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People with aphasia's perception of the therapeutic alliance in aphasia rehabilitation post stroke: A thematic analysis

Abstract

Background: The therapeutic alliance has been found to be a critical component of treatment delivery in mental health interventions. This construct may have the potential to inform both treatment efficacy and adherence in aphasia rehabilitation. However, little is known about how people with aphasia perceive therapeutic alliance construction in the context of aphasia rehabilitation.

Aims: This study aimed to investigate people with aphasias' subjective experiences and reflections of constructing and maintaining therapeutic alliances in aphasia rehabilitation.

Methods & procedures: In-depth interviews were conducted with eighteen people with aphasia who had received aphasia rehabilitation following a stroke. Interviews were subject to thematic analysis.

Outcomes & results: Data analysis revealed five core themes: 1) readiness to contribute to the alliance; 2) proximity with the therapist; 3) perceived attunement with the therapist; 4) receiving information; and, 5) collaborative engagement. The therapist's perceived ability to read and respond effectively to individuals' relational and situational needs contributed to the success of the alliance.

Conclusions: These findings offer novel insights into current practice, highlighting considerable variation in alliance formation across the profession, with ineffectual alliances obstructing engagement and eroding hope and effective alliances promoting adherence and instilling hope. Further research is recommended to understand which aspects of the therapeutic alliance are essential for optimising therapeutic efficacy.

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MeSH keywords: professional-patient relations, qualitative research, patient participation, stroke rehabilitation

Introduction

Therapeutic alliance embodies the collaborative component of the therapist-client relationship and the negotiated agreement between both parties in relation to breadth and depth of therapy (Horvath & Symonds, 1991). Therapeutic alliance, often used synonymously with the terms ‘working alliance’ (Bordin, 1979), ‘helping alliance’ and ‘therapeutic relationship’ (Agnew-Davies et al., 1998) has been a consistent source of variance in psychotherapeutic outcomes (Horvath et al., 2011; Martin et al, 2000). The origins of therapeutic alliance are firmly grounded within psychotherapy and Bordin's early conceptualisation of the therapeutic alliance, in 1979, continues to dominate theoretical frameworks and alliance measurement (Elvins & Green, 2008). Bordin identified three constituent components of therapeutic alliance which captured: 1) the mutual agreement in relation to the clients' *goals*; 2) the collaborative engagement required for therapeutic *tasks*; and, 3) the interpersonal *bond* necessary for effecting change (Bordin, 1979). More recently, emergent models have attempted to reconceptualise this construct as it is applied to a wider range of healthcare fields, allowing for the inclusion of the family system and constructs like patient empowerment (Kim et al., 2001; Pinsof et al., 1994). Patient empowerment extends the conceptual boundaries of the alliance to consider concepts such as self-efficacy, partnership and equality (Kim et al., 2004). For the purposes of this study, a broad definition of therapeutic alliance was applied, encompassing components applicable to psychotherapeutic conceptualisations (Bordin, 1979) and those derived from more recent applications to rehabilitation and medicine (Bishop, 2015; Bright, 2015; Kim et al., 2004; Lawton et al.,in press).

Several systematic reviews have consistently found the strength of the alliance to be related to treatment outcome, adherence and satisfaction in mental health and physical rehabilitation (Hall et al., 2010; Horvath et al., 2011; Lakke & Meerman, 2016; Martin et al., 2000). The notion that the therapeutic alliance may be an active component of stroke and aphasia rehabilitation has been highlighted in recent qualitative studies with professionals and patients engaging in stroke rehabilitation (Lawton et al, 2016; Lawton et al.,in press; Bishop 2015; Bright 2015).

The construct of therapeutic alliance appears to be particularly relevant to aphasia rehabilitation, precisely because the act of communication cannot be separated from personhood and social connection (Hersh, 2012). Thus, the existence of aphasia inevitably has consequences for alliance development, since its development is intrinsically linked to a person's ability to communicate. Indeed, relational and interactional aspects of therapeutic interventions are perceived to be central to optimising therapeutic efficacy and treatment engagement in aphasia rehabilitation (Bright, 2015; Fourie, 2009; Lawton et al. under review; McLellan et al., 2014; Worrall, 2010). Findings suggest that effective alliances are perceived to: inculcate hope (Bishop, 2015; Worrall, 2010); enhance patient motivation (Lawton et al., 2016); foster psycho-social well-being (Fourie, 2009); influence satisfaction; and, differentially affect linguistic-communication treatment outcomes (McLellen et al., 2014). Bright's findings suggest that speech and language therapists play a pivotal role in promoting patient engagement by integrating positive elements of relational practice into rehabilitation, such as getting to know the person, engaging in small talk and developing an understanding of patient priorities (Bright, 2015). Similarly, therapeutic actions and qualities, such as being understanding and being empowering, have been found to help to resolve some of the existential consequences induced by the communication disorder, engendering a context conducive to purposive rehabilitation (Fourie, 2009). The importance of acknowledgement and understanding in a supportive context has further been reported in promoting psychological well-being for people with aphasia in community aphasia groups (Attard et al., 2015). These studies highlight the potential utility of actively training clinicians to develop targeted interventions which improve engagement.

Although psychotherapeutic constructs of therapeutic alliance may be highly relevant, alliance construction and maintenance is subtly nuanced in the context of aphasia rehabilitation (Lawton et al., in press). This is, in part, due to the person’s communication deficits, but also because the process of stroke rehabilitation is inherently different to mental health interventions (Kayes & McPherson, 2012). Previous research has sought to explicate the process of therapeutic alliance formation from the speech and language therapist’s perspective (Lawton et al., under review) but, as yet, there has been no focus on understanding this phenomenon from the perspective of the person with aphasia. Given that clients’ and professionals’ perceptions of their therapeutic alliance often differ (Martin et al., 2000; Horvath et al., 2011), it is essential to determine what therapeutic alliance construction means to people who have aphasia. This will allow us to explore what aspects of the alliance can then be targeted to improve intervention delivery and engagement and contribute towards developing a theoretical framework, which can then be used to develop a robust therapeutic alliance measure. The main objective of this study was to explore people with aphasia’s (PWA) experiences and perceptions of developing and maintaining therapeutic alliances in the context of their aphasia rehabilitation post-stroke.

