

COLLABORATION WITH APHASIC CLIENTS TOWARD
AUTONOMOUS OCCUPATIONAL ENGAGEMENT

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Occupational therapists' facilitation of collaboration with aphasic clients in order to encourage the clients' autonomy in relevant occupational engagement.

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Dissertation presented to the University of Cape Town
in partial fulfilment of the requirements for the Degree of
Master of Science in Occupational Therapy

November 2000

DECLARATION

I, Julie Nell Bosch, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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20/11/2000

In memory of my brother,
Andrew James Hide,
and dedicated to my parents,
Margaret and Jon Hide
who laid the foundation for my learning.

With thanks to those who have encouraged me to pursue this study,
especially my husband, David Bosch
and my sister, Alisa Duffett.

Abstract

Occupational therapy seeks to facilitate engagement in occupation. Occupational therapists working with aphasic clients assist them to reconstruct meaningful lives following cerebrovascular accident. A series of focus groups were conducted using the co-operative inquiry methodology. The sample consisted of expert occupational therapists, as co-researchers for the study. The purpose of the study was to understand how expert occupational therapists collaborate with aphasic clients in order to facilitate their capacity to make choices and engage in occupation, so that other occupational therapists may learn how to provide inclusive and relevant treatment. The aim was therefore to describe the expert occupational therapist's experience of and responses to this challenge. The findings show that 'working with aphasic clients is like looking for keys ... to spur treatment on to meaningfulness'. The use of the client-centered approach is understood to be fundamental in relating generally used collaboration strategies to the aphasic client population, in order for the client's real needs and goals to be identified and accommodated by the occupational therapist in the collaborative treatment process.

Acknowledgements

Writing this dissertation has been a wonderful learning experience. I am indebted to so many for so much. I would like to acknowledge those who have made this experience possible and more meaningful by the contributions they have made.

I would like to thank my supervisor, associate professor Ruth Watson (Head of the occupational therapy department, University of Cape Town), for her untiring support and mentorship throughout the process of this research. Ruth has played a pivotal role in facilitating the evolution of this research.

I am grateful to Dr Dale Ogilvie of the logopaedics department, University of Cape Town, for her enthusiasm, invaluable advice and assistance with locating additional resources.

The guidance and encouragement offered by my fellow occupational therapy master's students and lecturers is gratefully acknowledged, particularly at our discussion groups: Hilary Beeton, Zelda Coetzee, Thea Coetzer, Madie Duncan, Marion Fourie, Siphokazi Gcaza, Theresa Lorenzo, Roshan Galvaan, Ancil Prinsloo, Eielwani Ramugondo, Lana van Niekerk, Vicky van Rensburg and Ruth Watson. I would particularly like to thank Marion Fourie for her assistance with editing, and Madie Duncan and Sue Dewas for their advice concerning the analysis.

Thank you to the therapists who completed questionnaires. I am particularly grateful to the focus group participants, Anne Blignaut, Judy Cawood and Susan Mudge, for the generous spirit in which they shared their experiences.

I am grateful to Gerry and Di Wernars for sharing their experience.

Thank you to the staff and clients of Booth Memorial Hospital who have encouraged and challenged me to learn.

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Definition of terms

Aphasia	An impairment due to acquired and recent damage of the central nervous system, of the ability to comprehend and formulate language. It is a multimodality disorder represented by a variety of impairments in auditory comprehension, reading, oral-expressive language, and writing. The disrupted language may be influenced by physiological inefficiency or impaired cognition, but it cannot be explained by dementia, sensory loss, or motor dysfunction (Rosenbek, La Pointe & Wertz, 1989:53).
Autonomy	The capacity to think, decide and act on the basis of such thought and decision, freely and independently (Gillon, in Sim, 1998:4).
Axial coding	A set of procedures whereby data are put back together in new ways after open coding, by making connections between categories (Strauss & Corbin, 1990:96).
Category	“A classification of concepts. This classification is discovered when concepts are compared one against another and appear to pertain to a similar phenomenon. Thus the concepts are grouped together under a higher order, more abstract concept called a category (Strauss & Corbin, 1990:61).

Choice	Having alternatives from which to make a selection (Grady, 1995:302).
Client-centered practice	An approach to providing occupational therapy, which embraces a philosophy of respect for, and partnership with, people receiving services. Client-centered practice recognises the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-centered partnership and the need to ensure that services are accessible and fit the context in which the client lives (Law, Baptiste & Mills, 1995:253).
Collaboration	A therapeutic strategy to enable participation of the client in the planning and implementation of therapy.
Co-operative inquiry	Two or more people researching a topic through their own experience of it, using a series of cycles in which they move between their experience and reflecting together on it. Each person is co-subject in the experience phases and co-researcher in the reflection phases (Heron, 1996:1).
Enabling	Processes of facilitating, guiding, reflecting, encouraging, or otherwise collaborating with people so that individuals, groups, agencies, or organizations have the means and opportunity to participate in shaping their own lives

(Canadian Association of Occupational Therapists, 1997 cited in Occupational terminology interactive dialogue, 2000:42).

Enabling occupation

Enabling people to choose, organize, and perform those occupations they find useful or meaningful in their environment (Canadian Association of Occupational Therapists, 1997 cited in Occupational terminology interactive dialogue, 2000:42).

Expert therapists

They "... become extremely skilled at reasoning about how to interact with their clients" (Mattingly and Fleming, 1994:178).

Framework

A theoretical framework (Schon's framework of the therapist's reflection IN and ON action) as well as the objectives for this study were used to inductively categorise the codes.

Interactive environment

A context which serves to support interdependence (Grady, 1995:306).

Interpersonal communication

Serves to link us through verbal and non-verbal expression so that we can ... share information and meaning ... we can tell our stories ... and develop plans for working together toward future goals (Grady, 1995:308).

Intrapersonal communication	The creating, functioning and evaluating of symbolic processes ... such as thinking, reflecting, solving some problems and talking with oneself... (Grady, 1995:307).
In vivo codes	Words and phrases used by informants themselves (Strauss & Corbin, 1990:69).
Knowing in action	Habitualised action that does not require conscious thinking, familiar routine (Sinclair, in Creek, 1998:74).
Medical model	Views disability as a personal problem, directly caused by disease, trauma or other health conditions, which requires medical care provided in the form of individual treatment by professionals. Management of the disability is aimed at cure or the individual's adjustment and behaviour change (ICIDH-2, 1999:25).
Novice therapist	Able to recognise the general facts needed for practice, but there will be gaps in ...knowledge (Alsop & Ryan, 1996:188).
Occupations	Goal-directed pursuits which typically extend over time, have meaning to the performer, and involve multiple tasks.... the ordinary and familiar things that people do every day (American Occupational Therapy Association, 1995d p1015, in AJOT, 1999:258).
Occupational engagement	The actual doing or involvement in occupation.

Open coding	The process of breaking down, examining, comparing, conceptualising, and categorising data (Strauss & Corbin, 1990:61).
Performance components	The elements that make up or provide the ability to do these activities. Strength, fine motor skills, and problem solving are examples of performance components (American Occupational Therapy Association, 1999:255).
Plot	A code that is conceptually large enough to capture the essence of the study.
Reflection in action	On-the-spot research in formulating solutions to unique problems, based on prevailing theory and drawing on personal experiences and assumptions (Kirby & Teddle, 1989) without interrupting what is being done at the time (Sinclair, in Creek, 1998:74).
Reflection on action	Thinking back on what has been done in order to discover how knowing-in-action may have contributed to an unexpected outcome, how actions have altered the outcome, or whether to change practice because of the outcome (Crandall, 1993, in Sinclair, in Creek, 1998:74).
Selective coding	The process of selecting the core category [plot], systematically relating it to other categories, validating those

relationships, and the filling in categories that need further refinement and development (Strauss & Corbin, 1990:116).

Social model of disability

Sees the issue mainly as a socially created problem, and principally as a matter of the full integration of individuals into society. Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment (ICIDH-2, 1999:25).

Subcategory

A grouping of codes within a category.

Sub plot

A code that is conceptually large enough to be considered a sub plot, and is supported by a series of codes, subcategories, categories and themes.

Theme

A code that is conceptually large enough to be considered a theme, and is supported by a series of codes, subcategories and categories.

Where possible I will be using the term client as opposed to patient. In many of the quotes however, the term patient has been used, and will therefore be retained.

For the sake of brevity, and ease of reading, the client will be referred to as 'he', and the therapist as 'she', unless otherwise specified.

Rationale for the study

For the past three years I have worked at Booth Memorial Hospital, a sub-acute geriatric hospital. I have sensed an increasing need in my own work with stroke clients for the therapeutic process to be relevant to the clients' identified needs and goals. I have therefore adopted a more client-centered approach to practice. This has resulted in my assuming less and making the effort to find out more about my clients' needs and goals. I have been particularly challenged to develop my therapeutic skills with aphasic clients. I found that I wasn't allowing the client enough time to respond and tended to rush the seeking of information concerning occupational history and choices by asking questions requiring yes/no answers. The application of the principles of client-centered practice is more challenging to apply to a client where conversation is compromised, but ironically more necessary as the aphasic client is not always afforded the opportunity to voice his needs and goals.

It has been my experience that aphasic clients are challenging to work with and that they require opportunities to express their needs so that therapy can remain relevant. Taking the extra time and effort to ascertain the client's needs, which cannot be shared by the conventional means of conversation, and requires more effort. It is also interesting because the client-centered approach to practice with aphasic clients requires the therapist to be creative. I noted that aphasic clients can respond well to certain collaboration strategies, such as individualising treatment by focusing on familiar objects in their environment. This made me wonder what other strategies I could try.

I sought after literature to guide this development, hoping to learn from other occupational therapists' experience. I did not find any occupational therapy literature, although other references provided some guidelines, such as the values in Table 1 (see p4), clinical reasoning (see p21) and

Mattingly's collaboration strategies (see p14). I did, however, find speech therapy literature on aphasia therapy, for reducing the communication symptoms, and on the more recent approaches to functional communication. The latter was interesting, however I found it limited in its usefulness in terms of describing a means to collaborate with aphasic clients about occupational choices. I therefore set out to discover if there are "expert" occupational therapists (see page ix) who collaborate with aphasic clients, and if so how they involve them in the treatment process.

The focus of this study shifted during its evolution from the importance of engagement in occupation per se to the strategies that would enable client engagement in preferred occupations. This shift was due to the increasingly apparent need for occupational therapy literature in the field of aphasia.

University of Cape Town

Introduction

This study seeks to investigate how expert occupational therapists collaborate with aphasic clients. There is a paucity of literature that addresses the application of the ideals of client-centered practice to collaboration with aphasic clients in occupational therapy.

Co-operative inquiry methodology has been used as a means to capture the expert occupational therapist's clinical reasoning (within an action-reflection cycle) concerning her experience of, and responses to the challenge of collaboration with aphasic clients. This research does not set out to examine augmentative and alternative communication methods to improve communication, but rather to understand a means whereby occupational therapists can collaborate with aphasic clients, facilitating their capacity in occupational choice and engagement.

Investigation into client-therapist collaboration is needed because it has been found to be an effective means of meeting the client's real needs. Hasselkus (1989, cited in Neistadt, 1995:429) reports that:

... occupational therapy and nursing studies suggest that client-provider collaboration on goal setting, treatment planning, and treatment implementation results in better client outcomes than a traditional medical model approach, in which the provider sets goals and plans treatment. The findings of these studies support the values about client participation in therapy.

The collaborative approach is recommended generally by occupational therapists in occupational therapy literature. Little is known about how the approach applies to aphasic clients. The

absence of relevant occupational therapy literature, points to the need to investigate “expert” occupational therapists’ methods of collaboration with aphasic clients.

The basic beliefs and values of our profession reinforce the relevance of this undertaking (see Table 1); Christiansen and Baum (1997:36) list these, summarised from other sources about the philosophical roots of the occupational therapy profession.

Table 1 Enduring values of occupational therapy

- Engagement in occupation is of value because it provides opportunities for individuals to influence their well-being by gaining fulfillment in living.
 - Through the experience of occupation (or doing), the individual is able to achieve mastery and competence by learning skills and strategies necessary for coping with problems and adapting to strategies.
 - As competence is gained and autonomy can be expressed, independence is achieved.
 - Autonomy implies choice and control over environmental circumstances. Thus opportunities for exerting self-determination should be reflected in intervention strategies.
 - Choice and control extend to decisions about intervention, thus identifying occupational therapy as a collaborative process between the therapist and recipient of care. In this collaboration, the patient’s values are respected.
 - Because of its focus on life performance, occupational therapy is neither somatic nor psychological, but concerned with the unity of body and mind in doing.
-

Chapter 1 Overview

Literature review

Occupational disengagement

Zemke and Clark (1996:vii) assist us in understanding the impact of disability on occupation, as well as the enabling role of occupation in reconstructing a meaningful life:

People are shaped by what they have done, by their daily patterns of occupation. Should disease or disability strike, individuals will be able to reconstruct meaningful lives – drawing on threads of their past selves to create a sense of continuity in their new situation. One way they do this is through commitment to action – to occupation.

Occupation is understood to play a pivotal role in shaping our lives. According to Ottenbacher and Christiansen (in Christiansen & Baum, 1997), impairment in a person's psychological, anatomical or physiological functions and/or structures can limit his engagement in occupation. Occupational therapists seek to assist the client to re-engage in occupation.

The cause of the disruption to occupation that will be addressed in this study is that of cerebrovascular accident. The prevalence of stroke is magnified by its relationship to the chronic diseases of lifestyle. According to Patel and Bresick (1997) stroke is the third most common cause of death in South Africa. Bonita (1992, in Patel & Bresick, 1997) reports that stroke mortality has declined over the last few decades. This has been attributable to the decline in case fatality rates, rather than a decline in incidence rates. There is therefore a greater proportion of

survivors of stroke and persisting disability resulting from stroke is more prevalent, affecting approximately 35% of stroke survivors (Barnford, Sandercock & Dennis, in Dewas & Patel, 1997).

Occupational therapy following cerebrovascular accident

The enduring values of the occupational therapy profession are outlined in Table 1 on p4.

Occupational therapists who operate with reference to these values would find themselves creating opportunities for their clients, following cerebrovascular accident, to exert self determination. Respect for a client's personal dignity and wishes makes client directed therapy possible. This would include the choice of personally important and meaningful occupations. This approach provides opportunities for the client to be self determining. The end product that the therapist most wants to achieve is engagement in occupation that is meaningful and relevant to the client.

As outlined in the above paragraph occupational therapists working with other client populations should be using this approach for meaningful treatment. These collaborative principles are especially necessary, however, when communication is compromised.

Aphasia

Aphasia poses a particular problem because the capacity of the client to express his self determination (in desire and/or action) may easily be undermined. The therapist may assume to know what is best for the client because he does not seem able to express his needs/values and because assuming appears to be easier than putting in the effort to ascertain what the client's values are.

Approximately 30% of stroke patients acquire a lasting aphasia, usually as a result of a left cerebrovascular accident (Bonita & Anderson, 1983, in Marshall, 2000). This can leave clients

with many unanswered questions, which they are unable to ask. Letourneau reports (in Lafond, Joannette, Ponzio, Degiovani & Taylor Sarno, 1993) that they find this very distressing. He goes on to say that the impact of the aphasia can be so severe that it becomes the dominant feature in the person's daily life as well as in therapy. These changes affect the quality of the aphasic person's life.

Taylor Sarno (in Lafond et al, 1993) views aphasia as being a 'disorder of person' rather than a 'disorder of language'. The onset of the aphasia produces an alteration of the person that "sets off a chain of attitudinal reactions to illness, disability, sense of self, ability to cope with being socially different, feelings of loss ... compounded by the real ... limits imposed by the communication impairment ..." (ibid. 1993:270).

The therapeutic relationship requires that therapists understand this experience and adapt to the client's performance and comprehension deficits. The therapeutic approach is both intellectual (providing explanations) and emotional (aims at empathic understanding). (Letourneau in Lafond et al, 1993)

Brumfitt (1996) speaks of the aphasic person's fundamental need to develop an alternative and new sense of self if he is to adapt to the changes resulting from the stroke. The state of transition experienced by the aphasic person following cerebrovascular accident needs sensitive handling.

