

# Engaging people experiencing communication disability in stroke rehabilitation: A qualitative study

**Background:** Engagement is commonly considered important in stroke rehabilitation, with some arguing it is essential for positive patient outcomes. An emerging body of research indicates the practitioner influences engagement through their ways of relating, communicating and working with the patient. People experiencing communication disability may face particular challenges with engagement as a practitioner's communication and interactional patterns may limit their ability to engage.

**Aim:** To understand how rehabilitation practitioners worked to engage people experiencing communication disability throughout the course of rehabilitation.

**Methods and Procedures:** A qualitative study using the Voice Centred Relational Approach. Longitudinal observational and interview data were gathered from 28 practitioners and three people experiencing communication disability in inpatient and community stroke rehabilitation services. Data were analysed using the Listening Guide.

**Outcomes and Results:** Engagement was a relational practice on the part of the rehabilitation practitioner. It was underpinned by a relational philosophy and was characterised by three core processes: embedding relational work throughout rehabilitation; getting to know the patient and working in ways valued by the patient; and communicating using relational dialogue and supported conversation. Practitioners wove these together with their technical, disciplinary-based work and rehabilitation tasks.

**Conclusion:** Patient engagement was constructed through relationships and strongly influenced by the practitioners' way of thinking about and enacting practice, challenging the idea that engagement is solely an intrinsic patient state and behaviour. The findings raise questions about which aspects of rehabilitation work and communication are legitimate and valuable when working to engage people experiencing communication disability. Viewing engagement as a relational practice and understanding the different ways this is enacted may support practitioners to reflect on their understandings of engagement, their patient's engagement, on their ways of working, and the frames and philosophies which surround and influence their practice.

**What this paper adds**

*What is already known on the subject*

Previous research has indicated patient engagement is important for rehabilitation outcomes. However, little research has considered how this engagement develops and is maintained. People experiencing communication difficulties may have particular challenges in engagement because of how staff communicate with them and involve them in rehabilitation.

*What this study adds*

We demonstrate how patient engagement is a relational process and practice, occurring through the relationship between the person experiencing communication difficulties and their rehabilitation practitioner/s. Our study elucidates the core components of engaging practices. We argue that relational work is a valid, legitimate form of rehabilitation work that needs to be valued and supported in education, practice and policy.

*Clinical implications of this study*

Practitioners need to critically reflect on how they engage patients in rehabilitation. They may consider which processes are present and privileged in their own practice, and in their broader clinical context. Speech-language therapists may consider how they support other members of the multi-disciplinary team to enact relational practices.

## Introduction

Patient engagement is increasingly discussed in healthcare literature and clinical services. Our recent conceptual review argued engagement involves a process of the patient and practitioner engaging with each other and the healthcare process, as well as being engaged in the healthcare services (Bright et al., 2015). The process of the patient and practitioner engaging with each other occurred through the relationship and communication between them, and in particular, through the sense of being in an authentic respectful relationship where patients feel they can talk and what they say is respected, listened to, and acted upon. This can create an atmosphere of collaboration and connection which supports the patient to actively participate in services, a 'state' of engagement. This may be characterised by a range of behaviours from simply participating to demonstrating active commitment and emotional investment in healthcare (Bright et al., 2015). Several authors have argued that the benefits of rehabilitation are limited if the patient is not fully engaged in the process (Kortte et al., 2007; Medley and Powell, 2010), describing it as important for patient satisfaction and patient outcomes such as mood and functional recovery (Kortte et al., 2007; Lequerica and Kortte, 2010). For these reasons, understanding how engagement occurs, and how rehabilitation practitioners can enhance engagement appears important.

Following a stroke, over 50% of people may experience communication disability (O'Halloran et al., 2009a; National Stroke Foundation, 2010). It is well-recognised that patient-practitioner communication and relationships can be challenged because of this. Patients depend on their communication partner (practitioners in this paper) to support their communication (Kagan, 1998; Togher, 2013). Yet a practitioner's communicative behaviours may negatively influence communication success and active participation in interactions

through actions such as controlling topics and communicative conduct (Finke et al., 2008; Gordon et al., 2009; Dickson et al., 2008) and ignoring a patient's communication attempts (Parr et al., 1997; O'Halloran et al., 2012). People experiencing communication disability have reported not being listened to (Dickson et al., 2008; Parr et al., 1997), feeling isolated, excluded and sometimes unsafe (Nyström, 2009; Hersh, 2015). The practitioner's communication may reflect their level of knowledge and skill in communicating with this patient population as well as their underlying attitudes or values with regard to communication (Hemsley et al., 2012; O'Halloran et al., 2012). Some practitioners consider communication with this patient group to be difficult, unnecessary or time-consuming (Finke et al., 2008; Hemsley et al., 2012; Hemsley et al., 2011; Nyström, 2009) and may not attempt communication (Finke et al., 2008; Hemsley et al., 2012). These behaviours are inconsistent with those important in developing a therapeutic relationship (Fourie, 2009) and patient engagement (Bright et al., 2015). While asymmetric communication patterns may be common in healthcare interactions (even when a patient has no communication impairment), there is evidence these are more common when the patient experiences communication disability (Hersh et al., 2016) and can have significant repercussions for patient engagement (Bright, 2016).