Method

Study design

A qualitative design was selected to elucidate the processes operating in the development and maintenance of the therapeutic alliance in aphasia rehabilitation from the subjective view of the person with aphasia. Qualitative inquiry is ideally suited to explicating subjective meaning, perspectives and interpretations, revealing novel complex processes which may otherwise remain concealed (Morrow, 2007; Willig, 2001) and has been used effectively to elicit perspectives and experiences with PWA (Brown et al., 2010; Grohn et al., 2014). A flexible methodology was employed to allow for the adaptation of methods to promote maximal inclusion for people with aphasia (Lloyd et al., 2006; Luck & Rose, 2007). The participant and researcher were, therefore, both actively involved in constructing meaning through dialogue. As such, the present study was informed by a constructivist paradigm, in which meanings and experiences are perceived to originate from social interaction and discourse rather than residing within the individual (Guba & Lincoln, 1994). Thus, meaning making is co-constructed through the interview process itself. This theoretical framework is particularly applicable given the nature of communication in aphasia rehabilitation, in which meaning is co-constructed through supported conversation.

The study has been approved for conduct by the Health Research Authority, Research Ethics Committee in the UK, reference 14/NW/0179, in addition to permissions from research and governance departments at individual National Health Service (NHS) sites, prior to the commencement of the study.

Selection Criteria

Purposive sampling was employed to select participants who: 1) had aphasia, the severity of which was determined by assessment on the Western Aphasia Battery (WAB-R) (Kertesz, 1982); 2) had experience of at least 4 sessions of aphasia therapy with a qualified speech and language therapist in the last year; 3) were able to communicate, in English, using a combination of methods including speech, gesture and writing to participate in in-depth interviews; and 4) were 18 years of age or above. Participants with mild to moderate aphasia were purposefully sampled to select those people with reasonable comprehension and spoken output. Thus, participants were excluded who scored: <7/10 in auditory comprehension, <4/10 in fluency and <5/10 in naming and word finding WAB-R language sub-test scores. Participants were excluded if they had deficits in vision, cognitive skills or hearing, impacting on their ability to participate in interviews. This allowed for the inclusion of a range of aphasia typologies including: anomic, transcortical, Wernicke's, Broca's and Isolation aphasia (WAB-R), but excluded those with more severe receptive and expressive difficulties, enabling the research team to gain valuable insights into the participants' lived experience.

Participant recruitment

Participants with aphasia were recruited from stroke communication support groups and via NHS Trusts in the North West of England. The field researcher (ML) visited eight stroke communication support groups to disseminate information about the study. Information was provided in verbal, written and pictorial formats to ensure information was accessible to PWA (Rose et al., 2003; Rose et al., 2011). Those who were interested in participating were invited to contact the field researcher for further information. Fourteen NHS Trusts in England within a 90 mile radius of the field researcher (ML) were selected. Speech and language therapists who specialised in stroke rehabilitation at the selected sites, were contacted via e-mail and asked to distribute summary information about the study to all eligible individuals. The referring speech and language therapist obtained a written consent from the person with aphasia which then allowed the research team to contact prospective participants.

The field researcher (ML) provided all participants with comprehensive verbal and written information, detailing the study's objectives and participant involvement. In accordance with guidelines (Kagan & Kimelman, 1995) for obtaining informed consent from people with aphasia, information and consent forms were provided in a simplified format to assist comprehension (large font, increased spacing, pictorially represented, simplified vocabulary and syntax). The field researcher (ML) administered the WAB-R to all potential participants to ascertain whether participants met the inclusion criteria and determine how conversations could most appropriately be supported within the interview context. All participants gave written informed consent prior to data collection.

Seven participants were excluded on initial screening as they did not meet the inclusion criteria: naming and word finding WAB-R scores <5 (n=2); SLT input <4 sessions (n=2); no recollection of aphasia rehabilitation (n=2); significant cognitive deficit (n=1). A further two participants chose not to take part in the study.

Participants

Eighteen participants (six women and twelve men) met the inclusion criteria, consented and participated in interviews. They were recruited from five different NHS Trusts in the UK and eight different stroke communication support groups. All participants had been seen by more than one therapist for varying lengths of time (1-72 months). Participants’ ages ranged from 45 to 88 years. Six participants were still receiving aphasia rehabilitation from a speech and language therapist, at the time of interview and all participants had received speech and language therapy input within the last year. No participants had returned to work following their stroke. On WAB-R screening, fourteen participants had mild aphasia (Aphasia Quotient (AQ) >76) and four presented with moderate aphasia (AQ 60.5-74.3).

Participant (pseudonym)	**Gender** male (m) female (f)	**Age range** (years)	**Previous occupation**	**WAB-R** (Aphasia Quotient)	**Length of SLT input** (months)

Table 1: Participant demographics

Joanna	f	65-71	housewife	77.3	5
Marie	f	45-54	shop assistant	80.6	29
John	m	45-54	operations director	77.4	19
Anthony	m	45-54	insurance manager	84	24
William	m	55-64	project manager	79.8	31
Sara	f	55-64	carer	71.1	23
Stella	f	45-54	nurse	94.6	10
Carl	m	55-64	project manager	86.4	72*
James	m	65-74	solicitor	74.3	12
Jeff	M	45-54	company director	90.9	3
Terry	M	65-74	operations worker	93.2	15
Betty	F	75+	housewife	90	9
Dave	M	75+	regional manager	60.5	8
Barry	M	65-74	journalist	99.4	3.5
Richard	M	65-74	graphic designer	89.8	60*
Stuart	M	65-74	process manager	94.2	1
Ian	M	45-54	project engineer	91.9	5
Jean	F	75+	housewife	68.3	10

Pilot interviews

Following two pilot interviews with PWA, the interview schedule was reworded to minimise ambiguity and clarify meaning. Given the complexity of the phenomenon of therapeutic alliance for PWA, a decision was made to give participants a copy of the written interview schedule, a week prior to the interview to encourage participants to reflect on their experiences. The schedule was also adapted pictorially and syntactically to assist comprehension.