It is particularly difficult for the professional to imagine what it would feel like to be aphasic. Although it is possible to envisage the frustrating struggle for words, or the difficulty in using limited gesture; it is virtually

impossible to imagine the loss of language capacity in the whole sense.

(Brumfitt, 1996:349)

The quality of this relationship is often more significant than the objective help offered by therapist. The therapeutic relationship provides a climate where the person with aphasia can satisfy some of his basic needs (such as security, understanding and acceptance) to boost his self esteem. Most effective therapeutic strategies use client-centered approaches, which take into account the psychological symptoms that accompany aphasia, minimise the communication limitations and exercise residual abilities. (Letourneau, in Lafond et al, 1993).

Marshall (2000) states that there is considerable evidence that aphasia is not only devastating to the person directly, but also for the carers. The incidence of depression and poor adjustment of the spouse can aggravate the quality of communication at home as well as the progress of therapy. However, Brumfitt (1996) is firmly of the opinion that even severely impaired aphasics can make sense of their social context and presumably use some form of non-verbal interpretation to do so.

Cognitive impairment

Wade (in Goodwill and Chamberlain, 1988) comments that following a cerebrovascular accident approximately half the number of persons present with a coma and confusion for the first few days. The level of consciousness can be measured using the Glasgow Coma Scale (GCS). If aphasia is present the GCS score for the individual three sections should be shown, or the motor scale can be used alone. Memory and orientation can be impaired. Perceptual impairment should be assessed as changes may suggest cognitive impairment.

Coughlan (in Goodwill and Chamberlain, 1988) states that personality change and cognitive impairment are likely to follow a severe brain lesion as well as lack of insight, lack of judgement and rigidity of thought. Severe speech and memory problems may compromise remedial therapy because of poor comprehension and retention of instructions.

Such cognitive losses can severely limit a client's ability to actively participate in and respond to therapy (Jackson, in Turner, Foster & Johnson, 1996). Effective therapy demands a high level of commitment from clients (Mattingly & Fleming, 1994). It is recognized that not all clients (following cerebrovascular accident) are able to contribute at this level, particularly if there is a cognitive impairment. It is not within the scope of this study to assess the capacity of the client for autonomous decision-making; rather the assumption that many aphasic clients can be included in the decision-making processes of treatment to varying degrees, is the point of departure.

Ethical principles

Basic ethical principles guide our actions as therapists. Two related principles are particularly relevant in this study.

The first ethical principle at work is that of respect for autonomy. Autonomy can be viewed from two perspectives: The traditional view, particularly evident in the medical model, promotes therapist autonomy; the second focuses on client autonomy, which preserves and enhances the client's capacity to think, decide and act. Polkinghorne (1996:816) highlights the necessity for the latter view, that: 'Basic to occupational engagement is a person's personal power to author choices.'

Various factors determine a person's engagement in occupation. Because the client is an individual with his own unique life experiences and value system, he has the capacity to make his own decisions concerning what he wants to do. This affects how he then engages in the doing.

The second ethical principle is that of beneficence which, simply stated, is to do what seems to be in the client's best interests. Commonly, and in line with the "medical model," application of this principle is based on the therapist's perception of what constitutes a desirable therapeutic outcome. This is however not the only interpretation of the principle of beneficence. Yerxa (1967, in Price-Lackey & Cashman, 1996:313) is helpful in considering the need for an alternative interpretation:

We are viewing the client, not as an object ... to be manipulated, controlled or made to conform but as a unique individual whose very humanness entitles him to choices in determining his own destiny

Clients and therapists bring different values to the therapy setting, and so certain functional abilities or other rehabilitation outcomes might not be correspondingly valued by the client and therapist (Sim, 1998).

The optimum methods of rehabilitation can be objectively identified by the practitioner, but determining the appropriate goals of rehabilitation is ultimately the prerogative of the individual concerned, on the basis of his or her own subjective values and priorities (Sim 1998:6).

If doing what seems to be in the client's best interests is understood to incorporate his views and priorities, then beneficence supports his autonomy.

Autonomy is imperative in order for occupational engagement, and thus occupational therapy, to be relevant. The more relevant rehabilitation is to the client's real needs, the more effective it becomes and the more efficiently can resources be utilised.

Client involvement in goal setting

The South African Patient Rights Charter states that patients have a right to participation in decision-making (Department of Health of South Africa, date unknown).

This principle has been recognised internationally: The World Health Organisation (1984, in Waterworth & Luker, 1990) views client involvement not only as preferable, but also as a social, economic and technical necessity. Ponte-Allan and Giles (1999) report that the Commission for Accreditation of Rehabilitation Facilities in the USA requires the documentation of clients' goals for treatment and client-therapist collaboration on treatment plans. Ozer (1980, in Nelson & Payton, 1991) developed the Patient Participation System for patients to be included in planning: it involves different levels of decision making in the form of open-ended questions, multiple choice, forced-choice and no choice options. These assist in facilitating collaboration, and are helpful strategies to set goals in therapy and beyond. Major concerns of the client can be addressed in this way prior to discharge.

As the traditional assumptions and procedures underlying therapist-client roles are transformed in the emerging health care delivery system, clients and their family members will be called upon to more actively participate

in making decisions about treatment, whereas therapists will be called on to more actively facilitate that participation (Tickle-Degnen, 1998:526).

The importance and benefits of client involvement in goal setting are also described by a number of therapists.

Schwartzberg (1993, in Neistadt 1995) sees the role of the occupational therapist as a facilitator and stresses the importance of maximizing the client's involvement in goal setting.

Trombly et al (1998:299) state that 'patient-identified goals and satisfaction with outcome are important aspects of evaluation of the effectiveness of rehabilitation.'

Ponte-Allan and Giles (1999) report quantitatively better client outcomes for clients following a cerebrovascular accident, when clients are included in the establishing of functional goals in occupational therapy. The clients who had made functional goal statements had significantly higher Functional Independence Measure scores on discharge compared to clients who had not set such functional goals ($p=0.0402$). Client-therapist collaboration on treatment goals can result in shorter hospital stays (Shendell-Falik, 1990 in Neistadt, 1995) and better goal attainment than in the traditional "medical model" in which therapists determine the treatment goals (Czar, 1987 in Neistadt, 1995).

Improvement in ability can have other benefits. This may be economic, for example improvement in a family's economic status when an economically active person can remain employed - whether the person is the client or the caregiver. (The latter being relieved of most of his/her caregiving responsibilities as the client no longer requires the assistance).

Occupational therapists have increasingly been concerned with involving their clients in the therapeutic process (Mattingly, 1994). Choice is necessary to develop 'a shared image of expectations of recovery' (Mattingly & Fleming, 1994:135).

Grady (1995) states that exercising choice in a therapeutic environment provides opportunities to explore abilities and options for life outside the therapy setting. Making choices is another way of exploring personal values. Making choices in therapy is preparation for choices necessary for life in the community. For the therapist, gaining insight into the client's context is most useful in understanding the extent and meaning of the effects of the stroke, as well as the client's priorities. This supports an elementary assumption that human experiences and behaviour cannot be properly understood if they are stripped of their everyday contexts (Jordaan & Jordaan, 1998).

Another aspect of this is the extent to which the client's capacity to make these decisions will be recognised by those around him both in the hospital setting and post discharge.

Sim (1998) recommends that goals and methods of treatment be continually renegotiated, rather than presuming that a one-off discussion will be adequate. This would improve the process of communication between the client and therapist, and promote mutual clarity of goals and expectations. This renegotiation requires flexibility from the therapist.

Chang and Hasselkus's study (1998) on occupational therapists' expectations in rehabilitation, highlighted the themes of agreement, negotiation, reframing or conflict between the expectations of therapist and client. The interplay between the therapists' and clients' expectations was one of the prime themes in their narratives.

Using a client-centered approach, we are not working only for harmonious relationships, but also to facilitate autonomy in occupational engagement, through collaboration. Gill (1987, in Grady, 1995) points to the need for an interactive model in which the client is enabled to participate actively in rehabilitation toward his own self-determination.

Collaboration

Collaboration is understood to be a tool for enhancing the client's autonomy. Referring to Chang and Hasselkus' themes (1998), it is seen to be a process of re-framing and negotiation.

Interpersonal linking increases the therapists' understanding of the change that has occurred in the client's life and of the priorities necessary for planning. This promotes collaborative goal-setting between the client and the therapist (Grady, 1995). This linking is crucial to meet the individual needs of clients (Sabari, 1998). We are challenged to understand each client as an individual.

Self-expression enables the sharing of meaning. Collaboration enables dealing with issues (over and above mundane things like gait and activities of daily living) that are likely to restrict participation, such as a fear of being criticised, lack of self confidence, and a poor quality of life (Angeleri, Angeleri, Foschi, Giaquinto & Nolfe, 1993, in Radomski, 1995).

Mattingly and Fleming (1994:184) found that therapists working with different patient populations had developed a similar set of strategies to encourage collaboration¹, these being: creating

¹ These are the collaboration strategies that were used to form the collaborative section of the code-book for this study. (See appendix B)

choices, individualising treatment, structuring success, creating a personal bond and collaborating with key people in the client's world.

Facilitating autonomy and collaboration

It is understood that the therapy process, being slow and frustrating, requires the motivation of the client. In order to gain this motivation, should it be lacking, the therapist needs to 'tap into commitments and values deep enough within patients to commit them to such a process.' (Mattingly & Fleming, 1994:179)

Grady (1995) goes as far as to say that the client sets the goals and the therapist collaborates to plan treatment with him that will help address the goals. The information shared and what it means to both client and therapist provide the basis for treatment planning.

A challenge for occupational therapy practitioners, is fostering choice that reflects their consumer's priorities for living and accomplishing occupational tasks. (Grady, 1995:302)

Therapists use intrapersonal and interpersonal communication to develop treatment plans. Communication moves from intrapersonal reflection to interpersonal linking through listening and speaking (Grady, 1995).

The challenge: Collaboration, autonomy and the aphasic client

In the light of the foregoing discussion, the medical model which is represented by the following scenario, is considered inappropriate:

Even in cases where a patient had difficulties with communication because of the stroke, a harmonious relationship could be established on the basis of staff primacy in planning and patient effort in doing. (Jones, O' Neill, Waterman & Webb, 1997:103-4)

Application of the collaborative approach when working with aphasic clients is however somewhat problematic; their very aphasia limits conventional methods of involving them in the therapeutic process.

Impairment does not necessarily imply limitation in autonomy. Aphasic clients should not be excluded from the process of collaboration, but rather, included by means of the exploration of a way for meaningful interaction. Inclusion can be made possible by the therapist's ability to interact with and accommodate the person (Gill, 1987 in Grady, 1995).

The collaborative model in aphasia

Aphasia therapy has traditionally followed the "medical model" involving didactic language re-training. (Howard & Hatfield, 1987). More recently through the incorporation of the "social model" (Kagan, 1998), it was found that "focusing solely on clinical repair of language and communication in the adult having aphasia is not sufficient to remediate the totality of what aphasia is or brings" (Lyon, Cariski, Keisler, Rosenbek, Levine, Kumpula, Ryff, Coyne, & Blanc, 1997:694). This has resulted in more of a collaborative approach. "Aphasia therapy if it is to be successful, needs to involve the aphasic patient as an active, involved, and even controlling participant in the re-education process" (Howard & Hatfield, 1987:5).

Fawcus (2000) comments that the aphasic person may indicate which of his problems are most affecting his communication and that the speech and language therapist will therefore focus initially on this 'named' problem.

Holland (1982) lists strategies used by people with aphasia to aid communication. These would be useful if introduced to an occupational therapy situation, to facilitate communication. It is however, not within the scope of this study to review the multiple communication strategies used by aphasia therapists (see p 23-24).

Lyon and others (1997) illustrate how speech therapists are recognising and using activity as an opportunity for communication. They give the example of a client who, through the adaptation of his bicycle, was able to resume the activity of cycling and consequently became involved in other sporting activities. This resulted in the return of speech associated with these particular familiar activities (ibid.).

Lyon and others (1997) indicate that the scope of speech-language therapy is perhaps blurred when it comes to restoring a sense of self and thus a feeling of being able to interact. It was suggested that activities can inherently strengthen the self-concept of the client and in turn leads to interactions with others. Activity is therefore a means to an end in speech therapy, whereas in occupational therapy activity, or more specifically occupation, is both an end and a means. (Gray, 1998).

Through the use of communication partners, communication and wellbeing can be enhanced in the setting that the client finds himself. Communication partners help the caregiver to realise what may be possible if the client is supported in doing activities. "... increased participation in life

provides a much richer experiential base for subsequent communication between caregiver and patient” (Lyon et al 1997:695).

Chapey, Duchan, Kagan, Lyon and Simmons Mackie (2000), speech therapists, propose a “life participation approach to aphasia” emphasising the attainment of re-engagement in life by strengthening daily participation in activities of choice. The aphasiology literature points to activity involvement as a tool to aid improvement in communication. This resonates well with occupational therapy philosophy (see Table 1, p4), but does not enlighten us as to the process used by occupational therapists to reframe and negotiate, that is, collaborate with the aphasic client.

This study focuses on the collaboration strategies currently used by occupational therapists working with aphasic clients. Collaboration is understood to be a tool to identify meaningful activities. Supported conversation for adults with aphasia (SCA) in the speech language literature provides a possible means to address the ‘how to’ for collaboration.

Kagan (1998) describes SCA as an approach to intervention in the field of aphasia to support communication and reduce communication symptoms. Kagan (1998) says that it is speech therapy’s application of the “social model of disability” to aphasic clients, but it is recognised that aphasia therapy is still needed to reduce communication symptoms for when the environment is not supportive. The goal of SCA is to reveal the client’s competence, through conversation. This is different from the goal in occupational therapy, which is to assist the client to re-engage in occupation.

Holland (1998) recommends that conversation be central in therapy instead of being used on the periphery, as an addendum to the more traditional remedial strategies to optimise communication.

A non-directive approach encourages opportunities for communication. Such supported conversation results in interdependence between the aphasic person and the communication partner.

“Aphasiologists know that while many persons with aphasia are competent to make decisions, they may be unable to express themselves sufficiently well to exercise their autonomy....Aphasia therapists are challenged to explore different strategies in the hope of restoring the person's autonomy, with whatever degree of persuasion or time is necessary” (Sarno, in Lafond et al, 1993, 276-7).

What is still not visible in the occupational therapy literature in the field of aphasiology, is how to get alongside someone with aphasia to collaborate effectively with them in the choice of occupation, for therapeutic benefit. The question therefore needs to be raised as to whether, and if so how the expert occupational therapists do this.

What are the experts doing?

According to Mattingly and Fleming (1994) an expert therapist has expertise regarding impairment and how to improve performance. Because of who she is and because she is established in the values of the profession (see Table 1 on p4), this expertise does not put the therapist in a position of authority over the client, make the therapist an authority on the client, or on the medical condition. Rather the therapist becomes a collaborator with the client in identifying problems and making choices.

An ethical, professional therapist has been identified as one who motivates and facilitates the active participation of the patient (Northen, Rust, Nelson & Watts, 1995:215).

The degree to which a therapist is able to enter a client's world and simultaneously manage the treatment session appears to be derived not only from experience, but also from the therapist's personal abilities or approach. The collaboration required is thus seen to demand a degree of personal involvement on the part of the therapist, not only regarding her commitment to the co-operative process, but also to pursuing an outcome that is meaningful to the client. The extent to which the therapist is comfortable with the interactive style and meaning-making aspects of therapy, seemed to be very strongly linked to this personal ability. (Mattingly & Fleming, 1994)

Mattingly and Fleming (1994) found that therapists try to include non-speaking clients into the therapeutic process (but do not document the methods used to achieve this). Grady (1995:307) points out that we can learn about these interactive roles through reflection.

"Reflective practice and clinical reasoning support our ability to gain insight into the interactive roles that can unfold between a therapist and a person seeking services"

Mattingly and Fleming (1994) in their study of occupational therapists' clinical reasoning, assume that clinical reasoning is a thinking process that develops over time. I too have understood the clinical reasoning to be an unfolding process: this prompted my use of the co-operative inquiry methodology (see p25-6) to see how this process facilitates therapists' development through the use of reflection IN and ON action.

