

Running Head: Working Alliance in Occupational Therapy

Working Alliance and Functional Outcomes in an Occupational Therapy Intervention:
A Cross Case Analysis

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Abstract

This is the first known occupational therapy (OT) study to examine the emergent patterns of the client-therapist working alliance during the course of a community-based OT intervention. The experiences of both the adult client and OT in each of four dyads are explored and described as they relate to the evolution of the alliance over time and the impacting contextual factors. These experiences were considered alongside the therapy outcomes. Mixed methods, including quantitative scales and interviews, were used in this multiple-case study situated within a pragmatism paradigm. Individual case and cross case analyses were conducted leading to the identification of eleven cross case themes. These findings suggest that the interpersonal relationship between a client and OT develops with the goal of becoming a safe harbour for the clients. The strengthening interpersonal bond appears to create an impetus within the client to engage in therapeutic activities. This enticed engagement results in the client's performance of novel activity purposefully selected by the OT as bearing personal meaning for the client. The clients' engagement often results in enhanced insight into their abilities and meaningful functional gains. This success appears to reinforce and energize both the momentum toward the collaboratively-established therapy goals, as well as provides a positive feedback mechanism into the working alliance. The OT's training, philosophy and skill, client's attributes, and environmental influences (both physical and social) all appear to have potential implications upon the working alliance's development and/or the therapeutic achievements. Further research will be needed to confirm or disconfirm these findings and may include further study with variable client populations (e.g., different ages, different conditions), the role of humour in the therapeutic

process, the impact of client's degree of social isolation on the alliance, as well therapists' disparate levels of use-of-self and the related impacts upon the alliance.

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Chapter 1: Statement of the Problem

It is commonly recognized in the occupational therapy (OT) profession that positive therapeutic outcomes depend on the quality of the relationships forged between clients and their therapists (Cole & McLean, 2003; Taylor, Lee, Kielhofner, & Ketkar, 2009). This is in fact not a new idea. Ora Ruggles, an occupational therapy pioneer, has been cited as saying: “It is not enough to give a patient something to do with his hands. You must reach for the heart as well as the hands. It’s the heart that really does the healing” (Carlova, 1961, p. 249). In this chapter, I will describe the discipline of occupational therapy, its core assumptions and values, and how OT perceives that therapeutic relationship is of central importance. Related gaps in the occupational therapy literature will be discussed as a rationale for this study. Finally, I present an overview of the structure of this dissertation.

Relationships are foundational to human experience. The positive implications of an individual’s sense of connectedness to others and the environment are appreciated across varied disciplines including occupational therapy, education, and counselling. According to attachment theory, healthy development in childhood depends to a significant degree on having a positive and close attachment to parental figures (Bowlby, 1988). More recently, the construct of a distressed adult client’s attachment to a reliable, accessible, and trustworthy therapist has been studied (Ross, 2006; Skourteli & Lenni, 2011). The alliance between a client and psychotherapist has come to be conceptualized as an attachment relationship with roots in the much earlier caregiver-infant relationship (Mallinckrodt, 2000; Strauss, 2000). Similarly, it could be expected that a positive and close attachment between a client and therapist within an occupational therapy intervention could provide a similar context conducive to client learning, growth, and development.

Occupational Therapy

Polatajko, Davis, et al. (2007) provide the following definition of occupational therapy:

Occupational therapy is the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life (p. 27).

Science is based on rational knowing. Art, on the other hand, is highly subjective, intuitive, and relativistic. The definition of occupational therapy looks to merge the two diametrically dissimilar cultures. Gilfoyle (1987) called for the synthesis of rational and intuitive knowledge into an action process of applying scientific knowledge to human experience. Therapists' scientific training teaches them what to do, but many consider there is a void in training how to do it, in other words the delivery method (Peloquin & Davidson, 1993; Cole & MacLean, 2003; Taylor 2008).

The Canadian model of client-centred OT practice is respected internationally (Baron, Kielhofner, Iyenger, Goldhammer, & Wolenski, 2006). This model embraces the spirit of Rogers' (1961) client-centredness. By using a client-centred approach, the therapist listens to the client's story and description of needs, which enhances the dyad's ability to work collaboratively to solve meaningful functional performance issues (Law & Mills, 1998). Within this model, occupation is the core domain of the profession and enablement is the core competency (Townsend & Polatajko, 2007, p. 2). Occupational therapists perceive engagement in meaningful occupation as a basic human need. The Canadian Association of Occupational Therapists (CAOT) (1997) has defined occupation as follows:

Occupation refers to the groups of activities and tasks of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity) (p. 34).

In fact, it is held that meaningful occupation is a major factor of health, well-being, and justice (Polatajko, Backman, et al., 2007). Occupations are, however, idiosyncratic. That is, individuals determine their own meaningful occupations and the level of importance and degree of satisfaction attributed to each occupation. A client's occupations are anticipated to vary substantially given internal and external factors such as life stage, ability, opportunity as well as cultural, institutional, physical and social factors of the environment (Polatajko, Backman, et al., 2007). Thus, in addition to the client-centred approach to enabling clients' participation in meaningful occupations, occupational therapy is set apart from other disciplines within the health care sector by its holistic appreciation of clients as well as their environments.

Therapeutic relationship in occupational therapy. Occupational therapists have long embraced the importance of the therapeutic relationship with clients. In the early twentieth century, occupational therapy leaders emphasized the utility of the therapeutic relationship in the humanistic encouragement of occupational engagement (Kielhofner, 2004). In the 1940s, the profession was swayed by the dominance of the medical profession. During this phase, the emphasis was on the elimination of pathology (Kielhofner, 2004). In the mid 1960s, however, there was a return to the focus on occupation and its inherent values. Peloquin (1990) charts a fluctuation over the years in the emphasis of two disparate

paradigms: clinical technique and humanistic caring. Peloquin also noted that a novice therapist may emphasize technical skills while striving to be recognized as a scientific practitioner. A more experienced and confident therapist, perhaps leery of an overemphasis on technique, may more readily focus on caring.

Alongside a contemporary emphasis on occupation, discussions have emerged regarding the importance of the client-therapist relationship. Occupational therapists firmly believe that the therapeutic relationship impacts therapy outcomes (Cole & McLean, 2003; Taylor, 2008). Despite the importance of the therapeutic relationship to effective therapy being well recognized in occupational therapy literature, a definition of the construct was only recently developed. By surveying occupational therapists, Cole and McLean (2003) developed the following commonly accepted definition of therapeutic relationship: “A trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy, and mutual respect” (p. 49). In comparison, many years previous, a definition of the therapeutic relationship was provided in the field of psychotherapy: “the feelings and attitudes that counselling participants have toward one another, and the manner in which these are expressed” (Gelso & Carter, 1985, p. 159). Three constituent elements of the therapeutic relationship in psychotherapy were also identified as working alliance, the transference relationship, and the real relationship (Greenson, 1967). Bordin (1979) subsequently defined the working alliance (also referred to as the therapeutic alliance in the psychotherapy literature) as comprising three essential components including: interpersonal bonds (liking, trust, and respect); agreement upon the goals or very purpose of therapy; collaboration on the therapeutic, in-treatment tasks. In contrast, the OT literature has not further elucidated the components of the therapeutic

relationship, but rather has focussed on clinical implications. For example, beyond defining the dimension of therapeutic relationship (Cole & McLean, 2003), OT research has identified the therapist characteristics conducive to a client's experience of a positive therapeutic relationship (Darragh, Sample, & Krieger, 2001), the value attributed to the therapeutic relationship by either therapists or clients (Cole & McLean, 2003; Palmadottir, 2003; Palmadottir, 2006; Prochnau, Liu & Boman, 2003), and the development of therapeutic relationships with family caregivers (Clark, Corcoran & Gitlin, 1995; Hinojosa, Sproat, Mankhetwit & Anderson, 2002). A recurrent research finding is that despite the homage paid to the therapeutic relationship construct, therapists feel ill-equipped to use themselves therapeutically to enhance this relationship (Cole & McLean, 2003; Peloquin & Davidson, 1993; Taylor et al., 2009).

Purpose of This Study

This will be the first known occupational therapy study to examine the emergent patterns of the client-therapist working alliance during the course of a community-based occupational therapy intervention. The experience of both the client and therapist in each relationship, its evolution over time, and the contextual factors will be considered alongside the therapy outcomes (e.g., changes in clients' perceived functional competence). Ample evidence from other domains indicates that the quality of the working alliance is a strong determinant of positive clinical outcomes and commonly accepted as a factor accounting for therapeutic success (Bachelor & Horvath, 1999; Martin, Garske, & Davis, 2000). A multiple case study approach will be undertaken integrating both qualitative and quantitative data. Case studies can provide description, test theory, and/or generate theory (Eisenhardt, 2002). This dissertation will both explore and describe participants' experiences, discuss manners in

which these experiences may describe the working alliance construct in community OT, and situate these findings within the existing literature.

Due in part to its later inception as well as its small comparative size, related research in the field of occupational therapy is limited to date, as detailed above. In fact, the discipline of occupational therapy has been referred to as a debtor profession in that it operates on borrowed knowledge from other disciplines, such as psychotherapy (Gilfoyle, 1987). Very few related OT studies have occurred in mental health (e.g., Eklund, 1996). No occupational therapy studies outside of mental health have prospectively investigated the widely-accepted link between client-therapist relationship and outcomes (Cole & McLean, 2003). Rather, solely clients or therapists have been asked if they sense a link exists. All occupational therapy studies to date have investigated the clients' perspectives of the relationship retrospectively (e.g., following an inpatient stay in hospital or a period of community-based treatment) (e.g., Palmadottir 2003, 2006) or sought only to understand the therapists' perspectives (e.g., Cole & McLean, 2003; Taylor et al., 2009). No studies appear to have investigated the therapeutic relationship in a privatized environment in which other factors (e.g., secondary gain, legal implications) may be impacting the relationship. All reviewed studies investigated therapeutic relationship as a global concept as opposed to the specifically defined working alliance. This study will be the first to investigate the evolution of the working alliance between a client and therapist as it is occurring over the duration of a course of therapy. This will be done specifically in a community occupational therapy context, including private practice.

Structure of the Thesis

This thesis is organized into chapters as the following brief description outlines. Chapter two provides a review of related literature from education, counselling, and the global healthcare environment. A focused review of pertinent occupational therapy literature then follows. Chapter three details the methodology used in the development of the study, as well as the collection and analysis of collected data. Chapter four presents the findings of study. These findings commence with a presentation of the findings from each case followed by the results of the cross-case analysis. Chapter five provides a discussion of the findings and a summary of the contributions and limitations of the study. Finally, implications for training, practice, and future research are outlined.

Chapter 2: Literature Review

The importance of connectedness through warm and caring relationships for healthy development is appreciated across many disciplines. From our earliest developmental stage, the importance of connectedness between maturing children and their parental figure is a commonly accepted notion in wider western society. This notion was explored further by Bowlby (1988) and Ainsworth (1985), who investigated children's attachment to their mother as a means of protection, support, and comfort. Attachment theory arose from their results and purports that an attached child bonds with a parental figure who is better able to cope with the world. This was termed "a secure base" by Bowlby (1988, p. 11). Maturing children with an established secure base will venture into the world knowing that when they return, they will be welcomed, nourished, and comforted if distressed. Although more obvious in childhood, attachment behaviour is observed over the life span and is most apparent when adults are frightened, fatigued, or sick. The importance of a secure base is appreciated across education, counselling, healthcare globally, and specifically occupational therapy. The essential influence of such a safe and supportive haven upon positive outcomes has been demonstrated in a variety of professional spheres, whether this be in education (e.g., Ryan and Powelson, 1991), counselling and psychotherapy (e.g., Rogers, 1957), or healthcare (e.g., Taylor, 2008).

Education

From preschool through secondary school, research findings demonstrate the importance of students' sense of connectedness to others in their learning environment. This connectedness has implications upon each student's development, including emotional maturation and academic achievement. A secure base in the home and school facilitates the

development of self-regulation and competence that can support children's undertaking of challenges (Grolnick & Ryan, 1989). Self-Determination Theory (Ryan & Deci, 1991) provides one conceptualization of how this sense of connectedness fosters development. Self-Determination Theory suggests that autonomy, competence, and relatedness interact and synergistically energize development and behaviour as well as have implications for motivation and learning. Specifically, relatedness refers to one's need to feel integrated within the social context, a secure communion with others. Close interpersonal connections at home and school can significantly facilitate autonomy and relatedness, which are both fundamental for learning.

Student-teacher relationships. Starting at a pre-school stage, the relationship established between a student and teacher is essential to learning and social success and can in fact forecast future patterns of student-teacher relationships. Using Bowlby's attachment theory as basis, Howes and Ritchie (2002, p. 3) maintain that regardless of age, a child's ability to learn depends on the existence of a trusting relationship with the teacher. Their research involved two longitudinal studies of children's pre-school programs and a cross-sectional study of children in infant-toddler, preschool, and primary-grade classrooms. They found that children with more positive relationships with their teachers were better able to make use of learning opportunities in classrooms (e.g., concentrate for longer periods of time, pay closer attention to their environment, demonstrate more effectiveness toward mastery) and construct more positive peer relationships (Howes & Ritchie, 2002, p. 6). The characteristics of the child-teacher relationship (i.e., secure versus avoidant insecure, insecure ambivalent, or disorganized) can be traced to the existing child-mother relationship in that this early relationship provides a "working model" of adult-child relationships for the

child (Howes & Ritchie, 2002, p. 13). Children's early experiences with teachers serve to organize their school behaviours and relationships with future school teachers.

Students' early experiences shape future trajectories as it relates to both student-teacher relationships and positive academic outcomes. Pianta, Steinberg, and Rollins (1995) undertook a three-year study of 436 children who were entering kindergarten. Consistent with previous findings (e.g., Howes & Ritchie, 2002), the child-teacher relationship was moderately to highly correlated with teacher reports of classroom adjustment in kindergarten ($r=.73$) and grade one ($r=.52$) (Pianta et al, 1995). Children with a highly positive relationship with their kindergarten teacher had fewer behavioural concerns and higher social competence two years later in grade 2 when compared to children with highly negative child-teacher relationships in kindergarten. In other words, the implications of positive child-teacher relationships in kindergarten were still highly observable two years later.

Pianta's model of adult-child relationships. Results from studies of student-teacher relationships led to Pianta's development of a model of adult-child relationship processes inspired by Bronfenbrenner's Bioecological Model of Development (Bronfenbrenner, 1995). The student-teacher relationship is a process within a dynamic social system that serves to regulate social behaviours and influence outcomes (Pianta, 2006, p. 686). The relationship is asymmetrical in that the more mature, professional adult has a greater responsibility for the quality of the relationship. This relational system is impacted by the context in which it is occurring. Factors impacting the system include the dyad-participants' characteristics such as expectations, beliefs about the self and the other, emotions, and behavioural interactions.

Teacher characteristics, including training, experience, personal factors and philosophical approach, mediate the student-teacher relationship, resulting in some teachers obtaining superior outcomes with their students (e.g., students' academic success, connectedness, and/or social competencies). Pedersen, Faucher, and Eaton (1978, as cited in Pianta, Steinberg, and Rollins (1995) investigated the impact of teachers on the success of children in school and in life. The students of their study were poor, inner-city elementary school students, who were followed over a period of approximately ten years. During that time, students in the first grade were assigned to one of three teachers. Those students fortunate enough to have "Ms. A" during first grade excelled (e.g., achieved superior grades, higher teacher ratings for effort, initiative, and leadership) throughout the duration of elementary school. Follow-up interviews with these participants several decades later demonstrated that they had achieved significantly higher socioeconomic status as adults when compared to the other former first grade students of the same school. Although Ms. A was a superior teacher of basic academics, what was highlighted in these students' vivid recall of their grade one teacher (their recall was much more detailed than the other participants with different teachers) was her ability to promote a positive self-concept in her students and her expectations of their success. Pianta's (2006) model recognizes such idiosyncratic characteristics of the individuals involved. These characteristics, among many possibilities, include biological determinants (e.g., age, gender, and temperament), personality, self-perceptions and beliefs, and developmental history. Teachers and students enter into a relationship with a higher order mental representation of the relationship based in part on their earlier attachment experiences (termed earlier by Bowlby's Attachment Theory

(1988) as a working model) and the expectations of themselves as well as the other individual in the relationship.

A child-teacher relationship has two participants, each approaching the relationship using an established working model. The previously cited studies looked at the children's perspectives, including those from varying levels of impoverished backgrounds (e.g., Howes & Ritchie, 2002). Teachers' own personal relational experiences also play a role in how they approach their role as teachers and participants within the dyadic relationship (Pianta, 2006, p. 692-693). A feedback loop, which is critical to the functioning of the relationship between the two individuals, involves language, behaviour, and communication. The quality of these interactions and how information is exchanged (e.g., tone of voice, posture, proximity, timing) is as important as what is actually occurring behaviourally (Pianta, 2006, p. 694). These three components (individual characteristics, representational or working models, and feedback mechanism) are themselves dynamic and reciprocal. This system is influenced by external factors such as school or board policies (e.g., mandated standards, disciplinary standards, placement and integration policies), classrooms (e.g., ratio of teacher to students, disability, racial/ethnic and socioeconomic nature of the classroom participants), and the community (e.g., cultural expectations of students' progress, the purpose of schooling). These external factors interact with other systems such as family and peers and may serve to pressure or support the student-teacher relationship.

School climate. As students mature and progress through the educational system, some of the external factors change. In higher grades in many schools, the size of classes increases, and there are multiple departmentalized teachers involved with the students throughout the day. These changes create a lesser opportunity for the relationships between

students and teachers to develop and flourish. Unfortunately, this occurs concurrently with tumultuous early-adolescence years when youth undergo significant biological, cognitive, and social-emotional developmental changes (Roeser, Eccles, & Sameroff, 2000). This evolution is reflected by a shift in the focus of the research literature. In these higher grades, the focus of inquiry shifts from the one-on-one relationship between teacher and student to the school climate and students' connection to others in the environment (e.g., Battistich, Schaps, & Wilson, 2004; Soloman, Battistich, Watson, Schaps, & Lewis, 2000). It is commonly accepted that a good quality school climate fosters a sense of connection to the school environment and in turn contributes to a reduction in emotional and behavioural problems in children (Loukas, Suzuki, & Horton, 2006). School connectedness, in fact, acts as a protective factor buffering against the negative effects of self-criticism and lack of self-efficacy, and enhances overall satisfaction with school (Loukas et al., 2006).

In summary, from pre-school through secondary school, the educational literature demonstrates consistent appreciation of the importance of the students' sense of connectedness to others in the learning environment. This sense of connectedness is critical to fostering the student's global and emotional health and adjustment as well as academic outcomes. Evidence has also been presented that early efforts regarding the students' relationship with others in the school environment has enduring benefits and even predictive strength.

Counselling

The importance of connectedness between a client and counsellor has long been embraced in the field of psychotherapy and counselling. Freud (1912/1950) was among the first to discuss the importance of the therapeutic relationship. Freud defined three aspects of

the therapeutic relationship: transference, countertransference, and the clients' friendly and positive linking of the therapist with a kind and benevolent persona from their past. This linking was later termed the alliance and has since undergone substantial development by several theorists (Greenson, 1967). The therapeutic relationship has been defined as "the feelings and attitudes that counselling participants have toward one another, and the manner in which these are expressed" (Gelso & Carter, 1985, p.159). A client's sense of connectedness to the therapist has a rich historical development and its attributed importance permeates the counselling literature.

Rogers' conceptualization of therapeutic approach. According to Rogers (1957), by the therapist creating an atmosphere of safety and sensitivity free from evaluation within the relationship, the client will be afforded an opportunity for self-discovery thereby using the therapeutic relationship as a context for personal growth and development. He considers that the capacity for development rests within each individual, although is awaiting the proper conditions of a helping relationship for clients' innate positive potential to be actualized. These are the "necessary and sufficient conditions" that facilitate an effective therapeutic relationship (Rogers, 1957). In Rogers' (1961) opinion, these conditions are common across all helping relationships from parent to physician to teacher to counsellor in which one person has the intention to promote the growth, development, maturation, improved function, and/or improved coping of another individual (p. 40). The three conditions that Rogers (1957) identifies as necessary and sufficient for an effective therapeutic relationship include: therapist genuineness and transparency; therapist's warm acceptance of the client as a person of unconditional worth; and, the therapist's sensitive ability to see and understand the client's world and self as perceived by the client.

Being genuine entails the therapists' insightful realization of their own feelings and attitudes and a willingness to express these through words and behaviour to clients in a transparent manner (Rogers, 1957). The second condition involves the acceptance or warm regard of the clients as people of value, no matter their condition, behaviour, or feelings. This means liking clients as separate people who possess their own feelings in their own unique manner. This open acceptance allows for a relationship of warmth and safety, a highly important characteristic of a helping relationship (Rogers, 1957). The final condition involves the demonstration of sensitive empathy meaning that therapists, without becoming overly involved, endeavour to truly understand and unconditionally accept clients' feelings and thoughts through the clients' eyes. This open acceptance and understanding then allows clients the freedom to further explore their inner psyche, free from external evaluation (Rogers, 1957). When these therapist-attitudinal conditions are present, definable changes occur in the clients: a deeper understanding of themselves that was previously suppressed; improved integration and functioning; movement toward the person each client wants to become; enhanced self-direction and self-confidence; a more self-expressive and unique individual; more understanding and accepting of others; and, enhanced effective coping with the problems of life (Rogers, 1961, p. 37-38). The therapist-attitudinal conditions require an insightful and mature individual capable of, and open to, ongoing growth and self-development.

Rogers expresses his own maturation and ongoing personal development was required to become an effective counsellor. He explains that he needed to "learn to live in increasingly deep therapeutic relationships" (Rogers, 1961, p. 14). He came to realize that an optimal helping relationship is created by a psychologically mature individual: "the

degree to which I can create relationships which facilitate the growth of others as separate persons is a measure of the growth I have achieved in myself” (p. 56). To that end, he identifies the therapist’s role in fostering conducive characteristics of the relationship and interaction: (a) being trustworthy does not mean being rigidly consistent, but rather demonstrating transparent congruence between the therapist’s attitudes and feelings with open expressions to the client; (b) creating a safe, positive, and caring environment; (c) ensuring a separation between client and therapist to promote the therapist’s and client’s own individualized sense of self; (d) unending curiosity to understand and see the client’s world through the latter’s eyes; (e) genuinely accepting who the client is; (f) ensuring sufficient sensitivity so that therapist’s behaviour is not a threat to the client; (g) eliminating external evaluation; and (h) recognizing that the client is not stable and defined by his past, but rather is in a state of dynamic change (p. 50-55).

Rogers’ necessary and sufficient conditions place the emphasis on the therapist’s role within the therapeutic relationship. His theory, however, was criticised by others who argued for consideration of the client’s role and the power that the client bestowed upon the therapist’s expertness, trustworthiness, and attractiveness. In other words, the client’s perception of these socially valued traits may contribute to the therapist’s power to influence the client’s thinking, feeling, and behaviour thus resulting in therapeutic change (Heppner, Rosenberg, & Hedgespeth, 1992). The dynamics of the change occurring within the client are also not fully contemplated. It is now widely considered that although Rogers’ identified conditions may be necessary for a positive therapeutic relationship, they alone are probably not sufficient (Bachelor & Horvath, 2006, p. 161).

Advances in psychotherapeutic research. In the 1950s, behaviourists such as Skinner challenged the notion that the interpersonal aspects of the relationship had a significant impact upon client behavioural changes (Bachelor & Horvath, 2006, p. 135). Rather, behaviourists considered that therapy was a learning process. Behaviourists challenged the efficacy and quality of the empirical research of all talk therapies. It was this challenge by the behaviourists that appeared to initiate renewed interest, improved research designs, and statistically sophisticated data evaluation with respect to the relationship concept (Bachelor & Horvath, 2006, p. 135). Results from these inquiries both support aspects of Rogers' theory as well as expanded upon other lesser considered issues.

Early psychotherapy research results were consistent with Rogers' assertions that there are conditions that are necessary and sufficient to facilitate client change across various types of helping relationships. Despite significantly different theoretical orientations and intervention techniques in psychotherapy, comparable client improvements have been found across approaches (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977).

Interpretation of these findings led to the suggestion that common variables across diverse therapies are likely responsible for a significant portion of the gains (Horvath, 1994, p. 260). These findings resulted in a resurgence of interest in the therapeutic relationship construct specifically (Bachelor & Horvath, 2006, p. 135).

Despite ongoing debate about the superiority of one model of psychotherapy over another, the existence of pantheoretical therapeutic factors is now widely accepted (Asay & Lambert, 2006). The findings support Rogers' contention for therapist-dependent relationship variables, but also support the claim for implicit client factors as well as other considerations that are universally applicable to all therapeutic endeavours. These

pantheoretical factors have been distilled from research spanning six decades of inquiry into what constitutes effective psychotherapy (Maione & Chenail, 2009, p. 57). This surge of interest is credited to a 1936 paper by Saul Rosenzweig, a classmate of Skinner, who suggested that common elements across diverse therapy approaches accounted for client improvement (as cited in Sparks, Duncan, & Miller, 2008). There are now several common factor model proposals, one of which is offered by Lambert (2003). Lambert's conceptualization groups these common elements into four categories: (a) common factors; (b) extratherapeutic change; (c) expectancy (placebo effects); and (d) technique (p. 97). These four categories will be further elaborated below.

In keeping, at least to some degree, with Rogers' previous assertions of necessary and sufficient conditions, several common factors appear to have significant implications for the outcome of therapy across different therapeutic approaches. At a conceptual level, these critical conditions include accurate empathy, positive regard, nonpossessive warmth, and congruence or genuineness (Asay & Lambert, 2006, p. 33). These common factors may be categorized according to a developmental sequence from support factors (e.g., therapist expertness; therapist warmth, empathy, acceptance, genuineness; therapeutic alliance), to learning factors (e.g., insight; feedback; cognitive learning), to client action factors (e.g., success experience; cognitive mastery; encouragement of facing fears, taking risks, and mastery efforts) (Lambert, 2003, p. 104-106). These common factors are considered to account for about 30% of the improvement achieved in therapy (Lambert, 2003, p. 97).

Extratherapeutic characteristics, which include client factors and other factors such as the client's environment, have also been shown to have implications for the success of therapy. These factors are considered to account for 40% of the improvement achieved

through counselling (Lambert, 2003, p. 97). These factors include client willingness and ability to engage and sustain a meaningful relationship with the therapist, the client's natural personality and propensities for motivation and reflection, and the client's ability to endorse achieved changes as having been due to his own action (Asay & Lambert, 2006, p. 32). Also considered in these extra therapeutic characteristics are factors such as the duration of the disorder, an underlying personality disorder, and the nature, strength, and quality of supports in the client's natural environment. Supportive of the existence and power of these factors are findings that a substantial number of clients improved without formal psychological intervention (Lambert, 2003, p. 98). This may be attributed to client-specific factors as well as the presence of naturally-occurring quality supports in the client's life. The strongest of these extra-therapeutic relationships is a marital relationship, but others also include friends, family, teachers and clergy who are supportive and able to instil hope (Asay & Lambert, 2006, p. 33; Lambert, 2003, p. 99).

Clients attend counselling seeking guidance, and the extent to which they anticipate positive results has implications for the outcome. Client's expectancy of being helped by the therapeutic endeavour is suggested to contribute 15% toward the overall recovery (Lambert, 2003, p. 97). The greater the degree of distress in the client, the greater the likelihood of a positive outcome (Frank, Gliedman, Imber, Stone, & Nash, 1959). To the extent that a placebo effect can represent a client's expectancy of being helped, Asay and Lambert (2006, p. 26) suggest a placebo effect size of $ES=.42$. In other words, the average client who receives a placebo treatment (e.g., placebo medication plus requisite clinical management) is better off than 66% of the clients who do not receive any treatment (Asay & Lambert, 2006, p. 38).

The final category of common factors is therapist technique. Proponents of various counselling schools debate the worthiness of one approach over another. Although there are some specific techniques that show superior outcomes with certain diagnostic groups (e.g., a behavioural approach to the treatment of phobic disorders), there is little empirical evidence to suggest the overall superiority of one approach over another. Lambert (2003, p. 97) opines that only 15% of the improvement achieved through psychotherapy can be attributed to the therapist's specific technique. With a relatively small contribution of technique to outcomes and the findings of by-and-large similar outcomes, it could be argued that a therapist concerned with client outcome is best to invest time in the consideration of the common factors and active ingredients of the therapeutic relationship.

The working alliance. The resurgence of interest in the therapeutic relationship and the identification of these common factors led to more questioning of the active ingredients of the therapeutic relationship and those elements that resulted in the client changes (Bachelor & Horvath, 2006, p. 135). Building on Greenson's (1967) three defined constituent components of the therapeutic relationship (the working alliance, the transference relationship, and the real relationship), Bordin argues for the value of the alliance. The alliance is an interpersonal relationship that develops over time and is universal to all successful helping endeavours (Bordin, 1979). Bordin considers that the strength of the alliance dictates the power available to achieve therapeutic change. Bordin's definition of the alliance, which will be further explored below, remains recognized as the most robust to date (Hatcher & Barends, 2006).

The alliance may be viewed as a collaboration between client and therapist against a common foe: the client's pain and suffering. Bordin (1979) outlines three essential

components of the alliance: interpersonal bonds (personal liking, valuing); agreement upon the goals, or very purpose of therapy; and, collaboration on the therapeutic, in-treatment tasks. There are two core assumptions upon which his conceptualization is based: (a) the alliance is concerned with the purposive work of therapy, and (b) the alliance is an interpersonal relationship that develops over time and is reciprocal and interactive in nature. Bordin's (1979) conceptualization of the working alliance is pantheoretical in that he does not concur completely with either the client-centred or psychoanalytical approaches. Rather, he considers the three components of the interpersonal bond, goals, and tasks are essential to all therapeutic encounters.

To advance the empirical evidence of the alliance construct, it was necessary to have measures developed to measure it. The development of a number of instruments occurred between the late 1970s and early 1980s (Horvath, 1994, p. 261). The Working Alliance Inventory, which is used in this study, is one such instrument that is extensively used to assess the working alliance in current research (Bachelor & Horvath, 2006, p. 136). The advent and refinement of these instruments were vital to alliance research. Following Bordin's 1975 seminal paper, alliance research increased outside of psychoanalytic domain (Gelso & Carter, 1985). Research has investigated the relationship between alliance and outcomes, the impact of different forms of treatment and different outcome measures, the effect of predispositional client and therapist factors upon the resulting relationship, the alliance across time, the influence of therapist actions on the alliance, and the impact of therapist training regarding the alliance (Horvath, 1994; Crits-Christoph, Connolly Gibbons, & Hearon, 2006). Based upon the research results, some have argued that the concept of the working alliance may well replace Rogers' necessary and sufficient conditions for

therapeutic success (Gelso & Carter, 1985). The proliferation of research and articles in this area is exemplified by a current-day search of “alliance” as a keyword in the PsycInfo database that results in more than 7500 articles. The high value bestowed upon the alliance construct is prevalent in the counselling literature: “I would maintain that [the alliance] is a ubiquitous and universal, as well as essential, perspective in all psychoanalytical and other therapeutic endeavours” (Meissner, 2006, p. 264). A review of a sampling of these research results regarding the working alliance will be presented below.

It appears that the quality of the working alliance is critical from the onset of treatment. Early assessments (after one to three sessions) of the alliance tend to be better predictors of outcomes than assessments that are undertaken later in the process (Horvath, 2005). Sexton, Littauer, Sexton, and Tommeras (2005) demonstrated that the client-therapist connection was determined early in the first session, and other researchers demonstrated that the initial strength of the working alliance predicts premature termination by clients after the first session (Horvath, 1995). There therefore appears to be a “window of opportunity” very early in the therapy process to establish a viable therapeutic relationship (Bachelor & Horvath, 2006, p. 139).

The pattern of client improvement has also revealed implications for the alliance. There is consensus in the psychotherapy literature that more improvement occurs earlier in treatment, although a slower rate of improvement does continue over the duration of treatment (Lambert & Ogles, 2004, p. 156). Although variables such as diagnosis require specific consideration, research suggests that a sizable portion of patients demonstrate clinically significant gains after 10 sessions (Lambert & Ogles, 2004, p. 155). Haas, Hill, Lambert, and Morrell (2002) found that clients who show early response to treatment make

up the bulk of clients who demonstrate clinically significant improvements. They suggested that future research should explore whether an earlier response to psychotherapy may be due to a superior alliance.

The implication of physical characteristics of participants on outcomes has also received attention in alliance studies. Stronger alliances have been demonstrated in client-therapist dyads in which the participants share similar characteristics (Luborsky, Crits-Christoph, Alexander, Margolish, & Cohen, 1983). For example, Wintersteen, Mensinger, and Diamond (2005) demonstrated that gender-matched dyads reported stronger alliances and superior therapy completion than cross-gendered pairings. In another study, female therapists were judged by clients as more effective with forming alliances (Jones & Zoppel, 1982). Research to date has demonstrated some gender differences in both clients and therapists with respect to the therapeutic process, however these findings need greater replications (Bachelor & Horvath, 2006, p. 160). Ethnically-matched dyads have also demonstrated superior outcomes to mixed-ethnic dyads (Farsimadan, Draghi-Lorenz, & Ellis, 2007). A similarity in ethnicity, which presumably entails similarity in culture and values, is likely an agent that facilitates a sound alliance (Bachelor & Horvath, 2006, p. 160). Although these factors are outside of the therapist's control, therapists are alerted to the misunderstandings that may arise as a result of such cultural and ethnic differences (Bachelor & Horvath, 2006, p. 161). Therapists' insight and alertness to these factors may allow them to undertake conscientious efforts to mitigate any potential negative effects they might have on therapy.

There is evidence that therapist training and reflectiveness regarding self and the client can serve to tailor the therapy process to the individual client's needs. Parallels can be

drawn to Rogers' (1961) call for therapists' personal development and the use of a client-centered approach to treatment. Such development permits therapists' sensitivity not only to their own traits, natural tendencies, and needs but also to each client's different phenomenological world and relational needs. Therapists are encouraged to remain attentive and to adjust their approach accordingly (Bachelor & Horvath, 2006, p. 144-147). For example, Bachelor (1988) defined three different forms of empathy that therapists can use to accommodate clients' different preferences and levels of receptiveness. She found that 44% of clients valued a cognitive-type of empathic response from their therapist (e.g., the client felt understood). Thirty percent of clients valued an affective-toned communication (e.g., therapist felt the clients' emotions and may have demonstrated a physical reaction such as teariness). The remainder valued a nurturing empathic response from the therapist (e.g., the therapist readily disclosed personal opinions). Therapists are advised to develop insight into each client's needs and develop the ability to flexibly respond authentically using these different empathic modes to best suit the client's needs. This is further supported by Dolan, Arnkoff, and Glass (1993) who demonstrate that therapists' adaptation of their interpersonal stance and intervention according to clients' different attachment styles fosters an effective therapeutic relationship. In addition to professionally-based development, therapists need to develop a personal reflective stance, a desire for their own personal development, and a flexibility of approach in order to optimally meet the needs of their individual clients.

In summary, research to date suggests that the alliance-outcome association accounts for approximately 6% of the variance in counselling outcomes (Safran & Muran, 2006). Although modest in size, evidence to support the link has consistently been found. The alliance is one of several common factors that together have been identified as being

responsible for 30% of client improvement in counselling (Asay & Lambert, 2006, p. 31). Gelso (2006) asserts that the working alliance “has been one of the most heuristic and clinically meaningful constructs in the history of psychotherapy and psychoanalysis” (p. 257). A number of questions, however, remain: Does the alliance directly impact outcomes, or does positive change result in the clients and therapists feeling better about their efforts and in turn their relationship? What is the trajectory of a healthy therapeutic alliance assuming that it is not in fact uniform across time (Horvath, 2006)? Although ongoing research is required, it is without question that the alliance, purported as universal to all helping endeavours, plays an important role in client self-discovery and healing.

Healthcare

Although the importance of the therapeutic relationship as a conduit toward recovery has been recognized in the counselling literature for a century (Freud, 1912/1950), its translation to the global health care arena has been less well integrated. There are, however, pockets of health care professionals who do embrace the value and importance of the therapeutic relationship. The nursing literature, for example, recognizes that human interaction reflective of compassion, touch, communication, caring, and empathy is instrumental in facilitating healing (Drench, Cassidy Noonan, Sharby, & Hallenborg Ventura, 2007, p. 120). In fact, the therapeutic relationship is as important to the recovery process as the appropriate selection of technique (Drench et al., 2007, p. 108). “Patients need healing along with their medical care – and compassion heals in ways that no medicine or technology can” (Goleman, 2007, p. 256). Differential levels of support for the importance of the therapeutic relationship construct are found throughout healthcare literature including in occupational therapy, nursing, physiotherapy, rehabilitation

counselling, and medicine (Palmadottir, 2006). This section will briefly review the status of the therapeutic relationship construct in nursing and medicine, including a differentiation between specialized medical care versus the holistic care of a family physician.

The inherent value of a humanistic approach to patient care is well understood and adopted by the nursing profession. Nursing has long been recognized as the health care discipline tasked with the ongoing “emotional work” or caring of the medical system (Goleman, 2007, p. 259). For inpatients, their most frequent contact is with nurses. The nursing literature embraces the role of nurses as holistic care providers and has identified that a skilled, competent healer must use effective communication to enhance healing (Scandrett-Hibdon, 2005, p. 261). Redsell, Stokes, Jackson, Hastings, and Baker’s (2006) study demonstrated higher client satisfaction following nursing consultations (when compared to physicians) due to more time being spent together and a more compassionate approach.

Medicine, on the other hand, is a highly rational and reductionist discipline (Goleman, 2007; Fins, 1996). With scientific technological advancements, the physician’s role has become one in which decisions and direction of care are predicated upon the results of these scientific investigations. Although well intended, physicians’ reliance upon such technical knowledge often results in routinized, automatic, and anonymous care (Fins, 1996). Physicians are trained to attend closely to physical details as they pursue plausible diagnoses, but are less well trained in interpersonal issues (Fins, 1996). As a result, physicians may become superb scientific technicians in their field of expertise, but tend to respond poorly to the humanistic aspects of clinical practice (Fins, 1996). This is not only an academic and professional concern, but is also a contemporary concern in wider society, as demonstrated by a recent Ottawa Citizen newspaper article (Kirkey, 2011). There is a tendency to order

several investigations to confirm diagnoses that turns patients from humans into static, computer-generated images of their body. The physicians interviewed for the article encourage all physicians to refocus upon the value of the doctor-patient relationship that comforts and reassures patients, tells the patients that they are more than a broken body, and that they matter.

The ever-increasing degree of specialization within the medical field results in fragmentation of the client's specialized medical management (Goleman, 2007, p. 256). Clients who are hospitalized or suffer with multi-system involvement require complex and specialized care best served by the enhanced specialization of the medical field. These clients are shuttled from one specialist to another each addressing the one segment of the client's condition related to their area of expertise. Unfortunately, this specialized care is most often in the void of a holistic appreciation of the client's condition. There is thus a splintering of clients into their constituent ailments rather than an appreciation of each individual as a whole person with multi-dimensional characteristics and needs.

The very culture of the medical discipline, with its cost, time, and legal pressures, causes physicians to become increasingly detached (Goleman, 2007, p. 254-255). The medical literature pertaining to therapeutic relationship indicates that there are ongoing needs to have its practitioners reflect upon and appreciate the importance of therapeutic rapport (Barker, 2007, p. 26). Studies conducted in the medical field in relation to therapeutic rapport have focused heavily upon communication (Barker, 2007, p. 30; Goleman, 2007, p. 254). For example, studies have investigated both the content of provided information, as well as the method of delivery (e.g., empathetic tone, taking the time to confirm understanding, use of humour). Studies have found that impaired communication predicted

the number of malpractice suits (Barker, 2007, p. 30; Goleman, 2007, p. 254). Appreciation of the therapeutic relationship in the medical literature, and most specifically in the medical specialties, appears to emphasize a more superficial level (e.g., focus on communication), to be less of an internalized value and principle of practice, and more of a defensive action (e.g., to avoid law suits) (Goleman, 2007).

An exception to this pattern is found in the family medicine literature. Family physicians, who provide generalized, holistic care, appear more genuinely interested in the therapeutic relationship than their physician specialist colleagues (Brody, 2000). Six physician characteristics have been identified as being conducive to sustaining partnerships with patients: interest in knowing the whole person; relationship over time; caring, sensitivity, and empathy; practitioners viewed by the clients as reliable and trustworthy; adaptation of medical goals to the needs and values of the patient; and, encouragement of the client's participation in the healthcare decisions (Brody, 2000). Reflection on these characteristics draws a contrast between the role of a medical specialist and a family physician in that many of these identified characteristics are more easily accommodated and natural to the family physician's ongoing and more holistic role. Furthermore, these characteristics are highly reflective of the more abundant findings of the counselling literature previously reviewed: a client-centered, holistic, and collaborative approach within a context of positive interpersonal relations.

Family physicians, who by virtue of their ongoing and holistic role with clients, are in a superior position to forge a strong therapeutic relationship, are encouraged to embrace the placebo effect of the therapeutic relationship as a boon (Hyland, 2003, p. 347). A placebo effect is recognized as more than an imitation intervention. Comparable to the

common factors identified in psychotherapy, a placebo effect includes the nonspecific effects of any client-healer relationship, including attention, communication of concern, careful monitoring, diagnostic inquiry, and labeling of complaints (Donnelly, 2004). These, in turn, alter the client's expectancy, anxiety, and relationship to the condition. Research has demonstrated that placebo effects impact more than just the subjective experience. Physiological changes have also been found (e.g., EEG, serum hormone concentration) (Donnelly, 2004). Placebos are, in fact, recognized as "the most effective medication known to science, subjected to more clinical trials than any other medicine" (Donnelly, 2004, p. 239).

Occupational Therapy

The ultimate objective of occupational therapy is to guide the actualization of clients' potential (Yerxa, 1980). This is achieved by using a client-centred approach during which the therapist empathetically listens to the client's story and description of needs. The achieved holistic understanding enhances the dyad's ability to work collaboratively to solve meaningful occupational performance issues (Law & Mills, 1998, p. 16). This description includes key attributes and values embraced by the occupational therapy profession that are considered to be of significant importance to the development of an effective therapeutic relationship: the use of a client-centred approach, the demonstration of empathy, a holistic understanding, a caring attitude, as well as the employment of collaboration between client and therapist that in part serves to remedy the power imbalance inherent in the relationship.

In the occupational therapy context, client-centeredness is considered in the context of enabling client's occupations. In other words, client-centred care means that intervention is respectful of culturally-defined and age-appropriate considerations for the individual's

own care (personal care), enjoyment of life (leisure), and social and economic contribution to the community (productivity) (Polatajko, Backman, et al., 2007, p. 39). Clients' ability to participate in a client-centred approach has been found to vary according to the client's desired level of participation, age, level of education, history of reliance on others, culture, acuteness/severity of condition, and cognitive capabilities (Sumsion, 2005). Parallels may be drawn between OT and the counselling literature that has determined that Rogers' conditions of client-centredness are necessary, however, in and of themselves, may not be sufficient. Rather, in keeping with the work of Asay and Lambert (2006, p. 43), there are multiple implicated factors including both those controllable by the therapist (e.g., client-centred approach) and those uncontrollable to the therapist (e.g., client ability to embrace this approach). Therefore, although Rogerian client-centeredness is often referenced in the OT literature (e.g., Townsend et al., 2007, p. 98), it is more so the spirit of his concepts rather than their pure implementation that is referenced as many concepts are not purely applicable, nor transferrable to a biomedical milieu.

An empathetic understanding allows therapists to see their own likeness in each client (e.g., appreciation of commonalities) but yet demonstrate respect for the client's uniqueness, dignity, worth, and perceived experience (Peloquin, 2003, p. 158-161). The therapist aims to see the client's world through the client's eyes and understand the implications of the illness or disability as it is specifically experienced by this client. A holistic approach to client care means that the person seeking therapy cannot be divided into parts. Rather, the therapist seeks a thorough understanding of the client, the occupations the client experiences as meaningful, and the features of the contextual environments in which these occupations are performed. Although caring is subsumed in an empathetic and holistic

appreciation of the specific client situation and experience, there is more to be embodied by the caring therapist. These embodiments include being flexible, having an emotional connection, and demonstrating specific attitudinal traits such as patience, honesty, trust, humility, hope, and courage (Gilfoyle, 1980). A collaborative approach facilitates client control over decision making and encourages clients to become actively involved in the problem solving process of their specific situation (Taylor, 2008, p. 8-10). In fact, the use of a collaborative approach seeks to readjust the power imbalances innate in the difference of knowledge, social position, and/or charisma between client and therapist (Mortenson & Dyck, 2006). These core values of occupational therapy work together in the artful delivery of the scientifically-based health care toward the development of effective therapeutic relationships.

Therapeutic relationship in occupational therapy. The therapeutic relationship in occupational therapy has been described as a manifestation of artistry reflected in the development of a connection between the participants (Peloquin, 2003, p. 157). Using an empathetic attitude, this connection grows through the therapist's holistic understanding of the client's condition and the multiple implications of disability as experienced specifically by this client (Peloquin, 2003, p. 158). Despite the prominence afforded the therapeutic relationship construct in the occupational therapy literature, there are in fact few empirical studies conducted on this construct in occupational therapy, especially when considered as a whole rather than constituent elements or characteristics (Cole & McLean, 2003; Taylor, et al., 2009). Rather, studies have investigated subcomponents of this construct including occupational therapists' verbal communications and interactions with clients (Allison & Strong, 1994; Eklund & Hallberg, 2001), the use of collaborative communication and

collaboration in general with both clients and their family caregivers (Clark, Corcoran, & Gitlin, 1995; Hinojosa, Sproat, Mankhetwit, & Anderson, 2002; Jenkins, Mallett, O'Neill, McFadden, & Baird, 1994), barriers to a good therapeutic relationship (Norrby & Bellner, 1995), clients' and therapists' valuation of the therapeutic relationship and its perceived implications upon therapy outcomes (Cole & McLean, 2003; Palmadottir, 2006; Prochnau, Liu, & Boman, 2003; Taylor et al., 2009), and therapists' characteristics conducive to clients' experience of a positive therapeutic relationship (Blesedell Crepeau, 1991; Boutin-Lester & Gibons, 2002; Darragh, Sample & Krieger, 2001; Devereaux, 1984; Gilfoyle, 1980).

A definition of the therapeutic relationship construct specific to occupational therapy was only recently developed. By surveying occupational therapists, Cole and McLean (2003) developed the following commonly accepted definition of therapeutic relationship: "A trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy, and mutual respect" (p. 49). In other words, the therapeutic relationship is composed of the non-technical and interpersonal aspects of health care, composed of key characteristics of collaboration, communication, empathy, understanding, trust and connection (Cole & McLean, 2003; Peloquin, 2003). Commonalities may be found between this definition and that proffered in the psychotherapy literature, including the common factors of therapeutic change, which has already further elaborated upon the constituent elements of the therapeutic relationship construct and their related implications. Therein lay substantial differences between the two fields. The field of psychotherapy research and literature has long ago defined the therapeutic relationship and its constituent elements. In comparison, the OT literature has only recently developed a

definition of therapeutic relationship and, in comparison, melds the overarching construct of therapeutic relationship with its constituent elements as defined in the psychotherapy literature as the working alliance and common factors.

The occupational therapy literature identifies those therapist characteristics and approaches that clients find highly conducive to positive rapport. Successful practitioner characteristics have been described as including: understanding; empathy; competence; caring; and, holistic care (Darragh et al., 2001). Other therapist characteristics required for establishing a positive therapeutic relationship include: belief in dignity and worth of the client; belief that each individual has the potential for change and growth; effective receptive and expressive communication; strong and positive values; using touch to convey sensitivity; and, judicious use of humour (Devereaux, 1984). The ideal persona of a therapist is described as a mix of competence and friendly caring (Boutin-Lester & Gibons, 2002). Therapists are encouraged to use a client-centred approach to tailor the therapeutic intervention to the specific needs of clients as each client has a different life-world and experiences disability from a unique perspective. This individualized understanding is critical to the outcome of intervention especially in light of the fact that occupational therapists “do with” clients, in contrast to other healthcare professions that tend to “do to” or “do for” (Blesedell Crepeau, 1991). Palmadottir (2006) qualitatively explored adult clients’ perceptions and descriptions of the relationship they formed with their occupational therapist while inpatients in a rehabilitation institution. The majority of clients expressed a great deal of satisfaction in this relationship. Most clients felt they had something special and of higher quality than they observed between other client-occupational therapist dyads around them. (Occupational therapy in a rehabilitation centre often occurs in a large, open occupational

therapy department in which several client-therapist dyads work simultaneously.) In addition to the extended and frequent contact as contributing to the positive therapeutic relationship, clients also pointed to the informality of the interaction that resulted in a close and trusting relationship as a causal factor.

Despite the importance bestowed upon the role of core occupational therapy values in the fostering of effective therapeutic relationships, their existence is not always apparent to the consumers of occupational therapy. Some occupational therapy clients have complained of therapists' impersonal attitudes that were experienced as dehumanizing and antithetical to a positive therapeutic alliance (Peloquin, 2003). As per Peloquin's (2003, p. 165) review of a large number of client stories, complaints included failing to see the personal consequences of illness or disability; denying clients' feelings; dismissing clients and their concerns; failing to demonstrate understanding and empathy; engaging in distancing behaviour; withholding important information; being silent or aloof; acting brusquely; and, misusing their power. Acknowledging that a relationship is embedded and influenced by the environment in which it is occurring, three contextual social beliefs are identified as being sources of such inhibited caring: a reductionist tendency to define clients' disability and focus on the rational fixing of the disability; overemphasis and overvaluation of techniques, protocols, and modalities to solve problems, thereby reducing therapists to one right method; and, the fiscal agenda of the establishment forces a focus on efficiency (Peloquin, 2003, p. 165). Such less than ideal relationships were described by clients using such terms as detachment (little contact, lack of closeness, although the clients did not necessarily dislike their therapists), sheer rejection and humiliation (a negative, destructive, and damaging

relationship, in which basic trust had not been established) (Palmadottir, 2006). Such resulted in clients developing fear, impaired self-esteem, and withdrawing from therapy.

In the OT literature, there is limited empirical evidence of a conclusive link between the therapeutic relationship construct and therapy outcomes. Although occupational therapy-specific studies of the link are very limited, in one observational study involving mental health clients receiving occupational therapy, no clear-cut linear relationship was found between the working relationship and client outcomes (Eklund, 1996). In this Swedish study, 20 participants of an occupational therapy group day program were recruited over a 4.5-year recruitment period. The utilized quantitative measures included a measure of the working relationship (client and therapist perspectives), a therapist-assessed patient participation scale, and several outcome scales completed by the client at the time of admission and discharge (e.g., Symptom Checklist, Health-Sickness Rating Scale, and Assessment of Occupational Functioning). Despite this limited empirical evidence, 96.5% of occupational therapists indicated that they either agreed or strongly agreed that the therapeutic relationship is critical to patient functional outcomes (Cole & McLean, 2003, p. 41). Similarly, clients also perceive a link between the therapeutic relationship and outcomes. Following discharge from rehabilitation institutions in Iceland, 20 adult clients were interviewed regarding their perspectives on the outcome of their occupational therapy intervention as well as those components of practice that clients perceived to have influenced their experience in therapy (Palmadottir, 2003). Those clients who attributed their enhanced functionality to the positive therapeutic relationship with their occupational therapist described their therapists as close friends with whom they shared an equal relationship based on mutual trust and respect (Palmadottir, 2003). In summary, despite the limited empirical

evidence, both therapists and clients alike consider that the therapeutic relationship contributes to therapy outcomes.

Despite these findings detailed above, many practicing occupational therapists do not feel well prepared and confident in their ability to employ “therapeutic use-of-self” to promote positive therapy outcomes (Cole & McLean, 2003; Peloquin & Davidson, 1993). Some authors use the terms “therapeutic alliance” and “therapeutic use-of-self” interchangeably with “therapeutic relationship” (Cole & McLean, 2003). Other authors, however, provide a specific and separate definition of the therapeutic use-of-self construct. The most widely used definition in the occupational therapy literature defines the therapeutic use-of-self as a therapist’s “planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process” (Punwar & Peloquin, 2000, p. 285). One study found that 80% of 568 surveyed American occupational therapists considered therapeutic use-of-self as the most important determination of therapy outcome (Taylor et al., 2009). Despite this, less than half of these individuals considered that they had received sufficient training in the use-of-self prior to graduation and less than one third thought that there was sufficient knowledge about the use-of-self in the occupational therapy literature. These findings suggest that more attention needs to be paid to the therapeutic relationship and the therapeutic use-of-self in the training and development of occupational therapists. In recognition of this void, one program’s administrators developed a course to enhance graduate occupational therapists’ readiness to practice by enhancing their intimate understanding of two fundamental and traditional concepts: the art of practice and the therapeutic use-of-self (Peloquin & Davidson, 1993). To achieve this objective, students received training in the development of their ability to reflect, empathize, and respond by

enhancing their receptive and expressive communication abilities. Further information about the outcomes of this training would be beneficial in determining the efficacy of this course's content in addressing the identified gap in training.

Taylor's Intentional Relationship Model and modes. "How can one's therapeutic use of self be utilized specifically to promote occupational engagement and promote positive therapy outcomes?" (Taylor, 2008, p. 45). To answer this question, and in response to the limited occupational therapy-specific theoretical information about how to approach and manage the therapeutic relationship, Taylor proposes the Intentional Relationship Model (Taylor, 2008, p. 45-64). This is the first model of its kind in the OT literature and is built upon her previous research, a literature review, the core values, ethics, and general principles of OT, her own experience as an OT providing psychotherapy, and contributions of other experienced OTs. Her model builds upon the theoretical bases offered by psychotherapy. Taylor, however, clarifies that with the central focus of OT being upon the client's occupational engagement, there are inherent differences between the therapeutic relationship in occupational therapy and that in psychotherapy. One difference, especially outside of a mental health milieu, an occupational therapist should not pretend to emulate the intensity, duration, and complexity of a therapeutic relationship occurring in psychotherapy (Taylor, 2008, p. 46). The intent of the Intentional Relationship model, whose sole focus is the relationship between client and therapist, is to complement existing occupational therapy conceptual models (Taylor, 2008, p. 46). Her contention is that the therapeutic relationship influences both occupational engagement and therapy outcomes (Taylor, 2008, p. 47).

According to the Intentional Relationship Model, the two functions of the therapeutic relationship in occupational therapy include: enabling occupational engagement; and,

providing a safe place where the client's emotions and coping processes as they relate to the client's occupational performance impairment and associated implications can be addressed (Taylor, 2008, p. 54). The therapists' role is therefore to determine the most effective manner to work with clients toward their occupational performance goal while ensuring a safe and supportive relationship for the clients to express emotions and trial various coping strategies. According to her model, there are four central elements involved in this established therapeutic relationship: the client, who is the central focus; the interpersonal events that occur during therapy; the therapist, who has primary responsibility for the relationship; and, the occupation defined as "the activity the therapist and client have selected for therapy" (Taylor, 2008, p. 53).

Within the Intentional Relationship model, there are two interrelated levels at which the relationship occurs: the macro and micro levels (Taylor, 2008, p. 54). Similarities may be drawn to this study's conceptual framework's representations of the nested layers of systems that impact the therapeutic relationship. In Taylor's model, the macro level involves the ongoing, relatively consistent pattern of involvement that develops over the lifetime of the relationship. The micro level involves the interpersonal events or stressors that occur during the therapeutic relationship that have the ability to either deleteriously impact or enhance the relationship between client and therapist. These two levels are interrelated in that the macro nature of the relationship modulates the client's interpretation of interpersonal stressors. In turn, the interpersonal events occurring at the micro level impact upon the macro pattern of the therapeutic relationship.

Taylor (2008) assigns the primary responsibility for the relationship to the therapist. Consequently, she outlines several fundamental principles that underlie the conceptualization

of her model that require therapist self-insight and reflection (Taylor, 2008, p. 57). Among numerous principles, therapists are encouraged to reflectively use a range of six therapeutic modes: advocating; collaborating; empathizing; encouraging; instructing; and, problem-solving (Taylor, 2008, p. 68-83). “A therapeutic mode is a specific way of relating to a client” (Taylor, 2008, p. 67). Taylor implores therapists to firstly self-reflectively identify their natural, predominant modes of interaction with clients and then develop the other lesser used therapeutic modes in order that they may consciously and rationally decide which mode is best employed with each client as per the specific client’s needs.

As Taylor’s (2008) Intentional Relationship Model is the only existing OT-specific model addressing the therapist-client relationship, a comparative analysis will be presented between Taylor’s model and the findings of this study. In addition, Taylor (2008) presents an exercise that was used with the participant therapists as a means to encourage their reflection on their predominant approach with their clients. The results from that exercise will be interwoven into the case analyses.

Gap in the occupational therapy literature. In addition to the limitations of the empirical findings as it relates to therapeutic relationship in occupational therapy, another significant additional factor that does not appear to have yet been considered in occupational therapy research is the implications of various contexts in which the relationship between client and therapist may occur. In contrast to both counselling and the majority of other healthcare disciplines whose services are most often delivered in clinical environments (e.g., hospital, clinic, counsellor’s office), community-based occupational therapy occurs in the in-vivo environment in which the client is engaging in meaningful occupations (e.g., home, school, work). Although similarities exist between institutionally-based and community-

based occupational therapy, community-based therapists experience fewer barriers in the use of client-centred practice (Mortenson & Dyck, 2006). This points to variable implications of different contexts. As depicted in the conceptual framework guiding this study, all alliances are embedded within and affected by context, “To see a therapeutic alliance only in terms of dynamics between a therapist and client would be an overly simplistic view. Individuals who partner in any venture find both opportunity and constraint from the locale, group, or culture within which the alliance occurs” (Peloquin, 2003, p. 165). None of the limited studies found in the occupational therapy literature considered therapeutic relationships that occur in the client’s in-vivo environment. As per Peloquin’s assertion, I consider that the therapeutic relationship that occurs between a client and therapist in the community has a great number and different array of environmental considerations. Add to this the implications of a unique medical-legal context of private practice and the considerations multiply. The identification and more thorough understanding of these considerations and their differential impacts upon the working alliance and outcomes will be undertaken in this study.

