Bedside Matters: A Conceptual Framework of the Therapeutic Relationship in Physiotherapy

by

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ABSTRACT

Background

The therapeutic relationship (TR) in physiotherapy, sometimes described as the rapport or the alliance between physiotherapist and patient, is an important aspect of clinical interactions. Physiotherapists are expected attend to the TR as a standard of patient-centred practice. Recent research that illustrates that better quality TRs can positively impact health outcomes, patient satisfaction with services, and patient adherence to treatment plans. However, a lack of conceptual development limits how the TR is addressed in research, clinical practice, and education. A specific definition of the TR and conceptual framework is needed to provide a foundation to understand and apply the TR in these 3 areas. This dissertation aimed to identify and conceptually describe the key components of the TR.

Methods and Results

The study design was interpretive description, a qualitative method. One-on-one interviews were completed with 11 physiotherapists and 7 patients managing musculoskeletal conditions in private practice clinics in Edmonton, Canada. Textual data was analyzed using qualitative content analysis, augmented by principles of constant comparison. Three components were identified and conceptually described: the necessary conditions of engagement, ways of establishing connections, and elements of the bond. This dissertation details each component in separate papers. The first paper (Chapter 4), "The necessary conditions of engagement for the therapeutic relationship in physiotherapy," provides a detailed account of the circumstances that underlie development of the TR. The second paper (Chapter 5), "A framework for establishing connections in physiotherapy practice" reviews the various ways that physiotherapists and

patients can develop meaningful attachments based on common ground and acknowledgement of personal and professional factors between them. The third paper, "The defining elements of the bond between physiotherapists and patients," illustrates the nature of the affective resonance between physiotherapist and patient.

Conclusion

Findings provide an overarching conceptual framework that could advance the way the TR is approached in research, clinical practice, and education. Together, these 3 components illustrate that the nature and development of the TR in physiotherapy involves multiple factors. Moreover, the findings clarify that the TR is a mutual endeavour involving a complex mix of professional and personal factors that can vary between clinical situations.

PREFACE

This thesis is an original work by Maxi Miciak. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Health Research Ethics Board, Health Panel. The title of the research project that received ethics approval was BEDSIDE MATTERS: THE ROLE OF THE THERAPEUTIC RELATIONSHIP IN PHYSICAL THERAPY, No. MS2_Pro00021472.

DEDICATION

To my beautiful partner, Michelle – my travelling companion.

Doing a PhD is a journey, and your partner needs to go with you on the journey. You have been an amazing travelling companion - selfless, supportive, and ever-present.

Thank you for seeing my future and sharing it with me.

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LIST OF ABBREVIATIONS

ID: interpretive description

MSK: musculoskeletal

PT: physiotherapist or physiotherapy

TR: therapeutic relationship

GLOSSARY OF TERMS

Common or Contextual Factors: personal and social factors (e.g., patient expectations, TR) that form the milieu of the clinical encounter (i.e., not the specific intervention). These factors can have a significant influence on the quality and outcome of the clinical encounter.

Iterative: the process of concurrent data generation and analysis used in qualitative research. In this process, data generation and analysis inform one another throughout the project, allowing flexibility to adjust research strategies (e.g., revise questions in an interview guide).

Patient, Client*: the individual involved in treatment with a healthcare practitioner.

Specific Intervention: the actual treatment technique used by the healthcare practitioner to address the patient's physical signs and symptoms.

Therapeutic Relationship**: the relationship between the healthcare practitioner and the patient with the common goal of addressing patient health needs.

*The terms "client" and "patient" are used throughout the literature. There are philosophical distinctions implied with each term. I will not make these distinctions in this thesis. Physiotherapist and patient participants in this study also had varying perspectives on the terms. I will attempt to remain true to the terminology used within the literature that is cited and within the participant quotations being referenced. I will be using patient as the overriding term in the thesis.

**The terms therapeutic relationship, therapeutic alliance, working alliance, patient-therapist relationship, patient-doctor relationship, nurse-patient relationship, among others, have been used interchangeably in much of the literature in the health related domains. I have used the specific terms as they have been used the literature being referenced.

CHAPTER 1 – OVERVIEW OF THE PROJECT

The therapeutic relationship (TR), often described as the rapport (Leach, 2005) or the alliance (Besley, Kayes, & McPherson, 2011b; Ferreira et al., 2013; Fuentes et al., 2014; Kayes & McPherson, 2012) between physiotherapist (PT) and patient, is a key element of the clinical interaction. The World Health Organization has recognized the TR in its International Classification of Functioning, Disability, and Health framework (World Health Organization, 2002), and teaching patient-practitioner interaction is becoming a mainstay of PT training curriculums. The need to train PTs in the "art" of interaction is supported by PT regulatory Colleges in Alberta and Ontario given that both have developed resource guides (College of Physical Therapists of Alberta, 2007; College of Physiotherapists of Ontario, 2013) that reinforce the TR as a standard (Physiotherapy Alberta - College + Association, 2012; College of Physiotherapists of Ontario, 2012) for ethical and caring practice.

Although relevant for these Colleges, defining the TR in healthcare has been challenging. The College of Physical Therapists of Alberta (2007) describes TRs as the ". . . working relationships established between PTs and patients or substitute decision-makers" (p. 1) based on respect and trust. The TR has been defined elsewhere as, "a purposeful, goal-directed relationship that is directed at advancing the best interest and outcome of the patient" (Registered Nurses Association of Ontario, 2006, p. 13). Both of these definitions provide descriptive boundaries of the TR but remain at the surface. Additionally, both use the term relationship in the definition, which raises the question of exactly what the relationship is. Moreover, the College of Physical Therapists of Alberta (2007) describe the TR as a "working relationship" (p. 1), which some psychotherapy literature suggests is one of three components (working alliance,

real relationship, transference/countertransference configuration) of the TR, but not synonymous to the TR (Gelso & Carter, 1994; Greenson, 1967).

Research in related healthcare disciplines, such as psychotherapy, has demonstrated that the quality of the TR influences clinical success. Meta-analyses in psychotherapy have clearly demonstrated that the TR has a moderate and consistent impact on outcomes, regardless of theoretical (e.g., psychodynamic, humanistic) and technical (e.g., defense interpretation) affiliation (Horvath, Del Re, Fluckiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross & Wampold, 2011; Wampold, 2001). A good TR, or aspects thought to be of a good TR (e.g., bond, communication), has also been related to higher patient satisfaction in nursing (Kim, Kim, & Boren, 2008; Tejero, 2010), occupational therapy (Gunnarsson & Eklund, 2009; Haertl, Behrens, Houtujec, Rue, & Haken, 2009), and medicine (Fuertes et al., 2007) as well as patient adherence in rehabilitation settings (Schönberger, Humle, & Teasdale, 2006; Schönberger, Humle, Zeeman, & Teasdale, 2006). In medicine, better patient adherence to medication regimes has also been positively correlated with the aspects of the doctor-patient relationship (Fuertes et al., 2007) as well as with patient-centred interviews (Stewart, 1984). Furthermore, cognitive (e.g., addressing patient expectations) and emotional (e.g., warmth) care provided by physicians has been positively correlated with improved clinical outcomes (Di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001; Steinhausen et al., 2014), such as reduced pain.

Research that evaluates the influence of TR in PT has become more common. Exploratory (Gyllensten, Gard, Hansson, & Ekdahl, 2000; Stenmar & Nordholm, 1994), prognostic (Ferreira et al., 2013; Hall, Ferreira, Maher, Latimer, & Ferreira, 2010) and experimental (Fuentes et al., 2014) research supports the contention that the TR can positively

impact health status clinical outcomes in addition to patient satisfaction (Goldstein, Elliott, & Guccione, 2000; Hush, Cameron, & Mackey, 2011; Beattie, Turner, Dowda, Michener, & Nelson, 2005; Beattie & Nelson, 2008; May, 2001) and adherence to rehabilitation recommendations (Wright, Galtieri, & Fell, 2014). However, the methodological strength of these studies is limited due to the absence of a TR self-report scale specific to PT. Typically, self-report scales developed in other disciplines have been used without prior validation in PT (Besley, Kayes, & McPherson, 2011a; Hall et al., 2010). Moreover, the dimensions and items of these scales are most often based in theory developed in the psychotherapy context and may have different meanings when applied in PT. While psychotherapy has used extensive theoretical background to develop valid and reliable self-report scales, this has not been the case in PT. Because the TR could be informed by unique disciplinary factors, there may be a need to add components (e.g., therapeutic use of touch) or subtract current components (e.g., "liking" the therapist) in the psychotherapy scales (Besley et al., 2011b). The few PT-specific scales and evaluation procedures (verbal and non-verbal) available have had only limited psychometric analysis or have been developed as TR subscales within the evaluation of other constructs such as patient satisfaction (Beattie et al., 2005) and rehabilitation expectations of individuals with low back pain (Cheing, Lai, Vong, & Chan, 2010).

Given the growing need to evaluate the TR's impact on clinical outcomes but the lack of a thoroughly validated measure of this construct in PT, a clear picture of the TR's essential components is needed. This type of clarity is fundamental for steering practice, research, and education in a patient-centered care context (Jette, 2006).

The Current Dissertation

Problem Statement

The TR has been considered important for positive PT experiences. However, we do not yet have a clear understanding of the fundamental components that constitute this unique professional relationship. In other words, what exactly is the TR? This clear starting point is pivotal for directing education, practice and research that maximizes PTs' abilities to help patients return to productive and active lives. Ideally, we would be able to concisely show PTs what components are important for developing TRs so they can be immediately applied to clinical practice. The increased emphasis placed on the TR as a requirement of ethical and effective treatment needs the supporting knowledge regarding the nature of the TR in PT. This knowledge gap is ideally addressed by first using qualitative methodology to identify and characterize the key components of the TR.

Purpose, Research Questions, And Research Objectives

The purpose of this project was to identify and describe the key components of the TR. The corresponding research question was then:

What are the conceptual descriptions regarding the components of the TR?

With this question in mind, the objective of this research project was to identify and provide in-depth descriptions of the key components of the TR relevant to PTs and adult patients managing MSK conditions in private practice clinics.

Structure of the Dissertation

In addressing the research question, three key components of the TR were identified: (a) the conditions of engagement, (b) ways of establishing connections, and (c) elements of the bond. Consequently, this dissertation is composed of three papers, each of which addresses a

component of the TR. The first paper, "The necessary conditions of engagement for the therapeutic relationship in physiotherapy", is found in Chapter 4 and is an in-depth review of the circumstances that are essential for a TR to develop in PT. The four conditions, *present*, *receptive*, *genuine*, and *committed* are based in PTs' and patients' attitudes and intentions toward engaging with one another in the clinical encounter. Chapter 5 is the second paper and is entitled "A framework for establishing connections in physiotherapy practice". This paper provides a thorough description of the various ways that PTs in private practice can foster meaningful attachments with their patients. In Chapter 6, the last paper, "The defining elements of the bond between physiotherapists and patients", clarifies the nature of the ". . . complex network of positive personal attachments . . ." (Horvath & Greenberg, 1989. p. 224) that make up the TR in PT. The descriptions of the elements *nature of the rapport*, *respect*, *trust*, and *caring* provide an in-depth account of the affective attachment that can form between PTs and patients through their intentions, attitudes, and actions.

Implications of the Dissertation

This dissertation, as communicated through the three papers, makes a valuable contribution to the PT discipline. To my knowledge, there is no current literature specific to the TR in PT that addresses the same compositional breadth as these findings. Moreover, the TR has not been presented as consisting of three components: conditions, connecting, and the bond. The TR in PT is often described in terms of what we do (e.g., communicate, collaborate) and what it creates (e.g., rapport, bond). These findings not only provide in-depth conceptual descriptions pertaining to both of these aspects of the TR, but also make explicit the important circumstances that create an environment for the TR to flourish.

Ultimately, these findings are useful in clinical practice, education, and governance. While the most obvious and immediate application would be in clinical practice, PT education programs will also benefit from the structure that these findings could provide to instructors teaching PT students to develop the TR. In addition, the findings may contribute to the understanding of personal and professional boundaries in practice, which would be of use to PT governing bodies (e.g., Physiotherapy Alberta - College + Association). PT governing bodies could also use the findings to inform best-practice guidelines, which not only affects the way that PTs practice, but also informs the public about appropriate expectations in terms of PT and patient responsibilities within the professional relationship.

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CHAPTER 2 - LITERATURE REVIEW

This chapter presents the literature and rationale that supports the need to identify the key components of the TR in PT. Specifically, I will present pertinent literature from health related domains (psychotherapy, nursing, medicine, occupational therapy, physical therapy), which provides the background that clarifies the key gap in our knowledge of the TR. The review is organized into four sections: (a) theoretical importance of the therapeutic relationship, (b) the impact of the therapeutic relationship on outcomes, (c) the patient's experience – a necessary perspective, and (d) outlining the knowledge gaps in physiotherapy.

Theoretical Importance of the Therapeutic Relationship

Theories of the TR have been developed in various healthcare-related disciplines. The following section outlines theory development in (a) healthcare-related domains and (b) physiotherapy.

Healthcare Related Domains

Healthcare encounters have been described as implicitly relational, with the TR embedded in the clinical encounter (Greenfield, 2006). Authors in healthcare related domains including psychotherapy (Horvath & Bedi, 2002), medicine (Fuertes et al., 2007; Mead & Bower, 2000), nursing (Arnold & Boggs, 2003; Forchuk, 1994; Forchuk et al., 2000), and occupational therapy (Cole & McLean, 2003; Taylor, Lee, Kielhofner, & Ketkar, 2009) consider the TR an important element of successful clinical interaction. It has been described as " . . . the quintessential common ground shared by most psychotherapies" (Horvath & Bedi, 2002, p. 37) and has been considered integral to medical encounters since Hippocrates (Di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001). Nurses view patient care and advocacy as key professional roles (Arnold & Boggs, 2003; Reynolds & Carnwell, 2009), which makes the nurse-patient

relationship a cornerstone of the field (Arnold & Boggs, 2003). Occupational therapy has also historically emphasized the interaction between the therapist and patient as central to the clinical encounter (Cole & McLean, 2003; Palmadottir, 2006; Taylor et al., 2009).

Given the importance placed on the TR, authors across health related fields have theorized about its key components. Psychotherapy has made the most substantive contributions beginning with Freud's psychodynamic theory. He conceptualized the relationship as a collaborative alliance formed within the transference/counter-transference exchange between patient and therapist (Horvath & Bedi, 2002; Truscott, 2010). Hildegaard Peplau used these principles to develop the "Theory of Interpersonal Relations" (Nyström, 2007), a well documented and used nursing theory that specifically addresses the TR (Forchuk, 1994). The theory outlines three interactive phases of the relationship: (a) orientation, (b) working, and (c) resolution (Fawcett & Swoyer, 2008; Forchuk, 1994). Subsequent psychotherapy authors have distinguished the alliance into (a) the bond between therapist and patient and (b) the actual tasks of therapy (Greenson, 1967; Horvath & Bedi, 2002). Notably, Bordin (1979) outlined the working alliance's specific components into *the bond*, *agreement on goals*, and *agreement on tasks*. Fuertes et al. (Fuertes et al., 2007) used these components to guide their study evaluating the association between cognitive and emotional dimensions of the TR and various patient characteristics (e.g., patient adherence) in the medical encounter.

Recent research in occupational therapy has begun to clarify the theoretical foundation of the TR from within the profession. The importance of the TR is theoretically supported by the "therapeutic use of self" or the occupational therapist's conscious use of personal qualities and skills to foster the therapeutic interaction (Taylor et al., 2009). Despite the profession's focus on holistic practice models, there is only a small body of research attending to the TR in

occupational therapy (Cole & McLean, 2003; Taylor et al., 2009). However, Cole and Mclean (2003) claim there are common characteristics throughout the occupational therapy literature, including collaboration, trust, connection, communication, empathy, and understanding. More recent research using qualitative methods to explore the TR in occupational therapy has identified dimensions that have included reciprocity, caring, acceptance, and rapport (Crepeau & Garren, 2011), as well as the use of humour (Crepeau & Garren, 2011; Morrison & Smith, 2013), fostering connections (Morrison & Smith, 2013), an impetus to act (Morrison & Smith, 2013), and shared success (Morrison & Smith, 2013).

Patient-centred care describes the conceptual evolution of the TR in healthcare domains. Although historically elusive and ill-defined (McPherson & Siegert, 2007; Mead & Bower, 2000), it has been suggested that the TR is one of its dimensions (Mead, Bower, & Hann, 2002), with some authors referring to it as "the heart" (Norfolk, Birdi, & Walsh, 2007, p. 691) of patient-centred care. Using psychotherapy theory as a foundation, Mead and Bower (2000) integrated Rogerian principles of unconditional positive regard, empathy, and congruence to help define the therapeutic alliance in the person-centered model of medical interaction. Doherty and Thompson (2014) describe an intimate link between a community nurse's ability to enact a patient-centred approach and the development of a TR. Patient-centered practice has been a philosophical pillar of occupational therapy (Palmadottir, 2006). Most research has focused on relational processes that could be considered common within patient-centered approaches, such as communication, collaboration, and caring, as opposed to conceptualizing the relationship between the therapist and patient (Taylor et al., 2009).

The theoretical importance of the TR is well articulated across the health related disciplines. Although gaps in breadth and depth of theoretical knowledge about the key

components of the TR exist, most disciplines would claim that, in theory, the TR is an essential element of successful clinical interactions. Given its importance across the health domains, I will now review its importance in PT.

Physiotherapy

The TR has been discussed in the literature for the last forty years (Cannon, 1994; Gartland, 1984; Grant, 1979; Rubin, Judd, & Conine, 1977). Biopsychosocial and patient-centred models of care formally identify the TR as a component of clinical interactions. Teaching patient-practitioner interaction has increasingly been included in PT training curriculums, focusing on interactive skills (e.g., communication, self-awareness) (Davis, 2006) within broader concepts such as respect and dignity (Purtilo & Haddad, 2007). References to Freudian (Davis, 2006; Purtilo & Haddad, 2007) and Rogerian (Davis, 2006) principles from psychotherapy are made in some PT course texts. The need to train physical therapists in the "art" of interaction is paralleled by PT standards of practice as stipulated by regulatory Colleges (Physiotherapy Alberta - College + Association, 2012; College of Physiotherapists of Ontario, 2012).

However, there is no clearly developed TR theory despite its importance to education and ethical practice. Unlike nursing and occupational therapy where the TR has historically been positioned as a key component of practice theory, PT has paralleled medicine, where the importance of the relationship has received more anecdotal notoriety. The resulting discourse has been diffuse, lacking the clarity to provide meaningful insight and action in clinical practice.

Much of the substantive thought and research has covered the broader concept of the "patient-therapist interaction." As will be discussed in Chapter 4, interaction is a global term that describes a situation where at least two people are behaving in relation to one another. The term does not necessarily describe the quality of the behaviors (e.g., nature of the verbal and non-

verbal communication) or the degree of investment made by those interacting. Moreover, the TR could involve numerous factors that could also be seen as common to all or most clinical encounters, such as patient self-efficacy, treatment techniques, and therapist competence. In this scenario, the TR becomes synonymous with the interaction or takes on an assumed role within it instead of being carved out as a definable construct (Kayes & McPherson, 2012).

This boundary blurring is illustrated in a literature review on the physiotherapist-patient relationship by Klaber Moffett and Richardson (1997). The authors did not distinguish between the terms "relationship" and "interaction" in their review, using them interchangeably. They grouped factors that had demonstrated positive influence on clinical outcomes and that they believed were integral to the physiotherapist-patient relationship. These groupings were: communication and patient education, patient compliance and adherence, self-efficacy, patient expectations and therapist enthusiasm, and operant conditioning. On closer examination, these groupings could be distinct from the physiotherapist-patient relationship, although it is conceivable that they could be linked to it. In fact, similar groupings such as patient characteristics (e.g. self-efficacy, compliance, adherence), change process (e.g. providing education), therapist qualities (e.g. enthusiasm), and interventions (e.g. operant conditioning), have been identified in the psychotherapy literature as factors that are common to all or most clinical encounters (Grencavage & Norcross, 1990). The main difference is that the psychotherapy common factors also identify "relational elements," distinguishing the TR as a unique phenomenon within the clinical encounter. There is a significant absence of literature citing the TR as a unique phenomenon in Klaber Moffett and Richardson's (1997) review, likely due to the limited amount of related research. Even so, the review was forward thinking for its time and context. Although not intentionally, the authors identified possible common factors in

PT with the potential to impact clinical outcomes as well as the quality of the TR. While the review supported the importance of contextual factors, it did not answer the question "what is the TR?" or clearly outline its characteristic components.

The patient-therapist interaction has been the topic of specific research, and as in Klaber Moffat and Richardson's (1997) literature review, there have been various interpretations of the TR. The TR has been positioned as a result of the patient-therapist interaction, with the quality of interaction identified as essential in establishing a relationship (Gyllensten, Gard, Salford, & Ekdahl, 1999). The TR has also been viewed as embedded within the interaction and important for positive clinical experiences (Gyllensten, Gard, Hansson, & Ekdahl, 2000; Gyllensten et al., 1999). Gyllensten and colleagues (2000) studied the interaction between PTs and psychiatric patients. In their findings, the TR was embedded within the theme "ways of contact," a component of the "interaction" dimension although the authors provided no specific characteristics of the TR.

This is a common finding in the literature. Authors refer to the TR as synonymous with other constructs (e.g., communication, caring, patient-therapist interaction, rapport), as an important aspect of other constructs (e.g., patient satisfaction) (Kayes & McPherson, 2012), as an element of successful interventions (Smith, Hale, Mulligan, & Treharne, 2013), or as implicitly consisting of factors that combine both characteristics and process without clearly making these distinctions. This is an important distinction because viewing the TR as either an outcome or a process (or both) will change how the construct is conceptualized. This is another reason why more thought and study is needed to understand the TR.

Although there is the lack of research exploring the TR as a specific construct (Besley, Kayes, & McPherson, 2011; Kayes & McPherson, 2012), Besley et al. (2011) have identified

themes of the TR from a conceptual review of the literature. The authors systematically approached the literature review, choosing articles (i.e., studies, theoretical discussions) that met the following criteria: (a) were directly related to PT and (b) had explicitly explored some part of the TR or identified it as a key finding. Sixteen studies were included and components of the TR were extracted. Although it is unclear how the authors analyzed the extracted data (e.g., thematic analysis) the following 8 themes were identified: (a) patient expectations, (b) personalized therapy, (c) partnership, (d) PT roles and responsibilities, (e) congruence, (f) relationship/relational aspects, (g) communication, and (h) influencing factors. The authors commented that while some of the themes (e.g., partnership) were addressed well in the literature, others were not (e.g., communication).

Although this review provides some clarity to understanding the components of the TR, there are limitations with the findings. First, the authors commented on various methodological weaknesses of the studies, such as potential bias with interpretation in one qualitative study and lack of generalizability to male PTs in another. Second, there were no studies that included both patient and PT accounts and only five articles that included patient accounts; of these 5 studies only 1 specifically addressed the TR. Third, the diverse nature of the literature could explain the descriptive and not necessarily distinct quality of Besley et al.'s (2011) themes. For example, while the themes "partnership" and "congruence" ascribe a higher level of meaningful interpretation and could possibly be used to guide practice, other themes like "influencing factors" and "communication" appear more taxonomic, limiting their use in clinical practice. This could be due to the limited number of articles that looked at the TR directly. Ultimately, the authors do call for further research to develop a stronger conceptual foundation of the TR.

One study in Besley et al.'s review that did more specifically address the components of the TR was Westman Kumlin and Kroksmark's (1992) qualitative study exploring the PTs' views of establishing the TR and activating patient resources (i.e., abilities and personal supports) in the first clinical encounter. The researchers used the phenomenographic qualitative method. They describe the aim of the method as ". . . gaining knowledge about people's conceptions of various aspects of the world" (p. 38) and to qualitatively describe the differences in how aspects of the world are experienced; this is in contrast to describing the physical world. The authors used semi-structured in-depth interviews with a purposive and heterogenous sample of 10 physical therapists. Despite the limited number of interviews completed (10 total) within a very diverse population, the qualitative analysis generated interesting findings. The authors noted two categories describing different perspectives: "physical therapist-oriented strategies" and "patient-oriented strategies." They described the physical therapist-oriented strategies as externally focused, combining therapist generated professional knowledge and expertise with limited patient participation. In this strategy, the PT would use the initial encounter to gather medical information and to provide information. On the contrary, PTs using a patient-oriented strategy focused on receiving and responding to information provided by the patient. Through dialogue and co-operation, the PT would help activate the patient's own resources to aid rehabilitation.

Westman Kumlin and Kroksmark's (1992) study addresses the process of developing the TR in the early stages of treatment. The authors distinguished that the participants believed there to be different approaches to developing the TR in the first encounter and that the style of engagement reflects the importance placed on the TR (not important or important). In other words, how the therapist engages is indicative of the quality of the TR. Still, it does not

specifically identify characteristics of the TR. Exactly "what" does using these approaches develop?

In summary, there is a limited amount of research that specifically provides a clear conceptual description of the TR (Kayes & McPherson, 2012). A good conceptual framework clearly and concisely synthesizes complex phenomena, providing invaluable direction for clinicians and researchers working in the complex clinical world (Jette, 2006). Moreover, most of the research that does exist addresses the patient-therapist interaction. This is problematic because the interaction could simply imply behaviours without a sense of investment (Doherty & Thompson, 2014) or embed the TR within the interaction with little or no formal description or definition. At this point, PT lacks the conceptual development (Besley et al., 2011) necessary to effectively inform education, practice and research.

The Impact of the Therapeutic Relationship on Outcomes

The review in the following section is of the positive impact of the TR in (a) healthcare related domains and (b) physiotherapy.

Healthcare Related Domains

Interest in the TR's impact on clinical metrics has been a mainstay in psychotherapy for decades. The discipline has an extensive history of evaluating the impact of the TR on treatment outcomes and has consistently documented that it does influence clinical success. Meta-analyses of this association over the last 20 years have demonstrated that the TR has a moderate and consistent impact on outcomes, regardless of theoretical and technical orientation (Horvath, Del Re, Fluckiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross & Wampold, 2011; Wampold, 2001). These meta-analyses included a broad cross-section of disorders (e.g., depression, eating disorders, bereavement), settings (e.g., inpatient,

outpatient), and structures of the clinical encounter (e.g., individual therapy, family therapy, group therapy). The second interdivisional task force on evidence-based therapy relationships, which took place in 2009, most recently confirmed the TR's impact on outcomes (Norcross & Wampold, 2011). Meta-analyses were completed on elements of the TR (e.g., working alliance, empathy, congruence) and expert panels came to consensus on the evidence. The task force concluded that the TR contributes to success, or lack thereof, at least as much as specific interventions and that the TR impacts outcomes independent of the intervention used. In addition, the task force also claimed "efforts to promulgate best practices or evidence-based practices without including the relationship are seriously incomplete and potentially misleading" (Norcross & Wampold 2011, p. 98).

Evidence in support of the TR has increased in other healthcare domains, such as medicine, nursing, and occupational therapy, over the last 10 years. As such, there is growing body of evidence that demonstrates that better quality TRs contribute to better outcomes in these fields. TR quality has been linked to patient satisfaction in nursing (Kim, Kim, & Boren, 2008; Tejero, 2010), occupational therapy (Gunnarsson & Eklund, 2009; Haertl, Behrens, Houtujec, Rue, & Haken, 2009), and medicine (Fuertes, Anand, Haggerty, Kestenbaum, & Rosenblum, 2015; Fuertes et al., 2007). Patient adherence to medication regimes has also been associated with the working alliance (Fuertes et al., 2015; Fuertes et al., 2007) as well as with patient-centered interviews (Stewart, 1984). However, in their review, Mead and Bower (2002) stated that they were not able to identify a consistent relationship between patient-centred consultations and patient health outcomes in primary care. Moreover, Mead et al. (2002) found that the therapeutic alliance, when operationalized as one dimension of their patient-centred care model, was not associated with patient enablement or satisfaction. The authors commented that ability of

clinicians to adjust their communication to the context (e.g., patient's needs), versus simply increasing the number of patient-centred behaviours, might be the "therapeutic essence" (p. 296) of patient-centred practices. However, better conceptual understanding of patient-centred care, and the TR in particular, is necessary to help clinicians' evaluate and respond to changing clinical contexts.

Specific to medical encounters, Di Blasi et al. (2001) systematically reviewed 25 studies for the impact of ". . . contextual interventions related to the patient-practitioner relationship in a clinical population with a physical illness" (p. 758). They reviewed how these contextual interventions (e.g., establishing a warm and friendly relationship, addressing patient beliefs) affected health status outcomes. Although their conclusions were limited by significant heterogeneity of the studies, they did claim to find a consistent pattern of better outcomes (e.g., reduced pain) when physicians provided emotional care (e.g., warm, friendly, reassuring) with cognitive care (e.g., addressing beliefs). They speculated that the doctor-patient relationship alone could impact health outcomes. In addition to health status outcomes, patient satisfaction with medical care has also been evaluated. The refined version of the Kim Alliance Scale explained 36% of the variance in patient satisfaction with primary care treatment (physician, physician aid, nurses) in two military (family and retiree patients) medical outpatient clinics (Kim et al., 2008). Moreover, increased interest in the therapeutic impact of the placebo effect has also inspired study of the doctor-patient relationship. Recent findings indicate that enhancing the TR increases the placebo effect, improving outcomes in individuals with irritable bowel syndrome (Kaptchuk et al., 2008).

Occupational therapists have suggested that the TR is essential to improving functional outcomes (Cole & McLean, 2003), although empirical evidence supporting this claim is

inconclusive (Eklund, 1996; Gunnarsson & Eklund, 2009). In a recent study, Gunnarsson and Eklund (2009) used the "Tree Theme Method" to assess whether the therapeutic alliance and patient satisfaction as "process factors" were associated with occupational performance health-related outcomes in a psychiatric population. Occupational performance considers ". . . the relationship between occupation, health, and well-being" (Clarke, 2003, p. 171). Conclusions were limited because a control group was not included. However, they did find associations between patients' and therapists' early ratings (after 2nd session) of the therapeutic alliance (modified Helping Alliance Questionnaire; Luborsky et al., 1996) and occupational performance (Canadian Occupational Performance Measure; McColl, Paterson, Davies, Doubt, & Law, 2000; Satisfaction with Daily Occupations; Mona Eklund & Gunnarsson, 2007), as well as self-mastery (Mastery Scale; Marshall & Lang, 1990). Therapists' early ratings also correlated with the patient's increased sense of coherence with managing life stress while remaining healthy (Sense of Coherence Scale; Eriksson & Lindstrom, 2005, 2007), reduced psychiatric symptoms (Symptom Checklist 90-R; Derogatis & Wise, 1989), and patient satisfaction (Client Satisfaction Questionnaire; Nguyen, Attkisson, & Stegner, 1983). In an earlier study, Eklund (1996) also found an association between the working relationship and global mental health (revised Health-Sickness Rating scale; Luborsky, 1975) and occupational functioning (Assessment of Occupational Functioning; Watts, Brollier, Bauer, & Schmidt, 1988) in a psychiatric day care unit. Limited power and variability in the participant perceptions of the working relationship (e.g., no poor relationships reported) likely resulted in difficulty clarifying the presence of an association between different ratings (e.g., fair, good) of the relationship and these specific outcome measures. Nonetheless, the findings suggest that the TR facilitates a positive outcome pattern, encouraging further study in other populations.

Physiotherapy

A majority of Swedish therapists surveyed believe the TR impacts treatment success, as evidenced by Scandinavian researchers Stenmar and Nordholm (1994). The researchers came to this conclusion after completing an exploratory study examining Swedish PTs' beliefs about factors necessary for successful outcomes. Moreover, regardless of sector (private practice/hospital) or condition treated (orthopaedic/psychiatric), PTs were more likely to attribute perceived treatment success to the patient-therapist relationship and patient attributes rather than to specific interventions. They speculated that PTs might believe specific treatment techniques are not sufficient in and of themselves to produce positive clinical outcomes.

Stenmar and Nordholm's findings were consistent with Hall et al.'s (2010) systematic review of the working alliance's impact on physical rehabilitation outcomes. These authors noted a provocative trend – a consistent positive correlation between the quality of the therapeutic alliance and outcomes. A total of 13 studies met the inclusion criterion and covered a broad diagnostic and adult age range including MSK conditions, brain injury, and cardiac conditions within adult, geriatric, and mixed age groups. Hall et al.'s (2010) findings were especially relevant to MSK and primary care PT. Musculoskeletal conditions (chronic neck pain, chronic low back pain, multiple diagnoses) comprised 6/13 studies, with 4/6 involving treatment by a single physical therapist. More globally, a single PT provided treatment in 8 of 13 studies. Studies with a single therapist (occupational therapy, PT, speech language pathologist, chiropractor, psychologist, recreation therapist) or a combination of therapists in a multidisciplinary setting were included in the review. Although heterogeneity between studies prevented meta-analysis, a consistent positive correlation between the alliance and pain, disability, physical and mental health improvement, and treatment satisfaction was still noted.

Results for patient adherence to treatment were inconsistent, with one study showing positive correlation and one, no correlation. The authors speculated that significant diversity of populations and measurement scales influenced the inconclusive findings.

Of the 13 studies in the review, 11 were completed since 2002, highlighting the growing attention paid to the TR in physical rehabilitation settings. Although these findings appear to illustrate the relevance of the TR, especially in PT, there are concerns regarding the valid measurement of the alliance that raise caution when interpreting the results (Hall et al., 2010). First, there was a high degree of variability in outcome measures used across the studies, with the majority developed and validated in psychotherapy (Hall et al., 2010). Of the seven self-report scales, only one (the MedRisk; Beattie, Turner, Dowda, Michener, & Nelson, 2005) has undergone psychometric testing in PT and this scale was developed to specifically evaluate patient satisfaction with PT treatment using a TR subscale. Two of the studies used observer ratings of verbal and non-verbal behaviours without patient or therapist ratings. Second, the threat to validity increases with the possibility that the same construct (TR) is not being measured across the studies (Hall et al., 2010). None of the measures had been validated in physical rehabilitation (Hall et al., 2010). Additionally, very diverse populations, varying across conditions, age groups, treatment providers, and treatment settings, were included in the review. This diversity limits interpretation of a trend across these populations. Even though it generally appears that a good TR has a positive impact on outcomes, the factors that contribute to the TR are not identified (Hall et al., 2010). For example, populations may vary in the meaning given the TR, which could translate to varying factors. Older patients may have different perceptions and experiences of the TR compared to younger adults. This lack of systematic evaluation in physical rehabilitation warrants caution for generalizing the findings.

Nonetheless, Hall's findings are significant despite these concerns. They confirm that further systematic exploration of the TR is essential. Almost one third (4/13) of the studies evaluated the relationship in single service MSK PT. This demographic illustrates the obvious importance of clarifying the TR's role within this context.

Responding to this need, Fuentes et al. (2014) directly addressed the impact of the therapeutic alliance on chronic low back pain in their double blind, placebo-controlled experimental controlled study. This was the first study of its kind in PT because it manipulated the presentation of the therapeutic alliance and its subsequent influence on clinical outcomes (i.e., the therapeutic alliance was the independent variable and pain intensity and sensitivity were the dependent variables). Participants were randomly assigned to one of four groups and received sham or active interferential current combined with either limited therapeutic alliance or enhanced therapeutic alliance as enacted by the PT. The study was strengthened by good protocol adherence (86%) and high internal validity. One possible weakness was the therapeutic alliance outcome measure, the working alliance subscale of the Patient Rehabilitation Expectations Scale. Although the measure underwent preliminary psychometric testing and was appropriate for the population (i.e., chronic pain) and setting (i.e., PT), it is possible that not all relevant aspects of the therapeutic alliance are represented (further discussed in discussion section in Chapter 4). Nonetheless, the study's findings were compelling. One such finding was that a higher rated therapeutic alliance had a positive influence on pain intensity and sensitivity that was clinically meaningful. Specifically, pain intensity and pain sensitivity were reduced in both the sham and active treatment groups when the therapeutic alliance was enhanced. Moreover, the group that received active treatment with enhanced alliance had the greatest reported reduction in pain intensity (77.4% reduction) and increased pain threshold (51.5%).

These findings exceeded the researchers' expectations and the parameters of a clinically meaningful difference. Yet, the most compelling finding was the comparison between the active treatment with limited alliance group and the sham treatment with enhanced alliance group. Although the difference between the two groups was not statistically different, the group that received sham treatment combined with enhanced therapeutic alliance reported greater reduction in pain intensity and sensitivity than the group who received active treatment and limited therapeutic alliance. In other words, the impact of the therapeutic alliance, on its own, had a greater influence on pain reports than active treatment on its own. Although the difference between the two groups was not statistically significant, the finding is still intriguing and supports the argument that the therapeutic alliance could have therapeutic value in and of itself. This is consistent with the conclusions of the interdivisional task force on evidence-based therapy relationships, as earlier described.

The Patient's Experience of the Therapeutic Relationship – A Necessary Perspective

Patients have not often been consulted when theories of TR were being developed (Bedi, Davis, & Arvay, 2005). Although the importance of patients' perspectives in research evaluating PT service is acknowledged (Hills & Kitchen, 2007), much of the PT literature specific to the TR has focused on therapist perspectives.

