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Relationships and communication between people experiencing communication disability and stroke rehabilitation practitioners: A metasynthesis

Introduction

The rehabilitation process is an elaborate interaction involving multiple parties and processes which impact upon patient engagement and satisfaction (Lequerica & Kortte, 2010). Commonly, people experiencing communication difficulty after stroke describe the relationship between themselves and their rehabilitation practitioners as being one of the most important components within the rehabilitation process (e.g. Bright, Kayes, Cummins, Worrall, & McPherson, 2017; Tomkins, Siyambalapitiya, & Worrall, 2013); these relationships can be a contributing factor to patient engagement, satisfaction and outcomes (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010; Jesus, Bright, Kayes, & Cott, 2016).

Despite communication being a key component in creating and sustaining relationships there is currently a lack of understanding of how this process occurs. There is a limited understanding of the characteristics which are important for relationship development and limited research exploring therapeutic relationships and interpersonal (relational) communication between people experiencing communication disabilities and healthcare practitioners. Studies that focus on related phenomena such as goal-setting (Tomkins et al., 2013), engagement (Bright et al., 2017), discharge (Hersh, 2001) and supported conversation (Duchan, Simmons-Mackie, Kagan, Black, & Square, 2001) elude to knowledge about relationships and communication however it is typically only mentioned and is not investigated further.

There is a paucity of information that examines the patient's experiences and perspectives. Synthesising the existing literature of how patients perceive and experience relationships and interpersonal communication will consolidate existing knowledge and enable it to be used appropriately. Gaining a greater understanding of the interplay between relationships and communication may enable practitioners to critically reflect on their personal way of practicing and respond accordingly.

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Aim

The aim of this study was to explore how therapeutic relationships and interpersonal communication are perceived and experienced by people experiencing communication disability in stroke rehabilitation.

Methodology and methods

Methodology

This literature review uses a Qualitative Meta-Synthesis Methodology which aims to synthesise findings of selected qualitative research studies to develop new understandings that have the potential to guide practice, theory development, future research methodology and/or policy developments (Thorne, Jensen, Kearney, & Noblit, 2004).

Data collection / Data sources:

A systematic literature search was conducted using the following databases; PsycINFO, CINAHL, MEDLINE, and SCOPUS. These four searches were combined. Key search terms used are presented in appendix 1. Additional literature was identified through citation tracking, Google Scholar, discussions with experts on Twitter, and emailing first authors of included papers.

Study selection: Articles were included in the metasynthesis if they were qualitative and reported patient perceptions and experiences of therapeutic relationships and interpersonal communication in stroke rehabilitation. Patients must have experienced communication disability due to a stroke. Papers were excluded if they solely discussed the use of supported conversation techniques without discussing other aspects of interpersonal communication with their health care practitioners beyond commenting on the presence of relationship or lack thereof. Studies were also excluded if they focused on communication about therapeutic processes (e.g. discharge planning) or communication of information without attending to the patient-practitioner relationship (e.g. Armstrong, Hersh, Hayward, Fraser, & Brown, 2012; Hersh, 2001; Rose, Worrall, McKenna, Hickson, & Hoffmann, 2009)) and if they were not published in English.

