MINDFUL DIALOGUES
IN
COMMUNITY-BASED
PHYSIOTHERAPY

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I, Diane Tasker, hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

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Diane K. Tasker

6th August 2012

* Subject to confidentiality provision as approved by the University.
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PUBLICATIONS ARISING FROM THIS RESEARCH

Peer reviewed journal articles


Tasker, D., Loftus, S., & Higgs, J. “From the space between us”: The use of poetics as a hermeneutic phenomenological tool within qualitative research. Creative Approaches to Research (accepted for publication).

Book chapters


Published abstracts and conference presentations


ABSTRACT

Human relationships developed in community-based physiotherapy are usually hidden behind the walls of family homes, embedded in the practice of physiotherapists who work in those settings. In this thesis, I argue that the relationship-based approaches to practice that community-based physiotherapists foster between themselves and the people they come to help, are of utmost importance for the promotion of wellbeing for clients.

Hermeneutic phenomenology was used as the framework for a research approach which utilised poetics, dialogue and narratives to reveal and interpret how the community-based physiotherapists, clients, families and carers who participated in this study experienced and fostered their therapeutic relationships. Data was gathered via home-based interviews with individuals and families. Participants included five private practice home-visiting physiotherapists in NSW, five of their clients, families and carers (involving eight family members and five carers). Participants were encouraged to talk about their interactions and professional relationships in these therapy situations, to reveal how they interpreted the meaning of those relationships. A physiotherapists’ focus group was also held to further discuss the thematic findings arising from the interviews.

Narratives and poetry from within the experiences of the participants revealed some typical ways of understanding and ‘being together’ in these community-based physiotherapeutic relationships, which contributes to discourse about community-based physiotherapy practice. My interpretation of the research findings revealed that community-based physiotherapeutic relationships were sustained and developed by the participating physiotherapists’ attitudes and processes of:

- **Being Mindful** of the particular context, experience and wishes of clients, families and the pre-understandings brought to the relationship by the physiotherapist
- **Staying Engaged** through dialogue to maintain connection between human beings and
- **Being Responsive** to individualise therapy for clients and enhance perceptions of identity for those people.
A conceptual model titled *Mindful Dialogical Relationships* deepens understanding of how community-based physiotherapists develop relationships with their clients, families and carers, interweaving practice with the knowledge and experience of all stakeholders through their developing relationships. Embodiment of these processes could improve other physiotherapists’ community-based practice to address the ongoing and important issue of how practitioners, clients, families and carers relate to each other to achieve better outcomes for both parties in these therapeutic and intensely human processes of interaction.
CHAPTER 1

INTRODUCTION

If I face a human being as my Thou,
He is not a thing among things,
And does not consist of things.
(Buber, 2000, p. 23)

1.1 STATEMENT OF THE RESEARCH PROJECT

In this chapter, I introduce the origin of my research interest and describe the context within which the study was conducted. My topic is described in an introduction to the research questions and the philosophical and theoretical framework chosen to ground the research direction. This is followed by a brief overview of the inquiry’s approach. Finally, the significance and limitations of the project are outlined.

1.1.1 Origin of the research interest

The curiosity that inspires qualitative research often comes initially from observations of the real world, emerging from the interplay of direct experience with emerging theory, of political commitment with practice, as well as from growing scholarly interests. (Marshall & Rossman, 1999, p. 25)

Over the last 25 years, as a community-based physiotherapist, I have become increasingly aware of the complexity and fragility of the human relationships that develop between physiotherapists,¹ clients,² their families and carers.

Much of this reflection has taken place while driving from one home visit to the next, around the Blue Mountains in Australia, where I live and work. My increasing

¹ For this research, I use (in the context of physiotherapy) the terms practitioners, clinicians, therapists and professionals interchangeably.

² I use the term “client” rather than “patient” (as advised in the Australian Standards (2006)), “to reflect the range of roles a physiotherapist may play, including a primary health care role”. Within the context of physiotherapy practice in Australia, the client may be an individual, a carer, a family member or an organisation (such as people with like conditions, community organisations, sporting clubs, school groups).
awareness of the importance of such human relationships to physiotherapeutic processes occurred when I worked in a community health centre in the 1980s and with children and their families in their homes and at school in the early 1990s. Within the context of increasing professional pressure to be accountable for my time and practice to healthcare managers and my profession, I realised that my time spent in meetings and doing paperwork had gradually exceeded the time I spent with clients.

In the late 1990s I moved into private practice to pursue a more independent form of physiotherapy practice, with an interest in community-based chronic and complex healthcare. I noted that a deeper, unhurried and more socially sensitive, interactive approach made it easier to support the development of wellness for my clients and their families and appeared to prevent excessive personal energy loss for me as a therapist and as a person. I had observed this particular quality of interaction in more experienced colleagues but needed to explore it for myself before I really started to understand what it was like.

**Building my work persona**

I remember having a discussion with a community health colleague (a clinical psychologist) regarding how to manage part-time work with home and family. She invited me to her home for lunch and carefully prepared a selection of foods that were traditionally cooked for new mothers in her home country of Pakistan. As we relaxed together, we discussed how we each practised her therapy craft. She told me that her way of managing was to allow the gradual integration of her work and personal life. She alternated work and personal activities on different days of the week. I was initially doubtful but her advice has proven helpful. Reflection around this idea of integration was the beginning of my exploration of the idea of “enhanced physiotherapeutic relationships” as a possible mode of practice, helping all the people taking part in such relationships to cope with the inherent complexity presented to them by our modern healthcare system and indeed by life itself. During the process of developing our identities as young physiotherapists, we try to develop not only our therapeutic skills but also a physiotherapeutic persona to assist with our interactions with the people we work with and for. It is sometimes only when we stop practising physiotherapy for a while that the thought can occur, “Who am I and who can I be?”. 
The swimmer

As a physiotherapist, I often wonder just how much I have contributed to a client’s progress. Is it what I did or how I did it, or what they thought and did, or something in the interaction between us? There are times in clinical practice when I have to stop and really question myself about this.

Some time ago, I visited an elderly man with back and hip pain. He was bent right over. His doctor told me that this flexed body posture has been present for at least 2 years that he could recall. This client also had very poor vision.

He had quite a prickly personality but gradually our conversation progressed. I asked him about his life in general and he told me with some distress that he couldn’t believe that this had happened to him, and that in his youth, he had been a very good athlete. He got out a photo album and showed me a picture of himself as a teenager. I admired his beautiful upright posture in the photos and asked him if he could remember what that had felt like.

We chatted about how he managed his mobility and arranged some appointments and a plan of action. I also assessed him physically and suggested that he use his walking frame in the house instead of just on outings.

Imagine my surprise when I visited the next week. He greeted me at the door with a big smile, standing nearly upright without his walker.

To say that I was surprised is an understatement. What I was sure of was that it was not just my physiotherapy procedures that had wrought this change.

Figure 1.1  The swimmer

The practice of physiotherapy is not only about “doing” but also about “being”. Formation of a professional persona is a delicate balancing act. Rogers (1989) described a core condition for therapists within clinical relationships as “congruence”, “an accurate matching of experience and awareness” (p. 282), where therapists feel accepting, honest, and open with clients and their reactions reflect an accurate awareness of their feelings and experience. Therapists need to integrate the way they project their feelings within a therapeutic interaction with the way they actually do feel.

“It is the opposite of presenting a façade, either knowingly or unknowingly” (Rogers, 1957, p. 97). As health professionals, there is an expectation that we know what we are doing, know how to do it and know why we are doing it. The following vignette illuminates this challenge.
Sympathetic souls

As a young physiotherapist working in a general hospital in Dunedin, New Zealand, I was initially quite overwhelmed by the formality of the medical system I had entered. Reporting to the ward sisters in their starched white veils made me uneasy. I soon realised, however, that I was not alone. My clients felt the same way and showed this with confidential eyebrow twitching and sympathetic murmurs. As my practice developed, I realised what rich sources of experience lay within these sympathetic souls. I had come to help them but they were helping me. To start with, I felt quite guilty about this state of affairs and attempted to maintain a proper professional distance. However, I realised that such distancing caused a decrease in any real co-operation and communication between us. Their life experience was not to be considered inferior to my professional knowledge and experience. It was better if we worked together with a mutual “give and take” attitude.

Reflecting on all this, I realised that we all face the existential task of achieving a compromise between our self-understanding and our understanding of the world. Such compromise is also essential for the members of clients, families and carers, if they are to achieve their desired goals of wellness and happiness.

In shaping my practice I have particularly been confronted by how to deal with expectations of the evidence-based practice era. Tension between the way health professionals project their image when communicating with clients and the way they might be feeling about those interactions can be influenced by the introduction and development of evidence-based medicine. Since the early 1990s, evidence-based practice and its principles have been increasingly discussed and promoted within the physiotherapy literature (Schreiber & Stern, 2005). However, along with professional judgement, physiotherapists need to understand the value and make use of a range of different forms of practice knowledge.

Using different forms of practice knowledge

Within community-based physiotherapy practice, where physiotherapists are “guests”, there is a particular need for “a broad array of knowledge and skills far beyond traditional notions of physiotherapy” (Heckman & Cott, 2005, p. 278). Quantitative evidence from research that uses the scientific method has tended to be more highly valued than other forms of evidence in the delivery of health services (Kennedy et al, 2003). From personal experience and communications from fellow therapists, I have
noted that such higher value can also be imposed upon therapists from the literature, training courses and other professionals, despite any personal misgivings they might have or the possibility of alternative approaches they might have discovered through actual practice.

Actual practice includes a gradual and subjective building of craft knowledge, involving interpretation in context, in contrast with the more objective and generalised nature of evidenced-based knowledge (Higgs, Richardson, & Abrandt Dahlgren, 2004). More recently, Shaw and DeForge (2012), have argued for a similar approach to understanding how physiotherapists might view their practice, emphasising that “claims to expertise always consist of partial knowledge claims that emphasize different elements of physiotherapy practice” (p. 427) and that physiotherapists must be better viewed as “bricoleurs”, embracing knowledge from a variety of partial perspectives.

Acknowledgement of the evolving and incomplete nature of knowledge could encourage physiotherapists to draw from those bodies of knowledge that are undervalued and marginalised, using philosophical and theoretical insights to explore new and varied ways to approach physiotherapy practice. An ability to draw on more marginalised knowledge can arguably enrich practice.

**Shaping my research topic**

Healthcare research often focuses on acute and tertiary healthcare rather than chronic/rehabilitation and low-tech community healthcare. My research is located in spaces that evidence-based practice tends to sideline: it deals with clients’ experiences, choices and feelings; it emphasises the importance of individual subjectivity rather than generalised approaches to treatment based on quantitative evidence, and it promotes the judgement of the professional as well as the use of standardised evidence in the co-creation of particularised care.

Reflection on interactions with clients, families, carers and other healthcare workers has led me to the following thoughts about the development of physiotherapeutic relationships in community settings:

- The desired effect of “wellbeing” or “flourishing” is identifiable to and experienced (often differently) by family, carers, therapists and clients. Such wellbeing transcends the physical and involves personal and interpersonal
aspects of health and healthcare. This complexity in therapeutic relationships is evident in the swimmer example above; the client wanted to “write his own story” but our chatting had influenced him too, perhaps in recalling his pride in his upright youthful figure.

- Relationships between clients, families, carers and therapists are inherently complex. This is often linked to such factors as personalities, family history, challenges in dealing with chronic illnesses and the situations (e.g. working in home/personal spaces) where community physiotherapy occurs.
- A deeper understanding of how such professional relationships can develop might help therapists to craft successful engagement strategies and outcomes for clients and their families/carers.
- Physiotherapists explore/teach/model therapy tenets to clients and carers/families via their relationships with those people. Attention paid to this tacit and under-acknowledged aspect of physiotherapy practice could improve the ability of both new and working therapists to enhance their professional practice for both their clients and themselves.
- Clients and their carers will be able, in varying degrees, to take part in this therapeutic exchange and use it to promote their own wellbeing.
- Some clients and/or the family/carers may wish to and be capable of leading their own healthcare within their home. Community physiotherapists will need to be able to assess this desire/ability and respond appropriately, to balance both the client’s wishes and their best interests therapeutically.
- Long-term clients and their carers have a wealth of experience and insight.

On the basis of these reflections, grounded in my experience, my research topic became centred on situated, person-centred, therapeutic relationships that sought to enable clients and carers to co-construct their therapy programs and shape their healthcare journeys.

**Approaching the literature**

Exploration of the literature further assisted me to shape the direction of my research. I explored particular bodies of literature, based on the degree of resonance I felt between my own insights into the research topic and the need to find appropriate academic backgrounds that might deepen my understanding of the phenomenon under study. Iser (1978) emphasised that development of one’s thinking emerges through the reading of
literature, to provide readers with the opportunity of carrying out fieldwork within themselves. Iser approached literary texts as “cultural artifacts in which we recognize what we are not and what we might be” (as quoted by Riquelme, 2000, p. 7). The iterative act of reading may therefore deepen understanding of oneself.

1.1.2 Statement of the research topic
This study explored the relationships that developed between five community-based physiotherapists, their clients, families and carers, in home-based and ongoing healthcare situations in NSW Australia. In particular, it sought to reveal those elements of interpersonal engagement within physiotherapeutic relationships that could promote improvement of clients’ wellbeing, could reassure and support carers and families and could build the integrity of the therapists’ ethical standing and morale within their jobs and their communities.

1.2 PURPOSE AND GOALS OF THE PROJECT
My research aimed to illuminate aspects of human relationships within community-based physiotherapy practice and explore how community-based physiotherapists developed reciprocity within those relationships with clients and their families and carers. Chronic and complex healthcare is, as its name suggests, ongoing and difficult to manage, for all stakeholders. Healthcare systems generally struggle to address such complex issues (Ginter, Swayne, & Walter, 2002). The importance of this issue became obvious when a student described to me the emotional response he felt on realising the enormity and difficulty of the life situations faced by people with chronic and complex health problems in our community, and the positive effect that well-planned physiotherapeutic interventions can have on people’s quality of life (Luke Blayney, personal communication, 2008). Such a response highlights the hidden nature of both the personal healthcare problems faced by a significant number of people in our community and the process that can occur when physiotherapists “come to call”.

In this thesis, I argue that the human relationships that develop between therapists, clients, families and carers are of the utmost importance for the way that community-based physiotherapists practise physiotherapy with those people. When reflecting on the question of how we practise physiotherapy, we need to realise that physiotherapy processes occur reciprocally between therapists and clients (Ek, 1990). This thesis

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3 Verbal permission was gained from Luke to use this comment in this context.
explores such reciprocal relationships in community-based physiotherapy and assigns to that reciprocity the importance and relevance it deserves. Our world is full of difficult human experiences. This work has been conducted from within the relatively small area of community-based physiotherapy. Taking a wider view, my research findings may also contribute deeper understanding towards the ongoing and important issue of how we relate to each other to achieve better outcomes for both parties in a therapeutic interaction.

I’m not ok, You’re ok
I’m not ok, You’re not ok
I’m ok, You’re not ok
I’m ok, You’re ok (Derived from Harris, 1967).

1.3 CONTEXT AND BOUNDARIES OF THE PROJECT

1.3.1 Setting and boundaries of the project
This study was conducted within the context of community-based physiotherapy practice in New South Wales, Australia. For the purposes of this project, the term community-based physiotherapy and healthcare is defined as physiotherapy and healthcare provided to clients within the environment where they “learn, work, play and love” (United Nations, 1986, p. 2). This upholds the spirit of the advice expressed in the Ottawa Charter for Health Promotion:

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (United Nations, 1986, p. 2).

Participants in this research project were contacted through approaches made to five community-based physiotherapists. Two of the participating therapists practised in the Blue Mountains area and the other three practised across the Sydney area. These therapists visited clients in their homes, workplaces or recreational venues. (The term “home” can include nursing home and group home).

For this research, I decided to approach physiotherapists in private practice, rather than salaried physiotherapists working in more institutional, community-based healthcare facilities, such as community health centres. This decision was made with a view to
accessing longer-term physiotherapeutic relationships in community-based healthcare. From my experience, community-based physiotherapists within public and institutional healthcare appear to be less deeply placed within local communities than private physiotherapists. Again, drawing from my previous experience and personal communications with practising physiotherapists, community-based public physiotherapy practice also appears to be necessarily constrained by set policies related to intake procedures, amounts of therapeutic time allowed for client contact, and pressure of waiting lists. Privately practising physiotherapists may have more control over these factors and may be able to monitor and respond to clients’ needs in a more individually customised way. I was interested in the ways in which people in such situations might interpret their physiotherapeutic relationships, from all sides of that relationship.

1.3.2 Focus of the research
The research focus of this project explored the development of the physiotherapeutic relationships that emerge between community-based physiotherapists, their clients, families and carers. People caring for relatives with chronic and complex healthcare needs at home depend on their communication with healthcare professionals for support of their quite prodigious efforts. The following vignette blends a variety of conversations that I have had with people who have been managing their healthcare issues at home for long periods of time but have needed hospitalisation for an acute episode or an injury.

A clear disconnect is apparent between the way Mary felt about the way she had cared for her mother Gwen in their home and her perception of that care as viewed by the rehabilitation staff. Her confidence was knocked by her interaction with the discharge planning process, despite the positive efforts being made towards getting Gwen home again. This may have been due to Mary’s feeling of being placed outside the decision-making process for Gwen’s discharge plans and to her perception of a lack of any real involvement.
“Talked about” but not “talked with”

Mary, a family member, had attended a discharge-planning meeting for her mother, Gwen. This meeting had been held within the hospital where Gwen was staying for treatment, after a fall at home.

Various therapists and nurses had attended and reported on how Gwen was progressing and what their opinions were regarding the possibility of her going home.

After the meeting, despite the plans that had been made for Gwen to go home in a few weeks, both Mary and Gwen expressed feelings of doubt and low morale. Mary said, “I thought I had been doing OK with Gwen’s care at home but now I’m not so sure!”

Both Gwen and Mary felt that they had been “talked about” but not “talked with”.

**Figure 1.3 “Talked about” but not “talked with”**

In my research I sought to explore the many aspects of communication within physiotherapeutic relationships in community settings, with a view to better supporting the professionals who essentially carry out that care. My research therefore focused on experiences and thoughts regarding development of community-based physiotherapeutic relationships, as interpreted by:

- Clients living at home, with chronic and complex healthcare problems
- Families of those clients
- Carers for those clients
- Physiotherapists attending those clients.

The roles and contributions of these people within community-based physiotherapeutic healthcare are inextricably linked. I argue that by focusing on their thoughts and feelings about their community-based physiotherapeutic relationships it may be possible to reveal benefits for other people in similar healthcare situations, and there may be transfer to other areas of interpersonal endeavour.

*We recognise the value of appreciating and celebrating the multiple and sometimes unexpected effects of the research process and product on people, organisations and societies. (Higgs, Trede, & Rothwell, 2007, p. 7)*
1.3.3 Research questions in this study
Marshall and Rossman (1999) argued that research questions drawn from both clinical experience and consideration of the existing literature guide exploration of the data and provide a framework for a systematic inquiry. My practice experience, reading and thinking led to a gradual increase in focus on the research topic, delineated in the following research questions about the human relationships that develop between physiotherapists, clients, families and carers in community-based physiotherapy practice.

- How do community-based physiotherapists experience and foster relationship-centred care within the dynamic and on-going therapeutic relationships they develop with clients, their families and carers?
- How do clients, their families and carers, experience and understand these on-going relationships with community-based physiotherapists?

1.4 KEY DIMENSIONS OF THE THEORETICAL FRAMEWORK FOR THIS RESEARCH

Within the development of the profession of physiotherapy, it is not surprising that dominant views should mirror the dominant discourses present in general healthcare, medicine and society. Although physiotherapy as a profession was established only within the last 100 years, it has been developing against a background of great change within society (including two world wars, globalisation, and changing attitudes and costs associated with health and wellbeing). Particular factors in Australian health care are the combined impact of an aging population, the increased incidence of chronic conditions such as diabetes and cardiovascular disease, and increased disability rates linked to improved survival rates following serious injury. It is within these changing contexts, that the concept of physiotherapeutic relationships in the care of people with chronic ill health is examined, using research and knowledge from other disciplines as well as physiotherapy to gain further insights.

My thesis initially discusses the general context and development of community-based physiotherapy within our society. Consideration is given to human relationships in healthcare and the development of the concepts of person-centred and relationship-
centred healthcare in the literature. The intention is to provide a context for deepening our understanding of community-based physiotherapeutic relationships.

1.4.1 Community-based physiotherapy in context

In Chapter 2, definitions used throughout the thesis are clarified. These terms include physiotherapy, wellness, wellbeing and good health. An exploration of how physiotherapy has expanded its practice in the area of community-based and chronic and complex healthcare and how this relates to this research is also presented.

Within Australia, the State Health Department in Victoria commenced physiotherapy home visiting in 1947 after the Australian poliomyelitis epidemic but the presence of physiotherapists based in community care centres and able to do home visits, did not generally occur until the 1970s (Park, 1972). Park (1972) reported that general rehabilitative care was usually undertaken by district nurses until, following work in Canada where physiotherapists were placed with district nursing services to carry out education of district nurses, similar efforts were made in Australia. There are strong elements of this role still present within physiotherapists’ work in community-based healthcare today, with an increasing emphasis on community access, continuity of care and integration of services, rather than hands-on treatment (Struber, 2003). This emphasis on education and consultancy by physiotherapists can also be related to the influence of the WHO on physiotherapy practice roles.

The influence of the WHO on the context of community-based physiotherapy

Since 1989, health policy has undergone some significant changes, which have impacted on the role of community-based physiotherapy. In 1996, Australia developed National Health Priority Areas in response to the World Health Organization (WHO) global strategy on health reform (Australian Institute of Health and Welfare, 2011). The WHO global strategy was planned with the aim of decreasing the burden of chronic disease for world communities. This aim was further reinforced in 2004 with the WHO follow-up report, “People at the centre of health care: Harmonizing mind and body, people and systems”. Awareness of the concepts of “Self” and “Other” have developed thinking about the way we exist in the world and depend upon each other for the creation of human relationships. Such discourse has opened up acceptance of individual concerns as having legitimacy within the community and between people. Ideas are explored within the context of healthcare, with the development of notion of person-
centred care within psychology and its translation into the discipline of nursing and other healthcare areas.

**Development of person-centred and relationship-based healthcare approaches**

The term “therapeutic relationship” within such approaches is often used within the areas of psychology, nursing and occupational therapy, but within physiotherapy the literature more often uses terms such as therapist/patient or patient/therapist relationship (French & Sim, 2004). Such a dry and clinical way of describing that human relationship does not do justice to its complexity. Accordingly, for the purposes of this research project, the term, therapeutic relationship was defined as “a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect” (Coles & McLean, 2003, p. 33). All branches of healthcare have gradually recognised the importance of interpersonal connections between clinicians and clients but such collaborative approaches to healthcare outcomes can be highlighted via community-based healthcare narratives.

1.4.2 Narratives for community-based physiotherapy

Chapter 3 considers a temporal and more individualised view of healthcare relationships by exploring the possible roles of narrative within physiotherapeutic healthcare relationships. Narrative medicine is a practice that recognises patients by receiving and acknowledging their stories of what has happened to them and how they have perceived their experiences within the unfolding stories that are their lives. “In order to have a sense of who we are, we have a notion of how we have become, and of where we are going” (Taylor, 1989, p. 47). Such concern for “the self” of the patient serves to place emphasis on interpersonal relationships and their potential, rather than just on patients’ biomedical conditions, patients/ bodies or practitioners’ viewpoints.

The concept of narrative recognises the storied nature of human relationships in general and clinical practice (and physiotherapeutic relationships in particular). Narratives provide us with master plots that help us to understand the usual sequence of events in relationships and how we are expected to proceed. A master plot, or story outline, has a temporal nature that can also help us understand the process of a developing relationship between people. While not employed as a major or overarching methodological strategy, the use of narratives was chosen as a powerful theoretical lens to inform this project.
The use and flow of narrative allows the fusion of ideas between people from different backgrounds. This is useful for understanding the development of clinical relationships in which participants are of various ages, cultures and personalities. For this project, the work of scholars such as Arthur (1991, 1995, 2004, 2007a), from a background of English, psychology and sociology, and Cheryl Mattingly (1998), from a background in occupational therapy and anthropology, helped to combine views from different disciplines, offering a rich and multi-faceted opportunity to study the phenomenon of clinical relationships.

1.5 KEY DIMENSIONS OF THE PHILOSOPHICAL FRAMEWORK OF THE THESIS

1.5.1 Qualitative research and the interpretive research paradigm

My research lies within the interpretive research paradigm and is focused on people involved in real-world activities and relationships, increasing the visibility of that world (Denzin & Lincoln, 2000). In the last century, there was dominance of the use of the quantitative research paradigm in medical and healthcare research. However, this misses out on key research priorities, since the subject matter being researched in qualitative research can be very different from what is studied quantitatively. Qualitative research is often about lived human experience rather than the material or even biomedical world. In contrast to quantitative research, which offers an interpretation of a material world that cannot interpret itself (Mattingly, 1993), qualitative research develops interpretations of an already interpreted human world. If we accept the philosophical argument that humans are essentially self-interpreting beings (Heidegger, 1962), it becomes necessary to acknowledge each participant’s views of, and contributions towards, the healthcare situations in which they find themselves. People need to manage many serious healthcare problems by themselves. A qualitative approach to research and knowledge allows engagement with their efforts and trials.

I argue that only through “listening and talking together” with the participants in healthcare will researchers be able to reveal the tacit dimensions of the relational processes that make up community-based physiotherapeutic relationships. We will be better able to develop new knowledge for the future if we fully acknowledge the experience and
pre-existing knowledge of the human beings with whom we work. It is not enough just to theorise from a practitioner’s point of view, we must also listen to what they and we have to say.

1.5.2 Social Constructionism

*Focusing on the processes of making meaning between people*

The philosophical movement of social constructionism studies processes of making meaning, which occur between people as they seek to communicate with each other and establish interpersonal relationships. In particular, proponents seek to understand the conventions of language and the social processes that are used by people within human interaction. Social constructionism proposes that knowledge is not merely individually generated but also created collectively as a result of the fluid, relative and subjective nature of our interpersonal processes (Schwandt, 2003).

Social constructionism was used to inform this project because it focuses attention away from either study of individual people or study of the external world, and towards the study of human inter-subjectivity and interaction. The methodology of hermeneutic phenomenology, which I have chosen for this research project, required iterative focusing and distancing of viewpoints to gain a holistic but deeply textured understanding of the research phenomenon. Social constructionism provides insights aligning well with this methodology. This is further discussed in Chapter 4.

*Exploring possibilities for change in the ways we communicate*

Drawing from the field of psychology, the strategy of communicative interaction can be seen as occurring within communicative space (Shotter, 1999, 2008). This strategy allows us to explore not only the conversations that occur in this space, but also how these conversations might contribute, in this case, to the way physiotherapists practise relationship-centred healthcare, for and with clients, families and carers.

> *We need to embody a new relational practice, to change what we notice and are sensitive to (as well as what we care about, and feel are the appropriate goals at which to aim). In other words, we need to change ourselves, our sensibilities, the “background practices” we have embodied that make us the kind of professionals we are.* (Shotter, 1998, p. 35)

One of the concerns of social constructionist thinking is to highlight different aspects of the background to our everyday life and to examine how those aspects might relate to particular human phenomena of interest (Shotter, 2008).
1.6 OVERVIEW OF THE RESEARCH APPROACH

1.6.1 Hermeneutic Phenomenology
Phenomenology involves the study of human experience as it is lived by people (van Manen, 1990). Such study aims to access the very essence of that experience by examining the talk or writings of people from where they are located within their own perceived worlds. The complexity of human experience is then “thickly described” (Ryle, 1949, 1971) in an effort to properly consider the depth and intricacies of that essential experience.

Within this phenomenological research project, participants were encouraged to tell stories about their physiotherapeutic relationships to reveal how the meaning of those relationships was managed. Within the interpretive paradigm and from the range of phenomenological approaches available, a hermeneutic phenomenological approach was adopted to explore the lived experience of clients with chronic and complex healthcare needs, and the related experiences of their carers and families. Hermeneutic phenomenology allows the iterative and embodied study of lived experience, co-created between participants and researcher (Spence, 2001).

Dialogues occurring between research participants and researcher in this project provided data in the form of interview transcriptions. The accounts of the participants consisted of the stories they told of their physiotherapeutic relationships and their interpretations of those relationships. Analysis consisted of further reflection and interpretation via further interaction with the literature, to create deeper understanding and meaning and to identify organising and global themes to apply to the field of community-based physiotherapy. The philosophical origin of hermeneutic phenomenology as a relevant research approach for this research project is discussed in Chapter 4.

1.7 SIGNIFICANCE OF THE PROJECT
My research makes important contributions to the discourse on community-based physiotherapy for people with healthcare problems who wish to live in their own homes. I argue that community-based physiotherapy processes depend on human relationships between community-based physiotherapists and their clients, families and
carers. This project provided an opportunity for the voices of clients, families, carers and their physiotherapists to be heard and projected. Projection and interpretation of the voices of community-based physiotherapists also highlighted and validated their subjective experience.

1.7.1 Contributing to the discourse on community-based physiotherapy

By focusing on the specific practice of community-based physiotherapy, the context of home and community was highlighted within healthcare. A key contribution of this research is to highlight the nature and importance of community-based care in the healthcare system. Throughout the ages, people have always been cared for at home when they have become ill or disabled. However, in Western society, the introduction of hospitals and the hegemony of specialist medical practices over the last century may have affected the place of community-based healthcare within healthcare systems. Community-based healthcare appears to have been relegated to an add-on role and is often seen as far less important than hospital-based care (Lechner & Neal, 1999). Along with community-based physiotherapists, general medical practitioners in community-based healthcare also practise in a more generalist, but no less skilled way, than their specialist and hospital-based colleagues (Pullon, 2008).

The development of community-based healthcare as an add-on to hospital-based healthcare (Lechner & Neal, 1999) may have occurred as a result of a lack of interest in chronic and complex healthcare by specialists who have historically focused on acute conditions, where there is a greater possibility of substantive cure (Bishop & Scudder, 1990). However, as the economic burden of healthcare for our increasingly aging population becomes more pressing, public interest has again turned to community-based options. Such options can save money but also have the potential to promote an enhanced quality of life for individuals with chronic health conditions. This is particularly relevant in an age of decreased length of hospital stays and a reliance on families and home-based care to transition clients into improved health, rehabilitation, or ways of coping with chronic conditions. Cynically, it is a matter of debate as to which is the most important issue for our decision-makers, cost containment or quality of life.

Focusing on contributions from all stakeholders in home-based healthcare

Within my study, the contributions from all the stakeholder participants in community-based physiotherapy situations demonstrated the way that all people within such
situations contribute to person-centred healthcare processes. Clients and health professionals frequently perceive their care as centred on the requirements of the healthcare system rather than on care of the clients (Titchen, 1998).

Assisting people with healthcare who wish to remain in their own homes is a desirable outcome for many people. As our society ages, discourse regarding the care of people with disability becomes more important and more urgent. It is dominated by concern from community members regarding the quality of care achievable by healthcare organisations, for example, hospitals and nursing homes. Increased understanding of the therapeutic support required in community-based healthcare settings may contribute some resolution to the increasing problems of our aging society and its healthcare needs. In community-based physiotherapy, such therapeutic support can be centred within the relationship that develops between physiotherapists, clients, families and carers.

**Acknowledging that community-based physiotherapy depends on relationships**

In informal discussions with colleagues from general medical practice and healthcare regarding this research, wholehearted belief was expressed that community-based healthcare essentially depends on therapeutic relationships with clients, their families and carers. In a world that values accountability for economic reasons as well as desirable healthcare outcomes, this project tries to illuminate the human relationships experienced by community-based physiotherapists and their clients. It might thereby contribute deeper understanding and new meaning to the discourse regarding the provision of customised therapeutic support for people living at home with chronic and complex healthcare needs.

1.7.2 To listen to and hear the voice of community-based physiotherapists

The subjective experience of everyone involved needs to be understood if healthcare is to be meaningful and effective. Within healthcare, evidence-based practice (where the emphasis is on biomechanical evidence) is generally promoted as “best practice”. This may imply that good health is a product achieved only by that approach. Such a reductionist view of therapeutic processes tends to privilege objective measurement and generalised strategies over subjective interpretation, particularly as numbers lend themselves more readily to a balance-sheet view of accountability and to the language and hegemony of biomedical science. Although it seems rational to use such thinking to
tidy up the messiness of real life, it must be acknowledged by the whole community that we must all take responsibility for healthcare.

Confusion and frustration can occur for physiotherapy practitioners as they struggle to blend accountability and bureaucratic management systems with the expressed and perceived needs of clients and families. In this research I sought to listen to community physiotherapists, whose experience of therapeutic relationships can sometimes seem to be invalidated by the very public bodies set up to support them in their work. From personal clinical experience I know that community-based physiotherapists need to relate to and co-operate with clients’ ways of living and being if they are to contribute effectively to the development of wellbeing for people. Efforts to impose a particular therapy model upon clients can be problematic, especially in the light of professional time constraints and the altered power balance that occurs within community settings, where therapists become “guests” (Heckman & Cott, 2005).

1.7.3 Providing an opportunity for the voices of clients, families and carers to be heard

This study contributes to the goal of acknowledging and projecting the voices of clients, families and carers, and recognising the importance of their contribution to therapeutic processes. In my experience, clients and families have definite views about the healthcare they want and need. The nature of their life situations necessarily entails high levels of fatigue and can result in their voices being sidelined within healthcare discourses. Guided by the thinking of scholars such as the literary critic Bakhtin, this research explored the phenomenological nature of those voices as essential “value centres” within healthcare. Throughout his work, Bakhtin (1981) placed great emphasis on the importance of dynamic relationships for the generation of meaning.

1.8 LIMITATIONS OF THE PROJECT

A focus on particular aspects of community-based physiotherapeutic relationships enhanced the depth of knowledge gained, but limitations also existed as a result of the particular choices and decisions I made as a researcher and as a function of the specificity of those decisions.
1.8.1  **Limited number of participants used for this study**
This study was intentionally conducted with a small number of participants within NSW, Australia, to allow in-depth interviewing. Meeting several times with participants helped to develop their trust when talking about the delicate issue of human relationships and how such relationships develop within home-based healthcare for complex, difficult health problems. While my decision to follow this line of inquiry was made with the above intent, further research could involve more people and expand inquiry into other areas of community-based physiotherapy (such as publicly funded community-based physiotherapy), other practice locations and other types of physiotherapy.

1.8.2  **Use of different methodologies**
The use of hermeneutic phenomenology for my project involved an attitude and an approach that were grounded philosophically as well as methodologically. All aspects of the research were affected by this choice, including my literature searching, data collection and data analysis. My research approach was carefully chosen for the specific task being approached and the particular research questions that were asked. Other research questions might require different approaches. For example, further research might choose to explore and access epidemiological data to provide a more statistical representation of this phenomenon. Mapping and scoping of community-based physiotherapy relationship development might provide a different view of this issue and perhaps provide ways of comparing the nature of physiotherapeutic relationship development across different areas of practice.

1.8.3  **Inquiry into negative community-based physiotherapeutic relationships**
Like any human relationships, community-based physiotherapeutic relationships can experience difficulties and problems. The presence of multiple co-morbidities for clients also makes the process of physiotherapy complex. This research did not attempt particularly to explore negative physiotherapeutic relationships. Indeed, the sourcing of participants through the practices of particular physiotherapists may have caused those therapists to choose people with whom they had developed good relationships. However, I understood this was not the case in at least two of the participant families approached where the therapists concerned told me of relational difficulties they had experienced in those particular situations. Further research may be useful to highlight areas of the practice relationship requiring more preparation and education, with a view to being able to avert or avoid such situations.
1.8.4 Clinical experience and relationships
This research did not address the effect of the amount of clinical experience on the ability of community-based physiotherapists to develop relationships in clinical practice, or how such experience might prevent burnout for therapists. This is a topic for further inquiry.

1.8.5 Public versus private funding of community-based physiotherapy
The issue how services are paid for must have implications for relationship building when the patient/client is paying for services directly as opposed to receiving services from the public sector. This thesis limited its scope to private physiotherapy situations which were mostly funded from sources aside from family finances.

1.9 OUTLINE OF THE THESIS

Titles of the thesis chapters are presented in Table 1.1. This first chapter introduced the origin of my research interest and described the general dimensions of my research project. In Chapters 2 and 3, the theoretical framework of my project is discussed, further exploring the context within which community-based physiotherapy is practised and using the lens of narrative to view healthcare relationships. In Chapter 4, I explain the research approach and procedures I used and discuss how my choices contributed to the achievement of an overall congruence between the research topic, the context within which it exists and my chosen research approach.

Chapters 5, 6 and 7 explore the data and its analysis, describing the thematic and global findings of this research and referring back to the literature to consider interpretations and themes arising from the research process. The conclusions arising from the research are discussed and critically appraised, and I reflect on the research process occurring within this project, providing a coherent viewpoint for future endeavour in practice, research and education.
Table 1.1: Outline of thesis chapters

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
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<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
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<tr>
<td>2</td>
<td>Community-based physiotherapy in context</td>
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<tr>
<td>3</td>
<td>Narratives for community-based physiotherapy</td>
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<tr>
<td>4</td>
<td>Research approach</td>
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<tr>
<td>5</td>
<td>A dialogue of voices</td>
</tr>
<tr>
<td>6</td>
<td>Being mindful, staying engaged and being responsive</td>
</tr>
<tr>
<td>7</td>
<td>Creating mindful dialogues in community-based physiotherapy</td>
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</tbody>
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CHAPTER 2

COMMUNITY-BASED PHYSIOTHERAPY
IN CONTEXT

For the object of understanding human events
is to sense the alternativeness of human possibility.
And so there will be no end to interpretation.
(Bruner, 1986, p. 53)

2.1 INTRODUCTION

This research explores the complex ways in which clients, families and carers and their therapists interpret the relationships that they develop together during community-based physiotherapy. I argue that the context of private community-based physiotherapy practice to a large extent defines and engenders its practice. This chapter explores the context of community-based physiotherapy within the profession of physiotherapy and the wider scene of healthcare. Privately funded physiotherapists practise within this setting, which provided the participants (physiotherapy professionals in NSW) for this study. Developing my understanding of the context within which community-based physiotherapy takes place also prepared me for investigating the way that therapists interpreted their clinical relationships “in the field”.

The World Health Organization (WHO) has influenced development of healthcare internationally and this has had relevance for the expansion of community-based physiotherapy in Australia. WHO’s development of goals for world healthcare practice and advice regarding the steps towards achieving these goals has opened up debate regarding the nature of healthcare practice. I argue that the way community-based physiotherapists conduct their interactions with clients has been affected by these

4 The term community-based in this context has been defined by the United Nations (1986) as “the practice of physiotherapy, conducted in the places where people “learn, work, play and love” (p. 2) (see also Section 2.4).
Promotion of the concept of community-based rehabilitation by WHO encouraged governments to financially support its development within communities and opened up opportunities for community physiotherapy. The concept and vision of community-based rehabilitation is discussed with reference to the way it has influenced private community-based physiotherapy. Person-centredness and interpersonal care in relation to community-based physiotherapy is then discussed.

The chapter concludes with comments regarding community-based physiotherapy and the emergence of private community-based physiotherapy within New South Wales and Australia and considers the effect of the concepts of “wellness” and “community” on this area of physiotherapy practice.

2.2 PHYSIOTHERAPY AS A PROFESSION

2.2.1 Physiotherapy – a definition

The professional practice of physiotherapy (sometimes known as physical therapy) is generally defined as:

The health profession concerned with the promotion of health, the prevention of disability, and the evaluation and rehabilitation of patients disabled by pain, disease, or injury, and with treatment by physical therapeutic measures as opposed to medical, surgical, or radiologic measures. (Stedman’s Online Medical Dictionary, 2006)

The Australian Physiotherapy Association has more recently clarified this definition to recognise that physiotherapy practice also incorporates evidence-based techniques, using clinical reasoning within a holistic approach, to best assist people to manage their movement disorders and optimise their overall function (Australian Physiotherapy Council, 2008).

My research is based on the premise that physiotherapy healthcare should be person-centred and relationship-based. A holistic approach to healthcare empowers people to manage their own health concerns. The empowerment and inclusion of people in and for their own health and wellbeing, formed part of the resolutions for the development of global healthcare by the United Nations (WHO 1978, 1986, 2005). In this research, I sought to reveal how community-based physiotherapists, clients, families and carers interpreted such holistic care via the human relationships that developed between them.
Table 2.1: Timeline of events and eras of thinking relevant to the development of community-based physiotherapy in Australia.

<table>
<thead>
<tr>
<th>Date</th>
<th>Events affecting healthcare and the development of community-based physiotherapy</th>
<th>Eras of thinking within physiotherapy</th>
<th>Emergence of Community-based physiotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1906</td>
<td>Establishment of Australian Massage Association (Chipchase et al 2006)</td>
<td><strong>1900 – 1940s – Very early physiotherapy</strong>&lt;br&gt;Prior to formal recognition of physiotherapy as a profession, massage was accepted as a useful mode of physical therapy but not formally named as such.</td>
<td>Minimal domiciliary care&lt;br&gt;1930s - Commercial bodies started offering insurance for hospital costs (Kinna 2003 p.1)</td>
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<tr>
<td>1914-1918</td>
<td>World War One</td>
<td></td>
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<tr>
<td>1930’s</td>
<td>Polio Epidemic in Australia (Post Polio Network (NSW), 2011)</td>
<td><strong>1940s - 1970s - Physiotherapy professionals working within the medical model</strong>&lt;br&gt;Physiotherapy commences as a profession dependent on specific referrals from doctors - ‘medical handmaidens’ (Doctor-centred and paternalistic healthcare (Parsons 1951)&lt;br&gt;Ultimate responsibility lay with the doctor and the medical profession.</td>
<td>Expansion of domiciliary care but main focus still on physiotherapy in hospitals and private practice clinics&lt;br&gt;- Victoria State Health Dept sets up a domiciliary service for poliomyelitis patients (Park 1972)</td>
</tr>
<tr>
<td>1939-1945</td>
<td>World War Two - Demand for masseuses increased greatly during World War II (Bentley &amp; Dunstan 2006)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1956</td>
<td>Last polio epidemic in Australia (Post Polio Network (NSW) 2011&lt;br&gt;- National Health Act governing private health insurance (Kinna 2003) provided some funding for private physiotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1976</td>
<td>“The APA rescinded the ethic requiring referral for treatment by a medical practitioner” (Chipchase et al 2006 p 6).</td>
<td><strong>1970s – 1990s</strong>&lt;br&gt;Development of physiotherapy professional independence&lt;br&gt;- Enhanced Primary Care (EPC) MBS items were introduced by the Australian government in 1999-2000 to improve the health and quality of life of older Australians, people with chronic conditions and those with multi-disciplinary care needs. (Commonwealth of Australia 2009)</td>
<td>Development of publicly-funded community-based physiotherapy with effect of Commonwealth Homecare and Paramedical Services Act&lt;br&gt;- In 1975, 32.5% of physiotherapists working privately (Anderson, Ellis, Williams, &amp; Gates, 2005)&lt;br&gt;(This information does not clearly differentiate the number of...</td>
</tr>
<tr>
<td>1978</td>
<td>WHO (1978) defines primary healthcare as a goal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Action/Event</td>
<td>Description</td>
<td></td>
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<td>------</td>
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<td>-------------</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>World Health Organisation (WHO) global strategy on health reform (WHO 1998)</td>
<td>physiotherapists working exclusively in the community rather than from a private clinic</td>
<td></td>
</tr>
</tbody>
</table>
| 2001 | International Classification of Functioning (ICF) (WHO 2001) | **2000-** Expansion of physiotherapy primary care practice  
- APA (Australian Physiotherapy Association recognises primary healthcare.  
- Lifetime Care and Support for lifelong treatment, rehabilitation and attendant care for people who have severe injury arising from a motor accident in NSW (Commonwealth Government of Australia 2006).  
**Increasing development of private community-based physiotherapy occurring with the support of some public-funding for home-based healthcare**  
- In 2001, 58.6% of physiotherapists working privately (Anderson, Ellis, Williams, & Gates, 2005). (This information does not clearly differentiate the number of physiotherapists working exclusively in the community rather than from a private clinic) |
| 2012 | National Disability Insurance Scheme Act | |
In the next section, I explore the development of physiotherapy further to see how this has affected the nature and development of community-based physiotherapy in Australia.

2.2.2 Eras of physiotherapy

Several key authors and researchers have described historical eras in the development of physiotherapy as a healthcare profession (Ritchie, 1999; Larsen, 2005; Bentley & Dunstan, 2006). Throughout that development, the relationship of physiotherapy to the medical profession has been problematic, with physiotherapists initially being perceived as medical assistants, masseuses and “handmaidens” to doctors (Ritchie, 1999) (see Table 2.1). In Australia, with the formal inception of the physiotherapy profession, the following statement was made at the Second National Congress of Physiotherapy in 1939 by the Honorary Surgeon at the Royal Melbourne Hospital, Dr A. E. Coates:

*Your profession as a handmaiden of medicine will continue to serve the human race, until in the fullness of time the dreams of prophets and poets, seers and scientists are finally realised. Disease will be banished, suffering will cease and as the Apostle St John envisioned, ‘neither shall there be any pain’. (quoted by Bentley & Dunstan, 2006, p. 83)*

From massage to physiotherapy

Even with the formal name change from “massage” to “physiotherapy” at the 2nd National Physiotherapy Congress in Melbourne in 1939 (Bentley & Dunstan, 2006) and the participation of Australia in World War 2, ongoing development of physiotherapy remained close to its previous role as an adjunct to medical healthcare (Bentley & Dunstan, 2006). With their origins in clinical massage and with strong support from the medical profession, early practitioners of what was to evolve into physiotherapy, quickly established an identity, an educational rationale and a degree of independence which provided a firm basis for the future development of the profession (Nall, 2006, p.235).

A doctor-centred and paternalistic view of physiotherapy’s role in healthcare was captured by Ritchie’s (1999, p. 251) term to describe the era of “dependency” in the development of physiotherapy. This era continued in Australia until the 1970s when “first practitioner” status was introduced by the APA in 1976, allowing physiotherapists to have first contact with clients without a doctor’s referral.
2.2.3 The development of community-based physiotherapy in Australia

As physiotherapy developed as a profession following the events of two world wars, greater use of motor vehicles, sports development and successive polio epidemics affecting Australia (Bentley & Dunstan, 2006), so too did community-based physiotherapy. An example of this can be seen in the establishment of home-based physiotherapy programs in Victoria in 1947 to provide assistance for people who had were coping with the effects of poliomyelitis (Park, 1972).

The establishment of first contact practitioner status for physiotherapists in 1976 (Bentley & Dunstan, 2006) resulted in greater autonomy for physiotherapists and provided a major impetus to the expansion of choice in their practice. For privately-based physiotherapists, it allowed greater choice in their practice modes and locations. Physiotherapists became able to be community-based (sometimes operating from their home rather than a separate clinic), consult directly with their clients and their families, and take referrals from healthcare professionals other than doctors. Such flexibility of practice options may also have contributed towards the development of an increased sense of personal and professional autonomy for many physiotherapists.

Opportunities for private community-based physiotherapists have expanded as a result of this general development of physiotherapy.

Funding for clients’ physiotherapy needs

Within private physiotherapy practice in Australia, physiotherapy may be paid for privately (often with the assistance of private health insurance) or with publicly funded assistance. Examples of the latter form of assistance include Lifetime Care and Support,5 Worker’s Compensation,6 Department of Veteran Affairs7 and the Enhanced Primary Care Scheme for allied health services.8 This last option is provided within a healthcare plan administered by the client’s general practitioner and can be initially

6 Worker’s Compensation Act 1987, No 70 (Retrieved from http://www.legislation.nsw.gov.au/fullhtml/infrastructure/act/70+1987+cd+0+) is an act designed to compensate and rehabilitate injured workers which can include the provision of community-based physiotherapy services (New South Wales Government, 1987).
8 In 2004, Medicare started to provide limited access to rebates through the Enhanced Primary Care Scheme (Commonwealth of Australia, 2009). Capped access to this scheme was limited to people with chronic and complex conditions referred by a general practitioner (Nall, 2006).
requested by the client or carers. Funding also includes some public healthcare funding for individuals with significant healthcare problems.\footnote{Public healthcare funding for individuals with significant healthcare problems is provided by a variety of government-sourced healthcare packages.} This is provided by a variety of government-sourced healthcare packages, designed to assist affected persons to remain in their own homes. Examples of these programs include the Older Persons Evaluation Review and Assessment (OPERA) program\footnote{The Older Persons Evaluation, Review and Assessment (OPERA) model of healthcare “provides options for older people, their families and carers to immediately access responsive and appropriate care that is designed to restore and maintain the older person's function and independence in the community” (New South Wales Department of Health, 2006, p. 5).} and the Extended Aged Care at Home (EACH) program.\footnote{The Extended Aged Care at Home (EACH) program provides a customised package of home-based services for people with high care healthcare needs. This can include community-based physiotherapy (Community Packaged Care Guidelines). Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/8050CA60A82FC36ECA25730E001800D/$File/Community%20Packaged%20Care%20Guidelines.pdf} Non-government organisations (for example, Catholic Community Care and Uniting Care Community Options) broker such financial healthcare assistance packages and refer to private community-based physiotherapists for consultant advice for clients and the carers they employ to assist those clients. Such funding has contributed to the development of privately-based physiotherapy services across Australia.

**Development of private community-based physiotherapy**

Since 1975 in New South Wales there has been a steady increase in the proportion of physiotherapists working privately, from only 32.5% in 1975 to 58.6% in 2001 (Anderson et al., 2005) and the introduction of first practitioner status for physiotherapists would have been a contributing factor in that growth. Although private physiotherapists provide well in excess of 10 million patient services per annum (APA, 2005), there appears to be no specific information regarding the discrete group of private community-based physiotherapists who visit clients within the community, and it is difficult to discern from the available figures what percentage of private community-based physiotherapists are involved in such independent, community-based practice. From long experience, I can report that physiotherapy practices operated from the therapist’s home are often mobile in nature, with the therapist conducting visits to clients wherever therapeutic contact is needed, for example in the client’s home, workplace, educational facility or recreational areas. Such home-based mobile practices could be considered a type of cottage industry, providing the physiotherapist concerned with a comfortable, flexible style of work and much lower financial overheads and
running costs. Most of the participating physiotherapists in this research project worked in this way. There appears to be no formal reporting of this style of physiotherapy practice.

