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THE WISDOM OF PRACTICE: SITUATED EXPERTISE, TEACHING AND LEARNING IN A TRANSDISCIPLINARY REHABILITATION CLINIC

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By

Elizabeth Mostrom

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ABSTRACT

THE WISDOM OF PRACTICE: SITUATED EXPERTISE, TEACHING AND LEARNING IN A TRANSDISCIPLINARY REHABILITATION CLINIC

By

Elizabeth Mostrom

An ethnographic and microethnographic investigation was conducted, guided by the following research question: What is the nature of interaction between an experienced physical therapist and patients with brain injury in the context of an interdisciplinary rehabilitation clinic? The study attempts to address a paucity of empirical research and knowledge about (a) the nature of expertise or mastery in neurologic physical therapy, and (b) face-to-face interaction between therapists and patients in clinical settings.

Participants in this study included an experienced physical therapist, other members of a rehabilitation team in a small private clinic, and three patients with brain injury. Data collection methods included participant observation, interviews, review of artifacts, videotaping of physical therapist-patient treatment sessions, and videotape reviews with the physical therapist. Fieldnotes and transcripts of audiotaped interview and videorecorded data were generated. Data were catalogued and analyzed using a constant comparative method.

The study describes the culture of the rehabilitation clinic and the communally adopted "philosophy of care" of "client centering."

This philosophy represented the sociocultural beliefs and norms for action and interaction among clinicians in this setting and provided a framework for further investigation and analysis of face-to-face interaction in the clinic. Key components of client centering included the development of "therapeutic alliances" between therapist and patient, an emphasis on teaching and learning in clinical encounters, and a "transdisciplinary approach" to care.

The primary characteristics of therapeutic alliances were identified and aspects of interaction that helped to create and sustain, or constrained, the development of alliances were described. Teaching and learning was found to be a prominent, reciprocal, and dynamic feature of interaction between the physical therapist and patients. Finally, reciprocal teaching and learning among practitioners in this clinic contributed to the construction of a transdisciplinary approach to care and the professional development of clinicians.

This study provides a detailed examination and contextualized description of practice in a rehabilitation clinic. It elucidates the transactional and complex nature of the joint construction of clinical encounters and grounds emerging theory about mastery in physical therapy in the particulars of day-to-day practice.

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Dedicated to

My husband, Herm, whose support, patience, inspiration, and love made this journey possible.

My son, Eric, who has brought great joy to my life and who provided much needed perspective on this endeavor along the way.

The memory of my friend and colleague, Patricia Leahy, a gifted clinician and remarkable person who dedicated much of her all too brief career to caring for clients with neurologic disorders and helping others to do the same with skill and compassion.

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Many people have provided invaluable assistance, guidance, and support in the course of my doctoral studies and it is with great pleasure that I now recognize and thank those individuals who have made substantial contributions to this work and my learning and development over the past few years.

I am especially grateful for the advice, guidance, and understanding of the Chair of my doctoral committee, Dr. Christopher Clark. A gifted teacher and mentor, Dr. Clark's knowledge, insight, and integrity, combined with compassion made this endeavor possible. I am also indebted to the other members of my doctoral guidance committee, Dr. Nancy Ainsworth-Vaughn, Dr. King Beach, Dr. Susan Florio-Ruane, and Dr. Penelope Peterson. Each of these individuals contributed unique personal and disciplinary perspectives to my study and their thoughtful questions and advice along the way encouraged me to think more deeply and broadly about my work.

Conventions of anonymity prevent me from naming the remarkable individuals at the clinic where this investigation was conducted. Their interwoven stories and conversations are shared in this dissertation and give meaning and texture to this work. I owe a great deal to these clinicians and patients who taught me so much--

for their openness, warmth, and willingness to invite me into to their lives, however briefly, and to share their stories. I especially wish to thank "Caitlin" who gave so generously of her time, was patient in the face of my never ending questions, and was always supportive of my work. All of these people have enriched my life as I hope their stories will enrich the lives of others who read this volume.

I am also indebted to many friends and professional colleagues too numerous to mention who offered reassurance and various forms of assistance throughout the period of this study. In addition, I would like to gratefully acknowledge the Foundation for Physical Therapy, Inc. which provided generous financial support for my doctoral studies and dissertation research.

Finally, I wish to thank members of my family for their love and support during this time. I especially wish to thank my parents, Lloyd and Jean Mostrom, who have always encouraged and supported the endeavors of their children to further their education, and my husband, Herm, and my son, Eric, who lived this dissertation with me and to whom this volume is dedicated.

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LIST OF SYMBOLS AND ABBREVIATIONS

Transcription Conventions

[	overlapping speech
]	latching (no interturn pause)
/ or ..	short pause (less than 1 second)
// or ...	long pause (more than 1 second)
	rising intonation (often assoc. with interrogative-?)
	falling intonation (often assoc. with . or !)
underline	spoken with emphasis
CAPS	very emphatic, louder
o-o-o	dragging out of vowel sounds
/???/	audible, but unable to make out words
....	dangling sentence, feeling of more to come....
	very soft speech
	harsh (often loud) speech
(smiles)	descriptions of non-verbal behaviors accompanying talk; e.g. facial expressions, gaze direction, positional changes and movement. Also used to identify chuckles/laughs and to suggest an implied (but not spoken) word or words

Chapter 1
THE GENESIS AND EVOLUTION OF THIS EXPLORATION

Introduction

This is a story of personal and professional learning and development; a story of gradual, sometimes erratic, movement toward and through my dissertation research. In telling this story I want to first describe and explore how the ideas and questions for this research endeavor emerged, how they evolved, and how they were transformed over the past few years as my life story as a practicing physical therapist, university faculty member, doctoral student in educational psychology, researcher, spouse, and mother unfolded.

During my time as a doctoral student I listened to my advisor, Dr. Christopher Clark, describe learning as a process of remembering, reconsidering, reinterpreting, and reorganizing that results in new knowledge, new questions, new directions, and, thus, growth. Concurrently, I had the opportunity to encounter people, ideas, theories, and research in a variety of disciplines and professions including educational and developmental psychology, anthropology, sociology, linguistics, teaching, physical therapy, occupational therapy, clinical psychology, medicine, and nursing. The diversity of the intellectual company I kept along the way has been both

enlightening and confusing from time to time; but there is no doubt that my emergent questions and transformed visions were indelibly influenced by the activity and conversations taking place in these disciplines. Although the discourse in these wide-ranging communities had the potential to be, at best, parallel conversations, and, at worst, divergent or conflictual, it was a pleasant and fortunate surprise to find there were many intersections of ideas and conversations across these disciplines that became interwoven into my own developing questions and thoughts.

This chapter, then, is a description of how I *remember* these years, how I *reconsidered* my research questions and ideas in light of my enlarging experience with texts and talk in a variety of disciplines, how I worked to make sense of (or *reinterpreted*) ideas, beliefs, and emerging theories in the course of this journey, and how I *reorganized* my reflections on, and thoughts about, this time into research directions and questions for my dissertation research and beyond.

The Beginnings

My initial questions and concerns grew out of reflections on my own teaching of future physical therapists over the past twelve years. In several of my classes I discuss with my students various models of physical therapy practice presented in our professional literature with the implication that these models represent or describe what expert or good physical therapy practice looks like or should be. My hope, of course, was that once my students were familiar with such conceptual models they would have a clearer

understanding of the nature and scope of physical therapy practice and would be better able to emulate the patterns of thinking and behavior described in the models. Many of these models were developed and put forth during the late 1970's and the early to mid 1980's. These years also saw an increasing advocacy for the recognition of physical therapy as a distinct and autonomous health care profession with a defined, unique, and scientifically grounded body of knowledge and a special realm of practice in health care in the United States.

Virtually all of the models of physical therapy practice put forth during this decade sought to define, to some degree, what physical therapy *is* , and how it should or might be, by (a) describing and defining current and emerging domains of knowledge, practice and education for physical therapists (APTA, 1984; Dean, 1985; Hislop, 1975); (b) identifying the role and responsibilities of the physical therapist in patient care (Hislop, 1975; May, Bing, Ballard, Luckhardt, & Barney, 1982; Yarbrough, 1986); (c) describing the nature of relationships between therapists and patients, family members, and other health care professionals, and discussing factors that influence these relationships and, presumably, therapeutic outcomes (Davis, 1986; Payton, 1985; Purtilo, 1984, 1990; Ramsden, 1986; Shepard, 1986); (d) defining the types of knowledge, skills, and abilities needed to practice competently in physical therapy (Johnson, 1985; May, 1984; Tammivaara & Yarbrough, 1984); and (e) describing the thought processes of therapists with particular attention to models of clinical problem-solving, reasoning, and decision-making that physical therapists might use in day-to-day

practice to ensure that the best possible solutions to patient problems were identified and implemented in the course of therapy (Henry, 1985; May & Newman, 1980; Olsen, 1983; Ramsden, 1985; Rothstein & Echternach, 1986; Stockmeyer, 1985; Watts, 1985; See also Wolf, 1985 for review).

Remarkably few of theses models of physical therapy practice, however, were based on *research* that involved naturalistic and extended observations and analysis of the work of physical therapists in clinical settings. So, although existing models of practice described, and implicitly and explicitly prescribed, the types of knowledge, skills, and attributes that physical therapists should posses as well as the ways that physical therapists should think, behave, and communicate with others, there was little evidence that these models were grounded in research about the daily realities of clinical practice in physical therapy. Instead, they were most commonly conceptualized from research and theory based in other professions and fields such as biological science, medicine, psychology, and sociology. While attending to and borrowing from theory and research in other fields is not problematic in and of itself (in fact, it is often very helpful), close analysis of how physical therapy might fit *or not fit* practice models derived from theory and research in related fields seems warranted.

For far too long I had watched my students struggle to understand, consciously incorporate, and exhibit the knowledge and behaviors encouraged by myself and these models--these ways of reasoning, making decisions, and problem solving like a "good" physical therapist--these ways of interacting with patients and peers

like a "good" physical therapist--with sometimes frustrating results that seemed to engender disillusionment rather than personal and professional growth. This was an uncomfortable realization at the same time it was an important call to action after all these years. I became increasingly uneasy with my teaching, my assumptions about student learning and professional development, and my expectations for students so early in their professional careers. Furthermore, I was disheartened by the limited amount of published research available on (a) the processes of learning to be a physical therapist, (b) the teaching of "professionalism" in physical therapy, and (c) what good (or not so good) physical therapy practice really looked and *felt* like in the complicated and dynamic everyday world of clinical practice.

My uneasiness grew to more serious concern as I began to examine more closely my own clinical practice and to look around me at the practice of other experienced therapists I had encountered in more than fifteen years of work in clinical practice and physical therapy education. My observations of and reflections on my own and other's clinical practice convinced me that research on the everyday work (interactional, cognitive, physical, social-relational, and moral-ethical work) of physical therapists was not only warranted, it was *essential.* What was needed was research that could provide a more grounded, embedded, and reflective view of the "knowing-in-action" (Schon, 1983; 1987), clinical reasoning, action, and interaction of physical therapists as they go about their daily tasks. I also saw a need for an enlarged vision of physical therapy practice that would encourage research that focused both on

the knowledge, thinking, and actions of the physical therapist in patient care *and* that considered and incorporated other participants in patient care encounters and the contexts in which they occurred as integral parts of the construction of therapeutic encounters. That is, we needed to explore how therapists and patients alike made sense of what was happening moment-to-moment during therapy and how they *jointly constructed* therapy. I became convinced that such research could generate valuable insight about physical therapy practice *in context* and could help us to evaluate and address the shortcomings of a literature regarding the nature of physical therapy practice that was highly prescriptive in its tone yet was frequently speculative, often based on anecdotal or artificially constructed accounts of practice, and habitually myopic and unilaterally focused on the physical therapist in patient care situations.

I also have a long-standing interest in the function and importance of communication in patient care and one of my most compelling concerns grew out of the realization that most existing models of physical therapy practice portray relatively static, universal, and unidirectional roles for the therapist in patient care and professional interactions. That is, many models of patient-therapist communication, and health care communication in general, prescribe a "same-for-all" or "correct" approach to interaction controlled by the practitioner that seem, to me, not value-free but heavily value-laden. These models appear to be firmly grounded in a Western biomedical model of health care which focuses on disease rather than illness as a primary concern, the *transmission* of practitioner knowledge in the form of treatment prescriptions, and

patient *compliance* with prescribed regimens (Engel, 1977; Fabrega, 1979). In a biomedical model of health care, little attention is paid to the perspectives of patients. Nor is the potential for involvement and transformation of *all* participants in medical encounters recognized or encouraged; health care is indeed 'delivered'.

Approaches to health care interaction grounded in a biomedical perspective have the potential to deny access to health care knowledge for individuals whose cultural experiences, perspectives, and expectations differ from those of the health care provider (Engel, 1977; Kleinman, 1980). Since most depictions of patient-professional interaction are therapist-focused or therapist-controlled, only marginal attention is given to (a) other co-participants in the interactions that constitute the practice of physical therapy, and (b) the social, institutional, economic, societal/cultural, and political contexts that surround, penetrate, and influence the everyday practice of physical therapy and the exercise of practitioner expertise.

My own experience conflicted with simplistic and linear representations of patient-professional interaction. I knew that clinical practice was far from static and unidirectional. Experience tells me that there are few universals in practice--that personal and contextual issues have everything to do with the ways that physical therapists interact with patients and others (e.g., family members and other health care practitioners) and the ways they make sense of and reason about and the clinical problems they encounter. In short, I became concerned that so little attention has been paid to (a) the transactional nature of physical therapy practice and (b) how

expertise or mastery in physical therapy might be constituted, constrained or inhibited, supported or enhanced, by the clinical environment in which that practice was situated and by the individuals who created that environment locally through face-to-face interaction.

Out of my uneasiness and concern, numerous questions emerged and begged answers: Do the models of physical therapy practice found in our professional literature describe and reflect the actual practice of physical therapy in the United States? What does physical therapy practice look like when we use both a wide-angle and telephoto lens to view the everyday work of physical therapists? What is the nature of interaction between experienced or master therapists and their clients at the local level in authentic situations in the socio-cultural context of clinical settings? These broad questions spawned others:

- *What* is the nature of clinical environments in which therapeutic encounters occur?
- *Who* are the individuals that participate in and construct the socio-cultural context of a particular clinical environment?
- *How* do socio-cultural contexts influence the nature of face-to-face interaction and the construction of meaning between therapists and clients in the clinic?
- *How* does an experienced therapist interpret and respond to contextual cues and make moment-to-moment decisions or adjustments in their practice in response to situational demands?
- *What* does this look like?

- *Why* does an expert therapist choose certain responses?
- *How* did she come to know (how did she learn) how to respond?
- *What* knowledge does she use to make interactional and clinical care decisions?

Sadly, I realized that during my many years of teaching physical therapy students I hadn't challenged myself or others to address or answer this flood of questions that seemed important for practitioners and educators alike. In fact, with regard to some of the latter questions, I had all too often been satisfied with explanations of clinician's knowing-in-action such as "it comes with experience" or "it just feels natural" or "I just knew [this was what I had to do/say in this situation]." Such explanations resonate with Polyani's assertions decades ago that people know more than they can tell (Polyani, 1958, 1962, 1966) and reminded me that we had left the tacit dimensions of practical knowledge unexamined and taken for granted. Even if asked about my own clinical "expertise", I realized that I would often give and be satisfied with explanations that held the dynamism of "coming to know" invisible (and presumably incomprehensible) rather than encouraging closer examination and exploration of the knowing, doing, thinking, feeling, teaching and learning of therapists and their clients in everyday practice.

As an educator of future physical therapists, I felt compelled to know what I was teaching toward; to have a clearer vision of the direction in which I was trying to foster the learning of my students and their personal, moral, cognitive, social, and professional development (not to mention my own). Now, *finally*, I was

questioning my *un*questioning acceptance of what I had been taught, what I was teaching, and how I was teaching. Did physical therapist practitioners and educators really *know* what expert or good physical therapy practice is? The answer to this question, it seemed, was "Yes" and "No." I think many physical therapists, myself included, "know" expert practice or mastery when they see it or live it. Even so, the profession had a scarcity of research on the "lived experience" (van Manen, 1990) of clinical practice, which caused me to question whether we could describe or represent expertise adequately in theory and otherwise in physical therapy curricula in ways that make lived experience and expertise shareable and useful for developing professionals.

The paucity of published research on the nature of expertise or mastery and face-to-face interaction in everyday clinical practice, while problematic, was in some ways understandable given the history of the fledgling profession of physical therapy. By their very nature, the questions I was asking encouraged interpretive approaches to inquiry and the use of qualitative research designs and methods. Yet these kinds of philosophical perspectives and methodological approaches to research were virtually unheard of in the physical therapy practice, education, and research community in the United States until the late 1980's and early 1990's.

As a relatively new profession, physical therapy, in it's search for professional identity and credibility, had attempted to follow in the footsteps of medicine. Not surprisingly then, calls for research to investigate and support physical therapy practice explicitly or implicitly suggested that such research should be grounded in the

positivist philosophical perspective (with its experimental and quasi-experimental research designs and quantitative analyses) so familiar and pervasive in biomedical research during the past few decades.

Prior to 1986, there were only two qualitative studies published in the primary research and professional journal for physical therapists in the United States (Scully and Shepard, 1983; Payton, 1985). Two ethnographic investigations of physical therapy practice in the United States had been conducted. The first of these was an unpublished doctoral dissertation study conducted in a large urban hospital in which Yarbrough (1980) explored physical therapist's perspectives about practice as a resource for curriculum development in physical therapist educational programs. A second study explored the nature of clinical instruction in hospital settings and therapist perspectives regarding clinical education in physical therapy (Scully & Shepard, 1983). It is only within the past few years that calls for alternative approaches to research in physical therapy have emerged urging increasing investigation of previously unexplored (or partially explored) aspects of physical therapy practice like those I have described (Ek, 1990; Jensen, 1989; McClelland, 1990; Schmoll, 1987; Shepard, 1987; Shepard, Jensen, Schmoll, Hack, & Gwyer, 1993). During this same period, a relatively new body of research literature was appearing and growing in professions such as teaching, social work, medicine, occupational therapy, and nursing that demonstrated the richness and importance of knowledge gained through interpretive and qualitative approaches to inquiry into the kinds of questions I have raised.

It was my good fortune to encounter some of this emerging literature as well as the works of Schon (1983, 1987) and Shulman (1986, 1987) who were writing about types and forms of professional knowledge and the wisdom of practice, at the same time that I was raising my questions about the nature of physical therapy practice and expertise in everyday contexts. These authors, among others, had raised and explored questions similar to my own (albeit with respect to different disciplines) and were encouraging further investigation into the everyday work and practical knowledge and wisdom of professionals.

The Call to Qualitative Inquiry: Taking the Interpretive Turn

Interpretive approaches to inquiry urge researchers to describe and seek to understand the lived experience of humans from the perspective of individuals involved in the social phenomena and human activity that comprise that experience. Philosophical traditions and perspectives like phenomenology, hermeneutics, and interpretive anthropology recognize that humans are constantly engaged in constructing meaning and making sense of their everyday experience and that the "reality" of that experience is individually, linguistically, and socially constructed by participants and influenced by the cultural or environmental context in which human activity occurs. Thus, description of phenomena in interpretive research draws heavily on subjective experience and differs dramatically from the kind of description found in research in the positivistic, objectivist tradition.

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When the subjective and interpretive dimensions of experience are considered as integral to understanding human activity, multiple realities become a possibility. As Merriam (1991) puts it:

> The world is not an objective thing out there but a function of personal interaction and perception. It is a highly subjective phenomenon in need of interpreting rather than measuring. Beliefs rather than facts form the basis of perception (p. 17).

The notion of multiple realities, as opposed to a single objective reality, raises some important epistemological issues especially as they relate to knowledge about human action. Recognizing that the idea of multiple realities is a troubling proposition for some, Eisner (1990) asks the thorny question: "If the ideal of ontological objectivity is rejected, must we therefore be thrust into solipsistic subjectivism?" (p. 10). Eisner answers this question with a response which, I believe, illuminates the world view suggested by the epistemology of social constructivism and anticipates the qualitative nature of research methods required by interpretive approaches to inquiry.

> We need not embrace a solipsistic subjectivism by recognizing that ontological objectivity is impossible.... I believe we are better served by recognizing that whatever it is we think we know is a function of a *transaction* between the qualities of the world we cannot know in their pure non-mediated form, and the frames of reference, personal skills and individual histories we bring to them. These histories are, of course, a contribution of the culture in which we live, both the social culture and our more narrowly defined personal culture. What we see and understand is not *given* by what Dewey called "objective conditions," they are *taken* by us. What we are able to take, depends on the world-out-there, a world we cannot directly

> know, and what we bring to it. It is in the transaction between objective conditions and personal frames of reference that we *make* sense. The sense we make is what constitutes experience. (Eisner, 1990, p. 10)

Eisner concludes that recognition of "the inevitable transaction between self and world" is a realistic and useful approach to understanding human knowledge and experience because such recognition

> ...would underscore the constructed, tentative, and framework-dependent character of perception and knowledge. It would contribute to a more pluralistic and tentative conception of knowledge, one more dynamic and less dogmatic, one with a human face. It would recognize that *doxa* (belief), not *episteme* (true and certain knowledge), is all we can have. (Eisner, 1990, p. 13)

Acceptance of the transactional, interpretive, social and cultural nature of constructing meaning and knowledge encourages the use of qualitative forms of inquiry as a way of trying to understand how human activity is shaped by the sense we make of experience and vice versa. Many qualitative approaches to research are available to investigators engaged in "the search for meaning" (Geertz, 1973) engendered by interpretive paradigms; among these are ethnography and microethnography or the ethnography of communication (Hymes, 1962; Erickson, 1986).

Anticipating the Search for Meaning in Clinical Encounters: The Promise of Ethnography and Microethnography

In his seminal essay, *Thick description: Toward an interpretive theory of culture*, Clifford Geertz (1973), encourages taking phenomenological and hermeneutic perspectives in social anthropology by arguing for a concept of culture that is interpretive or "semiotic."

> The concept of culture I espouse... is essentially a semiotic one. Believing, with Max Weber, than man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning. (p. 5)

Furthermore, Geertz suggests that ethnography is a particularly important form of investigation that lends itself to the interpretation of culture and the development of cultural theory that is "unseverable from the immediacies" of everyday life (p. 25). Borrowing from philosopher Gilbert Ryle, Geertz describes the methodological *and intellectual* effort of ethnography as "an elaborate venture in...thick description" (p. 6). Thick description, he suggests, must be characteristically detailed *and* interpretive of the flow of social action and discourse that articulate cultural forms or patterns of life in particular settings or societies.

Thick description, which is both the process and product of ethnography and microethnography, helps researchers and others to "make the familiar strange and interesting" (Erickson, 1986, p. 121).

In other words, it helps make what is invisible in everyday life, visible; the commonplace, uncommon. This unveiling or transformation occurs through careful attention to the concrete details of practice in particular settings and exploration of the "local meanings" (p.121) or common-sense understandings of happenings for participants within that setting. Thick description enables the researcher to identify meaningful patterns of activity and discourse in everyday life in particular social contexts and helps the researcher share insiders' understandings (the emic perspective) and depict those understandings for outsiders.

In ethnography the researcher is the primary research instrument. The ethnographer uses a variety of methods and techniques to engage in the investigative and intellectual endeavor of ethnography and to ensure ecological validity. Among these are (a) participant observation and the recording of observational fieldnotes, (b) participant interviews which can take a variety of forms, and (c) collection and analysis of written documents or other artifacts. With the advent of cinematography and audiotape and videotape technology, the forms of observational records and non-written artifacts available to ethnographers in their quest for understanding increased substantially. Concurrently, the potential for microanalysis of action and discourse expanded.

As I came to learn more about cultural anthropology, ethnographic, and microethnographic research through a year-long sequence of courses in fieldwork research, I realized that ethnography (both the process and goal) was a particularly appropriate strategy for addressing the types of questions I had

been asking about expert practice in physical therapy. I also felt excited that the potential for use of videotape data could pave the way for close analysis of discourse in the culture of a particular clinic. In the everyday face-to-face exchanges between therapist and patient I felt some of the "invisible" aspects of expertise and the contextualized "wisdom of practice" (Shulman, 1987, p. 1) might reside. In fact, the few qualitative studies that *had* examined the work of physical therapists and occupational therapists and the nature of interaction between therapists and clients in clinical encounters suggested this was so.

Therapist-Patient Interaction: What Research Tells Us So Far

In both physical and occupational therapy, most of the qualitative studies of face-to-face interaction in clinical settings have examined dyadic patient-therapist discourse as a lens through which to explore (a) differences between novice and experienced clinicians and to hypothesize about the nature and development of expertise (DePoy, 1990; Jensen, Shepard & Hack, 1990; Jensen, Shepard, Gwyer & Hack, 1992), and (b) the nature of clinical reasoning and decision-making by therapists (Fleming, 1991a, 1991b; Mattingly, 1988, 1991; Mattingly & Gillette, 1991; Payton, 1985). All of these studies used ethnographic and/or comparative case study approaches in their attempts to understand the phenomena of interest. Two additional studies, one in occupational therapy (Crepeau, 1991) and the other in physical therapy (Ek, 1990), employed microethnographic and sociolinguistic frameworks and methodological approaches to

investigation in an effort to understand the complex nature of interaction between patient and therapist during treatment sessions.

What do these studies tell us? The studies of clinical reasoning tell us that therapists employ various forms of reasoning as they make judgments about what actions to take in clinical situations. The forms of reasoning described in these studies include procedural, interactive, and conditional reasoning (Fleming, 1991a, 1991b), narrative reasoning (Mattingly, 1991), and a four-stage type of reasoning (Payton, 1985) similar to a hypothetico-deductive model described by Elstein, Shulman, and Sprafka (1978) based on studies of clinical reasoning in medicine.

The most extensive comparative investigation of novice and master clinicians in physical therapy has been done by Jensen and her colleagues (1990, 1992). These investigators examined therapist-patient interaction in outpatient orthopedic clinics using methods of participant observation, audiotaping, and patient and therapist interviewing. The authors identified five attribute dimensions that distinguished master clinicians from novice clinicians in their sample. Of these attribute dimensions, the investigators suggested that one dimension related to clinician knowledge while the other four related to what the authors called "improvisational performance" (Jensen et al, 1992, p. 715).

Improvisational performance by master clinicians was seen as an attribute dimension that enhanced the therapist's ability to respond to a patient's specific needs. For master therapists, the characteristics of improvisational performance were (a) the ability to control the treatment session and keep attention on the patient even

in busy clinics, (b) the ongoing collection, evaluation and use of patient illness and disease data during therapy, (c) the ability to create a "focused connection" (p. 716) with the patient verbally and non-verbally, and (d) the perceived primacy of teaching as a clinical skill by master practitioners. Although the authors discuss these four attributes or elements of improvisational performance as though independent of each other, my own sense is that what makes an improvisational performance masterful is the artful weaving together of these elements during the course of therapy sessions.

