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PERSPECTIVES IN REHABILITATION

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Governing neurorehabilitation

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ABSTRACT

Purpose: Person centred approaches to rehabilitation are promoted as an ethical means of addressing paternalistic power relations in clinician dominated medical encounters and improving outcomes. However, they fail to account for the complex nature of power. We sought alternative ways to explain the use of power in health service provision.

Methods: A poststructural discourse analysis using the view of power offered by Michel Foucault was undertaken. Foucault's concept of governmentality is useful to explain the way health services deploy technologies of power to achieve objectives of the state. Governmentality refers to not just political structures but all the strategies and procedures for directing human behaviour.

Results: Our investigation uncovered a web of strategic relationships operating that were both potentially productive and problematic and illuminate how client centred approaches in neurorehabilitation intertwines its subjects in strategic power relationships that involve webs of obligations and responsibilities.

Conclusion: The client-professional relationship promoted in neurorehabilitation as a moral way to practice can be a tool for mastery of one over the other, and assist the client to achieve their desired ends, but also has the potential to marginalise others who are unable to shape themselves into the desired ideal client.

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➤ IMPLICATIONS FOR REHABILITATION

- This analysis shows how power is subtle and productive in that it produces knowledge and roles for both clients and practitioners.
- It demonstrates how neurorehabilitation's disciplinary practices assist the client to achieve their recovery goals.
- It reveals how certain clients might be marginalised when they cannot shape themselves into the ideal rehabilitation client.
- As a final point we hope that by being aware of how power works in neurorehabilitation, practitioners can become aware of opportunities for challenging disciplinary practices that do not serve the best interest of the client.

Introduction

Neurorehabilitation is a health service for people who have experienced disease or injury to their neurological system. Contemporary constructions of this service describe it as an ethical and benevolent service concerned with optimising health, promoting wellbeing and enhancing human flourishing [1–5]. Neurorehabilitation services are targeted at those individuals identified as likely to benefit [6–8]; and are based on the expectation that in return for rehabilitation services the client accepts certain responsibilities [3,9]. Once determined as suitable candidates, neurorehabilitation clients are expected to actively engage in the rehabilitation process and help themselves to achieve their desired ends [10]. The clients are also expected to form a collaborative relationship with their practitioner and display certain characteristics: they must demonstrate the ability and willingness to participate in and benefit from a rehabilitation programme [6]; be motivated and engage with rehabilitation services [11,12]. Clients are also expected to contribute information to support meaningful goal setting [13], and as practice-intensity is said to be the effective component in neurorehabilitation, clients are expected to continue practicing prescribed tasks outside of therapy sessions [9].

These understandings of neurorehabilitation appear to demand certain behaviours and relationships from both clients and practitioners and suggest there are desirable client behaviours and the existence of an ideal neurorehabilitation client [14,15], These ideal behaviours however frequently relate to compliance with practitioner advice, congruence with practitioner expectations and/or achieving practitioner defined goals and appear to serve as reinforcement for practitioner authority

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[15–17]. This is in tension with client centred ways of working currently promoted within rehabilitation as an ethical approach and to address concerns of practitioner dominated health services.

Given these expectations and tensions we were interested in how neurorehabilitation clients themselves constructed rehabilitation and the forces that shaped client behaviour in the neurorehabilitation context. Drawing on poststructural understandings of power and discourse, we carried out a poststructural discourse analysis guided by the theories of Michel Foucault to uncover the ways in which neurorehabilitation was constructed, the different subjectivities clients took up in the rehabilitation relationship and the technologies of power at play in the neurorehabilitation client/practitioner relationship.

Methodology

Poststructural research challenges prevailing notions of the way things are and the assumptions that underpin ingrained practices [18,19]. Questioning the taken for granted as given, natural and normal, it provides frameworks for exploring everyday practice assumptions and understandings that shape behaviour and offers space for thinking if things could be otherwise [4]. The goal of poststructural research is not to uncover facts or reveal a truth. Rather, it offers opportunities to analyse the socially constructed nature of human behaviour and assumptions within language, and their power for producing subjectivities [20,21].

