

Therapeutic alliances in stroke rehabilitation: a meta-ethnography

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Therapeutic alliances in stroke rehabilitation: A meta-ethnography.

Abstract

Objective: To synthesise qualitative studies exploring patients' and professionals' perspectives and experiences of developing and maintaining therapeutic alliances in stroke rehabilitation.

Data Source: A systematic literature search was conducted using the following electronic databases: PsychInfo, CINAHL, EMBASE, Medline, AMED, ASSIA, ComDisDome from inception to May 2014. This was supplemented by hand searching, reference tracking, generic web searching and e-mail contact with experts.

Study selection: Qualitative peer reviewed articles reporting experiences or perceptions of the patient or professional in relation to therapeutic alliance construction and maintenance in stroke rehabilitation were selected for inclusion. Following a process of exclusion, seventeen publications were included in the synthesis.

Data extraction: All text identified in the 'results' and 'discussion' sections of the selected studies were extracted verbatim for analysis in a qualitative software programme. Studies were critically appraised independently by two reviewers.

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22 *Data synthesis:* Articles were synthesised using a technique of meta-ethnography. Four
23 overarching themes emerged from the process of reciprocal translation: (1) the
24 professional-patient relationship: degree of connectedness; (2) asymmetrical contributions;
25 (3) the process of collaboration: finding the middle ground; and, (4) system drivers.

26

27 *Conclusion:* The findings from the meta-ethnography suggest that the balance of power
28 between the patient and professional is asymmetrically distributed in the construction of
29 the alliance. However, given that none of the studies included in the review addressed
30 therapeutic alliance as a primary research area, further research is required to develop a
31 conceptual framework relevant to stroke rehabilitation, in order to determine how this
32 construct contributes to treatment efficacy.

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37 Keywords: Rehabilitation; Stroke; Professional-Patient Relations; Power (psychology);
38 Qualitative Research.

39

- 40 Abbreviations:
- 41 Critical Appraisal Screening Programme (CASP); International Classification of functioning
- 42 (ICF); Therapeutic Alliance (TA)
- 43

In the field of psychotherapy, the quality of the relationship between the therapist and patient, also known as the therapeutic alliance (TA), represents a major variable in treatment outcome in the therapeutic process.^{1,2} TA, sometimes referred to as working alliance, is an umbrella term used to describe the interpersonal processes operating during therapeutic encounters.³ Its roots are firmly established in the field of psychotherapy and its emergence dates back to Freud's theory (1912)⁴ of transference and counter transference. The conceptualisation of TA was further developed by Bordin⁵ (1979), who proposed a tripartite model based on: congruence in relation to the *goals* and purpose of therapy (1); collaboration on explicit *tasks* to meet those goals (2); and establishment of an emotional *bond*, characterised by trust and liking between the client and the therapist (3). Bordin proposed that the construct of therapeutic alliance could be applicable to all change situations, consisting of a change agent and a person seeking change, independent of treatment modality.⁶

The development of an effective therapeutic alliance has been found to be positively associated with treatment efficacy across a range of psychotherapeutic treatment modalities and aetiologies,^{1,2} suggesting that TA is a variable component of therapy "in and of itself".^{7 (p92)} There is burgeoning evidence to suggest that TA may be an essential component in all therapeutic encounters in the field of allied healthcare and medicine.⁸⁻¹¹ Establishment of an affective bond between the provider and patient has been positively associated with treatment adherence^{9,12,13} and health outcomes, including pain management, functional and physiological status¹⁴ and symptom resolution.¹⁵ In a systematic review, Hall et al.¹⁰ reported a positive effect of establishing a good TA on

treatment outcome in physical therapy. Similarly, studies in the field of brain injury have reported positive associations between an effective TA and treatment adherence and outcome.¹⁶⁻¹⁹

TA may have the potential to unlock some of the problems associated with adherence and engagement in rehabilitation,²⁰⁻²¹ which may help us understand why clinicians achieve different outcomes when the content of therapy remains the same.²² Indeed, the centrality of collaborative goal setting in the rehabilitation process is widely acknowledged²³⁻²⁴ and has been found to affect participation, motivation²⁵ and satisfaction.²³ TA, as a construct, appears to be of particular relevance to stroke rehabilitation because rehabilitation aims to promote recovery through optimising function and adaptations²⁶ and therefore requires the establishment of a common purpose²⁷⁻²⁸ and a shared commitment to engage in therapeutic activities required for goal achievement²⁹ within a context of mutual trust and empathy³⁰.