There has been limited research explicitly exploring the engagement process of people experiencing communication disability after stroke. Bright and colleagues (2017) identified the practitioner's own engagement was important in patient engagement. If the patient perceived them to be engaged, it helped engagement. Conversely, if they were considered disengaged, this negatively affected patient engagement. Two observational studies explicitly explored the engagement process (Horton et al., 2011; Simmons-Mackie and

Damico, 2009), demonstrating how engagement was co-constructed through the interaction between the patient and practitioner, influenced by patient factors such as cognition and emotion (Simmons-Mackie and Damico, 2009) and practitioner actions such as their verbal and non-verbal actions, activity selection, and delivery of instructions (Simmons-Mackie and Kovarsky, 2009; Horton et al., 2011). Engagement practices were socioculturally located, influenced by institutional values and priorities, and practitioners' understandings of how patients should behave (Horton et al., 2011). While these two studies provided detailed descriptions and analysis of individual treatment sessions, there remains little knowledge about the engagement process throughout the course of rehabilitation, as it occurs between patients and a diverse and representative range of rehabilitation practitioners.

The aim of this research was to develop rich understandings of the process of engagement for people experiencing communication disability after stroke, and in particular, examining how rehabilitation practitioners worked to engage patients throughout rehabilitation.

## **Methods**

This research was embedded within a wider study of patient engagement in stroke rehabilitation (Bright, 2016). This wider study had two components: an interview-based study exploring how people experiencing communication disability and practitioners conceptualised and experienced engagement; and an observational study exploring how engagement was enacted in rehabilitation. This paper draws on data from the observational study.

The research was underpinned by the Voice Centred Relational Approach (VCRA), a qualitative methodology which attends to the different voices (perspectives and stories) within a person's communication (Mauthner and Doucet, 1998). It takes the perspective that there are multiple voices within a person's story. Understanding these voices, how and when they arise, and how they interact can give nuanced insight into a phenomenon (Mauthner and Doucet, 1998). Our use of the VCRA is situated within a relational ontology and social constructionist epistemology, taking the position people exist within relationships, and that knowledge is socially constructed through interaction (Bright et al., 2018). The methods for the research have been published in-depth elsewhere (Bright et al., 2018).

The research was located within a rehabilitation service in a district health board of a large city in New Zealand. Rehabilitation was provided in both an inpatient unit and a community based service. The inpatient unit provided multi-disciplinary rehabilitation for two-to-twelve weeks, depending on patient needs and priorities. The community service provided intensive community (home) based rehabilitation for six-to-twelve weeks. Organisational and ethical approvals were obtained before data collection commenced.

## **Participants**

Twenty-eight patient-practitioner dyads participated in this research, involving three patients and 28 rehabilitation practitioners. One patient participated twice, once as an inpatient, and once as a community service user meaning this study has three patient participants over four rehabilitation episodes (see Table 1). We have used pseudonyms to help ensure confidentiality. We used purposeful sampling, seeking diversity in type and

severity of communication impairment (measured by the OHW Scales (O'Halloran et al., 2009b)), ethnicity and rehabilitation services used. Eligible patients were approached by a recruiting speech-language therapist who was employed by the district health board. Patients were eligible to participate if over 18 years of age, able to communicate with the researcher with supported conversation (Kagan, 1998), and living at home or were anticipated to return home. Potential participants were given information about the research and if interested, their details were provided to the researchers. The researchers then met the patients and family to discuss the study. Informed consent was gained before commencing data collection, using supported conversation techniques.

---Insert Table 1 here---

Each practitioner initially involved in the patient's care was approached once the patient participant had consented. Initially, all practitioners were approached. As the study progressed, we employed purposeful sampling to identify potential practitioner participants, seeking diversity in professional role and experience. Of the 29 practitioners invited to participate, 28 practitioners consented to take part (Table 2). We provide limited information about the practitioner participants to ensure internal confidentiality (Kaiser, 2009; Tolich, 2004), limiting the possibility of participants being identified by other participants or readers. This was a requirement of our ethics committee approval.

--- Insert Table 2 here ---

## Data collection

Data were gathered through multiple means: observations of clinical interactions, team and family meetings (n=160 observations over 147 hours); interviews with participants (n=108); and stimulated recall interviews with participants (n=5). These interviews used excerpts of videos of interactions to elicit thought processes and feelings about the interaction (Gass and Mackey, 2000). The data collection process is summarised in Figure 1. All data collection was completed by the first author.

--Insert Figure 1 around here--

The primary mode of data collection was observations. Most interactions between each patient-practitioner dyad were observed in the first two weeks of rehabilitation. Subsequent observations were event-sampled, observing events that were anticipated to be data rich as informed by previous data collection (i.e. a dyad in which one or both parties reported strong engagement), or were common events (e.g. ward round), or represented a variety of forms of interaction (e.g. informal interactions in the dining room). All interactions were audio-recorded with most event-sampled interactions being video-recorded. Field notes were recorded during and/or after observations, and after reviewing recordings.

Short debrief interviews (n=93) were completed after observed interactions, exploring each participant's perspectives of that specific interaction, asking questions such as "tell me about what you did to engage the patient in that session?" (practitioner) and "how engaged did you feel?" (patient and practitioner). While it was intended these would be conducted after most, if not all observations with both the patient and practitioner, practicalities such as

patient fatigue or their rehabilitation timetable, or practitioner commitments, meant this did not always happen. Semi-structured interviews (n=15) were conducted after discharge, exploring broader perceptions of engagement throughout rehabilitation as well as their thoughts and feelings about engagement and professional practice. Questions included “How did you perceive your patient’s engagement?”, “Can you tell me about your own engagement throughout rehabilitation?” and “What are the key values which inform how you work?”. These interviews were completed with purposefully selected participants, namely, practitioners who were observed four or more times, or those where previous data gathering suggested an interview may assist in developing a more comprehensive understanding of engagement practices. All patient participants were invited to participate but all declined.