It is within this void of the occupational therapy literature that this present study working alliance and participants’ experiences of that alliance during the course of a community-based occupational therapy intervention that includes medical-legal contexts. This evolution of the alliance, the participants’ experience within the relationship, and the identified and implicated contextual factors will be considered alongside the therapy outcomes (e.g., changes in clients’ perceived functional competence) from both clients’ and therapists’ perspectives.

Assimilation of Counselling Concepts

This study is assimilating counselling concepts (e.g., alliance and its impact upon outcomes) and employing them in an occupational therapy context. Messer (2003), a proponent of assimilative integration within the psychotherapy domain, supports a rational and reasonable integration of theoretical ideas or techniques from different schools of psychotherapeutic thought. These other techniques need to be backed up by evidence and assimilated in a contextually meaningful way. A firm grounding in any one guiding paradigm of psychotherapy is required while blending useful aspects from another approach without upsetting the integrity of the predominant approach. Assimilative integration avoids dogmatism by recognizing the value of other practices while permitting relative consistency in one's own theory of practice. Assimilative integration has been compared to a talented free agent being added to a sports team to fill a specific need while also complementing the team's existing chemistry (Ramsay, 2001). Lampropoulos (2001) suggests that assimilative integration is the best theoretically and empirically based integrative approach currently available in psychotherapy. Despite this, Messer cautions that importing a technique from one therapy to another results in its recontextualization, thus revising its meaning.

The concept of assimilation across psychotherapy approaches has implications for this proposed study. Many of the psychotherapy field's principles of the alliance and its associated impact upon outcomes are being assimilated, albeit with some caution, into the guiding principles of this OT study. Taylor (2008) similarly used these findings, in part, for the basis of her Intentional Relationship Model. There are many similarities that exist between counselling and OT (facilitating clients' resumption of meaningful function, caring and empathetic approach, time-limited intervention within scope of available time/funding).

They are, however, not identical in so far as the specific foci of therapy are divergent, the training and orientation of the therapists are dissimilar, and there are different dynamics, factors, and stakeholders involved. Research in the area of occupational therapy as it relates to the therapeutic relationship and especially the working alliance is in its infancy and, as a result, the assimilation of these constructs into the field of occupational therapy needs further exploration. This is evident, for example, in the different ways in which these concepts are understood in the two disciplines of OT and psychotherapy. Additionally, the working alliance, although broadly studied in psychotherapy, has received little investigation in OT. As a result, and despite Bordin's suggestion of his conceptualization of the alliance being universal to all helping relationships, there remain questions as to whether this construct of the alliance is different between psychotherapy and occupational therapy. Although the tasks, bond and goals components are relevant to both disciplines, the manner in which these are addressed in the two disciplines is disparate, as is the objective toward which these are focussed. This study represents a small step toward the exploration of this new terrain but evident caution is necessary in this assimilation.

Conceptual Framework

Based upon my review of the literature, understanding of the cross-disciplinary findings, in combination with the limited related studies in OT, I searched for a framework for this current study that would situate and inform the constructs of interest and their interaction with one another. My search led to social ecological theories and more specifically to the Bioecological model of development (Bronfenbrenner, 1995) in light of its focus on protagonist development through intersecting and contextually implicated

relationships. Presented here are the Bioecological model of development and its application to an OT context (Bronfenbrenner & Morris, 2006).

The Bioecological model of development asserts that genetics (biology) alone do not determine an individual's psychological traits, but rather the individual's actualized development of genetic endowments is molded through interactions with environmental influences (Bronfenbrenner & Ceci, 2006). This model proposes that human development occurs through progressively more complex reciprocal interactions (called "proximal processes") between an individual and the persons, objects, and symbols in the individual's immediate environment (microsystem). The form, power, content, and direction of these proximal processes vary as a function of the characteristics of the people and factors involved in the interactions and the environment in which these interactions occur. Psychological development is a reflection of the actualized genetic potential combined with the nature of the proximal processes described above. Bronfenbrenner's Bioecological Model (Bronfenbrenner, 1995), focused primarily on child development, offers a nesting of layered environments that have implications for the individual's development. These include the most proximal, *microsystem*, with which the individual has direct contact (e.g., family, friends, neighbours). The influences occurring in this system are strongest due to their proximity and are bidirectional in nature in that these individuals interact and impact the developing person and vice-versa. The *mesosystem* represents interactions of individuals, external to the developing person, within the microsystem (e.g., the interaction between a child's parents and that child's school) that influence the individual's development. The microsystem is nested within the *exosystem* with which the individual may never directly interact, but yet has an influence upon the protagonist through its impact on the microsystem

(e.g., a parent's work schedule has implications for the child). This exosystem is further nested within the *macrosystem*, which embodies larger and more abstract social forces such as culture, laws, and societal norms. All of these systems, which are dynamic in nature, have implications on the person's development over time. The final system is the *chronosystem* that represents time (e.g., the timing of life transitions during the individual's development).

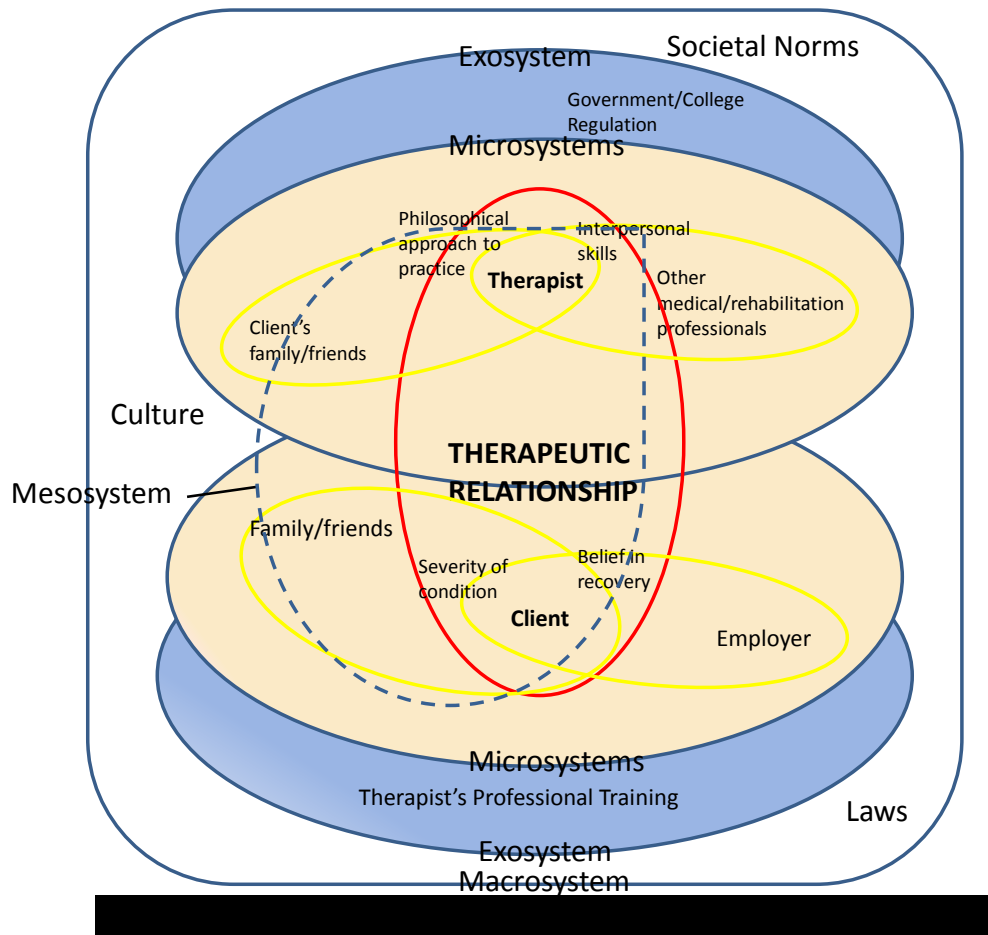
Occupational therapy (OT) is presumed to be a context for development and learning, and the interactions between the client and therapist represent a significant microsystem for development and provide the impetus for client development in this context. Although much of Bronfenbrenner's work has focused upon child development, he also discusses this model from a life course perspective (Bronfenbrenner, 1995). Other authors have used the Bioecological model in their discussions of adult development (Hoare, 2009; Willis & Schaie, 2006). As depicted in Figure 2.1 below, Bronfenbrenner's model has provided a frame of reference for this study of the adult therapeutic relationship occurring in an OT context. In addition to their biological genetic endowments, both adult participants have individual characteristics such as age, gender, language, ethnicity, socio-economic status, education, and occupation. Once an injury has occurred or an underlying condition has emerged, there are additional factors internal to the client that may have implications upon the client's recovery and/or the therapeutic relationship. These include, for example, the time elapsed between onset and initiation of OT intervention, the client's belief of recovery, the severity of the condition, and pre-existing/concurrent co-morbid conditions. There are factors internal to the therapist that may also have implications for the client's recovery and/or the therapeutic relationship. These include the therapist's philosophy of practice, experience, interpersonal skills, and therapeutic reasoning. To borrow the system titles from

Bronfenbrenner's model, each of these individuals is functioning within multiple microsystems. In addition to the direct client-therapist interactions, within these microsystems there are proximal processes occurring between the client and his/her family/friends, medical/rehabilitation professionals as well as potentially an employer, lawyer, and third party payer. These same individuals may serve as proximal processes to the therapist, who in addition, has professional considerations such as government/college regulations as well as professional training and scope of practice. In this context, proximal processes between the therapist and, for example the client's family and friends, serve as mesosystem interactions to the client. Although the therapist has direct interactions (proximal processes within her own microsystem) with the client's family/friends, the client's interactions with family and friends serve as a mesosystem interaction to the therapist. Permutations of this are numerous. The microsystems exist within an exosystem, which in this context, may include the therapist's professional training as well as the government regulation of the OT profession through a professional college. All of these layers are simultaneously nested within the culture, laws, and societal norms that function as a kind of backdrop for the therapeutic work occurring in OT.

In this study, I will focus upon the central microsystem of the working alliance comprised of the therapist and client. I will also consider the external factors, primarily occurring within other microsystems and mesosystems, which are perceived by the participants as impacting the working alliance and recovery. The final system for consideration in this study will be the exosystem, and specifically therapist's training upon the client's recovery and/or the working alliance. In keeping with this description, the

Bioecological model of development served to guide the development and implementation of this study.

Figure 2.1. Bio-Ecological Development Theory and OT



Research Questions

The questions of this study are threefold:

1. How do clients' perceived functional abilities and the working alliance change over the course of a community-based occupational therapy intervention?
2. How do the participants describe their experiences within the therapeutic dyad?
3. What are the contextual variables and external factors that are perceived (either by the participants or researcher) to impact the client-therapist relationship?

Chapter 3: Methodology

Introduction

This chapter describes the choice of a multiple-case study approach that uses mixed-methods and is naturally situated in the pragmatist paradigm. A multiple-case study approach was employed to allow comparisons of the experiences across four therapeutic dyads. An autobiographical reflection is provided in an effort to enhance the researcher's transparency in the conduct of this study. The participant recruitment process, data collection tools and procedures, as well as the ensuing analysis will be described. There were several efforts undertaken to enhance credibility of the study's findings as well as the trustworthiness. These efforts, as well as the potential transferability of the results, will be detailed below.

Multiple Case Study

This exploratory multiple case study uses both qualitative and quantitative data collection strategies. A case study approach is appropriate when there is a desire to understand complex social phenomena within a bounded system (e.g., client-therapist dyad) (Yin, 2009, p. 18). Case study investigations retain the holistic and meaningful characteristics of real-life contemporary events, like the relationship between a client and therapist. Yin (2009, p. 13) suggests that a case study approach is preferred when "how" or "why" questions are being asked, when the investigator has little control over the events under study, and when the item being studied is a contemporary phenomenon within a real-life context. All three criteria apply to this study in that the first two questions cited above are "how" questions, the investigator had no control over the events of therapy (e.g., goals,

activities, number of visits, participant's approach to the relationship), and that the dyads being studied were real and contemporaneous.

This study demonstrates differences and similarities that occur among four client-therapist relationships and the transcending patterns that emerge across the cases. Akin to the replication logic used in experimental research, multiple cases allow for some logic of replication (Yin, 2009, p. 54). For example, when a substantial finding is discovered in an experiment, the experiment is repeated in an attempt to replicate the finding several more times. This logic also underlies multiple case studies. Yin (2009, p. 54) describes two forms of replication: literal replication (carefully selected, highly similar cases) and theoretical replication (intentionally selected cases with contrasting characteristics to see what happens in light of a theoretical framework). Literal replication was used in this study in that the involved dyads were selected based upon several identified factors (e.g., one-on-one community-based occupational therapy program involving more than one visit with cognitively-intact adults). The case-level findings were compared across the dyads looking for both similarities as well as differences. Potential explanations for differences in patterns were also considered.

Varied sources of data (both quantitative and qualitative data were collected from both the clients and therapists) are used in this study in order to permit a degree of triangulation of the findings. Yin (2009, p. 124) asserts that a major strength of case study research in contrast to other methods such as experiments, surveys, or histories, is the opportunity to use many different sources of evidence. Both quantitative (validated and reliable surveys) and qualitative (interviews) methods are used concurrently in this study. The quantitative and qualitative data served to compliment each other and to enhance the

richness of the descriptions derived from each client-therapist dyad case. Mixed methods permit the weaknesses of both quantitative (e.g., lack of understanding of the context, lack of participant voice, personal biases of the background researcher are not discussed) and qualitative (e.g., bias of the researcher's interpretation, lack of generalization) methods to be addressed through more comprehensive evidence (Creswell & Plano Clark, 2007, p. 9). Although the qualitative and quantitative data were collected simultaneously throughout the duration of the study, the amount of qualitative data was substantially greater than the volume of quantitative data. According to the commonly used notation system of mixed methods research developed by Morse (2003), this would be notated as "QUAL + quan" (Creswell & Plano Clark, 2007, p. 41; Teddlie & Tashakkori, 2003, p. 10-12).

Pragmatism paradigm. Teddlie and Tashakkori (2003, p. 20-21) outline two dominant guiding paradigms in the performance of mixed methods research: transformative-emancipatory and pragmatism. The transformative-emancipatory paradigm is focused upon the asymmetric power relations of marginalized groups such as women, ethnic/racial minorities, and the poor. In contrast, researchers working in the pragmatism paradigm are not committed to any one system of philosophy or reality. Although both paradigms use qualitative and quantitative research methods, researchers working within the pragmatism paradigm embrace the overarching importance of the research questions and the best manner in which to investigate these questions while avoiding the forced choice between paradigms (e.g., postpositivism and constructivism) (Teddlie & Tashakkori, 2003, p. 21). The current study is situated in the pragmatism paradigm, as a social inquiry was not the focus of this study. "Being pragmatic allows one to eschew methodological orthodoxy in favour of *methodological appropriateness* as the primary criterion for judging methodological quality,

recognizing that different methods are appropriate for different situations” (Patton, 2002, p. 72, italics in original). As a result, pragmatism permits the use of mixed methods in order to look at the data, perform the analysis, and report the results from different directions (Creswell, 2007, p. 22-23). Pragmatism sets aside the use of metaphysical concepts such as truth and reality, and permits a practical research philosophy to guide methods in order to do “what works” (Creswell & Plano Clark, 2007, p. 26-27; Teddlie & Tashakkori, 2003, p. 21). The links between epistemology and methods are seen by some as being a distraction from the research questions that they endeavour to answer and is often a stance taken by researchers working in applied fields, such as health care (Teddlie & Tashakkori, 2003, p. 18). Patton (2002, p. 72) argues that epistemological reflection can in fact be a hindrance because it reduces methodological flexibility and adaptability. Rather, Patton (2002), a pragmatism proponent, indicates “**in real-world practice, methods can be separated from the epistemology out of which they have emerged**” (p. 136, bold in original).

Of primary importance to me is investigating the phenomena of the therapeutic relationship in occupational therapy in its natural state and learning about how the relationship is constituted and the factors that are implicated. The pragmatism paradigm allowed me to undertake this investigation in the manner that I considered most conducive to gleaning a deeper and practical understanding in the areas of particular interest to me and hopefully the occupational therapy and rehabilitation communities.

The Researcher as Instrument

Prior to discussing the methodological choices of this study, I will, as the primary researcher and analyst of the data collected during this study, discuss my own education, training, and philosophy with which I approached this inquiry. The purpose of these

declarations is to better understand the worldview from which the analysis has been completed (Patton, 2002, p. 566). I graduated and became an occupational therapist in 1993. Following brief employment in a hospital, I have since worked in private industry primarily with individuals injured in motor vehicle accidents. In 1997, I developed my own private practice and have employed other occupational therapists. In this private medical-legal world, there are often plaintiff and defence orientations. I firmly consider my orientation to be one that straddles both camps. The idea of spanning different worldviews is not new to occupational therapy. I adhere to the prevalent worldview occupational therapists hold of straddling my own humanistic, client-centred philosophy and the importance of meaningful occupations with the biomedical model of health care. While holding steadfast to the guiding principles of the OT profession, the post-positivist healthcare system focussed upon quantitatively-measured outcomes must also be navigated. This complexity is then superimposed upon a medical-legal private practice context. In a private practice arena, there is therefore constantly a need to manage several different perspectives simultaneously: that of the client, the therapist, the medical system, plaintiff counsel, and defence orientations. Respecting and balancing the interests of these different viewpoints while maintaining focus on the occupational therapy role and purpose is in many ways similar to the pragmatism paradigm. These various worldviews being constantly negotiated by the therapist have different perspectives regarding truth and reality as it pertains to the client's recovery. The therapist, while negotiating these different perspectives, must choose a method that will be effective with this specific client within the mix of these different realities.

When working with clients, the first step is to listen to the clients' stories. In other words, therapists must endeavour to understand the etiology of the clients' need for occupational therapy and the clients' individual perceptions of their situations. The next step is to understand what they want to achieve, in other words, their occupational goals. The factors embedded within the environment (e.g., people outside of the therapeutic dyad, financial issues, health issues) are also considerations to be contemplated as these may either facilitate or hamper the clients' and/or therapists' efforts. These factors must be acknowledged and considered in the treatment plan in order to facilitate the clients' successful occupational goal attainment. I empathize with clients in the losses they have suffered, problem solve with them to mediate these limitations, and encourage them to regain as best possible their valued lost occupational performance roles. I am inspired and energized by the clients who recognize (and potentially mourn) their lost biological or physiological capacity, yet do not perceive this as a barrier to their current and future function, but rather a hurdle to be overcome. These clients impact my ability to fully and genuinely empathize with clients who become fixated upon apparent minor and transient ailments that cause temporary impairments but yet result in an ongoing disabled pattern of thinking. What is it that makes some clients resilient and others susceptible to adversity? How come some clients, despite significant physiological or biological losses, persevere until they have attained their occupational performance goal? Are these innate characteristics or learned ways of being? Is it due to the wealth of supports in their environments? Does therapist skill have any bearing? These were among many of the questions raised in my daily practice. In the end, I decided to focus my study on aspects of

these types of questions that may allow therapists to cultivate improved understanding and skill as it applies to factors they can potentially moderate: the therapeutic relationship.

Participants

The first stage of recruitment involved inviting community-based occupational therapists who worked with adult-aged clients to participate in the study. The second stage involved inviting the therapists' new clients who met the criteria outlined below to participate. This process served to unite the two participants of each dyad that constituted one case or one unit of analysis. To enhance robustness, the aim was to involve a minimum of four dyads thus allowing for literal replication, or similar results (Yin, 2009). The sampling strategy was one of locating accessible cases that fit the inclusion criteria of the study.

Therapists. The researcher was interested in community-based occupational therapy intervention with clients living in their own homes. To protect against the possible confounding influence of treatment setting on the therapeutic relationship, OTs and clients were all recruited from within the community setting. The researcher therefore approached occupational therapists working with adults in the community in various organizations (e.g., a large publicly-funded home health care organization, private practices, etc.). All occupational therapists working in these areas were invited to participate. In order to meet the recruitment target of four dyads within a relatively short timeline, five therapists who met the inclusion criteria and accepted the invitation for participation were enrolled in the study. In the end, two of these five occupational therapists were in fact able to recruit two clients each during the recruitment period. The two participant therapists included one private practice therapist and one therapist employed with a publicly-funded clinic.

Clients. The clients meeting inclusion criteria for this study included new adult clients referred to the participating therapists (a) whose health condition had changed as a result of either an injury or some progression of an underlying condition such that they would be seen in occupational therapy; (b) were seen in their home; (c) required more than one visit; (d) had English language proficiency; (e) were cognitively capable (i.e., had no pre-existing condition of cognitive incapacity) to provide informed consent and complete the required instruments. Upon receipt of the invitation to participate from their occupational therapist, clients were encouraged to contact the researcher to indicate their interest in participating. The researcher confirmed that clients met these inclusion criteria at the time of this initial contact.

Data Collection Strategies

Instruments. Several data collection instruments and strategies were used in this study. Questionnaires included the Occupational Self Assessment (Baron et al., 2006) (used to measure the client's functional recovery) as well as the Working Alliance Inventory (Horvath, 1995) (used to quantify and chart the evolution of the working alliance from both the clients' and therapists' perspectives). Interviews were also undertaken repeatedly with each participant in order to glean in-depth descriptions of the therapeutic dyad experience. Each instrument and strategy will be described below.

The Occupational Self Assessment (OSA). The Occupational Self Assessment (OSA) is a self-administered, paper and pencil, assessment instrument and outcome measure. The OSA was designed as a clinical instrument used to guide collaborative treatment planning (Kielhofner, Forsyth, Kramer, & Iyenger, 2009). The instrument is composed of a two-part rating form that elicits clients' perceptions of both their ability as well as the value

they attribute to this occupational performance. The original OSA instrument has undergone several refinements. The original instrument included an environment section that subsequent research found to be too limited to provide a sound measure (Baron et al., 2006). Although the environment section remains available, it was removed from the OSA proper. For the purpose of this study, the environmental section was not used, as the interviews served to investigate environmental issues more in-depth and more in keeping with the conceptual framework. Examples of the items on the OSA include “concentrating on my tasks,” “physically doing what I need to do,” and “getting along with others.” During each interview, the clients self-administered the paper and pencil instrument, upon which clients assess their perceived degree of ability to complete specific tasks on a four-point rating scale (ranging from “I have a lot of problems doing this” to “I do this extremely well”). Secondly, clients then consider the value that they attribute to each task, again on a four-point scale system varying from “This is not so important to me” to “This is the most important for me.” During each client interview, the clients assessed both their occupational competence and the value each itemized activity holds among the 21 items comprising the scale. This allowed one measure of the clients’ perception of progress achieved during therapy to be quantified.

The OSA is based upon the Model of Human Occupation (Kielhofner, 2002) and the Canadian concept of client-centered practice (Canadian Association of Occupational Therapists, 1991) and has been shown to demonstrate construct validity (Baron et al., 2006). The competence rating scale and items were found to be stable over time (reliability coefficient not reported by authors) and have been accepted as a dependable assessment of change over time (Baron et al., 2006). Using Rasch analysis, Kielhofner and Forsyth (2001) determined that both the competence and value scales worked well to measure the respective

underlying constructs, which were distinct from each other. In another more recent study, Kielhofner et al. (2009) used Rasch methods to assess the internal validity, sensitivity, and reliability of the OSA. Their study demonstrated that the OSA items, in combination, have good internal validity and measure the unidimensional constructs intended by the competence and value scales. The amendment of the rating scale to a four-point scale improved the person separation and overall sensitivity of the measure and could be used in a consistent manner by 90% of participants with varying degrees of disability (Baron et al., 2006). The hierarchy of items (most difficult/valued to least difficult/valued) was judged to be well calibrated (Baron et al., 2006). The validity of the OSA appears not to be impacted by either culture or language when used by a wide range of persons who vary by country, age, and diagnosis (Baron et al., 2006). The OSA is a widely-used instrument, both in clinical practice and in research. A sampling of such areas of research include the mental health field (e.g., Fisher & Savin-Baden, 2003; Mahaffey, 2006; Melton et al., 2008; Pan, Chan, Chung, Chen, & Hsuing, 2006), disease processes such as HIV/AIDS (e.g., Anandan, Braveman, Kielhofner, & Forsyth, 2006; Kielhofner, Braveman, Fogg, & Levin, 2008; Paul-Ward, Braveman, Kielhofner, & Levin, 2005), societal issues such as domestic violence (e.g., Gorde, Helfrich, & Finlayson, 2004; Helfrich & Aviles, 2001), as well as research with the elderly (e.g., Sviden, Tham, & Borell, 2004; Bjorklund & Henriksson, 2003; Venable, Hanson, Schechtman, & Dasler, 2000).

Working Alliance Inventory (WAI). The WAI is one of the most widely used alliance measurement scales. It is based upon Bordin's (1979) theoretical model that identifies three constituent components (tasks, bonds, and goals) of the alliance (Horvath, 1995). The short format (12 items) of both the client and therapist versions was used in this

study (Appendix A and B respectively). The rater uses a seven-point, fully-anchored Likert scale to describe his/her thoughts and feelings of the therapeutic relationship. “ (The therapist) and I trust one another” is an example of an item found on the client version of this scale. A higher endorsement of the statement reflects a stronger working alliance. This measure has been shown to be an effective early predictor of successful counselling outcomes (Horvath & Greenberg, 1989). Martin, Garske, and Davis (2000) contend that the WAI is an appropriate measure for most types of research related to the study of alliance, as it is applicable to all types of therapy, and is based upon the underlying theoretical concepts that transcend helping relationships. Examples of the use of the WAI outside of psychotherapy are provided below.

A number of studies have demonstrated support for the WAI's validity. The WAI fairly represents the construct of the alliance as defined by Bordin (1979) demonstrating adequate content validity (Horvath, 1994). Bordin's pantheoretical underpinnings were considered during the development of the WAI in order to ensure utility, both clinically as well as in research, regardless of the counsellor's theoretical orientation (Horvath & Greenberg, 1989). Convergent validity is strong ($r = .84, .79, .72$ for the Goal, Task and Bond scales, respectively) when correlated with the California Psychotherapy Alliance Scales (Horvath, 1994). Discriminant validity between the WAI and the Counselor Rating Form scale was shown to be adequate (Horvath, 1994). Predictive validity was also adequately demonstrated with client-reported outcomes ($r = .42$) (Horvath & Greenberg, 1989). Multiple studies demonstrated that internal reliability of the instrument ranges from .93 to .84 (Horvath, 1994). In one study, test-retest reliability over a three-week interval was $r = .83$ (Horvath, 1994). In their meta-analysis, Horvath and Symonds (1991) identified

several studies that undertook repeated assessments of the working alliance during therapy using a variety of instruments, including the WAI.

The WAI, or modifications of it, have also been used outside of psychotherapy. In one rehabilitation context, Goldberg, Rollins, and McNary (2004) modified the WAI's wording to better suit the vocational rehabilitation environment for clients with serious mental illness. For example, the wording of the existing WAI item of "What I am doing in therapy gives me new ways of looking at my problem," was altered to become "What I am doing with my IPS worker gives me new ways of looking at my work situation." They found good test-retest reliability over a two-week interval ($r=.86$) for the client version and the therapist version ($r=.94$). Both versions showed good internal consistency (client, $\alpha = .88$; therapist, $\alpha = .92$). Schönberger, Humle, and Teasdale (2006a, 2006b, 2007) used the WAI in a study of brain-injured rehabilitation outpatients. Their study examined the development and interaction of the working alliance, patients' compliance and awareness during a brain-injury rehabilitation program, as well as the role of demographic characteristics and injury-related variables in this process. The WAI was administered to both therapists and clients four times during the 14-week rehabilitation program. The internal reliability on the therapists' WAI total scale at the four different points in time varied between 0.86 and 0.89. For patients' total WAI scale, Cronbach's alpha varied between 0.74 and 0.83. Re-test reliability over a 12-week period was $r = 0.75$ for the therapists' WAI scale, and $r=0.46$ for the clients' total scale. Solomon, Draine, and Delaney (1995) used the WAI to measure the strength of the working alliance between seriously mentally disabled clients and their case managers. Alpha reliabilities were high, ranging from .89 to .96 for both the client and case manager versions of the WAI. Forchuk (1995)

used the WAI to investigate the uniqueness of nurse-client relationships. This study of chronically mentally ill patients and their assigned nurses in a variety of programs demonstrated that each unique dyadic combination produces a unique relationship situation. Cronbach's alpha for the WAI was 0.93 for the client form and 0.95 for the therapist form.

In the current study, the client and therapist versions of the WAI were used to assess participants' perspectives of the alliance at several points in time during the intervention. The evolution of the alliance over time is described within each case.

Interviews

Therapists. An initial interview occurred with the therapists (Appendix C). In addition to completing a demographic questionnaire (Appendix D), the therapist's philosophical approaches to practice, experience, and their dominant mode(s) of therapeutic approach were discussed. Taylor (2008, p. 67) proposes that therapists have natural tendencies toward certain manners of interaction with clients: problem-solving, advocating, collaborating, empathizing, encouraging and instructing. She developed an exercise to assist therapists' recognition of their natural tendencies. With this gleaned insight, therapists are then encouraged to cultivate a wider repertoire of modes of interaction as appropriate to given client contexts. To aid such therapist-participant reflection of practice, the exercise developed by Taylor (2008, p. 68-83) concerning therapeutic modes of practice was provided to the therapists prior to the initial interview. This interview occurred prior to any client involvement and thus was specifically focused upon the therapist, her approach to client interaction, and her guiding philosophy regarding the therapeutic relationship without reflection upon a specific client relationship. A second and final therapist interview (Appendix E) occurred after discharge of the study's client participant from active therapy,

or completion of the study, whichever came first. This second interview allowed for focused reflection upon the relationship that occurred specifically with the client participant. Comparisons were made between the therapist-shared information from the initial interview (e.g., her approach to client interaction) and the specifics of this case's therapeutic relationship in order to identify contextual variables that shaped the therapist's decision making. Following each client visit, the therapist completed the WAI and faxed it to the researcher.

Clients. An initial client interview occurred following receipt of client consent. During this initial interview, the client also completed the initial OSA (Appendix F) and WAI (Appendix A). In addition to demographic information (Appendix G), further information sought during that initial client interview (Appendix H) included the client's expectations for recovery, perception of the severity of injury, the time elapsed between injury and therapy initiation, any other reported concurrent/co-morbid conditions, as well as the client's preliminary impressions of the therapist and their relationship. Thereafter, a subsequent client interview (Appendix I) occurred approximately monthly until either the end of the therapy block or completion of the study at which time a final client interview occurred (Appendix J). During each subsequent interview, the client was requested to complete the WAI (Appendix A) and the follow-up OSA (Appendix K). Thereafter, discussions focused upon the client's evolving experience of the relationship including the bond, tasks, and goals established within the dyad, the achievements to date, the contextual factors perceived to be impacting the recovery/relationship, and the therapist herself.

Piloting of both interview protocols was undertaken. The therapist interview protocol was piloted with three volunteering occupational therapists. The client interview

protocol was piloted with three other individual volunteers pretending to be clients. This piloting was undertaken prior to initiation of the study in order to refine and finalize the initial content of the interview protocols. As the study progressed, some of the questions were further modified. For example, one original question asked clients to identify those people and factors of the environment that they perceived to have an impact upon the therapeutic relationship with their occupational therapist. This proved to be a difficult question for clients to answer. The question was modified to be the identification of those people or environmental factors perceived as impacting their recovery process.

Procedure

Upon receipt of ethics approval from the University of Ottawa, Social Science and Humanities Research Ethics Board (Appendix L), the researcher contacted a manager within a home care service agency. All required documentation, instruments, and proof of ethics approval were provided. Upon receipt of her authorization, the researcher then contacted several supervisors of occupational therapists working in the community through this agency. The first attempt to find interested therapist-participants was through an email invitation, complete with attached invitation to participate (Appendix M) distributed through the supervisors in which interested therapists were asked to contact the researcher. That email introduced the study, participation expectations, and the nature of the clients to be included. The researcher also attended team meetings at the home care service agency offices to make a brief presentation about the study to recruit therapist participants (Appendix N). Simultaneously, a similar email was also broadcast to independent therapists as well as supervisors of private companies employing occupational therapists working in the community with adults in eastern Ontario. This included all independent therapists and

companies from the Yellow Pages directory as well as others of whom the researcher was previously aware were working in this area. Eventually, interested therapist participants contacted the researcher.

The remuneration strategy was communicated at the time of recruitment. All participants (therapists and clients) were compensated for their participation in the study. This was established to occur at a rate of \$40/hour, up to a maximum of \$200. Since the therapists participated in two dyads, they were compensated \$200 per dyad. As each client contributed at least five hours of time, each was paid \$200. This was paid via personal cheque upon completion of the final interview.

An introductory face-to-face meeting was held with each participating therapist. During the meeting, the researcher provided a general overview of the study and its underlying principles as well as the role of the therapists in the study. Once confirmation of their understanding of the study and their proposed role, the therapists signed a consent form (Appendix O). The ethics of client recruitment were reviewed. Each of the instruments to be used in the study was reviewed. During this meeting, the researcher provided each therapist with the required materials (client invitations to participate, reminder notices, stamps, envelopes, copies of WAI, facsimile coversheets). The initial therapist interview was also conducted during this first meeting.

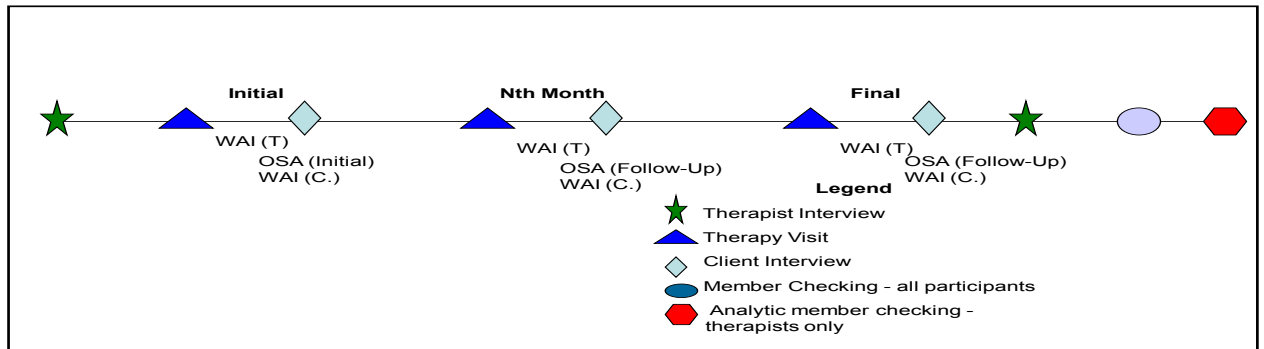
Figure 3.1. Data Collection Graphical Representation

Figure 3.1 above is a graphical representation of the data collection procedure. After the initial therapist interview, the therapists extended invitations to participate (Appendix P) to their new clients whom fell into the broad inclusion criteria (e.g., adults, cognitively competent). The researcher awaited the identification of each client participant before further data collection could occur. Upon confirmation of client participation described below, the researcher notified the therapist. The therapist then completed the WAI reflective of the first therapy visit and submitted it to the researcher immediately via facsimile, as well as following each therapy visit thereafter. In the dyad case of Kotter and Helene, they saw each other twice per week. So as not to unduly burden Helene, she completed and submitted the WAI to the researcher at two-week intervals. A final therapist interview occurred upon conclusion of the therapy/data collection period for the study.

During the invitation phase, the therapists were asked to consider possible involvement of all new clients who appeared to meet the inclusion criteria for this study. Eligible clients were invited at the end of the first clinical visit to participate in the study

(Appendix P). Therapists were provided with stamped reminder notices to mail to the clients to whom they had provided an invitation to participate in the study. These notices (Appendix Q), which briefly reviewed the study details and participation requirements, were mailed to the clients the day following their initial therapy visit. Clients were requested to contact the researcher directly to indicate their interest in the study. This contact allowed the researcher an opportunity to discuss the study further with the clients, to reduce potential coercion on clients for study participation, to ensure that the client met the inclusion criteria, and to schedule an initial meeting with the client.

During the initial meeting between the researcher and client, the study participation expectations were again reviewed. It was emphasized both verbally as well as in the consent form that the information shared by the individual members of the therapeutic dyad would never be transmitted by the researcher to the other person of the dyad nor to any third party in any form other than the aggregated study results. The consent form (Appendix R) was reviewed in detail. Upon securing the client's consent, the initial interview (Appendix H) proceeded during the same initial meeting. During each of the client interviews, the client was requested to complete the WAI and OSA assessment tools (Appendices A, F and K). Subsequent monthly interviews (Appendix I) were held with the client until therapy ended (for three participant clients) or no further new information was being gleaned (for one participant client). At that time, a final client interview occurred (Appendix J).

Once the data from the individual participants was analysed, individual narratives detailing each participant's experience during the course of therapy were created (Appendices T through AA). These narratives were returned to the individual participants (in order to maintain the confidentiality of the participant-specifically provided information

at this level). Participants were asked to review the narrative and confirm whether it accurately portrayed their experiences. All participants confirmed the accuracy of the original document, although some minor factual edits were made based upon two participants' feedback. Once the cross case analysis had been completed, a second form of member checking occurred at this analytical stage with the therapists only. The participant therapists were chosen as key informant due to their professional training and ability for such abstract reflection in combination with their years of experience working in therapeutic relationships in an occupational therapy context and their evident interest in the topic area.

Table 3.1 below maps the data collection strategy between the research questions and the various instruments used to collect data.

Table 3.1. Mapping of Research Questions to Data Collection Strategy

Research Question #1	How do clients' perceived functional abilities and the working alliance change over the course of a community-based occupational therapy intervention?
Data Sources	<ul style="list-style-type: none"> • Occupational Self Assessment (OSA) (client only) • Working Alliance Inventory (WAI) (client and therapist) • Interview data from the questions identified below: <ul style="list-style-type: none"> • Client interviews [initial 3, 5, 6], [subsequent 2, 3], [final 2] • Therapist interviews [final 5]
Research Question # 2	How do the participants describe their experiences within the therapeutic dyad?
Data Sources	<ul style="list-style-type: none"> • Interview data from the questions identified below: <ul style="list-style-type: none"> • Client interviews [initial 6, 11, 13, 14, 15, 16, 17, 18], [subsequent (2), (3), 7, 9, 10, 11, 12], [final 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18] • Therapist interviews [initial (2), 4, 5, 6, 7, 8, 9], [final 2, 3, 4, 6, 7, 8, 9, 10, 11]

	12, 13, 16, 17]
Research Question #3	What are the contextual variables and external factors that are perceived (either by the participants or researcher) to impact the client-therapist relationship?
Data Sources	<ul style="list-style-type: none"> • Interview data from the questions identified below: <ul style="list-style-type: none"> • Client interviews [initial 3, 7, 8, 9, 10], [subsequent 5, 6], [final 4, 5, 6, 12, 13, (15)] • Therapist interviews [initial 3, (4), 10, 11], [final 3, 14, 15] • Demographic information

Data Analyses

Multiple sources of data (triangulation) were used in the study in order to gain different perspectives from the two participants of each dyad at different points in time. The collected data were both quantitative and qualitative in nature.

The quantitative data were collected via two questionnaires, the WAI and the OSA. The evolution of the alliance was tracked by both the clients' and therapists' completion of the WAI. The clients' sense of functional competence was assessed using the OSA and tracked for the duration of the clients' study participation. The questionnaires were scored and once the dyad's participation in the study had been concluded, the scores were represented graphically to demonstrate the values yielded by these scales at different points in time. These results were considered alongside the qualitatively collected data in order to gather a more thorough description of the phenomena.

A theoretical thematic analysis of the qualitative interview data was undertaken for the purposes of this study. Braun and Clarke (2006) assert that thematic analysis is a flexible and useful research tool that can provide rich and detailed, yet complex accounts of data. They define thematic analysis as "a method for identifying, analyzing, and reporting patterns

(themes) within data. It minimally organizes and describes your data set in (rich) detail” (p. 79). In contrast to other qualitative analytic approaches, such as grounded theory and interpretative phenomenological analysis, thematic analysis is not strictly theoretically bound but rather can be used within a variety of theoretical approaches and use different methods. Thus, thematic analysis corresponds well with the pragmatism paradigm that guides this study. The following sections describe the specific process of thematic analysis in the context of this study.

In conducting the analysis, the researcher considered all the evidence, but focused upon the most significant aspects of the case study as defined by the guiding research questions (Yin, 2009, p. 160-161). The analyses were undertaken within the framework of the researcher’s own experience and knowledge, as well as the conceptual frame of reference inspired by the Bioecological theory of development that guided the development and implementation of this study, yet considered all major rival interpretations. Creswell (2007, p. 150-155) described a “data analysis spiral” in which the researcher moves in analytic circles of data management, reading/memoing, describing/classifying/interpreting, and finally representing. In other words, as the analysis proceeds, the researcher tends to revisit and reformulate previous considerations and decisions as a deeper understanding of the data evolves. Although the different levels of analysis undertaken during this study will be described below, this is presented with the caveat that the analysis did not always unfold in a linear manner, as the description may suggest.

Preparing and organizing the texts. The client and therapist interviews allowed for rich participant reflections upon the evolution of, and the factors impacting, the relationship. The interviews were conducted by the researcher, which allowed for a deep immersion in the

data from the time of collection. The interviews were transcribed verbatim. This transcription occurred within one week of each interview. The content of the transcriptions were then compared to the recordings again to confirm accuracy both for the words, but also specific punctuation and phrasing in order to preserve the original intent.

The researcher immersed herself into all aspects of the collected data. The transcribed verbatim interviews were read and re-read actively searching for relevant text as it related to the research questions. The relevant text represents “interesting aspects of the data items that may form the basis of repeated patterns (themes)” (Braun & Clark, 2006, p. 89). The relevant text (plus a little of the surrounding relevant data in order to maintain context) from each of the participants’ interviews was then organized into meaningful groups by entering it into an emerging grid of categories. A separate grid was developed for each participant’s data set. Each category in the grid was akin to Braun and Clark’s (2006) description of an initial basic code in that it represented the lowest interpretative depiction of the raw data and draws together related verbatim extracts. These grids collated the coded data extracts together into an array according to the broad elements of the guiding research questions as well as an evolving list of ideas about what was in the data and what was interesting about it. At times, interesting aspects in the data applied to more than one category of the grid and thus were applied as many times as deemed suitable. These grids thus evolved over time as new ideas emerged. They were used as a general organization/collating strategy and not rigidly applied in order to allow for all relevant text to be included, even text that did not fit neatly into a yet determined category or the dominant story. This permitted contradictory data to also be included.

As encouraged by Patton (2002, p. 253), there were both deductive and inductive approaches used in that the reviewed literature and the conceptual frame of reference contributed to the deductive aspects of the analyses, however, without a firm existing theory yet established in occupational therapy, inductive realizations were also sought. Patton (2002) suggests that the extent to which an inquiry is either inductive or deductive varies along a continuum. For instance, Patton (2002, p. 253) compares the combination of inductive and deductive approaches to a questionnaire that contains both closed-ended and open-ended questions. The grid of categories was flexibly applied in order to encourage inductive discoveries of themes strongly linked to the data themselves. I was constantly aware of the structure imposed by the developing categories and worked to simultaneously remain as open as possible to inductive discoveries outside of the structure imposed by the grid. In fact, the grids evolved as meaningful, relevant data excerpts were found that did not fit the existing categories and thus leading to the development of new categories.

Data reduction into themes. Working from categories and the relevant data extracts in the grid (client or therapist), recurring ideas were identified. The categories and corresponding data that were then determined to form these recurring ideas, as well as related ideas, were then grouped together and organized in a separate document. A broader analysis of each data set was then undertaken. The understanding of the rich qualitative data was developed and considered in relation to the graphically represented quantitative data from the WAI and OSA about the therapeutic relationship and client perceived functioning. These different sources of data allowed for comparisons between the qualitative and quantitative data that enhanced the developing understanding of thematic content by considering how the categories coalesced into themes and subthemes. This procedure led to

the development of a rich narrative representation of the overall experience of each participant within the dyad, as described by the participant.

Based upon these individual client and therapist analyses, a case analysis was then undertaken in which the transcending themes within each case (the therapist-client dyad) were identified. Themes were identified based upon their prevalence, but also their “keyness” in that they captured something important in relation to the research questions (Braun & Clark, 2006). A summative table of the themes within each case was developed to ensure coherent, consistent, and distinctive themes (Braun & Clark, 2006). This encouraged reflection upon the internal homogeneity (the extent to which the theme holds together) and external heterogeneity (bold and clear differences between themes) (Patton, 2002, p. 465). Themes that were in common between the therapist and client data were grouped together. Themes that were dissimilar were represented distinctively. The summative table also reinforced reflection regarding the manner in which all the themes fit together within the case. A well-organized presentation of the story of each dyad/case was developed (Braun & Clarke, 2006). Patton (2002, p. 449) emphasized that the foremost responsibility of the researcher is to do justice to each individual case so as to provide a solid foundation for the ensuing analyses and statement of findings.

Cross-case analysis. Each participant narrative (client and therapist) and corresponding case analysis were read and re-read in order to determine commonalities, differences, and the inherent contextual properties that may explain these commonalities and differences (e.g., literal replications) across the cases (Yin, 2009). The results of the analysis of each case were entered into a meta-matrix (Appendix S) in order to permit a thematic analysis across cases (cf. Miles & Huberman, 1994). A cross-case analysis was then

prepared that details these findings with the supportive evidence from the cases. A final thematic table was then created to ensure a coherent, internally-consistent, and yet distinctive representation of the identified cross-case themes. The essence, scope, and content of each theme are described in a couple of sentences in that final thematic table.

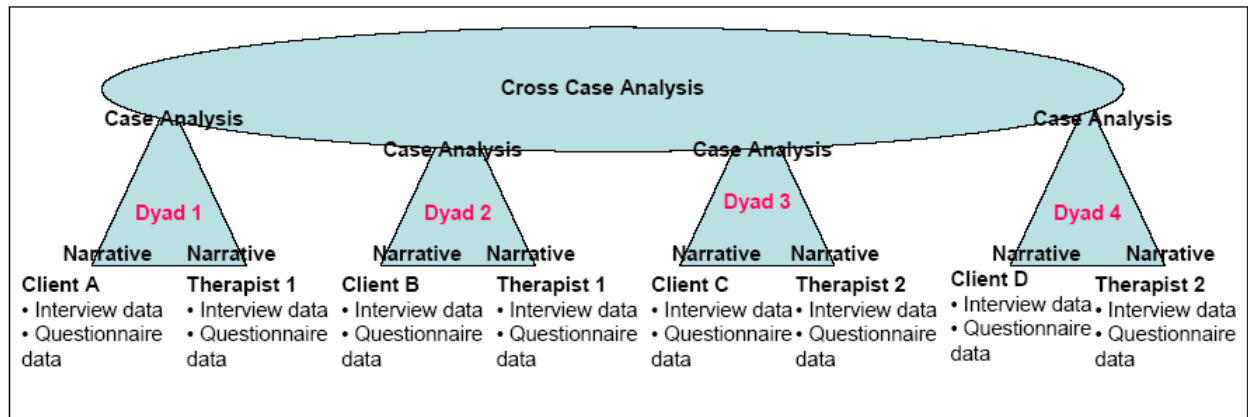
The cross-case results were presented to the two participant therapists. The participant therapists were chosen as key informants due to their professional training and ability for such abstract reflection in combination with their years of experience working in therapeutic relationships in an occupational therapy context and their evident interest in the topic area. This meeting was audiotaped. During the meeting, the final thematic table provided a framework to discuss the findings of the cross case analysis. The therapists were invited to comment on how the results did or did not reflect their experience when working with clients, both specifically during these dyads as well as clients in general. Feedback provided by the key informants led to refinement of the representation of one theme (e.g., Marie was aware of the emotional depth of the bond for Lise and hence was cautious in its management.). Both informants expressed concern with the quantitative scale of the WAI without opportunity for qualitative descriptions during the alliance development. Lastly, although data are not available to provide direct support, both therapists speculated that client's perceived functional competence that deteriorates as discharge from therapy is approached may be attributed to some dependency that has been created by the positive alliance. Their feedback was thoroughly considered prior to the final presentation of the results into a concluding thematic table and the description of the cross case themes.

In the final stage, there was an attempt to theorize the significance of each theme (and any subthemes), how it fits into the broader overall story, and its implications (Patton, 2002,

p. 480). An interpretation of the cross-case thematic patterns, their meaning, and the implications in relation to existing literature was undertaken (Braun & Clark, 2006; Yin, 2009).

Figure 3.2 is a graphic representation of the overall analysis procedure.

Figure 3.2. Data Analyses Procedures



Enhancing Credibility

Three primary methods were used to enhance the credibility of the analysis findings. Firstly, a peer reviewer was employed. Following her role, an auditor reviewed the processes and findings through a transparent audit trail. Lastly, two forms of member checking were used. These will be detailed below.

Peer review. A peer review process was used as an external check of the data-analysis process. A peer reviewer was employed to review the same data analyzed by the primary researcher. This peer reviewer is an occupational therapist with 27 years of experience and holds a PhD in Education. Her primary role was to act as a “devil’s advocate” to “keep the researcher honest” by asking questions about meanings and interpretations, and providing an opportunity for exploration of different potential interpretations (Creswell, 2007, p. 208). She independently read the transcripts, identified

categories and relevant text, and her own ideas regarding emerging themes. After the independent work was completed, a meeting then ensued between the researcher and peer reviewer. During that meeting, the themes identified by the peer reviewer were compared to those identified by the researcher. Rival interpretations were considered, discussed, and debated. These discussions allowed ideas to be more thoroughly considered and integrated as appropriate into the final presentation of the study findings.

Auditing. A second step involved an external auditor (Creswell, 2007, p. 209). The external auditor (in this case, the thesis supervisor) examined both the process of the data analysis and the findings arising from that process and provided additional input relative to the findings and conclusions of the study. While engaging in the coding process, memos and reflective remarks were included to permit an audit trail. The external auditor, drawing on the guidelines provided by Lincoln and Guba (1985, p. 378-392), examined the conceptual coherence and validity of the findings at each step of the analytic procedure, beginning with the initial categories through to the cross-case themes. The fundamental purpose of this review was to ensure that there was adequate support for the study's findings and conclusions. Feedback received from the auditor was considered by the researcher and appropriate revisions were made to the findings and conclusions. For example, the auditor checked the analyses and findings to ensure that there was sufficient supporting evidence to support the claims. He also provided elaborating or variant theoretical/paradigmatic considerations to challenge and enhance the findings.

Member checking. Two forms of member checking were undertaken at different stages of the analysis. Firstly, a narrative re-telling of each participant's story was developed from the data. These were returned to all of the individual participants (both clients and

therapists) to confirm the representativeness of each individual's lived experience during the therapy process. Feedback received was reviewed and, as appropriate, amendments made to the final copy of the narrative story.

The second level of member checking occurred only after the cross-case analysis was completed and theoretical propositions (e.g., the cross-case thematic table) drafted. At this stage, the two participant therapists were invited to a meeting in which the analyzed results were presented. This second layer of member checking using the two participant therapists as key informants at this analytical stage was included in order to receive the therapists' feedback into the study findings and the theoretical applications of the findings. Due to the therapists' education, expertise, and extensive experience in forming and maintaining therapeutic relationships, their insight and contribution to the final results were considered to be of key importance. The therapists' feedback was recorded, reviewed with the auditor, and then integrated appropriately into the final presentation of the paper as detailed above.

Enhancing Trustworthiness

Creswell (2007, p. 207-209) identified eight procedures to enhance the trustworthiness of qualitative analysis and recommended that at least two of them be used. As itemized below, this study, in fact, used several such methods (i.e., four) to enhance the trustworthiness of the outcomes. Prior to undertaking the analyses, a statement of the investigator's assumptions (see autobiographical reflection and the conceptual framework), approach, and the underlying theory were made explicit in order to allow the focus of the study and potential biases to be identified. The use of multiple data sources (repeated interviews of each client and therapist as well as questionnaires) permitted for triangulation in the data analyses. Attempts were made to demonstrate the steps undertaken in the

analyses and how the various interpretations were reached. The themes and constructs were communicated in such a manner to facilitate readers' understanding, including that of the individual participants. A coherent representation of how the developed theoretical constructs fit together was also woven into the telling of each case's story (Auerbach & Silverstein, 2003).

Transferability

Due to a myriad of specific contextual factors influencing each dyad, transferability of the outlined theoretical constructs to other therapy dyads must be carefully considered. Applicable transferability is best determined by the individual reader. Reader generalizability, or in this case transferability, is a common practice in law and medicine where the applicability of one case to another is determined by the individual practitioner in consideration of the similarities and differences among cases (Merriam, 1988). To facilitate the process of potential transferability of the research findings, a rich, thick description of each case has been presented as well as a cross-case analysis to determine commonalities, differences, and contextual elements among the participant dyads (Miles & Huberman, 1994).

Chapter Summary

This chapter has presented the reasoning for the use of a multiple case study approach situated within the pragmatism paradigm in order to investigate the therapeutic alliance, functional recovery, and associated contextual factors naturally occurring in four therapist-client dyads over the course of occupational therapy intervention. The participants and their recruitment process were detailed as were the data collection instruments and procedures. A

detailed description of the undertaken analysis was presented as well as the efforts to enhance the credibility, trustworthiness, and transferability of the study's findings.

Chapter 4: Findings

In this chapter, the results from the four discrete cases will be presented along with contextual information framing each case. A cross cases analysis will then be presented following by an examination of the similarities and distinctive features found across the cases.

Case 1: Lise and Marie

Fifteen years previous to this study, Lise was injured in a motor vehicle accident (MVA). Lise subsequently developed chronic pain and a highly limited repertoire of regular activities. This not only served to define her sense of self as disabled but also led to substantial social isolation. In the spring of 2009, Lise's physician referred her for interdisciplinary intervention to enhance her functional abilities, which had become overly limited by her chronic pain condition. Through the interdisciplinary clinic, Lise met Marie, her occupational therapist (OT).

Lise. Lise was 69 years of age at the time of her participation in this study. She speaks French and English. She is a Caucasian Canadian. She indicated that her familial socio-economic status is less than average (as defined by the 2006 Canadian census data for the Ottawa-Carleton region). Prior to the accident, Lise completed high school and was employed in a variety of occupations including homemaker and mother, receptionist, and a self-employed seamstress. Since the MVA, Lise has deemed herself retired from the workforce. Lise is re-married to her second husband. They have a blended family of several adult children, all of whom live outside of the marital home. Lise and her husband live in a high-rise apartment building to which her husband serves as the superintendant.

Marie. Marie is a 30-year-old, fluently bilingual (French and English), white, female OT. She is Canadian with a German family heritage. According to the 2006 census data, Marie assessed her family income as above average. She completed an undergraduate degree in Occupational Therapy and has been a practicing OT for six years. She has worked in a variety of environments including inpatient hospital (acute care and rehabilitation units), community (return to work, MVAs), and currently in an interdisciplinary clinic as a clinical educator.

Overview of Therapy Process

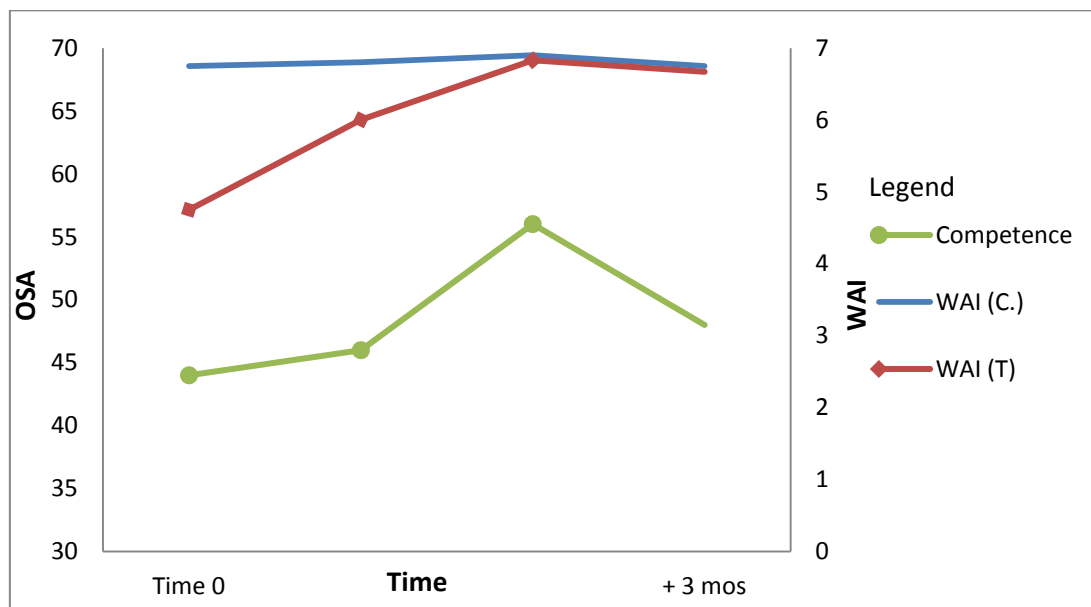
Marie met with Lise six times between September and December, 2009. All meetings occurred within Lise's home. Marie was the second health care professional from her clinic to meet Lise. From Lise's perspective, the original goals for intervention were to "start doing what I did before. I like looking after my house. My husband has been taking care of me for the last 15 years and I'd like to turn that around. I should be the one that's doing the cooking, everything." Marie identified the more specific, original, collaboratively-established goals of the intervention as "increase her endurance, her standing endurance in order to increase her participation in her leisure activities...participation in the kitchen." Although confident from the outset of Lise's ability to attain these goals, even Marie was surprised with how quickly Lise made progress: "better than I thought it would. I think she made some terrific gains, but I'm not going to take all credit for it. I think there are other disciplines and other factors that assisted in her making those gains, making our goals even more attainable." These gains appeared to energize Lise's momentum. Over time, Lise also began to share with Marie the existence of interpersonal difficulties within her marriage. Once Lise's achieved success with the original therapy goals, Marie explained that higher

level therapy goals were then established: “a little bit more independent from her husband in terms of getting out of the house or having a mode of transportation other than her husband...because she got better, she wanted to look into doing maybe some volunteer work.” By the time of discharge from therapy, Lise had made a few trips into the community independent of her husband with the support of ParaTranspo as set-up by Marie, and she was looking into potential volunteer opportunities.