Subjectivities are the beliefs and behaviours people adopt when they are ascribed or assume a subject position [22]. "Neurorehabilitation client" is a subject position that is given to those identified as meeting established criteria and displaying certain attributes, such as those referred to above. This subject position is associated with a view of the world and leads to certain experiences and feelings that contribute to the production of a sense of self [23]. However, this sense of self is not stable but fluctuates in response to everyday practices and relationships with others. The person taking up the subject position of "neurorehabilitation client" while attending rehabilitation sessions may in other situations take up subject positions of "climate change activist" for example. Subject positions and their subjectivities are constructed by discourses within power relations [24].

Discourses are more than collections of statements that have influence but refer to an organised system of concepts and language practices including procedures and regulation [25]. When discussing discourse, Foucault (2002) included the structures that generate, support, circulate and protect discourses [25]. For example, the biomedical discourse which informs aspects of neurorehabilitation is a set of understandings about health and illness. It both generates and is generated by institutions. The biomedical discourse refers to the associated knowledge (e.g., medical knowledge and texts), physical structures (e.g., hospitals and medical schools), practices (e.g., surgery and physiotherapy), subject positions (e.g., doctor, nurse, patient, allied health practitioner, orderly), and system level structures (e.g., public health messages). The biomedical understandings that generate these are continually reproduced, refreshed, expanded, and endorsed by the institutions. These govern the way biomedical topics can be meaningfully talked about, control who has authority and what counts as truth. Dominant discourses such as the biomedical discourse frame understandings of issues (e.g., disease control) and create places for the subjects of the discourse to view and interact with these issues [21].

Discourses operate within relations of power. In this study we were interested in the discourses that circulated in neurorehabilitation, the subject positions they offered clients and practitioners and what power relations were in play. Power for the poststructuralist is not a thing but a strategy, a relation between forces [26]. Foucault viewed power not as a fixed unidirectional negative force, but a dynamic and contextual relation that operates in webs of relationships [27]. Hence the power relationships between the practitioner and client can be productive, are not static and have the potential to shift. For example, just as the practitioner can set the rehabilitation interventions, the neurorehabilitation client can influence the practitioner's focus and activity as they work towards agreed recovery goals.

Foucault was interested in how power is exercised, its functions and effects [28]. He recognised the need to study the strategies, networks and mechanisms – which he called technologies, that were employed as devices of power [28]. He was interested in the interaction between the self and others and the devices that individuals, such as the clients in our study, use to exercise power over themselves and others [29]. Foucault attributed the term "governmentality" to these technologies for directing human behaviour [30–32]. Foucault's concept of governmentality refers to more than political structures and policies. It includes the minute micro tactics which control the behaviour of others, such as social pressure and those tactics which are targeted at the social body and aim to optimise the life of the population for example the regulation of pharmaceuticals.

Governmentality also focuses and operates on individual bodies to optimise their capabilities [30]. Foucault termed this technology of power *disciplinary power* [28]. In common usage we have two meanings for the word discipline; one as a branch of knowledge (e.g., physiotherapy) and the other referring to a means for correcting or controlling behaviour. Foucault recognised the connection between these, and explained discipline to be a set of strategies, procedures and ways of behaving which are associated with certain institutional contexts that permeate ways of thinking and behaving in general [27]. Discipline therefore can be considered a body of knowledge that moulds thoughts and shapes behaviours. The body of knowledge and the associated institutions are created by and create the discourse that forms the practices of the discipline [30]. As a power strategy, discipline is productive [it makes things happen] it comes from the outside but works by pressuring the self to work on the self. For example, the discipline of physiotherapy can assist in the restoration of physical function to a level considered appropriate for the client based on population norms however this achievement requires the client to be motivated and actively participate in the process.

A governmental strategy that combines the tactics of disciplinary power with the role of expert authority figures is a relational power strategy Foucault termed *pastoral power* [24]. Foucault appropriated the metaphor from Christianity, to describe the web of power strategies that agents of the state use to care for the welfare of the population [28]. He noted how institutions tasked their expert agents with responsibilities for facilitating relational spaces where subjects were encouraged to reveal truths about themselves to produce obedient, moral, self-governing subjects [31]. This relational and benevolent power strategy is directed at the individual, however its concern is for the health, wellbeing and security of the population [28]. The authority figure establishes a relationship with those they are assisting to achieve ends that are desired by the individual while at the same time serving the goals of their institution and those of the state. For example, the rehabilitation practitioner cares for and about the needs of their individual patient while at the same time attending to the

needs of their wider caseload while working within their professional boundaries and their institution's policies and guidelines.