Stimulated recall interviews with five practitioners were conducted during the patient’s episode of care. Interactions were selected for several reasons: patients and/or practitioners identified the interaction as significant in enhancing or diminishing engagement; the interaction was considered ‘typical’ for the dyad; or the interaction was perceived to be markedly different to usual sessions, by participants or by myself. A five-to-ten minute video recording was shown to the participant before they were asked to talk about what happened, and what they were thinking as they were working.

### **Data analysis**

Data collection and analysis was iterative, occurring concurrently with each process informing the other. Prior to analysis, all data from each dyad were combined into datasets

(n=28). The Listening Guide was the primary analysis technique (Gilligan et al., 2005; Mauthner and Doucet, 1998; Bright et al., 2018). It involved four readings of each dataset:

1. The first reading considered the stories within the data and the researcher's response.
2. The second reading explored how participants spoke of themselves, their actions, thoughts and feelings.
3. The third reading focused on how participants spoke of others and the relationship between themselves and others.
4. The fourth reading attended to the broader context surrounding the interactions.

I-poems (Gilligan et al., 2005) were constructed by combining statements which included personal pronouns such as "I" or "you" to help explore how people spoke of themselves and others. When such pronouns were absent or incorrect because of the aphasia, these were added in brackets, indicating the researcher's role in constructing the statement, e.g. "[I] hate what I do with her". These analyses were integrated into a written narrative, one for each patient-practitioner dyad (Gilligan et al., 2005). Analysis *across* participants involved a process of synthesis and constant comparison guided by the question: 'how do rehabilitation practitioners engage people experiencing communication disability in stroke rehabilitation?'.

Tracy's (2010) quality criteria were used. Reflexivity was supported through the use of the Listening Guide and its requirement that the researcher explicitly identify their response to the data in Reading One, and memoing and discussion between researchers. Thick description, multi-vocality and crystallisation (drawing on multiple forms of data from multiple time points and multiple perspectives) aided credibility (Tracy, 2010). Rigor was obtained by using a theoretically informed approach (Bright et al., 2018), spending

significant time in the field gathering rich data, using robust and transparent data collection and analysis techniques, which have been detailed elsewhere (Bright, 2016; Bright et al., 2018).

## **Results**

Engagement was a relational practice, evident when practitioners worked successfully and intentionally to engage people experiencing communication disability. Three practices were consistently present throughout their interactions:

1. Valuing relationships and embedding relational work throughout interactions;
2. Getting to know the person and working on what matters to them in a way that was valued by the patient; and
3. Communicating in ways which facilitated engagement by integrating supported communication, relational dialogue and active listening.

Practitioners wove these aspects together with technical, disciplinary-based work and rehabilitation tasks in a flexible, responsive way of working. This practice was underpinned by a relational philosophy. There was consistency between their philosophy, practice, and the patient's needs and priorities.

### **Valuing relationships and embedding relational work throughout interactions**

Practitioners who consistently enacted relational practices argued the interpersonal relationship was the “cornerstone of therapy” [Margaret, allied health practitioner (AHP)]. Margaret continued: “I feel it's more your relationship with your patient that's useful than actually what you know and do”, providing a springboard for other aspects of care,

“[opening] the doors to future conversations. You can follow up more, you can ask different questions” [Myra, nurse]. Practitioners who worked in this way considered they had an active role in engaging patients and worked intentionally to develop relationships.

Developing an interpersonal connection was a key step in developing a relationship. One practitioner described the process saying:

We developed a strong relationship quite quickly  
We found a connection, that connectivity  
We just started sharing each other’s stories  
We found points of interest  
I’d think “where is there a similarity between us?”  
[i-poem, Eleanor, AHP]

When practitioners shared something of themselves, patients came to know them as a person, giving a “sense of who people [practitioners] are”. Betty [patient] continued, saying “maybe I’m just an old lady but I like to know what people do and what people are”. She described engaging easily with Jessica, a rehabilitation assistant who “has given a lot of herself, various aspects of herself. I feel lucky I’ve got her”. This appeared to be facilitated by Jessica’s actions and disclosure which partly arose from her sense of connection with Betty, reflecting an iterative two-way relationship: “I just connected with her in such a way I felt that I could give some of my personal stuff, not a lot ... they like to know about you as well”. In intentionally sharing limited personal information, practitioners positioned themselves as people, not disconnected professionals.

A sense of relationship and connectivity was developed through non-verbal communication such as laughter, touch, body position, and maintaining eye contact. These conveyed a sense

of interest in the other person and acknowledged their contributions to the conversation, as evident in an interaction between Myra [nurse] and Betty:

Myra comes in to do the afternoon observations. Betty and I (researcher) are talking and Myra joins in the conversation, saying “they [observations] can wait for a bit”. She leans over the bed. She makes continuous eye contact with Betty, making suggestions when she is unable to get the words out, giving positive feedback when she is able to communicate her message. [Descriptive fieldnote]

Listening appeared crucial in enacting relational practices. This involved physical and communicative action, sitting or being physically together, listening for the meaning of the patient’s verbal and non-verbal communication rather than hearing and responding to the words or facts immediately evident in the person’s message:

She doesn’t respond to *what* the patient says, instead she focuses on *how* she is saying it, acknowledging the agitation, distressed tone and tears. While they are talking, she sits back, leaning back in the chair, watching and listening. She makes eye contact. A brief touch on the hand when he expresses anger. Waiting two, three, four seconds before talking. There is silence, a lot of silence, letting the person talk. [Descriptive fieldnote, interaction between Ryan and Melody, nurse]

After that interaction, Melody commented: "I'm really listening to the things he says are important". Listening was an intentional, disciplined act which allowed a space for a connection to develop, for a patient (and/or family) to feel heard and understood, and was considered to have therapeutic value.