Communicative competence. The observation by Jensen and her colleagues (1992) that master clinicians demonstrate better improvisational performance than novices suggests what may be a particular case of what Hymes (1972, 1974) and Gumperz (1982) call *communicative competence* in the context of the shifting demands of a physical therapy encounter. Communicative competence is a conceptual and empirical notion first developed and used in sociolinguistic research. Communicative competence involves knowledge of and the ability to communicate verbally and non-verbally in grammatically and situationally appropriate ways (linguistic and social competence become one) as interactional contexts shift across time and place. It involves knowledge and application of the syntagmatic (rule governed, sequential) dimensions of language, as well as the paradigmatic (selectional and innovative) dimensions of language (Cazden, 1988). Communicative competence also requires learning about and paying attention to *contextualization cues* (Gumperz, 1976) that signal who we are and what we are to do or say in situations from moment to moment.

Such cues are inevitably bound up with the socio-cultural-historical context in which interaction takes place. Perhaps master clinicians *are* more improvisational--more sensitive and responsive to contextualization cues and more communicatively competent than novices in certain clinical situations. But what does communicative competence, in it's full scope, look like at close range? And how and when is it achieved or not achieved, challenged, or enhanced in clinical encounters?

The data collected and presented by Jensen and colleagues (1990, 1992) does not allow us to answer these questions. Their data regarding the improvisational performance of master clinicians are derived primarily from content analysis and categorization of talk between patients and therapists and from interviews with patients and therapists. Few depictions or transcripts of interaction between therapist and client beyond the sentence level are provided, nor is there evidence of close attention to other verbal, linguistic, paralinguistic, and non-verbal features of patient-therapist discourse that no doubt contributed to the investigators' identification of attribute dimensions of master clinicians and their sense of enhanced improvisational performance. Although the work of these investigators represents an important contribution to our consideration of practitioner mastery in physical therapy and patient-therapist interaction, further examination of the above features of discourse *and* of the social and cultural environments in which clinical discourse is embedded could help us to more fully understand the complex, dynamic and reciprocal nature of communication in these situations.

Ethnography of communication in therapy sessions. Two microethnographic studies of patient-therapist interaction have provided detailed description of discourse and analysis of the interactional work that is being done in clinical encounters in physical and occupational therapy (Crepeau, 1991; Ek, 1990). These studies help us to gain further insight into the complexity of such clinical encounters.

Crepeau (1991) analyzed the interaction between an occupational therapist (OT) and a patient with quadriplegia during a single treatment session. Of particular interest to the investigator was the interplay and tension between seeking *intersubjectivity* (Schutz & Luckmann, 1973) and collaboration with the patient, and exercising power and control in the treatment session.

To explore these phenomena the investigator specifically examined two primary aspects of the communication between therapist and patient. First, as an indication of seeking intersubjectivity, the extent to which the therapist attempted to achieve a match of knowledge schemata (Tannen & Wallat, 1987) between patient and therapist was examined. Crepeau (1991) found that the therapist did this by (a) sharing the therapist's knowledge about functioning with quadriplegia through teaching and (b) by questioning and listening carefully to the patient about the "experience of being a quadriplegic" (Crepeau, 1991, p. 1020); in this way the therapist was both teacher and learner (as was the patient) and matching of knowledge schemata was more likely to occur.

To examine the exercise of control within the treatment session, the investigator looked at shifts in interactive frames or

footings (Goffman, 1981) within the session. She found that there were two broad categories of footings--work and social--within which other shifts in topic or alignment between therapist and patient occurred. Although it was found that the therapist often initiated the change in stance or footing verbally, thus exercising her control over the treatment session, it was noted that these changes in alignment were, in fact, often triggered by subtle non-verbal and paralinguistic cues from the patient that were an integral part of the dialogue. Thus, the therapist was sensitive to such contextualization cues and both the patient and therapist were, in effect, "controlling" or co-constructing the treatment. In addition, Crepeau (1991) found that the therapist usually initiated shifts from "work to social footings...at points of tension and frustration" (p. 1022) for the patient as a way of defusing such feelings which could impair collaboration and impede progress in therapy.

The findings of Crepeau (1991) demonstrate the complexity of trying to balance professional status, power and control of treatment sessions with the development and maintenance of "intersubjective understanding of the patient's lifeworld" (p. 1024). This complexity and the difficulties of achieving such a balance are further illuminated in a study by Ek (1990). Ek, who conceptualized physical therapy *as* communication, conducted a microethnographic case study of a physical therapist and a patient with "frozen shoulder" (adhesive capsulitis) during a full course of therapy which lasted four months. The investigator was seeking insight into what constituted a therapeutic encounter between the therapist and patient and how these encounters evolved and were sustained. Ek

(1990) closely examined the "doings" and the "talk" occurring during manual therapy sessions, the relationship of doings to talk, and how the patient and therapist made sense of these activities and interactionally accomplished a therapy session.

Ek (1990) found that manual treatment was organized around alternating phases of stretching ("hands-on" or "work") and phases of recovery ("hands-off"). She found that there were two primary types of dialogue occurring: (a) Treatment dialogue which was sustained by the PT and consisted primarily of instructions and feedback, and (b) conversations, about the patient's shoulder, initiated and sustained in most cases by the patient. Of interest was the observation that treatment dialogue appeared to be the therapist *register* (Cazden, 1988) but that there was constant interweaving of these two types of talk that suggested rapid shifts in participation structures during the session. Like Crepeau (1991), Ek found that the therapist was in control of the patient's arm during work phases but that the patient's verbal utterances, the paralinguistic features of those utterances, or non-verbal communications could influence the length of work or recovery phases thus demonstrating the therapist's attention to these features of communication in the treatment sessions. It was found that both stretching and recovery phases could be extended through talk and negotiation between therapist and patient. Interestingly, the PT and patient had differing views regarding who was in "control" during sessions and there were several misreadings of interactional cues that led to moments of conflict or confusion between patient and therapist.

With regard to exchange of knowledge during treatment sessions, it was felt that the PT shared her medical knowledge with the patient through treatment dialogue and that the patient shared her experiential and local knowledge of frozen shoulder through conversations. The latter were periods of "therapeutic listening" for the PT and times for the PT to learn from the patient–for the patient to become the teacher. In the encounter described by Ek (1990), however, there appeared to be less elicitation and "uptake" by the PT of conversational data from the patient than in the encounter between the occupational therapist and patient studied by Crepeau (1991). Thus, the foundation for establishing intersubjectivity may have been underdeveloped or weakened. There also appeared to be fewer interactional attempts by the therapist in Ek's study to collaborate with the patient or to balance power and control in the dyadic encounter with the net result that there was more opportunity for mismatch of knowledge schemata.

The detailed description and analysis of discourse during therapy sessions provided in the work of Ek (1990) and Crepeau (1991) helps us to better appreciate the complexity of balancing or redistribution of power and control and seeking intersubjectivity, connection, and collaboration between patients and therapists through interactional work in clinical encounters. Their microanalyses shed light on the ways that therapist's may or may not *interactionally* accomplish masterful improvisational performances as described by Jensen and colleagues (1992). It seemed to me that further investigation and close analysis of discourse in the cultural context of clinical settings might permit us

to more fully discern what, in fact, creates and constitutes mastery in physical therapy practice or what constrains it. Such investigation, I felt, should include ethnographic, microethnographic and sociolinguistic approaches to inquiry--approaches that would keep language-culture connections in the foreground and urge recursive and reflexive consideration of the relationships between cultural beliefs and local dialogue, activity and interpretation.

Conclusion

Thus far I have described what I think of as the beginnings of this research endeavor. As illustrated in this narrative, a beginning is not a particular moment in time; instead, beginnings have unique developmental trajectories influenced and transformed by a variety of factors. For me, a starting point was a series of questions about everyday practice in physical therapy that revolved around the nature of (a) situated expertise or mastery in clinical settings and (b) face-to-face interaction between therapists and patients. My questions were inevitably tied to a discomfiture with my own teaching in academic and clinical settings and to the paucity of empirical research and knowledge in the field regarding these phenomena. Subsequently, my exposure through my doctoral coursework to literature in a variety of disciplines introduced me to "alternative" approaches to inquiry about human activity and experience. This exposure provided a vision of how I might best go about addressing the questions I was raising. Finally, the emergence and discovery of some existing qualitative research on the work of

physical therapists and patient-therapist interaction in clinical encounters helped me to refine my questions.

Taken together, these experiences enabled me to construct a mental map of where I wanted to go and how I hoped to get there as I undertook this exploration. Even as I prepared for the journey, however, I recognized the potential for the evolution and transformation of my questions and the study itself as inherent in ethnographic research. I knew my map did not show all the different roads I might travel in the course of the study nor could it show all possible destinations. Such uncertainty was inviting.

Chapter 2

EARLY ENCOUNTERS: STORIES UNFOLDING AND CONVERGING

Starting the Journey: The Initial Phase of My Research

Identifying a Site and Participants

The search for a research site and participants was guided by my research questions and the recognition of a gaping hole in the physical therapy research literature on the nature and complexity of everyday work with patients with brain injury or neurologic dysfunction. My own experience and teaching suggested that working with neurologically impaired clients, particularly those with brain injury, was extraordinarily challenging for physical therapists. Clients with brain injury often present with unique combinations of physical, perceptual, affective, communicative and cognitive impairment that escalate the interactional and cognitive demands on therapist and patient.

My experiences working with such patients had been both frustrating and exhilarating; therapy was sometimes successful and sometimes unsuccessful from both the therapist's and patient's perspective. In all cases, what therapy *was* and what was accomplished was interactionally negotiated. Anecdotal evidence confirms that most physical therapists agree that working with patients with brain injury is extremely complex and challenging, and

yet there was *no* published research literature that investigated and described the everyday practice of physical therapists working with these clients. I was very curious about the nature of mastery involved in working with clients with this particular type of clinical problem.

In addition, rehabilitation for patients with brain injury rarely involves just the patient and a physical therapist. Because of the multiplicity, range, and chronicity of impairments produced by brain injury, treatment of the patient almost always includes family members or other caretakers and requires multidisciplinary involvement in care. Thus, the interactions, teaching, and learning that constitute physical therapy treatment for a patient with brain injury must frequently be expanded to include other members of the patient's family. Furthermore, therapy is no longer the solitary effort of a single rehabilitation professional; instead, many health care professionals, working as a "team" are jointly involved in therapy with the patient and family. This expanding circle of participants in therapy with clients who have brain injury enlarges the realm of interactional work for physical therapists and contributes to the complexity of rehabilitation with such clients.

Given these observations, my interest in practitioner mastery and patient-therapist interaction for the purposes of this study became focused on the nature of interaction between patients with brain injury and a therapist with substantial experience working with such clients in the context of an interdisciplinary rehabilitation clinic.

Finding Caitlin.[1] The search for an experienced therapist--one whom peers might call an expert or master therapist--began in my own backyard. My work as a practitioner, physical therapy educator, and coordinator of clinical internships for PT students had provided numerous opportunities to meet, observe, and learn from individuals whom I would consider experts in brain injury. I trusted my own perceptions about who was an expert in this area at the same time that I wanted to ask other clinicians for their opinions and nominations.

In the months preceding the initiation of the study, I asked physical therapy clinicians in a variety of rehabilitation clinics nearby to (a) reflect on and describe the characteristics and credentials of an expert in neurologic physical therapy and (b) to identify two or three individuals in the geographic area they would call experts or master therapists in that particular realm of practice. On numerous occasions Caitlin's name emerged and many therapists suggested that she embodied the characteristics, knowledge, practical wisdom and clinical skill they associated with expertise.

Caitlin, had been a physical therapist for 12 years at the time this project was initiated. During the previous six years Caitlin had limited her practice to working with neurologically impaired clients with a special interest in working with adolescents and adults who had sustained head injuries or brain injuries of varying etiology.

Caitlin is a respected and nationally recognized clinician, teacher, and speaker in the realm of physical therapy practice with brain injured individuals. She holds a B.S. degree in Biology and Physical Therapy and an M.S. degree in Physical Therapy with

emphases in motor learning and control, and adult education. She is an adjunct faculty member at a local university where she teaches graduate level courses on the treatment of patients with neurological impairment. Caitlin is also a professional friend and colleague and a therapist committed to continued involvement in clinical research and her own ongoing professional development. Shortly after initiation of this study, Caitlin became a board certified clinical specialist in neurologic physical therapy. So, even as we struggle to describe or define expertise or mastery in physical therapy clinical practice, Caitlin, as one of fewer than fifty certified neurology PT specialists in the country at that time, is a practitioner one might reasonably call an expert.

I contacted Caitlin and discussed my study with her. She was interested in participating but wanted to discuss the study with the owners of the private rehabilitation clinic where she was currently practicing since my research would obviously involve study of the clinic itself, clients and family members who received services there, and the other professionals who worked in the clinic. The clinic owners expressed a willingness and interest in participating in my study following their discussion with Caitlin but they asked that I come and meet with the clinic staff to describe my study in more depth, to formally request consent for participation from all staff, and to finalize arrangements for the conduct of the study as necessary.

Gaining Access. Caitlin was a known quantity to me, in some respects, as I began this journey--this endeavor to initiate fieldwork research in a clinical setting and to refine and hopefully answer some

of my questions. I did not know much, however, about the clinical site in which I would be conducting my research or the clinicians who were part of that community. And what an intriguing and wonderful surprise was about to unfold.

I met with the clinic owners and staff one snowy December morning in 1991 to discuss the nature and purpose of the initial phase of my study, answer questions, and invite participation. The clinic itself was small and comfortable and this small group of experienced clinicians from a variety of rehabilitation professions gathered informally in a circle of chairs in a conference area to talk with me. Individually and collectively the clinic "associates" had numerous years of experience working with challenging clients with unique rehabilitative needs. They were welcoming and interested in my project, they asked good questions, and all agreed to participate with the understanding that the microethnographic portion of the study (i.e., the videotaped observations of therapist with client during treatment), would focus primarily on Caitlin. Consent forms were distributed to potential staff participants and returned to me as data collection was initiated. Caitlin, the clinic owners and associates, and I agreed on a procedure for recruitment of an appropriate patient participant that felt comfortable to staff and involved a sequential approach to selection of and contact with potential participants.

Identifying a client participant. Caitlin agreed to screen client referrals to the clinic, looking for patients who met the following criteria: (1) patients with head trauma and/or brain injury whom she would typically follow, (2) good candidates for physical therapy and

other rehabilitation services, (3) the patient's level of cognitive and speech impairment, if any, would not interfere with his or her ability to understand the study, provide consent for participation, or significantly limit his or her ability to participate in interviews.

When an appropriate client was identified, Caitlin contacted the patient, John, and his wife, Diane, and briefly described the purpose and methods of the study and asked if they would be willing to participate. When John and Diane expressed interest and a willingness to participate, Caitlin put me in touch with them to provide further information on the nature of the study, answer any questions and seek their verbal consent for participation. Once verbal consent to participate was obtained, written consent forms were sent to John and Diane for review. Final consent forms were completed when I had my first opportunity to meet and talk with John and Diane in the clinic at the time therapy was beginning.

Beginning Data Collection and Analysis

In the first phase of this project I collected and analyzed data for six months during the Winter and Spring of 1992. Data included (a) observational fieldnotes and written records of informal interviews with staff members, (b) formal audiotaped interviews with the clinic founders, the physical therapist, and the patient and his wife who agreed to participate in this study, (c) videotapes of hour long of PT-patient treatment sessions (including one session which also involved the patient's wife), (d) audiotapes of videotape review sessions with the PT, and (e) written artifacts including clinic brochures, medical records, and therapist reports. Raw videotape and audiotape data was catalogued and selectively transcribed and

fieldnotes were expanded and typed. Finally, throughout 1992 and 1993, I continued to examine and analyze my audiotape and videotape data, catalogues, transcripts, and expanded fieldnotes as I looked for patterns and themes in the data which led to the formulation of assertions about and interpretations of observational and interview data.

The main research question for this first part of my descriptive/analytic study was: What is the nature of the interaction between an experienced therapist and a patient with brain injury in the cultural context of a small interdisciplinary private rehabilitation clinic? Naturally, there were numerous specific questions to be addressed in the study and these fell into two primary categories as suggested by the main question: (1) those directed at the nature of the interaction between therapist and patient and the forms of activity in therapy, and (2) those regarding the culture of the clinical environment in which therapy encounters were embedded. The ethnographic portion of this study sought to address the questions regarding the culture of the clinic and the microethnographic portion of the study sought to address questions regarding activity and interaction between therapist and client during therapy sessions.

There were many interesting, though preliminary, findings that resulted from the initial phase of the study, some of which related to patient-therapist and patient-spouse-therapist interactions during treatment sessions and others that related to the history and culture of the clinic, and the philosophic commitments of the individuals who populated and created this unique clinical community. I believe that these findings are best conveyed in the storied, embodied way in

which I encountered them. Thus, it is to the stories of this clinic, some of the clinicians, and the first client I worked with, John, and his wife that I now turn.

The Stories of the Clinic, Clinicians, and Clients

The Story of the Clinic

It is difficult, if not impossible, to understand people, places and the culture they describe without a sense of their history. With this in mind, I sought to gather information about the genesis of this clinic. Where did it come from? What visions, ideas, thoughts, questions or concerns led to the imagining and development of this clinic? Who was involved in it's development? Why? and How? What is the history of the clinic since it came into being? Much of this historical background was provided by two of the main characters in this story--and certainly the two main characters in the development of this clinic--the founders and co-owners of the clinic, Kay and Don. Since the origins of the clinic are tightly interwoven with the professional and personal lives of Kay and Don, I begin with parts of their personal and professional autobiographies and let them tell the story of the origin and development of this clinic.

Early Visions: Introducing Kay and Don. Kay is a social worker and is the office and business manager for the clinic. She is a vibrant, striking and articulate middle aged woman who looks far younger than her 40 plus years. On the day I completed my first formal interview with her, she was wearing a knee length black skirt, with a matching black and red hounds tooth checked wool

blazer and a red crew neck blouse. She wore an artistic gold pin on her left lapel. Kay's chin length, shiny, dark brown hair swung softly as she escorted me to her office and her bright, intelligent, brown eyes immediately captured my attention as we sat down to begin the interview. We sat comfortably in Kay's calming office, lit only by the lamp on her desk and the natural light coming in through the window, as she told me about herself and the beginning of the clinic.

Kay started her social work career at Vanderbilt Medical Center where she worked in child psychiatry for one year. The following year she worked at a state psychiatric hospital with deinstitutionalized patients with chronic schizophrenia as part of a behavioral therapy grant. During her time in Nashville, her husband was completing a law degree at Vanderbilt. Upon completion of his degree, her husband took a position in a firm in Michigan and they moved north. As it turned out, Kay ended up taking a position in a large rehabilitation hospital which drew her into an entirely different kind of social work than she knew from her first two years of experience. Kay began working primarily with individuals with physical disabilities and admitted to feeling like a neophyte social worker again as she began a career in this realm of practice.

During her early years at the rehabilitation center, however, Kay was fortunate to establish a professional relationship with one of the physicians who "staffed" the center and who became a "mentor" helping Kay to extend and deepen her knowledge of neurologic dysfunction. Kay felt this was extremely important since she was the individual largely responsible for teaching families and patients about the injuries and pathologies that were now major influences in

their lives. As Kay described it, this physician "... just sort of took me under his wing and taught me, essentially, everything that he would teach a neurology resident--and I just loved it" (K, 2/3/92, p. 9) Kay laughed as she recalled this time in the past when there were not any "in-house" physicians at the rehabilitation center and when Kay was sometimes called upon to act as an absentee physician. She remarked that such a scenario would never happen today but during that "brief window in time" she had learned to interpret lab reports and conduct mini-neurologic exams and call doctors when there were concerns regarding the medical status of some of the patients at the center.

Kay remained at the rehabilitation hospital for 10 years and during that time she worked in both the "old hospital" and the "new hospital" which opened in 1976. Initially, she worked mostly with clients who had suffered a stroke and their families, later beginning a "head injury team" and, even later, beginning a Chronic Pain Program. In addition, she organized the programs for sexual counseling of the physically disabled patients at the hospital. After a maternity leave in 1977, she returned to work on a part-time basis in the Chronic Pain Program. It was here that she first met Don, her fellow clinic co-owner today.

Don was a neuropsychologist who was completing a sabbatical at the rehabilitation center to expand his clinical experience and knowledge in his area of expertise. Don, like Kay's physician mentor, taught her more about the neurophysiological and neuropsychological aspects of the problems and patients with whom she was dealing. Kay felt that Don's "absolute grounding" in the

biologic sciences, and his sharing of this knowledge with her, further influenced her ways of thinking about her patient's problems and her way of being a social worker:

> It shaped how I think as a clinician--and I think this separates me from most social workers out there--that I know my way around biological systems that, normally, social workers wouldn't know. But you need to know that to do sexual counseling, you need to know that to work with the neurological diseases, you need to know that to work with stress related responses because a lot of what we're doing is modifying the body's limbic and autonomic reactions to the changes that are occurring. (K, 2/3/92, p. 9)

According to Kay, it was after her return to the rehabilitation center following her maternity leave that she came to understand the difficulty of juggling motherhood and work: "I didn't know how I was going to manage motherhood and a professional practice" (K, 2/3/92, p. 3). She found that although she wished to remain professionally active, she increasingly wanted to be able to set her hours around her child's needs. Interestingly, most of the staff that have subsequently become associates in her practice did so for this reason, among others, and there continues to be a predominance of part-time staff in the clinic, most of whom are mothers who have sought flexibility in their professional schedules. Kay's experience with the frustrations of trying to juggle and balance professional and family life has continued to influence her practice today which she describes as a practice "...that's organized around child-care. And that's a rule here--kid's come first. If your kid's are sick--never any question's asked" (K, 2/3/92, p. 15); this statement conveys the general

humanistic orientation in the clinic. At any rate, it was at this juggling point in Kay's life and career that she began to consider alternative work arrangements. She talked with Don about the possibility of starting a private practice and he was as interested and enthusiastic about the idea as she was.

Concurrently, several other observations and experiences in the institutional setting of the rehabilitation center became concerns for Kay and fed the emerging vision of a private clinic. While Kay was working at the rehabilitation center and managing discharge planning for many of the clients, she came to the realization that

> ...none of the traditional mental health services in the community were prepared to deal with issues of physical disability or health related issues, and so I was in the position of referring people to outpatient services of which there were none! (K, 2/3/92, p. 3)

To Kay, this dearth of available resources for the clients she served was both disturbing and disheartening; it spoke of the need for other venues and models for health care delivery for these individuals and their families.

In addition, in the hospital administration's attempt to deal with the expense of the "state-of-the art" new building and in an effort to show improved revenues in response to the change in the facility, there was increased pressure on health care professionals in the rehabilitation center to be "productive" and generate lots of "units". Units were billing units that were assessed for patient care in time increments and their use, along with the pressure to be very productive, encouraged clinicians to see numerous patients in a day

and/or several patients at a time. Increasing pressure to generate revenue also encouraged competition among various departments providing rehabilitation services for patients (e.g., physical therapy, occupational therapy, speech and language pathology, psychology) insofar as the ability to generate revenue could result in increased power and voice in administrative decision-making at the hospital. The indirect effect of such financial incentives for disciplinary competition was the "drawing of a line in the sand" between rehabilitation professionals and departments; it resulted in the establishment of distinct and separate realms of practice for rehabilitation professionals and the compartmentalization of care for patients and their families. One need only imagine the hustle and bustle so common in many physician's offices and large hospital clinics to envision the kind of "care" encouraged in the face of such pressures for productivity, revenue generation, and competition.

The increasing role of financial considerations in determining the nature and extent of rehabilitation services provided for patients and the notion of billing by units was also disturbing to Don. Since Don was a scientist and college professor and not a clinician (per se) by training, his reaction to these observations was perhaps even stronger than Kay's. As he put it,

> I was appalled by what I saw among all the therapists--the concern about units--and people would make decisions about when to treat and what to do based on units. People would make decisions about 'this was going to be a tricky patient but you weren't going to generate many units'--all that stuff just really ticked me off. And so I knew I didn't want to work in a hospital setting that way. The idea of being concerned about the patient and bringing everything to bear

> that you could, that you knew about, that might be creative or helpful to the patient and not thinking about units--that, to me, was the main thing. (D, 2/4/92, p. 4)

This quote portends some of the primary and broad assertions that I will make about this clinic and that make it distinctive in today's health care environment. First, a large number of the staff or clinic associates "escaped" to this clinic because of a disenchantment with some of the administrative and clinical practices they were encountering in large health care institutions. Secondly, the staff of the clinic espouse and are devoted to a philosophy of care that places the client at the center of the rehabilitation process and involves a commitment to being a "transdisciplinary" team of professionals serving the client's needs.

By 1979, Kay's idea had come to fruition and she and Don started a private rehabilitation clinic to provide services that heretofore were unavailable in the area. In Kay's own words,

> ...so, we were really the first people in the whole area that were providing *outpatient* follow-up care for the disabled population, specifically the neurologically disabled. (K, 2/3/92, p. 4)

Their first clinic site was a tiny and simple office located in the downtown area not far from the hospital where both Don and Kay had previously worked. According to Kay, the clinic was a single room that had a desk and a mat table that folded up against one wall so that at one moment the room could be a physical therapy treatment area and in the next moment it could be an interviewing or

counseling area for Kay or Don. Later they expanded the clinic by leasing an adjoining room which they used as the PT and Occupational Therapy (OT) room. Eventually, as the number of referrals from medical, rehabilitation, and mental health practitioners increased and their staff expanded, they required additional space. They moved to a larger clinic in a suburban location in 1987.

Kay described her early years in private practice as a period of gradual but progressive growth of the clinic and the services they provided. Initially she continued to work part-time at the rehabilitation hospital in the mornings working primarily with children with Cerebral Palsy and their families. Then, in the afternoons, she would see a more varied clientele in her clinic consisting primarily of patients with neurological impairment and individuals with sexual dysfunction related to physical disability.

Recruitment of staff for the clinic over the years has been primarily a "family affair." Kay's description of the recruitment of the first PT and OT to work in the clinic reflects a pattern of careful and gradual growth that recurred over the years as other clinical associates joined Kay and Don.