According to Yarett Slater and Cohn (1991), experienced therapists intuitively do what normally works: when confronted with problems though, the therapist is usually able to analyse and judge the appropriate intervention. The therapist is able to pick up relevant cues, consider a variety of

factors and arrive at a sense of knowing what to do next. This consideration, or reflection, occurs both in and out of the practical therapy situation.

Reflection

Schön (1983) identified two different ways to respond to surprising responses to familiar techniques. In the therapeutic context this is brought about by the client's individuality:

We may use reflection-ON-action, which consists of thinking back on what we have done. Reflection-ON-action occurs after the event and has no effect on the 'action present'. Or, we may use reflection-IN-action, which consists of on-the-spot inquiry that reshapes what we are doing while we are doing it. (Schön, 1990, in Dutton, 1995:6-7)

According to Mattingly and Fleming (1994) thought and action are interdependent. The client's actions, the therapist's actions, and the client's reactions to the therapist's actions are all dynamic and essential cues for the therapist's reasoning process.

Types of Reasoning

Fleming (1991) reports that expert occupational therapists draw on a combination of different types of reasoning in the treatment process. The first type is procedural, in which the therapist engages in cue identification, hypothesis generation, cue interpretation and hypothesis evaluation. The second is interactive reasoning. This is used to engage the person in the treatment session; to know who the person is; to understand the disability from the client's point of view; to individualise treatment; to communicate a sense of acceptance, trust and hope; to construct a shared language of actions and meanings and to determine if the treatment session is going well.

The third type described by Fleming (1991) is conditional reasoning in which the therapist reflects on the clinical encounter from both the procedural and interactive standpoints and attempts to integrate the two. The therapist interprets the meaning of therapy in the context of a possible future for the person, and thus engages in building a shared image of the client's future self, or establishing a prospective story through continuous hypothesis modification.

This clinical reasoning in practice means reasoning, not only about what is wrong and how to fix it, but also about how to engage the patient in that fixing process (Mattingly 1991(a)).

Within this reasoning process, the occupational therapist uses inductive and deductive reasoning. Mattingly (1989, in Alsop & Ryan, 1996) found that experienced therapists use inductive reasoning when they automatically consider a wide range of options before deciding what to do. Alsop and Ryan (1996) go on to say that therapists then employ deductive reasoning in deciding which course of action to follow.

Literature lacking

No studies were found that addressed the need (or the challenge) to foster choice and promote the interactive model in occupational therapy and beyond, with aphasic clients (following stroke). In spite of the stated importance of the interactive model, there is a lack of research in the area of collaboration with aphasic clients in occupational therapy.

There is literature in the area of occupational therapy with stroke clients, literature on collaboration, and literature on aphasia: however no literature was found combining the three areas.

Wulf (1973, in Goldberg 1993) a woman who recovered from aphasia gives a glimpse as to the qualities of such an expert therapist. This also offers some insight into the complexity of the issues that this study addresses:

A successful therapist has to be intuitively perceptive, attuned to using every clue, things nobody else would suspect were clues; a mind imaginatively sensitive to our needs, wants, desires, frustrations, weariness, hopes, abilities and our obvious disabilities.

University of Cape Town

Problem setting

Problem/ Research Question

The literature puts forward a strong case for client-centered practice. I have found in my own practice that such collaboration results in therapy that is more relevant to the individual client. I have experienced such a client-centered approach with aphasic clients (following cerebrovascular accident) as a challenge. I noted that aphasic clients could respond well to certain collaboration strategies. This made me wonder what other strategies I could try.

I sought after literature to guide my own practice, hoping to learn from other occupational therapists' experience. I did not find any occupational therapy literature that addresses the application of the ideals of client-centered practice to collaboration with aphasic clients, only general guidelines to collaboration. I did, however, find speech therapy literature on aphasia therapy, for reducing the communication symptoms, and on the more recent approaches to functional communication.

I therefore set out to discover if there are "expert" occupational therapists (see page ix) who collaborate with aphasic clients, and if so how expert occupational therapists involve their aphasic clients in the therapeutic process.

Purpose

The purpose of this study is to contribute to an understanding of how expert occupational therapists collaborate with aphasic clients, so that other occupational therapists that work in this field may learn how to provide inclusive and relevant treatment, including the facilitation of occupational engagement.

Aim

To describe expert occupational therapists' experience of and responses to the challenge of collaboration with aphasic clients, in the pursuit of enabling occupation.

Objectives

To highlight expert occupational therapists' experience of developing collaborative partnerships with clients who are aphasic, through a process of reflection on practice.

To identify the strategies that are used by expert occupational therapists for promoting choice and inclusion within the collaborative process with aphasic clients.

To describe expert occupational therapists' experience of the capacity of aphasic clients to participate in the process of enabling occupation.

University of Cape Town

Chapter 2 Method

Study Design

Qualitative methodology

This study takes the form of descriptive research, using the methodology of co-operative inquiry, which is a type of participative research. Co-operative inquiry focus groups were run to explore how occupational therapists work with aphasic clients post stroke.

According to Heron (1996), participatory action research is perhaps the best known form of participative research, for its use in the realm of social development. Co-operative inquiry differs from participatory action research. Co-operative inquiry is initiated by a need to learn, to seek transformation in the setting represented by the researcher, for example within the occupational therapy profession, rather than in an underdeveloped or impoverished community, as would be the case in participatory action research.

The methodology of co-operative inquiry includes reflection and action cycles, formed to affect and effect action and not merely to gain knowledge. There are four phases of action and reflection: In the first phase the co-researchers agree on an area for inquiry and to some set of procedures to observe and record the experience. The second phase involves applying this action in their practice between focus groups. The third phase is when the co-researchers become fully involved and see their experience in a new way. The co-researchers return in the fourth phase to review the experience (Reason, in Denzin & Lincoln, 1998).

A feature of this methodology which enhances the validity of the findings, is that of research cycling which is ...

the interaction of experience and reflection for both the individual and the group, ensuring that individual experience and reflection was open to influence by collective experience and reflection, and vice versa. (De-Venney-Tierman in Reason, 1994:125)

The participants in the collective reflection employ inductive and deductive reasoning.

Inductive reasoning can be flawed because of the tendency to ignore falsifying data, whereas deductive reasoning can be flawed because it is easy to misinterpret premises (Gilhooly, 1988 in Christiansen & Baum, 1997:169)

A "devil's advocate" role contributes towards maintaining a balance between this convergence and divergence.

The design and analysis of this study was influenced by the work of Schön (1983), who considers that no amount of knowledge is adequate to solve the problems posed by unique clients. Thus the ability to think IN action is what determines the quality of a therapist's work.

Ethical and legal considerations

Prior to undertaking the data collection I considered the ethical and legal considerations. The design and methods are appropriate to the research question. I have considered the reliability and validity of the study in this chapter (see p40-2).

The vulnerability of aphasic clients in the therapeutic process, one of the motivations for this study, has been considered (see p4) in the literature review. This points to the need for the therapist to exercise ethical reasoning. The ethical principles of respect for autonomy and beneficence and their bearing on this study have also been outlined in the literature review (see p4).

The anonymity of clients and participants has been maintained in the descriptions and extracts. The participants have however agreed to being named as contributors in this study. The participants stated that they benefited from their tacit understanding being verbalised and confirmed. They appreciated the opportunity for reflection, particularly with other “experts”. The research cost these participants their time for completing the questionnaire and for five focus groups (including the member checking session). The participants will receive feedback on the results of the study.

Full disclosure of my intended purpose and process for the study was given to the participants to obtain their informed consent. The purpose and process were then open to negotiation so as to equip them as co-researchers. The participants had the freedom to withdraw at any point in the study. . The feasibility of exploring the research problem was discussed in chapter 1.

Data collection

The study relied on the researcher collaborating with expert occupational therapists in an action-reflective process, through the use of focus groups. I therefore needed to locate expert occupational therapists for the focus groups. I went about this in the following phases:

Table 2: Data collection phases

	Method	Purpose
Phase 1	Design and pilot a questionnaire	To identify therapists for this study (this was not to evaluate the therapists' competence).
Phase 2	Design code-book	In order to establish a reliable indicator of an expert therapist I designed a code-book as a measure of the qualities of such an expert, with reference to the degree of collaboration and level of clinical reasoning used.
Phase 3	Interview Key informant	To enrich the code-book
Phase 4	Sampling: Locating prospective participants	To determine therapists' level of clinical reasoning and the degree to which they collaborate through the completion of the questionnaires
Phase 5	Score questionnaires	To isolate a sample of participants
Phase 6	Conduct focus groups	Create a forum for experts to discuss their reflection on action.

Questionnaire

A questionnaire was designed to select expert occupational therapists for the focus group interviews. This questionnaire (see Appendix A) was not an assessment tool to determine who such an expert occupational therapist is, as the questionnaire would need to be tested rigorously

for that. Rather, it was designed to indicate, based on their responses, if therapists are reflecting on their practice and to what degree they demonstrate the characteristics of an expert.

The three scenarios in the questionnaire were taken from my own practice to elucidate the strategies used in therapists' collaboration with aphasic clients. The scenarios were chosen as they require the respondents to show an ability firstly to reflect ON action, secondly to reflect IN action and thirdly to think both inductively and deductively. In the first scenario the potential participants were required to relate experiences by describing how they have responded to similar experiences, demonstrating their skill at reading cues and reporting on their learning from the experience (reflection-ON-action). The second scenario inquired about the therapist's emotional and action response (which spoke of their reflection-IN-action). The third scenario was designed to reveal their inductive and deductive reasoning.

The questionnaire was set to determine the degree to which the respondents collaborate and the level of clinical reasoning at which they are operating. The code-book was therefore created as a guideline as to the qualities that I expected to find in an occupational therapist who was functioning at the level of an expert.

Code-book

In needing to seek out expert occupational therapists, I designed a code-book (see Appendix B), against which I could view the therapists' responses to the three different scenarios. The code-book relates to two key elements: that is "collaboration" and "level of clinical reasoning".

A code-book is typically used in quantitative studies – as an interface between the questionnaire design and computer analysis of data. It is developed by the researcher as a tool to assign a

value to a response, to give it a numerical value on the computer. It is not something that has to be done in a particular way. I adapted the above conventional use in order to use the code-book in a qualitative way. (For references, see p105).

Mattingly and Fleming (1994) reported four strategies to encourage collaboration between the therapist and the client, as well as a fifth strategy of collaboration with others. These strategies were reported to be used by therapists working with different client populations. These five strategies created a basis for the collaboration section of the code-book.

In order to develop the code-book, I was advised to interview a key informant to determine if there were any other qualities that I should be looking for in an expert therapist (besides those mentioned either in the literature) or by the piloting sample. The speech therapy consultant for this study directed me to an information rich key informant (whom I shall call Linda) whom she thought would be able to tell her story of interacting with many therapists operating with varying degrees of collaboration. Linda's husband had recently had a stroke and was aphasic.

Key informant

Linda did not want the interview tape recorded as she said she could speak more freely without a tape recorder. I therefore made notes as she spoke. I asked Linda to describe her experience of how the therapists worked with her and her husband (the client), particularly in terms of how they included her own and her husband's needs and goals in the planning and implementation of treatment.

In the code-book, I already had five collaborative strategies from the literature. On reviewing the interview notes inductively (Miles & Huberman, 1994), I had a list of characteristics of a therapist

who does not appear to adequately meet the needs/goals of the client and/or family (novice), as well as a list of the characteristics (strategies and qualities) of those who do meet the needs of the client and/or family (expert). Of the expert traits, many were principles about collaboration. The latter principles augmented the five strategies I had from the literature (Mattingly, 1994), and appear in the collaboration section of the book of codes (see p102). This was then used together with the clinical reasoning section to deductively analyse the data from the questionnaires.

Linda's contribution helped to develop the code-book, specifically the section on collaboration. Most of the sub sections of the collaboration section in the code-book come from the interview. The remainder of the principles were extracted from responses to one of the questionnaires.

Pilot questionnaire

Three physiotherapists and two speech therapists, whom I thought would have sufficient experience to have developed their clinical reasoning, were asked to complete a questionnaire for the purpose of piloting it. This was done so as not to reduce the potential expert occupational therapist population.

Led by the data, I made some changes to the questionnaire, mostly in terms of the layout.

Study population and sampling

The objective of the sampling was to identify occupational therapists working with aphasic clients who are expert at clinical reasoning and who try to develop collaborative partnership and "a shared image of expectations of recovery" (Mattingly & Fleming, 1994:135) with aphasic clients.

Due to the choice of research design, purposive sampling was used. The sample was sourced via snowballing through a Neurology interest group that meets at Groote Schuur Hospital, Cape Town.

I asked the occupational therapists at this interest group to fill out an attendance register, so that I knew who they were, if they worked with adult stroke clients and if they would be doing so in the following few months. The inclusive criteria were that they should be occupational therapists working in Cape Town, proficient in English and able to participate in focus groups. From this list I sent out thirteen questionnaires to occupational therapists that I thought would have sufficient experience to have developed their clinical reasoning. I received ten questionnaires back.

Coding respondents as expert

Based on the qualities expected of an expert (in terms of collaboration and clinical reasoning), as outlined in the code-book. (see Appendix B, p102-4), each questionnaire was given a rating for clinical reasoning and for collaboration (see p106). Adding the number of collaboration strategies in their responses yielded a cumulative score for collaboration. A score for clinical reasoning was reached by counting the number of responses in each level of clinical reasoning and then assigning a score to the level at which they most frequently responded.

The maximum score for each axis (clinical reasoning and collaboration) was five. The resultant scores were indicative of the degree to which they collaborate and the level at which they reason, respectively.

Having scored the questionnaires, I found that the mean scores for collaboration were high and the range of scores was small. I concluded that the code-book's section on collaboration wasn't sensitive enough to identify the principles of collaboration.

I discovered both principles of collaboration and strategies for communication in their responses.

I therefore refined the collaboration section of the code-book further, to isolate the principles of

collaboration, rather than communication strategies that do not necessarily infer a collaborative approach. I did this by selecting the qualities from one of the returned questionnaires that really seemed to have the essence of collaboration, retaining these in the code-book and omitting the others. I then re-scored the questionnaires and arrived at six occupational therapists operating at the level of “expert,” that is, who scored at the highest level for both collaboration and clinical reasoning. The judgement regarding their apparent expertise, was made based on the scores for the questionnaire. (See Table 4, p106)

I had set out to get a minimum of four expert occupational therapists, but only three were available due to time constraints. The size of the focus group proved to be sufficient to allow for reliability in the data, as there was recurrence of information with increasing depth in each successive session.

The three occupational therapists in the focus groups were very accommodating, in spite of tight schedules.

I attained their commitment after explaining the necessary requirements. These were that they would need to commit to the following in order to participate:

- attend four focus groups over four consecutive weeks,
- reflect individually on action in the form of a reflection journal,
- reflect collectively on action in the form of discussion at the focus group,
- reflect on the discussion following the group to inform practice,
- try out ideas in practice, and
- share these reflections in the subsequent focus group.

They agreed that I could take their journals at the end of the four weeks, in order to use them for data analysis.

Focus groups

A focus group can be described as

... a semi-structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic (Carey, in Morse, 1994:226)

This forum created an opportunity for the expert occupational therapists to share, prompted by reflection on practice, their experience of developing collaborative partnerships with aphasic clients. This promoted the revelation of the otherwise tacit knowledge through the expert therapist's personal and collective reflection.

All therapists were practising at the time and thus had opportunities for treatment sessions with aphasic clients between focus groups: This prompted reflection ON action, and thus further in depth discussion within the focus groups.

The methodology of co-operative inquiry allowed for a collaborative approach to the focus groups and despite my role as group facilitator, I was also able to take on the role of a participant.

Structure for group

We met in one of the participant's homes, as per the most convenient arrangement. I provided refreshments for the sessions. I also provided each participant with a journal and kept one myself. I did not video tape the first session, as a video camera felt rather clinical in the home

environment. The audio quality was not good in a group setting and it was difficult to transcribe when more than one participant was talking. I therefore audio- and videotaped the remainder of the sessions to ensure audibility.