Development of private community-based physiotherapy in Australia was enhanced by the provision of some government funding through legislative change. Healthcare initiatives such as the Medicare Act (1984),\textsuperscript{12} the Enhanced Primary Care (EPC) initiative (1999-2000)\textsuperscript{13} and the Lifetime Care and Support Act (2005) were introduced (see Table 2.1). Such legislation provided some funding towards the provision of physiotherapy services for people with chronic health conditions. An example of the community expansion allowed by this government funding can be seen in the provisions of the Lifetime Care and Support Act, where allowance was also made for the extra time and travel requirements for the provision of community-based physiotherapy services to people living at home with the effects of severe injury and disability.

Such legislative development was driven in part from outside Australia by a series of WHO declarations (see Table 2.2) advocating a range of improvements to public health across the world, including the development of community-based physiotherapy. Private community-based physiotherapy practice development naturally benefited from this development.

### 2.2.4 The influence of the World Health Organization on the emergence of community-based physiotherapy

The WHO was established after World War 1, when the League of Nations was set up to promote and maintain international peace. Included within this was a health organisation. However, when the League failed with the advent of World War 2, its health organisation component carried on as the United Nations’ WHO.

WHO aims to make essential healthcare available to everyone (WHO, 1978, 2005) and empower people to take control of their healthcare (WHO, 1986), taking rehabilitation to where people live, work and play (WHO, 2002a, WHO, 2001). WHO frames and

\textsuperscript{12} \textit{Medicare} – A universally available healthcare system was introduced in 1975 as Medibank and added to by a government-owned private health fund called Medibank Private in 1976. Its aims now include simplicity, affordability, universality, efficiency and accessibility (Commonwealth of Australia, 2009).

\textsuperscript{13} \textit{Enhanced Primary Care (EPC) Initiative} - As part of the Medicare program, the Medical Benefits Scheme was established to provide funding for primary healthcare provided by general medical practitioners and in 1999-2000, Medicare Enhanced Primary Care (EPC) items were introduced for GPs “to improve the health and quality of life of older Australians, people with chronic conditions and those with multi-disciplinary care needs” (Primary Health Care Reform in Australia 2009, p. 16). Provision is made within this program for the funding of some physiotherapy service for people with chronic healthcare conditions, on referral from their general medical practitioner, who coordinates the care program for them.
classifies function and disability and advocates and monitors processes to ensure that health is promoted by and with people, not on or to people (WHO, 1997).

Table 2.2: WHO resolutions relevant to the development of community-based physiotherapy (derived from Hale, Croker & Tasker 2009, p. 141)

<table>
<thead>
<tr>
<th>WHO documents</th>
<th>Key concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alma-Ata Declaration of Primary Health Care (WHO, 1978, 2005)</td>
<td>Primary healthcare – “essential health care” made universally accessible to individuals and families by means acceptable to them, through their full participation and at a cost that the community and the country can afford. It forms an integral part both of the country’s health system of which it is the nucleus and of the overall social and economic development of the community” (WHO, 1978, p. 2).</td>
</tr>
<tr>
<td>Ottowa Charter of Health Promotion (WHO, 1986)</td>
<td>Health promotion is the process of enabling people to improve and increase control over their health by:</td>
</tr>
<tr>
<td>Jakarta Declaration on Leading Health Promotion into the 21st century (1997) (WHO, 1997)</td>
<td>Priorities for health promotion are to:</td>
</tr>
<tr>
<td></td>
<td>Health promotion should:</td>
</tr>
<tr>
<td>International Classification of Functioning (ICF) (WHO, 2001)</td>
<td>A framework and classification system to describe and measure function and disability related to health conditions, taking into account the interrelationship of personal, social, environmental and medical factors that impact on the individual</td>
</tr>
<tr>
<td>Community-based rehabilitation joint paper from the ILO, the United Nations Educational, Scientific and Cultural Organisation, (UNESCO) and the WHO (WHO, 2002a)</td>
<td>Community-based rehabilitation (CBR) is “a strategy … for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocation and social services” (WHO, 2002a, p. 1)</td>
</tr>
</tbody>
</table>
Physiotherapy in Primary Health Care

From WHO’s discussion and resolutions passed in the Alma-Ata Declaration of Primary Health Care (WHO, 1978), the term “primary healthcare” became popular, defined as

> Essential health care “made universally accessible to individuals and families by means acceptable to them, through their full participation and at a cost that the community and the country can afford. (p. 2)

WHO’s concept of comprehensive primary healthcare sought to focus on good health, wellbeing and preventive healthcare through equity and community empowerment. However, not all participating countries agreed with WHO’s interpretation of healthcare, believing that it would be too difficult to achieve and a more medically-centred model, “selective primary health care”, was therefore settled on by some countries. In Australia the interpretation of primary healthcare has hovered somewhere between these two definitions (Rogers & Veale, 2003).

With reference to the discipline of physiotherapy in Australia, the APA (2009) states,

> The philosophical underpinnings of physiotherapy — with its consumer focus and emphasis on enabling self-management — ideally place it as an integral part of future primary health care service delivery models. (APA, 2009, p. 7)

and defines “primary health care” as:

> Socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those in most need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes the following:

- Health promotion
- Illness promotion
- Care of the sick
- Advocacy
- Community development (APA, 2008, p. 2).

This definition aligns with that of the Australian Primary Health Care Research Institute (McDonald et al., 2006), which promoted the view (supported by a strong international evidence base) that efficient and effective primary healthcare can improve health and decrease health inequality for a country’s people. The APA (2008) also supported this
view, arguing further, that “nations with a strong primary care infrastructure have lower healthcare costs and generally healthier populations than those concentrating their efforts on the tertiary end of healthcare. Elements required for a strong primary healthcare infrastructure within individual country governance and healthcare structures (as proposed by the APA) include:

- Equitable access of services
- A consumer orientation
- Early detection and intervention practices (that emphasise health promotion as well as disease and injury prevention)
- Better management of chronic conditions
- Continuity and co-ordination of care
- A population health focus
- Improved information management of health needs and outcomes

(APA, 2008, p. 3).

These elements of the primary healthcare model can be usefully drawn upon when considering how WHO’s concept of community-based rehabilitation has influenced practice by community-based physiotherapists (discussed in section 2.3). By virtue of the economic nature of their practice, private community-based physiotherapists cannot fully participate in this model of care, particularly with respect to the factors of equitable access of service and a population health focus, but their practice can benefit from the tenets of primary healthcare in general.

2.3 THE CONCEPT OF COMMUNITY-BASED REHABILITATION (CBR)

The concept of CBR initially arose from the WHO’s need for a global strategy to address the severe global healthcare needs of under-developed countries and the lack of rehabilitative services for people in those countries. 80% of the world’s people who live with a disability live in developing countries, where “the gap between effective service provision and needs is about 97-98 per cent” (Hellander, 1993, p. 2). Although Australia is a developed country, its healthcare development has still been guided by WHO’s policies, and those developments have influenced community-based physiotherapy (and private community-based physiotherapy).
In his discussion of the history and development of CBR, Lang (2011) noted that there has been much variation in CBR’s key components and in its definition between countries and throughout its development. According to Lang (2011), some of this variation is due to the power dynamics that exist between service providers and disabled people. This is ironic given that WHO (2004a) promoted the concept of CBR as promoting

*Collaboration among community leaders, people with disabilities, their families, and other concerned citizens to provide equal opportunities for all people with disabilities in the community.* (p. 1).

Despite these dynamics, Lang (2011) noted that major change has occurred within the CBR movement with the introduction of the UN Convention of the Rights of Persons with Disabilities (United Nations Enable, 2006) and the growth of the international disability movement with its Social Model of Disability, which states, “Nothing about us without us” (Charleton, 2000, p. 17). Lang (2011) described how international health policy developed more rights-based approaches and healthcare itself started to acknowledge a more collaborative approach to the delivery of services to people.

### 2.3.1 CBR – a strategy and a philosophy

The WHO’s philosophy of health and wellbeing for all people across the globe is exemplified in the healthcare developments which it has initiated over the past 40 years (see Table 2.2), and CBR has become both philosophy and strategy towards meeting those aims in developing and developed countries. Most importantly, it promotes the belief that,

*Community Based Rehabilitation is implemented through a strategy that involves the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocation and social services.* (WHO, 2002a, p. 1)

In many industrialised countries, pressure is increasing on health services as the number of people with chronic and complex healthcare problems increases. Pressure is also growing to develop community-based services to help address this problem (Barnes & Radermacher, 2001). Therapists in both developing and developed countries need to

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17. The social model of disability was initially proposed by disabled academic Mike Oliver in an effort to differentiate between social and individual models of disability (Oliver, 1983) for the benefit of social work students learning to work with people with disability (Oliver, 1990). However, this difference originated from the distinction made between impairment and disability by the Union of the Physically Impaired Against Segregation (1976). It is of note that this difference forms the basis of the UN’s Independent Classification of Functioning (ICF) (see Table 2.2).
change their attitudes towards modes of service delivery and therapy roles within such healthcare (Twible & Henley, 2000). Furthermore, CBR needs to be understood as distinct models of healthcare service and as a philosophy that needs to be closely aligned with local community priorities rather than merely as a set of common priorities (Kuiper & Allen, 2004). I suggest that this is a laudable aim for other areas of community-based healthcare in Australia as well.

2.3.2 Models of CBR
Models of healthcare within CBR can vary widely. Variations in the location of care provision exist for people with illness or disability (see Table 2.3). Although the rehabilitation process usually starts in hospital, when people return home from hospital their healthcare can just be transferred from hospital settings into community settings with similar modes of service delivery. Such a biomedical practice orientation is seen in the “Expert” model of CBR. An example of this model can be seen when people living at home visit specialists in hospitals or when practitioners from hospital settings visit people in their home. This latter example also fits within the “Transplant” model of CBR. Cott, Wiles, and Devitt (2007) highlighted this difficult area of transition for clients and their families between hospital and community (home) in their study of preparing clients for life after stroke, and highlighted the need for smoother and more participatory transitions for these people.

Awareness of the different ways in which community-based rehabilitation can be modelled is of relevance to my research. Private community-based physiotherapy (which mostly involves rehabilitation) probably inhabits the “Partnership” model of CBR in people’s homes, although private therapists may also aim to achieve the more independent processes/outcomes for clients and families seen in the “Self-determination” model. Does rehabilitation in the home require self-determination or professional control? (Dow, 2000). Tension exists between the different contexts of hospital and home, between the world of health professionals and the world of clients. In a study of community-based rehabilitation in Victoria, Australia, imbalance occurred within the power relationships that occurred between staff and clients affecting rehabilitation outcomes for clients (Dow, 2000). Dow (2000) suggested that if the health system is to truly include clients and caregivers in healthcare, “the tensions between client self-determination, professional autonomy and fiscal control need to be addressed so that real strategies for inclusion of consumers can be developed” (p. 8). Such rehabilitation models of care need to progress to a chronic care management model, in
preference to rehabilitation outcomes which are often more defined by healthcare professionals than clients and their families (Cott et al, 2007). Such issues lie at the heart of the issue of CBR, what it is, and how it may be developed and maintained.

Table 2.3: Four models of care in CBR (derived from Kendal, Muenchberger, & Catalano, 2009, p. 2167)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice orientation</td>
<td>Bio-medical</td>
<td>Functionality</td>
<td>Ecological</td>
</tr>
<tr>
<td>Professional role</td>
<td>Active</td>
<td>Active</td>
<td>Supportive</td>
</tr>
<tr>
<td>Consumer role</td>
<td>Passive</td>
<td>Passive</td>
<td>Active</td>
</tr>
<tr>
<td>Knowledge source</td>
<td>Professional</td>
<td>Professional</td>
<td>Professional, consumer</td>
</tr>
<tr>
<td>Mechanism of change</td>
<td>Instruction</td>
<td>Education</td>
<td>Experiential exchange</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Transformation</td>
</tr>
</tbody>
</table>

2.3.3 Physiotherapy approaches in CBR

In their discussion of the need to prepare occupational therapists and physiotherapists for CBR in developing countries, Twible and Henley (2000) outlined differences in service provision between the different contexts of healthcare institutions and community settings (see Table 2.4). In the context of community, therapeutic processes and the interactions that are needed to facilitate these processes are enacted in ways that arise from and suit the context. Thinking and planning therapy in CBR has developed in sophistication as healthcare services have continued to strive for quality in CBR (See Table 2.4 and Figure 2.1). The elements of physiotherapy seen in Table 2.4 relate to the way physiotherapists might interact with their clients in CBR (useful for my project).
## Table 2.4: Elements of physiotherapy in CBR useful for community-based physiotherapy (derived from Henley & Twible, 2000, pp. 127-129)

<table>
<thead>
<tr>
<th>Elements of physiotherapy</th>
<th>Physiotherapy in CBR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Style of physiotherapy interaction</strong></td>
<td>Physiotherapy is often given in a more indirect style</td>
</tr>
</tbody>
</table>
| **Physiotherapy approach** | Manages the impairment or illness  
Problem-solving  
Eclectic use of different options for clients and families  
Well suited for chronic healthcare issues – adopting long-term solutions” |
| **Therapeutic relationships** | Relationships are client- and family-centred with “a partnership approach based on a two-way flow” (p. 127) |
| **Therapist status** | Physiotherapists are viewed as “a resource with expert knowledge about disability and pathology” (p. 127) for clients and families  
Family members and carers are viewed as “the expert about day-to-day functional issues and contextual factors” (p. 127) |
| **Imparting and sharing of knowledge** | Knowledge is given in a friendly and accessible form and manner, with consumer-friendly terminology used whenever possible  
All healthcare partners respect each other and the contributions they all have to give |
| **Sharing of physiotherapy skills** | Physiotherapy skills are often taught and transferred to carers and family members to assist with the care of clients |
| **Therapy and healthcare decisions** | Therapy decisions always involve clients and families |
| **Type of skills needed by physiotherapist** | “Management, teaching, networking, organisational, health promotion, as well as therapy skills” (p. 128) |
| **Considerations of context** | “Always considered” (p. 128) |

The competencies identified by Kendal et al (2011) in Figure 2.1 contribute areas of practice needing attention by practitioners, as well as ideas for graduate and ongoing education and professional accountability. This sets a standard for CBR practitioners;

CR [community rehabilitation] practitioners need to be prepared to conceptualize dynamic processes and multi-component systems, continually reflect on their own practice and manage complicated contexts. They must focus
on simultaneously managing change at the individual and systemic levels and engaging multiple partners in their processes (i.e. consumers, communities, collaborating agencies, and other professionals) while remaining focused on individuals and their needs. (Kendal et al., 2011, p. 150)

My research needs to be viewed within the context of this professional discourse. I aimed to provide deeper understanding of how members of one particular professional body (privately practising community-based physiotherapists in NSW) sought to enact their community-based practice through the person-centred relationships they developed with clients, families and carers.

<table>
<thead>
<tr>
<th>Professional qualities for inter-professional CBR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frameworks for understanding</td>
</tr>
<tr>
<td>Building networks</td>
</tr>
<tr>
<td>Cultural awareness</td>
</tr>
<tr>
<td>Holistic focus</td>
</tr>
<tr>
<td>Consumer engagement</td>
</tr>
<tr>
<td>Service continuity</td>
</tr>
<tr>
<td>Reflective practice</td>
</tr>
<tr>
<td>Community engagement</td>
</tr>
<tr>
<td>Boundaries and personal safety</td>
</tr>
<tr>
<td>Systems advocacy</td>
</tr>
</tbody>
</table>

Figure 2.1: Professional qualities for inter-professional CBR
(derived from Kendal et al., 2011, p. 148)

2.4 PERSON-CENTRED HEALTHCARE

However, as the 21st century has progressed, physiotherapists have increasingly faced the challenge to balance the need for EBP with the equally important human needs of clients and their families and carers. Tension occurs between these two goals for modern healthcare. Increased consumerism and a greater availability of health-related information for the general public, has also contributed towards an increased demand by patients and their families for fuller involvement in their healthcare. People have also developed a growing belief that access to such care is a civil right to be enjoyed by all (Cott, 2004). It is within this area of the discourse that my research project is situated. Cott (2004) noted that the discourse regarding a rising demand for client-centred care
arose alongside the development of the discourse surrounding EBP but was not “adopted with such enthusiasm and vigour as EBP” (p. 1412). With an obvious need for co-ordination between these approaches, Cott (2004) further suggested that although this might be difficult, the two approaches do not need to clash. An alternative perspective is that the evidence for the importance of client centredness for client outcomes equals if not outweighs the evidence for many other practices in rehabilitation (p. 1420). Indeed, Gzi et al (2007) argued that person-centred healthcare practices approach disability and complex health issues with a much broader and more comprehensive range of interventions, which has changed the medico-centric focus of healthcare of the past. The contrast between the use of many and various terminologies within person-centred healthcare and the more scientific discourse that focused on “hard” facts in clinical encounters may have also contributed towards the difference in acceptance between EBP and person-centred healthcare.

The terms “person-centredness” and “person-centred” within healthcare discourse are complex and interpreted differently by different people. Within healthcare generally, these terms can refer to the overall design of healthcare services, the planning for people with disability and/or chronic illness or the interaction between healthcare practitioners and their clients (Leplege et al., 2007). Even the terms related to “person-centredness” vary (client-focused, patient-centred, etc.), often with different meanings (Cott et al., 2001). Leplege et al. (2007) speculated that even more interpretations of patient-centredness have emerged as a result of the way the concept originated and developed in different healthcare disciplines.\textsuperscript{15}

Within the field of physiotherapy, discourse regarding person-centred care has been sparse and more related to areas of physiotherapy care other then community-based physiotherapy, for example;

- patients’ perceptions of acute and clinic-centred physiotherapy regarding person-centred approaches within physiotherapy for low-back pain (Cooper, Smith & Hancock, 2008)
- student perceptions of person-centredness regarding the perceptions of person-centred approaches to rehabilitation (Schmitt, Ackroyd and Burke, 2012)

\textsuperscript{15} Within this thesis I use the term “clients” but in the literature regarding person-centredness, the terms ‘patients’ and ‘service users’ are also used.
client’s perspectives of rehabilitation as clients with disability move from rehabilitation back to their homes and communities (Cott, 2004, p. 1413) (This study does explore concepts of personcentredness from the aspect of the rehabilitation unit into the transition to home and community)

Such sparsity of qualitative research reflects a gap between existing therapy theory and practice in the field (Carpenter & Suto, 2008), influenced to an extent by therapists’ assumptions of practice (Hammel, 2006).

Schmitt et al (2012) notes that the concept of individualisation may be particularly important to the area of rehabilitation and indeed person-centred care would seem to depend on such an approach. Development of person-centred healthcare practice has been most deeply affected by the shift to a biopsychosocial model, along with the more recent developments seen with the acceptance of the ICF (International Classification of Functioning, Disability and Health (WHO, 2001), (see Table 2.2). The ICF’s distinction between ‘impairment’ and ‘disability’ brings the focus of healthcare onto the interface of people and society through their community, thereby requiring a stronger emphasis on individualisation and mutual interpersonal interaction. Such processes of individualisation are also addressed in work from the Scandinavian countries, for example, micro-sociological studies of physiotherapy situations completed by Ek, (1990), and Thornquist, (1997). Although the term “person-centred” is not particularly mentioned in these studies, such work is all about the interaction between physiotherapist and client. Indeed when Ek (1990) speaks of the reciprocal processes that occur within physiotherapy sessions, this can be viewed as a pre-requisite for person-centred care. However, with the exception of Thornquist’s (1997) study of home-based physiotherapy, the context of community-based physiotherapy is not addressed in these works.

The next part of this chapter focuses on some of the ways in which person-centredness and dimensions of person-centred approaches can be manifested in healthcare relationships, from some different disciplinary perspectives. For my research, the topic of particular interest is the way person-centred healthcare approaches can influence interactions between community-based physiotherapists, clients, families and carers. The subjective experience of clients is a key aspect.

16 The terms person-centred and person-centredness are used within this thesis, rather than any of the other terms described in section 2.4.
Paying attention to the subjective experience of the client

As long ago as the 1960s, a general practitioner, Balint (1969), had begun writing about patient-centred medicine, advising that “the patient has to be understood as a unique human-being” (p. 269). As the use of person-centred approaches in healthcare have developed over the past 50 years in medicine, medical consultations have increasingly been perceived by doctors to be enhanced if attention was paid to the subjective experience of patients (Leplege et al., 2007). This growing acknowledgement of the role of patients in their own healthcare coincided with efforts to encourage patients to take responsibility for themselves and collaborate with their doctors for better healthcare outcomes (Leplege et al., 2007). This collaboration needs to take place within the clinical relationship that develops between practitioners and clients.

Mead and Bower’s (2000) work on a conceptual framework for person-centredness in medical consultations stimulated attention in the following areas:

- **A biopsychosocial perspective** – “broadening the scope” of issues to be considered beyond purely organic and physical issues (p. 1088)
- **Seeing the “patient-as-person”** – striving to understand people as unique individuals in unique contexts and hearing and understanding their experience of illness (p. 1088)
- **Sharing power and responsibility** – aiming for a more balanced interaction where the health practitioner’s voice does not overpower that of the client/patient, allowing “mutual participation” to develop (p. 1089)
- **Developing a therapeutic alliance** – perceiving value in the relationship that builds between practitioners and clients
- **Acknowledging the “doctor-as-person”** – using practitioners’ human attributes within the clinical relationship being developed (p. 1091)

These dimensions of person-centredness expanded the way that healthcare interactions could be viewed, by acknowledging the need for all parties in healthcare to communicate with each other freely as people, as well as healthcare practitioners and clients/patients. This conceptual framework provided strong grounding for the development of healthcare relationships and contributed to the study undertaken in this thesis. “At the core the patient-centered care is the quality of interactions between patients and care providers” (Jayadevappa & Chhatre, 2011, p. 22).
Encouraging and engendering relational environments in practice

Alongside the development of patient-centered medical practice in the mid- to late 1900s, Carl Rogers from the field of psychology developed ideas of “person-centered approaches” to psychological counselling (1989). This approach emphasised the necessary attributes and abilities of attending psychologists to provide relational environments that could encourage clients to open up and articulate their wishes for the future. This process was known as self-actualisation, the process whereby each person strives to become who they want to be. Rogers’ earlier work in the 1930s and 40s was with children (over the period of the Great Depression) and then with war veterans after World War 2, and could be seen as promoting adjustment to life (Baker, 2012).

According to Baker, in the 1950s and 60s, the work of Rogers developed in line with societal change (and the availability of healthcare funding for psychology) and the growing desire by many individuals for self-fulfilment or self-actualisation.

The development of the work of Rogers can be seen in some ways to parallel that of community-based physiotherapists as they seek to help people to adjust to chronic illness and disability and realise a sense of wellness and a good life for themselves and their families (see section 2.5.1). From the time of his training when he first attended theology college to his training as a psychologist at Columbia University, Rogers needed to conform to the tenets of psychological science and balance the qualitative and quantitative aspects of healthcare in the same way that other healthcare practitioners need to do today (Baker, 2012). In his lifelong fascination with the phenomenology of self, Rogers (1989) developed some core conditions for therapists, to enable them to help create change for and with their clients. These conditions are known as CUE (Core conditions for therapists) (see Table 2.5). Although Rogers initially argued that the adoption of such attitudes could assist therapists to be non-directive in their work with clients, allowing clients to express themselves freely, building trust and confidence, he later changed this thinking into what we now call client-centred approaches, which acknowledges that people sometimes want or need some direction. In the practice of physiotherapy, direction does take place within the physical interaction, especially in the first stages of therapy (Øien, Steihaug, Iversen, & Råheim, 2011) as physiotherapists utilise their knowledge of bodies and movement to help clients.

Rogers’ ideas provide a useful point of reflection for physiotherapists: how much should therapists say and do within a clinical interaction and how will that affect how
much clients can say and do?\textsuperscript{17} Such delicate balancing requires practitioners to maintain focus on the whole person.

Table 2.5: Core conditions (CUE) for therapists (derived from Rogers, 1989)

<table>
<thead>
<tr>
<th>Core conditions for therapists (CUE)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congruence</td>
<td>“An accurate matching of experience and awareness” (Rogers, 1989, p. 282), where therapists feel accepting, honest, and open with clients and their reactions reflect an accurate awareness of their feelings and experience</td>
</tr>
<tr>
<td>Unconditional Positive Regard</td>
<td>Respect for the client, shown by holding the client in high regard at all times</td>
</tr>
<tr>
<td>Empathy</td>
<td>Fully understanding a client’s thoughts and feelings</td>
</tr>
</tbody>
</table>

\textbf{Keeping emphasis on the whole person}

The realisation of the need for humanity in their approach to patients also underpins the journey towards person-centredness within the profession of nursing, where efficiency of care had become the hallmark of the profession. McCormack (2004) discussed this human imperative from a philosophical view, arguing that disturbing the “whole” nature of human beings can risk a person’s wellbeing. He argued that the emphasis of healthcare should stay on the actuality of the person rather than on the more abstract notion of a person-centred model of care. By revealing the caring side of their practice, nurses would be able to promote the value of the interpersonal connection between healthcare practitioners and patients (McCormack, 2004).

Nolan et al. (2004), also from the field of nursing, argued further that therapeutic nursing was not just enacted in the individual relationships between nurses and clients but “rather in a network of relationships” (p. 52). They proposed a “senses framework” for nursing older people in healthcare that would “capture those elements of relationships that participants considered important” (p. 51). These senses include:

- Security
- Continuity
- Belonging
- Purpose

\textsuperscript{17} “Rogers preferred to use the term ‘client’, rather than ‘patient’ because he considered that ‘patient’ implies that a person is ‘sick’ and needs to be ‘cured’” (Coon & Mitterer, 2009, p. 514).
and provide “a means of highlighting important, but often taken-for-granted, aspects of care that participants felt were often lost in debates about evidence-based care” (p. 51). In particular, a sense of continuity benefits from further consideration.

**Promoting continuity in clients’ lives and sense of self**

“A person’s identity is what provides the person with a sense of continuity, a sense of coherence and a sense of self” (Wills & Day, 2008, p. 548). These feelings can be severely disrupted when illness or disability strikes, or continuously affected in situations where disability has been present for all or much of someone’s life. Transitions from hospital to home also cause disruption for clients and their families with different styles of care needed for such different environments. In their study of clients leaving hospital to go home after having a stroke, Cott, Wiles and Devitt (2007) proposed that community-based rehabilitation needs to move towards a chronic disease management model, which realises the ongoing nature of such care and encourages participation of clients in life and community activities. Such a view is supported by WHO’s International Classification of Functioning (2002b), which describes people’s situations via a range of domains of functioning rather than just describing their disease or disability.  

Client situations can best be revealed by clients (or carers, if they are unable to speak) telling the stories of their lives and how they live them. For practitioners, the use of a narrative, listening approach to such life stories of clients can help them (the practitioners) understand the place and meaning of disability in their clients’ lives and how it has disrupted their sense of identity and continuity (Ellis-Hill, Payne, & Ward, 2000). Practitioners might then be able to respond in a more person-centred way to plan personalised therapy interventions for these clients (Ellis-Hill et al., 2000).

Ellis-Hill et al. (2000) described the discontinuity of self that occurs for people after having a stroke as a “self-body split”. In their life narrative study of this phenomenon, they discovered that stroke survivors struggled with self-body split difficulties for more than a year post-stroke, as they tried to build “a working relationship with their bodies”

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18 “ICF is named as it is because of its stress is on health and functioning, rather than on disability. Previously, disability began where health ended; once you were disabled, you where in a separate category. We want to get away from this kind of thinking. We want to make ICF a tool for measuring functioning in society, no matter what the reason for one's impairments. So it becomes a much more versatile tool with a much broader area of use than a traditional classification of health and disability” (WHO, 2002b, p.3).
The self-body relationship was dynamic, socially sensitive and situation-dependent, and people were more comfortable at home where their self-body split could be “silent” for longer periods of time. Implications of this research for practice include the suggestions from the authors that stroke rehabilitation needs to embrace the social and emotional aspects of rehabilitation for clients and that this needs to be conducted in contexts other than acute style settings. I agree that such therapy work needs to spring from a strongly person-centred approach to rehabilitation that includes “narrative as well as physical, hands-on skills” (Ellis-Hill et al., p. 732) to enhance a more compassionate approach for these people.

**Being compassionate**

People who have encountered chronic and complex health problems or disability also lose possibilities in life (van de Cingel, 2011). Often their lives are framed by the intrusion of continual care. Van de Cingel (2011) noted that this loss of possibilities becomes harder for clients to deal with as time goes on, causing suffering in its truest sense. Compassion is a necessary part of the relationship that develops between practitioner and client. In van de Cingel’s (2011) nursing study, findings revealed compassion to be “a process of intuition and communication, in which one can recognize some sort of a sequence” (p. 676). Such a process could be seen as narrative in its progression within a clinical relationship. Van de Cingel (2011) proposed seven dimensions of compassion (see Figure 2.2).

Van de Cingel (2011) found that nurse participants considered that compassion became “an instrument of care”, helping them to find out information to help their client achieve their desired health outcomes (p. 683) and softening nurses’ perceptions of some clients as difficult. Compassion was considered by participants (both nurses and clients) to directly contribute to good health outcomes for clients. Clients felt that the compassion of nurses helped to motivate them in their efforts to become well and get better more quickly. The interactions between the nurses and their clients were very person-centred.

It is possible that such person-centred approaches to healthcare could be more easily effected within community settings where different and more personal contexts for physiotherapy practice can be initiated and varied by clients and their families, allowing clients and their families to build capability and confidence to develop wellbeing and good health.
### Dimensions of compassion

| Attentiveness: Assuming the mindful approach of a person “who shows interest in whatever issue is important for the other person” (p. 676) |
| Listening: Giving “room to the story of the patient” (p. 677) |
| Confronting: “When the story is told, the room to breathe can be used for dialogue” (p. 677), paraphrasing what has been heard and acknowledging and valuing what has been said |
| Involvement: “the idea that the nurse recognizes your emotion and that she is concerned about you in the same way that you are yourself” (p. 677) |
| Helping attitudes: “Giving someone a hand” and suggesting alternative ways of coping (p. 678) |
| Presence: “To be there”, to be present is all about noticing what is going on with a patient. Practitioners can only be responsive (salient) if they are “present” (p. 678) |
| Understanding: Showing clients that they want to understand their feelings properly and will not “walk away from them” (p. 679) |

Figure 2.2: Dimensions of compassion (derived from van de Cingel, 2011, p. 676)

The next sections of this chapter describe community-based physiotherapy and the development of wellbeing and good health that lies at the heart of practice with clients, families and carers.

## 2.5 COMMUNITY-BASED PHYSIOTHERAPY

For the purposes of this study, I define the term “community-based physiotherapy” as the practice of physiotherapy, conducted in the places where people “learn, work, play and love” (United Nations, 1986, p. 2). This includes private homes, group homes, nursing homes, schools, day programs and workplaces, as well as in the general community, such as parks, gardens and leisure spaces. Examples of such practice are described in the scenarios of community-based physiotherapy of Table 2.6.

The use of the term *community-based* rather than *home or domiciliary* is important because it links such therapy to the concept of community-based rehabilitation (WHO, 2002a), where the concept of community drives the healthcare process. Hale (2004) argued that “the different wordings are a subtle play on words, in that ‘home or domiciliary’ are not equivalent to ‘community’” (p. 137) and quoted Chatterjee (2001), who argued that ‘community-based’ does not necessarily mean ‘community-driven’.
The physiotherapist participants in this research project could properly be said to be community-based rather than domiciliary or home-based, because they received primary referrals from different sources and practised their physiotherapy in different community settings as needed or requested by their clients and their families. It may be that privately funded community-based physiotherapy could also be said to be ‘community-driven’, given the situation that community members are often self-referrers. “A community health care worker sees people where they live, work, play, worship, study and die” (Stricklin, 1997, p. 159).

*Community-based physiotherapy can be viewed as being embedded within the WHO’s philosophy of primary healthcare, health promotion and community-based rehabilitation. (Hale et al., 2009, p. 140)*

Community-based rehabilitation and community-based physiotherapy in general both involve “the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocation and social services” (International Labour Organization (ILO), United Nations Educational Scientific and Cultural Organization, United Nation’s Children’s Fund, World Health Organization. 2002, p. 1). Although the implementation of the WHO (2002a) community-based rehabilitation strategy was designed to provide access to rehabilitation services in underdeveloped countries with sparse and often absent physiotherapy services, I suggest that community-based physiotherapy can be considered within its overarching philosophy. The joint efforts of the people involved in such physiotherapy endeavours are all aimed at developing wellbeing and good health for clients living at home.

### 2.5.1 Developing wellbeing and good health

The achievement of healthcare outcomes might be considered “good health” but in our modern world, there has been a shift in thinking from healing models to good health models, where the individual is viewed as proactive and self-regulating within their environment (Snyder, Lopez et al., 2002).

*Health is not a condition that one introspectively feels in oneself. Rather, it is a condition of being involved, of being in the world, of being together with one's fellow human beings, of active and rewarding engagement with one's everyday tasks (Gadamer, 1996, pp. 113-114).*

Wellness, wellbeing and good health are all terms commonly used to define an optimal and desirable state of being for people, depending on the perspective of the person concerned. “Wellness” might indicate an individual’s perception and feeling of good
health, whereas “wellbeing” is a term used to refer to a state of being which could include the person’s attitudes and situation and not just a sense of being well.

Table 2.6: Examples of scenarios of physiotherapy care in community-based physiotherapy (derived from Hale et al., 2009, p. 142).

<table>
<thead>
<tr>
<th>Home visit for a baby with developmental delay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marie (11 months old) sits in her highchair at the kitchen table with her Mum, Dad and Sue, her “physio”. Marie has very poor head control and is not yet able to sit by herself. Sue’s fortnightly physiotherapy visits provide a chance for Marie’s Mum and Dad to check on Marie’s movement development, and ensure they are holding and handling Marie in a way that will help her learn to move well. On this visit Marie’s dad says that they would love to take Marie on a bushwalk, and wonders if she can be carried in a backpack carrier like other babies? Sue helps them devise a safe and supportive way to do this (Hale et al., 2009, p. 142).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home-based stroke rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenny, a community-based physiotherapist, is working with Ben, a 65-year-old man recently discharged from hospital following a stroke. Jenny spends a great deal of time during the first visit discussing with Ben what he would like to achieve. Ben’s greatest wish is to walk his daughter down the aisle at her wedding without using any assistive device. Jenny then focuses her physiotherapy program on helping Ben to walk safely without an aid, and includes a plan for practising walking down the aisle at the church where the wedding will take place. This involves walking with Ben up and down the aisle, both on their own and with the family watching, demonstrating to Ben’s daughter how she could assist her father (Hale et al., 2009, p. 142).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education for volunteers undertaking elderly support visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>A group of people are meeting at their local neighbourhood centre. They have all volunteered their time to visit people in their homes and in nursing homes, but not many of them have had any experience with people with disabilities or healthcare problems. The local community physiotherapist is leading a session to explore issues they may face in this type of situation and how to conduct themselves physically. How do you approach a person with dementia? Is it all right for a volunteer to help the person up from their chair? The volunteers are very keen to help but also uncertain as to how to do it well and with safety. After the education session, the physiotherapist stays to have a cup of tea with them and to answer some more questions, some of which are more confidential in nature and need specific advice and referral (Hale et al., 2009, p. 142).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to public areas for stroke survivors and carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local hall is buzzing with people, wheelchairs and talk, as the stroke club gets ready for its weekly meeting and education session. Stroke survivors and their carers have organised the community physiotherapist and occupational therapist to come to this meeting to discuss the issue of access in public areas. Three people can’t get their power wheelchairs up the slope to the post office and one carer is getting sore wrists from helping her husband up the steps to the local dentist’s rooms. After showing different ways of assisting with stairs, the physiotherapist and occupational therapist help arrange a meeting with the local council to address access issues (Hale et al., 2009, p. 142).</td>
</tr>
</tbody>
</table>

Svenaeus (2000) used the term “homelike being-in-the-world” (p. 90) to describe a sense of the state of good health. He drew from Gadamer, who proposed that good health is not an introspective feeling but rather a state of being there, in the world with other people “It is the rhythm of life, a permanent process in which equilibrium re-establishes itself” (Gadamer, 1996, pp. 113-114).
The WHO (1946) has also stated that “health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (p. 100). Table 2.7 shows dimensions of wellbeing as perceived by clients and families living with chronic and complex healthcare needs. Each of these dimensions can be experienced when people express their views of what has meaning to them. For this project, I have accepted that “health” or “wellness” should also include that personal space where “human beings are active in the process of living their lives to the fullest” (Veitch, 2007, p. 6). When people encounter severe healthcare problems, the process of “living life to the fullest” is interrupted. The regaining of lost health depends on different factors enabling people to resume roles in their everyday lives (Gadamer, 1996). An example of this can be seen within community-based physiotherapy. Doolittle (1991), found that although many physiotherapists viewed stroke recovery in terms of movement return, people who had experienced a stroke viewed recovery as returning to previously valued activities.

Table 2.7: Dimensions of Wellbeing (Derived from Ryff, 1995, p. 101).

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-acceptance</td>
<td>The positive evaluation of the self and the past</td>
</tr>
<tr>
<td>Personal growth</td>
<td>An experience of continuing growth and development as a person</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Being self-determining and independent</td>
</tr>
<tr>
<td>Environmental mastery</td>
<td>A sense of mastery and competence in managing the environment</td>
</tr>
<tr>
<td>Purpose in life</td>
<td>The conviction that life is meaningful</td>
</tr>
</tbody>
</table>

Physiotherapists felt that paying attention to clients’ social needs could imply the use of merely passive clinical treatments (Wallin et al., 2008). Physiotherapist participants in the study of Wallin et al. considered that mostly active physical treatments were better practice. The physiotherapists were shown to focus on the physical impairment of their clients, only in the situation presented and in an “isolated and objectified manner” (p. 543). Such an approach paid little attention to the everyday challenges faced by clients. Contextual aspects of function were better accounted for by physiotherapists when clients were positioned as partners and their physical limitations were considered relative to their activities of daily living. Psychosocial aspects of people’s lives need to be fully integrated into physiotherapy approaches if they are to achieve an outcome of wellbeing (French & Sim, 2004). At the 2009 annual conference of the American Physical Therapy Association, much discussion occurred regarding the input of
physiotherapy to the healthcare of people with chronic and complex healthcare needs living at home. The important points were made that:

*People with lifelong disabilities are not “sick”, but they may have co-existing conditions that may be overlooked by healthcare professionals.*

*The number of people with lifelong disabilities is growing rapidly.* ...

*Physiotherapists are well positioned to assist patients with lifelong disabilities and to advocate for them.* (American Physical Therapy Association 2009, Welcome speech)

If this goal is to be achieved, physiotherapists may need to extend their vision and sphere of practice. Individual professional healthcare practice is moulded by many different influences to produce different styles or models of practice that vary depending on the conscious and unconscious choices of individual practitioners (Trede & Higgs, 2009). In the world of home-based healthcare there are many shades and combinations of issues and medical conditions to consider (often referred to as co-morbidities). Illness and injury may resolve for people but there is often residual disability to be managed, even in the presence of ongoing rehabilitation and treatment. It should be recognised that people with chronic healthcare problems want to live “good lives” like everyone around them.

**Living good lives**

When considering the best way to offer people more holistic assistance with disability and chronic illness, it is useful to look to the Good Lives Model of community and clinical rehabilitation proposed by Siegert, Ward, Levack, and McPherson (2007), who highlighted some underlying issues in community rehabilitation:

- Clients have strengths that can benefit themselves and their community.
- “Absence of certain human goods (self efficacy/sense of agency, inner peace, personal dignity/social esteem and social relatedness) is assumed to be strongly associated with and highly predictive of higher levels of disablement” (p. 1612).
- Developing clients’ skills and capabilities helps them achieve higher levels of participation and decreases the effect of their impairment (and disability).
- Rehabilitation should “add to an individual’s repertoire of personal functioning, rather than an activity that simply removes symptoms or manages a problem” (p. 1612).
- Rehabilitation can best assist clients to achieve good lives by reinforcing clients’ strengths and helping them to build new capability.
Siegert et al. (2007) argued that, by exploring individual life plans, practitioners can more easily help clients to achieve what they can consider “a good life” by incorporating balance between life expectations and reality. They gave the example of someone with acquired brain injury “who tries so hard to return to full-time employment that the resultant headaches and irritability jeopardise their family life, their work life or even self-care” (p. 1614). Within community-based situations, private physiotherapists need to be aware of the wider view of rehabilitation as it impacts on the lives of clients and their families.

While many private physiotherapists work mainly in their own clinics, privately operating community-based therapists usually conduct home and/or community visits to their clients. Many studies report that clients and their families prefer to receive healthcare within their own homes (Barnes & Radermacher, 2001). Obvious benefits include decreased levels of fatigue for clients with disability and decreased need for travel. Such visits may be undertaken to private homes, workplaces, schools or other community-based situations of relevance to the particular client. This mode of practice can be used to address the physiotherapeutic needs of people with chronic and complex healthcare problems (such as head injury, spinal cord injury, developmental disability, stroke and the care of frail, aged people).

2.5.2 Concepts of “community” for community-based physiotherapists

The term “community” is a complex idea and can have many facets of meaning, depending on the agenda and purpose of the person using the term. It is important for this project to clarify the meaning within the situation of home-based healthcare and physiotherapy.

In a review of the theory surrounding the concept of “community” Smith (2001) described the basic components of a community to be a commonality between people of place, interest and communion, with strong underlying qualities of tolerance, reciprocity and trust. The social networks that people develop when living together create a sense of belonging and a “community of meaning” as “people construct community symbolically, making it a resource and repository of meaning, and a referent of their identity” (Cohen, 1985, p. 118). Such extension of meaning for the term “community” is inherent in the notion of social capital.
Social capital

Social capital is a sociological term which was coined in the early 20th century in a study regarding local support for rural schools (Hanifan, 1916).

I do not refer to real estate, or to personal property or to cold cash, but rather to that in life which tends to make these tangible substances count for most in the daily lives of people, namely, goodwill, fellowship, mutual sympathy and social intercourse among a group of individuals and families who make up a social unit. (Hanifan, 1916, p. 130)

In a world striving for progress and becoming increasingly dependent on measurement and economic development, the concept of social capital seems to be part of an effort to recognise what people know in their hearts to have human and personal meaning and value, the need for encounter and connection between people. On an individual level this pattern of connection and reciprocity has been termed colloquially “the golden chain”, the process whereby a person would:

Help another member of their community without expecting anything immediately in return, and perhaps without even knowing you, confident that down the road you or someone else will return the favour. In the short run there is altruism, in the long run self-interest. (Putnam, 2000, p. 134)

Within my research project, there was a focus on the interactions and relationships between physiotherapists, clients, families and carers. These relationships occurred within the wider context of human communities. No matter whether we are clients, carers, family members, professionals or researchers, we are all part of a community and depend on reciprocal human interaction. Acknowledgement of that dependence underlies most interpersonal interaction, including physiotherapeutic interaction where therapist and client are also active and reflecting human beings (Ek (1990). This issue is discussed in greater depth in Chapter 3.

2.6 CONCLUSION

In this chapter I have explored the context of community-based physiotherapy in Australia within the overarching profession of physiotherapy and its development, in conjunction with relevant national and world events. The philosophy and strategies of the WHO have influenced the development of physiotherapy and the specific development of private community-based physiotherapy in Australia. The development
and integration of the concepts of community-based rehabilitation and person-centred healthcare from the perspectives of different healthcare disciplines have also contributed to that development, forming a strong background and context for this study of community-based physiotherapeutic relationships. Deeper understanding of such contexts helped me to prepare for this study, by setting the scene within which community-based physiotherapy relationships between therapists, clients, families and carers develop. The next chapter explores how the concept of narrative might be used to understand community-based physiotherapy relationships.
CHAPTER 3
NARRATIVES FOR COMMUNITY-BASED PHYSIOTHERAPY

Narrative is about transformation over time.
It’s about the relationships between
What we did yesterday and what we will do tomorrow.
It’s about what we do and how we describe.
It’s the way we talk about human beings.

Built into us is a narrative way of being.
We ascribe meaning and make sense of our lives through narrative.
It’s about how we make ourselves intelligible in the social world
Where we use stories to identify ourselves to others and to ourselves.
(adapted from Kearney, 2009, p. 191)

3.1 INTRODUCTION

Interactions between people getting to know each other and working together can be seen as strongly narrative in nature. “Human beings are narrative creatures and are essentially self-interpreting” (Titchen & Hobson, 2005, p. 13). In this chapter, I explore the concepts of story and narrative to inform this research into community-based physiotherapeutic relationships. I argue that stories are an essential part of human relationships. Mindful recognition of the part that narrative and stories can play within healthcare interactions could contribute towards the efforts of practitioners to achieve person-centred and relationship-centred care for their clients.

Discourse regarding consideration of narrative within the field of physiotherapy is sparse. I have therefore also sought literature across healthcare disciplines (physiotherapy, occupational therapy, nursing, psychology and medicine) and beyond
(sociology, anthropology, literary theory, education and qualitative research) in an effort to provide insights and perspectives on the topic of the use of narrative in healthcare as it might pertain to the different characters and interactions within community-based physiotherapy contexts.

Starting with searches using Google Scholar, I initially used search words including *physiotherapy, illness and disability*, in combination with *narrative* and *story* and then used the same search words to expand this search into relevant databases, in particular Academic Search Complete, EBSCO Host (all), CINAHL PLUS (with full text) and Nursing and Allied Health Source. In this initial stage, I also sought out books from authors who had demonstrated an interest in the application of narrative to different areas of healthcare, for example Frank (1991/2002, 1995, 2002, 2004, 2007a,) and Mattingly (Mattingly & Hayes Fleming, 1951; Mattingly & Garro, 2000 and Mattingly & Lawlor (2001). I read their books in order of publication and also checked their lists of publications for any other relevant papers they had written. I sourced relevant PhD theses (Alder, 2003; Ek, 1990; Kearney, 2009), checking their patterns of references to discover where work of this type might be currently occurring in the world.¹⁹

When the names of particular “giants”, for example, philosophers (Heidegger, 1962, 1977 and Ricoeur, 1983a, 1983b) and literary theorists (Iser, 1978 and Bakhtin, 1981) occurred within the work of more than one author, I extended my reading tangentially to find out about those people and how their work might have contributed to the topic of interest in this research. Hermeneutic sifting through layers of literature across disciplines is reflected in the writing throughout this chapter.

### 3.1.2 Physiotherapy qualitative research into physiotherapeutic interaction

Within the field of physiotherapy, doctoral research completed by Ek (1990) really commenced research into the space of physiotherapeutic clinical relationships and argued for the acknowledgement of reciprocity between physiotherapists and clients in clinic situations. In Table 3.1, the development of qualitative research into such relationships can be seen to have initially been looking from the physiotherapist’s perspective (Gyllensten et al 1999, Stenmar, & Nordholm, 1994)

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¹⁹ Unfortunately I was only able to read works where an English translation was available and therefore cannot be sure I have not missed some work in another language.
Table 3.1: Examples of research studies into physiotherapeutic relationships

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Title</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>Ek, K. M.</td>
<td>Physical therapy as communication: Microanalysis of treatment situations</td>
<td>Physiotherapy as a reciprocal activity</td>
</tr>
<tr>
<td>1999</td>
<td>Gyllensten, A., Lundvik, G.G., Salford, E., &amp; Ekdahl, C.</td>
<td>Interaction between patient and physiotherapist: A qualitative study reflecting the physiotherapist’s perspective</td>
<td>Physiotherapy from physiotherapists’ perspectives</td>
</tr>
<tr>
<td>2000</td>
<td>Mattsson, M., Wikman, M., Dahlgren, L., &amp; Mattsson, B.</td>
<td>Physiotherapy as empowerment: Treating women with chronic pelvic pain.</td>
<td>Physiotherapy from physiotherapists’ perspective</td>
</tr>
<tr>
<td>1994</td>
<td>Stenmar, L., &amp; Nordholm, L. A.</td>
<td>Swedish physical therapists’ beliefs on what makes therapy work.</td>
<td>Physiotherapy from physiotherapists’ perspective</td>
</tr>
<tr>
<td>1997</td>
<td>Thornquist, E.</td>
<td>Three voices in a Norwegian living room: An encounter from physiotherapy practice.</td>
<td>Community-based physiotherapy for the elderly from the perspectives of family, client and physiotherapist</td>
</tr>
<tr>
<td>2001</td>
<td>Ekenberg, L</td>
<td>Experiences of fathers and mothers of young adults with impairment</td>
<td>Disability in young adults from parental perspectives</td>
</tr>
<tr>
<td>2005</td>
<td>Smith, B., &amp; Sparkes, A.</td>
<td>Men, sport, spinal cord injury, and narratives of hope.</td>
<td>Narrative construction of a coherent life story in spinal cord injury</td>
</tr>
<tr>
<td>2008</td>
<td>Wallin, M, Talvitie, U., Cattan, M., &amp; Sirkka-Liisa, K</td>
<td>Physiotherapists’ accounts of their clients in geriatric inpatient rehabilitation.</td>
<td>Geriatric inpatient physiotherapy from physiotherapists’ perspectives</td>
</tr>
<tr>
<td>2008</td>
<td>Therkildsen Sudmann, T.</td>
<td>(En)gendering body politics: Physiotherapy as a window on health and illness</td>
<td>Physiotherapy from clients’ perspectives with particular reference to gender</td>
</tr>
<tr>
<td>2008</td>
<td>Iversen, S., Øien, A. M., &amp; Råheim, M.</td>
<td>Physiotherapy treatment of children with cerebral palsy: The complexity of communication within sessions and over time.</td>
<td>Complexity of communication in paediatric physiotherapy</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Physiotherapy perspective</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>2010</td>
<td>Soundy, A., Smith, B., Cressy, F., &amp; Webb, L.</td>
<td>The experience of spinal cord injury: Using Frank’s narrative types to enhance physiotherapy undergraduates’ understanding.</td>
<td>Physiotherapy from the physiotherapy student’s perspective</td>
</tr>
<tr>
<td>2012</td>
<td>Schmitt, J., Acroyd, K., &amp; Burke, L.</td>
<td>Perceptions of physiotherapy students of a person-centred approach in rehabilitation.</td>
<td>Rehabilitation physiotherapy from physiotherapy students’ perspectives</td>
</tr>
</tbody>
</table>

As time progressed, research studies extended their scope further into the complexity of physiotherapeutic communication (Iversen, Øien & Råheim, 2008, Øien, Steihaug & Raheim, 2011). Efforts have been made within physiotherapy research over the last 20 years to differentiate physiotherapy care between the treatment of different medical conditions, different age groups and from an increasing number of different and composite perspectives. However, a more integrative view has developed through exploration of Frank’s (1995) narrative styles as a lens to better understand the rehabilitation journeys of people with spinal cord injury (Smith & Sparkes, 2005, Soundey et al, 2011 and Soundy, Smith, Cressy, F & Webb, 2010).