People experiencing communication disability valued their relationships with practitioners. A strong relationship helped patients feel known by the practitioner, with one commenting: “[rehabilitation] is about the patient, not how they do things” while another said: “they come in here and they know me”. When patients perceived there was a strong relationship, they felt cared-about and cared-for. This was particularly important when patients struggled

in rehabilitation. Ryan [patient participant] commented: “I hate what I have to do ... but if it had to be with anyone, it should be with her. She always focused on you, she always said hi. She treats you like a person, not a number.” The relationship between the two parties helped create a therapeutic environment which supported engagement.

A hallmark of this relational approach to engagement was that practitioners embedded relational work throughout rehabilitation, combining both relational and technical, disciplinary-based work. Betty [patient] described this way of working as combining “professionalism and semi-professionalism [pointing to the heart]”, as though professionalism refers to technical knowledge and skill while semi-professionalism pertains to relational aspects of practice. Relational work occurred through all interactions, formal or informal, scheduled or unscheduled. This contrasted with practitioners who appeared to spend a short period of time in self-described ‘rapport building’, a standalone act characterised by asking several questions about the patient and their recent activities, before then focusing on their disciplinary work. It also contrasted with practitioners who only interacted with patients during timetabled interactions such as therapy sessions or on days when they were the patient’s named nurse, seemingly ignoring them if they saw them outside those times, such as passing them in the hall or dining room. When engaging relationally, the practitioner’s communication was consistent throughout interactions across the episode of rehabilitation, making it appear a genuine, authentic way of working on the part of the practitioner.

When practitioners prioritised relationship building both within their talk-*about*-action (when reflecting on their interaction in interviews with researchers) *and* their talk-*in*-action

(their observed actual interactions with patients), they were intentional and reflexive about their practice, attending to their ways of being and acting, and how this was interpreted.

They considered how they needed to work, and what their actions brought about, mindful of the positive *and* negative consequences of their practice. For instance, Ryan [AHP] reflected on a session saying:

There was a lot of flapping around at the start. I know the family have been a bit disappointed with the care in the stroke unit - the last thing you want is to look like you don't know what you're doing ... The first few sessions are all about getting them on board.

Another AHP commented on how she worked with a family member:

I'm trying to develop rapport and relationship with her so she feels ... I think she feels that people aren't on her side which isn't what it's supposed to be about ... It's about trying to listen and I think keep her informed. I think that's what happening ... I try and make sure I poke my head in ... it only takes five minutes but it's so important. I think she feels really alone.

These detailed reflections contrasted with those offered by practitioners who had more difficulty engaging patients, or who rarely appeared to enact relational practices. Sometimes they assumed relationships would develop naturally, with one doctor commenting "I think that by having a good working relationship with [Betty] everyday, that we would naturally build a relationship. I don't think there's anything formal I would do." Others described themselves as relational and engaging yet their descriptions of practice were non-specific, with Harriet [AHP] saying: "I think [I am a] relational therapist. Obviously I focused on getting to know her and building that relationship". When asked for more detail about how she built a relationship or why she considered it important, Harriet struggled to provide more detail. Her perceptions of her practice were not shared by her patient who considered there was no connection between them. The reflections of these practitioners were commonly broad statements consisting of assumptions while practitioners who consistently enacted

relational practices offered detailed critique of their practice, purposefully and reflexively considering *how* they worked and how they could facilitate relationship development.

### **Getting to know the person: What matters and how to work with them?**

When working intentionally and successfully to engage patients, practitioners prioritised getting to know the person, their personality, values, needs, concerns and experiences, to help them understand how they needed to work to engage the person in rehabilitation. They used this as the starting point for planning and enacting rehabilitation. Practitioners sought to gain a sense of who the patient is and was before their stroke and their experiences since their stroke, considering 'what does this person need me to do?'. One AHP commented: "I know they've had a really bad experience on the ward and have been really disappointed in their care". He took this knowledge and considered how he needed to work which informed the actions he gave primacy: "For me, it's really important to give them a positive experience ... you want them to leave with the feeling he's done something and that he's enjoyed it".

This could see practitioners emphasise different ways of working. For instance, when working with Ryan, the physiotherapist emphasised creating success in order to engage, while the occupational therapist prioritised developing a relationship by spending time talking with the same patient and his family. This reflects a personalised, intentional way of working.

A contrasting starting point often evident in clinical practice was 'what do I need to do?'

Relationships and patient priorities were backgrounded while the practitioner-prioritised tasks were foregrounded. Such tasks commonly reflected habitualised and often mandated

patterns of work centred on assessment, goal-setting and discharge planning. When prioritising technical, disciplinary-based work, assessments dominated early interactions and shaped what the practitioner knew of the patient. They sought knowledge about facts about past and current functioning, deficits, and environmental factors that might impact the patient on discharge. Two inpatient AHPs described their early priority as “finding out information today ... we needed to see her walk and get on and off the toilet”. When asked about the patient’s priorities, they responded “we didn’t touch on those.” While they planned to discuss these, one practitioner later commented “that’s something I failed to look back on”. When the starting point was ‘what do I need to do?’, the patient’s needs could get lost. When technical, disciplinary-based work was prioritised and relational and engagement-oriented work was absent, this appeared to negatively influence patient engagement.