The first physical therapist who joined the clinic was Emily. Emily was a friend with whom Kay had worked in various volunteer organizations (such as the Multiple Sclerosis Society) and for whom Kay had a lot of professional and personal respect. At the time, Emily was working for another agency, but was frustrated by some of the administrative requirements that she was encountering within that agency not unlike those with which Kay and Don had experienced frustration. As the need for physical therapy services for certain

clients became apparent, Kay talked with Emily about her new clinic and asked Emily to work with them on a case-by-case basis. Emily agreed and, eventually, she became their first full-time physical therapist. Today, approximately 15 years later, she continues to work with Kay and Don and works primarily with the clients with chronic pain who are seen in the clinic.

In similar fashion, the first occupational therapist, Nina, with whom both Emily and Kay had worked, was invited to join the clinic staff to provide some of the OT services for the clinic as they were needed. In general, then, the recruitment of staff early in the history of the clinic drew on a network of respected professional acquaintances or friends and was, as Kay put it, "...sort of...very informal. Like, gee, we have this interesting case and would you like to do that?" (K, 2/3/92, p. 4).

By the time Kay and Don moved to their suburban site, the clinic staff had expanded to include two administrative assistants/receptionists, two physical therapists, two occupational therapists, one occupational therapy assistant, two speech and language pathologists, and another social worker in addition to Kay and Don. (see Figure 1.) Of note, is that many of these associates, all of whom individually contract services to the clinic, like Kay at the inception of the practice, work part-time and are juggling family responsibilities with professional schedules and commitments.

In summary, Kay described the nature of the clinic expansion and staff recruitment efforts as non-recruitment efforts in the sense that we typically think of recruitment in today's health care environment:

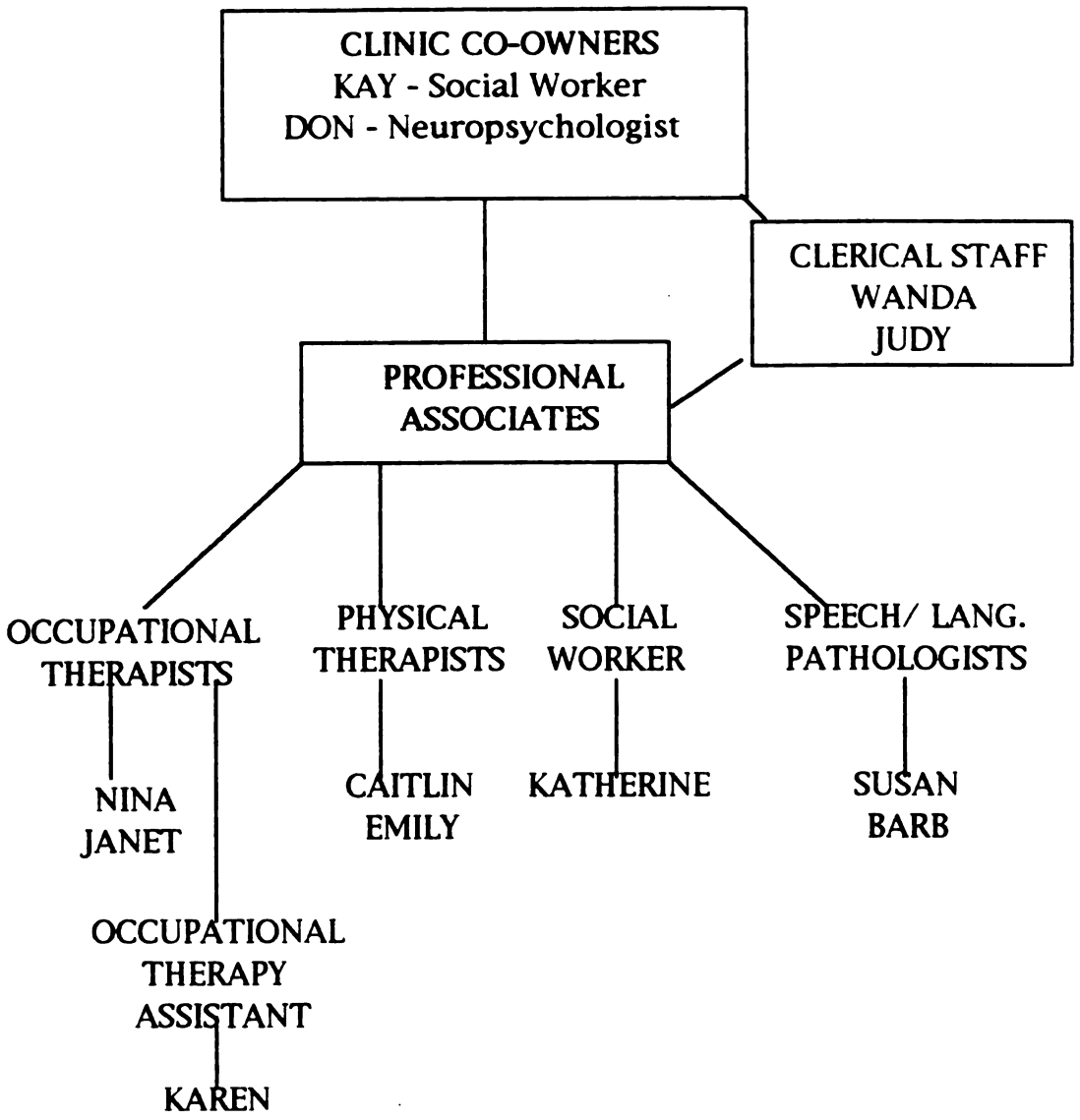

Figure 1. Clinic Staff and Associates, Jones and Thompson, P. C. All professional staff contract services to the clinic and are called associates. Only two of the twelve staff members are full-time employees.

> Basically, what we found was that there were a number of very skilled therapists [with whom they had personal contact directly or indirectly] who were very disenchanted with some of the more institutional approaches to therapy and who also needed the flexibility of how to raise their family.... And so our setting has proven to be a haven for really good therapists who want to be able to control their comings and goings and also have a real sense that it's not important to bill units. (K, 2/3/92, p. 5)

Kay added that, in this clinic, "...people don't feel that they have a quota of units that they have to produce and people don't have to treat patients simultaneously.... So, I think that's appealing" (K, 2/3/92, p. 5). This perception, in fact, was subsequently confirmed through the actions and words of several therapists.

Even though staff recruitment appeared to occur as a family affair, Kay, who was involved in most of the recruitment, admitted that there were some very specific characteristics she and Don were looking for as they talked with individuals about becoming associates and it is these characteristics of staff that, in some respects, begin to describe parts of the clinic philosophy and influence the enactment of that philosophy on a day-to-day basis:

> We were looking for people that didn't have to be told what to do--who were secure in their profession and knew what they wanted to do--who didn't require supervision--who were self starters. We were looking for people that were very creative in their problem solving...that they weren't just sort of going by the book (if there is a book).... People who read the literature and keep up on what is current. (K, 2/3/92, p. 6-7)

Finally, Kay added that she felt that they sought people who needed "relief" from the "political issues" that were becoming increasingly pervasive in certain types of health care decision-making. Instead, they wanted staff who would "...just work like hell to do the best job you can for the client and [know] that's what's appreciated and valued" (K, 2/3/92, p. 7).

To this point I have only briefly mentioned Don's story and his role in the development of the clinic; it is to this story that I turn next. Although I knew Don as a fellow faculty member at a local university where he teaches courses in rehabilitation psychology and neuropsychology for students in various health related programs, I had never encountered him in his clinical role. On the morning of my interview with him, Don came to the waiting room to welcome me and invited me back into his office which was, like Kay's, lit primarily by the natural light from the window and a lamp on his desk which also was home to a computer and stacks of papers and disks. Don who, at first encounter, seems more reserved than Kay, was dressed in a navy blue sport coat, gray pants, a loosely buttoned white shirt with a subdued burgundy tie. He has brownish-black, slightly graying hair with a neatly trimmed beard and mustache. His general demeanor was friendly and polite though not exuberant like Kay's.

Don obviously traced a different course to this clinic than Kay. His doctoral degree was in neuropsychology with a strong foundation in neurobiology although he had completed all the necessary coursework and "prelims" for a clinical psychology degree but had never completed the internship. After several years of academic teaching Don earned a sabbatical which he used to work in

a clinical setting (the rehabilitation center) to enrich his knowledge and understanding of clinical neuropsychology and the psychology of disability. There were two factors that seemed to contribute most to his desire to do this. The first of these relate to his experience with his daughter who had several severe congenital abnormalities which required surgical management. As a result of his daughter's problems, Don "spent a lot of time in hospitals" and was

> ...struck by the difference between life outside the hospital and life inside the hospital.... People examining their life--or reexamining their life--because of chronic illness or disability... [and this] seemed like a really important thing to do. (D, 2/4/92, p. 3)

Through these experiences in the hospital, Don had developed "lots of interest in the practical application of everything I had been studying" and his need to become more involved in this dimension of neuropsychology was heightened "when they cut funding for certain research programs that were dealing with the conditions that my daughter had" (D, 2/4/92, p. 3). So, doors seemed to be shutting on the scientific route toward helping individuals like his daughter and Don was interested in exploring some of the alternative paths for helping.

A second factor that stimulated Don's participation in a clinical "internship" during his sabbatical year, was the modeling of a fellow faculty member at the University. This individual was a doctorally prepared physiologist who subsequently went back to medical school and then remained involved in both teaching at the university and in collaborative research at various hospitals in the

area. To Don, "..this seemed like a prototypical model for the way to do things [in health science oriented fields]--except I wasn't doing anything clinically--I wasn't in hospitals except as a supportive family member" (D, 2/4/92, p. 4).

During his sabbatical year, then, Don went to the local rehabilitation center and worked as a research psychologist with several health care professionals, Kay included, on a grant that dealt with the behavioral treatment of patients with chronic pain. Don said this was a "really powerful year" for him and one that was influenced largely by his interactions with Kay and with the Physiatrist[2] member of the team who helped him to realize that "rehab was where the tire met the road" (D, 2/4/92, p. 3). The sense that clinical settings and everyday work with patients with disabilities is where theory and research in neuropsychology and rehabilitation psychology gets tested was both interesting and enticing to Don; it made him want to be involved in clinical work on a regular basis.

At the same time, however, Don was observing the use of unit billing and some other institutional practices that were *not* appealing to him as indicated in his earlier quote. This led to his consideration of creating a private clinic, in collaboration with Kay, in which they could practice with more autonomy and control over their clinical decisions than that afforded in institutionally based health care settings. Don went on to talk about how he and Kay approached their practice as they first began:

> Both of us started out being really focused on the people and really interested in trying to, not just to help people, but trying to figure out--well, *why* is this patient having a

> problem? We'd get a lot of cases of people that had been through the whole mill and then they came here--and sometimes we're successful and sometimes we aren't--but, it's like, we were willing to take on that challenge. (D, 2/4/92, p. 9)

Once again the focus moves to the people they are trying to help, many of whom are very challenging patients, who require some serious problem-solving on the part of the clinician and who demand creative solutions to the problems they present.

It was during this same conversation that Don also shared a story about Kay. Kay had wanted to go into the ministry at one point in her life and was accepted at the Yale Divinity School but didn't end up going there. Don thought that Kay "...sees doing therapy and working with people as a kind of replacement for that--what she does [in her practice] meets some of those same needs that she felt about going into the ministry" (D, 2/4/92, p. 8-9).

As Kay and Don's professional relationship developed, so too did their personal friendship. Ultimately, Kay and Don were married. So these are Kay and Don's stories; their stories and the history of the development of this clinic provide a preview of the things to come as I describe the clinic setting and structure and the clinic philosophy as represented and enacted by the clinic associates, in particular, by Caitlin as she works with clients with brain injury.

The Clinic in Evolution: Today and in the Future

Today the clinic associates collectively carry an active case load and provide a broad range of rehabilitative services on an outpatient basis. Referrals are received from the medical and

rehabilitation community as well as from the mental health community. As Kay put it,

> ...we end up having our feet in two worlds. Because I work in the mental health profession, I get referrals that are strictly mental health referrals and people have no sense that we have PT, OT or an allied health team here.
> (K, 2/3/92, p. 10)

On the mental health end of the spectrum the clinic provides services such as marital counseling, sexual counseling, and counseling for problems such as depression and anxiety. On the other end of the spectrum is the practice that is concerned with patients with health related problems--primarily neurological dysfunction and chronic pain--who are referred from other health care institutions and physician's offices. Clients come from diverse backgrounds in terms of their socioeconomic status and the clinic administrative and professional staff work with third-party reimbursers to try to ensure that clients are able to receive necessary services.

Perhaps the best description of the practice today and the philosophic commitments of the clinic associates is provided by the text from a clinic brochure (see Figure 2) which paints a picture I found to be an accurate representation throughout my time in the clinic. Interestingly, this brochure (which was revised and updated once during the three years I was conducting my study) and a few other small fliers discussing the clinic's specialty programs for the management of Chronic Pain and Head Injury represent the sum total of promotional material that this clinic has prepared over the years.

In this day of rapidly expanding rehabilitation services by hospitals and health care agencies, it becomes increasingly difficult to choose which professionals will produce the best results.

At Jones & Thompson Associates, P. C., we've resisted the trend toward expansion. We believe that a small group of master therapists working together as a transdisciplinary team can provide more consistent services to clients.

A traumatically or chronically ill client deserves the reliable services of the same caring therapist for as long as rehabilitation services are necessary. For more than a decade the staff of Jones & Thompson has been providing that kind of dependability.

At Jones & Thompson, there are no "departments" separated by hallways or buildings, so communication and teamwork are not impeded by size or architecture.

Clients can be assured that they will always be seen individually in private treatment areas by therapists chosen from a staff of ten who together have acquired more than 150 years of professional experience.

At Jones & Thompson, there are no preset treatment programs. Each patient is individually assessed and a pragmatic program is designed to meet his or her unique needs. Our therapists accompany the client to settings where learning or therapy will be the most effective: home, job, school, or community. To keep costs reasonable, whenever possible the client's family is trained to function as a part of the treatment team.

Skilled therapists in neuropsychology, social work, speech pathology, physical therapy, and occupational therapy work to maximize each client's self-sufficiency, according to the orders of the referring physician.

Although the staff of Jones and Thompson is known for its experience with a wide range of health-related problems, specific expertise exists in the treatment of persons with traumatic head injuries, chronic pain syndromes, Multiple Sclerosis, Parkinson's disease, stroke, disassociative disorders, and sexual dysfunction.

Next time you must make a decision regarding rehabilitation services, consider the importance of excellence and caring. Consider the team at Jones & Thompson Associates, P. C.

Figure 2. Text from Jones and Thompson, P. C. Clinic Brochure, 1992.

In response to my questions, both Kay and Don discussed their "non-marketing" approach to marketing which, as with other aspects of this clinic, stands in contrast to the practices of many other providers in the increasingly competitive health care environment. Their desire to resist expansion--to keep their practice small and provide a limited number of special services for clients with challenging problems--is equally unusual in this market.

Kay and Don describe their approach to marketing as relying on educating consumers about the types of services they provide and their highly qualified staff along with the continuous provision of high quality services. For example, Don, Kay, and other associates have been involved in providing inservice education to interested groups including physician groups, therapist groups, and volunteer health-oriented organizations. They seek to be thoughtful and thorough in their correspondence and phone conversations with physicians and other referral sources as well as provide quality care resulting in successful and functional outcomes for the patients with whom they work. Kay is actively involved with several volunteer agencies and serves on their advisory boards.

Don spoke quite emphatically about his dislike of the "politics" of "business building." Of their public speaking and inservicing, he said

> ...it's not my main motivation to go in there and drum up business. I mean, I don't even carry a business card. I think the philosophy of both of us... was to do a really good job at what you did--really have integrity--and if you did a really good job, then it [referral growth] would take care of itself. And sometimes that's true and sometimes it isn't. But I just don't like to deal with the politics out there. (D, 2/4/92, p. 7)

This statement is in keeping with a brochure claim that "We believe smaller is better." Don describes their resistance to expansion referred to in the brochure:

> We've fought changing very much because we thought that our philosophy would have to change if we got a lot bigger... basically, growth is not attractive to Kay or me. I think about staying the same size and offering even higher quality care. I'm always working on better ways... to educate and help our patients. (D, 2/4/92, p. 8)

Kay mimicked this response in a separate interview:

> I think that the community that knows us perceives us as good, but, you know, the idea that you have to do it full-time, and that you have to keep growing, and that you have to be marketing and you have to do a lot of aggressive things out there to maintain your market share... is not something that we really went into business for. I manage the business because I want to manage it. I could be the executive director of a social service agency easily with my background--I *want* to be a clinician and the people who work here want to be clinicians--and that means making different kinds of decisions, and whether this social experiment will work, I don't know. (K, 2/3/92, p. 11)

In this passage, Kay refers to their practice as a *social experiment* which it *has* been in many ways. The clinic was developed to provide services which prior to it's establishment didn't exist in the area. It was conceived of and developed as a clinic staffed by a "small group of master therapists working together as a transdisciplinary team" (see Clinic Brochure, Figure 2) with a strong commitment to keeping the patient at the center of the rehabilitation

process at a time that other health care institutions were directing their energies toward rapid expansion sometimes at the expense of patient participation in clinical decision making. In addition, according to Kay, the clinic has served as a "social service agency for therapists" in some respects by virtue of it's attention to therapists' personal and family needs and it's willingness to let those needs determine the extent and nature of the services that each therapist provides in the clinical setting. With regard to the latter, it was not surprising when Kay admitted that she did look forward to the day when some of the individuals who are part-time staff now will become full-time staff members. She saw this as the mechanism that would enable them to provide increased availability of services to the patients in the community who would benefit from the clinical expertise of the staff.

> Our goal will be to remain solvent and to keep a core group of people that feel really good about working with each other and a core group of referrals...and I'll probably keep working until I'm old and toothless. (K, 2/3/92, p. 11)

It saddened both Don and Kay that adherence to this desire to maintain a small practice and their commitment to clinical success with challenging clients more than financial success, in fact, has created very real concerns about the solvency and future of the clinic. As Kay put it in 1992,

> The whole health care system is getting so large that the concept of the small quality private practice clinic is, um, while it was very revolutionary when we did it in 1979...I really fear that the way the insurance industry decisions are

> made [today] that it won't be possible to do this long term. (K, 2/3/92, p. 11)

In 1995, these concerns about solvency and viability of this small private clinic were even more pronounced for Kay in the context of the rapidly changing health care environment. Over the past few years, spurred by calls for massive health care reform, changes in the insurance industry, and altered patterns of reimbursement for health care, institutions and health care corporations have dramatically stepped up efforts to purchase smaller practices and create large health care conglomerates and networks of affiliated, preferred providers. One of the outcomes of this trend is that physicians or other potential sources of referral for rehabilitation services are encouraged to refer patients to affiliated providers rather than to free-standing, private clinics. When I asked Kay about the impact of this trend on practice in this clinic she expressed both frustration and increased concern about the viability of the clinic as it currently exists:

> Am I optimistic? No. Do I think we'll be here in three to five years? I don't think so... at least not as we are today. (K, 9/15/94, p. 11)

Kay went on to say that her impressions were that they may find themselves unable to offer the full array of rehabilitation services they currently provide. She felt that the nature of the work in the clinic and the clientele may shift toward mental health and counseling services and away from rehabilitation services for clients

with chronic disability. This bleak prospect saddens many people, myself included. I feel grateful to have been a participant observer in this unique clinical community over the past few years and thankful to be able to share my observations with others.

The clinic brochure (see Figure 2) describes several of the clinic features that make it distinctive, yet endangered, in today's health care environment. Part of this difference lies in the setting itself, part in what the clinic associates call their "philosophy of care", and part in the knowledge, beliefs and actions of the very experienced clinic staff who enact this philosophy on a day-to-day basis through their interactions with clients and each other. In the search for understanding of this clinic and the staff and patients who populate and create it, I turn now to descriptions of the (a) the structural or physical environment and (b) the sociocultural environment of the clinic.

Physical Environs. The first phase of my study took place in a clinic site located in a rather quiet although growing suburban area of a medium sized mid-western city. The clinic is easily accessible via major thoroughfares in the area and is only ten minutes from most of the major downtown hospitals. The building, a fairly new brick structure with lots of windows and green trim, is nestled in a little valley just off a major secondary road. There are several other small professional buildings in the area.

On the day of my first data collection visit to Jones and Thompson, P. C., I entered the building through a side entrance nearest the clinic location on the first floor which permits easy access to handicapped individuals. The hallways in the building, though

freshly wallpapered, are unadorned by artwork. There is a dentist's office and a physician's office nearby on the same floor. As I entered the clinic one of the receptionists, Wanda, acknowledged me by my first name through the reception area window which was partially open at the time. Knowing who I was and my purpose, she talked to me a bit about the patient/therapist schedule for the day and then offered to check and see if Caitlin, the physical therapist with whom I would be working most, might be available to talk with me because of a patient cancellation earlier in the morning.

The Clerical Staff. As I sat in the waiting area (which was very quiet this morning because of inclement weather that was making it difficult for some clients to keep their appointments), I had an opportunity to talk with Wanda a bit about her work at the clinic and to observe the waiting, reception, and administration area. Wanda is a slender young woman, probably about 30 years old, who has short brown hair and a soft-spoken and controlled voice. Today she is dressed in navy blue slacks and a matching blouse with some simple gold jewelry. When she is not talking with me, other staff who intermittently wander into the area, or on the phone, she quietly completes activities such as scheduling patients, typing, transcription, and copying.

Wanda has been working at this clinic for seven years and during that time she said she has watched the clinic grow from a staff of five to a staff of 12 including herself and the other clerical staff member with whom she "job-shares." Wanda works part-time, mostly in the mornings, with alternate long weekends off. Judy, the

other receptionist, works mostly in the afternoons and also has alternate long weekends off.

Judy, like Wanda, has a long history with the clinic. She has been working with Kay and Don for nine years and has appreciated their willingness to consider the kind of alternative work arrangement that she and Wanda have participated in long before "job-sharing" was an accepted feature in many institutions. Judy's appreciation and devotion to Kay and Don and the clinic itself is reflected in a comment she made to me one day: "They're good people. I love it here. I'll probably die right there in that chair... (pointing to the chair behind the receptionists desk)" (FNs, 2/4/92, p. 10).

The longevity of service and dedication to the clinic seen in these two clerical staff members and the appreciation for consideration of alternative work arrangements by Kay and Don is repeated by several of the other professional staff members whom we will meet shortly.

The Waiting Area and the Comings and Goings There. A diagram of the clinic waiting area and reception area is provided in Figure 3. The waiting room is small (approximately 15' x 15') but was never crowded. In fact, during all of my observations, I never saw more than three individuals, myself excluded, in the waiting room at any one time. The lighting in the waiting area is subdued; there is a floor lamp in one corner of the room and there are a few recessed floodlights in the ceiling. There is a notable absence of the ubiquitous waiting room clock on any of the walls. The walls, though

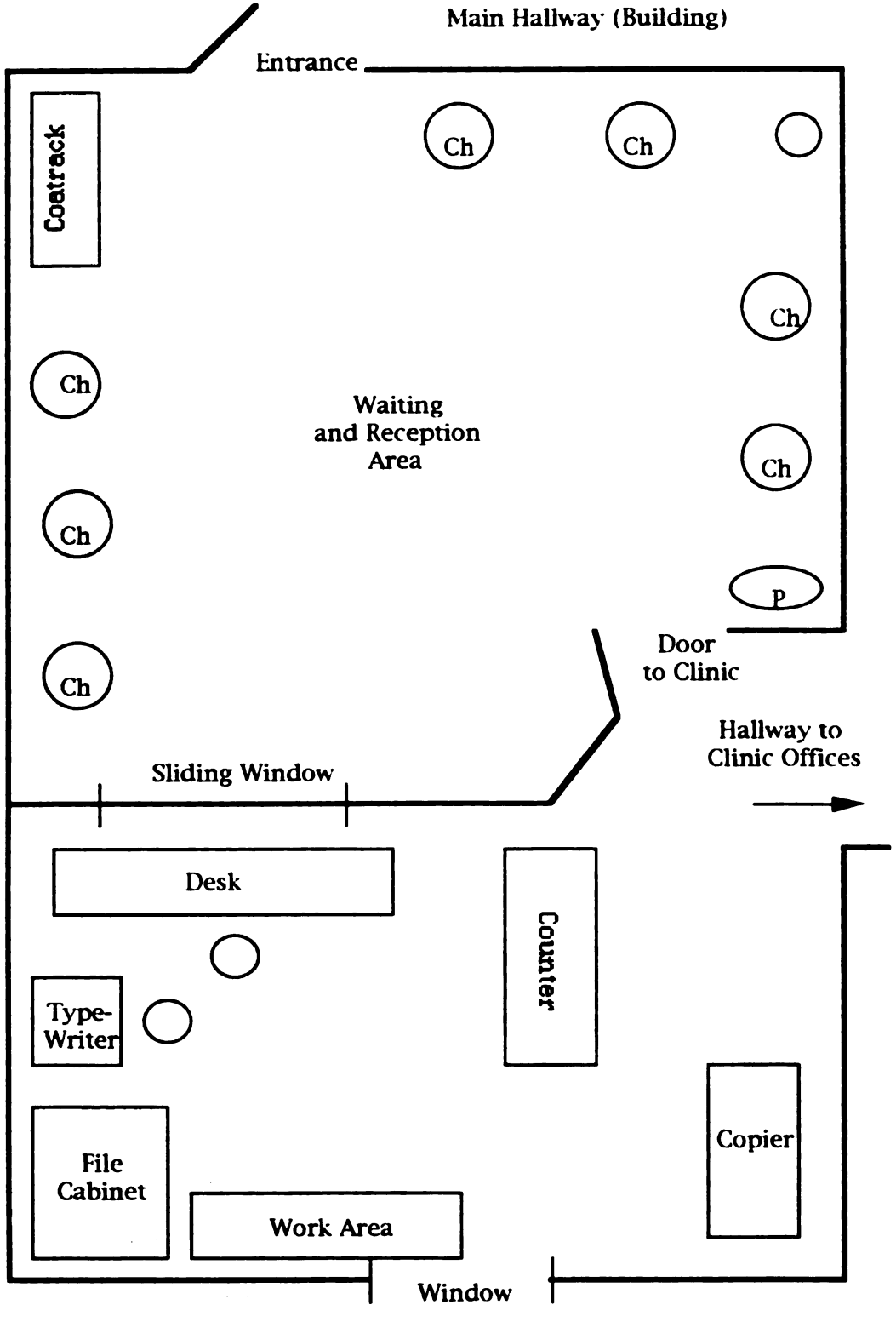

Figure 3. Layout of the Waiting, Reception, and Administrative Areas, Main Clinic Suite. Ch = chair; P = plant; L = lamp.

nicely decorated with a calming mauve-ivory-gray wallpaper and a chair rail, are not home to any artwork although there is a large picture that is visible through the receptionist's window that hangs to the left of the desk in that area. There are eight chairs upholstered in a light gray tweed kind of fabric around the waiting room and there is a small table with an artificial plant in one corner. Just behind the entrance door there is a coat rack and underneath this there is a collection of children's and adult magazines which included Time, Consumer's Reports, American Health, and Highlights for Children, among others. There is also a children's toy playhouse sitting under the coat rack. On all occasions when I visited the clinic, there was some "light" popular music playing softly in the room coming from speakers in the ceiling. In general the decor in the waiting room is simple and the feeling in the room is soothing.