Some of the studies outlined in Table 3.1 are discussed in this chapter while others are more particularly referred to in Chapters 5 and 6, where reference to specific research situations helps to make meaning and sense of previous research findings, which might readily transfer into the context of my research findings. Taking an overall view of this research history, my research extends this existing research by exploring the multiple perspectives of therapist, client, families and carers (with a variety of client ages and
conditions included) within the context of community-based family care and with a narrative ear.

Given the limited amount of relevant qualitative studies in physiotherapy discourse, I have also repeatedly sought to relate narrative concepts from a variety of disciplines to the clinical relationship that develops between physiotherapists, clients, families and carers. The use of a story outline set around the characters of client and therapist emphasises the use of narrative as a possible way of structuring useful information from the literature for viewing interaction between the main characters in community-based physiotherapeutic interactions. Specific use of narrative to inform the process of qualitative research is further discussed in Chapter 4.

3.2 NARRATIVE

In the following section, the possible function of narrative within human interaction is discussed. Narrative places emphasis on temporality (events occurring over time) and the telling of those events (Rimmon-Kenan, 2006). Viewing narrative as a form of interpretation, I discuss some of Ricoeur’s (1983a, 1983b) ideas regarding integration of time and space through the vessel of narrative and how this can open up complexities of thought and feeling in ordinary life activities through the process known as embodiment. The concept of narrative was increasingly discussed and applied to both research and practice during the 20th century. The final part of this chapter section discusses the use of this concept within research and medicine and how it might contribute to this research project.

3.2.1 A narrative is what a narrative does

“(Narrative is) someone telling someone else that something happened” (Herrnstein Smith, 1981, p. 228, as quoted by Rimmon-Kenan, 2006). Throughout history, stories have been used to communicate a unique account of events from the perspective of the story teller, creating powerful word pictures for the listener to easily and clearly remember (Sorrell & Redmond, 2002). The origin of stories as a serious concept for study can be seen in the work of Aristotle’s Poetics in 450BC (Aristotle (trans.), 1996), (see Table 3.2). A balance of the narrative elements described in Table 3.2 might be recognised in what any of us would call “a good story”; that is, a thought to take
forward, a message that resonates, creation of a memory, a thought or feeling provoked and an emotion to recognise.

Table 3.2  Possible effects of story/narrative characteristics within stories and human interaction (derived from Aristotle, as described by Greenhalgh, 2006, p. 4)

<table>
<thead>
<tr>
<th>Story characteristics</th>
<th>Effect of a story’s characteristics within that story (Greenhalgh, 2006, p. 4)</th>
<th>Possible effect of a story’s characteristics within human interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronology or temporality</td>
<td>“The unfolding of events and actions over time” (p. 4)</td>
<td>A thought to take forward</td>
</tr>
<tr>
<td>(The passing of time)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Characters</td>
<td>People who “take action and/or respond to the actions of others” (p. 4).</td>
<td>A message that resonates</td>
</tr>
<tr>
<td>(The people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td>“The local and wider world in which the characters enact their business” (p. 4)</td>
<td>Creation of a memory</td>
</tr>
<tr>
<td>(The places)</td>
<td></td>
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</tr>
<tr>
<td>Trouble</td>
<td>“A breach from the expected, as in surprise or “twist in the plot” (p. 4)</td>
<td>A thought or feeling provoked</td>
</tr>
<tr>
<td>(The action)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emplotment</td>
<td>“The rhetorical juxtaposition of events and actions to evoke meaning, motive and causality” (p. 4)</td>
<td>Recognition of an emotion</td>
</tr>
<tr>
<td>(The telling) *</td>
<td></td>
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</table>

*See also Rimmon-Kenan (2006)

The meaning and significance of stories helps people to remember an issue over time, rather than just retaining the facts of the matter (Bruner, 1990). Stories can be from an individual or an interpersonal perspective and express interpretations of the way we view and make sense of the world and our experiences in it. In particular, stories interweave plot and character (Paley & Eva, 2005) to help people make meaning of the changing events that occur over time in their lives (Herman, 2007). A story recalls experience, and the intention is often to relate it in a manner that stimulates a meaningful response and understanding from the listener” (Skott, 2001, p. 249). Such responses are inevitably subjective and integrated by what is termed narrative unity, that is, “the sense in which contingent and apparently disparate circumstances are brought together in a single thread, so as to focus the reader’s emotional response to the events described” (Paley & Eva, 2005, p. 97).
While “all stories count as narratives, not all narratives count as stories” (Paley & Eva, 2005, p. 85). Paley and Eva referred to narrative as an account of the sequence of events and the causal connections between them, and gave examples of narratives that do not count as stories, including diaries, experimental reports and case histories. They further argued that the difference between stories and narrative lies in the form and amount of organisation (narrativity) required to gain an emotional response from the listener.

Stories involve a high level of narrativity and narratives a low level of narrativity. For this project, and in company with Kearney (2009), I have chosen to consider stories as the *whats* and narrative as the *ways* that people make sense and meaning of their experience.

*Put simply, stories are the “whats” and narrative comprises the “ways” of human experience, being and discourse. Human beings are narrators, with narrative a mode of transforming knowing into telling. (Kearney, p. 49)*

Stories and narrative involve people’s efforts to manage space and time through their communication with each other. The integrating effect of the connection brought about by the use of narrative strategies within interpersonal interaction enhances the feeling of being together that human beings crave and need to create the feeling of being supported. Healthcare is about supporting people with health difficulties and person-centred communication is at the heart of that support.

### 3.2.2 Temporality and telling

*Wherever we look in this world, we seek to grasp what we see not just in space but in time as well. Narrative gives us this understanding; it gives us what could be called shapes of time. (Porter-Abbott, 2008, p. 10)*

As discussed in the introduction to this chapter, two key and relevant features of narrative for this project are the emphasis placed on temporality (events occurring over time) and the telling of those events (Rimmon-Kenan, 2006). Literary theorist and philosopher, Ricoeur (1983a), differentiated between two aspects of time; *cosmic* (chronological) and *phenomenological* (time as experienced by individuals) and posited that “chronological time becomes phenomenological or experienced to the extent that it is articulated through a narrative mode” (p. 52).

Differentiation occurs between these two characteristics in practitioner–client healthcare interactions when practitioners seek clear information of events occurring over time without “literary, indeed emotional embellishment” (Hovey & Paul, 2007, p. 56). Paley and Eva (2005) suggested that practitioners need to exercise *narrative vigilance* to
differentiate between “the emotional persuasiveness of the ‘story’ with the objective accuracy of the ‘narrative’ ” (p.83). However, Hovey and Paul proposed that by honouring “the story” (how events are experienced), through the act of story sharing, re-interpretation of that story can occur as clients’ perspectives change over time. Anchoring the definition of narrative for this project in the more colloquial term of stories and Rimmon-Kenan’s emphasis on ‘temporality’ and ‘telling’ allowed me to apply narrative concepts in this research into community-based physiotherapeutic relationships, where clients, families and their physiotherapists ‘told me what had happened’ within the relationships they developed with each other.

Within community-based physiotherapy, ongoing dialogue with people needing healthcare assistance better combines both the temporality of healthcare events that occur and the telling (experience) of those events contributed by people if that dialogue is to be narratively anchored in time and space. The concept of Russian literary theorist Bakhtin (1981) of chronotope helps us understand the way that people can interpret the clinical relationships they develop in different contexts (time and space), in this case, within community-based physiotherapy. Bakhtin “envisaged all of life as an ongoing dialogue which takes place at every moment of daily existence. Life is by its nature dialogic. And so is discourse” (Noriega Sanchez, 1998, p. 52). Bakhtin borrowed the word chronotope from science to describe how time and space might be used in literature to provide a clear and understandable setting for events and for human experience of those events, thereby enhancing the meaning of that interaction. Such thinking had relevance for this research project. The word chronotope (literally meaning time-space) refers to “the intrinsic connectedness of temporal and spatial relationships that is artistically expressed in literature” (Bakhtin, 1981, p. 84). An example of chronotope may be seen in the use of the concept of a village square within literature, where use of such an idyllic setting immediately implies:

An organic fastening-down, a grafting of life and its events to a place, to a familiar territory [...] unity of place [...] unity of rhythm, the common language used to describe phenomena of nature and the events of human life. (Bakhtin, 1981, p. 225)

For this research project, the context of home and family provides a powerful chronotope, affecting all that follows with its overtones and prior understandings. When reading these words, we can make immediate assumptions as to the context and setting of the narrative in question. Storytellers make tacit assumptions about their readers’
knowledge and history, and seek to influence the way that they will understand and extrapolate from what they read to make meaning for themselves. “The presence of such connectedness in chronotope makes narrative events concrete, makes them take on flesh, causes blood to flow in their veins” (Bakhtin, 1986, p. 250).

Within the field of palliative healthcare, the concept of chronotope in action can be seen with the entry of stories of individual clients into the professional discourse of nursing and medicine (Gunaratnam & Oliviere, 2009). Gunaratnam (2009) referred to “narratives as ‘chronotopes’, providing unique perspectives on time and context” (p. 48). For example, the actual idea of speaking about one’s imminent death is so powerful that the narrative itself could become the chronotope.

### 3.2.3 Processes of narrative and its relation to time

Narrative can be viewed as a form of interpretation, telling human experience to better understand it. Ricoeur (1983a) drew on Aristotle’s work regarding poetics to explain how the use of emplotment allows people to make sense of their experience by organizing it. (Poetics and poetry in relation to this project are revisited in greater depth in Chapter 4).

Ricoeur developed his understanding of how people make meaning of their experience over time by integrating Aristotle’s work regarding emplotment with Augustine’s treatises on the nature of time (written between AD 397 and AD 398). Augustine argued that “the measure of time is not to be found in things, but in the human mind” (according to Hausheer, 1937, p. 506). Ricoeur then proposed that narratives integrate the different aspects of time: cosmic (chronological) and phenomenological (experienced) through a process he called mimesis.

Table 3.3 Ricoeur’s three stages of mimesis within narrative (Derived from Ricoeur, 1983(a), Kearney, 2009, p. 58 and Alsaker & Josephsson, 2009, pp. 59-60).

<table>
<thead>
<tr>
<th>Ricoeur’s three stages of mimesis within narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefiguration (mimesis 1)</td>
</tr>
<tr>
<td>Configuration (mimesis 2)</td>
</tr>
<tr>
<td>Refiguration (mimesis 3)</td>
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</tbody>
</table>
The term *mimesis* refers to the act of representation of human experience, where time is configured to compose an imaginatively ordered whole of events, agents and actions that makes activity intelligible" (Kearney, 2009, p. 58). Ricoeur (1983a) proposed three different mimetic (representative) stages or moments of time (see Table 3.2) and argued that the moment of configuration (where interpretation occurs) was most important in expanding the world of the plot.

“Temporality is brought to language to the extent that language configures and refigures temporal experience” (p. 54). People enact everyday, but meaningful, activities as they tell someone else about them (Ricoeur, 1983a).

*Meaning has to be communicated before it can become meaningful, implying that the teller of and the listener to a story must reach a common understanding of the content of the story to communicate"* (Alsaker & Josephsson, 2009, p. 66).

From within the field of occupational therapy, Alsaker and Josephsson explored the way in which women with chronic rheumatic conditions made meaning within their everyday activities. Drawing on Ricoeur’s (1983a, 1983b) work, their findings revealed that meaningful issues for the participants were embedded within the practical action involved in everyday life. The women involved could then interpret those issues in a variety of ways. Alsaker and Josephsson speculated whether such meaning processes could be transferable to other situations and suggested that therapists could provide “try-out spaces” for different approaches to an issue requiring resolution (p. 66).

Perhaps the most interesting of the ideas coming from this study is their finding that “enacted processes of meaning occurred in the women’s quest for ordinariness” (p. 68). With reference to community-based healthcare situations, where physiotherapy takes place within the day-to-day activities of people living at home, the particular context of the home setting and the ordinary life activities occurring there can be expected to carry a great many different and important meanings waiting to be communicated. Human relationships with their complexities of thought and feeling could be included among those ordinary life activities. One concept that can be used to open up the complexities of thought and feeling in ordinary life activities is *embodiment*.

### 3.2.4 Embodied minds

*“There is no inner man, man is in the world, and only in the world does he know himself”*. (Merleau-Ponty, 1962, p. xii)

The use of the lens of embodiment within physiotherapy allows an “orientation towards the whole person” and encompasses the human body and its healthcare issues (taking an
objective view), people’s experiences (taking a subjective view), and social determinants of health such as legislation and institutions (taking a societal view) (Nicholls & Gibson, 2010). Embodiment, therefore, involves “respecting diversity, eclecticism, deviation, and difference, and having an inclusive attitude to the ways people view their own embodiment” (p. 503).

Gibson (2010) expressed the concern that physiotherapy’s technical bias towards predominantly physical and functional goals in therapy could actually result in clients’ marginalisation within society. Physiotherapy has historically adopted a “body-as-machine” approach to people’s healthcare issues, possibly in relation to its massage history and in an effort to better define and assume a particular area of health work (Nicholls & Gibson, 2010; Nicholls & Holmes, 2012). Nicholls and Holmes (2012) further argued that physiotherapy as a profession might have closed down possibilities to respond effectively to the more recent expectations of person-centred healthcare through its adoption of the body-as-machine metaphor, along with other disciplinary strategies designed to manage the sensitive issue of touch within physiotherapy.

Possibly, the most significant measure taken by the Society to legitimize masseuses’ philosophy of touch lay in the approach to the body that had to be learnt, or at least plainly demonstrated by registrants. The masseuses needed to be able to focus on the body-as-machine: they needed to be able to touch the inner thigh of a patient, for example, and think of the origins and insertions of adductor longus and not perceive it in any way as sensual. The ability to demonstrate this ability to the medical profession and the public at large was a defining feature of the Society’s quest for legitimacy. (Nicholls & Holmes, 2012)

Such pragmatic social reasons for the legitimisation of touch within physiotherapy were supported by the empirical nature of science. Natural science sought to reduce the complexity of thought and feeling with empirically proven explanations, building on the scientific investigations of brain structures and human behaviour (Varela, Thompson, & Rosch, 1997). In contrast, social science sought to explore the realms of human experience and expand understanding by using reflection, interaction and interpretation.

Academic and philosophical tension occurred at the interface of these different areas of enquiry. Varela et al (1997) described this interface as being at a crossroads, “janus-faced”, “looking down both roads at once”, but also with an inevitable circularity. Such circularity also occurs as we move back and forth between the inner and outer terrains.

20 The “Society” mentioned here refers to the Society of Trained Masseurs. This British organisation was started by female nurses in 1894 and later became the Chartered Society of Physiotherapy in 1943 (Massage Training Institute, 2012: “The history of massage”).
of our existence, the body as our physical, biological existence but also as our contextual, experiential and phenomenological existence. An example of such circular and embodied connection is seen in a study of Norwegian psychomotor physiotherapy, in which a narrative approach which involved patient–therapist reflection was used to assist people with chronic pain (Øien, Iversen, & Stensland, 2007). In this study of patients’ narratives of embodied experience, findings showed a connection between patients’ pain symptoms and their sensations of self–body detachment, connected to stories of difficult interpersonal relationships. Assuming a “not knowing” position, therapists adopted a curious attitude, searching to get to know individual patients’ narratives to then help them to work through their present difficulties and develop a more constructive narrative to manage their pain more effectively. Patient, Gina described the therapy process as a change from experiencing herself as an anxious mind to experience body and mind as more of a unity. She was moving back into her body; a change formulated as a narrative of awakening.

In a way my body was asleep, only functioning by carrying me around. The process of awakening includes giving room to everything I stored away when I was in a cloud of anxiety. (Øien et al, 2007, p.36)

The process of awakening was a powerful experience of being present in the world and in her life. This new experience of herself pointed to an emerging openness towards others. “Maybe the most important change was feeling better towards myself. Then I could turn outwards towards others” (Øien et al., 2007, p. 36).

The themes described in this study tell a tale of disconnection and reconnection. Below, I list these themes as they occurred in the article written by Øien et al. (2007). They poetically tell an interesting and powerful story from the patient’s point of view.

Being divided in body and mind
My back as a tortoiseshell
I’m not to be blamed
Breathing more deeply
My legs: My “stepchildren”
My body was asleep

(Derived from Øien et al., 2007, pp. 34-36).

Using an embodied view, people are their bodies but they also have their bodies (Merleau-Ponty, 1962). Øien et al. identified two main narrative patterns, “being in touch with” and “being detached from” the body, and related them to the essential paradox that Merleau-Ponty (1962) sought to explore, that “our understanding is based
on how our body, defined as subject, perceives the world” (as quoted by Øien et al., p. 32).

People physically live out their stories and physiotherapists could be uniquely placed to bear witness to such embodied stories. Story-telling can become a personal mental tool, making meaning of the strange landscape of illness, injury rehabilitation or disability. Narrative assists to impose a coherent structure onto people’s experience, creating movement from a negative to a positive viewpoint for them (Baumeister & Vohs, 2002). This complex and embodied process involves people’s body, feelings, thoughts, movement and physical interactions with the environment and people around them.

Narrative has the potential to improve physiotherapy practice by sensitising practitioners to that complex process involving the lived experience of their clients. Soundy, Smith, Cressy and Webb (2010) discovered that physiotherapy students found immersion in the emotional lives of other people difficult to manage. Frank’s (1995) narrative styles (see Table 3.4) were introduced to physiotherapy students to help them understand the lived experiences of people with spinal cord injury. Understanding the difficulty inherent in managing the emotional aspect of clinical relationships was particularly shown by the students’ responses to the “chaos” stories (of patients with spinal cord injury).

Although all the student participants found “quest” stories admirable and “chaos” stories depressing and difficult to hear, the first year physiotherapy students generally seemed to show more empathic responses than the third year students, who “seemed to unify a voice of physiotherapy and were perhaps more receptive to an ideal patient or narrative” (p. 56).

Soundy, Smith, Cressy et al (2010) suggested that this could indicate a loss of empathy through training. They further proposed that “for the patient, being heard by a therapist, regardless of the story, has value” (p. 56) and suggested that education and training regarding the use of such narrative styles could help physiotherapists in developing their treatment approaches. From my practice experience, being able to listen deeply and effectively is a skill that I had to develop over long periods of practice. Personal reflection on my mistakes and successes allowed for reflexive integration into practice of such issues as pressure of work to deal efficiently with high caseloads and needing to learn how to listen to patients’ stories while getting treatment done.
<table>
<thead>
<tr>
<th>Narrative style</th>
<th>Restitution</th>
<th>Chaos</th>
<th>Quest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plot</strong></td>
<td>“Yesterday, I was healthy, today I am sick, but tomorrow I will be healthy again” (p. 77)</td>
<td>“Living a life of overwhelming trouble and suffering”; “life is never going to get better” (p. 113)</td>
<td>“Something can be gained from this experience” (p. 115)</td>
</tr>
<tr>
<td><strong>Type of story/narrative</strong></td>
<td>A type of naming story where the teller seeks the true name of the disease and maybe his/her own true name as well</td>
<td>An anti-narrative; chaos experience “cannot literally be told, it can only be lived” (p. 98)</td>
<td>A self/other story of the teller’s journey, bearing witness to the teller’s transformation of self and character</td>
</tr>
<tr>
<td><strong>How the story works</strong></td>
<td>Promises hope of “outdistancing or outwitting suffering” (p. 97)</td>
<td>Describes the despair and loss of hope where life appears meaningless</td>
<td>Searches for a different way of being ill Accepts disability, embracing uncertainty and seeks to use the experience</td>
</tr>
<tr>
<td><strong>The active player</strong></td>
<td>The remedy and/or the health professional</td>
<td>The voice of the client is lost in the chaos</td>
<td>The client now has a voice and a story to tell</td>
</tr>
<tr>
<td><strong>Power</strong></td>
<td>Sustains the illusion of permanence Conforms to hegemonic views regarding cures in healthcare</td>
<td>Shows how quickly the foundations of any story can fall away Allows the patient to be heard, including and tolerating the client as a relevant member of society</td>
<td>Gives the client a voice Holds chaos at bay for the patient</td>
</tr>
</tbody>
</table>

### 3.2.5 The narrative turn in academic discourse

“Narrative is gradually coming to be comprehended as the ground in which, the relations through which and the vehicle by which humans develop knowledge of themselves and the world they inhabit. (Rankin, 2000, p. 1)

Rimmon-Kenan (2006) notes that narrative has become “a catchy term in everyday discourse” (p. 11). More generalised uses of the term often occur where statements or assumptions about unfolding events are viewed as the actual narrative of a phenomenon, becoming a “narration without a narrator” (p. 12). The development of the concept of narrative burgeoned from the 1920s. Narratologists differentiated between events in the order of their presumed “occurrence” in a story (“fabula”), and how those events were actually organized in the text (“sjuzet”) (Rimmon-Kenan, 2006, p. 13).

During the 20th century, there was eventually what became known as a narrative turn in a number of disciplines. The concept of a narrative turn refers to “the way human
conduct can be seen as the expression and enactment of different kinds of stories” (Brown, Nolan, Crawford, & Lewis 1996, p. 1569). We make sense of our experiences and activities through the stories we tell. This use of language within therapy and research is important because it is the medium through which those activities are conducted (Brown et al., 1996).

A variety of different uses for the concept of narrative are evident in the literature. Labov and Waletsky’s (1967) study showed that the term could be framed formally, suggesting that narratives could be useful for many different types of study exploring human experience. An example is seen in Mishler’s (1990) presentation of narrative studies as possible exemplars for research practice. Mishler argued that this use of narrative might provide elements of trustworthiness for qualitative research projects.

Within medicine, the use of a narrative approach to studying healthcare interactions provides insights that enable practitioners to understand more deeply their practice with and for clients or patients (Charon, 2006). The highlighting of narrative aspects of healthcare practice can help to deepen understanding of that practice and enhance the views of other people within healthcare relationships. Practitioners might then be prepared to support people (as well as their bodies) with healthcare problems.

Within narrative approaches to healthcare practice, there are different narratives to be told (Greenhalgh, 1999). Health professionals narratively interpret and integrate many different “secondary texts” (or stories).

For example, there is the experiential text (the meaning given by the patient to the experiences), the physical text (the information recorded from the examination of the patient), and the instrumental text (the information from special tests such as radiographs) (Loftus & Greenhalgh, 2010, p. 3)

This research pays particular attention to the experiential texts of clients, families and carers. Within the whole situation of community-based healthcare interaction, consciousness of the complexity of such situations needs to be raised and balance needs to be achieved between the existing different stories if the expectations of all participants for healthcare are to be fully considered.

In the following sections of this chapter, I have chosen to position this exploration of the literature around the characters most directly involved in physiotherapeutic relationships. That focus does not ignore the contribution of families or carers but
supports an emphasis in this thesis on the essential interpersonal relationship that develops at the centre of the therapeutic relationship.

3.3 THE CLIENT

3.3.1 Specific lives, specific stories

Stories provide a human lens to encapsulate the personal and contextual perspectives of situations and practices. Stories fill gaps by articulating the hidden and invisible aspects that dominant discourses tend to overlook. (Higgs, Cherry, & Trede, 2009, p. 41)

In this section I examine different aspects of the way narratives can provide specific stories to illuminate people’s lives. The context of healthcare affects people’s stories and the use of narrative provides a way of reflecting and making sense of the process of our “thrownness” into life (Heidegger, 1962). Patients/clients have “other stories” known only to them unless they choose to tell us about them and we choose to listen to their voices.

The other stories

Sweat on my back makes my uniform stick as I lean forward,
Holding my client’s stump in my hands
Seeing the tears run down his face.
Will anyone be able to love me now? I have no leg

Knees shake and I stiffen them to stop the feeling of falling down
Feeling the deep scarring across the neck of my client
Hearing his soft voice, telling me of his attempted execution.
Why am I still here? I should be dead

Laughter swells but humility sits steady within me
Crouching at the feet of my client
Listening to his wry and gentle voice

Do you know who I am?
I was “someone” once.
I am still that person.

(Tasker, Loftus & Higgs, 2013, accepted for publication)

Barker (2001) used ideas from narrative and embodiment to explore how the specificity and context of each person’s individual stories might provide interest, personal importance and motivation for different members of the people involved in home-based
mental healthcare. The concept of an embodied mind seems to imply that the mind is a specific entity, unique in itself. The stories that a person lives and tells are specific to that person and can only occur within the context of the life experiences that come that person’s way (Barker, 2001).

These aspects of people’s stories need to be assessed within the more generic context of healthcare. In his research into clinical reasoning for physiotherapists, which included neurological and domiciliary therapists, Edwards (2000) noted the importance of specificity and proposed two dialectics of clinical reasoning for physiotherapists. Firstly, the physiotherapist must understand the patient and his or her story as unique, while also perceiving the more generic aspects of that person’s experience. Secondly, the physiotherapist needs to be aware of “that interplay between the individual and the social learning which contributes to the formation of each therapist’s knowledge and to his or her conduct of clinical practice” (p. 6). All the people involved in home-based healthcare, including therapists, are individual “embodied minds” with specific stories. Therapists and clients are thrown together into the situation of a physiotherapeutic relationship. Their stories must therefore connect with each other.

The idea of “thrownness” originated from Heidegger (1962) who referred to the common experience where we all find ourselves “thrown” into the world. “Existence, for Heidegger, means to be thrown into possibility all the time” (Fox, 1997, para 6). Narrative might offer a way of reflecting and making sense of that process. Stories emerging from the interpersonal relationships that develop between therapists, clients, their families and carers can provide a powerful way to access the experiential knowledge of these people. Such story-telling can be physical, verbal or both. The embodied experience of people with healthcare problems can be a rich source of narrative knowledge for therapists (Sunvisson, 2006). Each person often has other stories apart from what they choose to make known to attending healthcare workers.

A study within the field of nursing narratively explored ways in which older people with dementia used and interpreted nonverbal behaviour within social interactions (Schwartz & Abbott, 2007). Student nurses gathered information in a variety of different ways, including case studies, journals, stories from practice, life reviews, and reminiscence therapy, and integrated all this information into a cohesive story with the aim of individualising and customising care for people with dementia. Key themes arising from the study of listening, partnership, reciprocity, and solidarity highlighted
the importance of nurse–client relationships and the role that “getting to know them” (the patients) played in those relationships.

Narratives can have several layers of meaning and have multiple benefits, suggested when one considers the implications of healthcare graduates entering their profession after being part of such a sensitive and sensitising study. Not only had the participating students learned from the experience how to listen to their clients, they had also contributed to ongoing practice of their healthcare professions, especially with regard to the provision of person-centred healthcare for people. Clinical relationships between people and visiting healthcare workers are necessarily social in nature.

*It is sometimes better to listen to our patients’ advice or wishes instead of asking all the questions or doing all the tests and procedures on them. They will tell you exactly what you need to know to treat them properly if you are just willing to listen.* (Senior nursing student quoted by Schwartz & Abbott, 2007, p. 183)

In community-based physiotherapy, access to such individual knowledge depends on the willingness of clients, therapists, carers and families) to honestly engage with each other and openly exchange and accept feelings and information about the situation being experienced by them all. This might be difficult in the presence of cognitive and communication challenges for individual clients and emotional distress and fatigue on the part of the family or carers.

However, this difficulty does not imply that one should not try to communicate. A study of quality of life responses in elderly people with low cognitive functioning indicated that these people still have likes and desires and preferences: “Not knowing where I am doesn’t mean I don’t know what I like” (Mozley et al., 1999, p. 776). The challenge for physiotherapists in such situations is to try to access the voice and wishes of their clients (and their families) in whatever way possible. It is this voice that tells the patient/client’s story. Voice in these situations might not always be verbal but can take other forms of expression: physical behaviour, family and carer reporting, or responses to interaction. Such expression is more difficult to access but still of importance to individuals and therefore also to health professionals. People with chronic and complex healthcare issues experience ongoing difficulty to be heard. They often exist in a limbo between the worlds of the “can be cured” and “can’t be cured”.

### 3.3.2 The difference between curing and healing

The use of a narrative lens can provide a way of deepening understanding for all stakeholders of the difficult life management issues that exist for people living at home
with chronic and complex healthcare issues. In particular, it might allow us to understand the differences between the healthcare processes of curing and healing, when hope for “can be cured” might change into acceptance of “can’t be cured” and when cure becomes irrelevant and quality of life or being in control of life choices can become much more important.

Despite the acceptance of healing as a core concept of medicine, medicine does not have an agreed operational definition of healing or a consensus as to its accepted mechanisms (Egnew, 2005). Curing is openly discussed and accepted and is seen as more mechanistic and technical/rational than the more esoteric notion of healing. Healing, which is more personal, is largely ignored. Pellegrino (1998) described a more holistic view of healing as a process which encompasses many dimensions of time, place and context, requiring a much fuller grasp of these personal and interpersonal dimensions (p. 329). When the medical profession fails in its goal of full health, patients/clients need to find a way to live with their changed life and uncertainty and create a new way to live; a new life story that is not founded on cure (Alder, 2003).

Curing, which can be seen as a restitution (restoring of health) narrative, is not always possible for all people. Are these people “failed patients”? In the view of the medical profession, whose perceived duty it is to “monitor and correct human imperfection”, a failed patient is someone who cannot get better or be made better, being “beyond restitution” (Alder, 2003, p. 30). These people are often blamed because they have failed to improve, comply, or just get better. In challenging this idea, Alder uses Clarke and Stewart’s (2003) term “wicked issues” to describe cultural roles and attitudes that are held by our community regarding difficult social issues, such as the value that is placed on order as opposed to disorder, the underlying belief that people with illness and disability are necessarily miserable and unhappy, and community attitudes that illness is bad. In a world where medicine enables more people to live with chronic and complex healthcare difficulties, the notion of the failed patient could become increasingly untenable because there are so many people who are striving to live fulfilled lives despite their chronic illness and disability. Healing is more about helping people to live fulfilling lives despite the uncertainty or even impossibility of a cure.

Healing narratives can offer a means of coping with uncertainty, and long-term care might be seen as a form of healing, even though the client might physically (or mentally) decline and eventually die. Although physiotherapists visiting people with
unremitting healthcare difficulties face pressure to work towards a physical cure (measured by functional outcome measures), they need to integrate narratives of healing as well as narratives of cure. Healing involves a lot more uncertainty than curing.

3.3.3 Seeking a way forward from a difficult individual reality

The way forward for people with chronic and complex health problems is filled with uncertainty. Individuals have different perceptions and attitudes towards uncertainty, which can impact markedly on their coping abilities and clinical outcomes (Mischel & Epstein, 1990). In Frank’s (1995) view (see Table 3.4), people with chronic and complex health problems can be denied a restitution narrative; compelled to live out a chaos or quest narrative as a way of dealing with uncertainty. Difficulty with uncertainty is complicated by the way that trauma can disrupt people’s ability to complete re-storying of their narrative in the presence of physical, cognitive and psychological impairment (Wigram, 1994).

The existence of chronic co-morbidities makes the individual reality of clients difficult and their way forward in life often unclear. Lack of such clarity puts individuals with healthcare problems at an immediate and distinct disadvantage in terms of perceived personal integrity and power. In an effort to clarify and examine this difficult area, Arthur Frank, a sociologist with an education and career background in English, Communication and Sociology studies, made scholarly meaning and sense of the particular life experiences into which he was “thrown”, to use Heidegger’s (1962) term, during his own severe illness. In his first book, At the Will of the Body, Frank (2002/1991) began to plot the territory of becoming ill, looking for themes and dealing with its processes. He presented illness as an incident but also as an opportunity, albeit a dangerous one involving loss, mourning, stigma and struggle. From his experience of cancer, Frank explored alternative, narrative ways of viewing the illness experience he underwent (see Table 3.4). Seeking a way forward from that difficult individual reality, he explored notions of seeing beyond pain, viewing the body and its sensations as territory to be explored and (in his story) approaching chemotherapy as an adventure.

The stages of acceptance and narrative development proposed by Frank (1995) could resonate strongly with all people experiencing chronic and complex healthcare problems, not merely those with illnesses. Studying the way people interpret their experience of chronic pain, Edwards, Jones, and Hillier (2006) described the interpretative resources of physiotherapy clients with chronic pain as limited, and
argued that this could cause the development of rigid and limited perspectives of that pain and associated decreased repertoires of movement patterns. The descriptions of patients’ experiences with chronic pain reveal an *enneshment* with the difficulties associated with pain. Using the narrative lens of Frank (1995), such enmeshment and limited resources might also be seen as part of a chaos narrative for a person experiencing chronic pain. Using altered frames of reference; other types of narrative could be developed, enabling patients to explore new ways of living and experiencing their lives, albeit with chronic health issues. In their study, Edwards et al (2006) proposed a new model of clinical reasoning, arguing for a different style of clinical reasoning that embraced both instrumental and communicative components of action and incorporated a more integrated view of body and mind within a physiotherapeutic approach. Such an approach would require deeper understanding of the processes that occur as clients and their families negotiate complex healthcare issues and their physiotherapists seek to assist them. Narrative offers such an approach.

A narrative approach acknowledges the full humanity of the client because its use is grounded in the lived experience of the people concerned.

*Intimate medical relationships occur in words. Our intimacy with patients is based predominantly on listening to what they tell us, and our trustworthiness toward them is demonstrated in the seriousness and duty with which we listen to what they entrust to us.* (Charon, 2006, p. 53)

### 3.3.4 Fieldwork on the self

Stories allow us to understand and learn from other people’s experience and stimulate listeners to search for meaning among many possible meanings (Iser, 1978). According to occupational therapists Mattingly and Garro (2000), a person’s stories encompass two separate inner landscapes, one of action and one of consciousness. If one understands the plot of the story (the action landscape), one might have a better understanding of the inner landscape of emotion and meaning for participants. Historically, stories have been treated as belonging to the world of literature. Mattingly and Garro referred to Iser’s (1978) work on reading theory; in particular, his idea of continual emergence through reading (bridging the gap between literature and culture), allowing individuals to read situations and experiences as fieldwork on themselves.

Possibilities of creative and ongoing change open up thereby (Mattingly & Garro, 2000). The idea of *a story lived* encompasses *a story felt* and also *a story told* (what happens to people, how they feel about it and how that is communicated to the people
around them). Such contrasts within the process of human relationships can come under the heading of *intersubjectivity*, a social science term referring to the way that people mutually build their relationships. Intersubjectivity implies that people can reach consensus about knowledge or experience “at least as a working agreement if not a claim to objectivity” (Marshall, 1998). If we apply this idea to community-based physiotherapy, all stakeholders to the situation need to come to some consensus about what they are doing together. Such notions of fieldwork on one’s self, the interpersonal building of relationships and gaining of interpersonal consensus have great relevance for the area of chronic and complex healthcare and the role of physiotherapy within it.

A rather beautiful and metaphorical expression of the idea of ongoing and incremental change occur in the proposition by Barker (2001) of a *tidal theory* for psychiatric nursing care. In England, between 1995 and 1998, Barker explored the need to understand psychiatric nursing and the power relationships that develop between psychiatric nurses and their clients. He proposed that to fully and respectfully address the life problems that can occur with mental health problems, a co-created healthcare plan can be constructed through dialogue between clients and their nurses. Barker borrowed from chaos theory, recognising that change and development occur through very small changes that follow patterns, which are paradoxically unpredictable. He used the powerful metaphor of water to effectively transmit his idea:

*LIFE IS A JOURNEY UNDERTAKEN ON AN OCEAN OF EXPERIENCE. ALL HUMAN DEVELOPMENT, INCLUDING THE EXPERIENCE OF ILLNESS AND HEALTH, INVOLVES DISCOVERIES MADE ON A JOURNEY ACROSS THAT OCEAN OF EXPERIENCE. (BARKER, 2001, THE TIDAL METAPHOR, PARA 1).*

Embarking on an ocean journey seems to imply hope and a time for enjoyment, healing or both. Hope is an important part of how people with more serious healthcare issues and physiotherapists can assist clients in managing their health and circumstances (Soundy, Smith, Butler et al, 2010). Wiles, Cott, and Gibson (2008) had previously argued that hope as a want is distinguished from hope as a need, emphasising the need for more critical and analytical research regarding differentiation within the concept of hope. The work of Soundy, Smith, Butler et al, (2010) went some way towards this aim. Their study of the perceptions of hope for people with healthcare problems, conducted with neurological physiotherapists concluded that “hope is not a free floating aspect locked in people’s minds” but rather a multi-dimensional process “embedded in interaction and developed through communication” (p. 87). They suggested that for
people with chronic disorders, imagination is important when considering the future but it must be carefully considered because it can also become a “vulnerability of imagination” (p. 87). Clients can feel hurt by being unable to achieve, and feeling unsupported in the pursuit of their hopes. When therapists are not sensitive to those hopes, the clients’ imagination that can lead towards hope can also make those clients feel very vulnerable.

Narratives can be used to make hope meaningful. “Patients can lose hope in recovery, but where specific hopes are lost, other hopes can be found, the hardest finding hope in the face of death” (Soundy, Smith, Butler et al, 2010, p. 87). The starting point for the telling of each person’s story is individually inescapable and true to that person. Clients, as narrator of their own life experiences, are inherently motivated and driven by the fact of their body’s situation and experiences. If people telling their story are able to make listeners consider the story to be sensible, then the story and, indirectly, the tellers of that story achieve authenticity.

3.3.5 Establishing authenticity for the storyteller

Authenticity refers to the complex and personal way people reach decisions for and by themselves, incorporating the essence of oneself, one’s world-views and one’s values (McCormack, 2003). People try to interpret their experiences meaningfully to themselves and to other people (Jones et al, 2009). Authenticity develops when individuals are able to articulate how they interpret their experiences clearly for themselves and for others (Frank, 2002, 2004). Frank argued that such personal authenticity is created when people enter into reciprocal dialogue and narrative processes. This important distinction is part of Frank’s argument that personal stories are not just an individual emotive expression but can also link personal concerns to more public issues, by their authenticity.

Questioning the authenticity of first person narratives, Atkinson (1977) critiqued Frank’s narrative approach, suggesting that too much weight was given to assuming the truthfulness of the storyteller. This criticism seems to fit with Atkinson’s general views about the breadth and variety of narrative enquiry methodologies. While acknowledging the value of interest in the area of narrative enquiry, Atkinson (2009) deplored what he perceived as an over-readiness to celebrate narratives and biographical accounts rather than rigorously analysing them. However, his critique could just be a note of caution.
about privileging the use of first-person narratives within a research method, warning that first-person narrative stories are not unique or sufficient in themselves.

3.3.6 The client as the narrator?

“Humans are narrators, with narrative a mode of transforming knowing into telling” (Kearney, 2009, p. 49). Can clients be central narrators in their own healthcare story? The title of this section of the thesis is implicit in the title of Frank’s (1995) book, *The Wounded Storyteller*, and highlights the role of clients. Clients tell their stories in a variety of narrative styles, often interwoven, and the resultant mix most resembles a kaleidoscope of styles and effects (Frank, 1995). To assist in listening and sorting these stories, Frank proposed some key possible narrative formats for listening to illness experiences: restitution, chaos and quest (see Table 3.3). These narrative styles were proposed as listening devices. The natural human tendency of wanting to be heard extends to everyone. Frank wrote of the difference between the “voice of medicine” and the “voice of life”: in healthcare interactions, the medical voice seems louder and more dominant than people’s life voices (Frank, 2004). Kleinman (1988) argued that modern medicine is not training its professionals to sufficiently hear or respect patients’ illness experiences; patients’ stories can be overwhelmed by the practitioner’s explanations and outlines of medical treatment, causing a loss of any possibility of gaining any useful information lying within their patients’ stories. In the face of the impersonal and clinical narrative often employed in medicine, (albeit in their service), clients react with a narrative of their own experience, in an effort to make their voices heard (Rimmon-Kenan, 2002). There is value, therefore, for patients in being heard by therapists, and this needs to be accepted by clinicians and their educators alike (Soundy, Smith, Cressy et al, 2010).

Within clinical interaction, “the role of the clinician is to provide the subjective “otherness” for an interactional narrative in which the patient will construct, and make sense of, his or her illness narrative” (Greenhalgh, 2007, p. 162). Greenhalgh’s use of narrative here resonates strongly with Frank’s (1995) quest narrative (see Table 3.3). In this style of interaction, clinicians can bear witness to another person’s story of life’s journey and transformation.

*It is the ethos of narrative ethics that one must tell of what one undergoes in order to understand it and that, as a consequence, the health professionals who accompany one through illness have a responsibility to hear one out. (Charon, 2004, p. 8)*
In that “hearing”, there are elements of the idea and practice of *bearing witness* to suffering, which can assist clients in their role of narrator. In some instances, clients’ conditions might preclude them from actual speech or impair their comprehension and expression of language. Where are their voices as narrators then?

Frank’s (1995) exposition of narrative styles was largely based on the experience of acute illness and might not adequately extend across into the area of chronic and complex healthcare, especially in the situation of disability and illnesses present from birth. A different narrative style might be needed for these situations; to speak for or with these verbally silent people, who have to wait to be noticed by those people around them who know them well and care enough to make contact, trying to interpret their needs and wants. Within the context of healthcare, the various stories of different family members and carers would not exist without the clients who are the original narrators. Clients need to create a new life story for themselves by communicating with other people to create possible futures for themselves.

3.3.7 The *dialogical stoic*

Frank (2004) used the work of Mikhail Bakhtin (1981) on dialogics and Marcus Aurelius on stoicism (as described by Hadot, 1998) to compile a composite persona called the *dialogical stoic*, combining ideas of dialogue and the possibility of individuals creating new realities for themselves (a new “story to be told”) when faced with the presence of illness. In his philosophy of dialogics, Bakhtin (1981) argued that human beings express their consciousness in dialogue with other people; he called such process *voice*. In this social process, the voices of other people make up part of one’s own voice and can sometimes be heard penetrating it (p. 202). This multi-voicedness might contribute to the building of a new story for people addressing difficult health issues.

Stoicism, as proposed by Marcus Aurelius, involves the practice of detachment as a method of freeing oneself from the fear of living with what fate might do to one’s body. In situations such as illness or disability people may have little control over their physical self, but the control that is available to them will involve how they can imagine themselves. Personal detachment and dialogue (with self and others) can help people to create a personal image and expression of themselves that might enable them to live with disability and illness. This persona would seem to encompass an individual, narrative expression, in particular, the quest style of narrative in a healthcare story.
The concept of the dialogical stoic is also of interest to the therapist. The practice of detachment as a method of freeing the self from the fear of conforming to overwhelming demands for accountability would seem to be a useful technique for professionals. Internal dialogue, when added to such personal detachment, could assist therapists to create a more integrated personal and professional image that helps them cope with uncertainty.

3.4 THE THERAPIST

3.4.1 The clinician’s uncertainty and sense of responsibility

The uncertainty that most clinicians encounter during their practice of healthcare creates problems within its provision (Frank, 2007a). While patients or clients experiencing illness and disability face the disintegration of their life story with great attendant uncertainty (Frank, 1995), health professionals also face some uncertainty in the practice of their profession within that same world of disability and illness. Health professionals, as “applied scientists, seek to act on certainty, not to take pleasure in doubt, and their patients expect that certainty” (Frank, 2007a, p. 393). However, healthcare is not an exact science and practitioners rely on professional judgement to make decisions in the face of uncertainty.

As allied health professionals, physiotherapists, particularly those working in community settings, also have a level of uncertainty related to the constantly changing nature of their relationships with other professions within the healthcare field. Much developmental change has occurred within the professional structures of all these disciplines. For example, physiotherapists no longer see themselves as “medical handmaidens”. Such overall narrative views occur for practitioners in many different healthcare situations.

In view of the public’s expectation of certainty, Frank (2007b) proposed that medical and other healthcare professions might have developed “hero” narratives with attendant forces of light and dark, and the “heroic” healthcare practitioner seeking to heal illness, injury and disability. Such pressure on the individual physiotherapy practitioner is exacerbated in situations such as community-based physiotherapy, where practice is undertaken in isolation from one’s peers and where there is often inadequate provision of support services or social contact for people with chronic and complex healthcare
needs. In such complex human situations, therapists might feel pressure to manage high levels of complexity in the interests of achieving health outcomes for their clients.

3.4.2 Disempowerment of health professional clinical judgement

Disempowerment of therapists’ clinical decision-making choices for clients can occur in (dominantly) biomedical contexts, leading to underground clinical practices (Mattingly & Fleming, 1994). Therapists might feel forced to both cultivate and then suppress and abandon the “healing dramas” they had chosen to use for their patients (Mattingly & Lawlor, 2001). A paradox of both the cultivation and abandonment of healing dramas is described in Mattingly and Lawlor’s case studies of paediatric occupational therapy clients, “The stormy young Picasso” (p. 41) and “Felicia and the raven-haired Pocohontas” (p. 37). The therapists involved had chosen their initial therapeutic approach in the interest of long-sighted holistic care for the children involved and their individual behavioural issues. However, in the face of the dominant biomedical culture within which they worked, the participating therapists were subsequently unable to confidently discuss, document or advocate those treatment programs.

Mattingly and Lawlor (2001) argued that the power of the medical diagnosis can determine how treatment might progress, with the power of the doctor being a strong influence in the process. These researchers found that the routinisation of medical processes in healthcare institutions contributed to the confidence of clients but also contributed to restraining the creative and responsive therapeutic efforts of the attending therapists, causing them to conform to expectations of active therapy/intervention. The development of a holistic but seemingly more passive therapeutic process was thus affected detrimentally. Along with this adherence to routine, the therapists faced a serious disconnection between their private beliefs about what was important for their clients’ therapy and what they (the therapists) felt they could “legitimately claim to know” (Mattingly & Lawlor, 2001, p. 51).

Disempowerment of health professional clinical judgement might have far-reaching social and life implications for both therapists and clients. In situations where clients can reflect, communicate and advocate on their own behalf, Mattingly and Lawlor (2001) noted that continuation of the healing work initiated by such therapeutic intervention might be possible. They concluded, however, that this might not occur for all clients, many of whom might have disadvantages of communication, cognition or social resources to contend with. Mattingly and Lawlor argued that the
disempowerment experienced by therapists in the above situation could flow on to the
next person/link in the chain, usually the client (despite the good intentions of the
biomedical model). The lack of interdisciplinary follow-through by a therapist in the
above situation, while understandable in light of the powerful authority of biomedicine,
also goes against the more modern trend for multi-skilling.

When physiotherapists practise in the community, it is often necessary for them to use
skills that seem to relate more to other disciplines such as nursing and occupational
therapy. The concept of multi-skilling was designed to deal with on-the-ground issues
in a timely, efficacious, and ultimately economically wise way (Brown, 2003). An
example of this might be seen when a visiting physiotherapist observes a client having
difficulty mobilising around the home. In the interests of preventing a fall, the
physiotherapist might help with reorganisation of the furniture layout, altering bed and
chair height, or might access suitable equipment from a local occupational therapy
department for the client. The physiotherapist might check a client’s skin integrity or
wound care if it is a problem. Referrals to other professionals could be required but this
is not always the case. It could be argued that there are two aspects to such multi-
skilling: economies/efficiencies and a sharing of authority/responsibility between
various professions within healthcare structures. Therapists often feel torn between
carrying out procedural therapeutic treatment goals and trying to fit treatment and
advice to more closely align with the individual client’s wishes and goals. Mattingly
(1998) described a narrative duality in which therapeutic effort becomes “a jagged
dance in which both the patient and condition are addressed and in which therapeutic
plots are created, interrupted, resumed and sometimes abandoned altogether” (p. 131).
The multi-skilling described above could be one such “jagged dance”.

Exploring the perspectives of the occupational therapist and the client with health
problems, Mattingly (1998) focused upon how client and therapist can work together.
She paid attention to the problems that might be encountered in such processes in
relation to collaboration and mutuality, uncovering tensions within the profession of
occupational therapy as it worked within the biomedical model of healthcare provision
within larger healthcare institutions. Within the larger context of healthcare, the healing
vision of therapists and their creation of healing dramas for their clients are often
constrained by the dominant medical culture. In the context of physiotherapy, where the
practitioner has more autonomy, better opportunities could exist for exploring a
dimension of professional practice that embraces the creation of healing dramas with
clients and their families and carers. Despite the fact that the biomedical model of healthcare can generally be expected to constrain more holistic healthcare, experienced community-based physiotherapists might still be able to enhance the physiotherapeutic relationships they create. These relationships can be managed and tempered to adhere to high standards of professional healthcare. In the next section I focus on the drama within healing narratives.

3.4.3 Creating drama within life narratives

Although people typically wish to make sense out of the life they lead, especially in the face of overwhelming illness or disability, Hayes Fleming (1991) argued that this requires coherence not just within the narrative created but also in their life. Narrative is often about conflict of some sort, and the possibility of its resolution can occur when drama is created by the collision between the proposed narrative planned by the therapist and the story/narrative as lived by the client. Such conflict resolution can well follow a course that is completely unexpected by any of the participants to that healthcare interaction.

Most importantly, the journey into the future envisaged by the therapist for the client requires the therapist to project an imagined outcome or story’s end as part of the therapy plan (Mattingly & Fleming, 1998). Mattingly and Fleming argued that such an act of visualisation should not provide rigid goals but rather open up a way forward. That visualisation will still encompass uncertainty, but the tension created between the potential and the actual reality of therapy can provide motivation for clients to pursue their goals within the unfolding narrative. In pursuing these goals, therapists must craft healing experiences for their clients.

