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Relational Practice: A Valued And Legitimate Way Of Working In Rehabilitation

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Disclosures

Kathleen Galvin

- No financial interest to disclose

Nicola Kayes

- Grant/research support form: Health Research Council of NZ, Auckland University of Technology, Waitemata DHB
- Advisory Board: Laura Fergusson Rehabilitation
- Consultancy: Research Review NZ

Felicity Bright

- Grant/research support form: Laura Fergusson Rehabilitation, Auckland University of Technology, Waitemata DHB

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Understand and reflect on existing philosophical and conceptual work and how that can inform us about the possibilities for relational practice in rehabilitation
2. Understand what matters most to the therapeutic relationship from the perspective of patients and practitioners
3. Critically reflect on how relational practice is currently enacted in rehabilitation
4. Consider how you can contribute to the positioning relational practice as a valued and legitimate way of working

Why focus on relational practice?

24 RCB 46:1 pp. 24–32 (2002)

The Relationship Between Working Alliance and Rehabilitation Outcomes

Daniel C. Lustig
David R. Strauser
N. Dewaine Rice
The University of Memphis
Tom F. Rucker
Bureau of Business and Economic Research/Center for Manpower Studies, The University of Memphis

The Therapeutic A
Clinicians and Pati
Outcome in Chror

Paulo H. Ferreira, Manuela L. Ferreira,
Kathryn M. Refshauge, Jane Latimer, R

Human technolog
our clients

Nicola M. Kayes & Kathryn

Person Centred Research Centr

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R.D. Adams, PhD, Discipline of Physiotherapy, University of

Purpose: **It is often observed tha practitioners carrying out the sa a quite different impact on outc connection between the practit to here as the therapeutic allian attention as potentially contribu**

The Influence of the Therapist-Patient Relationship on Treatment Outcome in Physical Rehabilitation: A Systematic Review

Amanda M. Hall, Paulo H. Ferreira, Christopher G. Maher, Jane Latimer, Manuela L. Ferreira

Background. The w psychotherapist has bee

Purpose. The purpos alliance is related to out

Data Sources. A ser

Study Selection. P tation were selected for

Data Extraction. F pants, interventions, and data for alliance and out

Data Synthesis. Th skeletal conditions, card ious outcomes were me adherence, and satisfact sured with the Working therapist during the thir

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AMERICAN CONGRESS OF REHABILITATION MEDICINE

Archives of Physical Medicine and Rehabilitation
journal homepage: www.archives-pmr.org
Archives of Physical Medicine and Rehabilitation 2016;97:1979-93

REVIEW ARTICLE (META-ANALYSIS)

Therapeutic Alliances in Stroke Rehabilitation: A Meta-Ethnography

Michelle Lawton, BSc,[a] Gillian Haddock, PhD,[a] Paul Conroy, PhD,[a] Karen Sage, PhD[b]

From the [a]Psychological Sciences, University of Manchester, Manchester, UK; and [b]Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, UK.

Abstract
Objective: To synthesize qualitative studies exploring patients' and professionals' perspectives and experiences of developing and maintaining therapeutic alliances in stroke rehabilitation.
Data Sources: A systematic literature search was conducted using the following electronic databases: PsycINFO, CINAHL, Embase, MEDLINE, Allied and Complementary Medicine Database, Applied Social Sciences Index and Abstracts, and ComDisDome from inception to May 2014. This was supplemented by hand searching, reference tracking, generic web searching, and e-mail contact with experts.
Study Selection: Qualitative peer reviewed articles reporting experiences or perceptions of the patient or professional in relation to therapeutic

Increasing evidence that…

- Patients and practitioners perceive it to be important
- Better therapeutic relationship = better outcome

BUT

- A tangible shift in rehabilitation education and practice is yet to be demonstrated

So, what constrains a more explicit focus on relational practice?

- Technical, disciplinary based skills privileged over core rehabilitation processes and relational ways of working?
- Overreliance on theoretical influences from outside of rehabilitation?
- Lack of clarity over how it can be operationalised in practice?

Our aims?

To draw on philosophical and empirical work to:

- Position relational practice as a legitimate and valued way of working in rehabilitation
- Explore how that might be operationalised in practice
- Prompt critical reflection and discussion regarding the challenges and opportunities for integrating relational ways of working into conventional rehabilitation practice

Part 1 : Using philosophical oriented theory to lead relational practice: the value of the lifeworld