Foucault's concept of discourse and his approach to power provide a frame for an examination of how power operates in neurorehabilitation. Drawing on these concepts we aimed to gain a deeper understanding of the dominant discourses and power relationships that shaped the subject position of neurorehabilitation client. We were interested in the discourses deployed by the clients when relating their experiences of neurorehabilitation and how these shaped their subjectivities and power relations.

Methods

There is no specific prescriptive formula for conducting poststructural discourse analysis [32]. Foucault considered his ideas as a toolbox that could be adapted as appropriate to a focus of inquiry [33]. The test for rigorous research is the coherence with Foucault's philosophical approach, the method applied and the appropriateness for answering the research question [34]. The researcher uses the theoretical base to formulate questions with which to interrogate the data, then the texts are read with a view to answering the research question in conjunction with the theoretical texts [20]. In this case, Foucault's theories of discourse and power guided this analysis.

Poststructural discourse analysis involves the analysis of texts. A text can be anything where the phenomena of interest is discussed or represented [35]. In this study we undertook a secondary analysis of interview transcripts. The primary study used a qualitative descriptive methodology [36], to explore the core components of therapeutic relationship from the perspective of 14 rehabilitation clients following a neurological event. Potential participants were recruited from four local neurorehabilitation providers. Clients were eligible to take part if they had received at least four neurorehabilitation sessions with the same practitioner within the last six months. Semi-structured interviews explored participants' perceptions of what mattered most in their relationship with their neurorehabilitation practitioner. As it was not feasible to incorporate the complete data set from the primary study in this analysis and to avoid the temptation for selection bias [37], texts were randomly selected by a third party for analysis in the current study. This approach to data selection is methodologically congruent given the focus on discourse rather than individual experience and perspectives which might warrant more purposeful sampling. Six full interview transcripts that lasted between 45 and 70 min were considered sufficient for our purpose given the depth of analysis [38].

Ethical approval was gained from the relevant Intuitional Ethics Committee. This secondary analysis was referenced in the ethics application of the primary study, and consent for data to be used for the purpose of this secondary analysis explicitly sought.

Poststructural research recognises that the world view of the researcher affects what is noticed and of interest, directing the gaze towards particular phenomena and away from others [39]. As such, it is important to state our connection to the topic of interest. The first author (CC), has a background in sociology and has worked in rehabilitation research for more than ten years. She was the research officer on the primary study that contributed data for this analysis. NK has a background in health psychology with an interest in exploring how the ways in which we work with, interact and relate to clients in rehabilitation impact outcome. She has a long-standing interest in therapeutic relationship and was the principal investigator on the primary study. DP has a background in nursing with an interest in disability and women's health, and expertise in poststructural approaches.

Analysis involved the systematic and explicit exploration of the interview transcripts primarily by the first author. The reading and re-reading of the texts sought to answer the questions: How is neurorehabilitation constructed by the clients? What subject positions are produced in the texts? What power relations are enacted and discussed? What is the effect of these power relations? Is there resistance, struggles or competing relations? Readings of texts occurred in parallel with reading Foucault's writing on power and discourse. With each reading we were looking for patterns in the data and exploring how these could be explained by Foucault's concepts to uncover the workings of power in neurorehabilitation. Frequent meetings with the study team were held to discuss the readings of the texts and developing insights.

Table 1. Sample characteristics.