3.4.4 Crafting healing experiences

Healing experiences can be seen as meaningful encounters for most people. Mattingly and Lawlor (2001) argued that significant healing experiences are carefully crafted social dramas with particular features necessary for true efficacy (see Table 3.5). Physiotherapeutic interactions and therapeutic relationships fit well within such an interpretation of healing possibilities within crafted social dramas. In particular, the intimacy of the physical contact, so necessary in the interaction between the client and the physiotherapist, provides a positive force for the healing process. Movement facilitation and efforts by both the therapist and the client to achieve improved and balanced movement enhance the “fused experience of multi-channelled
communication”, described by Mattingly and Lawlor (2001), and the use of therapeutic touch and proximity results in heightened attention to the moment.

Table 3.5  Creation of healing dramas within healthcare practice.  
(derived from Mattingly & Lawlor, 2001, p. 34)

<table>
<thead>
<tr>
<th>Features of healing rituals</th>
<th>Involvement in creating healing dramas</th>
<th>References</th>
<th>Relevance to community-based physiotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fusion of experience – from different sensory systems in a multi-channelled communication</td>
<td>Established by the use of many different channels of communication to carry meaning</td>
<td>Briggs (1996) Tambiah (1985)</td>
<td>Movement facilitation and efforts by both the therapist and the client to achieve improved and balanced movement enhances the fusion of experience</td>
</tr>
<tr>
<td>Acccentuating the interaction</td>
<td>Using aesthetic non-verbal communication</td>
<td>Jackson (1989) Laderm (1996) Stoller (1989, 1996, 1997)</td>
<td>Use of composite attention (as below) relates to Frank’s description of body relatedness in the chaos narrative (see Table 3.4)</td>
</tr>
<tr>
<td>Healing actions full of symbolism</td>
<td>Allowing the patient to locate him- or herself within a timeline stretching both back into the past and forward into the future</td>
<td>Kendall (1996)</td>
<td>Continuity of attendance and use of metaphor (e.g. life as a journey) in explanation and conversation</td>
</tr>
</tbody>
</table>

The existence of complexity within therapeutic relationships is often unacknowledged by mainstream healthcare. Mattingly and Lawlor (2001) discussed Oliver Sacks’ (1984) personal experiences about the madness of what was objectively and conventionally reported to be his reportedly uneventful recovery from a leg injury sustained from falling off a mountain. This was compared and contrasted with his personal account of healing, from the same uneventful recovery. There was a vivid description related by Sacks of the moment when he recovered sensation in his leg while listening to Mendelssohn’s Violin Concerto. The experience from the point of view of this
particular client is especially interesting as it was created from the observations of a Professor of Clinical Neurology. Sacks’ story shows the gap between the clinician’s simplistic and superficial view of a client’s recovery experience and that client’s personal experience of the same event.

3.5 THE CLIENT AND THE THERAPIST

3.5.1 Bridging the gap between the disease and the experience
The narrative approach advocated here aims to bridge the divide between, on the one hand, a reductionist objectification of disease processes that focuses on pathology and on the other hand, clients’ illness or disability experience and what that experience means to them. The use of the term *person-centred* when applied to any healthcare interaction often seems to divert most attention to the client. In the interest of promoting the healthcare relationship, however, it seems sensible to apply it to all the participants within such a relationship: clinicians, carers, clients and families (Berwick, 2009).

Within the clinical relationship, the clinician’s existing skills and knowledge and the client’s contribution interplay in a collaborative form of reasoning, creating a new form of knowledge (Edwards, Jones, Higgs, Trede, & Jensen, 2004). This altered view of the clinician/client exchange can emancipate either or both the participants “from previous limited or distorted perspectives concerning their situation(s)” (p. 80). It appears that *collaborative reasoning*, as described above, was previously described as *conditional reasoning* in “The therapist with the three track mind” (Hayes Fleming, 1991). Here, the therapist reflected on the clinical process and attempted to integrate both therapeutic procedural and interactive standpoints to make meaning for the possible future of the client. Although *conditional reasoning* does not seem to frame the client contribution with the same importance given it by Edwards et al (2004), the clinical process is also highly dependent on the client and the therapist building a shared image of a possible future, and this realisation led to the term used by Mattingly and Lawlor (2001), conditional reasoning. Indeed the term *conditional* alludes to the need for the client’s willingness to cooperate and connect within the therapy process. Connecting with and facilitating clients’ ability and willingness within physiotherapy interactions requires a more holistic view of that process. Narrative might provide a key.

Jones et al (2009) expanded possibilities for physiotherapy practice by including the concept of *narrative reasoning* within their proposed holistic approach to practice.
Their approach was based on a representation of Mezirow’s (1991) notion of a person’s meaning perspective,

*It is not so much what happens to people but how they interpret and understand what happens to them that determines their actions, their hopes, their contentment and emotional well-being and their performance.* (p. xiii)

Wigram (1994) suggested to clinicians that the most useful stance in assisting people to re-story their lives after traumatic injury is *narrative listening*, “an attitude of sympathetic witness, guiding the conversation only to help patients focus on their developing stories” (p. 421). Narratively listening does not mean that clinicians only listen, but rather that they assume a neutral tone within conversation. “attending to the unthought known” (Bollas, 1987).

### 3.5.2 Connection between the therapist and the client

*It is easier for us to shut our eyes than close our ears. It is easier for us to remain untouched and unmoved by what we see than by what we hear; what we see is kept at a distance, but what we hear penetrates our entire body.* (Levin, 1989, p. 32)

Essentially the clinical relationship between client and health practitioner is a “meeting of two selves” (Engel, Zarconi, Pethtel, & Missimi, 2008, p. 62). Table 3.6 summarises ways that narrative might be considered from different points of view (personal, interpersonal and clinical) within healthcare relationships and how narrative framing might assist in the organisation of meaning for a client’s healthcare intervention. Within physiotherapy, discoveries are made as therapists get to know and understand clients. Ek (1990) argued that therapist and client are active and reflecting human beings “present to each other moment by moment” (p. 22) and that this requires a joint effort by them both. Although not mentioning inter-subjectivity as a specific term, Ek implied in the use of the word *communication* the idea of both the giving of clinical information and the more human interactions that occur within physiotherapeutic relationships.

Ek (1990) proposed that,

*The patient’s knowledge and the therapist’s knowledge are of little value when isolated from each other, but when they intermingle during the course of treatment they are of the utmost importance in leading to the creation of new knowledge.* (p. 22)

Awareness of the value of these joint contributions of therapists and clients to the development of new knowledge was important in the discourse relating to physiotherapeutic interaction, coming as it did towards the end of the 1990s, when
society’s attitudes towards healthcare were expanding to appreciate the value of informed decision making and the importance of collaboration and communication with clients/patients in the delivery of healthcare (Braddock, Fihn & Levison, 1997).

Narrative can be used personally, interpersonally and professionally to facilitate and promote self-transformation in many different ways. Mindful use of healthcare can promote healing. The skill of the community-based physiotherapist would seem to lie in the interpretative integration of clients’ stories to develop clinical relationships. Stories can have multiple layers of meaning for each participant and are built upon the stories that come before them, implying an acceptance of the value of that source. Stories allow mutual evaluation of events by participants, with a sharing of both positive and negative viewpoints; they are much more than just a way of relating information to people. As Greenhalgh (2006) explained, “Without an audience, the text has no meaning” (p. 21).

Story-telling or the use of narrative within therapeutic relationships helps us to understand the connections between the personal world of meaning for the client and the healthcare provisions and approaches of the therapist. “The body I experience cannot be reduced to the body someone else measures” (Frank, 2002/1991, p. 12). The telling of a new and more relevant story requires a sense of connection that will reach beyond the present situation to a realisation of being a part of a much greater reality. Although each story comes from and belongs to the storyteller, it does not stand on its own. Other people will recognise and experience parts of that story too. Frank (1995) believed this progression of thoughts to be particularly important in its acknowledgement of the connection to a greater reality. He proposed that once that recognition occurs, healing might commence.

Mutual search for meaning by participants in a therapeutic relationship can be highly motivating. Frank (2007a) described a process of dialogical presence, which can occur when one is physically close to someone, while physically caring for them. In this intense moment of caring, social connection occurs beyond the inherent limitations and frustrations of the present moment. Caregivers often describe an emotional fulfilment where, by caring for others, you care for yourself at a deep level (Frank, 2007a).
Table 3.6  Summary of possible uses of narrative within clinical relationships.

<table>
<thead>
<tr>
<th>Personal</th>
<th>Interpersonal</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates mind pictures to clearly remember (Sorrell &amp; Redmond, 2002)</td>
<td>Increases motivation and enjoyment of the interpersonal connection</td>
<td>Assists the clinician to provide “subjective otherness” for an interactional narrative (Greenhalgh, 2006, p. 21)</td>
</tr>
<tr>
<td></td>
<td>Provides momentum for interpersonal dialogue</td>
<td></td>
</tr>
<tr>
<td>Tells events over time (Rimmon-Kenan, 2006)</td>
<td>Searches for meaning among possible meanings (Iser, 1978)</td>
<td>Examines the particular significances of a person’s illness</td>
</tr>
<tr>
<td>Provides temporal flow, allowing for change</td>
<td></td>
<td>Assists to “break the vicious cycles that amplify distress” (Kleineman, 1988, p. 9)</td>
</tr>
<tr>
<td>Imposes a coherent structure onto a person’s experience (Baumeister, 2002)</td>
<td>Allows the telling of what is undergone in order to understand it (Charon, 2004)</td>
<td>Provides insights to practitioners about their client’s situation (Charon, 2006). Allows practitioners to more deeply understand their practice with and for clients (Charon, 2006)</td>
</tr>
<tr>
<td>Makes meaning from changing events (Herman, 2007)</td>
<td>Provides people a way of choosing and trying out meaning from experience</td>
<td>Provides “listening devices” (Frank, 2004) Provides temporal organisation of people’s lives (Rankin, 2002)</td>
</tr>
<tr>
<td>Contributes towards the building of self-identity (Ricoeur, 1983)</td>
<td>Allows a “sick person” to retain the experience of being sick, aside from the disease (Kleinman, 1988)</td>
<td>Opens up client’s experience as a rich source of knowledge for the therapist (Sunvisson, 2006)</td>
</tr>
<tr>
<td>Opens up possibilities of creative and ongoing change (Mattingly &amp; Garro, 2000)</td>
<td>Assists the reaching of consensus about knowledge or experience (Marshall, 1998)</td>
<td>Assists the crafting of significant healing experiences through useful social dramas (Mattingly &amp; Lawlor, 2001)</td>
</tr>
</tbody>
</table>

Stresses the efficacy of human agency and the potential for self-transformation (Kearney, 2009, p. 55).

The motivation and flow of such interaction occurring within this process can best be described as *generosity* (Frank, 2004). Such generosity involves active and open listening on the part of the therapist to create a space of possibility for all participants to the interaction: therapists, clients and families. Such conversational exchange between people, with active listening of each voice from the perspective of the other, becomes an opportunity to test our own and others’ ideas in order to determine how we should act and how we should proceed (Zappen, 2000). Frank particularly discussed such
generosity within his proposed concept of *dialogical presence*. Unfortunately, the concept of generosity does not lend itself to the discourse of accountability that dominates healthcare today, despite the fact that it can be economically free, widely available and powerfully effective in maintaining interpersonal communication and personal resources for carers, clients and health professionals alike (Frank, 2004).

Frank (2004) proposed the idea of generosity as a renewable resource for the healthcare practitioner, allowing the generation of truly person-centred care. The humanity of all the people involved in healthcare interactions might then be more fully accepted by clinicians. Frank’s work on the use of first-person narratives of illness provides a connection between the humanities and medicine. Story-telling is such an inherent part of the way human beings reflect upon their life. It would be unusual if community physiotherapists did not practise this very human pattern of interaction with the people they work with. Such insight is needed if practitioners of healthcare are to practise in a sufficiently holistic and nurturing way to sustain both the systems they work in and themselves (Frank, 2004).

Believing that the healthcare system had become demoralised in its work of caring for people, Frank quoted from Heidegger’s critique of the medical clinic, describing patients as “object(s) on call for inspection” and “subject to the orderability” of the clinic (Heidegger, 1977, pp. 297-299). Frank advocated an increase in the practice of generosity if the medical/healthcare system is to re-moralise itself within the modern world. He proposed concepts to contribute to the sustaining and building of what he called the *soul* of the health and medical system.

> *My ideal clinic is where each participant – medical workers, patients, volunteers, and friends – sees what is happening in all the possible refractions of the mirrors of one another’s perceptions. Each is constantly asking: what does this look like to them, from where they are?* (Frank, 2004, p. 44)

Meaning is made between people when they communicate and that process is mediated by narrative, which assists to integrate both experience of time and experience through stories.

> *A man is always a teller of stories, he lives surrounded by his own stories and those of other people, he sees everything that happens to him in terms of these stories and he tries to live his life as if he were recounting it.* (Sartre, 1964)
3.6 CONCLUSION

In this chapter I explored the use of stories and narrative in healthcare, set around the central characters within physiotherapeutic relationships. Discourse from within the field of narrative offers much to physiotherapists when reflecting on the nature of their professional practice. Story-telling allows people to organise and make sense of lives disrupted by illness, injury and disability. Processes of self-actualisation in the presence of such difficulty can be assisted by attending physiotherapists if the particular physical issues that therapists come to address can be placed within the overall story that the client is attempting to build. Narrative framing of their interaction together can be assisted by neutral narrative listening on the part of the therapist and joint visualisation of possibilities. The next chapter discusses the research approach chosen for this research project.
CHAPTER 4

RESEARCH APPROACH

Because meanings cannot be grasped directly and all meanings are essentially indeterminate in any unshakeable way, interpretation becomes necessary, and this is the work of the hermeneutic enterprise.
(Josselson, 2004, p. 3)

4.1 INTRODUCTION

In this chapter I outline and discuss the research approach, ethical considerations and quality assurance strategies pursued in this research. The phenomenon investigated in this research is the way that community-based physiotherapists develop therapeutic relationships in home and community-based healthcare. The project is located within the interpretive paradigm. I chose hermeneutic phenomenology to guide the direction of the study and provide a rationale for this choice. Table 4.1 provides a summary of the research strategy.

4.2 RESEARCH PURPOSE AND QUESTIONS

From my clinical experience I know that community-based physiotherapists need to relate to and co-operate with their client’s way of living and being, to contribute effectively to the development of wellbeing for that person. People living at home with chronic and complex healthcare problems need and desire assistance to remain in their own homes and often require and receive the assistance of a community-based physiotherapist. However, efforts to impose an externally constructed therapy model on clients are problematic, especially in the light of professional time constraints and the altered power balance arising from the guest status of the home-visiting healthcare professional (Heckman & Cott, 2005). Increased understanding of these issues could make positive contributions to the working lives of physiotherapists, healthcare workers and clients, and have implications for future research and the education of
physiotherapists. Deeper understanding of this phenomenon might also contribute to ongoing efforts for resolution of the increasing problems of our aging society.

Table 4.1 Overview of the research approach

<table>
<thead>
<tr>
<th>Research purpose</th>
<th>To deepen understanding of the ways in which community-based physiotherapists develop relationships with their clients, their families and carers in home-based chronic and complex healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research paradigm</td>
<td>Interpretive paradigm</td>
</tr>
<tr>
<td>Research approach</td>
<td>Hermeneutic phenomenology</td>
</tr>
<tr>
<td>Research questions</td>
<td>How do community-based physiotherapists experience relationship-centred care within the dynamic and ongoing therapeutic relationships they develop with clients, their families and carers? How do clients, their families and carers experience and understand these ongoing relationships with community-based physiotherapists?</td>
</tr>
</tbody>
</table>
| Methodological lenses | - Social constructionism  
- Narrative  
- Social poetics |
| Research participants | 5 community-based private physiotherapists in NSW  
5 of their clients with severe chronic and complex healthcare issues living at home or in a group home  
7 of their family members  
6 of their carers |
| Data collection | 1-3 successive interviews with therapists, clients, families and carers  
Focus group with participating physiotherapists |
| Data interpretation | Co-constructed phenomenological narratives |

In this research I explored the development of such community-based physiotherapeutic relationships from the points of view of the different people involved in such family-based healthcare situations: physiotherapists, clients, carers and family members. The following research questions framed and guided the study’s direction.

- How do community-based physiotherapists experience and foster relationship-centred care within the dynamic and ongoing therapeutic relationships they develop with clients, their families and carers?
- How do clients, their families and carers understand and experience these ongoing relationships with community-based physiotherapists?

Deeper understanding of community-based physiotherapeutic relationships will contribute a relevant vocabulary and discourse, allowing health professionals to reflect on, engage with and articulate the problems of relating to people in such situations.
“Our problem is not what to do; it is how to talk about it” (Judt, 2010, p. 6); and, I would add, how to think about it.

4.2.1 Diagrammatic view of the research approach

Figure 4.1 on the next page shows an integrated overview of the overall approach chosen for this research. At the base of the diagram lie “the swampy lowlands” of practice (Schön, 1983, p. 42), where community-based physiotherapists form practice relationships with people in community settings.

Community-based physiotherapy is contained within the relationships, which therapists build with clients, families and carers. Talking about these aspects of physiotherapy practice initially occurred in research conversations between me as a practitioner–researcher and Charles Sturt University staff as research supervisors and mentors. That dialogue is seen in the area of Figure 4.1, which has the two faces of practice and research talking to each other. Research questions arose from this interaction and led into a range of decisions regarding the research process to be conducted.

The rainbow of decisions and avenues of approach arching over this interaction in the diagram depict the realisation that the phenomenon of interest could best be explored within the interpretive research paradigm, using hermeneutic phenomenology as its overarching methodology. This exploration was also stimulated by viewing the research phenomenon through the lenses of narrative, social constructionism and social poetics, and the eyes (or lenses) at the ends of that section of the rainbow indicate further insight gained by the use of those methodological lenses. Understanding of the phenomenon and the research process developed through reading, discussion and tuition, and prepared me for the process of data collection and interpretation that followed. A strong orange curve across the top of the rainbow in the diagram reflects the process of data collection and data analysis, leading to the research findings eventually providing findings back into practice.
4.3 RESEARCH PARADIGM

*Human behaviour, unlike that of physical objects, cannot be understood without reference to the meanings and purposes attached by human actors to their activities.* (Guba & Lincoln, 1994, p. 106)

Higgs (2001) distinguished three paradigms of research based upon their philosophical foundations:

- The empirico-analytical paradigm is based on positivism, where knowledge is constructed objectively and without subjective interference from people.
- The interpretative paradigm is based on idealism, where people construct knowledge.
- The critical paradigm is based on historical realism, where knowledge is shaped by social practice and culture and emphasis is placed on the acknowledgement of power relationships and the promotion of emancipation.

This research began with the assumption that people live within worlds that are constructed from the ways in which they interpret reality. Within the interpretive research paradigm, this research looked at the ways in which the participants in community-based physiotherapy made sense of their therapeutic encounters and relationships. When enquiring about our world, the way we live in it and the way we live with each other, researchers bring particular sets of beliefs and values (world views) to their research inquiry. These beliefs and values influence the methods used and the outcomes achieved, and are known as paradigms.

American historian and philosopher of science Kuhn (1996) originally used the term paradigm to reveal that researchers within different schools of thought think through and interpret phenomena of interest in radically different ways. Distinct paradigms of research change as time and views develop within society. Kuhn proposed that periods of “normal” science could be changed by the accumulation of anomalies within an area of inquiry, creating sudden paradigmatic shifts within academic discourse, a process he called “scientific revolutions”.

Although Kuhn was writing of the development of science within the positivist paradigm, paradigm shifts have also occurred within the social sciences, as researchers have sought to explore the difficult areas of human action, interaction and experience. Within the social sciences, the interpretive and critical research paradigms (see Table 4.2) are considered to be qualitative, focusing on qualitative modes of analysis, in
contrast to the empirico-analytical paradigm which focuses more on quantitative modes of analysis.

By using the interpretive paradigm to ground the research processes in this project, I sought to reveal the nature of physiotherapeutic relationships in community settings as experienced by the people who took part in them. The human relationships developed in community-based physiotherapy are usually hidden behind the walls of family homes and embedded within the tacit and therefore mostly silent practices of physiotherapists who work in those settings. The use of the interpretive paradigm for this research respected the different opinions and multiple realities of the research participants involved in community-based physiotherapy. Findings regarding community-based physiotherapeutic relationships were drawn from the interviews and focus group in this research and then interpreted by me, the researcher.

Researchers are located within research texts by their pre-understandings, prejudices and fore-meanings (Gadamer, 1966; Clark, 2008). “If we simply try to forget or ignore what we already ‘know’, we might find that the presupposition persistently creeps back into our reflections” (van Manen, 1990, p. 47). Perhaps it might be best to adopt Dahlberg and Dahlberg’s (2004) alternative term of bridling of one’s pre-knowledge, with its implicit note of “respect given”. This means that the prejudices (or pre-judgements, in a Gadamerian sense) that a researcher brings to a project are acknowledged and seen to be open and transparent.

I sought to accommodate my experiences and prejudices in a fair and ethical attempt to seek the essential experience that the participant physiotherapists developed in their clinical relationships. Throughout the project I made a conscious attempt to ground interpretation of the data in a transparent manner.
In the swampy lowland, messy, confusing problems defy technical solution... (But) ... in the swamp lie the problems of greatest human concern. (Schön, 1987, p. 3)

Figure 4.1: Mindful dialogues in community-based physiotherapy: The research approach.
The development of qualitative research

Across the history of research, the development of a growing interest into how human beings interact with each other has led to the emergence of alternative ways of enquiry that were quite distinct from more conventional scientific (empirico-analytical) approaches that arose during the Enlightenment.21 From the 1920s and 1930s, beginning with the fields of sociology and anthropology, the importance of qualitative research was consolidated as researchers entered different societies to study their cultures and customs (Denzin & Lincoln, 2000). Gradually, the use of paradigms of qualitative research spread as researchers sought to deepen understanding and make meaning of people’s actions and interactions within modern Western society. Denzin and Lincoln described this historical development as occurring in “moments of qualitative research” (see Figure 4.2). This research is located in the current era which builds on and transcends earlier eras.

<table>
<thead>
<tr>
<th>Seven Moments of Qualitative Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional</strong> (1900-1950) – looking for “the truth” in a positivist paradigm</td>
</tr>
<tr>
<td><strong>Modernist</strong> (1950-1970) – arguing against the positivist paradigm</td>
</tr>
<tr>
<td><strong>Blurred genres</strong> (1970-1986) – looking to the humanities as a source of inspiration. Researchers become bricoleurs, borrowing from many different disciplines</td>
</tr>
<tr>
<td><strong>Crisis of representation</strong> (1986-1990) – seeking to locate researchers and participants within reflexive texts</td>
</tr>
<tr>
<td><strong>Post-modern</strong> (1990-1995) – seeking to represent the “other”, abandoning the concept of the “aloof” observer who is completely objective and detached, attempting to fit “smaller-scale” theories to particular problems and situations (p. 17)</td>
</tr>
<tr>
<td><strong>Post-experimental</strong> (1990-2000) – acknowledging and incorporating context into the written text</td>
</tr>
<tr>
<td><strong>The future</strong> (2000 onwards) – showing concern for moral discourse regarding society’s concerns such as democracy, race, gender, and community</td>
</tr>
</tbody>
</table>

Figure 4.2 Seven moments of qualitative research (derived from Denzin & Lincoln 2000, p. 600)

Qualitative research traditions have “identified a need to move beyond an objective view of the world so that the complex human world can be examined in context from the subjective perspectives and complex truths of different individuals” (Herbert & Higgs, 2004, p. 63). The research processes within this project incorporated the context of home-based physiotherapy in the study; interviews were held within the homes of the participants, thereby using context both as the object and the method of exploration.

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21 “The Enlightenment is the period in the history of Western thought and culture, stretching roughly from the mid-decades of the seventeenth century through the eighteenth century, characterized by dramatic revolutions in science, philosophy, society and politics” and based upon principles of human reason (Stanford Encyclopedia, 2010).
Physiotherapy as a profession is of fairly recent origin (The Australian Physiotherapy Association was started in 1906 – see Table 2.1 in Chapter 2) and qualitative research in this area is even younger. I felt the need to read widely to seek support and inspiration for this research, becoming a researcher *bricoleur*; borrowing from many different disciplines and looking to the humanities as a source of inspiration (Denzin and Lincoln, 2000). I was particularly drawn to the work of literary critic and philosopher, Bakhtin (himself disabled in middle age) and to the work of the philosopher, Gadamer. Bakhtin (1981) was fascinated by the interactions and relationships between people, in speech and text, while Gadamer (1986, 1992,) became interested in the process of understanding that develops in the aesthetics of art. Gadamer (1994, 1996) later developed interest in people’s interaction with written texts and then applied his lines of thought regarding the role of language in interpersonal interactions, for example in medical care.

During the postmodern era, researchers sought to represent the “other” in a way that abandoned the concept of the “aloof” observer able to adopt a completely detached and objective perspective. As a practitioner–researcher I found these insights liberating, realising that I was not an impartial and aloof observer and did not have to pretend that I was. Within our research conversations, participants were encouraged to talk and tell stories to reveal how they managed the meaning of their physiotherapeutic relationships, co-creating meaning for this research with me as an active participant in the research process.

Related work has emerged from authors in other disciplines, including Mattingly (1998), from occupational therapy and anthropology, Shotter (1999, 2008) from psychology (also a Bakhtin scholar) and Frank (1995, 2002/1991, 2004), with a background in sociology, psychology and English literature. Such people bridged disciplines and their work contributed to my *bricoleur*-ship. I used their experience and interdisciplinarity to add a thorough grounding to this research.

**Rationale for choosing the interpretive paradigm for this research.**

Alternative paradigmatic developments in qualitative research from the 1950s onward are considered to be interpretive in nature, attempting to “make the invisible visible”, rather than attempting to “measure what can be measured”. The basic beliefs underlying qualitative research paradigms were summarised by Guba and Lincoln (1994) as
answering four particular questions, which assisted me to clarify what might reasonably be included within a line of inquiry:

- The *ontological* question – What is the nature of reality and what might be known about it?
- The *epistemological* question – What is the nature of the relationship between researchers and the knowledge they seek?
- The *methodological* question – How might researchers plan to find out this knowledge?
- The *ethical* question – How might researchers safeguard the interests of participants and the community throughout the research process?

(Denzin and Lincoln (2000) had extended their previous (1994) view to include issues of ethics, arguing that answers to these questions guide the whole research process.

The choice and use of the interpretive paradigm for the planning and implementation of this research is justified by answers to the above questions underlying qualitative research.

*Ontologically,* this research seeks to articulate the reality of community-based physiotherapy as experienced by the participants in this research. “Being” in physiotherapy practice, I also inhabited a similar practice *lifeworld* to that of the participants. Deeper understanding of the phenomenon occurred as I interacted with the research participants, engaging with their particular local and embodied realities. This meant that my subjectivity was a part of the research. Such an approach contrasts with the quantitative and empirico-analytical paradigm, in which researchers hold themselves “aloof” and apart from the participants and the research process, in an attempt to be completely objective and detached.

*Epistemologically,* the knowledge that I was likely to derive from the research was strongly influenced by my experience as a practising physiotherapist. Qualitative researchers typically adopt an involved, connected observer stance and immerse themselves, literally, in the concrete, everyday world they are studying (Titchen & Hobson, 2005, p. 123). As a practitioner–researcher I was located within that research process as a researcher but also as a practising community-based physiotherapist, in company with the physiotherapist participants in the project. My knowledge and experience as a person and as a physiotherapist inevitably contributed to the research
process, and new knowledge as a researcher also contributed to my clinical practice via a “research practice portal” (Tasker, McLeod-Boyle & Bridges, 2011). The idea of a “portal” indicates that space exists within both the research and the clinical practice processes for reflection and consideration of past practices and possible new ideas to occur. Different ideas and layers of interpretation were repeatedly and reciprocally fed into, and arose from, the research process as I worked to transform myself into a practitioner–researcher.

Methodologically, participants joined me in a series of conversational interviews and focus groups to relate their experience of community-based physiotherapeutic relationships. As a researcher, my aim was to interpret and co-construct knowledge and meaning with participants about their experiences. Iterative interpretation of transcripts of those texts revealed themes of meaning which helped to deepen understanding of the phenomenon being researched.

Ethically, I was originally motivated to follow this particular line of research interest because of a perception, formed throughout clinical practice, that the people to whom I provide physiotherapy need and deserve the best and most satisfying experience of physiotherapy possible.

_It is not enough to just take note of another’s beliefs, values, views and experiences. They must be integrated into the biography of that individual._ (McCormack, 2003, p. 204)

Recognition of people’s right to make decisions about their own healthcare promotes an underlying ethical attitude, allowing care to also be taken of the interests of research participants and the community throughout the research project. This research, as articulated in the research questions, fitted well within the interpretive paradigm. The research focus is placed on people involved in real-world activities and relationships and assists to make that world visible (Denzin & Lincoln, 2000).
4.4 RESEARCH APPROACH

Hermeneutic phenomenology was chosen as the approach for this research, reflecting and complementing the complex nature of the phenomenon to be explored and the project’s need for a congruent and carefully considered research approach.

4.4.1 Phenomenology

Phenomenology originates from the Greek words *phainomenon* (to appear) and *logia* (discourse), and is understood in terms of philosophy, methodology and method. Phenomenology has a long and intricate historical tradition (see Table 4.2) and has received contributions from many philosophers and thinkers (Grace & Trede, 2010). Phenomenology is the study of human experience. It seeks to describe an individual’s *lifeworld*, that is, the world as subjectively experienced by that person (van Manen, 1990).

In contrast to study of the world that attempts to be completely detached and objective, phenomenology considers knowledge and understanding to be embedded in everyday life. Such research might be likened to the journey of a traveller that leads to a tale to be told on returning home (Kvale, 1996).

*The interviewer wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of conversation as “wandering together with”.* (Kvale, 1996, p. 4)

Phenomenology’s use of rich and descriptive writing is an attempt to describe and reveal the essence of experience of the world as lived by a person, not reality as something separate from that person (Valle, King, & Halling, 1989).

Phenomenological research writing aims to stimulate in readers “a sense of connection to actual or potential experience” (van Manen, 1990, p. 27). Van Manen referred to “the phenomenological nod” that occurs when, while reading, readers involuntarily nod in agreement, recognising the essence of the lived experience of another person, as described in the resonance found in a piece of thick and rich phenomenological writing. Resonance in itself justifies lived experience as “the starting point and the end point of phenomenological research” (van Manen, 1990, p. 36). The field of phenomenology should be seen as a movement rather than a static history (Spielberg, 1960). It is driven by the ongoing need and desire of people to make meaning of how they and others experience the world around them.
Table 4.2  Development of phenomenology  
(derived from Grace & Trede, 2010; van Manen, 2002; Rollinger, 2004).

<table>
<thead>
<tr>
<th>Types of phenomenology</th>
<th>Main authors</th>
<th>Focus of study</th>
<th>Themes of study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epistemological</td>
<td>Lambert (1728-1777)</td>
<td>The difference between truth and illusion/error</td>
<td>Experience as a starting point</td>
</tr>
<tr>
<td>Descriptive</td>
<td>Brentano (1838-1917)</td>
<td>The difference between mental and physical phenomena</td>
<td>Characteristics of mental experiences and their inter-relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intentionality as the major difference between mental and physical phenomena</td>
</tr>
<tr>
<td>Transcendental</td>
<td>Husserl (1859-1938)</td>
<td>Consciousness and the essence of a phenomenon</td>
<td>Intentionality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Eidetic reduction (bracketing)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Constitution of meaning</td>
</tr>
<tr>
<td>Existential</td>
<td>Heidegger (1889-1976)</td>
<td>Pre-reflective lifeworld of everyday experiences</td>
<td>Lived experience</td>
</tr>
<tr>
<td></td>
<td>Merleau-Ponty (1908-1961)</td>
<td></td>
<td>Modes of being</td>
</tr>
<tr>
<td></td>
<td>Sartre (1905-1980)</td>
<td></td>
<td>Ontology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lifeworld</td>
</tr>
<tr>
<td>Hermeneutic</td>
<td>Heidegger (1889-1976)</td>
<td>Interpretation</td>
<td>Interpretation</td>
</tr>
<tr>
<td></td>
<td>Gadamer (1900-2002)</td>
<td></td>
<td>Textual meaning</td>
</tr>
<tr>
<td></td>
<td>Ricoeur (1913-2005)</td>
<td></td>
<td>Dialogue</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pre-understanding</td>
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<td></td>
<td></td>
<td></td>
<td>Tradition</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Language</td>
</tr>
<tr>
<td>Experiential (Phenomenology of practice)</td>
<td>van Manen (1973- )</td>
<td>Contexts of practical concerns of everyday living, practice and application</td>
<td>Practical, applied</td>
</tr>
</tbody>
</table>

The term “phenomenology” was first used by Johann Lambert (1728-1777), a mathematician and astronomer, who discussed the need to look back towards experience as a starting point, using analysis to investigate theories of knowledge. From the 17th to the 19th century a growing number of scholars sought knowledge and truth by scientific enquiry. Kvale (1996) used the metaphor for such knowledge seeking as searching for buried metal. Barry (2002) wrote of the quantitative researcher as a miner, digging at a seam to seek objective, quantifiable facts that have already been defined and understood beforehand, whereas phenomenology provides a way of getting at the new and unexpected in the unexplained and unexplored spaces of human experience.
Towards the end of the 19th century, interest developed in the nature of consciousness, in particular, the relationship between mental experiences, the content of those experiences and the external world. Working from within the empirico-analytical paradigm, the philosopher Brentano (1838-1917) sought to develop a scientific theory of the mind as a part of his approach towards a scientific psychology (Brentano, 1995). He worked to describe and categorise the characteristics of mental experiences and their interrelations, arguing that intentionality forms the major difference between mental and physical phenomena. Siewert (2008) referred to intentionality as the “aboutness of mental states – the fact that, for example, one’s thinking is of or about something”.

Brentano’s student, Husserl (1859-1938) continued with this work and is generally considered to have originated the philosophical tradition of phenomenology, although it should be acknowledged that his work was preceded and initially influenced by that of his teacher Brentano (Rollinger, 2004).

Working from within empirico-analytical phenomenological research, Husserl attempted to access everyday human experience (lifeworld), as perceived by individuals and before these perceptions become changed by further abstract thought. Husserl viewed such pre-knowledge as the essence of human consciousness. To access these “essences”, Husserl argued, it is necessary to “bracket” or suspend our beliefs, preconceptions and prejudices to be open to the essential nature of lived experiences (van Manen). This view arose from the way that Husserl approached relationships between the “self” and the world, but his followers developed phenomenology in ways that differed radically from his original ideas. Husserl’s student Heidegger (1889-1976) developed a relationship between hermeneutics and phenomenology. Titchen and Hobson (2005) described the difference between the approaches of Husserl and Heidegger as a difference in both concern and approach.

That is, the concern of Husserl’s transcendental phenomenology was that of epistemology, positioning the self as a conscious actor in a world of objects (Husserl, 1964). In this direct approach, researchers investigate the foreground of a phenomenon and ask research questions that attempt to uncover the mental content of an individual’s lifeworld (Titchen & Hobson, 2005). Examples of this approach are seen within the later development of the methodology known as grounded theory, which seeks to find common themes between the experiences of different people (Strauss & Corbin, 1988).
In contrast, the concern of Heidegger’s hermeneutic phenomenology was one of ontology, viewing the self as immersed in the world and not separate from it. Within this indirect approach, researchers form research questions that ask how participants interpret and make meaning of their experience in the world (Titchen & Hobson, 2005). Examples of this approach are seen within the development of hermeneutic phenomenology for social science research, where texts arising from dialogue with participants are composed and researchers engage in an open-ended dialogue with those texts.

4.4.2 Hermeneutic phenomenology
Hermeneutics originally involved the interpretation of texts. In Greek mythology, Hermes was the messenger who took messages from the gods to humans. Palmer (1999) mused that Hermes was the “quicksilver” god of sudden insights, ideas and inspirations (para 1). Having a helmet of invisibility, winged sandals and a magic wand to make humans sleep or wake, he was able to bridge the different worlds of mankind and the gods, making the invisible visible. Hermeneutics originally referred to the interpretation of biblical texts, but within qualitative inquiry generally it has been extended to include the interpretation and understanding of interviews and observed human practices (Patton, 2002).

Within hermeneutic phenomenological research, understanding and interpretation of new meaning occurs through a process of dialogue with texts constructed from phenomenological investigations. In the research context, hermeneutic dialogue initially takes place between researchers and existing literature. Findings in the form of transcribed interviews and focus groups might become further texts available for dialogue. Although Heidegger originally brought hermeneutics and phenomenology together, his student Gadamer (1900-2002) developed hermeneutic approaches towards this philosophy further. Gadamer (2004) argued that understanding is made possible by a person’s immersion in a world of language, and that they and others seeking to understand them are connected by their common humanity. When applying this thinking to a social research situation, researchers become involved in a reciprocal, dialogical process of interpretation with their participants because they are both in and of the social world (Spence, 2001). Researchers engage in an ongoing dialogue, striving to understand the phenomenon being researched.
From within the discipline of literary criticism, Bakhtin (1895-1975) discussed a dialogical engagement (Menippean dialogue) which pays attention to the “particularity” of “the other”, trying to “creatively enrich all the voices involved by giving them the freedom to reveal their expressive potential and being surprised by what emerges from the exchange” (Sullivan & McCarthy, 2005, p. 633). Although this genre of writing involved satire and the placing of grotesque characters within fantastical, dialectical situations (carnivale), Sullivan and McCarthy (2005) argued that use of Bakhtin’s ideas regarding dialogue serves to inform qualitative research inquiry, emphasising the possibility to be different through dialogue with another person or their ideas. Bakhtin’s work was still politically suppressed in the Soviet Union (where he lived and worked) when Gadamer wrote *Truth and Method* (1989, first published 1960), but both authors viewed text as effectively a living “other”, speaking to us and requiring a response in a process of creative understanding. Bakhtin (1986) argued that a “speaker” does not expect “passive understanding that, so to speak, only duplicates his own idea in someone else’s mind” (p. 69).

An open and dialogical approach suits the ethical research of human relationships. Sullivan and McCarthy (2005) argued that the creative and interpretive processes within Bakhtin’s view of dialogue combine both content and experience, assisting authors/researchers to maintain their voice ethically within the presence of all the voices involved in the research process, including their own.

*Such a dialogic posture means that we are defined less by the position that we hold (i.e. “psychologists”) and more by the particularity of our response to the other. As researchers, we too are “needy” selves searching for consummation and completion through dialogical encounters with concrete others. (p. 635)*

In a hermeneutic process, the notion of constant movement between present understanding and new insights and meanings occurs in what Gadamer (2004) termed a “fusion of horizons”, where researchers interact with participants in an effort to arrive at a shared meaning. In an iterative process, researchers arrive at new meaning. There is an open-ended play of thought and meaning promoting a deepening understanding of where other people are “coming from”, even in the face of disagreement.

*This play of understanding is therefore already in practice—it’s essence requires one to continually bring the known, but to continually give it up in practice. (Todres, 2008, p. 1570)*
Drawing on Gadamer’s ideas, Todres (2008) described this process as “embodied relational understanding”. Gradual and increasing understanding provides constant refreshment of one’s insight, incorporating a necessary openness to the “otherness” of particular phenomena. Researchers repeatedly move their focus from viewing the specific parts of the data to viewing the whole of a setting, gradually increasing their understanding of the issue being studied. Researchers reflect on the data and the relevant literature, seeking to clarify phenomena through the use of thick, rich description within their writing.

4.4.3 Rationale for choosing hermeneutic phenomenology for this research
Within the field of healthcare, Dahlberg, Todres, and Galvin (2009) comment that phenomenological traditions incorporate and acknowledge that life cannot be truly compartmentalised and human beings cannot be objectified. Their theory of lifeworld-led healthcare posits that an authentic approach to relationship-centred healthcare requires a deeper, more layered and existential philosophy of care, based on views of people and wellness rather than on a deficit model of sickness. Deeper understanding of the complexity that is involved within community-based physiotherapeutic relationships might be achieved by methodologies that have a corresponding philosophical depth to underpin them, and hermeneutic phenomenology provides this.

The practice of writing hermeneutically can reveal and develop knowledge found useful by local communities for those communities, but might also contribute to more universal knowledge (Eryaman, 2008). The researcher delves within a topic of interest to discover its parts and then stands back to perceive the whole and how those parts might contribute to that universal whole. Reflection on the themes of the phenomenon is supported by description through writing and rewriting. For this project, analysis of the collected data also used a hermeneutic approach by identifying basic themes within the data, then gradually developing organising themes and eventually global themes.

In this hermeneutic phenomenological research, a reciprocal, dialogical process of interpretation was undertaken with participants. Together, researcher and participants engaged in an ongoing dialogue, enacted through the process of interviewing and the conduct of a therapists’ focus group. Texts were constructed from these phenomenological investigations showing a gradual development of shared understanding (which Gadamer (2004) explained as a fusion of horizons). The
consideration of horizons enabled the interpretation of future horizons of possibility for the practice of community-based physiotherapeutic relationships.

Such an open and dialogical approach suited the research of the human relationships involved in community-based physiotherapy and allowed me to also maintain my own voice ethically within the presence of all the voices involved in the research process, both personally and professionally (Sullivan & McCarthy, 2005). Todres’s (2008) definition of “embodied relational understanding” really explains the nature of the research interactions that occurred during this research. The gradual and increasing understanding that developed throughout this research constantly refreshed my insight into the nature of the phenomenon and promoted my openness to the “otherness” of my participants (Todres, 2008). In the same way that I may have been changed by the hermeneutic phenomenological process in this research (see Section 7.7 for more detail), so too might physiotherapists be sensitised by the products of such qualitative research (Todres, 2008).

In trying to answer the research questions for this research (How do participants interpret the meaning of their community-based physiotherapeutic relationships?), the iterative and dialogical research methodology of hermeneutic phenomenology provided the necessary depth of approach needed for a complex issue.

4.5 METHODOLOGICAL LENSES

Methodology links a particular philosophy to the appropriate research methods and bridges philosophical notions to practical and applicable research strategies. (Byrne, 2001, p. 1)

While the approach of this project is predominantly hermeneutic phenomenology, it has also been informed by insights from the research of other disciplines, including insights from the fields of social constructionism, narrative and social poetics. Time was initially spent in reflection and wide reading of the literature to identify resources that might best clarify the direction of the research to be undertaken. As I researched the phenomenon of interest for this research, the areas of social constructionism and narrative arose in a logical and natural way that needed to be accurately described within my discussion, particularly with reference to my approach to reading the literature as well as the more practical methodological considerations required for the data collection and analysis.
These different methodological lenses were used for the literature searching to enhance that process and avoid shutting down the extensive reading process that I felt was needed in the absence of discourse about the phenomenon by the physiotherapy profession.

The different methodological lens of narrative and social constructionism assisted me to approach the problem of inter-personal aspects of clinical interaction in community-based physiotherapy by borrowing a view of that phenomenon in terms of,

- Processes of making meaning between people (a social constructionist lens).
- The participants’ identification of meaning through the chosen telling of stories (a narrative lens)

4.5.1 Social constructionism

People’s social interactions can be viewed as personally constructed (constructivist) and interpersonally constructed (constructionist) ways of knowing, in contrast to a positivist viewpoint, where truth is to be found, ready-made, within the observed world. In particular, social constructionism studies how people use different conventions of language and social processes to communicate with each other and establish meaning from within interpersonal relationships. Social research might then be moved on from the study of an individual person or the external world to the study and consideration of human communication and interaction. Knowledge is not merely individually generated but is constructed collectively (Schwandt, 2003).

Within social constructionism, meaning and understanding are viewed as important features of human activity (Lock & Strong, 2010). Lock and Strong argued that one person only understands part of the meaning of what another person says; ongoing conversation is required for both of them to gain greater clarity and understanding of each other’s point of view. It is an assumption of this research that co-creation of knowledge and meaning occurs both within the physiotherapeutic relationships and the research process itself.

*Research findings are always already partial and situated ... they actively construct the social world which is itself an interpretation and in need of interpretation. (Aguilano, 2004, p. 128)*

4.5.2 Narrative

Although the methodology of narrative inquiry is not specifically used in this research, many aspects of narrative inform a hermeneutic phenomenological approach. Schwandt
(1994) argued that qualitative researchers seek to understand and communicate human experience from the perspective of those who live it. Guba and Lincoln (1994) suggested that such knowledge is constructed within the relationship between researchers and participants. As participants recount experiences, it is inevitable that they will reconstruct and interpret those experiences narratively, in an effort to make sense of them. As Riessman (1993) noted, the truth of the story told is not important, it is the meaning, and researchers recognise that participants will choose what parts of the story to tell, to best convey their meaning of that experience to listeners. Bailley and Tilley (2002) supported Riessman’s position when they wrote that researchers explore participants’ narratives in “the belief that individuals make sense of their world most effectively by telling stories” (p. 575).

Narrative structuring contributes towards the building of a stronger phenomenological text and provides a powerful means of communicating findings and their significance to readers. Sandelowski (1991) argued that the acknowledgement of participants as narrators and their stories as texts to be further interpreted by researchers is particularly important, because it helps those researchers to find some solutions to the problem of the inadequacy of purely analytical approaches to the understanding of human experiences. The use of narrative as an interpretative process fitted well within the hermeneutic methodological strategies used for this research. By taking a narrative view I was able to see the study’s participants as whole people, within their particular context. Viewing the physiotherapeutic relationship as a story into which the participants entered, also provided a way of seeing different elements of that relationship: the who, what, when and why of how community-based physiotherapists’ practised, the way they practised and how their practice was enacted to achieve community-based physiotherapy relationships that were satisfying and productive for all the people involved.

4.5.3 Social poetics
Poetry often has the capacity to penetrate experience more deeply than prose (Furman, 2006). The study of social poetics involves the use of metaphor and other figures of speech occurring in ordinary speech and prose. Social poetics builds on the attention that Gadamer paid to linguisticality. Gadamer (1989) articulated the importance of linguisticality to understanding human activity. We speak of linguisticality as the amount to which things are grounded in language, in much the same way as we speak of their materiality or historicality (Loftus, 2011).
Analysing the expressions of research participants with insights from poetics helps researchers enter the complex *lifeworld* of participants. “The personal touch arouses interest, and interest sharpens awareness and understanding” (Whitburn, Davis, Higgins, Oates & Spurgeon, 1978, p. 154). Appreciation of poetics helps researchers to be more sensitive to the *deeply personal* aspects of participants’ stories. Participants’ expressions are used to focus attention on “relations between aspects of our own human activities, previously unnoticed in the everyday, background ‘hurly-burly’ to our lives, here and now” (Shotter, 1997, Section 2). Recognition and use of poetic language forms locates an essential *way of being* within participants’ socially constructed viewpoints, allowing us to connect with their experience. MacNamee (2000) wrote of this connection as “relational engagement” and explored the notion that all actions have a context within which they make sense. By more fully exploring how we talk, interact and make sense within human relationships, poetics seeks to make sense of experiences through the use of an embodied, relational and dialogic process (Cunliffe 2002). The use of poetics within the data analysis and presentation of findings in this project allowed me to access unexpected and hidden thoughts, feelings and meanings from a particular participant’s point of view. By observing and highlighting the poetics of everyday speech within human interaction, researchers create rather than discover new understandings of human experience and interaction (Aldridge & Stevenson, 2001). Use of the poetic in research encourages an open attitude in readers towards the reality of another person’s experience, engendering empathy and acknowledgment of the different ways that others experience reality.

Poetics were used for different purposes within this research, supporting the development of a multi-faceted and hermeneutic research process and providing intellectual momentum and a means of integrating ideas throughout the project. Prior to and throughout the research process, pieces of free verse (see chapter prologues and booklet inside the back cover of this thesis) were written to allow reflection and a layering and deepening of understanding. During data analysis, poetic phrases “found” within the data provided meaning markers acting to promote understanding between researcher and participants.

Appreciation of the poetic in the data assisted the presentation of findings via the use of “derived” poetry and also suggested points of entry for further consideration of certain issues. The use of poetics in this study enabled the phenomenon of interest to move from the local, specific and particular context of community-based physiotherapy.
towards wider issues of societal concern. The highlighting of human feelings and concerns about the physiotherapeutic process within this project could stimulate interest in other human activity processes and provide transferability of the ideas arising from this study into wider areas of human concern.

Qualitative research and interest in the human relational side of physiotherapy has only been raised in physiotherapy discourse recently. Accordingly, I felt it necessary to explore the discourse of different disciplines, to gain other viewpoints regarding the subject and importance of the interpersonal relationship within community-based physiotherapy practice. The use of different methodological lenses provided a tool to broaden my research aspect, supporting but not replacing the main methodology of hermeneutic methodology used for this project.

**4.6 RESEARCH PARTICIPANTS**

As this research focused on the physiotherapeutic relationship between people and took an individual and person-centred approach, I chose to purposefully sample five client participants and their attending physiotherapists. This number allowed successive interviewing to explore issues of interest more deeply. “Deciding on the number of participants for a qualitative study is a thorny issue. More does not mean better” (Finlay and Ballinger, 2006, p. 42). Nicholls (2009) advised that the sampling of 5-8 participants is common for phenomenological research projects. Participant access for this research was sought to a number of different client situations across different areas of NSW and to participants from different adult age groups. The 2:3 ratio of male to female physiotherapy participants chosen for this project mirrored the overall ratio of male to female physiotherapists in general private practice, where 73% of physiotherapist were female (APA 2005). A radiating sampling effect is also seen in the decision to interview family members and other carers for each of the client participants involved. Table 4.3 profiles the backgrounds and situations of these participants.