This feeling is not interrupted by the activity in the reception area or the coming or going of clients and staff. The sliding glass window to the reception area is often kept closed so that noise and conversation in that area does not flow into the waiting area. In addition, the movements of the receptionists or professional staff in that area never appeared frenzied.

When patients entered the waiting area, they seemed to have learned to follow a routine that differs from that frequently observed in other clinic waiting or reception areas. Only rarely did patients walk to the reception window as they entered the room to announce their presence. Instead, they would remove their coat and quietly take a seat. On the wall near the receptionist window was a sign that said "Please Be Seated We Will Be With You Shortly" and on the shelf

near the window was a small box of hard candies and two restroom keys for a restroom in the hallway outside the clinic entrance. As the patients entered the waiting area, however, their presence did not go unnoticed. Wanda or Judy would almost always look up and note that the patient had arrived even though there were no door chimes or other auditory signals to announce the patients arrival. If the window to the reception area was open, they might say "Hello, Betty"; alternatively, they would not say anything to the patient. Instead, usually not more than five minutes after the arrival of the client, a therapist would appear at the door between the waiting area and the main clinic hallway which led to staff offices. The therapist[3] would open the door, greet the patient by their first name, invite the patient back, and escort them to their office. This routine was observed on numerous occasions without exception and is illustrated by the following excerpt from my fieldnotes.

> A patient enters the clinic and Wanda greets her by name--"Betty"--before she comes to the receptionists window. The patient appears to be ~65. She is moderately obese and dressed well but comfortably in a pair of black pants and a mixed color sweater. She seats herself and begins to read a magazine and cough intermittently. A second person enters the room. This is a young man dressed in a striped sweater and "docker" type pants. He hangs up his jacket and carries a knapsack to a seat across the room from me. He does not go to the receptionist's window and soon after sitting down pulls out a book and some "Cliff notes" from his knapsack and begins reading. Shortly after this, another woman enters the waiting room and immediately seats herself one seat apart from the young man. She does not got to the receptionist's window either. During this time, although Wanda has continued her activities and has not *formally* recognized the last two entrants into the clinic, she has called a staff member on the phone to notify them of a client's

> arrival. Concurrent with this, Kay enters the administrative area. She picks up a patient file from the receptionist and comes to the door of the waiting area to greet Betty by name. The client and Kay proceed down the hall toward the back of the clinic where Kay's office is located. (Fieldnotes, 1/15/92, p. 5)

What seemed to happen, time and again, was that the therapists were aware of their schedules and typically spent 50-60 minutes with each client. In this clinic there is no scheduled overlapping of therapy times between clients, so there was not the routine need for the receptionists to notify therapists of a client's arrival unless the client was not contacted by the therapist within five minutes or so of their arrival and appointment time. The receptionists simply unobtrusively observed the patients arrival and monitored the length of time before the therapist arrived so that they could either (a) notify the therapist that the client had arrived (this notification would be done by phone) or (b) let the client know that the therapist would be with them shortly. Naturally, the receptionists answered questions if the patient did come to the window to request information or check on appointments.

As with the beginning of therapy sessions, at the conclusion of sessions, patients were always escorted back to the reception area by therapists where future appointments were often jointly set by the therapist, receptionist, and patient and then the session was personally concluded by the therapist. This closure and then the easy movement to begin a session with other clients is demonstrated by some excerpts from my fieldnotes involving Caitlin and one of her

clients, John, both of whom will become key players in much of my remaining story.

> Caitlin's door opens and I can hear her leaving with a male client (John). Caitlin says "I'm pleasantly surprised at how well you tolerated the movement today." They continue down the hallway in conversation to the reception area and schedule a future appointment. After this Caitlin says to John, "...thanks for coming in." As she escorts John out into the waiting area, she ensures that his "ride" is there and after another good-bye she turns to another client--a Vietnamese woman and her interpreter. She welcomes them and escorts them back into the clinic area. (Fieldnotes, 1/22/92, p. 5)

There are several interesting things to note about these patterns of interaction between clinic staff and clients at the beginning and end of therapy sessions--patterns that describe the social environment which is co-mingled with the physical environment in the clinic. They are consistent with the commitment to personal client attention that is discussed in the clinic brochure: "Clients can be assured that they will always be seen individually in private treatment areas by therapists...." (See Clinic Brochure, Figure 2.) Indeed, clients are escorted to and from their therapy/counseling sessions by their own therapists rather than being ushered into an office by some other staff assistant or aide. In virtually all interactions I observed in the waiting and reception area, only first names were used between clients and their therapists, therapists and family members, and between staff members themselves. This speaks to the personal, though still professional, nature of the interaction between therapists and clients as well as the close relationships between members of the staff.

Some questions that emerged as a result of these observations had to do with whether or not these interactional patterns contributed to the development of alliances with clients and the construction of client-centered approaches to care in this particular clinic. The formalisms that seem so persistent in many medical and health care settings (e.g., patients addressing heath care workers as Dr. so and so, nurse___, or Mr./Ms___, while patient's are addressed by their first name) that seem to accentuate the inherent asymmetry of status and power in some of these relationships is not evident in the interactional patterns described above. Likewise, none of the staff wear the omnipresent white jackets so familiar in many other health care settings. Could these patterns of interaction and differences in apparel diminish the potential for the creation of interpersonal distance between client and therapist?

The Main Office Suites. The main office suite and an adjacent second office suite also afford, by their design, some of the privacy and opportunities for interprofessional "communication and teamwork" discussed in the brochure. A diagram of the layout of the main clinic suite is shown in Figure 4. This suite contains Don's and Kay's offices, Caitlin's office and PT treatment area, Katherine's office (a social worker), a shared office for the speech and language pathologists which houses some of their equipment as well as some computers and a video monitor that are used for neuropsychological assessments and cognitive retraining programs. There is also a closet for storage, a handicap accessible restroom at the end of the hallway, and a staff break area. The decor in the main suite is an extension of that found in the waiting area. The lighting remains subdued

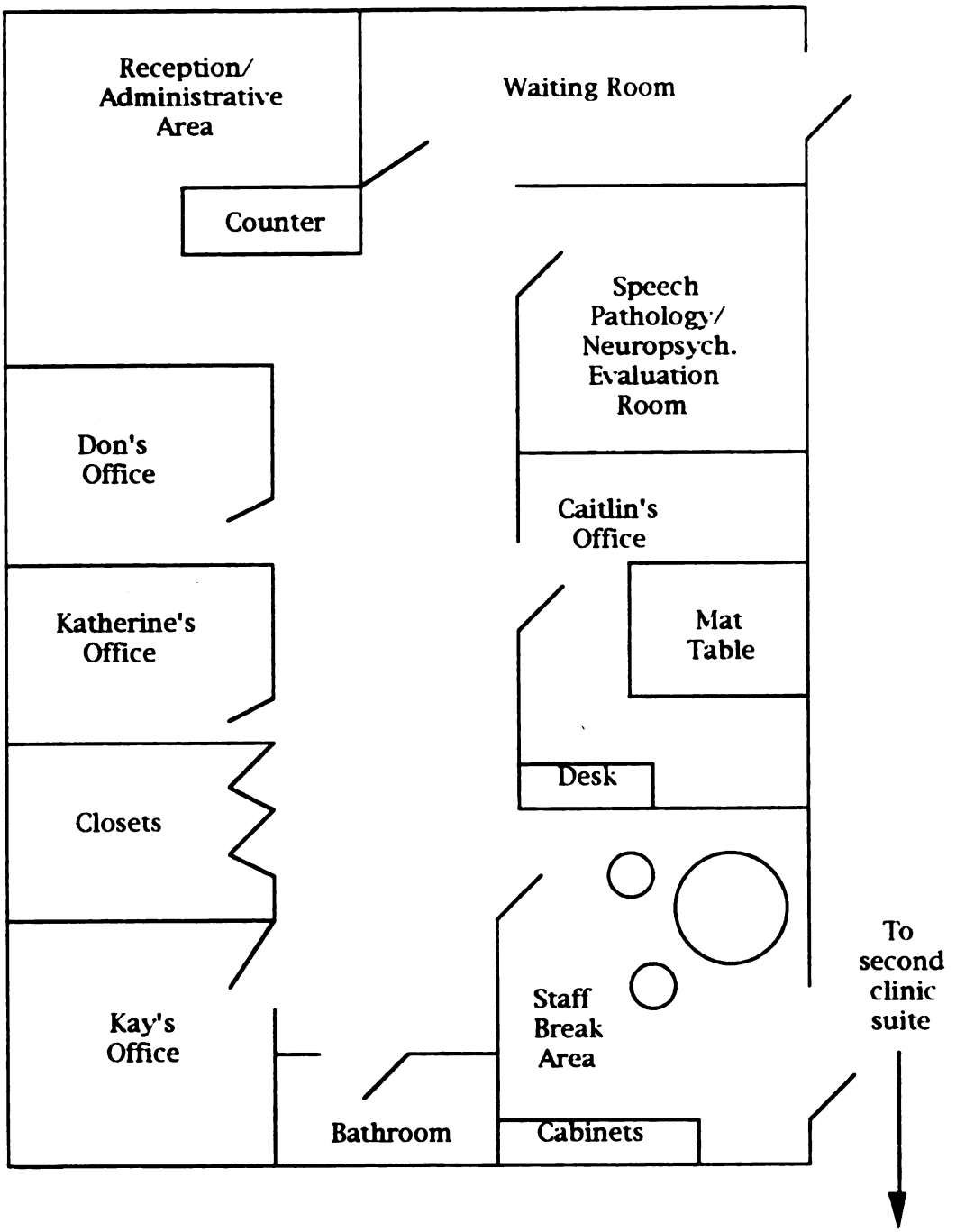

Figure 4. Layout of the Main Clinic Suite. (Not to scale.)

throughout most of the suite with recessed floodlights in the hallway and offices although there is overhead fluorescent lighting in the staff break area which is not a patient care area. The same mauve and gray lightly speckled carpet and lighter mauve-ivory-gray wallpaper extends through the entire main suite.

In the break area, the table is usually home to a full complement of coffee and tea paraphernalia and not infrequently a plate of cookies or goodies. On one occasion there was a delicious looking apple pie on the table. As Katherine passed through the break room on that day and chatted with me briefly, she mentioned that one of her younger clients with brain injury "...made it to show how independent she was getting..." in her activities of daily living (FNs, 1/22/92, p. 5). Katherine seemed genuinely proud and pleased of this client's accomplishment and said she looked forward to her continued demonstrations of independence! In addition to the table and chairs in the break area, there are some additional raised closets, a small refrigerator and coffee machine, a microwave oven, a fax machine, and a phone/intercom system. On the wall above the refrigerator hangs a framed certificate given to the clinic from the local United Way Agency in recognition of support and service provided to the community by the clinic staff.

There is a rear door to the main clinic suite that opens into the staff break area and this is frequently used by the staff as their entrance to the clinic. This door is used as an exit when therapists wish to escort their clients into the nearby second suite that is used less frequently but which served as the site for most of my observations of treatment sessions with Caitlin and John. (The

treatment room in this suite is slightly larger than Caitlin's other office which made video-recording of sessions less obtrusive.) The entrance to this second suite is a short walk down the hallway. A diagram of this second suite and treatment area is provided in Figure 5. This treatment area is shared by the PT's and OT's but is most frequently used by Emily (PT) who also has an office in the suite along with the OT's. The OT's and the OT assistant, however, are not heavy users of this area since they frequently provide many of their services in client's homes or in other settings in the community where the client must function. The second suite also contains another larger office that is used for weekly clinic team meetings, an additional storage area and another restroom.

The decor in this larger treatment area is not quite as subdued as the main clinic suite and Caitlin joked a bit about the decor from time to time noting, however, that it was not a heavily used area. In this area there is a green carpet and a yellow-green-silver wallpaper on the walls. As with the waiting area and the rest of the main clinic suite offices, there are no clocks evident in the treatment area. During every treatment session with Caitlin and John that I observed in this room, only the ample light from the large west facing window illuminated the room and no overhead lighting was used although it was available. According to Caitlin, this was done purposefully since John, like many patients with brain injury, finds bright light distracting.

The layout of the clinic as described above corroborates the statement in the clinic brochure that "...there are no departments separated by hallways or buildings, so communication and teamwork

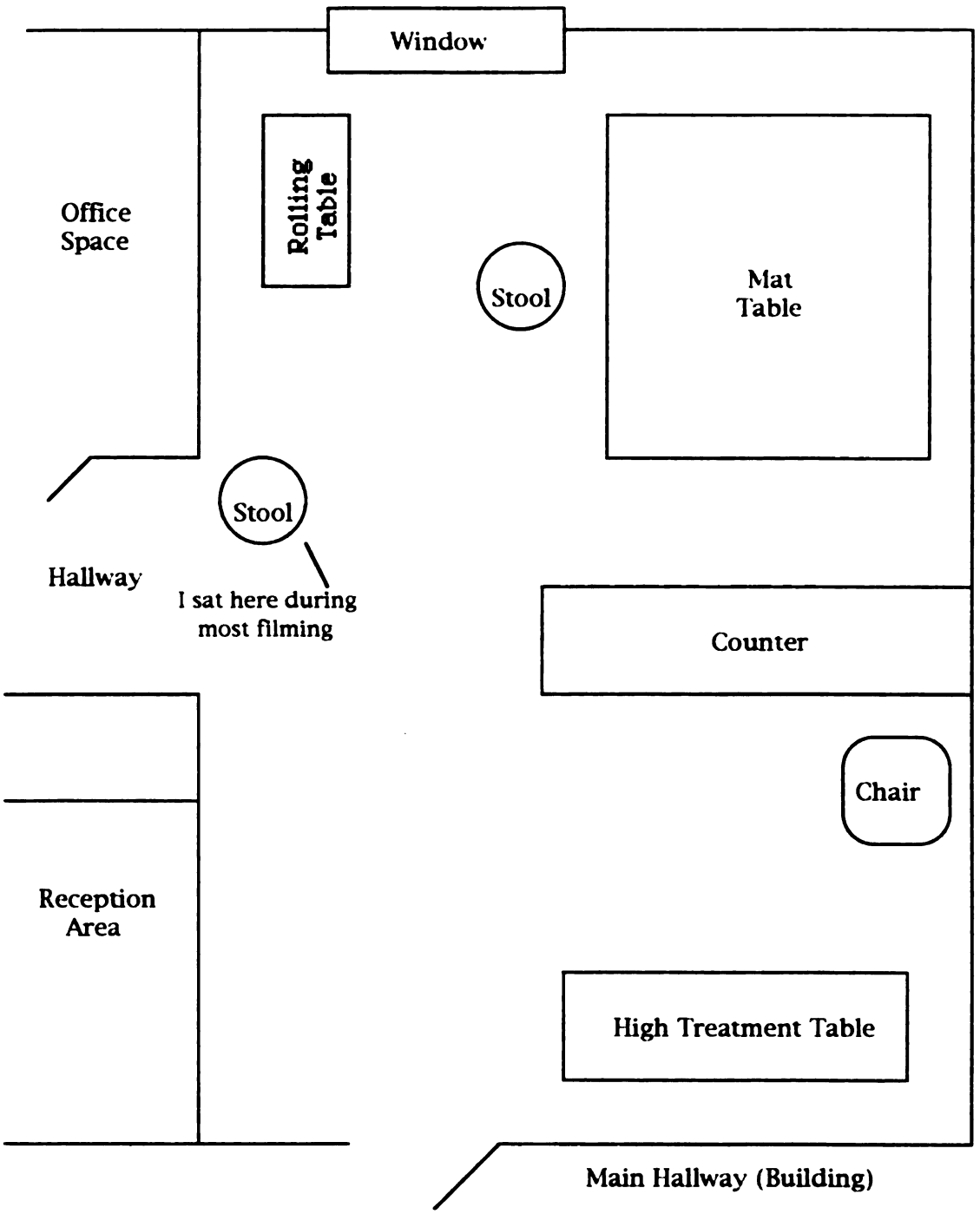

Figure 5. Layout of treatment area where all therapy sessions observed with John and Caitlin were recorded. (Not to scale.)

are not impeded by size or architecture" (Clinic Brochure, Figure 2). Indeed, this is more like a single department staffed by a team of therapists, who in other settings are often segregated into different departments according to their profession or discipline. In contrast, to the compartmentalization of departments and therapists often found in larger institutions, this clinic seeks to offer "... a small group of master therapists working together as a transdisciplinary team... [to] provide more consistent services to the client" (Clinic Brochure, Figure 2). Collectively, the professional staff of ten who comprise transdisciplinary teams for clients, "...have acquired more than 150 years of experience." These statements, taken from the clinic brochure, point to two additional distinctive features of this setting. First, the longevity of therapists working in one clinical setting that is evident here is unusual when compared to many larger clinical rehabilitation settings which are characterized by regular staff rotations or turnover. At this clinic, although many therapists work part-time, they have faithfully remained with the clinic since they became associates. Of all of the therapists in the clinic, Caitlin, who had 12 years of experience as a PT at the time the study was initiated and who had been an associate for five years, was the therapist with the least amount of experience in her professional field and is the therapist who most recently joined the group!

Secondly, the notion of a being a transdisciplinary team is raised and the brochure suggests that architecture as well as expertise contributes to the ability to create transdisciplinary teams in this clinic. A definition of transdisciplinary team arose out of a description of the broader philosophy of care which I first discussed

with Kay during an interview and that is also alluded to in the clinic brochure. This philosophy is labeled "client-centering" and among clinic associates there appeared to be a communally adopted core belief in, and commitment to, providing "client-centered care." The ideology of client-centering is a central and guiding tenet for practitioner action and interaction in this clinic. It describes the sociocultural system that helps to create the clinic environment in the broad sense and serves as a framework for interpretation and understanding of the daily work of clinicians in this setting.

The Philosophy of Care in the Clinic: Client-Centering

As I talked with Kay she described the clinic philosophy as one that revolves around a communal commitment to providing client-centered care. Now, client-centering is not a term that is new in clinical communities. This label and construct has been widely used in counseling literature and was first advanced by Carl Rogers (1957) in his work on client-counselor interpersonal relationships. Later, Carkhuff (1969, 1976) and Ivey (1983) extended Rogers' ideas to other fields including medicine, and Payton (1986) has applied them to physical therapy. In education, similar constructs have been advanced with the label of student-centering and client-centering (Eraut, 1994). Thus, I had heard and read about client-centering before beginning this study; I have even advocated client-centering in my own and others' clinical practice. Even so, I wanted to know what client-centering meant to this particular group of experienced clinicians since it was their interpretation of client-centering that would presumably guide and be reflected in activity and discourse in the clinic.

Starting Where the Client Is. When I asked Kay what client-centering meant to her, she said it meant doing the "best job" for the patient. When I asked her to elaborate on what doing the best job for the patient entailed she responded that first, and foremost, it was "...important to start where the client is" (K, 2/3/92, p. 7). Kay went on to explain that the clinic often receives referrals in cases where previous attempts to work with an individual by other rehabilitation professionals had failed. What the clinic team often discovered in these cases

> ...was that the [other] therapists were really trying to impose their own goals on the patient or the patient's family rather than listening to the patient and the patient's family about where they are and what it is *they* want. (K, 2/3/92, p. 7)

She emphasized that listening carefully and responding to the client's needs was essential "...so we're not providing services that they haven't requested...in ways that are not going to fly." (K, 2/3/92. p. 7)

Seeking Meaning and Setting Goals. Kay further described how client-centering influences goal-setting for or with the patient:

> ...it's figuring out what are the *new* goals. In a lot of rehab I think that rehab *is* the goal...and here—we're thinking about when you leave rehab, what are *you* going to do on a day-to-day basis that will be meaningful to you. (K, 2/3/92, p. 8)

The search for and creation of goals that are *meaningful to the patient* and that will thus define and direct the nature and extent of rehabilitation services provided involves much more than just careful listening to the patient and family about their problems and needs; it

also involves shifts in traditional professional-patient power relations inherent in biomedical models of health care and demands attention to patient and family perceptions regarding *illness* as opposed to a primary focus on disease (Engel, 1977; Kleinman, 1980, 1988). As Mishler (1984) and Schutz and Luckmann (1973) would say, it involves hearing and respecting the "voice of the lifeworld" of the patient in addition to the "voice of medicine".

To provide an example of how the clinic team tries to "start where the client is" and work with clients to identify meaningful goals, Kay described the case of John, a patient with a brain tumor who is terminally ill and has moderately severe physical and cognitive impairments and disabilities. Kay, in consultation with John, his wife, Diane, and the rest of the clinic team working with John, had made arrangements for John to work at God's Kitchen--a soup kitchen for the homeless in their community.

> ...He likes to cook and he's *very* social, and he goes down into this environment that accepts a wide variety of behaviors and he has a social contact. He's a terminal patient, but now he has a place to go and do something that's meaningful to him and he's giving to someone else and this was real important to him. ...And that's just one example, I think, of what we call creative intervention--that therapy has to have a goal--a place that it's going to... and we worked for quite a while to get him ready to go into that setting. We find that most of the job *placement* folks never *develop* jobs... so we do a lot of our own job development whether it's volunteer or the for-pay sector... because that's part of a person's identity. (K, 2/3/92, p. 8)

This story illustrates how John's team observed and *heard* what John needed and wanted and then acted on those desires. Together, client

and therapists co-constructed a goal that would meet several of John's needs and also serve therapeutic purposes. They worked hard to help him attain a goal that held meaning for him. Developing this job placement and getting John into God's Kitchen required that the clinic team serve as an advocate for John in the face of some employer apprehension regarding the placement early on.

Advocacy and Empowerment. Advocacy for clients and families is an essential component of client-centering; it involves the use of therapists' creative agency to affirm the potential and creative agency of their clients. In this way, advocacy ultimately serves client empowerment. Kay gave an example of how therapists and clinic teams have served as advocates for female clients as they return to the activities and responsibility of mothering.

> For female clients we find that they have two jobs; and we spend a lot of time trying to help insurance companies [who pay for the rehabilitative services provided to clients] come to understand that. We can't turn our directions to outside employment when we have a mother and she needs to run a home and it's most meaningful for her first to do that, and that that's a legitimate vocational goal. (K, 2/3/92, p. 8)

For Kay, then, client-centering involved giving voice and power to the patient and their family in the rehabilitative process; it involved (a) listening carefully to clients about their needs, (b) inviting active participation of the client in setting rehabilitation goals that held meaning for them, (c) the development of individualized, creative and educative programs or strategies designed to enable the patient to meet rehabilitation goals, (d) serving as an advocate for the client and family as they return to

activity at home and in the community, and (e) empowering clients through all of the above.

Caitlin, the physical therapist, echoed Kay's desire to place the patient at the center of the rehabilitation team and her own treatment planning. She explained how client-centering influenced her goal-setting *with* patients and talked about Kay's observation that in other settings sometimes "rehab" became the goal. From her own perspective, Caitlin commented on how, when she was working in other large institutional rehabilitation settings, she started to feel that the rehabilitation process for patients "... needed to be a lot more than what PT's traditionally offered in getting them walking." She didn't feel it was "fair" to these patients to bring them to the point where they could walk with a cane, for instance, and then say that goals were met. Instead, she recognized that her patients had many more specific and meaningful goals for themselves. Caitlin said she felt that the patient's "lifestyle" should be the guide to goal setting and treatment planning rather than having goals of just "...getting out of the hospital" (C, 1/27/92, p. 3).

Susan, a speech and language pathologist in the clinic, agreed that the nature of goal-setting and the potential for involvement and empowerment of patients in rehabilitation could change significantly according the practice venue and the stage of therapy. As she put it,

> You know,...when you're facility based, the facility dictates the treatment in many ways. It's not necessarily the client who dictates the treatment or the client's unique challenge or strength that dictates the treatment or, um, perhaps their work or family that dictates the treatment. The facility *does* and the confines that the facility puts you in. And so, what I've discovered, and as I've grown as a clinician, and as I've

> become more aware of what I can actually do... I've moved into more home-based and community-based kind of treatment because...the *real* work...the *hard* stuff...the *real* treatment comes when people are trying to get back to their lives.... This is where the client really dictates what their needs are. And we don't really know that until they're back into living their lives. They're in their home, they're trying to deal with their children, they're trying to deal with their spouse, trying to get back to their work, trying to do the physical things that they used to do...that's when I discovered that this is the harder work. (S, 7/28/94, p. 4)

Because the needs of patient's as they return to their lives are inherently diverse and uniquely individual, client-centering demands individualized approaches to treatment program planning.

Individualizing Therapy. Caitlin commented on this by stating that she felt her own focus and interest, and that of the clinic staff, was on the "uniqueness" of each patient. She felt that all the clinic associates shared a devotion to individualized programming for clients. According to Caitlin, the entire staff is interested in "looking at where and how the client must function--at home, in school, at work, in their social activities--and letting *their life needs* become the guide...." to the rehabilitation process (C, 1/27/92, p. 8). Additionally, Caitlin commented on how, in this clinic, there is an acceptance of and encouragement to spend additional time with patients and families in educational activities and preventative care which, in her experience, contrasted with the other models of rehabilitative care.

Since part of placing clients at the center of the rehabilitation team involves the development of individualized programs to meet the goals and needs of the patient, therapists often find themselves

trying to solve the complex and unique problems of clients in creative ways. A commitment to individualized approaches to rehabilitation is articulated in the clinic brochure:

> At Jones & Thomson, P.C. there are no preset treatment programs. Each patient is individually assessed and a pragmatic program is designed to meet his or her unique needs. Our therapists accompany the client to settings where learning or therapy will be most effective: home, job, school or community. To keep costs reasonable, whenever possible the client's family is trained to function as part of the treatment team. (Clinic Brochure, 1992, Figure 2.)

The statement above speaks not only to individualized programming and goal-setting, but introduces another key component of client-centering--that of using education as a tool for enabling and empowering the client and their caregivers.

Therapy as an Educative Endeavor. In numerous descriptions of client-centering from staff, therapists' reiterated that teaching and learning were central and reciprocal activities in therapy sessions. Therapists needed to learn about their patient's life-world and needs as well as being teachers for patients, their families, and others with whom the patient might work. Providing information and co-constructing knowledge about the patient's disorder and functional potential are seen as both enabling and empowering for clients. And enablement and empowerment are believed to enhance the self-regulation and self-sufficiency of the patient.