Pseudonym	Gender	Age	Diagnosis	Time since diagnosis
Ben	M	65	Motor neuron disease [MND]	4 Years
Calvin	M	53	Traumatic brain injury [TBI]	9 Months
Andrew	M	56	Traumatic brain injury [TBI]	6 Months
Emma	F	43	Spinal cord injury	+8 Years
Leonard	M	61	Stroke	2 Years
Brian	M	56	Stroke	I Year

Results & discussion

In what follows we present the results and a discussion of our analysis in relation to the governmental strategies observed operating in neurorehabilitation. The texts randomly selected for analysis were generated from interviews with one woman and five men, aged between 43 and 65. Time since diagnosis ranged from six months to eight years. See Table 1 for an overview of sample characteristics. The participants were all currently participating in neurorehabilitation. Two had experienced a stroke, two a traumatic brain injury, one a spinal cord injury and one lived with motor neurone disease. Three interviews were conducted in rehabilitation facilities with the remaining interviews held in the participants' residence.

We begin by exploring neurorehabilitation as a *disciplined disciplining discipline*. Here we are playing with the slipperiness of language and using "discipline" in its multiple senses referring to both the body of knowledge and the regulation of both the clients' and practitioner's behaviour. Following this, we explore the interconnected practices operating that intertwine the client and practitioner in a complex configuration of the power relationship. We apply Foucault's concept of pastoral power [24] to explain the power strategies the discipline of neurorehabilitation employs to accomplish its specific goals. These findings illustrate the way neurorehabilitation shaped the behaviours and thoughts of its subjects to protect and enhance their capabilities and achieve desired ends.

A disciplined disciplining discipline

Across the transcripts the neurorehabilitation practitioners most visible were physiotherapists. The participants described how their bodies as objects were manipulated by the practitioner and how under the guidance of their practitioner, they worked their own body to achieve their recovery goals.

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

Although an individualised service, neurorehabilitation used standardised practices and population norms to identify and address the needs of its subjects. The participants became subjects of neurorehabilitation through being identified as capable and worthy of investing in, and were submitted to observations, examinations, practices and control to optimise their capabilities and achieve their desired state. As subjects of the discipline, they were required to work on themselves and became particular kinds of people.

Qualifying as subjects of the discipline

The texts conveyed the ways that participants were subjected to a set of assessments that identified particular characteristics and allowed them to qualify as subjects of the discipline i.e., worthy of care. In Aotearoa New Zealand, the district health boards provide neurorehabilitation services for those who experience their pathology due to illness. One such provider included in their eligibility statement that potential clients must be "medically able with medical potential for full participation in a rehabilitation programme and with potential for improvement and good rehabilitation outcomes" [40]. In the texts the participants explained how they were subjected to assessments prior to commencing their rehabilitation programme. "I was in ward 23 and they were doing the assessment thing before I went and did anything" [Leonard]. Once judged as eligible subjects, the participants became subjected to the practices deemed necessary by the discipline.

The discipline

Neurorehabilitation is a discipline; a branch of knowledge that draws on the biomedical discourse. It names the phenomena "neurological damage" and constructs the practices those subjects identified as experiencing the phenomena, and assessed as eligible, are to be subjected to. The biomedical discourse suggests the body needs expert assistance to heal and that a particular body of knowledge is required to address the neurological damage.

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

In considering his problem to be a medical one that requires medical solutions that only experts in the neurorehabilitation discipline can offer, Leonard is reproducing the discourse of biomedical expertise, in doing so he is disciplined in that he takes up the subject position of "client" made available to him. It was through this biomedical discourse the participants came to know their bodies in a particular way.

As a way of thinking about illness and health care strategies, neurorehabilitation employs specialist language, equipment and practices. The participants adopted the language and learnt to view their bodies in the technical terms of the discipline.

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

In this passage Brian has become the doing and speaking patient. He is using the language and practices of the discipline, and while encouraged to view his impairment in positive language, he identifies his body as different through neurological disease. The discourse has influenced how he has come to think about his abilities and know his body.

The disciplining

Having adopted the biomedical renderings of the body, the participants learnt to act on their bodies as objects and problems to be solved.

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

The practitioner employed biomechanical understandings of the body produced by the biomedical discourse to instruct Brian in the neurorehabilitation disciplinary practices. Through this, Brian learns to discipline his own body using the techniques of the discipline to become self-disciplined. Thus, the disciplinary practices train both the body and the person.

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

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

Leonard sought knowledge from his practitioner so that he could comply with her practice as a physiotherapist in her work on his body. Both desire the same goal from the discipline – the rehabilitated functioning body.