Group content

The first focus group consisted of the introduction and negotiation of the purpose and process of the focus groups as well as the establishing of roles. The next two sessions consisted of discussion and a debriefing of what facilitated the process. In the fourth session drawing conclusions followed the discussion and debriefing.

Group process

The focus groups were semi-structured in format and lasted forty-five minutes to an hour. Fieldwork notes were kept to document the researcher's experiences and thoughts during the period of research.

The methodology of co-operative inquiry expects the participants to become increasingly more co-operative and autonomous over time, as they become more familiar with the methodology, more confident in sharing their experience and more comfortable to share with each other (Heron, 1996). I initiated the facilitation of the first focus group, but expressed my desire not to be the facilitator of further groups. I was hoping that an alternative facilitator would evolve as we went further into the process.

It is possible for a participant to take on the role of facilitator, once the purpose has been presented and negotiated: this would have allowed me to take on more of a role of a participant. In this group, however, it was more expedient for me to remain the facilitator, as the group was seeking a lot of direction and I needed to clarify and explore what they were contributing. Had

there been more focus groups and less pressure to get to the essence of their experience of collaboration with their aphasic clients, an alternative facilitator might have evolved.

My role in facilitating the co-operation became less active as the group became more autonomous. The participants started to clarify and explore of their own accord, which highlighted their role as co-researchers and enabled me to take on a more active role as participant.

I was aware that my own experience was less than the rest of the group. My inclusion in the group as a participant can however, be justified in that I have consciously done a lot of reflecting IN and ON action to 'find other ways' to develop collaborative partnerships in my own practice. My path of reasoning toward development as a professional has therefore been similar to that of the participants.

Data analysis

I transcribed the interviews between focus groups and reviewed them for areas that I thought needed clarification or exploration. This resulted in returning to the next focus group with questions (see appendix E). After the fourth focus group I began the first phase of formal analysis, the open coding and the axial coding, for which I used NVivo, a data management computer programme. In the second phase of analysis, the selective coding, I used Schön's (1983) reflection-IN-action and reflection-ON-action, together with my objectives for the study, as a framework to categorise the codes.

Open coding

In the first phase of the analysis, I analysed the transcriptions of the interviews initially with open coding (Neuman, 1997), to identify units of meaning in the raw data. The codes were predominantly in vivo, that is the actual phrases said by the participants, or a paraphrasing of them.

Axial coding

Through a process of axial coding, I began to inductively form the categories of relationships, experience, outcome, reflection and process, by fitting the more differentiated codes within more conceptually inclusive categories. This involved merging of codes into other categories (Miles & Huberman, 1994).

I selected "meaning units" from the tree codes by following Flick's (1998:184) sequence of 'cause, phenomenon and consequence' to structure the data. This resulted in the following sequence: In respecting 'who the person is' it is necessary to 'focus on the familiar'. This is done by 'trying to promote choice'. It is 'one's outlook on life' together with 'being creative' that facilitates the 'comfort of patient to interact'. The importance of choice is noted in that hope, decision-making and personality are compromised if no choice is given. This reinforces the 'power for choosing their activities'.

To create a more coherent flow of ideas, the categories were fitted into the following three themes: 'Relationship vitally important beyond activities', 'as therapist, give back the key for control of situation', 'they can start doing things for themselves'. A table was constructed as a very broad representation illustrating how the data emerged and fitted together (see Appendix E).

Member checking

I met with the focus group participants a fifth time to determine if I understood what they had shared. I showed them the tree structure that I had designed using NVivo to contain all the codes, as well as a table of themes and categories (Appendix F). I asked for their comments regarding the contents of Table 5 (Appendix F), and also to identify any codes that needed to be added or emphasised.

The participants confirmed my description of the findings and suggested areas that needed to be highlighted. The member checking enhanced the credibility of this study.

Selective coding

The analysis began to make sense when I started the selective coding (Neuman, 1997), where confirmability was achieved by maintaining the neutrality of the data, against Schön's framework of the therapists' reflection IN and ON action, as well as the third objective pertaining to the capacity of the client.

I followed a process of deductive coding and repeated recoding. I looked for the codes that address the therapists' experience of developing collaborative partnerships (being) and strategies used (doing), as well as the therapists' experience of the client's capacity. I read through the four journals to find meaning units that elaborated on the codes from the interviews.

The recoding process was assisted by the formation of network diagrams, not to achieve closure, but rather to spur on further analysis (Miles & Huberman, 1994). This involved negative case analysis for any discrepancies that existed in the data. I searched for other possible explanations for the findings. (Lincoln & Guba, 1985 in Gliner, 1994)

A process of successive approximation led me to the sub plot, consisting of three elements which represent the essence of the phenomenon under study, and which became central to the understanding and placing of the other codes (Neuman, 1997), (see Table 3 on p43).

When I then restructured the themes, categories and subcategories against the objectives, the sub-plots fitted exactly (see Table 3, p43). Table 3 might suggest that the '*experience of developing collaborative partnerships*' is equal to reflection-IN-action, or that '*strategies used for promoting choice*' is equal to reflection-ON-action. However, the nature of the data is so dynamic that the experience of 'being' informs the reflection-IN and ON-action and vice versa, as do the strategies (doing) and vice versa. The reflection-ON-action and reflection-IN-action inform each other as well. Another dynamic that was revealed in the analysis is that the client's perceived capacity informs the therapist's interactive reasoning (see p21). The therapists' reflections both IN and ON action were understood to enable the therapist to support the client's capacity through her empathetic '*looking for keys*'.

'Looking for keys' had been the second element of the sub plot, and '*I had to find other ways*' had been a theme in the section of 'strategies used'. However, because of the recurring prominence of '*looking for keys*', I realised that '*looking for keys*' was the plot. '*I had to find other ways*' was then seen to be the most prominent term in the strategies, and it therefore became the second element of the sub plot. This continual process of re-coding, according to the objectives, resulted in the following table of findings.

Table 3 represents the findings at various coding levels. The levels are in order of conceptual sizes and should be read from left to right following the framework column. These range from subcategories through to the plot. Each of these quotes are actual codes, but due to their conceptual size have been re-named, for example the code 'being human' became a theme. The

codes that fall within each of the subcategories have not been shown on this table because they are too numerous. (See definition of terms, page vii-xii).

Key Informant

I met with a key informant, an occupational therapist, who has many years of experience working with stroke clients, and is well recognised for this. She was not included in the sample, as she was unavailable owing to time constraints. I discussed the contents of Table 3 (see p43) with her to determine if this had been her experience as well. She confirmed the sub-plots and the fit of the themes and categories into the sub-plots. This interview added credibility to the findings.

Trustworthiness

I have considered the validity and reliability in chapter 2 and 3. These include the following:

Credibility

Triangulation

I have used a variety of different sources: Key informants (Linda and occupational therapist) and the focus groups.

The member checking was a useful tool for maintaining the credibility of the findings, in that the participants did challenge my assumptions when we were debating where certain of the concepts ought to fit.

Falsification mechanism

In upholding the credibility of the findings, I needed to be aware of and minimise possible threats to the study, such as a desire for the participants to conform to socially acceptable responses (Krefting, 1991).

Reason (in Denzin & Lincoln, 1998) found that in the process of group formation there is a tendency toward consensus collusion and unaware projection, which needs to be avoided. In order to establish opportunities for group members to challenge unwarranted assumptions, a falsification mechanism was established in the form of the roles of “devil’s advocate” and “supporter.”

Reflexivity

My participation in the focus group produced opportunities for me to reflect on my own practice, but more particularly on the collective reflection, in the form of the content and process of the groups. Reviewing the transcriptions resulted in returning to the participants with questions to clarify and explore the data.

The co-researchers in the focus group also kept journals, which prompted them to reflect individually on their practice. The collective reflections of the group formed the basis for the group discussions.

Allocating time for debriefing at the end of the focus group sessions, helped to minimise my own biases as the participants were at liberty to challenge my assumptions. My own journal writing helped me to be aware of my own biases.

Peer debriefing

I presented progress reports to a group of interested fellow students at study groups that were held on a regular basis.

Dependability

Dependability was seen in the consistency of the data, both over the course of the focus group interviews and in the analysis stage. The variability in the data, which does exist, can be ascribed to the co-researchers' individual experiences. I documented my interpretations, so that I could reflect critically on the analysis process and thereby limit my influence on the data (Krefting, 1991).

Confirmability

The descriptions given in this chapter, as well as the process notes (see Appendix G), form the basis of the audit trail.

Transferability

I have attempted to enhance the transferability of the findings by giving sufficient description of the process for the data collection and analysis.

Chapter 3 Findings

Table 3: Table of findings

FRAMEWORK	SUBCATEGORY	CATEGORY	THEME	SUB PLOT	PLOT
Experience of developing partnerships (BEING) (Objective 1) AND Reflecting IN	One's outlook on life	You as a catalyst for the patient to see things differently	Being human	Empathy is what communicates the goals and encourages reasons for picking oneself up and continuing	Working with aphasics is like looking for keys of what works ... to spur treatment on to meaningfulness
	Patterns of initiatives and responses	I think the patient can show you	Time to listen to words unsaid		
	Tune in to what real problem is	Trying to pick up clues	Trying to climb into the patient's mind		
Strategies used (DOING) (Objective 2) AND Reflecting ON	Find out about actual way of life	Stepping stones to build therapy on	Going the extra mile can be a short cut	I had to find other ways to make him progress	
	Carry over to others				
	An ethical question	So often when you do bother you do get improvement			
	No hope, decisions and personality if no choice				
	Supporting or pushing towards doing	Other strategies	Come to own little answers along the way		
	Theory distanced, can't really relate	Back to our basic principles			
	Been rewarding thinking back	Looking to see why they aren't open to therapy	Improve collaboration skills, having realised its value		
Capacity of client to engage in occupation (Objective 3)	She is prioritising as to what is important to her	She had come out of her shell – that gives her so much control	They can learn to choose again	Results in person taking over	
	Know and respect the person	See these patients as a whole	Comfort of the patient to interact		
	Power to choose their activities	Decision making important for who you are	Them making the decision of what they want to do and you accommodating that		
	They give their everything	I strongly believe that they can start doing more things for themselves			

Findings borne out by the literature

When viewing Table 3, it would be helpful to consider the following areas of literature, as outlined in the literature review, which support the findings: The enduring values of occupational therapy (Christiansen & Baum, 1997), the ethical principles of respect for autonomy and beneficence (Sim, 1998), the therapist's personal abilities and approach (Mattingly & Fleming, 1994; Letourneau, in Lafond et al, 1993), the therapist's reflection on her experience (Schön, 1983; Grady, 1995), collaborative goal setting (Grady, 1995), the aphasiology literature which points to participation in activities of choice (Lyon et al, 1997) as well as the advocacy of various communication strategies (Holland, 1982).

These findings are borne out by the literature, in that they capture the client-centered approach to practice that results in the therapist 'looking for keys of what works ... to spur treatment on to meaningfulness'. What appears to spur the occupational therapist on to bother 'looking for keys' is the therapist's awareness of the aphasic client's capacity to participate in the process of enabling occupation. Although reinforced by principles in the literature, the findings are original. No particular author can therefore be cited to confirm the findings.

Findings to be explored in discussion

I will now use Table 3 to structure the discussion, particularly the framework of the objectives. It is not possible to capture the dynamic nature of the therapists' experiences and the strategies they use on such a reductionistic table. I have however tried to capture this complexity in the ensuing discussion. I have incorporated Mattingly and Fleming's (1994) four key principles of collaboration into the discussion.

This discussion is illustrated with extracts from the focus group interviews, extracts from the therapists' personal journals and from literature. For the sake of anonymity, the co-researchers' names have been changed.

University of Cape Town

Chapter 4 Discussion of results

This discussion suggests an understanding of how expert occupational therapists collaborate with aphasic clients to provide inclusive and relevant treatment, including the facilitation of occupational engagement. In so doing, the therapist's experience of and response to this challenge of collaboration will be explored, to describe the expert occupational therapists' experience of the capacity of aphasic clients to participate in the process of enabling occupation.

The following plot emerged:

Working with aphasics is like looking for keys of what works ... to spur treatment on to meaningfulness

The 'looking' appears to be an approach that emanates from the therapist's desire to develop meaningful treatment. The therapist finds herself reflecting IN and ON practice to make sense of her interventions and to solve problems. Through posing questions and looking for answers to these questions, the therapist seeks to spur treatment on to meaningfulness, that is, to facilitate more relevant intervention in practice. The plot arose from the following extracts:

Caryn: Another thought I had on going home, and Jenny's just reminded me now. I find often working with aphasics is like looking for keys, of what works.

Focusing on abilities of the client and slowing down treatment, accentuating contact- physical and eye contact. Not to speak above, about the client when s/he is not there, always involving him in conversation with others, especially family members. Giving time to respond seems to empower, take control again. Eye contact connects, keeps therapist and client on equal level and spurs treatment on to meaningfulness. (Jenny: Journal p2)

Various levels of 'looking' have been identified: the most concrete being eye contact and clinical observation, in which the therapist's intention is to stay on an '*equal level*' rather than to direct therapy. The therapist takes a more in-depth look for '*keys*' in the form of reflection IN and ON action.

Julie: The more you reflect, the clearer things get, but also the more questions you have, I think. You made the comment last week that your second questionnaire had been better than the first, um, so you know the reflections that you, that we are writing. If you are reflecting on a specific experience it will take you all over the place, but it normally draws you back to, if you keep at it, it will draw you to your own conclusion, even if that conclusion is a question. It brings you clarity.

The following is an experience where the 'looking' occurred IN action, and didn't require reflection outside of the practice situation.

It was just the key to get it right

Caryn: Um, you know, I was thinking of one patient who was like really battling with reading and that, and suddenly finding that if he put his finger on the word, he could read. Or somebody else battling with writing words down and that. I suddenly found that if he spelt them out loud, it was just the key to get it right. Or, um, another Afrikaans guy who, if you told him like with money and that, 'vyf en dertig sent' (*thirty five cents*) and he had to try and write it down. He would get it wrong, but if you said 'drie vyf', (*three five*) he would get it right. So all the time, it's kind of like looking for little keys that will solve the problem.

The following three elements of the sub-plot (see Table 3 on p43) will now be explored.

Empathy is what facilitates the communication of the goals and encourages reasons for the client to pick himself up to continue ...
The therapist needs to find other ways for the client to progress ...
This process results in the client taking over.

Each of the objectives of the study will be used to frame this exploration.

Objective 1

To highlight expert occupational therapists' experience of developing collaborative partnerships with clients who are aphasic, through a process of reflection on practice.

The first element of the sub-plot that emerged to highlight the expert occupational therapists' experience of developing collaborative partnerships with aphasic clients is as follows:

Empathy is what communicates the goals and encourages reasons for picking oneself up and continuing.

Empathy is important. And that is what communicates the goals and encourages reasons for picking oneself up and continuing. (Jenny: Journal p4)

The therapist's experience of developing this partnership is one of empathy, which is understood here to be a multi-faceted term. It encompasses the therapist who, *'being human'*, is therefore in a position to take time to *'try and climb into the client's mind'* in order to understand the client better. Empathy is seen to be facilitatory as well, in that it enables the communication of goals and encourages the participation of the client. Kegan (in Brumfitt, 1996:359) describes the therapists' work as follows:

"The clinicians' fundamental activity is to convey to the client that they understand something of his or her experience in the way he or she experiences it. This understanding requires a special kind of empathy ... for the therapist to do the work without distress, fear or contempt, he or she needs to become acquainted with his or her own weaknesses. This implies that this (aphasia) could also happen to the therapist."

The following is the first of the three themes for the first element of the sub-plot:

Being human helps your relationship

Jenny: I think my neologisms and word finding problems are part of my speech problem which actually probably connects me better with my patients.

Mary: Exactly

Jenny: I really do think so. I think though, I think you need to also use yourself for example that you're not just so slick and organised

Mary: That's right, that's right.

Jenny: That you're very human with, with big big, you know, faults and things. I think that helps your relationship, and being open to that.

This characteristic of "being human" enables the therapist to use herself as a catalyst for the client to see things differently. This response from the therapist is informed by her interaction with the client, which produces a complex experience of empathy, on which I will now elaborate, beginning with the first category -

You as a catalyst for the patient to see things differently

Caryn: ... and there might be times where you are needing to encourage and support more, and times when one needs to, maybe, push a little bit as well.