Marie appeared to approach the relationship slightly tentatively initially perhaps due to the more challenging relationship between Lise and another health professional from the same clinic with whom Lise’s had commenced intervention before meeting Marie. Fortunately, these concerns were quickly dispelled. A strong and positive relationship developed and deepened over the three-month course of therapy. As reflected on the Working Alliance Inventory (WAI) results upon which there is a maximum score of 7, Lise originally assessed the relationship 6.75, progressing to 6.9 by the third interview. During the final interview, however, her WAI rating returned to her original assessment score, 6.75. Similarly, Marie assessed an improving alliance, which gradually increased from the initial score of 4.75 to a peak of 6.83 at the fifth therapy visit before a slight decline of 6.67 following discharge after the sixth visit. Both participants linked this positive alliance with Lise’s early attainment of her initially established therapy goals (e.g., kitchen activities). This progress in turn led to the establishment of higher level goals (e.g., independent functioning in the community) and the first steps toward their realization by the time of Lise’s discharge from therapy. According to the Occupational Self Assessment (OSA), Lise demonstrated an improvement in her perceived competence in the performance of the itemized functions. Her initial score of 44 (out of a maximum score of 100) again increased

over the course of therapy, again peaked in the third interview at 56, before decreasing to 48 following her discharge from therapy. Considered together, both the WAI (both therapist and client) and OSA scores demonstrated a gradual increase, peaking around the time of the third interview, and then declined slightly at discharge. There is no data available to explain this decline. Although a more comprehensive review of both individual participants' experiences over the course of this relationship may be found in Appendix T (Lise) and U (Marie), below is a graphical representation of the client's and therapist's WAI scores during the intervention as well as the client's OSA scoring (competence only).

Figure 4.1. Graphical Representation of OSA and WAI for Dyad #1



Case Themes

There were seven themes identified within this dyad. These are summarized in Table 4.1 below.

Table 4.1. Summary of Case 1 Themes

<p>Theme 1.1: A deep emotional connection</p> <p>Description: An affective bond between the OT and client, described as a feeling of “love”</p>
<p>Theme 1.2: Positive feelings drove client’s impetus to act with constructive consequences</p> <p>Description: Positive feelings stemming from the interpersonal connection motivated the client to engage in the therapeutic activities and subsequently led to constructive consequences affecting both client and therapist</p>
<p>Theme 1.3: Achievements instilled client confidence and trust in OT</p> <p>Concomitant with progress, client’s self-confidence and insight improved. There was a concurrent enhancement in the client’s confidence and trust in the OT’s competence.</p>
<p>Theme 1.4: Deepening relationship led to higher-level goals</p> <p>Description: After the client’s confidence and trust in the OT deepened, the client shared concerns more openly. Higher level goals were established to address emerging concerns.</p>
<p>Theme 1.5: OT principles enhanced the alliance</p> <p>Description: OT’s appreciation of the importance of the therapeutic relationship and professional principles strengthened the alliance.</p>
<p>Theme 1.6: Client-centred practice contributed to success of the alliance</p> <p>Description: Effective OT includes a customized therapeutic approach, which positively contributed to the success of this alliance.</p>
<p>Theme 1.7: Therapy was enjoyable</p> <p>Description: Both participants described the enjoyment that characterized their time together.</p>

A deep emotional connection. An emotional connection, or bond, was appreciated by both participants, as well as an observer (the other health professional involved in Lise's care). Although Lise consistently expressed positive experiences in the relationship with Marie, which was particularly profound from her perspective, this deepened over time to the extent that during the final interview Lise indicated, "I love Marie a lot more than [the other health professional]." In a conversation with Marie, the other health professional reportedly stated, "Oh she loves you. She doesn't really like me, but she loves you." When reflecting upon the positive bond with Lise, Marie described the following:

I think it's going to sound very weird, but you know there can be chemistry or no chemistry on maybe like an emotional love aspect. I think that the same thing works in therapeutic relationships. There can be a chemistry between two people, and they can have a good therapeutic relationship, or there is not necessarily a chemistry and is very much therapist/client...I don't want to use the term friend, but there was you know a trust...a liking.

Positive feelings drove client's impetus to act with constructive consequences.

The strong interpersonal connection was evidenced in Lise's statement during the final interview, "I wish it (OT) wouldn't stop. I would like her to come and see me once in a while after we're finished." Lise's social isolation combined with her strong positive connection with Marie may in fact have created an impetus for Lise to engage in therapy.

Marie opined:

She grew attached to the visits and to the company which addressed maybe certain issues of feeling lonely...I think the social aspect was a big thing for her, me coming in every week, it kind of encouraged her and almost pushed her to say, "Oh I'm going

to have to say something good to Marie that I accomplished something last week.” So maybe gave her a boost to do, to act.

Lise’s engagement translated into tangible and meaningful improvements, “Marie helped me with different activities, like showed me how to do things in my kitchen that would improve the way I was doing it...it was meaningful to me.” As a result, Lise’s insight into her abilities improved and, with it, her self-confidence. This is exemplified by Marie’s description of the turning point during this therapeutic intervention. After a therapy session in which they worked together to bake a cake, Marie returned for the next session prepared to bake a second cake, as per Lise’s stated goals. Upon arrival, however, Lise reported to Marie:

I already made a cake. I felt really good after what we did and I made the cake, and then did this, and this, and this, in the kitchen. You showed that I could do it...that I had the ability to do it.

During the final interview, after many of her supports (OT, PT, chronic pain program) had concluded, Lise reflected on her newfound confidence and determination, “I keep doing what they asked me to do. The fact that they’re done doesn’t stop me from doing things.” Lise’s attribution of her functional success to the rehabilitative efforts is paralleled in the WAI and OSA results that demonstrate a general concordant pattern of enhancement during the course of therapy.

Achievements instilled client confidence and trust in OT. In parallel with Lise’s improved self-confidence and insight, there was also a described concurrent enhancement in her confidence in Marie’s competence. Lise attributed her improvements to the therapy with Marie, “the relationship really helped me improve.” Lise explained that her confidence in

Marie grew because, “she talked to me about what we’re going to do and why we’re doing it. She knows what she is doing.” Furthermore, Lise indicated that she trusted Marie “because she was knowledgeable in what she was doing. She had confidence in what she was doing so that gave me confidence in her.” The constructs of having confidence in Marie’s competence and trusting Marie thus appeared to be intertwined, “Marie knew what she was doing and that helped me, I mean I trusted her...If you don’t trust people, they can’t help you...If I don’t feel she knows what she’s doing, then I’m not going to relate to her.”

Deepening relationship led to higher-level goals. Marie opined that the selection of attainable goals for the intervention period is an important consideration in that the attainment of the goals feeds the client’s sense of success and in turn influences the alliance:

It [the alliance] grew, in part, because she got better and as much as she got better she was able to do more and she realized, “I can do...what I had established.” These goals from the get-go I knew that we could attain them. She was like, “Really, I would be able to do things in the kitchen?” and then she went and did a whole bunch of things in the kitchen. So I think that [the alliance] grew because she got better...as she got better we were able to do more and push the envelope onto those goals.

The attainment of the therapy goals appeared to reinforce Lise’s confidence in Marie’s competence. As her trust in Marie deepened, Lise shared more intimate psychosocial information. The achieved success, parceled with the sharing of more intimate information, resulted in Lise establishing higher level goals (e.g., independent community mobility, community volunteering role). As a result, some of the psychosocial ramifications of Lise’s condition (marital discord, loneliness) were also addressed through occupational therapy

intervention. Marie noted “there was never one time that it was just the main goals in the initial assessment that we addressed. There was always a little component [of other issues].”

OT principles enhanced the alliance. Marie considers that OTs are more attuned to the therapeutic relationship than most other healthcare professionals. She attributes this to the conceptual practice models and core values extolled by the profession that she considers contribute to a positive alliance. One of these core values is the use of a holistic approach to client care:

Maybe it’s because it’s drilled into us - the holistic view of a person. Look at all the dimensions and the models that we have. We look at the environment and we look at the psychosocial, we look at the affective, the physical, the cognitive. That sometimes is not taught in other disciplines.

OTs use a client-centred philosophy in that the therapy goals and activities are to be focused upon personally meaningful occupations defined by the client. Marie pointed to the client-centred approach as being an important difference between the success of her alliance with Lise and that with the “other health professional”:

I think that might be a little bit of difference in my discipline and maybe in another discipline. Occupational therapy can take certain avenues and some activities that the client appreciates in order to achieve some of the goals, as opposed to maybe just doing...something that she is not liking, but it’s to maximize her function.

In fact, for Lise, what seemed to set Marie apart from others was the fact that “she is trying to understand [me] and what [I] need.” Lise considered Marie’s client-centred approach to treatment to be “very important”:

Marie asked about my problems and what I wanted to do. I told her I wanted to do some cooking and things like that. She said she would help and asked what I would like to do. I told her I wanted to start baking and using my stove.

A further core occupational therapy value that appeared to contribute to Lise's appreciation of the alliance with Marie was the use of collaboration between therapist and client. Lise described feeling like a valued participant in the therapy process, "We can talk to one another. She listens to what I say and I listen to what she says." As described by Lise, collaboration was also evident in their cooperative and mutual participation:

Well I happened to mention to Marie that I was in a sandbag group and I would like to do it on my own, without my chair. She said, "Oh well, we've got a little board. I'll bring it in." I then mention it to the girl in charge and she said, "Oh we'll leave the big board out so you can play, you can use it."

Client-centred practice contributed to success of the alliance. In addition to a high regard for Marie's professional competence, Lise also appreciated Marie's strong interpersonal competencies. Lise described Marie as "*entregens*," understanding, easy to get along with and talk to, very nice, and reliable. She described Marie as a "good teacher," and also appreciated her encouragement and support. Lise's high regard for Marie's interpersonal skills was further highlighted by the conflict with the "other health professional" that appeared to be interpersonal in nature attributable to a perceived lack of respect for Lise's identified needs, "the way she'd tell me to do the exercises and have me do more exercises for my arms than my legs and the problem is my legs not my arms...pissed me off." In comparison, Marie's approach to intervention with Lise was not haphazard or driven by her own comfortable habitual preferences, but rather was purposefully reflective of

Lise's idiosyncratic needs. Marie insightfully decided that her dominant therapeutic mode of problem solving was not most appropriate with Lise because "there wasn't necessarily problems that were the root of the goals that I had to work on." Rather, when working with Lise, Marie's predominant mode was instructing: "It was more like instructing, like how could she apply something that I was doing with her...more encouraging her, well on that good day you can do something but also don't do as much...she mostly needed just some guidance." Lise described, "she gave me tricks...she understood what I needed...she helped me." Marie demonstrated the ability to simultaneously function within the relationship, but also as an observer with the ability to analyze the interaction and modify her approach to enhance the success of the intervention.

Therapy was enjoyable. Both participants discussed the importance of the client's enjoyment of therapy. Marie explained that the activities performed during therapy are selected based upon the outlined goals, but she also considers the client's interests, age, and cognition. She further explained that she attempts to choose entertaining activities, although there is always an educational component, "we do try to get a form of play or game...something of interest...I try to put that in and then some education." In reflecting on the intervention, Lise emphasized the productive focus of the intervention, but she described their time together as "having fun." In her counsel to newly graduated therapists, Lise indicated that therapists should consider the importance of "making it fun...a fun basis...light...but not just fun...they're there to do a job, but make it fun to do though." Lise indicated that engaging in meaningful and productive pursuits toward her therapy goals in an enjoyable manner was a highlight of the intervention with Marie.

Case Summary

A deep emotional connection, or bond, was created between Lise and Marie that may have been fuelled by Lise's social isolation. This appeared to establish an impetus to act in which Lise then wanted to please Marie, or meet her expectations, thus encouraging Lise's engagement in activities in which she had not participated in many years. The ensuing achievements enhanced Lise's insight into her abilities and fueled her self-confidence, as well as confidence in Marie's competence. This success, in combination with the maturing relationship, led to Lise sharing more personal concerns with Marie as a result of which higher level goals were established. The concordant enhancement in the client's perceived functional abilities and the working alliance is further reflected by the general pattern found in the WAI and OSA results. Both the underlying values of OT, as well as Marie's interpersonal and professional skill, were considered to foster the therapeutic alliance. Both participants reflected on the enjoyment derived from the therapy time together. This central characteristics of the relationship was carefully characterized as occurring within the productive nature of the endeavour.

Case 2: Georgia and Helene

Georgia was injured in an MVA in November 2007. The most serious of her injuries was a facial injury that resulted in a permanent vision deficit. Shortly following the accident, Georgia was released back to work at the bank. Georgia described the treatment that she received during this return to work as "psychological harassment." She left work for a second eye surgery in April 2008, however, the surgery did not restore her vision as anticipated. Georgia continued to struggle with impaired vision, cognitive problems, persistent pain, and she was later diagnosed with depression.

Georgia. Georgia is a bilingual, white, Canadian who was 55 years of age at the time of study participation. Georgia assessed her family income as less than average as defined by Canadian Census data for the metropolitan area of Ottawa, Ontario. Georgia completed high school and had been working in a bank for 15 years prior to the MVA. Georgia had been planning to retire with a partial pension approximately 2.5 years following the MVA. Her pension was in jeopardy as she has not yet worked the minimum required years to receive the pension. Georgia is married and lives with her husband. The couple has an adult daughter and a young granddaughter to whom Georgia provides care two days per week. Georgia has several extended family members with whom she has a close relationship, “Regarding family, I am passionate to the bone.” She also enjoys her rural home and particularly the outdoors where she has ample gardens.

Helene. Helene, who was 45 years of age at the time of study participation, is a bilingual, white, Canadian with an above average household income. She graduated with an undergraduate degree in OT in 1988 and has since practiced in a variety of positions. She is currently self-employed with a clinical focus upon the treatment of clients with traumatic brain injury (TBI). Helene respects the importance of the therapeutic alliance. During the initial client interview, she asks clients their five most prominent wishes, “their bucket list.” She also encourages the clients to ask five questions about her. This reciprocal exchange encourages a budding interpersonal connection.

Helene describes herself as a non-traditional occupational therapist. For example, she will periodically interject an unconventional activity (e.g., pedal boating on the canal) into the therapy. She will build in goal-related therapeutic components, however, a significant consideration is the maintenance of the client’s interest in therapy. Helene identified her

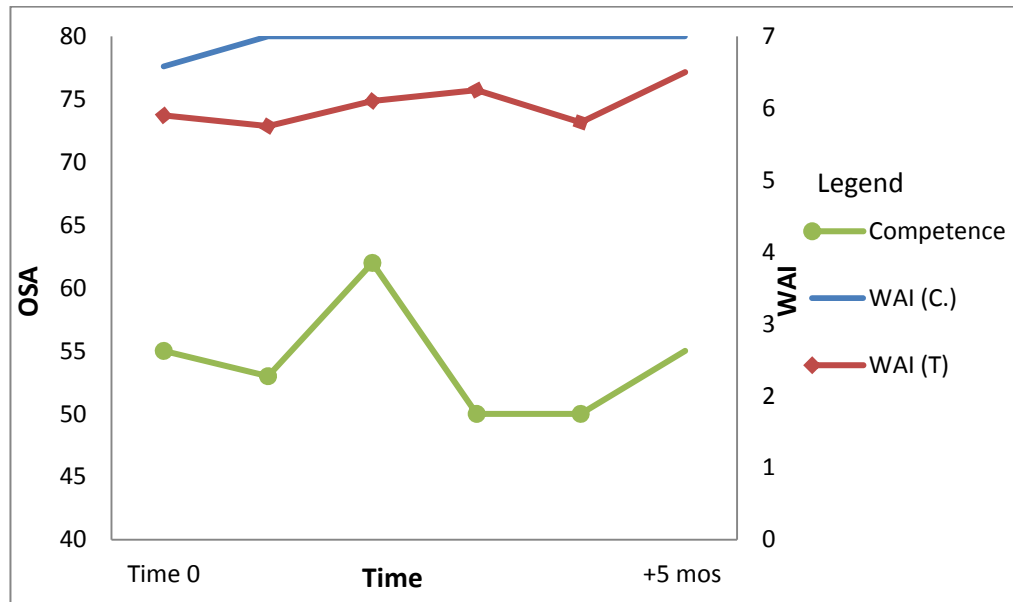
dominant therapeutic mode as problem solving. Running a distant second are collaborating and instructing. Empathizing and encouraging are not natural dispositions. Rather, she tries to mobilize the client through problem solving toward an action plan, “Yes I empathize with how you’re feeling but...let’s develop some insight into why this is like this so let’s problem solve it and then let’s go on to action mode.”

Overview of Therapy Process

The original referral that Helene received from the psychiatrist read, “Please see this lady with mild TBI for pacing strategies.” Helene and Georgia worked together in Georgia’s home for eight sessions from January through June 2009. Prior to initiating further therapy to address Georgia’s expressed desire for support to return to work, Helene requested a neuropsychological evaluation (neuropsych) to clarify the etiology of Georgia’s cognitive issues. The results were not in keeping with Georgia’s expectations in that they indicated the etiology of her cognitive issues was her emotional health rather than a brain injury.

The second block of therapy, which occurred between September 2009 and February 2010, was also comprised of eight in-home therapy sessions and was the subject of this study’s participation. Unlike the first block, this second block of therapy was not successful in the attainment of the originally-identified therapy goal. Georgia initially indicated, “I would love to be able to function like before...to be functional at work,” but “if we look at Georgia not working, I can live with this.” Therein lay evident ambivalence. Regardless, Georgia repeatedly referred to the central objective of her therapy as her work-related skills (e.g., ability to read, “volunteer work that will bring me as close to the things I used to do at work”). From Helene’s perspective, “the second [therapy] block was really intended to move towards assessing her generic worker skills in volunteer activities. Getting her to get

out, find something to do.” Although Georgia’s self-awareness improved, Helene explained, “The client didn’t really obtain clarity of what she was looking for.” By the end of the second block, Georgia had not identified a volunteer position in which to practice her work-related skills and had still not outwardly finalized her decision regarding returning to some form of employment. A parallel may be found in Georgia’s Occupational Self Assessment (OSA) results. Although there were some minor variations during the course of therapy, Georgia’s assessed her functional competence as a score of 55 (out of a possible 100) both at the beginning and end of this second therapy block. Despite the limited measurable functional enhancements, using the Working Alliance Inventory (WAI), Georgia assessed the working alliance as 6.58 (out of a maximum of 7) during the initial interview that increased to a 7 by the second intervention where it remained for the duration of the therapy. There was thus a ceiling effect limiting the degree of improvement over the course of therapy. Similarly, Helene initially assessed the working alliance as a 5.9 at the commencement of the therapy with a general overall pattern of strengthening to a 6.5 upon discharge from this second block of therapy. Below is a graphical representation of the client’s and therapist’s WAI scores during the intervention as well as the client’s OSA scoring (competence only).

Figure 4.2. Graphical Representation of OSA and WAI for Dyad #2

Consistent with their narrative descriptions, this dyad demonstrated a strong emotional bond, however, Helene admitted some level of frustration with the lack of progress toward Georgia's stated goal of return to work. This appears to be reflected by Helene's lowest WAI scores falling within the Goal subdomain of the scale.

In addition to Georgia's perceived mistreatment during her first return to work process, there were several other factors that formed a backdrop to the intervention with Helene. These included Georgia's ambivalence concerning her goal of returning to work, the actions of the two insurance companies implicated in this case, and the influences of Georgia's lawyer and family. A comprehensive review of each participant's experience over the course of this relationship may be found in Appendix V and W.

Case Themes

There were seven themes identified within this dyad, and these are summarized in the Table 4.2 below.

Table 4.2. Summary of Case 2 Themes

<p>Theme 2.1: Emotional health influenced therapy outcomes</p> <p>Description: Although initially resistant to the diagnosis of depression, client began to realize the impact of her emotional health upon her recovery in OT.</p>
<p>Theme 2.2: Working alliance created a milieu encouraging of the client's exploration of ambivalence about therapy goals</p> <p>Description: OT put aside focus on specific outcomes and encouraged client to use the confidential forum of their relationship to explore her ambivalence and preferred objectives.</p>
<p>Theme 2.3: Third parties influenced the therapy process</p> <p>Description: Client's trusted advisors (e.g., lawyer, family) reinforced and validated her feelings; her adversaries (e.g., employer, insurers) challenged her perceptions. Despite conflict-ridden environment, the therapeutic alliance remained strong and positive.</p>
<p>Theme 2.4: Client's confidence and trust in OT led to meaningful improvement</p> <p>Description: Client's confidence in OT's competence increased over time, as did her trust. Client's strict adherence to OT strategies effectively remedied her self-confidence.</p>
<p>Theme 2.5: The interpersonal connection provided an impetus to act</p> <p>Description: The interpersonal connection created an impetus for client to engage in therapy and related real-life challenging activities.</p>
<p>Theme 2.6: OT skillfully customized her approach to meet client needs</p> <p>Description: OT tailored her therapeutic approach to address the client's specific needs.</p>
<p>Theme 2.7: Laughter enhances therapy</p> <p>Description: Laughter was a common feature of the therapy meetings and facilitated working through challenges.</p>

Emotional health influenced therapy outcomes. Georgia was released back to work six weeks following the accident despite ongoing limitations. Due primarily to her visual deficits, but compounded by her pain and fatigue, Georgia struggled to perform her work duties, “Everything I had to read I would not read. I would pretend I’m reading but it was so demanding I would not read.” Georgia’s manager became concerned with her work performance. Resentment grew and culminated in Georgia describing the treatment she received as “psychological harassment.” Following the failure of further eye surgery, Georgia made a decision that she would not allow herself to continue to be mistreated, “It was hell!...I wanted to die because I’m not an animal...Finally I told myself I will not go back to work until I am 100% better.” As recounted by Helene, this mindset, likely exacerbated by her depression, deleteriously impacted Georgia’s rehabilitation progress:

The struggles I had were the whole emotional stuff...Georgia has some goals she wants to work towards. There’s some emotional barriers there...unless we address...[the underlying emotional condition] I don’t think we’re going to be able to use this stuff very much.

Georgia was resistant to the diagnosis of depression. Through Helene’s non-judgmental support, she began to appreciate the veracity of the neuropsychological findings that identified the etiology of her difficulties as being depression-related rather than due to a TBI. Helene explained to Georgia that regardless of the etiology of her difficulties, OT was involved to address her functional deficits, “Maybe you’re depressed. Maybe it’s the brain. But the reality is, functionally there’s problems.” Over time, Georgia’s insight improved, “Maybe I was depressed. ‘The want’ is back now and turning the situation around.” Helene reflected, “The last session was very telling when she said, “I’m starting to think now that

there is more to what [the Neuropsychologist] said than I actually thought.” She was kind of opening up that door.”

Working alliance created a milieu encouraging of the client’s exploration of ambivalence about therapy goals. Despite Georgia’s identified primary objective for this therapy block being a return to work, Georgia began to openly question whether a return to work was truly her prime objective. Helene encouraged Georgia to use their working alliance as a medium to seek clarification within the complex context of medical, insurance, legal, and employer factors:

She was comfortable as she got to know me, talking about some of her change of heart, going back to work, not going back to work, and I think I made it possible for her to say, “What’s between you and I is between you and I.” You need to use me to figure out what do you want? Do you want to go back to work? And there was the waffling back and forth but I saw that as a good thing. Whereas at the beginning, “Yes, I’m going back to work.”

As reflected in the OSA results, limited measurable progress was achieved during this therapy block. Helene explained, “As you get into the more complicated stuff like work it’s just harder to attain those high level goals with some of the residual difficulties. So, you know, she’s still left with a lot of questions.”

Third parties influenced the therapy process. The people who provided Georgia with emotional support became her trusted advisors, “Empathy, not pity. Empathy like they understand and to me just the fact that someone understands is supportive.” Helene described Georgia’s relegation of those who were less empathetic into a distrusted category:

Those people that she valued were the ones that were providing her with some reinforcement...they were validating it. So [the physiatrist], [her family physician], myself, were all people that acknowledged that there were changes after this injury. Her employer, [the neuropsychologist], [The Bank], her adjuster, this is where the little passive aggressive side of Georgia came out. She didn't like what she was hearing. Georgia resented the disputes and requirements of her insurers, especially since her insurance was held within the same institution as her employment:

I do everything [The Bank]...I send an email to [the claims representative] and I say, "The prescription, is it for you or is it for the chiropractor?" She answered to me, "You are not to send me emails."...This is what I have to go through with the insurance...The hoops, the stupid thing...the technical things.

Helene identified Georgia's lawyer and the funding issues as impacting the outcome of the therapy, but their alliance remained strong and positive. Helene considered, "[The lawyer] probably impacted the most actually...because she wasn't prepared to move forward with anything until she knew if she would have support." "The whole insurance. These factors impacted the goals of therapy, not our relationship."

Client's confidence and trust in OT led to meaningful improvements. Georgia had absolute confidence in Helene's ability to help her, "Everything that we've worked on together has had a positive impact on me." Georgia's great trust and confidence in Helene led to high compliance, "It's total trust...Lots of times I don't even question." Georgia's strict adherence to the use of strategies proposed by Helene led to tangible and meaningful improvements, "Everything has always helped me and I have kept my book. I take notes. Sometimes I forget and I go back to the book." Importantly, these improvements were

practical and meaningful, “At some point it’s good to talk about situations but you have to dip your fingers in it too...with Helene we were able to do that.” “It doesn’t have to be big but it has to...be meaningful.” Georgia’s enhanced abilities (e.g., to read, to engage in cognitive activities) resulted in improved self-confidence that she clearly attributes to Helene, “Helene definitely is on top for helping me regain confidence in myself.” Ultimately, Georgia regained her sense of “being a useful person.”

The bond provided an impetus to act. The interpersonal bond appeared to create an impetus for Georgia to engage, “To me her (skill and knowledge) was of most importance because it drove me.” This impetus was acknowledged despite Georgia’s ongoing goal ambivalence, “I don’t know if I want to do that work trial...because I don’t know if they’re going to try me at my old job with my old manager; this I am terrified. But I owe it to Helene to try.” An impetus to act appeared to be created by the interpersonal bond despite Georgia’s ongoing emotional struggles. The genesis of this impetus appeared to be Georgia’s respect for Helene as well as her desire for future interpersonal connection primed by her otherwise limited social contact:

I really want to keep in touch with my OT because I figure if you’re an OT you take care of this client, this person for so long and you made goals together, you want to see that person succeed and I feel that when I’m there, I want Helene to be the first one to know because I know it’s important to her.

OT skillfully customized her approach to meet client needs. Helene appeared to develop a keen sense of what Georgia needed of her and the relationship and in so demonstrated an enhanced ability to use the alliance as a medium for client development. Georgia extolled the value of Helene’s client-centered and tailored approach, “Helene is very

personal with my situation...It's better [than with other professionals]. It's more personal and it's more focused on my situation." Helene explained this approach was purposeful in its design, "She just thought the world of these strategies in that they made such a difference for her...I always try to apply very much to what they do." In light of Georgia's cognitive functioning, which was higher than the majority of Helene's other clients, Helene deviated from her dominant therapeutic mode of problem solving to collaborating, "I could do it more on an even collaborative level...she was able to contribute more in the sessions because she was higher functioning cognitively, what the issues were, what the problems were, what she had tried, what she hadn't." Georgia, in turn, actively participated, "When someone gives that kind of attention to you, you have to give it back. Like Helene always say no you do it for you. Yes, I know it's for me. But we're both working for me."

Helene used personal sharing to forge a strong interpersonal bond, which was necessarily strong to effectively navigate the contentious issues to be explored. Georgia cited, "When she talked about her mother that has Alzheimer, I am listening to this woman and I say "God she is so beautiful. I want to know more about her." This strong bond served to create a milieu capable of withstanding conflict and fostering client development:

The whole neuropsych thing was very pivotal because it wasn't the results that she expected. She was looking for me to support what she was thinking. I didn't take on that position. I empathized. I understood where she was coming from. Tried to get her to see that there could be a different perspective.

Over time, and attributable to Helene's insightful approach that served as a conduit, Georgia came to realize that the neuropsych results were more accurate than she had originally accepted.

Laughter enhances therapy. Georgia repeatedly referred to the enjoyment she derived from therapy, “She’s funny...we always had fun.” Helene reflected that the use of humour served to distract Georgia from the challenge of therapeutic activity, “I think she always had more fun and I think that’s where some of the psychological stuff comes into play, when it wasn’t so work focused and cognitive focused.”

Case Summary

Although Georgia’s emotional health impacted the measurable recovery as reflected in both the OSA results and the lack of goal attainment, the working alliance provided a conduit for Georgia’s developing insight into the implications of her emotional health as well as a confidential milieu in which she could explore her ambivalence about returning to work. Within her environment, Georgia identified trusted advisors and adversaries. Regardless of this conflict-ridden environment, the two women developed a strong working alliance and enjoyed their time together. Stemming from their interpersonal bond, there appeared to be an impetus to act created for Georgia. As a result, Georgia strictly adhered to the proposed strategies that in turn enabled functional improvements and enhanced her self-confidence. In summary, although the working alliance was necessary to enhance the client’s insight, in this therapeutic context, it was insufficient at this stage in the attainment of measurable progress toward the outlined goals. On the other hand, despite the lack of progress toward her return to work goal and some associated frustration, Helene worked to maintain a strong working alliance throughout the intervention.

Case 3: Jackson and Marie

Jackson was diagnosed with Parkinson’s Disease seven years ago. Recently, his symptoms worsened, so his neurologist recommended occupational therapy (OT).

Jackson. Jackson is a 63-year-old, retired high school teacher. He is Caucasian and speaks both English and French. His family income is less than average as defined by the 2006 Canadian census data. Jackson lives with his wife. The couple has two independent adult sons. After noticing a twitching in his finger seven years ago, Jackson's family physician referred him to a Neurologist who diagnosed Parkinson's, prescribed medication, and has followed Jackson since. Jackson's current difficulties include cognitive limitations, sleep disturbance, mood disorder, as well as mobility difficulties and associated falls. For Jackson, the primary objective of therapy was to enhance his physical functioning (e.g., improved walking endurance, reduce risk of falls).

Overview of Therapy Process

Although initially indifferent, Jackson acquiesced to his neurologist's recommendation for OT. Jackson met with Marie at his home for nine visits between March and June 2010. Jackson vaguely described the goals of the intervention as, "Well physically she could help me as far as being able to walk properly. To still enjoy doing the things that I used to do...Living and enjoying the time I have left." Marie identified the following more specific therapy goals:

One of them was to increase his endurance for walking. The other was to limit the risk of falls or the ability to get up from a fall. There was dressing...There was one related to memory. There was just establishing a daily routine of activities so he wouldn't fall into a zombie-like status.

Upon conclusion of therapy, Jackson assessed modest progress, "a little bit I think." This description is consistent with Jackson's results on the Occupational Self Assessment using which he assessed a modest improvement in his perceived competence from the beginning

(score of 41, out of a possible score of 100) through the end (score of 46) of therapy.

Throughout, his scores remained mid-range indicative of his feelings of modest competence.

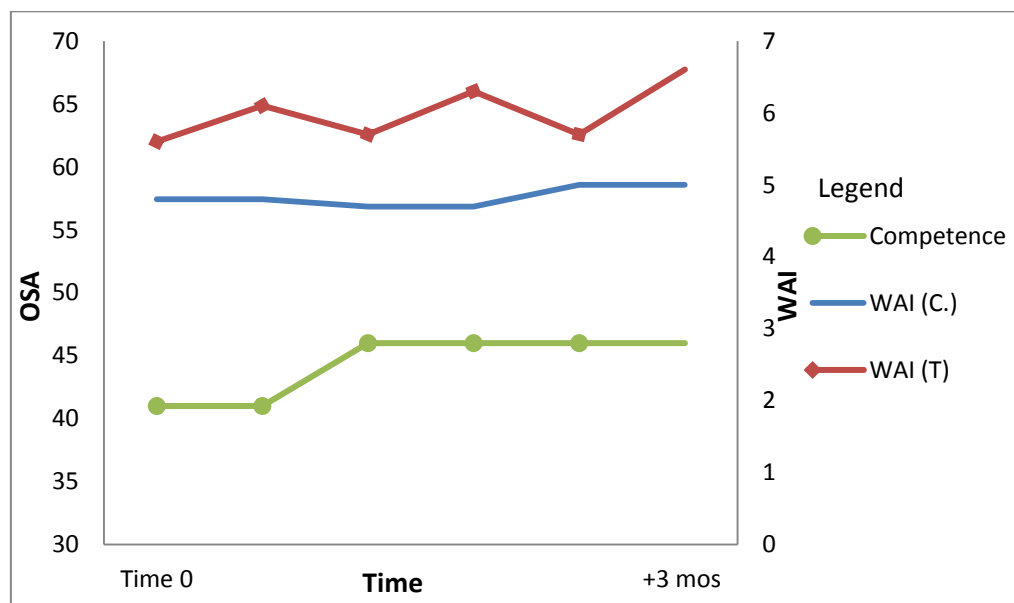
On the other hand, Marie appeared more satisfied with their achievements:

The walking we attained then we increased the distance and the frequency. He started establishing his own SMART goals in a book. Very quickly he was able to get up from the ground... We showed him the dressing aids.... [the memory goal] was mainly dropped at his request so we could work on the walking, the physical activity and just communicating, just talking...not a big barrier but a barrier was his mood.

As a clinical educator, Marie often has a student with her. In fact, Jackson met two OT students the second of whom was present for the majority of the therapy. Jackson initially approached OT with disinterest. Over time, however, he appeared to become increasingly engaged. In fact, it appeared that his enjoyment of the social contact was the engaging agent to the therapeutic process that served to address multiple implications of his disease. On the Working Alliance Inventory (WAI), Jackson consistently assessed a moderately strong alliance from the beginning (score 4.8, out of a possible 7) through the end (score of 5) of therapy. The most significant variation occurred in the goal domain that dipped during the second interview (initial interview score: 5.25, out of a possible 7; second interview score: 4.25; final interview score: 5.25). Jackson described a negative response to the goal related to cognition. As a result, he requested that this goal be dropped from the therapy agenda. It is surmised that this may explain the dip that occurred in the goal subscale mid-way through the therapy. Jackson enjoyed joking and teasing the therapists. Unfortunately the nature of his humour was often sexual. Due to Jackson's objectionable

sense of humour, Marie reinforced the professional boundaries and shared minimal personal information. Despite the discomfort caused by Jackson’s inappropriate humour, and perceived as a reflection of her dedication to the building of the working alliance despite the unfavourable context, using the WAI Marie initially assessed the working alliance as 5.6, out of a possible score of 7. This score variably but gradually increased to a score of 6.6 at the time of discharge. Despite the uncomfortable context at times, Marie described the time spent with Jackson as “pleasant” and “positive,” and opined that the importance of the alliance to Jackson was from a social companionship perspective. In other words, despite her own discomfort, Marie resolutely built an alliance whose sole focus was to address Jackson’s OT-related needs. A more comprehensive review of Jackson’s and Marie’s individual experiences over the course of this relationship may be found in Appendix X and Y. Below is a graphical representation of the client’s and therapist’s WAI composite scores during the intervention as well as the client’s OSA scoring (competence only).

Figure 4.3. Graphical Representation of OSA and WAI for Dyad #3



Case Themes

There were six themes identified within this dyad. These are summarized in Table 4.3 below.

Table 4.3. Summary of Case 3 Themes

<p>Theme 3.1: Spiral of Parkinson Disease’s sequelae required holistic OT</p> <p>Description: A vicious, perpetuating downward spiral involving multi-systemic limitations required holistic approach by OT</p>
<p>Theme 3.2: Fear was both motivation and barrier to OT goals</p> <p>Description: Client’s fear created both motivation and barriers in the pursuit of OT goals</p>
<p>Theme 3.3: Client’s spouse as therapeutic ally</p> <p>Description: Client’s spouse’s supportive yet challenging approach was consistent with the messages provided by OT and thus served to reinforce one another.</p>
<p>Theme 3.4: The use of humour in OT</p> <p>Description: Client places significant value on enjoyment and joking around in OT.</p>
<p>Theme 3.5: Sexual joking impacted therapeutic alliance’s bond, comfort, and trust.</p> <p>Description: The sexual nature of client’s sense of humour created a greater distance that was counterproductive at times to client’s desire for a personal connection and also initially impacted the comfort and trust of the alliance.</p>
<p>Theme 3.6: OT established working alliance that engaged client in the therapeutic endeavours.</p> <p>Description: Despite challenges, OT assumed the professional responsibility to create an alliance that appeared to engage the client in therapeutic activities and move toward achieving goals.</p>

Spiral of Parkinson Disease's sequellae required holistic OT. Jackson presents with several interrelated, disease-associated complaints impacting physical, cognitive, and mood abilities. He most openly identified physical limitations, "I also find it very difficult to go for long walks...and I'm afraid of falling again. I fell one time...I was walking and I started picking up speed. I was trying to slow down and I couldn't." Due to a fall three years prior, Jackson fractured his shoulder and is left with persistent reduced range of motion and strength. Subsequently, Jackson did not return to driving, "I stopped driving my car after I broke my shoulder and the decision that the streets would not be safe with me driving in the condition I was in."

Despite his focus on physical limitations, cognition was in fact Jackson's first cited complaint, "I'm having a harder time keeping my thoughts together. I go to say something and my mind goes blank...I am really bad repeating a story." As a result, Jackson prefers to minimize situations requiring conversation (e.g., Parkinson's support group). Despite his awareness, Jackson attributed his cognitive difficulties to age-related changes, "We sort of laugh about it, because all my friends my age anyways we're having the same thing." With Marie's encouragement, Jackson acquiesced to a cognitive assessment. Over time, however, Jackson requested that cognitive activities be stopped. Marie stated, "When we did it, he just got frustrated."

Marie reported a "dip" in Jackson's mood in the middle of treatment: "He became more distant, less motivated, just more flat. Less engaged or happy about certain goals that he had achieved." Concurrently, Jackson admitted to the researcher, "I'm not suicidal...I just feel a little bit depressed. I don't have that many friends out here and when you don't have a car it's a little difficult." Jackson's social isolation was further compounded by his

impaired mobility and related fear, as well as his reduced ability to engage in leisure activities (e.g., tennis). Social isolation and lack of meaningful engagements may have contributed to his mood that then likely exacerbated other conditions (e.g., fewer cognitive and physical engagements led to reduced conditioning) in a vicious perpetuating downward spiral. It is within this context that the holistic approach used in OT can be appreciated. As per Jackson's motivations, the predominant therapy tasks involved physical activities (e.g., walking, falls prevention, dressing), however, Marie also used these tasks to segue to encouraging a healthy repertoire of varied daily activity to maintain his activity engagement and address his social isolation. She encouraged Jackson to consider his cognition limitations, and also to seek medical assistance for his mood-related issues and explained to him the interconnected nature of health, "how working on one thing can help another."

Fear was both motivation and barrier to OT goals. Jackson repeatedly expressed varied fears. He predominantly described fear related to the implications of his impaired mobility, fall hazards, and reduced activity tolerance:

I also find it very difficult to go for long walks...I can't do that and I'm afraid of falling again...I go out everyday to pick up the mail, bring it back, but it's only a very short trip and I'm afraid of going much further because, there's no place to stop along the way.

Although Jackson feared for his safety, he also feared the implications of his condition upon the enjoyment others experienced in his presence. Referring to a pending European trip with his wife and her relatives, Jackson cited, "That's a fear I have about the trip we're taking too...I'm quite concerned about being able to contribute to the fun aspect." Jackson astutely pointed out that this fear has also created some motivation to improve his

mobility, “[The European trip] gives me a goal. And there’s a motivational factor in walking also because you don’t want to be stuck out there some place.” His fear associated with this trip thus served as motivation to entice Jackson’s engagement in the pursuit of the OT goals.

Although Jackson’s fear may have provided motivation on one hand, on the other hand there were also barriers created by his fear of others’ perceptions of him. For example, although there is a park in his neighbourhood that would be an ideal goal location to which he could walk, sit, and rest before continuing, Jackson expressed, “I’ll go out to that park out there and sit down for a few seconds but I’m afraid of being centred out as a child molester sitting in the park.” A similar type of worry was expressed as it related to the walks he took with Marie and her student, “I felt safer anyways with a third person being there...One time we went for a walk without Marie...I just worried about what somebody could arrive at when studying that.” Jackson’s fear of others’ illicit perceptions of him provided a barrier. In the context of these fears and in preparation for Jackson’s discharge from therapy, Marie investigated the ways in which he could continue to work toward his goals independently (e.g., endurance building in preparation for autumn European trip).

Client’s spouse as therapeutic ally. Despite his difficulty, Jackson’s wife patiently awaited Jackson’s activity participation in an apparent understanding of the importance to his long-term health, “[She] is tough with me...She’ll watch me struggling to put on my coat and leave it at that.” Jackson described her approach, “giving me hell when I required it. A swift kick in the ass...She’s tough when she has to be and I think she’s very supportive and I deserve it too on occasion.” Jackson recognized his wife’s efforts and established expectations as being to his benefit, although it did create some pressure on him that he appeared to resent at times:

I feel that I've got to fake like I'm busy sometimes. If [my wife] is coming home late...I feel like I turn off the TV set and make it look like I've been busy around the house all day long. She's just doing it for my, what's the word, goodness, or my success.

Marie also identified Jackson's wife as instrumental in his support network. Her expectation setting and patience in encouraging Jackson to engage in those activities in which he remains capable was consistent with the message offered by OT: the importance of Jackson's functional engagement in a meaningful repertoire of activities toward his overall health maintenance.

The use of humour in OT. Jackson places significant value on the importance of enjoyment, both for himself and others, and the use of humour in all aspects of his life, including in OT. As previously cited, he is concerned about his ability to be a source of enjoyment for others as he had been previously. This includes concerns for his wife, "I'm sure she loves me...but she remembers that I used to be a lot more fun than I am now." Jackson valued Marie's humour and the enjoyment he derived, "She kidded around and had a sense of humour."; "She was fun to be with." The ability to enjoy therapy was a characteristic that Jackson believed was important to the nature of the OT intervention, "I think it could have been very, very boring otherwise had we not kidded around and joked around a little bit."

Sexual joking impacted therapeutic alliance's bond, comfort, and trust. Jackson liked to joke with others, but his humour was sometimes inappropriate, "My wife told me to clean up my act and not make any little nasty jokes...Stuff I used to be able to get away with in high school....double entendre and stuff." From Marie's perspective, the sexual nature of

Jackson's humour created concern, "There were some boundaries sometimes that needed to be established. I think his humour sometimes is a little bit risqué." Marie used the case of Jackson to discuss with her students different manners (e.g., redirection, confrontation, setting of firm guidelines) to work with individuals who make inappropriate remarks. As a result, Marie made conscious decisions about the therapeutic purpose of the personal information she shared:

Not sharing too much of my personal life...still sharing some of who I am...I'm not going to completely hide the fact that I was taking part in a race just to show him I had a goal and I did this.

These boundaries may have created distance between Jackson and Marie that may not be typical of Marie's therapeutic relationships. This distancing was sensed by Jackson, "She was distancing herself from her conversations and stuff we'd had before and the student was increasingly expanding her influence with me." This distancing was antithetical to Jackson's desire to know Marie better, "I don't know that much about her personal life or anything."

As compared to the neurologist, Jackson noted enhanced comfort with Marie. He attributed this comfort to the informality of OT, its occurrence in his home, and his feeling of closer equality with Marie. Jackson was careful, however, to point out that he recognized and "respected her ability and her position." Despite this respect, Jackson occasionally used sexual humour. It is queried whether being opposite sex to the OT, the home environment (as compared to a more public clinical setting), and his assessment of closer equality combined to create an atmosphere in which he felt comfortable displaying his objectionable humour. Jackson expressed a sense of comfort with the presence of Marie's students, "I felt safer anyways with a third person being there." This unique statement appears to stem from

Jackson's fear of others' illicit perceptions of him without which a comfort in the third person's present may not have been a consideration.

Jackson attributed his strong, albeit not absolute, trust in Marie to her effective listening, his sense that she maintained his confidentiality, her reliability and resourcefulness, and Jackson's recognition of her training. Although Marie was initially punctual for appointments, overtime Jackson noted that her punctuality declined, which contributed to his less than absolute trust. To illustrate his degree of trust, Marie described their practicing of falls. Upon initiation of the activity, Jackson quickly acquired a position on the ground. When she asked why he proceeded so quickly, Jackson replied, "I figured if something happened, you guys were here to help me." When the nature of Jackson's higher trust in his neurologist was queried, Jackson eventually offered that the neurologist is male and he has known him longer. It is, however, possible that the sexual preoccupation that existed in the OT alliance may have also served to lessen his trust in the OT alliance, perhaps even in himself.

OT established alliance that engaged client in the therapeutic endeavours.

Jackson explained that he became involved with Marie when "[The neurologist] said there were people from [a local institution] who might be interested in the information that I might be able to provide." Similarly, Marie described, "[Jackson] was not hesitant or reluctant but he was indifferent about us coming initially...a lot more obstacles and barriers came out and every single time...he was opening up a little bit more." An evident transition occurred. Jackson was initially obliging and disengaged, but over time, he became more invested in the therapy. Marie attributed this evolution to the socialization opportunity, "I think for him it was the weekly visit, the companionship." In referencing both Jackson and Lise, Marie

questioned, “Sometimes I thought they liked me too much. Is it because they’re isolated and my weekly visit helped them?” There appeared to have been a power created by the social contact and warm friendly feelings. Jackson’s engagement in activities was enticed by the therapists’ attendance, “he realized we were coming then he would say, “Oh no, I’d better get this done.” The power of the relationship to elicit Jackson’s follow through can also be seen concerning his mental health:

He even said, “I didn’t want to fess up that my mood was an issue.” His wife even said that since the [autumn]...she saw his mood deteriorate. They spoke about it but he didn’t address it with the doctor or vice versa until May.

Despite the challenging environment created by Jackson’s sexual joking, Marie’s professionalism and focus on the client’s needs provided a foundation for a sound and effective therapeutic alliance in which accomplishments were realized. Marie focused on what was most important to the client, but some activities were encouraged based upon the therapists’ perception of limited insight, “Because of his state of mind, he needed guidance through accepting certain things that were going on in his life.” Although Jackson did eventually agree to assessing his cognition and subsequently setting related therapy goals, he later requested this be ceased, “There was stuff I did not enjoy doing...please don’t put me through this again...the memory joggers – I do very poorly on that and I just wanted to get out of that topic after a while.” Furthermore, Jackson appreciated the practicality of therapy. He described Marie as “down to earth and not giving me a bunch of theory but practical things to do.” These strategies made for tangible and meaningful improvements. Jackson explained, “What I’m dealing with here is I wanted some information as to how to get out of

bed more easily, practical things like that, and clothing, is there any easy way of getting a shirt on and off.”

Case Summary

Although initially disengaged, Jackson’s fear as well as the enjoyment that he derived from the social interchange appeared to entice his engagement. Jackson’s wife, his key support, sets participation expectations for Jackson that he attributes to his residual abilities, but at times finds burdensome. Jackson places a significant emphasis on the importance of enjoyment for both himself and others. The value in which he holds this construct may explain his use of humour, which unfortunately was objectionable to the therapists by virtue of its sexual nature. Marie reflectively reinforced the professional boundaries of the alliance, which was unfortunately antithetical to Jackson’s desire to have a more personalized relationship with Marie. Despite the challenging context, Marie’s professionalism and dedication prevailed toward the building of an effective therapeutic alliance as evidenced in both her and Jackson’s assessment of the strengthening working alliance over the course of the intervention. The strengthening of the working alliance converged with the modest improvements in Jackson’s perceived functional competence (as measured using the OSA).

Case 4: Kotter and Helene

Kotter was injured in an All Terrain Vehicle (ATV) accident in September 2009. The most enduring of his injuries is a traumatic brain injury (TBI). Kotter returned home from a rehabilitation centre six months post accident and has since been working intensively with Helene, a community based occupational therapist (OT) (who is also functioning as his case manager), as well as a speech language pathologist. Although Kotter’s study participation

was concluded nine months after he joined the study, his rehabilitation continued and he remained actively involved with his rehabilitation team.

Kotter. Kotter is a 39-year-old, white, bilingual male. He was born in Jamaica to Canadian parents and immigrated to Canada as a young child. He lives with his wife and young school-aged daughter in a rural, residential development outside of an Eastern Ontario town commuting distance to Ottawa. His wife has remained at home since the birth of their daughter six years previous. As a result, Kotter was the sole family income provider prior to the accident and prided himself on his strong work ethic, “I was always in Ottawa before. I was a workaholic.” Kotter worked as a sales coordinator for a weekly newspaper publication. The pre-accident family income was defined as less than average compared to 2006 area census data.

Overview of Therapy Process

Helene facilitated Kotter’s discharge home from the rehabilitation centre and then commenced intervention two to three times per week at Kotter’s home. Kotter’s ultimate objective was a return to gainful employment and his role as income provider to his family. In order to achieve this, he had to first regain his driver’s license that was revoked following his injury. Kotter did not describe short-term goals within these large, longer term objectives. As a result, he described the progress toward their attainment as, “slow.” During the final interview, Kotter quantified his overall progress to date as “sixty percent.” On the Occupational Self Assessment (OSA), used to quantify Kotter’s perceived competence and value he attributed to the listed tasks, there was a pattern of increasing competence in the first several months (68, 69, 76, out of a possible score of 100), with a peak in the fifth month with a score of 80. In the last three months of his study participation, however,

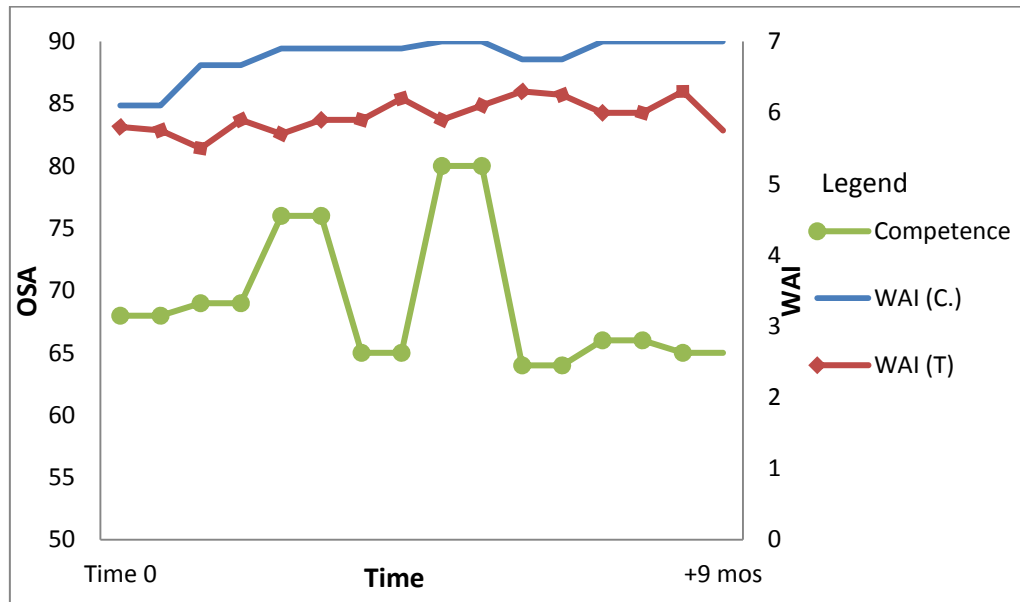
Kotter's perceived competence declined to approximate his original score, as assessed using the OSA (64, 66, 65).

Helene described the holistic therapy objectives, "to reintegrate him into as many of his life roles" as possible, including his own autonomy and his pre-accident roles as husband, parent, and worker. Working at a cognitive level to enhance the development of Kotter's insight, she explained, "the initial short term goal was being home alone safely, able to manage his basic instrumental activities of daily living with less supervision. We've achieved those goals. The next big goal is obviously can he work in any capacity?" To that end, Helene noted, "I don't think we have enough data...there's still room to get a better sense for whether he can integrate in that role."

The therapeutic alliance was described by both participants in highly positive terms characterized by their strong bond. Using the Working Alliance Inventory (WAI), Kotter assessed a strong working alliance from the beginning of the study (initial interview score of 6.1 out of a possible score of 7). Kotter had been acquainted with Helene throughout his transition to home process. This facilitated comfortable familiarity by the time of the initial assessment. This continuity of care/acquaintance during the transition from the rehabilitation centre to home may have served to further enhance the client's trust in Helene at this early stage. During the final interview, Kotter described Helene as follows, "I'm not saying she's perfect, but to me she is because I have no issues." This sentiment is reflected in the consistently strong WAI results (approaching or capping out at 7 by the third interview). The Bond subscale reached a ceiling effect by the second interview when Kotter maximally assessed the bond as 7 out of 7, which was consistent there onward. The Task and Goal subscales demonstrated some degree of minor fluctuation, which may possibly be explained

by Kotter's periodic lack of clarity concerning the purpose of therapeutic activities in comparison to his overarching goal of returning to his normal work life. Helene's evaluation of the working alliance using the WAI also demonstrated strong results, particularly in the bond subscale (ranging from 6.5 to 6.75, out of 7). This is consistent with Helene's qualitative depiction of the alliance, described as positive, easy, and pleasant, and facilitated by Kotter's high degree of compliance, engagement, energy, and social nature. The lowest of the three WAI subscales in Helene's evaluation was most consistently found in the goal domain (commencing at 5.25, varying as high as 6 and then dropping to a 4.75 at the time of study completion). Kotter's primary goals since his return home were a return to driving and work. Helene, on the other hand, was not confident that these were attainable goals given the extent of Kotter's cognitive impairments. This disconnect may possibly serve to explain the lowest rating falling in the goal subscale. The strong alliance, which demonstrated the ability to effectively withstand the stressors of the client's limited perceived functional competency improvement, was embedded within a supportive environment of neighbours and friends, as well as the existing marital relationship. Although a more comprehensive review of the individual participants' experience over the course of this relationship may be found in Appendix Z and AA, a graphical representation of the client's and therapist's WAI scores during the intervention as well as the client's OSA scoring (competence only) appears below. Notably, the working alliance grew stronger over time despite a lack, and in fact a slight deterioration, in the client's perceived functional competence, between the beginning and conclusion of therapy. This represents a divergence of the two constructs.

Figure 4.4. Graphical Representation of OSA and WAI for Dyad #4



Case Themes

There were eight themes identified within this dyad, and these are summarized in the Table 4.4 below.

Table 4.4. Summary of Case 4 Themes

<p>Theme 4.1: Injury presented challenges for OT process.</p> <p>Description: Client’s injuries and limited insight resulted in his frustration as well as a gap between his and therapist’s foci for therapy</p>
<p>Theme 4.2: Therapist used a customized therapeutic approach.</p> <p>Description: Therapist used an approach customized to the client’s specific therapeutic needs, as well as his interests and life roles.</p>
<p>Theme 4.3: Family provider: Client’s single-minded focus on therapy goal.</p> <p>Description: Client was the family’s provider, which he considered his primary responsibility and his primary objective for therapy</p>

<p>Theme 4.4: OT lent itself to client’s productivity and meaningful occupation.</p> <p>Description: While not working, client committed to remain productive in daily activities, which provided meaningful occupations and fodder for therapeutic activities.</p>
<p>Theme 4.5: Therapeutic alliance was a pleasant and respectful social connection.</p> <p>Description: The therapeutic alliance provided client with social connectivity, which he valued for its pleasantness with some degree of humour as well as mandatory respect.</p>
<p>Theme 4.6: Therapist’s self-disclosure and stretching of therapeutic boundaries reinforced the bond.</p> <p>Description: Therapist’s sharing of personal information and time reinforced the connection.</p>
<p>Theme 4.7: Environmental factors both helped and hindered the course of recovery.</p> <p>Description: Environmental factors and relationships impacted client’s rehabilitative course.</p>
<p>Theme 4.8: Therapist’s dual role enhanced trust and confidence.</p> <p>Description: Therapist’s dual role as OT and case manager enhanced client’s trust and confidence.</p>

Injury presented challenges for OT process. Since Kotter’s physical injuries had largely resolved, he considered himself mostly recovered. In keeping with his highly cooperative nature, Kotter complied with the medical restrictions imposed upon him (i.e., no driving, no contact sports, no drinking of alcohol). Over time, however, frustration grew: “One of my friends was going...skating with his daughter and he invited us...I told my wife I could bring my skates. She said, “No, no they don’t want you to do anything!” It’s like put me in a bubble then!”

Helene described Kotter’s impaired insight as a “huge barrier to further progress at the higher level because I don’t think there’s any question in Kotter’s mind that as soon as he

can drive, he can work.” As reflected in the weakest subscales on the WAI being the task and goal subscales, due to his impaired insight Kotter demonstrated limited understanding of the therapeutic endeavours, “He’s got a better understanding than two months ago as to why we want him to volunteer. Does he have a thorough understanding of that goal? I’m not sure the brain has [that] capacity.” The development of Kotter’s insight was Helene’s primary focus. Although both parties were consistent in their global objective for therapy, which was to reintegrate Kotter into as many life roles as possible, differences in the short term goals existed.

Therapist used a customized therapeutic approach. Helene made evident efforts to manage the gap between her and Kotter’s goals. For example, Kotter’s values, personality, and pre-accident life roles were evidently considered in the development of the goals and activities of therapy. For example, Helene described a therapy session:

He had to think of three activities on his own of things that he needed to do. What he chose was his Cognifit training for that day, a return e-mail...to a volunteer organization...and the third was a repair in the garage...Then I introduced three activities of my own which was a baking activity, a newspaper article reading with sort of general discussion and...the logical game.

Helene identified her natural therapeutic mode as problem solving. This was prevalent and successful in many areas with Kotter; however, Helene also reflectively changed modes when required, “If the problem solving model is just a little bit too challenging for him on certain issues, I will use more of an instructing mode.”

