Relationships in aphasia therapy: Why do we work as we do?

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BACKGROUND

A strong therapeutic relationship is the basis of successful aphasia therapy. In education and practice, we discuss the need to 'build rapport' with patients. Patients and therapists alike describe the importance of these relationships. While there is greater understanding of *how* therapists work to develop these relationships with people with aphasia, we sought to explore relationships from a different perspective., looking beyond *how* therapists develop relationships, instead examining *why* therapists work as they do to develop relationships.

RESEARCH APPROACH

A secondary analysis of a case study of patient-therapist interactions over the patient's two week stay in an inpatient rehabilitation service: 3 observations of interactions, 2 interviews with the patient and 3 interviews with the speech pathologist (SLP). We analysed the data using three theoretical perspectives (impression management, critical perspectives and structuration theory) to explore the complexities of practice.

RESULTS

Impression management:
How do people behave, present themselves, and *perform* in their face-to-face interactions in everyday life?
Goffman (1959)

The way we present ourselves is carefully managed and constantly adjusted depending on the way we read the reactions of others to us. Goffman (1959) likens this to being on the front stage, performing a role to an audience. Our data highlighted how keenly the SLP wanted to be seen as relational, as approachable and in tune with her patient. At the same time, she needed to be seen as efficient, goal-focused and committed to the health-team's priorities for timely discharge.

As we all do, the SLP is performing when interacting with others, consciously giving, and unconsciously giving off, information about herself. Her patient is similarly playing a role. The performance and management of impressions depends on the audience and requires continuous monitoring and balancing.

Critical perspectives:
What assumptions underpin practice? How is power exercised & reproduced? What are the unintended consequences of these practices?
Nicholls & Gibson (2012)
Whalley Hammell (2015)

The power relations between the SLP and patient enable particular relationships focused on the 'necessary' work of rehabilitation. The patient's role is to supply required information & complete 'necessary' tasks, deemed important because the service & the SLP profession value these. Through interactions, the patient's aphasia is made more visible; her words and body 'disclose' (dis)ability through (in)action and imperfect action. This contributes to a relationship centred on impairments rather than between people.

The discourse of 'time' impacts on how the SLP conceptualises and prioritises relationships and reflects particular understandings of what are the most valid, legitimate forms of work in rehabilitation – commonly disciplinary, impairment work completed for purposes of assessment or discharge planning.

Structuration theory:
How do social structures and an individual's agency interact to influence the individual's action?
Giddens (1984)

Like all complex systems, the context of the rehabilitation unit, the hospital, the health system and its place in the community contribute to the systems in which people work.

There are rules and activities for everyone in these systems, often expressed in particular forms of language, ways of behaving and interacting. The SLP's use of language related to her practice (e.g 'assessment', 'discharge') defines and places rules and boundaries around her activities. These are meaningful to the SLP, but less visible and relevant to patient. The SLP's language also directs her relationship with the patient, including how the relationship is enacted and who has power.

Language and practice, as understood by the SLP, is part of the (often tacit) norms and values of staff in her practice context. These may be hard to recognise and question.

DISCUSSION

Relational work is complex, constantly changing in response to our interpretations of 'others' – the patient, the team, the healthcare system and its perceived requirements. What we do face-to-face with our patients is influenced by many intrinsic and extrinsic factors, which we may not be aware of. Power relations, language, and the relative positions of patients, SLPs and the system all influence how SLPs work and how patients respond.

Theory helps us unpack the complexities of relational work and may help SLPs reflect on their practice, identify the factors that influence how they work, consider the unintended consequences of actions, and imagine different possibilities. It helps us understand *why* relational practices are complex, challenging to enact, and why there may be a difference between how we want to work and how we *do* work.

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