Mary: Ja, that is so

Caryn: Not always just empathy and understanding, because that's always got to be there, but also a case of helping the person to realise ...

Jenny: Like being a bit of a catalyst sort of.

Caryn: Ja

Jenny: Seeing things different.

Experienced occupational therapists are able to embed their intervention into a prospective story. This helps the client to form a new picture of himself, which serves as a baseline, or a reference point for monitoring change.

Treatment is meaningful to the patient only when the patient helps to construct the image of possible outcomes and then actively participates in the treatment activities. The patient has to have a stake in his or her own story (Mattingly, 1991, in Dutton, 1995:8)

This prospective story, which is more than treatment goals and plans (Mattingly, 1991(b)), is facilitated by the therapist's approach to her clients. The participants spoke about the importance of life experience to help the therapist relate more easily to the client.

It gives you quite an insight

Caryn: I had a knee op. and I was stuck in bed for three days, and I wasn't allowed out and I had to rely on the bell and everything. And it actually just gives you quite an insight ...

Mary: That is so

Caryn: ... into what it's like to be totally dependent on other people, ...

Mary: Mm Mm

Caryn: ... and even worse if you can't speak.

The sub category that supports the therapist as a 'catalyst' is her 'outlook on life', which is influenced by her life experience.

One's outlook on life

Jenny: The question of experience that's what I did write today, the following is important as it's something difficult to gauge or compare. It's one's outlook on life, I think it's the outlook on one's life that's important something more than time and wisdom.

The therapist's insight and outlook on life help her to share something of herself in creating a 'personal bond' (or gift exchange), that Mattingly and Fleming (1994) found therapists use as a key strategy for collaboration. They reported that therapists express a willingness to care for a client in a more personal way in order to obligate the client to do something for her. I did not come across this sense of obligation amongst the participants in this study. They did however speak of clients preferring not to have a one way relationship, and appreciating what the therapist shares about herself.

Jenny: Aren't you, when you're second ... you actually you're, a little bit, you're not the therapist as such, you're more than a, you're a listener, you're ground level, you're a comforter, you're a whatever at the bottom. So maybe, you are describing your God-given, I mean I think that it's actually accepting a lower position where you can actually lift the patient and actually support him.

The therapist can bring such an attitude into the therapeutic setting, and needs to understand this client whom she is trying to support. This understanding of the client informs the therapist's interactive reasoning (see p21); hence the need for -

trying to climb into the patient's mind

Caryn: I think it's trying to climb into the patient's mind. Just to illustrate with a patient I saw this week, um, he's a retired bank manager and having to sit back and think. If I was this guy, um, what would I be wanting to work on? And a couple of things like his difficulty expressing himself in writing. If he's going to write out his own cheques and be able to fill in his own forms at the bank and all that kind of thing and so putting it to him you know: 'This is the sort of thing I think we need to work on. How do you feel about it?' And then gauging his response to deal with them in therapy.

Mary: Mm, Mm

Caryn: I think it is often just intu., trying to get into their mind, of what you feel are the things that are important for him.

With such awareness, the therapist is better positioned to notice cues; she does this by picking up clues.

Creating a collaborative relationship goes far beyond being 'nice' to the patient. It involves a subtle interpretation of what a person wants from therapy. Therapists must interpret motives and meanings from the cues based on what patients do and say. Often this reading of what matters is not easy to ascertain.... They may not want or be able to talk to the therapist (Mattingly, 1994:180).

Trying to pick up clues all the time

Caryn: ... just trying to pick up clues all the time of what this person is needing.

Jenny: Without the patient telling you that he agrees, what needs to be, the therapist needs to rely more on her intuition and on clues and on the actual patient's reactions. What you were talking about, as to why you gauge what affects the motivation and participation.

The therapist finds herself identifying with the client in order to be relevant in enabling occupation. Alsop and Ryan (1996) report that lateral thinking implies the use of inductive reasoning, which is indicative of an expert therapist. In the therapist's search for being relevant, she feels the need to-
tune to what their real problem is

Caryn: I have just had a patient this week ... she had a stroke and she lives alone. Her son came out from England and has been with

her. And I was getting quite good performance from her in certain tasks. He left on Saturday and she's been on her own all weekend and I saw her on Monday and, um, just the drop in level of performance and that, and I put it down purely to the insecurity of suddenly having to cope on her own and that.

And I think those things you just learn with experience, like that because your aphasics often are sort of very insecure, whereas somebody else might think they might want to go to the loo, but if you think a bit laterally and that, maybe often tune to what their real problem is.

Mattingly and Fleming (1994) view 'individualising treatment' as a key principle for collaboration. This 'individualising' of treatment is said to occur when the therapist chooses treatment activities that fit the client's interests and sense of identity. They go on to say that the therapist at times uses unconventional or creative intervention strategies if the standard treatment framework is being unsuccessfully imposed on the client.

What this study shows, is that 'individualising treatment' is a complex process in which the therapist does need to be creative to identify and make use the client's interests. However, this is not merely a tool to sustain the client's motivation for occupational engagement. Rather, the client is understood holistically so that the client's interests are viewed as part of a bigger picture within which his real problems have been considered.

Due to the nature of the work with aphasic clients, the normal communication channels to establish the client's real needs are compromised. The therapist feels she has -

very little to go on

Jenny: The speech apraxia and the dressing apraxia, and the motor planning. When they don't understand you at all then that is totally confounding ...

Mary: Mm, it is

Jenny: ... because you don't actually have, you've got very little to go on.

It was found that motivating a client -

Depends on comprehension and ability

Julie: Does motivating a patient with speech disorders differ?

Caryn: I think it does, depending on the comprehension of the patient and, um, their ability to express problems.

The therapist therefore needs to listen attentively to the client, and this takes –

Time to listen to words unsaid

At times it's trying for words and giving space, time for reactions, to cry or laugh, and never to give up. Giving and making time is more important than ever, as rushing therapy sessions leaves [the] patient with a sense of anxiety and gives a message that there wasn't time to listen to words unsaid. (Jenny: Journal p4)

This speaks of an empathetic rationale to the strategies used in therapy. The '*words unsaid*' are understood to be more than "reading between the lines", but rather making time for opportunities for the client to communicate what he wishes to.

Listening beyond doing

Jenny: You're normally having to do something or come up with a plan but it's usually tied in what you do is important, but also giving that time to listen, which is beyond actually just doing something.

good aphasia therapists listen beyond the words, and hear into the silence of aphasia. (Holland et al, in Brumfitt, 1996:363)

A parallel is seen here between speech therapy and occupational therapy, in that expert occupational therapists listen beyond the doing. Both the speech therapist and the occupational therapist are taking the trouble to listen beyond the conventional tools of their professions, namely 'words' and 'doing' respectively. This acknowledges that -

the patient can show you

Julie: Okay, and how else could one verify or prioritise needs?

Mary: I think the patient can show you, they really can. It depends where you are, but even in clinical, hospital situations, they can. They can literally take you and show you if they need to have a drink or go to the toilet or those sort of basic needs they can, mime or, in a way tell you.

Julie: Okay

Mary: I mean yesterday in fact our one patient did just that. He wanted to go to the door and see if his wife was coming and the carer kept on saying: 'Do you want to go to the toilet? Do you want to go to the toilet?' No, he just wanted ... I said to him your wife's coming at so-and-so and then he was fine ... But, there was no way he could ask so he kept on leaning over like this and she said 'Don't just get up'. Meanwhile the poor man can't even get up.

The previous example also illustrates how a client, in attempting to communicate, can be misunderstood. The importance of knowing the client can alleviate such frustrations. In order to get to know the client, it is helpful to establish the client's -

patterns of initiatives and responses

Julie: Through following her lead in removing the pillow from her lap, I interpreted that she needed the toilet and on asking her, she did. This makes sense for short term identification of needs and goals, but how to arrive at long term goals requires careful attention to the pattern of initiatives and responses of the client over time. It is difficult to see from an isolated point what the long term needs are.

This '*careful attention*' led us to consider the strategies employed in the second part of the subplot.

Objective 2

To identify the strategies that are used by expert occupational therapists for promoting choice and inclusion within the collaborative process with aphasic clients.

In the therapy process the therapist is functioning with the knowledge that she has. When this is inadequate the therapist finds herself reflecting IN or ON the situation, as to how else to achieve the aims.

I had to find other ways

Caryn: The patient identifies the problem areas, and he wants to work on those. As a therapist I very much identify problem areas that I pick up from my assessment and that I feel are important for the patient. And I approach it very much that I will explain that to him and would like him to work with me on that. I think you do just get some patients sometimes like this young guy, this teenager and that, and just because of cognitive and perceptual problems that, um, we got to a stage when that wasn't working and I had to find other ways of getting him to progress.

Despite the expert therapist's ability to find other ways, much of her efficiency lies in the fact that the therapist's procedural reasoning is informed by her knowledge and experience, as well as her reflection on these. Upon reflection the expert therapist is aware of the importance of going –

back to our basic principles

Mary: You've got to go back to our basic principles and remember them.

Caryn: I think one thing that is basic that is also important: This morning I was working with a new patient. That just goes back to the basic principles of structuring your environment and that when you're trying to communicate with someone who's battling, just getting back working in a quiet environment. I was working with her and the door opened and somebody came in and the two people were talking and immediately we lost everything and it's difficult to get it back.

As expert clinicians they stressed the importance of setting basic principles in place. These basic principles seem to be what they learnt in theory as students. However as students they did not yet have the experience to integrate the theory.

Theory distanced, can't really relate

Mary: I don't know how much, um, is brought into the students' curriculum now on like the knowledge of human development. I don't know how much they do. They should at least bring that in so that you know at this stage the person's life is going to be this and this and this. I don't know how you do it.

Jenny: I think they do, they do kind of as you say ...

Mary: Very basic.

Jenny: No, I think it's as basic as it could possibly be, but it's distanced, you can't really ...

Mary: ... relate it to ...

Jenny: I think like Caryn bringing her family member in as a sort of a ... that actually clinched it for you. I think you have theory, but it helps actually seeing things slightly differently in that situation. So, but I do think they do have, I mean I can think back to my theory, but it didn't really mean that much to me.

The therapists expressed concern that students or newly qualified therapists don't yet have the practical experience to make sense of the theory. They also found that it is often personal life experience that helps the therapist to relate to a new situation. Experience helps us to see things differently. This lack of strategies early on in their practice led them into a process of reflection which helped them discover answers to their questions in the form of strategies.

Come to our own little answers along the way

Jenny: Before this meeting, before this research, we have questioned ourselves on numerous occasions as to what makes, a lot of questions we've been asking are questions we've been asking ourselves and come to our own little answers along the way.

At a particular point in the focus groups, in order to explore the strategies further I posed a “devil's advocate” question:

Julie: What I'm hearing is that there's not really anything special about the way we handle receptive aphasia, the principles are very similar. Would you agree or disagree?

The participants responded by naming the following strategies:

Simplify and demonstrate

Caryn: I think with receptive, um, sort of ... maybe just the things that you say have got to be a lot simpler and maybe more demonstration

Mary: Demonstration, ja

More but shorter treatment sessions

Jenny: Treatment times are much shorter with those patients, rather more treatment sessions for very short periods.

Focus on function

Jenny: You have to depend on your physical, your non-verbal skill far more than if they can actually understand but they can't express ... you have to get to communicate somehow with them, and so you might actually end up doing things much later, but you have to actually focus on function.

Use lots of facilitation

Mary: Start off with lots of facilitation, where you're using sensory input.

Focus on the familiar

Caryn: ... then again, trying to focus in on using things that are familiar to the person, so gaining background information.

Repetition to get it across

Caryn: ... otherwise the principles I think are the same, and maybe repetition, to get it across.

... be creative ↙

Jenny: If you are creative with what you present, don't just do the same old one, two, three step, but often your individual needs something more than just dressing, and doing something, so ...

Mary: Right, ja

Jenny: ... sometimes you actually need to, maybe, I don't know, as you said [referring to Caryn] thinking of something broader or whatever.

Caryn: He totally rebelled against speech, physio, OT [occupational therapist], the whole lot. He had tried everyone and I discovered he's crazy about rugby, and I used it as a theme. And I got him to do everything that I wanted to whether reading, or practising

writing, or maths and whatever just using a rugby theme . It teaches you to be creative.

Knowing when to push and when to support is described by Mattingly and Fleming (1994) as being part of 'structuring success': one of the four key strategies used by occupational therapists to encourage collaboration. Creating a just-right-challenge (Csikszentmihalyi, 1975, in Mattingly & Fleming, 1994), is an integral part of Mattingly and Fleming's (1994) 'structuring success' to devise activities that the client can successfully perform. The therapist needs to be sensitive to the subtle cues from the client to sustain his motivation.

Supporting or pushing towards 'doing'

Julie: Caryn ... you said that there might be 'times when you need to encourage and support more and times when you need to maybe push a little bit as well'. Do you recall that?

Caryn: Yes

Julie: I would like to know what are you supporting or pushing towards? Where is that leading to?

Caryn: I think the support sometimes, um, when a patient gets depressed and that, and I think often - more than your patients who have had a stroke on the left side - (your right sided are often much more aware of what has actually happened to them), and they often just need, you know, to feel that you understand, and that. But I think there are times when you need to really encourage them that they can maybe do something that they think they can't. So just the

whole time trying to encourage them to move on and tackle more difficult things.

The 'doing' encourages the client to '*move on*'. The therapists have an expectation that the client can learn how to choose and that this choosing reinforces the client's personality and identity. This is echoed by Chapey and others (2000) in the Life Participation Approach to Aphasia literature which emphasises the importance of participation in activities of choice to re-engage in life. A parallel is seen in the aphasiology literature, where the emphasis is on 'talking through the events which occurred' in order for the client to move on (Brumfitt, 1996).

Considering that it takes time to understand the client's needs there do not appear to be many short cuts, except that of '*going the extra mile*'. The therapist seeks out opportunities to see the client more holistically. This helps to prioritise therapy.

Going the extra mile can be a shortcut

Caryn: I think one thing that I have just learnt is sometimes to go the extra mile. At the time it might seem a lot of work. What I'm trying to say is going the extra mile to try and get hold of family or your collateral information

Mary: Mm

Caryn: can be a short cut in the long run ...

Jenny: Mm

Caryn: ... than just plodding on on your own, and I think that tool that is not always easy is still available to the therapist in the two situations; of trying to get hold of the family and that.

Julie: Setting things in place for other people to then be building up relationships.

In the process of prioritising treatment, one needs to determine what to focus on. Mattingly and Fleming (1994:182) report on a collaboration strategy that supports that of collaborating directly with the client:

Collaboration goes far beyond treating the designated 'patient'.

Therapists routinely consider how to work with other essential members of a client's world.

Stepping stones to build therapy on

Guidelines seem to be history, jobs, family relations, friends, connections. This information is seldom in the file and is difficult to attain from the patient initially (although his response emotionally to questions often is important/indicative). Family members give this information – and their interaction with the patient is vital in one's assessment. An open loving relationship seems to tell something of the loved person/partner. Often however speech/interaction with family is initially reduced to tears, but it can be important clues as to what to focus on and important stepping stones to build therapy on. (Jenny: Journal p3)

Stepping stones are understood to be more than interaction with family. In the member checking group, the concept of stepping stones was described as being two paths: a retrospective and a prospective path, leading up to and away from the time of the stroke. The retrospective path provides clues to the client's previous occupations as well as factors influencing these, such as the client's volition, roles, habits, skills and environment (Kielhofner, 1995, in Christiansen & Baum, 1997). This information can be used to form a prospective path to follow in treatment, on condition that the information is continually re-assessed to determine its current relevance. This prospective path also involves interaction with the client's family to facilitate better carry-over.

Collateral is useful for capturing what is known about the person already, from someone close to the client.

Find out about actual way of life

Mary: I don't think you can find out what their actual way of life was until you've spoken to whoever's around them. You can read a lot of things into their, um, like clinical observations, but I think you have to speak to someone who's known them.

It is important to be communicating back to others, both family and staff who are with the client, so that there is continuation or carry-over of the problem-solving process outside of the therapy setting.