Caitlin frequently talked about her "...role as a teacher and an advocate..." for the patients with whom she worked (C, 1/27/92, p. 4). She remarked that in her work in other clinical settings she felt

unable to fully exercise that role because of time limitations imposed by administrative requirements within the setting and the busy schedules of both therapists and patients. As Caitlin pointed out, "...patient and family education takes a lot of time.... [It takes] *time* to let them [the patient] be part of the rehab process rather than someone who is just being treated...or cured" by the rehab team (C, 1/27/92, p. 5). It takes time to learn about the tools and techniques patients and family members can use to facilitate recovery or to manage chronic disability and maintain an acceptable level of function.

According to Caitlin, part of the teaching and learning essential to client-centering is aimed at altering patient or family conceptualizations, based on previous experience, about their role in their rehabilitative care:

> I think that part of the education process is letting them realize that they're the *center* of the rehab team, rather than the team managing them. And I think in larger [rehabilitation] centers that can get lost real easily. (C, 1/27/92, p. 5)

Caitlin talked about what she thought were important parts of patient education, not the least of which was listening to the patient and responding to questions they have:

> ...patients *need* a chance for somebody to *hear* them...they *need* explanations of what might happen to them...what they can expect... or what treatment might involve. (C, 1/27/92, p. 5)

As Caitlin put it later, patients are "hungry for information."

Caitlin's emphasis on education and the development of what she called "*teacher*-client relationships" is evident time and again in her interactions with patients. I will let those interactions speak for themselves through vignettes and analyses to follow that dramatize this commitment more strongly than her words alone. Indeed, Caitlin repeatedly spoke of and demonstrated a belief that patients will care and participate more fully in their rehabilitation if they understand the rationale for what they are doing, the consequences of not doing particular things, and the options they have available in terms of their rehabilitation so that they are able to join with the therapist as a decision-maker regarding their care.

Another description of the emphasis placed on the educational aspects of treatment comes from Kay who, during an interview, expressed some frustration with insurance agencies unwilling to reimburse for "education" per se for clients. She was frustrated because she felt that this was, in large measure, what this clinic was all about as they worked for *permanent* and positive change for their clients:

> You can continue to see them [the clients] for approximately $100.00 an hour *or* you can *educate* them and have them do stuff on their own. I think our whole treatment philosophy is an empowerment model--how do we empower the client? How do we give them the information and the tools? You know, the whole experience of disability is so disempowering (if that's a word), that the therapeutic philosophy *has* to be empowerment...you teach people how they can be back in the driver's seat again. And that takes a tremendous amount of education. And you have people coming to you with all different levels of sophistication so that you can't have a

> standard educational approach...you can't have ready-made exercises that you just hand out and say, 'here, do ten of these.' I mean, that approach to physical therapy is anathema here. (K, 2/3/92, p. 12)

Kay then described how, after having successes with challenging patients with whom others had failed, insurance companies or other health care providers would call to try and find out what the "secret to success" was. Kay talked about her response to these inquiries:

> You know, people would call up and say, 'well, could you describe your program?' And I would say, well, could you describe your patient? (laughing) The program is designed to fit the patient, not the other way around--and most places operate the opposite of how we are. (K, 2/3/92, p.12)

So, in response to calls from others asking how this clinic and these clinicians got satisfactory results with the hope of replicating those results in other sites with other patients, Kay typically replies "...well, I think you'd have to replicate our therapists" (K, 2/3/92, p. 12)

Building Therapeutic Alliances. According to Kay, one of the reasons mere replication of a therapeutic regimen is potentially ineffective, in the absence of the expertise, wisdom, and skill of the experienced therapists who design treatment regimens with particular clients in this clinic, is that "therapeutic alliances" with clients may be absent or underdeveloped. Kay suggested that such alliances provide a foundation for client-centering and the individualized educational model of therapy she was describing. She believed that the ability to create alliances with patients contributed,

in large part, to the success the clinic associates have with challenging clients:

> ...when people are working with complicated cases, the ability of the therapist to build a therapeutic alliance, I think, is the difference--it's why we get success and other people don't. (K, 2/3/92, p. 12)

I asked Kay to provide and elaborate on her definition of therapeutic alliance. Kay emphasized how critical she thought the development of a therapeutic alliance was to the provision of high quality client-centered care. She defined this alliance as follows:

> It's finding out...what is the language of this patient? How does this patient think? What turns this patient on? How do I then communicate in their language and in their value system and bring something to them that's valuable? (K, 2/3/92, p. 13)

As suggested by Kay's own words, "building" an alliance is a developmental process--"Alliances evolve gradually... they take time" (K, 9/16/94, p. 3). They don't just happen instantaneously nor can they develop without involvement and effort from all participants. Discovering the patient's "language" and then creating a shared language (and ultimately understanding) that reflects and respects the patient's values *as well as* a professional's knowledge and judgment is no small task. The creation of an alliance, while an integral part of client-centering, is seen by Kay and other therapists as a relational foundation that facilitates the realization of many of the components and goals of client-centering discussed earlier. In one

interview, Kay stressed the importance of reciprocity and responsibility in therapeutic alliances. She described an alliance as "a relationship in which each participant is invested and *shares responsibility* for healing, learning, and change" (K, 9/15/94, p. 3).

According to Kay and other therapists, it is only in the relational context of a therapeutic alliance that some of the most difficult aspects of client-centering can be accomplished. Kay talked about how, in their work with patients with chronic and multiple impairments, it is critically important for therapists to

> ...address the client's and family's expectations for performance and make that match the client's ability to perform so there's not that discrepancy. [This means]...you have two choices; you can either work to increase the client's performance or you can modify expectations–and in most cases you're doing both–and being really up front with people about trying to align expectations with performance. (K, 2/3/92, p. 7)

This quote provides a glimpse of a tension that arises out of the alignment or "balancing act" alluded to in Kay's description of client-centering–a tension that is familiar in numerous health care situations–but one that is really brought into focus in this clinic where there is an explicit commitment to client-centering and active involvement of the client and family in goal-setting and decision-making about care in contrast to the more paternalistic and familiar practice of health professionals making decisions unilaterally and prescribing therapeutic regimens for patients.

This very real tension emerges when clients and their family members have goals and expectations for performance that are not

congruent with the expectations of the therapists or the clinic team based on their own professional knowledge, clinical experience and judgment with respect to a particular client's diagnosis, prognosis, their constellation of impairments, and potential for function. In such a situation, the issue becomes one of *how* and *if* the therapist is able to encourage and maintain the client's voice and role in goal setting and decision-making about their rehabilitative care and still bring their own professional judgment to bear in the process. Denying the patient's involvement in this process, even though their expectations may not be in alignment with the therapist's "reality" and predictions, is antithetical to client-centering and potentially disempowering for the patient. On the other hand, abandoning professional knowledge and judgment may not be in the patient's best interest in some cases either and could represent an ambivalence or irresponsibility that would hardly be called "caring" by the health professionals in this clinic.

So this is a tension between a philosophical and *moral* commitment on the part of these professionals to *patient autonomy* and involvement in decision-making about rehabilitative care on the one hand and *professional honesty* and integrity on the other. Listening and responding to both the patient's voice and the professional's voice is viewed as an essential ingredient for caring and both can reflect sensitivity and concern for the client. In situations where patient or family expectations are inconsistent with the patient's capacity for performance, bringing the patient's voice and the professional's voices into harmony is a challenge that requires continuous negotiation. The instructional, interactional and

cognitive work involved in aligning expectations with performance involves the co-construction of alternate realities understood by all participants about what the patient is able to do or not do safely. This difficult and potentially contentious negotiation is depicted in several of the stories to come about patients and their care in the clinic. In all cases, the therapists in this clinic would suggest that such negotiation is an important and valued activity that is facilitated by (a) the establishment and maintenance of a therapeutic alliance with the patient, and (b) the use of a "transdisciplinary" team approach with patients.

The Transdisciplinary Team. One of Kay's descriptions of a transdisciplinary team arose out of her description of client-centering when she discussed the importance of aligning client expectations with the possibilities for performance. Kay pointed out that this alignment or balancing will almost certainly involve some grieving on the part of the client because in most cases their lives will never be as they were before--there are inevitable losses and feelings of uncertainty about the future. In such situations, Kay stressed the importance of

> ...providing support for the grieving that goes with that--and that's not just something that happens in my office--that's something that happens throughout the team. We talk about our team being transdisciplinary rather than multidisciplinary because we just do everybody else's work to some extent... and the grieving part is real important because people are rarely going to return to the way they used to be. (K, 2/3/92, p. 7-8)

Kay clarified that she did not mean to suggest that she tried to be a PT or that Caitlin tried to be a social worker per se. Rather, through their mutual knowledge of their clients gained through formal weekly team meetings and numerous opportunities for informal dialogue, team members each come to know about and work to support and extend the therapies of the other during interactions with particular clients.

For Kay, being a transdisciplinary team meant sharing and distributing the responsibility for caring, helping, client-centering, problem-solving, and goal-setting across several team members working with a particular client. It also meant including the patient as a member of the team insofar as they had a voice in determinations about who would be on the team (i.e., determinations of what kinds of services are desired or required) and what goals the team would be working toward with the client.

Susan and Caitlin both discussed what they called the provision of *direct* versus *indirect* services in discussions about what being a transdisciplinary team meant to them. In this respect, Susan stressed the importance of being familiar with what other team members are working on with clients in their therapy sessions (what she referred to as "direct rehab") so that she could incorporate certain aspects of another therapist's program for the patient into her activities with the patient as appropriate ("indirect rehab"). To Susan, this integration of cross-disciplinary therapeutic activities and goals across situations and therapists provided a form of repetition that helped patients achieve their goals:

> I think the number one thing that's important, especially in Brain Injury...[is] redundancy in multiple contexts.... A lot of what we do at this level is really indirect. We have *direct rehab* and *indirect rehab.* The things that Caitlin may do like, you know, strengthening a muscle or vestibular training or some of the things that I may do like attention training... The research tells us that direct intervention can actually facilitate that cognitive function or that physical component. But a lot of things that we do are more indirect intervention. And I think that as a transdisciplinary team,... as long as we are all aware of what the overall goals are for this person's life and as long as we're aware of compensation techniques [for dysfunctions]...we can give somebody a lot of opportunities to practice. That's kind of what my sense is; that we are giving them multiple situations in which to practice. Using a Franklin Day Planner, for instance, during social work, in physical therapy, in their work setting.... (S, 7/28/94, p. 6)

Caitlin talked about how much she enjoyed the close interaction with other professionals, the interprofessional teaching and learning, and the "team problem solving" that goes on in this clinic in the service of being a transdisciplinary team. To her, ongoing dialogue among professionals and joint problem-solving made the construction of a transdisciplinary team an intensely educative endeavor. It enabled her to provide indirect services to patients (for instance, elements of cognitive retraining usually done by a speech pathologist or neuropsychologist) in the context of physical therapy sessions.

The close communication among professionals, the comfortable sharing of disciplinary expertise, and the permeability or flexibility of disciplinary boundaries in this clinic contrasted with Caitlin's past experience with multidisciplinary or interdisciplinary

teams in other institutions. In those settings, Caitlin suggested that team meetings became, more or less, a simple "reporting out" of test results and patient status to other health professionals without any communal follow-up, assumption of shared responsibility, or committed response to such information. For Caitlin being a member of this transdisciplinary team has allowed her to broaden her perspective and gain new insights into her patients, their problems, and therapeutic alternatives for those patients:

> One of the things that has helped me tremendously is working with the transdisciplinary team and much closer with the social worker and the speech pathologist and the neuropsychologist [than before]. They have brought me to a whole different perspective on my patients than what a PT normally comes from. And if you're transdisciplinary--*truly* transdisciplinary--you start getting a much broader perspective....We're always trying to consult with each other about what is happening within each other's therapies and to help each other. Looking at problems from a multi-systems perspective or multi-discipline viewpoint, is very different than just reporting out your findings. It's a different way of looking at the patient. And we're looking at getting patients back to functional lives out in the world and that's a bigger view than just trying to improve knee range of motion. (C, 8/16/94, p. 5-6)

Thus, being a transdisciplinary team is far more than a structural entity that serves as a mechanism for facilitating client centering in these conceptualizations; it is more than a structural means to a clinical end. Instead, a transdisciplinary team is a site for teaching and learning among professionals on behalf of clients; it is a relational and interactional phenomenon that provides for the social construction of client-centering in this community. It permits both

patients and therapists to participate in range of activities that foster learning and development.

Client-Centering: A Summary. In summary, client-centering, as conceptualized by members of this clinical community, involves several key components or activities as outlined in Table 1. In addition, client-centering is facilitated by the communal adoption of the clinic philosophy which represents the ideals, values, and beliefs of clinicians and creates norms for action in this sociocultural system.

The commitment to client-centering--this constellation of tightly knit cultural beliefs and norms for action--creates a framework for interpretation of activity and interaction in this clinic and raises important and interesting questions about how these experienced health care professionals try to live up to their ideals in the complicated world of everyday clinical practice with patients with brain injury. Before proceeding to a closer examination of some of these questions, however, I want to introduce a few more individuals--therapists and clients--who are prime characters in this story. These are individuals who have been encountered informally or superficially thus far but the characters and their stories require elaboration.

Table 1.

SUMMARY OF COMPONENTS and FACILITATORS OF CLIENT CENTERING

COMPONENTS	FACILITATORS
• Establishing client needs/goals – Giving the patient voice & power	
• Developing individualized treatment programs that address client's unique problems in creative ways	• Communal adoption of clinic "philosophy" and cultural beliefs/ norms for action
• Emphasis on client & family education	• Establishing a therapeutic alliance with the client
• Goal of client enablement/ empowerment	
	• Transdisciplinary team
• Serving as an advocate for the client (and family)	

More Therapist Stories

Caitlin's Story

Caitlin is an unassuming but experienced physical therapist who currently focuses her practice on working with neurologically impaired clients with a special interest in working with adolescents and adults with head injury or brain damage. Caitlin's own personal beliefs and professional development mirror those of other practitioners in the clinic and it is easy to see why Caitlin's association with this clinic has become such a positive experience for her because of the easy convergence of her own beliefs and professional needs with those of the clinic owners and other staff. But how did Caitlin come to be here?

Caitlin completed her undergraduate training in physical therapy in 1980 at a large midwestern university. After graduation she went to work at the same university hospital which provided her with experience in a multidisciplinary, tertiary, acute care setting for a year. Her intent was to gain experience with a wide variety of patients and clinical diagnoses in an institution that was a teaching hospital and "education oriented". Even so, Caitlin knew at the time of graduation that she was interested in ultimately practicing in a rehabilitation environment where patients would be seen for more extended periods of time than in the acute care hospital:

> I liked the aspect of developing a long term *relationship* with the patient--I liked the challenge of every patient being different even with the same diagnosis--having different problems, different goals. (C, 1/27/92, p. 3)

When Caitlin's husband (a family practice physician) accepted a residency in another city a year later, Caitlin left the acute care hospital and took a position as a staff therapist at the same large rehabilitation center in which Kay and Don worked.

For the next three years, Caitlin stayed at the rehabilitation center where a rotational sequence for therapists afforded her the opportunity to work with a wide array of clients with varying disabilities. In this center, therapists worked on "teams" identified by the primary patient population served by that team. Caitlin rotated through these teams including "stroke team", "spinal cord injury team", "traumatic brain injury team", "pediatric team" with staff rotations occurring about every four months. After approximately two years in this center, Caitlin assumed a clinical specialist position and became a full-time member of the "stroke team" where her responsibilities involved both patient care and the development and implementation of educational programs for stroke patients and their families (including support groups), student physical therapists, and other staff members at the center who were less familiar with the special needs and characteristics of patients who had suffered a stroke. In addition she had some supervisory responsibilities for the other physical therapy staff members on the stroke team.

It was during this time, however, that Caitlin also began to realize her dissatisfaction with certain aspects of rehabilitative care as rendered in this setting. As described in an earlier quote, Caitlin was concerned about the rehab focus being primarily on what the patient could do in the hospital setting (rather in the home and community setting) and about the more or less unilateral imposition

of therapist or facility goals on patients. Instead, Caitlin wanted to work more on community re-entry for clients and address quality of life issues that extended well beyond whether or not the patient could walk with a cane a distance of twenty feet in the hospital. She also started to feel "...fixed within a structure where you could only see a patient for half an hour at a time and were really only seeing your patients once a day at best and delegating all the other [patient care] responsibilities to assistants" (C, 1/27/92, p. 3) because of other supervisory and administrative responsibilities associated with being in a specialist position. This loss of extended contact time with her patients was frustrating to Caitlin, who felt that her commitment to patient and family education as an integral part of quality treatment was stifled by short treatment sessions and a limited number of encounters with the patient on a regular basis. Thus the seeds were planted for a change in her career but one that would not bring her to Kay and Don's clinic for a few more years.

After three years at the rehabilitation center, Caitlin and her husband Dave, who had now completed his residency, felt it was time to reevaluate their options and make some decisions about where they wanted to go from here. Caitlin had a desire to go to graduate school "... to get a lilt more advanced knowledge base" (C, 1/27/92, p. 3) and gain greater understanding in the realms of motor control, motor learning and neurophysiology which were so pertinent to some of the problems she was seeing with her patients with brain injury. She felt that she was just "...at a surface level" in terms of really understanding the mechanisms underlying some of the dysfunctions she was seeing and she "...felt that there was a lot more that could be

offered [to these patients]." In addition, Caitlin had a long term goal of teaching in a physical therapy educational program and she knew that she would need an advanced degree to enable her to obtain a faculty position in a university or college. Subsequently, Caitlin and Dave moved south where Caitlin completed a Master's degree program in physical therapy at a large state university. Her graduate curriculum focused on two primary areas: (a) adult education and (b) neuromuscular physical therapy across the life span which included content in motor control, motor learning, and motor development.

Caitlin felt that her graduate education changed her thinking in several ways and she was particularly influenced by two people whom she considered mentors during her graduate school experience. The first of these was her advisor who was a valued guide in her thesis research efforts. Caitlin described her advisor who is a nationally recognized researcher and educator:

> She was a real dynamic problem-solver and researcher. She really challenged me to look at the clinical process as a research process... to look at patient problems and underlying causes and to not get into treatment and just assume old biases or patterns [regarding treatment regimens]. (C, 1/27/92, p. 6)

The second individual who was influential in Caitlin's professional development was the Director of Medical Education at the University. This individual served as Caitlin's supervisor for her education internship. According to Caitlin, Fred "...had really good insights about how to approach the adult learner and he...opened my eyes to the processes of adult learning" (C, 1/27/92, p. 6). The mentoring of

these two individuals combined with Caitlin's "expanded knowledge base" led to several changes for Caitlin in the way she would approach her work in the future. As she put it,

> I was a lot more into clinical problem solving,... much more into looking at the interrelationship between cognitive and movement dysfunction,... much more into *teaching*,... much more looking into my role as a teacher and an advocate. (C, 1/27/92, p. 4)

She also added that while her interest in and commitment to teaching patients and families about the things that would enable them to understand their problems better and achieve their goals had been heightened, she was also much more interested in being involved in educating physicians and other members of the health care team with whom she worked regarding new theories of motor control and motor learning and alternative approaches for the management of clients with neurological impairments.

At the conclusion of her graduate program, Caitlin had her first child and she and Dave returned to the midwest where he had chosen a family practice group with whom he wished to affiliate. Concurrently, Caitlin was offered a joint position at a local university and at the rehabilitation center where she had worked prior to graduate school. So, as a new mother with a four-month old child, Caitlin assumed a half-time adjunct faculty position and a half-time "research clinical specialist" position at the rehabilitation center. At the center, Caitlin had was given responsibility for developing new clinical research initiatives and for directing ongoing research efforts among the therapy staff at the center in addition to some patient care

responsibilities. Not surprisingly, this became a year that Caitlin described as her "hard-time" year. She said that when she returned to the rehabilitation center she got a "reputation" as someone who was interested in challenging and changing ideas among the professionals at that facility. In some cases this was "...real uncomfortable...because people don't always like the new concepts--they don't like change or challenge" (C, 1/27/92, p. 4). Caitlin found that getting research and educational efforts off the ground at the rehabilitation center was much more difficult than anticipated and she was also surprised at how much work and time went into putting together new courses and syllabi for her university teaching position. These difficulties compounded with efforts at learning to be a mother led, after a year, to her consideration and examination of other practice alternatives that would permit her to continue her career in physical therapy and pursue areas of professional interest but that would also allow her more flexibility and normality in her schedule at home.

Caitlin had become aware of Kay and Don's clinic through an occupational therapist with whom she had worked at the rehab center. This therapist, Janet, now working with Kay and Don, talked with Caitlin about the community re-entry approach and activities at the clinic and the advantages of working with a small and supportive problem solving team. In addition, Caitlin had known Kay when she (Kay) was still at the rehab center and she had enjoyed her professional interactions with Kay during that time. Through discussions with Kay, Caitlin realized that by contracting services to this clinic (becoming a clinic associate) she could be afforded several

things that she had been seeking in her personal and professional life: (a) she could gain the flexibility and control of setting her schedule around her day care arrangements and intermittent teaching responsibilities at the university, (b) she could have more time with patients (50 minute to hour long treatment sessions) to be involved in the educational aspects of treatment programming to which she was so committed, (c) she could participate with a small and experienced team of health professionals who held the same enlarged and extended view of rehabilitation that embraced the patient's life needs as determinants of treatment and that had emerged for her over the past few years, (d) she could continue to be involved in clinical research efforts as she desired based on her own time and inclination, (e) she could have increased autonomy and independence in terms of her own PT evaluation and treatment planning.

This opportunity seemed too good to pass up and in 1987 Caitlin left the rehabilitation center and began working at Jones and Thompson, P. C. on a part-time basis. After a brief hiatus from her academic position (around the time of the birth of her second child) she resumed her part-time teaching for one to two semesters each year at the local university. Throughout the time this study was being completed, Caitlin worked approximately 15-20 hours per week in the clinic. She continued to be involved in professional speaking and inservice education for other therapists and health professionals on a regular basis making presentations for local groups as well as at national and international conferences. Caitlin remains committed to maintaining her involvement in clinical practice,

teaching, and research and in 1993 she was certified as one of fewer than 50 clinical specialists in Neurologic Physical Therapy by the American Board of Physical Therapy Specialties.

Susan's Story

Susan is a speech and language pathologist who came to work in the clinic first on a part-time basis in 1987 and was "recruited" in the same fashion described for many of the other therapists--through word of mouth in response to a particular client need and staff recommendation. At that time, a patient with challenging swallowing problems due to neurological impairment was receiving services at the clinic. The other speech and language pathologist at the clinic, Barb, had not had a lot of experience working with such problems and suggested to Kay that they might want to see if Susan could work with this particular client since she had a wealth of experience with such problems. As Susan put it,

> There was kind of a challenging case, and Barb didn't feel comfortable, and so, Kay and I met and I took that case...and then, kind of, the rest is history.... I started to take more and more as the need arose. (S, 7/28/94, p. 2)

Today, as is the case for many other clinic associates, Susan works part-time at this clinic and part-time for another rehabilitation group in the area that serves home-based clients in addition to caring for her infant daughter.

Susan's journey to the clinic mimics that of several other therapists, including Caitlin, insofar as she first worked in a large university hospital and then a large rehabilitation center. She, like

the others, ultimately became disenchanted with the "politics" and transience of staff in those institutions and emigrated to a smaller clinical practice. Susan graduated from the same midwestern university as Caitlin with a major in psychology and speech and hearing sciences. During her senior year she completed a clinical experience in a special clinic for the treatment of patients with aphasia which sparked her interest in pursuing graduate work in speech and language pathology. Susan received a scholarship and completed the requisite two years of graduate work and a clinical externship in a Physical Medicine and Rehabilitation Department of the university hospital. Once certified as a speech and language pathologist, Susan stayed at the university hospital for a fellowship year. She recalled her graduate and fellowship experiences as a time of learning and excitement:

> That's where I really got introduced to TBI [traumatic brain injury] and encephalopathy and I saw a lot of really different things... and because I was the new kid on the block, they threw me into everything and it was a really good training ground. It was awesome. I just loved it. (S, 7/28/94, p.2)

After three years at the university hospital, however, she left to follow up on a "really neat opportunity" at the same rehabilitation center where Kay, Don, and Caitlin had worked. Ultimately, Susan worked at the center for six years before leaving to work part-time with the smaller rehabilitation groups with whom she now works.

While at the rehabilitation center, Susan became the Brain Injury Specialist and in that role she supervised graduate students, clinical fellows, and all staff members who worked with patients with

head injury and brain damage. It was during her time at the center that Susan first began to see a few clients for Kay and Don at their request. Susan said her move to leave the rehabilitation center was precipitated and hastened by administrative dictums and practices at the institution that resulted in the loss of many "seasoned therapists" and staff in her department:

> Things were getting really politically messy...We lost nine out of ten [speech] therapists within a six-month period of time. And they kept hiring new grads and I just didn't like the philosophy of not trying to maintain some seasoned therapists... so I wasn't happy with that. So I decided...I loved working here.... (S. 7/28/94, p. 3)

Thus, Susan found a haven at Jones and Thompson and with the other small rehabilitation providers with whom she works. She is able to have some control over the number of hours that she works as she juggles professional and personal/family responsibilities; she is able to continue her work with clients with brain or head injury; and she is able to work with a small cadre of dedicated and experienced therapists who share her enthusiasm for learning and focusing rehabilitation efforts on the needs of patients in their everyday lives outside of health care institutions.

Client Stories

John and Diane

John is a client who was followed by Caitlin intermittently throughout the course of my study. John's wife, Diane, was also

seeing Kay during this time for counseling services related to John's impairments and the influence of those on their lives. I tell the story of John and Diane together since this is how they came to me; that is, I learned of John's story and his life with Diane largely during an interview with the two of them. Not only are their stories of interest but the way that they interacted around and through the telling of these stories is illuminating and is, perhaps, something that describes their past and current relationship as much as their stories do.

During the interview I asked John to tell me a bit about his life over the past ten years or so. John paused and then started this conversation by lyrically (half singing) reciting a poem that I couldn't make out on the audiotape in it's entirety because of his slightly slurred and sometimes halting speech. It went something like, "I was a poet, I was a picker, I was a...." (J/D, 4/1/92, p. 4). Diane, who often picked up the conversation for John as he labored to find words to express his thoughts, interrupted at this point and told me about John's past life. She said that when she met John, approximately seven years ago when he was 29, he was working as a self-employed sign maker. Before that he was in the Air Force after high school and he also did some "wandering around the country" with some friends. Then he got involved in some bands and, according to Diane, "...he was a very good singer" (J/D, 4/1/92, p. 4) At this point in the conversation John started singing "Scaramouche" as Diane continued to talk. She said that during his wandering years he had a marriage that didn't work. In 1978 John left the Air Force and then had a motorcycle accident around that time which did not leave him with any focal neurologic deficits according to the physicians who

evaluated him. In 1983, however, while in Colorado with his friends from the band that he had been playing with, he had two seizures. When the seizures were investigated by medical personnel they discovered the presence of an Astrocytoma in the fronto-temporal lobe of his brain.