Data Collection

The field researcher (ML), an experienced speech and language therapist, conducted face-to-face, in-depth, semi-structured interviews with participants, over a 16 month period. Participants were interviewed in their own homes, consistent with individual choice, on one occasion. Interviews were video-recorded, to allow for the inclusion of non-verbal communication (such as body language, gesture and writing) (Luck & Rose 2007). Interviews lasted between 40 to 90 minutes and participants were encouraged to take a break as required. The interview schedule focused on the participants' experience and perceptions of therapeutic alliance construction and maintenance in aphasia therapy and was guided by the literature (Lawton et al., 2016, Lawton et al., in press; Bishop, 2015; Bright, 2015; Bordin, 1979; Pinsof, 1994). Broad questions helped to guide the interview process, such as: What was your speech and language therapist like? What was the best therapy session? What was the worst therapy session? How did your therapist encourage you? Apart from the exercises, what did your speech and language therapist do or say that was helpful? What did your speech and language therapist do or say that was unhelpful? How did you decide what to work on? (see appendix 1). An open-ended interview frame ensured that participants had a high degree of volition over conversations so that emergent foci of interest were discussed in depth as they arose.

The researcher used a flexible approach, modifying the interview schedule to support communication within the dyad. Interviews were adapted using a variety of conversation support techniques to promote communication access (Kagen, 2001), allowing the researcher to gain valuable insights into participants' lived experience (Luck & Rose, 2007).

Techniques included: using drawing, gesture and written text to enhance understanding and provide a scaffold for conversations; offering word suggestions; repeating words or phrases to verify the researcher's understanding and interpretation; incorporating closed questions; using simplified syntactic structure and vocabulary; and, clarifying participant gesture or facial expression, particularly when it contradicted verbal intent. The following excerpt illustrates the latter adaptation:

Researcher: And did you feel relaxed with Sue (SLT) even though you found the work very hard?

Marie: Yeah [grimace]

Researcher: Your face is telling me something different.

Marie: Ken (husband), all right, Sue (SLT), smashing, Sue, but me, Sue, no.

A list of possible responses for several questions (grounded in the literature and previous participant responses) were given to two participants, whose expressive language was significantly impaired. Field notes were taken during and after interviews, detailing the context of data collection and the field researcher's initial interpretations. Data were transcribed verbatim and double checked by the first author (ML). Non-verbal behaviours pertinent to the research question were documented. All identifiable information was removed at transcription and pseudonyms were assigned.

Data Analysis

Data analysis commenced following the completion of data collection. Data were analysed by the first author (ML), using NVivo 10, employing inductive thematic analysis, following a framework outlined by Braun and Clarke (2006). Thematic analysis not only “provides a robust systematic framework for coding data” (Braun & Clarke, 2014 p1) but is epistemologically flexible. A flexible approach to data analysis was essential, given the methodological adaptations inherent in qualitative research with people with aphasia (Dalemans et al., 2009). The following steps were undertaken, as described by Braun and Clarke (2007):

1. Familiarising yourself with the data: The first author (ML) watched the video recordings and read the transcriptions on 3 occasions, documenting nascent patterns and meanings in the data relevant to the research question.

2. *Generating initial codes:* Units of text that conveyed meaningful information relevant to the construct under investigation were coded by the first author. Data were coded inductively across the complete data set.

3. Searching for themes: Codes which conveyed similar meanings or patterned responses were grouped into categories. Memos documented the researcher’s impressions about emergent themes. Categories were subsequently grouped together in tentative themes, based on participants’ implicit ideas, assumptions and perceptions (Braun & Clarke, 2007).

Themes	Category	Example

Themes were identified at a latent level. Graphic representations, in the form of thematic maps, were created to explore the relationship between categories and themes.

4. Reviewing themes: Refinement of tentative themes involved merging and juxtaposing codes and categories to ensure that themes were both coherent but distinct. Themes were continually refined as part of an iterative process until consensus was reached, across all the research team members, regarding the validity of the overarching themes in relation to their codes and categories. The identification of a theme was not dependent on quantifiable measures, but on whether it captured something important about the research question (Braun & Clarke, 2006). However, all themes were represented by at least several instances across the data corpus. Negative cases were sought and themes were revised to capture disparate patterns within the data. During the latter part of this phase, the first author reread the transcripts to confirm whether the identified overarching themes were reliably grounded within the data. Themes were not modified any further at this stage. (Table 2)