Getting to know the patient and what they needed commonly occurred through conversation. Practitioners would sit down with the patient and talk about what was important in this person’s life. These conversations opened up understandings of the person, their needs and their priorities. Practitioners did not simply consider *what* was important, but focused on *why* this was important:

You’re working on what they’ve described as being important  
I’m here to try and help them with strategies  
To get them to where they want to go is more important  
Toileting and showering are things that are important  
Ryan’s always been very dignified, well-presented  
He’s a proud man, it’s about helping to give him his dignity back  
[i-poem, Catherine, AHP]

Catherine’s conversations informed what she did and how she worked with him. She combined both technical, disciplinary-based work (addressing independence with personal

cares) and relational work (listening and taking time to talk), responding to Ryan's needs.

When enacting relational practice, practitioners combined their knowledge of the patient's experiences and priorities, and their own technical, disciplinary-based expertise to match their way of working to the patient's needs.

Some practitioners considered goal-setting was a technique for getting to know the patient and inform rehabilitation, as well as "helping the patient feel motivated" as Kelly [AHP] said. The processes could be confusing or hidden for patients. Practitioners often assumed patients understood the goal-setting process and why it was being done, with Kelly [AHP] saying "I think she probably realised [why we did goal-setting]". The patient expressed bemusement, saying she didn't understand what was happening or why. Patients were not always involved in the process. In many instances, goal-setting appeared to a service-mandated process rather than something meaningful for patients. Instead, conversations which explored who the patient is and what is of value and meaningful to them appeared more engaging, and were a hallmark of a relational approach to practice.

### **Communicating to engage through supportive relational dialogue**

Communicating in ways that enabled patients to both understand what was happening and express themselves within interactions appeared crucial for engagement. One patient described his comprehension difficulties as his "biggest issue" in engagement, saying "I couldn't understand what was actually happening". Patients talked of needing their "views [to be] understood", and of "being able to say what matters". This was important as

rehabilitation needed to be meaningful and valued by the patient if they were to become and remain engaged.

Practitioners who successfully and intentionally engaged people in rehabilitation wove supported conversation techniques throughout their interaction:

Catherine: I saw that cool picture in the dining room (referring to Ryan driving a racing car). You look good Ryan (thumbs up), it's a cool photo. Did you get to go ride on the track? (gesture 'driving')

Ryan: Yip

Ryan's wife: 2012 for his birthday

Catherine: How fast did they go? (gesturing 'fast') (pause 5 seconds)

Ryan: Maybe .. (unintelligible)

Catherine: (pause 2 seconds) Faster than 100kph? (surprised intonation)

Ryan: Oh yeah

Catherine: Pretty up there? (gesture 'high') (raised eyebrows, raised intonation)

Ryan: Yip

Catherine: Like 150 or something?

Ryan: Mmmm (neutral tone)

Catherine: No – lower? (gesture 'low')

Ryan's wife: Higher

Catherine: Wow – speedy (surprised intonation)

Within this interaction, Catherine used pauses, facial expression, simple questions, tone of voice, and gesture to support Ryan to understand and respond to her questions. Ryan appeared to want to participate, responding verbally and non-verbally and maintaining eye contact with Catherine. She supported him to actively participate by directing all questions to him. She maintained eye contact throughout their discussion and persisted in the conversation, seeking to understand his experiences. In this way, Ryan was supported to be an active participant in the interaction, even in the presence of severe communication

impairments. Communication reflected a process of dialogue which involved two-way communication flow. The flow of interactions bore similarities to regular conversation with both parties contributing, both seeking and sharing information.

A consistent characteristic of a relational approach to engagement was the presence of a dialogic approach which saw the patient constructed as a legitimate, valued communication partner. While interactions explored clinical topics, they were not limited to these topics. The two-way interaction reflected a connection between two *people*, not two disconnected parties solely defined and known by their roles and positions within rehabilitation. Patients were supported to participate even when their verbal output was limited:

Jessica checks facts as Arthur talks, identifying he was living with his sister. She encourages him to take the pen. He writes his previous address. When he gets stuck, she writes down options which facilitate ongoing discussion. Jessica draws on her knowledge of Arthur to support conversation - his sister's name, that he was a builder. This sees them go into a conversation about him going into building after leaving school. Jessica has been writing key words down; she refers back to these as they have the conversation - "I think you're telling me something about losing your hearing while you were a builder". [Descriptive fieldnote, Arthur and Jessica, AHP]

This was a holistic, conversational approach to communication which we termed 'relational dialogue'. Practitioners combined a range of communicative behaviours: communication *techniques* consistent with supported communication such as writing and gesture; *content* or topics, both clinical and non-clinical; communicative *conduct* such as body language and responsiveness to patient communication; and communicative *acts* such as joking, chatting or questioning. In the interaction between Tim and Ryan, informal comments such as "you're like me, I look at my wife all the time when someone asks me a question" deflected from Ryan's communication difficulties. Tim took the spotlight and possibly the pressure off him which demonstrated dignity and respect for Ryan while still maintaining a

conversational flow. In giving a little information about himself, Tim fostered a sense of relationship and two-way dialogue. This approach was an interactional approach to communication which created a space where information was shared and understandings were jointly constructed.