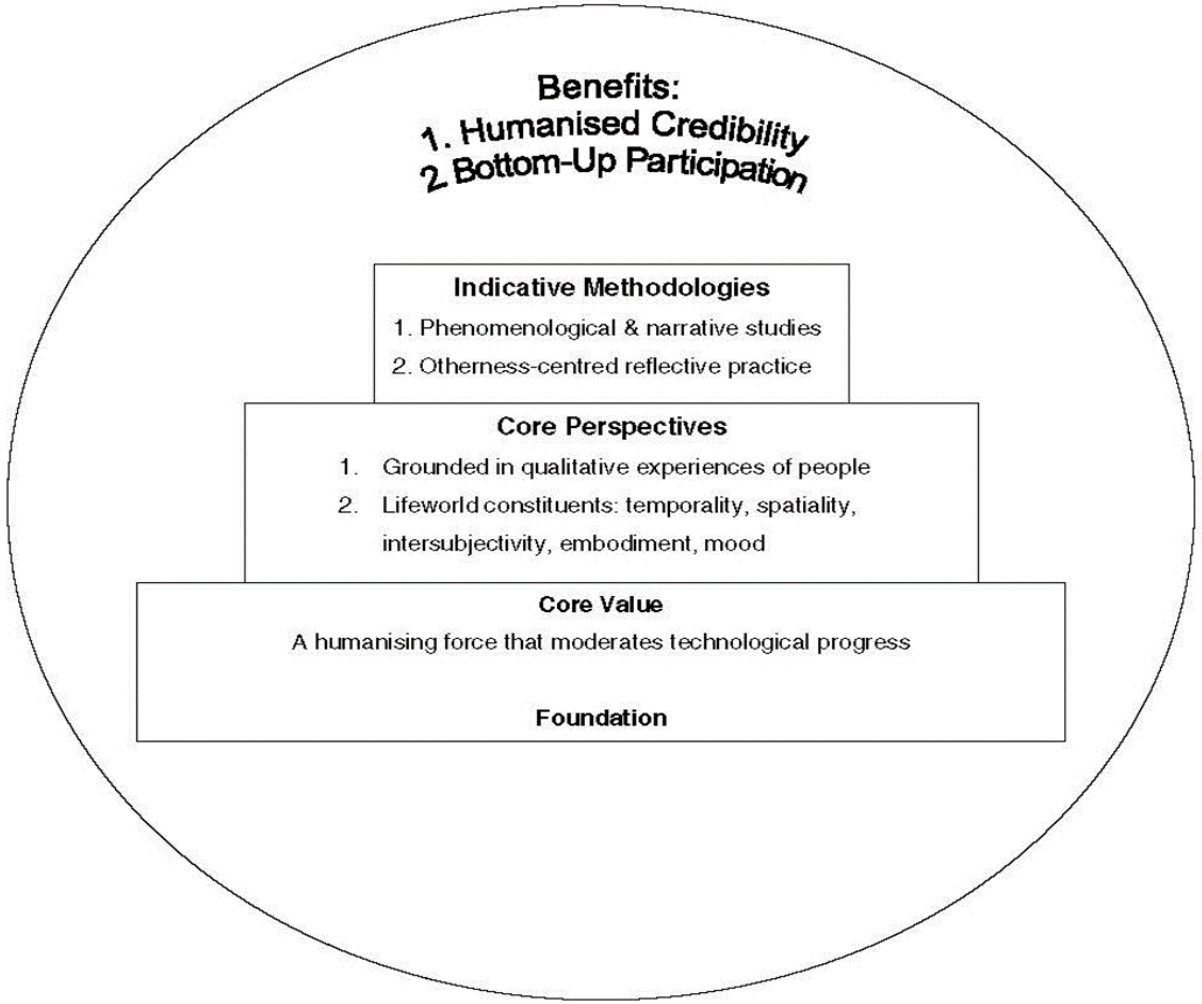
ACRM October 2017

Symposium

Kathleen Galvin

University of Brighton

Central question: What kinds of knowledge do we need to guide relational rehabilitation practices?



An emphasis that is becoming obscured

- On the one hand increasing specialisation alongside technological advances and research have significantly improved health outcomes and well-being
- On the other hand there is increasing evidence (current state of image in the media) and from qualitative research in particular that human dimensions of care can be obscured by a sometimes necessary technological and specialised focus.

The necessity of efficient and effective healthcare

- We all want health care to be efficient and this means an economic, statistical and outcome measurement emphasis.
- Unintentionally something can easily be ‘dropped out’ or ‘left to one side’
- ***The breadth and depth of being human***

Practitioners are ‘close up’ to existential issues in the everyday

- Falling ill
- Growing old in one’s body
- Leaving the life that you had (or it being wrenched away)
- Contexts of care where death is sometimes close
- Suffering and vulnerability: Rupture of lifeworld

The world of experience

- It is pre categorical and holistic
- Seamlessness of everyday life
- Transcends disciplinary and professional categories
- Descriptive power of lifeworld constituents can give directions for caring
- An understanding of everyday experiences be used more centrally in enhancing care
- A view of care as addressing human existence rather than *for example* ‘body object’.

The what of relationships in the lifeworld?

- Temporality – experience of time
- Spatiality – experience of space
- Intersubjectivity – experience of being with other
- Mood – colours our experience
- Embodiment – I am and *live as this body*
- Identity – continuity of self

Philosophically informed theory

Theoretical frameworks developed from lifeworld theory:

- Theoretical framework for considering the human dimensions of care
- An existential theory of well-being
- An existential theory of suffering
- Theoretical framework for considering human dignity experientially

A Theoretical Framework for considering human dimensions of care

International Journal of Qualitative Studies on Health and Well-being, 2009; 4: 68–77

informa
healthcare

ORIGINAL ARTICLE

The humanization of healthcare: A value framework for qualitative research

LES TODRES Professor, KATHLEEN T. GALVIN Professor & IMMY HOLLOWAY Professor

Centre for Qualitative Research, Bournemouth University, UK

Abstract

Qualitative research, through its illumination of people's perspectives and experiences, has contributed a particular kind of useful evidence for caring practices. Until now however, it has found its location in healthcare without making the powerful impact on humanizing practice that is its key strength. Our paper develops a conceptual framework for humanizing care, and through examples illustrates an emerging agenda that moves qualitative research into its next and overdue phase: to enter policy-making, curricula in professional education, and to be meaningfully translated into practice in ways that place people as human beings at the centre of care. This paper provides eight philosophically informed dimensions of humanization, which together, form a framework that constitutes a comprehensive value base for considering both the potentially humanizing and dehumanizing elements in caring systems and interactions. In each case, we show, with reference to published studies, how qualitative research findings are already consistent with the humanizing focus articulated in our conceptual framework. We finally describe a reciprocal relationship in which the humanizing value framework guides a dedicated focus for qualitative research, and in which qualitative research in its turn, supports the humanizing emphasis because of its intrinsic features.

Key words: *Humanization, qualitative research, phenomenology, philosophy of care*

Introduction

Research into health and healthcare has achieved substantial advancement in knowledge and improvements in care, through its focus on interventions, treatment and cure. Todres, Galvin and Dahlberg (2007) note how increasing specialization alongside technological advances and research have improved health and well-being. Alternatively, there is increasing evidence in the media and from qualitative research in particular, that the human dimensions of care can be obscured by a sometimes-necessary technological and specialized focus. Charon (2006) speaks of the "vexing failures of medicine—with its relentless positivism, its damaging reductionism, its appeal to the sciences and not to the humanities in the academy, and its wholesale refusal to take into account the human dimensions of illness and healing" (p. 195). It is within this context that the recently established Global Institute for Research in Humanizing Care Contexts has produced a document that notes that the attempt to humanize healthcare requires a dedicated research focus (Morse, 2007).

In this paper, we wish to explore the productive mutual relationship between a humanizing value framework for health care and the practice of qualitative research. We aim to show (a) that a conceptual framework for humanizing health care may provide a dedicated focus for guiding both research and practice; and (b) that the nature of qualitative research is able to offer distinctive support to a humanizing emphasis for care. The paper is thus philosophical in emphasis even though it draws on examples from qualitative research in order to illustrate the concepts developed.

In developing our humanizing framework, we have been most influenced by the existential-phenomenological tradition, and sociological perspectives that have illuminated phenomena such as human agency, anomie and alienation. Our perspectives on "what it

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- A focus on the dimensions of being human is a philosophical beginning place to contribute a positive direction for practice and research
- Practically, experientially : **What would make people feel more human in the places and contexts that they receive care?**