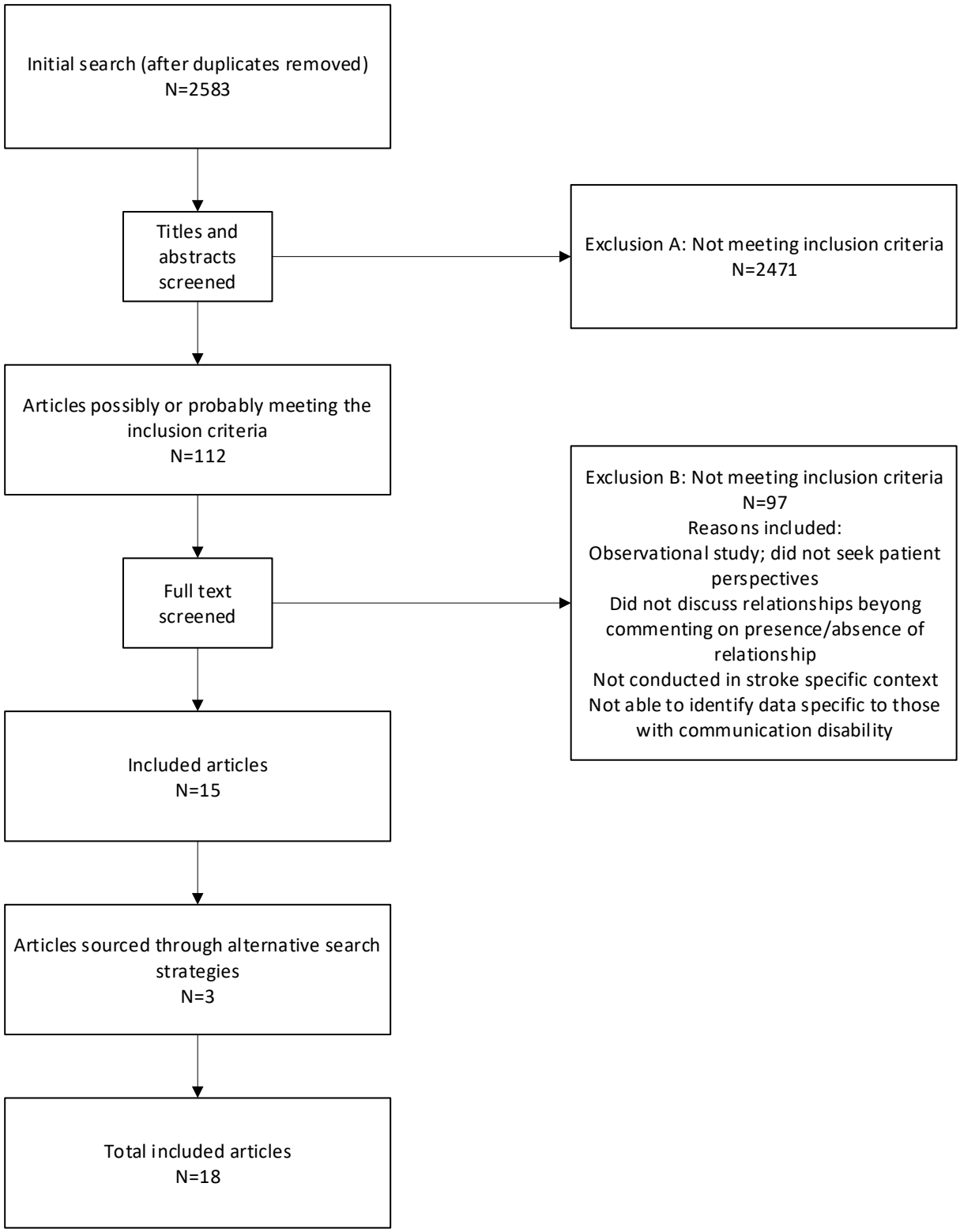
Procedures for identifying the selected articles included two independent researchers (FB and BR) screening all abstract and titles. The full text copy of the articles was obtained when articles were either identified as meeting the inclusion criteria from the screening process or when a decision could not be made from the title and abstract screen. Full texts were analysed for suitability according to the inclusion and exclusion criteria. Disagreements between the decision on including articles were discussed between both researchers (FB and BR) to meet an agreement.

The data analysis process was guided by thematic analysis (Terry, Hayfield, Clarke, & Braun, 2017) which included the development of codes and categories. After first familiarising, ourselves with the papers by reading each many times to gain an understanding of the topic, we identified material which constituted data for this metasynthesis. Only material in the Findings and Discussion which pertained to this topic were considered data and were analysed. Once this material was identified, we proceeded to code and category development. We generated codes to reflect the meaning of the data. Codes from each article were then extracted and compared across papers. They were then grouped into categories. Each category was developed in response to codes demonstrating similarities in meaning and ideas. These categories are detailed in the results section below.

Results

Search results: Search results are outlined in figure 1. The initial search resulted in 2583 articles being selected for the first stage of screening for suitability. 18 articles were identified and included in the meta-synthesis.

Figure 1: Search results



Relationships were foundational for rehabilitation. These relationships were created and sustained through communication. When communication was perceived as authentic and acknowledge the personhood of the patient, it was valued and helped develop relationships.