Carry over to others

Jenny: ... and let them know that there is something else available for afterwards, even if you aren't really able to build that good a

relationship, because you know at the end of the week he is going to be discharged, but you have identified problems. To just leave it as identified, and you know, and to leave it in the air, and not actually have ... It would be far more meaningful if you could actually pass that on to somebody, either the family members or maybe there is a therapist available for them. I think it's really important that we work together.

The therapist often hears of people generally holding very little hope for the aphasic person following a cerebrovascular accident. And yet it was found that –

So often when you do bother you do get improvement

Caryn: Maybe it's slightly off the track, I think something that still bothers me a lot is there's so much doom and gloom that there's no hope for your aphasics. And it's something I really just find, I mean there isn't improvement overnight but, um, especially your motivated patients and those younger patients and that, you see over time they do improve and so often I just find that doctors won't refer them to speech therapists. Or problems like sums or learning to write again and that sort of thing. Right from the start everybody just says that, 'why bother?' And yet so often when you do bother you do get improvement. You find people you see who first can't speak a word and a year later and that, they've improved.

The therapist engages in ethical reasoning IN and ON action where there is a value conflict (Schön 1990, in Dutton, 1995). If doing what seems to be in the client's best interests is understood to incorporate his views and priorities, then beneficence supports his autonomy. The tension appears when a client lacks motivation, and if his health is likely to deteriorate because of a lack of engagement in occupation. The therapist therefore needs to apply ethical reasoning as to determine how to respond to the client's seeming apathy (Sim, 1998).

It's an ethical question

Caryn: Maybe I'll chuck in a devil's advocate question here, that sometimes bothers me. If you've got, say, a really elderly aphasic patient in an old age home with no family involvement, and you often just get the feeling that the patient would rather just be left alone. What is your role as an OT? Should you try and achieve something? Or you are really picking up the vibes that this person actually would rather just be left alone, he's old and has had enough? What is our role there? And so that sort of situation where sometimes where, I do ask myself,

Julie: It's an ethical question

Mary: Mm

Caryn: It is an ethical question as well. And you've got a patient who as I say is really old and should one respect that feeling in him that he, he's actually not really interested and is quite happy to sit in a chair everyday and sit in front of the TV.

That is, should the therapist be deciding for the client, even if the client appears capable of making a choice and even if the client's decision appears to be contrary to the therapist's goals for the client.

Jenny: They might not be ready now, but they might be ready later, but you don't know exactly when to do that and ignoring it isn't the question. But taking a back seat and giving them time to react and not maybe being too invasive, and respecting that is also important.

Caryn: Ja

Julie: I think also screening for depression, which is the most obvious reason for them to be withdrawing like that

No hope, decisions or 'personality' if no choice

Caryn: And I just find that there is so much doom and gloom from everyone, that there's no hope

Jenny: Ja, you're also talking about: They're taking away hope, they're taking away decisions, they're taking away people's personalities and giving them nothing back in return. So you sit with, like you know our forefathers who, people who had a stroke, they locked in a little room and fed and looked after. And it's happening all over ... it's definitely more prevalent if you don't have people given a choice.

Choice appears to play a key role in maintaining the client's hope, decision-making and personality. The therapist needs to therefore consider how she facilitates opportunities for the client to choose.

Having a say in the matter

Julie: Just looking at the power issue: I drew a little diagram, just looking at the therapist on one side and the patient on the other – and the issue of control. I think each of you have brought up the issue. If the therapist is kind of dominant in the therapy process and the patient has a very small, um ...

Caryn: say in the matter

Julie: ... say in the matter ... compared to the therapist. And the patient having a more equal say in the matter, I think that's a nice phrase, and how that compares to what the person gets out of it. So if the therapist is putting the most in, and the patient is not having much say or input, I don't think the patient is going to get a lot out of it....

Mary: Mm, that is so. I've definitely seen that. They're too overpowering or kind of ordering the patient around. They immediately sort of close up and then you have no collaboration.

The expert occupational therapists found that the opportunity to discuss and think during the course of the focus groups helped them to consciously realise the value of partnership, and they anticipated that this would improve their collaboration skills further.

Improve collaboration skills, having realised its value

Jenny: I think having discussed it now and thought about it more, I think it will maybe improve on our collaboration skills, having realised its value. I think we, as therapists, can also still improve, and improve also with more ideas from each other and look maybe because we now will question things more clearly. Next time I have an aphasic patient I will actually sit down and have more clear ideas as to what is important so it's not necessarily just happening instinctively or maybe there will be a little bit more partnership.

During the course of the focus groups, the expert therapists were led to reflect-ON experiences to identify possible factors that contributed towards unexpected results. These factors could be attributed to the client and/or the therapist.

Looking to see why they aren't open to therapy

Jenny: And for you to then actually go and look and see why maybe if it wasn't effective for communication. Aha, maybe I wasn't doing as much or perhaps that they themselves weren't having a very good day and there are other things that are bothering them, or perhaps other circumstances, family arguments and things that they are switching off; they're not open to therapy.

With experience and reflection the occupational therapist can begin to become more relevant and more expert at developing collaborative partnerships.

... Been rewarding thinking back

Jenny: It is affirming definitely, and it's been rewarding thinking back.

Objective 3

To describe expert occupational therapists' experience of the capacity of aphasic clients to participate in the process of enabling occupation.

The first two elements of the sub-plot are informed by the therapist's awareness of the client's capacity to contribute to and participate in the process of enabling occupation. The third element of the sub-plot, is also informed by the first two elements of the sub-plot, which can –

Result in the person taking over

Jenny: I said treating holistically and meaningfully results in more motivation and empowerment and the person ultimately in taking over. That to me will be success. It's my definition of success.

The term 'taking over' could be considered as reductionistic. However the 'taking over' is enabled by and enables engagement in occupation. From the therapist's perspective the outcome of two clients can be quite different, with one being satisfactory and the other unsatisfactory and yet as individuals, the clients may have found the outcomes to be satisfactory, because of the people they were before the stroke.

Jenny: When they don't have speech they can end up in despair. So you as a therapist need to give them back the key or the rein of their situation so that they can actually gain control over the situation.

One can infer from this that the therapist shouldn't be holding the client's 'key', as the client is the other expert. King et al (1994, in Law, Baptiste & Mills, 1995) report that the client knows himself best:

The interactive practitioner realises that he or she is not the only one in the situation to have relevant and important knowledge. The consumer interacts by joining with a service provider to make sense of the situation and, by doing so, gains a sense of increased involvement and action – or choice (Schön, 1983, in Grady, 1995:302)

They can learn to choose again

Jenny: So I just feel that anyway you've got to actually get them to realise that even if they don't speak, even if they can make just one decision ...

Caryn: Ja I agree

Jenny: ... and then you actually can, um, and you're actually empowering them because you're saying you know, you make the decision and often they will say 'no no it doesn't matter', but then you actually

have to insist that they start choosing if not then, so that they can learn how to choose again.

In the above example the therapist goes as far as to 'insist' or push the client in an effort to empower him to make decisions.

Mattingly and Fleming (1994) name 'creating choices' as one of the four key strategies used by occupational therapists to encourage collaboration. They report that most occupational therapists give the client a choice from a range of options. They noted that more experienced therapists might allow the client to do things outside of the list of choices they presented. This is an attempt to encourage the client's autonomy in relevant occupations. If the therapist is not flexible in accommodating the client's aspirations, the relevance of the therapist's intervention is open to question.

She had come out of her shell

Jenny: And I came in with a plan, but in the mean time she had actually come out of her shell and she had enough confidence to say oh this is exactly what I had to do, and she was organised.

'Taking over' can also be understood to occur IN the process and not just as an end-product. And it is this ability of the clients to take hold of their lives and the decisions they make that is enabled by and enables their capacity to participate in the process of enabling occupation. The clients' capacity to participate is thus a means to an end, as well as an end in itself. Zemke and Clark (1996) speak of the enabling role of occupation in reconstructing a meaningful life.

She is prioritising as to what is important to her

Jenny: You can see she's enjoying therapy much more that she knows: 'Okay this my next problem: Let's do this'. And she reminds you as to what ...

Caryn: They were very real issues to her

Jenny: I think it fits into a lot of things that we've done before that experience, except she's prioritising as to what is important to her, um, you're giving her the key to control.

The client's participation appears to be dependent on the -

comfort of the patient to interact

Jenny: One of the questions I asked was how do you create the right therapeutic environment? How do you do that in particular to this question you know about the speech and, um, I just thought that it all leads to comfort, the comfort of the patient to interact. Um, his confidence, the confidence of the patient and therapist to let go of social hindrances, stopping building the barriers and so to participation of the patient. So I then compared home visits to hospital visits and saw what differences there were as to the possible meaningfulness. But we talked about that last week, about maybe the scope in the home was wider for treatment as to relevance and personality and such He will feel comfortable to express himself at whatever level he is able to.

Ponte-Allan and Giles, (1999:648) imply that the clients feel more comfortable to interact when they recognise the relevance of occupational therapy.

It is possible that patients who have practical goals may recognise the relevance of occupational therapy to their recovery and be more motivated to participate.

Creating an environment in which the client can feel comfortable to interact requires us to –

see these patients as a whole

Mary: They like their things, anything, their living to be as it was before, as much as possible. I think that one must see as a whole these patients who are aphasic, because it always comes up.

An experience that one of the therapists had when a relative of hers was hospitalised, led her to realise the importance of knowing who the client is. It would seem that it is perhaps respect for the person that leads one through an inquiry process as to who the client is.

Know and respect the person

Caryn: it crossed my mind that everybody working with him has actually got no idea who this man is ...

Mary: that's it, that's it

Caryn: ... and it's almost changed my thinking that everybody I work with, I must know and respect the person that I'm working with.

This can lead to the client trusting you.

You have to earn it

Julie: Is there an element of trust on the part of the patient? We've been speaking a lot about confidence and confidence building, that I was thinking of the word trust. What do you think about that?

Caryn: Yes, you have to earn it

Mary: That's right. You have to earn it. You've first got to give them the confidence that you are with them, that you are going to support them, that you are not going to drop them, or let them down.

Peloquin (1993, in Law, Baptiste & Mills, 1995:252) found that

Clients desire more than simply technical competence from therapists.

Clients value the caring which is shown by therapists who truly listen and learn from their experiences.

Below is an example of the therapist's experience of an aphasic client's capacity to participate in the process of enabling occupation.

Them making the decision of what they want to do and you accommodating that

Caryn: To me it's again being flexible in the therapy session that you might have planned something and you come in and the patient

actually wants to do something completely different that's important to them. So you've got to be flexible to work on that.

Julie: that is about them making the decision of what they want to do and you accommodating that.

Jenny: But they have the confidence in you to be able to actually say "this is what I want to do", and then you're flexible, so it's also got to do with your relationship with them.

Mattingly (1994) wrote of a therapist whose practice is well grounded in theory, and yet she valued flexibility over mere knowledge in other therapists. This flexibility is required for the continual revision of the therapeutic story that is continually unfolding in the inquiry process as the therapist and client work together.

I figure that any therapist who is able to work well on an interactional level with patients can pick up the knowledge base and can function while still learning that. But I don't think it works so well the other way around. (Mattingly 1994:271-2)

Decision making important for who you are

Jenny: I just find that decision making is one of the highest skills that one can have and yet, it is such a fundamental thing as to personality and the importance of who you are. If you don't have the ability to make decisions that means you are giving decision-making to anyone, somebody else, and then they can take it and then run

your life, and you can end up in an old age home and you don't have any decisions and you end up being institutionalised.

The promotion of decision-making in therapy reflects one of the profession's values (see Table 1 on p4). Namely "exerting self-determination," as stated by Christiansen and Baum (1997)

Power for choosing their activities

Jenny: There's an article in the OT [occupational therapy] journal about NOAH [Neighbourhood Old Age Homes, Woodstock, Cape Town] ... I think it very much touches on decision making, and giving them power for choosing their activities and you know, giving them autonomy and I think that one maybe can look at that. I've only half read the article, but I think this is why you get old age homes and you get old age homes.

This promotion of decision making is grounded in the therapist's personal and professional belief that the client can start doing things for themselves:

I strongly believe that they can start doing more things for themselves

Julie: There are choices at different levels I think.

Caryn: I think it very much depends on the level your patient is at. I mean, some of your aphasics, if you give them too many concrete choices and that, it's too much...

Mary: too much

Caryn: ... just overload, but I agree with Jenny, I think that giving basic choices and that is extremely important.

Jenny: You can actually go on from basics to more complicated, I strongly believe that some people can actually, once they feel important again, some little light gets switched on and they can start taking, doing things for themselves

Crowther (1995) defines co-operation as, "working together toward a common purpose", which brings us back to the prospective story that is developed in partnership.

They give their everything

Julie: What effect does co-operation have on engagement in occupation?

Caryn: I think it makes a big difference, I find then the patient is really motivated and they give their everything. And I think you can see they enjoy it, they are wanting to come again. It means something.

The client's so-called co-operation is to be interpreted here as active participation rather than a passive response. Pyppönen (in Brumfitt, 1996:360) supports this notion of co-operation:

Of course the patients cannot express themselves with many words or even nod after long complicated questions; but they can tell a lot if the therapist wants and has time to listen, and if the patient is willing to try to talk. Co-operation has to be built in.

Principles for practice that emerge from this study

The interface between client and therapist in the treatment situation is thus a complex process. The client, because of who he is, can and should choose to 'do'. The extent of this choice can be compromised by his impairment (particularly his aphasia), by his confidence to exercise this choice and by the social and physical environment he is in. His ability to 'do' can also be compromised by impairment. It has been shown that a therapist using a client-centered approach expresses an attitude towards the client that will facilitate the client's capacity toward relevant occupational engagement.

A therapist using the "medical model" is likely to attempt to direct the client to an outcome that the therapist assumes to be the most appropriate for the client. Therapists appear to have knowledge of communication strategies, regardless of the approach. It is, however, the attitude with which a therapist works, and hence her desire to collaborate that will determine the extent to which she "looks for keys", and thus the relevance of her intervention. This attitude is the qualitative dimension of the principles. This personal involvement on the part of the therapist, is what distinguishes an occupational therapist that is able to communicate from one who is able to truly collaborate, with the required effort that it takes to pursue meaningfulness and not merely follow a co-operative process.

The client's capacity thus informs the therapist in her reflections IN and ON the treatment process, in establishing this partnership.

Mattingly and Fleming's (1994) key principles of collaboration are, as stated previously, generally used for different client populations, and therefore do not apply specifically to aphasic clients. The principle of 'structuring success', to sustain the client's motivation, can be applied directly to

aphasic clients. Success is understood in this study as not merely a means to sustain motivation, but rather the development of a partnership in the pursuit of enabling occupation.

The other three principles require a more sensitive interpretation to this population of aphasic clients. The 'personal bond', 'individualising treatment' and 'creating choices' have all been described by Mattingly and Fleming (1994) as principles where the occupational therapist is directing the process, perhaps without due consideration of the client-centered approach to therapy, which has been found in this study to be an important element in collaborating with aphasic clients. Perhaps the most therapist-directed of these is the use of a 'personal bond', which relies on the client feeling obligated to reciprocate to the therapist.

Mattingly and Fleming (1994) describe 'individualising treatment' as a creative response used in the event of an imposed method of treatment being unsuccessful, in which interests are then identified and used to sustain motivation. This study has indicated that the client should be understood holistically and that his interests should be viewed in the light of his real problems.

Mattingly and Fleming (1994) describe 'creating choices' as a principle that experienced therapists use in which they might 'allow' a client to go beyond a list of options. In this study, however, the therapists are less directive. Rather, they encourage the client to go beyond that list of options, and are flexible in accommodating the client, to identify his aspirations.

The expert occupational therapists in this study found themselves *creating choices, individualising treatment, structuring success, creating a personal bond and collaborating with others*. These strategies as well as the others discussed here have been described in the light of '*looking for keys ... to spur treatment on to meaningfulness*'.

Limitations of the study

Work setting

I mentioned to the co-researchers that I was very aware that they are all currently in private practice. I asked them if and how the experience of an occupational therapist in the public sector may be different from their current experience. They replied that -

Jenny: I think you can make use of the setting and I think ... you did work in the government sector, ...