An astrocytoma is a malignant brain tumor which required surgical resection of the tumor and a course of maximum dose radiation therapy in follow-up. Since John did not have any health insurance at the time, he returned to his home town in Michigan where a neurosurgeon who knew the family donated his services for the first surgery. Concurrently, John's friends in Colorado did a benefit concert for him to raise money to offset some of the other medical expenses that would be incurred as a result of John's illness.

Diane said that John came through this first surgery well and was playing basketball a few days after he got out of the hospital. John added emphasis to this remark - "... a couple of hours--hours--after the surgery I was out playing basketball." Diane corrected his remark--"...after he was out of the hospital..."-- and went on to talk about some of John's disabilities after the first craniotomy (J/D, 4/1/92, p. 4). John did not have any major motor problems after this surgery but, according to Diane, he was "...never a very good organizer..." thereafter:

> I can't say he was chaotic, but there were just a lot of loose ends... had head injury been a bigger field then, he might have gotten some organizational help. Because if you look at his life from '83 on--it was very chaotic. He's disagreeing with me.... (J/D, 4/1/92, p. 4)

John was mumbling something that I couldn't make out and shaking his head. Diane, looking directly at John now, attempted to clarify what she meant for both John and me: "He was just never succeeding. He was never getting established in specific jobs" (J/D, 4/1/92, p. 4).

With this, John began to sing animatedly again, snapping his fingers--"I was the kind of guy who could never settle down...". Diane quickly added "...but see, once we met, I mean, he loved being settled down. He absolutely loved it." John smiled and agreed: "Yeah, I'm lucky. It was a nice change of pace--and it was nice to be with somebody that respected me and cared for what I was doing" (J/D, 4/1/92, p. 4).

Although Diane had, at this point, shared much of John's past history with me, she first met John *after* his initial diagnosis with a brain tumor and his first surgery. She talked about how she came to find out about John's medical history when they were getting to know each other. They were "swapping stories" about their lives and their jobs. When John found out that Diane worked at a community re-entry rehabilitation facility (part of a large rehabilitation network) for physically handicapped individuals, he then shared his "secret" with her. As she contemplated this secret, their growing love for each other, and their decision to get married she was scared. Through her work as a living skills assistant at the rehabilitation facility she had seen many individuals with head injuries and brain tumors and had encountered, first hand, the type of physical disability and loss of function that can arise from such problems, not to mention the cognitive change and emotional anguish that many of

the clients at the facility endured. And Diane knew that recurrence of John's tumor was a distinct possibility. As she put it,

> It was kind of frightening. But we kind of went into it and in the back of my mind I knew *it* was a possibility. But it was also one of those things where you were just kind of hooked (laughing softly)... you had to do what you had to do. So, I'm not the worrying type and we just decided we would deal with *it* if, and when, it came into our lives. (D. 4/1/92, p. 2)

In January of 1991, *it* did. John and Diane described the recurrence of John's tumor eight years after the original tumor was resected and about two years after John and Diane were married.

Toward the end of the 1980's John had returned to school and had obtained an associates degree in video production. Subsequently he began working as a videographer producing educational videotapes for various companies. But in late 1990, John was "laid off" and, according to Diane, his subsequent job search was "really haphazard." Concurrently, Diane noticed that John's driving was worsening but every time she mentioned something to John about his driving she was accused of "bitching." There were increasing numbers of incidents like this over the next few months and Diane said the "tension was building" between them to the point where they were "losing perspective...." Diane added that John also started to get "...clumsier--he was bumping into walls a lot" (J/D, 4/1/92, p. 3).

Not long after these changes were noted, John was in a minor car accident. He was waiting to turn left at an intersection. A car opposite him proceeded through a green light and when John turned

left he clipped the tail end of the car. Although there were no injuries as a result of the accident, John's car had to go into the "shop" for repairs. One week later, when John was driving a rental car (because their car was still in the shop), John had another accident. He was coming up over a rise and two cars were stopped as they prepared to make left turns. John rear-ended these cars and in the process hit his head on the windshield. For Diane, this was "...just too much--too close" (J/D, 4/1/92, p. 3).

John underwent a CAT scan (computerized tomography of the brain) to look for any potential damage from the accident. According to Diane, when the doctor's office called back with the results they had

> ...both good news and bad news. No further frontal damage from hitting his head--but--there was some severe swelling and an increased mass in the brain... was, kind of, how they put it. And they said come in after 5:00 tomorrow (chuckling knowingly) --it's like, okay, nobody goes to the doctor's office after 5:00. So that was, kind of, a sure sign. (J/D, 4/1/92, p. 3)

They recalled the day they "got the news"--May 1, 1991--almost one year before this interview. Diane said that at that time

> "...we were given a quote of 4-6 months [for John to live] without surgery and a year or two with surgery... so, we, like anybody else, chose to extend life" (J/D, 4/1/92, p. 3).

During one of his therapy sessions with Caitlin, John talked with her about the neurosurgeon's "prescription" for John when the tumor recurrence was detected. According to John, the physician had said

> 'Get out and enjoy life--do something you've always wanted to do....uh, take everyday one at a time....get out and do something you want to do.' So, within a day, I was sitting in Las Vegas dropping quarters into the slot machines. (C/J, 4/8/92, p. 2)

Caitlin responded with a smile: "You took that literally." And John replied, "Oh, I took him *very* literally...within half a day...." and he proceeded with an expanded description of his trip to Las Vegas which concluded with the following advice directed toward Caitlin: "Don't waste time if your doctor says get out there...(slurred and trailing off)" (C/J, 4/8/92, p. 2).

John had another craniotomy with tumor resection in June of that year and then underwent a course of chemotherapy for a few months. Because of the side effects of the chemotherapy, however, both John and Diane elected to discontinue this unpleasant therapy before the full course was completed. Following the second surgery, John was left with some physical, functional, and cognitive deficits but he was not being actively seen by any rehabilitation specialists. Diane, however, had begun counseling with Kay to help her deal with issues that surrounded John's emerging disability and poor prognosis. As Diane shared reports with Kay about John's declining function and concerns about his safety in activities of daily living (ADL), Kay encouraged Diane to ask John's primary physician for a referral for a physical therapy evaluation. Not long afterwards, in late July 1991, John was first seen by Caitlin and from this point on their stories merge.

At the time of John's initial evaluation, Caitlin found that John showed moderate weakness and loss of coordination in his left arm and leg with notable neglect of his left side, accentuated by a left visual field deficit. He had some slight balance deficits in standing and an abnormal gait (walking) pattern that grew increasingly unstable as he walked any distance and became fatigued. Caitlin noted some cognitive deficits as well that were subsequently evaluated further and confirmed by Don following a full neuropsychological screening in August and September 1991. In brief, John showed some distractibility and impulsivity and demonstrated a limited awareness of his deficits with poor self-report of his functional abilities and disabilities. The written summary of findings by the neuropsychologist suggest the severity of John's perceptual and cognitive deficits which were superimposed over his physical deficits at that time:

> The results of testing showed him to be profoundly impaired in all tests emphasizing pattern analysis, sequencing, concentration and visual memory. Language functions were less impaired...[but] the tests used did not require the patient to engage in extended logical thinking or to analyze complex language patterns. In my opinion, the patient can be expected to have difficulty making sound judgments regarding safety hazards. He will also continue to have problems correctly assessing non-verbal and subtle emotional aspects of interpersonal exchanges. The deficits seen appear to make any consistent, timely, and accurate problem solving impossible. (D, Clinic Report, 9/30/91, p. 4)

Don added that these deficits suggested that John's return to his previous vocational activities would be close to impossible and that "competitive employment in any field" would be unlikely. He also

stated that the prognosis for cognitive retraining was not good (although they would institute a trial of this therapy) because of the "profound nature of [John's] deficits and an apparent organic inability to fully comprehend their significance" (D, Clinic Report, 9/30/91, p. 4).

The pervasiveness of these changes, in particular John's difficulties in problem solving, follow-through, and recognition and acceptance of his disabilities, become apparent as we follow John's course of therapy with Caitlin. Caitlin described her early encounters and work with John during his therapy:

> At first, I think he was a bit reluctant to have any intervention...and then, um, once he came in he thought this was great.... I think it was a real good social outlet for him as well as he realized that he could get around better than he thought. The difficult part in the first couple of weeks with him was identifying his deficits--because he really doesn't see his deficits and minimizes what he does have. (C, 3/30/92, p. 2)

Caitlin went on to explain, however, that John did really well during his first month or so of therapy and they both enjoyed their work together--"...the first month was very positive and we saw some nice gains." During this time although Caitlin's (and Diane's) concerns were largely about John's safety in walking, John was most concerned about the loss of some of his fine motor function in his hand and left arm. So at the outset, Caitlin was faced with the need for balancing the patient's needs and goals with those of the therapist (and, in this case, the wife)--the need to bring these things together in a maximally therapeutic regimen. Caitlin and John's work to negotiate the nature of his therapy in the clinic and home will be described in detail shortly.

Caitlin went on to explain that after an initial month of gains for John in physical therapy, he began to show a gradual decline in function.

> During that second month...he started to gradually go downhill... and he has a real hard time dealing with the reality of the tumor growing and as he started to lose function it was really tough to work with him because he was really angry. (C. 3/30/92, p. 2)

Caitlin said that during this time occasionally John would try to hit or grab her arm. Such combativeness is not uncommon in patients with certain types of head injury or brain injury. John would also be abusive to his own arm which he would throw around in disgust when *it* wouldn't do something he wanted to do. It was during this difficult period that Caitlin appreciated the relationship that they had developed during the first month of therapy: "I'm so glad that I had that first month with him because I think that he trusted me and trusted my judgment" (C, 3/30/92, p. 2). She sincerely felt John's frustrations during this difficult time and was able to talk to him about them during therapy sessions: "...[he] kept waiting for a resurgence--he thought he was in PT to get better--and I wished he had been too, but unfortunately the tumor was growing" (C, 3/30/92, p. 2).

After this early period of decline, John's function seemed to level off during the late Fall of 1991. Caitlin explained that once John had seemed to stabilize and was functional, independent, and safe in his ambulation and activities of daily living, she knew that she needed to discharge John from regular therapy services in early December.

> Once he reached that point, it was a hard decision to say -- 'John, I really don't think you're going to benefit from therapy anymore--and I'd like to follow you up if any problems come up and see you once every four to six weeks.' (C, 3/30/92, p. 3)

After discharge, however, Caitlin explained that John would still call her at the office at least once per week "... just to (laughing) socially check in and bring up new problems and ask for different things at home." This checking in does not seem unusual considering the open and trusting relationship that had been developed between John and Caitlin. Caitlin had become his health professional consultant and conversant and she, alone, appeared to be the one person with whom he felt able to talk honestly about some of his problems and to ask for help. In response to his calls, she asked Nina, an occupational therapist, to join the "team" and visit John's home to assess his needs and provide adaptive equipment that would aid him in completing his normal daily tasks.

Caitlin did not see John again until February of 1992 after a period of regression during which John had a number of serious falls, one of which (in late January) resulted in severe contusions to his left rib cage and arm with persistent pain that began to limit his activities at home. Both John and Diane discussed this incident with Caitlin who recommended that John first see a physician to ensure that there were no fractures or other serious injuries sustained in the fall. There were none. But when the shoulder and arm pain and limitation of movement continued, Caitlin became very concerned about this and felt that it would be important to reinstitute therapy. She explained to

me, with some distress, how she had to work to convince John's primary physician to reinstate therapy on a short term basis:

> It [the arm pain and limitation] was affecting everything he did; it was affecting his sleep, it was affecting his ADL's, and I really had to do a sell job to his primary physician. I told him I just wanted to get him out of the pain-zone and teach him how to manage his shoulder on his own again--just for a short time--he literally said to me... 'Well, you know he's terminal.' I said, *I know that*, but we're talking about quality of life here and he said 'Well, why don't you just sling the arm--I mean, if it causes him pain, why don't we just sling it.' And, aaaah (with frustration), I was furious, you know, and I said there is no reason to do that and if you work it totally to the point of a frozen shoulder, not only could he go into a reflex sympathetic dystrophy *[both are debilitating problems]* but, you know, it's going to affect everything he does, it's gonna be painful all the time, and there's no reason that he should have to lose all that range [of motion] and function. I said--I'm not talking about long-term intervention--I'm just talking about four to six weeks of him getting serious about management and seeing the results and being able to do this on his own. (C, 3/30/92, p. 3)

This extended quotation speaks to the strength of the patient-therapist relationship that had developed between Caitlin and John in a relatively brief period and also demonstrates the commitment to client advocacy that Caitlin and other staff in this clinic have adopted.

This historical vignette brings us to the time when John, Diane, and Caitlin's stories began to co-mingle with my own. I first observed and videotaped therapy sessions in early March, 1992 after Caitlin had resumed therapy with John to try and help him to overcome his current problems with pain, increasing spasticity, and loss of function of his left shoulder, arm and hand. At that time Caitlin

was seeing John twice weekly and I was able to attend one hour-long therapy session per week for five weeks until John was discharged from this particular course of therapy. It was during these videotaped sessions that I was able to document and more intimately explore the nature of interaction between John and Caitlin as they co-constructed what therapy was in the context of the commitment to client-centering articulated by Caitlin and other clinic associates.

Interlude

The first phase of my study was conducted in 1992 with data analysis continuing through 1993. In 1994, I began a second phase of the study. The second phase was directed at following two additional clients with brain injury who were working with Caitlin. This allowed me to investigate the nature of interaction between Caitlin and her clients with more than one client. Furthermore, additional data collection and analysis provided an opportunity to examine emergent assertions from the first study in the context of other client experiences at Jones and Thompson.

By the time I resumed data collection in March 1994, Jones and Thompson, P. C. had moved from their former clinic site to a location across the street. This move occurred in late 1992 and according to the staff was a welcome change since the new clinic site provided several desirable features: (a) easier access for clients as they moved to and from therapist offices, (b) clinic offices which were more closely nested so that therapist-therapist communication was enhanced, (c) the addition of a team conference room, (d) a PT-OT area that was within the main clinic suite and that included a private, "quiet" treatment booth, and (e) the opportunity to determine certain

aspects of the clinic decor which they felt would be helpful to clients (e.g., less "busy" wallpaper, and changes in carpeting to ease mobility for clients who needed assistive devices and wheelchairs to ambulate). The layout of the clinic suite and the PT-OT area in this new clinic site is shown in Figure 6 and Figure 7.

The building in which the clinic was located was a relatively small, cedar sided professional office building nestled in a wooded ravine. Several therapists remarked on how they felt the new location was more calming and soothing for both them and their clients. Most of the clinic offices had expansive windows that looked out into wooded areas and provided soft, natural light throughout the day.

Of interest to me was that, in spite of the change of venue, the patterns of interaction in the waiting room, reception areas, clinic hallways, and offices remained remarkably similar. The main change I noticed was that Caitlin and her clients no longer had to travel down a corridor to a separate clinic suite for their therapy sessions. The similarities in these patterns of interaction in a different clinic setting and across a span of two years time suggested that my observations from the first phase of the study did, in fact, reflect cultural norms for action for this group of clinicians.

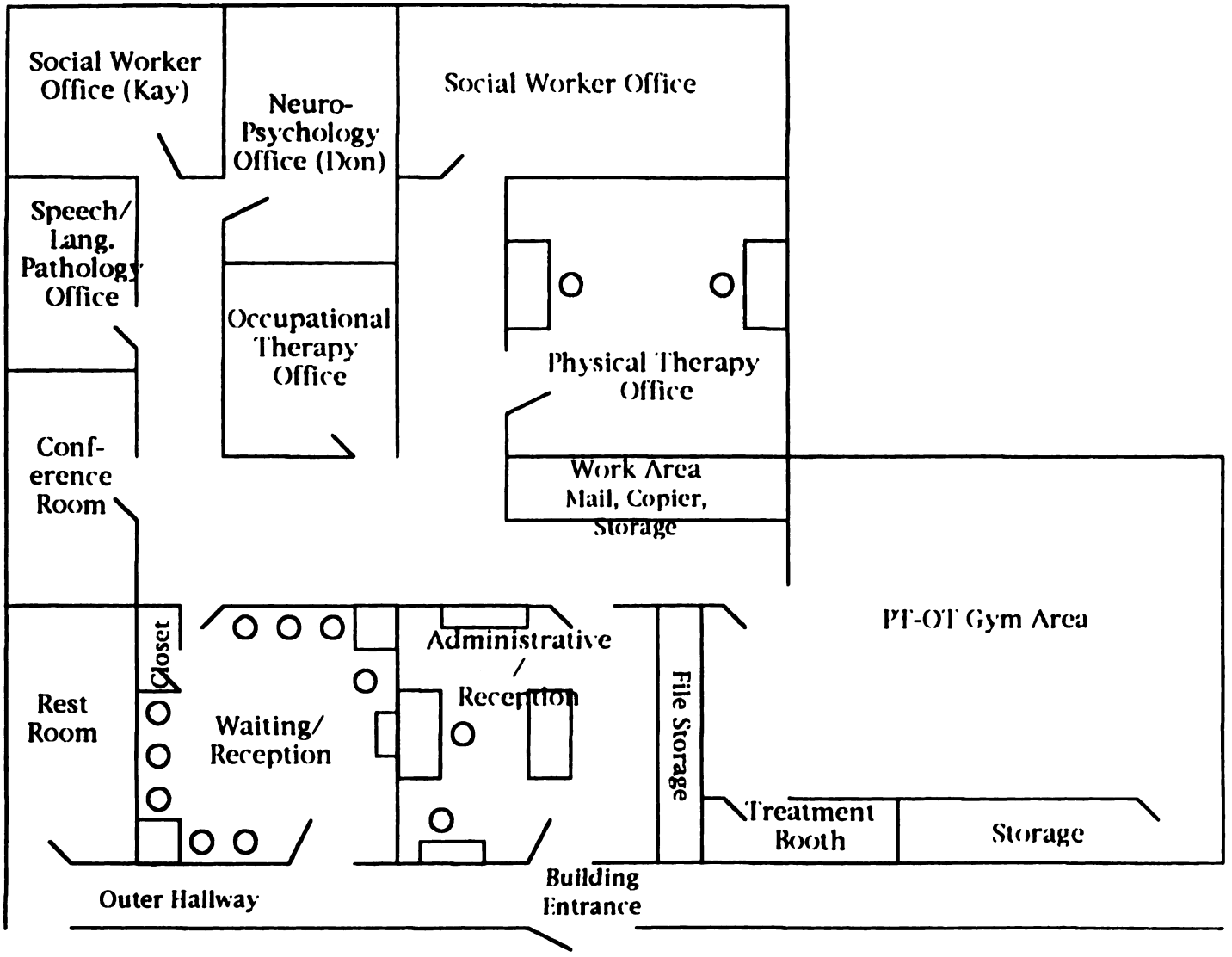

Figure 6. Layout of Clinic Suite, Second Clinic Site. (Not to scale.)

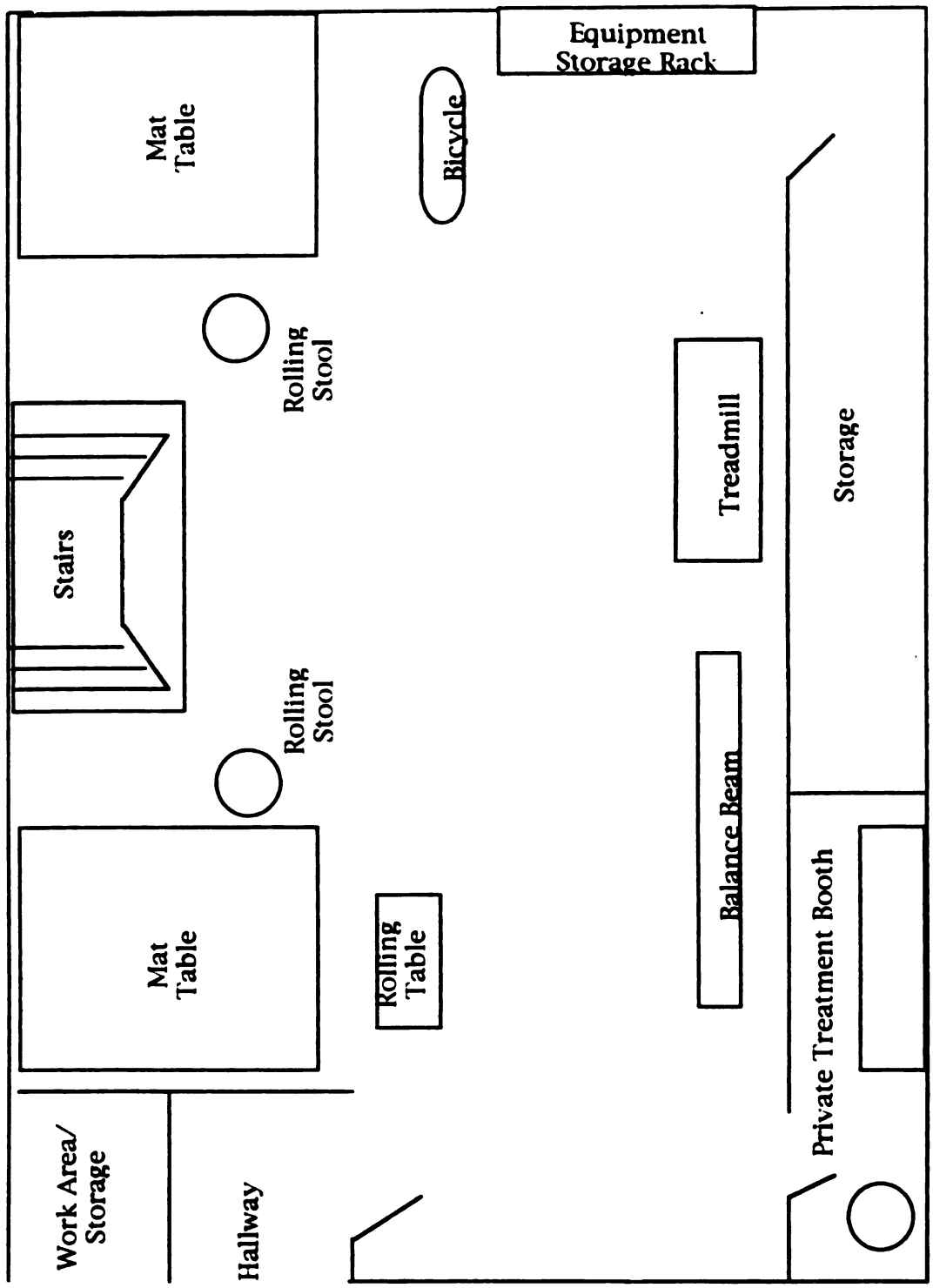

Figure 7. Physical Therapy-Occupational Therapy Treatment Area. Second Clinic Site. (Not to scale.)

Data collection for the second phase of the study extended for six months between March 1994 and September 1994. It was during this time that I met Marcia and Bill and it is to their stories that I now turn.

Marcia

I first met Marcia in May 1994 when she began a course of physical therapy with Caitlin because of residual balance and functional problems resulting from a head injury almost eleven months earlier. Marcia's quick wit and upbeat demeanor belied her 73 years and the substantial medical and physical difficulties she had encountered in the past year.

A mother of three grown children and proud grandmother to several grandchildren, Marcia was, in her own words, a "retiring" owner of a direct sales cosmetics business at the time of her accident. Both Marcia and her husband, a retired postal worker, had found that they both preferred "semi-retirement" to full retirement after more than 30 years of working and they continued to keep active in the community through some paid work and other church-related or service commitments. For Marcia, this meant continuing to dabble in sales at the request of long-time clients and friends. In addition, she serves on the Board of Directors for some community agencies and is a telephone volunteer for a local crisis line. For Jack, Marcia's husband, semi-retirement meant working as a cashier at a nearby conference hotel and enjoying travel during the winter to their condominium in Texas. Both Jack and Marcia were avid golfers.

Marcia recounted some of the events around the accident in June 1993 that resulted in her head injury and loss of consciousness, a

fracture of her left femur, and some jaw and neck dysfunction. In doing so, she warned me that she could not recall much about the accident specifically and said that her memory since the accident had been affected: "Well, I can tell you about it because someone told me, but, see, I didn't know what happened" (M, 6/30/94, p. 3). It was just another Saturday and Marcia and Jack were out doing "little errands" when they were hit head on by another car traveling at about 45 miles per hour as it swerved to miss a car sitting in a center turning lane of a busy thoroughfare. Both she and her husband were injured in the accident and were transported to a local hospital. Her husband sustained multiple contusions and a severe facial laceration that required "...something like 170 stitches or something" (M, 6/30/94, p. 3). He later required surgery for a vision problem related to the injury.

Marcia was unconscious for three days following the accident:

> I was just *out* for three days. I did not know what went on. People told me they came to see me and I didn't answer and...then the doctor said to me afterwards, 'Well, you know you had a concussion and you basically were unconscious for about three days'. (M, 6/30/94, p. 3)

In addition to her loss of consciousness, and associated retrograde and anterograde memory loss, Marcia also sustained a laceration of her left knee and a serious fracture of the left femur. Marcia's capacity for slightly satiric and witty repartee and her penchant for use of reported speech in her storytelling become apparent in her description of her fracture and how it was managed medically.

> Well, Dr. Davis showed me the x-rays... you know how they always show you x-rays and you haven't the slightest idea what you're seeing? (chuckling) He said 'you see here' (pointing) and I said 'yeah, I see a picture up there and it doesn't mean a thing to me.' And he said basically my femur bone wasn't fractured--it was shattered. That it sort of blew apart... more like pieces rather then a single break. So they put a rod from my knee to my hip and then watched as that was filling in with... he said 'see how wonderful that's filling in?' (smiling at me and looking puzzled) I said, 'yeah, I guess so'. (M, 6/30/94, p. 4)

Marcia reported that she stayed in an acute care hospital "where they did the surgery" for about 10 days after the accident. Following that she was transferred to another hospital for "a couple of weeks" where she was admitted to an inpatient rehabilitation unit while she learned to get around with the aid of a walker. After discharge from the hospital, Marcia continued physical therapy on an outpatient basis for a few months. In her outpatient therapy, the focus at that time was on improving the range of motion and strength in Marcia's left leg with a goal of learning to walk with the use of a cane instead of a walker.