Eight dimensions of humanisation

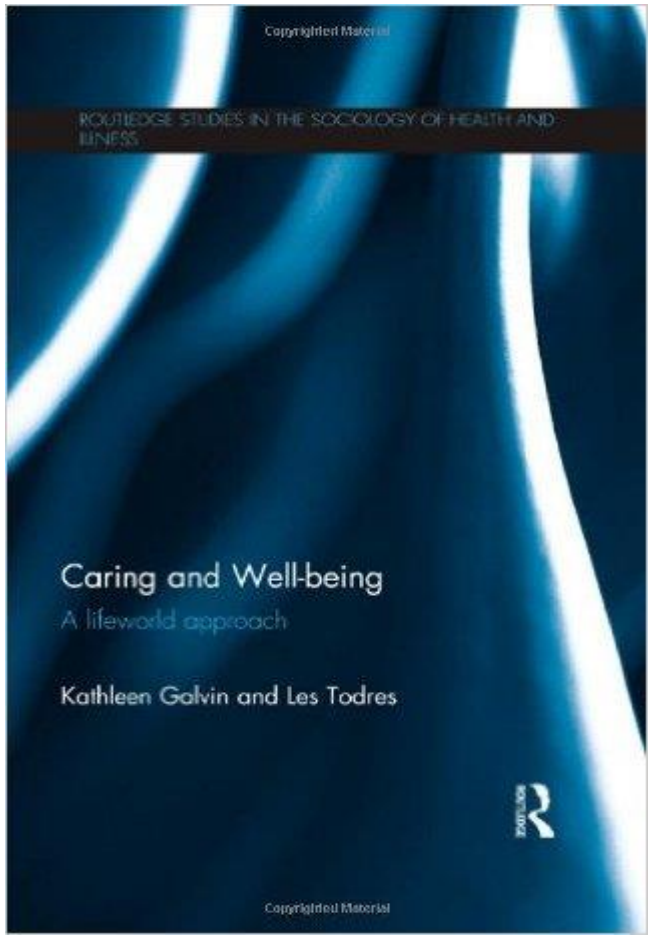
Forms of Humanisation	*Forms of Dehumanisation*	
Insiderness	*Objectification*	*Spectrum of possibility , not an either/ or*
Agency	*Passivity*	
Uniqueness	*Homogenisation*	
Togetherness	*Isolation*	
Meaning – making	*Loss of meaning*	
Personal journey	*Loss of personal journey*	
Sense of Place	*Dislocation*	
Embodiment	*Reductionist view*	

Conditions for Wellbeing?

- Physical Health
- Social Capital
- Economic Resources
- Humanised Institutions
- Political Freedoms
- Conducive Environments, and so on
- **Not always necessary, not always sufficient but support or obstruct well-being**
- **A resource based existential emphasis for well-being?**

Wellbeing and suffering are always in relation to one another

- There is always some freedom and some vulnerability in any condition
- There is always some possibility for moving forward as well as for ‘settling’ in any condition
- What wellbeing is possible within any situation?
- A care that is led from here can act in a way that represents all of these dimensions, then it may be possible that a human being will feel ‘met’



What kind of mobility (moving forward) is possible in illness?

Illustration from Diving Bell and Butterfly

Imagine This

Theory for Understanding Wellbeing

Int J Qualitative Stud Health Well-being

COACTION

HEALTH AND CARING FROM A EUROPEAN PERSPECTIVE

Kinds of well-being: A conceptual framework that provides direction for caring

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School of Health and Social Care, Bournemouth University, Bournemouth, United Kingdom

Abstract

This article offers a conceptual framework by which different kinds and levels of well-being can be named, and as such, provides a foundation for a resource-oriented approach in situations of illness and vulnerability (rather than a deficit-oriented approach). Building on a previous paper that articulated the philosophical foundations of an existential theory of well-being ("Dwelling-mobility"), we show here how the theory can be further developed towards practice-relevant concerns. We introduce 18 kinds of well-being that are intertwined and inter-related, and consider how each emphasis can lead to the formulation of resources that have the potential to give rise to well-being as a felt experience. By focusing on a much wider range of well-being possibilities, practitioners may find new directions for care that are not just literal but also at an existential level.

Key words: *Phenomenology, well-being, existential, conceptual framework, caring science, care, philosophy, Heidegger*

(Published 9 December 2011)

A lifeworld-led approach to care provides ways to describe health-related conditions and needs in ways that are more complex than conventional medical and diagnostic descriptions of health and illness (Dahlberg, Todres, & Galvin, 2009; Todres, Galvin, & Dahlberg, 2007). Such a lifeworld-led approach, however, does not only provide an alternative descriptive power but also a directional power, that is, well-being as a goal that is much deeper and more complex than just the absence of illness. If "well-being" offers a core direction for caring, then it is important to begin to articulate adequate conceptualizations of well-being that can do justice to both the essence of what it is, and to its possible variations in human lives. It is for this reason that we have found it highly productive to draw on a phenomenological style of philosophy to offer a conceptual framework that can articulate a multiplicity of kinds of well-being, and some of the possible paths towards it. But, let us start with well-being as an intertwined experiential phenomenon.

Our bodies know what well-being is.[1] We recognize well-being in many different forms and nuances when it is present, and recognize its absence in suffering. When asked the question 'how are you?', if we take a moment, as human beings, we can sense very concretely our state of well-being or otherwise, even if we are not able to find the best words to say all of it. This experiential sense of well-being can be articulated in many different ways. The task of a previous paper (Todres & Galvin, 2010) introduced a theory of well-being as "Dwelling- mobility", and attempted to capture the range of well-being experiences within a coherent existential whole. We asked the question: What is it about the essence of well-being that makes all kinds of well-being possible? Guided by Mugerauer (2008) and drawing on Heidegger's later work on homecoming (e.g., Heidegger, 1959/1966, 1969/1973, 1971/1993, 1971, Heidegger, 1977) we articulated the deepest experience of well-being as a unity of dwelling and mobility. In this earlier philosophically focused paper, we indicated how our well-being theory was inspired by a particular interpretation of Heidegger (Mugerauer, 2008), an interpretation that considers the trajectory of Heidegger's work as a whole, including both the continuities and discontinuities of his earlier and later works. This interpretation was

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(page number not for citation purpose)

- **Kinds of dwelling**: spatial dwelling, interpersonal dwelling, temporal dwelling, mood dwelling, bodily dwelling, identity dwelling.
- **Kinds of mobility**: spatial mobility, interpersonal mobility, temporal mobility, mood mobility, bodily mobility, identity mobility
- **Knowledge that can be put into action**

‘Mobility – Dwelling’: An existential theory of well-being

Well-being as mobility:

A capacity for moving in ways that expand one’s life , ranging from metaphorical forms of movement and possibility (the feeling, sense, and imagery of movement) to literal movement.

Well-being as dwelling:

A capacity for settling into the present moment and to ‘feel at home’ with what is there (sometimes inside, sometimes outside, sometimes both). Could be experienced as a sense of peace.

Well-being as dwelling-mobility:

The deepest possibility of well-being . The integration of the dimensions of both mobility and dwelling: a rooted flow, a sense of both adventure and home, possibility and peace.