The primary objective of this meta-ethnography was to synthesise patients' and professionals' perspectives and experiences of developing and maintaining therapeutic alliances in stroke rehabilitation. Although TA as a construct has yet to be applied qualitatively to the field of stroke rehabilitation, there are studies which explore aspects of the TA, such as therapeutic relationships or collaborative goal setting. This synthesis therefore aimed to create a deeper understanding of TA as a whole from its component parts. The secondary objective of this synthesis was to investigate the utility of psychotherapeutic constructs of TA, in particular, Bordin's pantheoretical construct of TA, to

the field of stroke rehabilitation. The technique used to synthesise the data was meta-ethnography which was specifically chosen as it lends itself to the application of theory and model generation of experiences³¹, can be used to present a novel interpretation of “the collective that may differ remarkably from the component parts”^{32 (p326)} and has been used extensively in the field of healthcare to examine experiences and views.³³⁻³⁴

Methods:

Design:

A tripartite design was employed: 1) systematic search; 2) critical appraisal and; 3) synthesis, based on Noblit and Hare’s (1988)³⁵ meta-ethnographic approach, adopted by Britten et al., (2002)³⁶ and Atkins et al., (2008).³¹

Search strategy

A systematic search of electronic databases was undertaken using PsychInfo, CINAHL, EMBASE, Medline, AMED, ASSIA and ComDisDome from inception to May 2014, by the first reviewer (ML). Key terms relating to a broad definition of TA, stroke rehabilitation, and perceptions were selected for the search strategy, using a modified version of the SPIDER search strategy tool³⁷ (Table 1). Subject headings were identified and modified for individual databases, in addition to using free text terms. The following search strategies were employed to compensate for problematic indexing and inadequacies of retrieval terms:³⁸ (1) hand-searching relevant journals in the field of rehabilitation (Topics in Stroke Rehabilitation, Clinical Rehabilitation, Journal of Interpersonal Communication Disorders); (2) manually searching bibliographies and undertaking forward citation searches of articles selected for full text screening; (3) contacting experts with specialist knowledge of TA within the field of rehabilitation; and (4) generic web searching (google scholar).

Study selection

Abstracts and titles from the database searches were screened for relevance, by the first reviewer (ML) and selected if they met the following criteria: (1) qualitative data in a peer reviewed journal, (2) experiences and/or perspectives of the rehabilitation specialist and/or patient, (3) TA or an aspect of the TA was discussed as the main conceptual focus of the

paper, (4) findings relating to stroke rehabilitation from an adult population, (5) available in English as a full article.

Studies were excluded if they reported mixed population data, with no stroke specific findings, because the process and, therefore, the experience of rehabilitation^{26,39,40} and goal setting⁴¹ for stroke patients is likely to be different to other neurological conditions.

References were imported into EndNote X7 software⁴² and duplicates were deleted. Full texts of potentially relevant articles were retrieved and then scrutinised independently by the first (ML) and last author (KS). Study inclusion was agreed via consensus.

Critical appraisal

There is currently no universally accepted approach to evaluating the methodological quality of qualitative studies⁴³ and debate continues over the merits of using quality checklists and tools.⁴⁴ As such, it remains unclear as to whether articles should be excluded based on quality appraisal.⁴⁴ Given that the quality of the written report does not always reflect the actual conduct of the research³¹ and the objective of the paper was to explore

perspectives and experiences of developing and maintaining TAs, all articles were included regardless of methodological quality, to ensure all relevant findings were reported. Quality assessment was used descriptively to reflect on the strength of the findings.