Caryn: Mm

Jenny: ... and I think already there I was forming relationships with aphasic patients and building on. I think you can do it, it's just that maybe, um, it's not as long term, but at least you can still give them a lot of comfort and actually still set goals with them and explain to them and actually make them feel a lot better about themselves generally.

The participants commented that the same strategies would apply, except that the therapist would need to rely a lot more on family involvement to assist in establishing treatment priorities, as well as for carry over. This is due to the brief admission period in an acute hospital. The findings are thus also transferable to therapists working in the public sector.

A limitation may exist in that the focus group sample did not include a therapist who is currently practising in an acute setting in the public sector. Such a therapist may focus more on performance components, and may be more entrenched in the "medical model". This limitation

was addressed in that the occupational therapist who was consulted as a key informant, works in such an acute setting, and confirmed the findings.

Time constraints

What has been collected, subject to time constraints, represents the reality of the experiences of the group members. With additional time and resources being available, one could explore the reflection in more detail through the use of video recording treatment sessions and having these as the basis for discussion. The therapists contributed different perspectives though, as their reflections and practice experiences were unique. This added diversity to the discussion. For example, each participant contributed different issues: clinical observation, the importance of basic principles, finding a base for communication and the issue of control.

Co-operative inquiry not fully utilised

Heron (1996) speaks of democratisation of research content and method within the focus groups. There was democratisation of research content, in the co-researchers demonstrated autonomy in determining the content of the discussion. The co-researchers' contribution to the method used to for the process of the focus groups was not as evident. Their contribution went as far as discussing the assigning of roles, such as that of "devil's advocate". This partial democratisation is typical of this methodology, although Lincoln and Guba (1989, in Heron, 1996) recommend full collaboration on method. A more thorough democratisation of the method might have been possible if the focus groups had been sustained over a longer period, allowing for a greater sense of ownership on the part of the co-researchers.

Chapter 4 Conclusion

This research has addressed the issue of the non-application of current theory of collaboration to clients with aphasia. It has also suggested an understanding of the expert occupational therapist's experience of this collaboration process in enabling occupation.

The assumption, as a point of departure, that many aphasic clients (following stroke) are able to be included in the decision-making processes of treatment to varying degrees, was particularly evident in the third element of the sub plot.

The expert occupational therapists' experience confirms the capacity of aphasic clients to participate in the process of enabling occupation. The principles that reinforce the necessity for, and facilitate, a client-centred approach are particularly necessary because the therapist has '*very little to go on*'.

The therapist's work with aphasic clients is therefore described as '*looking for keys for what works, to spur treatment on to meaningfulness*'. This is inspired by her experience of '*what happens when you do bother*'; that '*decision-making is important for who you are*', the establishment of the '*comfort of the patient to interact*' and the belief that '*the patient can show you*'.

The client-centered approach encompasses the use of empathy as a strategy. I would suggest that if Mattingly and Fleming's key principles of collaboration (for different client populations) were to be interpreted using the client-centered approach, they would include many of the strategies found in this study.

Some of the strategies, found to be very necessary for promoting choice and inclusion with aphasic clients, were identified such as *'trying to climb into the patients mind'*, taking *'time to listen to words unsaid'*, *'going the extra mile'* and *'finding other ways'* in the form of other strategies (see p62-4). The resultant understanding of how an expert occupational therapist collaborates with aphasic clients is by *'looking for keys of what works, to spur treatment on to meaningfulness'*.

It is evident in speech language therapy literature (regarding communication) as well as occupational therapy literature (regarding occupation) that both professions are pursuing meaningfulness for their aphasic clients, through the introduction of client-centered practice. This bodes well for future inter-professional collaboration to further develop the collaborative strategies used with our clients.

These principles are not thought to be exclusive to occupational therapy with aphasic clients or even to occupational therapy as a profession. Rather, it is suggested that other professions can also benefit from the application of these principles in the pursuit of meaningful treatment with aphasic clients. Collaboration principles are especially necessary when communication is compromised.

True collaboration requires the therapist to be aware of the capacity of her client and to put in the additional effort to truly collaborate. It is this extra effort that *'spurs the treatment on to meaningfulness.'* The ripple effect of the occupational therapist's promotion of the capacity of the aphasic client through the ethical principle of respect for autonomy supports the ethical principle of beneficence in that, such collaborative therapy benefits clients, their families, as well as the broader healthcare community.

Chapter 6 Recommendations

This study has suggested an understanding of how expert occupational therapists work with aphasic clients, in order that other occupational therapists working in the field may learn how to provide inclusive and relevant treatment. The essence of this understanding is that *'working with aphasic clients is like looking for keys to spur treatment on to meaningfulness.'*

I will now consider the findings as they relate to capacity development and the resulting recommendations, particularly with regard to the emerging profession of occupational therapy, the capacity of aphasic clients, and recognition of expert occupational therapists.

Capacity development elements of the study

Develop capacity in the emerging discipline of occupational therapy.

The principles of collaboration and the need to 'look for keys' for relevant therapeutic intervention extend to other professions as well. I therefore reminded the co-researchers of the focus on occupation. As Gray (1998) points out, other health care team members do not possess this occupational expertise.

Julie: I think all of the health science professions, everyone needs to collaborate, but I have chosen OT's in that the outcome is engaging in occupation, ...

Caryn: Mm

Julie: ... there is that what you've described: trying things out. I don't know if I'm quoting you now,

Caryn: Mm, looking for keys

Julie: Ja, looking for keys so that at the end of the day the patient is doing, re-engaging in doing, so that's why I'm looking at OT's

It is thought that aphasic clients can benefit from such strategies being adopted by many more occupational therapists, as well as by other professions, such as nursing and physiotherapy. It is perhaps the very nature of the occupational therapist's work that requires, and thrives on, such a client-centered approach when there is *'very little to go on'*, in order to *'spur treatment on to meaningfulness'*.

Realise the capacity of aphasic clients to participate in the process of enabling occupation

Caryn I think something that still bothers me a lot is there's so much doom and gloom that there's no hope for your aphasics

This statement reinforces the necessity for such a study. The capacity of aphasic clients, as experienced by expert occupational therapists, is enhanced through the occupational therapists' application of strategies to enable collaboration. In spite of a client-centered approach, this research has addressed the therapist's experience of the client's capacity. It is recommended that further research be conducted to determine the client's perception of his own capacity to participate in the process of enabling occupation.

The point of departure for this study, in terms of the client's capacity (see p9), was that many aphasic clients do have the capacity to be involved in the decision making process. The findings of this study identify the collaboration strategies used by 'expert' occupational therapists who recognise the client's capacity to participate actively in the therapeutic process. The question remains as to the therapeutic approach that would be used with clients that do not have this capacity. It is not within the scope of this study to address this and it is recommended that this question be addressed in further research.

Recognise the experts in occupational therapy in the field of stroke rehabilitation.

It is through collaboration with expert occupational therapists, in a process of reflection, that we have come to understand the expert occupational therapists' experience of developing partnerships with aphasic clients. An outcome from this is that through the documentation of tacit knowledge, the findings will improve the credibility of the occupational therapy profession. Reflection has been found to be a useful tool not only for identifying this tacit knowledge, but also for developing practice, through the use of action-reflection cycles to prompt collective reflection. It is proposed that therapists take responsibility for their own learning by establishing opportunities for reflection (both individually and collectively).

The following extract supports the need to make explicit the experience and the strategies of expert therapists. The co-researchers described a very different level of competence in their work, as students and inexperienced graduates:

Jenny: We just had a patient that couldn't speak and you would like go around it, you really weren't actually

Mary: Mm that is so

Jenny: actually coping properly, you sort of focussed on activities, but it wasn't really focusing on the relationship with the aphasic patient, which is vitally important beyond the activities. You actually have to build a relationship to get them more involved.

According to the comments of the co-researchers, over the years they have become more skilled at collaborating with aphasic clients, and they have become even more aware of collaboration in their practice, through reflection during the course of this research. They consider that the realisation of the value of partnership will further improve their skills.

This realisation points to the value of the co-operative inquiry methodology, not only for the purpose of this study, but also for the development of an occupational therapist's own practice. The process of action and reflection (both individually and collectively) has been found to affirm, challenge and encourage the development of practice with aphasic clients.

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Appendix A Questionnaire

Name _____ Date _____

Do you currently work with adult clients who are aphasic following stroke? Yes/No

If so, for how long have you done this? _____

Are you likely to be working with aphasic clients in the next few months? Yes/No

Please read the following three scenarios on these three pages. Your response will remain confidential, so please feel free to give your honest responses. Please answer the questions as specifically as you can, according to how you have responded to similar situations in the past. Where possible, please give examples to illustrate a point.

FIRST SCENARIO

You are seeing Mr M for his initial assessment. Mr M appears to be having difficulty understanding your explanations, specifically who you are and the purpose of this ADL assessment session.

a) How have you responded to similar situations?

b) What effect did your response have?

c) What did you learn from the experience?

a) _____

b) _____

c) _____

THIRD SCENARIO

Mr S is able to understand what you say to him. He speaks fluently, but his speech is illogical and he uses neologisms. You need to know about his home situation.

- a) What are the possible ways to go about finding out about his home situation?
- b) Which method would you use, and why?

a) _____

b) _____

Thank you for taking the time to answer these questions. Your assistance is very much appreciated.

Appendix B Code-book

The participants for the focus groups will be four occupational therapists with the highest scores on the scatterplot graph. The axes are DEGREE OF COLLABORATION and LEVELS OF CLINICAL REASONING.

RATING OF RESPONSES

- Degree of COLLABORATION

The score will be determined by the number of strategies included in the responses (max 5)

Strategies to encourage collaboration:

1. Creating choices
 - Opportunity for inclusion in the therapy process
 - Client-led: see how client chooses to do task

2. Individualising treatment
 - Give time for client to respond in order to facilitate understanding
 - Respect for client's needs
 - Therapist gives feedback

3. Structuring success, by means of a just-right-challenge
 - Systematic approach, therefore client not lost

4. Personal bond
 - Need to first connect
 - Determine what kind of person client is

5. Collateral
 - Listen to client and family

Or other

- Eye contact

Levels of clinical reasoning *score determined by the predominant level of responses.*

The following responses will score a (1) and are indicative of a NOVICE practitioner:

- Recognise facts and features of situations
- Attend to separate pieces of information
- Need to gain confidence by learning and following rules
- Rigid application of rules, regardless of context
- Difficulty in applying rules to specific situations

The following responses will score a (2) and are indicative of an ADVANCED BEGINNER practitioner:

- Consider additional cues
- Start to relate to client as an individual
- Recognise behaviour, can't attach meaning to it
- Not see entire picture
- Principles modified for specifics
- Difficulty prioritising concerns
- Attends only to current, observable behaviour
- Situational thinking – visualising how prerequisite goals will affect functional tasks for an individual

The following responses will score a (3) and are indicative of a COMPETENT practitioner:

- Lack flexibility and creativity – sticks to initial treatment plan
- Situational thinking + prioritise treatment concerns
- has a better understanding of the client's experience
- Sees actions partially in terms of long term goals
- Attempts client-centered care

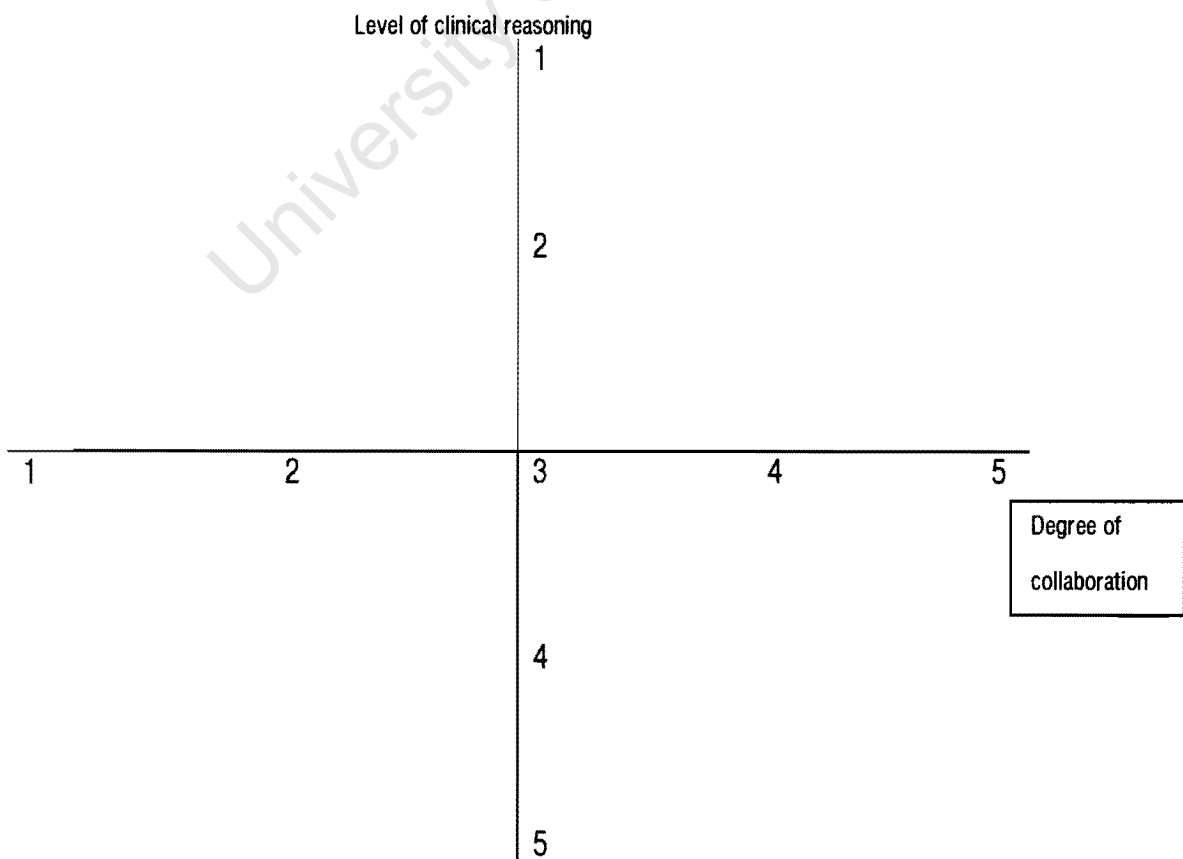
The following responses will score a (4) and are indicative of a PROFICIENT practitioner:

- Sees situations holistically
- Sense of direction/vision
- Able to deal with unfamiliar situations
- Manage decision-making well

- Modify initial findings as meanings vary
- Integrates info into a story
- Has a future orientation
- Recognises familiar patterns
- Recognises mis-match when differs
- Modifies treatment plan automatically

The following responses will score a (5) and are indicative of an EXPERT practitioner:

- No longer relies on rules
- Have an intuitive grasp of situations
- Use analytic knowledge only in new situations
- Visualise what is possible, based on reflective experience
- Reflective practice, creative, enquires
- Knows what to do : "just feels right"
- Makes clinical decisions in a "truly remarkable way"
- Give themselves time to "get a feel"
- Organised
- Normalise the experience



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Appendix C Table 4: Scores from questionnaires

Respondent	Collaboration responses						Collaboration Total	Clinical reasoning responses					Clinical Reasoning Total	Comments
	1	2	3	4	5	Other		1	2	3	4	5		
1	6	8	6	3	2	1	5+	0	0	0	1	25	5	Available
2	2	1	3	1	3	1	5+	0	0	0	4	8	5	Not treating
3	1	4	2	2	2	0	5	0	0	0	2	9	5	Available
4	2	0	0	1	1	0	3	0	0	0	10	5	4	Low score
5	1	3	2	1	1	0	5	0	0	0	5	7	5	Not available
6	4	0	0	1	4	0	3	0	0	0	14	13	4	Low score
7	3	3	4	1	1	0	5	0	0	0	3	9	5	Available
8	5	2	1	2	3	0	5	0	0	0	3	6	5	Not available
9	3	0	1	2	2	0	4	0	0	0	2	7	5	Low score
10	1	1	1	1	1	0	5	0	0	4	5	1	4	Low score

APPENDIX D Participant demographics

	Caryn	Mary	Jenny	Julie
Age	42	59	33	27
Where qualified	University of Stellenbosch	Pretoria college of occupational therapy	University of Stellenbosch	University of Cape Town
Year of qualification	1979	1962	1989	1995
For how long with CVA	15 years	10 years	10 years	4 years
Private sector experience with CVA	Current	Current	Current	Past
Public sector experience with CVA	Past	Past	Past	Current
Neuro-developmental therapy training	Yes	Yes	Yes	Yes

Appendix E Questions posed in sessions

At the first focus group I proposed the purpose and process for the four weeks. This was open to negotiation. I transcribed the interviews myself due to poor audibility of the participants. This was complicated by the group context in which it was sometimes difficult to distinguish the voices, particularly when they interrupted one another. I thereby became very familiar with the text and found the transcription to be a good opportunity for reviewing the data. I found that there were areas that required clarification and exploration.