5. Defining and naming themes: Theme labels were selected to capture the content and implicit meaning of the themes.

Table 2: Data analysis development; including themes, categories and examples

Readiness to contribute to the alliance	Intrinsic readiness	“ She came in and…again I was, and this I didn’t particularly
	Facilitating readiness	“ But they just need that little hurdle to get over to see the n it’s only when you get over it… you’re ready for more and m
Proximity with the therapist	Seeing the person	“I think umm Helen (SLT) is interesting my-myself you see.”[
	Treating the person	“I think she just connected that anything that I needed she w on the words or things like that she would do more time on t well we’ll do this then we’ll do that umm but then we’d she u as well and what I did or so she understood about from work my life then not so.” [John]
	Treating the impairment	“the community speech therapist, was more interested in th could help, and .. I needed more than that...” [Barry]
	Relational continuity	“if you keep changing they they don’t know me as a person t or what’s happened but not me as a person so you know.” [A
	Dependency	“it was a really .. horrible experience to lose my right leg if yo therapist was taken from me, you know.” [Barry]
Perceived attunement with the therapist	Instilling self-belief	“she was one of the good ones who thought ‘You’re going to
	Responsiveness	“I think it was almost a, a mutual agreement, you know, in ou .. skilfully avoided my, erm .. clangers or anything else to .. to [Barry]
	Feedback	“talking was absolutely, you say you’re going backwards, but therapist does help, the whole thing is bolstered. “ [Carl]
	Lack of responsiveness	“in the beginning it was too much, that was too much, it was sentences that they gave you were too long,… er, I, I was .. a really, I couldn’t get it out, I couldn’t .. I couldn’t make them
Receiving information	Managing expectations	“try to manage expectations and my expectations was in we she’d be sitting where you are now and she’d be like nodding saying, to try to think about you not got to try to limit yourse
	Understanding	“I didn’t understand what was going on so may have they ha
Collaborative engagement	Therapist-led agenda	“I just did what I was supposed to do, don’t ask me what tha
	Sense of agency	“some things she let me to decide.” [John]
	Personalising therapy	“A massive help and encouragement for me was being able t could see that she was focusing on that because it was a par
	Coercion	“She was a ma'am, wasn't she, like… when Sheila (SLT) gave

Rigour

Trustworthiness of data was enhanced through; 1) conducting pilot interviews which were subsequently analysed and discussed with the research team; 2) ensuring that questions were accessible and lacked ambiguity (Lloyd et al., 2006); 3) detailing decisions about methodological and analytical selection via a comprehensive audit trail, including written memos; 4) regular team de-brief meeting to ensure decisions were both defensible and grounded within the data; and 5) actively searching the data for negative cases. Furthermore, no new themes were identified from the data when analysing interview seventeen and eighteen. Whilst acknowledging the active role the researcher played in data collection and analysis, the first author (ML) attempted to enhance transparency by keeping a reflective journal documenting the first authors' assumptions and the decision making process and verifying meanings with participants. This was particularly pertinent given the author’s recent therapeutic alliance research (Lawton et al., 2016, Lawton et al., under review) and role as a stroke specialist speech and language therapist.

Results

Five themes emerged from data analysis (Table 2). *Readiness to contribute to the alliance* described the individual’s state of readiness to form a therapeutic alliance and the therapist’s ability to influence motivational readiness. *Perceived attunement with the therapist* and *receiving information* described the behavioural processes employed by therapists which contribute directly to the therapeutic alliance. The latter two themes, *proximity with the therapist* and *collaborative engagement* explored the relative effect of relational proximity and collaboration between the dyadic agents in relation to the formation of the therapeutic alliance.

Readiness to contribute to the alliance

This theme captured the participants’ positioning and readiness to initiate change and its relative interaction with the development of therapeutic alliance. In the immediate aftermath of stroke, participants described feeling a range of emotions, from anger and frustration, to feelings of despondency and dejection. Participants felt that therapy was “pointless” when they had yet to arrive at a point of readiness. In the first month following his stroke, Anthony spoke of not want to engage with his therapist because he was not ready to change, holding onto hope that things would return to *normal*: “I think it’s [therapy] a little bit, personally, pointless at that time." The participant's readiness was not only ascribed to the individual's psychological status but was also reflective of the person's insight. Therapy was often described as pointless when participants were not yet aware of their difficulties and had little or no understanding of their diagnosis.

Participants perceived that their engagement in the therapeutic process was central to the establishment of the partnership, recognising the reciprocal effort required to forge a positive alliance. Many participants believed that, if the therapist's efforts were not reciprocated, therapy was in danger of being pointless, one-sided and ineffective. Carl postulated that therapy should be withdrawn for those who were not willing to engage in the process:

> What you really need are the right people, at those sessions, people who want to get better. 'Cause the rest of it is time wasting. I go to the Stroke Association, I talk to them, and they've been to therapists and they don't really want to do it. [Carl]

However, whilst Carl suggested that allocation of services should be dependent on intrinsic readiness and motivation, his own experience in rehabilitation indicated that readiness may, in fact, be a co-constructed process in which the therapeutic alliance is utilised to instigate motivational change. In the following quotation, Carl described how his initial disengagement was gradually eroded when he began to establish a connection with his therapist: “I didn’t particularly want to go and again I thought the whole thing was a little bit pointless, but after two or three sessions I warmed up to this….” [Carl]

Readiness to contribute to the alliance was not only described by participants as a prerequisite to forming an alliance and establishing therapeutic engagement, but was also a state which could potentially be facilitated through the development of a positive connection.

Proximity with the therapist

Proximity with the therapist describes the degree of connection afforded to the therapist-client dyad. Participants experienced their alliances along a continuum, exemplified, at one end, by emotional proximity and, at the other end, by professional distance. Participants who described their alliances as close, spoke of therapists who were genuine, friendly, non-judgemental and caring. Close alliances were characterised by openness and connectedness, which reportedly created a relaxed atmosphere, conducive to therapeutic engagement. “She's very gentle and nurturing, anything goes with Nikki (SLT) and we sit and talk for well it seems like forever and then we do a bit of work.” [Stella]

Several participants spoke of an internal struggle to retain their identity post stroke and therefore valued therapists’ attempts to see them as a person, as opposed to an illness. Seeing the person was largely expressed by therapists giving time to get to know the person, which allowed individual competence, self-worth and autonomy to be explicitly acknowledged. The therapist’s ability to impart a genuine interest in getting to know the individual was aligned to relationally close alliances. The bond formed between the dyad was not only perceived to be a product of the therapist getting to know them, but was also a consequence of the therapist revealing information about him/herself. Barry described how getting to know his therapist as a person, by learning about her family and social interests, not only humanised interactions but promoted equity within the dyad: “It just marked her down as a person and not an inanimate, er teacher, you know.” However, self-disclosure was only perceived to be valuable when it enhanced interactions and did not dominate sessions or detract from the participant.