To review the quality of the research, the Critical Appraisal Screening Programme (CASP)⁴⁵ for qualitative research was chosen. The CASP consists of a 10 question checklist evaluating rigour, credibility and relevance. Each question contains prompts to examine: research design, recruitment strategy, data collection, researcher and participant relationship, research ethics, data analysis, findings and contribution to knowledge. A 3 point rating system⁴⁷ was used to appraise all studies (Table 2). Two reviewers (ML, KS) independently assessed each article for methodological quality, using the CASP criteria. Differences in opinion were mediated through discussion and agreed via consensus.

Data extraction and synthesis

Data were extracted using a standard form detailing the aims, methods, theoretical framework and context of each study. The ‘findings’ and ‘discussion’ sections of the selected articles were imported verbatim into QSR NVivo 10 software programme⁴⁷ for further analysis.

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171 This review adopted a meta-ethnographic methodology, which combines both an inductive
172 and interpretive approach to knowledge synthesis.³⁵ This meta-ethnographic approach is
173 characterised by seven stages, which do not exist in isolation but overlap and are subject to
174 repetition³⁵ (Table 3).

175

176 The first author re-read the studies several times and generated a list of key metaphors or
177 constructs from each paper³⁵ (phase 3). In order to determine how the studies were related
178 to each other, three members of the research team (ML, KS, collaborator) independently
179 created 'conceptual maps' from the list of key constructs, to establish the relationship
180 between studies. Overarching themes were used to frame and organise the key constructs,
181 which were subsequently merged and juxtaposed until consensus was reached regarding
182 the emergent relationships between the salient constructs (phase 4).

183

184 The overarching themes identified were broad enough to encompass the key constructs
185 across all the papers and, for this reason, the synthesis took the form of a 'reciprocal
186 translation', a process in which one study is translated into another by comparing the extent
187 to which findings and constructs from one paper are related to those in another.³⁵ An index
188 paper⁴⁸ was identified as a starting point for translation which reflected the core concepts
189 relevant to TA in stroke rehabilitation and subsequent papers were compared with this
190 paper, and so on, until all the papers had been translated into one, encompassing the
191 relevant concepts within all studies. New themes and constructs were added as part of an

iterative approach. Perceptions derived from patients and professionals were differentiated in order to identify similarities and differences in perceptions. Table 4 displays a summary of the abstracted findings from the process of translation (phase 5).

The process of developing a line-of-argument synthesis involved: 1) re-reading the reciprocal translations and studies on numerous occasions; 2) analysing the data thematically; and, 3) interpreting the findings (phase 6). Each member of the team subsequently reviewed the emergent line-of-argument synthesis and confirmed whether the first author's interpretation was consistent with the translated themes and key constructs of the findings from the original studies. The current synthesis was expressed in the form of a diagrammatic model to facilitate effective communication (phase 7).

Rigor

A meta-ethnography, by its very nature, is not replicable, nor does it attempt to be; rather it represents a "reading" of studies and, as such, it is likely that other readings may identify alternative interpretations.³⁵ Noblit and Hare suggest that these interpretations must be grounded in the primary articles selected for synthesis.³⁵ The authors employed several strategies to ensure that the synthesis was 'grounded' in the data extracted from the

original studies via: preservation of the authors' terminology, conducting regular team debrief meetings to discuss emergent themes and challenge emergent translations, keeping extensive documentation and audit trails, and, secondary reviewers reading and validating the process of synthesis. Rigor was further enhanced by the use of systematic search strategies and critical appraisal. The first researcher's own biases as a speech and language therapist may have differentially affected the interpretative process of synthesis, however members of the team had different clinical backgrounds, which served to challenge potential bias, enhancing the trustworthiness of the findings.