The clinical interaction inherently involves a patient and a therapist. Considering that patients' perceptions of the TR are more accurate predictors of psychotherapy outcomes compared to those of therapists' (Horvath & Bedi, 2002), it would seem clear that patient perceptions are relevant. Moreover, patient input in theory building or the exploratory phase of developing a self-report tool would seem to be essential considering the tool's domains are ultimately meant to evaluate patients' experiences. Subjective experience is difficult to capture

with measurement scales, which is one reason why it is essential to know, as precisely as possible, "what" is being measured (DeVellis, 2003). Scales currently used in PT research typically have not been developed using patient input. Therefore, it would be logical to gather this input prior to beginning scale development.

Another argument that supports the need to understand the patient's perspective is the modern premise that healthcare interactions should be patient-centred. In other words, good interactions center on the clinician engaging with the patient in a collaborative partnership that achieves a shared understanding of the patient's complaint or condition and the care plan moving forward (Mead & Bower, 2000; Norfolk et al., 2007). The interaction is no longer to be clinician dominated, but based on a dynamic and shared interaction. This philosophical shift requires patient input in treatment, hence, the need for patient input in research.

Outlining the Knowledge Gaps in Physical Therapy

The knowledge gaps in the TR are (a) impoverished conceptual development and (b) inadequate first-hand knowledge of patients' experiences. These gaps are not mutually exclusive and must be addressed to advance our practical understanding of the TR. Filling these gaps will impact PTs' abilities to help their patients return to active and productive lives by providing a necessary clinical heuristic (Thorne, Kirkham, & O'Flynn-Magee, 2004) of the TR, informing education and practice guidelines, providing researchers with a platform to study and evaluate the TR, and educating patients on what to expect from their therapist regarding the TR.

Positioning The Researcher And The Discipline

Qualitative research is both inductive and interpretive, requiring a high level of engagement between research and participants. For this reason, it is necessary to "position" the researcher by identifying the various perspectives that could influence the research process and

findings (Thorne, 2008). Positioning promotes transparency (Fischer, 2009) and researcher reflexivity (Thorne, 2008), encouraging a trustworthy and ethical process (Tracy, 2010). Thorne (2008) outlines three positions that need to be clarified in an interpretive description study: (a) theoretical allegiances, (b) position of the discipline, and (c) position of the researcher.

Theoretical Allegiances

Theoretical perspectives underpin research, regardless of method (Clark, Lissel, & Davis, 2008; Denzin & Lincoln, 1994; Sandelowski, 2010). Although not bound to a specific theory (e.g., symbolic interactionism), particular theoretical perspectives have informed this project. Declaring implicit and explicit theoretical perspectives help clarify where and how these perspectives inform the research process, and therefore, the findings (Thorne, 2008).

This study is explicitly informed by the contextual theory (Frank & Frank, 1991) of psychotherapy. Contextual theory provides broad characteristics of the context of the clinical encounter. These characteristics form meta-principles that could conceivably apply over any therapeutic encounter, regardless of disciplines (e.g., PT, psychotherapy) or treatment theory (e.g., psychodynamic). By informed, I mean that the meta-principles (see Appendix A) could act as a springboard to think about and study the TR. More specifically, these tenets have informed the initial outline of the interview process. These tenets do not directly characterize the TR, however, they do outline the context. My assumption was that these tenets influence perceptions of the TR, and therefore, would be useful in guiding the interviews. Although considered at the beginning of data generation, certain principles (and associated questions) could be excluded and new ones added as iterative generation and analysis progresses. Thorne (2008) is clear that initial theoretical perspectives need to be challenged and possibly refined or let go in lieu of new perspectives (Thorne, Kirkham, & MacDonaldEmes, 1997).

Implicitly, this project is influenced by critical realist social theory (Archer, 1995; Bhaskar, 1998; Collier, 1994; Pawson & Tilley, 1997). This meta-theory is a major element of some of my scholarly writing. Although I am not specifically using the tenets to guide my project, its ontological and epistemological perspectives influenced my interpretations of the TR (see Appendix B).

Position of the Discipline

Thorne (2008) describes disciplinary orientation (e.g. epistemology, theory, mandate) as a significant element informing the research decision-making process. In Alberta, PTs are described as "movement specialists" (Physiotherapy Alberta - College and Association, n.d.d) with the mandate of helping ". . . people take back control of their body and life by restoring and maintaining maximal function" (Physiotherapy Alberta College Association, n.d.b). The epistemological foundation underpinning this mandate has changed from therapist-centered (arguably positivist) to patient-centered (Kell & Owen, 2008; Richardson, 1999). This shift impacts PT research and practice in two ways. First, it implies that study of contextual factors (e.g., TR, patient beliefs) is important in understanding PT effectiveness. Second, it challenges the way PTs have traditionally been taught to view practice, thereby creating tensions with the way PTs enact practice. That is, there can be a gap between what we say we want to do and what we are currently doing. In addition, a superficial view of patient-centred services could mistakenly imply an over-emphasis on the patient's subjective experience as driving services, when clinical encounters are a complex interaction between objective and subjective realities addressed in social relationships (Thorne, 2008). I argue that addressing these tensions in clinical practice require specific heuristics (e.g., TR framework) that have some tentative truth value (Thorne, 2008) and represent current clinical practice. Physiotherapy Alberta -College +

Association does provide some guidance, educating clinicians to attend to the TR by focusing on the components of trust, power, respect and personal closeness (College of Physical Therapists of Alberta, 2007). However, this view positions the TR from a regulatory perspective and may not provide enough specific guidance to PTs during clinical encounter.

Position of the Researcher

Guided by the principles of naturalistic inquiry (Denzin & Lincoln, 1994), positioning the researcher becomes important because the researcher and the researched are linked through the research process, with the researcher impacting the nature of the findings (Denzin & Lincoln, 1994; Thorne, 2008). Personal characteristics and insider/outsider positions inherently impact research relationships and provide lenses through which phenomena are viewed and interpreted.

The perspectives arising from the lenses of gender, age, culture, and ethnicity could impact the quality of interviews and therefore quality of data (Olson, 2011). For example, gender and cultural perspectives could impact my engagement with a middle-aged man from India who has immigrated to Canada. Another factor is my perspective, developed from experiences as a PT and patient, that the TR is an essential component of the clinical interaction.

Continuously shifting insider/outsider tensions also influence qualitative inquiry (Dwyer & Buckle, 2009; Hockey, 1993), enhancing or impeding the research process (Finlay, 2003; Patton, 2002). I hold various positions in relation to both PT and patient groups, which creates possible tensions that require specific attention. For example, PT participants' expectations could be influenced by whether they view me as an insider or outsider (Hockey, 1993). Another tension pertains to professional knowledge and philosophical perspectives (Coar & Sim, 2006; Conneeley, 2002; Morse, 2001). For instance, philosophical differences between the participant and myself could impact data generation and analysis. In addition, PT participants could perceive

that I am testing their knowledge, which could impact the quality of their accounts. Researcher/clinician boundaries with patient participants can also be challenged (Bailey, 2007; Cartwright & Limandri, 1997; Hewitt, 2007; Richards & Emslie, 2000). For example, patient participants could view me as PT and seek medical advice or be hesitant to speak openly because of a perception of power imbalance. Specific strategies to address these tensions are addressed in the "Reflexivity Orientations and Strategies" section in Chapter 3.

Summary

This literature review provides an overview of the TR across prominent healthcare professions by addressing these four areas: a) theoretical importance of the TR; b) the impact of the TR on outcomes; c) the patient's experience – a necessary perspective; d) outlining the knowledge gaps in PT. The review of the literature pertaining to both TR theory and outcomes establishes the importance of the TR in healthcare. It also clarifies the knowledge gap in PT when compared to other professions. Most notably, a gap in conceptual development exists. Addressing this gap is necessary for rigorous evaluation (e.g., development of valid and reliable measurement scales) of the TR's impact on outcomes as well as for guiding PT clinical education and practice.

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CHAPTER 3 - METHODS

Design

Interpretive description (ID) was the qualitative research approach used in this project. It is a methodological decision-making framework designed for use in clinical (e.g., PT, nursing) and other applied research settings (Thorne, 2008). It is best used when practice-oriented questions require practical answers that can guide problem-solving within an environment that engages subjective (e.g., perceptions) and objective (e.g., diagnoses) realities (Thorne, Kirkham, & O'Flynn-Magee, 2004). Interpretive description draws on naturalistic inquiry (Lincoln & Guba, 1985), the discipline's mandate (e.g., social mandate to help others) and theoretical structures (e.g., patient-centred care), and the subsequent research question to inform coherent methodological decisions (Thorne, 2008).

The results of an ID study are *conceptual descriptions* (Thorne, 2008). Sandelowski and Barroso (2003) created a "typology qualitative findings". The typology consists of five types of findings based on the degree of data transformation (e.g., original interview data versus categories). Types of findings range on a continuum between findings that remain close to the data (e.g., a topical survey that reduces data to lists or inventories) to findings that are abstract and further away from the data (e.g., interpretive explanations). Conceptual descriptions are one type of finding in the typology. Thorne, referring to Sandelowski and Barroso's typology, describes conceptual descriptions as, ". . . thematic concepts exported from external sources or developed *in situ* from the data reveal latent patterns that have been discovered within the data through the application of interpretive analytical process" (Thorne, 2008, p. 164). I consider conceptual descriptions relevant to clinical practice in two ways. First, I believe conceptual descriptions to be conceptual enough to be operationalized by practitioners to interpret the

phenomenon of interest in the applied setting (e.g., clinic). Second, conceptual descriptions are also descriptive (i.e., near to the experience) enough to be considered a credible representation of the specific setting (e.g., private practice clinics) and be recognizable to practitioners working in that setting (Thorne, 2008).

Setting

PT occurs in a variety of settings with potentially different organizational (e.g., institutional, private), disciplinary (e.g., sole charge, interdisciplinary team), funding (e.g., government funding, private payment), and payment (e.g., salary, fee for service) characteristics that could potentially impact how PTs and patients experience the TR. PTs' diverse scope is also illustrated by application to numerous conditions (orthopaedic, neurological, cardiac, respiratory, and rheumatoid), populations (paediatric, adult, and geriatric populations), and settings (hospitals, rehabilitation facilities, home care, and private practice) (College of Physical Therapists of Alberta, 2013). This professional breadth created a methodological challenge that required I focus on a particular setting and population to begin in-depth exploration of the TR.

Edmonton private practice clinics were chosen as the setting for various reasons. Private practice demographics were used to inform projected PT and patient sample sizes. In 2013, 43% of PTs worked in private practice making it the largest practice segment in Alberta (College of Physical Therapists of Alberta, 2013). Orthopaedic conditions are the most common conditions treated by PTs in both private practice and outpatient hospital settings (Jette & Davis, 1991), which provided opportunity for the patient sample size to be achieved. This setting not only provided the basis for findings to be meaningful to a large segment of PTs, but certain contextual factors also made it a unique environment for gaining insight into the TR. Private practice patients are typically seen more frequently (Goode, Freburger, & Carey, 2010), and may

have longer treatment sessions than in, for example, primary care medicine (Blumenthal et al., 1999; Stange et al., 1998). Private practice PTs will typically work with a patient for the duration of treatment, whereas in the hospital context, shift changes create a rotating system of practitioners (e.g., nurses). Even hospital based PTs may see their patients for uncertain durations due to short inpatient turnover times. While the location of private practice clinics in community settings could increase access to services, a for-profit business model could also have therapists place more emphasis on the TR in order to build a clientele. In addition, patients in Alberta have "direct access" to PT services meaning physician referral is not necessary. This creates a context where PTs can be primary care providers, which could impact the TR by influencing patients' expectations of PTs (e.g., expect a diagnosis). Thus, focusing the TR study in the private practice setting with an orthopaedic population provided the platform to expand to other important practice areas.

Participants

PT and patient input was necessary for meaningful identification and description of the TR components. This is especially true when psychotherapy research suggests that patients' views of the TR can differ from those of the psychotherapist (Bachelor, 1995; Bedi, 2006) and are more predictive of outcome than therapists' perspectives (Horvath & Symonds, 1991). Additionally, the limited amount of TR knowledge invites the contribution of both perspectives, especially when most research specific to the TR, whether developing concepts or measurement scales, has not integrated patient perspectives.

Physiotherapist Participants

Female and male PTs were eligible to participate if they had a minimum of five years of clinical experience. This cut off was set after reviewing the literature of other qualitative

studies (Gard, 2004; Gunvor Gard, Gyllensten, Salford, & Ekdahl, 2000; Gyllensten, Gard, Salford, & Ekdahl, 1999; Westman Kumlin & Kroksmark, 1992), and because I assumed that PTs with this amount of clinical experience would have greater insight into their experience of the TR, thus resulting in richer interviews. Ultimately, PTs in this study had worked in clinical practice for a minimum of 10 years and in private practice for a minimum of 10 years. As anticipated, the PTs were able to comment, in great detail, on their experiences with the TR as well as their approach to and process of developing TRs.

Patient Participants

The study population was limited to adult (18-64 years) male and female patients. Patients were eligible to participate if they had received treatment for a MSK condition. These conditions (e.g., ligament sprain, non-specific low back pain) are the most common conditions seen in private practice (Jette & Davis, 1991). Patients managing all durations of injury (acute, subacute, and chronic) were eligible to participate. Patients also needed to have attended a minimum of three PT treatment sessions in order to be included in the study. Psychotherapy (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) and occupational therapy (Gunnarsson & Eklund, 2009) literature suggests that patient ratings of the TR early in treatment are positively correlated with clinical outcomes. This suggests that the TR can be established early in treatment and has a positive influence on outcomes. It was also anticipated that three sessions would provide patients with sufficient experience to contribute to exploration of the TR. A maximum number of treatment sessions was not applied. Although all patients attended at least three sessions, there was a large variance in number of treatments reported by patients. In some circumstances, patients had returned to their PTs over a period of time for the same issue, so were unsure of the exact number of sessions they attended while others had attended for a

discrete period. On average, there were four patients who had attended 10 or more sessions and three who attended fewer than 10 sessions.

The timing of the patient interviews was considered an important factor for determining eligibility. Interviewing patients during active treatment versus post-discharge might have influenced the authenticity and richness of responses. For instance, patients actively receiving treatment might limit negative reporting due to concerns that their reports would be discovered by their PTs and impact subsequent treatment. In addition, patients being interviewed while accessing services may have felt obligated to participate in order to maintain the TR with their PTs, which could potentially be perceived as coercive. In addition, it was believed that interviewing patients within four weeks of their actual treatment experience would facilitate richer descriptions of their relationships with their PTs (Thomsen & Brinkmann, 2009) and limit the degree of memory construction due to shifting beliefs and attitudes as the time between treatment and interview increases (Hyman & Loftus, 1998; Schwarz, 1999; Thomsen & Brinkmann, 2009). Considering these factors, two eligibility criteria were developed, both centred on discharge from active treatment, were (a) patients were to be interviewed post-discharge and (b) efforts would be made to interview within one month of discharge from active treatment. Discharge was described as being a discrete moment when the PT determined that treatment would formally end. However, as recruitment progressed, various factors (e.g., system-based timelines for treatment) led me to revise the criteria. First, the description of discharge shifted to a continuation/discontinuation of the treatment framework that acknowledged patient decision-making in addition to discharge as a discrete moment. Second, the post-discharge timeline was extended from 4 to 12 weeks.

Patients were excluded from the study if they had conditions that have their etiology in systemic causes and associated conditions (e.g., rheumatoid arthritis) and neurological conditions (e.g., stroke) even though they might have an MSK condition. It was anticipated that these patients might have rehabilitation needs that could influence the TR, and therefore require more in-depth exploration beyond the parameters of this study. Patients were asked during the initial contact with the researcher whether they had any of the excluded conditions and to provide the diagnoses of their treated conditions, to the best of their knowledge. Patients who had co-morbid conditions limiting their ability to communicate, (e.g., Parkinson's disease) or their cognitive capacity (e.g., dementia) were also not eligible to participate.

Patients who were receiving wage replacement or pain and suffering compensation through a third party (i.e., lawyer, workers' compensation, insurance) were ineligible due to the potential influence of institutional systems on the TR and the added complexity of negotiating relationships involving patients and their adjudicators, employers, and lawyers.

Sampling Strategy and Recruitment

There are no pre-determined and generalized sampling parameters in qualitative research. The sample size in an interpretive description study is based on the researcher's critical analysis of the specific research question, the context, and the phenomenon (Thorne, 2008), as well as time and resources (Patton, 2002). Because the TR is qualitatively experienced in some capacity by all PTs and patients in private practice, a sufficient sample size was needed to capture relevant perspectives of both groups in the private practice setting (Patton, 2002), provide enough quality data to account for both replication and negative cases (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Sandelowski, 1995), and result in findings that are conceptual

descriptions (Sandelowski, 1995). An iterative approach to data generation and analysis allowed adjustments in sampling to be made.

Physiotherapist Sample

Purposeful sampling (Patton, 2002) was the primary strategy used to sample PTs. It promotes deep and focused exploration of a phenomenon through the intentional selection of data sources (e.g., participants, documents) that the researcher believes best represents that phenomenon (Mayan, 2009) and the evolving analysis. Purposeful sampling allowed sampling across factors (Stern & Porr, 2011) such as clinical experience, gender, treatment specializations (e.g., "manual therapists" with post-graduate certification) and areas of interest (e.g., chronic pain). I anticipated these parameters would provide enough breadth to generate results that would theoretically and practically resonate with a large group of private practice PTs as well as permit a deep and detailed analysis of each TR component (Sandelowski, 1995). Dr. Gross and I, both PTs formerly employed in Edmonton private practice, used our knowledge of the private practice community to purposefully identify fourteen potential participants who we believed would provide rich interviews; 10 of the 14 agreed to participate. Snowball sampling was used to successfully recruit one additional participant. In this case, I asked one of the participating PTs for a recommendation.

Potential PT participants were contacted by email (completed by administrative staff in the Department of Physical Therapy, University of Alberta) or mailed a brief description of the study and the study information sheet (see Appendix C). PTs were advised to contact me via telephone or email if they were interested in participating or had questions. A time, date, and location for the semi-structured interview was set if the PT was eligible and agreed to participate

in the study. Formal informed consent (see Appendix D) procedures were completed at the outset of the interview.

The final PT sample consisted of 11 participants (six female and five male). PT participant ages ranged between 36-60 years, with a mean age of 47.8 years; demographic data were missing for two therapists. All PTs had been in clinical practice for at least 10 years and in private practice for at least 10 years. The majority of PTs (10/11) reported using at least one advanced restricted activity (i.e., an activity requiring authorization from the provincial College), such as intramuscular stimulation or spinal manipulation (Physiotherapy Alberta - College + Association, n.d.a). A description of treatment preferences can be found in Table 3.1. Post-graduate training was reported in women's health, vestibular rehabilitation, temporomandibular joint rehabilitation, and sports physiotherapy.

Table 3.1

PT Demographic and Treatment Information

PT ID	Gender	Age (years)	Treatments Regularly Applied								
			Ex	I/H	Acu	US	JMob	JMan	Edu	IFC	STM/T
PT-A	M	36	✓	✓		✓	✓	✓	✓	✓	✓
PT-B	F	53	✓		✓		✓	✓	✓		✓
PT-C	M	37	✓	✓		✓	✓	✓	✓	✓	✓
PT-D	M	54	✓	✓	✓		✓	✓	✓	✓	✓
PT-E	F	Not available	✓	✓	✓		✓	✓	✓		✓
PT-F	M	60	✓	✓	✓	✓	✓	✓	✓	✓	✓
PT-G	F	59	✓	✓		✓	✓	✓	✓	✓	✓
PT-H	F	Not available	✓	✓		✓	✓	✓	✓		✓
PT-I	F	46	✓	✓			✓		✓		✓
PT-J	F	42	✓	✓	✓		✓	✓	✓		✓
PT-K	M	43	✓	✓	✓				✓		✓

Note: Ex = Exercise; I/H = ice/heat; Acu = Acupuncture; US = ultrasound; JMob = Joint mobilization; JMan = Joint manipulation; Edu = education; IFC = interferential current; STM/T = soft tissue massage/techniques

Patient Sample

The project began with purposeful sampling (Patton, 2002), and integrated convenience sampling when recruitment stalled. Four different recruitment strategies were used over the course of the project. To begin, I approached three clinics to assist in recruitment: Centric Health, CURA Physical Therapies, and the Glen Sather Sports Medicine Clinic. Centric Health is an integrated healthcare services company that owns and operates 120 private practice clinics

across Canada, 6 of which are in Edmonton. CURA Physical Therapies is an independently owned and operated private practice, while the Glen Sather Sports Medicine Clinic operates under the jurisdiction of the Faculty of Rehabilitation, University of Alberta.

With all organizations, I made initial contact with a gatekeeper (i.e., research director, clinic owner, or clinic manager). Meetings were held with the gatekeepers to provide a brief orientation to the project and to clarify the role of the administrative staff: staff were to identify and distribute the study information sheet (see Appendix E) to patients who they believed would be able to openly describe and discuss their experiences of the TR. Administrative staff often becomes familiar with patients over the course of treatment, which I believed would allow them to purposefully identify patients who would be more likely to provided insight into the TR. Using administrative staff eliminated putting extra responsibility on PTs and reduced the possibility of actual or perceived patient coercion by PTs.

Ultimately, only CURA Physical Therapies and the Glen Sather Sports Medicine Clinic were successful in recruiting participants. A total of five participants, three female and two male, were recruited by these clinics. Although Centric Health had committed to providing three recruiting clinics, the main gatekeeper (i.e., research director) left the organization. Due to this loss, as well as other key personnel changes at the clinic administrative level, we decided to forgo the relationship with Centric and pursue other recruitment options.

Due to a slow enrollment rate, a second recruitment strategy that used convenience sampling was initiated. Four PT participants who also owned clinics were contacted by email and agreed to place posters (Appendix F) in their reception areas. The clinics were distributed across the city (three in south Edmonton, two in central Edmonton, and one in north Edmonton). No patient participants were recruited using this strategy although one male patient (from a

central clinic) made email contact, but did not respond to further correspondence. A third recruitment strategy involved the coach of a large Edmonton athletic club distributing an email containing a description of the study and the study information sheet to the member list. This initiative resulted in two male athletes agreeing to participate.

The last recruitment strategy involved PTs purposefully identifying patients. Although the initial recruitment plan deliberately excluded PT participation, the plan was reconsidered in order to stimulate recruitment. Three PTs who treated patients in the Student Physiotherapy Clinic of the University of Alberta's Faculty of Rehabilitation Medicine agreed to identify patients they believed were appropriate for the study. These PTs had small caseloads and their patients were often specifically referred to them because of their expertise. The process involved the PT identifying a potential participant and then passing the patient's name on to administrative staff; the staff member would then give the patient an information sheet upon discharge. This recruitment strategy elicited a response from one patient although she was ineligible to participate; therefore, no participants were recruited using this strategy.

Regardless of the recruitment strategy, patients interested in participating in the study were asked to contact the researcher by email or telephone to review the purpose of the study and the inclusion/exclusion criteria as well as to provide opportunity for patient questions. All participants received a study information sheet prior to the interview being scheduled. A time, date, and location for the semi-structured interview was set if the patient was eligible and agreed to participate in the study. Formal informed consent procedures (see Appendix G) were completed at the outset of the interview.

Seven adult patients (four males and three females) agreed to participate in the study. Their ages ranged between 18-62 years, with an average age of 42.3 years. Most patients (6/7)

had previously accessed physiotherapy services and most (5/7) had been experiencing their physical issues for greater than three months prior to seeking treatment. Information on various aspects of each participant's treatment can be found in Table 3.2.

Table 3.2.

Patient Demographic and Treatment Information

Patient ID	Gender	Age (years)	Was this your first PT experience?	If previous experience with PT, was it for same problem?	Was the MSK condition acute (<3 weeks) or chronic (>3m)?	Gender of the PT seen for this problem?
Patient-A	F	62	No	No	chronic	F
Patient-B	F	18	No	No	acute	F
Patient-C	F	54	No	Yes	chronic	F
Patient-D	M	55	Yes	n/a	chronic	M
Patient-E	M	51	No	Yes	chronic	F
Patient-F	M	33	No	No	chronic	F
Patient-G	M	23	No	Yes	acute	M

Data Generation and Analysis

Data Generation

Semi-structured Interviews. Semi-structured interviews were used to uncover the complexity of participant experiences of the TR. Interviews lasted between 40-90 minutes and were completed in a public location (e.g., coffee shop) that was convenient for the participants. All interviews were audio-recorded and transcribed verbatim by a professional transcriptionist. An interview guide (Patton, 2002) (see Appendices H and I) of open-ended questions was used to facilitate discussion about participants' perspectives of the TR. Concurrent data generation and analysis allowed for continual revision of the interview guide to reflect the evolving analysis; this facilitated increasingly targeted discussions that brought forth rich participant

accounts. The initial questions were non-specific to the TR in order to facilitate wider discussion about aspects of the interaction that could have implications for what the TR is and how it is developed. As the interview progressed, guiding questions became more specific and increasingly related to the TR. Probing questions were then used to build on participant comments in-the-moment in order to encourage thorough description.

An iterative approach reinforcing concurrent data generation and analysis facilitated reflexive assessment of the research questions and objectives to ensure methodological coherence (Richards & Morse, 2007; Thorne, 2008) It also allowed for saturation to be determined. Thorne (Mayan, 2009; Thorne, 2008) warns against over commitment to saturation, because the aim of an ID study is not to develop theory through the exhaustive process of exploring and comparing multiple variances of the phenomenon. The aim of an ID study is to make pragmatic sense of a clinical phenomenon to enable better clinical practice. Therefore, data generation continued until a reasonable point of saturation was reached where no substantively new components were identified and each component meaningfully described clinical reality. This point was reached through an iterative process of data generation (e.g., altering interview guides), data analysis (e.g., constant comparison principles), and rigour processes (e.g., memoing, peer debrief).

Other Data. Other data that factored into the global, and sometimes specific, analytic process included interview notes, memoes, analytic notes, and reflexive notes. Interview notes, completed prior to and after interviews, commented on contextual aspects of the interview, such as the environment, participant-researcher rapport, and interview quality (Patton, 2002). The interview notes were not analyzed in the traditional sense but augmented the analytic process by

highlighting relevant aspects from the interview data that were not discernable from the transcripts (Mayan, 2009). For an example of an interview note, see Appendix J.

Memoes and analytic notes are the researcher's written notes, sketches, and drawings, outside of the formal analytic coding process, that highlight notations of concern or importance, linkages with other data, negative themes, preliminary interpretations and theoretical thinking that could contribute to the development of the findings (Mayan, 2009). The following excerpt was taken from a written memo exploring PT-A's "bleed for them" comment, including the possible interpretations and consequences of the comment as well as links to the literature:

> "Bleed for them" also relates to "not abandoning", "being there for them", and "giving of self". This could be the demonstrative aspect of empathy. And when we consider "bleeding" for someone or "giving of self", I begin to think of boundaries and what is the function of boundaries in these scenarios. How much do you give if you are not getting back (see Bondi 2010 article on caring and geography)? When does the client need to respond by accepting then acting? PT-B spoke about setting boundaries with patients who are not adherent. And I also asked the question about whether therapists need to trust clients as well (haven't analyzed this data yet). (Maxi Miciak, October 25, 2012)

Data Analysis

Analytic conventions of ID. Interpretive description is not a method; it is a methodological decision-making framework that affords researchers in the applied fields of study (e.g., healthcare professions, education) the flexibility to make methodological decisions that exploit the goal of generating findings that can be applied in the setting being studied (Thorne, 2008). Therefore, unlike traditional qualitative methods with strong theoretical structure (e.g., grounded theory, phenomenology), ID does not have it's own analytic strategy. Ultimately,

researchers using ID must choose an analytic strategy that is congruent with the research question and data generation strategies being used. ID studies that use interviews as the primary source of data generation often rely on content or thematic analysis to analyze the text.

Although ID does not have its own analytic strategy, Thorne (Mayan, 2009; Thorne, 2008) is explicit about two ways of maintaining perspective during analysis. First, she recommends being attuned to themes versus an over-focus on specific words and phrases. A theme captures " . . . something important about the data in relation to the research question and represents some level of *patterned* responses or meaning . . ." (Braun & Clarke, 2006, p. 82) Second, Thorne (2008) also suggests transcripts be read numerous times prior to formal coding in order to develop a thorough working knowledge of the data and to prevent the researcher from focusing on a particular interpretation too early. With numerous readings, the researcher begins to know the data as a whole prior to interrogating smaller chunks of text.

Phases of data analysis. I chose to structure my analytic process into two concurrent phases. I did this for two reasons. First, I respected Thorne's (2008) perspective on curtailing early and focused coding because it could limit the researcher's ability to see multiple possibilities and increase the likelihood that the researcher jumps to interpretive conclusions. Second, I wanted to explicitly incorporate my reflexive plan (see Rigour section in this chapter) into the project. There are many procedural elements of qualitative research that do not follow set rules, and therefore, can be skimmed over or forgotten. As a novice researcher, I wanted to very distinctly experience procedural elements, such as reflexivity, in a consistent manner in order to allow me to evaluate their value. The two phases of data analysis were (a) immersion via a systematic process of data (audio and transcripts) review, reflexive journaling, and memoing prior to coding; and (b) formal analytic strategies. These phases are described below.

Phase 1 – Immersion. In order to achieve a consistent manner of reviewing data prior to coding and completing my reflexive plan, I employed a sequence of steps (see Table 3.3) with every interview.

Table 3.3

Description of the Analytic Steps During Phase 1

Phase 1 – Steps	Description of Process
Step 1	Listen to the audio recording of the interview within 1-3 days and reflexively journal while critiquing the interview, noting introspective and intersubjective factors.
Step 2	Clean transcript
Step 3	Within 2-3 days of cleaning the transcript, do the first read through and begin memoing.

These steps proved to be integral to accomplishing both the analytic and reflexive rigour that I aimed to achieve. Each step is described below.

Step 1. This step involved listening to the interview, focusing solely on the interview process versus assessing the content of what was being said. While listening, I would take notes in my reflexive journal. This step helped me focus on how I was contributing to the interview through my tone (e.g., curious versus assuming) and specific wording of questions (e.g., leading questions), as well as my interviewing style. I also paid close attention to how the interaction between myself and the participant was evolving based on factors such as whether I knew the

participant and how this affected our rapport, and whether I was able to respond to what the participant was saying with appropriate follow up questions.

Step 2. Once I received the interview transcript, I would clean it (i.e., check for accuracy of the transcription) by listening along with the audio recording. This step gave me a second listen to the recording, while also reading the transcript for the first time. I did not begin formal coding in this step. This process of immersing into the data follows what various researchers (Braun & Clarke, 2006; Hsieh & Shannon, 2005; Mayan, 2009; Thorne, 2008) describe as necessary in the early stages of analysis. The benefit was that I got to know the data quite well before formally beginning to attach interpretations to the text.

Step 3. In this step, I began to memo or articulate questions and theoretical thoughts about the text as I read through the transcript for the second time. I sensed at this point, after two listens and one read, that I was prepared to begin noting broad interpretations. After I began formally coding the first five transcripts, I also went back and coded my memos. What was interesting was that I found that language I had used in the early memos was language that started showing up in the formal coding, even though I had little contact with the memos during coding. Whether this was a form of verification (i.e., demonstrated rigour) or not, it was helpful to see that my thoughts were coming together.

In summary, at the end of Phase 1, I had a strong sense of the data. I began to make connections between the interviews. For example, as I memoed in one interview, I would bring in thoughts from another, comparing and contrasting what was said.

Phase 2. Formal Analytic Strategies. The analytic strategy for this ID study ended up being a combination of qualitative content analysis (Field & Morse, 1985; Hsieh & Shannon, 2005; Mayan, 2009) and constant comparison (Glaser & Strauss, 1967). Qualitative content

analysis began with initial coding or the assignment of a specific word or phrase to summarize a key attribute of a portion of text (Saldana, 2009). As patterns of codes were recognized (Braun & Clarke, 2006; Joffe, 2004), they were grouped into categories and sub-categories (Richards & Morse, 2007). At this point, constant comparison strategies were integrated to refine the analysis. Constant comparison is the recursive process of comparing text, codes, and incidents throughout the evolution of the analysis in order to progressively determine a conceptual structure of the data (Charmaz, 2014). In this analysis, these strategies assisted in the process of thinking about the categories in terms of properties (i.e., characteristics of the category) and conditions (i.e., circumstances that foster the category) (Glaser & Strauss, 1967). Comparative strategies were used to shape the categories by comparing codes between sub-categories within a particular category, in addition to comparing between categories. For example, codes can be compared to assess whether the category or sub-category holds together on its own, whether one collapses into another, or whether a new category or sub-category forms to contain the codes. Documentation of the use of constant comparison principles is provided in Appendix K. This exhaustive process resulted in richer conceptual descriptions. Negative cases were explored as they arose and contributed to clarifying aspects of the categories.

Using comparative techniques also helped to decipher the very rich and complex data. Participants were very forthcoming about their experiences and perspectives regarding the TR, which resulted in highly descriptive accounts of various personal and environmental factors involved in the TR. The layered nature of the data increased the complexity of the analysis and resulted in instances where text could be, and sometimes was, coded in more than one category. Although this is not uncommon in qualitative analysis (Saldana, 2009), it is notable here because

excerpts of text, when read as an example of one category in the results section of this paper, could be interpreted as relating to another category.

Data Management. NVivo 10.0 qualitative data analysis software was used to organize the textual data (e.g., transcribed interviews, interview notes, memos). It was also used to develop the coding and category structure. Audio and transcript data is stored on password-protected flash drives and on the secure Faculty of Rehabilitation Medicine research drive. Paper copies of participant information are stored in a locked file cabinet in the Faculty of Rehabilitation Medicine. Computers and flash drives will also be kept under lock and key for at least 5 years.

Rigour

Rigour in Qualitative Research

Rigour terminology in qualitative research has many identities representing the many different theoretical perspectives influencing this methodology (Mayan, 2009). Ultimately, terminology needs to be congruent with the project's objectives and philosophical underpinnings (Thorne, 2008). Therefore, I used traditional terminology to describe this study's rigour components - validity, reliability, and generalizability. These terms have different definitions in qualitative research when compared to quantitative research (Morse et al., 2002). Validity in qualitative research refers to the findings being indicative of the data or having some truth value; valid findings provide a meaningful account or representation of the data as a product of the participants' experiences (Mayan, 2009; Morse et al., 2002). Reliability refers to the repetition in the data of, for example, experiences, thoughts, ideas (Morse et al., 2002) as well as a traceable decision-making process (Finlay, 2006). Generalizability refers to the ability to transfer knowledge of a phenomenon from one situation or context to another (Mayan, 2009), such as

applying knowledge of TR in PT to occupational therapy. More specifically, it is the quality of the findings (via rigourous process) that allows in-depth comparison of situations or theories to determine what, if any, knowledge can be transferred.

Verification Strategies

Specific verification strategies were incorporated during and at the end of the project to enhance rigour. These strategies aimed to (a) maximize the researcher's engagement (Tracy, 2010) in processes of methodological coherence, researcher responsiveness, and theoretical thinking (Morse et al., 2002); and (b) use external sources to evaluate the rigour process (Morse et al., 2002). These strategies are described below.

Data Cleaning. Accuracy of transcriptions was verified by concurrently listening to the digital voice recordings of the interviews and reading the transcript. Changes to the transcript were made as needed.

Peer Debrief. Peer debriefing enhances validity by using individuals outside of the research project to critique the research process (Creswell, 2009). During this project, I met with two individuals familiar with qualitative methods although not directly involved in the study. One peer is an occupational therapist and one is a PT. I had numerous peer debrief meetings over the course of the project to critique emerging analytic ideas. In addition to providing critical feedback about the iterative process, these meetings also supported my reflexive engagement.

Audit Trail. The methodological decision-making process (e.g., altering recruitment strategy, revising the interview guide) was documented (Creswell, 2009) to promote transparency (Tracy, 2010).

External Audit. One individual familiar with qualitative methods and not involved in the study completed an end-of-project external audit (Creswell, 2009). The auditor critically

reviewed project documents (e.g., proposal, journals, findings) to determine a rigourous research process as well as the congruence between process and findings. The external audit report can be found in Appendix L.

Member Reflections. Gathering participant feedback has been espoused as a pillar of validity in qualitative inquiry (Finlay, 2006) and has been traditionally referred to as "member checking" (Thorne, 2008). However, the member check has been critiqued as a possible threat to validity due to the potential for researchers to over-focus on participants' agreement or confirmation of either data or findings (Morse et al., 2002; Thorne, 2008; Tracy, 2010). Even though some researchers have acknowledged that the purpose and process of the member check has been miscast (Morse et al. 2002), Tracy (2010) comments that the term "checks" can be interpreted as a confirmation of a singular truth or reality. In addition, seeking participants confirmation can negatively impact researchers' interpretive capacity, which can result in findings that are inappropriately left descriptive so that the participant can "see themselves" in the findings (Morse et al., 2002; Thorne, 2008)

For these reasons, member reflections (Tracy, 2010) were used in this study. Tracy (2010) describes member reflections as an "umbrella term" (p. 844) that could be used to across research paradigms. While member checks could be one form of member reflection, Tracy (2010) also states that member reflections could also involve engaging participants in discussion, critique, and collaboration about the evolving analysis. Member reflections can be done at various points of the research project (e.g., during interviews, end of project) and at various depths of analysis (e.g., transcripts, codes, themes) (Morse et al., 2002).