Part of the disciplining involved being observed and instructed on the correct way to act on their own body. Hence, the participants generally expected to be corrected and disciplined by their practitioner:

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

The disciplinary training is accepted as a mechanism for achieving recovery goals. Through the discipline Calvin learnt to alter his behaviour and work on his own body in a specific way. The correct way he seeks is that which is sanctioned by the discipline. This compliance with the discipline becomes internalised as the participants accept the authority of their practitioner.

The disciplined: shaping subjectivities

The assessment process that identified the participants as suitable subjects for neurorehabilitation created the subject position of "neurorehabilitation client." Through this naming as an eligible neurorehabilitation subject, the discourse influenced the participants' behaviours and affected their actions as they shaped themselves into the kinds of subjects they considered they were required to be. This passage from Leonard demonstrates his taking up this subject position and the behaviours he associated with this subjectivity:

> I could see that if you didn't have a positive connection with your physio it would affect you at rehab, it would affect your recovery, I think motivation was the big difference [...] My physio, she was the reason I got out of bed and had a shave every morning because I had my gym session at 9 o'clock in the morning [...] I just wanted to please her (laughs). I knew if I did things right, I would move onto the next bit and make progress and I didn't want to disappoint her. [...] I was prepared to try anything to get the repair work going and help it out [Leonard].

In this extract, Leonard has taken up the subject position of neurorehabilitation client and is presenting himself as a "good" client: compliant, punctual and motivated. He is self-disciplined, someone prepared to correct and regulate themselves for the sake of improvement, and thus deserving his eligibility as a subject of neurorehabilitation. Other participants also responded to this call to regulate their behaviours and display a commitment and dedication to their rehabilitation programme.

> I have to go with my game on. [...] You work your butt off. [...] I don't go "yeah I'm going to physio!". [...] You go with a particular attitude [...] just try my best, I should just go with a good attitude I think that's what I should do just go and try my best [Emma].

Foucault explained that disciplinary power comes from the outside but works by pressuring the person to work on themselves [33]. As good, moral subjects of rehabilitation, the participants enacted the behaviours they associated with the subject position that had been ascribed them by the discipline of neurorehabilitation. The participants received the expectation to practice their assigned exercises in the prescribed manner in the absence of their practitioner and modify their behaviour. They had internalised the discourses of the discipline and learnt to govern themselves. Foucault referred to this self-steering mechanism as a technology of the self [29]. By this, Foucault is referring to the ways in which human beings come to understand and act upon themselves within certain regimes of authority and knowledge, and the use of certain techniques directed towards self-improvement [41]. Neurorehabilitation provided the knowledge, practices and authority to promote the self-disciplined subject who worked towards desired goals.

Just as the subject position of the client is a discursive product, so is the subject position of the practitioner. It is important to note that the subject position of neurorehabilitation practitioner is produced in relation to that of neurorehabilitation client. This "practitioner" subject position, also created by the biomedical discourse and the discipline of neurorehabilitation, is sustained by the clients' interactions and expectations of the role. Across the texts the participants demanded certain behaviours from their practitioners:

> That they are competent in what they do, that's important [...] I look at her and think "how well is she doing her job?" And she is doing it exceptionally well. [...] I expect from them is that they will do the right thing for me and that's all I expect [...] If they weren't, I would confront them about it [Calvin].

Beyond demonstrating they had the necessary disciplinary knowledge to perform their role, the participants demanded accountability and efficiency from their practitioner.

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

The participants constructed the "good practitioner" as someone who was competent, proficient and efficient, met certain ethical standards and possessed particular character traits such as empathy, patience, genuineness and self-sacrificing – "not there for the money" and were prepared to do their best for the client.