A sense of being heard and understood was important for participants and was perceived to be dependent on the highly tuned communication skills of the therapist. The process of being listened to was associated with most alliances in speech and language therapy but participants often reported that this was absent from other relationships, including those with family members and healthcare professionals. The therapist’s ability to demonstrate empathetic understanding and attend to the participant’s psycho-social needs, particularly at a time of great emotional upheaval, was perceived to be fundamental to mitigating isolation and building trust. It was the therapist’s ability to *treat the person,* as oppose to the linguistic impairment in isolation, that exemplified relationally close alliances. In the following excerpt, Anthony describes how being able to confide in his therapist about how he felt, allowed him to make sense of his situation and forge a close connection with his therapist, because he had a sense of being understood as a person:

> She helped me because she understood uhh everything really so she umm helped me with me moods and things like that and family and understanding about you know because it's diffi it's diffi it's like a total change from what it was [Anthony]

Seeing the same therapist on a consistent basis allowed the alliance to thrive providing a positive or even satisfactory alliance had been formed in the short term. However, if the dyad had failed to form a connection, relational continuity did not facilitate further growth of the alliance. Alliances which were perceived to be very close, often described as friendships, were marked by relational continuity, over a period of either months or years. Although only Barry spoke of developing high levels of dependency towards his therapist within this theme, his experience suggests that, when hope was directly invested in the therapist, within a highly connective alliance, the ending of therapy could have devastating consequences for the individual, oblitering hope:

> I was conscious of all the grains … slowly slipping away and I thought my whole future and it's a cliché if you like, but my future was dependent and I could see it slipping away, so yeah, I, I was .. I was very dependent, and I had to .. .. think for myself eventually and .. it was not, a good experience when Louise (SLT) left me. [Barry]

At the other end of the continuum, participants spoke of therapists who adhered to a more clinical, formal approach, in which the linguistic impairment was the main focus of therapeutic interventions. Small talk and getting to know the person was minimised by the therapist, as it detracted from the focus of the therapeutic work. A small number of participants felt that liking their therapist and engaging in small talk was not relevant to the work of therapy. For this group of participants, a therapist-driven agenda which focused on *treating the impairment*, maintaining a clear professional-patient divide, was therefore not problematic as it aligned with their expectations of therapy and several participants reported being satisfied with this approach. In contrast, participants who had more intensive rehabilitations needs and were receiving therapy for longer periods of time, felt that focusing on the impairment without attending to the person, or the impact of the aphasia on the person's psycho-social wellbeing, directly threatened engagement. For Marie, who described feeling depressed and devoid of hope in the first year following her stroke, her first therapist's agenda, which focused solely on the linguistic aspects of therapy, neglected to recognise her positioning within the process and thus failed to meet her on her journey. This lack of wider engagement with her aphasia by the therapist left Marie feeling disengaged from the therapeutic process and indifferent about her therapist: "Gwen (SLT), all right, but Jackie (SLT), speech therapist and nothing else." [Marie]

Proximity with the therapist was both a variant of individual preference and temporality. Professional distance was often incompatible with participants' needs in the early stages of rehabilitation when they described feeling highly vulnerable. At this stage, participants spoke of needing more than professionalism; they needed compassion and empathy, a human connection.

Perceived attunement with the therapist

The art of therapeutic attunement was perceived to lie in the therapist’s ability to read and respond effectively to individual nuances and make therapy challenging, without being overwhelming. Barry described how his therapist’s ability to push him to achieve beyond what he perceived to be possible, instilling self-belief, was not only empowering but represented a transformative moment in the therapeutic process, instilling hope for future change:

> One day she would say, I want you to tell a story, the story is goldilocks and the three bears and I don’t want you to think about it, I just want you to speak for five minutes and tell me the story.. and so, erm, I was very thrown by this and very flustered, but, erm, .. I was speaking and she just said, just tell me how much you can remember of the story, so I was thinking five minutes, oh my god, you know, but then I was speaking and I recorded it and erm, there was some very, erm, long pauses at the beginning, but when I could talk .. I was going on for about fifteen minutes and I didn’t realise, and erm .. and that really, the mastery that that gave me of words and word flow and fluency was remarkable, and I would never have thought a nursery rhyme would be so empowering, a

> simple thing, but you know, who's been .. going into my bed, you know, was just remarkable. [Barry]

Similarly, knowing when not to push in order to safeguard the individual's psychological status, was central to maintaining an effective alliance. Participants described an unspoken agreement in which they moved on from tasks which were too challenging, in order to protect positivity within the dyad, allowing hope to be retained. In the following excerpt, John explained how, after multiple attempts to elicit a word unsuccessfully, they moved on to alternative tasks which allowed him to experience some success. This process was, however, dependent on the degree of attunement afforded to the dyad:

> When we got, I think we both...point when we think we'd like to get on with something else, you know, the point and I think she say, well I was feeling yeah...you know, I'd like to do some things, I need some stuff with can do better. [John]

For many participants, progress, particularly when it was slow, was often imperceptible. Giving explicit feedback about progress, which was responsive to the individual, was therefore perceived to be an effective mechanism to inculcate confidence and hope. Terry felt that, when he had reached an impasse in therapy, the therapist played a pivotal role in not only making progress visible but believing in him, offering hope that future improvement was possible. For Terry, the event signifies a catalytic shift in his outlook:

> A real rough patch, but the belief [pause], err, [long pause]. She could see something in me, that, yet although I could see it myself that was the goal I was going for. She could see beyond that, and she was getting me, by the scruff of the neck [gesturing], that's where you want to be across there like…it just gave me enough kick up the pants [laughs] to you know come back and fight. [Terry]

In contrast, several participants spoke of episodes in which they felt that their therapist had failed to respond effectively to them as a person. In the following excerpt, Stella recalled how, in hospital, the therapist's inability to respond effectively to the subtle nuances of the discourse, undermined her own sense of self-worth:

Stella:	When I laughed and I did things wrong, she didn't laugh.
Researcher:	How did that make you feel?
Stella:	It made me feel stupid for laughing at myself.