Results:

Sample

A total of 5787 titles were identified for review. Seventeen studies were subsequently identified for inclusion (Figure 1), published between 1995 and 2014. TA was not identified as a primary focus of interest in any of the studies; rather a component of TA was discussed as the main focus of interest. Several studies explored the role of collaborative goal setting in stroke rehabilitation.⁴⁹⁻⁵⁴ Others focused on aspects of communication and relationship

development^{48,55-58} (Table 5). Studies largely featured participants' early experience of stroke rehabilitation, primarily on inpatient units⁵⁰⁻⁶³; only a small number of studies explored an aspect of TA in the later stages of rehabilitation.^{48-49, 64}

The methods employed to capture participants' perceptions and experiences were largely interviews (n=13), which were framed within a range of epistemological paradigms, although these were not consistently specified. There was considerable variability in the methodological quality of included studies, with 2 studies^{55,59} consistently providing limited or no justification for 6 or more of the CASP dimensions. The major areas of methodological weaknesses across studies related to: the inadequacy of evidence of reflexive practice^{48-51, 53-64}, insufficiency of evidence of ethical consideration^{48-49,54,56,58-64} and a lack of transparency in analysis.^{55,59-60,62}

Participants

The sample was diverse (n=432), encompassing professionals from a range of fields (n=169). Physiotherapists (n=50) and speech and language therapists (n=50) represented a larger proportion of the sample, whilst doctors (n=10), nurses (n=25) and occupational therapists (n=15) were under-represented in the sample. Stroke patients (n=263) had a range of

deficits, including aphasia; however this was not consistently specified. At least seven different developed countries were represented in the sample. Study characteristics are displayed in Table 5.

Synthesis

Four overarching themes were identified from the process of reciprocal translation: 1) the professional-patient relationship: connectedness, 2) asymmetrical contributions, 3) the process of collaboration: finding the middle ground, and, 4) system drivers.

Professional-patient relationship: connectedness

Connectedness embodies the degree of cohesion and establishment of a genuine bond within the therapeutic relationship. All stakeholders believed that a solid therapeutic relationship was a crucial component of purposive stroke rehabilitation.^{48,55-57,60} Patients, in particular, believed that the therapeutic relationship was of paramount importance,

commensurate with the therapeutic activities targeted.⁴⁸ In the aftermath of stroke, patients assumed a position of vulnerability and dependence^{48,57,59,61-62} and, as such, assigned considerable importance to an attitude of caring,^{48,61-62} in contrast to speech and language therapists who primarily fostered rapport in an effort to promote therapeutic efficacy, as part of “doing a job”.^{48 (p284)} Despite these differences in priorities, the majority of patients reported that they had confidence in and trusted their healthcare professional.^{48,54-56,59,61,63} “I asked her quite blankly, ‘Are we getting anywhere or not?’ She said, ‘Oh, we’re doing fine’. That’s enough for me... Just keep going until she says, ‘Stop’”.^{55 (p103)} Equally, professionals recognised the importance of developing trust in therapeutic relationships and its potential to affect engagement.⁵⁶⁻⁵⁷ “As soon as we are able to foster a relationship of trust, patients begin to work with us, almost for our sake at first, and eventually realise that they can recover”.^{56(p221)}

For patients, in a position of vulnerability, being treated with dignity and being acknowledged as an individual rather than “just another patient”^{62 (p19)} was fundamental to feeling valued and was expressed through professionals ‘giving time’ and attention to individuals.^{55,57,61-62} Patients felt valued when healthcare professionals exhibited attributes of patience, tolerance, attentiveness, interest, kindness and warmth.^{48,61-62} Equally, nurses felt valued when their efforts were acknowledged by patients.⁵⁷ Professionals valued reciprocal behaviours in patients, specifically openness, enthusiasm, engagement and realism^{48,55,57} and employed a number of strategies to promote affiliation and solidarity through adapting their behaviour, giving time, displaying empathy, engaging in humour and giving encouragement.^{55-58,61,63-64} For professionals who had unsuccessfully attempted to

298 develop a relationship with patients, despite employing facilitative strategies, withdrawal
299 was perceived to be their final option.⁵⁵

300

301 Staff and patients ascribed meaning to each others' personal qualities and behaviour, with
302 staff identifying "favourite patients",^{55 (p105)} which had the potential to either solidify or
303 impede therapeutic relationships. Professionals conceived that the presence of
304 communication difficulties hindered dyadic interaction and inhibited the development of an
305 affective bond.^{48,55,57} However, some professionals perceived that they were able to
306 strengthen the therapeutic bond through spending time with patients with aphasia,
307 bypassing verbal barriers.⁵⁷