The participants shared a lot of information in the second focus group; this required clarification and exploration in the subsequent group. I have therefore chosen the third session as an example to of the key questions that I posed in that group, the reasons for the questions and the effect that they had on the process.

QUESTIONS POSED

Here follow some examples of the questions I posed in the third focus group:

Mary, you said “the biggest problem is that you need experience, um, and that it’s such an intangible thing to teach, this feeling or this collaboration.”
You used the word feeling and I thought that was quite interesting ... and I wondered what you meant. Can tell us more about this feeling, and what does it feel like?

Caryn, you said that you had a patient who was crazy about rugby, I will quote you now: “I got him to do everything that I wanted to, whether reading, or practising writing” *This phrase ‘I got him to do’ - Is the challenge, um, engaging the aphasic patient in action, in other words*

persuading him to do - that push that you were talking about? Or is it engaging them in the decision making process?

Can all patients be engaged in decision making? You mentioned the cognitive losses which doesn't always help them in the decision making process. Is that ability very much part of being able to collaborate with you?

Jenny, you said that as a student one tends to go around the issue of the person not speaking and that you weren't, um, you really weren't actually coping properly. You said you focussed on the activities, but not on the relationship with the aphasic patient, which you said is vitally important beyond activities and you said that you have to build a relationship to get them more involved. So my question is: *What is it about the quality of this relationship that gets them more involved? Is it that your intervention is more relevant?*

How do you establish the needs of the patient without assuming to know what their needs are?

I'm very aware that all three of you are working in private practice. And I just want to know what your thoughts are on this: *If it takes time in order to so see the pattern that is developing in terms of a patient's needs, and also that it takes time to listen, then how do you think occupational therapist's in an acute setting in the public sector, are managing to set long term goals and to develop that relationship. How do you think they collaborate with aphasic patients?*

Can you say what the output or outcomes might be without the collaboration? You are all collaborators, but have you seen evidence of what happens when somebody isn't collaborating?

Do you find that you have, um, space and time for reflecting on practice?

Can we take a minute just to talk about what helped in this session. Did anything help with the process? You asked for questions to get things going, did that help the discussion?

And then if you don't have anything more to add to that, I just want to ask you if you are going to take anything into this next week in terms of trying things out. Or, if you are just going to be aware of what it is you are doing?

Has anything come up that's been specific enough to think 'ah let me be aware of that' or 'let me try that, or try another approach'?

How do you go about that 'listening' and that 'supporting' that we spoke about, the 'tuning in' that we spoke about? How do you actually do that? What does it take from you and from the setting?

These questions not only helped to clarify issues from the previous session, but also helped to frame the discussion to explore the issues further. The co-researchers stated that they found the questions helpful to prompt their collective reflection. The questions contributed to the discussion, which was more in-depth than the previous week.

Appendix F Table 5 25 July 2000

Sub categories	Categories	Themes	Main Theme			
Decision making important for who you are	No idea who this man is	Relationship vitally important beyond activities	Encourage them to do and move on			
They feel incredibly stupid						
They're so aware of their problem						
You would go around it						
Know who the person is						
Find out about actual way of life						
stepping stones to build therapy on						
Just by walking into their house						
Focus on familiar						
Takes time to get a feel						
Going the extra mile can be a short cut						
Trying to live into their situation						
Time to listen to words unsaid						
Pattern of initiatives and responses						
Trying to pick up clues all the time						
You can see when they're not happy						
Intangible thing to teach	It's also got to do with you	As therapist give back key for control of situation				
One's outlook on life						
Isn't that putting you second						
Being human helps your relationship						
You are absorbed in it						
I had to find other ways						
Make use of the setting						
You need experience						
It helps seeing things differently						
Using what they've got at that time						
Trained to think wider	It teaches you to be creative					
You: catalyst for pt to see things differently						
Because I gave him the choice						
Identify something he can relate to and engage in						
Address frustrations – owning problems						
They give their everything						
Back to our basic principles						
Confidence to try						
Learn to build bridges						
You have to earn their trust						
See if they are motivated by it	Comfort of the patient to interact	They can start doing things for themselves				
She became more open to challenges						
Supporting him through empathy						
That to me will be success						
Who has a say in the matter						
They can learn to choose again						
No hope if no choice						
Result in the person taking over						
				Power to choose their activities		

Appendix G Process notes

04/07/2000

Having 'in-vivo'-coded the fourth focus group (FG). I am keen to move on to the first FG again and establish what is actually there, by assigning free nodes. Having done the in-vivo nodes for all four interviews, I feel that I have a good idea of the content, but I don't yet have a detailed conceptual understanding of it.

06/07/2000

I have assigned node titles to in-vivo codes. I am becoming more familiar with this programme and it is starting to work for me. I have cleaned up the in-vivo coding. This process involved converting the in-vivo codes into free nodes (by renaming them with node titles from the text). There was some duplication of sections of text where phrases within a paragraph and the paragraph had been coded unnecessarily. Now to try Focus group FG 2

08/07/2000

I spoke to a colleague yesterday who suggested I create tree nodes in the first interview before starting the second interview: to work to a deeper level with one interview, rather than making unnecessary changes to all four interviews. So I will 'tree-node' FG 1 before moving on. I have just grouped most of the free nodes into tree nodes for FG 1. I picked up a couple of duplications along the way. The free nodes fitted well into nine codes. I actually found myself starting to 'tree node' and re-name nodes first, after setting up three tree nodes, I realised that I am not familiar enough with the text. So I have gone back to rename nodes first.

09/07/2000

This NVivo program keeps crashing. The coding is taking longer than anticipated, but the fit of the data is becoming clearer. With 86 free nodes and 73 tree nodes (including seven key tree nodes), I will need to contain the volume by seeking similarities where they appear obvious. I have therefore made a print out of the tree nodes for FG 1 to see if any of them will relate or can be used for FG 2. I now have 150 tree nodes and 8 free nodes. This went quite smoothly, but it is obvious that there is still a lot of sifting to do with FG 2. Coding FG 2 has prompted me to re-visit FG 1, to consider the node titles, to alleviate creating too many unnecessary titles.

10/07/2000

I will now clean up in FG 2. Not finished with the re-sorting of nodes, but looking much better. Worked particularly on the relationships (occupational therapist and client) this is where most of the nodes are. I will move on to FG3 now. But need to come back to FG2 for a more critical review - I need to ask myself what I have coded and why, and what I haven't and why and whether the node titles are appropriate and whether they are relating most appropriately.

Having looked at FG 2, I need to broaden the titles of these tree nodes, to link them with the titles I've used in FG 2. Having gone back to FG 1 and 2, I am back to assign tree nodes to fg3. I will try to keep it data-led, but will keep the titles from FG 1 and 2 in mind so as to again avoid unnecessary terms. I have used previous titles, and added another called 'outcome'.

11/07/2000

I will now resume the sorting of FG 3. I'm wondering about the 'relationships' nodes. Is the reference to occupational therapist meaning expert or any occupational therapist? Is the reference to others then referring to non-family and non-expert therapists or non therapists or both?

I have sorted and collapsed tree nodes into the following four titles:
Relationships, reflection, experience and outcome.

I have tree-coded the first three interviews. These still need further thorough analysis, but I will now start FG 4. I am expecting to be able to use similar tree node titles to what I have used in the others, but this remains to be seen.

12/07/2000

I will continue with the sorting of the free nodes, and whatever else turns up along the way.
I will need to use the coding stripes to check overlap of coding

13/07/2000

I will start the coding stripe analysis to see what passages I have coded, and then break the current coded passages down into smaller meaning units. I have finished assigning the free nodes into trees and assigning titles to them. I will now sort the trees. I have just checked coding stripes for FG 1 - some overlapping sections, but there is good reason for it.

14/07/2000

I will now review coding stripes for FG 2. Coding stripes look alright for FG 2, but I will need to come back to this to refine the size of the meaning units.

15/07/2000

Now to sort trees to find the best fit for the data and conceptual sizes of nodes. Main tree nodes are now: Reflection, relationships, experience and process. I will now look at the coding stripes for FG 3. These meaning units are too big - I will definitely need to refine them. I have finally got to FG 4 to review coding stripes. Hopefully this won't take too long, and then I can break down the meaning units further. I have finished viewing coding stripes. I will now review size of meaning units in FG 1.

16/07/2000

I find myself spending a lot of time on 'relationship between client and occupational therapist', sorting by arranging codes under conceptually "bigger" codes. The question of engaging the client in action/persuading to do versus involving in decision-making has not been cleared up yet, but is tackled again in FG 4. At the moment it looks like doing is the bigger concept and decision making the smaller component to achieve the doing. It looks like if they are intact cognitively, that we can collaborate in the said ways, and providing it makes sense to the client, they will be motivated to co-operate.

17/07/2000

I need to re-code all four interviews now because of a faulty back-up, continual crashing of the data management programme, and because I cannot import coding across projects. I will need to code FG 2 from scratch, having only a print out of the codes to go on. I will therefore have to postpone the member checking focus group.

18/07/2000

I am re entering codes for FG 2 and sorting through the tree structure shifting the nodes depending on how I see them fitting together conceptually (according to size).

19/07/2000

Have sorted nodes for all interviews in order of the size of the concepts. They fit together well so far. I still need to go back to my objectives and code-book to draw further relationships.

20/07/2000

I thought the tree nodes were sorted yesterday, but I sorted them more. I wondered how I was going to manage the five headings; but two are about process (process and reflection), and outcome and experience have fitted well into relationships. So what I should probably do now is relate the codes to my objectives, to pick up any more relationships.

Have written up the tree codes for relationships, and moved more of codes in the process - the fit is much better now, and having done the three groups, I think I see how the three can be merged. Placing the hand written tree codes up on the wall alongside my objectives and asking myself what the codes say (in terms of the causes, phenomenon and consequences). This helped to seek out the most meaningful codes, which became the categories and some of the sub-categories [see Appendix E]. I sought out the codes that best represented the objectives and I linked these under the most descriptive code for the cause-phenomenon-consequence phases. These then became the themes at that stage of the analysis [see appendix E]. One theme is 'Being more relevant ...'. The other is perhaps: 'it was just the key to get it right', (but this is also about being relevant).

21/07/2000

I went through the codes again and merged the other relationship headings into relationship between occupational therapist and client. They fit well. What seems to be appearing is a flow from cause to phenomenon to consequences, but this will need some further work to improve the flow. When I have done this, I will write the codes up again, as this gives another perspective which helped last night and might help clarify the sub categories, categories and themes.

22/07/2000

What I have done is selected the "meaning units" from the tree codes - now up on my wall. I followed the sequence of cause, phenomenon and consequence (cause-effect to structure intermediate results, (Flick, 1998:184), in the form of: who the person is - focus on familiar - trying to promote choice - in process- one's outlook on life - creative - comfort of patient to interact - no hope if no choice - power for choosing their activities. This is a coherent flow of ideas - they are categories, in which I have sub-categories, but I'm not sure yet what the theme is.

23/07/2000

There were a few ideas from the participants' journals, which I have added to the code tree. I am now reading through my own journal to code reflections. I have gone through the journals and re-visited the tree coding. I have identified two themes 'relationship vitally important beyond activities' and 'encourage them to do and move on'.

25/07/00

Made changes to the table to create three categories, rather than two to create a better causal flow of codes: 'Relationship vitally important beyond activities', 'As therapist give back key for control of situation', 'they can start doing things for themselves'. These culminate in 'encourage them to do and move on'. The member checking group will be held today.

26/07/00

I asked study group about the code table. Interest in subcategories and flow of them and to some degree the categories, but the theme names will need to be changed. They also suggested that I relate the findings to the objectives.

27/07/00

The objectives were then interpreted using Schön's framework of reflection IN and ON action. I then fitted the subcategories, categories and themes from the code table around these three categories on a diagram in the form of an action-reflection cycle. I then went back to all four interviews and journals, as well as the member checking session and brought in any other codes that spoke to these categories. I still need to sort the codes into sub categories.

28/07/00

Knowing IN action and reflection IN action (when usual routines fail) this is more than feelings, but an interpretation 'in the moment'. Reflection IN action is an on-the-spot inquiry, a main focus. Reflection ON action is thinking back on what you have done.

I have edited the model for analysis and moved many of the codes across from reflection ON to reflection IN . Sometimes it's difficult to tell which it is, because it is something which they are discussing in the reflection ON phase, i.e. out of the practice situation, about the practice situation. Some of the "strategies" are therefore with "experience".

29/07/00

Spent the whole day fine-tuning the model for analysis. Comparing the table [in appendix E] with Table 3 [see p43]: the sub categories have stayed very much the same for reflection IN action, as compared to the second theme about the therapist. Reflection ON action is unlike any of the old cats or themes. The capacity of the client is similar to the 'doing things for themselves' theme, but more refined. I still need to redraw the model for a better flow of ideas.

30/07/00

Re-drew model – now much better flow of ideas

I met with a colleague who confirmed that the use of the model was a form of deductive analysis, in that I had used Schön's reflection as a framework for deducing the essence of the objectives, compared to what I done previously, which was inductive analysis. We identified themes and plots, all the time asking if this is answering the objectives, and whether the codes chosen as themes were the essence of this. I found I had to review the flow of ideas in the model to establish the essence by looking at how else the codes could fit together.

31/07/00

I am now re-drawing the model to find the essence of the meaning. When the same themes kept recurring, I realised I had arrived at the themes and a plot, which make sense. I now need to run this past an expert occupational therapist, as a key informant, to see if this is in fact the essence of how expert occupational therapists collaborate with aphasic patients.

01/08/00

I met with a key informant this afternoon and explained the problem statement and themes. She gave some useful comments, particularly sharing my concern that the collaboration is a two way process and the client's capacity must feature as an active factor in the treatment process and that it's not just about the therapist initiating the situation to be 'just right' for the client's inclusion.

She made comments that the therapist's reflection IN the session is about the relationship: that it is about empathy: if empathy is about being with, time, listening, encouragement, giving a chance. She asked if empathy is facilitatory though. I explained that the descriptions that they gave of

empathy were about facilitation. She asked if the satisfaction of the therapist and client came though, which it did.

She agreed that the process is about looking for keys for meaningfulness. She shared my concern that both of the first two themes are about the therapist doing/being TO the client, what about the client TO the therapist? When we turned over and "looking" became a strategy it made sense that it was about therapist TO client. The first theme about empathy is not so much a 'one way street', because the therapist is reading the client's initiatives and responses, and so the client has an informative and active role.

When we spoke about the client's capacity, she asked about volition and how cognitive problems might affect this. I said that the client's volition had come into the data. I thought then that the term 'taking over' was too reductionistic. She then gave examples of how the outcome with two of her clients had been quite different, and one was satisfactory for her and the other wasn't and yet both the clients found them satisfactory, because of the people they were before the stroke. I then realised that the taking over is IN the process and not just an end-product. And it's this ability to take hold of their lives and the decisions they make that is enabled by and enables their capacity for engagement in occupation.

02/08/00

I have written up more on the methodology. I still need to put in info from old memos on process. I have put in my questions posed in the focus groups in Appendix E under Questions posed in sessions. I found in the member checking a nice quote about 'giving back the key', as if the therapist shouldn't have it anyway, as well as a quote of mine: 'that is about them making the decision of what they want to do and you accommodating that'. Both of these point to the capacity of the client.