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22 The decision to interview adult participants was made because research already existed in the literature related to family-based physiotherapy with children (Young, Moffet, Jackson & McNulty, 2006).
Table 4.3: The research participants

<table>
<thead>
<tr>
<th>Client</th>
<th>Client’s living situation</th>
<th>Client’s age range</th>
<th>Family care team members interviewed</th>
<th>Attending physiotherapists</th>
</tr>
</thead>
</table>
| Jack   | Jack had suffered a severe acquired brain injury when he was 18 yrs old. He needed the assistance of 2 people to walk and assistance for all activities of daily living. He was able to communicate with the assistance of an Assisted Augmentative Communication (AAC) device and gestures but required support for this activity as well. | 20’s              | Brian and Honor, Jack’s mother and father. Brian worked full time but was able to join us for part of one interview, which was held around the kitchen table  
Sue, Jack’s carer was one of the team of carers providing care for Jack on a daily basis  
(Privately paid from Jack’s injury compensation)  
Interviews were conducted as a family in the kitchen of Jack’s home | Karen, Jack’s physiotherapist, worked from her own home. She had 25 years of community-based physiotherapy experience and had been a physiotherapist for 32 yrs in total. |
| Jenny  | Jenny lived in a group home. Her family visited often and were involved in her care. Jenny had developed a developmental disability as a baby, following a SIDS episode. When I met her she was unable to sit, or walk and unable to talk or gesture. She required full assistance for all her activities of daily living and was medically very frail. | 30’s              | Chrissy and Malcolm, Jenny’s parents met me at the group home where Jenny lives and we conducted the interview in the dining room there with Jenny present. Chrissy worked as a teacher and they had other children at home. Jenny’s carers were employed by the NGO who administer the group home in which Jenny lives  
Jaime cared for Jenny in her PSO setting but also did some carer hours at the group home.  
Bridie cared for Jenny in the group home as a registered nurse. I interviewed Jaime and Bridie in the staff office of the group home | John, Jenny’s physiotherapist worked for the NGO administering her group home but also worked privately. He had 19 years experience and had worked in several different countries |
<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Age</th>
<th>Details</th>
<th>Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dennis</td>
<td>Dennis had suffered a severe spinal cord injury with acquired brain injury from a car accident in his twenties. He lived in an inner city flat with the assistance of 24hr carers. An elderly lady living down the corridor visited him daily for a chat and a coffee.</td>
<td>20's</td>
<td>Anne, Dennis’s carer was employed by a care agency funded by his compensation funds. She was one of a team of carers provided by the carer agency. Dennis particularly chose Anne as the carer he wanted to be interviewed as he felt that she had had the most contact with him in company with his physiotherapist, Adam and so could best comment on the relationship that had developed between Dennis and Adam.</td>
<td>Adam, Dennis’s physiotherapist, visited him 2x/week. This private therapy was funded by Dennis’s compensation. Adam had worked for 7 years as a physiotherapist.</td>
</tr>
<tr>
<td>Joanne</td>
<td>Joanne lived at home with her husband in a large and comfortable house, within which she mobilised generally in a power wheelchair. She had suffered an acquired brain injury from a car accident some years earlier.</td>
<td>50's</td>
<td>Jim, Joanne’s husband cared for his wife in their very comfortable home. I interviewed Joanne and Jim separately. A carer (funded by Joanne’s injury compensation) visited daily to help her with her activities of daily living but Jim and Joanne decided that they would prefer that carers were not interviewed for this research project as there was no particular carer that had had contact with Joanne’s physiotherapist.</td>
<td>Lynne, Joanne’s physiotherapist, had worked as a private community-based physiotherapist (working from her own home) for 7 years but had been a physiotherapist for 24 years.</td>
</tr>
<tr>
<td>Eric</td>
<td>Eric lived at home with his wife. He used a wheelchair to get around in the house but was independent in his transfers from chair to bed etc. He suffered from back pain as well as immobility and a moderate degree of dementia.</td>
<td>90's</td>
<td>Gwen, Eric’s wife had worked with him when they were younger (as his receptionist) Their daughter, Marie lived a short distance away but visited daily as a carer, also assisting with community access – doctors’ visits, shopping etc and receives a carer’s allowance27 from Centrelink to assist with that activity; Gwen, Eric and Marie, his daughter, all attended individual interviews with me. They and Eric then joined together with me for a family interview.</td>
<td>Barbara, Eric’s physiotherapist, had worked as a community-based physiotherapist from her own home for 29 years but she had practised as a physiotherapist for 50 years (in total) in several different countries.</td>
</tr>
</tbody>
</table>

27 *Carer Allowance* is an extra government payment, which is available for parents or carers, who provide additional daily care for people living at home with a disability or medical condition (Commonwealth Government of Australia: Department of Human Services 2012, *Care Allowance*).
Initially I had decided to call each family group a ‘family care team’ but on reflection I decided to refer to participants as ‘therapists, clients families and carers’ or ‘family care groups’ in order not to medicalise the efforts of families caring for a family member at home.

4.6.1 Community physiotherapists: gateways and gatekeepers for the research process

Initially, I contacted the Australian Physiotherapy Association by phone to ascertain the names, contacts and whereabouts of community-based physiotherapists who worked via home and community visiting. Further consideration was then given to the geographical work areas of individual therapists to ensure a spread of participants across NSW for this research. I randomly contacted five private physiotherapists working within the area of community-based chronic and complex healthcare within NSW, in areas between Katoomba in the Blue Mountains and the coast of NSW, Australia. All participating therapists worked privately and had more than five years of professional experience in community-based healthcare (see Table 4.3). Most worked from offices in their homes.

Participating physiotherapists acted as “research gateways”, providing research access to clients and their families who were able to participate in this project. Those therapists also acted as “practice gatekeepers”, carefully advising of any vulnerability of clients or their families. In one instance, such advice led to the identification of recent events (related to illness) affecting one of the family members who had initially signed up for this research project. Discussion was then held with that person and it was mutually decided that the research process could cause added stress at a time when the person needed to concentrate on their own health and wellbeing. That particular family care group and client withdrew from the project and other participants were found, again with the assistance of the participating physiotherapist.

4.6.2 The practitioner–researcher: Also a participant

As a practising community-based physiotherapist, it was ethically and methodologically necessary for me to clarify ideas, efforts and assumptions that had contributed to my motivation and pre-existing knowledge. This reflective process brought biases to the surface and helped to clarify the research process. “Researchers cannot ‘eliminate’ their experience which is inextricably linked to interpretation” (Thompson, 1990, p. 246).

By asking the physiotherapist participants to approach clients and their families who might also be able to usefully participate in this research without extra stress being put
on that family, I was able to minimise my influence on the sampling process. The same 'gatekeeper' safeguard was seen to operate when interviewing clients with communication difficulties where families asked to have interviews conducted together so that those clients’ wellbeing could be best looked after.

With regard to the analysis of the findings, my clinical experience and history inevitably influenced the data analysis process but the methodology of hermeneutic phenomenology with its iterative processes of reflection and dialogue with the texts (produced through my interaction with the research participants) also provided some safeguarding of the effects of that influence. It should also be remembered that this research must also be acknowledged as an interpretive exercise leading towards a ‘fusion of horizons’ between researcher and participants.

I endeavoured throughout this research to remember that,

> Interpretations depend very much on who the interpreter is, who he or she is addressing, what his or her purpose is, at what historical moment the interpretation takes place.” (Said, 1981, p. 154-5).

### 4.6.3 Clients and their families: the reason

Five clients with a variety of chronic and complex healthcare problems and life circumstances were sought via their physiotherapists for this study (see Table 4.3). This provided a geographical spread of client, family and carer participants across NSW, from the mountains to the sea, and included a broad array of the different types of client situations usually seen by community-based physiotherapists. This variety of different health conditions experienced by clients and the ways in which those clients were able to communicate added a further layer of complexity within the interview process.

All participating clients had communication and/or short-term memory difficulties. This was accommodated within the interview process to allow as full an interview experience as possible. For example, time was spent in preparatory conversation and reminiscing with Eric, who had a moderate level of dementia. Such orienting conversation appeared to help Eric to feel alert and connected to the interaction and was combined with careful repetition of “last words spoken” to help him to maintain our research conversation.

### 4.6.4 Carers: helping people to stay at home

Participating community-based carers for people living in their own homes with chronic and complex health problems came from a variety of backgrounds. Of the five
participating carers, two were working for not-for-profit organisations, two were working for privately run carer organisations and one was a family member. In another situation, one family did not want their carer interviewed and this decision was respected.

4.7 DATA COLLECTION

I conducted 35 interviews with five community-based physiotherapists, five participating family groups and involving five clients, eight family members and five carers (see Table 4.3) and a focus group with the physiotherapists on their own. Different participants were able to contribute in different ways; for example, Dennis needed very short interviews to manage his fatigue.

Interviews were recorded with two iPods and the voice files were then sent via a secure file transfer protocol (FTP) site to a commercial transcription service, which specialised in the transcription of social science and healthcare interviews and was aware of the need for confidentiality. Completed transcripts were emailed back to me. The texts constructed from this process were stored on a laptop computer in secure voice files and document files, to allow concurrent reading and listening of the data.

After each interview, I sat quietly in the car to note any observations and reflect on the interview I had just completed. I recorded these reflective field notes onto an iPod. These notes were transcribed, as well as the interviews. All the interview voice files were listened to on the day that they were recorded and ideas were generated based on the stories heard in the interviews.

4.7.1 Interviews

Semi-structured interviews were used for this project, encouraging participants to express themselves more freely by asking questions in an unstructured style (Minichiello, 1995). Such interviews were then conducted “in-depth”:

Conversation with a specific purpose – a conversation between researcher and informant, focusing on the informant’s perception of self, life and experience, and expressed in his or her own words (p. 61).

Interviews with participants sought to explore the meaning that people assigned to the physiotherapeutic relationships occurring in home-based physiotherapy.
Although it is possible for much useful data to be gained from one in-depth interview, I considered that further interview contact would enhance trust and confidence between the research participants and me as a researcher. Participants could also have a chance to reflect on the first interview and possibly deepen their comments on the research phenomenon being explored. Accordingly, one to three interviews were conducted with participants (see Table 4.4: Spread of participant interviews). The interview guides were prepared with a wealth of different possible questions that might be asked, in order to help the interview process to flow easily. The number of interviews conducted with each participant depended on the degree of data saturation achieved and other issues regarding fatigue and the need of clients for carer attention during the interview.

Table 4.4 Spread of participant interviews

<table>
<thead>
<tr>
<th>Participants</th>
<th>Participant type</th>
<th>No of interviews conducted</th>
<th>Individua or group interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack, Brian, Honor and Sue</td>
<td>Client, father, mother and carer</td>
<td>3</td>
<td>Group</td>
</tr>
<tr>
<td>Karen</td>
<td>Physiotherapist</td>
<td>3 (in 2 time-slots)</td>
<td>Individual</td>
</tr>
<tr>
<td>Jenny, Malcolm and Chrissie</td>
<td>Client, father and mother</td>
<td>2</td>
<td>Individual</td>
</tr>
<tr>
<td>Jaime</td>
<td>Day program carer</td>
<td>1</td>
<td>Individual</td>
</tr>
<tr>
<td>Bridie</td>
<td>Group home carer</td>
<td>2</td>
<td>Individual</td>
</tr>
<tr>
<td>John</td>
<td>Physiotherapist</td>
<td>3</td>
<td>Individual</td>
</tr>
<tr>
<td>Dennis and Anne</td>
<td>Client and carer</td>
<td>3 (10-20 mins)</td>
<td>Group</td>
</tr>
<tr>
<td>Adam</td>
<td>Physiotherapist</td>
<td>3</td>
<td>Individual</td>
</tr>
<tr>
<td>Erin</td>
<td>Client</td>
<td>1</td>
<td>Individual</td>
</tr>
<tr>
<td>Jim</td>
<td>Husband</td>
<td>1</td>
<td>Individual</td>
</tr>
<tr>
<td>Lynne</td>
<td>Physiotherapist</td>
<td>2</td>
<td>Individual</td>
</tr>
<tr>
<td>Eric</td>
<td>Client</td>
<td>2</td>
<td>Individual and group</td>
</tr>
<tr>
<td>Gwen</td>
<td>Wife</td>
<td>2</td>
<td>Individual and group</td>
</tr>
<tr>
<td>Marie</td>
<td>Carer</td>
<td>2</td>
<td>Individual and group</td>
</tr>
</tbody>
</table>
4.7.2 Preparing to interview

Full details of the research study, its methodology and its rationale were initially discussed with individual participating therapists by phone. A meeting was then arranged, to discuss the paperwork such as information sheets and consent forms. At this time, it became obvious that the participating therapists had further questions that needed to be answered. More discussion was then held by email and phone to help them ascertain which clients might be able to participate, while also avoiding posing any risk to possibly vulnerable people.

Contact with possible patient and family/carer participants was made when participating therapists had ascertained that clients, their families and carers were willing to participate in the interview process. Potential participants were given details of the research by their therapist and invited to participate. Therapists were able to inform the researcher of any particular care that needed to be taken, for example, concerning issues of fatigue, communication impairment, family preference regarding interview situation, and comprehension ability, with the aim of ensuring comfort and ease for all participants interviewed.

The quality of the data acquired through qualitative interviews and focus groups is very dependent on the interviewing and facilitation skills of the researcher. I sought to acquire/enhance these skills by first practising on my own family members. I also became ‘the research participant’ in three practice interviews with a research colleague who ‘interviewed’ me so that I could better understand the experience of being interviewed.

4.7.3 Confidentiality and informed consent

Confidentiality and informed consent (and therefore awareness and prevention of any coercion of participants) were very important ethical issues to address within the research process. Confidentiality was relevant to the clients and their family and carers, but also to the five physiotherapy practitioners. Because of the relatively small number of practitioners working in NSW in this style of practice, there was a small chance that they might be identified through this thesis? However, every effort was made to limit this issue and to take care not to disparage participants in any way. There is nothing in the thesis that presents the participants in a negative light and any comments that may have indicated any participant’s identity were deliberately voided from the thesis. Client participants were vulnerable and dependent and a sensitive approach was needed to
ensure that no coercion occurred from either physiotherapists or during the interview process by other people participating in the interview. Families were closely involved at every stage of the research process and sometimes chose to be present with clients, especially when their communication abilities were impaired. Interviews were paused and sometimes halted in order to maintain client comfort in the process. This seemed quite successful, as evidenced in one situation where Jack decided to leave the interview to go to his room with his carer, leaving his parents and me at the dining room table to continue chatting without him.

Client and information anonymity and confidentiality were carefully maintained. The use of pseudonyms and thematic analysis of this recorded material assisted in distancing and obscuring the identity of participants from any identifying material. Participants participated voluntarily and in full knowledge of all the risks and benefits that might occur for them within the research process. When client participants were unable to given informed consent, the legal guardian determined those issues and signed on their behalf (Graneheim, Norberg, & Jansson, 2001).

4.7.4 Feeling and being “at home”

Interviews held with physiotherapist participants were conducted individually and in the place where they felt most comfortable. All client and family interviews were conducted within their homes. This was considered necessary to ensure that the higher care needs of clients could be more readily and more easily satisfied during the interview processes. In one instance, with a particular client who had a medical diagnosis of dementia, being in a familiar environment helped the participant to remain focused and able to interact with the researcher.

A safety protocol of phone calls to a reliable person before and after each visit (similar to that used within my community-based practice) was used to ensure safety in visiting for the research interviews. This practice is a usual part of any community-visiting activity in healthcare and I considered it sensible to adopt the same practice for community-based research visits. When visiting people in the community, the community-based physiotherapist (and in this research, the researcher) is alone and unable to ask for support from colleagues as in more formal clinical situations, if any problems occur.
4.7.5 Speaking or just “being there”

An issue that I needed to deal with in this research was the different levels of communicative ability of individual client participants:

1. Jenny could not talk at all.

2. Jack could gesture and use an augmentative communication device for words and short sentences.

3. Erin spoke with increased muscular effort and slurred speech.

4. Dennis could speak but was hampered by high levels of fatigue and the need for frequent bodily repositioning.

5. Eric could speak but was hampered cognitively by short-term memory difficulty and word-finding difficulty.

When their level of communication required assistance or clients were unable to contribute verbally, families asked that they be interviewed together. In the same way that therapists strive to customise the therapeutic interaction for trust and comfort to develop, it was felt that, ethically, this research project should also provide a similar level of support and comfort within the research process. Participation by all the clients was encouraged at whatever level was possible. For example, Jenny, who was unable to talk at all, was comfortably positioned within the circle of conversation and spoken to and spoken with and about in a conversational way throughout the interview. When she made a contributing movement or a noise, this contribution was noticed by her family and the interviewer and was commented on, with the view to including her as much as possible within the research interview/conversation. Any gestures used as communication were commented on for the benefit of the recording.

After some discussion with another client, Jack, and his family, it was decided that all of Jack’s comments would be written within the findings chapters in capital letters and with exclamation marks attached as needed. I suggested this because Jack used an augmentative communication device within interviews and could only type a few words as a comment, even when he obviously felt strongly about a topic of discussion. It became obvious on reading of the first interview that the paucity of Jack’s words

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23 Jack used an augmentative communication device (AAC), a small box-like device into which he could type words and then press a button to activate a mechanical voice to “speak” the words he had typed.
needed to be highlighted to amplify the meaning that he was wishing to convey. Jack was very pleased with the suggestion to capitalise his words.

4.7.6 Focus and flow between interviews

The structuring of the interview guide used for the first interviews (see Appendix C) altered depending on whether the participant was to be a therapist or a family/client/carer. As interviews and the focus group were completed, recordings and resultant transcripts were analysed for initial themes. For each interview, a full day was allowed to prepare, interview and then analyse the findings for initial themes. Careful planning and spacing of these activities supported a mindful approach for me as the researcher and encouraged deeper appreciation of the situation inhabited by the research participants. Through such immersion, I was better able to remember the style and feeling of the different interviews and appreciate the different layers of meaning that arose. I had found from previous clinical practice that careful spacing of interaction with people, layered with reflection regarding that interaction, was useful when dealing with complex clinical issues when I needed to gather sufficient information (from one visit to a client) to plan treatment advice or write a report. As a novice researcher, I translated this clinical experience into the research situation. Such iterative shifting from interaction to reflection and consideration might be viewed as a hermeneutic process, layering of parts to whole to deepen understanding of a difficult and complex issue.

After the first of the second round of interviews, research conversation in subsequent interviews developed from the themes arising from the first interviews, which were used to encourage further conversation. This provided a natural conversational flow which assisted us to work hermeneutically to deepen the research conversations held between participants and me. Although the process of gradual data analysis was initially also adopted as a time management device, when I realised this hermeneutic value, I began to use it consciously to deepen discussion and understanding of the themes emerging from our research conversations. The participating therapists had also requested some agenda of ideas to think about prior to the next interview and that opportunity was then offered to the other participants as well.

The provision of that agenda might have also contributed to the above iterative process of research conversation, initial analysis of themes arising from the data, and revisiting of those themes in further research conversation.
4.7.7 The physiotherapists’ focus group

As part of the research involved an exploration of the way physiotherapists develop their clinical relationships, a focus group was conducted with the participating physiotherapists to further explore themes arising from all the earlier interviews. The physiotherapists who participated in this research were from different age groups and had different levels of experience. Use of a therapists’ focus group allowed them to compare and discuss emerging themes from the findings in a way that was not possible with individual interviews, and provided narrative development within the data collection and analysis process. The methodological combination of hermeneutic phenomenology and social constructionism adopted within this research allowed the enhancement of interview data from the participant physiotherapists through the processes of this focus group. The physiotherapists participating in the focus group told stories from their practice to the other therapists in “conversation for the purpose of research” (Minichiello et al., 1995, p. 65), making deeper meaning of their experiences as community-based physiotherapists.

Deeper discussion of the themes arising from the findings was stimulated by this storied conversation. By this time, all individual interviews had been completed and the resultant transcripts had been prepared and analysed for themes of interest. An agenda of ideas and themes from those transcripts was prepared to guide the group discussion (see Appendix C). The use of focus groups in qualitative research provides data from discussion between research participants (Kitzinger, 1995).

The focus group was held at the Education For Practice Institute, then located in North Parramatta. My supervisor, Dr Stephen Loftus, attended as an observer. His comments after the focus group reassured me as to my interview style. The group discussion was held in a meeting room, sitting around a table together. Two iPod digital recording devices were used and the recordings were transcribed. After the discussion, the participants joined with the staff of the institute to have lunch together, a meal organised as thanks to the participating therapists. All participants were respectful of each other’s participation. The presence of my supervisor as an observer did not appear to influence the group process unduly in any way, other than to provide general support to me as a researcher. The clear identification of each participant’s voice for the benefit of the transcriber provided a gentle flow-on effect, reminding participants not to talk over each other.
“Limitations of focus groups include the tendency for certain types of socially acceptable opinion to emerge, and for certain types of participant to dominate the research process” (Smithson, 2000, p. 116). To address such limitations, care was taken to be aware that all focus group participants were able to contribute equally. However, it was noticeable that the participating physiotherapists maintained a professional attitude in this regard and I did not need to intervene at any stage of the focus group to address this issue. The participating physiotherapists may, however, felt under some pressure to appear professional in the eyes of their attending peers and in my eyes as the researcher. Attention was paid to instances that may have arisen in the data due to this effect.

4.7.8 Co-creating phenomenological narratives
Findings arising from the above interviews and focus group were created within the research conversations for this project. Participants’ stories contained instances of their experiences working at home with their attending physiotherapists. Themes arising from those interviews were discussed in further interviews and the physiotherapists’ focus group to check and develop the meaning of the physiotherapeutic relationships found by participants. I sought to express those experiences by writing vignettes that could be immediately recognised by readers as authentic to the original experiences of the participants in their community-based physiotherapy situations. For the participating clients, some of whom had limited ability to express themselves freely, I used their words as they were spoken to me and recorded in the interview transcripts.

4.8 INTERPRETATION OF THE DATA
Data analysis for this project has been conducted following guidelines for qualitative research. Such research approaches use an inductive process to generate ideas from the data, in direct contrast to the deductive process of knowledge generation, which “begins with the idea and uses the data” to test a constructed hypothesis (Holloway, 1997; Thorne, 2000) as quoted in Thorne 2000 para 5). The philosophy underlining qualitative processes of data analysis emphasises a reflective and reflexive process prior to, during and after data collection. As part of a systematic data analysis process, reasoned decisions made at all points along the way should reflect the theoretical framework of the methodology and be made clear to others (Denzin & Lincoln, 2005) (Koch, 1996).
Continuity of decision-making and analysis therefore exists throughout the research project.

Analysis of the extensive data collected for this project required a methodical approach to process it into a manageable format for viewing, interpretation and understanding.

4.8.1: Data analysis within this project

The process of data analysis for this project can be said to have begun with the process of auto-reflection to establish my pre-knowledge but formally, it began within and after the interviews that were conducted with the participants (see Table 4.5). I particularly followed the processes of data analysis described by Higgs (2010) as,

- Generation of a text
- Immersion in the data
- Understanding
- Abstraction
- Synthesis and themes
- Illumination and illustration of the phenomena

(These processes are depicted in Figure 4.3).

Recorded field notes gathered immediately after each interview allowed spontaneous observations to initiate the data analysis process. Immersion in the data began on the day of each interview and no other activities (personal or professional) were scheduled for the same day. The voice files were quietly listened to in an unhurried way, while noting themes, observations and further questions and forming an interview guide for the next successive interview with that participant. “Chunks of data’ were named in terms of the metaphoric and poetic content of the phrases within them and using the words within those phrases for labels.

Throughout the data collection and data analysis for this project, regular opportunities occurred to present my research status, its problems, surprises, “aha’ moments and frustrations. These opportunities gave me the chance to clarify my thinking and check the project’s research directions with the constructive critique of my peers and senior academics. It also assisted me to move between seeking and describing the phenomenon and opening areas of critical enquiry within that process. Riccoeur defines this process of criticality as a dialectic with the inquiry moving between ‘a hermeneutic of faith’ and ‘a hermeneutic of suspicion (as quoted by Nicholls (2009).
Specific requested presentations for visiting senior academics to the research group I was studying within, allowed viewing of the data and the phenomenon through different lenses. Feedback from those academics clarified the direction of the data analysis and raised issues of uncertainty for further critique.

Figure 4.3  Stages of data analysis in this research
Table 4.5: Interacting processes of data collection and analysis.

<table>
<thead>
<tr>
<th>Data collection</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>First meetings with therapists</td>
<td></td>
</tr>
<tr>
<td>First interviews with therapists</td>
<td>Initial data analysis</td>
</tr>
<tr>
<td>Recorded field notes after interview</td>
<td>Interview guide modified for later interviews</td>
</tr>
<tr>
<td>Subsequent interviews with therapists</td>
<td>Auto-reflection</td>
</tr>
<tr>
<td>Recorded field notes after interview</td>
<td>Interview guides modified for later interviews and focus groups</td>
</tr>
<tr>
<td>Progressive interviews with care teams</td>
<td>Ongoing data analysis</td>
</tr>
<tr>
<td>Recorded field notes after interview</td>
<td>Interview guides modified for later interviews and focus groups</td>
</tr>
<tr>
<td>Therapist focus group</td>
<td>Ongoing data analysis</td>
</tr>
<tr>
<td>Recorded field notes after interview</td>
<td></td>
</tr>
</tbody>
</table>

The processes of data analysis used for this research can be seen in Figure 4.3. The different stages depicted in that figure were part of an iterative process of asking questions of the data and interpreting answers to contribute to a deeper understanding of the research phenomenon being explored, that is, the way that community-based physiotherapists, their clients, families and carers experience the relationships that develop between them. Higgs (2010) suggested that data analysis processes describe the flow and integration particularly needed for a hermeneutic phenomenological approach to qualitative research, where immersion in the data reflects a hermeneutic process of exploration of the parts and whole of the research phenomenon.

Within this research, participants’ constructs within the data were organised into concept clusters, named in terms of the socially poetic content of phrases within them. To organise the data I employed interpretative ways of exploring the data, for example, writing poetry, using a theme card index and drawing diagrams to explore connections to wider themes.

Data from the initial interviews gave rise to themes (first order constructs), which were used to deepen discussion in successive interviews and also to provide discussion topics for the therapists’ focus group. These initial themes are outlined in more detail in Chapter 5, Section 5.2: Overview of the findings chapters.
I pursued understanding of the research phenomenon through a *fusion of horizons*, working between pre-understandings of the research process, the interpretive framework and the sources of information. Such *fusion* involved a hermeneutic search for themes arising from the data, the language of which helped to tell the stories of the participants. More abstract themes were then identified to explain aspects of how community-based physiotherapists experienced and developed clinical relationships with their clients, families and carers.

### 4.9 THE RESEARCH PRODUCT

In this study, the research method was mirrored in the research product. The process of developing a physiotherapeutic relationship in community settings requires creative effort from all participants to that interaction. Within that act of co-creation, each party to the relationship needs to recognise the lived experience of the other and to develop understanding of their individual experience and the joint experience they share. Within this research process as a whole, phenomenological narratives were also co-created between the researcher and the participants, providing material findings for the researcher to explore and interpret. All participants (including the participating physiotherapists), provided their experience of the physiotherapeutic relationship that they had developed. I (as the researcher) provided research interpretation through the development of the interview text and the narrative texts that I constructed from the participants’ words.

The physiotherapists’ focus group provided a way to further validate the findings arising from the interviews; both as a way of revisiting their own interviews with me and considering the themes arising from all of the interviews. Through the dialogue that ensued between them in the focus group, the participating physiotherapists were able to consider and respond to the thoughts and opinions of their peers. This opened up issues for discussion in a way that was not possible just by the interview process.

The research findings were developed through a hermeneutic phenomenological process but also inevitably as part of that process. The use of phenomenological narratives constructed with data input from the participants in the research process is mirrored by the enactment of co-created healing narratives within the community-based practice of the participating physiotherapists, seen in the model of practice I have proposed.
(depicted in Figure 4.1 as a ‘practice model’ circle sitting on the findings line as it progresses across the page). Further discussion of the findings and this practice model is provided in Chapter 7.

4.10 ETHICAL CONSIDERATIONS

Ethical approval for this research was gained from the Charles Sturt University Human Ethics Committee (Protocol no: 2008/175). It is important to note, however, that an ethical approach to research involves a complex and integrated process in the practice of research that goes beyond completion and compliance with an ethics application/approval process.

4.10.1 A call to a relationship

Ethical behaviour implies the development of relationships in which there is an intention to try and make “right” decisions that will not harm other people. Such intention acknowledges the necessity for integration of the parts and the whole, where the part might be the individual person and the whole refers to the relationships that make up a community. Kuokkanen (2010) proposed that “in cultures and societies that foreground reciprocity, individuals are brought up with an understanding and expectation of acting for others” (p. 63). The identity of practitioner–researchers lies in relationships where there is a highly developed “understanding and expectation of acting for others”, due to their ongoing participation in professional practice. This means that understanding the ethical issues begins with understanding relationships. “Ethics are not just a problem of knowledge but a call to a relationship” (Spivak, Landry, & MacLean, 1996, p. 5). A key aspect of a good relationship is respect.

4.10.2 Respect

Valuing the phenomenon being researched involved respect for each of the participants, recognising that each person has value and autonomy.

To appreciate a human phenomenon is to sense it, become aware of it, seek to understand it and value it. (Higgs, Trede, Ajjawi, et al., 2007, p. 204).

When interacting with each participant, I took care to keep this attitude of respect uppermost. An example of such respect occurred when thematic frameworks (used as interview guides for successive interviews with participants) allowed participants to reconsider important issues that might have arisen within previous interviews and to re-
discuss those issues in the light of that reconsideration. As advised by the National Health and Medical Research Council (2007), subjectivity of any interpretation of participants’ stories was respected in all analysis of research materials.

4.10.3 Ethics as a hermeneutic phenomenological attitude
Merleau-Ponty (1964) promoted phenomenology as an attitude rather than just a method, acknowledging the essential importance of “being in the world”. The cultivation of a phenomenological sensitivity to the lifeworld of others helped me to interpret and make meaning of the particular phenomenon being researched in this project. Thoughtful and dialogic interaction with successive research circumstances was required for an ethical taking care of participants, assistants and more generalised considerations for the wider community. Respect and consideration for the wellbeing and safety of people touched by this research was ensured by such an approach.

4.11 ENSURING QUALITY IN THE RESEARCH

For the purposes of this research, with its methodology of hermeneutic phenomenology and its need to be accepted by the physiotherapy profession and healthcare administrators, I chose to be guided by Guba’s (1981) criteria to assess trustworthiness in qualitative inquiry (see below). These criteria were developed specifically for the qualitative research paradigm.

4.11.1 Credibility
Merriam (1998) defined credibility as a question to be answered: “How do the findings fit with reality?” Credibility relies on transparency of a researcher’s approaches to all areas of the research, “allowing the reader to ‘see through’ the researchers’ decision-making and their analytical approach to the data” (Holloway, 2005, p. 6). This requires a rigorous and reflexive research attitude towards the constant decisions that must be made along the research journey. Accordingly, and as advised by Guba (1981) and Lincoln and Guba (1985), the following areas of concern within this research were addressed:

A recognised methodology was used. Although hermeneutic phenomenology has not been widely used within the field of physiotherapy, it has been used in the related fields of nursing, occupational therapy and psychology, and its use was considered to be particularly congruent with the phenomenon being explored and the research questions
being asked. Exploration of the phenomenon of interpersonal interaction between community-based physiotherapists and the people they provide physiotherapy to, benefited from the application of a methodology and a strategy which arose philosophically from a human interest in how people interact with their environment and the people around them. Therapist participants were chosen to represent the ratio of male to female therapists. Clients with a variety of medical conditions were sampled to ensure that findings could not be too narrowly attributed to the effects of one medical condition as opposed to another.

* A variety of different and overlapping research methods were used, including interviews and focus groups. The use of such a combination of research methods allowed the topic to be viewed from different positions and led to deeper insight and understanding of the perspectives and experiences of different people. Ethical research behaviour could then be enhanced, as I was conscious of how research actions might affect those people.

Multiple and ‘overlapping research methods’ can enrich findings and thereby overcome the limitations of the chosen methodology of hermeneutic phenomenology which can be very individualistic in its approach, as it accesses one person’s experience.

* Honesty and depth of information was encouraged by gradually developing trust and confidence between researchers and participants. Discussion within the second and third interviews regarding emerging themes from the earlier interviews permitted greater illumination of the research topic and gave participants a chance to review and think further about the experiences and ideas they were providing to me through the interviews.

* Regular debriefing sessions were held with my supervisor and regular presentations regarding the research project were made to doctoral student peers, teaching fellows, supervisors and visiting senior academics. Further presentations of the findings and interpretations at conferences allowed research ideas from this project to be heard within the prevailing professional discourse, gaining useful critique and encouragement to proceed.

* Findings of the project were “thickly” described and framed by examination of previous research within existing professional and academic discourses. Reflective comments and anecdotes (in blue boxes alongside the main text) were used throughout
the project to acknowledge my pre-knowledge and ponder on emerging themes and meanings within the existing literature and the research findings.

4.11.2 Transferability and dependability
Merriam (1998) advised that, within qualitative research, the description of findings must be sufficiently thickly written to allow readers to understand the phenomenon being studied and be able to relate it to a situation within their own experience. This effect is recognised as transferability within the paradigm of qualitative research. Such processes were further developed within this research project by seeking to increase the sense of resonance felt as readers use a phenomenological nod to confirm that resonance which lets them to compare elements of the findings with their own experience. In-depth description of the chosen methodology and the use of overlapping methods also helped to provide dependable findings.

Figure 4.1 shows the overall research approach as particularly demonstrating congruence of the different methodological choices made and the data collection process. Acknowledgment and integration of my pre-knowledge was combined with an in-depth description of methodological considerations to allow the integrity of this project to be properly scrutinised (Shenton, 2004).

_We know we have succeeded if we find the research illuminating, if others value it, if it makes a difference to the way people think and to the way things (systems, lives, well-beings) are in the world._ (Higgs & Horsfall, 2010, p. 134)

4.12 CONCLUSION

This research was philosophically grounded within the interpretive paradigm and theoretically guided by an overarching hermeneutic phenomenological approach. An open research attitude allowed the use of various methodological lenses, in particular, the use of social constructionism, narrative and social poetics to enhance Guba’s (1981) criteria for assessing the trustworthiness of naturalistic inquiries in a hermeneutic and phenomenological research process. The methods of semi-structured interviews and a focus group fitted well with the hermeneutic strategies of text construction and interpretation. I engaged in an ongoing dialogue, first with the literature and then with the participants and the literature. The following chapters present the findings of this research process, the form of which mirrors and is a product of the above approach.
CHAPTER 5
A DIALOGUE OF VOICES

Voice is the right and the ability to make oneself heard and to have one’s experiences and perspectives available to others; to participate in the construction of the self and to decide how to represent that self to others (Ashby, 2011, para 3).

5.1 INTRODUCTION

In this research project, I spoke to people from a variety of backgrounds. Many families and carers have been caring for loved ones who have had to cope with difficult healthcare issues for many years and have gained considerable knowledge and expertise from that experience. I argue that if community-based physiotherapeutic clinical encounters are to be successful, the respect and co-operation of these people must be earned and this can only occur through the human relationships that are developed between all concerned. The focus of this research is on these relationships. Community-based physiotherapy encounters could be enhanced if we listen to what physiotherapists and the people engaged in physiotherapeutic encounters have to say about the ways in which their practice-based relationships develop.

5.2 OVERVIEW OF THE FINDINGS CHAPTERS

This chapter is the first of three chapters which discuss the findings generated in this research and its interpretation, presenting to the reader my interpretive journey as I asked questions of the findings to authentically interpret the contributions of participants (see Table 5.1). In keeping with my methodology of hermeneutic phenomenology, I explored with the participants their experiences of community-based physiotherapy relationships and produced thick rich descriptions in the form of narratives embedded with poetry. These narratives were co-created from the participants’ words and stories that communicated their experiences and through my reconstruction of these multiple pieces of data into interpreted narratives. Poetic
resonance of particular phrases in these narratives initially assisted me to identify those elements that seemed to hold most importance and meaning for participants.

Table 5.1  Structure of content of the findings chapters

<table>
<thead>
<tr>
<th>Findings chapter</th>
<th>Content covered in the chapters in relation to the questions I used to dialogue with the narratives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chapter 5:</strong></td>
<td>Who were the participating clients? What did they have to say about their relationships with their physiotherapists and what was important within those relationships for them?</td>
</tr>
<tr>
<td><em>A dialogue of voices</em></td>
<td>How were the quieter or absent voices of clients supported within our research conversations and within physiotherapy processes? How do community-based physiotherapists manage their relationships with clients who have varying levels of communication ability and many different carers and family members around them?</td>
</tr>
<tr>
<td><strong>Chapter 6:</strong></td>
<td>In what ways did all the participants (physiotherapists, clients, families and carers) interpret physiotherapists’ approaches within their developing community-based physiotherapeutic relationships? (Initial basic themes from the data) Why might these physiotherapists have related to their clients, families and carers in the ways that they did? (Over-arching organising themes from the data)</td>
</tr>
<tr>
<td><em>Being mindful, staying engaged and being responsive</em></td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 7:</strong></td>
<td>How might physiotherapists make meaning of their relationship-centred practice in light of the research data? (Global themes) How might that meaning be transferred to other practitioners (‘Mindful dialogues’ practice model)? How might a ‘Mindful dialogues’ model of practice contribute to practice, education, and future research for community-based physiotherapy practice? How has this research process developed my thinking generally – reflections on the research process? With reference to this research project, what might happen next?</td>
</tr>
<tr>
<td><em>Creating mindful dialogues in community-based physiotherapy</em></td>
<td></td>
</tr>
</tbody>
</table>

The evolution of the findings is presented in Figure 5.1 and Table 5.1. Figure 5.1 illustrates the way I structured the findings chapter in relation to the research questions. Table 5.1 identifies how the chapters are structured to present the content of the findings chapters.

**Initial and organising themes arising from the findings**

By exploring the development of the relationship process (See Interview guides in Appendix C), a set of constructs were generated through my interpretation (or abstraction) of the actual words used by the participants. Initial themes from the initial interviews with all the participants (physiotherapists, clients, families and carers) became obvious to me by the degree of poetic resonance I felt on reading the
transcripts. Further discussion with the participants allowed me to both deepen understanding of the initial themes (first order constructs) and check their place and importance within community-based physiotherapeutic relationships. By considering the temporal nature of developing clinical relationships, I was then able to perceive three overarching themes of interest (second order constructs),

- Being mindful,
- Staying engaged and
- Being responsive

These overarching themes not only interpret and reflect the participants’ narratives and my constructs, but they were also labelled to reflect my core phenomenon: the relationships among physiotherapists, clients and carers in community-based physiotherapy. In addition, these terms resonate with my theoretical framework lenses of narrative and the importance of context and with my methodological lens of narrative, social constructionism and social poetics. The language used in each of these terms evokes a clear sense of the relationship processes that participants described to me and provides suitable metaphors to work with to better understand the attitudinal elements to be described in my proposed model of practice in Chapter 7. (See Figure 5.2 for the overarching themes and their constituent constructs).
The themes fitted through the evolution of the physiotherapeutic relationships as described to me by the participants (discussed in Chapter 6) and provided the basis of a suggested practice model for community-based physiotherapy (discussed in Chapter 7).

**Being mindful**

The findings showed that when entering clients’ home worlds, physiotherapists participating in this research were mindful of the situations inhabited by their clients, families and carers, acknowledging that all these people were undertaking a physically and emotionally difficult task filled with uncertainty. Healthcare was perceived as an intrusion even though it was often a much-needed service. The relationship between visiting therapists, clients, families and carers therefore needed to evolve slowly and steadily. Participants considered that this could best be achieved if therapists viewed themselves as *fellow travellers*: blending in with families’ situations, rather than just acting as *change agents coming to do a job*. Emotional connection was considered to be important to develop the relationship between community-based physiotherapists, clients, families and carers.

**Staying engaged**

Relationships between people developed if people stayed actively engaged with each other and for this to occur consistently, trust needed to develop between them. Participants told me how they became comfortable with their physiotherapists if those therapists listened carefully with an attitude of wanting to learn. Talking was used in a variety of ways but with an attitude of *talking with* rather than *talking to* people.

**Being responsive**

Participating community-based physiotherapists became increasingly responsive within the relationships they developed with clients, families and carers. Participants considered that an open attitude on the part of attending physiotherapists allowed them to become more emotionally attuned with the people they were visiting. Such attunement was enhanced by therapists’ activities of interpreting and advocating about the wellbeing of their clients to other family members and carers (and to other services if required). The difficulty and uncertainty of the situations being faced by clients and their families and carers was relieved to some extent by viewing progress as “baby steps to the future”, a process embodied within the physiotherapy process itself and encouraged by physiotherapists.
Figure 5.2 Mindful dialogues in community-based physiotherapy
5.3 LISTENING TO CLIENT VOICES FIRST

Varied perspectives and quiet voices

The participants in this research have provided insights into the development of community-based physiotherapeutic relationships from varied perspectives. In the same way that a practising physiotherapist will listen to many different voices in a community healthcare situation, as a researcher, I also sought to listen to the many voices of this study’s participants, including the quieter voices of clients with communication difficulties. This process required first, being receptive in listening to their words and stories; second, asking questions during interviews in order to provide an opportunity for them to talk on key issues, and then to probe, extend and clarify their responses; and finally, actively interpreting participants’ contributions. The findings revealed how participating physiotherapists developed clinical relationships with their clients, families and carers (and vice versa) and in what ways such aspects of physiotherapy practice may have contributed to person-centred relationships during community-based physiotherapy.

5.4 VOICES OF THE CLIENT PARTICIPANTS

Who were the participating clients and what did they have to say about their relationships with their physiotherapists and what was important for them individually?

Human dialogue involves a meeting of voices. When one voice is quieter, more care and attention is needed if the humanity and needs of the person behind that quieter (or even lost voice) is not to be overlooked or ignored. When the humanity of one person is neglected, it affects the humanity of us all. As healthcare professionals, we must therefore try to access those quieter voices, especially when we are attempting to improve our professional practice for them. After all, the whole point of professional healthcare is to place the interest of the client (patient) above that of the clinician and other third parties (Thirumoorthy, 2010, p. 23). To accomplish that aim, we need to hear their voices.

Clients participating in this project are introduced below via the contributions they were able to make to our research conversations. In community-based healthcare, people’s abilities to communicate vary widely. As outlined in Chapter 4, the communication
abilities of the client participants also varied widely (See Table 4.3 in Chapter 4: Participant profiles of participants). The interviews in this study mirrored the situation in healthcare where clients’ voices may often be quieter and less frequently heard than the voices of health professionals, family and carers (Frank 2002/1991). With my focus on the importance of mindful relationships I paid conscious attention to providing a space in my research for “the voices [of clients] that do not speak” (following advice from Ashby 2011, para 1).

Making space for “voices that cannot speak”

In this chapter, I address this issue by introducing each client first, using free verse poetry to do so. Where the client had difficulties with talking, for example, where an augmentative communication device was used; words used by that person are presented in upper case – to hear them more loudly and clearly. Some contributing comments (in brackets) were added where it was considered that extra context was needed to make better sense of the participant’s voice.

In one particular situation, the client concerned, Jenny, was unable to speak or contribute voluntarily at all. In this situation, comments about Jenny from her mother as well as “interpretive” and “derived” poems were written to try and give a feeling of how she was able to “be with” her family and carers. Definitions of these styles of writing are placed under the poems for and about Jenny.

Many-voiced conversations

Comments and support were contributed by members of the family and carer participants involved with those clients, demonstrated in the data by the many-voiced conversations (polylogues) that occurred within family settings. An example is given from one of the interviews with Jack and his family and carer to show how their contributions affected his “voice” within a conversation (See Section 5.6).

The following sections describe the general situation experienced by each of the client participants in this research,

- Eric
- Joanne
- Dennis
- Jenny
- Jack
using their words about their physiotherapeutic relationships and my interpretive comments regarding those findings in a free verse form of poetry.

Poetry is an imaginative awareness of experience expressed through meaning, sound, and rhythmic language choices so as to evoke an emotional response (Flanagan, 2013).

The use of such poetic form fits well with the phenomenological method chosen for this research. The actual words of the participants are presented poetically in an attempt to evoke the lifeworld of each person.

**Eric**

At the time of the study Eric was a well-educated man in his nineties. He had worked all his adult life as a specialist doctor, living and working in company with his wife. Despite his health difficulties of progressing dementia, back pain and mobility problems, Eric was pleased to participate in the research project. When I first visited him for an interview, he was waiting at the window for me to arrive and met me at the door in his wheelchair to welcome me to his home. He showed me into the dining room where we were going to do the interview together.

Eric’s wife and daughter assisted him to carry out these social niceties in the way he wanted, gently filling in any conversation gaps that occurred. Social conversation and reminiscences assisted Eric to stay focused, along with a cup of tea.

The walking’s the main thing really

I had a stroke.
I have a dropped knee and a dropped foot.
I'm confined to the wheelchair.
The physio makes me walk up and down the passage every time.
I don’t mind.
I've kept going.
It won’t get better.
I don't really know what I wanted her to help me with,
but I want be able to get around readily and comfortably.
The walking is the main thing, really.
When I'm doing the walking, she stands behind me.
She doesn't actually do other things
but she makes suggestions as to what I can do.

It’s just comfortable working
We talk about things that are going to happen or have happened.
We talked about her trip to New York.
I went there.
I didn’t have this difficulty then.
I just can’t think of the name of the place.

I’ve had some difficult times, times when it’s difficult to get going.
She’s very encouraging.
That works but there are some things that are just there.
If I’ve had a bad night, she just takes me as I am and we do what I can.
So we’ll go down the far end; then we’ll swap and she’ll tell me how good I am.

[Eric laughed]²⁴.
If I’m not tired, I’ll walk fairly straight and lift my legs.
But when I get tired, I go floppy.
She lets me go while I’m safe but we swap round at the end of the passage.
Then I have a spell and she talks to me.

I mean we’ve worked.
She enables me to do things that would not have been possible otherwise.
She makes me walk around everywhere [Eric laughed].
She hasn’t pushed or anything,
She comes here once a week, yes.
She just works on my doing things
She just fits in.

Comment on Eric’s interaction with his physiotherapist

While there was some fluctuation in his ability to remember events and names of things, Eric had a very clear and pragmatic view of the way he and his physiotherapist, Barbara worked together. From Eric’s words, we can see that the relationship he had with his physiotherapist, Barbara, was intertwined with the activity of their physiotherapy sessions, in particular, walking. The social and physical components of Eric’s physiotherapy session appeared to be equally important to the overall physiotherapy process for him, (possibly in part due to his need for regular re-orienting and supplementation for short term memory deficits).

Barbara told me that she took her time with Eric (and this was confirmed by the other participants in Eric’s family care group); not hurrying or pushing him and helping him to manage his mobility difficulties and fatigue in a way that was acceptable to him. Her approach made him feel comfortable and he appreciated that. The combination of physical activity, an unhurried approach, social interaction and a familiar environment provided support for the problems that Eric was experiencing (especially those

²⁴ Comments shown in brackets indicate words which I have added to make the message clearer.
problems that were due to his dementia and his mobility). His calm acceptance of his medical conditions and physical limitations also appeared to contribute to the obvious success of his physiotherapy interaction with Barbara. Her particular way of interacting with Eric lends support for the conclusion that there is a need for subtlety and complexity in such physiotherapeutic relationships. The nuances of these interactions/relationships are really far more important than we (health carers and health care literature) have acknowledged up to now.

**Joanne**

At the time of the study Joanne was a lady in her forties who experienced a severe acquired brain injury. She lived with her husband with the assistance of paid carers during the day. Joanne was able to mobilise around her large and airy house in her power wheelchair. She really still wanted to walk, although she needed assistance to do so and found it quite scary, due to her difficulty with balancing. The expectations of her family may well have been contributing to this situation although that was not said to me directly. Her speech was limited by dysarthria (a difficulty with the muscles of speech which causes speech to be slurred) but we were able to manage our interview together by my checking that I had understood what she was trying to say at regular intervals during the interview.

_I know now where I stand_

_I didn’t know what was going to happen_
    _I thought I would be normal._
    _I thought it would happen quickly._
_I was in rehab for one year and then I came home_
    _I was uncertain with her [the physio]_
    _but she’s a very comfortable person to talk with and friendly._

_She does everything, talk, touch, help._
    _I wouldn’t let everyone touch me._
_She’s a comfortable person and friendly._
_When I needed (to do something better), she would tell me._
    _If I did something wrong, she would tell me._
_Once she said to me - if I cried, she would sit there and talk to me_
    _She had feeling._
    _It’s the person._
    _It’s the person._
_It’s hard to put words to it_
    _[Joanne put her hand over her heart]_
    _She’s like my family, very calm_
It’s the person.

I have gym, twice a week [with a personal trainer]
He helps me walk but it’s not the same.
I have two carers, but it’s not the same as my relationship with Lynne.
She shows concern for me as a person.
She’s sensitive to my feelings
A lot has happened
I remember, when she told me I may never walk.
She came to help me
I was upset, but she was honest and that was okay
She said now it depends on me
I was prepared to push,
I was determined to walk
But I’m frightened of falling
Since then, she didn’t want me to break something.
Yes, I know now where I stand
I feel more determined.
She knew instinctively (how to make that call).
She tried very hard for me to walk.
I went so long, she had to tell me.
She tried and tried and tried, for me to walk,
but I was always scared, frightened.
The accident changed how I feel [about] people, life, everything.

Comment on Joanne’s interaction with her physiotherapist

Joanne’s words reveal her difficult process of rehabilitation after an acquired brain injury, as she tried to find her place in the midst of the chaos that follows such injury. Her last comment in the vignette above; The accident changed how I feel (about) people, life, everything, reveals a true chaos narrative, as described by Frank (1995). Joanne’s initial narrative also described how she tried to assume a restitution narrative (Frank, 1995) at first; as any of us might also do,

I thought I would be normal, I thought it would happen quickly.

Smith & Sparkes’, (2002, 2004) study of narrative hope for people with spinal cord injury used Frank’s narrative styles as a lense arguing that a client’s hope of resuming walking activity could be seen as a “concrete hope” but the holding out for such a specific resumption of normal activity in the face of permanent impairment might actually impede that person’s ability to ‘re-story their body-self relationship. Although Smith and Sparkes ((2002, 2004) study concerned spinal cord injury, Joanne’s efforts to resume functional walking may have made her narrative journey more difficult, perhaps
tipping her back into a *chaos* narrative. These difficult issues needed to be worked through with the assistance of her physiotherapist.