Family provider: Client’s single minded focus on therapy goal. Kotter was the sole provider to his family, which he considered to be his responsibility, “I feel my

responsibility is to be, my wife hasn't worked for six years, and I was the income." Kotter had otherwise been successful in reclaiming his life roles, "I pretty much have the rest. I mean I have my family and my home." Kotter reported confidence in having a position to return to with his pre-accident employer, "He said don't you worry. When you get back and when you get your license, you'll have your job back." Throughout the duration of the study, as the next step toward his return to work, Kotter was marking the slow progress toward the driving assessment required for the reinstatement of his license. Despite Kotter's confidence, Helene expressed concern:

I'm sitting on the fence...his divided attention is very, very poor. I don't think he will do well on road. I think he will probably get by on the off road but...that could go either way depending on how he is and where they take him.

Although Kotter never expressed concern for his success on the driving assessment, by the final interview, Kotter was beginning to discuss some trepidation about his ability to perform his pre-accident employment, "I just wonder if I'll be able to do it. Maybe I'll get the job back and then they'll have to fire me because I'm not efficient." Kotter's diminishing sense of confidence in his functional abilities, as reflected on the later OSA scores, may perhaps have been a byproduct of his emerging insight. At the time that Kotter's participation in this study was concluded, he continued to await the date of the driving assessment.

OT lent itself to client's productivity and meaningful occupation. In the absence of employment, Kotter expressed the need to remain productive, "Even though I don't work, I can stay occupied. I don't want to waste my time watching TV. I'll be productive in different ways." During each interview, when asked about his progress, Kotter consistently reflected on the various projects that he had completed. These included building a backyard

shed, landscaping, installing a waterline in garage, organizing a community garage sale, selling his car, as well as performing various home maintenance projects. This would appear to be consistent with Kotter's self-described pre-accident personality as a "workaholic." Helene developed her rehabilitation program accordingly: "It's been a client who is easily engaged in project based-type therapy." Kotter's propensity for "doing" fit well with OT's underlying philosophy of the importance of meaningful occupations to each individual's sense of self. The building of the shed was a project that ran through Kotter's study participation and exemplifies the multidimensional benefits of meaningful occupation including cognitive (e.g., planning), social (e.g., working alongside volunteering neighbours), and physical (e.g., the construction) benefits.

Therapeutic alliance was a pleasant and respectful social connection. Kotter valued social interchange, the opportunities for which were limited for him post-accident. The relationship with Helene provided a valued opportunity for social connection: "For him the therapy is also social, so there's that sense he enjoys it and gets a lot of value from it." Repeatedly, Kotter referred to professionals' ability to "be social" and "respectful" as determining factors in the quality of therapeutic alliance. He described one professional, "She wasn't very social. And she did not have a sense of humour and...it kept going in the wrong direction." Similarly, Kotter noted, "Same thing with [the physiatrist]...he's probably like [the psychologist]. Probably busy people, they don't have time for that. Well, if you're not social, you're not pleasant...It's not very entertaining." In comparison, Kotter described Helene as having "a sense of humour and she's professional at the same time." Helene identified that Kotter "does better with a therapist who has a lighter side," and she described "friendly banter" used with Kotter.

For Kotter, feeling respected was another factor that characterized positive therapeutic alliances. Kotter provided the following further description of the same professional mentioned above as not very social:

I wasn't impressed with her...sometimes she missed meetings. She did it twice. If you're sick why not call someone and just inform your appointments that you're sick instead of having them go to your office and waiting for an hour? Twice she did that...I understand things happen. You can be sick or issues happen but why not take the time to inform people?

To the contrary, Kotter felt respected by Helene and his speech language pathologist, "They're always punctual and I think it happened twice for both of them...being sick and they both called prior to the meeting." Helene and the speech language pathologist used a collaborative approach with Kotter, which further underscored their respect for him, "I think he feels that we are collaborating with him, that he is part of making the final decision." When asked what counsel he would provide to newly graduated therapists concerning the therapeutic relationship, Kotter emphasized, "Be responsible...be respectful."

Therapist's self-disclosure and stretching of therapeutic boundaries reinforced the bond. Kotter appreciated the fact that within professional boundaries, Helene shared personal information. For Kotter, this reflected positively upon Helene's level of trust in him, "What I know she knows of me, she's giving something back...she's treating me like a person. It makes it more pleasant. If I trust her, she trusts me back." From the introductory meeting, Helene purposefully uses an "open book" approach with her clients to establish rapport, "Tell me five things about yourself that I might be interested in knowing and on the flip side...I'll give you the opportunity to ask five things about me that you'd like to know."

Kotter cited several occasions he considered that Helene went “beyond the call,” one example being, “It’s hard to buy a surprise gift...she offered to help with buying two more things on my [Christmas] list in Ottawa. She’s going to get them herself. I said okay get a receipt, I’ll pay you cash.” To Kotter, this exemplified Helene’s personal extension of herself that served to further reinforced the strength of their bond.

Environmental factors both helped and hindered the course of recovery. There were several factors in Kotter’s environment that impacted upon his rehabilitative course.

Supportive network. There were supportive people involved with Kotter in many spheres of his life including his neighbours. Kotter’s neighbours rallied into a supportive network exemplified by the assistance provided by many with various aspects of the shed building. Helene described the neighbourhood setting as, “it’s almost like you’ve got puzzle pieces that fit well in themselves.”

Positive aspects of home environment. Kotter opined that the positive characteristics of his home far outweighed the drawbacks (e.g., transportation difficulties), “It’s nice to have a nice little yard for...sanity because I’m staying here all the time...I mean I’d rather here than our old house...Little lots.” For Helene, the home environment offered advantages for the therapy by virtue of the flexible, comfortable, and inviting setting rich with naturalistic opportunities for meaningful occupations that provided fodder for therapeutic activities.

Marital relationship. Helene explained there was early evidence of “complexity” in the marital relationship, “He was at the rehabilitation centre for three months...I think the first time [the team and wife] met was at the discharge meeting.” Kotter’s wife witnessed the accident and Kotter’s near death, the result of which Helene described, “There was a huge element of trauma and post traumatic stress on her part...there’s an incredible amount of

fear.” Upon Kotter’s discharge home, his wife was thrust into the role of enforcing the medical directives. This policing, however, led to tension and frustration for Kotter, “I don’t know who told [my wife] that [I am not allowed to ride a bike]...so I talked to Helene.” As a result of this tension, Kotter tended to dismiss his wife’s direction. Helene indicated that this “brought frustrations because [his wife] could be suggesting the exact same thing” as the professionals. Kotter described the negative impact of his wife’s drinking, “It’s just an awful way to finish the day...she talks about the stress she went through...and I’m thinking things happen. Live with it.” During the final interview, Kotter expressed concern for the integrity of the marriage, “We’re married, but we don’t seem married. I mean there’s not the affection there used to be...It’s kind of sad.”

Therapist’s dual role enhanced trust and confidence. Helene served not only as Kotter’s OT, but also as his case manager. As case manager, she was required to facilitate the coordination of interprofessional communication, referrals, and intervention, as well as required supports (e.g., transportation to appointments). Kotter appeared to consider that whether in her role as his OT or his case manager, Helene was best to be informed about all issues. Helene explained, “He’s been forthcoming just about everything because he sort of checks in with me.” For example, Kotter indicated that he spoke to Helene about his wife’s drinking but did not discuss this with anyone else on the team. Kotter explained that Helene’s dual role reinforced for him her competence and efficacy, “She does various different things. She’s organized...and she never lets me down. And when we set out to do, we do it.” He appreciated that Helene “made things happen.”

Case Summary

Kotter's limited cognitive insight was a significant barrier to his rehabilitation course. Kotter did not appreciate his limitations and his frustration grew over time regarding the medical restrictions and time required to reclaim his remaining lost roles (e.g., driver's assessment). Kotter's focus was upon the reinstatement of his driver's license so he could return to work and resume his role as family provider. Meanwhile, Kotter pledged to remain productive. Although initially confident in his ability to resume his pre-accident position, his sense of functional competence, as reflected on the OSA, began to decline toward the end of his study participation, perhaps a reflection of his emerging insight into his limitations. Helene's dual role as both OT and case manager appeared to serve to enhance the alliance that Kotter experienced as a pleasant social connection reinforced by respect and Helene's personal extension of herself. The alliance was embedded within a supportive environment of neighbours and the marital relationship.

Cross Case Analysis

The purpose of this cross case analysis is to identify higher order themes that emerged from the individual cases. These higher order themes describe in a more general way the process of working alliance development in OT considered alongside the client's perceived recovery. To identify these themes, the results from each of the individual cases were deeply considered in order to determine the commonalities and differences between the experiences of the dyadic participants and the contextual properties that may be proposed as explaining these phenomena. The following eleven themes were identified. They are firstly defined in the table below, following which they are individually further explored.

Table 4.5. Definition of Identified Cross-Case Themes

<p>Theme 5.1: A Strong Interpersonal Connection, Or Bond, Provides A Safe Refuge For Emotional Exploration</p> <p>Description: The client-therapist interaction was characterized by friendly emotional warmth, mutual interest, and respect. The interpersonal connection was reinforced as trust and respect for therapist's competence grew. As the bond matured, it provided a safe and confidential harbour in which the client could explore emotionally laden issues. This connection set an optimal environment for the client's engagement in the therapeutic process.</p>
<p>Theme 5.2: Humour As A Useful Therapeutic Ally</p> <p>Description: The use of humour during purposeful intervention was valued by all participants. The enjoyment derived from the humorous atmosphere appeared to be an extension of the positive interpersonal connection.</p>
<p>Theme 5.3: Bond Provides An Impetus To Act, Leading To Meaningful Improvements</p> <p>Description: The interpersonal bond enticed the clients' engagement in therapy and created an impetus for them to act either out of a desire to please or a sense of duty and respect for the OT. Therapeutic engagement through action resulted in meaningful improvement.</p>
<p>Theme 5.4: Functional Improvement Generates Shared Sense Of Success, Enhanced Trust, And Self-Efficacy</p> <p>Description: Functional achievement permitted both participants to experience sense of success that appeared to accompany reinforced trust, therapist competence, and self-efficacy.</p>
<p>Theme 5.5: Appropriate Therapy Goal Selection Impacts The Therapeutic Alliance</p> <p>Description: The therapy goal defines the objective of therapy. Evidence was found across the cases of the importance of the negotiated goals being client-centred, clearly-defined, and attainable during the therapy period. The realization of the goals appears to form a positively reinforcing feedback mechanism into the interpersonal bond.</p>

Theme 5.6: Working Alliance And Perceived Functional Competence Relationship

Description: The four dyads did not demonstrate a consistent pattern in the relationship between the working alliance and the clients' perceived functional competence.

Theme 5.7: A Client-Centred Orientation Was Appreciated By All Clients

Description: Both therapists' interpersonal interactions and professional techniques (e.g., reflective purposeful decision making, communication) toward a customized, client-centred approach positively impacted the therapeutic alliance.

Theme 5.8: Effective OT Realizes Practical Improvements Essential For Meaningful Occupations

Description: The OTs used a collaborative approach encouraging client's active participation and demonstrated a holistic understanding of a client's context. This resulted in tangible and practical changes as required for client's engagement in meaningful occupations.

Theme 5.9: Clients Learn About Their Health Conditions

Description: Therapists assisted clients' more accurate assessment of their abilities and the multiple factors impacting their condition. Given this clarification, clients were encouraged to set realistic objectives for therapy given their meaningful life roles.

Theme 5.10: Clients' Environments Influence Their Rehabilitative Course

Description: There were both physical aspects of the environment in which the therapeutic alliance was occurring, as well as social considerations. The clients' naturalistic environments (e.g., their homes) offered a comfortable and power-balancing setting conducive to meaningful and naturalistic therapeutic activities. One drawback to this environment was the limited confidentiality. Significant others in the environment impacted upon the client's pursuit of the therapy goal.

Theme 5.11: The Role Of Social Isolation In The Interpersonal Bond

Description: Each client participant experienced a variable degree of social isolation. This limited social interaction potentially primed the clients to be welcoming of the interpersonal connection with their OT.

A Strong Interpersonal Connection, or Bond, Provides a Safe Refuge for Emotional Exploration

For all client participants, the occupational therapy relationship provided a deeply valued social connection. For example, Lise indicated that she “loved Marie more than [the other health professional].” In reflecting on the connection, Marie similarly paralleled the therapeutic alliance to the chemistry of a romantic relationship. Georgia described the sense of connection with Helene created by humanistic commonality. This set-up a strong foundation that appeared to help the client endure the tensions that later emerged in therapy. Helene offered up the confidential milieu of the relationship as a safe place in which to explore Georgia’s ambivalence about returning to work. The function of the therapeutic alliance as a secure environment in which clients can safely explore emotionally laden topics was also evident in other dyads: Lise’s admission of loneliness and loss of meaningful roles, Jackson’s admission of activity-inhibiting fear, and Kotter’s marital relationship issues.

As the interpersonal bond evolved, it appeared that clients’ trust in the therapist deepened. A general pattern was observed across the cases: as clients’ trust in their therapist grew, their confidence in the therapist’s competence to help them solve their identified issues similarly increased. A pattern thus appears to emerge in which the interpersonal bond is reinforced through warmth, respect, and the therapist’s interpersonal skills over the repeating visits and trust in the therapist builds over time and proven therapist dependability.

Concomitant with that developing trust, there appears to be a deepening of client confidence

in the therapist's competence and her ability to assist the client's attainment of the therapy goals. The interpersonal connection appears to be the essential first step in the process of establishing an engaging therapeutic environment.

Humour As A Useful Therapeutic Adjunct

A theme found to emerge across the cases was the importance all participants attributed to the appropriate integration of humour into therapy. Both therapists described their purposeful use of enticing therapeutic activities. For example, Helene indicated that she will periodically interject an untraditional activity into therapy (e.g., pedal boating on the canal). Into that therapeutic activity, she will build goal-related tasks, however, a significant consideration of the activity is the maintenance of the client's interest and excitement in therapy. Marie similarly explained that the activities she proposes in therapy "depend on the person's interest, on their age, on their cognitive level...we do try to get a form of play or game...something of interest. I try to put that in and then some education."

All clients expressed an appreciation of the use of humour in the therapeutic endeavour with their therapist. The use of humour appeared to be a natural extension of the positive bond established in each of the four dyads. Although an atmosphere accepting and enticing of humour was valued and spontaneously discussed by all participants, there was a difference in the degree of prominence afforded this construct. For Kotter, who was younger than the other three participants who were already retired or considering it imminently, his primary focus for his rehabilitation was the return to employment in order to regain his role as sole provider to his young family. The gravity of his situation in combination with his productivity-focused personality may be factors that explain the difference in weighting that he afforded this construct. To the other extreme, Jackson's use of risqué humour resulted in

Marie considered it prudent to establish firm boundaries and ensure that the interactions were therapeutically-defined.

Bond Provides an Impetus to Act, Leading to Meaningful Improvements

The positive bond appeared to create an impetus to act for the clients either out of a desire to please or a sense of duty or respect for the therapist. Evidence was found across all dyads. Marie opined that her weekly visits created an incentive for Lise to act by virtue of Lise's desire to report subsequent accomplishments to Marie during the next visit. For Georgia, her desire to reciprocate the care and attention afforded by Helene fed her desire to push herself outside of her comfort zone (e.g., a return to work trial despite being terrified) as she "owe[d] it to Helene to try." Although Jackson initially appeared indifferent toward OT, Marie attributed his progressive engagement to the companionship provided by the weekly visit and the impetus created by these visits. For Kotter, the impetus to act was evidenced in those activities (e.g., cognitively-focused computer-based activities) in which he was less inclined to participate. He compliantly performed these activities to meet Helene's outlined requests.

For all participants, their active engagement in therapeutically-prescribed activities resulted in meaningful improvement. For Kotter, his insight into his cognitive limitations began to emerge, an essential precursor for his future rehabilitation. For the other three clients, there had been a significant time lapse between the onset of their condition/injury and the commencement of OT. During this time, Lise, Georgia, and Jackson all appeared to have developed patterns of excessively depleted function beyond that which would be predicted on the basis of their diagnosed health conditions. Especially for these three, the impetus to act led to newfound and positive revelations about their function and thus resulted

in observable improvements in their daily functioning. Not all of the clients' functional enhancements were reflected on the OSA results, especially those such as Georgia and Kotter who were reaching for higher level goals pertaining to return to work.

Functional Improvement Generates Shared Sense of Success, Enhanced Trust, and Self-Efficacy

Clients' successful achievements resulted in a sense of satisfaction for both the clients and the OTs. This shared experience of success appeared to reinforce the bond of the interpersonal relationship. As a result of the recognized progress, clients acknowledged the therapists' apparent competence. In parallel, from the success, the therapists reported experiencing the sense that they were efficaciously impacting their clients' abilities.

Clients attributed their functional achievements to the OT intervention out of which clients' engagement in the therapy appeared to grow. A good example occurred when Marie attended for a therapy session with Lise, the plan for which was to bake a second cake together. Upon arrival, however, Lise reported to Marie, "I already made a cake. I felt really good after what we did and I made the cake, and then did this, and this, and this, in the kitchen. You showed that I could do it...that I had the ability." The client's meaningful success not only created an improved sense of self-efficacy, but also reinforced clients' trust in the OT's competence in that she attributed the achievement to the OT intervention.

The therapists also acknowledged the implication of client achievement upon their own sense of efficacy within the therapeutic relationship. For example, Helene indicated when Kotter's cognitive abilities and insight began to improve, she began to feel more purposeful in her endeavour with him. In contrast, positive professional reinforcement was

missing in Helene's work with Georgia, who fell short of the therapy goal and upon conclusion of therapy left both with questions about Georgia's future.

Appropriate Therapy Goal Selection Impacts the Therapeutic Alliance

In each dyad, the importance of attainable, client-centred, and clearly-defined goals was illuminated. The therapists used both their interpersonal (e.g., negotiation) and professional (e.g., decision making) skills to collaboratively formulate therapy goals with the client. The realization of these carefully selected, meaningful therapy goals appeared to be a positively reinforcing feedback mechanism upon the previously identified components.

Marie identified the importance of having confidence that the client can attain the identified therapy goals during the available time. Ensuring the attainability of established goals sets the client up for success. Goal attainment appears to provide clients enhanced self-confidence and insight into their abilities. Goal attainment also served as the quantitative measure of success in the therapeutic endeavour.

In keeping with a client-centred approach, the therapy goals were preferably set, or at least endorsed, by the client. In some cases, therapists identified a performance issue that was not fully recognized by the client that should be addressed in therapy. Therefore, there was a role for therapists to guide client recognition in the hope that the clients would come to endorse the therapist-proposed therapy goal.

As was most clearly demonstrated by Georgia's case, it is important to clearly define the therapy goals early in the course of therapy. The direction of the therapeutic efforts is dictated by these therapy goals and, in the case of Georgia, the therapeutic objective was unclear. Without this clear direction, goal attainment became doubtful and served to frustrate

the measurable progress achieved through therapy, in the end leaving both participants with questions.

Working Alliance and Perceived Functional Competence Relationship

Despite evidence from other domains that indicates that the quality of the working alliance is a strong determinant of positive clinical outcomes and commonly accepted as a factor accounting for therapeutic success (Bachelor & Horvath, 2006; Martin, Garske, & Davis, 2000), no such consistent pattern was found in this study. Although some cases (e.g., Lise; Jackson) demonstrated similar patterns of improvement in both constructs, other cases (e.g., Georgia; Kotter) did not demonstrate convergence. In the cases of Georgia and Kotter, despite working alliances approaching optimal levels, client-perceived functional competence did not improve or in fact, in the case of Kotter, deteriorated slightly from the beginning through the end of study participation. In each case, there were identified contextual factors influencing the clients' perceived competence such as funding models, nature of the client's condition, cognitive insight, and fear.

A Client-Centred Orientation Was Appreciated By All Clients

Therapists' client-centred approach was deeply valued by all clients. Not only did therapists customize their interpersonal interactions (e.g., communication styles, differing types of empathetic response), the therapeutic activities and goals were customized to the idiosyncratic needs of each client, "Like it's Georgia, it's not in general, it's Georgia." Therapists' attentive listening to the client stories, what they experience and value, and demonstration of appropriate empathy appeared to forge stronger relationships on an interpersonal level.

A discernable pattern emerged in Helene's and Marie's use of personal sharing. Helene preferred to use an "open book" approach with her clients and she pushed the boundaries of the relationship in a somewhat more personal direction. For Georgia, the result was that she wanted to maintain contact with Helene beyond the conclusion of therapy. Kotter deeply appreciated the fact that Helene went "beyond the call" when she addressed items for him, such as Christmas shopping for his wife. In both cases, the client felt a deep appreciation for Helene's specific efforts for the presenting needs. There was no evidence or discussion of personal sharing between Marie and Lise. Due to the sexual tension that occurred in the relationship with Jackson, Marie reflectively decided to limit the sharing of personal information with Jackson to only that information that held a therapeutic purpose.

In all cases, the therapists demonstrated their appreciation of the importance of ongoing reflective decision making regarding the customization of their approach to best address each client's idiosyncratic needs. The therapists demonstrated that the therapeutic endeavour requires an ongoing, rational approach as well as prudent management. This included both the therapists' general approach to therapy but also more specifically the approach to emotionally-laden content. Helene exemplified professional insight in the realization of what role her clients would best be served by her assuming, most notable during periods of emotional turmoil. Helene did not assume the role that the clients evidently wanted her to assume when it did not serve the clients' developmental need. Helene made these decisions despite the discomfort or "interpersonal sparks" that ensued. Notably, none of these events occurred early in the relationships. Rather, it appeared that Helene had determined that the therapeutic relationship had developed to the point that it was strong enough to withstand these stressors.

Effective OT Realizes Practical Improvements Essential for Meaningful Occupations

The importance of people's ability to engage in idiosyncratically-defined meaningful occupations is a central tenet to the profession of OT. The occupations facilitated in this study varied, and in some instances progressed, from personal care and mobility, to home management, to leisure and community engagement. To achieve such practical and tangible enhancements, the two OTs worked collaboratively with their clients to actively engage them in an enhanced understanding of the interplay between their conditions, their desired occupations, and the environments in which they were functioning. This in turn served to reinforce the client's interest in therapy in that there were evident links between the benefits of therapy (therapy outcomes) and the direct, tangible implications for the client's life roles. This addressed clients' needs related to their sense of self and feeling of usefulness as well as their desire for productivity.

Clients Learn About Their Health Conditions

The multifaceted implications of clients' conditions, including physical, emotional, and/or cognitive aspects were identified by the OTs and served as an educational objective for therapy. In other words, the therapists endeavoured to enhance client insight into the implications of one impaired system upon another (e.g., implication of physical health upon emotional health and vice versa). Furthermore the therapists' focus upon clients' meaningful activity engagement, rather than their impairments appeared to permit clients to better understand their existing functional capabilities rather than focusing upon their limitations. This enhanced insight assisted clients' more accurate assessment of their abilities. For the three individuals who experienced a lapse between condition onset and the initiation of occupational therapy, this was a process of educating them that their actual abilities were

higher than those they had come to routinely employ. In contrast, for Kotter, who was more recently injured, this was a process of enhancing his awareness of his cognitive limitations. As a result of their enhanced insight, clients gleaned an improved appreciation of their capabilities and retained abilities to engage in occupations. This, in turn, appeared to facilitate realistic setting of therapy objectives as per their individual life roles and interests.

Clients' Environments Influenced Their Rehabilitative Course

Each of the four clients had significant influences in their environment that impacted their rehabilitation. The fact that therapy occurred in their homes allowed for a comfortable and power-balancing setting conducive to therapy interactions. Furthermore, this home basis for therapy allowed for meaningful activities in their naturalistic environment to provide material for therapeutic activities thus enhancing client learning, practice, and engagement. One considerable drawback of the home-based therapy was the limited ability for confidential dialogue as required for clients to openly discuss emotional concerns perhaps implicated by those who were in the therapy environment (e.g., spouse). It appeared that significant others in the environment had an influence on the client's pursuit of the therapy goal. Their influence upon the therapeutic alliance is less clear. For example, Lise's husband's suicide attempt during the course of data collection appeared to have inspired Lise more than ever to work toward independence. Jackson's wife served as therapeutic ally toward Jackson's goal pursuit. For Georgia, her lawyer's cautionary warnings fuelled her ambivalence toward her originally stated goal of returning to work. Kotter's neighbours' support for the shed building served to facilitate the related therapy pursuits. Thus, individuals and factors outside of the specific client-therapist working alliance impacted the therapy process. Therapists recognized these elements and worked to optimize client

progress within these contexts by involving supportive individuals in the educative component of therapy either directly (e.g., Jackson's wife as therapeutic ally) or indirectly (e.g., planning of Kotter's shed building with the support of neighbours with whom only Kotter directly interacted).

The Role of Social Isolation in the Interpersonal Connection

Prior to Marie's involvement, Lise relied upon her husband and other family members to accompany her on all community outings. As a result, such was limited and Lise spent abundant time alone in her home. Georgia grieved the lost social interactions she had pre-accident with her customers and co-workers at the bank. Some years earlier, Jackson stopped driving following his shoulder fracture. Giving up driving, in addition to the loss of function that permitted leisure pursuits such as tennis, resulted in Jackson becoming isolated. Kotter's driver's license was revoked following his traumatic brain injury, which especially in his rural location, limited his community integration. The social isolation experienced by each client appeared to prime the clients to deeply appreciate the interpersonal social interaction with their OT. Although not anticipated to be completely unique to community-based OT, it is likely a more prevalent characteristic of the disabled clients with whom community-based OTs are working.

Summary of Individual Case Themes

There were several themes identified that were in common across several or all cases. There were, however, also identified themes that served to differentiate the cases from one another, providing a point of distinction about the case. These similarities and differences will be presented below.

Common themes. There were many commonalities among the themes generated from the individual cases. Perhaps the most evident was that all participants described a positive connection, or bond. This connection, which may have been primed by the clients' social isolation evidenced in each case, was fortified by common human elements exhibited by the therapists as described by the clients. The clients responded similarly, and the interactions came to be characterized by warmth, mutual respect, and caring.

The essence of client-centred practice receives fundamental concentration in the Canadian training of occupational therapists. In the OT context, client-centred care means that intervention is respectful of culturally-defined and age-appropriate considerations for the individual's own care (personal care), enjoyment of life (leisure), and social and economic contribution to the community (productivity) (Polatajko, Backman, et al., 2007, p. 39). Such a client-centred approach to therapy was consistently observed across the dyads in this study. This individualized approach was highlighted by all clients as fostering their engagement in therapy and differentiated the OT intervention from other general (e.g., generalized conditioning and exercise) or fragmented (e.g., medical specialty) interventions. Although clients readily identified and discerned this characteristic, evidence of client-centred practice also occurred at levels less visible to the clients. In three out of the four dyads, the OT purposefully and decisively shifted her therapeutic approach from her dominant mode (e.g., problem solving) to that mode by which she considered the client would be best served (e.g., collaboration, empathizing, instructing). For example, Helene's setting aside of the focus of therapy on specific outcomes with Georgia exemplified that she understood the client's greatest need, which was to explore her ultimate therapy objectives rather than those imposed by funding sources. Helene then encouraged Georgia to use the confidential forum

of the alliance to gain the clarity that would best benefit Georgia in the long term. Similarly Kotter's lack of insight into his limitations and single-minded focus on returning to work created a challenge for Helene. However, she repeatedly linked the therapeutic activities, although only distantly related to the return to work objective, with the skills necessary to eventually return to work. By taking the time to link the current activities to Kotter's long term goal, this fostered the client's motivation to engage in the therapeutic activities. There was thus a commonality established by the therapist's ultimate focus upon the clients' specific needs.

In each case, there were idiosyncratic influential factors within the environment in which the therapeutic alliance was embedded. These factors included social (e.g., spouse, neighbours) and physical characteristics (e.g., limited confidentiality, rural implications) of the environment. Across the dyads, these factors differentially impacted the rehabilitative course. For example, Lise attributed her husband's purposeful self-administration of a medication overdose to her improving functional abilities. Following this event, despite concern and empathy for her spouse, Lise resolutely declared that this event would not derail her rehabilitation efforts toward enhanced autonomy. Lise's firm determination to continue the work of therapy toward functional independence regardless of this event appeared to reinforce the alliance with Marie. In contrast, Georgia's lawyer cautioned her regarding the therapeutic activities with Helene in light of the pending litigation with the two insurers. This created disparate foci in that Helene's goal was to enhance Georgia's functional abilities in her originally stated goal of returning to some form of work whereas the lawyer's cautionary advice was working against this momentum. When contrasted to their previously

established stronger alliance during the first block of therapy, Helene opined that the lawyer's role deleteriously impacting the progress of therapy.

In all four dyads, there were expressions of humour and concomitant enjoyment. All clients identified that the laughter that occurred in therapy facilitated the work of therapy and resulted in therapy being an enjoyable time with their OT. Although present over all dyads, there was a variable emphasis afforded this construct. This may be most poignantly contrasted between Jackson, who significantly focused on humour and playful teasing, and Kotter for whom a sense of humour in his therapists appeared to be a positive characteristic of a strong therapeutic alliance rather than of central importance in and of itself.

Distinctive Features. In addition to commonalities occurring across the dyads, there were one to three themes that represented unique aspects about each case. For example, in the case of Georgia, the client-centred approach to therapy resulted in a forfeiting of objectively assessed progress toward the originally stated goal of return to work. When Georgia's ambivalence and struggle regarding her return to work became evident to Helene, Helene set aside the focus of therapy on this specific outcome and encouraged Georgia to use the alliance to explore her ambivalence and preferred objectives. Contributing to Georgia's ambivalence were the competing agendas of the insurers and her lawyer. Similar to the "neutral" position assumed by Helene regarding the neuropsychological report in order to aid Georgia's acceptance of those results, Helene assumed a similar position in the context of aiding Georgia's decision regarding her therapy goals and direction. To the detriment of her own sense of professional efficacy in this alliance, Helene encouraged Georgia to use the confidential forum of their relationship to seek this clarification.

In the case of Jackson, his inappropriate sense of humour created discomfort for Marie and her student and also resulted in Marie's reinforcement of the professional boundaries of the relationship. This was antithetical to Jackson's desire for a more personal connection with Marie. The existence of discomfort impacted the therapeutic alliance, but also demonstrated Marie's professionalism in resolutely building a positive alliance through which Jackson was encouraged to participate in therapeutic activities toward his occupational goals. A second distinctive feature of this case was the systematic influence of Jackson's fear. On one hand, he was fearful of falling and suffering an injury or being helpless. He was also fearful of others' perceptions of him as either a child predator or being involved in an illicit relationship. On the other hand, his fear of declining abilities motivated him to engage in the arduous aspects of therapy in order that he could best participate in the pending European trip with family.

For Kotter, his lack of cognitive insight caused by his severe brain injury presented challenges in the OT process. Kotter had a single-minded and potentially unrealistic focus: a return to gainful employment in order to support his family as soon as possible. Kotter's lack of insight required that Helene prudently and repeatedly reinforce links between the proposed therapeutic activities and those skills required for effective return to work. These efforts to draw such links were required to maintain Kotter's engagement in therapy. Despite Kotter's cognitive limitations, his pre-accident characteristic of gleaning significant satisfaction from productivity coalesced well with the meaningful activity-engagement orientation of occupational therapy. As a result, Kotter's recovery was facilitated by his innate desire to actively engage and remain productive.

Although all clients described an interpersonal connection with their therapist, for Lise, the depth of this connection was more intense. Lise described her connection with Marie as “love.” Notably, the chemistry of the alliance bond was compared to a romantic relationship by Marie and the intensity of Lise’s bond to Marie was appreciated by [the other health professional]. The intensity of Lise’s subjective experience of the relationship with her OT set Lise apart from the others and may have been reflective of her sense of loneliness and degree of social isolation.

This chapter has presented the contextual properties and identified themes of each of the four individual cases. These results were then considered across the cases and the identified cross case themes were presented in an effort to depict, in a more general sense, the process of the working alliance development during community-based OT intervention as well as the clients’ perceptions of functional recovery. Finally, a summary of the commonalities and distinctive features found across the cases was presented.

Chapter 5: Discussion

Despite limited empirical evidence, both OTs and their clients alike consider there to be a link between a strong therapeutic relationship and positive occupational outcomes (Palmadottir, 2003). The focus of this study was the exploration of the client-therapist alliance and therapy outcomes in four dyads during the course of community-based occupational therapy intervention. The experiences of both the client and therapist in each therapeutic alliance, the evolution of the alliance over time, the client's perceived functional recovery, and the impacting contextual factors were considered. This multiple-case study using a mixed-methods approach allowed comparisons of the experiences of the participants within each case as well as across the four therapeutic dyads. The qualitative and quantitative data within each case were individually analysed, and themes were generated from each case. The case themes subsequently were analysed to discern broad cross-case themes that describe key elements of the therapeutic alliance in a community-based occupational therapy context. In this chapter, those emergent cross-case themes will be further explored, including possible links among the themes. These findings will be situated within the existing literature. Next, I will discuss the contributions of this study to OT practice and training, as well as possible directions for future research. Finally, several limitations of the study will be explored as well as the contribution of knowledge offered by this study.

Study Results and Links to Research

The results of this study can be distilled into nine themes. Each theme will be described as it relates to the findings from this study and situated within the existing literature.

An interpersonal connection. The findings of this study suggest that the essential initial step of the therapeutic process is the development of an interpersonal connection. This is consistent with previously cited findings and assertions found in the psychotherapy literature (e.g., Lambert, 2003; Rogers, 1961), education literature (e.g., Grolnick & Ryan, 1989; Loukas et al., 2006) as well as the OT literature (e.g., Carlova, 1961; Cole & McLean, 2003; Taylor et al., 2009). As a result, this is not an unexpected finding but was evident throughout all cases. Through common human elements, such as friendly emotional warmth and caring as well as mutual interest and respect, the connection between client and therapist evolves over time from a relatively superficial and professional interaction to a more profound connection, or bond. In this study, as evidenced by the WAI results across all dyads and all participants, there was a consistent pattern of a deepening alliance over the first one to two months of therapy. This pattern of strengthening alliance over time was also further supported by the interview data. This described interpersonal connection is akin to Bordin's (1979) interpersonal bond that includes personal liking and valuing. It appeared that as the participants grew more acquainted with each other and the therapist repeatedly demonstrated warmth, caring, and respect, the degree of mutual interest and liking grew over time. This interpersonal connection appeared to be a leading component, which although initially immature and held at a polite distance, grew more profound over time. The inherent trust, respect for the therapist's competence, and strength of the alliance appeared to grow over time as the interpersonal connection matured into a bond and was reinforced by repeated contact. The mature bond appeared to provide a safe place for clients to explore emotionally-laden topics with the therapist and to apply new learning from therapy to real-life situations outside of these sessions. In other words, the interpersonal connection matures

over time into a relationship that appears to function like a secure base as described by Bowlby (1988).

According to Taylor (2008), one of the main functions of the therapeutic relationship in occupational therapy is to provide a safe place where the client's emotions and coping processes as they relate to the client's occupational performance impairment and associated implications can be addressed. This study demonstrated that as the interpersonal connection matured, there was often an observed evolution of the types of occupations receiving focus in intervention. Initially, the targeted occupations were everyday, common physical tasks (e.g., getting dressed, kitchen activities). However, over time and concomitant with both the maturing bond and the client's functional improvements, the occupations explored in OT turned towards those with inherent emotional investment (e.g., sense of meaningfulness achieved through family, volunteer or vocational roles). Although observed across all dyads, this was poignantly exemplified in the case involving Lise. Lise was initially focussed upon being able to assume more duties within her home, such as kitchen activities. As she achieved success in this area and also began to more openly share psychosocial concerns with Marie, the goals of intervention shifted toward higher level meaningful occupations outside of the home. This evolution of explored occupations from common, everyday occupations to those with deeper emotional implications suggests further evidence of the deepening bond through the development of this safe place in which client's emotions and coping can be effectively explored.

Taylor's (2008) Intentional Relationship Model (IRM) also emphasizes the significance of interpersonal events upon the therapeutic relationship. She defines interpersonal events as naturally occurring communications, reactions, processes, tasks, or

general circumstances that potentially detract from, or strengthen, the therapeutic relationship. These events are both inevitable as well as ripe with threat and opportunity. Examples of interpersonal events include a client's strong display of emotion during therapy (e.g., crying, anger) or a difficult circumstance (e.g., client is embarrassed about having lost bladder control). Concomitant with the event is the therapist's reaction to the event. When such occurs, the clients' interpretation, which Taylor (2008) describes as a product of the clients' unique characteristics, may have a significant effect on the clients and I would suggest in turn impacts the alliance at the level of this interpersonal connection. In this study, one example of such an event occurred between Georgia and Helene as it related to Georgia's receptivity to the neuropsychological assessment findings. Helene described her purposeful "playing it up the middle" rather than "siding" with Georgia's emotional reaction. This could have resulted in Georgia losing trust in Helene. Rather, it appeared that Helene's purposeful stance and encouragement of Georgia to consider the possible validity of the assessment results resulted in Georgia's enhanced insight some time later. Helene indicated that her stance on this topic in fact appeared to serve to enhance the trust within the alliance as she opined that the result was that Georgia came to recognise "this OT can really help me work through some of that and not take one position or the other, just kind of be in the middle." In summary, the interpersonal connection appears to mature into a safe place or secure base that with diligent therapist management should ideally be able to withstand relationship stressors caused by interpersonal events.

Humour as a therapeutic modality. All study participants, both client and therapists, attributed importance to the use of humour in the therapeutic endeavour whether this be to enhance comfort or diffuse tension. All participants described jokes and laughter

that occurred during therapy as well as enjoyment derived from at least some meaningful therapeutic activities. This appeared to be a natural extension of a positive interpersonal connection. The use of jokes and laughter not only energized the interactions between clients and therapists but also appeared to advance the work of therapy. The use of humour took on different forms across dyads. For some clients, such as Kotter, the use of humour enhanced the pleasantness of the social interaction with his professional team members. Helene described the interaction with Kotter as being characterized by “friendly banter” in light of Kotter’s “need for a therapist with a lighter side.” Jackson’s use of humour, although sometimes inappropriate, appeared to be an attempt to forge a more personal and friendship-like connection with his OT, Marie. For Georgia, laughter, such as occurred during the role playing activities, appeared to distract her from the perceived challenge that she attributed to cognitive activities.

There are few references to the therapeutic value of humour in therapy specifically in the OT literature. Devereau (1984), in identifying those occupational therapist characteristics conducive to effective therapeutic relationships, cited the judicious use of humour. Crepeau (2011) identified humour as a dimension of the therapeutic relationship and described its role in promoting reciprocity. Guitard, Ferland, and Dutil (2003) conducted a study in OT that also connects to this construct. In their study on playfulness in adults and its potential implications for occupational therapy, they identified the following components: creativity, curiosity, sense of humour, pleasure, and spontaneity. They found that a playful internal predisposition allows adults to distance themselves from self, others, situation and worldly conventions and in so achieve a different perspective on a problem. The authors proposed that these new perspectives can generate potentially valuable approaches to addressing

problems. Consequently, Guitard et al. (2003) contend that playfulness could represent a valuable tool in OT intervention to enhance occupational performance and promote overall health and well-being. As evidenced in their study and supported by the findings of this current study, there appears to be therapeutic value in the use of humour in therapy, thus encouraging the approach to the arduous aspects of therapy with a playful disposition.

Outside of OT but consistent with the findings of this study, humour has been suggested to enhance clients' engagement and maintenance of interest in therapy (McCreddie, 2010). The use of humour in both psychotherapy and health care has demonstrated several positive implications. In fact, the use of humour as a therapeutic agent or as a complementary/alternative medicine is touted in the prevention and treatment of conditions both in psychotherapy and health care (Mora-Ripoll, 2010; Takeda et al., 2010). Blevins (2011) suggests that there is a significant relationship between a counsellor's sense of humour and the counsellor's effectiveness ratings. Humour therapy has also been shown to have positive effects upon mood, satisfaction with life, and enhanced sleep for depressed elderly (Ko & Youn, 2011; Walter, et al., 2007), recovery from childhood physical and sexual violence (Bryant-Davis, 2005) as well as in palliative care (Dean, 1997). Although positive psychological functioning and enhanced quality of life appeared consistently, there are some patient populations such as those with chronic obstructive pulmonary disease with whom laughing aloud may be contraindicated and hence caution must be exercised (Lebowitz, Suh, Dia, & Emery, 2011).

Impetus to act leads to functional improvements. The bond forged between each client and therapist appeared to create an impetus within the client to act. For some clients, the impetus appeared to stem from a sense of duty or respect for the therapist, such as Kotter

and Jackson who completed less motivating assigned tasks just prior to the therapist's arrival for a therapy visit. For others, such as Georgia and especially Lise, there appeared to be a desire to please the therapist by reporting their participation in a reviewed activity.

Regardless of the source of the impetus, clients engaged in activity in which they seemingly would not have otherwise participated without the involvement, prompting, support, and encouragement of the therapist. This motivation was apparent both during therapy sessions as well as between sessions. The result of engaging in augmentative activities is that clients experienced observable improvements in their everyday functioning that they attributed to the therapeutic endeavour.

In this study, the impetus to act preceded functional recovery and learning. In contrast, in his discussion of common factors in therapeutic relationships, Lambert (2003, p. 104-106) describes a developmental sequence in the therapeutic process that begins with support factors (e.g., therapist expertness; therapist warmth, empathy, acceptance, genuineness; therapeutic alliance), progresses to learning factors (e.g., insight; feedback; cognitive learning), and finally to client action factors (e.g., success experience; cognitive mastery; encouragement of facing fears, taking risks and mastery efforts). Herein may lay a point of differentiation between the two disciplines of counselling and OT. Occupational therapists "do with" their clients (Blesedell Crepeau, 1991). In other words, there is an inherent activity-engagement emphasis in OT. Although the results of this study agree with Lambert's outlined sequence that support is the first step, divergence occurs in the ordering of the second and third steps. The results of this study appear to suggest that the clients' action precedes learning. In other words, clients engage in activity as a result of the bond

with the therapist, and as a result of that engagement in therapeutic activities, learning is achieved.

This notion is in keeping with an action or apprenticeship approach to learning in which the learning arises out of action and interaction that occurs in a real-life context, and there is a natural progression in the instructor's role from modelling, to coaching, and then to fading (Brown, Collins, & Duguid, 1989). In other words, learning is optimally achieved through learners' acting within and upon their naturalistic environments. Throughout such an action process, learning is amplified by articulation and reflection (de Jong & Pieters, 2006). This lends support to the important role of therapeutic dialogue in OT accompanying the activity-engagement emphasis.

Shared sense of success and self-efficacy derived from functional improvement.

The enhancements achieved during the course of therapy appeared to provide a shared sense of success for the clients and therapists. In parallel to Kotter's satisfaction with his therapy progress, Helene noted she began to "feel more purposeful" in her role with Kotter as his cognitive insight began to emerge. Notably, the progress providing the sense of satisfaction to each participant was different. In this case, Kotter's satisfaction stemmed from his reclaimed sense of accomplishment through his ability to complete functional projects, whereas Helene was most appreciative of Kotter's emerging cognitive insight gleaned through these projects. Parallels may be drawn to Dumont and Smith (2001) who characterize effective psychotherapy as facilitating clients' learning about their capabilities by recognizing both their positive potentials and qualities as well as those constructive and contributing qualities of their environment. Dumont and Smith (2001) suggest that successful experiences and learning, achieved through a carefully constructed scaffolding

approach of just noticeably more difficult challenges, lends itself to deepening trust in the alliance as well as both participants experiencing enhanced self-efficacy. Whether through OT or counselling, clients appear to be empowered by newfound meaningful abilities, and therapists' professional sense of efficacy with the client may be reinforced, as exemplified by Helene.

Helene, with more than 20 years of experience, attributed her sense of efficacy within the relationship with Kotter to the emerging signs of his developing insight. Thériault and Gazzola (2005) describe a continuum of counselling therapists' feelings of incompetence. Their described continuum ranges from 'inadequacy' through 'insecurity' to 'incompetence proper'. As reflected with Helene, it is possible that therapist feelings of incompetence are also active in OT, and data from the current study provide some preliminary, albeit tenuous, evidence to this effect. If such a continuum could be applied to occupational therapists, the findings of this study appear to fall within the domain of 'inadequacy' in that the client's occupational recovery serves as a positive reinforcement to the therapist of the effectiveness of the chosen approach. Thériault and Gazzola (2010) suggest that this continuum represents a dynamic process even for experienced psychotherapists and their subjective sense of competence. Notably, Taylor (2008) cautions that OTs need to keep successes and failures in perspective as therapists' ability to control clinical interactions is limited. Therapists need to avoid viewing alliances with clients as a source of their own self-esteem or barometer by which to measure their own interpersonal competence. Such may in fact lead to emotional exhaustion or burnout.

Therapy goals are important. The results of this study underscore the contention that effective OT goals should be client-centred and clearly-defined, and they should be

attainable during the available therapy block. Bordin (1979) emphasized the importance of collaboratively-established therapy goals that clearly outline the purposive work of therapy. In the rehabilitation literature, some authors speak of the use of SMART goals (e.g., Bovend'Eerdt, Botell, & Wade, 2009). This acronym refers to goals that are specific, measurable, attainable, relevant, and time-bound. The results of this study suggest that the realization of these carefully selected, meaningful therapy goals may be a positively reinforcing feedback mechanism in that their attainment appears to strengthen the alliance. An illustrative contrast may be made from this study's findings. After 15 years of depleted function, Lise selected specific therapy goals with Marie, quickly attained them and set new, higher level goals. Lise directly attributed her dramatic improvement to the therapeutic relationship with Marie, "[The relationship is] very good. It's important. It really helped me improve." In comparison, the goal for Georgia's second therapy block was never well defined and she made no discernable progress during this therapy block. Helene opined that the strength of the alliance was less during this second block. The findings of this study suggest that the successful attainment of collaboratively-established, client-centred goals serves to positively reinforce the working alliance.

Although there is no specific link made to the implications upon the working alliance, the existing OT literature attributes significant importance to ensuring therapy goals are clearly-defined and client-centred. Such goals not only facilitate effective communication with other team members but also enhance therapy efficacy through improved structure as well as client satisfaction (Doig, Fleming, Cornwell, & Kuipers, 2009; Parkinson, Shenfield, Reece, & Fisher, 2011). Client engagement is enhanced by utilising meaningful therapy tasks directed toward realistic, client-centred goals and can have

significant implications for client's quality of life (Kasven-Gonzalez, Souverain, & Miale, 2010; Lequerica, Donnell, & Tate, 2009). Clinical utility and treatment validity are enhanced by combining client-centred goals with effective means to measure progress (Doig, Fleming, Kuipers, & Cornwell, 2010). The ability to measure progress is important within a complex environment of multiple stakeholders assessing progress from different perspectives (Lloyd, Waghorn, & Williams, 2008; Richard & Knis-Matthews, 2010).

Therapist role in the development of an effective working alliance. The therapists' manner of relating was appreciated by the clients, but less evident to the clients was the vital role of the therapists' professional training and judgment in the development of the working alliance. The client participants repeatedly referred to those interpersonal skills demonstrated by the OTs that helped to foster the interpersonal connection and by extension, the alliance. These identified skills include the way in which OTs communicated their warmth, caring, and respect, as well as the way in which the OTs customized the intervention to each client's specific needs. Parallels may be drawn to Rogers' (1957) necessary and sufficient conditions that include: therapist genuineness and transparency; therapist's warm acceptance of the client as a person of unconditional worth; and, the therapist's sensitive ability to see and understand the client's world and self as perceived by the client. The OT literature similarly identified those characteristics conducive to strong therapeutic alliances as including: understanding; empathy; competence; caring; holistic appreciation of the client's context; belief in dignity and worth of the client; belief that each individual has the potential for change and growth; and, strong and positive values (Darragh et al., 2001, Devereaux, 1984). Psychotherapy research has also identified the importance of therapists' demonstration of positive behaviours including warmth, understanding, and affirmation

(Miller, Taylor, & West, 1980; Najavits & Strupp, 1994). There is thus consistency between the two bodies of knowledge that outline the need for therapists to consciously lead with fundamental relationship skills demonstrating acceptance, warmth, and empathy, which have been shown in the psychotherapy literature to be related to outcomes (Asay & Lambert, 2006). These were in fact the same characteristics attributed to the OTs by the client participants in this study as significant contributors to their positive alliances. Taylor (2008) points to occupational therapists' responsibility "for making every reasonable effort to make the relationship work" (p. 51), which distinguishes therapeutic relationships from other social and non-therapeutic relationships. According to Taylor (2008), this responsibility is fulfilled using three main interpersonal capabilities: an interpersonal skill base; therapeutic modes; and, capacity for interpersonal reasoning. The leading role in establishing a milieu in which the therapeutic alliance can prosper is thus assigned to the OT.

Occupational therapists trained in Canada embrace a client-centered approach to therapy, the goal of which is to guide clients to the actualization of occupational engagement (Polatajko, Backman, et al., 2007, p. 39; Yerxa, 1980). In this study, client-centredness was appreciated by the clients by virtue of therapists' customization of therapy to the specific client need. This started with the form of communication. Jackson expressed gratitude that Marie did not use "big words" nor "a bunch of theory." The clients also appreciated that the therapeutic activities and goals were directly linked to their meaningful occupations and were specifically aligned with their individual values and needs. Effective OT also necessitates a holistic understanding of clients. Holism has been defined as a "view of persons as whole beings, integrated in mind, body, and spirit" (CAOT, 1997a; 2002, p. 181).

Each dyad in this study worked on more than one system by virtue of the appreciation of the symbiotic relationship among physical, cognitive, and emotional health.

Therapists' holistic understanding of clients' conditions enhances the dyad's ability to work collaboratively to solve meaningful occupational performance issues (Law & Mills, 1998, p. 16). Collaboration between client and therapist in part serves to mitigate the power imbalance inherent in the relationship that results from the difference of knowledge and social position that separates the client and therapist (Mortenson & Dyck, 2006). A collaborative approach facilitates client input into clinical decision-making and encourages clients to become actively involved in the problem solving process of their specific situation (Taylor, 2008, p. 8-10). In every dyad, the participant clients relayed that although they may not have been the initiators of every therapeutic activity, they came to endorse each activity in light of the links that the therapists made to the clients' therapy objectives.

Taylor (2008, p. 68-83) encourages OTs to reflect upon the manner in which they interact with individual clients. Taylor (2008) describes this manner of interaction as a therapeutic mode, defined as the "specific way of relating to a client" (p. 67). As a first step, Taylor implores therapists to identify their natural, predominant modes of interaction with clients and then develop the other lesser used therapeutic modes in order that they may consciously and rationally decide which mode is best employed with each client in light of the client's needs. In so doing, therapists may learn to more effectively and purposefully use themselves therapeutically for the client's recovery. In this study during each initial therapist interview, the therapists identified their dominant therapeutic modes used with clients (e.g., problem solving). Despite this dominant mode, in three of the four dyads, the therapists identified that the mode used with the client was not their dominant mode but rather

collaborating, instructing and/or empathizing. This reflectiveness regarding the specific mode or approach by which each client would be best served appeared to enhance the alliance and enable the development of a safe environment for clients to explore emotionally laden topics. The strongest example of this occurred in the case of Georgia. Helene identified the manner in which she reacted to Georgia's emotional reaction to the neuropsychological assessment results as pivotal to their alliance. Rather than siding with Georgia, Helene remained neutral and encouraged Georgia's reflection upon the results. Helene attributed her non-judgemental and open stance in this pivotal emotional event as leading to Georgia's eventual opening up to the possibility of the existence of an emotional health condition.

Rogers (1961) describes the need for psychotherapists to mature psychologically and "learn to live in increasingly deep therapeutic relationships" (p. 14). In so doing, therapists may then "create relationships which facilitate the growth of others as separate persons...a measure of the growth I have achieved in myself" (Rogers, 1961, p. 56). Considered in an OT context, this may mean that OTs may have to deal with emotional discomfort in an alliance, as Helene did with Georgia, in order to create the milieu required to foster client development. Therapeutic use-of-self has been defined in the occupational therapy literature as the "planned use of . . . personality, insights, perceptions and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). Occupational therapists often report receiving insufficient training in the use-of-self prior to graduation, and many consider there is insufficient knowledge about the topic in the occupational therapy literature (Cole & McLean, 2003; Peloquin & Davidson, 1993; Taylor et al., 2009). Although both participants OTs demonstrated reflectiveness in the selection of an appropriate mode to use with each

client, Helene's decision making with Georgia is a poignant example of her refined ability to use herself therapeutically for the benefit of her client.

The role of idiosyncratic client attributes with regards to the working alliance.

Akin to the participants of this study, OT clients have idiosyncratic personalities, genetic determinants, cultures, values, prior experiences, and needs that all contribute to their approach to the therapeutic alliance. For example, although OT implores the use of a collaborative approach in therapy, some clients, by virtue of these distinctive characteristics, prior experiences, and/or health condition may be unable, or unwilling, to actively engage in a collaborative therapeutic endeavour (Peloquin, 2003). Although in this study, cultures were all relatively similar and clients all actively collaborated in the therapeutic endeavour, the individualized characteristics impacted upon the therapist's approach to each client and the therapy objectives. Notably, all alliances in this study were positive and strong which demonstrates that despite characteristic differences, strong alliances can be built. Although positive, the consistently lowest quantitative alliance ratings were produced by Jackson. Jackson admitted indifference to OT intervention in the beginning. He was later diagnosed with depression and began treatment during this OT therapy block. This mood disorder may have been a factor impacting Jackson's degree of interest in therapy and hence his approach to the alliance.

Psychotherapy research has identified the nature of clients' problems (e.g., personality disorder, mood disorder) and the individual characteristics that make-up the clients effect therapy outcome, in part due to their approach to the therapeutic alliance (Asay & Lambert, 2006). Taylor (2008) references both clients' situational interpersonal characteristics (e.g., emotions, behaviours, and reactions that are contextually-bound and

inconsistent with how the client typically interacts) and enduring interpersonal characteristics (e.g., emotions, behaviours, and reactions that are consistently representative of the client's manner of interacting and emanate from their personality). Taylor (2008) assigns the responsibility of recognizing and understanding these unique interpersonal characteristics as well as appropriately responding to the OT. Effectively responding to these characteristics by selection of the appropriate therapeutic mode will enhance the client's response to the therapy process and to the therapist.

Clients learn through therapy. Through therapy, clients can achieve significant learning. Rather than focusing upon impairment, occupational therapy concentrates upon clients' engagement in client-defined meaningful occupations. Through therapist-guided active engagement in therapeutic activities, clients can learn about the multiple factors impacting their condition but, more importantly, how their engagement in meaningful occupation remains achievable. After fifteen years of chronic disability, Lise came to realize through the efforts of Marie, that she retained the abilities to engage in many activities in which she had not participated for many years. Furthermore, as was beginning to emerge by the end of Georgia's therapy with Helene, clients may learn how emotional health impacts physical health and vice versa and as well as related implications for their meaningful occupations. Parallels may be drawn to solution-focused counselling in which counsellors encourage clients to change behaviour, "do something different," as a means of eliciting new experiences and new insights with a present and future orientation in line with the client's objectives and vision (Tallman & Bohart, 2006, p. 112).

Environmental influences on the working alliance. The therapeutic alliance occurring between a client and therapist is embedded within a larger environment. This

environment is constituted by both physical and social aspects, both of which were found to have implications in this study. By virtue of community-based occupational therapy occurring in clients' environments, the therapeutic activities can use readily available real-life meaningful occupations which enhance both clients' engagement in therapy as well as learning. For example, Kotter did not appreciate computer or desktop activities, however, with Helene's focus being upon his cognitive remediation and development of insight, the steps required in the building of the backyard shed allowed for a meaningful and effective melding of Kotter's interests with the therapy objectives. There can, however, also be limitations imposed by this physical setting, including limited confidentiality (e.g., as family members mill around the area in which therapy is occurring). The corollary may be that issues are not raised by the client or their presentation shaped by the social implications (e.g., presence of a family member who would be offended if the client presented the information in a completely accurate and forthright manner). In the case of Lise, once marital issues came to light, Marie had to prudently alter her means of communication to use more closed-ended questioning in case Lise's husband suddenly appeared in the environment. Alternatively, at times, Marie and Lise found ways in which they could change the location of the therapy from the couple's apartment to other environments (e.g., a recreation room within the building) that allowed for more open communication, albeit still in an environment that offered limited confidentiality. In a study of community occupational therapy mental health, one of the identified barriers to a client-centred partnership was the lack of confidentiality inherent in the setting (Blank, 2004). Other limitations of community-based therapy services found in the literature include poor communication and coordination with other professionals (e.g., social workers) and family members as well as a focus on

discharge from services as an end in itself rather than upon client rehabilitation goals (Tyson & Turner, 2000).

There are many individuals in the environment who may impact the rehabilitation course. These individuals can serve as therapeutic allies for clients' occupational recovery, such as Jackson's wife did in this study. Alternatively, the individuals may feel personally or professionally vulnerable by the prospect of the client's functional recovery and thus provide a resistant or diverting force to changes arising from the therapy, as demonstrated by Lise's husband's reaction (i.e., a medication overdose). Asay and Lambert (2006) identify the presence of naturally occurring quality supports as having implications for the success of the therapeutic relationship in psychotherapy. The strongest of these supports is said to be the marital relationship, but others also include friends and family. There were no such similar findings discovered specifically in the OT literature; however, in a related vein, Bronfenbrenner's Bioecological Model (Bronfenbrenner, 1995) refers to relational processes that impact development. These processes can occur via direct contact with others (e.g., family, friends, neighbours) within the developing person's immediate environment. These influences are strongest due to their proximity and, as proposed by Bronfenbrenner, are bidirectional in nature in that these individuals interact and impact the developing person and vice-versa. A lack of such supports, as is often the case with socially-isolated disabled individuals, is anticipated to impact a client's approach to the therapeutic alliance in that these clients may not only welcome but emotionally need the social contact that is inherent in the OT intervention.

It is expected that these findings may provide OTs with a more refined perspective on the working alliance with clients and strategies that therapists may use to enhance the

alliance and their therapeutic use-of-self. These include purposeful attention to the clients' relational needs within the evolving interpersonal connection in therapy. Therapists may also consider the philosophical underpinnings of occupational therapy, the use of humour, and reflective and careful choice of the therapy goal. Clients' idiosyncratic characteristics and social contexts as well as the environment in which therapy is occurring also bear consideration, although significant limitations exist in therapists' ability to influence these factors.