	MOBILITY	DWELLING	MOBILITY-DWELLING
SPATIALITY	Adventurous horizons	At home	Abiding expanse
TEMPORALITY	Future orientation	Present-centeredness	Renewal
INTER-SUBJECTIVITY	Mysterious interpersonal attraction	Kinship and belonging	Mutual complementarity
MOOD	Excitement or desire	Peacefulness	Mirror-like multidimensional fullness
IDENTITY	I can	I am	Layered continuity
EMBODIMENT	Vitality	Comfort	Grounded vibrancy

Some metaphors for well-being experience

Dwelling	Mobility
Stillness Home Peace Grounded Rooted	Movement Adventure Excitement Openness Flow

Kinds and Levels of Well-being

	MOBILITY	DWELLING	MOBILITY-DWELLING
SPATIALITY	Adventurous horizons	At home	Abiding expanse
TEMPORALITY	Future orientation	Present-centeredness	Renewal
INTER-SUBJECTIVITY	Mysterious interpersonal attraction	Kinship and belonging	Mutual complementarity
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IDENTITY	I can	I am	Layered continuity
EMBODIMENT	Vitality	Comfort	Grounded vibrancy

Mobility with an intersubjective emphasis:

	Mobility	***Dwelling***	***Dwelling- Mobility***
Spatiality	*Adventurous horizons*	*At homeness*	*Abiding expanse*
Temporality	*Future-orientation*	*Present-centeredness*	*Renewal*
Inter subjectivity	***Mysterious interpersonal attraction***	*Kinship and belonging*	*Mutual complementarity*
Mood	*Excitement or desire*	*Peacefulness*	*Mirror-like multidimensional fullness*
Identity	*I can*	*I am*	*Layered continuity*
Embodiment	*Vitality*	*Comfort*	*Grounded Vibrancy*

Mysterious interpersonal attraction

Dimensions of suffering

When dwelling is absent:

spatial dwelling (**exile**),
no interpersonal dwelling (**alienated isolation**),
no temporal dwelling (**elusive present**),
no mood dwelling (**agitation**),
no bodily dwelling (**discomfort/ pain**),
no identity dwelling (**object or 'thing'**).

When mobility is absent:

no spatial mobility (**imprisoned**),
no interpersonal mobility (**aversion**),
temporal mobility (**blocked future**),
mood mobility (**depression**),
no bodily mobility (**stasis and exhaustion**),
no identity mobility (**I am unable**)

Dwelling Suffering Spatial Emphasis Exiled

	Mobility	***Dwelling***	***Dwelling- Mobility***
Spatiality	*Imprisoned*	*Exiled*	*Roomless*
Temporality	*Blocked Future*	*Elusive Present*	*No Respite*
Inter subjectivity	*Aversion*	*Alienated Isolation*	*Persecution*
Mood	*Depression*	*Agitation*	*Restless Gloom*
Identity	*I am Unable*	*I am an object or thing*	*I am fragmented*
Embodiment	*Stasis & Exhaustion*	*Bodily Discomfort and Pain*	*Painful Closing Down*

Mobility suffering with an intersubjective emphasis:

Aversion

	Mobility	***Dwelling***	***Dwelling- Mobility***
Spatiality	*Imprisoned*	*Exiled*	*Roomless*
Temporality	*Blocked Future*	*Elusive Present*	*No Respite*
Inter subjectivity	*Aversion*	*Alienated Isolation*	*Persecution*
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Embodiment	*Stasis & Exhaustion*	*Bodily Discomfort and Pain*	*Painful Closing Down*

Aversion: polarises ‘me’ from ‘you’

A kind of sense of victimisation:

I feel invisible or full of shame

I feel ugly

I experience humiliation

Or one who feels the aversion: ‘I need distance from this person’

I want to move away from these others

I am trapped with these others

Imagine This

Dimensions of Human Dignity

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International Journal of Public Health Policy and Health Services Research

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Dignity as honour-wound: an experiential and relational view

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Keywords
caring, caring science, dignity, ethics of care, existential theory, health, Heidegger, Husserl, lifeworld, medical humanities, phenomenology, philosophy, wellbeing

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Abstract

In this paper, we draw on a phenomenological–philosophical foundation to clarify the meaning of dignity as a coherent phenomenon. Consistent with an evocation of its central meanings, we then introduce and delineate seven kinds of dignity that are intertwined and interrelated. We illustrate how these kinds of dignity can provide a useful template to think about its qualities, its 'rupture' and its 'restoration' in human life, particularly in relation to health and social care contexts. We then consider the implications of these relational and experiential views for current debates about the notion of dignity: Is dignity a useless concept? Is dignity objective or subjective? What are the useful ways of characterizing different varieties of dignity? We conclude by pointing to a metaphor that may hold the sense and meaning of our deepest human dignity: The gathering of both value and vulnerability, in which human value does not depend on the eradication of human vulnerability, but occurs within its very context.

Introduction

The term 'dignity' has many resonances in human life. People refer to this term in multiple situations and also refer to multiple variations of dignity's absence. It is this variation of its use as a term that has led scholars to question its philosophical, psychological and ethical value as a distinctive phenomenon. Although we do not wish to support a philosophical 'anything goes' approach to dignity, we do want to be respectful to the complexity of this phenomenon and how it is shaded in ways that reflect many possible variations and nuances that human beings refer to in a meaningful way. In other words, rather than question its existence as a meaningful phenomenon, we wish to honour its complexity. For us, many of the variations and lived resonances of dignity and indignity appear to be referring to something that can be seen to cohere as the essence of dignity. Although it is not fashionable to pursue this line of thinking, we would like to show how a philosophical clarification of the structure of dignity at its deepest ontological level also offers the possibility for very practical directions for caring for ourselves and others in ways that are up to the task of some of our deepest human intuitions.

This paper is directed towards a number of interrelated concerns:

1 Drawing on a phenomenological–philosophical style of thinking, we attempt to clarify the meaning of dignity as a coherent phenomenon.
2 We offer a framework that can show how this coherent phenomenon can be the source of multiple variations of 'dignity'. Although these variations are interlinked and overlapped, we find it useful to name seven kinds of dignity, at least in relation to our own disciplinary background in health and social care.
3 In beginning to consider the possible practical directions that this framework may offer, we then focus on the 'rupture' and 'restoration' of human dignity with specific reference to health and social care situations.
4 Finally, we offer a number of implications of our view of dignity for current debates surrounding the integrity and nature of dignity.

We hope to show that a phenomenologically oriented analysis is very useful to practice-related concerns in at least two ways: Firstly, that it provides philosophical clarifications about the essence of what this particular term in relation to health and social care could mean within the vocabularies of communities in clinical

- The dignity of the body
- The dignity of identity
- The dignity carried in our moods
- The dignity of time
- The dignity of the ways we relate interpersonally
- The dignity of a 'sense of place'
- The dignity of death

Is this value base a luxury?

Conclusion: A Lifeworld- Led Perspective

- A contribution to philosophically informed theoretical insights and their import for the practice of rehabilitation.
- What possibilities does this perspective open up in terms of how we view:
  - the person
  - practice
  - evidence

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Part 2: What matters most at the interface between patients and practitioners?