Member reflections were used at two points during the project. First, I verified, to the best of my ability, the proper understanding of the participants' accounts both during and at the

end of interviews (Patton, 2002). Second, I met with one PT participant during the early phase of coding and another PT as categories were developed to get feedback on my interpretations. Lastly, I will be providing all participants with a review of the findings after confirmation of project completion. Participants will be invited to voluntarily provide their reflections to inform future research. This use of member reflections is congruent with my epistemological view in this project and with Thorne's (2008) perspective on member checking.

Memoing. Memos that documented my ongoing thought process and evolving interpretations of the data were made prior to initial coding and during subsequent analysis (Glaser & Strauss, 1967; Mayan, 2009). Memoing helps to clarify and magnify ideas (Mayan & Miciak, 2014) as well as generate meaning ". . . by taking the analysis to places it would not have gone if we did not pay particular attention to documenting the tensions in and questions and hunches about our data" (Mayan and Miciak, 2014, p, 129). Memoing took various forms, such as typed notes (see Appendix M), written notes and sketches (see Appendix N), and voice memos. Using various strategies helped to stimulate theoretical thinking and enabled me to memo even when I was away from the data (Mayan & Miciak, 2015). This process helped me generate findings with the potential to be meaningful representations of the participants' accounts by reinforcing a reflexive and critical process (Creswell, 2009).

Reflexivity Orientation and Strategies. Reflexivity, the conscious self-evaluation of the researcher's impact on the research process and subsequent outcomes (Finlay, 2002), is at the center of a rigorous qualitative project. Many subjective and inter-subjective factors could impact research rigour (Finlay, 2002). I used two variants of reflexivity as described by Finlay (Finlay, 2003): introspection and inter-subjective reflection. *Introspection* involves the researcher's awareness of the personal positions such as insider/outsider relations, culture,

philosophy, discipline (Patton, 2002); past experiences (Finlay, 2003); and emotional responses (Finlay, 2003). Introspection also involves considering how these various factors inform interpretations and decision-making. *Intersubjective reflection* focuses on the " . . . situated, emergent, and negotiated nature of the research encounter" (Finlay, 2003, p. 8): That is, intersubjective reflection addresses the relational interplay between researcher and participant and the factors that influence this interplay to generate data and inform meaning. Specific to this study was the influence of my positions as both a clinician and researcher on my relationships with participants (Cartwright & Limandri, 1997; Coar & Sim, 2006). I also considered that this interplay could occur between my position as a clinician researcher and the PT discipline in general (e.g., researcher's position within the discipline). Considering these two variants, my systematic reflexive plan was implemented at two points: (a) introspection during interviews as documented in interview notes and (b) intersubjective reflection while listening to interviews and documentation in written journals.

In addition to my formalized process, I also had an informal or spontaneous reflexive practice. This typically manifested during various points in the project when I noted theoretical or disciplinary influences contributing to my thought process or the decisions I was making. The following excerpt is taken from one of my journal entries. This entry illustrates potential tensions within my experience of the research process. One tension is my personal struggle with terminology (i.e., patient versus client). A second is the potential impact that terminology could have on my perceptions of power in the TR. The excerpt reads as follows:

> I am having some difficulty deciding on terminology. I have a bias, personally, toward "client". I think it comes from my background at [name of workplace]. The "business" of [name of workplace] puts client as the word (even though technically I would say they

> are patients). "Client" also allows for more space for the person being treated to be an active member of the encounter – equalizing power imbalance, possibly . . . for some reason, I don't like the term "patient". It feels less empowered, more subservient . . . even though in some circumstances, I believe patient may be he more appropriate term. e.g., in ER where decisions are made for the individual . . . but in private practice PT I am not so sure . . . even using the term "client" doesn't mean that power is equal – that may not be what is enacted during encounters. Philosophical perspective may be more at the root . . . what I have decided to do is email some colleagues to get their opinions on the terms they use. (Maxi Miciak, December 8, 2011)

Other situations that required my reflexive engagement included if and how my knowledge of psychotherapy theory and my personal treatment philosophy as a PT were impacting my interpretations during data analysis. For example, I was mindful of my personal approach to developing TR and whether I was not only recognizing different perspectives but also representing these perspectives. I also tried to be aware of using common words, such as trust and respect, during the analysis because these are words that are often used when describing the TR, and I wanted to ensure that I was not imposing words and interpretations too quickly.

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CHAPTER 4 – THE NECESSARY CONDITIONS OF ENGAGEMENT FOR THE THERAPEUTIC RELATIONSHIP IN PHYSIOTHERAPY

The therapeutic relationship (TR), commonly described as a strong rapport between patient and physiotherapist (PT), is becoming a focal point of PT research and practice. PTs are now expected to establish and maintain strong TRs as a standard of patient-centred practice. This has led to an increase in teaching patient-practitioner interaction, highlighting skills such as communication and self-awareness, and embedding these in concepts such as respect and dignity (Purtilo & Haddad, 2007). The TR is also gaining momentum in research. For example, a recent experimental controlled study demonstrated that a positive TR can augment treatment to achieve enhanced PT clinical outcomes in the treatment of chronic pain (Fuentes et al., 2014). This is in addition to a systematic review (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010), which highlighted that the quality of the therapeutic alliance, a component of the TR that describes the working collaboration between therapist and patient (Gelso, 2013), can positively influence physical rehabilitation outcomes.

Despite the increased attention on the TR, there has been little theoretical development to steer PT research and practice. Many PT researchers (Cheing, Lai, Vong, & Chan, 2010; Ferreira et al., 2013; Hall et al., 2010) have been influenced by Bordin's (1979) theory of the working alliance, while educators reference PT textbooks that refer to Freudian (Davis, 2006; Purtilo & Haddad, 2007) and Rogerian principles (Davis, 2006).

Of these theories, Rogers' (1957) "necessary and sufficient conditions" of genuineness (freedom to be one's self), empathic understanding (understanding of the patient's feelings and meanings combined with congruent interactional behaviours) and unconditional positive regard

(accepting attitude) have been indelibly woven into the understanding of the TR (Truscott, 2010). Rogers suggested that the inner resources patients would organically unfold toward healing if therapists were able to convey a non-judgmental and understanding attitude while authentically being themselves in interactions with patients (Rogers, 1957; Rogers, 1958). Meta-analyses have demonstrated that empathy (Elliott, Bohart, Watson, & Greenberg, 2011) and positive regard (Farber & Doolin, 2011) are moderately associated with clinical outcomes in psychotherapy. Although there has been some debate about whether these conditions actually describe the relationship or are integral to the person of the psychotherapist (Gelso, 2013), Rogers (1957) was clear that these conditions are essential characteristics of the TR as they are expressed through the psychotherapist's characteristics.

Additionally, Rogers' (1958) suggested that these conditions could be applied to any helping relationship. While it is conceivable that the conditions could apply to the TR in PT, psychotherapy and PT are markedly different therapeutic endeavors. Although there might be broad tenets that apply to both, there could also be nuances or even different or additional conditions within the physiotherapy TR (Besley, Kayes, & McPherson, 2011b).These nuances will ultimately influence what PTs should focus on during their interactions with patients and how the quality of the TR should be evaluated in PT research and practice.

But does the responsibility for the TR lie solely with the PT? The concept of engagement has also emerged as an influential factor in the clinical interaction and outcomes. Lequerica et al. (2009), in their exploratory survey study of PTs' and occupational therapists' impressions of patient engagement in rehabilitation therapy, defined patient engagement as, ". . . a deliberate effort and commitment to working toward the goals of rehabilitation therapy, typically demonstrated through active participation and cooperation with treatment providers" (p. 753).

Therefore, engagement implies a substantial degree of investment, on the patient's part, in the process. Although it would seem clear that patient engagement would be necessary for successful rehabilitation, what enables a patient to engage and what is the therapist's responsibility in fostering such engagement? Indeed, what factors are necessary for both therapist and patient to engage in therapy?

Given that the conceptual understanding of the TR in PT is limited, we undertook a thorough qualitative investigation to identify and conceptually describe the key components of the TR. This investigation resulted in three distinct components we consider essential for a TR between PT and patient: *the necessary conditions of engagement*, *ways of establishing connections*, and *the elements of the bond*. This paper, detailing the first component (i.e., the necessary conditions of engagement) is the opening paper in a series of three that, together, describe the components of the TR. This first component responds to the question: What are the necessary conditions of engagement that are the foundation of the TR in PT?

Methods

Design

Interpretive description was the qualitative research approach used in this study. It is a methodological decision-making framework designed for use in clinical and other applied research settings (Thorne, 2008) where practical answers to practice-oriented questions are desired. Although tenets of naturalistic inquiry (Lincoln & Guba, 1985) form the broad philosophical foundation for methodological decision-making, the disciplinary mandate (e.g., social mandate to help others) and research question provided the practical foundation for coherent methodological decisions in all phases of the study (Thorne, Kirkham, & O'Flynn-Magee, 2004).

Setting

The setting was private practice PT clinics in Edmonton, Alberta, Canada. In addition to the notable percentage of Albertan PTs working in private practice clinics (43% in 2013) (College of Physical Therapists of Alberta, 2013), there are several contextual factors that make private practice clinics ideal for gaining insight into the TR. For example, the community location of clinics could increase access to services, or a for-profit business model could have therapists place more emphasis on the TR in order to build a caseload. In addition, patients have direct access to physiotherapy services in Alberta. Because physician referral is not always necessary, PTs are primary care providers, which could impact the TR by influencing patients' expectations of PTs.

Participants

Male and female PTs and patients were eligible to participate. PTs were eligible to participate if they had a minimum of 5 years of clinical experience and were currently working in private practice in some capacity. Adult (18-64 years of age) patients were considered eligible if they had been treated for a musculoskeletal condition, had received at minimum three PT sessions, and were within 12 weeks of their last session. Patients were either formally discharged from treatment by the PT or could return for continuing treatment as needed. Patients were ineligible if they had co-morbid conditions limiting their cognitive capacity or ability to communicate, or if they had received wage replacement or pain and/or suffering compensation through a third party.

Sampling Strategy and Recruitment

Physiotherapist Sampling Strategy and Recruitment. Purposive sampling was used to recruit 11 PTs. Two of the authors with knowledge of the Edmonton private practice community

identified PTs they believed would be able to provide in-depth accounts of their TR experiences. Purposive sampling allowed the investigators to sample across factors such as treatment specializations (e.g., "manual therapists" with post-graduate certification) and areas of interest (e.g., chronic pain). Of the 11 PTs, five were male and six were female. Their ages ranged between 36-60 years, with a mean age of 47.8 years; demographic data were missing for two therapists. All PTs had been in clinical practice for at least 10 years and in private practice for at least 10 years. The majority of PTs (10/11) reported using at least one advanced restricted activity (i.e., an activity requiring authorization from the provincial College), such as acupuncture or spinal manipulation (Physiotherapy Alberta - College + Association, n.d.a). A description of treatment preferences can be found in Table 4.1. Post-graduate training was reported in women's health, vestibular rehabilitation, temporomandibular joint rehabilitation, and sports physiotherapy.

Table 4.1.

Physiotherapist Demographic and Treatment Information

PT ID	Gender	Age (years)	Treatments Regularly Applied								
			Ex	I/H	Acu	US	JMob	JMan	Edu	IFC	STM/T
PT-A	M	36	✓	✓		✓	✓	✓	✓	✓	✓
PT-B	F	53	✓		✓		✓	✓	✓		✓
PT-C	M	37	✓	✓		✓	✓	✓	✓	✓	✓
PT-D	M	54	✓	✓	✓		✓	✓	✓	✓	✓
PT-E	F	Not available	✓	✓	✓		✓	✓	✓		✓
PT-F	M	60	✓	✓	✓	✓	✓	✓	✓	✓	✓
PT-G	F	59	✓	✓		✓	✓	✓	✓	✓	✓
PT-H	F	Not available	✓	✓		✓	✓	✓	✓		✓
PT-I	F	46	✓	✓			✓		✓		✓
PT-J	F	42	✓	✓	✓		✓	✓	✓		✓
PT-K	M	43	✓	✓	✓				✓		✓

Note: Ex = Exercise; I/H = ice/heat; Acu = Acupuncture; US = ultrasound; JMob = Joint mobilization; JMan = Joint manipulation; Edu = education; IFC = interferential current; STM/T = soft tissue massage/techniques

Patient Sampling Strategy and Recruitment. Purposive and convenience sampling were used to recruit seven patient participants. The first author approached clinic owners with details of the study and asked if they would participate in patient recruitment. Of the nine participating clinics, three clinics used administrative staff to purposively identify patients and provide them with study information sheets and 6 clinics agreed to place recruitment posters in their waiting rooms. Another recruitment initiative involved the distribution of study information to a large Edmonton athletic club via a coach's email. The participants that responded to the email were included through convenience sampling. Of the seven participants, three were female and four were male. Their ages ranged between 18-62 years, with an average age of 42.3 years.

Most patients (6/7) had previously accessed physiotherapy services and most (5/7) had been experiencing their physical issues for greater than 3 months prior to seeking treatment. Information on various aspects of each participant's treatment can be found in Table 4.2.

Table 4.2.

Patient Demographic and Treatment Information

Patient ID	Gender	Age (years)	Was this your first PT experience?	If previous experience with PT, was it for same problem?	Was the MSK condition acute (<3 weeks) or chronic (>3m)?	Gender of the PT seen for this problem?
Patient-A	F	62	No	No	chronic	F
Patient-B	F	18	No	No	acute	F
Patient-C	F	54	No	Yes	chronic	F
Patient-D	M	55	Yes	n/a	chronic	M
Patient-E	M	51	No	Yes	chronic	F
Patient-F	M	33	No	No	chronic	F
Patient-G	M	23	No	Yes	acute	M

Data Generation and Analysis

An inductive and iterative approach to data generation and analysis was undertaken. Semi-structured one-on-one interviews were completed in a public location of the participant's choice. Interviews lasted between 40-90 minutes. All interviews were digitally audio-recorded and transcribed verbatim by a transcriptionist. An interview guide (Patton, 2002) of open-ended questions was used to facilitate discussion about participants' perspectives of the TR. Concurrent data generation and analysis allowed for continual revision of the interview guide to reflect the evolving analysis; this facilitated increasingly targeted discussions that brought forth rich participant accounts. The initial questions were non-specific to the TR in order to facilitate wider discussion about aspects of the interaction that could have implications for what the TR is and

how it is developed. As the interview progressed, guiding questions became more specific and increasingly related to the TR and engagement. Probing questions were then used to build on participant comments in-the-moment in order to encourage thorough description. Other forms of data included the primary investigator's interview notes, analytic notes, and memos. The first author completed all of the interviews and analyzed all data. Data were generated until a reasonable point of saturation (Glaser & Strauss, 1967) was achieved, meaning that each identified component of the TR reflected clinical reality.

Data analysis occurred in two concurrent phases: (a) a systematic process of data (audio and transcripts) review, reflexive journaling, and memoing prior to coding; and (b) formal coding as guided by conventional content analysis (Hsieh & Shannon, 2005) and constant comparison (Charmaz, 2014). Content analysis began with initial coding (Charmaz, 2014) or the assignment of a specific word or phrase to summarize a key attribute of a portion of text (Saldana, 2009). As patterns of codes were recognized (Braun & Clarke, 2006; Joffe & Yardley, 2004), they were grouped into categories and sub-categories (Richards & Morse, 2007). At this point, constant comparison strategies were integrated to refine the analysis. Constant comparison is the recursive process of comparing text, codes, and incidents throughout the evolution of the analysis in order to progressively determine a conceptual structure of the data (Charmaz, 2014). In this analysis, these strategies assisted in the process of thinking about the categories in terms of properties (i.e., characteristics of the category) and conditions (i.e., circumstances that foster the category) (Glaser & Strauss, 1967). Comparative strategies were used to shape our categories by comparing codes between sub-categories (within a particular category), in addition to comparing codes between categories. This exhaustive process resulted in richer conceptual

descriptions. Negative cases were also explored and contributed to clarifying aspects of the conditions of engagement.

Using comparative techniques also helped to decipher the very rich and complex data. Participants were very forthcoming about their experiences and perspectives regarding the TR, which resulted in highly descriptive accounts of various personal and environmental factors involved in the TR. The layered nature of the data increased the complexity of the analysis and resulted in instances where text could be, and sometimes was, coded in more than one category. Although this is not uncommon in qualitative analysis (Saldana, 2009), it is notable here because excerpts of text, when read as an example of one category in the results section of this paper, could be interpreted as relating to another category. It should be noted that practices to insure rigour, including reflexive journaling, memoing, member reflections, and peer debrief, were used to weigh and ultimately make final analytic decisions. In addition, an external audit was completed at the end of the project by an individual familiar with qualitative methods and not involved in the study. The auditor critically reviewed project documents (e.g., proposal, journals, findings) and confirmed that the research process was thorough and that the quality and nature of the findings were congruent with the process. The University of Alberta Health Research Ethics Board approved the study.

Findings

Distinguishing Between Engagement and Interaction

In order to understand the conditions of engagement, it is necessary to distinguish between *engagement* and *interaction*.[1] Interaction is a broad term that describes a situation where

[1] The distinction between interaction and engagement was developed through memoing about their distinguishing properties and was a part of the analytic process.

at least two people are enacting behaviours in relation to one another. However, the term engagement suggests that there are particular characteristics that enrich the quality of an interaction. When a person is engaged, there is a heightened sense of involvement and investment on one or more levels (e.g., physical, cognitive, emotional). The individual is invested in the process and potentially the outcome of the interaction. Considering this distinction between interaction and engagement, there are particular conditions in a physiotherapy TR that create a foundation where PT and patient engagement is fostered. We have labeled these conditions as follows: (a) present, (b) receptive, (b) genuine, and (d) committed.

Present

Being present within a PT interaction reflects an individual's[2] intent and ability to be and remain "in-the-moment", in the "here and now", of the therapeutic interaction. It is more than being in a particular physical place for a determined period of time: The individual has settled into the interaction and blocked out distractions or is embodied in time and space in order to give all attention to the immediate situation. More specifically, being present involves the occupation of time and space with another individual in a manner that is focused on the person and the situation at hand. Patients must not only physically attend appointments to be present, they must also be willing to attend and contribute to the tasks of therapy. PTs must make conscious choices about the amount of time they spend in direct proximity with patients, in a setting that is often chaotic, with various competing responsibilities. There were instances when remaining with the patient was believed to be of utmost importance, such as when a patient needed ". . . more one-on-one time" (PT-J) for guidance with exercises or was experiencing emotional distress:

[2] The use of the term "individual" refers to both therapist and patient.

PT-B: . . . they start crying . . . the biggest thing . . . is don't pull away. Don't walk out of the room. Don't leave them. Stay, maintain that connection until they're okay.

Some therapists commented that the amount of time the therapist was present with the patient could be important for establishing the TR. In fact, one therapist commented that formally scheduled 30 minute treatment sessions ". . . allows more of an establishment of a TR." (PT-B) Yet, many impromptu situations arose where the therapist made a decision to remain with a patient, despite the allotted timeframe:

PT-C: I spent a lot of time talking with her. I spent over an hour with her on the first day and I didn't actually do anything with her other than examine her.

PT-I: I think that if I'm with somebody who's gone through 20 years of struggle with this, I think I have to take more time at the beginning.

Patients also noticed their therapists' efforts: as one patient stated, "they'll spend more time with me than they should" (Patient-B). Patient-E appreciated that, "time was of no consequence", because it gave the impression that the therapist was willing to do ". . . whatever it takes . . . I feel like you [therapist] are dealing with the issue at hand, not just trying to get in and out. In, out, goodbye. See you next time."

Patients also noticed when therapists were not present, in terms of their perceptions of therapists rushing and how it impacted the quality of their experiences:

Patient-E: . . . the typical physiotherapy situation. You've got x number of beds and there's someone in every bed. He's literally running around to each person . . . I didn't at that time feel like I was getting quality care. I was getting care but not necessarily quality care. The guy was very for the most part personable but very quick and abrupt.

Patient-C: She seemed very rushed most of the time, but not crabby, but kind of crabby.

What was compelling was that patients were able to distinguish between a "busy" therapist and a "rushed" therapist. In other words, a therapist could be busy and still be present despite the hectic environment:

> Patient-D: They were busy as can be just on a cycle going from one to the next to the next and coming back. They always took the time to make you feel like you were a decent person.

Therapists and patients described the importance of "settling into the interaction" and creating a focused time and space or a "bubble" (PT-K) that allows both patient and therapist to fully engage in the interaction. Such was the case when PT-B described how she knew that patients were present:

> PT-B: There's an absolute shift in their body. It's something I see in their body reaction. Maybe it's a change in the breath, but there's a shift, almost like a bit of a relaxation that they are willing to be there . . . it can be in a minute or it can be two minutes after we've met or it might take an hour.

Therapists spoke of common distractions such as multiple responsibilities and a busy caseload, as well as personal factors including mood and family situations. Inevitably, therapists believed they needed to make adjustments in order to be able to focus:

> PT-K: Well, I mean, I'm a clinic owner. I'm not "on" when two of my physios quit on the same day because I'm thinking about something else. We are opening a new clinic here in a couple weeks. I have the risk of not being on because I have so much to do. I love treating. I try to protect that bubble. I make sure if I'm going to start a clinic that I have four or five other "go to" people that can get things done. That's [new clinic] going well now, but I would say there are times when the life stresses are going nuts. The one time I

know for a fact I lost a client because I treated her too aggressively and that was around the time I was getting a divorce.

In addition to taking personal responsibility to ". . . turn those issues off when I go in to see a patient" (PT-G), therapists also keenly described deliberately using non-verbal cues and the material space to create focus for themselves and the patients. Adjustments to the material space ranged from the negotiation of materials in-the-moment, such as when PT-B described letting her patients sit in the chair because ". . . it is a way I capture them. They can't move out of the chair", to making use of more permanent arrangements, such as private rooms versus curtained cubicles, to help patient and therapist "narrow down" (PT-E). One therapist described constructing her clinic " . . . with separate rooms . . ." for patient-related reasons, but also because, "I function better because I'm not around people all the time . . . I get too overwhelmed. I need quiet" (PT-B). Patients were also aware of how the nature of the material space could help them focus, but also how it could make them the focal point of the interaction:

Patient-B: And personally the physio that I go to, private rooms…you're with that physio for the half hour that you are booked for. Door is shut. You are in a room as a patient. You are getting that attention.

Patients' spoke of their need to be present during the treatment in order to understand their bodies and ". . . feel the treatment" (Patient-E) as well as contribute to the process:

Patient-A: I just couldn't sit there and say, "oh ya, oh ya". It's "okay, this doesn't feel good, that doesn't feel good" . . . I had to help be a leader in this also. That's how I looked at it. If I can't tell her [PT] how it's feeling or how it's reacting, I can't help her.

Patient-F: I think someone who is not really interested in the body, it's probably hard to work with such a person or harder to make them feel better again. When you ask them, "Where does it hurt?" [they say] "Somewhere here."

Receptive

Although being present precipitates the unfolding of the conditions of engagement, being receptive follows closely behind. Receptivity is a foundational condition because it involves the willingness and ability to be open to what a particular person and situation demands. This involves the attitude that is necessary for individuals to negotiate a plan to move forward; it also involves a focused receptivity where one individual, namely the PT, is attentive in order to become aware of salient issues, needs, and wants of the patient or situation. The following paragraphs describe these two scenarios.

Being receptive requires patients and therapists to manage personal agendas and be willing to be ". . . open to all these things [treatments]" (Patient-A). Even though therapists have specific knowledge and skills that will substantively inform the nature of treatment, they also need ". . . to be open and listening and not go into this with a pre-determined agenda. I'm going to get through this no matter what you [patient] say to me"(PT-B). Being willing to listen to a patient's story ". . . because that's important to me as the patient so that you hear and understand what I need you to help me [with]" (Patient-E) can set the stage for developing the TR. Specifically, allowing patients to tell their stories and to offer their impressions can be important for developing a safe and receptive atmosphere:

PT-I: Let them tell you their story. The big thing is that I think that patients that are struggling and have that, really have big problems, they need to tell their story. You need to listen and shut your mouth.

Just as therapists need to ". . . listen to all their [patients'] fears, all their issues . . ." (PT-G), patients also need to listen and be open to suggestions. When they do not, it can be a challenge for the therapist:

> PT-G: . . . You try to explain what you are doing and they keep interrupting you. They keep challenging everything you say. They say, "No, that's not true," and half the time they have looked it up on internet or their friend told them. They don't listen to anything you say. That I find really difficult.

In addition to being open to patients' circumstances and ideas regarding therapy, PTs must also be attentive to verbal and non-verbal cues. For example, the excerpts below illustrate how therapists' attentiveness allowed them to gain insight into the patients' physical and psychological states:

> PT-B: They are guarded, they are tightening . . . you can just see that they are upset.
>
> PT-A: If they are not talking to you or if they have passed out, which has happened, or if their tone has raised or heightened then you know something is going on . . .

Therapists also spoke of how being attentive was essential in identifying how to connect with patients. Therapists recalled how they would deliberately note, either mentally or in the chart, patients' comments; this enabled them to ". . . gauge where that person's at and what their interests are . . ." (PT-E) in order to develop the TR.

Genuine

To be genuine in a relationship is to be real or convey a sincerity of being in-the-moment in a TR. Being genuine has three aspects. First, it involves *being yourself* or acting in ways that are congruent with your own enduring qualities and personal values. This is in addition to honoring needs that reflect who you are in the moment, while allowing others the same

opportunity. For instance, a therapist or patient who is typically very engaged might, on a particular day, need to set boundaries on the degree they emotionally or physically invest in the interaction. Second, being genuine involves *being honest* and communicating in a direct and transparent manner. Third, being genuine includes *investing in the personal*.

Being Yourself. In order to convey genuineness in a helping relationship, individuals must be able to bring themselves into the relationship in terms of remaining congruent with their personal qualities and values, while also maintaining an attitude of acceptance of others in the interaction. Both therapist and patient must feel comfortable enough to sincerely present themselves, and not put on a facade:

> PT-I: . . . I'm pretty open with people. I can talk to anybody. I don't think that changes. I think the way you and I converse would be no different than how a patient and I would converse. I don't change who I am in any role in my life . . . I am who I am. I think patients probably feel comfortable asking me that because that's kind of how we interact as people.

Patients notice when therapists are being themselves. For example, when therapists are able to convey their "warm", "personable", or "approachable" personalities, it helps establish an accepting environment where patients can also express themselves, as this patient describes:

> Patient-B: I feel like they are not going to judge you. When you go into a doctor's office, that I find a little intimidating, whereas physios . . . from the physios that I've had, they are definitely warm and open . . .

When a therapist has an accepting attitude, s/he conveys an intention to curb judgment toward the patient and be open to changing circumstances in order to accept the patient ". . . where that individual is . . ." (PT-E). The therapist understands that each patient comes with

his/her unique context, which includes life stories and situations, as well as social and cultural influences and individual personalities. Regardless of whether these contextual factors are related to the patient's rehabilitation, the therapist attempts to maintain a stance where she does not hold things against the patient:

> PT-H: I'd say it's a place where you can just be free, not worry about what the person thinks about you, not worry about expectations or...you know you are free to talk, free to be. However, in what I consider to be a TR, there still has to be boundaries and guidelines . . . It's not anything goes. However it's nonjudgmental is what I'm saying. So even if people form opinions, it's not used against you, you know what I mean?

An attitude of acceptance also extends to patients' bodies, given the therapist's role and the various vulnerabilities that can give rise to negative perceptions of the body and injury. Under these circumstances, the patient might feel more exposed and sensitive to real or perceived judgment:

> PT-F: . . . it's giving them a sense that when you're going to look at their body and examine their body that you don't make any judgments . . . Those things plus probably many others gives them a level of comfort where they cannot feel afraid or at risk or threatened . . .
>
> Patient-D: . . . [he] was very good at making me feel like you weren't abnormal . . . I don't want to be singled out as out of shape or old or . . . I didn't quite know what to expect when the physiotherapist came in . . . I expected a fair bit of judgmenty-type things the way that doctors would sometimes.

Being Honest. Honesty is likely a necessary condition for any healthy relationship. There are two main qualities that describe being honest: (a) transparency and (b) directness. Being

transparent involves patients and therapists providing the necessary information to help the patient move forward in a safe and meaningful way. Information is provided to manage expectations of the rehabilitation process and each individual's role in that process. This can include information regarding impressions of the physical problem and the rehabilitation process; personal limitations in skill and knowledge; outcome expectations; expectations of the patient's participation; and the therapist's role and responsibilities.

> PT-B: Yes. I guess that's it and being realistic about what's going to happen . . . I'm really honest with people about that and I explain to them and especially with those more complex, that they are 80% of what's going to make a difference. It's not the doctor. It's not the physio.
>
> Patient-C: If she didn't know, she would say "I don't know" . . . it was great because she wasn't stringing me along . . .

Patients must also be transparent concerning information related to their injuries or conditions. In this patient's opinion, it ". . . is important for the patient to tell the whole truth to you [therapist] . . ." (Patient-C). Therapists were clear that they needed to trust that ". . . they [patients] are telling you the truth, that they are telling you all the factors that are contributing." (PT-E)

The intent to be transparent regarding the more obvious or expected aspects of the rehabilitation process would be considered standard practice for PTs. However, PTs might also be transparent about more sensitive topics such as issues pertaining to the patient-therapist relationship as well as psychological and social factors that the therapist believes are impacting the patient's progress:

PT-H: She did have an injury but I had to explain to her that, "The injury that you have cannot cause all of these problems that you are having. Let's try to figure out what else is causing it."

In addition to being transparent, the therapist is also direct, which pertains to the tone and manner of communication. The therapist communicates in a clear and potentially forthright manner. Although being direct might be interpreted as being stern, especially when communication can be challenging or confrontational (e.g., when there is limited progress), the tone could also convey a sense of concern or compassion. Ultimately, the therapist's intention is to be clear and leave little doubt as to what has been communicated:

PT-K: If they can't relax, I'll either tell them straight out, "This treatment is not going to work for you. I really want it to but it won't. This is what I recommend."

Investing in the Personal. It is expected that the majority of the patient-therapist engagement be centred on the primary focus of restoring or maintaining physical mobility and function. However, many patients and therapists revealed that a personal aspect to their relationships also existed and was important to the overall quality of the TR. Being invested in the personal was revealed through (a) an interest in the person and (b) a willingness to disclose about self.

Interest in the person pertains to the therapist's or patient's desire to broaden the scope of caring to include the personal – to an interest in the other's life beyond the reason for referral:

PT-C: Folks that like to talk, folks that ask me how I'm doing, folks that ask me how things are going…we end up talking about things unrelated to their condition or the weather, those folks, we have a discussion. We have interest in each other. If I remember

something about them and ask them how is your son doing in university and then they respond. You have a discussion about the son, you have a relationship.

Even though there is often a therapeutic need to know about various aspects of a patient's life, when therapists project a personal perspective onto the relationship, they have a true interest in the patient; they are willing to invest energy into knowing the patient as a person to some degree. This is what differentiates the personal from the therapeutic – there is a true intention to know the patient outside of the need to know information relevant to the rehabilitation process. For the therapist, this type of investment can be indicative of an authentic interest in people and their lives:

Interviewer: . . . it sounds like you're connecting but you are really connecting to, "I want to know you as a person. I'm interested. I have an interest in you."

PT-I: Exactly. Exactly. Yeah, I feel that so strongly. I just can't tell you.

Although not driven by the specific rehabilitation goals, this investment in the personal can enhance the therapeutic space by creating a more hospitable and safe environment and putting the patient at ease:

PT-I: Even when my questioning starts, you know I always ask them about them first. So I always make it clear that that's really important to me . . . I ask them to tell me a little bit about yourself outside of what's brought you here. Do you work outside of the home? What sorts of things do you enjoy doing? Even the way I ask those questions is very different . . . I hate that question, "What do you do for work?" I don't like that. To me, that's just that thing. It's not about the person. You know so I think that's important. I'm not trying to be manipulative and conniving but I think that I can get to a person's level of

comfort and they can relax a little bit if I ask them questions that are not directed to their sore knee or sore shoulder and we establish that first.

Even though it might be difficult for patients to express an interest in the personal aspects of their PTs' lives because of patient-therapist roles and professional boundaries, patients could take the initiative to get to know their therapists if they chose to. This could happen in casual conversation as described by PT-I or through more poignant interest as recalled by PT-J:

PT-I: I probably think patients got to know me and asked questions once I started. There's some patients that really got to know me . . . I think patients for the most part are so respectful about that. I think right or wrong they feel that wouldn't be okay to...they'd ask the casual question. If I said, "How was your week?" They'd say, "How was yours?"

PT-J: . . . they [patients] are truly, genuinely interested in what you tell them. There's definitely some patients that come in that they don't really give a crap with what's going on with you. They just want you to fix them and get out of there. Then there's some patients that ask you almost as many questions as you ask them.

Furthermore, some patients found value in knowing their PTs on a more human level:

Patient-B: It makes a huge difference knowing that they can relate to you first of all and they have a real life. They are not just a physio . . . I forget that these people go home and have kids and have a family. It's nice. You are both real people so you should probably treat each other like people . . . I think that's huge.

Willingness to disclose is another aspect of being invested in the personal. When individuals are willing to disclose, they are offering something that they perceive as more "personal" or "intimate" and that might not be related to the primary intent of the interaction. There might even be a sense of vulnerability with disclosing. The disclosure could be peripheral

to the patient's rehabilitation. Therefore, the intent with disclosures can be social or therapeutic. Willingness to disclose is different than being honest, which was defined earlier as communicating information that is necessary for the physical rehabilitation process to be safe and focused. Given this, however, the distinction between necessary and peripheral information can shift depending on individual perception and context, as is illustrated in the following excerpts:

> PT-F: . . . you can talk about personal interests and not get personal so hobbies and what you might do in your non-professional life that doesn't have to do with anything intimate . . . sports are good, music is good, leisure activities...that can give them more information about you but not more close personal stuff.
>
> PT-E: It depends on the patient . . . I've been in practice now for 30 something years so I have patients who knew me when my kids were little and so some of those patients know that I have boys so they'll ask over the years. I'll tell them some of my personal life. Then others you just talk about things of mutual interest . . . it really varies from patient to patient and then there's the patients who come in and they are very closed in the sense that they are not telling you much about their personal self and therefore, I may not talk much about my personal self. I may talk about the generalities, the weather, the Jazz Fest that just came up . . .

Although many therapists agreed that they opened up to some degree about their non-professional lives, one therapist was clear that discussing anything outside of the clinical problem would be considered intimate:

PT-D: . . . I really don't talk much on the personal side. I really don't think any of my patients even know how many kids I have or what I do in my spare time. I don't think any one of them knows that . . . that's purely on the personal side.

Patients' investments not only come from revealing aspects of their lives outside of a therapeutic agenda and traditional history taking, such as talking about family or hobbies, but also with disclosing more personal aspects of their physical issues. Although it was perceived by one therapist that there are some patients who ". . . don't know you [therapist] and they are comfortable disclosing that information to you" (PT-A), this same therapist also commented that patient disclosures sometimes required a ". . . leap of faith . . ." in the therapist. He went on to recall this situation with a patient:

PT-A: [patient speaking] "I haven't told anyone this, it's personal but I was having sex with my wife and I couldn't stand very well and it hurt after" . . . so I think for them to disclose that kind of information, I think the patient is taking a bit of a leap of faith with you.

Patients, both in terms of disclosure regarding aspects of their physical issues and their personal lives, echoed this sentiment:

Patient-C: I think you get more comfortable and so you're more willing to tell them what you are feeling. You are not scared to tell them . . .

It is important to note that there is a spectrum of how much therapists and patients are willing to invest in the personal (see Figure 4.1). For example, one therapist was very clear he was not interested in his patients' personal lives:

PT-D: Most of the time, I'd say 90 percent of my patients or even more, I don't know about the personal things, their personal life or any such things. I make it a point to stay outside of those kinds of conversations.

There could be various factors that influence an individual's proclivity to invest in the personal. For instance, a patient might be more reserved by nature and therefore disclose less. Individuals may also be weighing whether they have permission to take this type of risk in relationship. For example, a therapist may have different experiences regarding professional boundaries or be gauging his/her own disclosures on the degree and nature of the patient's disclosure. Therefore, it is important to keep in mind that there is not one way to be in a TR:

PT-K: My partner is exactly the opposite of me . . . my professional boundaries and his professional boundaries are on either side of the continuum of professional boundaries.