'Relational dialogue' contrasted with an approach we have called 'practitioner-centred monologue'. This was evident when practitioners controlled the process of communication and appeared to focus on information-seeking or information-giving. The practitioner's verbal and non-verbal behaviour could minimise the patient's role resulting in the patient's needs and preferences being sidelined or only briefly acknowledged to the degree to which the practitioner allowed as evident in this interaction between Kelly and Betty:

Kelly: I want you to think how you're feeling in terms of your overall health, what you can do or are having difficulty with, your mood, your overall health. 0 is very bad. 100 is very well. Where do you put yourself now?

Betty: Particularly now, afternoon is when I really am going right down and I think that is because I'm obviously building no I'm not really, it's just entertaining people it's very weary. [While Betty is talking, Kelly sighs several times and looks at her watch].

Kelly: So right now, how are you feeling about everything now, where would you put yourself now?

Betty: 40-50

Kelly: So 45 then. [brief laugh] Sorry about that, we just need to do it for the outcome measure.

[Descriptive fieldnote, Betty and Kelly, AHP]

Kelly's focus on completing the outcome measure, her lack of responsiveness to Betty's narrative and her actions such as sighing and looking at her watch effectively sidelined Betty and her concerns within this interaction. This positioned Betty as a recipient of what Kelly perceived she needed to do, which Betty commented on, saying: "She obviously had a lot of

questions to ask. Does she come in with a script she needs to go through with me? This is what she's got to finish?". Within the interactions of other dyads, it was apparent the practitioner's use of supported conversation techniques, when combined with a focus on finding out what the practitioner considered they needed to know could limit the patient's communication and their ability to meaningfully participate as a conversational partner. This is evident in the interaction between Bridget [AHP] and Betty. Bridget, in an interview, stated she simplified her questions, primarily asking yes/no questions to support comprehension and expression

Bridget: Do you have hobbies?  
 Betty: Yes  
 Bridget: Do you go out regularly?  
 Betty: Yes  
 Bridget: Oh, is that to Toastmasters?  
 Betty: Yes  
 Bridget: What night is that?  
 Betty: Wednesday  
 Bridget: How do you get there?  
 Betty: I drive  
 Bridget: OK

When communication was centred on clinical information-seeking and when the practitioner controlled the topic and conduct of interaction, this could inhibit the patient's ability to express what was meaningful and important to them. When enacting 'practitioner-centred monologue', practitioners controlled the *content* and *conduct* (who was spoken to and when) of the interaction. Communication *topics* were clinically oriented and often focused on stroke-related impairments. The primary communicative *acts* were questioning, often using a rapid request-response-format which focused on finding out the specific information they needed to know, or telling what was going to happen. 'Practitioner-centred monologue' resulted in a transactional form of communication centred on the practitioner's needs with

the patient's needs and perspectives being sidelined. It is important to note that *all* practitioners demonstrated characteristics of 'practitioner-centred monologue' at times. What distinguished engaging practitioners was that they used both approaches at different times, for different purposes. This reflected that communication needed to be multi-faceted. The combination of modifying communication in response to the person's communication impairment, enacting a relational approach to communication within interactions, and active listening were core aspects of communication consistently evident when practitioners were successfully and intentionally engaging people through relational practices.

### **Enacting engagement as a relational practice: A summary**

Central to a relational approach to engagement were the practitioner's professional values and philosophy of practice:

I'm just walking alongside him and the family  
It's a person-centred approach to practice  
Empowering him  
Showing him that I am here to walk  
We're helping with rehab but we shouldn't be calling all the shots  
We shouldn't be telling people what to do anyway  
It's us together not us and them  
We're not here to have a different perspective to them.  
It's working alongside, it's not me dictating  
It's what we're working on  
[i-poem, Catherine, AHP]

Practitioners who worked in this way clearly articulated their philosophy of practice, in both their talk-*in*-action and talk-*about*-action. This informed their understandings of rehabilitation practice, including the role of engagement and relational work, the practitioner's role in these, whose knowledges and experiences were valid and valuable, what elements of care were important in rehabilitation, and what forms of rehabilitation

work were valued and considered legitimate, as evident in Catherine's i-poem. Engaging through relational practices involved a complex, interwoven way of working. By addressing the patient's priorities in ways which were meaningful, and continually critically reflecting on their own practice, practitioners were able to successfully engage patients in their rehabilitation. Practitioners who worked in this way closely attended to their way of being and acting with the patient. They saw themselves as active ingredients in engagement, conscious that their way of working impacted on patient engagement. Practitioners did more than *say* they valued engagement. They critically reflected on how their work impacted on engagement, and worked in different ways to facilitate engagement. They incorporated relational work and communication throughout their interactions, positioning each as a legitimate aspect of rehabilitation practice. This way of working was skilled and nuanced. Their practice was explicit, coherent and intrinsically consistent. Relational practices involved a complex interplay of philosophy and practice, requiring consistency between these, and between the practitioner's way of working and the patient's needs and priorities. It was a unified, connected approach to engagement.

## **Discussion**

Engaging people experiencing communication disability in stroke rehabilitation occurred through relational practice, underpinned by a relational philosophy of practice. Engagement appeared to emerge within and because of relationship, Practitioners wove together relational work, knowledge of the person and their needs and relational communication, and prioritising these alongside technical, disciplinary-based work and rehabilitation tasks in a highly skilled and individualised manner. Viewing engagement as a relational practice offers

a novel perspective on engagement in stroke rehabilitation. It shifts the focus from the patient state or behaviour as is currently emphasised in much of the engagement literature (Lequerica and Kortte, 2010; Lequerica et al., 2009), instead foregrounding the practitioner and the relationship between the patient and practitioner. Viewing engagement as relational and co-constructed (Bright et al., 2017) is consistent with a growing body of literature which argues for the centrality of relationships in rehabilitation and clinical practice (Douglas et al., 2015; Worrall et al., 2010; Kayes et al., 2015).