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With special thanks to: Dr Gareth Terry, Dr Felicity Bright, Christine Cummins, Dr Suzie Mudge, Professor Kathryn McPherson

AUT CENTRE FOR PERSON CENTRED RESEARCH

Multidisciplinary team

- Health, Social and Clinical Psychology
- Physiotherapy
- Speech and Language
- Occupational Therapy
- Nursing
- Sociology
- Medical Anthropology
- Disability

Three core interrelated purposes

1. Rethinking rehabilitation
2. Embedding person-centredness
3. Making a difference

Informed by the voices of our participants

"While you're having the treatment and things you get a lot of attention […] but once you're put out back into the world you're left hung out to dry a wee bit—it's quite a difficult time."
(Person w cancer)

"It's like having a tin can with holes punched in it, no matter how much water you pour into it, it is still pouring out. So even if you pour heaps more water in, it will still pour out, you will never get anywhere."
(Person w MS)

"Certainly the dealing with the shock and change and challenge of perhaps…. the highlight for me, in that first 3 weeks anyway, was going through a phase when I truly, really wanted to die. It was a conscious and rational choice. I choose to die, death is the best option"
(Person w stroke)

"They want you to feel your pain and embrace your pain etc., etc. I spend my whole life learning how to deal with my pain and live with it as best I can. I do not want to embrace it. It is not my friend!" (Person w chronic pain)

Patient narratives point to…

- A number of unmet needs
- The complexity of rehabilitation particularly in the context of enduring consequences

What happens at the interface between patients and practitioners appears key to:

- Engagement
- Recovery and adaptation
- Long term health and well-being

While *what* we do it important, *who* we are and *how* we work appears critical

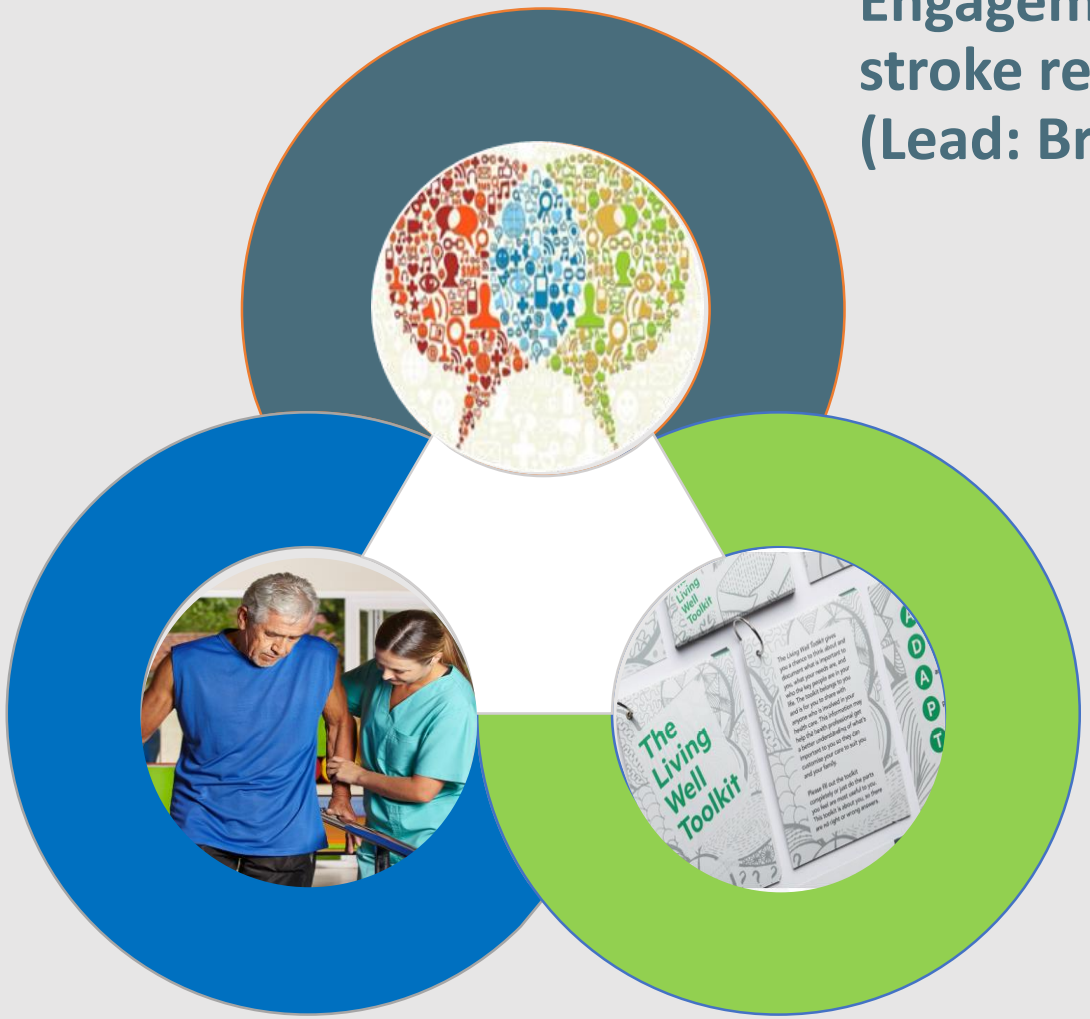
But, what matters most?
How can we optimise what happens at the interface?

Secondary analysis

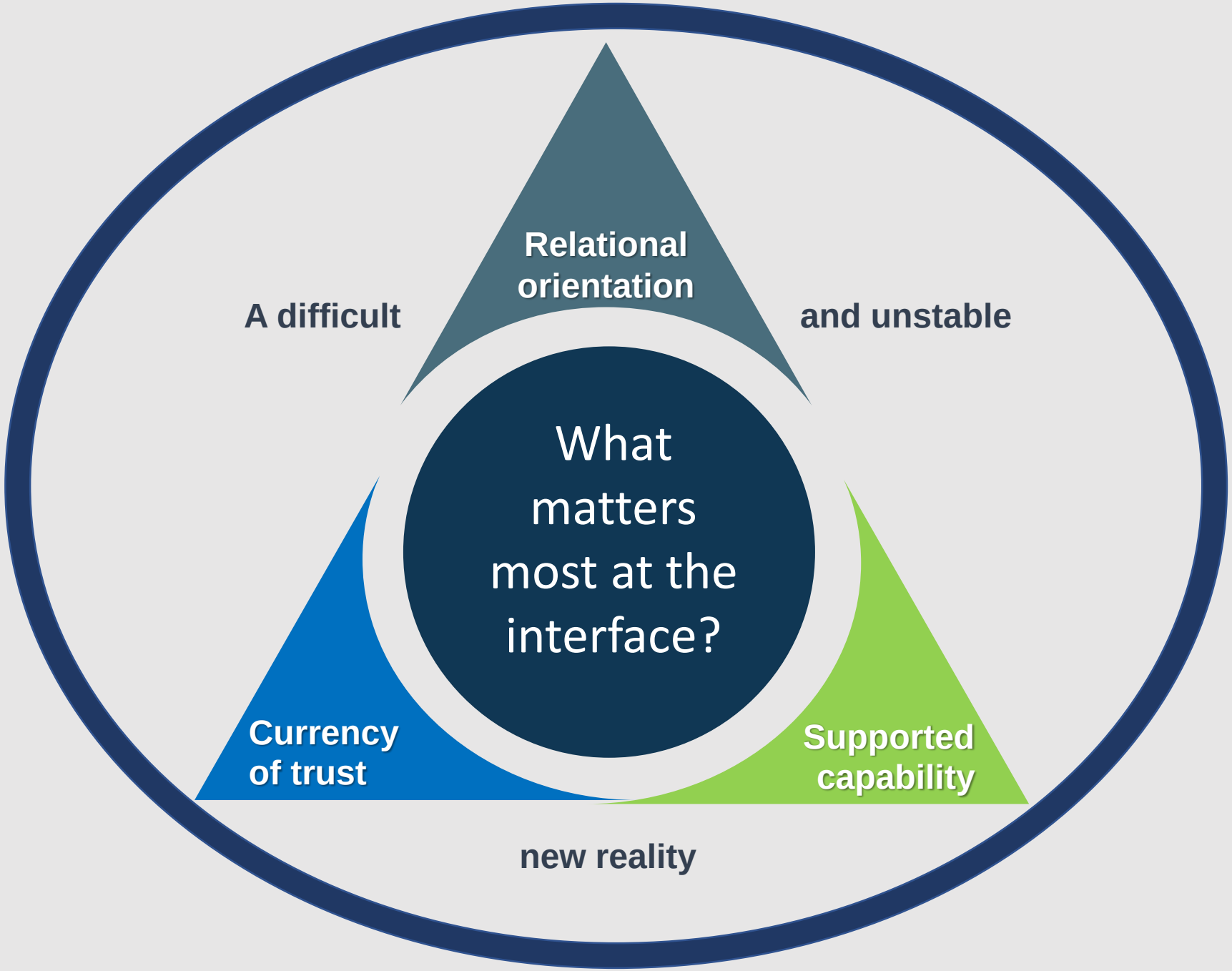
- Ten years of research
- 12 qualitative projects exploring experiences and perspectives of…
  - rehabilitation
  - interactions between patients and practitioners
  - new ways of working
- Three projects purposefully selected for analysis
- Data included:
  - 40 interviews and three focus groups with clients, carers, or family members
  - Two interviews and six focus groups with practitioners