Her relationship with her physiotherapist, Lynne, sustained her through the process into which she had been *thrown* (qua Heidegger 1962). Joanne trusted Lynne and when the situation arose where it became clear that her walking was not going to become independent (as everyone had hoped), Joanne was able to gain some acceptance of this situation, knowing that both she and her therapist had tried their best. She said now it depends on me.

*I was upset, but she was honest and that was okay.*

This last comment gives the idea that Joanne may have started to “take the reins” back from her therapist as part of that acceptance, possibly starting to make her own personal decisions about what she felt she could realistically do herself. Such balancing of the gradual resumption of a person’s decision-making for themselves with the emotional difficulties related to disappointment in limited physical progress is part of the rehabilitation process.

Joanne had found her physiotherapist to be understanding of her fear of falling and supportive of her generally. She also appreciated the emotional support she gained from Lynne. Such support and understanding proved to be an important part of her ability to come to terms with what she was able to achieve with regards to her mobility.

Despite this, she also felt that she wanted to continue with more regular physiotherapy, (possibly due to the particular physiotherapy skills of her physiotherapist), although her physiotherapist, Lynne, did not feel more physiotherapy was necessary because Joanne was able to work on her mobility with carers and a personal trainer. (Joanne’s husband seemed disappointed about this.)

The presence and assistance of an experienced physiotherapist can be most helpful but for the therapist, there are also difficult professional decisions to be made along the way, regarding assistance, dependence, honesty and the maintenance of hope. In all of the conversations with clients and families in this study, I noted that hope existed as a comfort and a sustaining force in the difficult healthcare situations inhabited by the participants. Within recent literature (Soundy, Smith, Butler et al, 2010, Soundy et al, 2011) discussion has been opening up regarding the importance of hope in
physiotherapy-assisted rehabilitation processes. The initial hope of people after injury relates to restitution narratives (Frank, 1995), where there is an expectation and drive towards the resumption of normality returning the body to its former health and function, particularly the activity of walking.

The social implications for the identity of affected people of the ability to walk independently has an inevitable influence on their perceived need to continue trying to walk, even in the face of overwhelming physical difficulty. “Because PT [physiotherapy] is understood as geared toward normalizing the body, it functions to reinforce a “normal/ disabled” binary, even when professionals do not discuss walking as a goal and may even actively discourage it” (Gibson & Teachman, 2012, pp. 481). Although their study referred mainly to children’s physiotherapy, there are still obvious implications for adult therapy as well. Physiotherapists may feel that professional accountability structures suggest that a lack of physical progress (measured by functional outcome measures) should result in cessation of therapy and physiotherapy assistance. Gibson and Teachman’s study further suggested that physiotherapists’ participation in decisions with clients and their families “to walk” or “not to walk” can be quite frustrating for physiotherapists. In Joanne’s situation, the decision whether to walk functionally (but with risk) or not had obviously been a very difficult one to make and it was not clear if Joanne had really decided how she would be proceeding.

**Dennis**

At the time of the study Dennis was a young adult who had had a devastating car accident, causing a high level incomplete spinal cord injury and some acquired brain injury. He lived in an upper storey inner city apartment with a large balcony and received 24 hour carer support. His physiotherapist, Adam, visited him for movement and walking activities two or three times each week. On most days, an older lady neighbour visited him for coffee and a chat. When I visited him, Dennis was sitting in a large, padded, care chair in front of the TV. I understood from his physiotherapist that Dennis had decided not to use a power wheelchair but preferred to be pushed around by his carer. His carer was in the adjacent bar style kitchen, carrying out housework activities as we conducted the interview. Dennis was happy to be included in our research project. He obviously valued his contact with his physiotherapist and what that intervention has assisted him to do. I had the impression that he was glad to be able to
contribute to any activity, which might enhance or further develop the field of physiotherapy because of the benefit he had derived from it.

I needed to place the microphone right up on Dennis’s chest to capture his voice because his voice was very soft and tended to fade out as he became fatigued. Fatigue was an obvious and very difficult part of the way Dennis interacted with people socially and physically. I noticed that he tried to maintain some control over his care, giving sharp and sometimes quite terse instructions to his carer. He seemed to try and add some social niceties into such conversations but the fatigue issue appeared to limit his ability to do that. During our research conversation, Dennis needed to stop our talk frequently to ask for changes of position and all the interviews were quite short, also due to overwhelming fatigue.

That’s as far as I can go

I had a car accident where I smashed into a concrete telegraph pole and I ended up with a C2 incomplete tetraplegia.
I also had a closed head injury as well as small memory problems.
I went to rehab,
I went to brain injury rehab and spinal injury rehab.
I started seeing someone else for a while as a physio and then somehow it worked out that he [Adam] came and he has been my physio ever since.
Yes, everything has worked out really well.
We’re at that stage,
we’re like mates,
we always laugh and muck around together and stuff
but also he’s a really good physio.
My vision originally,
was to get back walking,
to get back to normal hopefully.
After a certain amount of time,
I realised that wasn’t going to happen by itself.
So basically, now we keep stretching all of my limbs and everything, ranging my muscles.
I do a walk with him every time he’s here.
He comes three times a week
and what I basically want from him now;
I’ve said “I want to keep walking a bit each time and get to the stage
where I can just keep all my muscles and everything working to a certain point”
so that when and if they do find a cure...
Well I’ll say “when” because I’m optimistic.
When they do find a cure,
I’ll be ready to do it;
ready to go forward and I won’t have lost anything.
I wouldn’t say he’s tough.
[talking about Adam , his physio]

He always encourages me to do things
but he knows that if I don’t want to do something,
that’s my call
and he won’t push it any further
because he knows how far... [I can go].
He knows that I push myself really far
and he knows
that if I’ve said “that’s as much as I can do”
that’s pretty much as much as I can do,
when we’re walking,
if I’ve said “Oh, that’s as far as I can go”
he used to say “Can you do a few more steps?”
and after a little while I would just look at him
and he would stop
because I really push it as far as I can
until I say “I’m buggered”.
I get fatigued a lot.
Maree [my carer] and I are the “A” team but
Adam also attends to me himself.
He does caring things, carer type things as well,
Yep, more than just a physio
That’s what I think
Over the years he has become a friend
I will keep in contact with him
Yeah, so I call the progress.

The good thing about Adam
is that I can always get up and walk with him.

Comment on Dennis’s interaction with his physiotherapist

Dennis’s story also holds hope as a central tenet but it had been “put on hold” to a large extent. Dennis had realised that he had “gone as far as he could go” both in a general sense and every time he tried to walk. While he appeared to have abandoned a full restitution narrative in his life story, the hope of a cure still seemed to linger. He felt that he needed to stay ready for any new scientific break through which might once again offer him a chance of recovery. Whether Dennis really believed this to be a realistic
possibility was not clear, but it was clear that hope was still a comfort and a reason for carrying on with life.

Well I'll say "when" because I'm optimistic. When they do find a cure, I'll be ready to do it; ready to go forward and I won't have lost anything.

The way that Dennis spoke of his hope for a cure was quite casual, almost automatic. His view is supported by the work of Smith and Sparkes (2005) who argued that “hope for a ‘cure’ when framed in terms of restitution is often articulated in a taken-for-granted manner that lacks reflexivity” (p. 1102). As Smith and Sparkes (2005) also commented, it is a matter for conjecture as to why Dennis spoke of this hope in the way he did; was it a genuine feeling or rather the way that he thought people would expect him to feel?

Dennis’ physiotherapy was an important activity in his life for him. He appreciated Adam’s continuing visits and the comradely interaction they had together and trusted Adam’s professional knowledge. Adam’s friendliness contributed to Dennis’ self-esteem.

Yes, everything has worked out really well.
   We're at that stage, we're like mates,
   we always laugh and muck around together and stuff
   but also he's a really good physio.

With his particularly high level of disability, Dennis also depended on Adam for assisted walking. Although the walking activity was not for the usual functional reason of getting from one place to another, it was important for him as an exercise opportunity and provided some context for his relationship with Adam.

A question also arises as to how much people maintain activity for its own sake (and its functional benefit) and how much to continue their relationship with their physiotherapist because they enjoy the interaction and support. From yet another viewpoint, Smith and Sparkes (2005) noted that the men with spinal cord injury may “quickly learn that they need to express certain kinds of hope if they are to maintain relationships with others and secure the professional services they require” (1105).

The place of continued activity and interaction plays an important part in the maintenance of hope.
I can always get up and walk with him.

It is hard to imagine a situation for oneself where the only chance you have to do what was an ordinary activity like walking is when a professional physiotherapist visits to assist you. The absence of opportunity to do ordinary activities (like walking) could have signalled a loss of hope for Dennis. The ability to at least maintain some semblance of walking might well give a feeling of normality and a means of being able to view a road ahead of some sort.

**Jenny**

At the time of the study Jenny was a young woman, who lived in a group home. She had profound physical and intellectual disability and was unable to walk, talk or care for herself in any way. Her family was very involved with her care and the group home encouraged their involvement in every way possible, (and the family wished to be involved). Jenny had little voluntary movement. She attended the research interview with her parents and lay in a side-lying positioning aid\(^{25}\) for comfort. When she made any sound or movement, her parents and I would direct the conversation towards her, in an effort to include her within our discussion as much as possible. Jenny’s presence was essential to the interview, affecting every word spoken by everyone present because it was “all about Jenny”. She was “there” and “with us”.

It was important to highlight Jenny’s need to be communicated with. On the next page, I have included comments from Jenny’s mother about her daughter. I follow this with poems written for Jenny; firstly, an example of “derived” poetry\(^{26}\) (A conversation with Jenny) and then an example of “interpretive” poetry\(^{27}\) (Listen to me). The interview with Jenny’s therapist, John showed his understanding of her need to be included in conversation. I have transcribed this in full within the section titled Being responsive. I wrote the interpretive poem based on my clinical experiences with other young adults like Jenny (and in keeping with what I had learned about Jenny, particularly), in an

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\(^{25}\) Side-lying positioning aid is a piece of equipment that looks like a narrow, waist-high padded bed on castors which is used to assist someone with a severe disability to lie on their side but be moved from room to room to access different activities while staying in that side-lying position.

\(^{26}\) I have defined and used the term “derived poetry” (in preference to the term “found poetry”) to refer to free verse composed of words and meaning derived directly from the data and in the same chronological order as the words spoken in that data. Within the literature regarding general poetry, the term “found poetry” refers to the appropriation of topics and words found in other text. Since 1990, the term has also been used in qualitative research where meaning is distilled from transcribed data and co-constructed with the participant (Richardson, 1992). Within this hermeneutic phenomenological study, ultimate interpretation of the research findings is really conducted by the researcher. I have therefore used the term “derived poetry”.

\(^{27}\) Interpretive poems “utilize poetic device to create an evocative and moving document, which allows for the subjective responses of the researchers” (Langer & Furman 2004, p. 8).
effort to increase the sense of her presence within the research and the difficulty she and her carers faced in joint social situations. I felt that Jenny needed to have her introduction like the other participants.

What our daughter, Jenny likes and how life is for her:

Jenny doesn’t want us to sit beside her
She’s a sticky beak all right
She’s eavesdropping on our conversation
Jenny doesn’t want us to just sit beside her,
we have to sit on the lounge with her and cuddle her.
At home, she was always in someone’s arms,
even if people came to visit,
she was always nursed
and that was part of how we communicated with her.
We used to lie her on the bed
in the morning or at night,
You’d lie in, it would be still and you’d just be lying there and talking to her.
If you go to the theatre or even movies, you hold her hand.
There has to be some kind of interaction.
If she starts getting grumbly,
in the past I would have just thought
“Oh, Jenny might be getting a bit tired”
but now you’re more aware.
“Maybe she needs to do some side lying”
or she needs to change position.

The following piece of “derived poetry”, taken directly from the data, gives an essential and distilled feeling for the interaction between Jenny and her therapist, John. Its message is reinforced by its juxtaposition with the interpretive poem, Be quiet, that follows.

John’s conversation with Jenny (based on comments by Jenny’s physiotherapist, John).

[I tend to] ask any question that I would ask you [in an everyday conversation]
What’s going to happen? Where are we going?
Keep an eye on her face
Her face will tell me
She will look
She’ll turn her head when her carer and I talk
But I don’t talk to staff about her.
What I do is
I have a conversation with Jenny
Comment on Jenny’s interaction with her physiotherapist

Jenny’s interaction with her physiotherapist was very physical and sensory in nature (relating to the hands on nature of her therapy). With the absence of verbal interaction, these modes of interaction appeared to have become enhanced. Jenny’s mother had become very aware that non-verbal communication was very important to Jenny. Johnson, Douglas, Bigley and Iacono (2010) argue that “people with severe intellectual disability have limited communication skills, small social networks, and may experience isolation” but that people interacting with them can feel “enjoyment, personal satisfaction, and love in their interactions with them even though such interaction can be very challenging because it does not conform to their normal perceptions of interaction” (p.175). The comments by Jenny’s mother reinforce this view. Verbal communication by her physiotherapist, John focussed on communicating with other people about Jenny and this included his speech to her. His communication sought to enhance her social situation (discussed further in Section 6.4: Being Responsive). His interaction with her carers was all about advocating for Jenny.

Jack

At the time of the study Jack was a young man (in his late twenties) who had had a severe acquired brain injury from an accident as a young teenager. After being in hospital for over a year, he came home to live with his family. Visiting carers provided extra help. When I visited Jack’s home to conduct our research interviews, we all sat around the kitchen table. Sue, Jack’s mother felt that he would feel more comfortable with his family and carer present. Jack sat in his wheelchair at the table with his augmentative communication device on the table in front of him. His carer, Honor sat beside him to help him as needed.

Part way through the second family interview, Jack’s father, Brian, joined us. The conversation became much lighter and jocular in nature. Jack stayed for a while, joining in with the conversation but then went to his room with the gift of chocolates that I had

(153)
brought for him. In his absence, Brian and Honor then appeared to feel freer to discuss their interaction with Jack’s physiotherapist, Karen.

The following text is composed of Jack’s comments and responses in an effort to concentrate on him as a person, in his own right and as Karen’s client.

"I WAS TOO YOUNG"

HELLO, HOW ARE YOU?
I WAS TOO YOUNG
IT SUCKS
[The physio] PRODS
[But] THAT IS FINE
YES, THAT IS FINE MOST OF THE TIME
[I feel] GOOD [when I work with Karen]
    I LIKE HER.
WORKING WITH MY PHYSIO IS HARD WORK AND FUN
    [What do you know about your physiotherapist?]
I AM ONLY CONCERNED ABOUT MY ABILITY
    [I can] WALK IN THE WALKING FRAME
THE ACTUAL [Physio] WORK CAN GET BORING
    [What do you want your physio to be like?]
    LADY OR MAN?
    LADY OR MAN?
    BE HILARIOUS AND FUNNY
    [If I had a male physio], I WOULD STRUT MY MUSCLES
    [and] GET MY SESSION OVER
    [Who would be better- lady or man?]
    LADY

    [Jack would you like me to put your comments in capital letters?]
    YES, I DO LIKE THAT IDEA

Comment on Jack’s interaction with his physiotherapist

For Jack, his physiotherapy was a productive activity, contributing to a sense of purpose and helping him to continue with assisted walking at home.

WORKING WITH MY PHYSIO IS HARD WORK AND FUN
The fun came from the humour in the physiotherapy sessions as Jack loved to joke with his carers. It was of note that the therapist appeared to be aware of Jack’s need for fun and had the sensitivity to incorporate it into his therapy.

**The effort of communication for Jack**

It became very obvious to me as I looked at the transcripts of our interviews, that despite my best efforts to include Jack in the conversation, the effort and difficulty for him in typing out words on his communication device made his participation in our conversation a trial for him. Jack’s carer and mother seemed to monitor Jack’s feelings and possible levels of stress quite carefully, often inserting humorous comments to keep the conversation going; trying to engage Jack with a view to encouraging his participation but also managing any possible frustration that might occur in the inevitably more formal situation of our research conversation.

Unless he had a very definite comment to make or I addressed him with a direct question, Jack mostly participated in the activity of communication in a peripheral and physical way. In our first interview, he contributed facial expressions, laughter and gestures and was obviously interested but in our second interview, Jack’s father joined us and the dynamics of the group changed. Jack seemed to become tired and bored. It is possible that he viewed his father as competition for attention. He asked to leave and, as I had given him a gift of chocolates, he went off with his carer to his bedroom. It was not clear whether this move was a result of family dynamics or the altered communication that occurred with the increased number of people around the table. The thought also occurred to me that Jack may not have wanted to share his chocolates with anyone because his father did joke about the chocolates when he joined the conversation.

**Repeating comments for emphasis**

Sometimes, Jack repeated his comments. At first, when reviewing the transcripts, I wondered whether this may have been due to neurological perseveration (an involuntary repetition of verbal comments) but on further consideration, I interpreted the particular comments that he had repeated, as issues he wanted to emphasise. Occasionally Jack made comments about something he had been thinking about but by then the general conversation had moved on. Some of this difficulty was clearly due to the amount of time that it took him to type words, which may have also contributed to his repeating
phrases, perhaps a way of drawing our attention back to his contributions when we had
moved on too fast in the conversation for his communication strategies.

5.5 COMMENT REGARDING CLIENTS’ VOICES

“Whose voice is it anyway?”

In the process of trying to draw out the “voice” of the client participants, I became
aware that where the ability of clients to communicate and speak was decreased,
families, carers and therapists would increasingly try to speak and advocate for that
client. I began to ask myself; “Whose voice is it anyway?” (Ashby 2011, Para 1).
Managing communication with people who have difficulties with cognition,
comprehension and expression presents a very difficult and delicate area in healthcare.
A group of people with disability involving communication difficulties, commented in a
handbook for carers,

We are used to people saying we cannot communicate, but of course they are
wrong. In fact we have powerful and effective ways of communicating and we
usually have many ways to let you know what it is we have in mind.

Yes, we have communication difficulties, and some of those are linked with our
impairments. But by far the greater part of our difficulty is caused by ‘speaking’
people not having the experience, time or commitment to try to understand us or
to include us in everyday life (Hooton & Westaway, 2008, p. 25).

Connecting to the “voice” of the participants within the findings

My emerging themes were drawn directly from the data utilising the words used by
participants. This allowed the authentic voices of the participants to emerge and reveal
their personal experience. As Vanderstoep (2009) said, “The personal voice is the most
authentic, and any movement away from personal experience is a move away from
authenticity” (p. 194). Recognition of that authenticity allows us not just to listen to the
voices of participants but to hear them better (Spivak, 1988). The narrative
contributions of participants also assists us to remember what they were trying to tell us
rather than just the bare facts (Bruner, 1990).
Enhancing clients’ voices

Community-based physiotherapists come to visit clients to assist with their healthcare issues but inevitably end up communicating with families and carers as well. The voices of the clients in this research are delicate and quiet in nature. The meaning that clients, families and carers gained from their interactions with their physiotherapists has been distilled by bringing all of their words together in a way that they may not be able to do in normal conversation, given the difficulties they experienced with speech, cognition and the difficulties they may experience managing a conversation with someone. Thornquist’s (1997) study noted that even when clients are able to communicate independently, physiotherapists may often need to negotiate families’ interpersonal communication styles in order to enhance a client’s “voice” within home-based physiotherapy. Findings from this research support Thornquist’s observations but I would also argue that it should be a matter of concern for physiotherapists to listen and attend to the voices of carers as well as clients in their overall care for community-based clients and families. In the following section, I have constructed another text from one of the family interviews where the family told me a particular story to describe how Jack interacted with his physiotherapist, Karen. The conversation was an integration of contributions from everyone present. Jack’s contribution was mainly physical but his place in the following family conversation seemed very relaxed.

5.6 LISTENING TO CLIENTS WITH THEIR FAMILIES AND CARERS

There’s a right way and a wrong way and “Jack’s way”

“He was such a flexible kid,
his physio was amazed at how he could do something.
We came up with the saying:
“There’s a right way and a wrong way and Jack’s way”.
One day, his physio said to Jack
“Come on, we need to lift your head”
Alright, how did you raise your head the first time, the eyebrows?”. (Jack raised both his eyebrows as high as he could.
Everyone laughed).
“The (rehab) physio said ‘It’s the first time in all my years of practice that I’ve seen someone use their eyebrows to actually stand up.’
So as I said
‘There’s a right way and a wrong way
but Jack found the ‘Jack way’ “.
Interviewer: “And what does his physio, Karen think about Jack’s way”?
“She’ll say “Not that way, Jack, my way”. I think that she has probably compensated for Jack’s way.
She’s kind of twigged it a bit [the physiotherapy process]
so that he feels that he’s still doing it his way,
but she’s actually got her way too”.
(Jack was nodding).
Sue (Jack’s mother): “It’s a bit like a husband and wife thing, you know”.
Honor: “Yes, she (the physio) picks up things.
A couple of months back,
Jack was doing this particular exercise (sit to stand practice) in his bedroom
and he’d been doing it for about a month between visits
and we thought
“oh he’s doing so well with this, look how straight he’s standing”.
Karen, the physio came, stood back and watched him
and then she smiled and pointed.
‘You do realise ... because I had a mattress under Jack’s bed
and he was pushing back against it (with his lower legs) to stand up
(rather than pushing up through his feet).

It was subtle enough that we didn’t pick it up.
But he knew he was doing it.
Sue said:
“We were standing beside him so we couldn’t see,
that he was doing that”.
(Jack was laughing and putting his thumb up.)

Jack: INCREDIBLY FUNNY, ACTUALLY HILARIOUS

Comment on the conversation with Jack and his family

In this conversation, Jack, his mother (Sue) and his carer (Honor) told me a story to demonstrate that while Jack had his own way of approaching things, his physiotherapist, Karen did too. In this therapy story, Jack’s physiotherapist, Karen, was able to help correct Jack’s standing exercise in a way that fitted in with Jack’s way of doing things. He enjoyed a good joke and Karen understood that.

Jack enjoyed this story-telling exercise and contributed to this story in a very physical way and took part with gestures and facial expressions; and gave a very funny demonstration of the way he used his eyebrows to help get himself moving from sitting to standing. His participation did not need much typing (on his communication device)
and our conversation seemed to be more enjoyable for him because of that. In some ways, this style of conversation could be viewed as more meaningful than usual for Jack, due to the effort taken by Honor and Sue to make the interaction relevant to him. They made space within the conversation to direct comments towards him in such a way that he was able to join in with the activity of conversation, without having to type his responses. Despite his lack of spoken words, Jack also had the last written word, much to his satisfaction.

Taking a more critical stance, it could be suggested that in this situation where other people could speak more easily than he could, Jack may have decided not to type for speech. He may have felt happier to participate physically but on other occasions, he might also decide not to “speak” as a form of resistance to what was occurring. Jack was a young man who had previously been very active. He had loved running and football prior to his accident. As occurred in the second research interview, when Jack wanted to leave the conversation, he just did (physically in his wheelchair).

Jack’s contributions seemed to be enhanced in this particular joint conversation. The very personal knowledge that family members had of each other may also have assisted Jack to communicate and interact with his physiotherapist. Such informed interaction is of great help in the planning and carrying out of therapy care. The participants had taken great care to develop meaningful relationships and communication. There was an innate awareness of the importance of good relationships by all concerned. The dialogic interaction that took place between participants here was a good example of how experienced and caring family members and carers can help clients to take part in the activity of a conversation by “patching the narrative” with and for them. Physiotherapists also use a *patching the narrative* approach (see below) to increase social focus on the clients’ situations and concerns.

### 5.7 PATCHING THE NARRATIVE

How were the quieter or absent voices of clients supported?

“People with limited communication skills are likely to be dependent on the involvement of others to act as advocates, facilitators or interpreters, which inevitably begs the question of ownership of the message” (Grove & Bunning 1999, p. 191).
Although this seems to be stating the obvious, this study does highlight the difficulties carers and therapists face when working with people with communication impairments. This will always present difficult challenges for community-based physiotherapists as they seek to balance communication with and for clients with significant disability and communication difficulties. In trying to form a holistic view of a client’s situation and planning how to proceed with physiotherapy processes, I propose that community-based physiotherapists actually rely on patched narratives, which combine the knowledge that carers and family have about the client, along with direct communication with the client and the therapist’s observations of the client in their particular setting. This term, patched narratives, acknowledges that the story that the therapist builds from and about their client cannot always be fully owned by that client. Perhaps it is not possible for anyone to fully own their own narrative given the essentially dialogic nature of human affairs and thought. The particular human condition of clients with chronic and complex health problems may also dictate a degree of quietness in clients’ voices and further limitations both in the stories they live out and the stories they want to live out. However, visiting therapists still need to try and hear their voices as much as possible. Such patched narratives can only be constructed through ongoing communication between clients, families and carers through multi-voiced and continuing conversation.

5.8 MULTI-VOICED CONVERSATIONS

How do community-based physiotherapists manage their communication with clients who have varying levels of communication ability and the many different carers and family members around them?

When talking with Eric and his family, it was noticeable that his wife and daughter contributed to the conversation in ways that enhanced Eric’s voice, especially when he experienced memory problems. For Jenny who was unable to communicate verbally or with assistance, she was spoken for in any conversation about or with her although her carers and family tried hard to include her and refer to her whenever they could. This could be seen as people talking over the voice of clients, for example, in Thornquist’s (1997) study, where a wife overspoke her husband and the physiotherapist needed to use her body, available space and choice of communication styles to try and balance the communications of husband and wife. In the participants’ situations although such
overspeaking might sometimes occur it seemed to happen less where carers were mindful of their clients’ communication difficulties. In the above examples clients depended on the conversational initiatives of people who knew them well to allow the creation of their stories.

In *A conversation with Jack and his family*, Jack’s voice and experiences were actually partially spoken by other people (in this case, his mother and his carer). His communication difficulties greatly limited his verbal participation. He found it more enjoyable to join in the activity of conversation by acting and allowing people who knew him well to speak for him. The humour and flow of that conversation could then proceed and Jack was a part of it all. Indeed he was also the reason for it occurring and he showed how pleased he was by nodding, laughing and giving a thumbs up sign. He also had the last words, **INCREDIBLY FUNNY, ACTUALLY HILARIOUS.**

*The word in language is half someone else’s.*

*It exists in other people’s mouth, in other people’s contexts, serving other people’s intentions: it is from there that one must take the word and make it one’s own. (Bakhtin 1986, p. 293-294)*

Bakhtin is saying what we all know intuitively at some level; we depend on other people to build useful language through the development of conversation between us. This is dialogue. People are familiar with the concept of a monologue, where only one person speaks (even if other people are present) and dialogue which occurs between two people in a reciprocal interaction (Sometimes we may also speak of having a dialogue with oneself). These ideas can also be applied to clinical interactions between a physiotherapist and a client, especially in one-to-one interactions. However, in home-based healthcare, the communication arena can present differently. Clients may need significant assistance from their carers and family with planning activities and carrying out movement. In many home-based healthcare situations, there can be many family members and carers, who help to care for that client and they will also communicate with the visiting physiotherapist. For physiotherapists, lines of communication become multi-voiced.

**Polyphony**

Clients with communication difficulties need the presence and contributions of other people to be able to create and communicate their story. In literature, authors seek to populate stories with many and diverse voices through a range of characters and
narrators who can have different perspectives. The dialogue between the voices can become a complex and creative act just as it became in *A conversation with Jack and his family* (see above).

Community-based physiotherapists may often feel as though they have strayed into the pages of a novel as they enter very complex healthcare situations in the community. Drawing from the musical concept of *polyphony*, Russian literary theorist/critic and philosopher, Bakhtin (1984) termed the multi-voicedness in some novels as “polyphony” (p. 279). In his work on dialogism, he sought to explain the nature of such situations in literature, where independent but interconnected voices provide a diversity of views {Bakhtin, 1984 #769}(Vice, 1997) often with attendant disagreement and conflict. Most importantly, “polyphony refers to the autonomy of the characters’ voices” (p. 112). The use of advice from a literary critic such as Bakhtin may seem far-fetched in consideration of health interactions. However, when we take note of the narrative function that physiotherapists may be assuming within clinical relationships developed in community settings, Bakhtin’s thoughts on dialogism assist to highlight the important on ongoing integration of the voice of others in the therapeutic narrative being heard and built with clients, families and carers. As community-based healthcare practitioners, therapists try to respect clients’ autonomy in healthcare processes as part of a person-centred approach to practice and have to deal with the polyphony of all the participants within client/family situations.

Jack’s individuality and autonomy can be seen with his family conversation (see above), *There’s a right way and a wrong way but Jack found the “Jack way”*. Jack’s mother and carer promoted his autonomy through the vehicle of the conversation held. They became *dialogic narrators* in an effort to enhance Jack’s voice, creating a more relationship-centred approach.

**The generation of multiple voices in care-giving**

As well as considering the voices of different people who may be involved in community-based healthcare situations, the concept of polyphony can also apply to the various roles that one person may need to assume as a caregiver. The “multiple voices generated in care-giving” (Dobbins 2009, p.21) require negotiation. Dobbins discusses the different voices that may occur during home-based caring and proposed that there is,
Not the single, prototypical voice, but rather a negotiation of multiple voices generated through care-giving. People don’t just pick a voice and stick with it. They live through a kind of polyphony, or multivoicedness … (There may be multiple voices in greater or lesser harmony. But all voices are present: all voices are part of the chorus of experience (p.21).

“Nested narratives”: Multi-voicedness in family settings

Multi-voicedness has also been considered in family-based therapy, where Gergen (1983) proposed the concept of “nested narratives” in family situations; a micro-narrative can be nested within a macro-narrative (p. 263). This term refers to the structuring of one person’s story within larger or broader family and societal narratives and could certainly be applied to the situation in which people find themselves in home-based healthcare. Although this is a useful way to view situations with many stories within a larger story, it assumes that such stories are already well formed. I consider that my term patched narratives better articulates the composite and polylogical complexity of a family’s relationship with their community-based physiotherapist.

Hearing the client’s voice

Karen’s interaction with Jack and his family in There’s a right way and a wrong way and “Jack’s way” subtly acknowledged Jack’s need to be heard. He was then able to make his presence felt through his sense of humour. Karen’s professional insight into the actual state of affairs occurring with his standing (where he had tricked his carers into thinking he was doing all the effort of standing) also served to enhance Jack’s individuality and sense of self. In a Bakhtinian sense, by stepping back to make sense of the moment and appreciating another’s point of view (White, 2009), Karen was able validate Jack within the therapy process or contribute value to him. Bakhtin (1990) describes this process of stepping back from the dialogue as an “excess of seeing” (p. ix, part 1). Seeing from another person’s point of view and incorporating that view into the interaction assigns value to them. From within the field of family and network therapy, Seikkula (2008) argued that what was needed was “to be present and to guarantee that all voices become heard” (p. 480). I would argue that community-based physiotherapists need to also add to this function of ‘hearing all voices’ to actively incorporating those voices into the healthcare narratives that are being developed. Such dialogue between healthcare professionals, clients and caregivers is important in a broader sense as well. By caring for and about them and seeking to advocate for an improved quality of a client’s everyday life, healthcare professionals can assist the presentation of a coherent story for that person within their family and community.
5.9 CONCLUSION

This chapter focuses on the concept of the participants’ voices, keeping them to the fore as I sought to understand how these community-based physiotherapists developed relationships with their clients and their families and carers. I have argued that the very nature of community-based physiotherapy practice incorporates multi-voiced conversations as an essential part of supporting people with chronic and complex healthcare issues, especially when they have communication difficulties. Community-based physiotherapists need to patch the narratives of their clients with those of their families and carers in a way that allows the voice of the client to be heard.

In the next chapter the emerging themes arising from the data are discussed in more depth under the themes of being mindful, staying engaged and being responsive.
The effectiveness of physiotherapy practice is not just dependent on the technical skills of a physiotherapist but on the whole complex process of interpersonal communication through which physiotherapy practice is realized. (French & Sim, 2004, p. 216)

6.1 INTRODUCTION

The participants in my study described and discussed the various ways in which they contributed to the development of their physiotherapeutic relationships. Their words, “the participants’ constructs”, were organised through my deep immersion in the data into “concept clusters” as I sought to interpret key messages and identify emerging themes across the data. These themes were repeatedly checked against the data and through this process of critique I identified three key themes and dimensions (see Table 6.1) that combine to portray the essential ways that the participants experienced their therapeutic relationships. These three themes (being mindful, staying engaged and being responsive) portray the therapists’ behaviours in creative, positive and effective therapeutic relationships. This interpretation is illuminated in my Mindful Dialogues Model in Chapter 7.

Importantly, in this research I sought to explore participants’ experience of community-based physiotherapy relationships in order to more deeply understand the therapist’s role and responsibilities; so the processes of being mindful, staying engaged and being responsive refer to the physiotherapeutic relationship and how therapists act within that relationship.

The therapeutic processes of being mindful, staying engaged and being responsive serve to highlight relational behaviours that facilitated effective physiotherapeutic
relationships for the participants in this research. These relational behaviours are encompassed in my *Mindful Dialogues Model* for community-based

Table 6.1: Key dimensions and elements of relationship-based approaches in community-based physiotherapy

<table>
<thead>
<tr>
<th>Key dimensions</th>
<th>Elements</th>
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| **Being mindful** | *Being mindful involved blending together understanding (mindfulness) and (mindful) actions that embodied this understanding. Mindfulness included the following elements:*  
Understanding the nature of home-based healthcare as hard work and the impact of physiotherapy on family situations  
Being sensitive to the difficulties that families and carers face, including helping them deal with the realisation that progressive deterioration lies ahead  
Recognising that home-based healthcare is an intrusion into family life  
Realising that community-based physiotherapeutic relationships need to evolve  
Blending in with each family’s situation  
Being conscious of the need for people’s social and personal personas to be made available within therapeutic interaction  
Allowing themselves to connect on an emotional level to better identify the meaning that people ascribe to their physiotherapy interactions  
Perceiving themselves as fellow travellers, on a journey with their clients and their families and carers. |
| **Staying engaged** | *Key elements within this dimension were:*  
Building trust within the relationship  
Becoming comfortable together  
Talking with the people they had come to help  
Listening and learning from clients and their families and carers |
| **Being responsive** | *Key elements in this dimension were:*  
Being open  
Becoming emotionally attuned to their clients and their situations  
Interpreting and advocating clients’ wellbeing  
Caring for the carers  
Helping clients and family care teams take “baby steps “to the future  
Being friendly |

### 6.2 BEING MINDFUL

*To be mindful is to wake up, to recognize what is happening in the present moment. We are rarely mindful. (Surrey, 2005, p. 4)*

It is appropriate to apply this concept to the community-based physiotherapeutic relationships explored in this research where therapists (and families and carers) worked hard to maintain and improve the health and wellbeing of their clients. Chronic and
complex health care is, as its name suggests, ongoing and difficult to manage, for all stakeholders. The word mindful encompasses these participant therapists’ qualities of being aware, caring, thoughtful and present in the moment for their clients. The therapist participants in this research needed to be with people in a quiet thoughtful way, listening to their stories without judgement and watching for signals to show a way to proceed and develop the interaction. The complex and holistic aspects of such relationships became apparent as I analysed the data. Participant physiotherapists incorporated the following elements of relationship-centred care in their practice.

*Understanding the nature of home-based healthcare as hard work and the impact of physiotherapy on family situations*

Physiotherapy participants in this research perceived that community-based physiotherapists need to understand the nature of community-based healthcare as hard and all-consuming work, especially in the context of the introduction of physiotherapy programs. Their clients and families faced difficult challenges dealing with the day-to-day intrusiveness of complex healthcare problems into their homes and lives. My client/family participants perceived the health care process at home as their work, whether they were paid or unpaid.

> It must be done.
> Oh it’s a form of work, there’s no question.
> It is work for me because it’s something I’ve got to do.
> It must be done, you know.

(Comment from Eric’s wife, Marie)

Participants made reference to the role of work in their life now. Jack commented that his physiotherapy was "hard work but fun". Eric viewed his walking activities with his physiotherapist, Barbara, as ‘working’ and commented, "It’s just comfortable working". These participants’ perception of their physiotherapy as “work” might have been acknowledging the difficulty of the activities they were undertaking but could also have perceived the activity of physiotherapy and their relationship with their physiotherapist as productive and worthwhile.

I argue that work is generally a hidden aspect of home-based community healthcare that is undertaken by people looking after family members with chronic and complex healthcare issues. In the 21st century in Australia, a growing number of people with very high levels of disability and healthcare needs are now living at home with their families.
An example of this can be seen in the areas of acquired brain injury and spinal cord injury, where people can be living at home on ventilators and with 24-hour high care requirements. People with dementia also live at home with their families. This care is hard and challenging work for all concerned.

Concepts of work might be used by people to deal with confronting and difficult issues about their own or a loved one’s healthcare. From my clinical experience I have observed that the physical and emotional difficulties faced by people coping with chronic and complex healthcare sometimes seem overwhelming. For the therapists, understanding these ideas about work and helping their clients and carers see daily healthcare activities as a form of work might allow these people to organise their day in a way that related to more normal life and achieve a sense of stability and wellbeing. Promoting the idea of living as work could encourage clients, families and carers to relate therapy to the notion of “their work”, similar to what goes on in the outside world. This would foster a sense of connection with what able-bodied people “out there” are doing, as well as recognising the joint responsibility (with the therapist) for the success of therapy in such a long-term situation that pervades the client’s whole life.

Frank (2004) proposed that Sennett’s (1998) concept of work (as contributing towards a person’s character) should be extended to people within illness processes, providing possible improvements for those people in terms of feelings of self-worth. This healthcare work by families is not paid for in monetary terms but could be considered voluntary care work by family members and involuntary work by the clients themselves, who literally “live their work”. Unless we include the views and voices of clients and unpaid carers and broaden the concept of the healthcare workplace to include communities and homes, we might miss many problems and their solutions (Ward, 2007). Families dealing with complex healthcare need to motivate each other and organise their lives to accommodate and deal with a great complexity of issues, appointments, services and different healthcare professionals.

**Recognising that home-based healthcare is an intrusion into family life**

Despite the apparent value of physiotherapy, all participants perceived that therapy presented an intrusion into the home, even though it might have been a necessary one.
It’s nerve-racking for the family to have somebody in their home and on the other shoe, it’s nerve-racking for the physio to come in until she and they feel comfortable being in the environment.

(Comment from Sue, Jack’s mother)

Besides the many tasks and activities that were added to the day of a home-based health carer, family participants needed to arrange and be available for appointments with various healthcare visitors. The community-based physiotherapist was just one of those visitors.

Monday, yes, the nurse will come,
Tuesday, yes, the girl to clean will come,
Wednesday, yes, the nurse,
Thursday (big sigh) nobody,
Friday, yes, the nurse will come

Your life, you know, people coming in and out for our good.

In the physiotherapy literature, Heckman and Cott (2005) from Canada described this process for physiotherapists as simply “working in a different world” (p. 275). From the client’s and family members’ point of view, it might be viewed rather as “you have entered my world” or even “you have intruded into my place and my space”, even if that client and family requested the visit. From participating physiotherapists, there was a recognition that they always had to:

Remember why I am here.

I think because you become so much to these people, they have all their hope in you and gradually you take them on the journey of the reality of that is “well yes, we can have hope but” you know “this is what we’re seeing and it’s probably not going to work out the way we’re hoping, but let’s just see” and gradually they start to understand the situation then it’s not so much responsibility or anything, it’s relational I think and so that’s then when we have to be mindful of ‘remember we’re here as the physio’, yes and so that’s a trap for feeling close, that’s the biggest trap, absolutely.

(Jack’s therapist, Karen).

This awareness seemed also to be related to the accountability that therapist participants felt towards the health system generally, as well as to clients and families. However, the awareness of being a visitor in someone else’s home clearly contributed to that recognition, “you’re there with a purpose and the person knows you’re there with a
purpose” (Comment from Jack’s physiotherapist, Karen). There was also awareness by these therapists that people’s homes were special and distinct from other community spaces.

Going into someone’s own space is very different.
This is their private domain.
This is sacred space for them.

(Comment from Jack’s therapist, Karen)

The terms used by Karen (above), *private domain* and *sacred space*, evoke particular respect for the world of these individuals and their home. The terms are strengthened by their proximity to each other in this data piece. Coming as they do in a situation where great efforts were being made to provide person-centred home-based healthcare, this was a particularly important aspect of the interaction to consider. Karen was a very experienced physiotherapist for her young client, Jack, who had a severe acquired brain injury. She had obviously reflected deeply on the dynamics occurring within her home-visiting role as a community-based physiotherapist, and expressed a deeper unease about the possible long-term effects that could be developing within society as a result of providing home-based healthcare.

Home is the area they have always been able to escape to and now we are taking therapy into that area.

(Comment from Jack’s therapist, Karen)

Karen’s recognition of the importance of such *sacred space* could also be related to Bakhtin’s concept of *chronotrope*, linking space and time to better consider the movement of therapy into the space of the home and the place of the family. It is necessary to recognise this concept as important if health professionals are to protect the rights of people for privacy within their own home and perhaps their body as well. Its use helps therapists to think deeply about the effects of their presence as health carers in people’s homes.

This issue is of growing relevance for a society where the concept of “hospital at home” is being explored and paid health carers increasingly visit (if not occupy) people’s homes. Karen’s instinctive choice of words crystallised the issues of privacy and the intrusion of formalised home-based healthcare into personal spaces and places. The
strength of her feeling about this situation led her to express herself as strongly as she
could within the therapists’ focus group and to choose words clearly expressing that
strength of feeling. Her heartfelt words evoked other aspects of what constitutes home,
such as *my body, my home*. People choose the words they speak to tell another person
about an experience and to convey the depth of meaning of that experience. Such
meaning can often be read within transcripts as phrases that “leap out” to the reader as
important. Unexpected and hidden thoughts, feelings and their meanings become
apparent when words and phrases are put together in poetic forms. These forms can
resonate with the reader, making the meaning more memorable and sometimes
introducing a strong idea. An example of this effect can be seen in the phrase “the home
as sacred space”. In this sense, even normal conversation can be poetic.

My interpretation of poetic language forms within transcripts allowed fuller exploration
of the talk, interaction and sense-making that occurred within the physiotherapeutic
interactions in this research (see the free verses presented in Chapter 5). The evocative
nature and use of a poetic turn of phrase in conversation, for example, “the home as
sacred space” cannot be underestimated in its ability to illuminate the many disconnects
of feeling and thought that therapists (as home visitors) inevitably encounter within
their professional practice. Such disconnects are all part of the complexity of these
therapeutic relationships staying hidden under the surface of practice, silenced by more
dominant modes of professional discourse (see Kinsella, 2006). The complexities that
exist have implications for the development of those same relationships.

**Being sensitive to the difficulties that families and carers face, including the dawning
realisation that progressive deterioration lies ahead**

Participant physiotherapists recognised that they needed to be sensitive to the
difficulties faced by families and carers, including the dawning realisation that
progressive deterioration lies ahead. Barbara, Eric’s physiotherapist, mused,

> I don’t think my client voiced any expectations. I think it was just sort of
seeing at that stage. I think it was about seeing how he could stay in his
home with his family caring for him.

The health of clients living at home is naturally of great concern to the families and
carers who care for them, especially when the client’s health deteriorates. Such
deterioration can have a major impact on those concerned. Eric’s daughter commented,
He’s got a whole complication of things going wrong. The other night we forgot to put the pan in under the commode. (He gets up a few times during the night to use it). In the morning, there was a massive puddle on the floor. I said “So did you get your feet wet this morning” and he said “I wouldn’t know”. He can’t feel his feet! I didn’t really know it was as bad as that.

Such sudden insights can open up instances of Frank’s (1995) chaos narratives for both clients and their families and carers as the reality of their situation becomes more fully known to them. For people living at home with deteriorating situations, it would appear that there may be different and alternating styles of Frank’s narratives at play, creating particularly complicated and emotionally tiring situations for people to work their way through.

Other participants also spoke of difficult times that they had experienced, including the effects of the healthcare process and aspects of the medical or physiotherapy intervention:

Jack has been through some [experiences], I won’t say horrendous, probably horrendous for us but necessary for Jack. Jack was in callipers from his hip to his foot.

(Comment from Jack’s mother)

The label of chronic (ill health) implies long-term or even permanent care. Physiotherapy could offer hope of some improvement or at least maintenance of clients’ function and their ability to stay at home, providing a stable support through difficult times. Participant family members spoke of their hopes of the physiotherapy process.

My big hope of physio was that he would be able to continue to transfer [from bed to chair?] because I think while he can continue to transfer, we can look after him at home but I just don’t know that we could do that if he can’t. He’s quite strong in his upper body which is great and his feet just have to go with him you know, he just moves them bit by bit.

(Comment from Marie, Eric’s daughter).

The immersion of a family in ongoing healthcare problems can seem unending to tired families. Jack’s father tacitly acknowledged this reality and the ongoing need for hope:
The physio gives you hope, that not only Jack's life could improve but also ours, because the more mobility Jack gets, the better off we all are. We're not picking him up and carrying him into the bedroom or the toilet.

The physiotherapist being there mattered to these families. Physiotherapy activities for Jack were intertwined with the expectations and hope of his parents. Their relationship with the physiotherapist on Jack’s behalf provided an avenue to maintain that hope for the whole family. Such a role for Jack’s physiotherapist, Karen, also helped to bridge the gap in rapport that can exist because of the inevitable intrusion of healthcare into the home setting. She commented,

It's all about comfort and discomfort coming in to someone's home. You have to have a relationship because without it, how do you inspire, how do you motivate a sense of hope and peace to the situation when all hell is breaking loose and you are just pouring the oil on the waters and trying to move forwards with them to get progress physically but also to get progress emotionally, acceptance-wise for the people around them to allow the physical progress to happen.

It's just getting to that understanding.

Even when physiotherapists were working to maintain rapport with clients and families, situations naturally arose where they experienced the need to balance and manage expectations of clients and families. Therapist participant Adam spoke about his recognition of this complex issue of bridging expectations in situations when, as a therapist, he had a different view of how to proceed,

Respect their wishes but they still know that you think this may be a better thing for them but you're not going to say "If you don't do that, then I'm not going to see you" So you just say "I think this is a better option, but you don't; so that's your choice”.

The underlying message that can be seen in this therapist’s comment is that he will respect the hopes and wishes of his client and family even if he cannot agree with them, and he will stay with them relationally. This is a comforting and stable therapeutic support, which builds trust and confidence for clients and families and allows the therapeutic relationship to evolve.
Realising that community-based physiotherapeutic relationships need to evolve

The findings showed that patterns of care evolved as the interpersonal relationship between participating physiotherapists, clients, families and carers gradually developed. Participants spoke of their appreciation of the human side of the relationship they formed with their physiotherapists.

It's personal, your life is personal. You've got to have a bit of a relationship before you can get very far but it starts that way, showing that you're interested to know what's happened and interested in how it might affect now. Ordinary things in the day, she just took an interest and so genuine you know. Yes, from the outset, she was really interested in me, really understanding. His one foot drags, you know. She's going to try to borrow a gadget from the hospital, she's going to try that when she comes back but you know, she really is interested in me. I don't mean me, but in the person.

(Comments from Gwen, looking after her husband, Eric, at home)

Bridie, Jenny’s carer, was also aware that it was the personal interaction with Jenny’s physiotherapist, John, that allowed the evolution of a caring relationship for members of Jenny’s family, carers, Jenny and John himself.

The care that John is giving to our clients here is a bit more personal than the care that I was getting from the physio that I was seeing. I felt like I was maybe just another person at the clinic I was going to. It was just sort of going through the motions.

(Comment from Bridie, Jenny’s carer)

Relationship-centred care within the home did not simply happen for these participants. It was enacted by all the participants and evolved through dialogue as people allowed their therapists to learn about them within their home and community. Brian (Jack’s father commented that (trust) comes with time too, you know. You've got to build up the trust and a bond, I suppose. Physiotherapy assessments and treatments are usually planned to occur in a particular place and time but human interaction is not always so organised that all relevant information can be transferred in designated timeslots.

Most of the care provided to clients at home happens when the physiotherapist is not there. Physiotherapists can only know about what happens in their absence if the client,
family and carers confide in them. Trust is required and this develops over time with repeated interaction and attendance.

You kind of get to know their social situation and you get to know some of their personal quirks and beliefs and some of the things that are really important to them and then it kind of just evolves.

(Comment from Dennis’s therapist, Adam).

I’ve got to know Jenny and I think that’s what it’s all about; getting to know the client and having that experience.

(Comments from Bridie, Jenny’s carer)

These findings echo those of a study of the development of individualised family plan processes for children with disability (Summers, 1990). Family and professional stakeholders preferred “a process that evolves much like a friendship: using conversation and mutual self-disclosure, avoiding formal measures of any kind, and proceeding at a pace that is unhurried and with an attitude that is non-judgemental, supportive and caring” (p. 97). Insights like these have developed understanding of the caring interactions needed for people with disabilities and their families. For example, in their study into home-based healthcare for children with chronic illnesses, Stein and Jessup (1984) showed that the care provided today influences the adults they become tomorrow. This study is of note for my research, particularly in relation to one of the participants, Jenny who was in her twenties and had lived in a residential care setting since she was five years old.

The clinical interactions revealed in my research were dialogic in nature, multi-faceted, accepting of diversity, as reflected in the words of Linell (2004, p. 4) that “our being in the world is thoroughly interdependent with the existence of others”.

**Blending in with each family’s situation**

Therapist participants recognised that they needed to blend in with clients and families who were also quite definite about this requirement of their therapists. “Home-based healthcare is a difficult, complex and exhausting caring ‘job’ that extends through day and night” (Tasker et al., 2012, p. 9). Therapists’ ability to blend in quietly with the home routine helped them to relax, gain trust and interact with clients as physiotherapists. One family carer described the experienced therapist’s ability to blend
She just fits in, that's all I can say, she just fits in (comment from Eric’s wife).

Eric’s physiotherapist, Barbara, had the practice wisdom and experience to become part of her client’s world. The fact that she just fitted in meant that her presence and interaction with these people had become part of their accepted world. Eric and his family were comfortable with her. They were used to her being there with them. Barbara’s presence was then less of an intrusion than it would otherwise have been. She had become part of their world. Indeed, Eric’s wife said,

**She’s a friend of the family now.**

Such wise blending into a client’s situation seems to be in contrast to physiotherapy conducted in more institutional settings, where patients and health professionals frequently perceive healthcare as centred on the requirements of the healthcare system (Titchen, 1998). Physiotherapists may have been socialised to feel a professional need or even expectation to remain objective and emotionally removed from the people with whom they are interacting in the physiotherapeutic clinical situation. In contrast, “blending in” would seem to allow the therapist to retain more human qualities, in order to promote the level of communication and professional intimacy needed for the more complex relationships needed in home-based styles of healthcare interaction.