Our research highlights the tensions in enacting relational practices. One key tension arises from ideas of what work is valued and legitimised in rehabilitation, which both reflected and influenced a person's philosophy of practice. Many practitioners gave primacy to assessment and treatment, reflecting a 'technical-rationalist' approach which dominates the medical model of care and has influenced what knowledges and practices other professions prioritise (Byng et al., 2002; Trede and Higgs, 2008). Accordingly, technical, disciplinary-based work is prioritised in rehabilitation practice, research and clinical guidelines (Whyte and Hart, 2003; National Stroke Foundation, 2010) while limited attention is given to the practitioner's role in influencing rehabilitation processes and outcomes (Kayes et al., 2015). We suggest it is important to consider what is excluded when technical, disciplinary-based work is given primacy, and what this might mean for patient engagement.

Patients in this research consistently reported that working on what is meaningful and having the sense that rehabilitation is adding value was important in engagement, something also evident in the rehabilitation and communication disability literature (e.g. McPherson et al., 2014; Armstrong et al., 2012; McLellan et al., 2014). While rehabilitation

services commonly have structured assessment and goal-setting processes, our research suggests these did not necessarily facilitate engagement. We suggest our findings could prompt practitioners to reflect on *how* these mandated and often taken-for-granted processes occur, what is achieved through current processes, and whether these truly help identify what is meaningful to patients. Our research indicated that authentic informal interactions over time with the practitioner getting to know the patient, identifying and acting on what the patient considered important were key to engagement, reflecting a person-centred approach to care (Bright et al., 2012). The starting point of ‘who is this person and how do I need to work with them?’ appears to be an important starting point in this relational approach to engagement, recognising that each patient may have different needs and priorities for rehabilitation.

Relational communication was a core component of relational practice. It was constitutive, facilitating relationships and engagement and helping people develop a sense of safety with, and trust in their rehabilitation practitioners. Inherent in relational dialogue was a sense of “openness-to the other” (Frost, 2010), being open to hearing the other, understanding their perspectives, and changing their way of being-with and working as needed. Relational dialogue was a creative approach to communication tailored to the communicative, emotional and relational needs of the patient. Small talk, interactional flow and active listening were crucial, creating a sense of solidarity and alignment, a shared understanding and sense of being together (Burnard, 2003). Relational communication was collaborative (Togher, 2013) and authentic (Hersh et al., 2017), reflecting principles of communication support (Simmons-Mackie, 2013). Interactional flow occurred within and across interactions, contributing to a living dialogue across the patient’s episode of care, reinforcing the

relationship on an on-going basis. Of particular note was how the combination of a technical, disciplinary-based focus and supported conversation *techniques* (used without evidence of the *principles* of communication support (Simmons-Mackie, 2013)), could sometimes impede engagement. It could result in the practitioner directing the interaction, a transactional approach in which information-seeking or information-giving was prioritised while acts such as active listening were backgrounded. We suggest it is the combination of relational communication *and* supported conversation, used consistently over time, which makes this multi-stranded approach to communication engaging and relational.

## **Clinical implications**

The findings of this research have a number of clinical implications. Viewing engagement as relational and co-constructed in nature should prompt practitioners to explicitly attend to patient engagement and their role in this (Bright et al., 2017). Drury and Munro (2008) proposed practitioners should view themselves as hosts, valuing the act of *manākitanga*<sup>1</sup>. Framing engagement in this way opens up ways of viewing the practitioner's role, shifting from being a provider of technically oriented services to giving primacy to creating an environment which is engaging for the patient, responding to who they are and what they need. A characteristic of relational practice was the combination of relational work and technical, disciplinary activities. Both were important. Attending to *how* the technical, disciplinary work is done is important. Even when activities are mandated, practitioners have some control over how they interact and have scope to incorporate relational practices within their work. However, we also suggest this research should prompt services to

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<sup>1</sup> New Zealand Māori for hospitality

consider what forms of work are considered valid and legitimate, and how policies, guidelines and service structures may enable or constrain relational practices in rehabilitation. Communication was central to engagement. Practitioners may find it useful to critically consider their communicative content, for instance, whether communication is solely clinically related. Close attention to communicative conduct might prompt practitioners to consider how their communication impacts on patient participation and engagement. Considering the range of communication acts such as laughter, touch and eye contact might also open up different ways of developing relationships and working with patients. Finally, we suggest speech-language therapists have a critical role in supporting both the patient and the multidisciplinary team as they work to engage together. We encourage speech-language therapists to consider how they can support their colleagues to embed relational practices when working with people experiencing communication disability.

### **Limitations**

A more diverse combination of participants may have provided additional insights into engagement practices as the participants were not fully representative of the stroke patient population nor rehabilitation professions. While observations provided rich insights into how practitioners engaged people experiencing communication disability, practitioners may have modified their behaviours as a result of the observational method. However, as their actions likely reflected how they *thought* they should act to facilitate engagement (Gwyn, 2002), the data still provide insight into engagement practices. This research focused on engagement processes and practices within the patient-practitioner dyad. Attending to the sociocultural

context in which rehabilitation occurred might have provided a more nuanced understanding of practice. Finally, there is an inherent assumption that engagement is good and necessary. It is not known if engagement is necessary with every practitioner, or perhaps if it is important with some key practitioners. Further research should continue to develop the conceptual base for engagement, to explicate core components of engagement, and examine the relationship between engagement and outcomes.