Engagement in stroke rehabilitation (Lead: Bright)

What matters most in the therapeutic relationship (Lead: Kayes)



Living well toolkit (Lead: Mudge)


Relational orientation
A difficult
and unstable
What matters most at the interface?
Currency of trust
Supported capability
new reality

A difficult and unstable new reality

“So there’s all this danger, you know, you don’t sort of realise until you get home”

- The psychosocial context within which rehabilitative care occurs
- Client’s lives and identities are radically changed
- Clients are entering new, unexplored (for them) terrain
- ‘Real’ world more risky, troubling, and unfamiliar

“I’m not a person to sit around and do nothing. This has been a hell of a shock because I’ve always worked with my hands and doing things. So, suddenly boom, you know, can’t do it anymore. Because when I first went to hospital, like I was carried in. Couldn’t walk. Couldn’t talk. Couldn’t go to the bathroom. Couldn’t do anything” (Paul, PwStroke).

“I remember the first time the therapist at the hospital talked about setting goals, I said something about tramping again perhaps swimming perhaps even playing golf again – she said, “What about getting up in the morning and getting dressed?” and I thought, ‘Hell’s teeth we’re on a different page here” and my heart sank a bit’” (Ann, PwStroke)

“You just sort of get excited thinking, ‘we are going to go home, it’s going to be wonderful’. You get home and then there’s all these obstacles and stuff […] So there’s all this danger you know, you don’t sort of realise until you get home. And then if you have got nobody there to support, to sort of like turn to. It’s a nightmare” (Mary, FM of child w TBI)

Impact on well-being across all dimensions?

	MOBILITY	DWELLING	MOBILITY-DWELLING
SPATIALITY	Adventurous horizons	At home	Abiding expanse
TEMPORALITY	Future orientation	Present-centeredness	Renewal
INTER-SUBJECTIVITY	Mysterious interpersonal attraction	Kinship and belonging	Mutual complementarity
MOOD	Excitement or desire	Peacefulness	Mirror-like multidimensional fullness
IDENTITY	I can	I am	Layered continuity
EMBODIMENT	Vitality	Comfort	Grounded vibrancy

Relational Orientation

“I mean I’ve only known them all of two weeks but you’d swear I’d known them for six months”

- Treating the relationship as the priority - as the basis of rehabilitation
- Moving beyond the transactional
- Providing momentum for progress – potential to enable greater engagement, and a willingness to participate in tasks that from the outside seemed difficult or mundane
- Relationship as a protective factor

“You know about them. They know about you. You’ve got to feel relaxed in their presence you know. Just as I say, I found it hard that they know all about me, and I know nothing about them. I think it would be nice if you could know who this person is this, they’ve done this, this is their training, they’ve been here so many years. They’ve worked with stroke people. To make you feel at ease straight off. Just complete strangers, you get sick of meeting strangers. You actually get sick of professionals in your life.” (Bradley, M, PwS)

“So I just think they were just a hospital organisation of course. There wasn’t much emotional buy-in. There was no real relationship. Maybe because they had so many people coming through, they just, they haven’t got time. I think if you don’t bond to your PT, to your therapist you know, you don’t get as much as you should out of it. If they’re aware when you walk in tired or you’re down” (Andrew, PwStroke)

"I think you've got to trust that they know what they're doing, that they care about what they are doing, that they are going to do it to the best of their ability, that they've got your best interest at heart"
(Person w SCI)

Currency of Trust

“I think it’s important to gain the faith of the person that you are dealing with”

- Initial leap of faith necessary
- Competence alone not sufficient to sustain trust
- Trust takes time, needs to be reinforced, has various rupture points – especially in times of transition or difficulty
- Losing trust in one clinician has a bearing on trust for others

“So I think it’s important to gain the faith of the person that you are dealing with, you have to prove to them that you know what you are doing. So that to me is a very important part and that’s how my occupational therapist and my physiotherapist and the people before have gained my faith through being confident in what they do” (Peter, PwStroke).

“I don’t know if it’s the usual practice but my physio at [inpatient service] he actually took me out one day to [community physio clinic] and we met them and I actually saw my physio and the physios there talking to each other and getting really excited and like talking about all these new plans for me and stuff and it was just really important to see that handing over. And that was several weeks before I actually stopped at [inpatient service] but still I knew that the seeds had been sown and sort of thing and that I wasn’t just going into a place that completely didn’t understand me and I had to build my whole sort of yeah” (Jarrad, PwTBI)

Currency of trust

- Resonance with Pinsof's Integrated Systems Theory of Working alliance
- Challenging how we think about professional boundaries

Supported capability

“She tends to make you believe in yourself a lot more than you normally would”

- Acts as a counter to individualised understandings of ‘efficacy’
- Challenges notions of adherence and compliance
- Views the role of therapists and significant others as enhancing or enabling capabilities of the client
- Rather than the independence imperative, a web of supportive personal and therapeutic interdependence as best practice

