicians view as being the most important components of a strong therapeutic relationship, and what factors may influence it.

*Theme one - Everyone is different:* Each client appeared to have a unique view about what makes a relationship ‘therapeutic’ for him or her. Clinicians may need to consider each client’s preferences and needs within each of the three components in order to build a strong relationship.

**Figure 1: Core components of a strong therapeutic relationship**



Each of these core components are described in more detail below:

A personal connection: refers to how clinicians and clients relate to each other as human beings. Some clients valued having a personal connection with their clinician such as a friendship-type or family-type bond (e.g. by the mutual sharing of personal information, emotions and/or humour). Other clients did not value such a personal connection, seeing other aspects as more valued and important.

A professional collaboration: is about having a shared focus, such as an agreed goal or a detailed plan that clients and clinicians are working towards. Spending time listening and getting to know the client, as well as taking the time to explain the rehabilitation process, seemed to be important. Some clients preferred to take more of a lead in these partnerships whereas others were happy for the clinical experts to decide on the best course of action.

Family/whānau collaboration: clients had quite different views on how involved they wanted their loved ones to be in their rehabilitation. This decision seemed to depend on the role family members played in a client's life e.g. as advocates, key decision makers and/or rehabilitation partners. Family dynamics were also important. Working with family/whānau had the potential to strengthen a client's relationship with their clinician.

### *Theme two - A relationship built on rocks can withstand the knocks*

Our findings indicated that sometimes relationships deteriorated between clients and clinicians. There were different reasons for this and the outcomes from the relationship breakdown also varied:

Contributors to relationship breakdowns: Clinicians may have made some *incorrect assumptions* around a client's needs or preferences, or may *not have responded* in a way that was expected of them. This sometimes got in the way of the personal connection, professional or family/whānau collaboration.

Examples of when a personal connection was affected included clinicians who were seen to talk too much about themselves or who appeared to be uncaring when they carried out their role. Sometimes having different goals or not having a clear explanation about the purpose of a treatment compromised the professional collaboration. At other times, it was felt that clinicians had not discussed important information with the key decision makers in the family/whānau or may have confused the role of loved ones, which weakened the family/whānau collaboration.

Outcomes of relationship breakdowns: It appeared a breakdown had the potential to have positive or negative consequences. Negative consequences included clients feeling distressed or frustrated, distancing themselves, terminating these relationships, or declining treatment. This seemed to occur when the relationship was just beginning to form and when there was a lack of explanation and management of the issue.

Positive outcomes included creating a more effective rehabilitation plan and a more collaborative, stronger partnership. Positive outcomes seemed to occur when there was already a strong relationship in place and when the issue was discussed and suitable solutions found.

*Summary:* Clinicians may need to understand *what matters most* for each client including their preferred degree of personal connection, professional and family/whānau collaboration. Relationships can then be adapted to suit each client. Relationships may falter as a result of incorrect assumptions and/or a clinician's lack of personalised response to a client's needs. However, a strong existing therapeutic relationship may allow for conflict to be well managed, which may preserve and strengthen the relationship.

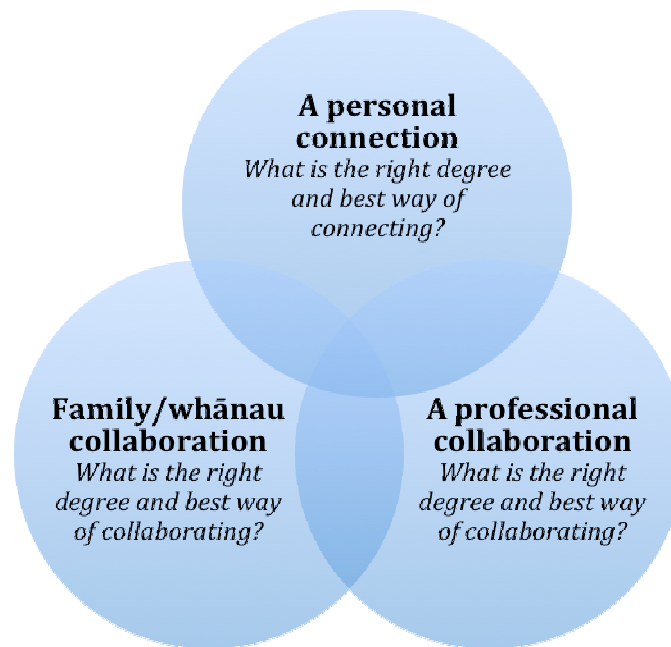


## Appendix L: Member Checking Information: Clinician Participants



### Summary of Initial Findings

Core components of a Strong Therapeutic Relationship



### Combined Themes

<b>Core components of a strong therapeutic relationship</b>	<b>Relationship enhancers</b>  <i>Core processes: attunement and responsiveness</i>	<b>Relationship detractors</b>  <i>Core processes: assumptions and lack of responsiveness</i>
A personal connection	A compatible degree of connection: an emotional co-investment Rehabilitation delivery: empathetic and personalised Appropriate reciprocity: self-disclosure, emotion and humour	An incompatible degree of connection Rehabilitation delivery: lack of humanistic care Inappropriate self-disclosure and insufficient humour
A professional collaboration	A shared focus and plan Suitable levels of collaboration/power Spending time listening, explaining and planning	A divergent or lack of focus Unsuitable levels of collaboration/power Clinician impulsivity: failure to stop, listen and explain
Family/whānau collaboration	The right degree of collaboration Clarity around the role of family Managing family dynamics	An unsuitable degree of collaboration Confusion around the role of family

## Appendix M: Auckland University of Technology Ethics Committee Approval



# MEMORANDUM

## *Auckland University of Technology Ethics Committee (AUTEK)*

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To: Nicola Kayes  
From: Rosemary Godbold, Executive Secretary, AUTEK  
Date: 25 September 2012  
Subject: Ethics Application Number **12/237 Understanding the therapeutic alliance in stroke rehabilitation.**

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Dear Nicola

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEK) at their meeting on 10 September 2012 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEK's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement by AUTEK at its meeting on 8 October 2012.

Your ethics application is approved for a period of three years until 25 September 2015. I advise that as part of the ethics approval process, you are required to submit the following to AUTEK:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 25 September 2015;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 25 September 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEK is notified of any adverse events or if the research does not commence. AUTEK approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEK grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to

make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTECH Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at <http://www.aut.ac.nz/research/research-ethics/ethics>).

On behalf of AUTECH and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold

Executive Secretary

**Auckland University of Technology Ethics Committee**

Cc: Megan Bishop [megbis11@aut.ac.nz](mailto:megbis11@aut.ac.nz), Kathryn McPherso

## Appendix N: Next-of-kin Assent Form



# Next-of-Kin Assent Form

*Project title: Understanding the Therapeutic Alliance in Stroke Rehabilitation*

*Project Supervisor: Dr. Nicola Kayes nkayes@aut.ac.nz  
(09) 921 9999 x 7309*

*Researcher: Megan Bishop megbis11@aut.ac.nz  
[workplace number]*

### Declaration by next-of-kin:

I have read and I understand the Participant Information Sheet. I have had the opportunity to ask questions and I am satisfied with the answers I have received.

I agree that ..... (participant's full name) may participate in this study.

I have been given a copy of the Participant Information Sheet, Consent Form and Assent form to keep.

Next-of-Kin's name:

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

*Approved by the Auckland University of Technology Ethics Committee on 25/09/12  
AUTEK Reference number 12/237*

*Note: The Participant should retain a copy of this form*