Resisting the discipline of neurorehabilitation

The self-disciplined self-governing individual is produced within a neoliberal discourse which demands self-responsibility and the obligation to maximise ones' life as a kind of enterprise [41]. This on one level allows for autonomy and freedom of choice. However, the opportunity to exercise this agency is limited by the biomedical discourse which sets boundaries of what can be done and in what way and the subjectivities it makes available. The self-governing subject can bring challenges to neurorehabilitation. Not only do they reproduce the disciplinary discourses and practices (as in the examples given above), but they can resist them. For example, Leonard, who constructed himself as the compliant neurorehabilitation subject, also related how he was frustrated with some of the cautions placed on him and struggled with the pace of recovery that had been set for him:

> She [the physio] wouldn't take any risks with me. I felt I could do better, I could do more than what I was being allowed to do sort of thing, like very, I was quite close to discharge and I started to walk around unaided without a stick [...] and the staff nurse came over and said "what do you think you are doing?" [Leonard]

Neurorehabilitation uses population norms to predict the rate of recovery for its clients [42]. These calculations form the basis of the client's rehabilitation programme. Leonard challenged the pace of recovery that had been set for him by walking around the ward unaided. While the purpose of disciplinary practices is to enhance the capabilities of the clients, they also aim to protect them [30]. In this quote we see competing discourses where both the physiotherapist and the staff nurse employ a discourse of safety and require Leonard to exercise caution and limit his unaided mobilisation. They are concerned not just with enhancing abilities but also with protecting Leonard's capabilities and managing his safety.

Although the clients were able to adopt or reject aspects of the discipline, the texts revealed they were not free of the discourse. They were still subjects of the discipline of neurorehabilitation and under its influence as they chose options made available to them by the discourse. Despite earlier suggesting he was willing to "crawl over hot coals" for his therapist and constructing himself as the super-patient in terms of adopting some of the exercise practices, Leonard later challenged her expertise and sought alternative approaches from a consultant to improve his physical function.

> The consultant I had, asked the physio to do FES on my arm and on my drop foot too and I got the distinct feeling that (the physio) [...] didn't like doing the electrical stimulation [...]we only had short sessions of it because it was supposed to tire you out, but it never did. In fact, I bought a TENs machine for when I got home and fixed the pain in my arm and woke my foot up. [Leonard]

Once discharged Leonard was freer to work at his own pace using the practices of the neurorehabilitation discipline such as the electrical stimulation to achieve his recovery goals. Although he has challenged the authority of the practitioner and the controls of the discipline the discipline still permeates his thoughts and actions.

Pastoral power: the benevolent power relationship

Beyond observing, instructing and disciplining their clients, the neurorehabilitation practitioners were also constructed as caring

for and about their clients. Across the texts we observed how the discipline of neurorehabilitation capitalised on the relational power strategy Foucault described as *pastoral power* [24]. The discipline of neurorehabilitation promotes the use of the therapeutic relationship between the client and practitioner to optimise rehabilitation outcomes [43]. The texts revealed how the participants entered this relationship with their practitioners because they trusted the practitioners were working in their best interest towards the same goals. The practitioners' disciplinary knowledge gave them authority to assess and treat the individual client and gain more knowledge, which helped them tailor their approaches to meet the specific needs of their clients. This knowledge also gave them access to other more personal intimate knowledge of the individual client. The participants commented on how their practitioner knew things about them that others did not.

> (The physio) could relate to what I was going through and my wife couldn't […] she knew what I was feeling […] I had no clue then that it was fatigue making me grumpy. [Leonard]

The practitioners' knowledge of the pathophysiology underpinning Leonard's unusual emotions – how the fatigue was a consequence of his stroke and affected his moods – enabled the practitioner to appear to have insight into Leonard's personal dilemmas and have access to the truth about him. Foucault recognised the close connection between knowledge and power and demonstrated how knowledge about people is constructed as a function of power [28]. Their formal disciplinary knowledge gave practitioners access to supplementary knowledge about the client which assisted them in their practices.

As the practitioner came to know the limitations and abilities of the clients, the client in turn appeared to be more willing to trust and follow the practitioner's advice.

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

Client-centred approaches require the practitioner to gain knowledge about the unique context and meaning of illness of the client to facilitate individualised service provision and the setting of meaningful client-centred goals [44,45]. Consequently, clients are required to disclose personal information to their practitioner. Giving out personal information about oneself to a person in authority who has committed to assist you can be viewed as an "act of confession." These acts of confession are a central strategy to the outworking of power [46]. The practitioner encouraged a revelation of hidden secrets that with their expertise they were able to interpret and then guide the client towards self-understanding. In this way, the practitioner got to know the clients and the clients got to know themselves.