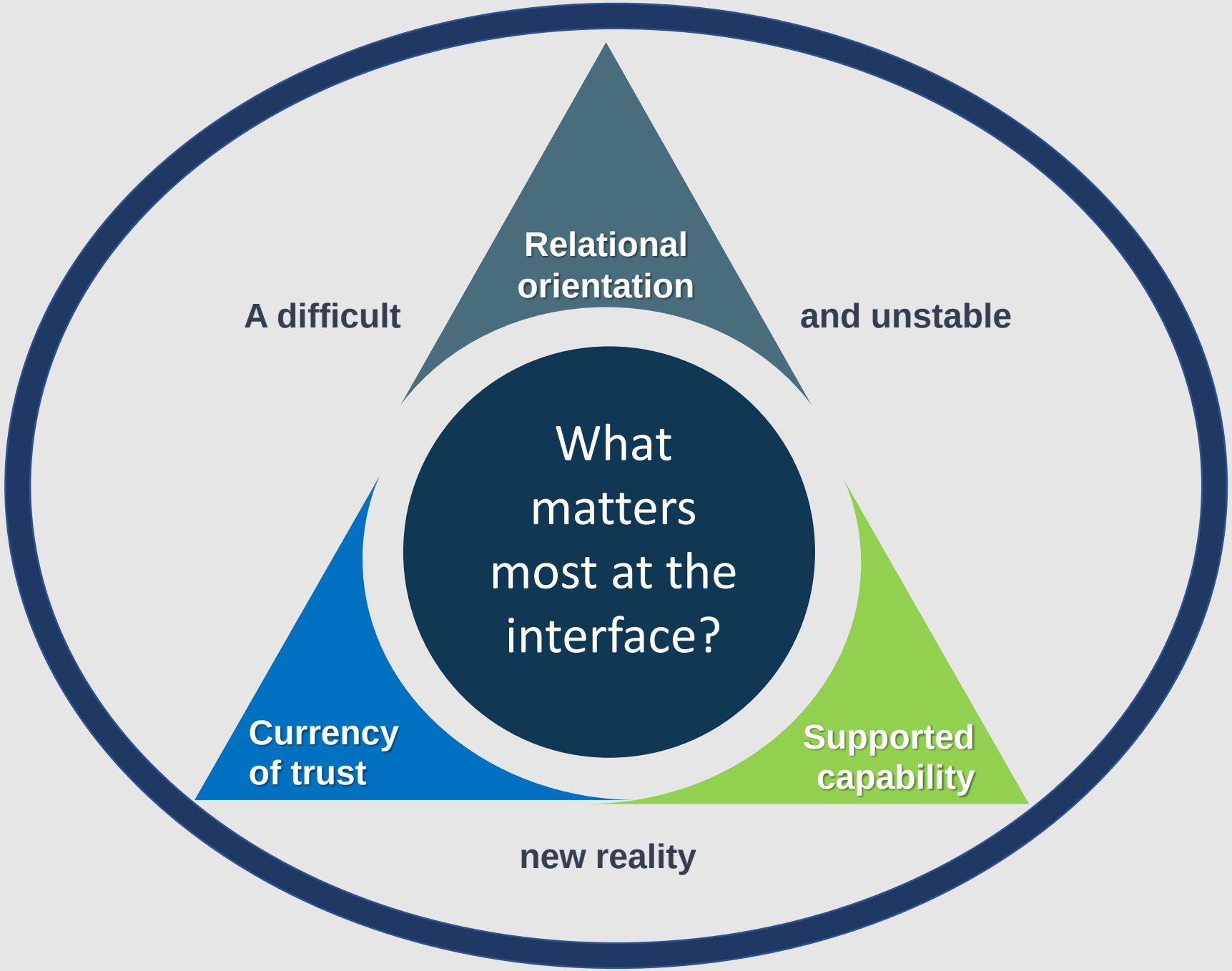
“You sort of get the feeling that yes you can do the things she teaches you yeah and she I don’t know she tends to make you believe in yourself a lot more than you normally would” (Heather, PwSCI).

“I think it took it me a good twenty minutes to make one cup of tea and she just sat there she said “take your time” and “don’t rush it and think about what you are doing” and that sort of thing. She would use her own hand expressions, like she’ll say “look at your hands and open your fingers imagine opening your fingers and stuff like that and grabbing a cup.” And I’d sort of just watch her movements, and my hand moves with hers, sort of thing” (Pat, PwTBI)

“I think the therapist and their listening and their flexibility in being able to work with me… if I wasn’t quite feeling there or involved, they had the ability to change it. And that I understood what was required of me in what they were saying. And caring. They have a lot of energy and positive feedback and that spurred me on. This isn’t bad at all. I can do this. If they’re positive in their energy and the material they give me, and it’s not the same thing every day […] so I think it’s, the therapists’ attitude and skills that helped me through and persist.” (Harold, PwSCI).

Supported capability

- Resonance with:
  - Relation-inferred self-efficacy (RISE) component of the tripartite model of efficacy (Lentz & Lopaz, 2002; Jackson et al. 2012)
  - Relational autonomy (Ells et al, 2011)


Relational orientation
A difficult
and unstable
What matters most at the interface?
Currency of trust
Supported capability
new reality

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AUT

Part 3: Enacting relational practice in rehabilitation

Dr Felicity Bright

Associate Professor Nicola Kayes, Professor Kathryn McPherson, Professor Linda Worrall

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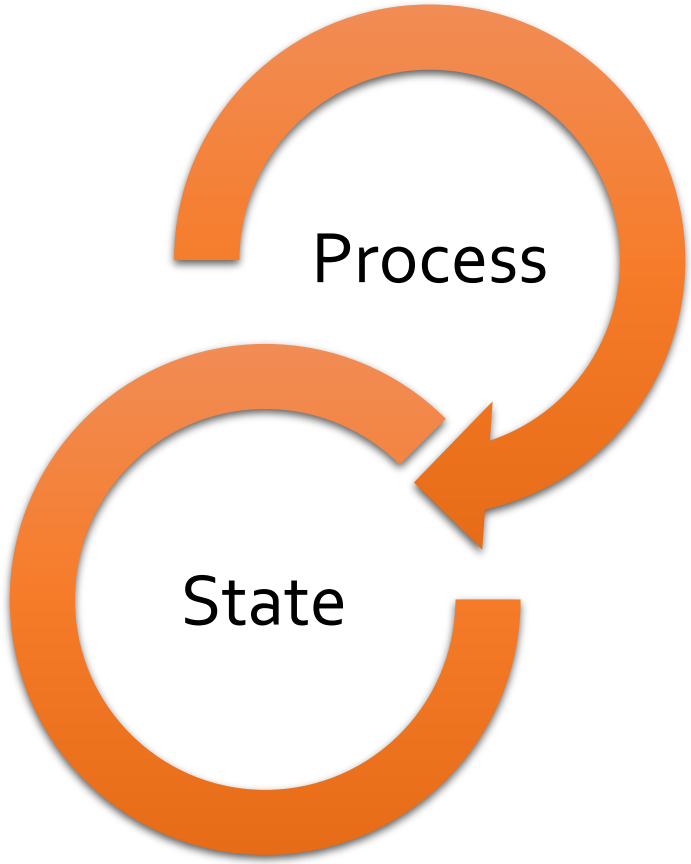

Engagement is a co-constructed process and state. It incorporates a process of gradually connecting with each other and/or therapeutic programme which enables the individual to become an active, committed and invested collaborator in healthcare.