So Marcia was no stranger to physical therapy and I was interested in how she came to be referred to this particular clinic for additional evaluation and therapy. My question to Marcia about this generated a lengthy, but revealing, story about the persistence and interference of subtle neurological, sensory-perceptual, and cognitive changes in people's lives following head injury and concussion. The chain of Marcia's referral to the clinic began with her internist who, at a follow-up appointment after the accident, was inquiring about her remaining symptoms. As Marcia put it,

> ...he said 'what is really bothering you?' and I said 'Well, the fact that I don't remember anything is really bothering me'. I said that's bothering me more than the fact I can't walk. I don't like being an idiot. And I said, it's not just that I can't remember things that happened at the time of the accident.... I said I just feel like I'm losing it. When I'm talking with someone all of a sudden I don't know what I'm talking about. Or I'll start something and think 'what the heck was I talking about again?' I said it's just really awful... and I have warned people who know me (chuckling)... that I am going crazy so if I do any of this stuff, you know, they can just ignore it. So I said, I *would* like to know, you know, how much of a head injury I had. And he said, 'well, you had a concussion. When your brain gets shaken around in your head you don't really know where it gets hurt.' (M, 6/30/94, p.5)

On several occasions in this transcript and others, Marcia describes herself as an "idiot", "crazy", or "losing it" when she tries to explain some of the memory, language processing, and cognitive alterations she is experiencing. These aren't uncommon descriptions used by individuals with post-concussion syndrome following head injury. Nor are they unwarranted perceptions or feelings since many patients like Marcia are told they're "just fine" or "doing well" when they are acutely aware that they are not functioning at all like they used to or want to. The end result of Marcia's conversation was a referral to a neurologist for further evaluation although Marcia, in her typically ebullient but skeptical way, was not convinced at first that such evaluation would be helpful. In response to her internist's suggestion that she see a neurologist, Marcia quipped,

> Okay, so they could tell my *why I'm crazy?* And what are they gonna *do* about it? He said 'probably nothing.' And I said, thanks a lot, never mind, I won't go to the neurologist.

(M, 6/30/94, p. 6)

Later Marcia changed her mind, however, in the face of persistent and increasing problems as she became more active and mobile.

> Well, then, as I continued having... getting up and around on my feet more... it bothered me that I was so terribly dizzy and that I still kept having these horrible things with my brain. I don't know what the heck it was....(M, 6/30/94, p. 6)

Marcia went to see the neurologist who confirmed her diagnosis of post-concussion syndrome which loosely defines a cluster of signs and symptoms of varying intensity often seen in patients after moderate or mild head injury. Dr. Stevens, the neurologist, recommended that Marcia see the head injury team at Kay and Don's clinic. In response to this recommendation Marcia probed, once more, about whether the activities at the clinic would be directed at primarily diagnosis or at actually improving her situation and functional status:

> I said, okay, so what are they gonna do? Other than maybe telling me why I'm so dizzy or why I can't think straight? What can they really do about it? And he [Dr. Stevens] said they have a number of therapists there and they're very good and he said 'I really feel that'... he said, 'you know, you can always quit, but I think you'll really find that they get at the root of your problem and help you.' And I said okay, so I came here. (M, 6/30/95, p. 7)

Marcia was first seen at the clinic in May of 1994 for a series of what the clinicians at the clinic call "screens." These screening

interviews and examinations are designed to help the clinicians, along with the patient, determine the specific nature of the patient's concerns and problems and permit them to design a preliminary treatment plan to address those concerns. Based on referral information from the neurologist, Marcia was scheduled to be seen by four clinicians as part of the screening process: Kay, who conducts most "intake interviews" for patients with head injury, Don, the neuropsychologist, Susan, a speech and language pathologist, and Caitlin, the physical therapist with whom I was working.

Initial screening interviews and evaluations revealed several areas of reduced function for Marcia compatible with diffuse cortical impairment associated with post-concussion syndrome. The neuropsychological screen indicated that Marcia had some disturbances of auditory attention and memory which produced problems in encoding and retrieving auditory information. Functionally, this translated into word finding and word substitution problems. In addition she showed some impairment in non-language related functions such as pattern recognition, pattern matching, and sequential reasoning that could account for some of Marcia's reported difficulty in organization and making decisions. (D, Clinic Report, 5/5/94) Marcia's premorbid history did not suggest that these were substantial problems for her prior to the accident. Based on these findings, the neuropsychologist suggested that Marcia might benefit from some cognitive retraining and rehabilitation which is typically carried out by the speech and language pathologist.

When Susan, the speech and language pathologist, first saw Marcia a few days after the neuropsychology screen, her findings

concurred with those of Don. In the course of the interview, however, Susan found that Marcia had already begun to "retrain" herself. Marcia had developed a calendar planning system and was using some pencil and paper strategies to help compensate for her memory problems and increase her organizational control. She was also working as a volunteer on a telephone crisis line which required the kind of cognitive work that Susan suggested as a treatment option for Marcia: "Involvement in a challenging language based activity to learn how to compensate for higher level word finding deficits" (S, Clinic Report, 5/9/94). As a result of the initial screen, both Marcia and Susan determined that ongoing regular speech therapy sessions did not seem indicated nor was Marcia particularly interested in them. They agreed to get together for another session, however, to review what the therapist called "encoding and retrieval strategies" that might help Marcia with her memory and organization.

Kay, the social worker, had detected Marcia's "pragmatic" and results oriented personal style (so evident in earlier quotes from Marcia) at the time of her intake interview. She wrote in her initial report that

> Marcia is a very pragmatic woman. If the team has specific interventions that offer a possibility of reducing her symptoms or allowing her to compensate better [for her deficits] she will be interested in pursuing treatment. (K, Clinic Report, 5/2/94)

All team members, including Marcia herself, agreed with this depiction. For this reason, the team determined that Caitlin, the

physical therapist, would provide most of the regular rehabilitation services for Marcia since that was the area of greatest need as far as Marcia was concerned. This meant that Caitlin would need to indirectly address through her therapy with Marcia some of the cognitive retraining concerns of the neuropsychologist and speech and language pathologist as well as some of the educational needs regarding the effects of head injury which the social worker had identified.

Caitlin's screening examination revealed that Marcia was having a variety of problems in functional movement related tasks including dynamic standing balance, walking (with a cane), climbing stairs, bending over when dressing or working in the house, and trying to resume golfing activities. She reported problems with fatigue, dizziness, balance, and residual pain in her left hip when she was active. Caitlin determined that Marcia's problems with dizziness, dysequilibrium, dynamic balance and walking were the result of "multisystem impairments" which included vestibular dysfunction[4], residual weakness and decreased endurance of the left leg and hip muscles, delayed or abnormal postural control strategies in standing and walking, and limitation in head and neck range of motion (C, M Clinic Report, 5/17/94). This collection of impairments along with Marcia's reliance on vision to maintain her orientation and space and balance put her at risk for falls especially in low light situations or whenever she had to walk on non-level surfaces (e.g., the golf course). Marcia was interested in improving her function in these problem areas and Caitlin concluded that Marcia could benefit from physical therapy. As she wrote in her screening report:

> Patient appears to be highly motivated and energetic to work on maximizing her recovery and functional independence. She is a good candidate for further physical therapy intervention. (C, Clinic Report, 5/17/94)

So Marcia started a short course of twice weekly physical therapy with Caitlin that lasted until she was discharged in early July when her goals had been largely realized.

Bill's Story

Bill is a 62 year old pharmacist with a friendly but straight-forward demeanor. He was referred to the clinic by his neurologist because of some persistent complaints of headaches and dizziness following a mild head injury some six months earlier. On the day that I formally interviewed Bill, he settled into a comfortable leather recliner in one of the social worker's offices, his gray hair and blue eyes sparkling in the afternoon sun shining through the office window.

Bill was obviously committed to his work as a pharmacist and was most concerned that his current symptoms were making it difficult to perform up to his own expectations at work. He felt like he was not as efficient at work as he was before the accident and he was unable to complete a full day of work without becoming fatigued developing a headache. He felt his symptoms were limiting his ability to best serve the needs of his customers. Given his long history as a pharmacist, Bill was understandably disturbed by these developments and was concerned that he might have to retire earlier than anticipated or hoped.

Bill shared some of his work history with me and talked about how his work was, in some ways, a family affair. Bill has been a pharmacist for approximately 40 years. He owned his own small drug store where he was the pharmacist for almost 30 years. He had four children who, according to Bill,

> literally grew up in the drug store. And they all worked the counter. We had an inner city store, so as a result they knew how to handle anybody. And I insisted on that. It's a life experience you can't buy. (B, 7/5/94, p. 1)

Bill talked proudly about his four grown children, whose occupations spanned from doctor to computer design engineer, and his grandchildren. He talked about the warm relationship he has had with his wife during their long marriage although he hinted that there was some tension after his head injury due to some of the changes he has experienced. Many of Bill's hobbies involve activity with the family such as golfing, bowling, fishing and relaxing at their cottage "up north." Bill's description of these activities are indicative of his characteristic style of speech which is clipped and direct and also of the performance demands he places on himself in both work and play.

> I play golf, not good at it, but you know, I'm not bad. I'm a 190 bowler, so--not bad... I did fairly well there, up until I got injured. (B, 7/5/94, p. 2)

Indeed, many things had changed for Bill since his accident. At the time Bill began to seek assistance for his problems at the clinic, he had returned to work after a medical leave of

absence. As a rule he was trying to work roughly 40 hours a week in a pattern of four days on, three days off. He said that at minimum he worked nine hour days and that sometimes his workday extended for twelve to thirteen hours which he found extremely fatiguing and difficult at this point. Bill's grueling schedule was not of his own making. With more than a hint of regret, Bill explained that shortly after he turned 50, his store was purchased by a large drug store chain. This change in ownership led to alterations in both the number of hours and days he worked as well changes in when Bill took time off from work.

I asked Bill to tell me about his accident which occurred in early October 1993. He said it happened on a Sunday which he described as "an easy day at the store." It was about an hour before closing time and Bill began to prepare for "closing up."

> I had everybody waited on. Everything was going along real well. I went in the back room to wash up. Came out of the back room door. Now this is the back room of a chain store and there were boxes piled at least seven foot high in the area I had to go through, and it was about a three foot, maybe four foot aisle cleared so you could get back...Next to the door was a ladder. I remember seeing the ladder... they had the ladder facing the wrong way. But that didn't worry me, it was just sittin' there, so why worry about it. As I came out [of the back room], a box or something or a hose got in the way of closing the door. So I held the hose back and slammed the door to get it closed. And I turned around and took three or four steps and I heard something. I have no idea what it was. I started to turn and I think I saw the ladder. I don't remember. I don't remember getting hit. I don't remember anything. I thought I just got up right away. But from what they tell me.... (B, 7/5/94, p. 3)

The employees who found Bill told him that he had been hit by the ladder and two large boxes, one of which was a case of motor oil. Bill said that after he "came to" he realized that his glasses were broken, his head was hurting and bleeding, and that he was having trouble seeing. He didn't recall how he got back to the front counter of the pharmacy but he remembered trying (with limited success) to return to some of the tasks he needed to do before closing up for the day.

Bill decided to call his wife to come and drive him home because he "felt real lightheaded". He asked the store manager to close up for him and he went to sit and rest in his car where he would be away from the flow and demands of customers.

> The next thing I remember, my wife was driving my car, I think I talked to her, I wasn't sure. And the next thing I remember, I was inside the hospital, which I didn't want to go to. I remember that. I'm sure I told her I didn't want to go to the hospital. But she took me to the ER room, and, uh, that's where they checked me out. (B, 7/5/95, p. 3)

At the hospital, Bill underwent a series of tests including an examination by a neurologist and computerized axial tomography (CAT scan) of his skull and brain which didn't show anything abnormal at that time. Even so, Bill had several signs and symptoms of some neurologic insult to the brain; by his own report, he was lethargic, he had absent or impaired sensation in his left arm and leg and weakness in his left extremities. In spite of these symptoms, Bill negotiated a "deal" with the hospital staff to go home for the evening rather than being admitted to the hospital.

> I talked them out of that. I, I, I started getting my senses back then. And I've worked in hospitals and they're okay, but they're for sick people... He [the physician] made an agreement with my wife that if I went home that she'd wake me up every hour to make sure that I was still--knew what I was doing.... (B, 7/5/95, p. 4)

Many of the passages I have used to let Bill tell his story are notable because they typify Bill; fiercely independent and proud, driven to do the best that he can at what he does, and somewhat impatient with weakness, fallibility, or needs that require accommodation of or dependence on others for help. This persona runs through many of Bill's therapy sessions with Caitlin.

By the time Bill returned to see the neurologist three days after the accident, he was having more problems with a persistent headache and "severe dizziness" in addition to the moderate memory, strength, and sensory problems detected earlier and which hadn't changed dramatically in this short span of time. Bill described his chief concern at that time as his dizziness:

> Shall I say it was severe enough that I had to hold on to stuff as I walked around the house.... In fact, if I turned my head quick I got real nauseous real quickly. Bad news. So I was smart enough to learn real quick--don't do that. I'd do nothing to cause me to get dizzy. I'd get up slow, exceedingly slow. I'd sit in the bed for maybe two or three minutes before I stood up. I have a dresser right next to my bed and I'd actually lift myself up on the dresser...just to make sure I wouldn't fall because I tried to get up once fast and I fell right back into bed...so, I finally learned...you just don't get up fast, you don't move fast. (B, 7/5/95, p. 5)

Bill's difficulties with dizziness and adjustment to positional change and movement are indicative of vestibular system dysfunction which is a common sequelae of head injury (and which was also seen in Marcia).

In response to this new and functionally disabling problem, Bill's neurologist prescribed a series of positional sensitivity exercises or maneuvers for Bill to do at home in addition to continuing to rest. These exercises are designed to help the vestibular system to "reset" and habituate to alterations in head and body positions that are so much a part of our everyday movement repertoire. The exercises present a significant challenge to the vestibular system and are sometimes unpleasant for patients because they create dizziness and nausea at first. Bill described them this way:

> You know, [lie] down on one side, wait till the dizziness leaves and then sit back up fairly quickly. Not too quick. Don't want to fall off the bed. Then to the other side. And I did that for about a week up to three times a day. I really didn't want to do it, but I wanted to get on with it and I wanted to get out of there and back to work. I just can't see sitting home. (B, 7/5/94, p.4-5)

Again, Bill's self driven style comes through here. During the next two months Bill's physician kept Bill on a medical leave of absence from work while Bill worked at home on a series of general exercises and activities to try and regain strength and diminish his symptoms of dizziness and headaches. In addition, Bill was taking some medication to help with control of symptoms. But Bill was getting restless and anxious to return to work and in mid-December he said

he "finally talked him [his physician] into letting me go back to work."

Bill's return to work was gradual but difficult. At first he started working on a part-time basis moving to almost full-time work by the end of January. He described some of his difficulties this way:

> I could work four to six hours but I was tired when I got done, and, I, uh, couldn't perform as fast as I did before. That bothered me. And my, uh, remembering where drugs were on the shelf was very difficult.... See, usually I work the store [pharmacy] by myself with no outside help and as a result I did all the waiting on customers, cashing out, pulling drugs off the shelf, putting 'em back on, I could pull a drug off the shelf and when I went to put it back up, I'd forgotten where it came from. Now I *never* did that before. And that bothered me... (B, 7/5/94, p. 6-7)

The other problem that Bill was encountering as he returned to work full-time was increasing frequency and intensity of his headaches:

> But my headaches, aaaah (with frustration)...come around January they started catching up with me...I said maybe I can get away with it, and I knew I was pushing myself. And the headaches started getting a little worse and a little worse and I said 'well something's gonna give out here somewhere--either me or the headaches...." (B, 7/5/94, p. 7)

In spite of his headaches, Bill insisted on continuing his work as a strategy for "fighting" the headaches. During the ensuing months, Bill and his physician tried a variety of medications to help reduce the dizziness and headaches with limited success and some undesirable side effects. In light of Bill's persistent problems which

were not responding to conventional pharmaceutical interventions, Bill's physician referred him to the clinic for further evaluation and treatment. As Bill put it,

> Matter of fact, that's why he sent me over here.... He thought it might just be something other than what he was looking at. He wanted, basically, some other opinion and he apparently had tried this over here and found it successful with some of his patients, so why not give this a try? And I'm open to any idea to get me away from my headaches or dizziness. (B, 7/5/94, p. 7-8)

Bill was first seen by members of the clinic team in mid-April of 1994, approximately six months after his accident and head trauma. Kay, Caitlin, and Don were involved in the initial screening interviews and examinations with Bill. Based on the results of the examinations it was concluded that Bill might benefit most from a short course of physical therapy to address the constellation of problems, all interrelated, with which Bill was presenting and which were limiting his function at work and home. These included (a) visual-spatial orientation and processing problems characteristic of trauma to the right parietal cortex, (b) poor control of vestibular-ocular reflexes, (c) stress responses to visual and cognitive processing demands which were probably contributing to headache formation, (d) mild vestibular dysfunction, (e) mild balance deficits in standing and walking, (f) mild left sided weakness, and (g) severe headaches leading to increased fatigue and attention and concentration problems especially in the work environment.

I first met Bill in early May when he began physical therapy treatment sessions. Bill worked with Caitlin approximately once a

week for a period of eight weeks. Therapy sessions were directed toward patient education regarding the effects of mild head injury as well as the development of home exercise and activity programs that would enhance vestibular system adaptation and recovery and visual control, improve balance, increase strength and endurance, and decrease the frequency and intensity of headaches. It was hoped that all of these interventions would help Bill achieve his goals of continuing to work with fewer functionally disabling symptoms and avoiding early retirement.

Conclusion

So, this is Jones and Thompson, P. C. I have introduced you to the history of the clinic and the clinicians who, over the years, have created and populated this place. You have heard beginnings of their stories and those of the clients whom I followed during the course of this study. Now I turn to a closer examination of how the stories of clinicians and clients unfold during therapy at Jones and Thompson. More specifically, in the following chapters I examine the meaning and enactment of three of the central tenets of client-centering: (a) the creation and sustenance of therapeutic alliances, (b) the realization of client education and empowerment, and (c) the development of a transdisciplinary approach to care.

Chapter 3

BUILDING A FRAMEWORK FOR CLIENT CENTERING: CREATING AND SUSTAINING THERAPEUTIC ALLIANCES

Introduction

In Chapter Two I introduced the concepts of client centering and therapeutic alliances as described by the therapists at Jones & Thompson, P.C. The strength and pervasiveness of these philosophical and practical ideals as both the driving force and framework for the clinical work of these therapists was fascinating to me. I wanted to further explore these interrelated concepts and how they were realized or transformed in everyday clinical practice. The questions, then, which arose and guided this part of my study and analysis were:

1. What is a therapeutic alliance and what is it's relationship to client centering? How and why is it important?
2. How is a therapeutic alliance realized--or not realized--in face-to-face encounters between patients and therapists?
    a. What contributes to the creation and development of a therapeutic alliance?
    b. How is it sustained?
    c. What constrains or inhibits the development of therapeutic alliances?

To begin to answer these questions I turned first to the therapist's descriptions and definitions of these relational concepts.

What the Therapists say about Client Centering

Recall that Kay defined client centering as *"starting where the client is"*. For her, and other professionals in the clinic, this meant finding out what was meaningful to the patient in their lives and what *their* goals for therapy were rather than unilaterally imposing the therapist's goals on the patient or the patient's family or caregivers. In other words, client centering demanded that goals for therapy be established *with* clients rather than *for* them. Rehabilitation and educational programs would then be *individualized* and built around what held meaning for the patient. As Caitlin put it, the patient's "life needs" become the guide to therapy.

Client centering did not mean, however, abandoning the perspectives of therapists in discussions about what rehabilitative care would be; rather, it meant inviting the patient to be a member of the *team* as decisions were made about the nature and extent of therapy. It meant giving voice and power to the patient and their family in the rehabilitative process and establishing partnerships that provided for co-participation in decision making about care. In the therapist's conceptualizations, voice and power are not just reified objects that can be handed to a patient; they are relationally negotiated phenomena and can only be realized through listening to, respecting, and integrating the patient's perspectives into the entire rehabilitative process. According to therapists at Jones and

Thompson, it is this respectful listening to and acting on patient's perceived needs that invites the patient into *conversations* about their care with health care providers. Seeking and engaging in such conversations with patients is not just a professional commitment for therapists in this clinic; it is a personal commitment as well and makes their own work more enjoyable and meaningful. According to Susan,

> ...that's why I really enjoy working here--because we listen to the clients--they're an integral part of the team. They're the ones, they're the ones who say this is what I want to do...." (S, 7/28/94, p. 5)

One of the interesting themes that emerged as therapists talked about what client centering meant to them was that many therapists saw their commitment to this ideal as a response to their disenchantment with biomedical/medical models of health care. The biomedical model of health care has historically been professional or physician centered and assumed as it's primary focus the diagnosis and treatment of an individual's biological disease and related physical impairments (see Figure 8) while giving little attention to the perspectives of the patient regarding the meaning of their pathology for their lives (Cassell, 1982; Engel, 1977; Kleinman, 1980, 1988). Thus, the biomedical model of health care does not encourage the exploration of the ramifications of biological pathology for the individual patient and those around him or her; it tends to neglect and most certainly does not embrace the socioculturally and psychologically mediated *illness experience* of the individual.

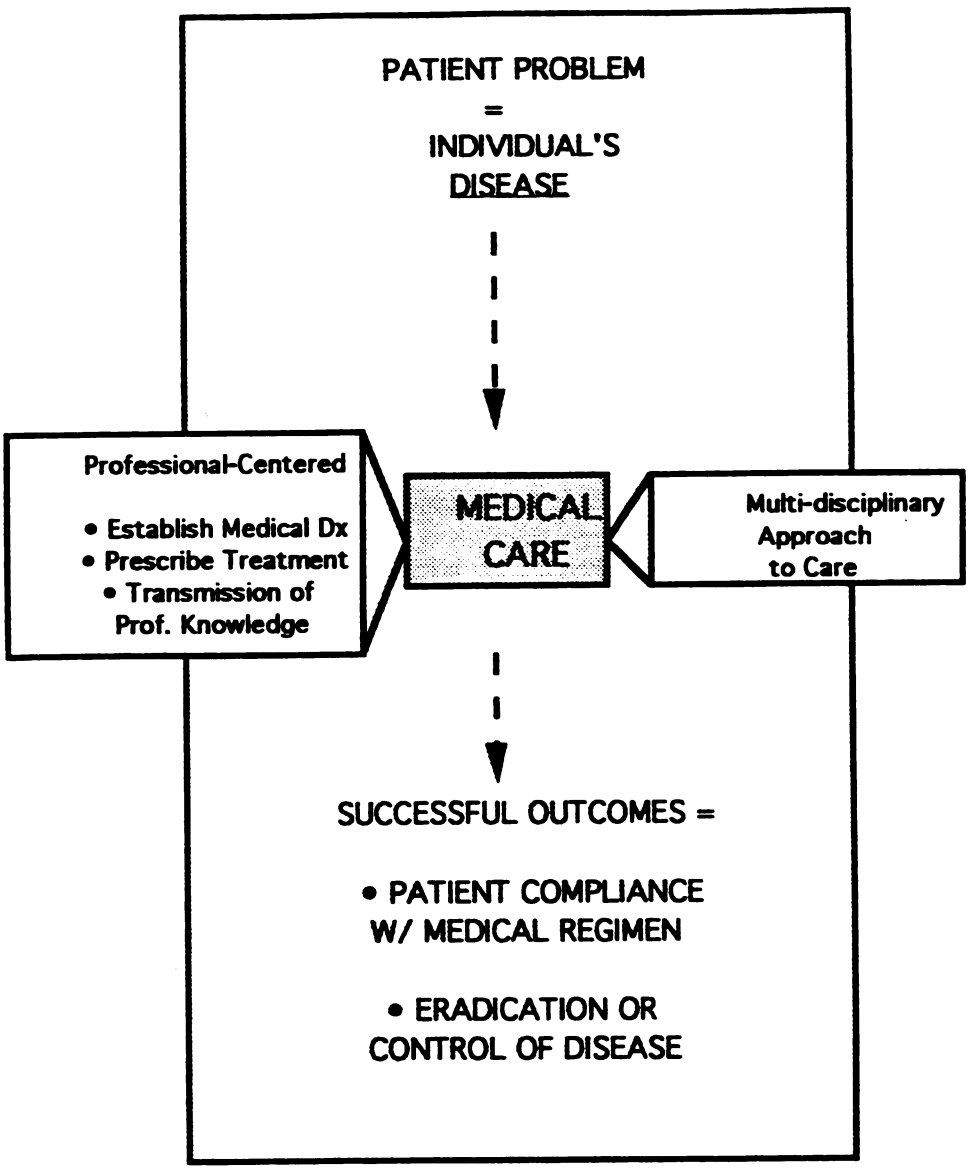

Figure 8. Traditional Biomedical Model of Health Care.

Listen first to the words of Kay as she discussed some of her frustrations in getting the medical community to be aware of and value the kinds of services provided for clients at Jones and Thompson:

> But part of our problem all along is that we operate within the biomedical model which means that the gatekeeper is the physician, and the physicians are tuned in more to life and death or gross pathology kinds of situations and don't really have a very good understanding of what we do, or can do, or even what some of the disruptions [in patient's lives] are. (K, 2/3/92, p. 10)

Here, the conflict for Kay between an approach to health care "tuned in" to disease and pathology and an approach to health care that is tuned in to the disruptions that pathology produces in patients' life patterns and circles becomes apparent.

Caitlin also discussed several reasons she was disenchanted with a biomedical model of health care when she talked about why she left a large rehabilitation center to come and work at Jones and Thompson, P. C. She felt that (a) time for patient, family, and practitioner dialogue about care was at a premium and was devalued in such systems, and (b) a focus on identification, eradication, or control of disease altered patient and practitioner roles and responsibilities in ways that decreased the importance of education in health care and potentially disempowered clients.

> In the acute care medical model where...the patient is in a role where they're being *cured* by the rehab team and the physician...rather than learning about the tools to manage his recovery or to manage his chronic disability...that's a real

> difference in my mind.... And I think a part of the education process is letting them realize that they're at the center of the rehab team...rather than the team managing them.... It takes a lot of *time* to sit down and talk with the patient and family and let them be a part of the rehab process rather than someone who is just being *treated* .... I've come to realize that patients need a chance for somebody to *hear* them, and *hear* what *their* problems are.... (C, 1/27/92, p. 5) [Italics represent speaker's emphasis].

I believe the latter portion of the quotation above points to an important distinction the therapists at Jones and Thompson, P. C. would make between professional versus client centered approaches to care--the difference between listening to patients and *hearing* patients. This distinction has been made elsewhere (Brody, 1987; Coles, 1989; Frank, 1991; Kleinman, 1980, 1988), but perhaps nowhere more pointedly than by a physician's slip of the tongue when asked a question by a patient as he was auscultating the patient's chest: " 'Quiet' ", he said, " 'I can't hear you while I'm listening' " (Baron, 1985, p. 606).