308

309 Contrary to a dominant trend in which patients reported positive experiences of stroke
310 rehabilitation, were reports of inhuman treatment, carelessness, disregarded concerns and
311 episodes of insensitivity, which threatened to erode trust and debase patients' dignity.⁵⁵⁻
312 ^{56,61-62} "You really don't know a thing, which proves the point that you don't have any dignity
313 at all, because 'we (the hospital staff) do as we like.' And that's that". ^{61 (p829)}

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315

316 ***Asymmetrical Contributions***

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Across seven papers, collaborative goal setting was rarely adopted in stroke rehabilitation^{48,50,53,54,56-58} and when patient-therapist dyads engaged collectively in goal setting, the process was largely therapist led, with the therapist generating the goals for intervention.^{53,57-58} Both interviews with patients and professionals and observational data, suggested that asymmetrical contributions in goal setting were produced collaboratively.

Dyadic influence: Agents of asymmetry

Patients' attitudes towards participation were diverse. For some patients, the desire for decisional control was important, whereas for others, the concept of collaboration was either unimportant or alien and there was an expectation that the healthcare professional would adopt an 'expert' role, assuming decision making responsibility, whilst the patient assumed a role of the acquiescent recipient.^{48,61-62} This desire for low decisional control has been ascribed by professionals to both temporality and the process of "coming to terms"^{52(p151)} with stroke. In contrast, many patients wanted to be actively involved in goal setting and become joint partners in the planning and process of goal setting.^{48,52,63} For some patients, lack of decisional control was associated with "a loss of self-determination".^{61(p830)} "Cause they boss you around, cause you're sick, aren't you? And then you've got no say. I've noticed that now".^{61(p829)} Interviews with stroke patients indicated that younger patients appeared to advocate more active involvement in decision making.⁴⁸

Similarly, professionals perceived that patients wished them to assume an 'expert' role and direct goal setting.^{48,52-53,57} For a small number of professionals, the family's decision superseded patient autonomy which was reportedly concordant with patient expectations.⁵⁶ In contrast, therapists across four other studies emphasised the importance of establishing collaboratively agreed goals^{48,50,60,63} and identifying and incorporating patient specific goals.^{55,60,63} However, patient interviews and observation have revealed that this process was not always evident in practice.^{53,63}

Professionals perceived that a range of factors intrinsic to the individual served to inhibit participation namely: the patient's passivity, psychological adjustment and coping strategies, previous experience with illness, and the patient's age and personal characteristics.^{48,50,52,54-55,59,62} Passivity featured across a number of studies,^{48,54,55,59,62} which professionals attributed to variables of age, time post-stroke, communication impairment and cultural diversity.^{48,54,62} Aetiological factors such as depression, reduced insight, physical, cognitive and communication difficulties were perceived by professionals to play a significant role in impeding collaborative goal setting.^{48,50,54,55,58}

The clinician's level of experience was deemed by professionals to directly impact on the nature of collaboration.^{48,52,63} Indeed, therapists wanted to involve patients^{50,60,63} but "did not appear to know how to do it".^{63 (p1203)} Physiotherapists perceived that they were on a "journey"^{52 (p150)}, in which their skills evolved over time, developing from an "initial black

and white mechanistic view...to a greater focus on patient empowerment”^{52 (p151)} However,
some physiotherapists felt that skills such as rapport could not be learnt.⁵²

The process of collaboration: Finding the middle ground

The process of collaboration was closely aligned to the theme of ‘connectedness’, because a
solid therapeutic relationship was conceived by professionals to provide the context for
collaborative goal setting and, therefore, the premise for establishing congruence.^{48,49,52,54,60}
Therapists attributed episodes of incongruence to a weak therapeutic relationship and
misaligned goals.^{50,54} Interviews with professionals revealed that goal setting was led by
their hospital policy requirements which demanded realistically achievable goals to be set
within a short time frame and focused on return of function.^{48,50-51,54} Consequently,
therapists’ goals were framed largely at the impairment and activity level of the
International Classification of Functioning (ICF) (World Health Organisation) and were not
always analogous to patients’ perceived goals, particularly if they were representative of the
participation level of the ICF.^{48,50,54,63} When goals misaligned, interactional difficulties
ensued which had the potential to be time consuming and unpredictable,^{50-51,53} demanding
“significant effort”.^{52(p153)}