Implications for OT Practice and Training

The implications of the findings of this research project are numerous from a training perspective. Until very recently (e.g., Taylor, 2008), there was no model that unified OT practice concepts with the therapeutic alliance or therapeutic relationship constructs. The findings of this study serve to further the understanding of the therapeutic alliance process in community-based OT intervention with adults. The findings may enhance OTs' understanding of their role in the therapy process and the ways to effect the therapeutic alliance. This recognized need to combine the relational aspect of care with clinical competence is increasingly recognized across health care disciplines as a whole. For example, in September 2011 a \$42-million endowment was provided to the University of Chicago medical school to fund research and training on doctor-patient relationships in a medical context (Easton, n.d.). It is the donors' contention that more physicians need to be trained regarding the importance of a compassionate, client-centred nucleus to the provider-client relationship. The findings of this OT study similarly propose that effective care needs to contemplate relational considerations alongside clinical competence.

These relational considerations start with the core principles of OT, namely client-centred practice. Canadian-trained OTs have long been educated to embody a client-centred approach to practice and the associated principles of a holistic view of the person and the importance of collaboration. Consequently, OTs seem prepared to embrace the importance of the therapeutic alliance with clients, but the operationalization of these concepts in daily practice remains obscure for many occupational therapists (Cole & McLean, 2003; Peloquin & Davidson, 1993; Taylor et al., 2009). Although OT training programs reference the relational concepts, they are often interwoven into other training topics and not specifically addressed onto themselves. Given that OTs report that they consider they are graduating without the skills necessary to address the therapeutic alliance (Peloquin & Davidson, 1993; Taylor et al., 2009), the principle implication arising from this study is the identification of concepts that OTs may employ to enhance the development of sound working alliances with their clients. Some of these concepts include skills that can be honed, whereas others are concepts best identified, but perhaps outside of the control of an OT. Based upon these identified mechanisms, it is recommended that a course specifically dedicated to learning foundational relationship skills should be introduced into the OT training curriculum. The findings of this study may provide some conceptual guidance for the design of such a course. For example, foundational relationship skills include that clients need to feel that the therapist is genuinely interested in and understanding of them specifically, demonstrates effective communication, and employs empathy, warmth, and respect. The importance of such basic tenets should orient training away from an exclusive focus on therapeutic techniques and toward a balanced approach of the two elements. Therapists need to learn how to develop a productive, safe, and optimistic atmosphere within their therapeutic

alliances that fosters growth and experiential discovery by the client. It is this interpersonal relationship and safe relational space that matures over time and is the initial required step in the therapeutic process.

The study's findings may also encourage therapists' reflection on the use of humour as an effective modality to enhance client comfort within the relationship as well as facilitate the arduous aspects of therapy and entice clients' engagement in challenging tasks.

Therapists should determine the appropriate degree and nature of humour to be employed as well as its' emphasis based upon specific client attributes (e.g., age, culture, personality), while remaining aware that the goal is to facilitate client engagement in challenging activities that promote functional enhancements. As suggested by Helene, she chooses most therapy activities based upon the goals of therapy and attempts to instil humorous aspects such as the role playing activity with Georgia. Periodically, however, she reverses this prioritization in that she chooses an activity purely based upon its degree of enticement with the goal of maintaining the client's interest and excitement in therapy. Into such activities she embeds therapeutic components; however, such is not the primary focus of the chosen activity. For example, she may take the client pedal-boating on the canal. Prior to attending, she may task the client with conducting preliminary research as it fits with the goals of therapy. Therapists are encouraged to provide ongoing reflection, on a case by case basis, as to the power that humour may have toward the therapeutic alliance and the attainment of the therapy goals.

Important to the therapeutic process is the therapy goal. Early in the process, therapists need to set specific goals into which both the client and therapist can buy and be motivated. In the cases where the therapy objective is more long term (e.g., Kotter's return

to work), the setting of short term, attainable goals can serve as landmarks of progress and maintain motivation. The findings of this study suggest that the process of successfully working together to a common end point likely supports the alliance and the therapeutic endeavour. It is therefore recommended that OTs provide adequate time for proper goal setting early in therapeutic process. As therapy progresses, proper monitoring of goals is important, so that realized goal attainment can be recognized and celebrated serving as further reinforcement of the alliance. Alternatively, attentive monitoring permits modifications to goals, so that chances of attainment can be maximized.

OTs, especially novices, tend to focus upon didactic knowing as a means to demonstrate professional competence in the absence of professional experience (Boyt Schell, Blesedell Crepeau, & Cohn, 2003). For example, while working with clients, novices tend to emphasize technical knowledge so that clients perceive the novice OTs as competent. A view of expertise mostly limited to technical OT skills can create barriers to mobility and career changes within the vast field of practice that constitutes OT. For example, employment positions are often categorized as either paediatrics, adults, or geriatrics, either community-setting or clinical setting, most often either physical medicine or mental health focused, and this does not account for specialized positions such as those dictated by complicated diagnoses such as neurological injuries, hand injuries, or addictions. Although certainly a sound technical knowledge base appropriate to any practice setting is vital, the findings of this study imply that therapists should also value the critical interpersonal dimensions of their clinical abilities rather than just the discrete intervention skills and techniques specific to a new practice setting. By returning to sound OT principles, such as collaborating with the adult client toward the remediation of meaningful occupational

performance issues, the novice OT or even an experienced OT now working in a new practice area can learn to become highly effective by focusing on the interpersonal connection while developing a repertoire of technical skills and experience.

The findings of this study are consistent with Taylor's (2008) IRM model in the recognition that the first step in the building of strong therapeutic alliances is for therapists to cultivate insight into their own abilities, strengths, and weaknesses. In other words, therapists must bring a sound knowledge of OT to their practice, but also very importantly, must know themselves and how they are generally received and perceived by others. Taylor has termed this the therapists' interpersonal style. This insight should then fuel desire for ongoing personal development, which is consistent with Rogers (1961) suggestion that optimal helping relationships are created by a psychologically mature individual. OTs should be able to identify their own personality style, skills, strengths, and limitations and then continuously strive to enhance their repertoire of related skills and strengths. As they mature as both therapists and individuals, an ongoing reflective stance will serve to identify further potential areas for development that would benefit the therapeutic alliances they build with clients.

Akin to the new College of Psychotherapists of Ontario that requires psychotherapy trainees to participate in their own psychotherapy with the aim of developing this personal, reflective insight, a similar recommendation may be suitable for OTs as well, and perhaps even all health care providers in general. The College of Occupational Therapists of Ontario develops paper and pencil prep modules that registrants are required to complete annually, in addition to a biannual professional development plan. Historically, the prep module topics have included, for example, record keeping, professional boundaries, the implications of

being a regulated health professional, and prescribed standards. A prep module focussed on the topic of personal and professional insight building would require all college registrants to participate in such an exercise. Such would not only encourage reflection on a topic they may not have previously considered, but also may inspire a therapist's development of related professional development goals.

Implications for Future Research

Recognizing that this is the first study of its kind in OT to look at the process of therapeutic alliance development specifically in the context of community-based OT practice with adults, further study is required in order to confirm or disconfirm these findings. Of significant interest will be determining how these findings are both similar and disparate from a replication study in a highly similar context as well as other service milieus. To that end, future studies are recommended with a similarly aged and capable adult population being treated in both an inpatient and outpatient clinical setting. Further inquiry may also include clients falling into other age groups such as children, adolescents, and the very aged, as well as clients in disability groups such as degenerative conditions (e.g., dementia, amyotrophic lateral sclerosis, multiple sclerosis), cancer care, end of life care, and severe mental health disorders (e.g., addictions, schizophrenia).

Further study of the role of humour in occupational therapy as it relates to the alliance is needed. For example, one inquiry may investigate whether there is an optimal level of humour to be achieved in the alliance. A related inquiry may examine the impact upon the alliance when humour is either absent or overly emphasized. There are grave contexts and conditions (e.g., severe emotional health), or personalities and cultures, from either client and/or therapist perspectives that may contraindicate the use of humour into

therapy. In these contexts, future inquiry may investigate the impact of the absence of humour on the therapeutic process and alliance.

In this study, the two therapists used different degrees of both self-disclosure and boundary crossing depending on the case. The use of these two techniques appeared to be a means of therapeutic use-of-self. There was evident contrast between the two therapists in that Helene appeared to more openly use these techniques. This may be explained from different perspectives including the fact that Helene's cases are longer term compared to Marie's given differences in their practices, but may also point to a difference in the therapists' comfort with these techniques in therapy. The OT literature identifies that many OTs do not feel well prepared to practice the therapeutic use-of-self with clients and this tends to be an on-the-job learned skill (Cole & McLean, 2003; Peloquin & Davidson, 1993). The disparate levels of comfortable use of these techniques evidenced in this study occurred despite strong alliances in all four dyads. Taylor's (2008) Intentional Relationship Model (IRM) places a central focus upon therapists' therapeutic use-of-self toward the promotion of occupational engagement. Taylor (2008) proposes a model explaining how components of the client-therapist relationship interact and can be impacted by ten principles related to the OT's cultivated skill in the therapeutic use-of-self. The contention of the IRM is that the quality of the client-therapist relationship is dependent upon the therapist's therapeutic use-of-self which is in turn linked to therapy outcomes. The findings from this study in which there are strong alliances despite evident differences in the therapists' use-of-self call into question the centrality of the therapeutic use-of-self construct as defined in Taylor's model. Further study is indicated in which there is a focus upon the therapeutic use-of-self construct and how this impacts the alliance in OT.

Lastly, all client study participants demonstrated some degree of social isolation which I suggest potentially primed these clients for the interpersonal connection with their OT. Further study comparing and contrasting clients with variable degrees of social isolation would assist with clarifying and defining the impact of this isolation construct upon the alliance. For example, a larger scale study with two groups of clients (e.g., community-based clients who characteristically tend to be more socially isolated by virtue of their impaired mobility and clients who attend therapy centres as outpatients) may assist with more clearly delineating the impact of social isolation upon the alliance construct.

Limitations

This study was situated in a community-based context. There are characteristics inherent in a community-context that differentiate it from a clinic or institutionally-based intervention and represent several limitations for transferability of these findings to other practice contexts. It is expected that the community-based nature of the study differently influences the therapeutic alliance. The intervention occurring in the client's home tends to reduce the power imbalance between the OT and client, and it offers meaningful and relevant occupations *in-vivo* as fodder for therapeutic activities. The influence of other people in the client's home environment on the therapeutic process is also more pronounced in community settings. Furthermore, there are more limited opportunities for confidential sharing of information in the client's home with others present. This may impact the alliance by curtailing the client's sharing of information with the OT. In addition, clients receiving community-based OT tend to be more socially isolated than those who receive institutionally-based therapy. Clinical experience reveals that many clients who receive community-based OT have limitations, such as impaired mobility, that contribute to their

social isolation. Thus, community-based clients may be more welcoming of contact thus in so potentially priming them for developing a strong interpersonal connection with the OT. Although strong alliances are expected to still be achievable in inpatient settings, it is questioned whether the same themes found in this community-based study context would emerge in a different treatment setting.

There are also limitations by virtue of the study's design. In this study, each occupational therapist was a participant in two of the cases. One of the benefits of the design is that it permitted observations of the therapists' customized approaches in two different cases given the relational dynamics and contextually-bound client considerations. On the other hand, two therapists can provide only a relatively narrow view of the alliance construct in OT. Different and more varied observations of the alliance may have been gleaned from a wider sampling of occupational therapists.

Both Taylor's (2008) Model and the findings of this study have relied heavily upon the research generated in the psychotherapy field. This assimilation of knowledge constructs must be undertaken with caution. Although there are inherent similarities between the two disciplines, there are also evident differences in the type, intensity, foci, and duration of therapeutic alliances. This reliance upon psychotherapy findings is due to the fact that research as it relates specifically to the alliance in the OT literature is limited to date. Most OT-specific research has been qualitative in nature. There is an absence of large-scale quantitative research regarding the topic of therapeutic relationship or alliance, as has been conducted in the psychotherapy field. Such types of inquiries are indicated in order to determine discipline-specific findings toward the development of OT-specific theoretical foundations regarding the alliance construct.

The participants of this study were all willing participants who stepped forward to offer their time and contribution. In addition, all participants were remunerated for their participation. In light of the participant self-selection and the high demand of time required for participation, the OT and client participants to this study are likely not broadly representative of OTs and clients generally. As a result, there is some question as to how these findings represent therapeutic relationship in OT relationships generally. Similarly, the two occupational therapists expressed interest in the concept of the therapeutic alliance with their clients and were introspectively reflective on this topic. As a result, these two therapists may be more attuned to the interpersonal connection with their clients and invest time and energy into the construct during their therapeutic endeavours. Of the more than 100 occupational therapists invited to participate in this study, only five offered to participate, and in the end only two OTs succeeded in recruiting clients to join in the research project. There were many reasons provided for therapists' non-participation (e.g., disinterest in the construct, elevated stress and limited time due to their current caseload demands). It is questioned how the nature of this reasoning for not participating may impact OTs' therapeutic alliances with clients.

The volume of data collected in this study was heavily weighted toward the clients. Although it would have been ideal to have balanced the data with monthly interviews of both the clients and therapists, the initial and final interview of the therapists (with per visit completion of the WAI) was decidedly more feasible as it was less burdensome on the therapist's time. Ongoing reflective and analytical analysis of the development of the alliance from both perspectives throughout the relationship may have resulted in a more thorough understanding of the process of alliance development and the inherent factors.

Although all accounts were retrospective in nature, client interviews occurred monthly and hence the data were both closer in time, and allowed for a monitoring of alliance development over the course of the relationship. In contrast, dyad-specific therapist interviews only occurred at the end of the relationship and hence retrospective recall may have lost some details and potentially produced different kinds of accounts than if they had of been collected at the same frequency as the client accounts. The terminal interview with the therapists also did not enable monitoring of the ongoing development of discussed issues. Rather, by the time of the therapist interview, the therapeutic relationship in three out of the four dyads had been completed and there was therefore no reflection as to ongoing development of the alliance by the therapists. This retrospective gathering serves to limit the recall and shape the nature of the collected data.

The scales used to assess both the alliance and the clients' functional recovery may have demonstrated a ceiling effect. If this is true, then the scales did not provide a complete portrait of these dimensions over the course of therapy. For the two clients who demonstrated either no or negative functional gains from the beginning to end of therapy on the OSA, they in fact discussed in the interviews gains made through their OT intervention. In both cases, these clients (i.e., Georgia and Kotter) were working toward higher level goals (e.g., related to return to work) than the other two clients (i.e., Lise and Jackson) who did demonstrate enhance competence on the OSA (who were working upon goals such as dressing, cooking, and community mobility). The use of another instrument able to differently assess client's perceived competence in higher level domains might have provided a fuller representation of the client recovery. Furthermore, in three of the four dyads, a perfect score on the WAI was assessed at at least one point in the study. Of most

concern was the bond subscale that most consistently reached its maximum (whereas the task and goal subscales reached the maximum less often). As a result, at least as it related to the bond subscale, the WAI may have captured the early rapport but may not have been sensitive to the evolution as the alliance deepened over the months of occupational therapy. As a result, it is uncertain whether the results represent a complete and accurate picture or a distorted one. In a similar vein, the two participant therapists also reflected that they found the quantitative scale of the WAI to be restrictive. They would have preferred to have had an opportunity to provide qualitative information, descriptions, and examples in order to better explain their attributed WAI scoring as the instrument was being completed during the course of the relationship.

As a result of these limitations, the results of this study offer limited transferability to the wider OT context in specific diagnostic groups (e.g., mental health, dementia), in variable settings (e.g., hospital or clinic-based care), and with different age groups (e.g., pediatric, adolescents, very aged). Inherent in the nature of voluntary participation in such studies, it would be difficult to entice the participation of those who are less socially inclined and those who have a negative impression of OT or of the therapeutic alliance. The transferability of this study's findings is limited to such populations.

Contribution to Knowledge

I began this inquiry in search of a greater understanding of how OT outcomes (e.g., clients' meaningful occupational engagement) and the working alliance change over the course of occupational therapy intervention. Rather than solely focussing upon the relationship between these two constructs, however, I wanted to better understand both clients' and therapists' experiences from different perspectives of the same therapeutic

relationship and those factors perceived to have impacted the relationship in the community-context. This was the first known occupational therapy study to examine the emergent patterns of the client-therapist working alliance during the course of a community-based occupational therapy intervention.

Although there was no relationship found in this study between the working alliance and the client's perceived functional abilities, clients readily attributed their functional recovery to the OT therapeutic endeavour. This is consistent with previous findings in which both clients and OTs perceive there to be a link between these two constructs without specific supporting evidence of a link (Cole & McLean, 2003; Palmadottir, 2003). Further specific inquiries will be required in order to definitively demonstrate whether a link in fact exists.

The primary affordances for learning from this study were the identification of key elements of the therapeutic alliance in an occupational therapy context. Although OTs have long considered the therapeutic relationship to be of critical importance, the operationalization of how to foster its development toward occupational engagement remains elusive to many OTs (Cole & McLean, 2003; Taylor et al., 2009). The key elements identified in this study provide suggestions on how OTs may in fact enhance their therapeutic alliances with clients. Although the concept of an interpersonal connection in and of itself is not anticipated to be a novel suggestion for OTs, what is novel is its characteristic development from superficial rapport through to a safe harbour for exploration of emotionally-laden topics and coping processes as it relates to clients' occupational performance issues. The presented findings suggest those therapist embodiments (e.g., friendly emotional warmth, carrying, mutual interest and respect) that may facilitate this

optimal development of the bond that is concomitant with the evolution toward progressively deeper-meaning occupations as the focus of therapy. By focussing upon the refined development of those therapist characteristics and skills conducive to the development of the bond, the creation of a secure base and evolution of therapeutic focus may be more easily realized with a more varied client population.

The models of practice in OT commonly reference the impact of environment upon client occupation (CAOT, 1997; Kielhofner, 2002). The consideration of the environment, however, appears to be novel from the perspective of working alliance research. Although environmental issues are found in the education literature referring to learner's sense of connectivity (e.g., Battistich et al., 2004; Soloman et al., 2000), there was no psychotherapy, health care, or OT literature found that considered the impact of the environment upon the therapeutic alliance. This study undertook to explore and identify those environmental conditions that impact the therapeutic alliance, specifically in community-based OT intervention. OTs may become more adept at identifying those environmental attributes and influences that may either foster or impact upon the working alliance and in so determine if there may be specific approaches that may be undertaken to most efficiently employ or accommodate these identified factors.

In conclusion, the findings of this study address a preliminary step toward filling a gap in the OT literature about the process of therapeutic alliance development over the course of OT intervention and those factors found to influence its development. The findings highlight the central importance of the interpersonal connection, the profoundness of which matures over time to provide a safe place in which clients can explore means to enhance their meaningful occupational performance. Therapists' relational embodiments

and occupational therapy's philosophies, such as a client-centred approach, can serve to further facilitate the development of the working alliance. The findings point to the importance of the client-defined meaningful occupations providing fodder for both the activities undertaken during therapy as well as providing basis for the identified and carefully established therapy goal. Lastly, client characteristics and the implications of environmental contextual factors were found to shape the therapeutic process. Further investigation into the constituent components (therapist, client, environment) as well as the developmental process of the therapeutic alliance are indicated, however, these findings may provide foundational information toward better understanding these phenomena and their interaction. Although the development of the discipline of OT has been greatly aided through scientific advancements, the results of this study, in large part, echo the long ago shared sentiment of an occupational therapy pioneer, Ora Ruggles. She has been cited as saying, "It is not enough to give a patient something to do with his hands. You must reach for the heart as well as the hands. It's the heart that really does the healing" (Carlova, 1961, p. 249).

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Appendices

Appendix A: Working Alliance Inventory – Client Version

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Appendix B: Working Alliance Inventory – Therapist Version

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Appendix C: Initial Therapist Interview

- To occur after the orientation session but before client-participant involvement in the study.
- Therapists will be provided with a reflective exercise to complete prior to the interview (related to question 4).
- To occur at a location of convenience to the participant (e.g., therapist's office)
- Expected duration: 1 hour

1. Introduction

- introduce purpose of the interview: to gather background information concerning the therapist, her therapeutic approach, and current reflections upon the therapeutic relationship.
- Two interviews: now and upon discharge of the client.
- You and the participant client with whom you are working will be one of up to four dyads in the study.
- Information will be maintained confidentially, including your client. You will be identified only via pseudonym – is there one you would prefer?
- Member checking to occur after the preliminary analysis of final interviews.
- Collected information will be presented in aggregate form in report.
- I will be tape recording our meeting. The purpose of tape recording our conversation is to ensure that I properly remember what you say. The conversation will be transcribed word for word.
- Should I ask a question and you wish to receive clarification, please do ask. You are also welcome to skip any questions with which you are uncomfortable.

2. This is meant to be a fun question. Use your imagination when answering this question. When you envision the perfect therapeutic relationship between you and a client, what colour (meal, song) is it and why (What does that colour mean to you)?

3. In her text, *The Intentional Relationship*, Dr. Renée Taylor describes six different manners/modes in which therapists may approach their therapeutic practice with clients.

- Problem-Solving
- Advocating
- Collaborating
- Empathizing
- Encouraging
- Instructing

As per the exercise from her book which you were provided prior to this interview, what were the dominant modes of your therapeutic style? Did the results meet with your expectations? What reflections do you have concerning this exercise?

4. What are the considerations or preoccupations you have when initially meeting a client?
(sample probes: How are these pre-occupations manifested/accomplished? In other words, if I were to attend a meeting with you and your client, what would I observe? Do these considerations change from session to session?)
5. Describe how the goals of therapy are established with each client.
 - What happens if you and the client disagree upon the goals?
6. How are the activities to be performed in therapy decided?
 - What occurs when you sense that a client is not invested or is not interested in the therapeutic activity?

Halfway Check In: We are now approximately halfway through the interview. How are you doing?

7. How important is it that you like your client and that the client likes you and why?
 - In your opinion, what are the implications upon treatment?
 - Have you been in situations in which you did not like your client? Tell me about that therapeutic experience.
 - Have you been in situations in which you sensed, or knew, that the client did not like you? Tell me about that experience.
8. What do you think of the following statement:
“Establishing trust in the therapeutic relationship is critical to the treatment process.”
 - How do you establish trust in a therapeutic relationship?
9. How important is it to be confident in your ability to help your client?
 - What do you do to enhance your level of confidence?
 - Have you ever lacked confidence in your ability to help a client? Tell me about that experience and what you did?
10. Sometimes there are people external to the client and therapist whose actions/philosophy/feedback have implications upon the therapeutic relationship. In your experience, what top three people (or roles) would you identify as having the most profound effect upon the therapeutic relationship and how?
11. Factors external to the relationship itself may also have implications upon the therapeutic relationship between a client and therapist. For example, these may include client or therapist characteristics, could be related to the injury/condition, the health care system, or factors in the environment. In your experience, what are the top three common factors which you would identify as impacting the therapeutic relationship with a client?

12. Before we finish, is there anything else which we have not yet discussed that you would like to share as being important in your therapeutic relationships with clients?
13. Demographic survey
14. Conclusion: How did the interview go for you?
15. Thank you.
 - Process from here (client recruitment, communication regarding scheduling of client visits and of therapy completion)

We will meet again following client discharge for a similar reflective interview, however, that one will focus similar questions upon the therapeutic relationship established between you and the specific client involved in the study

Appendix D: Demographic Survey – Therapist

For the sake of knowing you and your specific characteristics more thoroughly, you are requested to complete the following survey. In the following categories, please select the response(s) which best describe(s) you. Should you not feel comfortable answering any question, please leave it blank. This information will be maintained confidentially and only presented in aggregate form in the final report.

1. Please select (✓) the answer which best describes you:
 Female Male

2. Please indicate your year of birth: _____

3. What languages do you speak (please list languages in the order in which you are most comfortable conversing)?
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____

4. Were you born in Canada? Yes No
 If you were born outside of Canada, please specify the country: _____
 In what year did you immigrate: _____

5. What are the ethnic or cultural origins of your ancestry (for example, Canadian, English, French, Chinese, Italian, German, Scottish, East Indian, Irish, Cree, Micmac, Métis, Inuit, Ukranian, Dutch, Filipino, Polish, Portugese, Jewish, Greek, Jamaican, Vietnamese, Lebanese, Chilean, Salvadorean, Somali, etc.)? (You may have more than one.)

6. Please identify (✓) which of the following characteristics describe you:
 - White
 - Chinese
 - South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
 - Black
 - Filipino
 - Latin American
 - Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian etc.)
 - Arab
 - West Asian (e.g., Iranian, Afghan, etc.)
 - Korean
 - Japanese
 - Other, please specify: _____

7. Statistics Canada stated that the 2006 median income for a family in the metropolitan area of Ottawa was \$84,000. Based upon this information, please indicate into which category your annual family income falls:

less than average
 near average
 above average

8. Please indicate your highest completed level of formal education/training:

Elementary School
 High School
 Registered Apprenticeship or other trades certification or diploma
 College, CEGEP, or other non-university certificate or diploma
 University, certificate or diploma below a bachelor level
 University, bachelor degree
 University, master's degree
 Professional doctorate (e.g., medicine, dentistry, veterinary medicine, optometry)
 Doctorate

9. Tell me about your work experience as an Occupational Therapist:

Year Graduated from OT School:

Years of Professional Experience:

Settings/milieus in which you have worked:

Did you have a profession before becoming an OT? Yes No

If yes, in what field(s) and for how long:

Any other comments or interesting facts as it relates to your professional work experience:

Appendix E: Final Therapist Interview

- To occur after client discharge
 - To occur at a location of convenience to the participant (e.g., therapist's office)
 - Expected duration: ~ 1 hour
1. Introduction
 - introduce purpose of the interview: to gather information from the therapist about her reflections regarding the therapeutic relationship which occurred specifically with this client.
 - Information will be kept confidential.
 - Member checking to occur after preliminary analysis of final interviews.
 - Collected information will be presented in aggregate form in report.
 - You are welcome to skip any questions with which you are uncomfortable.
 2. Again, for our fun question. You will remember in our initial interview, you told me about a colour that represented your ideal therapeutic relationship with a client. What colour would you use to describe the relationship which occurred with this specific client and why (what does this colour mean to you)?
 3. As per the exercise which you completed prior to the initial interview describing the different manners and modes of therapeutic practice with clients, which modes did you use with this client? Which mode(s) dominated your interaction?
 - Problem-Solving
 - Advocating
 - Collaborating
 - Empathizing
 - Encouraging
 - Instructing
- As per your initial completion of the exercise, was this/these mode(s) a natural fit for you, or were you required to use lesser preferred modes?
4. What were the goals of your intervention with the client?
 - How were these established?
 - Did you and the client agree on these goals?
 5. Describe your perception of the client's recovery process.
 - When compared to other clients with similar conditions, did the client meet expectations, exceed, or under achieve. Discuss
 6. What activities did you and the client do during therapy?
 - How were these activities determined?
 - Was the client always interested in the activities?
 7. Describe the relationship that you had with this client.
 - What are the characteristics of this relationship?

8. What two to three words best capture the essence of this relationship?
9. What are the strength/qualities of the relationship
10. What aspects of the relationship were not as strong?

Halfway Check In: We are now approximately halfway through the interview. How are you doing?

11. How would you describe the degree of “liking” which occurred in the relationship?
 - Was it mutual?
 - Did it change or fluctuate over the course of therapy?
12. Describe for me the degree of trust which occurred in the relationship? Can you describe a situation exemplifying this degree of trust?
 - What reflections do you have upon the ‘trust’ which occurred?
13. Describe your level of confidence in your ability to help this client meet the outlined goals.
 - Was this level of confidence consistent throughout the course of the therapy (e.g. beginning, middle, and end), or did it fluctuate?
 - Did you undertake any efforts (and what were they) in order to increase your level of confidence to help this client?
14. Outside of you and the client, who (people) impacted the therapeutic relationship and how?
15. You may remember that in our first interview, we spoke of factors outside of the specific client-therapist relationship which impact upon the relationship. Examples included personal characteristics, factors related to the client’s injury, the health care system in general or factors in the environment. What factors can you identify as having impacted your therapeutic relationship with your client? How?
16. Describe to me a ‘defining moment’ (or a moment which stands out in your mind) which occurred during the course of your therapeutic relationship with this client.
 - what occurred?
 - why is this ‘defining’?
 - when did it occurred?
 - who did what and what was response?
17. ‘Inevitable interpersonal events’ may occur in any relationship. Such may include a misunderstanding or hurt feelings. Describe any such situation which occurred during this therapeutic relationship. In other words, did anything go wrong during the course of intervention and what was the implication?

18. Before we finish, is there anything else about therapeutic relationships that you find important that you would like to share with me?
19. Conclusion
 - How did the interview go for you?
20. Thank you.
 - Process from here (data analysis and member checking)
 - Preference for receipt of analyzed data? (Meeting, mail, email)
 - Email address:
 - Password:

Appendix F: Occupational Self Assessment – Initial

Removed due to
copyright protection.

Removed due to
copyright protection.

Appendix G: Demographic Survey – Client

For the sake of knowing you and your specific characteristics more thoroughly, you are requested to complete the following survey. In the following categories, please select the response(s) which best describe(s) you. Should you not feel comfortable answering any question, please leave it blank. This information will be maintained confidentially and only presented in aggregate form in the final report.

1. Please select (✓) the answer which best describes you:
 Female Male

 2. Please indicate your year of birth: _____

 3. What languages do you speak (please list languages in the order in which you are most comfortable conversing)?
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____

 4. Were you born in Canada? Yes No
 If you were born outside of Canada, please specify the country: _____
 In what year did you immigrate: _____

 5. What are the ethnic or cultural origins of your ancestry (for example, Canadian, English, French, Chinese, Italian, German, Scottish, East Indian, Irish, Cree, Micmac, Métis, Inuit, Ukranian, Dutch, Filipino, Polish, Portugese, Jewish, Greek, Jamaican, Vietnamese, Lebanese, Chilean, Salvadorean, Somali, etc.)? (You may have more than one.)
-
6. Please identify (✓) which of the following characteristics describe you:
 - White
 - Chinese
 - South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
 - Black
 - Filipino
 - Latin American
 - Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian etc.)
 - Arab
 - West Asian (e.g., Iranian, Afghan, etc.)
 - Korean
 - Japanese
 - Other, please specify: _____

7. Statistics Canada stated that the 2006 median income for a family in the metropolitan area of Ottawa was \$84,000. Based upon this information, please indicate into which category your annual family income falls:

less than average
 near average
 above average

8. Please indicate your highest completed level of formal education/training:

Elementary School
 High School
 Registered Apprenticeship or other trades certification or diploma
 College, CEGEP, or other non-university certificate or diploma
 University, certificate or diploma below a bachelor level
 University, bachelor degree
 University, master's degree
 Professional doctorate (e.g. medicine, dentistry, veterinary medicine, optometry)
 Doctorate

9. What is (or was) your work or occupation (e.g., homemaker, full-time unpaid caregiver (e.g., stay-at-home parent), legal secretary, plumber, fishing guide, wood furniture assembler, secondary school teacher, retired)?

Occupation: _____
Number of hours worked per week: _____
If retired, when did you retire? _____

Appendix H: Initial Client Interview

- To occur either during the same meeting as client consent is received, or at a mutually convenient time shortly thereafter.
 - To occur at a location of convenience to the client (e.g., the client's home)
 - Expected duration: ~1 hour
1. Introduction:
 - Purpose of the interview is to better understand what you have to say about the relationship with your occupational therapist. Your information is important as you are one of only four clients included in this study
 - I want to know what you think, rather than think I know what you think
 - Confidentiality (will not be shared with anyone, including your therapist) and presentation of all collective information at the end (following discharge from therapy). A pseudonym will be used. Is there one you would prefer?
 - I will be tape recording our meeting. The purpose of tape recording our conversation is to ensure that I properly understand what you say. The conversation will be transcribed word for word.
 - I will also be taking some notes during our meeting in order to help me keep on track and ask you better questions.
 - Once all interviews are completed, an analysis will be returned to each participant to ensure that I have not misunderstood anything
 - Should I ask a question and you wish to receive clarification, please do ask. You are also welcome to skip any questions with which you are uncomfortable. Do you have any questions before we begin?
 2. Introduce the demographic survey
 3. Tell me what happened which led to your need for occupational therapy.
 - Perceived severity of injury
 - Impact upon everyday lift (functionally)
 - Timing of injury/illness/surgery and commencement of OT
 - Was OT available when you most needed it?
 4. OSA – Complete steps 1 and 2, then 3
 5. Tell me about your hopes and expectations as it relates to your recovery.
 - Duration of recovery?
 - Extent of recovery? (total versus expected remaining impairment)
 - How will you know when you have recovered? Are there activities which you plan to use as your measure of being sufficiently or fully recovered?
 6. What are your current goals for your recovery?

7. If you have previously suffered an illness or injury, please describe for me what the process of recovery was like for you?
 - Extent
 - Speed
 - Complications
8. Are there people around you who you believe will have an impact on your recovery? Please explain.
 - Positive impact
 - Negative impact
9. Can you identify any situations or factors with which are you currently faced which you think may delay your recovery? Examples of such may include a family or home situation, weather or environmental factors, an example such as the recent bus strike in Ottawa, something about the health care system, financial constraints due to your condition, the impact of other health conditions etc.
10. Are there any factors or situations which you think may promote your recovery from this injury?
11. How many therapy sessions have you had?
 - (b) What activities did you do?

Halfway Check In: We are now approximately halfway through the interview. How are you doing? Are any changes required?

12. WAI
13. This is meant to be fun question. If you were to describe an ideal relationship with your therapist, what colour (meal, song) would it be and why (what does this colour mean to you)?
 - What colour is it right now? What does that colour mean to you?
14. Tell me about your impressions of your therapist to date.
 - Describe her/him to me.
15. What is your reaction to, or reflections regarding, the following statement:
“Establishing trust in the therapeutic relationship is critical to the treatment process.”
Sample probes: How would you describe the level of trust in your relationship to date?
16. You have met your therapist X times so far. How would you compare the relationship with your therapist to other professionals who you have worked with in the past. These professionals may be your doctor, another therapist, an accountant or

a lawyer. How does this early relationship compare to other professional relationships?

17. Describe to me the level of confidence you have in your therapist's ability to help you through your recovery.
18. If you and your therapist would have met under different circumstances, do you envision that you could be friends? Why?
19. Before we finish, is there anything else which we have not yet discussed which you would like to add about what you find to be important in the relationships with your therapist?
20. Conclusion
 - How did the interview go for you?
 - Are there any problems so far?
20. Thank you.
 - Process from here (how will I find out about therapy visits, I will then call to set up another interview - not more than monthly)

Appendix I: Subsequent Client Interview

- To occur monthly, or should therapy be occurring less frequently, following each therapist visit.
 - To occur at a location of convenience to the client (e.g., the client's home)
 - Expected duration: 1 hour
1. Introduction:
 - Remind of the purpose of the interview: to understand the relationship which occurs between you and your therapist.
 - I really want to know what you are experiencing and thinking in the relationship.
 - Confidentiality (will not be shared with anyone, including your therapist) and presentation of collective information at the end (following discharge from therapy) using pseudonym previously identified.
 - I will again be tape recording our meeting. The purpose of tape recording our conversation is to ensure that I properly understand what you say. The conversation will be transcribed word for word.
 - I will also be taking a few notes during the interview to help me keep on track.
 - Once all interviews are completed, an analysis will be returned to each participant to ensure that I have not made any misunderstandings.
 - Should I ask a question and you wish to receive clarification, please do ask. You are also welcome to skip any questions with which you are uncomfortable. Do you have any questions before we begin?
 2. With respect to your recovery, what has occurred/changed since we last met?
 - Highlight challenges
 - Successes
 3. Tell me about your recovery to date. (Tell me your story.) (This may be naturally answered as a result of the previous question.)
Sample Probes:
 - meeting expectations/goals? Time? Function? Symptoms/Pain?
 - overall reflections
 4. OSA
 5. Who around you do you feel is aiding or promoting your recovery? Please explain your reasoning
 - People delaying your recovery
 - Discuss
 6. You will remember that we previously discussed those factors or situations around you which you felt may have a negative impact upon your recovery. Lets reflect on

those now (list them) and see if they had the impact you were expecting. Are there any new factors or situations, or ones you have not previously considered which are having a negative impact on your recovery?

- Same as above for factors promoting your recovery

7. Tell me about the last therapy session. What do you do? How are the activities decided?

Halfway Check In: We are now approximately halfway through the interview. How are you doing? Are any changes required?

8. WAI

9. When you think about your therapist, what three (or more) characteristics would you use to describe her/him?

10. How confident do you feel today in your therapist's ability to help your recovery?

11. On a scale of 0 to 10 where 0 is no trust and 10 is absolute trust, where would you place your degree of trust in your therapist?

- Discuss
- What would need to occur to change/improve this degree of trust?

13. Have there been any incidents in which either you experienced or you sensed that your therapist experienced a misunderstanding or hurt feelings? What happened? How did you work through it and how? How did this impact your relationship?

14. Before we finish, is there anything else which we have not yet discussed which you would like to add about what you find to be important in the relationship with your therapist?

15. Conclusion

- How did the interview go for you?
- Are there any problems so far?

16. Thank you.

- Process from here (meet again)

Appendix J: Final Client Interview

- To occur upon discharge from therapy
 - To occur at a location of convenience to the client (e.g., the client's home)
 - Expected duration: 1 hour
1. Introduction:
 - Remind of the purpose of the interview: to understand the relationship which occurs between you and your therapist.
 - I really want to know what you are experiencing and thinking in the relationship.
 - Confidentiality (will not be shared with anyone, including your therapist) and presentation of collective information at the end (following discharge from therapy) using pseudonym previously identified.
 - I will again be tape recording our meeting. The purpose of tape recording our conversation is to ensure that I properly understand what you say. The conversation will be transcribed word for word.
 - I will also be taking a few notes during the interview to help me keep on track.
 - Once all interviews are completed, an analysis will be returned to each participant to ensure that I have not made any misunderstandings.
 - Should I ask a question and you wish to receive clarification, please do ask. You are also welcome to skip any questions with which you are uncomfortable. Do you have any questions before we begin?
 2. Tell me the story of your recovery.
Sample Probes:
 - Met expectations? Time? Function? Symptoms/Pain?
 - During our first interview, you indicated that _____ was your measure of sufficient or full recovery. Have you participated yes? If not, what are you plans in this regard? How close do you feel that this goal is?
 3. OSA
 4. Who were the people who had the most significant positive or supportive role in your recovery? How? Discuss
 - People who negatively impacted
 - Compare to prior list – same, or different. If different, why?
 5. In the past you have identified:
 -
 -
 -as being factors or situations which you felt had a negative impact upon your recovery. In retrospect, how much of a role did these factors or situations play in your recovery? Were there other factors or situations which you perhaps had not

considered at the time that in retrospect have become more evident as having a negative impact? Discuss

6. In the past, you identified:

-
-
-

as factors or situations which you felt were aiding or promoting your recovery. Now that you have reached this stage, what are your reflections upon these factors/situations? How much of an impact did they have upon your recovery? Were there other factors or situations which you had not previously considered which you now think positively impacted your recovery? Discuss

Halfway Check In: We are now approximately halfway through the interview. How are you doing? Are any changes required?

7. WAI

8. Again, for our fun question. Now that you have reached the end of your therapy, if you were to describe the relationship with your therapist as a colour (song/meal), what colour (song/meal) would it be and why (what does this colour mean to you)?

- Initially you described _____ as representing your ideal therapeutic relationship. How does “today’s colour” and “initial colour” compare?
- Describe the relationship between you and your therapist.

9. Tell me about your final, overall impressions of your therapist.

10. If you and your therapist met in a different manner (non-professional), could you two likely develop a friendship? Explain

- Did you “like” your therapist?

11. If you could, what would you change about your therapist?

12. Were there any incidents in which either you experienced or you sensed that your therapist experienced a misunderstanding or hurt feelings? What happened? How did you work through it and how? How did this impact your relationship?

13. Discuss with me the value of your therapist’s professional skill and knowledge and how it contributed to your recovery? I am trying to understand the level of confidence you had that your therapist could help you through your recovery.

14. During the initial interview, we discussed your reflections concerning the following statement:

“Establishing trust in a therapeutic relationship is critical to the treatment process.”

- Discuss the degree of trust in this therapeutic relationship

- Did this change over time?
 - Were there things which the therapist did which impacted your degree of trust?
15. How would you compare the relationship which was established with your therapist to other professional relationships (e.g. physician, other therapist, accountant, lawyer etc.)?
 16. If you were to need therapy again in the future, would you want this therapist to return? Discuss.
 17. Suppose you were the therapist in the intervention which has just occurred, what things would you do the same?
 - and differently?
 18. If you were to attend a class of newly trained therapists ready to go out into the world, what would you tell them about the therapeutic relationship with their clients?
 19. Before we finish, is there anything else which we have not yet discussed which you would like to add about what you find to be important in the relationship with your therapist?
 20. Conclusion
 - How did the interview go for you?
 21. Thank you.
 - Process from here (member checking - how received)

Appendix K: Occupational Self Assessment - Follow-Up

Removed due to
copyright protection.

Appendix L: Ethics Approval

File Number: 01-09-03

Date (mm/dd/yyyy): 04/22/2009



Université d'Ottawa **University of Ottawa**
Service de subventions de recherche et déontologie Research Grants and Ethics Services

Ethics Approval Notice Social Science and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
<input type="text"/>		Education	Supervisor
<input type="text"/>		Education	Student Researcher

File Number: 01-09-03

Type of Project: PhD Thesis

Title: Therapeutic Relationship and Functional Outcomes in an Occupational Therapy Intervention

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
04/22/2009	04/21/2010	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A

File Number: 01-09-03

Date (mm/dd/yyyy): 04/22/2009



Université d'Ottawa University of Ottawa
Service de subventions de recherche et déontologie Research Grants and Ethics Services

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: ethics@uOttawa.ca.

Signature:

[Redacted Signature]

[Redacted Name]

Protocol Officer for Ethics in Research
For [Redacted Name] President of the Social Sciences and Humanities REB

[Redacted Signature]

Appendix M: Invitation to Participate (Therapist)



Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

INVITATION TO PARTICIPATE (Therapist)

A fellow Occupational Therapist, [redacted], is conducting a PhD research study through the University of Ottawa. As an Occupational Therapist working with adults in the community, you are invited to participate in this study.

TOPIC: **Therapeutic Relationships and Functional Outcomes
In an Occupational Therapy Intervention**

BENEFITS:

The aim of this study is to better understand both clients' and therapists' experiences within a therapeutic relationship. Clients' functional improvements achieved during the course of therapy will be considered in parallel to the established therapeutic relationship. Benefits of participating in this study include that therapists and decision makers may gain an improved understanding of the value of the therapeutic relationship and its potential impact upon clients' ability to resume those meaningful activities. The results of this study may impact future decisions regarding the manner in which clients choose or have therapists assigned to them, and individual therapists' approach to their clients.

REQUIREMENTS:

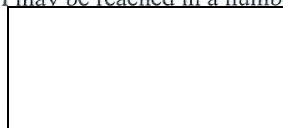
- Participating therapists, of which there will be four, will be interviewed twice (estimated duration of one hour): prior to client involvement and following client discharge from active therapy.
- These interviews will be conducted by [redacted], and will occur at a location and time of convenience to you.
- One of your clients will also be involved in the study. Following each participant client visit, there is a brief instrument (less than 5 minutes) which is to be completed and faxed to [redacted].

SPECIAL NOTES:

- Participants will be paid \$40/hour for their time and contribution to a maximum of \$200 per participant.
- You will be introducing the study to all new adult clients who you know will receive further occupational therapy. Interested clients will then contact [redacted] for more information and permit [redacted] to determine if the client meets the eligibility criteria.
- Your client is therefore also a participant in this study. It is both yours and your client's experience within the same therapeutic relationship which is of interest.
- At no time will the information which you share be divulged by the researcher to your client. Rather, information will only appear in a collective, aggregate form in the final report and any quotes will not include personally identifying information.
- There will only be four client-therapist dyads involved in this study. Committed therapists will become participants to the study on a first-come-first-served basis. A sequential list of other interested therapists will be developed in case of attrition.

I look forward to personally speaking to you further about this study. I am excited about this learning opportunity and the importance of this study to the discipline of occupational therapy. I may be reached in a number of manners:

- Telephone:
- Toll-Free:
- Facsimile:
- Email:



Appendix N: Sample Recruitment Presentation to Therapists

**Therapeutic Relationship and
Functional Outcomes in an
Occupational Therapy
Intervention**

Introductory Information Session

Have you ever wondered:

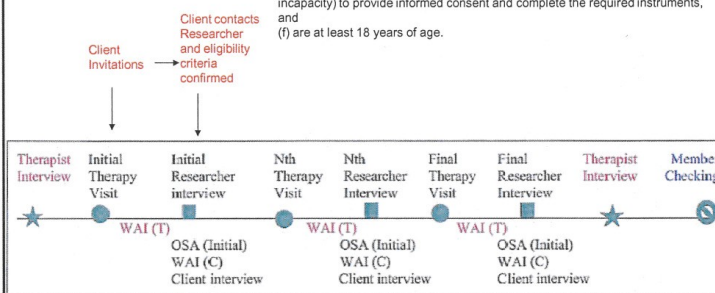
- why your interventions work well with some clients but do not effect comparable improvement with others who have similar conditions?
- why there is sometimes a better 'connection' with certain clients? Is it 'them', 'you', 'both', or 'other factors'?
- if the relationship with your client impacts the outcomes of therapy?
- what we can do as practitioners to enhance clients' therapeutic experience and/or their functional recovery?

First study of its kind in OT

- Case study methodology (4 therapist-client dyads)
- Therapists and clients experience within the same relationship as it is naturally occurring
- Identification of the contextual variables perceived by the participants as impacting the relationship
- Does a pattern exist between the therapeutic relationship and the functional recovery?

Procedure

(a) the event (injury, illness, surgery, change in function) necessitating occupational therapy has occurred in the past six months,
 (b) are living in the community (not an inpatient)
 (c) require more than one visit,
 (d) have English language proficiency,
 (e) are cognitively capable (i.e., had no pre-existing condition of cognitive incapacity) to provide informed consent and complete the required instruments, and
 (f) are at least 18 years of age.



Total Estimated Time:

Activity	Time Estimate
Reflective activity (30 mins.) and first interview (1 hour)	1.5 hours
Extending invitations & sending reminder cards	5 minutes/new client
WAI following each client visit and faxing to Tricia; informing Tricia of next visit	5 minutes/visit
Final interview	1 hour
Member checking	.5 to 1 hour
Total estimated time over a <i>few months</i>	4 to 5 hours

What's In It For You?

- \$40/hour for your time and contribution, up to \$200 maximum (same for clients)
- Self-reflection and challenging of presuppositions and taken-for-granted assumptions can lead to enhanced therapeutic skills and, by extension, effectiveness
- I will provide a letter regarding your participation for your COTO portfolio. Is your participation a viable addition to your Professional Development plan with COTO?
- I will present the outcomes of the study to you and/or your team, if interested

Steps From Here:

1. University of Ottawa ethics approval to include therapists within facilities.
2. Ethics approval from the Montfort Hospital.
3. I will then send the 'Invitation to Participate' to a point person (who?) to dissemination to all potential therapist participants within your organization.

Interested?

- If yes, great!
- If not, why? (Can I change something?)

To discuss further, please contact me:

- Telephone:
- Toll-Free:
- Facsimile:
- Email:

Appendix O: Therapist Consent Form



Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

CONSENT FORM (Therapist)

**THERAPEUTIC RELATIONSHIPS AND FUNCTIONAL OUTCOMES
IN AN OCCUPATIONAL THERAPY INTERVENTION**

Researcher:

Supervising Researcher: **Faculty of Education,
University of Ottawa**

I am invited to participate in the above mentioned research study conducted by This research is being conducted as a mandatory requirement of a PhD program at the University of Ottawa.

The purpose of the study is to better understand both therapist and client experiences of the therapeutic relationship and any patterns which may emerge as these experiences relate to the client's functional recovery. If I agree to participate in the study, I will be asked to participate in two interviews (beginning and conclusion of the study). These interviews will occur at a time and location of my convenience and will not occur at the same time as my provision of occupational therapy visits with my client. It is estimated that each interview will require one hour. I will be providing Invitations to Participate to my new adult clients and once the client-participant has been established, I will be completing a short survey (less than five minutes) following each client visit. Upon completion of the study, the data will be analyzed and returned to me for my optional review to confirm the content. I will be paid \$40/hour for my time and contribution to a maximum of \$200.

I understand that it is the relationship between me and my client which is being studied. My client is therefore also a participant in this study. At no time will the researcher share information which I provide to my client. Rather, only aggregate information will be presented and any quotations used in the final paper will not provide any clearly identifying information.

The only identifiable risk associated with my participation in this study involves the sharing of personal information such as personal reflections. I will be encouraged, however, to not answer any question with which I am uncomfortable. Neither my decision to participate nor the information provided will in any way impact my employment or role as an occupational therapist with my client.



uOttawa

Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

The benefit to participating in this study is that therapists and decision makers may gain an improved understanding of the value of the therapeutic relationship and its potential impact upon clients' abilities to resume those meaningful activities which form part of their pre-accident routines. The results of this study may impact future decisions regarding the manner in which clients choose or have therapists assigned to them, and individual therapists' approaches to their interactions with clients.

I have received assurance from the researcher that the information I share will remain strictly confidential. My name or any other identifying information will not appear within any documents related to the research. All written material will be kept and securely stored by the researcher in a locked cabinet. Only the researchers and professional assistants (e.g., transcriptionists) will have access to this information and it will be destroyed five years after publication.

I am under no obligation to participate and, if I choose to participate, I am free to withdraw my consent to participate in the research project at any time, or I may refuse to participate in any part of the study without fear of negative consequences of any kind. If I choose to withdraw, all study data gathered up to the time of withdrawal will be returned to me for my personal destruction. I understand that the results of the study will be compiled into a thorough report for submission to the University of Ottawa. My identity will remain anonymous in all reports.

I, _____, agree to participate in the above research study conducted by _____ This research is being conducted under the supervision of _____ University of Ottawa, Faculty of Education.

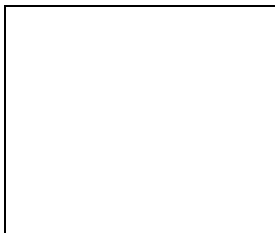
I understand that requests for further information may be addressed to the researcher, _____ or her supervisor, _____ Contact information is located at the top of this form.

Should I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, (613) 562-5841, or ethics@uottawa.ca

There are two copies of this consent form, one of which I may keep. If I wish to receive a summary of the findings of this research, I will contact _____, as per above.

Participant's signature: _____ Date: _____

Investigator's signature: _____ Date: _____



Appendix P: Invitation to Participate (Clients)



Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

INVITATION TO PARTICIPATE (Client)

An Occupational Therapist, [] is conducting a PhD research study through the University of Ottawa. You are invited to participate in this study.

TOPIC: Therapeutic Relationships and Functional Outcomes in an Occupational Therapy Intervention

BENEFITS:

The aim of this study is to better understand both clients' and therapists' experiences within a therapeutic relationship. A second component will be to compare the functional improvements achieved by the client to the established therapeutic relationship. The benefits of participating in this study are that therapists and decision makers may gain an improved understanding of the value of the therapeutic relationship and its potential impact upon clients' ability to resume meaningful activities. The results of this study may impact future decisions regarding the manner in which clients choose or have therapists assigned to them, and individual therapists' approach to their interactions with clients.

REQUIREMENTS:

- An estimated one-hour interview will occur either monthly, or less frequently, over the duration of your occupational therapy intervention. The number of interviews will vary with the length of your treatment. It is estimated that the number of interviews will vary between two and six.
- These interviews will be conducted by [] and will occur at a location and time of convenience to you.

SPECIAL NOTES:

- Participants will be paid \$40/hour for their time and contribution to a maximum of \$200 per participant.
- Your therapist will also be a participant in this study. It is both yours and your therapist's experience within the same therapeutic relationship which is of interest.
- Your decision to participate, or not, will have no impact upon your therapy.
- At no time will the information which you share be divulged by the researcher to your therapist. Rather, information will only appear in a collective, aggregate form in the final report and any quotes will not include personally identifying information.
- There will only be four client-therapist dyads involved in this study. Clients who meet the eligibility criteria will become participants to the study on a first-come-first-served basis.

If you are interested in participating in this study, or have questions, please contact me directly. I may be reached in a number of manners:

- Telephone: []
- Toll-Free: []
- Facsimile: []
- Email: []



Appendix Q: Text of Reminder Notice to Clients

Dear Study Invitee

During a recent meeting with your occupational therapist, a brief one-page summary was provided to you detailing a research study being undertaken by an Ottawa-area occupational therapist. The purpose of this correspondence is simply to encourage you to consider whether you would be interested in participating in this study. would welcome the opportunity to provide you with more information. She may be contacted at

email: . Thank you for your time in considering this opportunity.

Appendix R: Client Consent Form



Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

CONSENT FORM (Client)

**THERAPEUTIC RELATIONSHIPS AND FUNCTIONAL OUTCOMES
IN AN OCCUPATIONAL THERAPY INTERVENTION**

Researcher:

Supervising Researcher: , Faculty of Education,
University of Ottawa

I am invited to participate in the above mentioned research study conducted by Occupational Therapist. This research is being conducted as a mandatory requirement of a PhD program at the University of Ottawa.

The purpose of the study is to better understand both therapist and client experiences of the therapeutic relationship and any patterns which may emerge as these experiences relate to the client's functional recovery. If I agree to participate in the study, I will be asked to participate in monthly interviews (or less frequently) over the duration of my occupational therapy intervention. These interviews will occur at a time and location of my convenience and will not occur at the same time as my occupational therapy visits. It is estimated that each interview will require one hour. Although the exact number of interviews is uncertain at this time (and is a reflection of the duration of my occupational therapy intervention), it is estimated that the number of interviews may vary between two and six. Upon completion of the study, the data will be analyzed and returned to me for my review to confirm the content. I will be paid \$40/hour for my time and contribution to a maximum of \$200.

I understand that it is the relationship between me and my therapist which is being studied. My therapist is also a participant in this study. At no time will the researcher share information which I provide to my therapist. Rather, only aggregate information will be presented and any quotations used in the final paper will not provide any clearly identifying information.

The only identifiable risks associated with this study involve the sharing of personal information such as my medical history, demographic information, course of recovery, and personal reflections. I will be encouraged, however, to not answer any question with which I am uncomfortable. Neither my decision to participate nor the information provided will in any way impact my receipt of occupational therapy services.



Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

The benefit to participating in this study is that therapists and decision makers may gain an improved understanding of the value of the therapeutic relationship and its potential impact upon clients' abilities to resume those meaningful activities which form part of their pre-accident routines. The results of this study may impact future decisions regarding the manner in which clients choose or have therapists assigned to them, and individual therapists' approach to their interactions with clients.

I have received assurance from the researcher that the information I share will remain strictly confidential. My name or any other identifying information will not appear on any documents related to the research. All written material will be kept and securely stored by the researcher in a locked cabinet. Only the researchers and professional assistants (e.g., transcriptionists) will have access to this information and it will be destroyed five years after the results have been published.

I am under no obligation to participate and, if I choose to participate, I am free to withdraw my consent to participate in the research project at any time, or I may refuse to participate in any part of the study without fear of negative consequences of any kind. If I choose to withdraw, all study data gathered up to the time of withdrawal will be returned to me for my personal destruction. I understand that the results of the study will be compiled into a thorough report for submission to the University of Ottawa. My identity will remain anonymous in all reports.

I, _____, agree to participate in the above research study conducted by _____ This research is being conducted under the supervision of _____ University of Ottawa, Faculty of Education.

I understand that requests for further information may be addressed to the researcher, _____, or her supervisor, _____ Contact information is located at the top of this form.

Should I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, (613) 562-5841, or ethics@uottawa.ca

There are two copies of this consent form, one of which I may keep. If I wish to receive a summary of the findings on this research, I will contact _____ as per above.

Participant's signature: _____ Date: _____

Investigator's signature: _____ Date: _____



Appendix S: Cross Case Analysis Meta Matrix

	Theme	#	Lise	Georgia	Jackson	Kotter
Interpersonal connection	Social Connection, companionship, – emotional/personal, akin friend	1.1 3.5 4.5	Social isolation Love	Social isolation	Social isolation Sexual tension	Social isolation
	<ul style="list-style-type: none"> Competence ↔ trust 	4.8	X	X		X Dual role
	<ul style="list-style-type: none"> Safe and confidential milieu in which to explore/work through issues 	2.2 3.2 4.5	Psychosocial concerns	goal ambivalence	fear	Marital issues; wife’s drinking
Fun	Fun/Humour	1.6 2.7 3.4	X	X	X -reaction	Not as imp as progress, but present
Impetus → ↑ function cycle	Rel provided impetus to act	1.2 2.5 3.6	X 15 years	X 1.5-2 years	X 7 years	↓, too focus product’y 6 mos
	↑function → + feelings self and other → ↑trust and confidence → improved insight into abilities	1.2 2.4	X	X ↓Helene		X For Helene too
Therapy	Therapy Goal: Attainability → + feelings TR (feedback mechanism)	1.3 4.1/ 4.3	X	goal?– oscillation - ↓progress	X	X
Therapist characteristics/training	Therapist qualities/attitude <ul style="list-style-type: none"> interpersonal (caring, personal sharing, respect, listening) professional 	1.5 2.6 3.6 4.2 4.6 4.8	X	X	X Punctuality -	X X
	purposeful decision making, communication	4.6 4.8	X	X X	X	X X
Client attributes	OT Values <ul style="list-style-type: none"> c-c collaboration/active participant holistic/attuned TR meaningful/practical 	1.4 3.1 4.2 4.4	X X X X	X X X X	X X X X	X X X X+ productive
	Implications of condition <ul style="list-style-type: none"> recognition/acceptance multi-dimensional implications (holistic OT) emotional response 	2.1 3.1 3.2 4.1	Over-accept; over limit X	X X X	X (over time) X X (fear)	X GAP X X frustration
	Clarification of ultimate goal – personal insight, reflection, revelation	1.3 2.2	Changed over time	X – goal?– oscillation	Changed over time	X – is rtw goal realistic
	Role w/in family unit considered in therapy	4.3	X relieve husband	X ultimate objective?	X fun for wife	X income provider
	Implications of environment	2.3 3.3 4.7	X marital	X Neg lawyer/ER	X Wife t. ally	X marital diffs. neighbours
Legend: X: Presence of construct found						

Appendix T: Lise, Dyad #1

Background

More than 15 years ago, Lise was injured in a motor vehicle accident in which her son and granddaughter were killed. Following surgery for her injuries, Lise attended treatment (e.g., pool therapy), however, found it too painful and stopped. Lise was followed by various physicians until she was told there was nothing else to be done other than medication management of her pain. Recently, Lise's family physician changed her medication. This change resulted in a significant improvement in Lise's ability to attend, concentrate, and "be present" in her daily life. With this improvement, Lise's pain specialist proposed a multidisciplinary approach to her chronic pain condition that mainly impacts her back and legs and results in balance problems. Due to her disability since the accident, Lise relied on her husband to address most home management tasks (e.g., cooking, cleaning, shopping) and some personal care. Lise's participation in pleasurable activities (e.g., shopping, socializing) outside of the home was also limited.