(Bright, Kayes, Worrall & McPherson, 2014, p. 8)

Interviews

14 practitioners

7 people experiencing communication disability

Observations

28 practitioners

4 patients

187 hours of observations throughout rehabilitation episodes

Voice Centred Relational Approach

Attend to voices

How people speak of themselves, others & relationship

Consider talk-in-action and talk-about-action

Engagement was a relational practice

Engagement was a relational 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 all on the same page,
We're not here to have a different perspective to them.

It's making that connection
It's talking about what matters
Gradually building rapport
At the moment he can't tell us
But letting him know that we know about it and who he is
We try and have him as part of it
You're working on what they've established as being important
They've made clear that toileting is really important
I'm here to try and help them with strategies
To get where they want to go is more important
To get him in a car, one of the key goals
He's a proud man, it's about helping to give him his dignity back
That's how I show person-centred care
It's working alongside, it's not me dictating
It's what we're working on

A philosophy of practice

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Valuing relationships

- Cornerstone of rehab
- Knowing & being known
- Reflexivity

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Getting to know the person

- Who are you?
- What do you need from me?
- How do you need me to work?

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I know they've had a really bad experience on the ward and have been really disappointed in the care they've received … This is a tough time for them.

I try and make sure I poke my head in [to talk with them]… it only takes five minutes but it's so important. I'll let her vent if it helps. She can do it as much as she likes.

For me, it's really important to give them a positive experience, trying to find something that would leave them with a positive experience … That he's enjoyed it.

Getting to know the person

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- What do you need from me?
- How do you need me to work?

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Relational communication

Attending to relationships,
communicative needs & emotions

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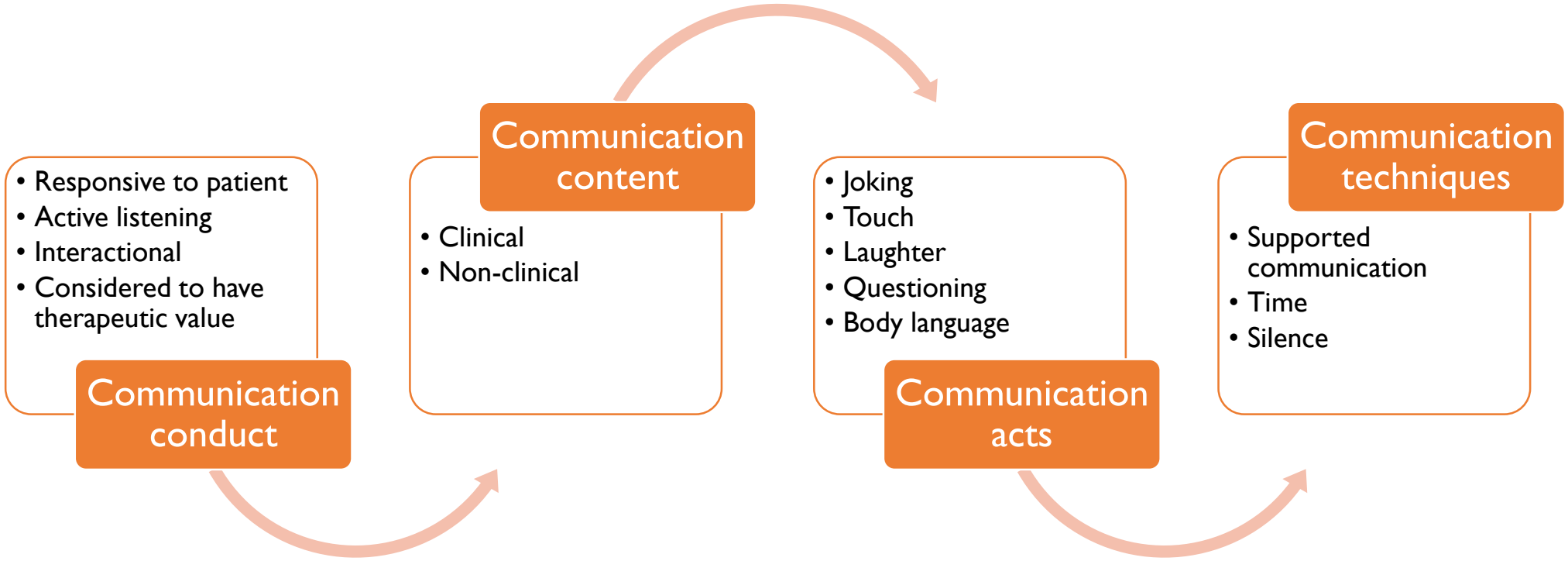
Communication conduct
• Responsive to patient
• Active listening
• Interactional
• Considered to have therapeutic value
Communication content
• Clinical
• Non-clinical
Communication acts
• Joking
• Touch
• Laughter
• Questioning
• Body language
Communication techniques
• Supported communication
• Time
• Silence

Understandings of relational practice are influenced by many factors

Relational practice: A philosophy of practice

Relationships underpin and surround views of practice, practitioners and patient-practitioner interaction

Relational work is a rehabilitation in its own right and has therapeutic value

Relationships are woven through everything the practitioner does, and thinks about doing

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Relational practice as a valued and legitimate way of working

- Lifeworld-led perspective provides the moral and ethical imperative for relational practice
- Patient narratives highlight the impact on well-being across all dimensions
- Relational ways of working may be critical to promoting well-being (versus exacerbate suffering)
- Provides a useful foundation for informing how we enact this in practice

Some prompts for discussion?

Do you think this has any value and why?

What forms of work are most valued by you/your context?

How might working from a lifeworld-led perspective impact:

- How you work?
- What you do?
- What forms of work you value most?

What would make it possible for you to embed relational ways of working into practice?

Obtaining CME/CE Credit

Credit is only given to attendees who:

- Successfully complete the entire course/session.
- Evaluate the course – by clicking on the link in an emails sent them.
- After you have completed the evaluation, an email will automatically be generated to you with a link to print your certificate.

The evaluation system will close 30 days after the date of the workshop.

What next steps?

- Empirically build upon a philosophically informed articulation of ‘well-being’, ‘suffering’, ‘human dignity’
- Practice applications of framework for ‘wellbeing’, ‘suffering’, ‘dignity’ that can take account of a range of situations in health and social care contexts
- Can new articulation sensitise staff to human suffering and wellbeing possibilities?
- Interested in ways to help students and practitioners keep open and sustain their motivation for caring.

Imagining what it is like and leading care from there.

Potential Directions for collaboration:

- Practice demonstrations
- Programme of theoretically informed literature reviews
- Programme of research studies that build on lifeworld ideas
- Developments in articulation and assessment of care ---Caring Science
- Lifeworld led perspectives in a range of research areas