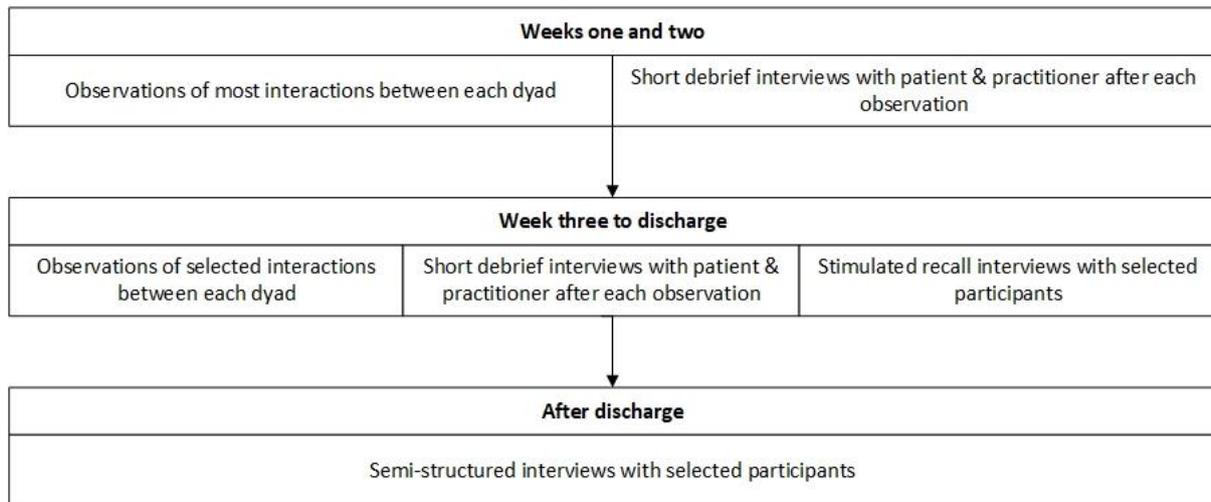
## **Conclusion**

This research has contributed new understandings of engagement. Elucidating the “recognisable elements” (Simmons-Mackie and Damico, 2011) of engaging practice helps move engagement from being somewhat invisible and often assumed, to one that is transparent, complex and nuanced. Our research demonstrates engagement is strongly influenced by the practitioners’ way of thinking about and enacting practice. This challenges the idea that engagement is an intrinsic patient state and behaviour. Engagement is complex, inevitably involving, and impacting upon, all those involved. This research indicates it impacts on both the process and experience of rehabilitation. As such, it should arguably be something practitioners explicitly attend to and reflect on. It is hoped the findings of this research open up different ways of ‘springboarding into a relationship’ and engaging people experiencing communication impairments in stroke rehabilitation, and indeed potential for new (and revised) interventions to enhance the experience of rehabilitation and its outcomes.

## Acknowledgements

We thank the participants in the study for sharing their experiences of stroke rehabilitation.

**Figure 1**



## Tables

**Table 1:** Characteristics of people experiencing communication disability

|                                       | <b>Betty<br/>(inpatient)</b>                   | <b>Ryan</b>  | <b>Betty<br/>(community)</b> | <b>Arthur</b>   |
|---------------------------------------|--|--|------------------------------|---|
| Type of communication impairment      | Aphasia  | Aphasia; apraxia of speech   | Aphasia                      | Cognitive-communication impairment; dysarthria  |
| Severity at start of rehabilitation   | Moderate                                       | Severe   | Mild                         | Severe (speech)<br>Moderate (CCI)   |
| Severity at end of rehabilitation     | Mild   | Moderate   | Mild                         | Severe (speech)<br>Moderate (CCI)   |
| Observed stroke-related impairments   | Mild hemiparesis<br>Reduced balance<br>Fatigue | Dense hemiparesis<br>Visuoperceptual impairment<br>Incontinence<br>Fatigue | Reduced balance<br>Fatigue   | Moderate hemiparesis<br>Cognitive impairment<br>Visuoperceptual impairment<br>Fatigue |
| Time post-stroke at start of research | 1 week   | 2 weeks  | 6 weeks                      | 16 weeks  |
| Rehabilitation service                | Inpatient                                      | Inpatient  | Community                    | Community   |
| Ethnicity                             | NZ European                                    | NZ European  | NZ European                  | Cook Island Māori   |
| Age                                   | >65 years                                      | 45-65 years  | >65 years                    | 45-65 years   |
| Length of care                        | 2 weeks  | 3 months   | 3 months                     | 2 weeks   |
| Number of practitioners participating | 8  | 12   | 4                            | 4   |

**Table 2:** Characteristics of rehabilitation practitioners for observation

| <b>Participant characteristics</b> |  |    |
|------------------------------------|--|----|
| Clinical experience                | <5 years:                                | 13 |
|                                    | >5 years:                                | 15 |
| Profession                         | Speech-language therapy:                 | 5  |
|                                    | Occupational therapy:                    | 5  |
|                                    | Physiotherapy:                           | 4  |
|                                    | Doctors:                                 | 4  |
|                                    | Nurses:                                  | 7  |
|                                    | Rehabilitation or healthcare assistants: | 3  |
| Workplace                          | Inpatient:                               | 20 |
|                                    | Outpatient/Community:                    | 8  |

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