Lise

At the time of study participation, Lise was approaching 70 years of age. She is bilingual in French and English, with French being her first language. She is a Caucasian Canadian. She indicated that her familial socio-economic status is "less than average" (as defined by the 2006 Canadian census data for the Ottawa-Carleton region). Lise completed high school and was employed in a variety of occupations prior to the accident including homemaker and mother, receptionist, and a self-employed seamstress who operated her own shop for more than five years with several employees. Since the motor vehicle accident, Lise has deemed herself retired from the workforce. Lise is re-married to her second

husband. They have a blended family of several adult children all of whom live outside of the marital home.

Treatment

In addition to continued medical management, Lise attended a chronic pain group. The group provided education concerning chronic pain management techniques. Lise also received occupational therapy as well as other services through an interdisciplinary program. Lise took an immediate preference to Marie, her occupational therapist. Occupational therapy intervention was comprised of six visits that occurred over a three-month period. All visits occurred within Lise's home, where Lise's husband would flow in and out of the home as he attended to various superintendant responsibilities within the apartment complex where the couple lives.

Lise's Goals

Lise's goal for occupational therapy was "to start doing what I did before. I like looking after my house. My husband has been taking care of me for the last 15 years and I'd like to turn that around. I should be the one that's doing the cooking, everything." Lise's anticipated that this recovery "could take up to a year." Although not explicitly stated by Lise as goals of therapy, other objectives were also discussed over the course of the study and her OT intervention. These included her desire to improve her ability to participate in social activities and achieve enhanced independence in community mobility with lesser reliance upon others.

Achievements

Lise's functional recovery was measured during each interview (see results in Appendix T-A). There was a significant improvement in Lise's confidence and realization of her abilities approximately two months after therapy commenced:

I do a lot more things. I can walk better. When I stand, I am more comfortable standing and I can do it for longer. I cook more. I've done some cookies. I've done some cakes. I've actually made a meal. Cooking is significant...cooking was the main part.

I can walk, go around to the parking lot by myself...I've taken my [wheel]chair and gone to the Independent store. I didn't do it before and now I take off by myself.

These improvements appeared to have coincided with her husband beginning to allow her to engage in activities from which he had protectively sheltered her since her injury. Lise appeared highly satisfied with her functional improvements. After discharge from occupational therapy, Lise reported:

I do a lot more than I used to...I'm able to do a little bit of cooking...I'm able to do a couple of washings whenever I feel good. I decorated my (Christmas) tree. Got a couple of gifts underneath there...I do better [with getting where I need to go] because Marie got me organized with ParaTranspo.

Environmental Influences

Lise cited many people as impacting her recovery in a positive manner. These included the members of her professional team (physicians, therapists), home support workers, family members (husband, daughters, sisters), and friends/acquaintances who live

in the building with Lise. The positive implications included the services delivered (e.g., exercises, medication, home support) as well as the emotional and social support and encouragement.

There were some feelings of ambiguity in a few circumstances pertaining to the impact that some people were having upon her recovery. A disturbing event occurred approximately 2/3 of the way through her three-month occupational therapy intervention. Her husband purposefully took an overdose of medication.

[My improved functionality] is affecting my husband. He feels a bit depressed and he feels as if he's losing his caregiving job. He's been doing it for 15 years and all of a sudden he doesn't need to do it anymore so its kind of hard for him...on Saturday he actually took an overdose of pills, not bad pills, just Metformin. He put a piece of paper on himself which marked "thank you." God knows for what. We called 911 and he went to the hospital. I don't know if its all related to the fact that he's not doing anymore or he's stressed out having done all he did...It scared me quite a bit. It won't stop me from doing things. I've talked to him quite a bit and made him understand and even himself he doesn't know what happened. He doesn't know why he did it. It is something I've got to deal with more or less...this is definitely not going to stop me from doing things.

By the final interview with Lise approximately one month later, fortunately much appeared to have resolved. Notably, however, a different root cause for this event was given.

It's...a lot better now. He went through a very stressful period. It's when I crashed [pain flare up] it really got him down because I think he had a feeling that I was

reverting back to what I was before when he had to do everything for me...when he realized it was just something that could happen. We tried to prevent it...but...

This event precipitated significant learning for Lise. During the afternoon of his overdose, Lise's pain flared uncontrollably. She recognized the connection between her elevated stress and her pain flare-up.

Exemplifying early trust in Marie, Lise told Marie during the first visit that she was "not satisfied" with the [other health professional]. This sentiment continued throughout Lise's other intervention:

I shouldn't say that [the other health professional] was not helping...but I didn't like the way she talked...She was getting on my nerves more than anything else...her voice, the way she'd tell me to do the exercises and have me do more exercises for my arms than my legs and the problem is my legs not my arms...pissed me off.

Lise was also perplexed with the evaluation of her [other health professional's] impact upon her recovery. Although she recognized the beneficial implications of the prescribed therapy to her recovery of strength, Lise experienced a negative emotional reaction toward the [other health professional] who Lise described as lacking empathy and an ability to relate to her:

She was getting on my nerves more than anything else.

I didn't feel like working with her you know. I don't know why, but as I say she just wasn't as easy to get along with, let's say, as Marie is...I was a lot more motivated with Marie than I was with [the other health professional].

I would change [the other health professional's] attitude...It's as if she forces you

to do things and you're not up to doing certain exercises.

Lise attributed the enhancement of her own functionality to the assistance from others (including her rehabilitation team). She recognized the beneficial impacts of the learning that she was achieving (e.g., through the chronic pain group) and, although the group and various therapies wrapped up their ongoing weekly interventions, she felt that she had the requisite knowledge to continue, "I keep doing what they asked me to do. The fact that they're done doesn't stop me from doing things."

Although Lise cited the implications of cool and damp weather on her pain, "when it's very bad weather, I have sore legs," the fact that the weather during that autumn remained unseasonably warm with limited precipitation was recognized as a further benefit to her recovery efforts as Lise liked to walk outdoors toward the goal of increasing her overall walking tolerance.

Lise's Reflections on Marie and Their Therapeutic Relationship

Lise had an immediate positive impression of Marie. Lise described Marie as "good, she really wants to help me," conscientious, friendly, and a good communicator. As intervention with Marie unfolded, Lise's positive impression of Marie deepened. She described Marie as *entregens*, understanding, easy to get along with and talk to, very nice, understanding, helpful, reliable as well as competent, "she knows what she is doing; she's very good at what she is doing; she's helped me quite a bit. I'm sure she must have helped others too." She described Marie as a "good teacher," and also appreciated her encouragement and support in the quest for the attainment of the therapy goals.

What seemed to set Marie apart from others was the fact that “she is trying to understand [me] and what [I] need.” Lise considered Marie’s client-centred approach to treatment to be “very important”:

Marie asked about my problems and what I wanted to do. I told her I wanted to do some cooking and things like that. She said she would help and asked what I would like to do. I told her I wanted to start baking and using my stove.

Lise had confidence in Marie’s ability to help her “because she talked to me about what we’re going to do and why we’re doing it. She knows what she is doing.” Lise also described a deepening trust. Lise identified the manner in which Marie taught her how to do things for herself as an important factor to her enhanced trust in Marie, but she also appreciated that Marie came to each visit prepared with a “plan B” (alternate activity). Lise indicated that she trusted Marie “because she was knowledgeable in what she was doing. She had confidence in what she was doing so that gave me confidence in her.” Lise explained that she did not think she could have trust in a professional in whom she lacked confidence in their competence, “Marie knew what she was doing and that helped me. I mean I trusted her...If you don’t trust people, they can’t help you...If I don’t feel she knows what she’s doing, then I’m not going to relate to her.”

The activities undertaken during therapy included initially some education, but evolved into concrete activities in which Lise found meaning, including working on her balance so she could participate in a social sandbag activity in a standing position and kitchen activities (e.g., baking a cake).

Marie helped me with different activities, like showed me how to do things in my kitchen that would improve the way I was doing it...it was meaningful to me.

Lise had a tendency to compare Marie to the [other health professional] with whom she was working at the same time. She indicated that she “definitely liked Marie better. I have a lot more confidence in Marie than [the other health professional]. I love Marie a lot more than [the other health professional].” Lise held a deep appreciation for the therapeutic relationship. “I wish it wouldn’t stop. I would like her to come and see me once in a while after we’re finished.” “We can talk to one another; she listens to what I say and I listen to what she says. [The relationship is] very good. Its important. It really helped me improve.”

Lise had a deep appreciation for Marie’s interpersonal skills and the manner in which Marie related to her. Marie’s approach made her feel important and a part of the therapy process by being an active participant. Although she emphasized the productive focus of the relationship, Lise highlighted that her time with Marie was spent “having fun.” She indicated that engaging in meaningful and productive pursuits toward her therapy goals in an enjoyable manner was a highlight of the intervention with Marie.

The Working Alliance Inventory was used as a measure of the working alliance over the duration of the therapy. These results may be reviewed in Appendix T-A. Lise’s assessment of the working alliance started high and improved (slightly, given the limited room for improvement) over the duration of therapy.

Summary

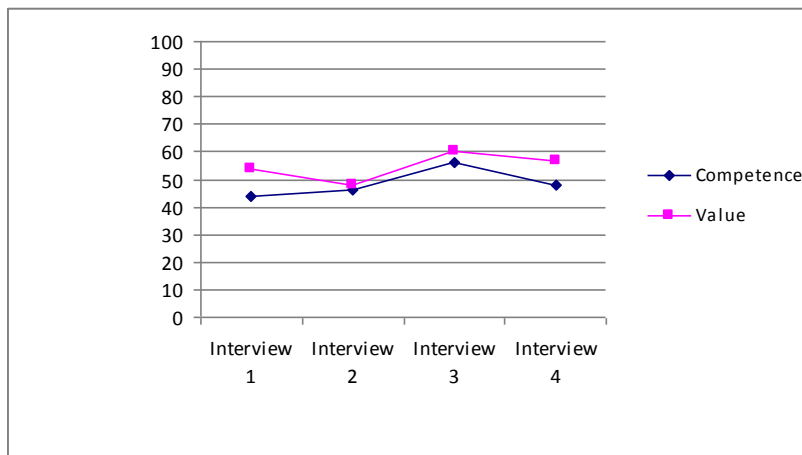
Over the course of Lise’s three-month occupational therapy intervention, which occurred approximately 15 years post injury, Lise realized a significant and meaningful improvement in her functional abilities. Lise was very pleased with the progress that she achieved in the kitchen activities, which was her primary goal. Lise also demonstrated

enhanced independence in her community activities, having independently attended shopping errands with the aid of Para Transpo when necessary.

Lise attributed the therapeutic relationship with Marie as being of fundamental importance and significantly contributed to the attainment of those meaningful goals. Marie's client-centred approach to therapy and the encouragement for Lise to be a collaborating participant in the therapy process appeared to enhance the strong bond that developed between the two women. Lise thought very highly of Marie's interpersonal skills and professional competence. She had high degrees of trust and confidence in Marie as exemplified by the eventual sharing of psychosocial issues in addition to more concrete functional goals. Also of salient importance to Lise were the social relationship and the enjoyment she derived from the intervention directed at her personally-identified meaningful occupational goals.

Appendix T-A: Lise Dyad #1**Occupational Self Assessment Results**

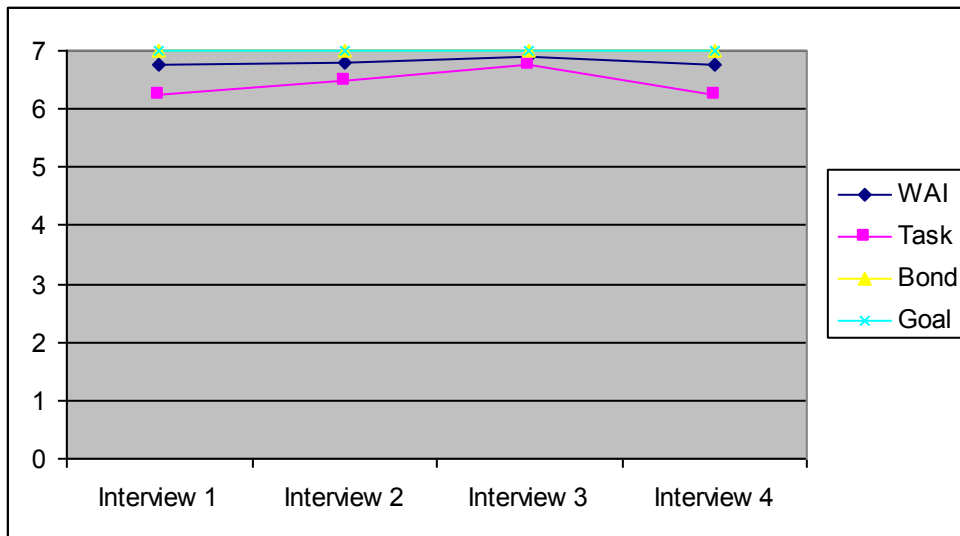
The Occupational Self Assessment (OSA) was used in this study as a measure of Lise's perceived functional abilities from the beginning of therapy through discharge from therapy.



As may be viewed, Lise demonstrated a consistent improvement in her perceived competence in the performance of the itemized functions. The relation of her competence as compared to the value that she places on this function is represented in the above graph. It is notable that a slight decline in her perceived competence occurred at the time of discharge. This trend was also seen in her assessment of the working alliance. There is insufficient data to suggest a reason for this decline.

Working Alliance Inventory Results

In this study, the Working Alliance Inventory was used to assess Lise's perspective of the evolution of the alliance over time.



With the maximum score on this scale being 7, Lise's assessment of the working alliance (WAI) was very strong from the beginning. There was thus little room for positive improvement (ceiling effect). There was, however, positive, albeit minimal, improvement in the WAI results from the first to the third visit. The fourth visit showed a return to her baseline assessment. There are three scale items that form the basis of this scale. Throughout the entire therapeutic relationship, Lise gave maximum assessment (7) to both Bond and Goal subscales. The one scale that showed a modestly lower score was the task subscale.

Appendix U: Marie, Dyad #1

Background

Marie was 30 years old at the time of study participation. She is fluently bilingual (French and English) female. She is Canadian with a German family heritage and hails from a military background. According to the 2006 census data for the metropolitan area of Ottawa, Marie assessed her family income as being above average. She completed an undergraduate degree in Occupational Therapy and has been a practicing Occupational Therapist for six years. She has worked in a variety of environments including inpatient hospital (acute care and rehabilitation units), community (return to work, motor vehicle accidents) and her current role as clinical educator in an interdisciplinary clinic.

Marie identified her dominant modes of interaction with clients as involving problem solving as well as empathizing and instructing. She attributes this tendency to her military upbringing in which she considers that she was taught how to solve and address issues. Marie balances her dominant problem solving approach with her interpersonal skills, “I can instruct but I can be nice doing it.” Marie acknowledges enhanced professional confidence over the last six years, becoming more comfortable over time in who she is as a therapist and what that implies for her strengths and limitations. Marie approaches client care with a solid understanding of her role as an occupational therapist. Marie emphasizes the development of an early, open and comfortable rapport, “Generally, I try to enhance their comfort through small talk and allow conversation to flow without too much note taking.” Marie considers that this comfortable rapport is vital to the validity of the information shared by the client. Marie is reflective upon her innate desire to work with and help others. She approaches her clients seeking this underlying interpersonal connection:

I went into the profession because I liked being with people so I hope that they can like me and they can feed off of that. It also goes with how you go into the relationship. If you go in very strict and stern, you may not get as much of a sharing of information.

Marie recognizes that the therapeutic relationship is a mutual experience in that both parties need to be active participants. That collaboration is vital to the attainment of the therapy goals. Once the goals of therapy are established, Marie generally selects two to three activities to suggest to the client (Marie always prepares a 'Plan B' for therapy sessions "because everybody is going to have an off day or a day that they just don't feel like it"). The activities are selected based upon the goals, but are also considerate of the client's interests, age, cognition and the nature of the therapy session (e.g., shared session with another professional). Marie attempts to choose "fun" activities, although there is always an educational component.

Role with Lise

Marie met Lise approximately 15 years following injuries sustained in a motor vehicle accident. Despite her identified dominant modes of practice, Marie indicated that this was not the manner in which she approached her role with Lise. When working with Lise, Marie's primary approach was instructing as well as encouraging and empathizing. Marie indicated that her natural predilection toward problem solving was not appropriate with Lise. Marie explained that she primarily instructed Lise on how to apply the learning achieved through occupational therapy, as well as through the other involved disciplines and the pain management group, to the performance of her meaningful occupational goals.

Goals of Intervention

The goals of intervention were initially to improve Lise's overall activity endurance in order to enhance her participation in kitchen and leisure activities. As she progressed and developed deeper trust in Marie, Lise shared psychosocial concerns based upon which further goals were outlined. These included a desire to interact with and help others in a volunteering role (e.g., at a library, at a hospital). In order to access these sites, however, Lise would require transportation. Since her injury, Lise had become reliant upon her husband and family for community mobility. Lise wanted to establish independence from them in terms of community mobility.

Marie indicated that the attainability of the goals during the intervention period is an important consideration for her and, in fact, proved critical to Lise's progress during this intervention. Lise was initially very excited about the prospect of resuming kitchen activities. This accomplishment appears to have enhanced Lise's self-confidence that in turn permitted her to start to identify higher level, meaningful goals. Marie indicated, however, "there was never one time that it was just the main goals in the initial assessment that we addressed." As Marie and Lise worked together, the trust grew and Lise shared more intimate information. Psychosocial ramifications of Lise's condition therefore were also addressed through occupational therapy intervention.

Achievements

Lise's initial goals of enhanced endurance and improved functionality within her home were accomplished by the middle of the therapy program. Higher level goals involving volunteering and independent community mobility (e.g., use of Para Transpo)

were then developed. After independently using Para Transpo, Lise relayed to Marie that she now had “*the want*’ to do.”

When Marie was asked to describe a defining moment with Lise, she recounted the following:

I think it was the week following the first time we did something in the kitchen. She said “Next week I want to do another cake. I already have the cake that I want to do. I already have all the ingredients. I want to do this with you, is that okay?” So she took a little bit of control. And I said, “That’s great. We’ll work on some more things like joint protection, energy conservation,” things like that. She was very happy. I came back the next week ready to do that intervention and she was like, “Oh I already made a cake. I felt really good after what we did and I made the cake, and then did this, and this, and this, in the kitchen. You showed that I could do it...that I had the ability to do it.” So I think that was a big turning point for her. I saw something different in her.

On reflecting on Lise’s progress, Marie stated:

[She did] better than I thought she would...especially because of the long history of difficulty with pain management, stress, anxiety. She did better. I think she made some terrific gains, but I’m not going to take all credit for it. I think there are other disciplines and other factors that assisted in her making those gains, making our goals even more attainable.

Environmental Influences

Marie’s impressions of the people impacting Lise’s recovery included Lise’s husband, daughters, physicians, the chronic pain program, as well as the [other health

professional]. In Marie's view, all had positive implications in that they supported Lise's recovery. Although Marie appreciated the relationship strain between Lise and her [other health professional], Marie considered that the gains made through that intervention aided the attainment of Lise's occupational therapy goals.

The environment in which therapy was occurring was also a factor. It was limiting in the manner that her husband would flow in and out of the home and impact the degree to which Lise felt comfortable sharing some information with Marie. The benefit of the environment, however, was that there were other locales within the housing complex to which the dyad could go in order to complete some activities and allow Lise to openly share information.

Marie indicated that Lise's mood and outlook was impacted by her level of pain. During episodes of elevated pain, Lise would be a little hard on herself. Marie would address this during the initial portion of therapy sessions in order to assimilate learning achieved through such experiences (e.g., of overdoing activity and thus suffering an escalation in pain).

Lise was injured in a horrendous accident that caused the death of her son and granddaughter and precipitated the events that led to her losing contact with another granddaughter. Marie considered that this hurtful past was also a factor influencing Lise's recovery. Lise, however, appeared to Marie to not to want to fully engage this topic. Marie questioned if counseling would further facilitate Lise's recovery.

During the course of her intervention, Marie was asked by the Community Care Access Centre (CCAC) to assess whether Lise continued to require the services of a personal support worker to aid her bathing. This placed Marie in a difficult position in that she knew

how much Lise appreciated the assistance. If Marie reported that Lise was able to safely and effectively engage in this task independently, Lise would lose this support. Marie declined to provide her opinion.

Marie's Reflections on Lise and Their Therapeutic Relationship

Marie was initially cautious in her approach to Lise. Marie explained that the [other health professional] from her clinic had already met Lise and expressed some concern.

When Marie first met Lise, however, her concerns were quickly dispelled:

From the get-go I didn't get the same sense as this [other health professional] got of the relationship. From the get-go it was good. That's regular...some people interact well together, others don't. Some people have a certain impression or assumption of a person and then others don't. Because from the get-go I didn't get that at all...and even the [other health professional] later said, "Oh she loves you. She doesn't really like me, but she loves you."

Marie consistently felt confident in her abilities to assist Lise. Marie felt that her experience in working with other clients with multi-dimensional psychosocial and chronic pain issues assisted her level of confidence:

I would say if I hadn't been maybe used to dealing with somebody with chronic pain or the whole social aspect of it, maybe it would have been a little bit more uncomfortable...There was never one time that it was just the main goals in the initial assessment that we addressed. There was always a little component [of other issues].

The mutual trust in the relationship also deepened over the course of the therapy. As a result of the deepening trust in Marie, Lise shared psychosocial issues, and these were then

also able to be addressed during intervention. “In the first sessions it was never discussed that their relationship was strained until maybe halfway through and then we addressed it.” Marie exemplified trust in Lise by providing a letter of reference as required of the volunteer placements, “because I trust that she has the ability to do what we discussed, the volunteer work.” It would also appear that as Lise developed trust in Marie, she also learned to trust her own instinct (e.g., regarding her abilities):

She trusted what I would say because she would apply that the following week and then she would bring back feedback saying, I’ve tried that and I don’t feel too good. I said, trust yourself; if you’re not feeling great don’t do it for me. All of this is for you, these are your goals. So, for example, playing sandbags standing, she’s like no I haven’t done it yet because I wasn’t feeling too good with myself and you not being next to me didn’t feel great about it. So I think that she has good introspection in terms of what she was able to do but she was also trustworthy as to me saying I think you’re able to do it.

Marie indicated that as Lise’s trust in the relationship and in herself improved, she was better able to realize the attainability of the therapy goals, in which Marie had been consistently confident. Furthermore, Marie sensed that the attainment of the goals fostered a deepening of the trust that Lise held in the relationship:

It grew, in part, because she got better and as much as she got better she was able to do more and she realized that yeah I can do...what I had established. Like these goals from the get-go I knew that we could attain them. She was like, “Really, I would be able to do things in the kitchen?” and then she went and did a whole bunch of things

in the kitchen. So I think that it grew because she got better...as she got better we were able to do more and push the envelope onto those goals.

Marie perceived a link between the client's recovery and the therapeutic relationship in that as the client experienced meaningful recovery, she also experienced an enhanced therapeutic relationship:

[The relationship] grew in terms of what she felt comfortable sharing with me. The more I went, the more she shared...things that maybe didn't even have to do with the therapy goal but were good information for me to know...details about the relationship at home and then also her mental status or just her function at home. It definitely grew, and I think it also grew because she also got better physically. There are certain things that changed, that gave her hope and I think that every time that I went we achieved something else and it was tangible stuff.

Marie indicated that she and Lise enjoyed their time together. Marie sensed a mutual and balanced degree of liking that grew stronger over time. Marie did note, however, that there may have been a tendency for Lise to view Marie as "more than just a therapist, as a friend." This may have been an implication of Lise's social isolation. The interaction may in fact have provided a positive impetus for Lise to engage in the intervention:

She grew attached to the visits and to the company which addressed maybe certain issues of feeling lonely that we had covered [volunteer work]. So I think the social aspect was a big thing for her, me coming in every week, it kind of encouraged her and almost pushed her to say, oh I'm going to have to say something good to Marie that I accomplished something last week. So maybe gave her a boost to do, to act.

Marie credited the client-centred focus of occupational therapy and the use of personally meaningful goals and activities with the efficacious therapeutic relationship achieved with Lise. This was especially apparent to Marie as she compared her relationship with Lise to that achieved between Lise and the [other health professional]:

I think that might be a little bit of difference in my discipline and maybe in another discipline. Occupational therapy can take certain avenues and some activities that the client appreciates in order to achieve some of the goals, as opposed to maybe just doing 10 repetitions of something that she is not liking, but it's to maximize her function.

Marie considers that occupational therapists are more attuned to the therapeutic relationship with clients than most other professionals:

Maybe it's because it's drilled into us - the holistic view of a person. Look at all the dimensions and the models that we have. We look at the environment and we look at the psychosocial, we look at the affective, the physical, the cognitive. That sometimes is not taught in other disciplines.

Marie described the therapeutic relationship with Lise as embodying an openness, a sharing of information, collaboration, and cooperation of two active participants, effective communication, trust, mutual respect and sympathizing, evolving, positive and pleasant.

Marie further described:

I think it's going to sound very weird, but there can be chemistry or no chemistry on maybe like an emotional love aspect. I think that the same thing works in therapeutic relationships. There can be a chemistry between two people, and they can have a good therapeutic relationship, or there is not necessarily a chemistry and is very

much therapist/client. But here there was still someone she felt open enough to share things with me, so I don't want to use the term friend, but there was a trust...a liking.

The Working Alliance Inventory was used to assess Marie's assessment of the working alliance with Lise throughout the duration of the therapy. These results may be reviewed in Appendix U-A.

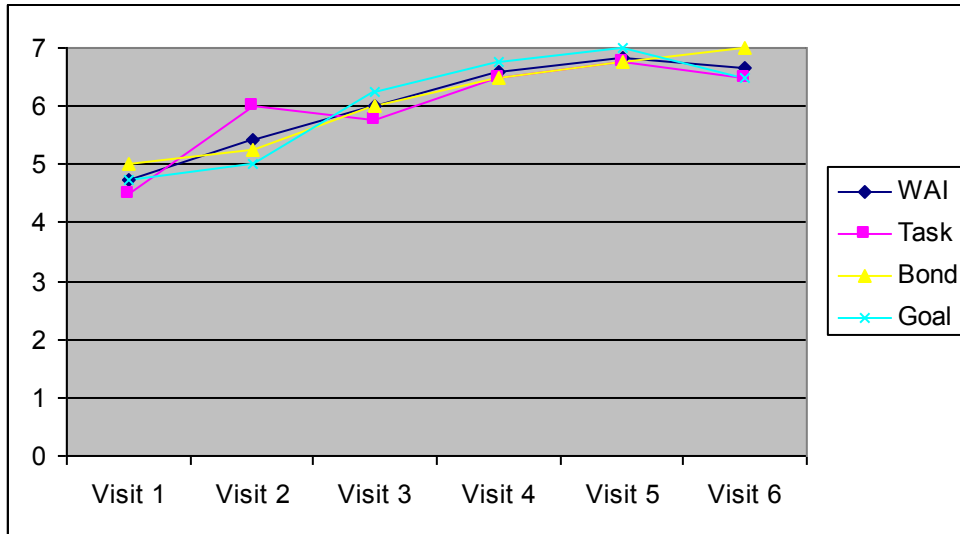
Summary

Although Marie initially approached the relationship with Lise in a cautious manner, the need for such caution was quickly dispelled. Marie equates this to a different chemistry that existed between she and Lise than that which existed between Lise and her [other health professional]. Goals were developed based upon Lise's interests and desire to regain mastery of her home environment. Lise was an active participant in the therapy, engaging in all activities presented both during and between therapy visits. Lise achieved the initial goals of therapy more quickly than anticipated and through her open sharing with Marie, higher level goals were then established and partially realized prior to her discharge from therapy. Marie suggested that the underlying values and premise of occupational therapy aided Lise's goal attainment that in turn enhanced the therapeutic relationship. The goals and activities held significant meaning for Lise. The goals were attainable and as Lise achieved success, Marie felt that Lise's trust in Marie deepened to the extent that she shared more personal and psychosocial concerns as well as related goals. Although the [other health professional] may have felt a need to "push" Lise to achieve gains through their intervention, this was not Marie's experience. Marie considers that the client-centred approach toward meaningful goals in combination with a different interpersonal approach was the difference in the experience of the two therapeutic relationships. Marie considered,

however, that the success in occupational therapy was also attributable to a series of events and efforts undertaken by others. A significant event occurred approximately two months into the three-month intervention when Lise recognized her abilities and freely engaged in kitchen activities between therapy visits, thus allowing the remaining available visits to focus on her higher level, established goals.

Appendix U-A: Marie Dyad #1**Working Alliance Inventory Results**

In this study, the Working Alliance Inventory was used to assess Marie's perspective of the evolution of the alliance over time.



As may be reviewed in the above diagram, Marie assessed an improving, approaching optimal, working alliance (WAI) with Lise over the course of the intervention together. There was a steady and similar improvement in all three subscales of task, bond and goal.

Appendix V: Georgia, Dyad #2

Background

Georgia was injured in a motor vehicle collision in November 2007. Georgia suffered several soft tissue injuries in the collision as well as a significant eye injury as a result of hitting her head on the steering wheel. Despite ongoing pain in her body and visual deficiencies, approximately two months following the collision, Georgia returned to work at [The Bank]. Georgia considered herself a loyal employee of the bank and had in fact won customer service awards. Upon her return, however, she did not receive the support from her manager that she anticipated she would. Rather, Georgia described the treatment she endured as “psychological harassment.” A third eye surgery occurred in April 2008. Unfortunately, the surgery was unsuccessful in restoring Georgia’s vision in the injured eye. Georgia has not returned to gainful employment, either at the bank or any other location, since that surgery. By the time of the study commencement with Georgia, two years post collision, Georgia listed her ongoing issues as primarily involving her visual deficits, difficulty with reading, headaches as well as cognitive issues including difficulties with word finding, divided attention, and cognitive endurance. Georgia was initially resistant to the diagnosis of depression imposed by physicians, however, over time appeared to recognize the implications of her mood upon her functioning:

Maybe I was depressed. ‘The want’ is back now and turning the situation around, I can do that. It’s been a year now that I am on the [antidepressant] medication.

Georgia

Georgia was 55 years old at the time of study participation. She is a bilingual, Caucasian Canadian. Georgia assessed her family income as less than average as defined by

Canadian Census data for the metropolitan area of Ottawa. Georgia completed high school and had been working in a bank for 15 years prior to the motor vehicle collision. Georgia had been planning to retire approximately 2.5 years post collision with a partial pension.

Georgia is married and lives with her husband. The couple has an adult daughter and a young granddaughter for whom Georgia provides care two days per week. Georgia has several extended family members with whom she has a close relationship. Georgia's family is of vital importance to her, "Regarding family, I am passionate to the bone." She also enjoys her home and particularly the outdoors where she has ample gardens and enjoys feeding wild animals. Georgia also enjoys social interaction with others and prides herself in "getting along with everyone that [she] meet[s]."

Treatment

Following the motor vehicle collision, Georgia received treatment from various physicians and specialists, psychologists, physiotherapists and occupational therapists. Although Georgia spoke highly of most people involved in her care, she did change family physicians following the motor vehicle collision.

Helene was Georgia's third occupational therapist and was referred to see Georgia as a result of issues related to cognition. Georgia first met Helene in January 2009, more than one year following her motor vehicle collision. They worked together for several months to address issues related to daily and home-related functioning. Prior to progressing the therapy goals toward higher level cognitive remediation (to address such goals as return to work), Helene recommended that therapy await the results of a neuropsychological assessment. This required a four-month hiatus from therapy that then resumed in September 2009 and

lasted until February 2010. It was this second block of therapy that involved participation in this study. All intervention occurred within Georgia's home.

Georgia's Goals

In the first block of therapy with Helene, Georgia had improved her home-related functioning to a level with which she was satisfied. The goals of the second block of therapy were higher level and increasingly complex. Although there were subcomponent goals to address Georgia's ability to focus, attend, and read despite ongoing visual deficits, the overarching goal of the therapy was to "see what I am capable of at work." It was hoped that these skills could initially be practiced in a volunteer capacity. Importantly, however, the goal of return to work created significant emotional turmoil for Georgia, "Definitely I will not go back to what I went through before. It was a terrible experience." Though Georgia expressed the goal of return to some form of work in the initial interview, she also noted some ambivalence, "from what I experienced, I may not get there." Georgia's emotional reaction to considering a return to work at the bank was overwhelming, into which Georgia developed amazing insight:

So now it's like when Helene starts talking about things that I used to do at my work, I see myself at my desk the last month, the last 3 months and there's no way, I cannot do that. So that is really delaying my, because (coughs) I am not a psychiatrist but each time I get close to my return to work something happens. Like now I am coughing. I'm coughing forever. But to me it's obvious, I've never been sick all my life.

Even by the final interview after occupational therapy intervention had been concluded, Georgia continued to demonstrate fluctuations in this regard:

Yes, right now I don't know if I want to go back to the same branch but to me what is important is that I will...[The Bank] will help me find something that I like...I loved my job but this I know I don't have the capacity. I keep on saying this but maybe patching my eye all day, I don't know if I'll read any faster but I have to be beep beep beep at my work and I don't know if I can be beep beep beep beep anymore but definitely I want to give a chance to...and myself a chance to stay with [The Bank]. I don't want or I don't see myself working full time because before my accident, my plan was to take my early retirement in June 2009. Which has now passed but being on sick leave, it backwards my time for my early retirement so I'm back two years and half now. I would have to work another two years and half to get my goal. So I don't have 2 ½ years to give physically, emotionally, I don't have the same capacity anymore. So it's difficult to make a decision but my priority now is to get in touch with human resources because [the disability insurer is] not...they don't seem to want to give me any disability counsellor, they say it's my insurance...they'll probably want to close my file but before they do I want them to support me in helping me finding some kind of work. That's their responsibility.

Upon conclusion of the study, Georgia indicated that her priority was to reach a settlement with her long-term disability insurer. Helene opined that the resolution of the insurance-related issues would assist with clarifying the direction to be taken by Georgia.

Achievements

During this therapy block, there was a resolution of Georgia's persistent coughing (due to a viral infection). She also achieved enhanced self-confidence as it related to her functioning in general as well as specifically her cognitive functioning and visual deficits.

Georgia was able to recognize improvements in her cognitive functioning (scenario 1 below), as well as achieve enhanced self-confidence through her own persistence and courage (scenario 2).

Scenario 1

Yesterday when I did the attention test, in June when we did that it was not good. My attention had to be on that one thing only. Yesterday my granddaughter is sick so she is not at the daycare, I babysit her. And during the time Helene was here Jenny woke up and she was with us while I was doing my testing, my work with Helene and it was kind of multi-tasking but I had to click on the little thing every time it is 10 minus 2. Like every time there is a minus 2, like 7, 5, I would have to click. It would say different numbers, so my attention had to be...really there. I did very well. I did not feel I was able to do multi-tasking like that. If there is music in the background or something, I can speak...but if I have to listen to someone else it's...too much. But I find that yesterday things were getting a lot better through the testing and through the experience with Jenny because she has my focus, primary focus. She is my granddaughter...but I was also able to answer. I missed a few. But it was a great improvement. Helene and I were very pleased with the results. It makes me feel wonderful.

Scenario 2

[Georgia had an 8:00 a.m.-appointment with a specialist at the Ottawa Hospital.] My husband was to drive me because it is dark when I leave. It's in Ottawa so I have to leave at five thirty/six o'clock to make sure that I'm there on time and my husband had an emergency at work. I had no choice to go. So I got up very early which is

okay with me. But the thing is, I had to drive with one eye closed and it was full of fog and at some point I thought, “Oh my God I don’t even know where I am!” I was scared, scared, exhausted, tired...I had no idea where I was. I thought I was lost...there was so much fog and there was a big line up behind me. I said, I don’t care, I don’t care, I’m not driving any faster. So I got really, really scared but then once I got to the hospital, I relaxed, I was fine. My headache was huge, but in the end I did it. I did it! I was pleased. Very, very happy...But it’s good improvement for me because you know the concentration, the ‘wanting’ is back. Because the wanting was gone for a while.

Georgia directly attributed her enhanced self confidence to the therapy with Helene.

I’m gaining confidence. Something that I had completely lost. And I know with her suggestion or testing her, the strategy. It’s helping me gain confidence in myself. So it’s very good...it’s like little step, little step, little step, but every day I find there is a little more to it. So it’s fun.

Georgia assessed her progress in her recovery as follows:

It’s improving. It’s improving. For the longest time it was stable, I thought my God, I’m going to stay like this forever, but now it’s, there’s a notch, and if I’m thinking as a percentage, I think I am almost eighty percent.

Georgia was never able to find a volunteer position in her community during the winter months of this therapy block. (She had held a previous volunteer position in a greenhouse and hoped to return in the following spring, however, during the winter months, the greenhouse option for volunteering was not available.) An opportunity to integrate and

apply her newly acquired learning and skills into a work-related environment was therefore never realized.

Georgia's functional recovery was measured during each interview (see results in Appendix V-A). As may be noted, Georgia perceived competence remained relatively consistent from the beginning to the end of therapy that may be explained by the fact that the primary goal of intervention was not realized.

Environmental Influences

Georgia thought highly of the majority of the physicians and professionals who she encountered during her recovery. There were, however, a few exceptions. Georgia described her original family physician as having "poor caring, poor engagement. She wasn't there for me." Georgia sensed that this physician did not have any interest in her case. "It's a car accident, lots of forms to fill out with the insurance. I felt I was in her way. I did not feel any empathy, sympathy with my situation." When this physician was unavailable, Georgia was required to use another family physician, Dr. F. Georgia never returned to her original family physician after meeting Dr. F as she found Dr. F's care more thorough and her approach more in keeping with Georgia's expectations. With a smile on her face, Georgia explained, "A doctor is like a pair of shoes, you have to shop for the right one. Dr. F is the perfect fit."

Georgia indicated that she was satisfied and felt well supported by most specialists who she met, but she did note "You go see a specialist, that specialist takes care of one thing" (e.g., fragmentation into their area of specialty). She explained that it was only Dr. F and Helene who addressed her needs holistically. In addition to her treatment team, Georgia had a significant and positive support structure in her immediate and extended family and

social network of friends as well as her lawyer. Georgia saw their role as being one of “understanding what I’m going through. Empathy, not pity, empathy like they understand and to me just the fact that someone understands is supportive.” A notable pattern was the high regard in which Georgia held the people who she perceived as being in her support network.

Interestingly, Georgia assigned herself both a supportive and hindering role in her recovery. From a positive perspective, Georgia identified that she was not giving up and actively participating by integrating the provided education and skills achieved through therapy into her daily functioning. To the contrary, however, Georgia recognized her fear of returning to work as a barrier:

I am terrified of going back (to work) and failing again. And not only failing. I’m terrified that I don’t have the capacity...I know I don’t have the capacity to do what I was able to do before and I am terrified that at one point I will be forced to do it maybe. In a way no one can force me to do what I don’t want to do or what I can’t do, but it’s, my God, it’s really...

Georgia’s manager at [The Bank] was most certainly and consistently, if not increasingly, a source of angst for Georgia. Georgia expressed a passion for her employment position, the customers with whom she interacted as well as some co-workers. Despite this, Georgia was steadfast that the experiences that she endured during her return to work following the motor vehicle collision was unjustifiably horrific and qualified to her as “psychological harassment.”

Georgia's original physician was also seen as a contributing factor to this angst as it was she who released Georgia back to work in a state that Georgia retrospectively considers to have been too soon.

Georgia demonstrated ambivalence toward the role of her insurance companies, of which there were two. There was an insurer responsible for her motor vehicle collision, as well as an insurer for her long term disability. These insurers would periodically lob issues of responsibility back and forth until Georgia had to involve a lawyer. On one hand, Georgia expressed appreciation for the extent of funding afforded her for various therapies and treatment (including Helene) through these insurers, however, on the other hand, she resented the repeated struggles she was required to endure to access this funding (which at times also caused lags in treatment). During one interview with the researcher, Georgia admitted the following suspicious and paranoid thinking:

At first when we started our meetings like this I thought you were hired by, when I saw this register thing [Georgia was pointing to recorder], I thought you were hired by my insurance company.

(Before continuing, the researcher referenced the consent form that Georgia had signed during the first meeting to ensure that Georgia was properly grounded in the researcher's role, purpose of the interviews and the confidentiality in which the information that she had shared would be held.) Georgia explained that this suspicious thinking was the result of her insurers treating her with such perceived suspicion. A further degree of ambivalent emotion regarding these insurers was caused by the fact that Georgia paid for all of her insurance through the same institution for which she worked. Although Georgia rationally explained

her understanding that these are all separate institutions under the umbrella of [The Bank], she felt that her loyalty to her employer in this regard was completely disregarded.

Georgia's Reflections on Helene and Their Therapeutic Relationship

As exemplified in the monthly administration results of the Working Alliance Inventory in the enclosed Appendix V-A, Georgia held the relationship with Helene in very high regard. Georgia described Helene as very professional, knowledgeable, eager to help, hard working, patient, strong, caring and wise. She described that her approach was “never overdone,” but rather working with Helene was simple and easy.

She never puts you have to do this, or it should be like this. She just offers things in a way that is offered things. It's not offer things, she'll ask me how do you feel about this? Then she'll find something that is helping that situation.

She explained that the strategies that Helene taught her and Helene's knowledge and skill was vital to Georgia's recovery to date, “she's the one who helped me the most.” Helene's therapy was focused upon Georgia and her specific needs:

She is enthusiastic about finding ways, about my situation, finding ways to help and to gain my recovery.

Helene is very personal with my situation. Like it's Georgia, it's not in general, it's Georgia. It's better [than with other professionals]. It's more personal and it's more focused on my situation.

On several occasions, Helene shared personal information that resulted in Georgia developing a deeper sense of who Helene was as a person, rather than just an occupational therapist. This appeared to aid Georgia's opinion of Helene:

Like when she talked about her mother that has Alzheimer, I am listening to this woman and I say “God she is so beautiful. I want to know more about her.”

She has mentioned that sometimes, she will keep relation with some of her patients even though she doesn't treat them and she talked about the fact that during Christmas, her and her husband they talked about how many hours she puts in a week for her work and she said you know to me it's not work (Chuckles). So yes she has a lot of bureaucracy a faire but she said to me I don't feel I'm working so when you talk like that it's because you love your work.

This personal sharing led to Georgia drawing similarities between herself and Helene such as the fact that both are devoted to their families. This personal sharing appeared to be an important aspect of Georgia's deeply held impression of Helene. There was an occasion, however, when Helene's sharing of other experiences seemed to cause Georgia to take pause as she explained her level of trust in Helene. In the following passage, Georgia had been asked to rank her degree of trust in Helene between 0 (no trust) and 10 (absolute trust):

I'm going to say 9 just because there is a situation that she, she doesn't ever give names but she's helping a young girl but it's been 9 years, and there is no, so like if I think about the trust, is it because of Helene that the therapy is not proper for that person, or that person is not doing her part. No I'm going to put 10. I'm going to put 10. I absolutely trust Helene with me.

Georgia consistently described a high degree of trust in Helene. She explained that this trust was enhanced by Helene showing a specific interest in Georgia's situation, her

professional knowledge, and the real-life improvements achieved through the application of practical solutions:

100% trust in her role as my therapist. It's total trust. Because there has never been any incident that, "Why did she make me do that?" You know, never, never. It's always like a beautiful river that flows. Lots of times I don't even question...I have known Helene since January last year [11 months at the time of the statement].

When she first came in and she had a plan. First she met with me and she had questions and when she put all that together she came up with a report on things we're going to work together. It always made sense to me, we're going to work on this...it all made sense.

Georgia further explained that the trust grew over time because of what Helene was teaching her, Georgia was applying to her life between therapy sessions and "it was working, so yes I am going to do these things and all week I'm going to do this." Georgia found that the improvements that she realized by applying Helene's strategies led to real-life, practical enhancements in her functioning:

I would say if we compare with [the psychologist], I find Helene was more psychologist helpful than my psychologist because at some point it's good to talk about situations but you have to dip your fingers in it too...with Helene we were able to do that.

Everything we've done always had a very positive impact on me...okay I still don't like reading, but at least the little things I need to read now I have a way to read and it makes it okay because Helene showed me. Okay don't overwhelm, break it down,

little tricks like this. In every way, everything that we've worked together has had a positive impact on me.

Although Georgia was committed to being an active participant with Helene in the therapy, she also exemplified some reliance upon Helene to develop the therapy activities and direction:

I am not an occupational therapist but she identified some situations toward the panicking situation. So it's going to help her finding out how to deal with my panicking stuff.

To me when someone gives that kind of attention to you, you have to give it back. Like Helene always says no you do it for you. Yes, I know it's for me. But we're both working for me. I like that fact that I get her support. All I need is her support and you know she's the specialist in this cognitive things.

Although Helene clearly expressed to Georgia that she should be participating in the therapy and work for herself, Georgia developed a devotion to the efforts that Helene was putting into their work together. The therapeutic relationship therefore created some impetus for Georgia to act:

Definitely Helene is so right about the fact that there should be a trial for me to go back to work. I'm terrified, I am terrified but I agree with her. I don't know if I want to do that trial at this point because I don't know if they're going to try me at my old job with my old manager; this I am terrified. But I owe it to Helene to try.

The impetus to act created by the therapeutic relationship, then translated into gains being made and in turn fueled Georgia's integration of Helene's teachings into her everyday life,

“To me her [skill and knowledge] was of most importance because it drove me yes, I’m going to do this exercise; I’m going to do this homework because it’s working.” Georgia links her degree of trust in Helene to her sense of Helene’s competence. In reflecting, Georgia considered that the two constructs of trust and confidence in Helene’s competence grew together over time and was directly linked to the real life, positive improvements that Helene’s therapy offered to Georgia:

Trust builds because I am not...I don’t give my trust juste comme ça. It built; it built because of her knowledge. This lady knows what she’s talking about and it’s always been so helpful.

Georgia enjoyed the therapy sessions with Helene. She described the shared laughter during therapy sessions, although there was always a productive focus:

She’s funny. Oh my God a lot of fun, we had a lot of fun when we played roles you know because one time we pretended I’m starting my own business and what would I like to do so she was...Yeah, well she was wearing many hats like I was hiring her so what kind of questions do I...that we always had fun.

It was always fun and it was always oh my God! I did not know that! Ben, tabernaouche! You know it was always a wow.

Georgia had an emotional connection with Helene that was special in the scope of all of the professionals with whom she worked since the motor vehicle collision:

When our session was over in June I said I want to get her something special because I may never see her again and I want her to have a souvenir of me. So I got her a plant. It’s a shrub and I bought one for myself and I bought one for her and my

thought was she will always have a little part of me in her yard...It's who she is.

Who she is, the caring part of her. I'm a caring person so I think we...connect.

Although the available therapy sessions wrapped up prior to Georgia's goal of workplace integration, whether employed or voluntary, was realized, Georgia intends to maintain communication with Helene in order to report back the success that Georgia still intends to achieve:

What is important to me is that I keep in touch with [Helene]. I really want to keep in touch with my OT because I figure if you're an OT you take care of this client, this person for so long and you made goals together, you want to see that person succeed and I feel that when I'm there, I want Helene to be the first one to know because I know it's important to her.

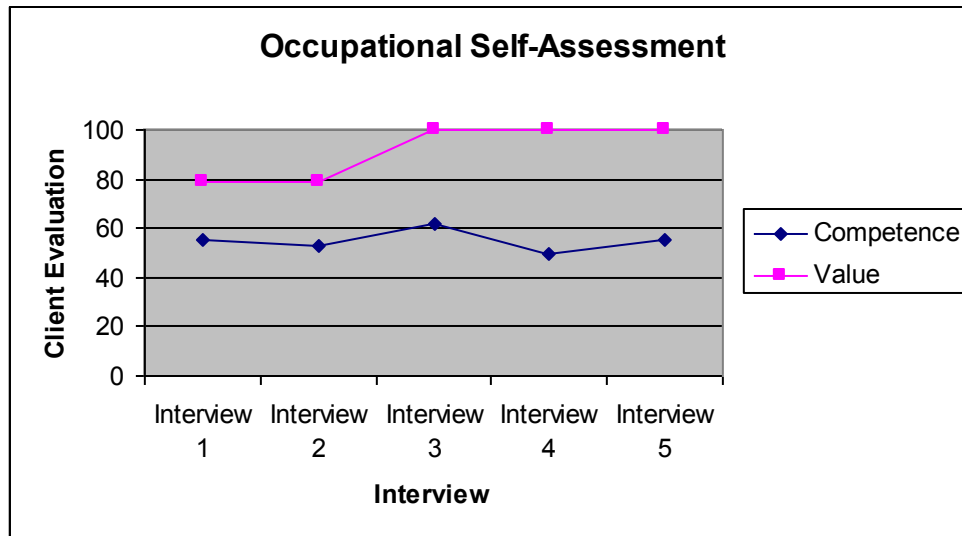
Summary

Although the goals that Georgia outlined for this therapy session were not completely realized, Georgia does attribute significantly enhanced self-confidence to her therapy with Helene. Despite ongoing issues related primarily to her visual deficits, cognition, and emotional health, Georgia is now more confident in her ability to work on a part time basis in some form of employment and feels ready to undertake some form of volunteer placement to demonstrate this. Georgia came to realize over the five-month period of her involvement in this study that her emotional health did have implications upon her functioning that she had previously not appreciated. Georgia considers that the therapeutic relationship with Helene was a catalyst to her improvement. Georgia appreciated Helene's strong interpersonal skills and perceived that Helene had a deep interest in helping her achieve her own meaningful goals. Georgia enjoyed her sessions with Helene. The personal sharing in

which the two women participated deepened the emotional connection. Georgia was an active participant in the therapy through which she achieved real-life, practical enhancements.

Appendix V-A: Georgia Dyad #2**Occupational Self Assessment Results**

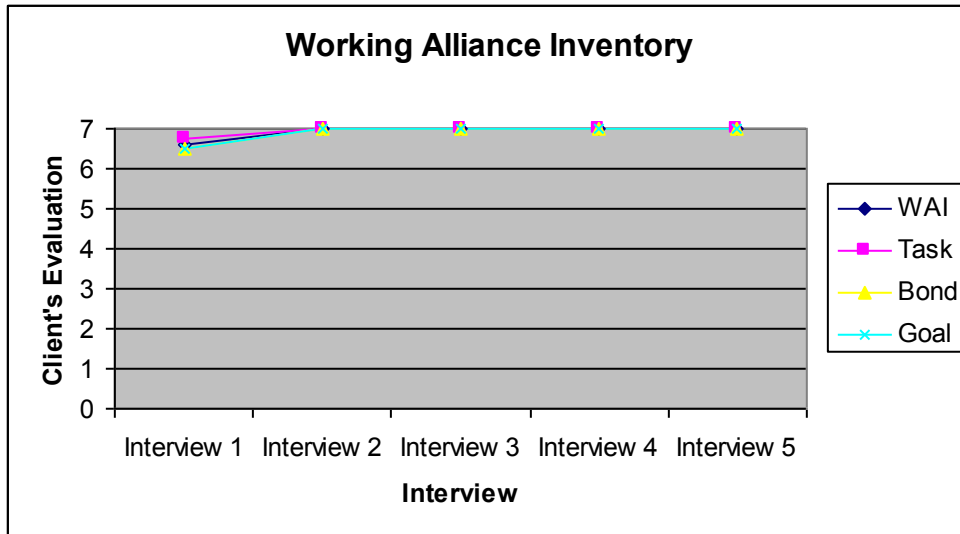
The Occupational Self Assessment (OSA) was used in this study as a measure of Georgia's perceived functional abilities from the beginning of therapy through discharge from therapy.



As may be viewed, Georgia's perceived level of functional competence remained relatively unchanged over the course of the therapy. This may be explained by the fact that the overarching goal of this intervention period was not realized during this time frame.

Working Alliance Inventory Results

In this study, the Working Alliance Inventory (WAI) was used to assess Georgia's perspective of the evolution of the alliance over time.



With the maximum score on this scale being 7, Georgia's assessment of the working alliance (WAI) was very strong from the beginning. There was thus a ceiling effect that resulted in that there was little room for positive improvement. Georgia held and maintained a very high, maximal evaluation of the working alliance with Helene. There are three scale items that form the basis of this overall scale. Throughout the entire therapeutic relationship, all three (task, bond and goals) showed very similar assessment.

Appendix W: Helene, Dyad #2

Background

Helene was 45 year of age at the time of study participation. She is a bilingual (French and English), white, Canadian. As defined by Canadian Census data for metropolitan Ottawa, Helene categorized her familial income as higher than average. She graduated with an undergraduate degree in Occupational Therapy in 1988 and has been practicing since that time in a variety of positions over the last 22 years. Helene is currently a self-employed occupational therapist with a clinical focus upon the treatment of clients with traumatic brain injury. Over the years, Helene has developed a healthy respect for the importance of the therapeutic relationship with her clients. She opined that this was not always as evident to her as a younger therapist:

I think initially you're building so much skill that I don't think you focus so much on the therapeutic. I'd have to look back and think in my case in my early, early years at [the hospital]. You're running off your feet learning skills in the beginning. I don't think it could be taught. I really don't. I think it is developed, or not.

Helene describes herself as a non-traditional occupational therapist. For example, Helene will periodically interject an untraditional activity in which the client is interested in participating (e.g., pedal boating on the canal). Into that activity, she will build goal-related tasks and therapeutic activities, however, a significant consideration of the activity is the maintenance of the client's interest and excitement in therapy. Helene indicated that she enjoys providing clients treatment, to find solutions, and ensure that the clients know that she is available to them. When first meeting a client, Helene will focus her initial interview on the client's degree of participation in meaningful and purposeful activity. In order to achieve

a thorough understanding of the client's desires for therapy and life in general, she will ask them their five most prominent wishes. She will also ask new clients to provide her five facts about themselves that they consider she would be most interested in knowing and then she turns the question to allow the clients to ask five questions about her:

I do maintain that professional boundary side, but I'm keen on telling them about who I am, what my background is, what I do as an occupational therapist, what kind of practice I have from home, so to establish that sort of connection of 'I want you to know that while I'm involved with you I'm involved. This is how you can reach me'.

Drawing parallels to her pattern as a parent, Helene identified her dominant mode as a therapist to be one of problem solving. Running a distant second are collaborating and instructing. Helene admitted that empathizing and encouraging are not natural dispositions for her as a therapist. Although Helene is able to employ empathy and encouragement, she tends to try to mobilize the client through problem solving toward an action plan:

Yes I empathize with how you're feeling but I think my therapeutic approach is very much, you're in this situation, there's highs, there's lows, but let's develop some insight into why this is like this so let's problem solve it and then let's go on to action mode.

Role with Georgia

Helene was referred to see Georgia by a physiatrist with a specialization in brain injury. He was questioning the etiology of Georgia's cognitive complaints as either a brain injury or an emotional health issue but asked that Helene become involved to look at pacing issues. Helene began working with Georgia more than one year post accident. Their initial

therapy block lasted from January through June 2009. The focus of those eight sessions was instructional based and the sessions were methodically developed to review cognitive compensatory strategies. These strategies were applied to her everyday meaningful activities around her home. As Georgia's long-term goal was a return to work, at the end of that first therapy block, Helene recommended that Georgia move outside of her home environment into a volunteer role. Georgia was successful in such a placement at a garden centre that allowed her to build her stamina and challenge herself from a social communication perspective (e.g., receiving direction from a supervisor, dealing with customers etc.).

Prior to continuing therapy, Helene recommended a neuropsychological assessment in order to better understand the profundity and etiology of Georgia's issues. Due to some associated delays, therapy was ceased between June and September 2009 until the neuropsychological assessment results were available. Those results appeared to indicate that the cause of Georgia's cognitive issues were primarily emotional health in nature and not a brain injury. Helene indicated that as a result of Georgia's higher cognitive functioning as compared to most of her significantly brain injured clients, Helene's primary modes of therapeutic approach morphed:

I felt that I could do it more on an even collaborative level, a little bit of instruction, lots of encouragement because of her self confidence. And some empathy; that was her natural need to have that but not to any extreme. I definitely think she was able to contribute a bit more in the sessions because she was higher functioning cognitively, what the issues were, what the problems were, what she had tried, what she hadn't. So it was definitely more on even ground of collaborating as opposed to someone who is much more concrete, which I'm used to.

Goals of Intervention

Georgia's identified long term goal was a return to work. She had been a loyal bank employee for many years and had planned to retire within a couple of years of the collision with a partial pension. Helene indicated the following objectives for the second block of therapy with Georgia:

The goal of OT was to expose her to situations that would build her confidence and reduce her anxiety in the face of perceived cognitive challenge and move her beyond the comforts of home because she clearly had identified that she missed being with people.

The second block was intended to move towards assessing her generic worker skills in volunteer activities. As the second therapy block progressed, however, it became evident to Helene that Georgia was struggling with whether a return to work at the bank was really her primary goal. To that end, Helene worked with Georgia to identify what components of her employment role Georgia was genuinely missing.