Professionals attributed interactional dilemmas to what they believed were patients' unrealistic expectations and the prioritisation of "privileged" goals.^{51(p210) 48,50,52,53} In the early stages, professional's perceived that patients were still 'coming to terms'^{52(p150)} with their stroke and may not have been ready to accept their prognosis, preferring to place their hope in recovery.⁴⁹ In contrast, patients' perceptions of recovery varied, from the realistic⁶² to hopes which "were tinged with realism".^{49(p404)} Both professionals and patients conceived hope as a fundamental driver for recovery.⁴⁸ Professionals believed that the act of balancing realistic expectations and maintaining hope was dependent on developing a genuine relationship and approaching patients sensitively, limiting psychological stress.⁴⁸⁻⁴⁹ Indeed, for professionals, the process of establishing realistic goals was closely intertwined with the process of acceptance and had to be carefully negotiated in order to preserve hope, integral for recovery.

Both patients and professionals recognised the importance of information provision and education, essential for setting goals, patient engagement, and engendering respect in the therapeutic dyad.^{48,50,53,61-63} Yet patients perceived that the provision and accessibility of meaningful information was often inadequate.⁶¹⁻⁶³ Professionals ascribed this inadequacy of information provision to professional time constraints, the patient's ability to communicate and the professional's perception that the patient wanted them to assume control.⁴⁸

There was considerable variability in professionals' reported responses to episodes of incongruence during the process of goal setting, which encompassed: "navigating"⁵¹

patients towards more amenable goals; limiting or avoiding talk of ‘unsuitable’ goals; and negotiating with patients to establish concordant goals.^{51,53,55} Negotiation was perceived by clinicians to be reflective of a genuine attempt to work collaboratively with patients and was aligned to many staff-patient relationships described as close or “participatory”.^{55 (p104)} For professionals, negotiation was deemed to be successfully employed to reach concordance^{49,55} and reflected an attempt by both parties to compromise, recognising the reciprocal benefit of maintaining a purposive alliance.⁴⁸ Professionals’ attempts at redirecting patients to more ‘suitable’ goals, which aligned with their clinical priorities,⁵¹ served to perpetuate the asymmetrical nature of the partnership, emphasising “established clinical roles and perceived resource capacity”.^{51(p211)} Although professionals recognised that limited time resources^{48,53} impacted on collaborative goal setting, a number of clinicians also believed that, by limiting or avoiding conflict, they would preserve the established patient-professional bond⁴⁹ and safeguard patients from psychological stress.^{49,53,56}

All stakeholders perceived that the process of reaching concordance was not restricted to the dyadic relationship but extended to the patients’ families.^{48,54,56,60,63} Professionals valued familial collaboration and recognised the potential benefit in facilitating realistic goal setting, particularly when linguistic and cognitive barriers constrained patient involvement.^{48,54-55} Family involvement varied on a continuum from full active participation to non-involvement.^{48,56,63} A few speech and language therapists believed that, for some patients, family involvement could be detrimental, particularly if a relative dominated a therapy session.⁴⁸

427 *Motivation: A by-product of collaboration?*

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429 Therapists perceived that employing a patient-centred framework in which patients were
430 fully involved in goal setting had the potential to motivate patients.⁵⁰ Equally, incongruent
431 goals were perceived by patients to be demotivating.⁴⁸ “I want to read, yes, yes but there I
432 read, but they take those away and say do this (gestures to writing). I threw it away. I threw
433 it away, because it was so silly”.^{48(p290)} Motivation was closely aligned to hope and therapists
434 perceived that giving a sense of hope would promote motivation.⁴⁸⁻⁴⁹ A small number of
435 professionals and patients conceived that motivation was the result of developing an
436 effective therapeutic relationship and of professionals engaging in productive patient
437 interaction.⁵⁶ Therapists’ experience of developing ineffectual relationships suggested that
438 this can have an adverse effect on therapeutic adherence.⁴⁸ Thus, the strength of the TA,
439 rather than collaboration alone, may have the potential to influence patient motivation.