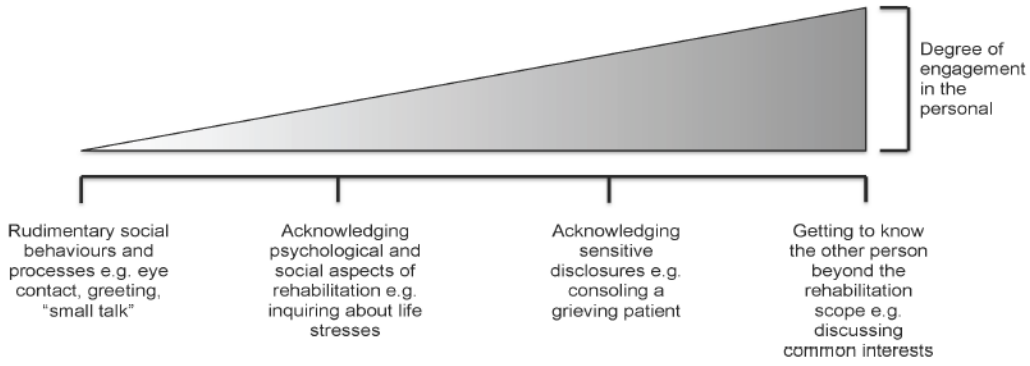

Figure 4.1. Personal engagement is represented as a continuum. The continuum involves the relationship between the nature of engagement and the degree of personal engagement. The degree of personal engagement is dependent on the intentions and behaviours of PT and patient.

Committed

In order to be engaged, therapists and patients must be committed. PTs have a social mandate to help people; a patient's well-being matters, or, as PT-A put it, "their well-being is your well-being . . ." This speaks to an ethic of care that not only addresses the duty that PTs have agreed to uphold as professionals, but also the existential desire to be of service to another person in a way that substantively contributes to restoring some semblance of well-being in that person's life. Some therapists and patients made the point of stating that therapists do not "fix" patients, but that both have significant roles to play and each needs to be committed to his/her role:

> Patient-B: Figuring that out too you have to take care of yourself in order for them to be able to take care of you too. If you are just going to go and expect them to do it all for you, it's not going to happen. You're not going to get better I find.

With these points in mind, there are two aspects that characterize being committed: (a) committed to understanding and (b) committed to action.

Committed to Understanding. Both therapists and patients must be motivated to understand the situation confronting them, even though factors such as knowledge and skill may influence the degree to which this applies to each individual. When the PT is committed to understanding the patient, there is a ". . . need to understand more about what you [patient] are describing. . ."(PT-B). Therapists were not satisfied with a generic overview of the patient's situation:

> PT-D: . . . if you give out the impression that you know what's happening in this person's back without showing them the interest or without making an effort in understanding it, you won't be able to help them.

The therapist is not only dedicated to understanding the patient's physical situation, but also the patient's story and the psychosocial factors that could be influencing the patient's rehabilitation:

> PT-C: So that's what I mean by their story. Who is this person? What's going on in their life right now? . . . I try to get a picture of the unspoken. Things that they wouldn't think would be important but would help me to cue in and go wait a sec[ond]. This is an issue where this person has a whole other issue that I need to be aware of anyway.
>
> PT-H: If a person has what we would call a chip on their shoulder let's say, you try to find out what the chip is. I see it as part of my job to get over that chip . . . If I can find out what brought it on . . . whatever. Empathize. Sort of understand.

Even though the PT is expected to commit to understanding the different facets of the patient's situation, it was also clear that patients needed to be invested in understanding their situation:

> Patient-E: Part of it was I felt I needed to understand as much of my own physiology and biology in order to help what it is that she was trying to do for me so I could help myself.

Committed to Action. When a therapist is committed to action, s/he is committed to making ". . . all efforts . . ." (PT-D) to honour the best interests of the patient. PTs ". . . do their best to do the best that they can . . ." (Patient-C), and will go beyond due diligence to help the patients achieve their goals:

> PT-I: I know it's very hard to stand by and not do what you know you can and should, right? Yeah, [I] couldn't imagine living with yourself.

This commitment not only pertains to the in-person interaction, but to the entire realm of care. Therapists who are committed to action recognize that there are many facets of care that need to be addressed and that multiple stakeholders might need to be considered. Therapists stated they

would ". . . go that extra little mile . . ." (PT-A) in situations that required more case management.

It was also important for patients to be committed to act in their own best interests. Therapists spoke about the necessity of patient "buy in" or as PT-G stated, " . . . they also have to agree with what you are saying and be motivated to take part in the treatment themselves because it's not just passive." Patients in this study seemed to understand that their motivation to participate was essential. In comparing himself to other patients he witnessed during PT treatment, this patient had the following to say:

> Patient-G: . . . they [patients] are expecting the physiotherapist to "fix them" and they don't need to fix themselves . . . I understand what physio means and how I need to aid myself as well. So it's a really good working relationship because I can go there and he knows that if he tells me something to do, I will go do it.

Patients highlighted a different dimension of being committed, which appears to augment understanding and acting. This dimension is continuity. Continuity related to the patient seeing the same therapist versus being shuttled between therapists. Having ". . . your therapist . . ." (Patient-B), one therapist dedicated to a patient, facilitated the smoothness of the session and the amount of work the patient had to do to help familiarize the therapist with his/her body and situation. It was also positive in regards to the PT getting to know the patient's body, activity levels, and treatment history:

> Patient-G: . . . I found that when I saw other physiotherapists, you know they are sitting there, "What's your past injuries? How many injuries have you had? What's your sport history?" All that stuff. When I saw (name of physiotherapist), it was like, "Oh hey (name

of patient). What do we need to work on today?" He already knows how much I exercise and everything.

This attitude was apparently not unique to participants in this study. One patient participant, who also worked as a receptionist in a PT clinic, commented that the patients who came into her clinic ". . . want to see the same person. They do not want to see anybody else regardless." (Patient-B)

Clarifying the Link Between "State of Being" and "Conditions"

It is important to understand how an individual's state of being relates to the conditions of engagement. To clarify, an individual's state can be described as the quality of consciousness experienced by that individual in any given moment. This quality of consciousness is informed by a complex marriage of momentary thoughts, feelings, and sensations in addition to more enduring attitudes, values, and beliefs. An individual's state will inform that individual's intentions and ability to behave in ways that carry out those intentions. On the other hand, a condition of engagement can be described as the mood, sentiment, or circumstances between two individuals. The conditions stretch beyond the individual to exist in the intersubjective space between individuals. However, in a human relationship, the way that one person is "being" informs the overall nature of the mood or sentiment between them. Therefore, the conditions exist as a function of states; they are outside of the individual's psyche, yet inextricably linked to it. For example, to have a condition of genuineness in relationship, it is assumed that at least one of the individuals is being genuine. Moreover, the conditions can reciprocally influence an individual's state. For example, the PT can develop the condition of presence, which can

influence the patient's ability to be present. Therefore, the conditions of engagement are both informed by and set the tone for the way two individuals are "being" in relation to one another.

Unfolding of the Conditions of Engagement

Just as the development of the TR is not a linear process, the conditions of engagement do not present themselves in a mechanistic fashion. Yet, there is a natural establishment of 'order' or a way in which the conditions unfold. This unfolding allows for the creation of a safe space for patient and PT to establish meaningful connections. Within this order, being present and being receptive are the cornerstone conditions that allow for patient and PT to meaningfully engage. Being present is the foundation that allows the other conditions to unfold while being receptive provides the structure that enables pertinent information to be gathered. There is more of a personal aspect to being genuine and being committed; the degree to which either condition is established is reliant upon unique individuals and circumstances of each. Essentially, the conditions of engagement set the tone for "being" with the other and self. They represent a dynamic intent that both therapist and patient bring to the relationship (see Figure 4.2).

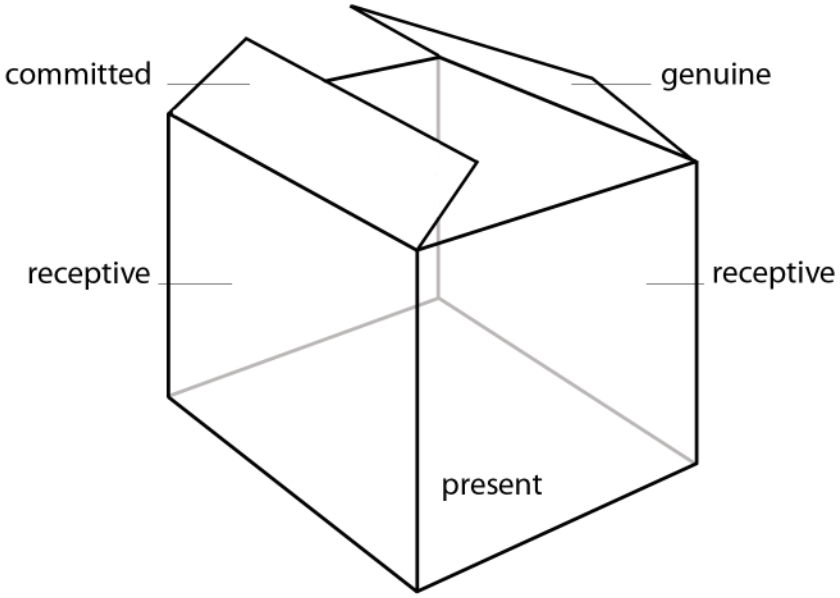

Figure 4.2. The safe container created by the conditions of engagement. The foundation and the walls of the container represent the two cornerstone conditions, present and receptive respectively. Committed and genuine are more variable and are therefore represented by the mobile nature of the lids of the container.

Discussion

These findings reveal the necessary conditions of the TR in physiotherapy. Results offer insight into the complexities of the TR in PT in addition to supporting the various approaches and concepts that have already been used in practice and research. First, they support and contribute to the current literature on relational approaches in healthcare such as patient-centred care. Second, they offer insight into the applicability of psychotherapeutic principles to the physiotherapy TR. Third, the conditions address the notion of engagement in healthcare encounters. In addition to expanding on these three topics, we will discuss how the findings can best serve practice and research.

Our findings support a patient-centred care approach. Mead and Bower (2000) identified five dimensions of a patient-centred approach: (a) biopsychosocial perspective, (b) "patient-as-person", (c) sharing power and responsibility, (d) therapeutic alliance, and (e) "doctor-as-person". Through these dimensions the practitioner, in a caring and accepting manner, aims to understand the patient's physical and psychosocial experience of their disability in a way that shares responsibility for decision-making with the patient. Our conditions would provide the foundation for Mead and Bower's (2000) patient-centred approach to be realized in clinical practice. For example, receptive, committed, and genuine conditions create a safe therapeutic space that is necessary for a patient-centred exchange that highlights collaboration in order to establish meaningful patient-driven goals. Our findings also align with Leplege et al.'s (2007) conceptual analysis of patient-centred care, specifically as their findings pertain to respecting the patient as a complex person with unique needs and as an active participant in the rehabilitation process.

Although the conditions of engagement appear to support current concepts and approaches in PT, the bigger question is whether they converge with psychotherapeutic principles. Physiotherapy has previously borrowed theory from psychotherapy practice, but has this been appropriate? Given that there are pragmatic differences between the two therapeutic domains, it is relevant to consider how our conditions compare to Rogers' (1957) conditions. In general, aspects of Rogers' genuineness, unconditional positive regard, and empathic understanding weave into our conditions of engagement. For instance, Rogers describes genuineness as being the expression of an integrated self through self-awareness and transparency (Truscott, 2010). These aspects of genuineness can be found in our condition of being genuine in terms of the therapist's ability to honour his/her personal psychosocial situation

and to be direct with patients, as well as his/her willingness to disclose personal information. Another example is the consistency between Rogers' unconditional positive regard and what we describe as the attitude of acceptance PTs must have towards their patients. In addition, being committed to understanding parallels Rogers' empathic understanding in terms of having a real intent to listen to patients and understand their experiences.

Even though there are consistencies between the two sets of conditions, there are also nuances that distinguish the two; most notably, we added being present and being receptive. Rogers (1957) limits his discussion of being present to a basic level of the patient and therapist being "in contact" (p. 90), and to some degree influencing the experience of the other. In fact, Rogers does not use the term "present" nor is being in contact typically acknowledged in the same way as his other conditions. On the other hand, we define being present as a foundational condition and clearly describe the focused manner and intentional use of time and space in creating a safe therapeutic environment. In addition, we also explicitly name being receptive as a condition, which some might interpret as an aspect of Rogers' empathic understanding. We understand receptiveness to have distinguishing characteristics, namely that a therapist can be receptive but not be empathic.

Nuances aside, one key difference between Rogers' and our conditions resides in who is responsible for developing the conditions of engagement. Rogers describes the psychotherapist as providing the conditions of engagement whereas our findings indicate that the conditions of engagement require contributions from both PTs and patients. We agree that the PT is responsible for establishing the conditions in order to provide a safe space for the patient to engage in the TR. Indeed, the PT's capacity to do so, with some patients, could be the deciding factor in their willingness to contribute to the TR. In addition, the degree and nature of

therapists' and patients' contributions to each condition will vary due to differences in roles and professional boundaries. Nonetheless, our participants were clear that engagement involves, to some degree, the deliberate participation of both patient and therapist in order for the conditions to flourish. In other words, therapist participation is "necessary but not sufficient" for meaningful engagement and ultimately, for a TR.

This is consistent with Bright et al.'s (2014) concept analysis of engagement in rehabilitation. They concluded that both clinicians and patients have roles in patient engagement. This is exemplified in Lequerica et al.'s (2009) findings regarding patient engagement in rehabilitation. Although a poor response rate (20%) and questionable validity of the questionnaire limit the conclusions that can be drawn from the study, their findings were compelling. Even though the study explored patient engagement, the findings inevitably addressed therapist engagement by highlighting that therapists facilitate patient engagement by "building rapport" or by ". . . taking time to simply talk to the patient about their life . . ." and ". . . listening carefully . . ." (Lequerica et al., 2009, p. 757). Their findings indicate that engagement is in fact two-way and that both therapist and patient engagement can be essential in developing the conditions during the encounter. In addition, Bright et al. (2014) also describe the "state" (p. 7) of being as an aspect of patient engagement, which is consistent with our view that an individual's state is inextricably linked to the way that individual engages in rehabilitation. However, our findings also describe the therapist's, and to a somewhat lesser degree, the patient's state, whereas Bright et al. (2014) focus on the patient's state. Nonetheless, Bright et al.'s (2014) synthesis of the process of engagement includes aspects that appear to relate to each of our conditions. Indeed, our findings offer at least a preliminary response to their call for further study of clinician engagement.

Ultimately, how does knowledge about physiotherapy-specific conditions of engagement impact PT research and practice? This is important to consider given that theory developed within the psychotherapy context has been borrowed by physiotherapy to inform research and practice. In terms of research, we need to be mindful of whether TR measurement scales that have been developed using a psychotherapeutic lens are valid within the physiotherapy context. This is true even if theories such as Bordin's working alliance or Rogers' conditions are claimed to be universal. This view is congruent with Besley et al.'s (2011b) conceptual findings, as well as their evaluative (Besley, Kayes, & McPherson, 2011a) findings, which clarify that while the measurement properties for the Working Alliance Inventory (Horvath & Greenberg, 1989) and Helping Alliance Questionnaire (Luborsky et al., 1996) were "adequate" (Besley et al., 2011a, p. 80), there were also aspects that appeared to be missing. The authors called for a better conceptual understanding of the TR within the PT context to aid in developing more rigorous measurement tools. In addition, further elaboration on patients' contributions to developing the conditions of engagement, especially in terms of being yourself, being present, and being receptive would help clarify the collaborative aspect of the TR.

Regarding practice, the conditions of engagement speak to the essence of what is required to have a meaningful TR. Much literature has focused on the importance of communication in developing the TR in clinical practice (Pinto et al., 2012). However, TRs are more than a compilation of skills and behaviours that can be dutifully checked off when completed. TRs are dynamic and require investment and intent to ensure behaviours and skills are congruent with the situation. Along this line of thought, it is important to note that the personal can be an important aspect of the physiotherapy TR. Even though therapists and patients in this study described a spectrum of perspectives and practices regarding what was considered personal, and the

boundaries regarding the nature of the personal disclosure, the majority of therapists and patients agreed that a personal element, understood as patients' and therapists' authentic interest in the other's life outside of the rehabilitation context, was important to the TR. This expands on the literature on patient-centred care, which acknowledges the personal as it pertains to exploring the meaning each patient ascribes to illness and clinicians' self-awareness regarding the personal factors that influence the interaction (Mead & Bower, 2000). This study illustrates that patients and therapists may want to know one another as people while respecting professional boundaries.

Strengths

The triangulation of data sources was a strength of this study. This was especially important given patient contributions are lacking in the TR literature. Another key strength was the quality of the data, which enhanced credibility of the findings. Participants were very forthcoming and able to articulate both insights and highly descriptive examples of their experiences. Moreover, all therapists had over 10 years of clinical experience, which augmented the quality of the data. The majority of patients also had more than one experience with PT. In addition, the sample had good variation in terms of male and female participants, age range of patient participants, and various therapist treatment specializations.

Limitations

Although these findings would likely have the most value within private practice physiotherapy, their conceptual nature increases their generalizability to other PT contexts and health care professions. Much of the interview discussions centred on the PT, which is not surprising given the therapist's role in the TR. Nonetheless a second interview might have provided opportunity to probe patients more about their role in establishing the conditions of engagement. Finally, exclusion of patients who were receiving wage replacement benefits or

were involved in litigation for their injuries limited the nature of the data that was generated and hence the possible breadth of the findings. Nevertheless, this would have required a significantly larger sample in order to obtain saturation in the data, which was outside of the time frames and resources of this study.

Conclusion

Participants in this study have made it clear that TRs do not "just happen". Through participants' candid accounts we have clarified that there are conditions specific to the PT encounter that create a safe environment and facilitate mutual engagement of therapist and patient in the TR. These conditions address therapists' and patients' intentions and attitudes and are essential for meaningful clinical interactions. Furthermore, applying these conditions in conjunction with relational skills (e.g., active listening) will shape actions that are appropriate for the situation and people involved. Lastly, these findings also suggest that theories developed in other disciplinary contexts (e.g., psychotherapy) need to be used judiciously when developing theory that guides practice and research regarding the TR in PT.

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CHAPTER 5 - A FRAMEWORK FOR ESTABLISHING CONNECTIONS IN PHYSIOTHERAPY PRACTICE

The therapeutic relationship (TR), often described as the rapport (Bordin, 1979; Cole & McLean, 2003) or working alliance (Bordin, 1979; Gelso, 2013; Hall, Ferreira, Maher, Latimer, & Ferreira, 2010; Schönberger, Humle, Zeeman, & Teasdale, 2006) between practitioner and patient, has historically been considered the cornerstone of a meaningful clinical interaction (Stenmar & Nordholm, 1994). Its influence has been recognized in patient-centred care (Physiotheray Alberta - College + Association, 2012; Macleod & Mcpherson, 2007; Mead & Bower, 2000, 2002) and the International Classification of Functioning, Disability, and Health (World Health Organization, 2002) models. This recognition has been mirrored by the increasing importance placed on teaching physiotherapy (PT) students relational and communication skills that focus on approaches such as active listening. Resource guides (College of Physical Therapists of Alberta, 2007; College of Physiotherapists of Ontario, 2013) that highlight the TR as a standard of ethical and caring practice (Physiotherapy Alberta - College + Association, 2012; College of Physiotherapists of Ontario, 2012) also reinforced its importance in clinical practice. In addition to being recognized in PT education and practice, research evidence indicates that the quality of the TR is associated with patient satisfaction (Beattie, Turner, Dowda, Michener, & Nelson, 2005; Hush, Cameron, & Mackey, 2011) and clinical outcomes (Hall et al., 2010). Despite a growing body of literature that highlights the therapeutic value of the TR in PT (Ferreira et al., 2013; Fuentes et al., 2014; Hall et al., 2010), there is limited research that provides guidance to PTs on how to develop the TR.

The term *connection* has been used to describe the positive attachments between healthcare providers and patients (Bright, Kayes, Worrall, & McPherson, 2015; Cole & McLean, 2003; Gelso, 2013). In this study, a connection is defined as a link with another person based on a common ground or acknowledgement. When PTs establish meaningful connections with patients, they ensure their patients are seen, heard, and appreciated. This brings PTs affectively closer to their patients and fosters the sense that therapists and patients are "in something together". Furthermore, a connection has an "in-the-moment" or immediate quality when aspects of patients' experiences are acknowledged as they emerge.[1]

There are various ways of establishing connections. Each of these means of connecting may have unique and specific characteristics. A framework that addresses establishing connections would provide PTs with a conceptual approach that focuses how they understand and develop the TR. With this in mind, the authors aimed to identify and conceptually describe the ways that PTs establish meaningful connections with patients.

Methods

Design

Interpretive description was the qualitative research approach used in this project. It is a methodological decision-making framework designed for use in clinical and other applied research settings where practical answers to practice-oriented questions are desired (Thorne, 2008). Interpretive description draws on naturalistic inquiry (Lincoln & Guba, 1985), the discipline's mandate , which for PT is helping people return to meaningful activities by restoring function (Physiotherapy Alberta College +Association, n.d.b), and the subsequent research question to inform coherent methodological decisions (Thorne, 2008).

[1] The definition of the term connection was developed during the analytic process through memoing.

Setting

The setting was private practice PT clinics in Edmonton, Alberta, Canada. In addition to the notable percentage of Albertan PTs working in private practice clinics (43% in 2013), (College of Physical Therapists of Alberta, 2013) there are also contextual factors that make private practice clinics ideal for gaining insight into the TR. For example, the community location of clinics may increase access to services and a for-profit business model might have PTs place more emphasis on the TR in order to build a caseload. In addition, patients have direct access to PT services in Alberta (i.e., physician referral is not always necessary), which makes PTs primary care providers; this could impact the TR by influencing patients' expectations of therapists (e.g., ability to provide a diagnosis and prognosis). Moreover, patients can also pay out-of-pocket for services, which could again influence expectations and therefore the nature of the TR.

Participants

Physiotherapists were eligible to participate if they had a minimum of five years of clinical experience and were currently working in private practice in some capacity. Adult patients (18-64 years of age) were considered eligible if they had been treated for a musculoskeletal condition, had received at least three PT sessions, and were within 12 weeks of their last session. Patients were either formally discharged from treatment by the PT or could return for continuing treatment as needed. Patients were ineligible if they had co-morbid conditions that limited their cognitive capacity or ability to communicate. Patients were also excluded if they had received wage replacement or pain and suffering compensation payments through a third party. This was due to the potentially complex relationship dynamics between multiple stakeholders (patients, PTs, lawyers, adjudicators).

Sampling Strategy and Recruitment

A total of 11 PTs, five male and six female, were recruited. Two investigators (MM and DPG) with knowledge of the Edmonton private practice community used purposeful sampling to identify potential participants who they believed would be able to provide in-depth accounts of their experiences of the TR. Investigators considered factors such as treatment specializations (e.g., "manual therapists" with post-graduate certification) and areas of clinical interest (e.g., chronic pain). These factors were considered because they could be a product of treatment philosophies and involve varied treatment approaches, both of which could influence the TR. PTs' ages ranged between 36-60 years, with a mean age of 47.8 years; demographic data was missing for two therapists. All PTs had been in clinical practice for at least 10 years and in private practice for at least 10 years. The majority of PTs (10/11) reported using at least one advanced restricted activity (i.e., an activity requiring authorization from the provincial College), such as acupuncture or spinal manipulation (Physiotherapy Alberta - College + Association, n.d.a). A description of treatment preferences can be found in Table 5.1. Post-graduate training was reported in women's health, vestibular rehabilitation, temporomandibular joint rehabilitation, and sports PT.

Table 5.1.

Physiotherapist Demographic and Treatment Information

PT ID	Gender	Age (years)	Treatments Regularly Applied								
			Ex	I/H	Acu	US	JMob	JMan	Edu	IFC	STM/T
PT-A	M	36	✓	✓		✓	✓	✓	✓	✓	✓
PT-B	F	53	✓		✓		✓	✓	✓		✓
PT-C	M	37	✓	✓		✓	✓	✓	✓	✓	✓
PT-D	M	54	✓	✓	✓		✓	✓	✓	✓	✓
PT-E	F	Not available	✓	✓	✓		✓	✓	✓		✓
PT-F	M	60	✓	✓	✓	✓	✓	✓	✓	✓	✓
PT-G	F	59	✓	✓		✓	✓	✓	✓	✓	✓
PT-H	F	Not available	✓	✓		✓	✓	✓	✓		✓
PT-I	F	46	✓	✓			✓		✓		✓
PT-J	F	42	✓	✓	✓		✓	✓	✓		✓
PT-K	M	43	✓	✓	✓				✓		✓

Note: Ex = exercise; I/H = ice/heat; Acu = acupuncture; US = ultrasound; JMob = joint mobilization; JMan = joint manipulation; Edu = education; IFC = interferential current; STM/T = soft tissue massage/techniques

Seven patient participants (four male and three female) were purposefully recruited through 2 of the 9 participating clinics. Another recruitment approach involved distribution of study information to a large Edmonton athletic club via coach's email. The participants that responded to the email were included through convenience sampling. Patients' ages ranged between 18-62 years, with an average age of 42.3 years. Most patients (6/7) had previously accessed PT services and most (5/7) had been experiencing their physical issues for greater than 3 months prior to seeking treatment. Information on various aspects of each participant's treatment can be found in Table 5.2.

Table 5.2.

Patient Demographic and Treatment Information

Patient ID	Gender	Age (years)	Was this your first PT experience?	If previous experience with PT, was it for same problem?	Was the MSK condition acute (<3 weeks) or chronic (>3m)?	Gender of the PT seen for this problem?
Patient-A	F	62	No	No	chronic	F
Patient-B	F	18	No	No	acute	F
Patient-C	F	54	No	Yes	chronic	F
Patient-D	M	55	Yes	n/a	chronic	M
Patient-E	M	51	No	Yes	chronic	F
Patient-F	M	33	No	No	chronic	F
Patient-G	M	23	No	Yes	acute	M

Data Generation and Analysis

An inductive and iterative approach to data generation and analysis was undertaken. Semi-structured one-on-one interviews were completed in a public location of the participant's choice. All interviews were audio-recorded and transcribed verbatim by a transcriptionist. An interview guide (Patton, 2002) of open-ended questions was used to facilitate discussion about participants' perspectives of the TR. Concurrent data generation and analysis allowed for continual revision of the interview guide to reflect the evolving analysis, which facilitated increasingly targeted discussions to bring forth rich participant accounts. The initial questions were broad and non-specific to the TR but became more specific and increasingly related to the TR as the interview progressed. Probing questions sought to build on participant comments in-the-moment in order to encourage description. Other forms of data included the primary investigator's interview notes, analytic notes, and memoes. The primary investigator completed all of the interviews and analyzed all data. Data was generated until a reasonable point of

saturation (Glaser & Strauss, 1967) was achieved meaning that each component meaningfully described clinical reality (Thorne, 2008).

Data analysis occurred in two phases: (a) a systematic process of data review (audio-recordings and transcripts), reflexive journaling, and memoing prior to coding and (b) formal coding as guided by conventional content analysis (Hsieh & Shannon, 2005) combined with constant comparison, memoing, and reflexive journaling. Content analysis began with initial coding (Charmaz, 2014) or the assignment of a specific word or phrase to summarize a key attribute of a portion of text (Saldana, 2009). As patterns of codes were recognized (Braun & Clarke, 2006; Joffe & Yardley, 2004), they were grouped into categories and sub-categories. At this point, constant comparison strategies were used to refine the analysis. Constant comparison is the recursive process of comparing text, codes, and incidents throughout the evolution of the analysis in order to progressively determine a conceptual structure of the data (Charmaz, 2014). In this analysis, these strategies assisted in the process of thinking about the properties (i.e., enduring characteristics) and conditions (i.e., supporting circumstance) of the categories (Glaser & Strauss, 1967). Comparative strategies were used to shape the categories by comparing codes between sub-categories and then comparing codes between categories. This exhaustive process resulted in rich conceptual descriptions. Negative cases were also explored and contributed to clarifying aspects of the ways of establishing connections.

Rigour

Various rigour strategies were used throughout the project to demonstrate transparent engagement (Tracy, 2010) and to evaluate the research process (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Journaling (i.e., reflexive notes, memoes, audit trail), member reflections, and peer debrief were strategies used during the project. After the project was completed, an external

audit was done in order to evaluate the research process (e.g., determine evidence of reflexive process) and the coherence of the findings. The auditor reviewed project documents (e.g., journals, findings) and concluded that the audit criteria were met. The study was approved by the Health Research Ethics Board at the University of Alberta.

Findings

Establishing connections is an important element of PT practice. As PT-H commented, "it is our challenge and our duty to try to connect with everyone." In this study, three main categories formed a framework (see Figure 5.1) that could be used by PTs for establishing connections with their patients: (a) acknowledging the individual, (b) giving-of-self, and (c) using the body as a pivot point.

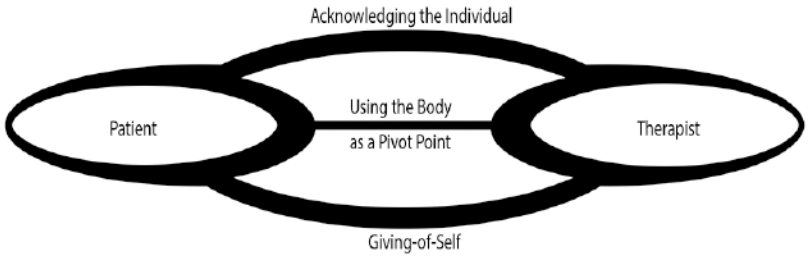

Figure 5.1. The ways of establishing connections between PT and patient are represented by 3 main categories. *Using the body as a pivot point* is an essential common ground between PT and patient, and is therefore, the center connection. All categories of establishing connections have the potential to draw PT and patient affectively "closer" together.

Acknowledging the Individual

Acknowledging the individual involves interacting with patients in ways that recognize their uniqueness as people in addition to their roles as patients within their rehabilitation. Acknowledging the individual is composed of 3 sub-categories: (a) meeting as an equal, (b) validating the patient's experiences, and (c) individualizing the treatment approach.

Meeting as an Equal. Meeting the patient as an equal allows for connections to be forged by promoting collaborative efforts where both PTs and patients make meaningful contributions to advancing the rehabilitation process. In order to be able to collaborate, therapists and patients both referred to the importance of acknowledging the power dynamics inherent to the TR. This power imbalance could be due to differences in skill, knowledge and role expectations:

> PT-A: . . . I'm always going to be in a position of power. That's why we have professional ethics and what not. . . I know something that they don't or I can do something that they don't…otherwise they wouldn't be coming to see me.

Therapists and patients felt it was important to be on ". . . equal footing" (PT-K) or ". . . a level playing field" (Patient-A). To address the perception of a power imbalance, PTs claimed they would attempt to meet patients ". . . on their frequency" (PT-C) using both verbal and non-verbal communication. For instance, PTs stated they would talk ". . . on their [patients'] level rather than creating yourself as somebody above them that they are subordinate to" (PT-K) or use non-verbal cues, such as when PT-F described his intentions for deliberately sitting lower than his patients:

> PT-F: I want to reduce . . . an impression of status or power from the patient's point of view . . . I think it's my technique of illustrating to them without words of course that I'm no better or worse than them. I'm not here to chastise. I'm not a power figure above them . . .

Many therapists voiced that they viewed the TR as a collaborative endeavor or as PT-F commented, "I'm here to collaborate with them at their own level." In the spirit of collaboration,

therapists and patients reported that PTs actively involved patients in determining short and long-term expectations as well in making 'in-the-moment' decisions:

> PT-K: . . . so they have to help me problem solve. I usually say to them, "You spend a lot more time with yourself than I spend with you. I need to have your help otherwise the chances of this working are less." I think that that's something that you do with a person who is on equal footing in all respects . . .
>
> Patient-B: That's definitely something that they ask right from the beginning. What do you want to fix? What is your expectation for treatment? Where do you want to go with this? That I think is important to establish at the beginning for sure.

By collaborating and engaging the patient in decision-making, PTs instill a sense of ". . . working together" (Patient-G) to achieve goals and demonstrate that they value the patient's thoughts and perceptions:

> PT-G: Sometimes you think about things a different way after you talk to them, or you give them something to do, and they come back and give you feedback on what was happening, that makes you change what you are doing and maybe not just for them, maybe for other people as well. They come up with a better idea or something.
>
> Patient-B: Someone [therapist] doesn't feel like they are better than me. You're allowed to express your concerns.

Another way PTs might have established equal footing was by acknowledging aspects of the patient's life outside of rehabilitation. By doing so, therapists are acknowledging that patients are seen as more than their injuries; the patient was ". . . not a neck or knee . . . [but] . . . an

individual with a lot of stuff" (PT-E). The PT is not the fixer and the patient is not the thing to be fixed:

> PT-I: I treat my patients as a person and a person first and their injury, condition is just part of them. It doesn't define them.

For the PT, creating a sense of equal footing could begin with the way a patient is greeted:

> PT-C: When you meet someone for the first time, typically you say hi. You offer a hand. You make eye contact. You might smile.

The PT might also engage in small talk to initiate conversation and help the patient relax and feel welcome:

> PT-I: . . . you connect with them on some level. "Oh you know how was your drive in today? Did you find us okay?"

> Patient-B: Asking how was your day? How was your week? . . . Just asking any plans for the weekend, that kind of thing.

One potential way of establishing connections was by PTs noting social aspects of the patients' lives and writing down these details (e.g., shared experiences or activities) in order to ". . . remember who they are" (PT-A):

> PT-A: . . . what I'm looking for as I'm assessing them . . . is how can I connect with this person on their level? If they are an athlete, do I play the same sport? If they are a parent, do I have kids the same age as they do? Do we have similar interests?

> PT-G: She raised money for a certain charity and she started telling me about that. So I

would ask her about that and she'd tell me something that was happening so next time she came in I'd say, "So how did that function go on the weekend?"

Interestingly, PTs commented that an active acknowledgement of themselves as unique individuals could also deepen a connection:

PT-J: And I try to share. . . I mean I don't tell patients my innermost secrets but I try to tell them a little bit about myself . . . they all know about my cats because I incessantly talk about my pets. You know things like that. I think that helps them to see you as a person too. You're not just that white coat.

Validating the Patient's Experiences.

PT-J:. . . I know that in the past having physios or doctors that are willing to sometimes just kind of listen and validate what you are feeling is much more helpful than just having "a fix" for it . . . having somebody actually validate what you are going through I think is helpful on a whole different level.

Validating a patient's experiences is potentially an important way of acknowledging the individual and can be a powerful way of connecting with the patient. For instance, therapists conveyed that they are 'in the patient's corner' by verbally affirming the patient's physical experiences and pledging to support, go ". . . to bat . . . " (PT-A) or ". . . advocate on my behalf" (Patient-C):

PT-I: . . . it was this validation piece. I just said to him, "I don't care what anyone has told to you. They are wrong." I just said, "They are wrong." I took him and I walked him

down the hallway and one of our shoulder surgeons was there and I said, “I'm not leaving until you see this guy”.

Patient-C: . . . I was vulnerable . . . the way she treated me. She gave me the sense that she knew the huge impact this was having on me . . .

Being in the patient’s corner also came in the form of motivating the patient or conveying a belief in the patient’s ability to improve or recover. PTs commented on being reassuring and communicating confidence not only in the recovery process, but also in the patient’s ability to be an integral part of the process:

PT-H: . . . you need to toss people...you need to toss them a line. "I've had this for twelve years and everybody says it's never going to get better. All my friends who had this were never the same again." You have to toss them a line and that's hope . . . not unrealistic expectations, but hope . . . you think something is going to help so it does because somebody gave you a line.

PT-J: You have to get patients to believe that what they are doing is going to get them better. I think I'm effective in that.

PTs not only validated rehabilitation-related experiences, but the patient’s personal experiences as well. They did this by acknowledging aspects of the patient’s life, as they came up during sessions, regardless of whether there was a direct link to rehabilitation. Moreover, verbally acknowledging a patient’s personal disclosure can help establish a safe environment by causing “. . . them to relax because you’ve acknowledged where they are at . . .” (PT-E) or result in better understanding of the patient’s physical issues:

PT-E: I would never ignore it. I would acknowledge in some way even if it's something that I can't identify with. Just say "that has been really hard for you" if I don't know. Sometimes they will say . . . "I think I'm grinding my teeth more" . . . they give you something back. Sometimes they say well they are just managing . . . if there's nothing relevant that I can say, I say "well maybe I can help you with this [the injury] and that would address one thing you to need to cope with."

Individualizing the Treatment Approach. PTs and patients commented that individualizing the treatment approach was an important part of developing the TR. Therapists do this by considering the unique constellation of physical, psychological, social and cultural experiences, as well as the specific needs and goals, of each patient. Adjustments need to be made throughout the rehabilitation process, from refining treatment plans and understanding difficult situations to the micro adjustments made during an actual intervention because a ". . . therapeutic relationship can go very quickly if you are not sensitive to a person's need on a particular day" (PT-E). PTs adapted from patient to patient, from session to session, and from moment to moment in order to establish connections:

PT-B: I don't know the answer [for treatment] until I see them again. "What do you need" will then, lead me to where I am going to do my reassessment and what therapeutic intervention I'm going to commence.

Patient-B: . . . doing things like altering an exercise for you. You doing something and them altering it to fit you. . .

PTs reported seeing many patients with common musculoskeletal conditions, such as non-specific low back pain and osteoarthritis. Despite the potential for repetition due to the

similarity of these conditions, therapists commented that ". . . there are no algorithms" (PT-B) where treatment was concerned and that each patient deserved to be treated with the same enthusiasm and attention to detail regardless of how common the injury might be:

> PT-D: For me, every condition that a person comes in with is not repetitious. For you that is a new condition. I might have seen thousands of backs by now but your back problem is your back problem. If I do not show the interest or the excitement in working with you, it doesn't make a difference how many backs I have seen.