Achievements

Helene felt that at the end of this second therapy block she, as well as Georgia, were left with a degree of uncertainty. Helene reflected on the significant success and progress achieved in the first therapy block compared to the second block:

The client didn't really obtain clarity of what she was looking for. When I look at my initial mandate and the referral read "Please see this lady with mild TBI for pacing strategies." So I think that was the initial need for OT, look at her fatigue, her productivity, her pacing and I think we accomplished that in the first treatment block but beyond that when I was fortunate to be able to continue to be involved with her

because the initial request was very much straight forward - OT training and pacing strategies. But as we delved a little bit more into life roles, what was important to her, given her age looking forward was really competitive work that she was wanting or was it really to go out of the house and being able to socialize, which is part of what she missed at work. So I think as we got into expanding our goals it was not something she expected us to look at in OT. She felt we went way beyond what initially I came to work with her on. So I feel that we met our original goal, but as you get into the more complicated stuff like work it's just harder to attain those high level goals with some of the residual difficulties. So, you know, she's still left with a lot of questions.

Although Helene thought that the goal of applying the learned strategies to an *in-vivo* volunteer placement was a realistic goal, she indicated that the nature of the file and the contextual/ environmental influences, detailed below, impacted the degree of success of this therapy block.

Environmental Influences

As identified by the Neuropsychological Assessment, that neuropsychologist reportedly described Georgia as, "She would be fiercely loyal as a friend but very difficult as an enemy." That fierce loyalty was appreciated by Helene both in their relationship as well as in Georgia's relationship with those people in whom Georgia had trust and rapport:

Those people that she valued were the ones that were providing her with some reinforcement that what she was feeling, they were validating it. So "the psychiatrist," "her family physician," myself, were all people that acknowledged that there were changes after this injury. Her employer, [the neuropsychologist], [The Bank], her

adjuster, this is where the little passive aggressive side of Georgia came out. She didn't like what she was hearing. Her lawyer would be in the first sort of camp. So a definite need for her to have this support to carry her through.

Helene identified that Georgia had a positive support network in her husband, friends, and extended family. Georgia was very excited about and engaged in the care of her granddaughter. Georgia's husband had been seriously injured in a previous motor vehicle accident and sought the counsel of the same lawyer with whom Georgia was now working. As a result, Georgia placed a high degree of trust in the guidance provided by her lawyer in cautiously dealing with her employer and the two insurance companies addressing her claims. Helene indicated that although she did not consider that the lawyer had a negative impact upon the therapeutic relationship that she experienced with Georgia, she did consider that the caution that he instilled in dealing with the insurance process and claim resolution resulted in the goals of the therapy being impacted:

He probably impacted the most actually if we look at that, because she wasn't prepared to move forward with anything until she knew if she would have support.

The whole insurance. These factors [funding model and 'game' of dueling insurance claims] impacted the goals of therapy, not on our relationship.

Her lawyer's direction created some ambivalence in Georgia and in her role with therapeutic endeavours with Helene:

So we spent our last session exploring a little bit what the options were. And of course she's not wanting to make a, you know for me when the whole legal stuff

comes into play I think well sometimes it's just a big hassle. She's not wanting to make any decision before there's mediation. Before things get settled with that.

This was not to say that Georgia was not a compliant participant in therapy. Helene was careful to differentiate Georgia's level of commitment to the other factors at play:

I don't want to use the term 'lack of commitment' from her end, because I don't think it's volitional but I think because of her uncertainty on the legal end, her displeasure in her workplace when she returned, her perception that things really changed. I think she was compliant in the session but I think there was a certain resistance to commit beyond our OT sessions to something in the big wide world. I'm a bit of a risk taker myself. So I like the client to say, "You know what? I'm going to try it." And I'm the type to say, "You know what? We're trying it." So she wasn't a risk taker. She was cautious and I would have liked her to push the envelope a little bit more.

Georgia harboured significant negative emotions toward her employer. Although Helene tended to associate this negative emotion with the poor treatment received during the initial return to work following the motor vehicle collision, the neuropsychologist unearthed a more historical root:

She had had many years ago some work issues with a supervisor and had decided to quit or something around workplace issues and had never felt appreciated in the workplace. I was completely floored because here I am 6 months after I started...And what came up was how much she loved her job and that's what she wanted to do for work and when [the Neuropsychologist] dug into that Georgia did

not like that because it could have portrayed a side of her that was not the compliant employee who might have secondary gains by not going back to work.

Several professionals expressed concern for Georgia's emotional health. Georgia was prescribed antidepressant medication but Georgia was initially resistant to accepting the implications of her emotional health. Helene considered:

There was a huge emotional overlay, and I definitely sense in Georgia, I'm not a psychologist but personality-wise somewhat of a dependent personality. There was some anxiety there and I think a little bit of passive aggressiveness.

By the end of this second block of treatment, however, Georgia appeared to Helene to be recognizing the implications of her emotional health:

The last session was very telling when she said, "I'm starting to think now that there is more to what [the Neuropsychologist] said than I actually thought." She was kind of opening up that door.

Helene considered that the occupational therapy would have been more successful in the second block should a psychologist have been involved with Georgia throughout their intervention. Although Georgia had received psychological intervention, it had been concluded by the time that Helene started to work with Georgia. A further delay was caused by the viral infection that Georgia battled for several months during that autumn.

Although Helene noted a "psychological avoidance" of anything related to work, (e.g., working on ability to resume reading), Helene noted that Georgia's varied interests was strength for the application of the strategies being practiced in therapy:

Outside of the work cloud, if you could put it that way, she could find a lot of opportunity to apply what we were doing and be successful, but it was not as

threatening as the whole work thing. That was a big black cloud that's maybe a little greyer now, not so black as initially.

Helene's Reflections on Georgia and Their Therapeutic Relationship

Prior to commencing this second block of treatment, Helene and Georgia met with [the Neuropsychologist] to receive the feedback from the neuropsychological assessment. As previously explained, this report included some historical information that Helene sensed made Georgia uncomfortable (about her prior work relations). Furthermore, this report indicated that Georgia's cognitive compromise was not due to a brain injury but rather due to Georgia's emotional health. This created turmoil for Georgia who appeared disappointed that she had not received the diagnosis of a brain injury. Her Psychologist had discharged her from active therapy that Georgia judged to mean that her emotional health issues were deemed to be resolved. The report did, however, support Helene's ongoing role with Georgia in order to work on her self-confidence in the area of perceived cognitive difficulties. After a few therapy sessions, Helene arrived for a session to find that Georgia had the neuropsychological report out with notes made. Georgia remained upset about the report and the neuropsychologist's findings. Helene indicated that her management of this situation was critical to the ongoing therapeutic relationship with Georgia:

She needed justification from me. I had to stay very neutral in that session...she was very anxious about the use of anxiety and depression and that that was standing in the way. I tried to go back to some of my earlier sessions where a cognitive activity had been introduced and before I even started she began to panic. I was trying to give her concrete functional examples of how emotions can interfere with function. As we progressed on she didn't go back to the neuropsych. She re-engaged, but that one

could have been a make or break time because she was looking for me to side with her on the neuropsych. I stayed very neutral and I think she was okay with that. I didn't tell her, "[The neuropsychologist] is right. You're right," you know, "both of you aren't right." "This is what it is, if you really have more concern you need to go back and talk to her about it.

Helene identified that spending this therapy session again reviewing the results and attempting to aid Georgia's understanding and rationalization of the assessment results was critical. Helene felt that Georgia wanted her to side with her against the findings. Helene realized that her maintenance of neutrality was fundamental to the progress yet to be achieved in occupational therapy:

I played it right up to middle. The reason I played it right up the middle is that the conclusions I think, in my own personal opinion, were pretty well bang on, but the functional disability was the same, whether it had been a brain injury, the eyes...So I really took a moment to reassess when I started that second block and I thought, "Okay, my goal remains the same with Georgia, building her confidence." We're filled with cognitive decisions in our day. So whatever the cost might be I did agree with [the Neuropsychologist's] approach that the idea was not to prolong psych intervention and OT intervention ad nauseam because that would only feed her into the crutch of "I need this. I need this."

Helene indicated that the trust in the relationship with Georgia was high. Helene perceived that her handling of the neuropsych report situation, which Helene termed as a "hurdle," was key to Georgia understanding that Helene would not leave her stranded, but rather was ready and willing to help, regardless of the etiology of her issues:

The whole neuropsych thing was very pivotal because it wasn't the results that she expected. She was looking for me to support what she was thinking. I didn't take on that position. I empathized. I understood where she was coming from. Tried to get her to see that there could be a different perspective and how other things, like vision and other things, could affect cognition. And I think once she got over the emotion of this assessment I think she really felt, you know, "I could trust this person to be neutral. To go beyond what my lawyer, what my LTD carrier, what [the bank] is telling me, and I could really go to this OT and she'd be neutral and she'd try to see different perspectives. I think that session we did to review word by word her neuropsych and hear out her frustration and try to see "No matter what it is Georgia, if it is emotional, if it is..."... "we can make you work through that. It's great if there's no brain injury.".. I did validate for her that she wasn't making up these problems that she was having. Whereas she hadn't heard that from some of the doctors... So from an OT perspective my angle was, "Maybe you're depressed. Maybe it's the brain. But the reality is, functionally there's problems." So I think for her that was a real issue of trust that this OT can really help me work through some of that and not take one position or the other, just kind of be in the middle.

Helene further described the relationship with Georgia as reflective, purposeful, and productive. She indicated that the strengths of the relationship rested in their open communication and comfortable rapport. In fact, this comfort led to Helene encouraging Georgia to "use her to figure out what Georgia wanted." Helene encouraged Georgia to "use her" to figure out if she wanted to go back to work. Helene considered that Georgia's comfort waffling on this issue was a reflection of her deepening trust and comfort in their

open dialogue. Through this open dialogue, the aim was to “expose what she was thinking and feeling and knowing that it wasn’t meaning that I was going to support her or not support her.”

Helene is accustomed to working with clients with more pervasive cognitive deficits than those experienced by Georgia. As a result, Helene enjoyed the more collaborative nature to their work, Georgia’s intuition and reflectivity, and Georgia’s ability to think abstractly as well as her desire to learn. Helene indicated that Georgia enjoyed probing Helene’s knowledge and Helene enjoyed the educator role. Helene queries whether Georgia’s higher level of functioning, reflectivity, and insight also caused her to require a different therapeutic approach than her other, lower-functioning clients:

So I found myself to be more so than in other clients needing to be encouraging. I’m not going to use the word nurturing. She might use the word nurturing. She needed somebody to talk to a lot. To work through her things. So from that sense there was definitely an encouraging part that I had to play more than I might with another client.

Helene admitted that Georgia’s emotional health issues impacted her own sense of efficacy as an occupational therapist in this relationship:

The struggles I had were the whole emotional stuff, where I thought, Georgia has some goals she wants to work towards. There’s some emotional barriers there. I couldn’t penetrate those from an OT background necessarily and we almost needed a third person at the table during our sessions to say, “Okay, what I’m teasing out here functionally Georgia, you are able to do this, this and that but some of these emotions are standing in the way.” So there was, not in all the sessions, but there were sessions

where I thought, you know, I'm not really making progress because there's some emotional stuff there. So that left me feeling a little bit frustrated. And of no fault of Georgia's but just kind of with that missing piece and knowing that she is compliant by nature so she was agreeing and thinking this was all good what we were doing and this would all be useful when we got to the higher level stuff but there was always a little part of me that said, "Yeah, but unless we address...[the underlying emotional condition] I don't think we're going to be able to use this stuff very much."

As a result of these barriers, Georgia's goals were not realized. This had some implications on Helene's sense of satisfaction with how therapy turned out with Georgia:

You feel more rewarded if you are in line with your client's goals. They're in line with your goals; they're moving forward with their goals and I think it has a lot to do as well with sort of the team you're on. Georgia is a good example of somebody who would have needed a little bit more than just OT.

The Working Alliance Inventory was used to assess Helene's assessment of the working alliance with Georgia throughout the duration of the therapy. These results may be reviewed in Appendix W-A.

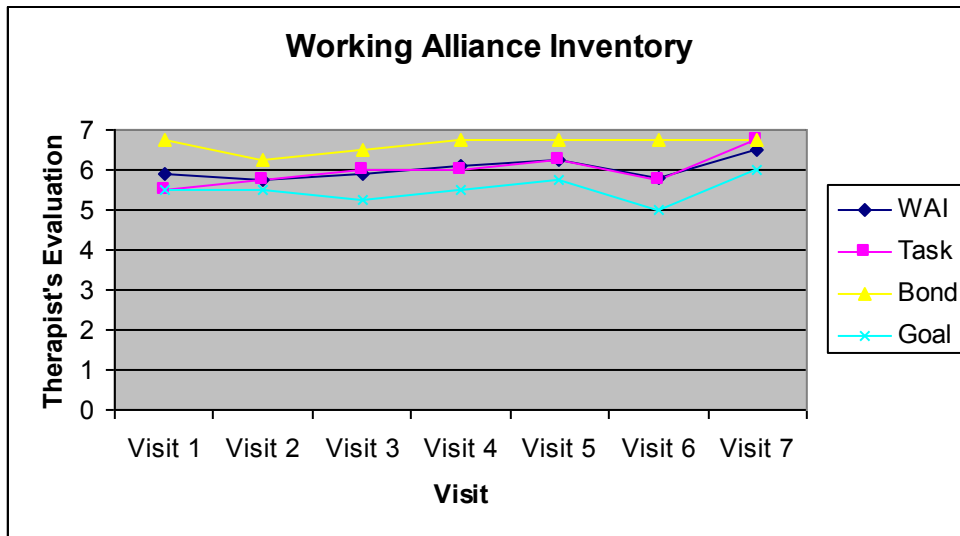
Summary

Georgia was a client who presented with multi-factorial issues. The complexity of her condition is exemplified by the fact that it was approximately 1.75 years post accident when clarity as to the etiology of her cognitive compromise was received through neuropsychological evaluation. Georgia also experienced significant ambivalence in her goals for her therapy. This ambivalence as well as the significantly impacting environmental and contextual factors detailed above were perceived to have a profound impact on her

progress and resulted in a lack of measurable achievement during this second occupational therapy block. These factors formed the backdrop to this therapeutic relationship. Although a positive and supportive relationship was established between Georgia and Helene, the external factors and inner turmoil experienced by Georgia regarding the direction of her therapy goals impacted upon Helene's sense of efficacy. Helene exemplified superior skills in her ability to appreciate the manner in which she needed to handle Georgia's reaction to the neuropsychological report and her therapeutic approach to Georgia. Her well-honed therapeutic use-of-self was also appreciated in the manner in which she encouraged Georgia to use her as a means of figuring out what she really wanted to accomplish with respect to her return to work.

Appendix W-A: Helene Dyad #2**Working Alliance Inventory Results**

In this study, the Working Alliance Inventory (WAI) was used to assess Helene's perspective of the evolution of the alliance over time.



As may be reviewed in the above diagram, Helene assessed a strong overall Working Alliance from the initiation of this intervention that may be partially explained by the fact that Helene and Georgia were already well acquainted from a previous therapy block. This strong alliance persisted for the duration of their therapy session. Consistent with the other information shared by Helene, this dyad demonstrated a strong emotional bond (Bond), however, Helene admitted some level of frustration with the lack of progress toward Georgia's stated goal of return to work that may be represented by the lowest scores falling within the Goal domain.

Appendix X: Jackson, Dyad #3

Background

On a flight back from Europe approximately seven years ago, Jackson noticed a twitching in his finger. He attended his family physician who assured him that he needn't worry, however, appeased Jackson by referring him to a Neurologist, Dr. N. Dr. N confirmed that Jackson had Parkinson's disease. Medication was started immediately. Jackson has been regularly followed by Dr. N since that time. Jackson's main complaints include cognitive difficulties ("I'm having a harder time keeping my thoughts together. I go to say something and my mind goes blank quite often. I am really bad repeating a story. I noticed the last 2 months or something, 3 months probably."), sleep difficulties, as well as mobility problems and associated falls. Jackson's primary objective for therapy was to address his physical limitations. He tended to dismiss his cognitive changes as being normal age-related decline, "we sort of laugh about it, because all my friends my age anyways we're having the same thing." Jackson also indicated some depressed mood that he attributes to his physical difficulties and resultant isolation, "I have my days I guess. I'm not suicidal or anything. Just feeling down in the dumps a little bit. I hope it doesn't get any worse anyways. But I just feel a little bit depressed. I don't have that many friends out here and when you don't have a car it's a little difficult...I'm dependent upon my wife, who is making it tough on me on purpose anyways. But take OC Transpo and stuff to have to wait for three hours whereas the damn thing didn't show up and having to account for my time also, budgeting time and just not being totally free."

Jackson

At the time of study participation, Jackson was 63 years of age. He is a retired high school teacher. He has been retired since the age of 55 years. He speaks English and French. He is a Canadian of Canadian heritage. He qualified his family income as less than average as defined by the 2006 Canadian census data for the Ottawa-Carleton region.

Jackson lives with his wife and has two adult sons with homes of their own in the general vicinity of Jackson's urban community.

Treatment

Jackson explained that in the spring of 2010, Dr. N linked him with Marie's clinic. Jackson explained, "Dr. N said there were people from a [local institution] who might be interested in the information that I might be able to provide. I gave them a call and they got back to me. I had a bit of a problem with regards to language because I was supposed to be fluent in French and I'm not really. But it worked out that she was looking for a client for her student and it worked out for the better. [We worked together for] probably two to three months. Usually once a week." During this time, the only other sporadic intervention that Jackson described being involved with were support/education groups. He was not, however, interested in continuing his involvement with that group:

I sort of dread the thought of going to a class of conversationalists dealing with this topic. Not that I'm embarrassed by it but I just, I suspect I'll feel uncomfortable doing that...I went to one already. And it was a local one, and I guess what I understood from yesterday was that I'm supposed to get...oh what's the word...my mind goes blank quite often like this. I went to one class yeah. There were about 8 or 10 people there (all diagnosed with Parkinson's). She phoned me up to tell me that

she had a meeting yesterday and it didn't work out yesterday because I was already at the neurologist. But I didn't find it helpful at all. I would rather latch onto something that looks immediately beneficial to me. Plus they're all old. Eighty or something like that. They refer to me as the kid.

Jackson's Goals

Jackson was initially vague about the goals that he had for occupational therapy: ...need to improve myself anyways, better understand what is going on. Not to be a drain on my children...just being a positive influence and not to require that much of their time or efforts. Well physically [Marie] could help me as far as being able to walk properly. To still enjoy doing the things that I used to do. Playing tennis. Playing with my stamps...basically physical things.

In summary, Jackson offered his overall goal was to continue "living and enjoying the time I have left." By the final interview, however, which occurred following Jackson's discharge from therapy, Jackson identified the importance of setting attainable goals for himself, many of which he felt he had achieved during the occupational therapy intervention with Marie and her students. During that final interview, Jackson's retrospectively identified goals included:

Riding a [an exercise] bicycle...Just listing my goals for the following week and seeing if I could match them...some games (e.g., Wii Tennis)...Again I was concerned about walking far enough so that I would not be able to turn around and come back and also the timer, the walking timer there, the odometer...We went over things that I might be able to use for my own personal needs.

Achievements

Jackson's functional recovery was measured during each interview (see results in Appendix X-A). Jackson's condition limits his independent functional participation in many activities in which he was interested in the past. Jackson is now unable to perform many of the more physically demanding tasks required to maintain his home and yard (e.g., install shelving, yard maintenance). Jackson suffered a fractured right shoulder years ago due to a fall. This fracture did not heal properly and Jackson is limited both by reduced shoulder range of motion and strength. Jackson had, however, become more limited in his repertoire of activities than necessarily dictated by his disease-related limitations. Through occupational therapy, Jackson came to realize that he retained untapped abilities:

One (goal) was being able to walk around the block here. I did that too with Marie's help. She was there and we walked quite a long walk, for me anyways...I guess she partially just distracted me from my fatigue I was feeling, but I thought I was going to be able to do it everyday from that point on but it would be unrealistic at this time I think. I have improved my stamina a little bit. Not a great distance, I don't know. It will be about a 15 – 20 minute walk.

As a result of his achievements, Jackson noted, "I feel more positive about myself." When specifically queried, Jackson noted that he felt more confident in his abilities because of the practice and the strategies developed to encourage his participation. Despite this, Jackson admitted, "I still feel frightened on occasion. I fell the other day."

Environmental Influences

Jackson cited many people as impacting him in a positive manner. These included a friend, his wife, extended family (sons, daughter-in-law, grandchild, wife's relatives) as well

as Marie and her student. Jackson's friend John is described by Jackson as "a positive influence. He picks me up often anyways, drives me places which I normally could not get to. Just for lunch...lunch and we invite our families each to our homes anyways quite often. Oh, he's helped me physically with a lot of things around here that I couldn't have done. Building storage shelves and stuff downstairs, well beyond the requirements of a friend anyways, he does a lot."

Jackson described his wife as "tough with me and doesn't take diddly shit from me. She'll watch me struggling to put on my coat and leave it at that." She expects Jackson to optimize his functional participation and makes these expectations known to him. Although Jackson indicated that he felt that these expectations were usually realistic, it does place some pressure on him:

I feel that I've got to fake like I'm busy sometimes. Or if [my wife] is coming home late or something I'll be sitting here in front of the TV set and I feel like I turn off the TV set and make it look like I've been busy around the house all day long. She's just doing it for my, what's the word, goodness, or my success...She'll say, you know, "Did you exercise today?" and "Did you get the meal started?" and stuff like that.

On several occasions, Jackson expressed sadness about the loss of enjoyment that he represents to others:

I'm sure she loves me and stuff like that but she remembers that I used to be a lot more fun than I am now. She'd like me to be happier and establish a closer circle of friends. I don't have that many retired friends around me at all. Although I'm not sitting on my butt all day long either though. I've got a lunch engagement after I say goodbye to you actually.

Overall, however, Jackson describes a supportive and encouraging relationship with his wife:

Giving me hell when I required it. A swift kick in the ass or something. Just things like “don’t look for sympathy from me” – that type of thing. She’s tough when she has to be and I think she’s very supportive and I deserve it too on occasion. I know she won’t just give me a blank cheque for anything...I’ll help you in any way. She hasn’t quite stated it that way.

The qualities that Jackson appreciates in his wife, he also noted to be Marie’s attributes:

Being down to earth and not giving me a bunch of theory but practical things to do. Just very supportive and always smiling. She’s a good lady. Some of the same things that my wife is doing for me. She’s kind of tough too.

Jackson also appreciated Marie’s student who he described as a “good one”:

A couple of other things she did that I was impressed with anyways. She went out of her way to do it on her time, she did all the photocopying on her card too I’m sure.

Jackson appears to relish people around him who are positive and have a sense of humour.

For example, he described one of his daughter-in-laws as:

She’s always good sense of humor. She’s from Mexico City and she’s just a very positive person. She’ll phone when she’s got nothing really to say but just to say she’s here. But I do miss playing tennis against my daughter-in-law and beating her. Back when I could raise a tennis racquet anyways.

Other factors in the environment identified by Jackson as having beneficial effects included the spring/summer weather as he relishes being in the warm sun and enjoys being outdoors for walks and on his back patio. During the late spring, he was also finding passion

in the Stanley Cup Playoffs that he indicated provided his evenings certain structure and excitement.

Jackson does not like being in situations that demand sustained conversation such as the support/education group. He does, however, enjoy his friends who he feels make him social allowances.

Fear

Jackson's condition-related reduced endurance makes him "fear running out of steam when [he's] halfway there." Jackson has experienced several falls with resultant injuries (e.g., fractured shoulder). These occurrences have resulted in a significant fear:

I also find it very difficult to go for long walks or anything like that. I can't do that and I'm afraid of falling again. I fell one time and it's one of these situations where I was walking and I started picking up speed. I was trying to slow down and I couldn't. I started dragging my hands outside the fenced area where there were some trees and stuff. Finally slowed it down and came to a stop and my face in the snow just about and fortunately there was somebody coming by and helped me up. They thought I was having a heart attack or something. When walking with people I tend to drag my feet which is a common reaction I think but I go out everyday to pick up the mail, bring it back, but it's only a very short trip and I'm afraid of going much further because there's no place to stop along the way.

This fear is not without foundation. During the study, Jackson experienced another fall that reminded him of the need to be cautious and undertake the planning and safety precautions reviewed by Marie:

I still feel frightened on occasion. I fell the other day. I was bending over leaning on some boxes and all my weight was on one thing and I couldn't get up so I had to let myself slide down. Cut myself a little here and my leg. It just brought me back to reality about being careful because I hadn't fallen in eight months or something I don't think. Maybe start to review some of the emergency trials I'd have to go through again like in the winter time I fell in a snow bank there. That had frightened me quite a bit. But I just have to be more vigilant I think as far as where am I going to end up. I slipped and I was leaning against some sharp boxes and stuff. I just didn't have the strength to get up from there. Fortunately my wife was upstairs here, I was in the basement and I called her and she came, of course, and gave me hell too!

This fear of falling and his recognition of his reduced mobility worry him as it relates to a European trip he is planning to take with his wife and her relatives in the autumn. He worries about his endurance as well as the fact that his lack of speed will impact the enjoyment had on the trip by others:

That's a fear I have about the trip we're taking too. I'm a little concerned about, I shouldn't say I'm a little concerned I'm quite concerned about being able to contribute to the fun aspect of the trip. There's two thousand people aboard the ship. It's a little scary I think. I've got a walking stick I can use but we're going to St. Mark's Square in Venice. I just remembered there is no place but I'll need to sit or rest. They don't want squatters there basically and I wish I could carry my own seating arrangement but I'm not going to be carrying a wheelchair along with me so I don't know.

Jackson astutely pointed out that this fear has also created some impetus for him to improve his mobility with Marie's help:

[The European trip] gives me a goal. And there's a motivational factor in walking also because you don't want to be stuck out there some place. It's a fear I've got also right now. I'm concerned about slowing them down and just I hope they realize what condition I'm in.

Jackson also expressed on several occasions worries about other people considering his behaviour as being potentially improper. For example, although there is a park in his neighbourhood that would be an ideal goal location for him to walk to and then be able to sit and rest before continuing, he worries that others will wonder if he is there as a child predator:

I'm not made to walk but I'll go out to that park out there and sit down for a few seconds but I'm afraid of being centred out as a child molester sitting in the park.

This same type of worry was expressed as it related to the walks he took with his occupational therapist (and her student) in his community:

I felt safer anyways with a third person being there all the time. One time we went for a walk without Marie. That was about it. It wasn't a long walk either....I just worried about what somebody could arrive at when studying that.

Jackson's Reflections on Marie and Their Therapeutic Relationship

When asked to reflect upon his impressions of the relationship held with his occupational therapist, Jackson's response was in correspondence with his previously described fear of someone having an illicit impression of him:

I'm not comfortable right now with dealing with this relationship thing because it sounds like you're hinting that there might have been a non-professional.

Once the nature of the inquiry was clarified, Jackson offered the following:

Very professional on occasion. By that I mean if I really wanted to be straight laced and stuff, I would not end up saying anything probably. I'd be afraid of going outside of my realm of professionalism I guess...But open to joking and so on.

As per his expressed cognitive communication difficulties, Jackson did appear to have some difficulty putting into words his impression of the relationship with Marie:

These are tough questions you give me. I'm not trying to escape from answering them properly, I just don't know how to answer them or they're things I've never considered.

I don't mean to be evasive either, I just can't think of an answer.

You could ask me the same questions in five minutes and I probably wouldn't have the same answers I'm sure.

Jackson did consistently report a positive impression of both Melanie and her student. The most frequently expressed valued qualities included a sense of humour, kidding around, joking and having fun.

She doesn't initiate humor very much. She'll respond to it though.

She has a sense of humour.

I think it could have been very, very boring otherwise had we not kidded around and joked around a little bit. It was an enjoyable one hour or an hour and 15 minutes.

She was enjoyable, she's quite positive in her outlook. That's about it. She was fun to be with.

That being said, Jackson also noted that there were serious topics being discussed and Marie set clear expectations for which she praised Jackson when he attained them:

She – she was good – she kidded around and so on and yet she was serious about a lot of other things like how will I know that you're not giving me a line right now and as soon as I leave I would not be in a position to help or to be part of the stuff we talked about and went over. So she was beneficial that way. She gave me hell on occasion and on other occasions she flattered me and said you're doing really well and stuff.

Jackson described Marie as open, nice, attractive, supportive, smiling, friendly and a good listener who he trusted to maintain confidentiality. He had confidence in Marie as he recognized her education and experience. Despite being a retired high school teacher, he indicated an appreciation that “she doesn't use big words.” Jackson respected Marie's professionalism to which he no longer felt personally equivalent, “my quality probably went down some time ago, I'm not very self confident anymore.”

They established goals for their intervention together and Jackson indicated that “she did a good job with the schedule of topics.” Jackson, however, was reticent to address the cognitive issues initially identified. He did persevere through a few activities, however,

when he clearly expressed his desire to leave the topic, he appreciated Marie's accommodation of his request:

There was stuff I did not enjoy doing at all and made it clear to her, smiling at the same time but please don't put me through this again. That was the memory joggers – I do very poorly on that and I just wanted to get out of that topic after a while and she didn't come back to it at all either so that was good.

He appreciated that Marie offered to visit him on the days that were most convenient to him and "came full of vim and vigour." He described a moderately high trusting relationship with both Marie and her student that he indicated was based upon the fact that they listened well, maintained his confidentiality, were (initially) punctual and did not forget to address anything that they said they would (e.g., bringing of assistive devices). Jackson indicated that he had a higher degree of trust in Dr. N but other than his gender and having known him longer, he was unable to explain the nature of this difference. Despite the higher degree of trust in Dr. N, Jackson admitted to feeling more comfortable with Marie:

[Dr. N] is your stereotypical doctor I think. I feel more comfortable with Marie than I would with Dr. N I think. He's a very nice guy but...He's very professional, smiles a lot, keeps his meetings very short and brief. That's about it. He's just more your typical doctor I think and very professional. He smiles a lot though.

It's much more informal [with Marie]. You feel you're talking to an equal rather than somebody who's following a script...So I don't know that much about her personal life or anything. But I feel comfortable with her that's all.

I feel more comfortable with Marie than I would with Dr. N. He's a very nice guy but...[the fact that the occupational therapy is occurring in the] home is important I think.

Jackson repeatedly indicated the value that he attributed to Marie's sense of humour, her ability to joke and kid around with him, as well as have fun. He did indicate, however, that she tended not to initiate humour, rather simply respond to him. Jackson's wife apparently cautioned Jackson on the use of his humour:

My wife told me to clean up my act and not make any little nasty jokes with her.

Stuff I used to be able to get away with in high school. All these double entendre and stuff...Suddenly, woah, they did not find that funny dear.

Jackson indicated that he did thereafter attempt to be prudent in his type of joking and kidding he did with Marie as compared to, lets say his friends:

I respected her ability and her position. I got along well with her so I would hate to see something ruin that relationship.

Despite this prudence, Jackson did suggest that the one aspect of their interaction that he considered may have caused some discomfort was his sense of humour and desire to joke around:

I like to kid around with people but you're sensitive to their views or feelings.

Occasionally I miss the point and go too far I think and I've got to keep my – keep it apart type thing.

Jackson appeared to want to know a bit more personal information about Marie (e.g., the person behind the therapist). He noted, however, that she tended to distance herself from the conversations to allow an increasingly expanded role for her student. Jackson remarked, for

example, “I don’t know that much about her personal life or anything. But I feel comfortable with her.”

Jackson indicated that although he held Marie in high regard, he considered that Marie was trying to extricate herself from the intervention in order to leave more room for the student’s participation. Jackson tended to feel more of a relationship with the student, with whom he considered he had had the most interactions:

The OT student. She’s very professional too. I found that she did most of the work actually and Marie was doing something else, marking papers possibly at the time. And just interjecting some points once in a while; otherwise she was out of the conversation.

As a retired teacher, Jackson appreciated Marie’s position as an educator and drew a direct correlation to when he had had a student teacher in his classroom.

Initially, Jackson described an appreciation for Marie’s punctuality. This tended, however, to dissipate over time in that her tardiness “became a joke a bit afterwards.” Jackson went on to explain, “I wasn’t that worried actually. I was more anxious to see the session end... I don’t feel all that comfortable as you can tell right now or through a lot of this. I just – I don’t express myself all that well.”

The activities undertaken in therapy were meaningful to Jackson. The concerns/interests that he raised in a meeting were addressed during the next session:

They’ve usually written down a couple things or the time before I’d mentioned she could give me some help on something and she writes it down and she remembers the next time I see her anyways. What I’m dealing with here is I wanted some information as to how to get out of bed more easily, practical things like that, and

clothing, is there any easy way of getting a shirt on and a shirt off, and she just welcomes my suggestions and input and she admits that she will research it and get back to me the next time.

Activities that Jackson described doing during therapy included some information/educational activities (e.g., Para Transpo coupon program), practicing falls and their prevention, self-care activities (e.g., dressing), Wii (tennis specifically), problem solving issues related to his pending trip, walking, and overall meaningful activity engagement. He valued the practicality of the intervention and the real-life differences achieved. He appreciated the fact that Marie was “down to earth and not giving me a bunch of theory but practical things to do.”

The Working Alliance Inventory was used as a measure of the working alliance over the duration of the therapy. These results may be reviewed in Appendix X-A. Jackson’s assessment of the working alliance remained relatively consistent over the duration of therapy.

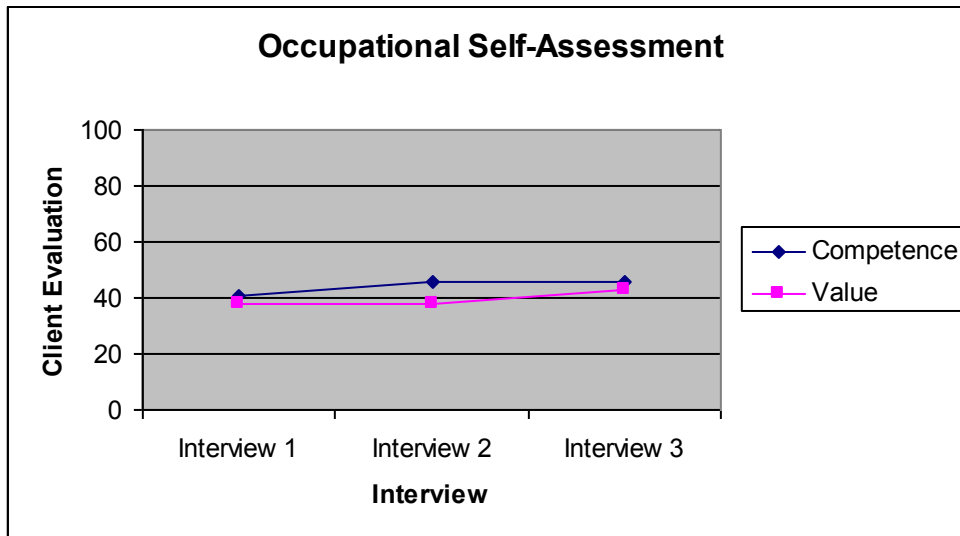
Summary

Over the course of Jackson’s three-month occupational therapy intervention, which occurred approximately 7 years following a diagnosis of Parkinson’s Disease, Jackson realized some improvements in his confidence and walking endurance. The nature of his condition represents some significant limitations, the accommodation of which was facilitated through the education and techniques reviewed during occupational therapy. Jackson described a comfortable and supportive relationship with Marie and her student. He appreciated their humour and the enjoyable social experience of the therapy sessions as well as the fact that the intervention was focused upon goals and activities that were meaningful

to him. When he expressed a desire to terminate cognitive-related activities, this was respected. The practicality of the intervention and the resultant real-life improvements made a difference for Jackson. The intervention provided a problem-solving milieu regarding the European trip that is planned to occur within a couple of months of the therapy.

Appendix X-A: Jackson Dyad #3**Occupational Self Assessment Results**

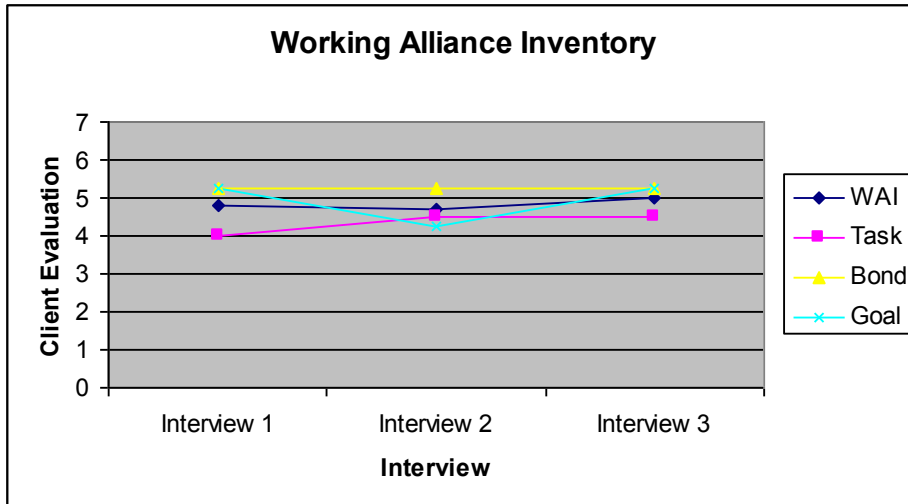
The Occupational Self Assessment (OSA) was used in this study as a measure in Jackson's perceived functional abilities from the beginning of therapy through discharge from therapy.



As may be viewed, Jackson demonstrated a modest improvement in his perceived competence in the performance of the itemized functions. Despite this improvement, Jackson's mid-range evaluation (ranging from 41 to 46) demonstrates a feeling of lacking competence in many of his routine daily functions. The relation of his competence as compared to the value that he places on this function is represented in the above graph. Although modest, the value that Jackson attributed to his functional abilities also increased over the course of the therapy that is consistent with Jackson's report of feeling better about his abilities.

Working Alliance Inventory Results

In this study, the Working Alliance Inventory (WAI) was used to assess Jackson's perception of the evolution of the alliance over time.



With the maximum score on this scale being 7, Jackson's assessment of the working alliance (WAI) was moderately strong from the beginning through the end of therapy. These scores on the WAI, as well as its three subscales (task, bond and goal) remained relatively constant over the course of the therapeutic intervention. Over time, Jackson's scoring of the tasks that were being undertaken in therapy improved. A dip is found in the goal domain during the second interview. Jackson described a negative response to one of the initially identified goals of addressing concerns with his memory. As a result, Jackson requested that this goal be dropped from their goal list. It is questioned whether this may explain the dip that occurred in the goal subscale mid-way through the therapy.

Appendix Y: Marie, Dyad #3

Background

A review of Marie's background is provided in Appendix U.

Role with Jackson

Jackson's neurologist referred Jackson to the clinic at which Marie works.

Occupational therapy intervention was commenced on March 16, 2010 and the final visit occurred on June 16, 2010. There were nine home visits during this three-month intervention. With Marie's position as a clinical educator, one student was completing her placement when intervention with Jackson was commenced and then a second student started her placement. Jackson's occupational therapy was therefore delivered primarily by the two occupational therapy students, but Marie the constant presence throughout the intervention. As a retired teacher who had worked with student teachers during his tenure, Jackson willingly embraced the students. Marie explained:

I put the accent on the fact that I was there to more supervise, the student was going to be providing the information, the guidance just as when he was a teacher, he had his students and how he would help them. I used that parallel in saying you know I'm there to assist the student but I'm also there in the back as well.

Jackson appeared initially indifferent toward the intervention, however, over time, he became more open to the intervention as he began to raise difficulties with which he hoped the occupational therapy intervention could assist him.

Marie identified the most prevalent modes of therapeutic interaction with Jackson as being encouraging, instructing, and collaborating. Her natural dominant mode of problem

solving “was probably the one that was the least there.” Marie indicated that Jackson required encouragement:

Because of his state of mind, he needed guidance through accepting certain things that were going on in his life. From the get-go, just being an OT, I pinpointed two aspects that I thought needed to be addressed but they’re always touchy subjects – one being memory and the other one being mood. Every time we went to see Jackson he was more open to discussing other issues than just physical ones, ones that are maybe not as visual.

Marie explained that instruction was used regarding the disease process itself:

Just instructing him that he’s not alone, this is a progression of the disease. Let’s say for the mood – the mood is a portion that is actually treatable in the course of his disease so that this is what we can do to address it. We’re not letting go of the physical aspect because that’s very important to him and that helps his recovery. But that we felt it was something that we could discuss with him and that we always wanted him to be open about it.

Marie explained that due to the numerous people involved (Jackson, Jackson’s wife, Marie’s two students), collaborating with all of these parties was an important aspect to the success of this relationship.

Goals of Intervention

The goals for intervention were based squarely on what Jackson identified as being functional issues that were important to him. These goals included improving his walking endurance, limiting the risk of falls and practicing the ability to get up from a fall, facilitating independence with dressing, assessing his memory and practicing strategies to address its

impairment, and establishing a daily routine of functional and meaningful activities. As intervention progressed, these goals morphed, as per the client specified preference and as other issues emerged. Jackson easily identified his physical limitations, however, required time and encouragement to identify other performance-related limitations and associated goals:

His lack of range of motion in his shoulder. His endurance, his walking, his balance. Never was he hesitant about saying, I'm going to get on the floor and practice getting back up. Memory – I just said a few words then the next time said a few more and said would you be interested in having a memory test? It stays between us. Yeah, okay I'd be interested and then afterwards he formulated an objective of, "I would like my memory to be better." That was later on because the aspect of mood came into the picture. It's hard because he has Parkinson's so sometimes his affect is flat but his mood was also flat so it was trying to address that piece as well and he opened up about it so there was a portion of our sessions that also addressed that. Encouraging him to establish his own goals for himself and realizing how working on one thing can help another.

Achievements

Marie reflected on the accomplishments made during this block of therapy. Not only did they attain the initial goal of walking outside, they then increased the distance and frequency. Jackson was able to demonstrate efficiency with getting up from falls. Devices to facilitate his dressing were introduced and practiced but in the end, Jackson decided that he preferred to remain independent, without the use of aids, as long as possible. Jackson came to realize the importance of planning and engaging in various activities throughout the

day and became proficient in his ability to establish his own “smart goals.” To that end, Marie felt that this goal was partially attained in that Jackson came to recognize the importance of this planning and goal setting, however, his mood and motivation presented a barrier.

The motivation was definitely there to welcome us in, to have us come over, to do the walk but to actually do the work when we weren't there, writing it everyday was...[less carry over]...Until he realized we were coming then he would say oh no, I'd better get this done.

Jackson asked that his originally identified goal of working on his memory be eliminated from the therapy program. Rather, he preferred to work on the physical goals, such as walking. Overall, Marie reflected on Jackson's success during therapy:

It depends on the actual goal but I would say that he met expectations based on – according to me but I think that he didn't meet his own expectations – he wishes he was somewhere else so that's what we tried to do, progress him slowly.

Environmental Influences

Marie identified three “people” as having influence during this relationship with Jackson: her students, Jackson's wife, and Jackson's dog. Marie had two students on placement during this block of therapy. Marie explained that Jackson knew from the beginning that working with students of occupational therapy would be the nature of the provided intervention. Marie explained that the students' personalities and approaches were quite different in that one therapist was more action oriented, whereas the second one appeared more engaged with Jackson's affective presentation. This created some requirement for Marie to intervene in the therapy session to direct the session toward the

intended activity. Jackson readily engaged with the occupational therapy students and allowed Marie to withdraw to the background. For example, Marie described, “Even when we would go out walking, I’d take the dog, the student would be right next to the client and I’d be more in the back.”

Marie identified the dog as being a positive factor in the relationship toward the attainment of Jackson’s goals to improve his mobility that also allowed for the practice of balance and fall prevention in an in vivo activity outside of the home:

Well, he always wanted to go for the walk and to benefit the dog as well so that was actually a positive spin I guess because he’d be like let’s go and walk the dog. Then if the dog did a poo, he was like no, let me take care of it and then he’d...we’d practice balance while he picked up the poo.

Jackson’s wife was also occasionally present in the home. It appeared to Marie that Jackson’s wife was less inclined toward the students. Rather, she turned to Marie for information and guidance concerning Jackson’s condition:

I sometimes had discussions with the wife and the student would go and do the walk and the walking training with Jackson so I would provide some information to the wife that the student might have but she would ask me. She was less...I don’t think that she wasn’t open to the fact that they were students but she would direct more questions and conversations to me.

Marie explained that students tend to be less efficient in a therapy session as compared to a practiced therapist and thus by Marie addressing the wife’s concerns and questions allowed the student to focus her time upon Jackson.

Others factors that impacted upon the progress achieved during therapy sessions included the weather (when it was raining, they did not go for a walk outside) as well as “technical difficulties” (during one session they had difficulty operating the Wii console). Jackson’s mood also impacted upon the planned intervention, “We would plan a session and we went and it wasn’t going to happen so it’s readjusting based on what the client is presenting you with.” As intervention with Jackson continued, the impact of his mood became more apparent, “I don’t know if it necessarily dipped but I think he just showed more of his true colours.” Marie encouraged Jackson to discuss his mood with his physician who then in turn provided Jackson with medication. Jackson’s mood appeared to improve approaching the end of therapy:

Yes at the tail end I saw that his mood was getting better, he was more lively, more smiling, more motivated, his jokes came back. I think before when I saw him at first it was a front and he even said, “I didn’t want to fess up that my mood was an issue.” His wife even said that since the [autumn], they’ve been talking about it. Since the [autumn] she saw his mood deteriorate, they spoke about it but he didn’t address it with the doctor or vice versa until May.

Marie’s Reflections on Jackson and Their Therapeutic Relationship

Marie described the relationship with Jackson as “warm and fuzzy,” lively, therapeutic, and progressive in that “there was a progression of his confidence in sharing or opening up.” Marie indicated that this would represent both her relationship with Jackson as well as that which Jackson held with the student. Jackson was pleasant to work with and was in fact “a very good case for a student to have because he respected the student in front of him.” Marie explained that working with Jackson was “easy” as “it makes my job easier

as an educator if a client is cooperating with the students.” Marie points to this ease of interaction as fuelling the sense of liking in the relationship that she described as positive and mutual. Marie sensed that Jackson wanted a more personal level of interaction than Marie felt was indicated, “he would always try to get some personal information.”

Marie described a high degree of trust in the relationship from its inception. She reflected that Jackson felt more confident when the therapists were present and “pushed himself a lot more when we were there which to me demonstrated that he trusted us. That we would either A – succeed or if something happened, we would be there. During walks he would always push himself to the furthest of his ability during a walk because we were there.” Marie provided the following further illustrative example of Jackson’s degree of trust in the therapists:

The first fall we practiced, he practiced close to a chair so the chair would be there to help him get up...he got down in a matter of seconds, got back up in a matter of seconds. He [asked, do you] want me to practice it anywhere else? I [suggested] where there’s no furniture because you don’t always choose where you fall...He [went] in the hallway, gets himself on the ground, gets himself back up. I [asked], “Why did you do that so quickly?” He [indicated]. “I figured if something happened, you guys were here to help me.”

Jackson initially steered clear of discussing cognitive or emotional difficulties although these were evident to Marie from the beginning. Marie identified Jackson’s eventual ability to share emotional health related information to be a significant reflection of Jackson’s growing trust and openness:

I wouldn't say him sharing his mood and the fact that he had gone on medication was something that we had to redirect to get back on track in a negative aspect. It's more like wow; he was able to share that with me.

Marie consistently felt optimistic in her ability to ameliorate Jackson's functioning. That being said, however, she also recognized the limitations of her role:

I guess I always feel like we could...sometimes we could work on something harder. I think that's partially the way I am – wanting to work and achieve certain goals that we've established that we've let go or that we've changed. Sometimes I feel there's so much more that could be done but I'm also limited in the amount of time and I'm not helping him by helping him. I'm creating a sort of dependence on us when I want to do the contrary and get him independent.

This sentiment was also expressed by Marie's students in that they recognized that there was much more to be achieved with Jackson than what was being accomplished. Marie explained that this involves an optimal teaching point for her students as to the defined scope of practice and role with a client:

So we had this discussion with my students a few times because they were like, "Well he can do so much more." [I explained], "He could but it's not necessarily up to us to now provide him with that. There are other resources in the community that he can use and utilize to help him attain his own personal goals." And draw the line of what are our therapy goals and what are his personal goals...It was all in a binder.... All the resources that we spoke to him about, either community resources or just even equipment that we spoke about, list of vendors, everything basically was

all placed in a binder [which was prepared] by the student and presented to him the last visit.

Defining Moments

Marie identified three defining moments in the relationship. Jackson had been initially reticent to complete the task of maintaining a tracking of his activities throughout the week. The purpose of this was to encourage his planning and follow through upon meaningful activity engagement that had been lacking. Marie identified the first time he completed the weekly tracking to be a turning point. This occurred around session five of the nine-session block. A second defining moment was when Jackson indicated that he was open to undergoing cognitive and emotional health testing:

When we first kind of explored that it was like, “Oh no, my memory – no, I don’t want it assessed.” Then when he said, “Yeah, okay I’ll do a cognitive test.” For me it’s like okay, he trusted us to help him if there is something to be done. Also discussing his mood and completing the [Geriatric Depression Scale] with my student as well.

Lastly, Marie identified the last visit as being pivotal. Jackson’s mood had improved and he had been able to integrate their efforts and education to independently take public transportation to an appointment:

...the last visit. His mood was better; he had taken the coupon program with Para Transpo to go to his assessment at the Parkinson’s Society – all things that we had been discussing since the beginning. We had discussed it, he had heard about it, we gave him the information on session two or session three but he had never taken it.

That was the first time he took that service. He had purchased the coupons to take the taxi and took it...

Challenges

There were several challenges to the relationship that were also identified by Marie. These challenges included Jackson's wife, who when present approximately a third of the time, "talked a lot. She would take over sometimes and you could tell he would just sit. I think he was actually more open with us when his wife wasn't there. Maybe he felt more free to talk about what he wanted to." Jackson's mood was also a factor in that Marie indicated that it digressed during this period prior to improving once Jackson discussed it with his physician (at Marie's prompting) and commencing medication:

He became more distant, less motivated, just more flat. Less engaged or happy about certain goals that he had achieved. We spoke about the mood if he got on medication as well. More discussion about mood came about and he started going up. Like the last visit we had last week, it was dramatic at how he felt.

Although Jackson's impaired cognition was not perceived by Marie to impact the relationship, she did indicate that it impacted the intervention:

Not the relationship, more the interventions. Like if we tried to do certain interventions that related to memory based on the objective, he was like, "Yeah, I'd like to remember this amount" and when we did it, he just got frustrated and I think that's partially why he decided to...[drop that goal]

Lastly, a challenge was also posed by Jackson's sense of humour. Jackson's humour, which was primarily of a sexual nature, made for some discomfort and the requirement for Marie to set some clear boundaries:

There were some boundaries sometimes that needed to be established. I think his humour sometimes is a little bit risqué so I would turn it back on to him and say, “Okay, well we’re not here to discuss that or do that, my presence is not here for that” or “Okay, Jackson, let’s get back on track.” But I think that’s part of his personality so I didn’t play into it too much and he was easily redirected.

As a result of her experience and maturity, Marie did not feel “offended” by his attempts at humour but she did wonder if her students may have been offended. She used this as a teaching opportunity with her students in how to deal with these types of situations:

Well, the first time that he did his poor choice of humour, I was taken aback. “Okay, this isn’t going to fly” and the constant redirection when he would do this...[The students] might have [been offended] because they discussed it. It wasn’t not discussed with my students. They were like he has kind of a weird sense of humour and I would actually warn them – well, I warned the second one, “He has kind of a poor choice of humour so if it offends you, say that’s offensive. If you see that in what you’re doing, you can just say it’s not appropriate or okay let’s move on to our next task. Do what you feel is appropriate for you and for your forming of the relationship.”

Marie recognized Jackson’s cleaving for more of a relationship in that he sought personal information from Marie. Marie recognized the potential boundary violations this could create and made purposeful decisions regarding the amount and nature of the information to be shared in an effort to encourage the goals of the intervention with Jackson:

Not sharing too much of my personal life because I know if that door would be open, I mean it could create a mountain of questions or just if that door is open they would

come running in. I mean still sharing some of who I am and what I do. For example, we were walking saying what are you doing this weekend? I'm not going to completely hide the fact that I was taking part in a race just to show him I had a goal and I did this and he asked me about it later so there were certain boundaries that remained in place.

Social Interaction

Marie recognized the power inherent in the social interaction for Jackson. Jackson had become socially isolated and appeared to be desirous of their personal interaction. Marie opined that this weekly contact was important for Jackson from a social interaction perspective, but she ensured a focus was placed upon the therapeutic goal-oriented perspective:

I think for him it was the weekly visit, the companionship. Sometimes he might have forgotten the fine line between what was therapeutic and what was just a friendly visit. So we would discuss that, "These are the goals, is this still something you want to work at or what is the next week's goal? What are you going to work towards?"

Marie was unable to appreciate any significant impact on the therapeutic relationship with Jackson caused by the student learning experience. Rather, Marie opined that there was the benefit to Jackson of two therapeutic relationships, one with the student and one with Marie:

He made an effort to engage with the student, wouldn't look at me if she would ask a question, he would respond to her. But he would still sometimes ask for my opinion, however, if I wasn't there I don't think the relationship wouldn't have been the same – like it would have been the same between the student and Jackson.

Relationship Comparison

When asked to compare and contrast the therapeutic relationship with Lise and Jackson, Marie offered several reflections. In both circumstances, Marie identified individuals who had become isolated as a result of their limited repertoire of functional activities. As a result, they both found companionship in the weekly occupational therapy visits that occurred in their homes. In both circumstances, Marie queried if the social isolation led to the clients thinking of Marie as more than just a professional relationship, “sometimes I thought they liked me too much.” That being said, Marie questioned if even just this social contact with someone helped them gain momentum. Both individuals “were having problems even just giving themselves responsibility for their own rehab.” Neither had received occupational therapy prior to Marie’s intervention. In both situations, Marie pointed to the client-centred nature of occupational therapy intervention to have been key toward the overall successful of the intervention:

[Both clients] hadn’t really had OT either so maybe the fact that we originally based it on activities they appreciated and just did active listening worked for them as opposed to some other type of intervention that didn’t.

Summary

A characteristic feature of this relationship was the nature of the clinical-education role that Marie played with two occupational therapy students who were the primary source of service delivery to Jackson. Marie, however, noted that Jackson, a retired school teacher accustomed to working with student teachers, embraced the students’ role as well as Marie’s role as the experienced therapist present primarily to supervise the students. Marie was, however, the constant as the students changed part way through this block of therapy.

The goals and activities were client-centered in that they were based upon Jackson's expressed concerns and interests that were primarily of a physical nature. Eventually, Jackson expressed concern related to his memory, however, he also later expressed a desire to discontinue working on this goal. As therapy progressed, Jackson shared more openly concerns about his mood for which he then sought assistance from his physician as per Marie's prompting.

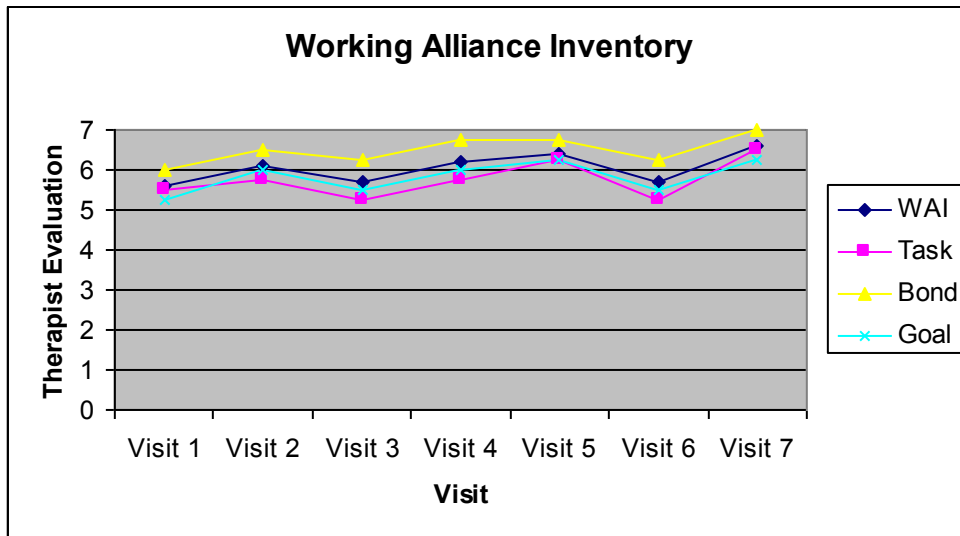
Significant achievements were realized as it related to Jackson's outlined goals. A reflection of the summative achievement occurred during the last session of therapy when Jackson had integrated many of the gains and learning achieved through occupational therapy toward his independent community mobility using Para Transpo to attend an assessment. Marie points to the client-centred aspect of the intervention as having been pivotal to Jackson's success. This success was further enhanced by the trust that built over time allowing Jackson to eventually share concerns related to his mood and then seek appropriate related treatment.

Jackson demonstrated a sense of humour that caused Marie to take pause and ensure the reinforcement of therapeutic boundaries to ensure no ensuing violations. This was further reinforced with Jackson's desire for more personal information about the therapists. Marie made purposeful decisions regarding what personal information to share with Jackson to ensure that it reinforced the goals of the intervention.

Appendix Y-A: Marie Dyad #3

Working Alliance Inventory Results

In this study, the Working Alliance Inventory (WAI) was used to assess Marie's perspective of the evolution of the alliance over time.



As may be reviewed in the above diagram, although there were some fluctuations in the assessment of the working alliance over the course of the intervention, it was consistently a moderately strong assessment from the beginning through the end of the intervention. As described by Marie, the time spent with Jackson was pleasant and positive, and appeared to be important to Jackson from a social companionship perspective. He was not, however, always invested in the proposed activities of the therapy sessions that may be representative of the lowest evaluation consistently provided to the task subdomain.