The therapeutic relationship and the confessional act are among a set of practices associated with pastoral power [24]. The neurorehabilitation practitioner as an agent of the state is tasked with the wellbeing of their individual client. They also carry a responsibility for their caseload and are implicated in concerns for the health, wealth and wellbeing of the population through their professional obligations. The pastoral power relationship has been used to explain various health care situations where the practitioner is charged with forming a relationship with their client to achieve particular governmental objectives. Foth and Homes (2017), for example suggest that this relationship has become particularly important in welfarism where public health nurses became a key resource for governing the health behaviours of individuals [47]. Similarly Waring and Martin (2018) explored the role of pharmacist as agents of the state who developed pastoral care relationships with their clients to endorse governmental objectives of medication adherence [48].

Here we are suggesting that the therapeutic relationship designed to address power imbalances, is actually operating as a power strategy. As a strategic power relationship, the therapeutic relationship can be productive as this collaboration between practitioner and client works to identify and achieve recovery goals and is benevolent; as it is based on caring about the individual and their desired outcomes. This relationship however has the potential to place each practitioner in a web of obligations that can be problematic as they balance their own professional obligations and external demands. The practitioner as a subject of this discipline of neurorehabilitation is answerable not just to their individual client, but also to their supervisors and funders who may have differing priorities and competing discourses [49].

Strengths and limitations

This secondary analysis applied Michel Foucault's theories of power and discourse and provided an opportunity for an alternative viewing of transcripts where neurorehabilitation clients discussed their relationship with their practitioner. Secondary analysis had benefits specifically related to economic use of research resources, as well as limitations related to the construction of the data and the analysis process. However, it is important to be mindful when engaging with our analysis and interpretation that the data was collected primarily to answer another research question. Further, a qualitative interview is a constructed artefact produced by the interviewer and participant for a particular purpose [20]. Hence, it is historically and socially situated, and generalisations cannot be made. The analysis attempts to discuss the transcripts within these boundaries, recognising the limitations while taking the opportunity to uncover what is taken for granted.

Conclusion

Across the transcripts, Neurorehabilitation was constructed as a material and discursive practice: a *disciplined disciplining discipline.* Constructed as a discipline that demanded discipline, neurorehabilitation used discipline to protect and enhance the capabilities of its clients. Neurorehabilitation appeared to be a space and a practice for people deemed eligible to become both its subjects and objects. The practices and discourses of the discipline constructed the assessments that defined eligibility and assessed who could become both the subjects, and the objects of its practices. Using special equipment and specialist staff with particular knowledges, traits and skills, neurorehabilitation involved performing specific practices that focused on abilities, working on and with the body.

This view has illuminated the governmental technologies of power operating within neurorehabilitation moulding the behaviour of both the client and practitioner. The practices and discourses of neurorehabilitation shaped the participants into self-governing moral subjects. Under the guidance of their practitioners, the clients worked to protect and enhance their capabilities and become the ideal rehabilitation client.

These governmental strategies employed by the discipline of neurorehabilitation, while benevolent and productive, intertwined its subjects in a strategic power relationship that involved a web

of obligations and responsibilities. Through recognising the potential of this power relationship, practitioners can become aware of opportunities for challenging disciplinary practices that do not serve the best interest of the client. This might include acknowledging those practices that marginalise those who are for various reasons are unable to demonstrate the required behaviours and shape themselves into the ideal client. This is particularly so for those who experience lack of affect following stroke and are unable to demonstrate their motivation, or where cultural or social barriers inhibit their understanding of their obligations and responsibilities. For example, navigating the competing discourses of safety and the expectation for being self-disciplined and taking responsibility for practicing their prescribed exercises outside of therapy sessions. To further this work and build on the strengths of Foucauldian analysis it would be important to explore the exclusionary practices produced by these discourses.

This viewing contributes to a broader understanding of the workings of power in the relationship between the neurorehabilitation client and their practitioner. We hope that by being aware of how power works in neurorehabilitation, practitioners can be alert to the ways their practices can close off or open up opportunities for challenging rehabilitation-as-usual and create spaces for alternatives.

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