PTs expressed they were not assessing and treating patients by ". . . giving a recipe . . ." (PT-B), but were tailoring treatment by doing things such as providing a personal touch with hand-written treatment plans or adjusting to the patient's specific needs:

> PT-C: The treatment for this is different for everybody. Here's the key things that you need to do . . . I think it's important that you actually handwrite this down because what you're giving them is a personal plan. This isn't a sheet that I pulled from a brochure or photocopied or emailed you right?. . . How do you translate it into a relationship? This is the plan for you. This is not the plan for a diagnosis of plantar fasciitis. This is the plan for you who has pain in your heel and this is why you have pain and this is what you are going to do to get better.
>
> Patient-B: They'll specify it to what you need to do . . . they make it specific to you. They know that you can handle that so that's what they are going to give you . . . once you do that, they change it again. I think that helps seeing that they specialize. That sheet is for you.

In order to establish meaningful connections with patients, PTs tried to understand psychological and social factors that could shape the treatment plan. For instance, PT-D recalled correlating ". . . stories with them [patients] from their culture" to help patients of a particular ethnicity understand the importance of exercise in prolonging the time until joint arthroplasty was needed. Therapists also tried " . . . to be conscious of what restrictions or constraints . . ." (PT-J) individuals face with following through on treatment plans:

> PT-J: You know, treating a mom with four young kids, I'm not asking her to do an hour of exercises every morning before the kids go to school because that's not going to happen. But if I say, "Okay once the kids go to bed at night, can you spend 10 minutes doing this?"

Giving-Of-Self

Giving-of-self is an expanded personal investment of mental, emotional and physical energy and involves actions that occur inside and outside of the direct patient-therapist interaction. In other words, when the situations calls for it, the PT will spend more time or energy in helping the patient. A PT can give-of-self inside the interaction in various ways. Therapists described situations that required them to dig deeper and take greater action to ". . . empathize a little bit more, just understand them [patients] a little more." (PT-A) There were also more overt ways of giving-of-self such as the PTs making themselves ". . . easily available to them . . . instead of sitting in a medical office for a few hours, they know if I'm in the clinic, I'll see them or I'll come on the phone." (PT-D) Another is by fitting a patient into a tight schedule:

Patient-G: So I [patient] would say, "I know I don't have an appointment and you're super booked but I need to get my shoulder worked on before my race in three days." He'll say, "Okay I'll make sure I get you in." That's super important to me.

Actions that occur outside the interaction are those that do not involve direct communication with the patient. For instance, ". . . good case management" (PT-A) was important and in some cases could involve more administration or advocacy:

PT-E: . . . I promised to send a note to her doctor. I think she has a labral tear in her hip . . . so you know, is that as important when she goes to the doctor? He's worried about neurological symptoms or whatever, you know? So these things [labral tear] are not getting addressed.

Therapists also engage in solving problems outside of the interaction. For instance PTs might research a patient complaint or the best way to address a situation on their own time or even just ". . . spend more time thinking about them." (PT-A):

Patient-E: . . . she's actually taking what happened last time, relating it back to her source whether it's actually talking to a colleague or going back to her books or her notes from a seminar and applying what occurred in that session to what we can maybe do in the next session.

Although most PTs revealed a propensity to give-of-self, they were also aware of the potential of ". . . giving too much" (PT-F) and getting caught in a maladaptive relational dynamic, such as when a patient becomes emotionally dependent on the PT. Therapists claimed they would set boundaries to prevent giving too much. For example, PT-C explained that if a

patient wasn't willing to engage, ". . . at that point, I'll completely change my expectations of what I'm going to be able to do for them and I may scale way back . . ."

Using the Body as a Pivot Point

The main point of contact between PT and patient is the patient's body. In a PT interaction, therapist and patient will inevitably return to the body, regardless of the various psychological and social connections that might unfold:

> PT-D: If somebody tells me that they are going on a cruise, most of the time what I ask them is "oh, I hope your back held out . . . hope you were able to walk."
>
> PT-E: Then of course we are done talking about hiking or whatever and we are talking about the presenting symptoms, what is still an issue for them . . .

Therapists and patients have a vested interest in addressing physical problems, and this common interest is a vehicle for establishing meaningful connections. In fact, it is essential that patient and PT establish a connection with and through the patient's body in order for the TR to be sustainable. Using the body as a pivot point is not about being body-focused or creating a schism between the body and the psychological and social aspects of the person; it is about respecting the patients' bodily experiences and helping them become aware of and (re)connect to their bodies. Therefore, the body becomes a pivot point that enables the PT to establish connections with the patient by: (a) clarifying physical problems and solutions, (b) facilitating the patient's connection to the body, and (c) using touch to a bridge a gap.

Clarifying Physical Problems and Solutions. Therapists are responsible for providing patients with answers that explain their physical issues and for developing a rehabilitation plan. A connection is initiated through the assessment process by demonstrating that the PT is ". . .

trying to really find out what's going on" (Patient-F). Moreover, PTs who intently question and assess are able to create a focus for getting to know the patient through the body while engaging the patient in the process:

> PT-D: I actually have them recreate their fall if I have to. I'll bring them out in my gym area and I'll tell them okay tell me what happened? What were you lifting? What were you doing? Recreate it for us. They are very happy to do it. It's very seldom I will have somebody who will come into me flashing a piece of paper and saying my doctor says I have this. As far as I'm concerned that's the doctor's problem. That's not the patient's problem. I tell them that okay we'll look at it at a later stage. You tell me what happened . . . they are more than happy to talk about it.

This inspires confidence and ". . . draws you [patient] closer to them [therapist]" (Patient-A). Patient-B also describes this feeling of closeness:

> Patient-B: . . . it's like being with that physio for the first time and them assessing you and asking those questions first of all, you kind of feel obviously closer to them.

The connection is strengthened when the PT provides a plausible explanation and ". . . a solution . . ." (PT-D) that are thorough and fit with the patient's experience. Patient-F, a self-described skeptic, commented on the importance of the therapist's explanation and solution being congruent with his experience:

> Patient-F: . . . I could not find anything that made her diagnosis not sound right you know? . . . she assessed the problem. I think she got it right. She gave me exercises that made sense to me. I can see why I'm doing that not just because some book said "if that patient has that problem, do this to them".

Patient-A described the importance that having a clear explanation and a rehabilitation direction on her ability to participate in her own rehabilitation:

> Patient-A: I've gotta have it . . . I've got to know how things work. If it doesn't work, then I'll go back to the person or my doctor and say okay now what's the reason for this? . . . and I guess part of it would be is sometimes you're given a direction to do something but not told what the final outcome is of what they are looking for. If that final outcome is not given to you, then you can't set a goal. If you know that this is the final outcome, then you can work toward that goal too. You will understand why you need to do these certain things.

Generating explanations and solutions are necessary throughout the course of the patient's rehabilitation. Challenges often arise at various points over the course of treatment, from complex presentations during the initial assessment, to lulls in progress, and to symptom aggravations during treatment. If not addressed, these situations can damage connections. Therefore, it is important for PTs to persist in getting to ". . . the root of the problem" (Patient-F) and not dismiss their patients' bodily experiences:

> PT-A . . . especially if they come back sore. If something goes off the track, so to speak . . . number one, you have to show them you are still concerned about their injury. You go back to the objective part of things. Okay, let's look at your movement again. Let's check this out.

Facilitating the Patient's Connection to the Body.

> PT-B: . . . as a profession, any treatment we do has to engage the patient . . . if we just chat with the patient about what we did on the weekend all the time as we are doing stuff,

they are not paying attention to what is happening in their body and optimizing the healing potential.

Patients' connections to their bodies consist of knowledge about and awareness of the body, especially as it pertains to the injury or condition, and is necessary for successful rehabilitation:

> PT-I: I think unfortunately that's what's missed in a lot of active types of rehab is that piece of not just, "Here's what you should do, off you go," but "Here's what you should do and here's why and oh do you get that?" Having that full loop where they do it, they feel it and they realize, "Oh my goodness, I can see how that changes that." That full loop has to come.

The PT's job is to facilitate the patients' (re)connection to their bodies by ". . . touching and cueing" (PT-I) as well as by sharing knowledge of anatomy and the healing process. For instance, PTs spoke of: maintaining verbal contact with patients during assessment and treatment (e.g., explaining the injury or treatment technique); helping patients become aware of what aggravates and alleviates physical signs and symptoms by teaching them ". . . how they can move and function easier" (PT-B); or asking for feedback while cueing patients to focus on sensations:

> PT-E: I say to them ". . . I need feedback from you about what I'm doing and how you are doing with it. Is it too much? Is it too little? Keep talking to me".

> Patient-E: . . . she explains to me what she's doing and why she's doing it, what I should feel from it, what I should get out of it and where it should go.

This process generates a connection between PT and patient, with the body as the pivot point. Furthermore, the connection between PT and patient is created or strengthened by the therapist and patient working together to (re)connect the patient to his/her body:

> PT-I: . . . we work together and then what I teach them is what it should feel like, but then I'm with them while they figure that out . . .

Moreover, patients have more in common with their PTs as they connect to their bodies. This knowledge and awareness of the body enables them to actively contribute to the process, thereby fortifying a connection with the PT. Patients can then use this information to guide treatment and make decisions, becoming their ". . . own therapist" (PT-B):

> PT:B: . . . what's your body telling you? Check in. You're saying you are ready to do more. What's your fatigue level like?
>
> PT-G: . . . when they are doing their stretches I'll say, "Okay you've got to keep aware of this even if you're felling good, you have to do a little bit because you have to pay attention to when things start to tighten up and start working on it yourself before it gets painful and you have to come back."

Using Touch to Bridge a Gap. Touch is an integral aspect of PT and involves not only the body of the patient, but the body of the PT as well. Patients expect PTs to touch their bodies, as Patient-A commented, ". . . they have to be able to feel it. That's a given. I'm not uncomfortable with that." Therapists, regardless of their treatment orientations, also recognize that touch is a very important aspect of connecting in the TR with the power to ". . . make or break . . ." (PT-A) a TR:.

> PT-A : I think it's [touch] very, very important. That's a relationship unto itself.

PT-J: I don't know as a physio how you treat without touch . . . I think it changes relationships.

Touch is used in various capacities during a PT interaction. Due to the pragmatic nature of the interaction, touch is a part of assessment procedures and with specific treatment techniques as well as when cueing patients to their bodies:

PT-I: So I'm always touching and cueing and you know like with a lot of the shoulder stuff you know there's a lot of PNF [proprioceptive neuromuscular facilitation]. I wouldn't consider myself a "manual" therapist from that . . .

Interviewer: But touch is important to what you do.

PT-I: Very important.

PT-F: . . . you use the palpation skills that you have and the touch skills that you have to gain their confidence in you that they understand what you're trying to get them to do. This is a step toward a larger goal.

Although a very literal body-to-body connection is established via touch, the influence of touch can go much deeper than the obvious physical contact. Touch can build a connection that words sometimes cannot achieve. It is an intimate act that can convey acceptance and caring, as well as invoke relaxation:

PT-F: . . . I think I want to build confidence, I want to build trust. I want to build that [the] education that I might give would be accepted. I want to build all the things that my job is to do to have a positive outcome. We use touch as a tool to achieve those things. That happens at a deeper, more personal level . . . it's not a sexual thing. It's absolutely

just at a level of building trust. It builds and then the patient usually has the comfort, less tension or anxiety and they drop some guards and they let you talk about their muscles and their tension and their anxiety levels. That kind of comes with touch.

The manner in which a PT touches a patient is important in developing connections that could foster a sense of trust. Therapists commented that not all patients respond positively to touch for reasons such as previous negative experiences with touch and fear of increased pain. In this way, developing the patient's comfort in being touched could bridge the affective gap between PT and patient:

PT-H: Touch is another vehicle to help crack the egg. If you haven't gotten somewhere with the verbal . . . the way that you touch somebody actually can open up that door. Can open up doors, trust.

PT-G: It's almost like an intimacy between, right? You've got your hands, especially if it's on their back or something like that. It's more of a closeness, again it builds trust. They need to trust you to relax while you're doing it.

Given the ubiquitous nature of touch in the PT interaction and therapists' awareness of its potential potency, PTs adjusted not only the manner in which they touched patients, but also when and under what circumstances they touched. For instance, when describing how she used touch as a means of bridging ". . . a little bit of a gap . . ." between herself and the patient when educating patients on their injuries, PT-J also noted that she was sensitive to a patient's comfort level and would be more ". . . conscious of how much I touch them" if she sensed patient apprehension.

Discussion

It has been proposed that the TR is a common factor (Miciak, Gross, & Joyce, 2012) of the PT clinical encounter. PTs in this study were very conscious of the need to establish connections with their patients in order to develop the TR. Notably, our findings reveal three key categories that form a practical conceptual framework for establishing meaningful connections: acknowledging the individual, giving-of-self, and using the body as a pivot point. Such a framework is important for education, practice and research given that there have also been recent calls for better conceptual understanding of the TR in rehabilitation settings (Besley, Kayes, & McPherson, 2011a, 2011b). Even though some might interpret that recent research showing the quality of the TR is associated with PT clinical outcomes (Ferreira et al., 2013; Fuentes et al., 2014; Hall et al., 2010) negates the call for better conceptual understanding, we argue that these results support the need for a framework. This is in addition to Pincus et al.'s (2013) suggestion that the evaluation of the biopsychosocial model's true value in addressing low back pain has been limited by inadequate application of the model in the clinical setting and research. Therefore, a conceptual structure, which specifies practical ways of establishing connections, could positively direct clinical and research efforts.

Our results are consistent with a psychologically-informed approach (Main & George, 2011) to addressing common musculoskeletal disorders, such as back pain. These results are congruent with psychologically-based interventions used in PT, such as cognitive behavioural concepts (Nielsen, Keefe, Bennell, & Jull, 2013) and motivational interviewing (Cheing et al., 2014; Vong, Cheing, Chan, So, & Chan, 2011). For instance, motivational interviewing emphasizes an empathic approach to help mobilize a patient's resources (Britt, Hudson, & Blampied, 2004), which is consistent with various aspects of acknowledging the individual and

giving-of-self in our results. Our framework of establishing connections provides an umbrella structure that could be used in conjunction with various approaches to make it easier for PTs to reflect on their practices and operationalize an approach to developing the TR.

Our results are also supported by Besley et al.'s (2011b) literature review of the TR in PT. One of the aims of the review was to identify the key components of the TR. The authors used a systematic approach to identify 16 articles that either explicitly aimed to identify aspects of the TR or in some way discussed the TR as an aspect of a different construct (e.g., TR as an aspect of patient satisfaction). Even though their inclusion criteria were broad, which is understandable given the limited amount of research that has specifically aimed to identify the key components of the TR, their compilation of TR components provides valuable insight into the current understanding of the TR. Despite the general nature of their results, which somewhat limits their practical utility, some of their components are congruent with our ways of establishing connections. For instance, their components "personalised therapy" (p. 87) and "partnership" (p. 87) are congruent with our "individualizing the treatment approach" and "meeting as an equal" respectively. Another example is their component "physiotherapist's roles and responsibilities" (p. 87), which has aspects of what we describe in "facilitating the patient's connection to the body" in terms of the PT sharing knowledge and helping the patient take on greater responsibility in their rehabilitation.

Our findings also suggest that personal connections can be established with patients and that these connections may be an important part of the fabric of the TR. While PTs are often interested in personal and social factors that influence the patient's rehabilitation, our findings suggest that the personal can also involve the therapist connecting with the patient's personal life beyond a therapeutic scope. This is congruent with Smith et al.'s (2013) finding that personal

conversations were an important part of the TR for community-dwelling people with multiple sclerosis who were trying to increase their physical activity levels using the support of PTs. Personal connections might also fall within the scope of the *real relationship* as described in theory developed in the psychotherapy context (Gelso, 2013). This TR component reflects the universal human aspect of all relationships and is characterized by psychotherapists' and patients' ability to be genuine with and realistically perceive the other (Gelso, 2013).

While our results support previous research on the TR, we also build upon existing knowledge. One key area is the PT's giving-of-self inside and outside of direct patient contact. While previous research has recognized that understanding and empathizing are important for developing the TR (Besley et al., 2011b), giving-of-self both acknowledges these relational necessities while also expanding our understanding of how PTs go out of their way to understand or accommodate their patients. Giving-of-self also highlights the potential taxing nature of giving, especially if therapists are not reflexive about their relational boundaries. This could offer insight into understanding PT burnout as it relates to emotional exhaustion over time (Fischer et al., 2013).

Another of our results that advances the conceptual understanding of how PTs establish connections with patients is the category *using the body as a pivot point*. While literature on the TR has addressed the body (e.g., understanding the patient's physical complaints, achieving therapist-patient agreement on the treatment plan, and identifying patients' resources) (Besley et al., 2011b), using the body as a pivot point reinforces the patient's body as an essential common ground between PT and patient. For example, the process of helping patients develop body awareness leverages the body as an access point for patient and therapist to share success and provide patients with the opportunity to be directive in their rehabilitation. Moreover,

connections can be established via usual practices such as a thorough history taking and physical assessment. These medical rituals, in addition to demonstrating the PT's genuine intent to help the patient, can also be therapeutic because of the historical meaning attached to these processes and their potential to engage neurobiological placebo effect pathways (Kaptchuk, 2011; Moerman & Jonas, 2002). In other words, these rituals and processes help to establish a connection between PT and patient by focusing both on a common space, the patient's body. In practice, this means that although a well-balanced approach that integrates multiple ways of establishing connections is likely needed, the body is an essential point of connection. This reassures PTs that how they interact with their patients' bodies continues to be an integral aspect of the interaction.

We deliberately designed our study to exclude potentially complex scenarios, such as patients with chronic neurological conditions (e.g., multiple sclerosis) or those receiving wage replacement benefits (e.g., workers' compensation, insurance claims). Although not prompted, PTs spoke of these situations and how they affected the process of establishing connections and the TR. However, focused study of establishing connections in these various contexts is needed. For instance, work disability systems, such as workers' compensation, can influence clinicians' perception of their roles and responsibilities with patients (MacEachen, 2013; Stigmar, Ekdahl, & Grahn, 2012). MacEachen (2013) describes this as a "gray zone" (p. 222) between professional ethics and adherence to system processes. Moreover, PTs' own motivation to establish connections could be influenced by their beliefs regarding injured workers' motivation levels (Stigmar, Ekdahl, & Grahn, 2012), which has the potential to impact program effectiveness. This speaks to the need to understand patient and PT perspectives on challenging rehabilitation scenarios and the TR (Potter, Gordon, & Hamer, 2003; Reid, McPherson, &

Kayes, 2007). Potter et al. (2003) acknowledge the influence that therapist, patient and context have in playing out "difficult patient" scenarios, while the PTs in their qualitative study identified the need for better interaction skills. Patients with complex musculoskeletal conditions also have expressed the need to establish a trusting relationship where they feel believed and supported (Reid et al., 2007) by their healthcare providers.

Establishing connections is a dynamic endeavor that not only requires initiating and deepening connections, but also maintaining connections in the face of adversity in the TR. Considering this complexity, future research in PT could judiciously draw upon theory developed in the psychotherapy context to understand alliance rupture and repair. Alliance rupture is defined as "a tension or breakdown in the collaborative relationship between patient and [psycho]therapist" (Safran, Muran, & Eubanks-Carter, 2011, p. 80). In terms of establishing connections in PT, rupture could apply to the fraying or severing of connections between PT and patient. Given the various challenging situations that can arise during rehabilitation, it is important to understand what specifically ruptures connections in the TR and how therapists manage relational tensions in order to maintain or repair connections.

Strengths

A strength of this study was the triangulation of data sources. This was especially important given the lack of patients' contributions in the TR literature prior to this study. Another key strength was the quality of the data, which enhanced credibility of the results. Participants were very forthcoming and able to articulate both insight and highly descriptive examples of their experiences. Moreover, all PTs had over 10 years of clinical experience, which augmented the quality of the data because the PTs likely had multiple experiences of the TR and had the opportunity to be reflective about their practices. The majority of patients also had more

than one experience with PT, which may have contributed to their capacity to discuss the TR in this setting. In addition, the sample had good variation in terms of male and female participants, age range of patient participants, and various PT treatment specializations. The results may also inform the other health care providers (e.g., physicians, nurses, occupational therapists) who need to develop TR for improved health outcomes

Limitations

Much of the interview discussions centred on the PT, which is not surprising given the therapist's role in the TR. Nonetheless a second interview might have provided opportunity to probe patients more about their role in the TR. Finally, exclusion of patients who were receiving wage replacement benefits or were involved in litigation for their injuries limited the nature of the data generated and hence the possible breadth of the results. Nevertheless, this would have required a significantly larger sample in order to saturate the data, which was outside of the time frames and resources of this study.

Conclusion

A positive TR is recognized as a cornerstone of successful PT interactions. PTs must be able to establish connections with patients in order to develop the TR. However, there has been little conceptual understanding of how this happens. Situated together, acknowledging the individual, giving-of-self, and using the body as a pivot point make an important contribution to PT by clarifying a structure that outlines the numerous and varied ways that PTs can establish connections with their patients. The results signify the need for therapists to demonstrate the necessary commitment in supporting their patients, to collaborate with patients using a well-balanced approach that gives healthy attention to the patient's body, to recognize each patient's uniqueness, and to foster the patient's role within the rehabilitation process. Ultimately, this

structure could help PTs to develop TRs and expand policymakers' views on evaluating system and program effectiveness.

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CHAPTER 6 – THE DEFINING ELEMENTS OF THE BOND BETWEEN PHYSIOTHERAPISTS AND PATIENTS

The therapeutic relationship (TR) between practitioner and patient is a contextual factor that increasingly appears to be critical for understanding successful clinical interactions. Positive TRs in rehabilitation have been found to be associated with increased patient satisfaction (Beattie, Turner, Dowda, Michener, & Nelson, 2005; Hush, Cameron, & Mackey, 2011) and adherence to treatment (Schönberger, Humle, Zeeman, & Teasdale, 2006), as well as improved clinical outcomes (Ferreira et al., 2013; Fuentes et al., 2014; Hall, Ferreira, Maher, Latimer, & Ferreira, 2010). One recent experimental controlled study highlighted the influence of the TR on clinical outcomes in physiotherapy (PT) by demonstrating that a positive TR helped to achieve enhanced clinical outcomes in the treatment of chronic pain (Fuentes et al., 2014).

Despite its link to important clinical metrics, there has been little research that clarifies the key components of the TR in PT. Moreover, there have been many terms used inter-changeably in the literature (Kayes & McPherson, 2012) such as therapeutic alliance (Ferreira et al., 2013; Fuentes et al., 2014; Kayes & McPherson, 2012; May, 2001) and working alliance (Cheing, Lai, Vong, & Chan, 2010; Schönberger et al., 2006), in addition to variations of patient-practitioner relationship (Hall et al., 2010; Klaber Moffett & Richardson, 1997) or interaction (Beattie et al., 2005; Klaber Moffett & Richardson, 1997). Early research in psychotherapy also struggled with this definitional question. The current variability with the terminology used in PT is a result of and contributes to a lack of clarity regarding the TR. The lack of foundational knowledge and varied terminology gives rise to the question, “what are we studying?”

One aspect of the TR that appears to be consistent across various understandings and disciplines is the concept of the *bond*. A healthy bond can be understood as the "affective glue" that keeps two people together in a relationship. Horvath and Greenberg (1989) define the bond as ". . . the complex network of positive personal attachments . . ." (p. 224) that exist between practitioner and patient. It provides the foundation that enables the relationship to function smoothly and holds the relationship steady during times of increased stress. The bond has its conceptual roots in psychotherapy where it, along with various descriptions of the bond's elements, has historically been accepted as a component of TR. For instance, Bordin's conceptualization is based on the elements of trust, rapport (i.e., liking, disliking), and attachment (Bordin, 1979; Stiles et al., 2002), while Stiles et al. (2002) consider friendliness, acceptance, understanding, and support to be characteristic of bonds. In rehabilitation professions and settings, the bond's elements are not as explicitly defined but appear to be implied through definitions of the TR or the measurement tools used to evaluate the TR. For example, Cole and MacLean's (2003) definition of the TR includes trust and rapport to clearly describe what the TR is, but does not directly name the bond within the definition. Rehabilitation researchers, including those studying in PT contexts, have commonly used the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989), a psychotherapy measurement tool based on Bordin's theory, to evaluate the strength of the working alliance (Ferreira et al., 2013; Hall et al., 2010; Morrison & Smith, 2013) or to inform the development of rehabilitation-specific measurement tools (Cheing et al., 2010). This implies that the bond (one component of the working alliance) is understood, in whole or part, through the filter of a theory developed within the context of psychotherapy.

The application of Bordin's theory in PT research is not surprising, considering he suggested it could apply outside of psychotherapy in other helping professions (Bordin, 1979). As such, the evaluation of the bond in PT research has largely been based on a conceptualization that originated in the context of psychotherapy. Even though PT and psychotherapy share broad commonalities (i.e., one individual as the helper and one seeking help; a treatment plan that requires participation of both therapist and patient) (Frank & Frank, 1991; Miciak, Gross, & Joyce, 2012), they are decidedly different therapeutic endeavours. Although there might be elements of the bond that generally apply across disciplines, such as trust and rapport, each discipline is unique. Therefore, there may be nuances of a common element that apply in one discipline and not another, or elements that are specific to a discipline.

There is little research that has focused on clarifying the components of the TR or the elements of the bond in PT; this clarity is important for valid research of the TR in PT and for informing the way clinicians address bond formation in clinical practice. Therefore, we undertook a qualitative study in order to identify and conceptually describe the key components of the TR in PT clinical encounters. Three components were identified: (a) conditions of engagement, (b) ways of establishing connections, and (c) elements of the bond. This paper details the bond between PT and patient by responding to the question: what are the defining elements of the bond in PT practice? The Health Research Ethics Board at the University of Alberta approved the study.

Methods

Design

Interpretive description was the qualitative research approach used in this project. It is a methodological decision-making framework designed for use in clinical and other applied

research settings where practical answers to practice-oriented questions are desired (Thorne, 2008). Interpretive description draws on naturalistic inquiry (Lincoln & Guba, 1985), the discipline's mandate (e.g., helping patients maintain or improve function), and the subsequent research question to inform coherent methodological decisions (Thorne, 2008).

Setting

The setting was private practice PT clinics in Edmonton, Alberta, Canada. In addition to the notable percentage of Albertan PTs working in private practice clinics (43% in 2013) (College of Physical Therapists of Alberta, 2013), several contextual factors make private practice clinics ideal for gaining insight into the TR. For example, the nature of the TR could be influenced by community location of clinics increasing access to services, or a for-profit business model could result in PTs placing an emphasis on developing bonds in order to build a caseload. In addition, patients have direct access to PT services in Alberta (i.e., they do not necessarily require physician referral), which could impact the TR by influencing patients' expectations of PTs as primary care providers.

Participants

Male and female patients and PTs were eligible to participate. PTs were eligible to participate if they had a minimum of five years of clinical experience and were currently working in private practice in some capacity. Adult patients (18-64) were considered eligible if they had been treated for a musculoskeletal condition, had received a minimum of three PT sessions, and were within 12 weeks of their last session. Patients were either formally discharged from treatment by the PT or could return at their own discretion. Patients were ineligible if they had co-morbid conditions, limiting their cognitive capacity or ability to communicate, or if they

had received wage replacement or pain and suffering compensation payments through a third party.

Sampling Strategy and Recruitment

A total of 11 PTs, five male and six female, were recruited. Authors MM and DPG used their knowledge of the Edmonton private practice community to purposefully sample PTs they believed would be able to provide in-depth accounts of their TR experiences. The investigators considered factors such as treatment specializations (e.g., "manual PTs" with post-graduate certification) and areas of clinical interest (e.g., chronic pain). PTs' ages ranged between 36-60 years, with a mean age of 47.8 years (demographic data was missing for two PTs). All PTs had been in clinical practice for at least 10 years, and in private practice for at least 10 years. Most PTs (10/11) reported using at least one advanced restricted activity (i.e., an activity requiring authorization from the provincial College), such as intramuscular stimulation or spinal manipulation (Physiotherapy Alberta - College + Association, n.d.a). Treatment preferences are described in Table 6.1. Post-graduate training was reported in women's health, vestibular rehabilitation, temporomandibular joint rehabilitation, and sports PT.

Table 6.1.

Physiotherapist Demographic and Treatment Information

PT ID	Gender	Age (years)	Treatments Regularly Applied								
			Ex	I/H	Acu	US	JMob	JMan	Edu	IFC	STM/T
PT-A	M	36	✓	✓		✓	✓	✓	✓	✓	✓
PT-B	F	53	✓		✓		✓	✓	✓		✓
PT-C	M	37	✓	✓		✓	✓	✓	✓	✓	✓
PT-D	M	54	✓	✓	✓		✓	✓	✓	✓	✓
PT-E	F	Not available	✓	✓	✓		✓	✓	✓		✓
PT-F	M	60	✓	✓	✓	✓	✓	✓	✓	✓	✓
PT-G	F	59	✓	✓		✓	✓	✓	✓	✓	✓
PT-H	F	Not available	✓	✓		✓	✓	✓	✓		✓
PT-I	F	46	✓	✓			✓		✓		✓
PT-J	F	42	✓	✓	✓		✓	✓	✓		✓
PT-K	M	43	✓	✓	✓				✓		✓

Note: Ex = Exercise; I/H = ice/heat; Acu = Acupuncture; US = ultrasound; JMob = Joint mobilization; JMan = Joint manipulation; Edu = education; IFC = interferential current; STM/T = soft tissue massage/techniques

A total of seven patient participants (three female and four male) were recruited. Five patients were purposively sampled and recruited by the administrative staff of three clinics. Another recruitment approach involved distribution of study information to a large Edmonton athletic club via coach's email. The two participants that responded to the email were included through convenience sampling. Patients' ages ranged between 18-62 years, with an average age of 42.3 years. Most patients (6/7) had previously accessed PT services and most (5/7) had been experiencing their physical issues for greater than 3 months prior to seeking treatment. Information on various aspects of each participant's treatment can be found in Table 6.2.

Table 6.2.

Patient Demographic and Treatment Information

Patient ID	Gender	Age (years)	Was this your first PT experience?	If previous experience with PT, was it for same problem?	Was the MSK condition acute (<3 weeks) or chronic (>3m)?	Gender of the PT seen for this problem?
Patient-A	F	62	No	No	chronic	F
Patient-B	F	18	No	No	acute	F
Patient-C	F	54	No	Yes	chronic	F
Patient-D	M	55	Yes	n/a	chronic	M
Patient-E	M	51	No	Yes	chronic	F
Patient-F	M	33	No	No	chronic	F
Patient-G	M	23	No	Yes	acute	M

Data Generation and Analysis

An inductive and iterative approach to data generation and analysis was undertaken. Semi-structured one-on-one interviews were completed in a public location of the participant's choice. All interviews were digitally audio-recorded and transcribed verbatim by a transcriptionist. An interview guide (Patton, 2002) of open-ended questions was used to facilitate discussion about participants' perspectives of the TR in general. Concurrent data generation and analysis allowed for continual revision of the interview guide to reflect the evolving analysis, which facilitated increasingly targeted discussions about TR components (e.g., the bond) as they took shape over the course of the analysis. The initial questions were broad and non-specific to the TR but became more specific and increasingly related to the TR as the interview progressed. Probing questions sought to build on participant comments "in-the-moment" in order to encourage description. Other forms of data included the primary investigator's interview notes, analytic notes, and memos. The primary investigator completed all of the interviews and analyzed all data. Data were generated until each component of the TR meaningfully described

clinical reality, marking a reasonable point of saturation. Applying an iterative approach throughout data generation (e.g., updating interview guides), data analysis (e.g., including constant comparison principles of analysis), and rigour strategies (e.g., peer debrief, memoing) enabled this point to be determined.

Data analysis occurred in two phases: (a) a systematic process of data review (audio and transcripts), reflexive journaling, and memoing prior to coding and; (b) formal coding as guided by conventional content analysis (Hsieh & Shannon, 2005) and constant comparison strategies. Qualitative content analysis began with initial coding (Charmaz, 2014) or the assignment of a specific word or phrase to summarize a key attribute of a portion of text (Saldana, 2009). As patterns of codes were recognized (Braun & Clarke, 2006; Joffe & Yardley, 2004), they were grouped into categories and sub-categories. At this point, constant comparison strategies were used to refine the analysis. Constant comparison is the recursive process of comparing text, codes, and incidents throughout the evolution of the analysis in order to progressively determine the properties (i.e., enduring characteristics of the category) and conditions (i.e., circumstances that foster the category) of categories (Glaser & Strauss, 1967). In this analysis, these strategies assisted in the process of thinking about the properties (i.e., enduring characteristics) and conditions (i.e., circumstances that foster the category) of the categories (Glaser & Strauss, 1967). Comparative strategies were used to shape the categories by comparing codes between sub-categories within a particular category, in addition to comparing between categories. This process garnered rich descriptions that were used to build a conceptual structure from the data. Negative cases were also explored and contributed to clarifying aspects of the bond elements. Reflexive journaling, peer debriefing, memoing, and member reflections were the rigour strategies used throughout all stages of the project.

Findings

We determined that the bond was 1 of 3 key components of the TR, which also included *conditions of engagement* and *ways of establishing connections*. Furthermore, we clarified that the bond consisted of these four elements: (a) nature of the rapport, (b) respect, (c) trust, and (d) caring. These elements will be described below.

Nature of the Rapport

A goal of any therapist-patient relationship would be to establish a "good rapport" or an ease of interacting where there is a reciprocal acknowledgement of the other person. A good rapport between therapist and patient is especially important in PT interactions for various reasons. For instance, there can be greater opportunity for social interaction covering both professional and personal domains because PTs and patients will often directly interact with each another in sessions that last longer, are more frequent, and span over a longer period of time than, for example, interactions between surgeons and patients:

> PT-J: . . . I work in a setting that has surgeons and docs and PTs . . . I find that people have a much different relationship with their PTs . . . I find that patients, especially with surgeons . . . aren't as concerned with personality, bedside manner. They just want to know that . . . somebody is technically good at what they do. . . but when you [patient] are seeing somebody a little more regularly than you see most surgeons . . . I think that them being comfortable with you as a person . . . because you are in lots of cases in their personal space and I think they need to be able to trust that. They need to be comfortable . . .

Characteristics of the PT context require that PT and patient "get along" in some capacity, thereby making the rapport an integral part of the bond. The strength of bond between PT and patient is linked to the nature of the rapport and could influence clinical outcomes:

> PT-J: . . . I think that you know being able to develop that relationship, develop rapport makes a massive difference in your outcomes . . .

PTs and patients in this study agreed that the nature of the rapport is based on an appropriate mix of professional (professional ethics) and personal factors (personality and social commonalities). The mix of professional and personal factors determines the unique rapport of each patient-therapist relationship, as reflected by two dimensions: (a) professional rapport is the foundation and (b) personal rapport.

Professional Rapport is the Foundation. PTs and patients articulated that the professionalism of the PT was essential in developing the rapport:

> PT-A: First of all, you have to uphold all your professionalism. As far as ethics, you have to get to be able to relate to the patient so you feel that friendship, I guess if you want to call it. You still have to be professional.

PTs' comments reinforced that a professional rapport was grounded in their responsibility to provide care to their patients or uphold a ". . . duty of care . . ." (PT-C). PTs take an oath, stated or unstated, to hold the care and well-being of their patients in the highest regard. This professional regard could be described as ". . . altruism. . . ." (PT-G) or as PT-C described, bringing them ". . . into the protective fold of what I consider my responsibility. . ." to care for patients:

> PT-C: I still remember a description of a traditional profession. You know the clergy, law and medicine, going back hundreds of years and how those three professions have a

different obligation and duty than merchants and businessmen . . . maybe it goes back to that idea of trying to separate out what we consider our responsibilities above and beyond what's the normal interpersonal responsibility . . .

Fulfilling this responsibility likely informs that way that PTs approach patients and the clinical interaction in general, in addition to acting as a "touchstone" that keeps the interaction on track. Furthermore, patients seek the help of PTs to heal and return to or maintain their participation in meaningful activities, which shapes the primary intention of the interaction and the expectations of PTs and patients. The way PTs reinforce the professional aspect of care through their attitudes and actions helps develop the nature of the rapport because it informs what is and is not done – what is talked about and what is not talked about. Moreover, PTs commented that they would shift the way they interacted in order to reinforce professional intentions:

PT-C: . . . if I do have someone that I've known or seen before and I'll have a friendly visit for a moment. Then it's change of tone and I think at that point I think of people as a story. I need to hear your story . . . I think I depersonalize it in that sense.

PT-A: I have lots of fun with my patients but when it comes to talking about their injuries and their cases, I'm always following up on that each time they are at the clinic.

Maintaining a ". . . professional air . . ." (Patient-C) does not mean that PTs approach their responsibilities with coldness or rigidity. Therapists could be ". . . very professional but yet caring . . ." (Patient-C). For instance, PT-J voiced that she bucked ". . . political correctness . . ." and used the term patient instead of client because ". . . it doesn't seem like it's the same relationship with the person if they are client as if they are patient" while PT-F made the same claims:

PT-F: I was never personally comfortable with that [using the term client]. I'd say patient because I felt there was more of a personal relationship when you called them a patient rather than a client.