Appendix Z: Kotter, Dyad #4

Background

Kotter was socializing with friends on September 20, 2009. He was operating his friend's All Terrain Vehicle when it flipped and landed on him. Kotter described his injuries as, "broke my ribs, cracked my jaw, and damaged my back and I was passed out and there was blood coming out my ears. Pretty serious." Kotter was hospitalized and maintained in a medication-induced coma for a month. It has been explained to Kotter that during this time physicians expressed concern to Kotter's wife for his very survival, "Okay, next week on Friday we're gonna decide whether we unplug him...So basically saying, "He's not doing well. He might die." After three months of acute care hospitalization, Kotter was transferred to a rehabilitation centre for another three months. He returned home six months following the accident. His driver's license was suspended due to the severity of his brain injury. Kotter has not yet returned to work.

Kotter

At the time of study participation, Kotter was 39 year of age. He is Caucasian, bilingual (French and English), and male. He lives with his wife and young school-aged daughter in a small residential development outside of a rural Eastern Ontario town. His wife has remained at home full time with their daughter since their daughter's birth. Prior to his accident, Kotter was the sole income provider for the household and prided himself on his strong work ethic, "I was always in Ottawa before. I was a workaholic." Kotter worked as a sales coordinator for a weekly newspaper publication. The pre-accident family income was defined as less than average according to the median family income for the metropolitan Ottawa area.

Treatment

Upon discharge home from an inpatient facility, Kotter initially received a short course of physiotherapy although he was soon discharged due to his lack of physical complaints and impairments. For approximately four to six months post discharge, he attended group counselling with similarly traumatically brain-injured (TBI) patients. Although he valued the shared experience with others, the cost was determined to be in excess of the subjectively-assessed benefits and Kotter decided to discontinue his attendance at the time of renewal. Kotter continues to be followed by both his occupational therapist (decreased from three times per week to twice per week) and speech language pathologist (decreased from twice per week to once per week). Psychology is involved with Kotter's wife, however, it was not deemed necessary with Kotter on an ongoing basis. Kotter is, however, contemplating seeking psychological counselling for a recently arisen concern. Medical/specialty follow-up occurs sporadically and includes physiatry (brain injury reassessment), orthodontist (to reinsert an appliance removed at the time of his injury), plastic surgery (revision of accident-related scarring including a tracheotomy scar), and optometry (to assess vision changes and appropriate prescription/replacement of glasses).

Kotter's Goals

Kotter's long term goal was consistent throughout the duration of the study, "[I would like to] return to the routine that I used to have. It was family, work, driving. I was mobile. I didn't have to rely on other people to get me around," "I want to get back to normal," "My goal is to have things the way they were." "I so much want normal life again. I

pretty much have the rest (of what is required to have a normal life). I mean I have my family and my home and various different things.”

Kotter broke down the steps toward this long range goal, “Getting my license. Getting another vehicle. Easing back into work. I just want to basically do it [ease back into work] properly. I don’t want to try to return and then get fired.” He explained that these long term goals would be achieved through “just basically more OT and speech work.” He reflected that Helene and he “haven’t discussed our goals or my goals... Well we don’t discuss what we’re going to work on. Maybe like quick talking. Just so you understand, this is not like a disagreement. We just don’t discuss it.”

Kotter’s short term goals were task-oriented with an overall focus on remaining productive, “I’m making the best of it. I’m filling my days with exercises and stuff around the house, and I made a list of things I want to do and I want to build a shed so I’ll make the best of it. At least if I don’t work I’ll do stuff around here. As long as I remain productive,” “Well I’m working, like I said, landscape and various different things and exercises. So at least I’m trying to make the best of it. Even though I don’t work, I can stay occupied. I don’t want to waste my time watching TV. And I’ll be productive in different ways.”

Achievements

Rather than assess his progress through the achievement of rehabilitation-specific short term goals, Kotter’s sense of progress was related to the completion of numerous projects and tasks around his home. These included building a backyard shed, landscaping (building a rock border, cement walkway, and concrete pad beside pool), installing a waterline in garage, organizing and advertising a community garage sale, selling his car (which included detailing the car, advertising and negotiating), as well as performing

ongoing home maintenance such as weekly grass cutting and whipper snipping, seasonal tasks such as cleaning windows, and less frequent tasks such as finding and uncovering his septic tank lid to have the septic tank emptied (which he coordinated with several neighbours in order to decrease the cost per household) that he then modified to facilitate its access in the future.

In the final interview (approximately one year and three months post accident), when asked to reflect upon his achievements to date, Kotter expressed positive, albeit slow, progress toward his goal:

It's coming along. It's just like slow process but it's improving. I'm getting frustrated with my spelling. I send lots of emails. And I always feel like I have to double check my spelling. It's getting better. At first when I was at the [large urban hospital] people were complaining they couldn't understand me because I was talking French. I must have been really messed up. And then I was getting my words mixed up from French to English and that's no problem now. Just the spelling, I got to double check because I'm always using the dictionary, but it's improving.

I seem to be doing things. In the right direction for my license, getting my license test. So that's good. I had a meeting with Dr. M [physiatrist] and then I had to pay the five hundred bucks, but at least I'm on the waiting list. I'm hoping soon but at least I'm on the waiting list. I don't know, I'll just live with whatever.

Environmental Influences

In addition to his professional team, Kotter has a substantial support network that, to some extent, existed prior to the accident, but to a larger extent has developed since the accident.

Kotter's wife has been a primary support throughout Kotter's recovery. She is involved, in the periphery and as necessary, with his therapists and drives him when she is available and no other plans have been made. Kotter's accident has been difficult for her. She attends counselling to address her own associated emotional health concerns. Not only was it emotionally stressful from the perspective of almost losing Kotter to his accident-related injuries in the early going, it has resulted in substantial changes to their routines. Kotter was the sole income earner. Although Kotter noted feeling fortunate to have the insurance cover many of his costs as well as an income replacement, on several occasions he noted that the family has more limited resources now with him not working. His wife cared for the household finances prior to the accident and she remains in the role. Kotter therefore discusses large expenditures with her (e.g., the costs of building the shed). She is also in the position of supervising Kotter and ensuring that he abides by the medical restrictions imposed by the rehabilitation team:

But I don't know who told [my wife] that [I am not allowed to ride a bike]...so, so I talked to Helene about that.

One of my friends was going to [a nearby town] to go skating with his daughter and he invited us and my daughter. And my wife doesn't have skates and I told my wife I could bring my skates and she said, "No, no they don't want you to do anything!"

It's like put me in a bubble then!

She also prefers to be present for appointments when important decisions concerning Kotter's care are being made. This does not, however, always work with Kotter:

I have wrote up all this stuff with [my speech language pathologist] because I thought maybe I'd go by myself because my wife was probably not available. The original date was supposed to be December 1st but they called and said they're going on holiday. So they said how about December, no it was December 3rd was the original date and they said how about December 1st? And she's like, "Oh that didn't work for my wife. So she said well how about December 8th? She goes yeah that works for me. So then I called them back because I wanted to do it sooner and they said oh someone beat you to it. They took that time on December 1st, but I wasn't sure whether I was going to get in so with [my speech language pathologist] I did like questions, like a checklist. That way I can reassure my wife because she wasn't going to be there. I can note them down like any risk? I need this, I need that. And then I went over that same list with Helene, so...But anyways I'm still going to bring the list even though my wife's going to be there.

Kotter also has a close relationship with his young daughter, "My daughter is good company. She's giving me a smile to my face," "She's always sweet." When at the rehabilitation centre, Kotter was often visited by his mother (who lives in Ottawa), however, since returning home, her visits are less frequent. Kotter also has a brother who lives in the United States who visited a few times while Kotter was in hospital. These individuals provided additional support to Kotter and were often cited by Kotter when discussing those individuals supporting his rehabilitation process.

Kotter has maintained ongoing contact with his employer. When in Ottawa for various appointments, Kotter would stop by to see his co-workers. He also maintains email

contact. The warm interactions appear to be reciprocal in that Kotter has been assured of his position by his employer:

My boss he's anxious to have me back and he wants to keep in touch with me. He said, "Don't you worry. When you get back and when you get your license, you'll have your job back." So we'll just keep in touch and we'll go fishing together.

Kotter has also attended a few events on behalf of his employer since his injury. On one occasion, his presence was specifically requested by a customer that served as positive reinforcement for Kotter. Even during the final interview, 15 months post injury, Kotter indicated that his name continues to be listed as the sales coordinator in the publication. This allows for a sense of continuity and comfort, however, although Kotter was initially very confident in his ability to return to work once he had his driver's license reinstated, by the end of his participation in this study, he was expressing some concern:

They still have my name printed every week in the papers. The sales coordinator, but I just wonder if I'll be able to do it. Maybe I'll get the job back and then they'll have to fire me because I'm not efficient.

Kotter's neighbours have provided additional supports during Kotter's recovery.

Neighbours provided transportation assistance, cared for his daughter when he and his wife attended appointments, attended to tasks that Kotter was medically restricted from performing (climbing ladders, cutting the grass on the sloped ditch area), and assisting him with the projects that he undertook (e.g., building the backyard shed). From these interactions, several friendships developed. One neighbour encouraged Kotter to attend coffee with him and his group of friends every Tuesday morning. Not only does Kotter

enjoy the opportunity to socialize, however, it realized a solution to his transportation to his volunteer role in town each Tuesday morning.

Kotter and his wife recently hired a lawyer to commence a tort action against the owner of the All Terrain Vehicle upon which Kotter was riding at the time of the accident. Initially, Kotter was uncertain of the impact that the lawyer would have, primarily upon the relationships he holds with his neighbours in the small rural community:

I'm just thinking we might offend them, like going after them, but I don't know. I guess it can't hurt...the lawyer, might cause issues. Might put off the part of the neighbourhood from friends and stuff like that. [That particular neighbour] is not that close...it might put some issues for other friends. Our neighbour, right across the street and he helps me out a lot, he might have to jump in as a witness because he was the only witness. So...I don't know. So he could be...like he might be torn, "Do I go on this side, or his side?" So which way does he go?

By the final interview, however, these concerns appear to have dissipated:

It could be positive. It can't be negative because they're not going to be any cost to us. The only way they're going to get paid is if they win they'll take a percentage of it. So I was like what's the risk? It's risk free. The only thing is it might set off the people who are neighbours that we're going after their insurance. But the only thing is they were never our best friends...He wasn't very responsible...He didn't seem like a good father and he drank a lot...I think that's most important too is I can see him like on the weekend he goes from one house to another to drink beer. I think that's his priority. He might be mad because even though it's not out of his pocket his rates for insurance might go up. Because we're going after their insurance. And I

heard his insurance is mad because he didn't tell them. I don't know how much damage was to the ATV but he's a mechanic and he fixed it himself.

Initially, Kotter found it difficult spending social time with his friends and neighbours participating in the same activities he did prior to the accident:

Socializing with friends. We used to play poker every weekend but I did it once since I've been back and they offered again, but I'm saying well maybe I'll pass because they were all drinking. It's like no point.

For the first year following the accident, Kotter was not permitted to drink alcohol. In fact, he appreciated the improved health consequences of not drinking and made a decision not to return to drinking beer as a result. This did, however, place Kotter in a position of needing to learn how to socialize without drinking and smoking as per his pre-accident routine. Over time, Kotter became more comfortable with this change and began to enjoy the evening socialization again:

Friday I went to poker with the neighbours. I found it more interesting than last time. The previous time, I didn't enjoy it because perhaps I found that they're always playing the same game and I was the only one that wasn't smoking and drinking. I felt that I was out of place...Maybe I'm just living with it.

As previously noted, Kotter lives in a rural development outside of a small town. He cherishes his current home, "It's nice to have a nice little yard for...sanity because I'm staying here all the time...I mean I'd rather here than our old house...Little lots. Postage lot." Kotter admitted that his rural location resulted in transportation issues that would be more easily remedied in an urban environment, however, he considered that the benefits of his current rural environment outweighed the drawbacks.

Self-Talk: Remaining Positive, Being Patient

In addition to Kotter's desire to be productive with his time, another central premise to the interactions with Kotter was what appeared to be self-talk to remain positive and be patient.

Remain Positive. Although Kotter may discuss a situation of frustration or concern, he consistently left such a topic with a positive sentiment. Several examples occurred, a sampling of which are presented below:

I just wish I could turn back time and not go on that bloody ATV. That messed up my life, but at least it's going in the right direction to get back.

[Unexpectedly, a November furnace inspection found a fault in Kotter's existing furnace. It was shut down until it could be replaced.] It all worked out and the good news is well good news is well the bad news is I didn't know we needed a new furnace. The bad news is we're out of money. But the good news is it could have been worse. We could have had carbon monoxide poisoning and died. So that's the good news. We didn't get a health issue. And now we have warranty, labour and parts for ten years.

Be Patient. As explained above, Kotter had a need to feel productive and see progress. He often marked his progress in the completion of projects (or stages of large projects) during the study period. This desire for progress and forward movement resulted in him having to be patient in areas that were outside of his control. Repeatedly, Kotter expressed his need to be patient. This appeared to be a self-talk mechanism to encourage himself to be patient:

I've got to rely on people to get me where I want to go so I've got to be patient...And he was about 20 minutes late picking [me up]. I stood in front of the group, we were just waiting. I guess there's a lot of residents there and they were all eating their lunch and it's like well I've got nothing else to do, but I'm thinking I can't wait until I get my license back because I wouldn't have to wait for 20 minutes for nothing.

I don't do any sports...They don't allow me...They don't recommend me taking a bike. So I can't fix my problem for transportation. Even though I feel I could, but whatever I'll just be patient.

Well if I get my license back, to return to normal with working and driving and...Well I want to like get back to normal. But I'd like my old life back. But whatever, I'll live with it...because I'm just trying to be patient

Kotter's Reflections on Helene and their Therapeutic Relationship

As reflected in the results of the Working Alliance Inventory represented graphically in the Appendix Z-A, Kotter has had a consistently strong and optimized opinion of the therapeutic relationship with Helene, "I'm not saying she's perfect, but to me she is because I have no issues."

Kotter described Helene only in positive terms: very easygoing, very pleasant, very well organized, knows her stuff, always on time, she never misses an appointment ("or she calls to advise when not able to attend or will be late"), very friendly, has a sense of humour and she's professional at the same time, very kind, flexible, responsible, "willing to trust me," "she steps in where needed," "she's getting it done," and is responsive to his needs.

Kotter described a high degree of trust in Helene. On a scale of 0 to 10 representing a range between no trust and absolute trust, after a short time Kotter consistently ranked his trust in Helene as 10, “because she’s never let me down in the past...she seems to do her profession, she knows what she’s doing.” In addition to her competence leading to enhanced trust, Kotter also attributed the fact that he sensed that Helene trusted him as a factor in his high trust of her: “I think she must [trust me] because one time...she left her keys in the vehicle...obviously she trusts me enough for that. She’s never let me down and she always goes beyond what I expect. So that’s probably why I trust her.” Kotter noted that the trust in Helene grew over time:

I remember meeting her at the rehabilitation centre...I met her a couple of times in a meeting and I didn’t know how it was going to go with that person. I didn’t know what her duties are, were... just the warm about what she’s doing like not treating me like an idiot. Do what she needs to do but in a pleasant way. And I don’t know like she seems to be doing everything the right way.

Mutual respect, which he had not always encountered with his treating professionals, was a repeatedly expressed factor by Kotter when describing positive relationships, either with Helene or others:

Everyone seems fine...They’re always punctual and I think it happened twice for both of them, [speech language pathologist] and Helene, being sick and they both called prior to the meeting.

If she’s ever late...she always gives me a call to say, “Heads up I’m running into extreme traffic. I’m going to be a little late.”

Kotter appreciated Helene's personalized approach that he perceived to enhance his sense of confidence in Helene. She shared personal components of her own life and experience with Kotter in a manner that he perceived to be warm and sensitive, but remained professional:

Little things. I mean, when you can tell me a bit about...she knows all about my life. She can throw in the odd thing of herself, that she's colour blind. Most people would probably keep that a secret. Obviously she shares a little bit. She can return. What I know she knows of me, she's giving something back...That way...she's treating me like a person. So, it makes it more pleasant. So if I trust her she trusts me back. She trusts that I'm not gonna make fun of her.

It wasn't just, it was business but she did it in a pleasant way. She shared things, personal things. When I was looking for options for the shed, buying it from a shed builder or building myself, she gave her thoughts what she used herself. She said she went with the same place I got an estimate for a shed, but it was big bucks. So I ended up doing it myself but it was nice that she shares that. If you were just strictly business you won't go confident, you'll be totally confidential. You won't go into your personal life.

Helene's responsiveness was also a factor in the strong relationship. When Kotter raised a concern regarding the content of reports (e.g., either an error or his perspective), Helene attentively listened and responded to Kotter's satisfaction. She also responded when Kotter indicated that he no longer wanted to work with the OT Aide:

When I told her I had the issues...she took my side and she made it happen. So I'm pleased...I told her I said please be confidential, don't tell him and I told her all the things that bugged me about him. And it was a big list. And she was pleasant about it. She said okay you don't need him. Let's go your way.

In addition to being Kotter's occupational therapist, Helene also served as Kotter's case manager. This dual role appears to have further enhanced the relationship. Kotter clearly indicated appreciation for Helene assuming the case manager role, "I guess I don't have a case manager. She's basically it. She's like stepping in. She's stepping in where needed." As a result of these two roles, Helene's undertakings with Kotter were more varied and expansive. For Kotter, this meant that he passed all issues through Helene (and not necessarily his other treating professionals). In these dual roles, it is most often Helene whose role it is to address the arisen issue. This led to a deep trust between Kotter and Helene as a result of this extensive sharing. The two interconnected roles also resulted in a greater variety of activities being performed together. Kotter clearly indicated that Helene directed the activities, however, Kotter was highly compliant, "She doesn't *ask* me if I want to do this. I just go with the flow. I mean she recommends it. I'll accept it." From his provided description, however, evidently Helene chose activities that addressed Kotter's presenting concerns at the time (e.g., attending the Ministry of Transportation together to address license renewal, parenting issues, etc.). When there were no specific presenting issues, however, Helene most often arrived with selected therapeutic activities in which Kotter compliantly participated:

What do we do? What we're going to do next we're going to do like a parenting stuff for my daughter and...What did we do last? It was just like a game exercise, like

pretending I was at work...Like a bunch of messages on something like this [recorder]. And I had to take notes down or I had to fill out my agenda like for times and I had like we were playing on the one week. Monday, Tuesday, Wednesday, Thursday, Friday and then all the different times and I had to be organized and not miss an appointment and this and that. So it was interesting.

In comparison to his speech language pathologist (the only other therapist who was involved with Kotter on as long term basis as Helene), Kotter appreciated the diversity of functional activities which were performed with Helene:

I guess it's interesting because she moves around to different exercise or various, or shopping or this or that. Like one time...she thought I should get like a new cell phone. And then we went shopping and/or we'd go shopping for exercise equipment, or we do simple exercises. There's always something different. That's probably why she can do the case manager, because she can move around and do different things compared to like nothing wrong with [the speech language pathologist], but she simply does the speech stuff. So Helene seems like an ideal person for the case manager.

As a result of Helene's two roles with Kotter and the variety of activities in which she engaged, it was difficult for Kotter to precisely define her responsibilities. He was, however, highly appreciative of all that she did and noted times when he considered that she extended beyond her specific professional role:

I don't know what Helene's responsibility is but she's taking the time to...at first she was driving me around for shopping for stuff for exercises and like she's talking to Dr. M for my license. So she's taking the extra time. I don't know if that's her

responsibility but that's nice...I think she's going beyond her call, but maybe that's her call. I don't know.

I enjoy our sessions and she tries to help the best way and she wants me to not go through this again. She's solving all the problems, possible problems for boots, non-slip and this and that, agendas and she went to trying to help out with solving problems for buying gifts. And that way I'm not always with my wife. It's hard to buy like a surprise gift...And she offered to help with buying two more things on my list in Ottawa. She's going to get them herself. I said okay get a receipt, I'll pay you cash. So that way there's no cheques and my wife's going to see them on the computer.

Kotter not only trusted Helene, but this trust was fuelled by the confidence that he had in her as a professional. At the group counselling for TBI patients, Kotter met other patients who had Helene as their occupational therapist, "I bumped into a few people at [the TBI-Centre] that also have her as an OT." He also took comfort in the fact that the professionals he was working with at the rehabilitation centre knew her, "Well I know she knew the OT at the rehab. So I guess she goes, moves around. She's obviously not new...So she knows her stuff." He also attributed his confidence to her ability to "make things happen":

Well I probably don't know everything that she's doing but I know she's organized with insurance and she made everything happen for the exercise equipment that I got. So it was covered through them. And she found the cheapest route for taxi drives through...one of our neighbours recommended, whose in this community, and she's making everything work out.

Although Kotter's compliant and genial nature facilitates relationships with others, there were professionals with whom he had interacted during his rehabilitation process with whom he experienced some reservations:

There was one 'teacher' at the rehabilitation centre I wasn't impressed with her... Her sense of humour wasn't up there. And sometimes she missed meetings. She did it twice. And if you're sick why not call someone and just inform your appointments that you're sick? Instead of having them go to your work, your office, and waiting for an hour, twice she did that. She wasn't very social. And she did not have a sense of humour and two meetings missed, it kept going in the wrong direction... I understand things happen. You can be sick or issues happen but why not take the time to inform people?

In addition, there was a psychologist and physician with whom Kotter did not feel as close as he did with his other professionals:

Same thing with [the physiatrist]. I guess he's not... he's probably like [the psychologist]. Probably busy people, they don't have time for that. Well, if you're not social, you're not pleasant. You're very dry, short, and right to the point. It's not very entertaining.

Summary

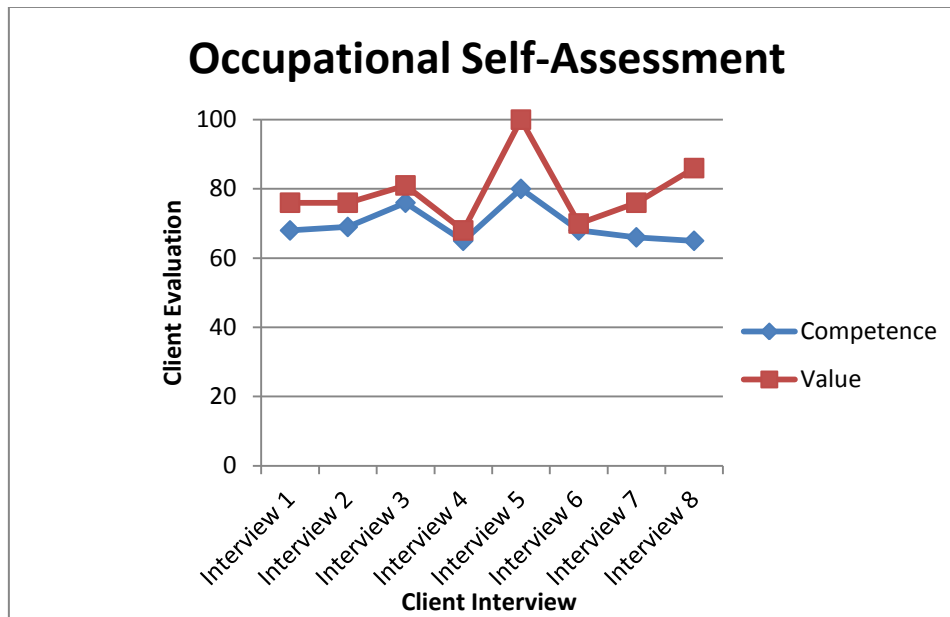
Kotter's nine-month participation in this study was concluded approximately 15 months following a serious brain injury. Although he has made many gains to date, he continues to work with his team of professionals to realize his ultimate goal of reclaiming his normal life in its totality. Helene has been instrumental in Kotter's progress and rehabilitation since returning home six months post accident. The relationship, currently

approximately one year old, which has been forged between Kotter and Helene, is punctuated by a high degree of trust and confidence that Kotter has in Helene's abilities and his deep appreciation for her pleasant, personal, and contentious approach to address those issues that are most important to him. Kotter continues to look to the future with optimism and the hope that he will, with Helene's continued guidance both as his occupational therapist and case manager, achieve a resumption of those remaining roles and responsibilities that he held prior to the accident but he has not yet to reclaim (e.g., driver's license to allow community independence, employment, provider to his family).

Appendix Z-A: Kotter Dyad #4

Occupational Self Assessment Results

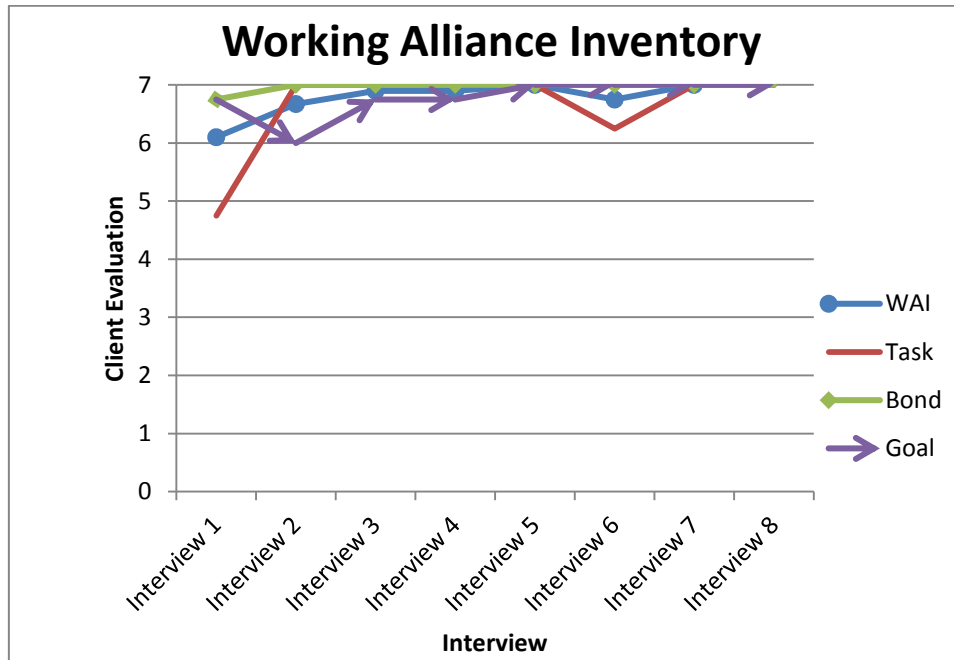
The Occupational Self Assessment (OSA) was used in this study as a measure of Kotter's perceived functional abilities during the course of therapy.



The value that Kotter placed upon the various functions and roles described in this instrument was consistently higher than his perceived competence. In the first couple of months following his return home from inpatient centres, there was a general pattern of increasing competence. In the last three months, however, there was a slow decline. It is questioned whether Kotter's growing repertoire of experience post-injury and testing of his abilities in a variety of activities and environments challenged his confidence and led to greater insight into his abilities and limitations.

Working Alliance Inventory Results

In this study, the Working Alliance Inventory was used to assess Kotter's perspective of the evolution of the alliance over time.



The initial assessments of the overall relationship and the various constituent constructs were high from the beginning of the study. Kotter had just begun working with Helene on an ongoing basis upon his discharge from the rehabilitation centre, but had been periodically acquainted with her throughout the discharge process. There was already, therefore a state of comfortable familiarity at the time of the initial assessment using the WAI. This continuity of care/acquaintance during the transition from the rehabilitation centre to home may have served to further enhance the client's trust in Helene at this early stage. During the final interview, Kotter described Helene as follows, "I'm not saying like she's perfect, but to me she is because I have no issues." This sentiment is reflected in the consistently strong WAI results, particularly the Bond subscale, which grew stronger and optimized over the months of working with Helene. The Task and Goal subscales demonstrated some degree of

fluctuation that may be explained by Kotter's periodic lack of clarity concerning the objective of therapeutic activities in comparison to his overarching goal of returning to his normal life.

Appendix AA: Helene, Dyad #4

Background

A review of Helene's background is provided in Appendix W.

Role with Kotter

Helene began working with Kotter while he was still an inpatient in a rehabilitation centre. As his community-based occupational therapist and case manager, Helene's role was to facilitate his discharge home and establish the community-based team that would follow Kotter upon his discharge home. Kotter was discharged home in March 2010. Helene has since been working with Kotter several times per week within his home and community. Helene's particular focus upon brain injury rehabilitation was pivotal in her role with Kotter who suffered a serious frontal lobe injury. Consistent with this type of injury, Kotter has limited insight and awareness into the resultant cognitive limitations as well as cognitive-communication issues that result in a need for his treatment providers to be "blunt and straightforward." Helene explained that the focus of therapy was the development of Kotter's insight. Importantly, at the time of study completion, Helene had been working with Kotter for approaching one year. Although their participation in the study was concluded, the therapy with Kotter was ongoing and was expected to continue for the foreseeable future.

Helene explained that in keeping with her natural modes as a therapist, the dominant modes used with Kotter were problem solving as well as instructing. Although these modes may be the most natural for Helene, she also explained that their use was rationally selected based upon Kotter's specific needs:

Problem solving, just my typical approach with brain injuries, so lots of various situations, very poor insight on his end so attempting to look at a problem very systematically with the pros and the cons and breaking down the problem just to get him to do a little bit more problem solving himself and be a little more flexible in the way he's seeing a situation. So I think it's a very structured model that kind of works with his kind of practical organized nature. So it's been sort of a natural style...Problem solving has been so important because of the lack of insight.

Instructing would be maybe not as strong certainly as problem solving but I think there's been lots of education with Kotter. In my mind he's very concrete so if the problem solving model is just a little bit too challenging for him on certain issues, I will use more of an instructing mode. Let's move on to this and these are the reasons why we would do this. I see that more as instructing.

Helene explained that advocating and empathizing were not extensively used with Kotter due to his personality, abilities, and presentation:

I don't use advocating very much. He's quite a good self-advocate and I don't use empathizing very much...He's not a needy kind of guy who needs a lot of empathizing. I think I will encourage because he is quite proactive but he doesn't need a whole lot of touchy, feely, empathy kind of approach. He's a much more practical, move ahead kind of guy.

Helene described her dual role with Kotter, as both his occupational therapist and case manager, as highly complementary, "The roles for me have blended well because I've used a ton of the case management functions that a case manager would do and I have him

do it.” The responsibilities and tasks associated with the case management functions have thus served as fodder for therapeutic activity for Kotter’s cognitive rehabilitation. Helene reflected on both the efficiency inherent in this approach as well as the empowerment permitted to the client who becomes practiced and confident with the self-sufficient navigation of his new rehabilitation milieu:

That’s partly part of the model of this particular adjuster who does that, who uses OT a lot for case management from filling out CPP forms to booking transportation to following up on medical appointments; seldom am I doing that outside of my time with him. So I will say, “What needs to be planned around this appointment?” I will let him figure it out and I will let him do the communication, e-mail, phone, so I just use it as a cognitive activity so he’s probably doing seventy-five percent of his case management within the context of our sessions.

Goals of Intervention

From Helene’s perspective, the overarching goal with Kotter was to enhance his insight and provide cognitive retraining:

To improve his ability to attend, to multitask. Early on the goals were very basic attention, using organizational memory aids...that’s kind of a strong area for Kotter but there’s definitely been a fair bit of developing problem solving abilities and attempting to see how others might see someone, a perspective on something a little bit more differently. It’s been very much gradually increasing activity demands in his day so taking on more tasks around the house that require more divided attention, more problem solving.

Considered at an occupational performance level, occupational therapy efforts were focused upon “reintegrating him into as many of his life roles” as possible. Initially the goal was to facilitate Kotter’s ability to remain at home alone safely by demonstrating his independent management of instrumental activities of daily living (IADLs). These goals were achieved. Another focus of occupational therapy was to facilitate Kotter’s role as a parent (e.g., simple play activities early on progressing to looking at accommodating his daughter’s schedule and requirements (e.g., homework) into his own schedule/routine). Recently, the focus has begun to turn to Kotter’s work capacity:

I mean the big goal is to see can he re-enter into the work place and be gainfully employed. So I don’t think we have enough data and, given that we’re just at the one year post injury, there’s still room to get a better sense for whether he can integrate into that role.

Helene considered that the goals for therapy were determined “pretty unilaterally.” Due to Kotter’s limited insight, he is unable to appreciate the scope of his limitations and their implications. As a result, Helene has considered Kotter’s pre-accident activities, roles, and values in the development of the therapy goals to which she considers that Kotter has agreed:

Yes, I think we did agree on the goals. Did Kotter understand the cognitive goals? I still think because of his difficulty with reasoning and processing that...he understands and agrees, yes I think that is clear. He understands that one of the goals of volunteering right now, for example, is for us to be able to observe work behaviours and for him to be out there to practice communication. So at a basic level, he’s got a better understanding than two months ago as to why we want him to

volunteer. Does he have a thorough understanding of that goal? I'm not sure the brain has the capacity to have that thorough understanding.

As a result, Helene explained that she makes efforts to explain the rationale behind the outlined goals and activities; however, Kotter's ability to understand and describe this in return is limited:

I think he has understood the goals but he's not always been able to articulate and explain them and that could be the cognitive communication piece too but I think it's also insight into...I mean for him it's quite...it's got to be very practical.

Helene and the speech language pathologist are working collaboratively with Kotter to encourage him to become a more active agent in the decisions and direction of his rehabilitation, although his cognitive compromise poses challenges:

The groups he attended at [the TBI Centre] was really...it took many, many sessions with speech and myself to get him to get to the point of determining with the problem solving..."Am I getting something out of this group or am I not?" We didn't really want to make the decision for him and we tried to use a very decision making type of approach but at the end of the day it was the concrete reasoning, when he saw the cost of the group that made him decide to stop the group...In all fairness to him, he was getting social benefit from the group. He enjoyed the social side and there's definitely some therapeutic value to having him talk to people who have lived experiences like him. But as far as the purpose of the group of building awareness, even based on feedback from the facilitators, he never really got to any level where there was much awareness as to why he was in the group. It was more of a team

versus a Kotter decision but at the end of the day he ultimately was the one who made the decision.

Kotter is a highly compliant individual and consistently participated in therapy and plans developed by the therapists. Recently, however, for the first time, Kotter decisively asked for a change to the therapy plan:

The rehab aide had had as a major role to assist him with his IADL's that he was becoming independent in doing and at the higher cognitive end sort of see how he did communication wise in the community. Kotter never saw that he had a problem with that so he never saw that there was a role for a rehab aide to monitor his social communication. And he was perfectly right in saying he had gotten to the point where he was safe and independent to do his IADL's provided someone gave him a ride to where he needed to go. That was really the only intervention that he sort of made the decision to stop because he didn't see the purpose.

Achievements

Since returning home in March 2010, when 24-hour supervisory care was indicated, Kotter has made substantial gains in reclaiming his independence in his daily activities:

He was perfectly right in saying he had gotten to the point where he was safe and independent to do his IADL's provided someone gave him a ride to where he needed to go.

Helene considers that overall, given the severity of his brain injury, Kotter is "meeting expectations." She indicated that he has even exceeded expectations in some areas (e.g., his ability to oversee his affairs, plan and organize, use strategies). She attributes this high degree of success in these areas to the fact that Kotter has "really bought into the rehab

model to the extent where he might follow up on a recommendation that the speech language pathologist and I might have but won't follow up on his wife's recommendation" (due to his perception that the rehabilitation professionals have superior knowledge to that of his wife). When he recently attended an appointment with his physiatrist, "they were somewhat shocked at his functional recovery. I think he's done extremely well." That being said, however, Helene indicated that Kotter's lack of insight is a "huge barrier to further progress at the higher level because I don't think there's any question in Kotter's mind that as soon as he can drive, he can work." Helene is, however, not confident at this time that Kotter will be successful with his driving evaluation:

I'm sitting on the fence on that one. There has been no improvement on divided attention and memory on the [Cognifit] program. There's been improvement in the focus area; his divided attention is very, very poor. I don't think he will do well 'on road', I think he will probably get by on the 'off road' but he's one of those clients that could go either way depending on how he is and where they take him. I've upped the ante in the last month with doing a ton of sessions where he's doing four to five activities within a session. I time, I switch, he's got to switch from activity to activity; he gets flustered. He gets quite flustered and that's within a familiar home environment which is the two of us so I don't know how he's going to do.

Helene explained that the therapeutic activities are a blend of client-identified areas of interest and/or concern, as well as activities that Helene considers to be important to Kotter's cognitive rehabilitation process. Helene considered that Kotter was interested in the activities 80% of the time (which she considers to be rather typical for clients). He

demonstrated superior levels of engagement with practical, project-based activities as compared to computer and desk-top activities.

To that end, Helene senses a “disconnect” between her concerns for his remaining achievement and Kotter’s expectations, but indicated that “he won’t argue about it because he’s compliant and nice.” Helene expressed “some degree of frustration at the therapy level because you think with all of this awareness work, we’re not really making that much progress in that area” (of developing Kotter’s awareness into his deficits). Helene is, however, hopeful that Kotter’s insight will continue to improve over time. To that end, Helene has appreciated recent progress:

I think there’s a glimmer of insight that’s happened in the last three to four weeks where, for example, various opportunities that have come up this week for volunteering, like five opportunities...And it was interesting today where he said I’m not sure I want to do this activity Helene because it wouldn’t really work on what [the speech language pathologist] is wanting me to do as far as communication. It’s more physical. I thought, “Oh, that’s good. There’s a bit of insight there.”

As a result of Kotter embracing of the rehabilitation model and his high level of compliance, Helene indicated, “He’s been an easy client to work with because if you’re directive using an instructional model, he does good carry over.” Kotter may not appreciate his limitations or the specific reasoning behind a proposed strategy, but he will readily engage professional recommendations and strategies toward the attainment of his specific projects. “Insight is so poor that if you were to ask Kotter what do you do in OT and speech...it would be a concrete answer. He would never come up with ‘I’m trying to develop self awareness.’ In his mind, he does volunteer work, he’s doing these projects

around the house, he's starting to multitask a little bit, it's quite concrete." Helene's reflection can, in fact, be accurately confirmed in the summary of Kotter's own concrete description of his rehabilitation process.

When asked to reflect on defining moments to date in therapy, Helene pointed to Kotter's wife's one-week summer vacation. Many people (e.g., wife, mother, neighbours) expressed concern for Kotter remaining at home without his wife during this time. Helene, on the other hand, was confident that with the right supports in place, Kotter had progressed sufficiently that it was going to be successful, which in fact it was:

I had great confidence and my view was this is actually a perfect therapeutic activity. You're on your own for eight days and you're going to do it. Just be really organized, follow your list. I think for him that was an important time and quite empowering.

This experience represented advancement and confirmations on several levels. His therapists had confidence in Kotter that others did not have. They trusted in Kotter and his abilities. They showed confidence in him and set him up with supports and systems to facilitate his success. Helene opined that this event served to further reinforce the positive therapeutic relationship. Furthermore, as a result of this experience, Kotter appeared to begin to gain a sense of abilities and his independence, but also some of his difficulties:

This week on his own, there was the beginning of him appreciating some of the difficulties that we thought he would have and him being a little more open to having some of his deficits highlighted because he's not understanding them to any great degree but he became a little bit more willing to hear them out. I think that transition week in early August probably was the sense that 'they know I've got these deficits,

they...She's here treating them but she's got trust that I can do this, so I proved that I can do it.' So there was the sense that yes we do bring his problems to his awareness but we also give him credit.

Environmental Influences

Kotter's wife, Helene explained, has positively supported his rehabilitation process. "I think she has influenced very positively that this is really what he needs and we know what we're doing." At stages when therapies were decreased, Kotter's wife became very concerned and reacted with a high degree of anxiety. Helene attributes this to her support of the therapeutic interventions and "great trust in the rehabilitation team." While supportive of Kotter's rehabilitation efforts, Kotter's wife is very protective of their daughter. Helene explained, "She's been pretty vocal about him not ever driving with [their daughter] because that would just be putting [their daughter] at risk." Helene openly empathizes with Kotter's wife's anxiety and understands her concern.

There is pre-existing complexity in the marital relationship between Kotter and his wife that was discernable during Kotter's inpatient stay:

We sort of knew we would be looking at this kind of relationship because even when he was at the rehabilitation centre for three months, there really wasn't any relationship between his wife and the team. I think the first time they met was at the discharge meeting. And the day when the family can kind of visit and do the therapy, there wasn't a commitment there. There's a lot of complexity.

Any issues that may have existed in the marital relationship pre-accident, have been magnified by both the trauma of the accident itself and the role that Kotter's wife has had to assume since Kotter's injury:

There was a huge element of trauma and post traumatic stress on her part with the accident that she witnessed and the near loss of when they almost lost him and I think it's very complex. And the fear, there's an incredible amount of fear.

Helene acknowledged that the supervisory role into which Kotter's wife has been placed is a "very tough position" for her. In many ways, Kotter's wife has lost her role of being a partner, and instead is now responsible to supervise and facilitate Kotter's recovery. "It's brought frustrations because she could be suggesting the exact same thing but the way she's wording it or presenting it or the trust there is not the same." In other words, Kotter appeared to trust his rehabilitation professionals more than he trusted his own wife. He was open to all professional direction, however, if this same concept was presented by his wife, he dismissed it. To this end, Kotter's wife may have had a somewhat negative impact upon Kotter's rehabilitation as well. Interpersonal and marital issues became evident to the therapists. These issues, Helene suggested, impacted upon Kotter's wife's ability and/or willingness to follow-up on therapy recommendations:

We have a communication journal where we provide summaries of sessions and recommendations on how a strategy could be used in normal life activity. We seldom see carry over with that. I think she's really feeling, "That's what the therapists do" or "Kotter can do that on his own" but I think on certain things, the problem solving being one, we felt they needed a better model between the two of them to address certain issues at home. It's just not been successful. They don't use the model the way we use it in our sessions.

Efforts have been undertaken with Kotter's wife to explain the implications of Kotter's injury that include limited insight and cognitive communication issues. These limitations

result in processing difficulties with respect to abstract thinking, feelings, and emotions.

Although Helene and the speech language pathologist can explain this in therapeutic terms, it creates difficulties in the ongoing personal interactions between Kotter and his wife.

Helene explained that she and the speech language pathologist have worked closely planning and delivering Kotter's rehabilitation, "We're really a threesome on this."

Although few sessions have occurred together, they discuss and coordinate their approach to ensure that there is consistency in the message and strategies being delivered.

Helene noted that the environment in which the therapy occurs, Kotter's home, community, and the family unit, is a very pleasant environment:

It's very conducive. They're very respectful of people coming in. If we want activity, we can have activity. They're accommodating. His flexibility and his wife's flexibility, they're not people that necessarily want the same day same time every week. So there is a lot of flexibility with this particular client for me to change or to make sessions longer. I think he feels the same, that there's been lots of flexibility that way so that's been a positive factor.

Helene also cited Kotter's rural, close-knit community as another factor conducive to his recovery and the rehabilitation efforts:

Whether it's to volunteer or to do a community project, I think because of where they live, rural community, close knit community, lots of friendly neighbours that have been more than willing to offer a volunteer placement or...so I think the environment that he lives in...it's almost like you've got puzzle pieces that fit well in themselves.

Helene explained that friendships and supports have developed over time (e.g., the drivers arranged through a community association to drive Kotter to appointments have

provided Kotter's advice on certain things and have now invited him to their coffee club morning). "So you sort of see that there is a lot of acceptance of Kotter and a good, good support system that's been there." In fact, due to the tensions present in the marital relationship, Helene considers that these external and cultivated community supports have been crucial to Kotter:

You sort of look at them as a couple and I think Kotter has received supports from the outside more than he has from within. I think he would probably find that from a quality of life and social communication perspective his needs are met outside of his coupled relationship. I think there's very much a lot of interaction with neighbours that he's willing to help out. They're willing to help him. There's definitely that sense so it makes one's job as a therapist a bit easier because you're not having to go find the supports.

Kotter has recently met with a lawyer to represent him in a lawsuit against the owner of the All Terrain Vehicle upon which he was riding when the injury occurred. Helene has appreciated no perceptible impact from the lawyer's recently initiated involvement.

Helene's Reflections on Kotter and their Therapeutic Relationship

Helene described Kotter in many favourable terms: pleasant, funny, compliant, social, likeable. "It's a fun relationship because he's got good humour...he's quick witted...there's not a lot of effort needed." "Even where there is a bit of turmoil that you see in him, there's definitely an endearing part to his personality." Helene opined that due to his personality, Kotter does better with a therapist who has a 'lighter side' and, in fact, he had a less than favourable outcome with a past therapist described as "serious" and "by the book." Rather, Helene noted that "friendly banter" with Kotter aids the development of the

therapeutic relationship. Helene considered there to be a mutual degree of liking in the relationship. Helene reflected that although she always “liked” Kotter, she considered that this grew deeper “as he got a little more serious.” This coincided with Kotter’s emerging ability to be self-reflective and demonstrate deeper cognitive thinking and in turn led to Helene’s sense of satisfaction with the therapeutic efforts, “I think you get your own sense of self satisfaction where there’s a kind of progress, and you think, “Okay, we’re finally starting to see a little bit of change.” As a therapist, Helene then began to “feel more purposeful. I mean it’s all very well to do cognitive activities but if at the end of the day the person really doesn’t have any insight and they’re doing it just for the sake of doing it, it’s not as satisfying as when you start to see change.”

Helene described the therapeutic relationship with Kotter as open, honest, positive, and collaborative. She described a high degree of mutual respect. It is her impression that Kotter views the therapists (both Helene as well as his speech language pathologist) as having expertise to be trusted and used to guide the therapy. Helene senses that Kotter is “very committed” to therapy, and as a result he is easily engaged in therapy, “This is a guy who invests a lot in therapy so I have a lot of respect for that.” Kotter’s pleasant and social personality also aids to energize the relationship and the achievements, “He’s a social person so I think there’s definitely an ease of communication because for him the therapy is also social so there’s that sense he enjoys it and gets a lot of value from it. I think it’s one of those things where he sees himself moving forward...”

Due to her dual role as both occupational therapist and case manager, Helene’s involvement with Kotter was more diversified and comprehensive than if she had been solely

his occupational therapist. As a result of her case management role, Kotter would pass almost all issues by Helene at the beginning of meetings:

...because with the case management role, he's been forthcoming just about everything because he sort of checks in with me. I've even said to him recently, 'You don't have to check in with me about everything. You're at the point where I don't need to know who you send an e-mail to, what their response is.' I think it's just very much kind of the brain [injury]...I think he needs that to sort of organize his thoughts for the session but it's probably increased that element of trust that we talked about because he'll go through his weekly things that need to be done and not necessarily look for feedback but he's checking in.

Helene indicated that dual role is a contributing factor to the very high degree of trust inherent in the therapeutic relationship:

Let's say medical appointments...where he might get feedback from a physician...well, actually he's going this week for his consult with the plastic surgeon to see about a revision of his trach scar and so he will say, "The doctor may tell me this, this and that but I know you've researched it Helene and what are your thoughts on this?" So he'll have the appointment and if there's some issue of whether I should do this procedure or not, he will be the first to call and say, "I think we really need to talk about this. This is a procedure that they've been proposing and you can usually analyze things pretty good. What do you think?"

In fact, Helene and the speech language pathologist both sensed a higher degree of trust in the direction they provided than that which Kotter afforded his wife's direction:

There's definitely more trust than he would trust his wife in discussing this. And I think part of the fact that Kotter is as trusting of the therapeutic relationship is that he just doesn't have that communication at home with someone who can do that with him so there's been multiple situations where we've had to say, "You know what? This is something that you should be talking to your wife about and making decisions with your wife and not with [the speech language pathologist] or myself." Oh, it hasn't crossed his mind.

Helene attributes this to Kotter's cognitive sequellae of concreteness and compartmentalization in that he perceives his therapists as being the ones to provide the therapeutic direction and this is not his wife's role.

In combination with the limitations inherent in Kotter's brain injury, this set-up a dynamic that required prudent management by Helene. At times when Kotter had not considered discussing situations with his wife, interactions ensued during which Helene acted as mediator between Kotter and his wife:

So of course there was a huge blow up and then we sat down for a session and said, "Okay, let's have a clear plan of what you're going to do to plan that week and communicate with your wife." It was just a total structured calendar of every day at two o'clock send your wife an e-mail, tell her what I'm up to, every second day at this time make a call so between [the speech language pathologist] and I everything was blocked in. "Oh," he said, "this is perfect. I'm going to follow this plan" which he did to a tee... When the plan was brought to his wife we said, "We thought this would be a good exercise in therapy to have a plan so you're feeling reassured when you go." Of course his wife's reaction was, "I've been talking to him for three weeks

about making this and he didn't think this was necessary and now he's done it and he's quite fine with it."

To use Helene's term, these situations, of which there were a few, created "interpersonal sparks" between Kotter and Helene namely when Helene had to intervene and mediate the communications between Kotter and his wife:

I'd have to say, "Listen Kotter, stop for a sec, look at your wife's perspective. These are the points she's bringing forward and they're valid points." He was most upset at his wife because he didn't really want to hear that but there was probably a little bit of agitation that this OT that's supposed to be siding with him is now playing the Devil's Advocate. Nothing that would sort of linger but there was three or four definite moments of...which would have been a full blown fight between them, that was sort of...you could see that that was going to happen and I just happened to be there to sort of say, "Okay, before this blows up, let's look at the issue," but she was angry and rigid, he was angry and rigid...there I sensed tension because I was looking at both perspectives and he wanted me to look at his perspective.

Although by the time that Helene next met with Kotter he was prepared to not discuss the situation further, Helene addressed the topic as did the speech language pathologist who was also reportedly involved in similar discussions between Kotter and his wife. Both therapists used these occurrences as a means to problem solve around issues related to Kotter's cognitive communication difficulties. In the end, Helene sensed that any negative emotions harboured by Kotter were unfortunately directed toward his wife that Helene attributed to the strong sense of trust and confidence that Kotter held in the therapists as compared to his wife.

Helene pointed to her training and experience in cognitive rehabilitation as being a significant factor in Kotter's buy-in to the rehabilitation process and the therapeutic relationship as compared to the respect he afforded his wife as a lay person:

But it's kind of that brain injury approach. You can't just say, "You're a child now, you're brain injured, I want you to do this, this, this and that." You're better off to sit and make him make the plan which we've worked on and it is getting a little bit better but I think it's just a different type of relationship. That's why we're cognitive therapists.

Secondly, Helene pointed to a salient difference in being the approach used by the therapists as compared to Kotter's wife. Both Helene and the speech language pathologist were using collaboration tempered with mutual trust in their approach to intervention with Kotter.

Helene opined that this may further explain the differing levels of Kotter's receptivity:

I think the difference perhaps at times is in the way the advice is being given. I think he feels that we are collaborating with him, that he is part of making the final decision. Although the approach we've used is for him to see where he's gone wrong, at the end of the day I think he feels like we do trust, like I do trust that with the facts I've given him, you can make the decision right now.

Helene has felt consistently confident in her ability to facilitate Kotter's recovery and continues to be optimistic for his recovery:

Since March I have been working with him and I've seen progress and I've seen the gains I've been wanting to see so I'm confident that we can still make progress. He certainly hasn't plateaued and he's still very engaged so those are indicators to me...I'm fairly confident that we can move forward.

The Working Alliance Inventory was used to assess Helene's assessment of the working alliance with Kotter throughout the duration of the therapy. These results may be reviewed in enclosed Appendix AA-A.

Comparing Relationship with Kotter to that with Georgia

Helene was asked to consider the relationships that she held in this study with Kotter as well as previously with Georgia.

Commonalities exist in Helene's lead with her dominant problem solving approach with both individuals in order to "look at a person's situation and get them to work with me on figuring out various solutions to their every day." Notably, however, this dominant mode was interchanged with other modes, as per the client's specific needs. For example, due to Kotter's cognitive limitations, the problem solving model sometimes was ineffective. In these circumstances, Helene changed to an instructional approval. Due to Georgia's depressive condition, she was much more needy emotionally. This required more extensive use of empathy and encouragement.

Helene reflected that both individuals were outgoing and readily engaged in the relationship. Both clients appreciated the added social connection of the therapeutic relationship. Both also appeared to reach for a personal connection with Helene beyond the strictly professional relationship, which Helene willingly provided. Helene reflected on her "open-book," social, and "light" personality as being an effective fit for these two individuals. This fit was, in and of itself, conducive to the development of effective, positive, and strong therapeutic relationships.

The clients' different levels of awareness and insight resulted in different approaches and shaped the characteristics of the ensuing therapeutic relationship. Georgia was much

more aware of her limitations and as a result struggled more emotionally with her condition than Kotter. More emphasis needed to be placed on engaging Georgia in meaningful activity, reassuring her, and encouraging her to appreciate the positive achievements she was making. In comparison, Kotter, although more pervasively impaired, lacked the insight to appreciate his impairments. Kotter exhibited “no fear because he doesn’t really recognize that there might be problems in the next step so we’re not really having to spend time convincing Kotter of trying something out because he’s quite confident that whatever he’s going to try at, he’s going to succeed so it’s different that way.”

Although both Georgia and Kotter had a lawyer, Helene sensed that the role of the lawyer with Georgia led to Georgia being more cautious of her engagement in the therapeutic activities with Helene due to the implications on her legal action. With Kotter, Helene appreciated no discernable implications to the rehabilitation relationship by the role of the lawyer.

Summary

Kotter sustained serious life-threatening injuries in the September-2009 All Terrain Vehicle accident. Among his injuries, the most enduring and functionally impairing was the brain injury with concomitant cognitive impairments. Kotter returned home six months post accident and thereafter was involved with a community-based rehabilitation team with particular focus upon occupational therapy and speech language pathology. Kotter successfully regained functional independence in his day to day life and, with proper strategies and structures in place, and may even be capable of independent living. Given his family structure, however, the testing of these abilities to this end was not required. From Kotter’s perspective, he was consistently focused upon returning to work. In order to attain

that goal, Kotter identified that he must successfully achieve the reinstatement of his driver's license. These two goals remained unattained by Kotter at study participation conclusion, 15 months post accident.

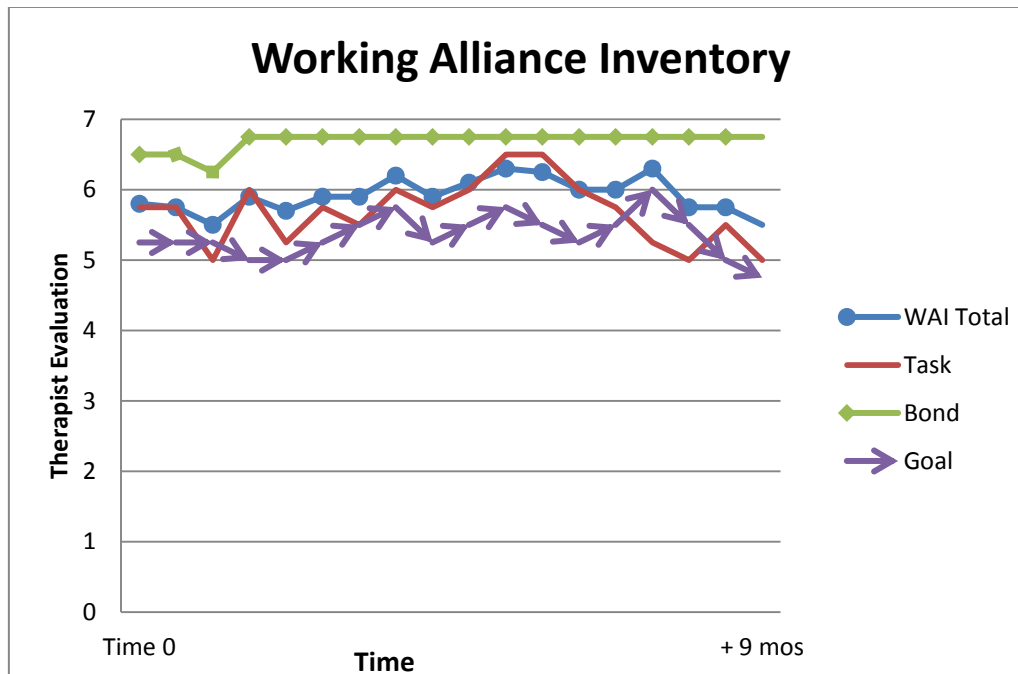
Helene worked with Kotter in a dual and complimentary role as both his occupational therapist and case manager. She perceived that this duplicity allowed for an enhanced relationship. Kotter learned to trust her with all information inherent to the rehabilitation process. Furthermore, Kotter became engaged in the active management of his rehabilitation process in that the case management activities formed the basis of some of the cognitive rehabilitation activities undertaken during occupational therapy sessions. Helene identified a disconnect between her concerns for his enduring impairments and Kotter's unyielding expectations to return to work. As a result, Kotter's lack of insight and awareness resultant from the brain injury created some barriers. Kotter's goals and Helene's goals were disparate in that Kotter did not appreciate the profundity of his impairment. The enhancement of his very awareness and insight into these limitations was a primary goal for Helene. Despite this gap, Helene attempted to engage Kotter in therapeutic activities in which he demonstrated a direct interest, although some table top and computer activities, to which Kotter was less inclined, were also used. Due to Kotter's compliant and genial nature, his participation was never in doubt. In fact, Kotter fully embraced the rehabilitation model and trusted the guidance and direction provided by his therapists, significantly beyond that which he showed his wife. Despite some discrepancy in goals and preferred activities toward the attainment of these goals, a strong bond between Helene and Kotter existed. Marital tensions were, however, present. Fortunately, Kotter had a strong community network that supported his rehabilitation process and subsidized the emotional and cognitive-

communication support of the home. Helene expected Kotter's rehabilitation to continue for the foreseeable future as Kotter worked toward regaining the remaining valued roles of his pre-accident life.

Appendix AA-A: Helene Dyad#4

Working Alliance Inventory Results

In this study, the Working Alliance Inventory (WAI) was used to assess Helene's perspective of the evolution of the alliance over time.



A strong bond is evident in the analysis of the repeated Working Alliance Inventory administrations, completed at regular intervals by Helene since Kotter returned home from inpatient care. This is consistent with Helene's description of the relationship with Kotter that she described as a positive, easy and pleasant relationship facilitated by Kotter's high degree of compliance, engagement, energy and social nature. The lowest of the three subscales was most consistently found in the goal domain. Kotter's primary goals since his return home have been a return to driving and work. Helene, on the other hand, is not necessarily confident that these are attainable goals given the profoundness of Kotter's

cognitive impairments. This disconnect regarding the goals of therapy may serve to explain the lowest rating falling in this subscale.