440

441

442 ***System drivers***

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444

445 Organisational and financial drivers had a tangible impact on the nature of the relationship
446 and collaboration, achieving the paradoxical effect of impeding a ‘patient-centred’ agenda,
447 central to many healthcare policies. All stakeholders recognised that service constraints had

a direct effect on time resources which impacted on frequency and length of rehabilitation^{48,61} and, for professionals specifically, affected getting to know the patient, essential for forming a relationship and working collaboratively.^{48,55,57} Time constraints hindered nurses' ability to be available and responsive^{55,57} and were perceived by patients to differentially affect self-esteem, damaging not only nurses' relationships with patients but also relationships between patients, vying for attention.⁵⁵ Similarly, nurses expressed dissatisfaction if they were unable to be responsive to patients.⁵⁷

Lack of collaboration was not only a consequence of reduced time capacity but an indirect consequence of fiscal and organisational drivers which directed clinicians to prioritise 'privileged' short term goals to meet discharge targets.^{48,51,54} Fiscal policy dictated the length of therapeutic input and led to early discharge, which was perceived by patients and professionals to threaten hope^{48,60,63} and had the potential to induce dyadic conflict.⁶⁰

The public and time-centric arena of the hospital context was a significant factor in causing doctors and nurses "to operate closer to the hierarchical than the participative end of the spectrum" in forming relationships with patients.^{55(p108)} The lack of privacy afforded in hospital was perceived by professionals to further inhibit the formation of close bonds,^{48,55} particularly for those professionals whose relationships were limited to the ward environment.⁵⁵

470 ***Line-of-argument***

471

472

473 Underlying the process of developing and maintaining a positive TA was an inherent power
474 differential between the patient and professional in stroke rehabilitation, in which the
475 power balance was disproportionately weighted towards professionals. Despite
476 professionals' efforts to redress the balance, disequilibrium remained dominant (Figure 2).
477 The synthesis indicated that triadic influences (system drivers, professionals and patients)
478 contributed to this imbalance of power.

479

480 Maintaining homeostasis within the professional-patient dyad was dependent on: (1)
481 establishing connectedness in order to build equality and openness, as a premise for both
482 goal setting and targeted therapeutic interventions, (2) inclusion in goal setting in line with
483 patient choice to promote autonomy, and, (3) negotiating amenable goals, not only focusing
484 on patient choice but meeting the professionals requirement to set goals which they
485 believed were achievable, in order to establish concordance. Disequilibrium threatened
486 when the above conditions were not met.

487

488

489 ***Discussion:***

The finding that the TA was characterised by an imbalance of power was perhaps not unsurprising, since its presence in the formation of the TA is inescapable,⁶⁵ however it is the inadvertent perpetuation of this imbalance throughout the process of alliance formation and development, by both dyadic agents which was perhaps unexpected and needs to be redressed. The synthesis findings mirror those of a recent systematic review exploring stroke survivors experience of rehabilitation, in which empowerment was perceived to be threatened by inadequate information provision, lack of collaboration and disrespect.⁶⁶

The benefit of maintaining a positive TA was perceived to be great, both in terms of engagement and motivation. A number of studies have suggested that the development of an effective therapeutic relationship may be fundamental in activating patient engagement²⁰ and motivation,⁶⁷ highlighting the potential of TA as a mechanism for change.

The question remains as to whether Bordin's constructs of TA⁵ are indeed transferable to the field of stroke rehabilitation. The theme of 'connectedness', which is closely correlated to Bordin's construct of '*bond*' (3), was characterised by a feeling of wanting to be liked, cared for and trusted, resonating with Bordin's⁶ suggestion that these attributes were common across all modalities. The synthesis did not, however, consider the importance of other components embedded in psychotherapy,^{68,69} such as understanding and unconditionality relevant to the 'bond' construction, which is not to suggest that these aspects were not relevant but rather that the questions have yet to be asked.