Patients also recognized that the professional intent of the interaction could be maintained while also fostering a sense of ease, such as when Patient-B described the difference between communicating with a PT versus a physician:

Patient-B: . . . I feel like physio for me I'm more comfortable so I'm more casual . . . at the doctor's office . . . you have to bang it out.

Personal Rapport. In addition to the professional rapport of the bond, a personal rapport can exist. The personal rapport imbues a friendly quality that reinforces a sense of ease between PT and patient:

Patient-B: They have to keep it professional. You are not going to know where they live . . . I'd still want to know just things about their life, that makes the treatment a little more comfortable.

Patients commented that the personal rapport with their therapists ". . . made it [treatment] enjoyable" (Patient-B), and not sessions they ". . . dreaded going to" (Patient-A). One PT, in speaking about advice she received from a mentor early in her career, commented:

PT-J: . . . if you can develop a good relationship with your patient and get your patient to like you, that's half the battle. Sometimes that's more important than your actual skill . . .

The personal rapport between PT and patient is influenced by many factors. Therapists and patients can ". . . click" (Patient-A) because of ". . . basic human personality and what you are drawn to from another person" (Patient-A) or by having similar life circumstances and interests:

Patient-A: (XXX – name of PT) is about the same age as my daughter. She just had a child and we just clicked. We just hit it off. I originally asked her which program did you go to? "Oh", I said "my niece was in that program" . . . we very early built a rapport . . .

Patient-B: . . . They like running. I like running. You talk about that kind of stuff and it helps you in the long run. That would be so hard if it was just in and out.

This sense of closeness or camaraderie can cultivate more personal, yet acceptable, overtones that further characterize the nature of the rapport:

Patient-G: If he wasn't my physiotherapist, I would think he would still be a friend.

Patient-C: Honestly it was like going to visit a friend every week and last week was my last session. I was really sad.

PT-I: She was a grandma and I just loved her. We got so close. She was lovely . . .

There are ebbs and flows of the personal dimension of the rapport as it contributes to the bond between PT and patient. They may reacquaint themselves with friendly small talk or pleasantries at the beginning of an interaction, move into focused professional discussion and activity pertaining to the patient's physical concerns, and then revisit the personal by having ". . . a good conversation . . . casual . . ." (Patient-D) on mutual topics of interest while treatment ensues:

PT-A: You establish . . . the orthopedic connection because you are going to reassess them anyways . . . then you work on re-establishing that bond . . .while I'm treating again, "oh how are the kids" or "did you end up watching the movie that you were talking about . . .?"

PT-G: . . . later while I'm working with them now having to ask some questions I'll say, "Oh what kind of dog do you have? How many dogs?" That kind of stuff. Something that's come up in the assessment, I'll come back to it . . .

Even though this closeness could strengthen the bond between patient and PT, it also has the potential to be detrimental to the rehabilitation process. Therapists ". . . need to know how far do I go with being personable . . ." (Patient-E):

Patient-E: It has to be personable but it still has to maintain professional . . . I know from my own perspective. I can go on about my own children but I also realize this is a treatment professional situation. We do need to be personal and connect but I'm not going to carry on. I know when to draw myself back . . .

Personal rapport cannot adversely influence the therapeutic purpose of the encounter. Patient-F confirmed this when he described a situation with his PT where the amount of personal conversation did not encroach on their therapeutic work:

Patient-F: . . . [there] was also not too much talking [so] that I was sitting there [thinking], "Come on, come on already. Let's do it [therapy]."

Respect

On the most basic level, respect is an acknowledgement of a person's inherent importance or value. During analysis it was noted that the words respect and trust appeared at times to be used inter-changeably. Although they might be related, they are also distinct, as PT-E's comment describes:

PT-E: I think immediately you start into a place of trust or a place where a person has at least at minimum if not trust yet at least respect that you have some knowledge.

For instance, there can be respect for another, but not necessarily trust in another. Respect builds trust; therefore, respect is a minimum requirement of the bond:

> PT-A: I think you have to respect the therapist. If you don't respect them, then . . . that bond is not going to be there.

Moreover, respect must be mutual. Although it might be the PT's responsibility to initially demonstrate respect, it is reciprocal in that ". . . how he treats me would be affected by how I treat him" (Patient-D):

> PT-H: ...there has to be respect on both sides. When there's not that respect, you don't have the same influence in helping this person, do you know what I mean?
>
> PT-I: . . . I always know that . . . if I haven't gotten to a point where there's at least a respect both ways, I'm just not going to go much further.

Respect within a TR is based on the acknowledgment of a person's humanity and contributions (i.e., knowledge and skills) to the rehabilitation process. In terms of respect, patients expressed that it was important to feel valued and that there was a ". . . regard . . ." (Patient-A) for them as people. When speaking about the importance of feeling like she was a person while undergoing her rehabilitation, Patient-A expressed:

> Patient-A: You feel like you're valued. You feel like you're important for them. You feel that they have a regard and a compassion for other people.

Therapists demonstrated their regard for their patients by making them feel ". . . welcomed" and ". . . appreciated" (Patient-E) by, for example, expressing gratitude for the patient's presence by saying, ". . . thank you so much . . . for coming, how can I help you?" (PT-D) or by making each patient feel as though s/he was the centre of attention, regardless of ". . . who the person was . . ." (PT-D):

Patient-A: The other thing is she attended to everyone that I could hear with equal respect and equal openness. You were her main focus. That made me feel really good being there.

Upholding the patient's dignity at a time when s/he might be vulnerable is an important way of demonstrating respect and cultivating the bond. As PT-D commented, ". . . suffering from any ailment is a constant issue for any individual." Not only are patients experiencing some degree of physical compromise, they also might not know exactly what to expect from a PT interaction or be hesitant in terms of exposing their bodies or being touched. Cultural and gender factors can also impact the therapeutic interaction as it relates to the patient's body:

PT-D: [A] challenging situation in terms of ethnicity where female patients don't like male members to treat them, we have signs in all our cubicles. Our front-end staff if they see somebody, especially if it's a female patient coming in and they are from a different ethnicity or otherwise, the will ask them "are you okay with a male physio? Would you like us to be in the cubicle?"

Therapists explained that they must be conscious of acknowledging these situations in order to maintain a respectful approach with patients, such as when they needed patients to expose their bodies during assessment and treatment:

PT-H: Yes but I always ask permission first . . . like the ones [patients] . . . I'm not sure if they are ready to [disrobe], I don't just go, "put a gown on" . . . even if I was not having them undress . . . but I need to see their shoulder blade [or] thoracic spine, right? I will say, "Do you mind if I roll this shirt up and tuck it under your bra? Do you mind that?" . . . I always ask permission . . .

Patients also voiced that their physical vulnerabilities needed to be acknowledged without judgment. For example, Patient-D spoke of the impact that interactions with health professionals could have on his self-esteem:

> Patient-D: I wouldn't have gone back the second time if I felt uncomfortable . . . if I was humiliated in any way . . . I wouldn't go back.

Therapists and patients also spoke of respecting therapists. Although comments were not as poignant as those regarding patients, respect for PTs came in the form of acknowledging they were people underneath their professional faces. For instance, Patient-D spoke of the likelihood of PTs feeling ". . . valued . . ." in conversations that extended beyond rehabilitation to acknowledge similar interests. On the contrary, PTs recalled instances that indicated a lack of respect, such as when they perceived undertones of discrimination based on gender or ethnic background, or when patients were belligerent:

> PT-F: . . . I just started my little education thing and he just . . . he said, "This is . . . f-word bullshit." I was sitting beside him quite close . . . and that's what he said right in my ear . . .

Additionally, both PTs and patients commented on the importance of valuing what each contributes to the rehabilitation process, which could be as simple as considering (i.e., not discounting) the patient's story:

> PT-B: I don't judge what they tell me. I don't make a judgment on their description of their story. I don't make a judgment when somebody says I sit on the exercise ball to do my back exercises and it really hurts me, I don't go "that doesn't make any sense that sitting on a ball would make you feel worse".

Patient-F: . . . she still was not saying I was wrong . . . she really valued my personal assessment in what is going on here. She was listening to me.

Therapists' main contributions are their specialized knowledge of the body, injury, and rehabilitation. Because the primary reason for the interaction is to address the patient's functional limitations, both PTs and patients agreed that there would not be much of a bond without the patient respecting the PT's knowledge and skill:

PT-G: . . . You want respect from them with your skills. You want them to kind of buy in to everything that you are saying.

PT-D: They will see that I will go out of my way if I have to in terms of going on the phone, talking to their physicians, talking to their employers. In short, I'd say I gain their respect.

Trust

Trust is a term that is often used when describing good relationships and is an essential element of the bond in PT:

PT-J: I think trust is a huge thing. If your patient doesn't trust you, then I don't think there is a therapeutic relationship there, for me anyways . . . I think by and large most people are going to . . . have better outcomes if you have that trust and the patient has confidence in you.

Given that the PT interaction happens within a professional context that can involve various degrees of personal engagement, there are three aspects of trust characteristic to the TR in PT: (a) trust in the PT as a professional, (b) overlap of professional trust and personal trust, and (c) physiotherapist's trust in the patient.

Trust in the Physiotherapist as a Professional.

> Patient-D: I just had confidence in them . . . They are calm. They know what they are doing. They don't make you feel like an idiot. Then you finally succumb to them fixing your leg and you don't have any more of that fighting it kind of thing.

Trust in a professional interpersonal relationship typically involves the patient believing in the PT's: (a) professional intention and (b) credibility.

Professional Intention. Possibly the most basic aspect of a patient's trust is the confidence that the PT's intention is to help them achieve their rehabilitation goals without causing undo physical or psychological harm. The patient needs to be confident that the therapist is ". . . on my side" (PT-I), especially when injury has left patients feeling ". . . vulnerable . . ." (Patient-C):

> Patient-C: . . . I knew that I could just put my recovery in her hands and that she would do the very best that she could with what she has.
>
> PT-E: . . . that they feel some trust and they feel comfortable enough to say "well I didn't like that technique" or "I was sore after".

The patient must perceive that the PT is ". . . genuinely interested in my improvement . . ." (Patient-G). For instance, Patient-B commented on how she ". . . almost felt scammed . . ." when talking about her experience of receiving extended treatment without notable improvement; this planted a seed of doubt about the therapist's intentions. On the contrary, this same patient commented that she knew her most recent PT ". . . would do her best for me and if there was no hope for improvement, she would say it." And although PTs are not expected to short-change themselves in terms of reimbursement for their services, treatment ". . . can't just be about getting a pay cheque" (Patient-C), especially if this intention supersedes their professional duty of care:

PT-E: I interview people [potential PT employees] . . . when they come in, I know where that person is coming from. Are they into therapeutic relationships or are they into their paycheque at the end of the week? It's like how many patients can I see in an hour? It's a difference. It's not that one does not have to have payment for one's services . . . it is important. But a therapeutic relationship doesn't happen unless your first goal I think is to be there for the patient, to listen to the patient's needs and to try and achieve their goals . . . I think it's an outlook. A therapeutic relationship is an outlook that a physiotherapist has in terms of their role and how they practice.

Credibility. Patients come to PT for expert guidance regarding their functional limitations. Therefore, in order for a bond to form, patients need to be able to trust that their PTs are knowledgeable and have the necessary skills. The patient is able to trust the therapist when the therapist demonstrates s/he, ". . . knows what the heck he's talking about . . ." (PT-A). For example, PT-A described a situation where his patient disclosed more sensitive aspects of his injury history because he made an accurate diagnosis and recommendation:

PT-A: . . . he [the patient] knew I was the one who said you need an MRI because chances are you probably tore your meniscus . . . at that point, he was willing to disclose the information . . . that's a pretty good sign that that relationship is pretty strong . . .

Therapists and patients also expressed that the patient's confidence was bolstered when the therapist demonstrated s/he knew ". . . what it was she was doing . . ." (Patient-E). PT-F spoke about using ". . . the palpatory skills that you have and the touch skills that you have to gain their confidence . . .", while patients highlighted the importance of the therapist knowing what to look at, what to feel, and what to do regarding the body:

Patient-A: . . . she could feel the rigidity in the ankle itself, she could work on that and it really helped. She knew professionally exactly what she was doing, where to look.

Patient-F: . . . I was completely amazed at how thorough his assessment was . . .

Patients and PTs acknowledged that experience and reputation might be factors that influence patients' perceptions of professional competence:

PT-G: . . . They have to trust you and I think being older and having lots of experience they'll believe you more. "Oh you're been doing this for a long time. Have you seen this before?" "Oh many, many times . . ."

Patient-B: Knowing that their specialty is sports . . . that helps a lot. I think you feel more comfortable going into that appointment knowing that they are going to get what you are saying . . ."

Even though PTs with less experience still have something to offer the patient, there was a perception that ". . . they're still more book . . . they have to think too much. They haven't got the feeling of it down yet . . ." (Patient-A):

Patient-G: . . . an outstanding variable would be the fact that he's been a physiotherapist for awhile, he graduated in 1999 versus if I get a replacement for him, they are usually new . . . they are not as athletic or even if they are, they haven't had as much experience.

Contrary to this perspective, some patients commented that multiple qualifications were not as important as experiencing an effect from treatment. Patient-F candidly stated that ". . . usually what doesn't convince me [is] when there's all these certificates in and around the room . . . it's just paper." In other words, regardless of ". . . guru . . ." (PT-E) status or advanced qualifications, patients needed to feel that the treatment ". . . really did have an effect" (Patient-D):

Patient-E: . . . in the first few sessions she espoused to me her education, her training and everything. I'm like, "Okay, fine, I'm kind of interested in that but that's not so important as the results." You can have 150 degrees, if you don't know what the hell you are doing, I'm not coming back right? . . . Can you fix me? That's what really mattered to me. I'm sure it might to most other people. That was really what it boiled down to . . . it wasn't that she was just trying to feed me information or feed me a line so to speak, what she actually said worked . . .

Although relevant, the PT's credibility was not necessarily dependent upon physical improvements. For instance, PT-F spoke of times when physical improvements were not forthcoming yet he salvaged credibility by being honest with the patient about limitations in skill and knowledge or by referring the patient on to appropriate services:

PT-F: Oddly enough they appreciate you for that . . . they don't think badly of you. You always think they do right, but a lot of them don't . . .

Ultimately, the PTs ability to demonstrate knowledge and skill, regardless of the degree of expertise, could have an impact on the patient's overall experience of PT and help to develop the bond. This might also limit the chance that treatment will be perceived as a ". . . waste of my time . . ." (Patient-A):

Patient-B: It gives me confidence that I will get to the place that I want to be, and that I can ask them questions that I wouldn't ask unless you knew they were doing what they need to do.

Overlap of Professional Trust and Personal Trust. Although the heart of the patient's trust rests in the professionalism of the PT, the patient's trust in the therapist as person is woven into this trust. The patient's trust in the therapist as a person can be expressed within the

therapeutic aspect of the relationship. For instance, patients need to ". . . develop the confidence in you that you're not going to judge them. They can say whatever they want . . ." (PT-B). Being non-judgmental can be a personal and professional ethic. In addition, the patient's ability ". . . to confide in you [therapist] . . ." (PT-G) could be informed by the PT's credible knowledge, and bolstered by the therapist's warm and personable personality. For instance, when discussing what contributed to the trust he had in his PT, Patient-E commented on the overlap between professional and personal characteristics; he stated that in addition to knowing ". . . what she was doing . . .":

> Patient-E: She's personable . . . I often think . . . that all healthcare workers, all education teachers, all have that humanitarian feel about them. They are personable and that's why they are in the field that they are in. I think that's important.

Other personal aspects such as camaraderie or having shared interests could contribute to the sense of trust and the development of the bond, which was exemplified by Patient-G's assertion the trust he had in his therapist was in part because, "he's a triathlete. I'm a triathlete . . . that also was a factor." Patients and PTs made comments that indicated there were personal overtones that potentially transcended the primary intention of the encounter, indicating that trust could have personal roots:

> Patient-D: I remember talking about stress. We did talk about stress a lot . . . I totally trusted the guy maybe more than it's his job . . . I felt like he would have listened if I said more.
>
> Patient-A: Drawing you closer would be a trust. You might tell them things about your family or yourself that you might otherwise do. It was just like having a good friend.

The important indicator of trust, which is embedded in both professional and personal aspects of trust, is the PT's use of touch. A patient must trust in the therapist's skilled hands (i.e., credible skills and knowledge) as well as in the therapist maintaining professional boundaries (i.e., professional intention) in terms of touching patients. In addition, some patients have difficulty with touch in general and are placed in an awkward predicament where touch is part of a legitimate assessment and treatment intervention:

> PT-H: You can't enter a person's space unless they trust you. You can't effectively enter a person's space unless they trust you.
>
> PT-A: . . . if someone is relaxed and letting you put your hands on . . . especially if it's a groin strain, that's the ultimate sign of trust, or their back, especially if they are not clothed in that area . . .

Physiotherapist's Trust in the Patient. The bond in a TR in PT appears to be a shared experience. This is exemplified by the PT's trust in the patient. "Of course you have to trust your patients . . .", affirmed PT-E. The TR is a trusting relationship that ". . . has to be a completely shared responsibility . . ." (PT-F) bounded by a mutual reliance on goodwill between PT and patient. Like their patient counterparts, PTs spoke about having confidence in the integrity of the patient's intentions and actions. Therapists commented that ". . . periodically we do have those situations where we are not given the whole story" (PT-E), or the necessary information for appropriate assessment and treatment. This could be for various reasons, including the patient's reluctance to divulge the reason for their symptom aggravations (e.g., as being caused by a treatment or self-inflicted). Although, like their patients, PTs were also wary of ". . . ulterior motives . . ." (PT-G), which they often perceived as coming with litigation or workers' compensation claims:

PT-D: In my conversation with them when they keep on referring back to their claim or they keep on referring back to what happened or they turn around then tell me you should document this very well, my lawyer is going to need this . . . now suddenly the trust relationship has changed.

The therapist's trust could also extend to confidence in the patient's analysis of the injury. This was clearly expressed by two patients, both competitive athletes who were invested in paying close attention to their bodies. These patients appreciated when PTs ". . . realized that I sort of know what's going on, what the problem is . . ." (Patient-F):

Patient-G: . . . I could be like, "Okay it hurts right here. This ligament is fine . . . it hurts more when I plantarflex instead of dorsiflex" . . . I would tell him that because he would take it as "okay he knows exactly what hurts". . . another physiotherapist . . . could very easily see me as another dumb patient that has no idea what he's talking about and then disregard anything I say . . . which has happened before . . .

The PT's trust in the patient went beyond the patient's analysis of the injury to include trust in the patient's ability to manage the injury or appropriately progress activity. The bond between PT and patient could be strengthened because the PT trusted the patient's ability to judge their symptoms and respond appropriately:

Patient-F: . . . I think that was really important for me to hear [from the PT] "you know what you're doing. I am confident in your judging properly what's going on in your body to not make it worse."

Patient-F: Hearing this from a physiotherapist, "I'll trust the way you judge the pain in your body. You know when you have a problem." That was really good I found.

Caring

Healthcare professions are typically described as caring professions, and PT is not different in this regard. PTs have an ethical responsibility to care about, and for, the people who access their services:

> PT-B: . . . you don't do this because you are trying to be better, you are trying to care. You do this because you genuinely care. I genuinely care about people.

Although caring might be a pillar of PT practice, what is the experience of caring as it relates the bond between PT and patient? In this regard, it is important to clarify whether caring is one sided and the therapist's responsibility or whether caring, as an element of the bond, implies that there is a degree of bidirectional caring, with the patient also feeling an affinity for the therapist.

In general terms, caring can be described as a concern or regard for the well-being of another person. Caring becomes more specific in the bond between PT and patient. When PTs care about patients, there is an emotional investment in the patient's health; they put their patients' best interests at the forefront. Caring is about therapists wanting their patient's health to improve, and wanting to understand and act in ways that provide support and assistance in this regard:

> PT-C: I don't think I can help this person if I don't actually care about them . . . Do I actually care whether or not they get better?
>
> Patient-B: I find when I go to physio, they care about why I'm there and they want to get you better. The doctor is like, "okay I'll write you a prescription for this. Bye bye now".

Both PTs and patients commented that PTs who they believed cared were those who remembered, took time, listened and tried to understand, were supportive, and appeared concerned about the patient's well-being:

> Patient-B: That's how you know that they care, knowing that they remembered why you came and how long you haven't been there for.
>
> Patient-C: Was I feeling good about things? Was I doing okay at home? What kinds of things were working for me? What kind of things weren't? She always asked that.
>
> PT-H: . . . "people don't care how much you know until they know how much you care". So I think the basic part is to establish that you are there for them.

Although the focus of therapists' caring is the patient's rehabilitation reasons for seeking services, therapists also conveyed caring for the patient as a person. Although caring about the person might seem to be an implicit aspect of caring about the patient, patients identified that being a person extended beyond their roles as patients. This could mean that the PT's interest in the patient went beyond the immediate injury to include aspects of the patient's life in general, which might or might not be impacted by the physical issue:

> Patient-C: . . . the caring too is that I'm a human being and I have a home to look after and I have family and I have needs and wants.
>
> PT-B: Asking how my week was. Asking personal questions. Asking "how was your day?" "How was your week?" "Did this affect this?" Just asking "any plans for the weekend", that kind of thing. . . . just engaging in conversation . . .

Some patients also noted that when therapists cared about them as people it helped them feel normal, ". . . you are not being treated just like another person going in and out. They care about you". (Patient-B)

Even though patients and PTs in this study were more apt to reference caring in terms of the PT's contribution to this aspect of the bond, patients were not excluded from caring about their therapists. In other words, both PTs and patients revealed that caring could be reciprocal, or as PT-C voiced, ". . . you care about each other". Unlike the breadth of therapists' caring, patients' caring was expressed as a personal affinity toward the therapist, which is understandable given that patients are not responsible for providing care. For instance, some patients conveyed a personal affinity toward their PTs by describing them as a ". . . buddy" (Patient-G) or ". . . like a friend . . ." (Patient-C). Some PTs also commented that some patients conveyed interest and sometimes concern for them. There did appear to be an element of time in these situations, notably, when the rehabilitation was longer term or the patient had returned to the same PT ". . . periodically over a few years" (PT-I) for more than one course of treatment or for different issues:

> Patient-A: . . . It was nice. It got to the point where I sort of felt she was more like a friend or a daughter than just someone over and above someone who was trying to help and get out of . . . any issues that I had with my foot.
>
> Patient-G: . . . it's grown into a much more dynamic and extensive relationship . . . we are friends . . .

Discussion

This study aimed to identify and describe the key elements of the bond in the TR in PT. In general, the four elements (nature of the rapport, respect, trust, and caring) would likely be cornerstones of most strong relationships. However, the personal aspect of the attachment between PT and patient extends the bond's boundaries in terms of clarifying the complex mix of its professional and personal aspects.

Relevance to the Current Literature

Our results reveal that bond elements (nature of the rapport, respect, trust, caring) in physiotherapy TRs have both professional and personal qualities. Various psychotherapy theories have addressed one or both of these qualities. A common theory referenced by PT researchers is Bordin's theory of the working alliance. The working alliance ". . . refers to the quality and strength of the collaborative relationship . . ."(Horvath & Bedi, 2002, p.41) between psychotherapist and patient and has three components: bonds, agreement on goals, and agreement on tasks (Bordin, 1979). Psychotherapy authors referencing Bordin's theory describe bonds as the mutual liking, care, trust, and respect (Horvath, 2006; Horvath & Bedi, 2002; Horvath & Greenberg, 1989) between psychotherapist and patient. The WAI, developed from Bordin's theory, includes items that address comfort, respect, and acceptance (Horvath & Greenberg, 1989). However, it is not entirely clear the degree to which these descriptions refer to personal or professional affiliations. Furthermore, the WAI items that appear to address the patient's confidence in the psychotherapist and therapeutic process evaluate agreement on goals and tasks (Horvath & Greenberg, 1989) not the bond, whereas we describe the patient's confidence in the PT's credibility as an aspect of trust.

Other psychotherapy theorists have attempted to more clearly distinguish the nature of professional and personal bonds. For example, Greenson (1967) claims that both the psychotherapist's respect for the patient as a person as well as his/her respect for the patient as a professional are both important aspects of the working alliance. Building upon Greenson's work, Gelso (2013) goes further to refine the bond's personal and professional attributes. He describes the "working bond" (p. 120) as the bond that results from the working alliance, or the psychotherapist and patient working together for a therapeutic purpose. The working bond has

aspects that are consistent with how we describe the bond that forms from PT and patient engaging in a collaborative professional relationship. In addition to the working bond Gelso (2013) also describes a personal bond that arises from the *real relationship*. The real relationship is the universally human aspect that is a function of all relationships and exists regardless of whether a working alliance is formed. From Gelso's description, the personal bond can be strengthened by personal disclosures and can develop into mutual caring. Gelso (2013) describes a degree of "overlap" (p.126) between professional and personal bonds, which we also address. While both Greenson and Gelso claim that a personal bond is essential to the TR, they are reserved regarding psychotherapists discussing aspects of their personal lives with patients. On the contrary, our findings indicate that this type of disclosure can be important for developing rapport with physiotherapy patients.

Our results are consistent with literature in different PT research domains, most notably in the patient satisfaction literature. Hush et al.'s (2011) systematic review of patient satisfaction in musculoskeletal PT care included clinical trials, observational studies, survey, and qualitative studies. The researchers determined that professionalism, competence, and caring were consistently related to patient satisfaction. Even though the authors reported that response bias in the original studies was a limitation, the findings are compelling given that treatment outcome was neither frequently nor consistently associated with satisfaction. Beattie et al. (2005) in their psychometric analysis of the MedRisk Instrument for Measuring Patient Satisfaction, stated that the PT's professionalism, which included the patients' perception that their therapists respected them, was predictive of patients' satisfaction with their care.

Implications for Research, Practice, and Policy

Our results provoke discussion about the evaluation of the TR and the bond in PT. Psychotherapy measurement tools, such as the WAI (developed from Bordin's theory of the working alliance), have most commonly been used to evaluate the quality of the TR (Besley, Kayes, & McPherson, 2011a; Hall et al., 2010) in PT. Not surprisingly, there has been a call for PT-specific scales (Besley et al., 2011a; Besley, Kayes, & McPherson, 2011b; Hall et al., 2010), especially considering that psychotherapy scales have not undergone rigorous psychometric analysis in PT (Hall et al., 2010). The Pain Rehabilitation Expectations Scale (PRES) (Cheing et al., 2010) has to some degree addressed this gap as its initial psychometric analysis took place in an outpatient PT context. This scale was developed to measure treatment and rehabilitation outcome expectations of people with back pain. Preliminary psychometric analysis determined its internal consistency and factorial structure were credible. The tool's three sub-scales (working alliance, proxy efficacy, and expectations/motivation) were developed through literature review of placebo analgesia and the psychosocial aspects of pain as well as expert consultation with physicians and psychologists. It appears there are items in the working alliance sub-scale that are consistent with our findings, such as nature of the rapport ("My therapist is friendly and warm") and trust ("I trust my therapist" and "I have confidence in my therapist's ability to help me").

What is compelling about the PRES when compared to our findings is that a number of items in the proxy efficacy sub-scale (i.e., the subscale that rates the patient's confidence in the therapist's professional capabilities) (Cheing et al., 2010) were congruent with our description of trust in the PT as a professional (e.g., credible knowledge and skills, reputation), and possibly our description of respect, as well. These similarities are not surprising given that Cheing et al. (2010) reported a strong correlation between working alliance and proxy efficacy. However,

because these items are in the proxy efficacy subscale they do not contribute to the evaluation of the working alliance, which could have implications for future research. For example, Fuentes et al. (2014) used the PRES working alliance sub-scale in their study evaluating the pain modulation effects of therapeutic alliance in patients with chronic low back pain. Although the PRES was relevant both in terms of the population (i.e., chronic pain) and context (i.e., PT), the evaluation of the working alliance might have been incomplete given that important aspects of the bond could have been missing. This is consistent with Besley et al.'s (2011a) assessment of the measurement properties of two commonly used TR scales in PT, one being the WAI, which identified that potentially relevant aspects of the TR were not addressed, such as the professionalism of the PT.

Although our results pertaining to the personal aspect of the bond appear congruent with the psychotherapy literature, there are discrepancies with the PT literature. An example is found in the nature of the rapport. For example, when confronted with the question in the WAI that addresses PTs and patients "liking" the other, Besley et al. (2011a) reported that many PT and patient participants in their study commented that they did not comprehend or resonate with the question. However, our findings indicate that this personal aspect is important for some patients. These divergent findings indicate that the personal aspect of the bond needs further clarification. In addition, Cheing et al.'s (2010) measurement scale, which appears to be loosely structured on the WAI, does not address personal aspects of the bond that we have noted, such as conversation about life events in general or whether the patient likes the therapist. Thorough evaluation of the bond regarding the personal quality of the attachment between PT and patient could be important in the development of a tool that evaluates the overall quality of the TR.

These findings also have implications for evaluation of quality of care and clinical outcomes, especially in terms of program evaluation and third party payment for services (e.g., insurance, workers' compensation). Our findings are in line with what Fadyl et al. (2011) found in their qualitative study exploring the quality of care for people who experience disability. Through interviews and focus groups with service-users, health care professionals, and formal and informal carers, they found that the appropriate combination of technical competence and a "human" approach was needed for quality care. Their findings clarify an obvious need for understanding and evaluation of the TR. Moreover, understanding the impact of the quality of the TR on outcomes could influence how third party payers evaluate service providers, which in turn could influence how PTs practice. In addition, good overall quality of care, regardless of clinical outcome, could influence patients' decisions to return for subsequent treatment or to recommend the services of a particular PT or clinic to others seeking care (Goldstein, Elliott, & Guccione, 2000).

Strengths and Weaknesses of the Study

Various aspects of the study design bolstered the trustworthiness of our findings. First, data sources were triangulated (PT and patient interview data), which was important given the limited contribution from patients in the TR literature. It also enabled more nuanced analysis. Second, the quality of the data was excellent in terms of a high degree of description and insight from participants, which enhanced credibility of the findings. We anticipate this was due to: (a) the PT's extensive clinical experience (all had over 10 years of clinical experience) and (b) the majority of patients having more than one experience with PT, which contributed to their ability to describe their experiences and provide negative cases. Third, the sample had good variation in terms of male and female participants, age range of patient participants, and various PT treatment

specializations. Finally, the generalizability of the findings to other health care providers (e.g., physicians, nurses, occupational therapists) who need to develop a TR for improved health outcomes is improved due to their conceptual quality.

Despite these strengths, there were some shortcomings. Much of the interview discussions centered on the PT, which is not surprising given the therapist's role in the clinical interaction. Nonetheless a second interview might have provided opportunity to probe patients more deeply into their role in the TR. In addition, exclusion of patients who were receiving wage replacement benefits or were involved in litigation for their injuries limited the nature of the data that was generated and hence the possible breadth of the findings. Nevertheless, this would have required a significantly larger sample in order to saturate the data, which was outside of the time frames and resources of this study.

Future Research

Our findings indicate that future research needs to focus on refining a conceptual understanding of the bond given that is it a key component of evaluation in physiotherapy research on the TR. Although our findings appear congruent with theory generated in the context of psychotherapy, greater understanding of the relative importance of both personal and professional bonds in establishing strong affective attachments between PT and patient is needed. This is especially true as it pertains to the development of a measurement tool that can be useful to clinicians, program evaluators, and third party payers. This assertion is in agreement with other research in the field (Besley et al., 2011a, 2011b; Hall et al., 2010; Kayes & McPherson, 2012). Although we believe our findings provide a comprehensive conceptual representation of the bond, research in other settings (e.g., workers' compensation, hospital) and populations (e.g., neurological, older adult) is necessary to refine a complete conceptual framework. These

findings, in conjunction the other two components (conditions of engagement and ways of establishing connections), also provide the foundation to develop a self-report measure of the TR in PT. For this to happen, a concept analysis that includes review of literature specific to the TR in PT, but also other concepts that reference the TR in PT (e.g., shared decision making, patient satisfaction, patient engagement) should be completed in order to identify potential gaps with the three components. In addition, more clarity pertaining to the personal dimension of the TR is needed. This could be accomplished using a Delphi design or another qualitative exploration using focus groups.

Conclusion

Our findings indicate that bonds formed in PT interactions have professional and personal qualities. Although our elements of rapport, trust, respect, and caring would appear to be characteristic of bonds in general, we identified underlying aspects of each. This enhanced description clarifies a picture of the bond specific to PT, which provides a firm step toward developing a measurement tool to evaluate bonds in PT contexts.

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CHAPTER 7 – GENERAL DISCUSSION AND CONCLUSIONS

The purpose of this dissertation was to identify and describe the key components of the therapeutic relationship (TR) in physiotherapy (PT), especially as they concern the private practice therapist-patient interaction. Three components were identified: (a) the necessary conditions of engagement, (b) ways of establishing connections, and (c) the defining elements of the bond. Each of these components was described in a separate paper, but key findings will be summarized in this chapter.

The first paper, "The Necessary Conditions of Engagement for the Therapeutic Relationship in Physiotherapy" gave an account of the circumstances that foster the TR in PT. Four conditions – *present*, *receptive*, *genuine*, and *committed* – create a safe space for therapist and patient to come together professionally and personally. While present and receptive were more rudimentary in terms of providing the supporting structure (Chapter 4, Figure 4.2), genuine and committed were more flexible in terms of adjusting to PT and patient factors (e.g., personality) as well as situational factors (e.g., perceived lack of transparency). These conditions involved a complex interplay between states of being (i.e., quality of consciousness) of the therapist and patient and the intersubjective mood or sentiment between PT and patient.

The second paper, "A Framework for Establishing Connections in Physiotherapy Practice", reviewed the various ways that PTs and patients could take action to form meaningful attachments. Three main categories of establishing connections were identified: *acknowledging the individual*, *giving-of-self*, and *using the body as a pivot point*. In addition to covering various different ways of connecting, the categories also support the notion that a collaborative approach

can contribute to the development of the TR. Moreover, the findings also highlight that connections can be established by PTs and patients through the addressing the patient's body.

The third paper, "The Defining Elements of the Bond in Physiotherapy", characterized the enduring positive attachment between the PT and patient. The elements identified – *nature of the rapport*, *respect, trust*, and *caring* – were experienced between PT and patient. Although these elements might be considered characteristic of bonds in provider-patient relationships across healthcare professions, these findings offered insight into the professional and personal dimensions that could be specific to the PT interaction.

In addition to providing a clearer conceptual picture of the TR, there are three themes that run through all of the components: (a) the TR is a mutual endeavor, (b) the TR is professional and personal, and (c) the body is central to the TR. These themes provide an over-arching understanding of the characteristics of the TR and how it is enacted in PT practice. Furthermore, the conceptual descriptions and themes have enabled the development of a definition of the TR in PT practice. In addition to reviewing and synthesizing these themes, the remainder of this chapter will include a proposed definition of TR, a review of each study's strengths and limitations, and an overview of future directions for research.

Common Themes

The Therapeutic Relationship is a Mutual Endeavour

The mutual nature of the TR is a key theme in all three papers. The TR is a two-way endeavor that requires both PTs and patients to be open to giving and receiving in order to share an affective attachment. Even though therapists are responsible for taking the lead in creating a safe environment and nurturing the TR (Physiotheray Alberta - College + Association, 2012), patients were expected to be active participants by both PTs and patients themselves.

The mutual nature of the TR is especially prominent in Paper 1, where the conditions of engagement are described as being mutually generated by therapist and patient. This perspective challenges Rogers' (1957) contention that it is sufficient for therapists to provide the necessary conditions (genuineness, empathic understanding, and unconditional positive regard) that bring about therapeutic change. In Rogers' theory, the patient is described as distressed and in need of the psychotherapist to create a therapeutic space that activates the patient's innate healing capacity (Truscott, 2010). The patient's involvement is described in terms of being reflective in order to identify personal resources. Although the interaction is centred on patients and their capacity to be the masters of their own personal growth, Rogers does not describe patients as active contributors to the conditions that foster the TR.

Although Rogers might not clearly define the patient's contributions to the TR, Bordin's (1979) theory of the working alliance is more explicit about the importance of mutual contribution. All of Bordin's (1979) components of the working alliance – agreement on goals, agreement on tasks, and the bond – express the patient's active involvement, to some degree. By definition, an alliance implies a partnership that is formed to address some issue that both therapist and patient agree needs to be addressed; both then agree on (implicitly or explicitly) and carry out the necessary tasks to achieve the shared goals. In this dissertation, Paper 2 clearly addresses the importance of a collaborative partnership by "meeting the patient as an equal", or as Crepeau and Garren (2011) describe the TR in occupational therapy (within the context of hand therapy) as a ". . . mutual exchange between equals" (p. 879). Connections can be established between PT and patient by addressing perceived or actual power imbalances, which can create a level playing field for the patient to contribute to setting treatment goals, managing expectations and problem-solving. Even though the PT might at times need to facilitate the

contribution, "working together" and "shared responsibility" were common sentiments of both PTs and patients in this study. Mutual involvement in the TR also aligns with a recent review on patient engagement in rehabilitation. Bright et al. (2015) suggested that patient engagement is not solely contingent upon patient behaviours, but rather was impacted by a relational process between patient and practitioner. This view positions engagement, and the TR, as requiring mutual involvement by both practitioner and patient.