Furthermore, any communication attempts by the health care practitioner, even if unsuccessful, were perceived as important as these demonstrated that the health care practitioner was wanting to try and engage with their patient.

Patients perceived relationships as being foundational and productive, able to either facilitate or hinder engagement in rehabilitation. This idea challenges a dominant notion of relationships being a nice element of care, and suggests that relationships have therapeutic value (Hersh, Sherratt, et al., 2012). This reflects that therapy and interpersonal communication is received and experienced through the interpersonal relationship (Boutin-Lester & Gibson, 2002; Tomkins et al., 2013; Worrall, Davidson, Hersh, & Ferguson, 2010). When patients were asked about care experiences, they commonly recalled experiences about interacting and connecting with their health practitioner rather than describing the therapeutic tasks and activities (Worrall et al., 2010). For example, Greg, a man with aphasia, reported that the most important thing was "They were concerned about me … they made me better" (Hersh, Sherratt, et al., 2012, p. 230). These relationships and connections appeared pivotal for providing and maintaining hope for patients, something impacted by the strength of the therapeutic relationship. When the therapist was perceived to be supportive and hopeful, it appeared to help the participants think positively and hopefully about the future (Bright, Kayes, McCann, & McPherson, 2013).

Relationships with health practitioners were commonly considered to develop slowly and progressively throughout the course of the treatment and care (Hersh, Sherratt, et al., 2012). This may reflect that many patients enter rehabilitation with complex emotions, with some reporting feeling terrified, horror-stricken and "small and helpless" (Nyström, 2009, p. 2507) when they become aware of the consequences of their stroke, and may struggle with being confronted by the stroke-related impairments: "It was a shock! The physician pointed at the wall and asked me what it was. The word wasn't there, I couldn't say anything. Nothing was there! (Nyström, 2009, p. 2507)". They entered the relationship from a point of fear and vulnerability. Patients described a process of appraising their health practitioner, reading and interpreting the practitioner's intentions as conveyed through their communication attempts, searching for qualities which indicated genuine interest and care (Bright et al., 2013; Nyström, 2009). When a patient realised that the health practitioner really wanted to know and understand who they are and how their condition impacted them, rather than simply following system-determined processes, they found it easier to feel safety and trust in the

practitioner (Nyström, 2009). When health practitioners persisted to communicate with their patients, it was perceived as meaning they supported the patient, were "in it for them". Patients also considered this conveyed a sense of hopefulness that the patient can achieve his/her therapeutic goals (Bright et al., 2017; Bright et al., 2013; O'Halloran, Grohn, & Worrall, 2012). For example, Vivien, one women with aphasia, expressed feeling an increased sense of empowerment if an effort was made by the practitioner to include and inform her: "Of course, once you've got a name for something, it's like you've got half the problem sorted. You can chase things and you can do things. You mightn't be able to cure it and everything else but you can understand it more" (Worrall et al., 2010, p. 291).

Communication holds an interesting role of being both the focus of therapy, and the vehicle for the delivery of the therapy (Hersh, Sherratt, et al., 2012). Interpersonal communication was central to the creation and sustainment of the relationship throughout the therapy (Bright et al., 2013), facilitating a sense of connectivity between the patient and practitioner. When the practitioner communicated with the patient in a way that supported the patient's sense of personhood, that they perceived the practitioner was wanting to connect with them as a unique, competent individual, this was meaningful to the patient (Hersh, Worrall, Howe, Sherratt, & Davidson, 2012; Tomkins et al., 2013; Worrall et al., 2010). The communication between the two appeared pivotal for a person's identity; a lack of communication, or more specifically, a lack of attempt to communicate in a way which recognizes personhood, was critical (Berg, Askim, Balandin, Armstrong, & Rise, 2017), and the myriad of unintentional consequences such as the patient feeling excluded, alienated and isolated in response to the lack of communication was brought to our attention (Brady, Clark, Dickson, Paton, & Barbour, 2011a, 2011b). Such interactions showed respect for the patient as an individual. Participants identified five useful components which encouraged positive interactions and the development of their relationship during their contact time with their health practitioner: the ability to put someone at ease; the ability to make an individual feel important; the visitor/SLT displaying a positive mood themselves, and being empathetic (Young, Gomersall, & Bowen, 2013). Patients responded positively to conversations which went beyond clinical content, which sought an understanding of patient experiences and perspectives. A technique that was perceived by patients as being beneficial towards the development of their relationship and enabled the practitioner to connect with the patient's personhood included practitioners trying to engage in authentic conversations which included