The themes of ‘asymmetrical contributions’ and ‘finding the middle ground’ are closely aligned to Bordin’s key construct of ‘goals’ and establishing congruence in relation to the purpose of therapy (1).⁵ This process was marked by interactional dilemmas in stroke rehabilitation. Similarly, alliance development in the field of psychotherapy is characterised “by much negotiation”.^{70(p63)} Where this process departed from the psychotherapeutic experience, is in its reinforcement of therapist-identified goals, emphasising the perceived dominance of ‘privileged’ goals in stroke rehabilitation, shaped by the current service delivery model. In contrast to psychotherapy, one of the major barriers to obtaining concordance related to the aetiological challenges specific to stroke rehabilitation (linguistic and cognitive deficits), resonating with findings from earlier systematic reviews.^{24,71}

The current synthesis failed to delineate a third component of the construct of TA which aligned with Bordin’s component of ‘task’ (2). This may reflect an absence of articles addressing this aspect or may be indicative of a lack of applicability, highlighting a need for further research to ameliorate our understanding of this construct in stroke rehabilitation.

Study limitations:

The dearth of papers available focusing on TA as a primary research area has meant that key aspects of the TA relevant to stroke rehabilitation are likely to have been neglected. Indeed, findings suggest that core components of the therapeutic relationship relevant to physical rehabilitation^{10,72} were absent from psychotherapeutic constructs of TA, highlighting the need to explicate and conceptualise the process of TA within stroke rehabilitation.

It is likely, however, that the diversity of the professions, the setting and the conceptual focus of the selected studies may have led to the development of a synthesis which overestimated some aspects of TA in stroke rehabilitation (asymmetrical contributions in goal setting, inpatient environment) and underestimated other aspects (such as communication⁷²), undermining the conceptual 'richness' of the synthesis. A number of key constructs were heavily influenced by professional perceptions, such as 'balancing hope with expectations', in which professionals assumed that patients would have to accept their residual deficits in order to progress, when in fact stroke survivors reported that testing boundaries and assuming autonomy led to more realistic expectations, negating the requirement to set 'realistic' goals,^{73,74} thereby, highlighting the need for further exploration of this construct from the perspective of both stroke survivors and providers.

The papers were selected on the basis of their conceptual focus rather than their representativeness of a sample population. Therefore, the synthesis was grounded within a range of epistemological frameworks and methodologies. The inclusion of papers deemed methodologically 'weak' may have affected the findings. Removal of methodologically

‘flawed’ papers^{55,59} however did not differentially affect theme and construct development. Equally, the findings from methodologically weaker papers did not contradict other papers and it became clear throughout the process that those studies with conceptually ‘rich’ data made a greater contribution to the synthesis than those representing strong methodological findings.

Conclusions:

This synthesis offers new insights into professionals’ and patients’ experiences and perceptions of developing TA in stroke rehabilitation, highlighting the importance of developing ‘connectedness’ as a context for collaboration and managing potential tensions.

There are a number of components of Bordin’s construct which may be applicable to stroke rehabilitation, however, our conceptual understandings are merely embryonic at this stage and we currently lack a conceptual model on which to frame our understandings of this concept in the field of stroke rehabilitation. Rather than answering questions about what we know about TA in stroke rehabilitation, this review has highlighted what we do not know.

575 Future research needs to; 1) develop a conceptualisation of TA in stroke rehabilitation,
576 which can then be used to inform the development of, 2) a robust measure of TA applicable
577 to stroke rehabilitation, in order to, 3) explore the relationship between TA and stroke
578 rehabilitation. Failure to address these issues may mean that patients fail to reach their full
579 potential.²²

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791 Figure Legends:

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793 Figure 1: Search strategy and exclusion process

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795 Figure 2: The power differential

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797 Table 1: Search terms

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799 Table 2: Critical Appraisal Screening Programme (CASP) analysis

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801 Table 3: Noblit and Hare's seven stage ethnographic process

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803 Table 4: Abstracted findings from the process of reciprocal translation

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805 Table 5: Characteristics of synthesised studies

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