The findings from Paper 2 are also consistent with the literature that describes patient empowerment and decision-making as being key elements of patient-centred care in rehabilitation settings (Leplege et al., 2007) and shared decision-making in medical encounters (Charles, Gafni, & Whelan, 1997, 1999; Hoffmann, Montori, & Del Mar, 2014; Hofstede et al., 2013; Hofstede et al., 2014). Despite the apparent importance of patient involvement in decision-making, some research suggests that patients are positioned as recipients of care with limited decision-making capacity (Bendz, 2000; Payton, Nelson, & Hobbs, 1998) or do not contribute as much as they would like in regards to goal-setting and treatment decisions (Payton et al., 1998). However, Pinto et al. (2012) concluded that communication promoting patient involvement in medical consultations was positively associated with a higher quality therapeutic alliance. In this dissertation, fostering patient involvement was viewed as a prime way of establishing connections between PTs and patients.

Mutuality is also expressed through the bond between therapist and patient. A bond implies that two people have an enduring affective resonance between them. However, describing the bond as mutual endeavor adds a different dimension. It implies autonomy on behalf of both PTs and patients. In this respect, all elements of the bond presented in Paper 2 were mutual expressions. Although it is expected that some elements of the bond, such as rapport

and respect, need to be mutual, trust and caring could appear to be limited to the therapist or patient's individual experiences of the bond. However, this was not what participants in this study expressed. While it might be assumed that trust is more of a unilateral expression, with the patient needing to trust the therapist (e.g., trust in the therapist's intention, skills and knowledge), participants in this study were clear that therapists must trust their patients in terms of the patient's intention for coming to therapy and transparency regarding information pertinent to rehabilitation. On the other hand, caring may be viewed through the lens of the therapist's duty of care, which overlooks the potential for patients to care about their therapists. Even though there could be limitations due to role expectations, participants spoke about patients caring about their therapists. MacLeod and MacPherson's (2007) discussion of the nature of caring in person-centred interactions also speaks to mutuality. The authors described caring in rehabilitation as partnership between practitioners and patients and their families. Although practitioners might have the role of fostering a sense of security for patients and their families, caring becomes two-way by virtue of the practitioner and the patient forming a partnership to address the impairment and the rehabilitation plan.

Therapeutic Relationship is Professional and Personal

All three components of the TR identified in this study contained professional and personal dimensions. Although it was apparent throughout the three papers that the "professional" was a foundational aspect of the TR, PTs and patients commented that personal influences could also impact the nature of the TR. However, while the professional aspect of the TR is congruent with current literature, the personal aspect of the TR is less defined.

PTs and patients in this study were clear that the professional dimension of the TR was essential. The professional dimension relates to the profession's mandate, which is to ". . .

restore, maximize, and maintain movement . . ." (Physiotherapy Alberta - College +Association, n.d.c) and function after physical injury or dysfunction. PTs have a moral responsibility to care for and about their patients (Greenfield, 2006; Jensen, Gwyer, Shepard, & Hack, 2000) and to engage in collaboration (Bellner, 1999). Paper 1 addressed the duty of care as an expression of the PT's professional commitment to understand and act to help the patient in addition to establishing a safe space for the patient by being present and receptive. In Paper 2, PTs established meaningful connections with patients by fulfilling their professional responsibility to attend to patient's physical goals and establish connections to patients' bodies. In Paper 3, the professional was a dimension of all elements of the bond, such as with the duty of care as a pillar of the PT's caring in addition to the patient's trust in the PT's professional intentions, skills and knowledge.

Being professional could also extend to recognizing the "personal". Approaching the patient as a whole person can be considered a professional obligation given that patient-centred care is woven into PT practice (Physiotheray Alberta College + Association, 2012). The need to approach the patient as a whole person or to acknowledge and actively address the psychological and social as integrated aspects of the patient's experience (i.e., not as distinct from the patient's physical experience) is well established in the literature (Besley, Kayes, & McPherson, 2011b; Engel, 1977; Fadyl, McPherson, & Kayes, 2011; Macleod & Mcpherson, 2007; Pinto et al., 2012; Stewart, 2001). Jensen et al. (2000), in their multiple case study (combining within and cross-case analysis) of expert PTs, established that approaching patients as people by, for example, listening to their stories and identifying social resources and barriers, was fundamental to PT practice. Findings in Paper 1 outlined the importance that PTs and patients placed on an attitude of acceptance as well as a commitment both to understand the patient's story and to act

to honour the patient's experience of injury and illness. There were various ways that participants acknowledged that patients are unique and integrated individuals (e.g., validating the patient's experiences of injury and rehabilitation, individualizing the treatment plan), which were reviewed in Paper 2. These attitudes and connections inevitably were representative of bonds that were respectful of patients' unique experiences (Paper 3).

PTs in this study often took their patients' care very personally. Approaching the patient as a whole person was an aspect of the professional dimension of the TR. However, there were also times when an emotional investment on the part of the PT appeared to deepen the personal aspect of being professional. This emotional investment was exemplified in Paper 2 by PTs giving-of-self. Giving-of-self requires an attitude that extends beyond a duty of care and moves into an existential desire of PTs to go out of their way to help others. This deep caring about and for the human condition was described by Greenfield (2006) in his qualitative study on the meaning of caring in PT. In Greenfield's study, expert PTs described caring as a moral imperative. Furthermore, connecting to people, developed via fulfilling their professional obligations, was what made being a PT meaningful. MacLeod and McPherson (2007) have critiqued caring in patient-centred practice. The authors questioned whether caring, as an emotionally invested component of patient-centred care, was lost; they reinforced that clinicians need to be emotionally invested in order to truly engage in patient-centred care.

Although the professional dimension of the TR contained aspects of personal involvement, participants in this study revealed a distinct dimension of the personal. PTs and patients having an interest in, or caring about, one another in non-rehabilitation ways characterized this dimension. In Paper 1, the condition of being genuine was identified as providing an opportunity for therapists and patients to express themselves, and Paper 2 outlined

various ways that these connections are established, such as talking about common interests or acknowledging a patient's challenging life circumstances. Many PTs and patients agreed that this type of personal investment was important to the TR. Despite the obvious dividends that connecting with aspects of patients' personal lives could have in developing the TR, many PTs commented that they had a genuine interest in people and their lives, which transcended a therapeutic agenda. This is consistent with Crepeau and Garren's (2011) finding that "ordinary conversation" (p. 877) built personal rapport that could help a patient open up about their physical issues in addition to allowing for the occupational therapist's genuine sense of caring to be expressed. Many patients also spoke about the importance of knowing about their PTs as people even though they also respected the need for professional boundaries. Crepeau and Garren (2011) also highlight the ". . . importance of the reciprocity . . ." (p. 878) in ordinary conversation, while their participants commented on the maintenance of professionalism. It is important to note that the participants in our study expressed and experienced this dimension of the personal in varying ways and degrees depending on factors such as an individual's own boundaries, interpretations of what was personal, and the dynamics of each unique therapist-patient relationship.

Even though PTs and patients identified this dimension of the personal as an important aspect of the TR, it has rarely been discussed in detail in the literature. This aspect of the relationship may be "underground" due to the influence of regulatory bodies in structuring relational boundaries, or it could be that this is such an implicit dimension of human interaction that it has not been considered as contributing to the TR. The latter view has been challenged by recent literature that suggests that having conversations about more than rehabilitation can add a dimension to the TR (Smith, Hale, Mulligan, & Treharne, 2013). However, there is still

confusion about the personal aspect of the TR in PT. Besley et al. (2011a) found that PTs and patients did not resonate or were unsure of what "liking" one another meant in terms of the TR and the rehabilitation process. In fact, PT-E in this study commented that she was unsure of what it meant for a patient to like her while PT-J commented that having a patient like the therapist could sometimes be more important than technical skill.

This perspective on the personal might also challenge current views on the ethics of personal disclosure in PT. In a resource document on the TR and maintaining professional boundaries, Physiotherapy Alberta - College + Association (2007) states that personal disclosures should typically be avoided unless the PT believes that the disclosure is for a therapeutic purpose. For instance, a PT might disclose an injury or a condition in order to help the patient. This perspective is in line with Opel (2012), who challenges the notion that physicians should not discuss their own physical conditions with patients. In his essay, he addresses the blurring of professional and personal boundaries based on his life experiences and how they dovetail with patient experiences. He notes that physicians must be aware of their intentions for disclosing their health experiences (e.g., therapeutic for the patient versus therapeutic for the physician), but claims that physicians can tailor their ". . . personal medical experiences to match those of our patients, extracting the tidbits likely to be the most applicable and supportive. I think positive and transformative outcomes await us and our patients if we do" (Opel, 2012, p. 17).

Even though the Physiotherapy Alberta - College + Association (2007) resource document speaks about the therapeutic use of disclosures, they do not go into depth in addressing the spectrum of possible personal disclosures. What is clear in the document is that boundaries are crossed when the disclosure meets the personal needs of the PT in lieu of the patient's needs.

However, participants in this study voiced a wide range of perspectives on what is considered a personal disclosure. In addition, as described in Paper 2, some patients commented that knowing their PTs on a more personal level could help to develop the TR. Nevertheless, both Physiotherapy Alberta - College + Association (2007) and the participants in this study are clear that personal aspects of the relationship cannot infringe upon the professional purpose of interaction. PTs and patients in this study also commented that the foundational nature of the TR must be professional, regardless of the personal connections formed. Patients in Paper 3 also commented that the nature of the rapport could not be such that being personable took precedence over treatment in the interaction.

Body is Central to the Therapeutic Relationship

The body was a common theme throughout the three components of the TR. Although the body might be considered a focal point of the PT interaction because of the profession's focus on movement and function (Physiotherapy Alberta - College +Association, n.d.c; Jensen et al., 2000), its relevance pertaining to the TR introduces a new way of thinking about the body. Within the TR, the body becomes a common ground between PT and patient in therapeutic and non-therapeutic ways.

Therapeutically, the body is the focal point of in-person active treatment between PT and patient. PTs consistently address patients' bodies through therapeutic routines such as history taking, assessment, and exercise prescription. This was exemplified in Paper 2 by the category using the body as a pivot point. This category directly positions the body as central to PTs establishing connections with patients. For instance, PTs and patients both spoke of the importance of having plausible explanations for patients' physical issues; PTs spoke about their role in facilitating patients' body awareness. These findings dovetail with Gyllensten et al.'s

(2010) qualitative study that aimed to clarify the meaning of body awareness as communicated by professionals and patients in psychiatric rehabilitation. The authors noted that sharing knowledge and enhancing the patients' understanding and awareness of the body are key factors of the therapeutic process in PT. The authors proposed that the process of facilitating patients' knowledge and awareness not only aids in developing the relationships patients have with their own bodies, but also in nurturing the relationships they have with others (Gyllensten, Skär, Miller, & Gard, 2010). In terms of patients' relationships with their care providers, Hofstede et al. (2014) noted that provision of information (e.g., diagnosis, care trajectory) was important in facilitating patients' participation in shared decision making. This supports the notion that enhancing patients' knowledge of their bodies could influence the TR.

Active treatment of the body can also impact the element of the bond (Paper 3) between PT and patient. For example, in Paper 3, the PT's professional credibility was identified as an aspect of the patient's trust in the PT. The PT's competent technical skills and knowledge pertaining to the way the body works contributes to the PT's credibility. This is consistent with literature identifying clinician competence as an aspect of the TR (Besley et al., 2011b) in PT and occupational therapy (Crepeau & Garren, 2011), in addition to other areas of research including quality of care in healthcare, rehabilitation, and disability services (Fadyl et al., 2011) as well as patient satisfaction with services (Hush, Cameron, & Mackey, 2011). Other examples of the body's influence on the bond included PTs trusting that patients' were giving honest accounts of their physical issues as well as PTs respecting boundaries regarding the patient's body (e.g., disrobing).

The body is also a focal point of collaboration between PTs and patients. PTs and patients establish a working relationship based on rehabilitating limitations that stem from the body.

Papers 1 and 3 address the need for PT and patient to collaborate on identifying goals and tasks of therapy, while in Paper 2, PTs and patients described being involved in giving and receiving of feedback and instruction. These ideas correspond to patient-centred practice (Leplege et al., 2007; Stewart, 2001) and shared decision-making models (Charles, Gafni, & Whelan, 1997, 1999; Dierckx, Deveugele, Roosen, & Devisch, 2013; Hoffmann, Montori, & Del Mar, 2014; S. N. Hofstede et al., 2013; Stefanie N. Hofstede et al., 2014) in healthcare settings. However, successful collaboration in practice can be challenging (Dierckx et al., 2013; Slade, Molloy, & Keating, 2009). For instance, patients with chronic low back pain in Slade et al.'s (2009) qualitative study reported that although they desired a partnership where their care providers asked for their opinions and treatment goals, patients sometimes felt unheard. These patients indeed wanted to be acknowledged for their own expertise.

In addition to the potential role the body plays in facilitating the TR through the therapeutic tasks of the PT interaction, the body can also be important to the TR in non-therapeutic ways. This came through in Paper 1 in the condition of being present. PTs and patients spoke of non-verbal communication that created focus for both PTs and patients, such as eye contact, postures, and proximity (Hargreaves, 1982). The literature provides mixed support for these findings. Research in PT practice has indicated that touch was the most prevalent (54%) non-verbal behaviour exhibited by PTs, while eye gaze (84%) was the most prevalent non-verbal behaviour by patients. Ambady et al. (2002) completed a two-part study on the impact of non-verbal communication on older patients' cognitive (e.g., confusion), psychological (e.g., depression) and physical function (e.g., activities of daily living) outcomes. In the first study, they found that "distancing behaviours" (e.g., not smiling, looking away from the patient) were correlated with short-term (admission to discharge) reductions in cognitive and physical

outcomes and long term (3-months post-discharge) reductions in physical outcomes. In addition, behaviours of "facial expressiveness" (e.g., smiling, concerned frowning, nodding) were correlated with better short and long-term physical and cognitive outcomes. The authors hypothesized that the more facially expressive behaviours conveyed engagement and concern; this was confirmed in a second study where the authors found that older patients perceived PTs who were facially expressive as warmer, caring, and empathic. However, when specifically looking at the impact of non-verbal behaviour on the therapeutic alliance, Pinto et al. (2012) were unable to make any definitive conclusions in their systematic review about the association between non-verbal behavior and a positive therapeutic alliance.

Deliberately framing the link between the body and the TR is important because it suggests that what PTs already might do in their practice relating directly to the patient's body can help to develop the TR. Even though a well-rounded approach that might involve using communication strategies (e.g., active listening) and addressing psychological and social concerns would likely be helpful in establishing the TR, PTs can take solace in the suggestion that going about their routine work with patients and their bodies can also facilitate a TR. One study that broaches this perspective is Gyllensten et al.'s (2003) study of patients' experience with body awareness training and their experience of the TR in PT. This qualitative study (case study with cross-case analysis), which took place in Sweden, used video and interview data from 11 participants (six inpatient, five outpatient) with psychiatric diagnoses (e.g., anxiety, schizophrenia). Although the study appeared to look at body awareness and the TR separately, the researchers noted an interesting pattern: patients who reported doing their exercises on a daily basis also reported good TRs. The authors noted that PT ". . . treatment involves working with body-related skills, as well as touch and not only verbal interventions . . ." (p. 181) and that

this was an aspect of the working alliance in PT. This could imply that addressing the body is central to establishing a TR.

Proposed Definition of the Therapeutic Relationship in Physiotherapy

The conceptual nature of the TR components enables a definition to be developed. A definition of the TR, systematically developed from research, has been lacking in the PT literature. This could be due to the limited scope and amount of TR research in PT, especially regarding conceptual development (Besley et al., 2011b). Various terminology (e.g., working alliance, therapeutic alliance, helping alliance, therapist-patient interaction) and definitions have been borrowed from disciplines such as psychotherapy and occupational therapy (Besley et al., 2011b; Kayes & McPherson, 2012). This dissertation has aimed to clarify the components of the TR in order to provide a conceptual structure that would help PTs manage the complexity of the TR in clinical practice. Identifying the three components of the TR – conditions, connections, and bonds – has thus enabled the construction of a working definition of the TR in PT:

> The TR is the coming together of PT and patient through intentions and attitudes that foster mutual engagement in the patient's rehabilitation. This enables professional and personal connections to be established, forming an affective bond based on rapport, respect, trust, and caring that is experienced by and for PT and patient.

This definition is comparable to Cole and MacLean's (2003) definition, which was developed in occupational therapy and has been referred to in the occupational therapy and rehabilitation literature. Cole and Maclean (2003) completed a literature review and subsequent survey of American occupational therapists and defined TR in occupational therapy as ". . . a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect" (p. 44). When

compared to our proposed PT definition, both speak of connections, rapport, respect and trust. Both also speak of a mutual process between therapist and patient.

Despite the similarities, there are important differences. First, our PT definition clearly acknowledges intentions and attitudes whereas the Cole and MacLean's (2003) definition likely implies them, but is not specific. Our PT definition also specifically clarifies the bond as a distinct component of the TR; however, Cole and MacLean imply the bond is a ". . . trusting connection and rapport . . ." (p. 44), yet later comment on mutual understanding and respect as aspects of the process of developing trust and rapport. In addition, it is not clear to what degree the mutual nature of the TR is reflected in Cole and MacLean's definition; for example, is the trust mutual or is the trusting connection based on the patient's trust of the therapist? Finally, Cole and MacLean do not distinguish between professional and personal aspects of the TR.

PT researchers have often relied on terminology and definitions developed within the context of psychotherapy. Although the concept of the working alliance (Bordin, 1979) has often informed PT research (Cheing, Lai, Vong, & Chan, 2010; Ferreira et al., 2013; Fuentes et al., 2014; Hall, Ferreira, Maher, Latimer, & Ferreira, 2010), it is important to note that it does not necessarily encompass the full experience of the TR. It addresses the working relationship between therapist and patient, which focuses on the goals and tasks of therapy and the affective bond that is necessary in such a partnership. The bond, seen from this perspective, can be interpreted as more of a function of the professional partnership between therapist and patient; the personal aspect is more difficult to delineate, although is likely asymmetrical with the patient being more expressive in the personal dimension. However, this is not the only psychotherapeutic definition that has been used in PT. Szybek et al. (2000) applied Gelso and Carter's (1985) definition in their theoretical paper that explored the application of

psychotherapeutic theory to the PT-patient relationship. Gelso and Carter (1985) define the TR in in the psychotherapy context as, "the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed" (p. 159). Even though the definition is general (Gelso, 2013), it has been a reputable working definition within psychotherapy research (Norcross & Lambert, 2011). It incorporates attitudes, aligning with the findings of our study in terms of (conditions of) engagement; both definitions also speak to the mutuality of the TR. Moreover, the general nature of Gelso and Carter's definition allows for the inclusion of both personal and professional intentions; these intentions inform actions, which can result in connections that have more personal or professional qualities.

The biggest difference between the two definitions is the degree of specificity. The definition composed from the components of the TR identified in our study attempts to make it clear that there are professional and personal connections. Gelso and Carter (1985) questioned whether the personal aspect of the TR was so entwined within the overall social experience of the therapeutic endeavour that it was not readily discernable from other components of the TR. Nonetheless, Gelso (2013) describes the "person-to-person" (p. 125) nature of the *real relationship* that happens whenever two people get together. Including the personal aspect of the TR in the definition could be relevant for understanding the impact that it has on the quality of the TR and on clinical outcomes.

Conceptual Framework of the Therapeutic Relationship

The TR in PT is composed of distinct components: (a) conditions of engagement, (b) ways of establishing connections, and (c) elements of the bond. These components and their sub-components form a conceptual framework of the TR. This framework is illustrated in Figure 7.1. The figure implies relationships between the three key components. These relationships are

tentative, given that theory-generating inductive methods (e.g., grounded theory method) were not used to generate findings, nor have the relationships they been statistically validated.

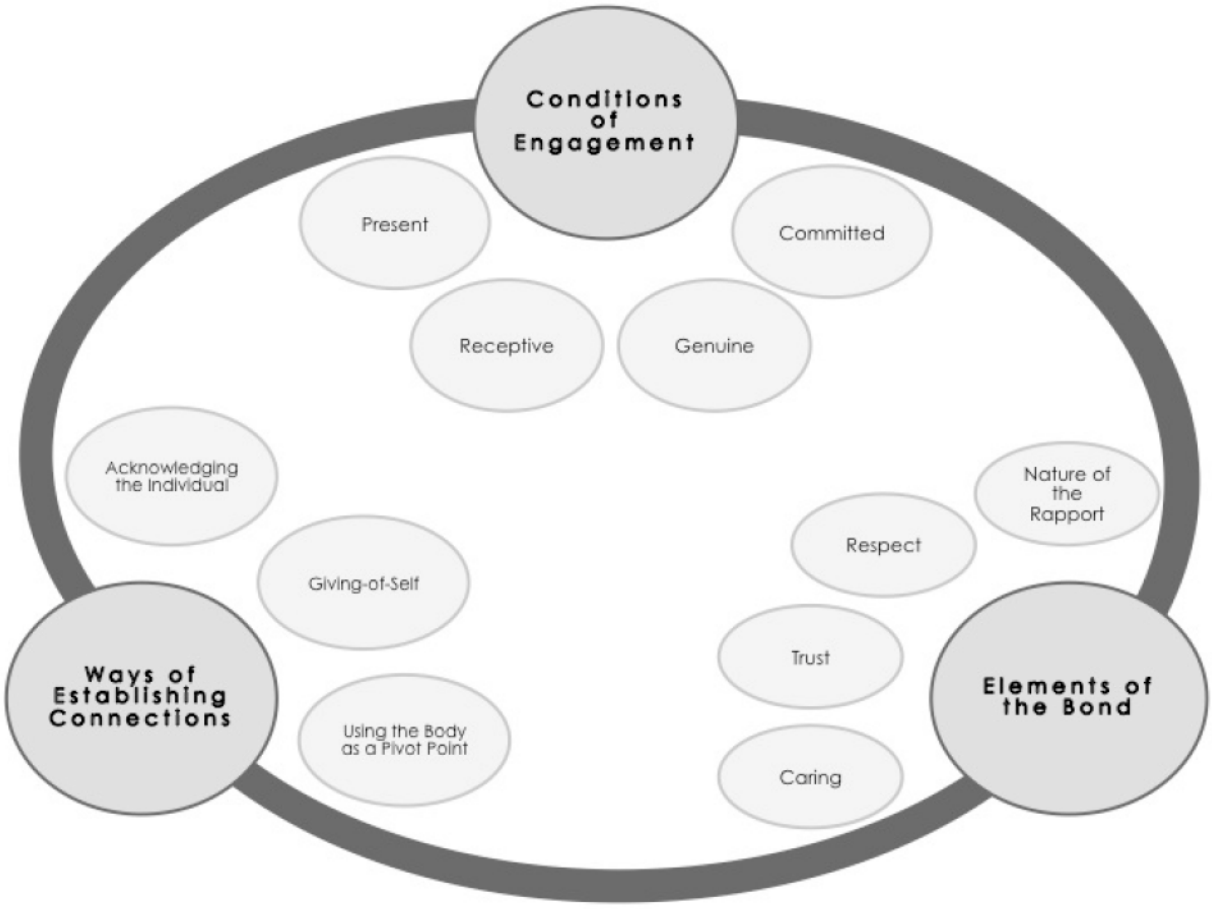

Figure 7.1. The conceptual framework of the TR in PT is comprised of three main components. The sub-components of each component are also illustrated. The figure depicts the TR as a contained space held together by the implied relationships between the components. The sub-components surround their respective components.

However, the quality of the findings (e.g., degree of abstraction, detail provided within each component) provides a credible starting point to begin theorizing the relationships. These relationships cannot be specifically defined in terms of direction or strength. Nevertheless, I hypothesize that the relationships are bidirectional to some degree. For example, the conditions of engagement have been deemed necessary for the TR to flourish. The ways of establishing

connections are action-oriented and could be the products of the conditions (see Appendix N, Figure N3). However, conditions can be deepened as PTs and patients act in ways that are consistent with the conditions. For instance, *using the body as a pivot point* (way of establishing connections) can be a product of *being committed* (condition of engagement) and could also reciprocally deepen PTs' and patients' ability to *be present* (condition of engagement). Viewed in this way, the relationship between the conditions of engagement and the ways of establishing connections becomes more generative versus linear. Another example is found between elements of the bond and conditions of engagement. In this scenario, *trust* (an element of the bond) could conceivably exist before the therapeutic encounter, such as when a PT has "guru status", when a patient returns to a PT because of previous success, or when a patient is referred to a PT by a friend or family member. From this perspective, trust in the PT's credibility could influence the patient's ability to be present or committed.

It should also be noted that the sub-components are "floating" next to, not directly attached to, their parent components. I felt that visually representing the sub-components as attached to the parent component might be pre-mature. There could be relationships between the sub-components of a particular component or between components, and illustrating a direct attachment may not best represent these relationships. Leaving the sub-components floating allows for greater flexibility in visually representing these relationships as they become clearer. Moreover, given the potential for reciprocal or generative relationships between the sub-components, representing these relationships in a linear fashion (i.e., straight lines representing a direct attachment) may not be imagery that best communicates the nature of the relationships.

Strengths and Limitations

Strengths

Our study had various strengths, which enhanced the trustworthiness of our findings. This included triangulation of data sources with the inclusion of both PT and patient participants. Much of the research specific to conceptual development of the TR in PT has only included PTs' contributions. Including both participant groups allowed for the categories and sub-categories to be thoroughly explored. Moreover, PT and patient accounts tended to support one another, with each group providing its own valuable insight to the findings. For example, regarding the necessary conditions of engagement, PTs provided important insights into how they created an environment that facilitated their own and their patients' ability to be present; patients contributed a unique dimension to being present via their comments about the importance of consistently seeing one PT.

A second strength was the demographic diversity of the PT and patient samples. Both samples had adequate male/female distribution and the age range (18-62 years of age) of the patient sample was wide. The age range of the PT sample (36-60 years of age) was also adequate, especially considering that all PTs had over 10 years of clinical experience. The PT sample demonstrated diversity in terms of treatment preferences and areas of advanced training and clinical interests. This was important for various reasons. For instance, adherence to a particular treatment modality (e.g., spinal manipulation, intramuscular stimulation) might be indicative of a more general philosophy of practice, which could conceivably influence the PT's approach to the TR.

A third strength was the exceptional quality of the data, with PTs and patients providing rich accounts of their experiences. One factor that might have contributed to PTs' abilities to

provide thorough descriptions was their level of experience; all PTs had more than 10 years of clinical experience. In addition, 8 of the 11 PTs were also clinic owners and another had previously been involved in clinic management. Some of these PTs commented that developing TRs with patients was part of their clinic's philosophy. However, it was more difficult to develop possible explanations for patients' thorough accounts. Because patients self-selected to be a part of the study, it could be assumed that they had a relatively impactful TRs. Some patients also reported that they had long-term relationships with their PTs, either for the same physical problem or for various issues, which could have provided the duration and depth of experiences that contributed to their ability to speak about the TR. In addition, many patients were able to compare the experiences they had between different PTs as well as between different healthcare providers (e.g., doctors, chiropractors, pharmacists), which enhanced the quality of the data.

Finally, the conceptual nature of the findings potentially makes them useful in practice, education, and research. As described in Chapter 3, the findings are conceptual descriptions. This makes them broad enough to aid in interpretation of clinical activities and experiences while also being descriptive enough to be recognizable within a specific context (e.g., private practice). Because of the conceptual nature of the findings, they may also be useful to clinicians in both private practice and to PTs practicing in other settings (e.g., hospital) as well as with different populations (e.g., neurological patients). The findings, in whole or part, might also qualitatively generalize to other professions such as occupational therapy, medicine, and nursing. These propositions are supported by the external auditor's comment that "although you have focused on private practice, where I think this is most relevant, I definitely see generalizability to other settings and other disciplines" (Appendix L).

These findings could be used in clinical education. Specifically, they could be used to streamline how students are taught about the TR, both theoretically and practically. Because the findings dovetail with other models (e.g., patient-centred care and shared decision making) and communication strategies and interventions (e.g., active listening, motivational interviewing, cognitive behavioural principles), they could provide an overarching theoretical perspective.

Theories and frameworks are also needed to advance research pertaining to the TR. They add the structure that can aid researchers in being systematic and thorough when studying complex phenomena (Miciak, Gross, & Joyce, 2012). These findings could also answer the calls for better conceptual understanding of the TR in order to develop rigourous PT-specific measurement scales (Besley et al., 2011a, 2011b).

Limitations

In addition to its strengths, the study also had its limitations. For instance, a large portion of PTs' and patients' accounts of the TR centred on the PT's role. While most would agree that the PT is responsible for attending to the TR and providing an environment for it to flourish, the findings make it clear that patients also have a role to play in the TR. Although data saturation was technically achieved in terms of being able to make a meaningful statement about clinical reality, the patient's role could have been explored further with a second interview. Unfortunately, data generation and analysis unfolded in a way that did not allow a second interview with patients to be completed within the designated timeframe (i.e., inclusion criterion) of 12 weeks from the last treatment session.

Another potential limitation was the exclusion of patients who were receiving wage replacement or pain and suffering compensation through a third party (e.g., lawyer, insurance claim, workers' compensation claim). These patients' perspectives would have likely added

depth to the understanding of the TR. Unfortunately, the relationships between multiple stakeholders (e.g., patients, case managers, other health care providers, lawyers) adds a layer of complexity that would require a larger projected sample size in order to reach saturation. Therefore, due to the resources and timeframes of this study, this population was excluded from this study.

Future Directions

The findings from this study provide a foundation to move forward with TR research. There are two main areas of TR research that should be pursued: (a) continued conceptual development and (b) development of a PT-specific measurement scale. These areas will be addressed below.

Continued Conceptual Development

Although the findings from this study provide good breadth and depth of conceptual development, they are not complete. A concept analysis of the TR within PT and across various models (e.g., shared decision making) and concepts (e.g., empathy, patient engagement) that include the TR in their descriptions and discourse would help to pull together existing knowledge. Further study needs to take place with different populations (e.g., patients receiving wage replacement or pain and suffering compensation) and settings (e.g., PTs working in institutions such as hospitals or on interdisciplinary rehabilitation programs). In addition, different qualitative (e.g., grounded theory, focused ethnography) and quantitative (e.g., descriptive, exploratory) designs will be necessary in order to provide answers to the questions that address gaps in the existing components, as well as the relations among the components. In addition to designs, different data generation strategies (e.g., video observation, studying dyads, Delphi technique, survey) may also aid in this process by providing the data that will clarify

aspects of the components. For example, studying video recordings of PT sessions with dyads might better reveal the qualities of the personal dimension of the TR and how it unfolds.

While not addressed in the objectives of this study, social and material factors might also play a role in the conceptualization of the TR. For instance, PT and patient participants spoke about patients' social interactions with administrative staff and other patients and PTs in the clinic in addition to the impact of the material space (e.g., private rooms versus curtained cubicles versus communal treatment areas). The possibility that the TR might extend beyond the parameters of the one-on-one interaction between PT and patient is a compelling line of inquiry.

Development of a PT-Specific Measurement Scale

A trustworthy PT-specific measurement scale is necessary for rigourous prognostic and experimental research. Even though there have been recent prognostic (Cheing et al., 2010; Ferreira et al., 2013) and experimental (Fuentes et al., 2014) studies that have addressed the impact of the alliance on clinical outcomes, these studies used measurement scales that may not have been entirely representative of the TR in PT. Developing a measurement scale could occur in conjunction with research that develops further conceptual understanding. Moreover, it is conceivable that developing a measurement scale using a mixed methods approach could also help with conceptual development.

Conclusion

This dissertation identifies and describes three components of the TR in PT – conditions of engagement, ways of establishing connections, and elements of the bond. From these components, a definition of the TR is proposed:

> The TR is the coming together of PT and patient through intentions and attitudes that foster mutual engagement in the patient's rehabilitation. This enables professional and

personal connections to be established, forming an affective bond based on rapport, respect, trust, and caring that is experienced by and for PT and patient.

Furthermore, three themes – the TR is a mutual endeavor, the TR is professional and personal, and body is central to the TR – weave through all the components. These themes provide an overarching understanding of the TR in PT. Taken together, the components and themes illustrate the complex nature of the TR. Notably, they reinforce that the nature and development of the TR is variable. In other words, there is no single way to be in a TR and there are no prescriptions for how to develop a TR. Ultimately, this allows individuals to evaluate each relationship, as it is happening, and to respond in-the-moment based on personal (e.g., personality) and situational (e.g., duration of the treatment session) factors. In doing so, PTs and patients have the opportunity to fulfill professional (e.g., patient-centred care, shared decision-making) and personal expectations of the TR.

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APPENDIX A

Table A.1.

Contextual Theory Tenets

Tenet	Description
Tenet 1	An emotionally charged and confiding relationship between the client and helping individual (e.g. therapist).
Tenet 2	A healing setting where the client believes the therapist can help and the therapist is working on the client's behalf.
Tenet 3	A plausible rationale explaining the client's symptoms that is also associated with a particular procedure to address the symptoms.
Tenet 4	Active participation of both client and therapist in the procedure.

APPENDIX B

Table B.1.

Critical Realist Tenets

Critical Realist Tenet	Methodological Implication
Reconciling Subjective and Objective Realities	Perceptions and observed patterns contribute to knowledge or "truth".
	This truth is fallible and open to revision.
Mechanisms and Context Interact to Manifest Change	Causal mechanisms can be numerous and are often hidden.
	Mechanisms are activated by circumstances within contexts.
Stratified Nature of Reality	The *actual, real,* and *empirical* strata are the three stratifications of reality .
	Questions about "why" correlations exist are asked.
	Interactions between strata are potential points of inquiry.
Social World As An Open System	Contextual variables are understood, not controlled.
	Variables are in constant flux with the potential to interact with one another.
Methodological Eclecticism	Methodology and methods must match the question being asked.

APPENDIX C

Physiotherapist Information Sheet

Title: Bedside Matters: The Role of Therapeutic Relationship in Physical Therapy

Principal Investigator: Maxi A. Miciak, BScPT, Ph.D. Candidate
Faculty of Rehabilitation Medicine
Phone 780-492-1610
Email: maxi@ualberta.ca

Co-Investigators and Supervisors: Dr. Douglas P. Gross, Faculty of Rehabilitation Medicine
Dr. Maria J. Mayan, Faculty of Extension

Background: The *therapeutic relationship*, or the relationship between the patient and the health care provider is important for good treatment. Yet, we do not know a lot about this important topic in physical therapy. This study will look at the therapeutic relationship in physical therapy.

Purpose: You are being asked to participate in a research study to better understand relationships between physical therapists and their patients. The information you give will help us identify and describe the key components of the therapeutic relationship in physical therapy.

Procedures:
The study will involve a 60-minute interview with me (Maxi Miciak) about the relationships you have had with your patients. You will choose a public place where we do the interview. The interview will be audio-recorded so that I do not forget what we talked about. A typist will listen to the recording of the interview and make a typed copy.

The study *may* involve answering some questions about your answers so I am sure I understand what you have said. This will take about 15 minutes over the telephone or in person and will happen after I have read the typed copy of the initial interview. I may also ask you to participate in a follow-up interview.

Possible Benefits:
You may develop a better understanding of the therapeutic relationship, which you may choose to use in future relationships with your patients. You will also be contributing to the professional knowledge in this area. Otherwise, there are no direct benefits to you.

Possible Risks: There is minimal risk to you. Confidentiality cannot be guaranteed due to the nature of research involving interviews.

Confidentiality:
Your name will not be in the typed copy of the interview or in any articles or presentations about the study. A code (letter + number) will be used in place of your name. You do not have to tell your patients or anyone at your physical therapy clinic you are in the study. Only the researchers will see your personal information. The typist and I will listen to the audio recording of the interview. If you are involved in a follow-up interview, you may be asked to read parts of your transcript for clarification purposes. I may use some of your answers in articles and presentations about the study, although your name will not be used. All of the information will be stored on a password protected computer and a password protected storage device at the University of Alberta for 5 years then destroyed.

Your information will be kept confidential except:
- When the law or professional ethics requires that I tell someone.
- When the Health Research Ethics Board at the University of Alberta monitors the research.

Voluntary Participation: Taking part in this study is voluntary. You can withdraw at any time prior to the interview or before your interview is analyzed. You can choose not to answer questions. I may ask you to do another interview, which you may decline.

Reimbursement of Expenses: You will have to provide transportation to and from the interview. You will be given a small token of appreciation for your time during the first interview although not for any clarification questions I ask you after reading the interview transcript.

Contact Names and Telephone Numbers: If you have any questions about the study, you may call Maxi Miciak at 780-492-1610.

If you have questions or concerns about your rights as a project participant please contact the University of Alberta, Health Research Ethics Board at 780-492-0302.