discussing a range of topics that were not directly linked to the care or therapy (Hersh, Wood, & Armstrong, 2017). Patients expressed that authentic conversation held value to them whilst they were staying in hospital, and it was something they felt nostalgic toward after having been discharged (Hersh et al., 2017). However, engaging in authentic conversation was difficult if past experiences were not common between the health practitioner and the patient. For example, Oliver was very willing to engage in rehabilitation but he did note that a lack of shared experience and shared knowledge was limiting: … 'The girls are good. But it's hard sometimes to talk about things with people who haven't been there, done that sort of thing' (Hersh et al., 2017, p. 15). While patients understood the reason for clinically-oriented conversations, many said they would have liked the conversations to be undertaken in a more conversational manner that involved them as people, not just "patients" (Hjelmblink, Bernsten, Uvhagen, Kunkel, & Holmström, 2007). Patients expressed that when there was a focus on therapy requirements or a lack of authentic communication, this could negatively affect the relationship, partly because the practitioner appearing to be "disengaged and distant" (Bright et al., 2017, p. 06).

While it was important that practitioners made an effort to engage patients through conversation, it was interesting that some patients took responsibility for a lack of communication on themselves and many rationalized this lack of communication, as demonstrated in the following quote: "they scurry over and turn me. They walk away, not even putting the bed rail up… They don't want to talk. I think they feel awkward because I couldn't talk back then. They've not even tried" (Bright et al., 2017, p. 06). When this occurred, patients described feelings of frustration, hurt, anger and disrespect as the practitioner's disengaged behavior made them feel excluded as their personhood was not being acknowledged. Patients expressed feeling objectified, and as though they were another task on a factory line to be completed. This type of clinicians behaviors were perceived by the patient as meaning they [patient] were lacking intelligence, they were incapable and that they were being rendered invalid as a human being (Mackay, 2003; Tomkins et al., 2013). Furthermore, patients also described feeling a sense of fear when they were ignored or left out of conversations by their health practitioners because of their communication difficulty: "She [the nurse's aid] put the newspaper on my bed, but didn't say anything. After my aphasia, she never talked to me again and avoided eye contact. I understood that she was

afraid. Therefore, I also became scared" (Nyström, 2009, p. 2506). When practitioners failed to communicate, or there was a lack of perceived attempts to communication, the outcome would be an uncomfortable, tension filled relationship, leading some patients to terminate their care; for instance, one person described his experience of his speech pathologist only talking to his spouse and not to him resulting in him ending his therapy "yes but I, my wife is at home, and then my wife and the speech-pathologist are talking and I'm just sitting there" (Berg et al., 2017, p. 1125).

Discussion

The metasynthesis was designed to explore how therapeutic relationships and interpersonal communication are perceived and experienced by people experiencing communication disability in stroke rehabilitation, as reported in the literature published to date. A core finding of this study was that interpersonal communication was perceived by the patient to be the tool which can connect both the practitioner and the patient together to either enable or hinder the creation and sustainment of their relationship. The data suggests that patients who come into rehabilitation are also entering relational processes with each of their health care practitioners from a point of vulnerability. These relational processes are enacted through communication, which highlights why relationships and communication are so interlinked. It was important to engage in authentic communication which acknowledge a person's 'personhood'. Based on the health care practitioner's efforts to communication and how the patient perceives, experiences and responds to this, strong interpersonal relationships may or may not develop. The entwined nature of relationships and communication are particularly important for speech-language therapists, as communication performs multiple functions. It is the focus for rehabilitation, the medium of rehabilitation, and foundational for relationships.

While there is an increased interest in understanding therapeutic alliances and relationships within the stroke context, there was no evidence of that any research had explicitly sought to examine this. All 17 papers included addressed topics related to therapeutic processes and treatment of impairments. Only two of the selected papers were completed within the context of Aotearoa New Zealand (Bright et al., 2017; Bright et al., 2013). It is not known, the results do not incorporate or give insight into how current health policies and strategies such as New Zealand's current Māori Health Strategy, He Korowai Oranga, may impact on patient's perceptions and overall experiences of rehabilitation within the stroke specific context

(Ministry of Health, 2016). This is important to note, as ensuring the patients "personhood" is being acknowledged was a main finding within our results, which is a key element to He Korowai Oranga, and is commonly seen as an element throughout Māori health models (Durie, 2001).