Yes, I think definitely, I mean it is awful when you go in somewhere yourself and someone sort of grabs you and moves you around. If it's going to be a longer-term relationship, you need to start off on the right foot. I think you need to just have something, you know, that's a little bit more than their physical ability, that's in the relationship.

(Comments from Eric’s physiotherapist, Barbara)

I propose that the therapists’ ability to blend in with the needs of families and clients allowed truly contextualised care but also decreased the amount of stress placed on the client and family by the inevitably intrusive nature of any healthcare visit. Gwen, Eric’s wife, described the stress of being hurried in the morning as she prepares for the visit of healthcare practitioners visiting her husband in their home:

Have to get out of bed, quick, quick, because you've got to be ready. They might not come for another hour or two yet, but you've got to be prepared in case.

(Comments from Gwen, Eric’s wife)
Making therapists’ social personas available

Despite their awareness of maintaining a professional persona, participating physiotherapists were conscious of the need for their social and personal personas to be made available to the people they were visiting. By giving part of themselves, socially and personally, therapists felt more able to accommodate the difference in situations between themselves and their client, establishing a more “level playing field” relationally and acknowledging the humanity of the other person in the relationship.

I think it’s about seeing that people have got another side to them, to their creaking joints and their inability to walk far and they’re having to use a walking frame which makes them feel old and things like that, but I think that it’s, it’s just seeing them as people, acknowledging them.

(Comments from Eric’s physiotherapist, Barbara)

This quote demonstrates an inherent awareness of the complexity of the dialogical relationships that develop. There are several layers of meaning present for the therapist. These layers range from the directly therapeutic, dealing with the “creaking joints” to engaging with real people who “feel old” and acknowledging this. Understanding of these social interactions can advance the development of more careful and mindful therapeutic relationship skills. Personal, social and professional aspects of the physiotherapist’s identity are inextricably bound together as she or he approaches clinical interactions with the client. The above quote implies that there is also an emotional connection present.

Allowing themselves to connect on an emotional level to better identify the meaning that people ascribe to their physiotherapy interactions

Emotional connection assisted the therapists to identify the meaning that people ascribed to their clinical interactions. Such connection within the developing physiotherapeutic relationship was considered by all participants to be important for trust in the relationship to be developed and maintained. One client said, She cares about me as a person.

Hyam (2011), an experienced nurse and educator, blogged in a very honest way:

I want to make emotional connections with the people I care for. This is important to me and it allows trust into the relationship along with ‘being’ there for the other person. I want to treat others the way I would want to be treated. (Para. 7).
Emotional connection can help community-based physiotherapists to find words that will connect and resonate with people, identify the meaning ascribed to clinical interactions and promote and advocate wellbeing for those clients and their carers.

Jack’s mother, Honor, recounted an instance of this,

The (rehab) physio said, ‘It’s the first time in all my years of practice that I’ve seen someone use their eyebrows to actually stand up.’
So as I said, there’s a right way and a wrong way
but Jack found the “Jack way”.

Interviewer: And what does his physio, Karen think about Jack’s way?

Honor: She’ll say “Not that way, Jack, my way.

Perceiving themselves as fellow travellers

There was a strong sense of journey in many accounts that enabled participants to make sense of the ongoing relationship.

Poignant reminders of how life used to be and what life is now,
The photos on the wall,
Seeing them in their home,
The struggle of it all, the loss of it all.
I never devalue that. I never ignore that.
You’re travelling that road with them.

(Jack’s therapist, Karen)

The feeling and perception of themselves as fellow travellers might assist health professionals to cope with the difficult and emotional situations they see their clients living in. These therapists recognised that when they leave their clients who have chronic conditions, they leave them with ongoing healthcare problems that usually cannot be cured.

Heckman and Cott (2005) described “the homecare journey as an opportunity to liberate people from their physical, social and environmental restrictions” (p. 278) and noted that this was different for each person. This is a very idealistic way for physiotherapists to view homecare but the concept of therapists as fellow travellers could be an important way of balancing other aspects of healthcare. More objective distance might be needed for clinical observation and judgement with the emotional connection spoken of above. The metaphor of a fellow traveller also indicated the need for physiotherapists
and their clients to stay actively engaged through the client’s long and difficult journey of chronic and complex healthcare. This engagement can also be seen in terms of mindfulness.

**Research comment on relational mindfulness/being mindful**

The quotes and themes presented in the preceding pages support my contention that mindfulness is a key aspect of the relationships that developed in these settings. *Mindfulness* is often represented as a characteristic of meditation, incorporating an ability to stay “in the present moment”. In this research, I have also used the notion of being mindful to refer particularly to the sensitive taking care of and taking responsibility for how an interpersonal interaction proceeds. Such an attitude seeks ongoing awareness of *how things really are* for the person being assisted, requiring the therapist to be *present and focused* on the other person throughout their interaction together.

Surrey (2005) wrote of “relational mindfulness”, the process needed within therapeutic interactions when clients cannot be merely passive but must actively participate to improve their situation. Community-based physiotherapy is just such a situation, even though clients might also need physical assistance to move or carry out any physiotherapy advice or exercises and sometimes need their families and/or carers to help them do this. I propose that the adoption of a mindful attitude by the physiotherapists in this study supported the development of the clinical relationship they sought to develop with their clients, families and carers and, via that relationship, helped the physiotherapy process in subtle ways not immediately apparent.

Epstein (1999, p. 1) suggested that “Mindfulness can link evidence-based and relationship-centered care and help to overcome the limitations of both approaches” and argued:

*Mindful practitioners use a variety of means to enhance their ability to engage in moment-to-moment self-monitoring, bring to consciousness their tacit personal knowledge and deeply held values, use peripheral vision and subsidiary awareness to become aware of new information and perspectives, and adopt curiosity in both ordinary and novel situations. In contrast, mindlessness may account for some deviations from professionalism and errors in judgment and technique.* (p. 2)

In this study, participants frequently spoke of particular aspects of their community-based physiotherapeutic relationships that demonstrated the mindfulness of the
participating therapists as they strove to be aware of their clients’ situations and stay present with them to better open up possibilities for the clinical relationship to develop.

6.3 STAYING ENGAGED

The findings revealed that staying engaged enabled interactions between therapist, client, context and environment to proceed in a manner that could become a seamless and satisfying experience for everyone concerned. While physiotherapeutic attention involved the physical interaction one would expect with physiotherapists, all participants reported that the social and relational aspects of their human interaction were important to them within this context; helping them to stay engaged. A productive clinical relationship, with the ongoing and reciprocal activities that it entails, also requires a great deal of trust. These physiotherapists needed to engage with clients, families and carers in processes of:

**Becoming comfortable**

Participants reported that becoming comfortable assisted the building of trust within their physiotherapeutic relationships. Joanne’s husband, Jim, noted that Joanne’s physiotherapist, Lynne, interacted with her in a comfortable and friendly way. He had also particularly observed the development of trust between them and felt that such trust depended on truth in their relationship,

> We joke with this therapist. We smile, we tell the story, what happened, you know. “Lynne”, when coming home here, is one of the family. She was very friendly with my wife and I could see the trust. She was the only person that my wife was comfortable with and I was very comfortable with this therapist too because she tried to tell my wife the truth, you know.

In his comment above, Jim makes it quite clear that he was able to become comfortable with his wife’s physiotherapist because he trusted her to be honest in her dealings with them. This issue of honesty allowing the building of trust has been discussed within the discourse for the law profession where negotiation has previously been assumed not to need the characteristic of trust in all instances. However, Pounds (2004) argues that the connection between very human interactions is a mindful process which “has everything to do with waking up and living in harmony with one-self and with the
world” (p. 183). Joanne needed to find her way into the next part of her life after her accident and work her way through what was possible for her in the future with regard to her mobility and ability to walk. She needed to trust her physiotherapist and that involved the need for honesty.

Building trust within the relationship

The building of trust is not easy. Karen, a very experienced physiotherapist, who had been in private community-based practice for over 30 years, related a story (from a clinical situation she had encountered some time ago) about this delicate process.

It was very precarious for about three and a half weeks as our relationship developed. As he [the client] started to realise his foot wouldn't actually break, then we started getting somewhere and now he waits for me to come to the house to set up anything that his musculo-skeletal physio might give him to do because he can't translate what they're telling him in their rooms, to be able to do it at home. It's just all too much for him. So he's relying on me now and has confidence in me, but those first couple of visits, part of me knew what was going wrong, but I didn't quite know how to put it right, you know, you couldn't just go out to talk to him for an hour.

(Karen, Jack’s physiotherapist)

The musculo-skeletal physios referred to here clearly had not established the depth of relationship that this client needed, possibly due to the complexity of his history and condition. Karen understood her client on a number of levels, physically, emotionally and imaginatively. She understood how he was thinking about his foot. She tried to put herself in his shoes and see the world through his eyes – a feature of good dialogical relationships. Personal and social development of her relationship with this client was needed but Karen felt constrained by the time and the formalised accountability structures she had to work with. She felt the need to develop trustful and open communication with her client.

Barbara (Eric’s physiotherapist) was also very aware of her need to develop the same trustful and open communication with her client.

It's the atmosphere, it's the rapport, it's the confidence, it's the trust. It's the trust that they give you.

Karen’s story supports Heckman and Cott’s (2005) insight that community-based physiotherapists perceive that people are more empowered within their own home and therefore, that they, the physiotherapists, need to “spend time gaining their client’s trust...
and cooperation to be able to achieve the therapeutic goals” (p. 282). Barbara’s experience also supported this need.

I knew that I had to talk with him after I’d done his physio. There had to be trust and you had to help them to create an atmosphere of trust where they could relax over a cup of tea, (in this particular case) and chat with you.

(Barbara, Eric’s physiotherapist)

Karen needed to take account of her need to develop a relationship of trust with her client as well as her need to be professionally competent. Smith (2005) noted that although it is often suggested that trust depends on the perception of another’s competence, a sense of the person’s moral competence might also be important. Clients and families expect their healthcare professionals to be ethical, kind, caring, compassionate, sensitive and insightful. It is clear from the data that the building of trust requires similar human qualities.

One of the physiotherapy participants, Adam, noted how necessary it was to gain the client’s and family’s trust early in the developing relationship with a client. He told me that he used a wide range of evidence-based movement assessment tools to provide a thorough examination of the client’s physical situation. In the first instance, this appeared to be a properly professionally accountable activity, and indeed it was, but there was an honest recognition by this therapist that those assessment tools and the human interaction required to carry them out were also being used for the more social process of *getting to know you* and *getting to know about you*. Such strategies can assist both parties to get comfortable with each other within the developing relationship and can allow clients to consent to further interaction.

Adam realised that his client Dennis was not able to “*do as much*” on a first home visit because Adam initially lacked enough insight into his client’s situation and Dennis was not yet comfortable enough to be able to give him that insight. He reflected on the way that he entered a therapeutic relationship generally and the role that more formal assessment processes took in a newly developing clinical situation.

*Your initial one [visit] is really quite clinical. You try and ask as many questions as possible because that rapport and that insight into what actually happens in their life isn’t really there yet. On the first time, you might not do as much, like, you’re not comfortable with them yet or they’re a bit funny about it.*
From the client and the family’s point of view, there is no guarantee that physiotherapy will help them in the situation they find themselves. Clients and their families with chronic and complex healthcare problems might have worked with numerous therapists over the years, with varying degrees of success or failure.

Parents are very protective and with good reason. They might have had experiences in the past where things didn't go so well. Past experiences come in to play with every interaction that they're going to have with everybody that looks after their child.

(Comment from Jenny’s carer, Bridie)

The findings showed that trust was important. A trustful attitude is based on a “willingness to be vulnerable to another based on the confidence that the other is benevolent, honest, open, reliable and competent” (Tschannen-Moran, 2004, p. xiii). It is of particular relevance in social interactions when one person depends on the uncertain action of another for a good outcome (Smith, 2005).

The above quote supports my claim that these community-based physiotherapy relationships are narrative in nature. Past experiences contribute to the life stories that clients and their families and carers live out and to the stories they want to live out in the future. Trust might develop because the attending physiotherapist presented a narrative trajectory into the future that was comprehensible and acceptable even if it was not perfect. This argument is supported by Mattingly and Fleming (1998), who explained that the journey into the future envisaged by the therapist for the client requires the therapist to project an imagined outcome or story’s end as part of the therapy plan (as discussed in Chapter 3: Creating drama within life narratives).

The building of trust allows physiotherapists to work more closely with their clients, families and carers. I argue that trust needs to be built dialogically from within these relationships, especially when the very nature of chronic and complex healthcare involves difficult and ongoing work in the home.

I think that sharing is a very important part of, well my relationships with people, it’s the sharing and so in sharing this, the give and take. When I’m given something I see it as a gift.

(Barbara, Eric’s physiotherapist).
Jones (1996) suggested that the gaining of trust can be justified and is cultivated by paying attention to “the kind of things that are likely to support, create or extend our trust” and avoiding other activities that might “undermine and limit our trust” (p. 22).

Physiotherapists working in the community depend just as much on the human and social elements of care as on the therapeutic dimensions of care (Heckman & Cott, 2005). Perceptions and experiences brought by the different people involved contribute to any new relationship and to the possible outcomes of the physiotherapy process that ensues. Stenmar and Nordholm (1994) argued that “the patient’s own resources and the patient-therapist relationship rather than the treatment techniques are the most important factors in explaining why physical therapy works” (p. 1034). Trust is closely related to a sense of feeling “comfortable” in these relationships.

Anne, a carer who assisted Dennis (a young man with a quadriplegia and acquired brain injury), also considered this very human issue of trust.

If the physio can get this trust relationship going, then the physio process will be much better. I mean, you put yourself in a situation with someone you don’t know. I wouldn’t want to work with a physio that I don’t trust. Personally, I think the relationship has to be something connecting each other. It actually says “Yes, let’s do this”.

Eric’s therapist, Barbara, referred to this sense of connection as “being translated” into an inner circle of trust,

Trust develops between you and the client and they’ll often tell you things that are very sensitive that they can’t talk about with each member of the family and I think you’re seen as part of like the “inner circle”. There’s the inner circle and then there are people in the outer, but you have been translated into that inner circle.

The “inner circle” mentioned above would seem to refer to the issue of whether the community-based physiotherapist is an “insider” or an “outsider”. Karen, one of the other very experienced therapists, qualified the “insider” status that might be bestowed on a visiting therapist,
Look, sometimes it comes down to families once again, sometimes you’re always the insider and sometimes you’re always the outsider because they’re so private but sometimes it fluctuates and I think we have to recognise that and not take it personally and allow them to be them.

Coming back to our definition as to why we’re there in the first place – as the physio. They’ve allowed us to become an insider in the situation for a while, they’ve allowed it. If they now say, “No, we want to take it back again” that’s where they’re at, it’s their choice.

Bakhtin emphasised “that a relation is never static, but always in the process of being made or unmade” (Holquist, 2000, p. 29). This dynamic nature of relationships is seen clearly in Karen’s comments above and illustrates the issues physiotherapists face as they try to understand and engage with their clients’ situations.

They have all their hope in you and gradually you take them on the journey of the reality of that is “well yes, we can have hope but” you know “this is what we’re seeing and it’s probably not going to work out the way we’re hoping, but let’s just see” and gradually they start to understand the situation then it’s not so much responsibility or anything, it’s relational

(Comment from Jack’s physiotherapist, Karen).

In this comment, we can see that therapists try to co-create a shared image of a possible future with clients, families and carers in what Mattingly and Lawlor (2001) described as conditional reasoning (as discussed in Chapter 3, section 3.5.1). Acceptance by therapists of the client’s and the family’s view of the healthcare difficulty or disability (and what clients feel they can realistically do), can assist in that client’s ability to improve levels of life satisfaction. In such situations, acceptance needs to go both ways in a truly dialogic way.

Dennis made it very clear that he depended on his physiotherapist, Adam, to listen to him and hear what Dennis felt he could realistically do without constantly pushing him to do more.

He always encourages me to do things but he knows that if I don’t want to do something, that’s my call and he won’t push it any further because he knows how far... [I can go].

(Comment from Dennis)

It is not hard to imagine the feeling of powerlessness that could occur if physiotherapists do not sensitively manage this issue for people who struggle constantly
to live their lives. In such situations, acceptance needs to go both ways in a truly dialogic way. The participants are constantly working at the relationship, taking care to make the relationship function and taking pains to be acutely sensitive to the other. They are each trying to see the world through the other’s eyes.

An element of such dialogic interaction was also seen in Joanne’s narrative,

   Now I know where I stand.

Clients and families can demonstrate acceptance of their attending physiotherapist through the many opportunities provided by the shared activities between them. A dialogical view allows the complexity inherent in human relationships to be opened up. By entering and becoming part of the client’s world for the time of the visit, physiotherapists can be better able to perceive clients as they perceive themselves. Adoption of their viewpoint can lead to a deeper understanding of what clients truly wish from the physiotherapy process. Talking with people provides physiotherapists with a way of maintaining their engagement with clients and families to further this process.

   And I think sometimes that you have a little bit of direction behind the chat you know that it leads to some, like the recreation may be and yes and then you can bring in respite but it’s directed with conversation, during conversation.

(Comment from Barbara, Eric’s physiotherapist)

**Talking “with” the people they had come to help**

I propose that casual talk becomes an important part of dialogue between family care clients, families and carers and the visiting physiotherapist, embedding interpersonal communication within the particular context for that client. Seemingly casual conversation occurs naturally when a physiotherapist comes to call. One family member said It fills in the spaces in a very comfortable companionable kind of way. For Barbara (a therapist with over 35 years of experience), casual talk engendered ease and comfort for people, helping them to relax and allowed them to think more deeply about their situation. I think that I would ask people to sit down and talk with them, okay, as just two normal people, two ordinary people.

(Frank, 2004) emphasised the importance of dialogue as a necessary and reciprocal activity and discussed the notion of *just talk* as occupying a lower level of importance
than dialogue. Yet findings from the participants in this project seem to contradict Frank’s view. Casual talk between clients, family, carers and therapists could initiate or introduce difficult areas of discussion as a way of reflecting on “parts”, in a genuine effort to discover the ongoing truth of the “whole” of their individual story. Jenny’s physiotherapist, John, told me,

I think it’s listening to what the subject is and how you can make that connection too. For example, we had a good discussion with a family about respite for the parents.

We wanted to open the conversation about “okay, how are you guys doing, do you need some time away from taking [care] of, you know, two disabled kids?” and something came up like recreation or something and then I said “okay, how is your recreation going? Do you find time to, you know, relax?” So that opened the conversation to talk about respite and getting someone to take care of the kids.

So actually, you’re chatting, to look for subjects that you can ‘hang your hat on’?”

(Interviewer)

Yes. I think sometimes that you have a little bit of direction behind the chat you know, that leads to something, like the recreation maybe, and then you can bring in respite but it’s directed with conversation, during conversation.

It is useful to apply a hermeneutic lens to conversation conducted between the client and therapist with particular reference to “parts” and “whole”. “Just talk” could refer to when the therapist and client/family chat about a variety of topics, both specific and general. By adopting an open listening approach which encourages the client or family to confide information regarding emotionally difficult topics of information, the therapist might be able to creatively access a more holistic contextualised idea of that person’s life world. This can create further space for trust to develop. These community-based physiotherapists clearly used a hermeneutic approach by taking the parts of a conversation and piecing together the narrative wholes that clients were living out. Only then could they see where their therapy might be of best use to their client. They listened and learned to hermeneutically bind together the parts and whole of the clinical relationship.
**Listening and learning**

Having an open attitude and maintaining an ongoing cycle of *listening and learning* was viewed by participants as essential to the relationship between community-based physiotherapists and the people they were working with. Such listening and learning appeared to happen for all participants, as dialogue built between them.

> I think to do your job effectively, one of the biggest things is to listen so even though I have my tests and I might do all that, you always have to keep listening to what actually they are reporting to you, what their difficulties are and what they want to do and that then determines how you then change your program.

This participant, Adam, endeavoured to stay engaged with his clients by listening to them in an ongoing way. From experience, he had learned to appreciate clients’ knowledge of themselves and their particular situation, and recognised that this knowledge was a changing phenomenon.

> I think as you get more experience, I think you tend to listen more and you tend to listen better. You’re kind of open. You know that everyone’s different. You know you can’t just treat these complex people all the same so you’re really comfortable in saying “Well look, what do you want?” like “What do you think you need?” because they’re the expert on themselves. You do get really comfortable because you realise that you can’t know everything. You know that everyone is very different and they’re the best person about knowing about themselves.

(Comment from Dennis’s physiotherapist, Adam)

Adam was aware that he needed to stay open to his clients’ individuality if he was to be able to recognise their knowledge about themselves. In her study regarding expert physiotherapists, Jensen (2000) also identified clients as the most important source of knowledge within the physiotherapy processes. To access their clients’ highly contextualised knowledge, therapists need to establish common ground between themselves and their clients. This can be accomplished by *attentive listening* (Therkildsen Sudman, 2008): “a kind of listening that holds one’s own views in abeyance long enough to hear a possible ‘truth’” (Alcoff, 2003, p. 239, as quoted by Therkildsen Sudman, p. 50). Adam expressed this putting aside of one’s views by telling me: *You realise that you can’t know everything.*
Receptive attentiveness and presence can be expressed by physiotherapists through their ability to listen to their clients in an open way, and this attitude promotes the building of trust.

6.4 BEING RESPONSIVE

“Taking the fullest responsibility for what she or he can do, living a life responsive to others’ needs” (Frank, 2007b, para. 18).

The findings revealed that the process of being and becoming increasingly responsive depended on the dialogue that built between participants. “Dialogue is generated in the way we respond to each other” (Seikulla, 2011, p. 191). For the process of this research, I have used the term responsiveness to refer not only to responding to issues but rather, more broadly, responding to people and their concerns. Such responsiveness required an open attitude on the part of the therapist participants.

Being open

Bridie, Jenny’s nurse, identified openness as important to physiotherapeutic relationships.

I think it’s a fairly open relationship. You’re really able to go and approach him [the physiotherapist]. You don’t feel intimidated by the fact that he’s the physio and he knows more about people’s bodies and how they work and that sort of thing. I just find that he’s willing to listen. He might not always agree with what you’ve got to say but he will listen and he will take the time and consider what you are saying. ...

I guess it can be a bit tricky sometimes when you’ve got your opinion about something and you think that it’s the right thing and they’ve got their thinking.

It’s hard, but I guess I feel you’re able to get to that middle ground most of the time, ... I don’t think there’s really been a situation where we haven’t been able to work through things.

(Comments by Bridie, a carer for Jenny)

The focus group of participating physiotherapists also discussed this need in community practice for a kind of openness. One of the most experienced therapists (Barbara) related the concept of openness to negative capability, a term given by the poet Keats (1817) to the situation of openness “when man is capable of being in uncertainties, mysteries,
doubts, without any irritable reaching after fact and reason” (as cited by Wu, 2005, p. 1351). Barbara had been listening to a discussion of Jane Campion’s film about the poet Keats and related it to her physiotherapy practice,

Yes and just standing back and letting things happen and this particular actor was saying that it didn’t matter if he didn’t do the same thing; the essence of what he was trying to get across was within him, but how he expressed it was different, and so I think that’s flexibility.

(Comment by Barbara, Eric’s physiotherapist)

Keats was discussing people’s ability to sublimate their assumptions and ego, making themself negative, in a sense, in order to be able to enter a world of uncertainty without prematurely making superficial judgements or, as Tafarella (2009) put it, oversimplifying the situation with rationality. Within professional practice, Schön (1983) referred to this world of uncertainty as “the swampy lowlands” of practice (p. 42). In Barbara’s acceptance of the need to let things happen, she was also describing the need to be open and the process of becoming emotionally attuned.

**Becoming emotionally attuned**

These physiotherapists needed to be attentive and responsive at different levels within the clinical relationship. Physiotherapy involved a customising of interaction to the client’s, family’s and carer’s needs and abilities. Findings revealed that participating physiotherapists used relationship-centred practice approaches to enhance communication and interaction with their clients. One example of this occurred when therapist participants let the conversation flow while mentally highlighting issues of concern and connection to the therapeutic process and waiting for important issues to emerge.

We joke with this therapist. We smile, we tell the story, what happened, you know.

(Comment from Joanne’s husband, Jim)

In my clinical experience I have heard this process described as “scouting around in the talk”, an expression which tells the tale of a careful and sensitive approach to finding out the whole story of a person whom the therapist has come to try to help. It can be seen as a hermeneutic approach to the human side of a clinical relationship.
If a person thinks that she’s being listened to, that helps, no matter what the subject is, and being the focus of their attention, that helps because other little side things will be noticed while you’re focused on the person doing something. Yes, it’s just being the focus of attention I suppose.

(Comment from Eric’s wife, Gwen)

For clients who could not speak, the physicality of the physiotherapy interaction lent itself well to the creation of a virtual conversation, supplemented by physical and visual cues to create a rich sensory experience for that client. John described how he approached Jenny when he came to visit her for her physiotherapy contact,

In a situation when they can’t respond, I ask any question that I would ask you, you know, how are you, what did you have for dinner, did you have visitors today? I try to explain what the plan is, what’s going to happen and where we’re going and how long it’s going to take. I also try to make physical contact, using voice and touch. I try to keep an eye on her face because her face will tell me how things are going. I try to make eye contact or she will look in the direction where sounds are coming from. Sometimes she’ll turn her head when her carer and I talk. I don’t talk to staff about her. I have a conversation with Jenny and I keep eye contact with Jenny but I listen to what the carers say while I try to maintain the conversation with Jenny.

“John’s conversation with Jenny” (see interpretive poem in Section 5.4: Jenny) crystallises the blended process that Jenny’s physiotherapist mindfully created together with Jenny and her carers within the clinical relationship, highlighting the difficulty or tension in physiotherapy practice, when the therapist could not know “for sure” that they had interpreted the needs of their client accurately, for their best wellbeing or as that client might wish. These therapists practised in “the space between them”, always striving to stay engaged and connected in order to achieve the best level of communication they could.

This interaction and John’s comments regarding his consciously relationship-centred approach offered another example of a clinical situation that combined elements of the different aspects of healthcare that practitioners strive to combine in their practice: caring relational service and more objective clinical attention to client’s healthcare needs. For John, years of personal and professional experience and careful mindfulness of the humanity and individuality of his young client enabled him to blend personal caring and professional attention for his client, Jenny. Such blending of care and
attention transcends the disconnect described by Kinsella (2006) and Mattingly and Lawlor (2001), where hegemonic attitudes of accepted ways to practise professional healthcare might clash with an individual’s perceptions and moral decisions regarding person and relationship-centred practice.

Feedback from Jenny’s physiotherapist, John, regarding the derived poem, “A conversation with Jenny” and the process it describes was given a phenomenological “nod”, physically and verbally, Yes, that’s it (John). Such interpersonal engagement also involved John’s ability to interpret and advocate wellbeing for his client.

**Interpreting and advocating wellbeing for clients**

Carers coming into people’s homes to help them with their physical care have different degrees of skill and education. Physiotherapists know that clients’ care is dependent on those carers and indirectly on the physiotherapist’s ability to interpret that care so that the carers can understand and carry out activities (physical assistance and more formal physiotherapy activities and exercises) in a way that will best benefit clients. Carers participating in this study told me of instances when their relationship with the visiting physiotherapist enhanced their ability and confidence to care for their client. Jenny’s carer, Bridie, told me that she worked with an underlying fear that she might accidentally hurt Jenny, who was physically very fragile.

> I hadn’t worked with people with such profound physical disabilities before. I was a little bit uncertain about physio and just day-to-day care. I guess I was a bit worried about hurting people. It is a big concern, when you haven’t worked with people, you know, in that situation. It’s just realising how important that touch and that movement is to our clients. What we would think is not a big deal, like if someone touched us in that way, it’s nothing, it’s water off a duck’s back – whereas for them, because they are more frail and they have pain that we don’t know about … I’ve progressed in what I’m doing but you still have that fear in the back of your mind, when you’re moving these clients, just every now and again, you’ve just got that thought.

In Bridie’s comments above, it is important to note that this is more than just wanting to be “checked”; she is fearful of causing harm to Jenny because of her frailty. That fear needed to be addressed if Jenny’s need for touch and movement was to be met. Jenny’s mother knew that touch was Jenny’s main way of engaging in meaningful communication (see the comments from Jenny’s mother in Section 5.4: Jenny). The need for confirmation and checking by attending physiotherapists, for carers carrying
out physiotherapy activities is illustrated by Ekenberg’s (2001) study of the experiences of mothers and fathers of young adult children with cerebral palsy. All parent carers “wanted to be checked and confirmed as doing the right training” (p. 82).

Carers also reported being aware of working autonomously in home settings and feeling an increased sense of responsibility for their client’s safety and wellbeing.

You know they [clients in the group home] have got their plans in their files and we were able to always refer to but that’s not the same as being actually able to go and talk to the physio who developed that plan and say, “look, this is what it looks like on the plan but this is what’s really happening”.

I guess just the reassurance that the plans that he put in place were safe for Jenny and it was safe for me to be doing those things, just a bit of a confidence builder, I guess, just being able to go and bounce things off John – just to make sure that I was doing the right thing by Jenny, as I said, not having that experience before, I really just wanted to make sure that I was doing the right thing in the right way in terms of physio.

(Comment by Bridie, Jenny’s carer)

Ongoing dialogue between clients, carers (family or paid) and their community-based physiotherapists was important for all the participants. That need for ongoing dialogue could conflict with the limitations on physiotherapists’ time imposed by economic, workload and time constraints. In Jenny’s situation, her physiotherapist, John, visited regularly and carers had easy and open access to him via phone and face-to-face contact as well as written communication. Not all clients enjoy this level of care.

He will give you time and he will explain things and you’re able to ask questions and you know, yes, there’s no silly question that you can’t ask. Even if it’s just something simple, (a simple routine or a simple stretch that you’re doing), if you’re unsure, you can still go and ask. You’re not uncomfortable to go and ask, even the smallest thing; if it’s important to you then it’s important to the client.

I think in terms of his actual physical interactions with the clients, when he’s doing things with the clients, he’s very gentle but he’s very sort of purposeful in the movements.

It made me take a step back and think, “Maybe I should, you know, take that example and use that in my everyday work as well”, be that little more, (not that I’m not gentle) but just his manner. It sort of sparked in me. It’s just like an “ahah” moment, like “hang on, yes, yes, like that”.
I just think that movement and that touch is really important for them and I guess I hadn't really thought about until then.

Even though I'm gentle with my interactions with them, I guess I really hadn't thought about it until I saw that we were having some problems with pain and positioning and it really just struck home that day.

It make me feel more aware and I guess more, just more determined to take it on and to model that for others I guess, as well.

(Comment from Bridie, Jenny’s carer)

Jennie’s carer, Bridie, was insightful regarding the more subtle aspects of the way that physiotherapist John interpreted Jenny’s physical care needs for her carers.

He does come from a different perspective. I think he’s probably able to pick up things that we wouldn’t necessarily pick up straight away.

I’d said to him, “I’ve noticed a change”. It was the first time that I’d noticed this change in this particular person and I guess I was a bit worried. I said to John, “Can you come and have a look at this?” and you know, he actually reassured me that [the change I had been worried about] it had been happening over a period of time. He probably already knew about it. I don’t know why I hadn’t seen it. I guess because he does come from that different perspective, he’s just able to see differences a little bit more clearly.

The development of such confident dialogue could open up possibilities for the development of deeper understanding and improved skills and abilities for carers and families trying to care for people at home. Formal support of caregiving in the home can improve the competency of carers (Greenberger, 2003) and decrease the stress of such caregiving (Hepburn, Tomatore, Center & Ostwald, 2002). Families undertaking home-based healthcare for loved ones may benefit from the introduction of education regarding caregiving.

Education regarding caregiving in clients’ homes by visiting physiotherapists combines “talking” and “doing”, often at the same time. Dennis’s physiotherapist, Adam, was aware that the building of trust also depended on how he physically conducted the initial physiotherapy process.

Physio is more than just talking. You can demonstrate your knowledge and your ability to diagnose and everything by talking to them but you can also demonstrate your knowledge in your ability to actually treat, to actually perform the rehab.
When you get in there and you do your therapy and you're proficient at it, people say, "oh yes, he knows what he's doing".

An emphasis on teaching suggests that there is a best “way to do things”. In some situations that will be true, but ongoing dialogical interaction, such as the interaction described above between John, Jenny’s physiotherapist, and Bridie, her carer, also promoted a mutual resolution of difficult issues and contributed in a very real way to the building of confidence and care skills for that carer. The practice of community-based physiotherapy requires a broad range of knowledge and skills (Heckman & Cott, 2005). In her research into expert physiotherapy practice, Jensen (2000) argued that successful physiotherapy encounters depended on physiotherapists’ abilities to teach clients and families.

Karen gave some perspective from the therapist’s point of view:

I think my goal is to empower them and the people that are there, all the time, rather than have dependency on me and I think that’s the difference to being in a hospital. Dependency can happen when you come to your one-on-one physio. It’s all about you and me and what I’m telling you to do, whereas in the situations in which I think most of us are working, we’re needing to empower confidence, empower ability, empower ongoing commitment and motivation for the person that we’re seeing and all those people that are critical in their day-to-day circumstances, so that’s their carer, that’s their family where appropriate, or recognising the limitations of family and so focusing more on caring. Empowering them rather than having them rely on you.

Seen in dialogical terms, although physiotherapeutic relationships might initially have a balance of power that seems to favour the physiotherapists, this quote shows that this therapist was willing to give power to others. Indeed, she felt that this balancing of power was important for a therapeutic relationship and the wellbeing of her clients. Karen (Jack’s physiotherapist) was very aware of this. Therapists who can build up ability and confidence in clients, carers and families enable them all to do well with the healthcare tasks they are undertaking.

Caring for the carers

Carers and families have to cope with difficult situations and sometimes seemingly unreasonable demands from clients. All carers and families in this research reported that their therapist played a significant role in the modelling of caring behaviours. The
therapist in the role of “guest” and “visitor” might be seen as a gentle and considerate person who can provide mentoring. Subtlety is required to play out such a delicate role.

Look, I'm in a glorified position, I go there, I do something he really likes doing, physical stuff and walking. I'm there for an hour and he likes my role in his care, so he's probably nicer to me than to his carers. I do like to stick up for the carers. When he's being unreasonable I'll say, "Look, it's probably not that fair to have a go at them".

(Dennis’s therapist, Adam)

In such a situation the physiotherapist was clearly doing more than simply providing physical therapy. The complexity of the relationships was highlighted by this sensitivity to the subtlety and nuance required in the home situation. This is a key feature of dialogical relationships: the more complex they are, the more need there is for subtlety and nuance. There was clearly a more holistic caring role being enacted in this setting. Certainly, many families and carers spoke of the caring qualities of their physiotherapists. Advocacy for carers by participating physiotherapists added to the layered complexity of the physiotherapeutic relationship that gradually built between the people concerned. Family and carers spoke of their dependence on the human relationship to feel comfortable with their visiting physiotherapist, allowing them to more easily talk about any caring difficulties they might be having. Acknowledgement of the human and personal aspects of community-based healthcare for carers might include important issues to do with caring for the carers, such as preventing carer back injury or adjusting and modifying physical care for clients to better balance the work for their carers. Anne, Dennis’s carer, remembered when she hurt her back doing her caring work for him,

I did a bad movement with Dennis and I had a sore back for about a week so I was talking with Dennis and saying, “I'm sore, I don't think I really can lift you today” and that day Adam [the physiotherapist] was coming and Dennis was so worried that he told him, “Adam, she’s been so sore, what can we do?” and Adam told us what to do and told Dennis to help me by reminding me to do my exercises and to be careful when I was working. He told me what to do to make it better. Now Dennis himself has been caring for me saying, “bend your knees, don't bend your back” and “have you been doing the exercises, because I don't want you sore again.” So Dennis changed a bit because of that. I think that Dennis realises now that we carers are not supermen. We also have weaknesses.
From the accounts given from participants, it appeared that these aspects of the physiotherapeutic relationship often occurred alongside other physiotherapeutic activities in quite a spontaneous way, as the physiotherapist participants responded to particular situations. It could initially present as an “add-on” activity or communication but there was an important underlying implication that such interaction could help the therapist to also “get comfortable” with family members and carers, building trust and providing models of care. One of those models included an attitude of breaking up a difficult issue into manageable parts, Taking baby steps to the future (as Jack’s mother commented).

Helping people to take baby steps to the future

Coping with severe health issues at home can be overwhelming. Changing perspective from a seemingly unmanageable whole to a perspective that focused on particular and discrete “baby steps” was identified by families and clients as an important way of helping them to alter their view of a particular situation and carry on in the face of catastrophic personal situations. Honor and her husband looked after their young adult son, Jack, who had acquired a traumatic brain injury as a teenager and was cared for at home by family and paid carers.

Honor learnt to take “baby steps” to deal with an often overwhelming situation,

  Everybody needs to get comfortable, basically. It’s baby steps, is what we’ve done with Jack, baby steps, learn something, master it, then go on and learn something and master it, don’t try and do everything all at once.

The physical practice of physiotherapy lends itself to this process of identifying small, manageable goals for clients with severe and complex health problems. Physical activity and interaction can be enhanced by physiotherapists’ physical touch, along with guided or accompanied movement (Gyllensten, Lundvik, Gard, Salford & Ekdahl, 1999). Eric too gave a simple explanation of the way his physiotherapist, Barbara, accompanied him physically for his walking activities,

  When I’m doing the walking, she stands behind me. She doesn’t actually do other things but she makes suggestions as to what I can do.

The simplicity of Eric’s statement above belies the complexity of his experienced physiotherapist’s work in this situation but it does give a hint at his feeling of comfort and confidence in this activity and his acceptance of his physiotherapist’s presence and
the advice she gave him. Clients, families and carers were reassured and steadied by their physiotherapist’s guidance to engage in the present to create a way of proceeding into the future. Narrative as a theoretical basis can be used to make sense of these particular findings. For example, Eric and his family were faced with the need to create a way of living at home (a life story) with Eric’s multiple healthcare difficulties, which were deteriorating. With Barbara’s assistance, they were living out a story of careful adjustment to difficult life circumstances enabling Eric to continue living at home with his family. Eric’s physiotherapy care needed to be carefully responsive to his healthcare problems (including his dementia). Each visit attended to Eric as he was on that day,

She just takes me as I am and we do what I can.

(Comment from Eric)

Such “baby steps” can be seen in hermeneutic terms. They are parts relating to the whole. The creation of baby steps with their physiotherapist gave clients a base for managing their problems, sustaining them in the face of the overwhelming whole of their health situation and the future lying ahead of them.

**Being friendly**

Many participants contributed comments about community-based “physios” being “friends” or “friendly” with clients, families and carers. The decision by the therapist to be friendly or just friends is a difficult and delicate issue. These terms needed to be explored further. In the following participant comments, it can be seen that different therapists have differing opinions and ways of approaching this issue. The first example is from Barbara. The type of balance described from her situation with Eric might only be achieved by very experienced therapists developing over many years of physiotherapy practice. In their home, Eric’s wife, Gwen, relied on the “job” done by his physiotherapist, Barbara, as well as appreciating her relaxed friendly attitude,

Her work is strengthening his legs. That is important to me because I'm very concerned about him and so I appreciate her input into his wellbeing and her, well having just sort of become a friend of the family.

It’s very easy and very nice you know. This girl has done a good job. She’s friendly and helpful. She is a friend of the family now.

Barbara was a very experienced physiotherapist who had been in private community-based physiotherapy practice for 29 years. She valued a relaxed and friendly approach
with her clients and appreciated her acceptance by this family, perceiving it as “a gift” or an honour,

Oh yes, oh yes, I’m certainly there as the physio but I want to relate on a much friendlier sort of level, I think. It’s just like sitting and talking with your friends or very good acquaintances or something like that – just normal interaction.
I find they end up calling me their friend or part of their family as well, which is a great compliment. That is a gift.

In this particular situation, this family viewed their therapist differently to the way they viewed other healthcare visitors, and Eric and Gwen’s daughter noticed this,

If you look at the nurses who come in, they’re all friendly but I don’t think you would count any of those as friends, not like this therapist.

The development of such closeness could have other benefits for clients and families. Jenny’s physio, John, worked with profoundly disabled young adult people, many of whom had experienced severe illness and/or surgery. He often had to deal with distressed families, the emotional demands of palliative care and possibly the death of young people with whom he had been involved over many years,

If you’re a friend you’ll have more freedom, from both sides, to discuss [difficult] issues without someone being affronted.

Adam also mentioned that gaining experience had made him feel more confident. He reflected on this process,

I think I’ve changed a lot, you know in the past 4 or 5 years. I think I’ve become a lot better at becoming comfortable quicker with them, because I’m probably more confident as well. I’ve worked in a community a lot in the last 5 years and now I feel a bit more confident. I think initially, I might have taken a bit longer to kind of have confidence and make it more two-way, I think initially it was more analytical.

Dialogical relationships allow some degree of flexibility. Adam clearly realised the importance of developing a dialogical relationship as opposed to adopting a more monological and techno-rational approach, although he would probably not have used such terms himself,
I think flexibility can be helpful, in terms of preventing burnout or getting back in to things if you have burned out a bit but because this personal sort of things that comes up as an autonomous therapist, there is self-doubt and there is no system to protect you, you know, if you stretch yourself out too far into people’s homes.

Within the focus group, two of the participating physiotherapists added comments about why they thought trust might be engendered by a friendly approach. Therapists contributed the following comments:

Barbara: We spend more time with them face-to-face and we touch them.

Karen: You’re working together with them.

Barbara: Maybe looking at aspirations, goals and what they have achieved and giving them time, personal time.

Karen: Their home is a more intimate sort of setting, it’s more like “this is their place” now and I’m in their world. You see the pictures of all the places they’ve been or the way they were and that’s just in their face and your face, I think you have to be somebody who they can rely on.

The development of life experience skills would seem to be an important part of a therapist’s ability to maintain the balance of such a “friendly” relationship. Adam, a younger, participating therapist, stated, As your life skills get better, you get better at understanding people, and used the word “discerning” in the discussion about this topic, explaining, there’s a big difference between a personable and professional relationship and a personal friendship. “Discerning” indicates some critical thought based on the physiotherapist’s reflection and consideration of the relationships developing between clients, families, carers and attending physiotherapists.

6.5 CONCLUSION

In this chapter, key dimensions of these special mindful, dialogical physiotherapeutic relationships of being mindful, staying engaged and being responsive were interpreted from the data, and the elements within those processes were discussed. Within the development of their community-based clinical relationships, the participating physiotherapists sought to stay open to their clients, establish trust and advocate for
clients and their carers in a collaborative effort for the health and wellbeing of clients. My exploration of the physiotherapeutic relationships within this chapter has formed the basis for a model of physiotherapy practice, *Mindful Dialogues in community-based physiotherapy*. This is discussed in Chapter 7.
We need to embody a new relational practice, to change what we notice and are sensitive to (as well as what we care about, and feel are the appropriate goals at which to aim). In other words, we need to change ourselves, our sensibilities, the “background practices” we have embodied that make us the kind of professionals we are.

(Shotter, 1998, p. 35)

7.1 INTRODUCTION

In this concluding chapter, I reflect on how this thesis answers the research questions that I asked at the beginning of the project and summarise the contribution that it makes. Discussion follows regarding what I identified as key matters relating to developing relationships between community-based physiotherapists, clients, families and carers. I propose a narrative style model of practice, Mindful Dialogical Relationships, to contribute to the area of physiotherapeutic relationship development in community-based healthcare practice. I reflect on the project that I have conducted and discuss possible implications and ideas for future research directions.
7.2 ANSWERING THE RESEARCH QUESTIONS

This project sought to answer the following research questions:

How do community-based physiotherapists experience and foster relationship-centred care within the dynamic and on-going therapeutic relationships they develop with clients, their families and carers?

How do clients, their families and carers, experience and understand these on-going relationships with community-based physiotherapists?

This research revealed that:

- Community-based physiotherapists experienced and foster relationship-centred care by developing mindful dialogical relationships with their clients, families and carers using a narrative and conversational style of interaction which provided a dynamic and flexible way for the players in the therapeutic relationship to get to know each other and discover what each player in the relationship considered was important for them.

- Community-based physiotherapists needed to negotiate multi-voiced conversations, acting as dialogue facilitators to patch the narratives, making sense of their clients’ stories and advocating for people as necessary within the wider home-based healthcare situation.

- Within community-based healthcare situations, physiotherapeutic relationships were intertwined with the physical activities of physiotherapy for clients.

- Community-based physiotherapists endeavoured to:
  - Be mindful of the complex context within which such therapy was conducted and of the needs, interests and input of the various players
  - Stay engaged and connected with the people they had come to help and
  - Be responsive to respect the identity and needs of their clients and carers in the clinical encounter.
7.3 CREATING MINDFUL DIALOGICAL RELATIONSHIPS: A MODEL FOR PRACTICE

To create means to bring into reality. So that kind of balance between dealing with the problems as they emerge and keeping a larger long term focus on: Why are we here? What are we really trying to create? Why does any of this matter to us?” (You Tube, Peter Senge on the creative process).

A Mindful Dialogues Model of community-based physiotherapy practice provides a framework for thinking about and planning the way community-based physiotherapists can develop sustainable and productive physiotherapeutic relationships with clients, families and carers (See Figure 7.1). The thoughtful social interaction discussed by participants in this research provided opportunities for physiotherapists to better explore, contextualise and facilitate therapy for their clients.

Figure 7.1 Mindful dialogues in community-based physiotherapy
Building trust and confidence offered possibilities to discover the best options for person-centred physiotherapy practice for each person, providing continuity of purpose for families in their endeavours to create an optimal life for all family members. Such positive interaction presented as a gentle background activity but should not be underestimated in its power to affect the essentially human dynamics of community-based physiotherapy.

Findings from this research showed that therapists’ abilities to be mindful, stay engaged and be responsive (discussed in the next three sections) occurred in an ongoing and dynamic process (denoted in Figure 7.1 by the coloured multi-sections). Drawing these three dimensions of mindful, dialogical relationships together was the practice of valuing different participants’ narratives and utilising narratives to interpret and create such relationships. Therapists need to engage with all aspects of the model if they want to provide good care; many activities need to be harmonised and frequently adjusted.

The diagram above shows the dynamic and woven nature of the relationship dimensions of being mindful, staying engaged and being responsive (depicted by the intersecting angled sections of the icon in the centre of the diagram). These dimensions of care depend on the many ways that physiotherapists develop their therapeutic relationships (depicted in the middle part of the whole relationship circle of the diagram). The whole of that relationship is resourced by the physiotherapists, clients, families and carers along with physiotherapists’ knowledge and experience.

An example of the adjustment (spoken of above) can be seen in the instances where therapists discovered some new aspect of the situation that they had not been aware of before. Such opportunities for reflection can provide deep insight for healthcare professionals and motivate them to continue in their efforts to relate to clients, families and carers. Reflection and ongoing engagement with these people helped to open up a relational space where therapists could sustain and deepen their understanding of different people in different situations.

My model refers to community-based physiotherapeutic relationships where there are at least two people engaged in these dialogues (and often multi-voiced conversations or polylogues) but it is not all of these people and their perspectives that is the focus of this research. The focus is on the therapists themselves being mindful, responsive and engaged so that they can foster constructive and effective interpersonal relationships that fully respect their clients. This does not preclude the idea of clients or families also
facilitating engagement and dialogues and shaping the relationships. Indeed, my findings discussion in the previous chapter illustrates that this was the case for a number of client and family participants. However, exploring in depth the role of these players is beyond the scope of this research and I aim to pursue this topic after my PhD is completed. Therapists can use this model when reflecting on their practice generally or more specifically, when preparing for a particular client’s physiotherapy. The model of Mindful Dialogues can be used in practice to frame discussion about different clinical topics. For example, this practice model has now been used to frame discussion regarding communication for safety in healthcare for people with limited communication abilities (Tasker and De Bortoli, 2013, in press). Many possible approaches to the healthcare situations of specific clients could then be deeply and richly explored, providing truly contextualised and relationship-centred healthcare for those people.

7.3.1 Being mindful

Being mindful in my model refers to physiotherapists’ relationship approaches, which embody awareness of the particular context, experience and wishes of clients, families and carers (See Figure 7.2) across all aspects of community-based physiotherapy practice.

Being mindful

Being mindful involved blending together understanding (mindfulness) and (mindful) actions that embodied the therapists’ understanding of the patient’s (and family’s/carers’) narratives and situation. Mindfulness for physiotherapy participants included the following elements:

- Understanding the nature of home-based healthcare as hard work for clients, families and carers and the impact of physiotherapy on family situations
- Being sensitive to the difficulties that families and carers face, including the realisation that progressive deterioration lies ahead for most
- Recognising that home-based healthcare is an intrusion into family life
- Realising that community-based physiotherapeutic relationships need to evolve
- Blending in with each family’s situation
- Being conscious of the need for the therapists’ social and personal personas to be made available within the interactions
- Allowing themselves to connect on an emotional level to better identify the meaning that people ascribe to their physiotherapy interactions
- Perceiving themselves as fellow travellers, on a journey with the people they come to assist

Figure 7.2 Being mindful
Participating physiotherapists in this research spoke of their need to be mindful of and sensitive to such human dimensions throughout their therapeutic relationships. When a community-based physiotherapist “comes to call”, they are entering someone’s home, where they are a guest (Heckman & Cott, 2005). Community-based physiotherapeutic relationships can only occur because of the hospitality of clients and their families who welcome and allow therapists into their homes and their lives. Past this initial hospitality process, acceptance and trust then needs to develop if successful therapy is to develop. Seeing and hearing how it really is for clients, families and carers is necessary before therapists try to suggest any possible actions and interventions. The embodied nature of such mindfulness incorporates (literally - as in the corporeal body) the way physiotherapists need to be sensitive in all their dealings with the people they come to assist. For physiotherapy participants this sensitivity had become a part of who and what they were as people. Mindfulness is also integral to the entire clinical encounter including the physical physiotherapy activities as well as relationships.