APPENDIX D

Physiotherapist Consent Form

Part 1 (to be completed by the Principle Investigator)

Title of Project: Bedside Matters: The Role of Therapeutic Relationship in Physical Therapy

Principal Investigator(s): Maxi Miciak — Phone Number(s): 780-492-1610

Co-Investigator(s): Dr. Douglas Gross — Phone Number(s): 780-492-2690
Dr. Maria Mayan — 780-492-9209

Part 2 (to be completed by the research participant)

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in his research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your employment status?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to you records?	☐	☐

Who explained this study to you? _____

I agree to take part in this study: **YES** ☐ **NO** ☐

Signature of Research Participant _____

(Printed Name) _____

Date: _____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO RESEARCH PARTICIPANT

APPENDIX E

Patient Information Sheet

Title: Bedside Matters: The Role of Therapeutic Relationship in Physical Therapy

Principal Investigator: Maxi A. Miciak, BScPT, Ph.D. Candidate
Faculty of Rehabilitation Medicine
Phone 780-492-1610
Email: maxi@ualberta.ca

Co-Investigators and Supervisors: Dr. Douglas P. Gross, Faculty of Rehabilitation Medicine
Dr. Maria J. Mayan, Faculty of Extension

Background: The relationship between patient and health care provider is important for good treatment. This is called the therapeutic relationship. We do not know a lot about this important topic in physical therapy.

Purpose: You are being asked to participate in a research study to better understand relationships between physical therapists and their patients. The information you give will help us identify and describe the key components of the therapeutic relationship in physical therapy.

Procedures:
The study *will* involve a 60-minute interview with me (Maxi Miciak). You can choose the public place where you feel most comfortable to do the interview. You will be asked questions about the relationship you had with your physical therapist. The interview will be audio-recorded so that I do not forget what we talked about. A typist will listen to the recording of the interview and make a typed copy.

The study *may* involve answering some questions about your answers so I am sure I understand what you have said. This will take about 15 minutes over the telephone or in person and will happen after I have read the typed copy of the initial interview. I may also ask you to participate in a follow-up interview.

Possible Benefits:
You will be helping us understand an important part of physical therapy treatments, which may benefit you should you receive physical therapy treatment in the future. Otherwise there will be no direct benefits to you.

Possible Risks: There is a small chance other people may identify you in articles and presentations about the study. Although not likely, it is possible that you may talk about things that upset you. If you require help for this please contact me and I will provide you with information about counseling options.

Confidentiality:
Your name will not be in the typed copy of the interview or in any articles or presentations about the study. A code (letter + number) will be used in place of your name. You do not have to tell your physical therapist or anyone at the physical therapy clinic that you are a part of the study. The interview will occur after you are done all your physical therapy treatments.

Only the researchers will see your personal information. The transcriptionist will listen to the audio recordings of the interviews. All of the information will be stored on a password protected computer and password protected storage device at the University of Alberta for 5 years then destroyed.

Your information will be kept confidential except:

- When the law or professional ethics requires that I tell someone.
- When the Health Research Ethics Board at the University of Alberta monitors the research.

Voluntary Participation: You do not have to be in the study. You can withdraw at any time prior to the interview or before your interview is analyzed. You can choose not to answer questions. I may ask you to do more interviews, which you may decline.

Reimbursement of Expenses: You will have to provide transportation to and from the interview. You will be given a small token of appreciation for your time during the first interview although not for any clarification questions I ask you after reading the interview transcript.

Contact Names and Telephone Numbers: If you have any questions about the study, you may call Maxi Miciak at 780-492-1610.

If you have questions or concerns about your rights as a project participant please contact the University of Alberta, Health Research Ethics Board at 780-492-0302.

APPENDIX F

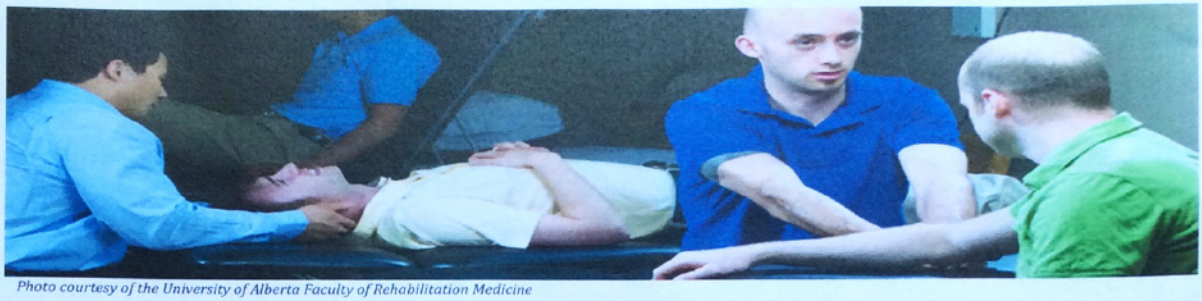

Photo courtesy of the University of Alberta Faculty of Rehabilitation Medicine

FINISHING YOUR PHYSICAL THERAPY TREATMENTS?

INTERESTED IN TALKING ABOUT YOUR EXPERIENCE?

I am Ph.D. student at the University of Alberta studying the treatment relationship between patients and physical therapists.

If you…

- Are between 18 and 64 years of age
- Do not have any difficulties communicating
- Are willing to do a 60 minute interview
- Do not have rheumatoid arthritis or a neurological condition
- Are not being paid wage benefits from WCB or an insurance company
- Your injury was not a result of a motor vehicle accident

Contact Maxi to learn more about the study. Your call will be kept confidential. If you are interested in participating, the study will start ***after*** you have completely finished your physical therapy treatments.

780 - 492-1610
maxi@ualberta.ca

780 - 492-1610
maxi@ualberta.ca

780 - 492-1610
maxi@ualberta.ca

780 - 492-1610
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Figure F.1. Recruitment poster.

APPENDIX G

Patient Consent Form

Part 1 (to be completed by the Principle Investigator)

Title of Project: Bedside Matters: The Role of Therapeutic Relationship in Physical Therapy

Principal Investigator(s): Maxi Miciak — Phone Number(s): 780-492-1610

Co-Investigator(s): Dr. Douglas Gross — Phone Number(s): 780-492-2690
Dr. Maria Mayan — 780-492-9209

Part 2 (to be completed by the research participant)

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in his research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your employment status?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to you records?	☐	☐

Who explained this study to you? _____

I agree to take part in this study: **YES** ☐ **NO** ☐

Signature of Research Participant _____

(Printed Name) _____

Date: _____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO RESEARCH PARTICIPANT

APPENDIX H

Initial Physiotherapist Interview Guide

I referred to individuals coming to physical therapy as 'patients' – what terminology do you use?
What is the difference between the terms patient and client?

What does the term 'therapeutic relationship' mean to you?

How do you think the therapeutic relationship develops in your interactions with clients?
Can you give an example of a time when this happened in one of your sessions?

Sometimes it can be difficult for patients/clients to talk about injuries and pain or how these things affect their lives. What do you do to help people talk about their experience?

What sorts of factors do you pay attention to when developing the therapeutic relationship?
Can you describe a time when you did consider _____ factor?
What was the result?
How did the (insert term therapist uses) respond?

How important is the therapeutic relationship to the treatment interaction (outcome)?
What do you think it adds?
What is its function?

NOTE: within each of these questions, I will be asking questions that guide the participant to provide more in-depth description.
E.g. Can you speak about that a bit more?

<u>Topics to Consider Expanding On During the Interview</u>:

- Collaboration, working together
- Agreement on diagnosis/treatment plan
- Ability to confide in the therapist
- Decision-making

Table H.1.

Therapist Interview Guide Rationale

Phase	Focus	Purpose	Possible Questions
Phase 1			
Broad questions	Non-specific to the therapeutic relationship.	Facilitate broader discussion regarding aspects of treatment that could have implications for what a therapist believes the therapeutic relationship is and what is done to develop the relationship.	I referred to individuals coming to physical therapy as 'patients' – do you use patient or client? What is the difference between the terms patient and client?
Phase 2			
Broad Questions	Specific to the therapeutic relationship	Introduce the therapeutic relationship in a broad enough manner to elicit a spectrum of responses that can be followed up on with subsequent questions.	What does the term 'therapeutic relationship' mean to you?
Phase 3			
Specific Questions	Specific to the therapeutic relationship.	Introducing questions that narrow responses to meta-principles of the interaction that can influence the therapeutic relationship. (e.g. confiding relationship) or actual factors the therapist believes are a part of the relationship.	What sorts of factors do you pay attention to when developing the therapeutic relationship? Sometimes it can be difficult for (insert term participant uses) talk about injuries and pain or how these things affect their lives. What do you do to help people talk about their experience?

APPENDIX I

Initial Patient Interview Guide

Some people see themselves as patients when they are in physical therapy, and some see themselves as clients. How did you see yourself and why?

Tell me about your experience of being a patient/client in physical therapy.

Describe what made it _____?
How successful was your treatment?
What made/would have made therapy helpful?

Overall, what impact do you think your relationship with your therapist had on your experience of physical therapy?

How did the relationship impact _____?
What would have changed for you if you didn't believe that your therapist could have helped?

What stands out to you about the relationship you had with your therapist?

What did he/she do or how did he/she act? How did these actions/words affect you?
How did these contribute to the quality of the relationship?

Sometimes it can be difficult to talk about injuries and pain or how these things affect different parts of a person's life. What was it like to discuss these things with your therapist?

What were the most important qualities of the relationship you had with your physical therapist?

How is the relationship you had with your physical therapist different than what you have had with other health care professionals, such as your doctor?

What influence did _____ have on your experience?

<u>Topics to Consider Expanding On During the Interview</u>:

- Collaboration, working together
- Ability to confide in the therapist
- Decision-making

Table I.1.

Patient Interview Guide Rationale

Phase	Focus	Purpose	Possible Questions
Phase 1			
Broad questions	Non-specific to the therapeutic relationship.	Facilitate broader discussion regarding aspects of treatment that could have implications for what a patient believes the therapeutic relationship is and what is done to develop the relationship.	Some people see themselves as patients when they are in physical therapy, and some see themselves as clients. How did you see yourself and why?
Phase 2			
Broad Questions	Specific to the therapeutic relationship	Introduce the therapeutic relationship in a broad enough manner to elicit a spectrum of responses that can be followed up on with subsequent questions.	Overall, what impact do you think your relationship with your therapist had on your experience of physical therapy?
Phase 3			
Specific Questions	Specific to the therapeutic relationship.	Introducing questions that narrow responses to meta-principles of the interaction that can influence the therapeutic relationship. (e.g. confiding relationship) or actual factors the patient believes are a part of the relationship.	What stands out to you about the relationship you had with your therapist? What did he/she do or how did he/she act? How did these actions/words affect you?

APPENDIX J

Example of Interview Note

Interview Note
Physical Therapist Interview – BMPT09 (DM520050)
June 6, 2013
9:00am
Participant's office

My impression of the setting – I know this office well. It is a homey office. An inviting office. Usually smells good. Wood furniture (which I love) – I feel grounded in the office. I was noticing the family pictures today, that formed the backdrop behind the participant. Relationships are important. Some sense of order seems to be important. The office space feels personable, not disheveled. Is that just for her sanity or is it set up to create a welcoming space? Maybe both. I had to ask her for a clipboard (geez), because there was nowhere for me to write or hold my interview guide, really.

My impression of the participant – she seemed a bit nervous to start. I think in an interview, even though we know one another quite well, there is always the idea of the performance because it is a formalized discussion. She also voiced that she hoped that I didn't expect her to remember our mock interview (I reassured her that I didn't and that I actually hoped more that she hadn't). She was dressed smartly, as usual.

My impression of myself – today was tough to get into because I wasn't feeling that great physically, so was trying to manage that. Even though I have done a number of these interviews, I always seem to stumble into the first question! But as things get rolling and I can piggy-back and respond, things get covered. I definitely felt more engaged as we went on – I was very interested in what she was saying – engaging in what she was saying, thinking about what she was saying and responding internally to it versus trying to think of the next question or, how do I express this… maybe it is a function of moving into a more conversational interview…the idea of shifting from 'asking' questions to 'responding'. And maybe this creates the safe space for the person to speak more deeply, more vulnerably. She did begin to get teary when speaking of a situation where she had really stood up for a patient. I also recounted some of my experiences more so than I have in other interviews. I think this was a function of us knowing one another quite well, for so many years and in different roles. This I think was the same for other therapists who I knew better – I didn't fear making them uncomfortable with my experiences

My impression of our interaction – we began with idle chit chat about my knee since she noticed that I had been limping and playfully imitated my walk. Then we went through her 'mood flip cards' and identified that she felt a bit cranky today, which maybe contributed a bit to what seemed like a disjointed start. Either I didn't communicate what I was hearing/interpreting very well or she was not hearing me or interpreting me differently than I had intended. But we seemed to come around and get into things. Felt like we were both circling the wagons. I just

didn't want to imply that I was looking for a particular answer, but also wanted to probe a bit – I did qualify this, saying that it was my job to probe a bit (i.e. please don't think I am being confrontational or that I don't agree with what you are saying). We just really deepened into the conversation as it went on.

Post-recording Conversation – (note: I did write scratch notes and scanned them to pdf as PT09 June 6 2013 Extra Notes) Some interesting conversation took place after the DVR was turned off. First, I remembered the question I forgot to ask, being, are their personalities or types of situations that you find more challenging. She responded by stating younger group (15-20) because they think they are invincible and therefore do not take much responsibility, especially with follow through. She then remarked that this group often comes with parents, and if you don't have a good relationship with the parents, it won't work. She recounted a recent situation with a 15 y/o female gymnast and her mother -The interaction with the mother via email after a competition. This led into the way she replied to the email – she was not going to accept blame – she set a boundary for herself – and she responded by reframing the situation in what she felt was constructive for moving forward with the rehab. From her perspective, the mother responded in a different tone than the original email, an 'oh, I better not mess with her' tone and asked about booking the next appointment. This led to the discussion re: how setting boundaries, knowing what to absorb and what not to absorb (or take responsibility for), and setting boundaries around that can have a positive influence on the relationship.

She also spoke more to email contact with patients, especially ones who were having difficulty following through or progressing – to email her daily just to say if they were able to do the exercises and what the response was – this wasn't to be a watchdog, but had the intent of being a more constant support/maintaining connection because in this day, PTs may see patients more infrequently.

We also spoke about shared responsibility – that the most challenging situations are the ones where the patient doesn't take responsibility. The therapist has a role with responsibilities that center around their knowledge and skills – the therapist is responsible for giving 100% but the patient is also responsible for contributing. She agreed that when the therapist is giving and the patient is just taking, not contributing back into, it can be depleting for the therapist. She stated that it was important to outline expectations about roles. This led to speaking about athletes in general and that they were a very difficult population in that way. They had a sense of entitlement, they get things done for them. She also talked about patience, and that she had patience where other therapists she knew didn't have as much and depending on the challenge of the situation, this was necessary. She also spoke to how some therapists have more rigid boundaries re: responsibility of the patient and will take less of an understanding approach.

I also spoke about what a privilege it has been to interview the therapists so far. How I felt that these therapists were not just 'experts in their own experience', they were experts in developing relationships with their patients. We talked about how therapists don't really see ourselves as experts in that way, but more in the vein of experts in conditions or techniques. She commented how maybe this was what we were missing in understanding what makes therapists and therapy effective.

APPENDIX K

Documentation of the Use of Constant Comparison Principles During Data Analysis

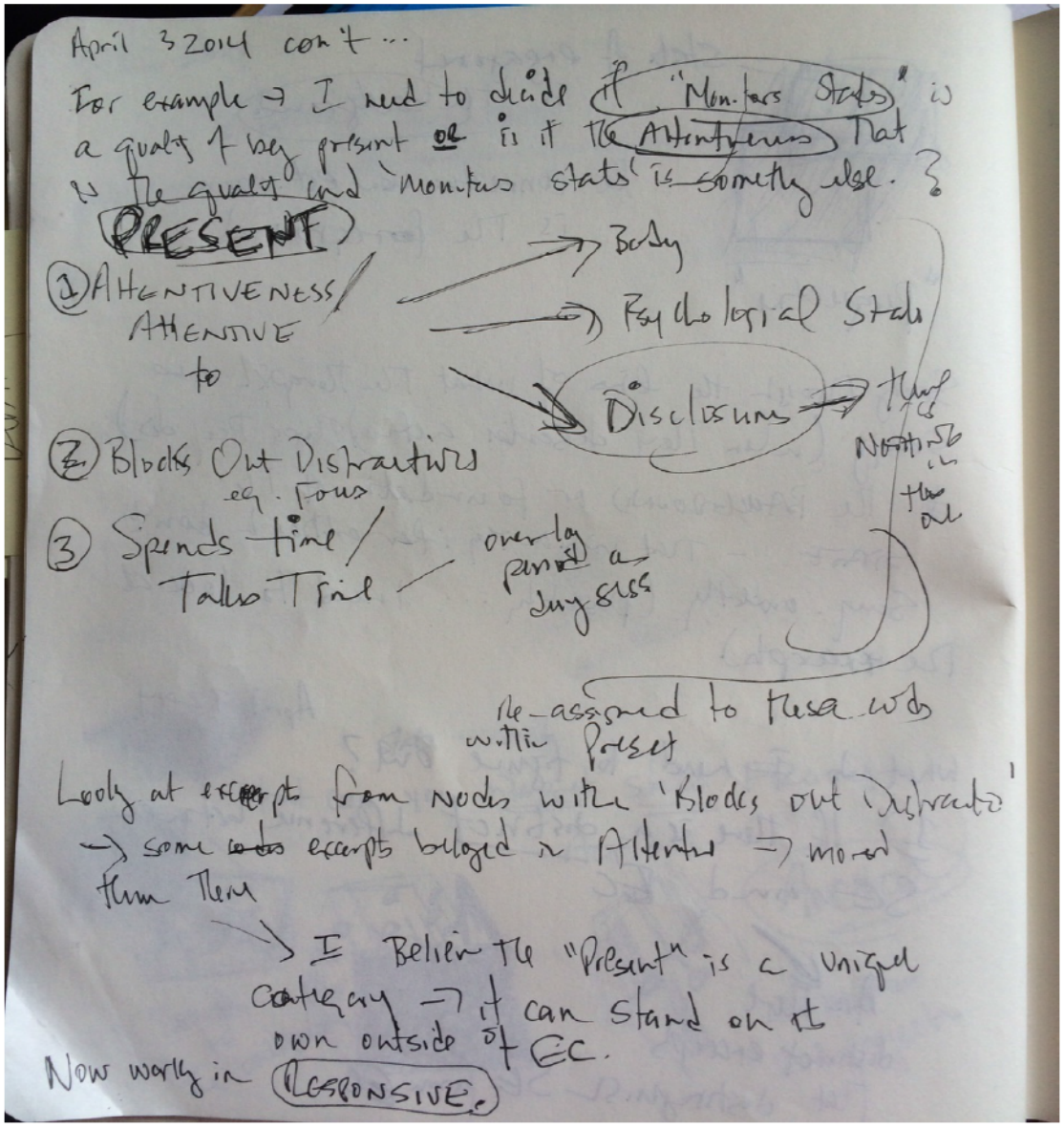

Figure K.1. Photograph of handwritten notes in one of my journals, dated April 3, 2014. These notes illustrate the process (in part) of comparing codes, sub-categories, and categories.

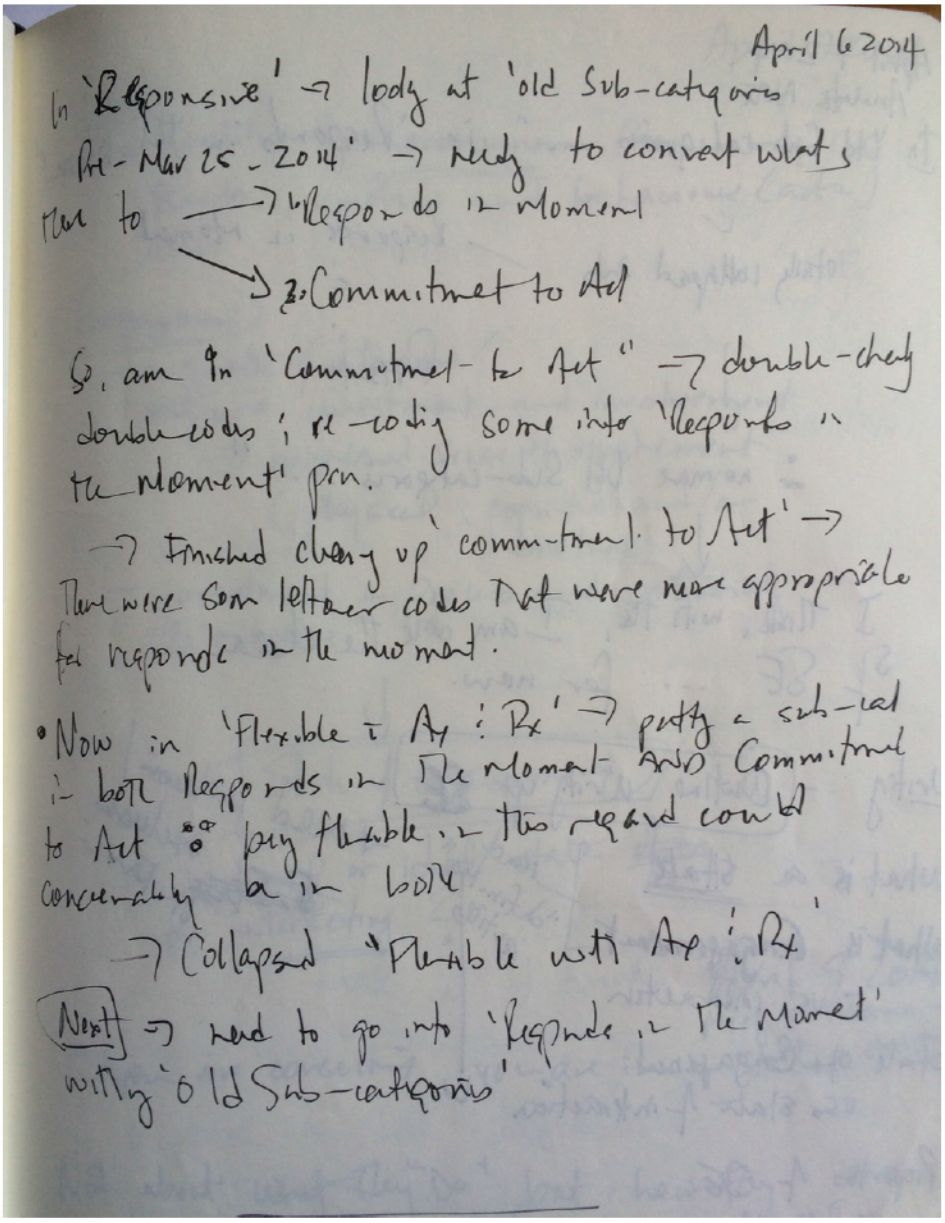

Figure K.2. Photograph of handwritten notes from in one of my journals, dated April 6, 2014. These notes are a continuation of from April 3, 2014. They illustrate the process (in part) of comparing codes, sub-categories, and categories.

APPENDIX L

UNIVERSITY OF ALBERTA

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April 10, 2015

Dear Maxi

RE: External audit

Thank you for the opportunity to audit your doctoral work. I completed the review between 26 and 29 January 2015. During this time I reviewed your project proposal, your detailed journals, your memos, a quick review of your codes, and I read through your three papers.

As I indicated in the audit table I felt that you followed a systematic a rigorous process in conducting your research and in analyzing your findings. I saw evidence of your analysis. I saw how you thought about and "agonized" about many aspects of your data and how you assigned codes and arrived at categories/themes. This was really evident in your journals and memos and I definitely saw how things evolved over time and as you got deeper and deeper into your data. I thought your findings and conclusions were plausible based on what I had read and I believe that your findings have practical application to and relevance for our profession and for other professions.

As a patient, the relationship we develop with the health professionals who treat us, and how those health professionals make us feel, whether they make us feel important, that they have time for us etc., impacts how much we trust them, follow their advice, even come back for repeat visits. Your research highlights important aspects of this therapeutic relationship and its relevance in practice and will be of interest beyond the physiotherapy community.

Sincerely,

Mark

Mark Hall, PT PhD
Associate Professor
Academic Coordinator of Clinical Education

Figure L.1. A letter from external auditor regarding conclusions about the study process and findings.

AUDIT COMPONENT	Y/N	COMMENTS
Research Process		
Evidence of Research Decision-making Process e.g. audit trail of project-related/methods decisions	Yes	Evidence of a process to analyze transcripts of interviews. Decisions related to how this will be achieved. Changes in methods detailed.
Evidence of Theoretical Decision-making Process e.g. peer debrief, memoing, category development/abstraction/ conceptualization, analytic logic	Yes	Significant memoing, evidence of decision making regarding coding. Struggles evident when thinking about concepts and appropriate word choice to describe concepts and categories. Evidence of debrief sessions with peers. Evidence of decision making related to collapsing of codes, debriefing and exploration of categories concepts
Reflexive Process e.g. reflexive journaling	Yes absolutely.	Significant energy devoted to reflexive journaling, evolution and exploration of concepts, appropriate word choices to describe findings
Quality of Findings		
Validity (findings are indicative of the data)	Yes	While I haven't seen all the data I can definitely see how you have worked through your data in your memos and your journals. Many of the concepts and the exploration of those concepts from the journals and memos are evident in the papers.
Reliability (process that relates to the quality of the findings) e.g. appropriate degree of conceptualization, enough 'raw data' to support findings/thick description	Yes	Participant quotes definitely provide context to your findings, and your provide extensive description of your results that allow the reader to fully understand – the substantiating quotes also help to support these findings
Pragmatic Obligation e.g. findings are clear and provide clinical guidance; ethical obligation	Yes	Have just finished reading paper 1 and can definitely see many practical applications. Some of this is common sense – stuff you are taught in PT school but then commerce and space get in the way. Time to connect and invest in your patient is essential to building the relationship – and even busy PTs can create a

Figure L.2. Image of the table that was completed by the external auditor. The table displays the evaluation criteria and the evaluator's responses. The table is continued on the following page.

Disciplinary Relevance e.g. findings are applicable to the chosen setting and population, findings are generalizable to other settings and populations in the discipline; the study is necessary for the discipline	Yes	space and time to allow for that strong relationship to develop. Although you have focused on private practice where I think this is most relevant I definitely see generalizability to other settings and other disciplines. Definite relevance to the profession – use of touch, therapeutic relationship and building of rapport, communication and connection with the patient are all very relevant to PT.

Note: This is an image of the original table as completed by the external auditor.

APPENDIX M

Example of Memo Completed with NVivo Data Management Software

Name: GENUINE vs AUTHENTIC CARING - distinguishing

Description: i was in the process of retooling state of engagement; started to realize that maybe the idea of the professional sensibiilty of 'caring' was distinct from being genuine

Created On: 5/29/2014 2:08:24 PM
Created By: MM
Modified On: 5/29/2014 9:53:19 PM
Modified By: MM
Size: 3 KB

Genuine
Is more about the being one's self and allowing the other to be him/herself. It is therefore about the acceptance of self - non-judgement. Being one's self is reflected in the opennes of personality and in personal disclosures. There are no facades. Although the therapist is maintaining a professional atmosphere (as is outlined by the roles of therapist and patient e.g. therapist does not usually solicit advice about personal issues from a patient) The therapist is also not trying to be someone they are not. For example, the therapist may be a private person in general, and therefore, would not disclose personal circumstances to the patient (PT05) or she may be a 'touchy' person and choose to have more physical contact (PT09). As well, the therapist is *congruent* meaning that s/he is responding in a way that is reflective of who he/she 'is' in the moment (e.g. may cry with the patient as this is a part of her personality (PT10), sets a boundary based on his energy levels (e.g. PT11, PT06, PT02) the situation and his/her values and principles. The quality of the way the therapist is communicating also speaks to being genuine; therapists who are being genuine are communicating honestly - they are direct and transparant.

Authentic Caring
It is not 'I care because I must care' - it is 'I care because I do care'
a) Is more about the duty of care as a professional - having the patient's best interests at heart for no other purpose (e.g. referrals) than the well-being of the patient. The patient's well-being is the therapist's well-being (PT01). There is a ***commitment to understand*** the patient in terms of the the reason they coming to physiotherapy i.e. body and the associated psychological and social factors and ***a commitment to act*** accordingly to honour the best interests of the patient.
b) There is also a sense of caring about the person - what is happening in the patient's life, what her likes/dislikes, hobbies are. 'I care about your life', which may get enacted, for example, by remembering or talking about the patient's life. The therapist asks about the patient's daughter because she cares (not just in a manipulative way), even if it is to care enough to know that it is important for the relationship. *getting to know the person*

Distinguishing Features

- authentically caring has an element applies more to practice - it is directly about the reason the patient is in physiotherapy. It is about the helping relationship and the role the therapist has in the relationship.
- being genuine extends to a greater human story - acceptance, non-judgement; but, it does also apply to the therapeutic setting. The therapist tries not to judge the patient and there circumstances, whether those circumstances are directly related to the reason the person is physiotherapy OR whether it extends to other circumstances.
- a therapist, in being genuine and congruent, may set a boundary the limits the amount the therapist 'cares'. For instance, if the patient is not following through on the agreed treatment plan, the therapist may suggest discontinuation of treatment. The therapist is not caring indiscrimantly, with regard for self. The therapist's principles and values intervene in the relationship.

Linking Features

- there are aspects of 'authentically caring' that may be a part of the person's genuine sense of self. e.g. a therapist that is fascinated by people in general (PT03) may have this fascination blend well with caring about a patient's life.

APPENDIX N

Examples of Different Formats of Memos

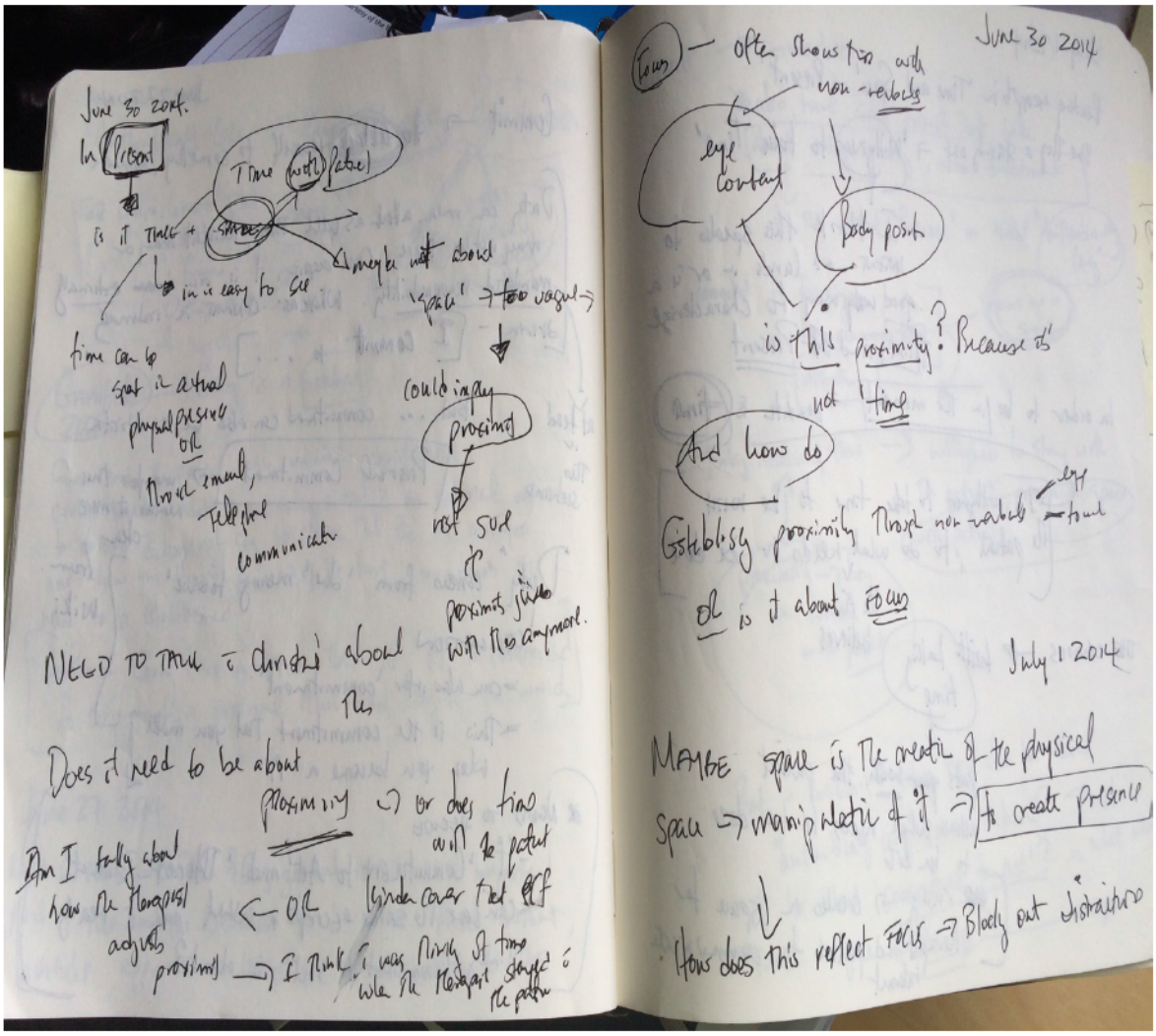

Figure N.1. Handwritten (notes, crude diagrams) memos in one of my journals. These memos explore the relationship between space, time, and presence.

Figure N.2. Memoing as drawing/gesture on a "Buddha Board". The memo is a drawn/gestural exploration of the therapist "hooking in" or connecting to the patient. Drawing helped me to write about connecting and connections.

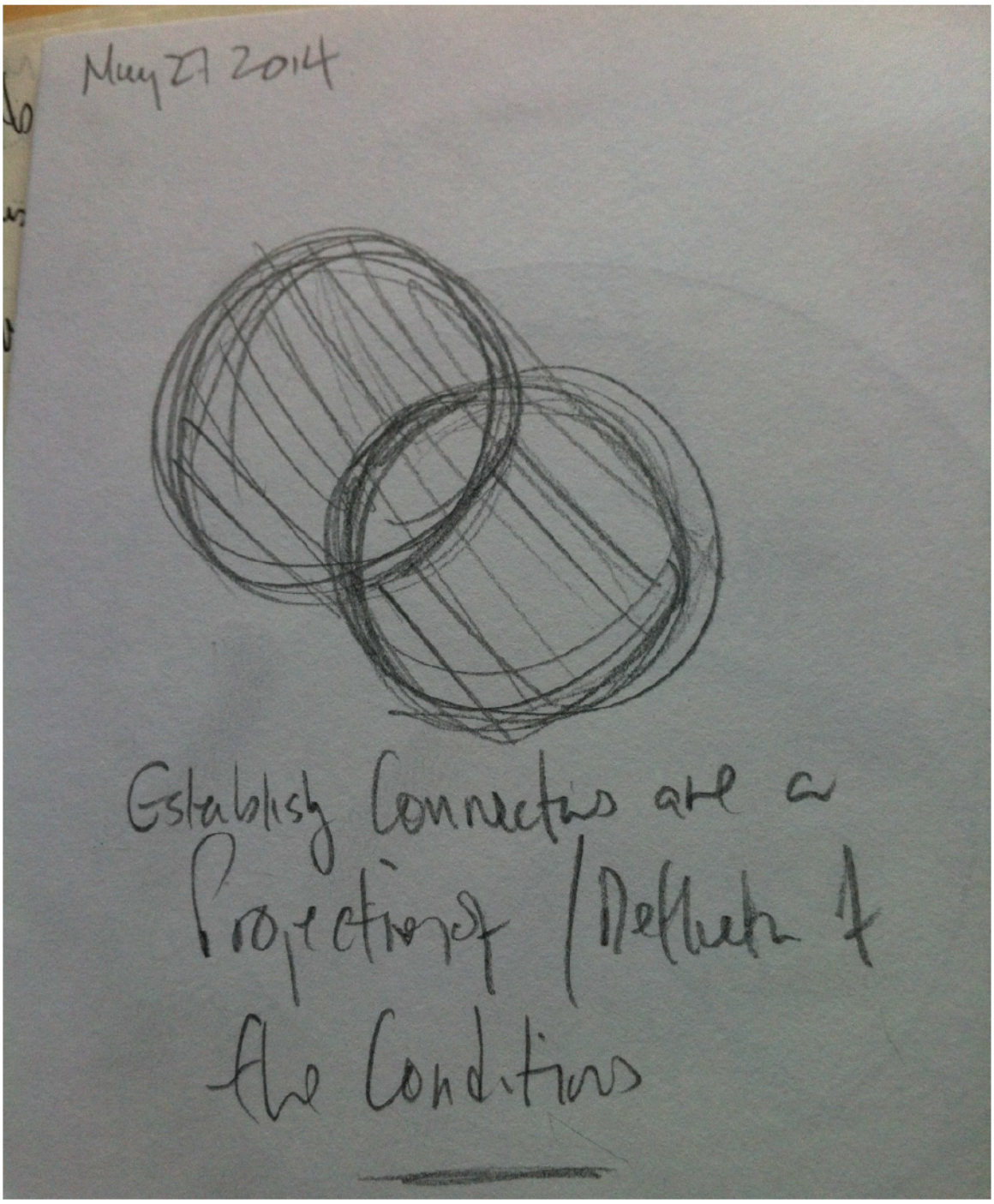

Figure N.3. This drawn memo attempts to explain the relationship between the conditions of engagement and establishing connections. Memoing by drawing/sketching helped me to critique the relationship between conditions and connections.