Similarly, therapists who were unable to read and respond effectively to signs of disengagement, were at risk of completely alienating participants from the rehabilitation process. Several participants spoke of therapists who had inappropriately pitched tasks at a level which was too challenging. The failure of therapists to respond and adjust tasks accordingly, in this context, amplified participants' anxieties and frustrations. In the following excerpt, Betty described how her therapist's lack of responsiveness and her failure to change therapeutic tasks in response to the situational context of the therapeutic encounter, left her feeling devoid of hope: "I think I broke down, er .. I just, I just was on edge all the, all the time, and I think as she'd gone, I think I broke, couldn't help it." [Betty]

Receiving Information

The theme *receiving information* described how effectively meaningful information about the participant's diagnosis, prognosis and the rehabilitation process, was imparted and explores how this process either impeded or facilitated alliance construction. The majority of participants felt that their therapist had been explicit about the prognosis of recovery and most participants had a sense that full recovery was unlikely. Participants spoke of wanting to hear this information, despite acknowledging its devastating impact. Failure to address these issues was perceived by several participants to threaten trust within the dyad. The way this information was relayed and the timing of these conversations was important and many participants spoke of their therapist's skill in managing expectations, balancing the realistic, without extinguishing hope:

> That was good information, I thought. I could have imagined because of stroke, somethings happened and you could see the logic of that, that it may not be perfect, but it could be improved, or get back to a certain point. I sort of accepted that, yeah, yeah. [Stuart]

Several participants reported that there was a sense of the unknown during the early stages of rehabilitation; little information had been disseminated or what information had been given, had not been processed effectively to allow the participant to make sense of their situation. In these early stages of rehabilitation, it was important for some participants to make sense of what was happening and to understand both the aphasia diagnosis and the rehabilitation process, whereas others just wanted to know that help was available. Indeed, for several participants, the mere presence of the therapist symbolised hope amidst the tumult of recovery:

> Researcher: Did you feel like you wanted to know more about things?
>
> Stuart: No, not at that point. Probably that came a little bit later, I'm not sure when, but later. At that point, I was just grateful that someone was doing something for me. And that there was a way to sort of improve the situation.

In contrast, Jeff described how the discussions with his therapist, about returning to work and the obstacles he faced because of his aphasia, were deemed to be therapeutic, in and of themselves:

> It's not just purely about the the the therapy it's all it's it's it's the therapeutic, the actual discussion that you're having because you you you're talking with

> somebody who's got a relative…who's got an understanding and seeing other people that you need it's it's it's good to get the feedback and the understanding about yourself. [Jeff]

Participants described their understanding of aphasia and stroke as evolving, in line with their ability to absorb this information and their own receptive language acquisition. The skill of the therapist was perceived to dictate how effectively participants were able to access and process this information. Betty described being bombarded with too much information by her first therapist, which left her feeling isolated and disconnected from her therapist. In contrast, Betty's second therapist provided accessible information which she could relate to, which provided the foundations on which to build a purposive alliance: "She showed me, she showed me how she'd done it, you know, see how she'd done it, and she drew me some pictures how your mind misses things and they were very true." [Betty]

Being able to see the point of doing a given activity was not only dependant on the participant's cognitive and receptive language abilities but also on the therapist's ability to explain the relevance of a given activity. Concordance for some participants was reliant on developing a sound understanding of the relevance of a given task, as indicated in the following quotation: "But it was good because, they'd ask you something, and you might disagree with them, right but then you'd say well now I can understand that and you'd do it." [Ian]

Collaborative engagement

The theme *collaborative engagement* captured the participant’s desire to participate and assume ownership of the therapeutic process. The majority of participants had little or no idea of what their goals were and described handing over this responsibility to the therapist. Participants however were largely satisfied with this therapist-led agenda and believed that this was part of the therapist’s role and expertise. Indeed, participants’ roles were deeply entrenched and inextricably linked to a system which personified the patient-expert dichotomy. In the following excerpt, Sara referred to her therapist’s expertise in explaining why she felt that it was not appropriate to engage collaboratively in the goal setting process: “Well, they have their qualifications, don't they?” [Sara] But it was not only a sense of meeting role expectations that stopped participants wanting to become more involved in goal setting. Many participants perceived that therapist-identified goals were successful in meeting their rehabilitation needs. For Richard, who described his therapist as a friend, the notion that he should be involved in goal setting seemed alien because the goals and activities his therapist had identified, aligned with his own needs: “Again…(laughs) I didn’t need…No…Because it was working for me I didn’t need to question whether another tack might…be more suitable.” [Richard]

Genuine collaboration was perceived to be dependant, for many, on the therapist’s ability to listen to the participant’s personal narrative and identify goals concordant with individual priorities. Participants who felt their therapist had attempted to incorporate what they wanted to do, felt that therapy was highly personalised and relevant, which directly impacted on their engagement in rehabilitation. In the following excerpt, William described how making a therapeutic task functional was highly motivating, embroidering hope into his isolated existence on a hospital ward:

> William: Me and Margaret (SLT) are in Morrisons [supermarket] y'know.
>
> Researcher: Okay.
>
> William: I mean it's umm wors no first time in the supermarket and its lovely y'know. Its invigorating…Vent you see and worlds my oyster now how you see.