Conclusion

This metasynthesis has highlighted how closely communication and relationships are entwined. When each patient enters rehabilitation, they are also entering a relational process with their health practitioner that is enacted through communication. Patients with a communication difficulty enter this relational process from a point of vulnerability, and begin to read their health care practitioner through their communication attempts. They read for validating communication qualities, which signifies to them that their health practitioner will not only be focused on their care processes, but will be mindful of and acknowledge their personhood. The relationship develops in response to the health practitioner's communication attempts and how these are perceived, read and interpreted by the patient. What the health care practitioner does, and perhaps more importantly, how it is received and experienced by their patient, that directs the course of the relationship. This metasynthesis gives us deep insights into how therapeutic relationships are formed. Although this project focuses on communication impairments within a stroke specific context, the findings may well have a bearing on a range of health care practitioner and patient interactions which may come of interest to the wider rehabilitation and health domains throughout New Zealand.

Personal reflection

Completing this research project as a student who is currently in their third year of studying occupational therapy has been incredibly interesting. The underpinning philosophy of occupational therapy consists of enabling individuals to engage in their world through the act of meaningful occupations (Townsend, 2013). To achieve this, the occupational therapist must engage and communicate with their patient or client in a way that enables the practitioner to understand the individual's spirituality (values, beliefs and principals) that guides them in their everyday activities and tasks (Townsend, 2013). This idea of spirituality, aligns incredibly closely with the idea of "personhood" in this study. Consequently, the findings from this study may be used to not only inform practice with individuals who have

experienced a stroke and now have communication disorder, but rather act significantly in informing how occupational therapists engage in interpersonal communication to create a validated relationship with their patient across a wider context of rehabilitation.

The Occupational Therapy Board of New Zealand's' Competencies for Registration and Continuing Practice (Occupational Therapy Board of New Zealand, 2015) consist of five qualities an individual must be competent in achieving. Most specifically, I think of competency number one which outlines an occupational therapist must be competent in Applying occupational therapy knowledge, skills and values. A way in which this is achieved is outlined by 1.3 as the following: You use a range of strategies for communicating. You adapt how you communicate to each context, acknowledging and respecting the values, beliefs, attitudes and practices of your clients / tangata whaiora (Māori clients). Additionally, competency number three states that you must be competent in Building partnerships and collaborating. A way in which this is achieved is outlined by 3.2 as: you act with integrity, building and maintaining respectful relationships with your clients, colleagues, peers and other professionals. This highlights the importance of expanding on this research to expand our knowledge in the field of interpersonal communication and relational processes from the experiences of the patient. If more research can be completed, then occupational therapists may be able to have a deeper understanding of how to enact and achieve these competencies for registration each year to enable positive outcomes for each of their patients.

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Appendix 1

Table 1: key terms for the literature search

1	(aphasia OR dysphasia) OR dysarthria OR (apraxia OR dyspraxia) OR (cognitive-communication) OR (“communication disabil*” OR “communication difficult*” OR “communication impair*”)
2	(care OR car*) OR (relationship OR "therapeutic relationship" OR "therapeutic alliance" OR "working alliance") OR presence OR communication OR conversation OR interaction OR rapport OR interpersonal OR partnership OR engag*
3	("speech therapist" OR "speech-language therapist" OR "speech language therapist" OR "speech pathologist" OR "speech-language pathologist" OR "speech language pathologist") OR nurse OR assistant OR psycholog* OR psychiatr* OR ("social work*") therapist* OR ("health professional" OR "healthcare professional" OR "health care provider" OR "healthcare provider") OR "health practition*" OR (physician OR doctor) OR (physiotherapist OR "physical therap*") OR "Occupation* Therap*" OR practitioner*
4	Qualitative OR “grounded theory” OR phenomenology OR “discourse analysis” OR “conversation analysis” OR “thematic analysis” OR “qualitative descriptive” OR “interpretive descriptive” OR interview* OR “focus group” OR observation* OR review