Although this thesis did not attempt to directly examine the physical side of therapeutic interaction, it is clear that successful physiotherapeutic relationships involve more than just talking with and more than just moving and touching clients during physiotherapy interactions.

The success of community-based physiotherapy interactions depends on the ability or willingness of clients, families and carers to work with their therapist and for everyone concerned to understand the community-based physiotherapy process, as changeable and ongoing. Physiotherapists in this study recognised that their transitory presence in clients’ lives and their ability to participate or influence events for their client was inevitably piecemeal. Engagement with everyone concerned with clients’ care was necessary for these physiotherapists to successfully negotiate the different contexts and individual experiences within the changing human and health situations they attended.

7.3.2 Staying engaged

The physiotherapists in my study demonstrated and reported the importance of staying engaged and connected with clients, families and carers by listening, talking and learning with the various people involved for each client (See Figure 7.3).

The physiotherapist participants reported that getting comfortable with people is a necessary prerequisite if trust and confidence is to develop and that encouraging clients, families and carers to share stories is an important means of building that trust.
Staying engaged

Key elements within the dimension of engagement are:

- Building trust within the relationship
- Becoming comfortable with clients, families and carers
- Talking with the people they had come to help
- Listening and learning from clients, families and carers

Figure 7.3 Staying engaged

They observed that such stories are usually based on illness experiences, rather than just “the facts of the case”.

The help I want is not a matter of answering questions but of witnessing attempts to live in certain ways. I do not want my questions answered; I want my experiences shared. (Frank, 2002, p. 13-14)

The research showed that opportunities exist for clients and/or families to tell therapists of their experiences and these opportunities can be enhanced if therapists are able to stay fully and sensitively engaged with clients, so that difficult issues can be freely expressed. All participants in clinical encounters want to be heard but the medical “voice” can sometimes seem louder and more dominant (Frank, 2002). In community-based healthcare settings it was clear that the therapists in this study respected the voices of the people they came to assist and recognised that balance is needed if everyone’s voice is to be heard. Relationships based on good engagement offer opportunities for such balance to develop.

Previous research (Ek, 1990) showed that the physiotherapy process occurs “moment to moment in real-time” (p, 2) and is reciprocal in nature, allowing both therapists and clients to learn and change. Iversen, Øien and Råheim (2008) argued that children with cerebral palsy receiving physiotherapy at school experienced deeper meaning and improved quality of movement through mutual creation of meaning within communication with their therapists. This reinforces my finding that possibilities for substantive change can only occur through ongoing engagement between therapists, clients, families and carers.

It can be difficult to stay engaged with people who are stuck in chaos narratives; “living a life of overwhelming trouble and suffering” and feeling that “life is never going to get better” (Frank, 1995, p. 113). The voice of the client can seem lost in chaos and even experienced therapists may feel the chasm of the other’s despair yawning at
their feet. It is tempting for therapists to simply try “to fix things” with evidence-based techniques and activities and ignore what clients are feeling, but in the settings typical of this project, therapists sought a balance between the voice of medical science and the sensitivities of those they were caring for. In my research findings, this sense of “the edge of despair” can be felt in Joanne’s narrative *I know now where I stand* as she struggled to come to terms with the difficulty of her walking.

Sometimes *balance* between these voices of medicine (the biomedical, illness narrative) and life (including the wellness narrative) will include a combination of physical activity and relationship activities, acting together as a framework for clients and/or families and carers to move forward. Examples of this can clearly be seen in the relationships between Eric and his physiotherapist, Barbara and between Dennis and his physiotherapist, Adam, in the description of their assisted walking activities. Opportunities for real dialogue can be facilitated by the inevitable touch and physical proximity that occurs within physiotherapy sessions and therapists commonly become aware of the power of this aspect of their interaction with clients. While it is beyond the scope of this research to deal in more depth with this haptic (touch) aspect of relationships in physiotherapy, its influence and presence must be sensitively acknowledged and incorporated within all the processes of being mindful, staying engaged and being responsive.

### 7.3.3 Being responsive

>'Truth is not born nor is it to be found inside the head of an individual person, it is born between people collectively searching for truth, in the process of their dialogic interaction' (Bakhtin, 1984, p.110).

The need for therapists to *be responsive* (See Figure 7.4) within the relationships they dialogically build with clients, families and carers is essential. The word, “responsive” can be used within healthcare discourses in different ways. In this thesis, regarding the creation of mindful dialogues, its use does not refer to “responding to an issue” but rather indicates a state and attitude of responsiveness, enabling a deepening of the interpersonal physiotherapeutic relationship that develops in community-based healthcare. Such deepening is dialogical in the sense that all parties to the relationship contribute to it, being sensitive to how the other participants perceive the relationship and what they contribute to it.
Being responsive

**Key elements in the dimension of responsiveness are:**

- Being open
- Becoming emotionally attuned
- Interpreting and advocating clients’ wellbeing
- Caring for the carers
- Helping clients, families and carers take “baby steps” to the future
- Being friendly

Figure 7.4  Being responsive

While the ability of some clients to contribute much to therapeutic relationships can be limited, it is crucial that therapists respond sensitively in all cases. *Being responsive* also relies on the previously mentioned characteristics of being mindful and staying engaged. In the findings from this research, achieving adequate responsiveness was dependent on the physiotherapists’ experience and ability to combine their own inner reflective dialogue and relational dialogue with dialoguing with clients, families and carers. By adopting an open attitude towards the other person and demonstrating respect for the people involved, the physiotherapists were able to provide mentoring and guidance to clients, families and carers as they needed it. Their willingness to cope with ongoing complexity acknowledges and accepts that there can be no final solution to all the difficult issues being faced by clients, families and carers.

When community-based physiotherapists leave their clients at the end of each visit, they inevitably leave them with their chronic and complex healthcare issues. While exploring therapy possibilities for clients with chronic and complex health difficulties, hope can exist because of the ongoing nature of therapeutic relationships. Adam (Dennis’s physiotherapist) commented,

> You always have to keep listening to what actually they are reporting to you, what their difficulties are and what they want to do and that then determines how you then change your program. (Adam)

**Being responsive to constantly refresh one’s insights**

The therapists’ ability to be responsive within clinical relationships allowed them to constantly refresh their insight into clients’ situations and increased the possibility of finding possibilities for planning and evolving the therapy. Responsiveness combined with trust building as relationships developed. This became apparent at many points in
the project. Parallels of this idea can be seen in Gadamer’s (1975) terms; being aware of one’s own biases and prejudices in the attempt to be open to whatever the phenomenon reveals to you. By adopting an open listening approach, which encourages the client or family to confide information about emotionally difficult topics, therapists provided opportunities for building trust, and at the same time, developed a more holistic impression of that person’s life world by a gradual “fusing of horizons” (Gadamer, 1975, p. 305). This term can be used to refer to the interaction that occurs between people in an effort to arrive at a shared meaning. Having an open approach allowed a deepening understanding of where the other is “coming from”, even in the face of disagreement. Such practice is hermeneutic with a melding of the parts, which are the casual conversations, and the whole being the clinical relationship.

Drawing on Gadamer’s ideas, Todres (2008) described this deepening understanding as “embodied relational understanding”. Gradual and increasing understanding provides constant refreshment of one’s insight, incorporating a necessary openness to the “otherness” of particular phenomena. In conversational exchanges between people, the active listening of each voice from the perspective of the other becomes an opportunity to test our own and the other’s ideas in order to determine how we should act and how we should proceed (Zappen, 2000). The experienced physiotherapists in this study demonstrated this ability to constantly refresh their insight.

### 7.3.4 Using Narratives

The findings showed that the development of mindfulness, engagement and responsiveness relies on a narrative style of interaction for physiotherapists in community-based practice. Even though health practitioners from all disciplines listen to the stories that their clients, families and carers tell them to make sense and meaning of a client’s situation it was clear that in the home-based settings of the study these narrative skills appeared to be highly developed. Clients and families, in their turn, rely on healthcare practitioners’ narrative skills to help them make sense of their lives and develop a manageable life story with which to continue.

In today’s healthcare, strict accountability and time constraints can get in the way of the therapist’s professional judgement and the way they work. A narrative approach (as seen in a Mindful Dialogical Relationships model) can help us understand how physiotherapists construct stories for their clients that allow integration of therapists’
craft and expertise with evidence-based practice and the abilities and wishes of clients and families.

**Multi-voiced conversations**

As part of this narrative exercise, community-based physiotherapists liaise and communicate with many people as mentioned above and these *multi-voiced conversations* require careful, mindful care and negotiation, if the wellbeing of the client is to be promoted. Therapists often need to act as a *narrator* in such conversations, they sometimes *patch the narrative* to advocate for and engage with others (clients, family and carers) and they provide flow and momentum to therapy through narratives.

In situations where clients have decreased abilities to communicate independently, families and carers will also use multi-voiced conversations to include clients in the social activities of conversation within therapy. Physiotherapists then become a part of family conversations and stories (See *There's a right way and a wrong way and Jack's way* in Chapter 5). Physiotherapy activities in these community settings intertwine with meaningful human relationships for clients. Physiotherapy interactions can also serve to model care to carers, thereby advocating for clients, carers or family members.

**The role of asking questions**

In order to construct a narrative with which to begin to make sense of clients’ situations from a physiotherapy point of view, therapists inevitably ask questions of clients, families and carers. Such questioning is usually taken for granted as part of a professional interaction. Following analysis of the data, I considered the nature and role of dialogue in this research and in the practice of community-based physiotherapy. A model of question asking from the field of management inquiry called Appreciative Inquiry could prove useful for further studies. This philosophy of change originated with the work of Cooperrider and Srivastva (1987), which used dialogism within a social constructionist framing of inquiry to interact with organisations, helping them to change and develop. “Appreciative inquiry focuses on ‘when things worked well’, encouraging a solution-focused discussion to explore how individuals can do more of what works rather than less of what does not” (Jones et al, 2009, p. 31).

Community-based physiotherapists are not only looking for deficits to assist with but for positives to build on, helping clients to have a more balanced view of their lives.
The narratives they devise with clients reflect such balance. This particular way of using questions comes from the area of systems management but its possible use for the more specific area of interpersonal interaction could provide a fruitful avenue for future research.

7.4 SUMMARY OF THE CONTRIBUTION OF THIS RESEARCH

This research contributes new knowledge to the area of community-based physiotherapeutic relationships and its findings have the potential to be transferable to physiotherapy practice generally and to the practice of other healthcare professions. Implications of this research for future research, practice and education are discussed below.

Previous research regarding home-based physiotherapy for the elderly (Heckman & Cott, 2005) identified the importance of context for the practice of home-based physiotherapy and the need to expand our ideas of knowledge and craft, “beyond the basics” (p. 280) within such practice. research supports and extends these findings; exploring the situations of younger people in community-based physiotherapy (four of the five clients in this research were under 60 years of age) and the craft knowledge of their therapists contributing to the development of their clinical relationships.

More recent Norwegian studies have explored physiotherapy interactions for children with cerebral palsy in school settings (Iversen et al, 2008) and Norwegian psychomotor physiotherapy for people with chronic neck and back pain, seen as outpatients (Øien, Steihaug, & Raheim, 2010). Iversen et al’s (2008) research highlighted the importance of shared, effortless dialogue and meaning construction and co-construction for physiotherapeutic interaction. Øien et al’s (2010) research highlighted the necessity for therapists to be sensitive to and negotiate difficult and dynamic situations to create change and new ways of interacting with each other.

This research reveals an embodied style of physiotherapeutic relationship development perhaps only possible in people’s homes that provide a special context strongly influencing every aspect of the relationship being developed between clients, families and carers. The aspect of private practice within the study added a further dimension that affected relationship development.
Private physiotherapists receive compensation for their work from a variety of different sources (as discussed in Chapter 2, section 2.2.3). Although it was not possible to explore this aspect of financial influence, efforts were made to cover some different methods of payment for service involved.

Eric – Veteran Affairs funding for private physiotherapy

Jenny – Not for profit organisation physiotherapy

Jack – Compensation funding for private physiotherapy

Dennis – Compensation funding for private physiotherapy

Erin – Compensation funding for private physiotherapy (although I understood that this family could have afforded private physiotherapy independently).

The way that such physiotherapy is funded could affect the physiotherapeutic relationship in various and complex ways but it was beyond the scope of this thesis to explore that aspect of the physiotherapeutic relationship. A comparison between public and privately funded physiotherapeutic relationship situations could be a useful avenue of future research to explore.

The number of other influences being considered made for complexity in the research, for example, effort was also made to include in this study, clients with a range of different communication abilities and their families and carers. This mirrors the reality of everyday practice for community-based physiotherapists in private practice and fills a gap within the literature regarding the physiotherapeutic relationships that develop between community-based physiotherapists, clients, families and carers in the provision of physiotherapy for adult people of different ages and communication abilities living at home with chronic and complex healthcare issues.

7.5 IMPLICATIONS FOR PRACTICE

7.5.1 Enabling and sustaining mindful embodied dialogues in practice

An implication of utilising mindful, embodied dialogues in community-based physiotherapy is that physiotherapists generally should be more reflective. There is value for them in stopping to raise their heads above their busy work lives, to look around them, and consider how they enact and frame their practice. Physiotherapists
have a reputation among themselves and among other health professionals as being “heads down, tails up”, working hard. Findings from this research can encourage other therapists to adjust that “busyness” tendency, to create a more mindful balance between action and reflection in their practice.

The need to “raise one’s head above a busy work life” was identified by Adam, one of the physiotherapist participants as an important issue. Adam had been sensitive to his lack of knowledge and experience in human relationship matters, both as a student and later as a practising therapist and wondered why this subject was not brought up for more attention in undergraduate education and ongoing professional development activities. One aspect of this need for reflection was the ability to decide on and negotiate boundaries.

**Negotiating personal and professional boundaries within the physiotherapy relationship is difficult for all parties**

Negotiating boundaries between personal and professional aspects of the physiotherapeutic relationship can be a difficult, anxious and ongoing process for everyone concerned (despite the good will of most people). At the same time, negotiation of boundaries is also an important way for therapists, clients, families and carers to become comfortable with each other and manage the intrusion and inconvenience felt by clients and families who are being visited in their own home by healthcare professionals. A curious paradox also exists in the convenience of being visited in your own home when energy and time are at a premium. The careful presentation of both the personal and professional personas of the therapist seemed to assist in bridging these issues with people. Despite the anxiety felt by some of the therapist participants about this issue, the findings suggested that therapists found the relationships they developed with clients and their families to be rewarding.

> I'm certainly there as the physio but I want to relate on a much friendlier sort of level, I think. I find they end up calling me their friend or part of their family as well, which is a great compliment. That is a gift.

(Comments from Barbara, Eric’s physiotherapist)

The resourcing of participating physiotherapists’ care and effort could be achieved by their accessing the human aspects of the clinical relationship they sought to develop.
The different elements within the *Mindful Dialogical Relationships* model can encourage physiotherapists to consciously develop a coherent and manageable way of developing boundaries within their professional practice in a manner which will meet the needs of their clients and themselves.

**Resourcing clinical relationships within mindful dialogical relationships in practice**

The human and social qualities of therapists, clients, families and carers can become resources for the therapeutic relationship being developed. Such resourcing can help to balance the flow of effort from and to the therapist involved. In this research, motivation for the therapists appeared to come from different sources, the therapists themselves (while *being mindful*), community members with whom they interacted (while *staying engaged*) and their own professional training and experience (allowing *responsiveness*).

*Being mindful* draws on the personal resources of the therapists themselves, who need to take care of and accept responsibility for the developing human relationships between clients, families and carers and themselves. Therapists need to think about and notice aspects of the therapy situation, taking into account and accepting the varying presentations and wishes of the different people involved. Their ongoing and carefully crafted relationship approaches can be conceptualised within a proposed model for practice. The model of *Mindful Dialogues* establishes a common ground of contact upon which the people concerned in community-based physiotherapy situations can build ongoing interaction. The need for *common ground* was also highlighted by Iversen et al (2008), although their study was with children rather than adults.

*Staying engaged* acknowledges the difficulty of staying alert to other people’s concerns and maintaining connection with the people the therapists are trying to help. As therapists strive to *stay* engaged with the people they come to assist, they rely on conversation with those people for topics with which to frame ongoing interaction. As John (Jenny’s physiotherapist) said,

> I think it’s listening to what the subject is and how you can make that connection too.

Resources for this part of the relationship can therefore be sought from the people with whom physiotherapists interact. Such dialogue can form the content and provide
motivation for the conversation needed to maintain interpersonal connection between physiotherapists, clients, families and carers.

**Being responsive** encourages physiotherapists to maintain an open, receptive approach, allowing all concerned parties within the relationship to keep options open for future possibilities. In many situations, these future possibilities will be driven primarily by the knowledge and expertise of the physiotherapist concerned but would also take into account the ideas and experience of everyone concerned. By incorporating the clients’ ideas and perceptions, therapists highlight and enhance the identity of all the people they come to assist.

### 7.5.2 Enacting mindful community-based physiotherapy relationships

This research revealed community-based physiotherapy practice as a complex and ongoing phenomenon. While physiotherapy can enhance patients’ health (particularly mobility and daily activities), its physical benefits were only part of what was needed for clients to be able to achieve a greater sense of wellbeing. Considerable effort was needed by physiotherapists and other people involved in home-based healthcare to help clients fully benefit from therapy. Clients, family members and carers all have a critical role in community-based healthcare twenty-four hours a day, not just while the therapist is “in the house”. Physiotherapists cannot just visit, carry out 30-60 minutes of purely physical therapy and expect positive outcomes. Such complex life and health situations as these clients experienced need something more than therapy. Rather, collaboration in the form of relationship building, shared care/therapy and collaboration in planning therapy that is integrated into people’s lives needs to occur between therapists, clients, family and carers, created within human relationships for the good of the client concerned.

**Collaborating within human relationships**

People live within relationships and these relationships provide the context for the interactions that clients have with healthcare workers. This research showed that attending physiotherapists needed to be mindful of this context and engage in a dialogical process that built relationships while at the same time enabling clients and carers to participate in how therapy was to be framed and implemented. When physiotherapeutic relationships (and therapy) were working well it was because the physiotherapists, clients and carers were collaborating together. I identified mindfulness as a vital key to the success of interactions in such therapeutic collaboration. Such a
relationship must not be a manipulative means of achieving compliance; it is a respectful vehicle for collaboration. Mindful relationships are essential for success in this form of therapy. Relational success here is seen as part of the optimal outcome for the wellbeing of clients, families and carers. This can be applied to practice by therapists routinely reflecting on how well they are managing to “stay in touch” with clients and family care the people they come to assist and how easily other participants in the relationship are able to articulate their needs and wishes.

**Integrating evidence-based practice with human needs**

People with chronic and complex health issues face great uncertainty and depend on healthcare practitioners to help guide them towards improved wellbeing and at least some mitigation of that uncertainty. Such guidance ideally does not spring just from the therapists’ professional knowledge and experience, it is also informed by the narratives of the clients and carers: it is a responsive endeavour. The therapists in the study had to work towards this improved wellbeing in a world dominated by evidence-based practice. Evidenced-based practice in healthcare seeks best health outcomes for clients by adopting treatment founded on the scientific research method. A major problem with this approach is that the scientific research-derived evidence can be based on artificial, acontextual experiments and not be relevant to the complex clinical situations that many therapists and their clients have to confront, such as those in the study. Therapy based strictly on such evidence-based practice aims for certainty but complex situations cannot, by their nature, always be predictable. The unpredictability of real life situations requires interpretation, a greater degree of flexibility and particularity and collaboration. Such an approach requires therapists to develop a rich understanding of the context and complexity of chronic care and home-based care, to generate and test their practice-based knowledge as a complementary source of evidence for practice alongside research-generated knowledge and an appreciation of the role of people’s (therapists’, clients’, carers’) narratives in shaping, modifying and realising successful, individualised and holistic health care practices and outcomes.

One aspect of this collaboration is that people “on their own turf” may not always agree with all aspects of the advice given to them (even if it is evidence-based) when working with their visiting physiotherapists. Within the context of community settings, findings generally indicated that clients and their families felt more empowered in their own homes to change their mind when and how they liked, show mood changes and
generally behave like the real people they were. A good example of this could be seen when Jack decided to leave the research conversation and depart into another room. Such personal agency contrasts with the more apprehensive and disempowered position that patients within an institutional setting can often feel, where they can be under pressure to “toe the line” of that institution.

This means that for therapists, such as those in the study, the challenge in community-based physiotherapy is to integrate their practice-based evidence with research-based evidence – combining both of these sources of evidence - and, just as importantly, to incorporate the narratives and wishes of clients and families.

If we are to follow Sackett et al.’s injunction to integrate individual expertise with the best available evidence, we will need a means of talking about how to do so. A dialogical approach gives us permission to explore, critique and synthesise ideas so that we can talk about clinical reasoning in new and more meaningful ways. 28 (Loftus, 2012, p. 1174)

This integration did occur in the settings of the study. Indeed, the talking referred to in this quote occurred between the people involved in the physiotherapy activity as they negotiated what they wanted from the clinical encounter. The findings show that this negotiation is best understood as a dialogical process within the relational space created by therapists within the therapy situation. The required negotiation means that physiotherapists in these settings have to listen to and consider the voices of many different people. Physiotherapists in these settings must widen their perspectives on what they pay attention to in physiotherapeutic interactions.

A key issue related to this research is that therapist participants were experienced physiotherapists. The success of their mindful dialogues was due to the richness of their practice experience, their awareness of the value of narratives and dialogues derived from their reflections on practice and their chosen work context and practice models. For therapists new to community-based physiotherapy and to chronic care, such narratives and experiential knowledge are likely to be missing or only emerging. The implications of this novice-experienced differential in capabilities and insights will be further discussed below in relation to practice and educational implications of this research. Therapists need to develop their narrative and dialogical abilities for practice. Reflection through talking with other practitioners needs to include the what, why, when, where, who and how of practice. These are narrative skills. It became obvious in

28 Sackett, Richardson, Rosenberg, Haynes (1996) argued that the best possible evidence needs to be combined with the clinician’s expertise.
the focus group which was conducted with participant physiotherapists for this research, that the therapists benefited from such discussion of the narrative and relational ways they practised their therapy. Talking in group situations like this or in one-to-one relaxed conversations between physiotherapists can be invaluable for therapists at any level of expertise for both personal and professional support, but especially in the early years. Such talk needs to be separate to clinical supervision although that avenue is of great value as well.

*Listening to and considering the voices of many different people in community-based physiotherapy*

When illness or disability is present for people living at home, significant help from other people is usually needed. Negotiation and collaboration must be sought from a variety of people if all viable health care and life capacity building options and choices are to be properly explored for clients and the efforts of the carers best supported. Clients can then engage with physiotherapy in a way that is acceptable to them and more likely to bring about desired outcomes.

Edwards et al (2004), in identifying different styles of knowledge exchange between physiotherapists and their clients argued for a collaborative model of decision-making in physiotherapy practice, allowing for exploration of polarities within physiotherapy processes. Their research supported that of Mattsson, Wikman, Dahlgren and Mattsson (2000) who proposed that physiotherapists’ overall method of working could be viewed as “the art of adjusting” (p. 125).

Findings arising from this research also shed light on this “art of adjusting”. Therapists made careful efforts to engender good will and promote collaboration towards goals that were mutually agreed upon between practitioners, clients, carers and family members. Emphasis needs to be put on the term, “mutually agreed upon” because without that essential aspect of the clinical relationship and its outcomes, collaboration is just a buzzword for policy documents. The collaborative efforts of all the participants in this research were seen to be embodied within the relationships that developed between physiotherapists, clients, families and carers. Physiotherapy cannot really be successful without such collaboration, particularly as the actual physical *movement work* for clients needs to take place when the physiotherapist is not there as well as when they are. Collaboration needs to be seen within practice as an ongoing activity. It is a difficult process, constantly demanding of therapists that they balance their professional views with their clients’ views and opinions. It requires therapists to stay within the space of
the interpersonal relationship with clients, families and carers and avoid withdrawing into a purely technical relationship.

7.6 IMPLICATIONS FOR PROFESSIONAL DEVELOPMENT AND PROFESSIONAL ENTRY CURRICULA

Most of the physiotherapist participants were very experienced in the field of community-based physiotherapy. However, it seems that practitioners such as these rarely come together to share their insights. There is always a danger that their practice wisdom can be lost when they eventually leave the profession. It can be argued that such experienced professionals should be provided with the opportunity to regularly meet and be encouraged to share stories of their practice, in ways that allow the subtleties of Mindful Dialogical Relationships to emerge and be articulated. Wenger (1998) argued that such coming together can help establish a community of practice where participants can encourage and motivate each other as well as troubleshoot each other’s practice problems. The model of Mindful Dialogues can be a tool for organising such conversations. However, a real benefit of such a community of practice would be for more junior and less experienced practitioners who are experiencing the challenges of community-based care and who are looking for ways of meeting those challenges. There is every reason to believe that they could benefit enormously from hearing the practice stories of the more experienced practitioners, particularly if those stories are articulated within the model of Mindful Dialogues. Within undergraduate curricula, there is a recognition that students need to become aware of the clients’ or patients’ situation, personally as well as clinically. Mindful Dialogical relationships provide a way of introducing different ways of approaching the interpersonal relationships that will enable them to become aware of and connect with the experiences of those people.

More generally, students could benefit from more exposure to ideas from other disciplines such as anthropology, sociology and philosophy and even literary theory. These disciplines have influenced the development of this model of care, and the model can provide a useful springboard, introducing ideas that can inform physiotherapy practice beyond the purely technical rational approach of the biomedical sciences.
7.7 REFLECTIONS ON THE METHODS USED IN THIS RESEARCH

Discourse to develop practice

Qualitative research is becoming more prevalent within the discipline of physiotherapy. There is a growing number of examples of qualitative research that have connections to this study, including studies exploring concepts such as hope (Wiles, Cott & Gibson, 2008) and the place of the body in physiotherapy (Nicholls & Gibson, 2010). Phenomenology is increasingly accepted as a legitimate theoretical framework and approach for physiotherapy to research experiences of other people, especially clients and their families (Shaw & Connolly, 2012).

Working healthcare professionals, as well as academics, can benefit from new ideas from disciplines and discourses besides those of the biomedical and technical rational. Methodologies such as hermeneutic phenomenology and narrative inquiry have provided new theoretical lenses through which physiotherapists can understand their practice. There are many aspects of the way we practise as physiotherapists that can be opened up to deeper understanding through the use of such lenses. From my experience, working physiotherapists generally tend to feel excluded from the world of academic research but there are many questions that arise in practice, which would make interesting research projects for practitioners as well as academics. If this situation is to change then practitioners need to develop a range of research skills such as better critical thinking to give them the confidence to engage in such projects.

My experience of using ideas from a range of disciplines outside mainstream physiotherapy has allowed me to develop an awareness of the importance of critical thinking. I suspect that the importance of critical thinking is not fully acknowledged by healthcare professionals. How can we become more critical in our practice unless we can develop ourselves personally, interpersonally and socially to become more aware of these different spheres of our practice? A hermeneutic approach has proved particularly useful for that process.

The value of a hermeneutic approach

The experience of this doctoral journey has expanded my reading and thinking considerably. In particular, ideas I have gained from philosophical literature have confirmed and expanded many quiet questions and wonderings from different stages of
my life; ideas about the experience of time, consciousness, interaction with other people and how that affects us as developing and interactive human beings. Seemingly small questions ranging back as far as my childhood have been resurrected, articulated in the literature that I have been exploring.

I have found some of the literature challenging and have learned to value the strategy of revisiting it again and again, in order to deepen my thinking and progress this research. Iterative reading and thinking has slowly helped me to learn to hermeneutically and critically “ask the next question”, a process so important to the development of practice. I think that many practitioners could benefit from the opportunity to develop such hermeneutic awareness. A hermeneutic approach can allow one to see situations from the viewpoints of others. In my case, for example, it also allowed me to appreciate the mirroring that can occur in practice.

**The metaphor of mirroring**

Mirroring occurred between my chosen research method of constructed narratives (commonly used in qualitative research, particularly phenomenology) and the realisation that community-based physiotherapists also use narrative dialogical activities to develop their therapeutic relationships. Taking this wider view, mirroring can be used as a tool to grasp the issue of multi-voicedness in community-based healthcare situations. Frank (2004) argued for a deeper level of interpersonal interaction in healthcare.

> My ideal clinic is where each participant – medical workers, patients, volunteers, and friends – sees what is happening in all the possible refractions of the mirrors of one another’s perceptions. Each is constantly asking: what does this look like to them, from where they are? (Frank, 2004, p. 44)

The metaphor of mirroring allows a greater appreciation of the dynamic and nuanced nature of the interaction between community-based physiotherapists, clients, families and carers and its dialogical nature. By **being mindful**, community-based physiotherapists can ask: what might this look like to them, from where they are? By **staying engaged** and employing the resources of conversation (listening and talking), therapists mirror the skills and experiences of these people in the therapy process. Physiotherapists can become more responsive to the people they come to help by learning to see and appreciate what is happening “in all the possible refractions of the mirrors of one another’s perceptions”, including using their lens of physiotherapy practice.
Developing an eye and an ear for “the poetic”

People make meaning of their experiences in conversation with other people and are often powerfully influenced by imagery; poetic phrases within dialogue can offer a means of coming to a deeper understanding of those personal meanings. The use of poetics within the data analysis phase of this research enabled me to more clearly identify issues within the data that appeared to have greater meaning for participants. Poetics was used as part of this hermeneutic research process, articulating my role in the research, facilitating data analysis and assisting presentation of phenomenological findings where I shared some of the words of participants with others. The resonance that I felt on hearing particular terms could also be seen in other people hearing those “poetic flags” for the first time. Communication to others about the meaning in the research that I had conducted was enhanced by such use of poetic phrases. I further noticed this effect when I returned to practice. Particular terms used by clients, carers and family members seemed to leap out to me, stimulating further reflection about how some word combinations can be particularly evocative.

Poetics can illuminate a phenomenon of interest in ways that can resonate with readers and provoke thought in memorable ways. New ideas emerging from practice might then better succeed in entering the larger discourse of a professional practice, in this case; physiotherapy. If a poetic phrase moves from the conversation of a participant into the lexicon of practice for a particular discipline, then that participant’s voice will have been truly heard. This is one way in which our clients really can collaborate in developing our practice but only if we hear them.

7.8 IMPLICATIONS OF THIS RESEARCH: FUTURE RESEARCH DIRECTIONS

This research contributes significantly to expanding knowledge about and informing the practice of area of community-based physiotherapy practice and has implications for future practice, education and research. It also supports the personal aspirations of individual physiotherapists striving for success in any of these areas and seeking a sense of meaning and work/life balance. Along with the hermeneutic method employed for this research, the findings are hermeneutic in nature; providing a thoughtful and iterative approach to managing complex situations in chronic and complex healthcare.
Within the area of community-based physiotherapy practice, physiotherapists work mostly away from other physiotherapists in situations that involve much autonomy and responsibility. In contrast to more formal clinic situations, such therapy can offer more opportunities for reflection within a workday. This research has focused on a specific phenomenon but the act of that focus raised other questions about community-based physiotherapy which were outside the scope of this project. Those questions remain as possibilities for further research. Opportunity exists to plan a series of comprehensive studies arising from this study, including:

- the retention of community-based physiotherapists in practice
- relationship approaches practised by publically-funded community-based physiotherapists
- clients’ and family’s roles in in decision-making within community-based physiotherapy
- people receiving community-based physiotherapy who have communication difficulties
- haptic elements of community-based physiotherapy
- phenomenological applications for education of community-based physiotherapists.
- testing the transferability of these findings by exploring the differences in relationship-based practice between novice and experienced community-based physiotherapists

**Researching the retention of community-based physiotherapists in practice**

A broader application of relational mindfulness to the practice of community-based physiotherapists could allow them to better manage work/life balance and the ability to continue within their profession. It was noticeable that several of the therapist participants in this research had been practising in private community-based physiotherapy practice for many decades and led fulfilling professional lives. This area would provide an interesting area for possible research.

**Researching relationship approaches practised by publically-funded community-based physiotherapists**

This research concerned the practice of privately practising community-based physiotherapists but it would be interesting to also research the practice of publicly
funded community-based physiotherapists and compare and contrast the two forms of practice. Of particular interest in modern healthcare are the areas of physiotherapy practice involved with ACAT (Aged Care Assessment Teams), palliative care and transitional care (from hospital to home).

**Researching clients’ and family’s roles in decision-making within community-based physiotherapy**  
An interesting issue arose from this research. Who was really managing the healthcare situation for clients and who was making the clinical decisions? Comments from client and family participants suggested that therapists do not always make the decisions. This issue was hinted at by some participants but not consistently enough to be considered as a finding. However, it is a hidden issue within physiotherapy practice, related in part to the small amounts of time that therapists have contact with clients. Future research could be extended to examine more deeply clients’ and carers’ responsibilities and roles within healthcare relationships. Full examination of these factors was obviously beyond the scope of this research.

**Researching with people receiving community-based physiotherapy who have communication difficulties**  
Research with and for people who have limited communication would seem to be best conducted by speech pathologists but it could be of value to incorporate the skills of a physiotherapist practitioner-researcher in such studies. In particular, videoed data could be facilitated by the insights of a research physiotherapist. Making the effort to spend research time with clients with communication problems could also provide physiotherapists with alternate views of how they might enhance communication with these people as well as possibly revealing how physiotherapists really interact with them, rather than how they think they communicate with clients.

**Researching haptic elements of community-based physiotherapy**  
I have previously mentioned that this research has not been able to extend its scope to include the haptic (physical) aspects of community-based physiotherapy in home settings. Videoing data for research could include use of space within such clinical relationships and explore those aspects within the physiotherapist care and family interactions as well. Because such relationships develop over time, it could also be useful to do such research by staying with clients and families over longer periods of time and interviewing them at regular times throughout their developing physiotherapeutic relationships.
**Researching phenomenological applications for education of community-based physiotherapists.**

A study into the use of Frank’s narrative styles in illness was conducted with physiotherapy students to explore the way they encountered and experienced the different narratives of people with spinal cord injury (Soundy, Smith, Cressy et al, 2010). “For the patient, being heard by a therapist, regardless of the story, has value and this has to be recognised as an important part of training and care delivery” (p. 56). Further research in this area of the contributions that clients/patients can make to the education of physiotherapists could incorporate more phenomenological ideas, for example, the possibility of clients being clinical tutors for physiotherapy students, not necessarily in terms of clinical expertise but rather in terms of relating in human terms with people with disability or with communication disorders; practising seeing things from their point of view without having an initial agenda to consider other than “getting to know you”.

**Testing the transferability of these findings by exploring the differences in relationship-based practice between novice and experienced community-based physiotherapists**

It would be possible to conduct a similar research project with novice physiotherapists to explore their experience and understanding of complex community-based care. Similar research projects could also be conducted in different locations with different participants and different demographics and from different socioeconomic backgrounds. This would permit the transferability of the findings to be tested.

### 7.9 CONCLUSION

Many years ago, I chose to be a physiotherapist. It is a wonderful profession, full of challenge, surprise and wonder. I came to this research to explore an aspect of my professional practice that has always intrigued me, the way that human relationships influence physiotherapy practice and possible outcomes for clients and their families.

It is important to think about how we practise as well as what we practise. Such reflective thinking can have implications for ourselves as people as well as therapists, assisting us to develop satisfying work lives with our clients and their families. Creating
productive relationships within home-based healthcare situations involves the use of our heads, hearts and hands. It is person-centred care. It is also relationship-centred care.

Mindfulness, engagement and responsiveness are necessary components of community-based physiotherapy relationships. The practice model of Mindful Dialogues that I have proposed promotes the building of sustainable relationships for community-based physiotherapists working with and for clients living at home with chronic and complex health care problems. It provides a useful framework for considering other issues in clinical relationships as well, for example, communication for safety in healthcare for people with limited communication. The interweaving of personal and professional dialogical spaces in physiotherapy practice and working with narratives as well as more “clinical” data is challenging and complex but such integration can allow the development of relationships that are therapeutic in the full sense of the word.

Having developed the Mindful Dialogical Relationships practice model, I applied it to my own practice. I have found it to be a powerful reflective tool to enhance awareness of that practice. Only recently, the wife of a client followed me out to the car to thank me for spending so much time with her husband to explore what was important for him. As I drove away, I realised that I had actually been there for a shorter time than I would normally have allowed. This relationship building drew on a proposed practice model to examine and extend practice approaches. I am seeing my practice and practice relationships in a new mindful light.

As for me,

I wash my hands.

I smile,

I lift my face to the sun as I leave

I open the car and sink into the hot interior,

Letting the heat soak into my body, cover me like a coat.

I drink some water, check my diary for where I must be next

I turn on the cool air

I drive away
REFERENCES


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http://dx.doi.org/10.1007/BF01955967


APPENDIX A

PARTICIPANT INFORMATION SHEETS
Research Project Participant Information Sheet

**Title:** “Reconceptualising Physiotherapeutic Relationships in Community-based Chronic and Complex Healthcare”

**What is the study about?**

This project seeks to study the way physiotherapists practise person-centred care for people with chronic and complex health problems in their own homes and in the community. The project also seeks to study the way clients, carers and families interpret that physiotherapy care.

**Who is carrying out the study?**

The study is being conducted by Diane Tasker, BPhty (Qld) as part of the requirements for a PhD under the supervision of Dr Stephen Loftus, Senior Lecturer, and Professor Joy Higgs, Strategic Research Professor at the Education For Practice Institute, Charles Sturt University.

**What does the study involve?**

You will be asked to take part in one to three interviews that will be audio-recorded. The researcher can conduct interviews in your own home, or any other location that is convenient. Interview questions will be about the care you receive (and have received) from community care physiotherapists. The research may not benefit you directly but it is hoped that physical therapy practice might improve as a result of the research.

**How much time will the study take?** 1-3 interviews lasting up to an hour each.

**Can I withdraw from the study?**

Being in the study is completely voluntary and you are under no obligation to participate. You are also free to withdraw from the study at any time without prejudice or consequence. There is no anticipated risk, physical, financial or emotional that will be created by your participation.
People participating in focus groups should be aware that it might not be possible to remove all information provided by focus group participants as their input may have triggered further discussion. Every attempt will be made to withdraw their comments but in some circumstances, it may not be possible to totally remove their comments.

**Will my results be kept private?**

All aspects of this study, including the results will be strictly confidential and only the researchers will have access to the data. Reports of the study will be submitted for publication but individual participants will not be identified in such a report.

**Can I talk to other people about the study?**

Yes, you are welcome to discuss this study with anyone you choose.

**Where can I get further information?**

You are welcome to talk further with the researcher, Diane Tasker, at any time during the process of this study. You can contact her by phone: (02) 47573362 or by email at ditasker@bigpond.com If you would like to speak further with her supervisor, you can talk to Dr Stephen Loftus during work hours by phone: (02)88388964 or by email sloftus@csu.edu.au

**NOTE:** Charles Sturt University’s Ethics in Human Research Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer  
Ethics in Human Research Committee Academic Secretariat  
Charles Sturt University  
Private Mail Bag 29  
Bathurst NSW 2795  

Tel: (02) 6338 4628 Fax: (02) 6338 4194

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.
Dear

Thank you for agreeing to take part in a focus group for the research project: 

“Reconceptualising Physiotherapeutic Relationships in Community-based Chronic and Complex Healthcare”

As you know, this project seeks to study the way physiotherapists practise person-centred care for people with chronic and complex health problems in their own homes and in the community. The project also seeks to study the way clients, carers and families interpret that physiotherapy care.

An agenda of discussion topics is attached for your interest. Please do not hesitate to contact me if you would like to discuss the program in any way.

You will be one of five therapists attending the focus group session with facilitator Diane Tasker (PhD candidate) and observer, Dr Stephen Loftus (Supervisor)

Venue: The Education for Practice Institute
16 Mason’s Drive
North Parramatta
P: (02) 8838 8911
(A map is attached. Parking is available on site)

Date: Wednesday 11\textsuperscript{th} August 2010

Program of events:
11.30-1.00pm Focus group session
1.00-.200pm Lunch is to be provided.
It is anticipated that lunch will provide a pleasant way for everyone concerned to connect with each other professionally and personally. It is also a way of thanking you all for your support and participation throughout this project.

We look forward to seeing you.

Yours truly,

Diane Tasker
(PhD candidate)

Dr Stephen Loftus
(Deputy Director, Institute of Education for Practice)
APPENDIX B

PARTICIPANT CONSENT FORM
PARTICIPANT CONSENT FORM

Title:
Reconceptualising Physiotherapy Relationships in Community-based Chronic and Complex Healthcare.

Principal Investigator: Diane Tasker
ditasker@bigpond.com

Supervisor: Dr Stephen Loftus BDS, MSc, PhD
sloftus@csu.edu.au

The Education for Practice Institute
Charles Sturt University
16 Masons Drive
North Parramatta
NSW 2151
Tel 02 47573362
Fax 02 47573362

In giving my consent, I acknowledge that

- The purpose of the research has been explained to me including the (potential) risks/discomforts associated with the research.
- I have read and understood the information sheet given to me.
- I have been given the opportunity to ask questions about the research and received satisfactory answers.
• I understand that I am free to withdraw my participation in the research at any time, and that if I do and will not be subjected to any penalty or discriminatory treatment”.

• I understand that any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published without my written permission.

• I understand that interviews/focus groups will be audio taped”.

Charles Sturt University’s Ethics in Human Research Committee has approved this study. I understand that if I have any complaints or concerns about this research I can contact:

Executive Officer  
Ethics in Human Research Committee  
Academic Secretariat  
Charles Sturt University  
Private Mail Bag 29  
Bathurst NSW 2795  
Tel: 02 6338 4628 Fax: 02 6338 4194

Signed by: .............................................................

(In the case where the participant is under the age of 18 or is unable to sign due to physical or cognitive difficulties, the signature indicating consent may be completed by that person’s legal guardian.)

Date: .............................................................

Thank you for your participation.
APPENDIX C

INTERVIEW AND FOCUS GROUP GUIDES
Interview Guide (Clients, families and carers)

Introduction:
Ensure participant’s comfort and let them know how long the interview will be.

Outline the different parts of the interview you would like to cover within the interview and assure them that you can meet again with them if they feel there is more they would like to contribute or if more information is needed.

Outline the goal of the study. (We are trying to find out how community-based physiotherapists develop good person-centred relationships with their clients and their families and carers.)

Is there anything about the study you would like me to tell you before we begin?

Background:
Tell me about your situation, your story?
How did you get involved with your physiotherapist?
What issues were you hoping that the physiotherapist might address?
What else were you hoping for? This may be a more general wish.
What sort of general background do you have?

Previous perceptions of physiotherapy:
Had you or anyone near you had any sort of contact with a physiotherapist before?
How did you find those experiences?

Perceptions of first meeting with physiotherapist:
Do you remember how you felt about that meeting?
What did you think of the therapist’s approach and how they interacted with you and other members of the care team?
Was there anything particular that the physiotherapist did, that you remember as making an impact on you or the situation? “Paint me a picture.”
For example:
	Do you remember how the physiotherapist used her/his voice when interacting with you or other members of ‘the team’?
	Do you remember how the physiotherapist used her/his body or hands when interacting with you or other members of ‘the team’?
	Do you remember how the physiotherapist used her/his gaze when interacting with you or other members of ‘the team’?

Perceptions of what occurs within a session with the physiotherapist:
Do you remember how the physiotherapist interacted with the client (Name them)?
What did the physiotherapist do?
How did the physiotherapist talk to you and the client (Name them)
How did this affect the client and their situation?
How did they interact with you and how did that interaction make you feel?
Was there anything particular that the physiotherapist did, that you remember as making an impact on you or the situation?

**Perceptions of occurrences after and between meetings with the physiotherapist:**
How did the client (name them) react or respond after the meeting/s with the physiotherapist?
Do you remember any particular developments that occurred after or between meetings with the physiotherapist? (This may be aside from activities that occurred within the physiotherapy meetings).

**Looking at the overall development of the physiotherapeutic relationship:**
How would you describe your relationship with the physiotherapist?
How would you describe the relationship between the physiotherapist and the client (name them) and/or the other members of ‘the team’
Can you describe how you think your relationship with the physiotherapist developed and how it developed for the other members of ‘the team’ from your perspective.
What do you think were the most important parts of that relationship for the client (name them) and for you?
Can you tell me about a particular incident or occasion that impressed itself on you as a good example of the way the therapy relationship had developed?

**General Questions:**
How has your interaction with physiotherapy in this situation altered how you think about things?
What have you taken from that situation?
After this physiotherapy experience, how might you approach such a situation again?
If you could give advice to a young physiotherapist just starting out, what advice would you give them about establishing and maintaining their physiotherapy relationship with their clients and families?
What “dos” and “don’ts” could you list?
Interview Guide (Physiotherapists)

Areas of questioning

Introduction:
Ensure participant’s comfort and let them know how long the interview will be.
Outline the different parts of the interview you would like to cover within the interview and assure them that you can meet again with them if they feel there is more they would like to contribute or if more information is needed.
Outline the goal of the study. (We are trying to find out how community-based physiotherapists develop good person-centred relationships with their clients and their families and carers.)
Is there anything about the study you would like me to tell you before we begin?

Background:
Tell me about the particular physiotherapy work you do?
How did you get involved with this client?
What issues were you expecting you may need to address for this client?

Perceptions of first meeting with physiotherapist:
Where did the meeting with the client take place?
How did the session go?
What approach did you take with the client and their carers.
How did they interact with you?
Was there anything particular that you did, that you felt may have made an impact on the client or the situation? “Paint me a picture.”
For example:
   Do you remember how you used your voice when interacting with the client and their family.
   Do you remember how you used your body or hands when interacting with the client and other members of ‘the team’?
   Do you remember how you used your gaze when interacting with the client or other members of ‘the team’?

Perceptions of what occurs within a session with the physiotherapist:
Do you remember how you interacted with the client (Name them)?
What sort of activities did you do?
How did the you talk to the client ( name them)
How do you think this may have affected the client and their situation?
How did they interact with you and how did that interaction make you feel?
Was there anything particular that you did, that you hoped would make an impact on the client or the situation?
Perceptions of occurrences after and between meetings with the physiotherapist:

Do you remember any particular developments that occurred after or between physiotherapy meetings with the client? (This may be aside from activities that occurred within the physiotherapy meetings).

How did you change your approach to the client and ‘care team’ after the first physiotherapy session.

Looking at the overall development of the physiotherapeutic relationship:

How would you describe your relationship with the client?

How would you describe the relationship between yourself and the client (name them) and/or the other members of ‘the team’

Can you describe how you think your relationship with the client developed and how it developed for the other members of ‘the team’ from your perspective.

What do you think were the most important parts of that relationship for the client (name them) and for you?

Can you tell me about a particular incident or occasion that impressed itself on you as a good example of the way the therapy relationship had developed?

General Questions:

How has your interaction with this client and their ‘care team’in this situation altered how you think about things?

What have you taken from that situation?

After this physiotherapy experience, how might you approach such a situation again?

If you could give advice to a young physiotherapist just starting out, what advice would you give them about establishing and maintaining their physiotherapy relationship with their clients and families?

What “dos” and “don’ts” could you list?
Topic agenda for therapist focus group:

Feedback regarding the individual interview process from each participant:
It may be useful to reflect on the interviews you had with me. How did you find the interview? Were there any particular issues that you consider might be important when considering the physiotherapeutic relationship and the provision of person centred care to people at home. Were there any issues that you would like to explore further with the other therapists present?

Possible topics to discuss:
Other topics that have emerged as themes from the data may then be discussed:

- Family care teams- is there such a thing and who is in it?
- The home as a workplace -what is the work of healthcare and who does it?
- Ways in which the therapist might converse with their clients, families and carers – strategies that you use to help deepen and maintain the clinical relationship?
- Physical interactions within the clinical relationship and their importance to the clinical relationship?
- Bridging the gap between what the client and family want and what you can provide? What is in that gap?
- The place and importance of non-clinical communication within the clinical relationship?
- Boundaries between personal and professional and how this can be explored and managed by the therapist?

Roundup and reflection:

- Share some issue from this focus group that resonated for you regarding community-based physiotherapy practice.
- What would you like to see developed within physiotherapy education with regard to physiotherapeutic relationship building skills?
Physiotherapy in Australia - Definition of Physiotherapy as a Profession
(Australian Physiotherapy Council 2008)

Physiotherapy in Australia

“Physiotherapy in Australia involves a holistic approach to the prevention, diagnosis, and therapeutic management of disorders of movement or optimisation of function to enhance the health and welfare of the community from an individual or population perspective. The practice of physiotherapy encompasses a diversity of clinical specialties to meet the unique needs of different client groups. Most patients treated by physiotherapists have musculoskeletal, respiratory or neurological disorders. Obstetric, psychiatric and other types of patients are also treated.

The practice of physiotherapy in Australia uses an evidence-based, clinical reasoning process. The physiotherapist is a primary contact practitioner and may undertake the following activities: the performance of physiotherapy assessments, including diagnosis, and the treatment of any injury, disease, or other condition of health, or the prevention or rehabilitation of injury, disease, or other condition of health. Physiotherapists may use physical interventions, and/or exercise prescription and/or electro-physical agents within a framework of empowerment of the individual/carer or the community through education. Practice is informed by physiotherapy specific research and the general scientific literature. In this way physiotherapists in Australia engage in evidence-based practice. Physiotherapists may practise in a general or specialised hospital, or in a specialised unit, for example, intensive care, paediatrics, geriatrics and obstetrics, with in-patients or out-patients. Physiotherapists may also practise in special schools, community health centres, health clinics, nursing homes, psychiatric clinics, government agencies, industry, sports clinics or they may establish a private practice. Some patients are treated at home or, in some Australian States, through domiciliary nursing care centres.”

(Australian Physiotherapy Council, 2008) Page 3

The Australian context is further defined within this document:

“Australia has a federal system of government and is divided into six independently governed States and two Territories. Each Australian State and Territory has separate legislation covering the recognition of physiotherapy qualifications. (However, under the Mutual Recognition Act, subject to certain conditions, if a person is registered to practise an occupation in one State or Territory, they can carry out an equivalent occupation in any other State or Territory). To practise physiotherapy you must be registered with the local State or Territory physiotherapy registration authority. The unregistered practice of physiotherapy is illegal.” (Pge 2)