The therapist's adherence to a person-centred agenda was evidenced during the therapeutic process by amenability to change, in line with the participant's choice or needs and letting the participant lead. For some participants, particularly for those who had been in position of power previously, it was important to be given the opportunity to assume a sense of agency: "Sometimes she would lead the sessions and sometimes she would .. not .. .. erm .. .. well .. she would let me .. have the floor and that, I think that was important as well." [Stuart]

The level of inclusion was perceived to be dependent for many on their ability to participate, but equally it was recognised that giving choices allowed people with more impaired language to engage collaboratively. Participation was also affected by temporality, with many participants suggesting they had neither the desire nor the ability to engage in the process of goal setting in the immediate aftermath of stroke. Several participants spoke of wanting to be guided by their therapist, amidst the chaos and uncertainty of recovery. It was only when goals were considered pointless or did not meet individual need that alliances characterised by a high degree of paternalism, threatened engagement. For Anthony, working on a therapist-led agenda which appeared to be irrelevant, felt demotivating: “It’s not giving me any beneficial, for me, it’s not giving me benefit so why?” [Anthony]

A small number of alliances were characterised by a coercive alliance, in which the therapist dictated the therapeutic agenda. These alliances were marked by a lack of collaboration and directly threatened therapeutic engagement and participants’ self-determination. Participants who experienced their alliances as coercive described feeling high levels of anxiety both during and prior to therapy sessions. Stella compared one of her therapists to a “dictator” (Stella) and spoke of being reprimanded if she did not complete her home practice. She described feeling a sense of dread prior to sessions:

> Stella: Well I had to do it. I tried not to do it and I got told off so I had to do it. It was that simple I had to do it.
>
> Researcher: How did that make you feel?
>
> Stella: Like a naughty schoolgirl.

Alliances characterised by coercion reinforced dichotomous expert-patient hierarchical divisions and had the potential to erode participants' self-esteem.

Discussion

This study aimed to explore PWA's experience and perceptions of constructing and maintaining therapeutic alliances in aphasia rehabilitation. PWAs' experience of the therapeutic alliance was influenced by a number of dyadic variables, namely the individual's own readiness to initiate change and enter into the therapeutic alliance, and the therapist's perceived ability to be read and respond effectively to the individual's relational, psycho-social and informational needs. Goal congruence was dependent for many on the therapist's ability to incorporate individual priorities into therapeutic tasks.

The findings are consistent with earlier studies suggesting that readiness to engage in therapeutic interventions related both to the person's need to adjust to major health changes and their ability to see the relevance of the therapy (Green & Waks, 2008; Laver et al., 2010). Following a stroke, patients may find that they are subjected to increased stress, characterised by feelings of unpredictability, uncontrollability and overloading (Ostwald et al., 2009), which may explain why participants did not always feel ready to initiate change. According to Lazarus & Folkman (1984), an individual's cognitive appraisal of the event determines whether the person believes that he/she has the resources to respond effectively. If an individual perceives that they do not have the resources to cope, then they are more likely to have an emotional focused coping response, which may manifest itself as a lack of readiness to engage with their therapist. Within mental health contexts, the suggestion that a positive alliance might be forged without the client being in a state of readiness, is contradictory (Polaschek & Ross, 2010). However, Polaschek and Ross (2010) found that, even when readiness for change was absent in the client, therapists had been able to establish a positive alliance, which was subsequently used as a supportive mechanism to promote clients' progress, moving clients from the contemplation to preparation stage of change (Prochaska & DiClemente, 1982). They postulate that therapists were able to establish an alliance because they adapted early goals and tasks with each client, in order to maintain engagement. Thus, the therapist’s goal of immediate action was delayed, because it would have been incompatible with client's ambivalence and would have led to conflict. Similarly, the current findings suggest that the therapeutic alliance might have the potential to affect readiness, as long as therapists have been trained effectively to instigate these behavioural changes (Lawton et al., in press). This is particularly relevant to stroke rehabilitation as service provision is time-restricted and might not allow for readiness to develop.

Involvement in goal setting was a variant of the passing of time and participants’ changing needs, a finding replicated by earlier studies (Laver, 2010; Lawton et al., 2016; Lloyd, 2014; Playford, 2009). Genuine collaboration was not a process reliant on participants identifying and prioritising their own goals for therapy, as perceived by speech and language therapists (Lawton et al., in press), rather it was dependent on the therapist listening carefully to the PWAs’ narrative, in order to generate goals concordant with individual priorities and needs.

Similarly, participants were acutely aware when goals were not collaborative, as goals were reportedly incongruent with participants' priorities. This approach to goal setting closely aligns to the therapist-led approach outlined in Leach et al's (2010) goal setting practice which contends that, whilst this approach incorporated many of the values of patient centeredness, it cannot be truly defined as such because it is largely directed by the therapist. In the context of aphasia rehabilitation, however, this approach is, in fact, reflective of a collaborative, person-centred agenda, even though the process in which those goals are constructed is intrinsically different because of the person's communication deficits.

Amidst a climate of uncertainty in the early stages post stroke, participants described the importance of establishing a human connection, although this was not exclusively limited to this stage of rehabilitation. Participants' experience of relational proximity which had the potential to impede or strengthen the alliance, varied considerably. Treating the person, as opposed to the impairment, was core to understanding the success of close connective alliances. Failure to incorporate the individual's lived experience, focusing only on the therapeutic symptoms and tasks can lead to therapy which "becomes the picture card or the naming task" (Simmons-Mackie & Damico, 2011 p 36), negating to recognise the patient's positioning within this process and their expansive experience. Relational proximity was not only dependent on acknowledging the client's frame of reference, but was also reliant on the therapist assuming multiple roles, adopting not only a linguistic role, but the role of counsellor, facilitator and advocate. The current findings suggest that being too distant or maintaining rigid, inflexible boundaries can directly affect participants' engagement. However, becoming too attached posed further risks to participant dependency and encouraged over-reliance. The apparent dissonance between developing a genuine, authentic relationship and maintaining professional boundaries, in order to avoid dependency, has been recently highlighted (Hersh, 2010; Worrall et al., 2010; Lawton et al., in press). In order to mitigate these risks, Hersh (2013) advocates that therapists need to steer boundaries away from the safety of rigidity towards the balanced middle ground. Therapists should develop a positive therapeutic relationship based on honesty, trust and respect which is more likely to protect against potential exploitation and provide the necessary infrastructure for establishing the *middle ground*. It is only within this context that therapeutic efficacy can be truly optimised.

The emergent findings suggest that the establishment of a positive alliance not only impacted on engagement but also directly affected hope. Both instilling a sense of hope and maintaining hope were perceived to be by-products of a positive alliance. Instilling and preserving hope were interwoven into alliance development, through developing relational proximity, managing expectations sensitively and being attuned to individuals. It is not only the process of instilling hope but also persevering hope, which have been shown to be key to motivation (Bright et al., 2011; Green & Waks, 2008; Liechty & Braun, 2006; Worrall et al., 2010). Participants in this study wanted honest feedback about their recovery, which contrasts with earlier research suggesting some patients may wish to prioritise hope over realism (Kubina et al., 2013; Lawton et al., 2016). However, these findings are consistent with Bright and colleagues (2013) who found that unfulfilled hope could be detrimental to recovery. In contrast, Synder et al (2002) maintain that carrying unattainably high hopes, as long as they are not classed as denial, can motivate individuals and should not be perceived as psychologically damaging.

The findings demonstrate that temporality was a variant of readiness, relational proximity and collaboration. Indeed, timing was central to explicating how effectively alliances were cultivated and maintained in aphasia rehabilitation. Different aspects of the alliance assumed greater importance for participants, dependent on their own positioning and their changing psycho-social needs over time. The success of the alliance was perceived to be reliant on the therapists' ability to meet the individual wherever they were on their journey post stroke.

Recent research has highlighted the potential significance of the family as a third potential dynamic in alliance construction in stroke rehabilitation (Bishop, 2015; Kayes & McPherson, 2012; Lawton et al., under review). However, the theme of family or significant others did not emerge in the current analyses. The absence of family members as a theme does not preclude their involvement in the alliance or therapy, but rather suggests that the alliance with the family may have been perceived by participants to be separate to the patient-therapist alliance.

The applicability of Bordin's pan-theoretical constructs of *bond, goals* and *tasks* to the field of aphasia rehabilitation were highlighted in the findings. The construct of *bond* can clearly be evidenced in the theme proximity. Similarly, the constructs of *goals* and *tasks* align closely to the themes of collaborative engagement and attunement. Although many of the findings suggest that common experiences and perspectives of the alliance are shared across disciplines, such as the importance of getting to know the person (Crepeau & Garren, 2011; Ross & Hasselkaus, 2005) or treating the person as oppose to the impairment (Dizopa & Ahern, 2009; Plexico et al., 2010; Worrall et al., 2010), it is evident that several processes, such as collaborative goal setting, are altered in aphasia rehabilitation, precisely because of the nature of communication disruption.

Clinical Implications

The current findings have direct implications for clinical practice and training, highlighting the need for aphasia therapists to consider the potential use of *self* to instigate behavioural change in their clients and to promote readiness (Miller & Rollnick, 2012) and consider how psychological and social resources or buffers can be integrated to support people's coping responses (Ostwald & colleagues, 2009). Therapists need to work flexibly and holistically to accommodate clients changing socio-emotional needs and individual relational preferences and they need to be cognizant of the effect of rigid relational boundaries, which have the potential to impede alliance development and engagement. The current findings suggest that the construct of collaboration needs to be redefined, in the context of aphasia rehabilitation. Therapists need to shift their focus away from asking clients to identify goals and move towards a process in which goals are co-constructed, generating goals which are reflective of the client's narrative and aspirations, through a process of active listening. Under- and post- graduate training need to reflect this change and focus on embedding patient-centred practises which give therapists the skills to support patients to construct their own narratives and help identify patient priorities.

Limitations and future direction

In limiting participation to those with mild to moderate aphasia the authors have not captured the views of people with more severe language problems. Whilst the authors would argue that it is a key strength of the paper, because the findings have emerged from the participant's voice, as opposed to being imposed on it, we recognise that the findings may have been different for people with more severe receptive and expressive language deficits. Future research therefore needs to explore whether the current findings reflect the perceptions of people with more severe aphasia and determine which elements of the alliance are integral as opposed to supplementary. The findings are limited to the context in which the data were collected. Data were collected from participants who were diverse in terms of their ages and experience of services and therapists. A further limitation pertains to the underrepresentation of cultural diversity and female participants in the sample. The sample size, however, was meaningful (n=18) (Guest et al., 2006).

Conclusions

The therapist's ability to tailor the alliance to the client's preference and relational needs dictated how successfully the alliance was perceived by PWA. These findings offer novel insights into current practice, suggesting that positive alliances had the potential to stimulate both hope and engagement. In contrast, ineffectual alliances could engender disengagement and damage both self-esteem and hope. The findings highlight the need for therapists to consider a holistic approach which disposes of rigid relational boundaries and embraces personhood.

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Appendix 1: Topic guide

1. Tell me about when you first saw your speech therapist?
2. What was speech therapy like?
3. How did you get on with your speech therapist?
4. What's important in a good relationship (with your therapist)?
5. How much did you trust/like your therapist?
6. What was the best therapy session?
7. What was the worst therapy session?
8. Apart from the exercises and activities, what did the speech therapist do or say that was helpful?
9. What did the speech therapist do or say that was unhelpful?
10. What would have helped you to get on better with your speech therapist?
11. How important is it for you to see the same speech therapist?
12. How did you decide what to work on?
13. Did you have a say about what happened in speech therapy?
14. How important is it for you to be involved in deciding what to do?

15. How important is it to understand why you are doing something (in therapy)?

16. How did you know when you were doing well in therapy?

17. How did your speech therapist motivate you?

18. How did your relationship with your therapist affect how you felt about doing therapy?

19. What did you hope to get from therapy?

20. What was expected of you in speech therapy?

21. How did your expectations change over time?

22. How did the relationship change over time?

23. How important was it that your therapist got on well with/included your family?

24. What advice would you give to healthcare professionals? (about developing relationships with patients)