For Caitlin, another difference between the medical model of care and the model of care therapists at Jones and Thompson were trying to construct was a matter of providing "options" for clients about their care and then letting them "...choose and to be the final decision-maker" about the direction, nature, and extent of their rehabilitation (C, 6/3/92, p. 2). Thus, client centering was part of these therapists' attempt to construct what has been variously called a biopsychosocial (Engel, 1977, Jensen & Lorish, 1994) or bio-social

(McClelland, 1990) model of health care as an alternative to the traditional biomedical model of health care.

The biopsychosocial model of health care. The biopsychosocial model of health care shown in Figure 9 is my attempt to visually and conceptually represent some of the key features, characteristics, and commitments suggested by descriptions of this approach to care in the literature and by the therapists in this clinic. Central to a biopsychosocial view of health care is a shift from a focus on the patient's disease as the primary problem to the illness experience for the patient. Many authors have suggested that a substantial part of the sociocultural discord, discrepancy, and distance that has existed between clinicians and patients is rooted in a failure of clinicians to attend to, and take as important, the patient's subjective experience of illness in addition to the objective findings associated with disease processes (Baron, 1981; 1985; Cassell, 1982, 1991; Coles, 1989; Engel, 1977; Frank, 1991; Kleinman, 1980, 1988; Kleinman, Eisenberg, & Good, 1978). Further contributing to the distance between clinicians and patients is the fact that many patients seeking medical or health care in twentieth century Western society have learned through experience that reports about their subjective appreciation of their symptoms and the effect of symptoms and disease on their lives are only infrequently solicited and rarely taken account of in medical encounters (Frank, 1991). Thus, they may be hesitant to share descriptions of their illness experience with health care providers believing such descriptions to be unimportant to the task of medicine

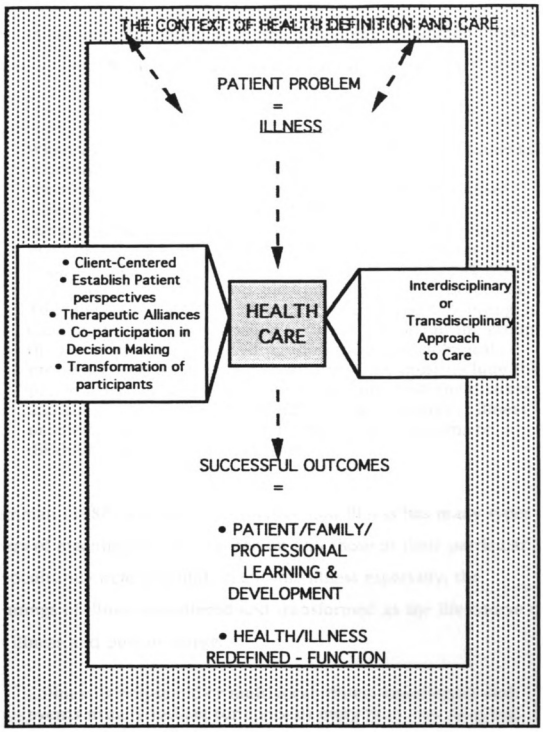

Figure 9. Emerging Biopsychosocial model of health care.

which, in this century, has largely been seen as the diagnosis and treatment of disease.

In his seminal work The Illness Narratives, Kleinman (1988) describes how the meaning of the term illness differs from that of disease:

> When I use the word *illness* ...I mean something fundamentally different from what I mean when I write *disease*. By invoking the term illness, I mean to conjure up the innately human experience of symptoms and suffering. Illness refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability. Illness is the lived experience of monitoring bodily processes.... Illness involves the appraisal of those processes.... The illness experience includes categorizing and explaining, in common sense ways accessible to all lay persons in the group, the forms of distress caused by those pathophysiological processes. And when we speak of illness, we must include the patient's judgments about how best to cope with the distress and the practical problems in daily living it creates.... Illness problems are the principal difficulties that symptoms or disability create in our lives. (pp. 3-4)

Kleinman (1988) goes on to emphasize that illness has many types or layers of meaning for the sick person and those in their particular sociocultural circle and that, in chronic illness especially, the meanings of illness are altered and transformed as the life course of the illness and person merge.

> ...illness is polysemic or multivocal; illness experiences and events usually radiate (or conceal) more than one meaning. Some meanings remain more potential than actual. Others become effective only over the long course of a chronic disorder. Yet others change as changes occur in situations and relations.... Chronic illness is more than the sum of the many

> particular events that occur in an illness career; it is a reciprocal relationship between particular instance and chronic course. The trajectory of chronic illness assimilates to a life course, contributing so intimately to the development of a particular life that illness becomes inseparable from life history. Continuities as well as transformations, then, lead to the appreciation of the meanings of illness. The appreciation of meanings is bound within a relationship: it belongs to the sick person's spouse, child, friend, or care giver, or to the patient himself.... In the long, oscillating course of chronic disorder, the sick, their relatives, and those who treat them become aware that the meanings communicated by illness can amplify or dampen symptoms, exaggerate or lessen disability, impede or facilitate treatment.... However, these understandings often remain unexamined, silent emblems of a covert reality that is usually dealt with indirectly or not at all. (pp. 8-9)

These descriptions of what illness is and an appreciation of the multiple and dynamic meanings of illness help us to understand how an approach to health care built around an assumption that illness is the central problem for which patients or clients are seeking help can be fundamentally different than an approach that sees as it's primary task the diagnosis and treatment of disease.

In a biopsychosocial model of health care, the clinician is encouraged to try and come to an understanding of the patient's illness experience--to ask different sorts of questions than only those that converge on a diagnosis; to listen to the patient's stories about their symptoms and the influence of disease processes on their lives; to invite and engage in dialogue that permits exploration of the meanings the patient's experiences hold for them; and to value the patient's beliefs, stories, and meanings, using these insights in negotiating and constructing approaches to care that are helpful and

transformative for participants. No longer can clinicians let patients be a "translucent screen on which the disease is projected" (Baron, 1981, p. 7)—a screen, which in a biomedical model of health care, might be seen as clouded by the patient's sociocultural identity and life stories.

In his autobiographical account of his struggles with heart disease and cancer, Arthur Frank (1991) has carefully yet painfully documented some of the dilemmas of a patient living illness in a disease focused medical system:

> One day my body broke down, forcing me to ask, in fear and frustration, what's happening to me? Becoming ill is asking that question. The problem is that as soon as the body forces the question upon the mind, the medical profession answers by naming a disease. This answer is useful enough for practicing medicine, but medicine has it's limits. Medicine has done well with my body, and I am grateful. But doing *with* the body is only part of what needs to be done *for* the person. (p. 8)

Frank goes on to describe his definition of illness and how (a) this contrasted with medical definitions of his problem, and (b) he felt his illness "voice" was silenced in many medical encounters.

> Illness is the experience of living through the disease. If disease talk measures the body, illness talk tells of the fear and frustration of being inside a body that is breaking down. Illness begins where medicine leaves off, where I recognize that what is happening to my body is not some set of measures. What happens to my body happens to my life.... Illness talk is a story about moving from a perfectly comfortable body to one that forces me to ask: What's happening to *me* ? Not *it* , but *me* ?... Talking to doctors always makes me conscious of what I am *not* supposed to say. Thus, I am particularly silent when I have

> been given bad news. I know I am supposed to ask only about the disease, but what I feel is the illness. The questions I want to ask about my life are not allowed, not speakable, not even thinkable. The gap between what I feel allowed to say widens and deepens and swallows my voice. (1991, p. 13)

Biopsychosocial approaches to health care are about putting the person, the Arthur Franks of this world, and the personal meanings of illness back into the health care equation–about helping the patient to regain not only voice but power in health care encounters and processes.

In contemporary medical ethics, returning "voice" to patients and a *sharing* of power and responsibility in decision making are ways of respecting patient autonomy and avoiding paternalism in medical encounters (Brody, 1987, 1992; Tomlinson, 1986). To truly negotiate and achieve co-participation and a sharing of power in patient-professional encounters, Brody (1987) suggests that health care providers must adopt a *relational* versus decisional ethic in clinical decision making processes. Such an ethic encourages dialogue between patients and practitioners and the "trying out" of different ideas and possibilities regarding approaches to treatment. In these discussions about sharing power, it is clearly recognized that there are various forms of power that can be constructed, negotiated, distributed or claimed in clinical encounters (Ainsworth-Vaughn, 1995; Brody, 1992; Davis, 1988). In addition, a sharing of power does not, and should not, imply that the clinical knowledge and technical expertise of health care providers is overlooked or abandoned in arriving at decisions about a patient's care (Brody,

1987); it is simply filtered through or infused with patient perspectives on their illness.

What I have attempted to do in the foregoing section is to outline and explore some of the characteristics or features of a biopsychosocial model of health care as described in some key works in the literature. In doing so, I have contrasted this approach to health care with a biomedical model of health care. While I hope you'll agree that descriptions of these conceptual models can serve as a framework for thinking about what might be happening in everyday patient-therapist encounters, the models themselves seem strangely distant from the lived experience of clinicians and patients in which I was so interested.

Earlier I suggested that the clinicians at Jones and Thompson were working on a day-to-day basis to construct a biopsychosocial model of health care--one that starts from attention to patients' illness experiences or "where the patient is" rather than focusing primarily on disease processes. For these clinicians, working almost exclusively with patients with chronic illness and disability, establishing therapeutic alliances and client centering were essential relational components of this approach to care. But what did these things--client centering and therapeutic alliances--look like at close range? How were they described by the therapists themselves and constructed through discourse in the context of practice with clients with brain damage? I return now to the voices of the therapists and the clients to tell the rest of the story.

What the Therapists Say about Therapeutic Alliances

In one interview with Kay, I explored her perceptions about the nature of therapeutic alliances in depth. In response to the question "What is a therapeutic alliance?", Kay described this alliance as a "relationship in which each participant is invested and shares responsibility for healing, learning, and change" (K, 9/15/94, p. 3). She emphasized the importance of "reciprocity" in the relationship which she felt could be developed and sustained through respectful and caring interaction with patients. When I probed further about what, in particular, seems to be required for the development and sustenance of such alliances, Kay described several factors which she felt are necessary for and contribute to the development of therapeutic alliances; foremost among these were (a) time, (b) respectful listening, and (c) the intertwined phenomena of reciprocal disclosure, mutual vulnerability, and trust.

The importance of time. Kay emphasized that alliances can not be created in single, brief or hurried encounters with clients. As she put it: "Alliances evolve gradually, they take time" (K, 9/15/94, p. 3). For Kay and other members of the team, this realization was translated into a commitment of therapists to spend a relatively extended period of time with each client (usually one to two hours per visit) during which they could focus solely on that person and their needs. In addition, once a therapist initiated therapy with a client, it was only that therapist who provided services within their discipline. For instance, once Caitlin started treatment with a particular client, she would always be the physical therapist working

with that client even though there was another physical therapist on staff in the clinic. The therapists at Jones and Thompson, then, viewed the ability to spend uninterrupted and extended periods of time with patients as critical to the development of alliances and a relationship which could be client centered, nurturant, educative and healing. These commitments were systematized in standard working procedures used in scheduling of clients on a day-to-day basis.

Kay contrasted this approach with that found in some other rehabilitation settings where some therapists might be "...seeing four patients at a time" or where there can be a discontinuity of care providers because the provision of services sometimes comes down to "...just whoever is available at the time." Based on my own experience in rehabilitation settings, the latter observations are by no means exaggerated or unfair. Indeed, it is not uncommon for the provision of some rehabilitation services (especially physical and occupational therapy) to be extremely fragmented within and across therapy sessions and disciplines for a given client. In such situations, the obvious need for time to develop therapeutic alliances has been overshadowed and has become problematic in a health care environment that is increasingly focused on the need to be productive (i.e., the volume of patients seen and the number of units billed is very important), efficient and cost-effective. While the provision of efficient and cost-effective health care is not, in and of itself, an unreasonable goal for health care providers, it can become problematic when it is translated into approaches to care that involve doing *for* the patient what is believed to be possible in the

least amount of time using the least expensive labor to achieve satisfactory--not necessarily optimal--outcomes.

The therapists at Jones and Thompson believe that an alternate approach to care, one that is client and relationship centered, requires different ways of thinking about and using time in clinical encounters to optimize outcomes for both patients and therapists. For them, time is an essential for the process of developing alliances--a process which also requires what these therapists describe as "respectful listening".

Respectful listening. According to Kay, the central tenet of client centering, "...starting where the client is", is impossible to realize without respectful listening. Such listening "...involves listening carefully and trying to understand where the patient is coming from and where they want to go" (K, 9/15/94, p. 4). This description and theme was repeated by Kay and other therapists on numerous occasions as they stressed the importance of listening, trying to understand, and respecting the patient's "lifeworld". Kay described *respectful* listening as a form of listening that conveys genuine interest in the client and one that *hears* and acknowledges what clients have to say as important in the therapeutic process. She pointed out that it is essential that the therapist has, and conveys, a willingness "...to capture and understand the patient's sense of things" as a starting point for the relationship and client centered therapy (K, 9/15/94, p. 4). Furthermore, Kay suggested that a critical component of respectful listening is the avoidance of "passing judgment" on a patient's perceptions or views regarding their illness

even though they might not match the therapist's or others' perceptions. This does not mean, however, that there won't be any work to alter client perceptions along the way. It simply means that therapists believe that such transformations in perceptions--which are sometimes necessary to bring the client's reality into closer alignment with that of others--are best realized in the context of a therapeutic alliance. And an alliance cannot be developed in the absence of respect, conveyed through interaction, for the client's reality.

On several occasions Caitlin talked about the importance of accepting the client's reality and the need for non-judgmental interactions which she found particularly important in her work with clients with various forms of brain injury often accompanied by sensory-perceptual and cognitive impairments. In an early interview, Caitlin said she had

> ..learned to never question the patient's perceptions regarding something they're experiencing. I think that one of the things that I have really learned over the years is that even if you may not believe your patient--whether it's how much pain they're having or how much time they're spending [doing exercises]--is to realize that, to them, it seems like two hours or to them it seems like their pain is that intense and there's no reason to even challenge that perception. (C, 6/3/92, p. 3-4)

Later in the study, after observing several interactions between Caitlin and her clients that reflected this non-judgmental approach to patients views, I asked her to talk with me about how she felt she learned this "lesson".

> I don't think it was any single incident. I think it was more over years of experience and realizing that not only patients, but individuals in general, perceive things differently. And it's not our role to question how they're perceiving things--it's valid to them.... You just see that perceptions don't match over and over again--but it's just their perception of the whole situation, and it's not productive to question what they're experiencing. You just need to understand where they are at and try to work from there. (C, 8/16/ 94, p. 4)

Working "from there" for Caitlin, and for other therapists at Jones and Thompson, can mean working to alter patient perceptions regarding certain aspects of their illness experience without denying or abandoning the patient's reality or "sense of things."

> You can't deny someone else's feelings. It's what *they* are experiencing. But you can try to alter that experience over time....You respect that [their perceptions] and just try to gradually stretch the window.... (C, 8/16/94, p. 5)

So respectful listening--working to hear and understand the patient's perspectives about their illness in non-judgmental ways--is an essential strut in the framework for client-centering. Without it, the ideal of client centering as articulated by these therapists would be difficult if not impossible to achieve.

Reciprocal disclosure, mutual vulnerability, and the development of trust. While Kay felt that time and respectful listening were essential to the creation of alliances, she emphasized that one of the facilitators and characteristics of an evolving therapeutic alliance is a "gradual increase in reciprocal disclosure" between participants (K, 9/15/94, p.4). Kay recognized that one of

the inherent asymmetries in health care is that is that clinicians ask patients and family members to disclose a great deal about themselves without offering much, if anything, about their own lives. Kay felt that many patients wanted and needed to know something about their therapists as both professionals and people. Naturally, clinicians usually have more choice than clients do about what they disclose in the course of therapy; even so, Kay suggested that increasing reciprocal disclosure between therapist and client--an offering of and listening to each other's stories--was often associated with an "...increasing trust combined with a declining sense of vulnerability" (K, 9/15/94, p. 4). Kay felt that reciprocal disclosure, developing trust, and declining vulnerability go hand in hand. She offered as an example of this stories of how clients, after a few sessions with their therapist, often say: "Remember what I told you during that first session? Well...it's really more like this...." Kay believed that a willingness to share alternate representations of experiences with therapists than those initially expressed was usually possible only in the context of declining vulnerability, increasing trust, and reciprocal disclosure.

The need for reciprocal disclosure in therapeutic encounters has been discussed by others (Brody, 1987; Coles, 1989, Rodin, 1982; Rodin & Janis, 1982) and is reminiscent of the pointed request by one of the patients Robert Coles worked with during his medical residency. This patient said to Coles: "You tell me your story, and I'll tell you mine" (Coles, 1989, p. 16). Such direct requests for reciprocal disclosure and storytelling in medical encounters are rare

indeed and typically go unanswered. But at Jones and Thompson, the recognition of and response to this *potential* need of clients is considered to be important in the evolution and sustenance of therapeutic alliances. A sharing of self by participants is believed to be a facilitator for the development of a trusting relationship between therapist and client as well as being an indicator or outcome of such a relationship. Without disclosure the development of trust may be impaired or inhibited; without trust, disclosure may be limited or constrained.

The issue of vulnerability in relation to trust and disclosure is an interesting one. Disclosure is tricky business: It opens us up, it makes us vulnerable. And there are different degrees of tolerance for vulnerability and disclosure across individuals and situations. As Kay pointed out, "...there are boundaries for disclosure for everyone" (K, 9/15/94, p. 5). She, and other therapists, recognized that excessive or inappropriate disclosure can threaten mutual respect and the development of trust between participants in clinical encounters in the same way that too little disclosure can.

Several questions are raised by these descriptions of the complicated relationships between disclosure, trust and vulnerability. Can there be trust without some sense of mutual vulnerability? Even if that vulnerability takes different forms for different individuals? Is trust about vulnerability overcome or diminished or more evenly distributed among participants in therapy sessions? Is it about replacing feelings of vulnerability with a sense of safety in the therapeutic relationship? All of the clients at

Jones and Thompson are vulnerable because of the very nature of their problems and their acceptance of the status of "patienthood" which involves presumed and real asymmetries of knowledge, power, and control in clinical encounters.

My interest was piqued by these challenging questions and the realization that these phenomena must be interactionally constructed and negotiated through discourse during therapy sessions. It is through close examination of the talk and doings of therapy that we might gain insight into how and whether these phenomena and alliances are achieved or expressed in the context of clinical encounters. Before moving to descriptions and analysis of such talk and doings in physical therapy sessions, I will briefly discuss what factors therapists at Jones and Thompson believed constrained or impeded the development of therapeutic alliances with clients.

Impediments to the development of therapeutic alliances. The therapists at Jones and Thompson knew that therapeutic alliances and the ideal of client centering were not always realized in day-to-day care. I asked Kay if she could describe some things that she felt constrained or prevented the development of an alliance. First and foremost, Kay felt that an absence or lack of those things discussed above--time, careful listening, reciprocal disclosure and trust--were serious impediments to the development of therapeutic alliances. In addition, she said that sometimes "...just plain old personality conflicts" become apparent and interfere with the development of an alliance (K, 9/15/94, p. 5). She explained that sometimes a "...good match [between client and therapist] just doesn't occur." Kay tries to

assist in creating "good matches" between clients and therapists through her careful review of referral information on clients and her observation and listening to clients in initial "intake" interviews (which she usually conducts) or during encounters with clients in Head Injury Screening Clinic. Then, based on her knowledge of therapists on the team and her observation of the potential client, she may suggest to the team that a particular therapist and client should work together. This initial pairing is further negotiated by the team based on several factors (see Chapter 5). Even so, achieving good "personality matches" between client and therapist is not always possible and can impair the development of an alliance.

A second factor that constrains or "slows down" the creation of a therapeutic alliance, according to Kay and the therapists who work extensively with patients with brain injury, was lack of client self-awareness or limited self-monitoring and self-assessment abilities. As suggested above, this problem was seen primarily as something that constrained or "slowed down" the process of establishing and maintaining therapeutic alliances--made the process more difficult--rather than being a total impediment to it. Many of the clients seen in this clinic with varying degrees of severity of head and brain injury have significant impairment of cognitive and perceptual function. Of the three clients followed in this study, John is the best example of a patient with altered self-awareness and self-assessment abilities as a result of his brain damage.

Kay referred to John in her description of how these problems influence the development of a therapeutic alliance. John, because of

the nature of his injury, had difficulty creating what Kay called "a gestalt" regarding what he realistically could and could not do safely. In his case, like others, Kay said therapists therefore had to "...work piece by piece, over and over again, on particular tasks" to help John gain altered or new perspectives on what he could realistically accomplish given his disability (K, 9/15/94, p. 7). This was no small interactional task in the case of John and is illustrated in numerous vignettes and analyses to follow. Insofar as the development of an alliance is viewed as providing for or suggesting a merging of meanings and perceptions for patient and therapist regarding situations, abilities, and disabilities, the impaired ability to self-assess can make the task of creating alliances difficult at best. As discussed earlier, in the context of a commitment to respectful listening and client centering, it is not desirable or appropriate to confront patients and say "No, your reality or interpretation is not acceptable or correct." And yet therapists must still work to help patients come to realizations that what they think they can do or want to do may no longer be a realistic, safe or wise activity for them.

Finally, Kay said that "...client disinterest, lack of commitment, or hostility weakens the foundation for shared responsibility..." between client and therapist (K, 9/15/94, pp. 5-6). Recall that shared responsibility was deemed to be a central feature of a therapeutic alliance which was defined as "a relationship in which each participant is invested and shares responsibility for healing, learning, and change." Kay admitted that client disinterest or

hostility is not unusual early in her interactions with clients but she saw hostility, in particular, as a function of the situation and the "threat to self-esteem" that the patient's problem and their seeking help creates. That is, she saw hostility as a fairly natural and anticipated outgrowth of the patient's feelings of vulnerability. According to Kay, what was important for the creation of an alliance and shared responsibility was *change* in these areas as the relationship progressed. She felt that hostility and disinterest can be altered or overcome with time and the other forms of interactional work described above. Even so, she added this proviso: "But sometimes it isn't! Sometimes this is just a plain old hostile and disinterested person!" (K, 9/15/94, p. 6). In such cases, the therapist or team usually finds that they are unable to help the patient insofar as helping has now become a one-sided effort and this is not part of what they see as helping patients. When therapy becomes a one-sided effort--when there is no evidence of a sharing of responsibility in care--therapy will usually be discontinued because the chances of facilitating positive change for that client are seen as extremely limited.

Several authors (Katz, 1984; Brody, 1987, 1992) have discussed the importance of shared responsibility in truly helping medical encounters, and in doing so, have invoked the metaphor of *conversation* as a description of physician-patient interactions that encourage and preserve shared responsibility among participants. According to Brody (1987), one of the important features of the conversation metaphor is that

> ...it suggests a...meaningful sharing of responsibility. The physician may be the one who must start the conversation, indicate that a conversation is in order, and explain technical matters in understandable terms. But the patient also has a responsibility: he has an equal power with the physician to terminate the conversation or to keep it going.... Neither participant in a true conversation can properly be viewed as totally passive or totally lacking in responsibility for the outcome. (p. 177)

If inviting the patient into and engaging in a conversation is seen as essential to the creation and sustenance of therapeutic alliances, then disinterest, lack of commitment to the relationship, and hostility on the part of one of the participants could most certainly represent a substantial impediment to achieving this ideal.

The aspirations of the clinicians at Jones and Thompson and their descriptions of a therapeutic alliance (including the things that either facilitate or constrain the creation of alliances), invoke, for me, an image of a relationship centered practice. Perhaps the heart of client centering isn't the client per se; perhaps, instead, it's the relatedness developed with each client. For these therapists, this relatedness is captured by the conceptual description of a therapeutic alliance; but the business of creating alliances, of negotiating partnerships, of sharing responsibility, and redistributing power is realized, or not realized, through face-to-face interaction between client and therapist. Let us move, then, to a closer look at the interactional work of participants as they construct alliances--alliances that participants hope will become therapeutic.

Co-constructing Therapeutic Alliances

In this section I focus on various features of interaction between clients and Caitlin that seemed to be illustrations of the therapist's and patient's work to create and sustain therapeutic alliances. This work, as suggested by the heading for this section, is not done by the therapist alone; rather it is done by all interlocutors in the clinical encounters. This is not to say the work is equally distributed across participants at any given time--it isn't in my estimation. But, ultimately, both patient and therapist contribute to and co-construct therapeutic alliances--alliances that necessarily look different from client to client but nonetheless seek, in their various forms, to provide for a sharing of responsibility for care and client centering.

Giving Individual and Undivided Attention to Clients

The work of therapists to focus their full attention on an individual client during the time they were in therapy was a recurrent observation not only in my observations of Caitlin with her clients but also in my observations of other therapist's interactions with their clients as they moved to and from therapy sessions. Part of this work I have already described in Chapter Two in my discussion of the general patterns of interaction between therapists and clients as they came and went in the waiting room and in the hallways of the clinic. Recall that therapists routinely came to the waiting room to invite their clients back into their offices or into the therapy gym. They escorted the patient to and from therapy

sessions, side-by side, talking as they went. Patients and therapists usually addressed each other by their first names and none of the therapists wore the white laboratory jackets (and name tags with many letters after their name) so ubiquitous in many medical and rehabilitation centers.

In addition to the focused attention given to patients during encounters with clients at the begining and end of therapy sessions, one of the features of these encounters that struck me was the general fluidity of movement and conversation--the smoothness of transitions into and out of therapy sessions. Although this smoothness or fluidity is hard to describe with words alone, perhaps a few vignettes of transitions into and out of therapy sessions will give a sense of this feature of interaction between Caitlin and her patients. This is part of what I will call the *rhythms* of therapy and interactions and I claim that these rhythms are part of the focused attention and respectful listening to clients that contribute to, and are the result of, the creation and sustenance of therapeutic alliances.

The rhythms of therapy. To describe some of these transitions and rhythms, it seems most appropriate to start at the beginning of a therapy session. One of the most notable things that I observed during Caitlin's treatment sessions with John, Bill and Marcia, was a remarkable smoothness of transitions into and out of the treatment sessions as well as the easy interweaving of the client's and Caitlin's movements and conversations, both social and professional, during these transitions and therapy itself.

To illustrate the organization of these transitions I will first describe the start of two sessions and the closure of a third session with John that were representative of the great majority of such transitions. To begin all therapy sessions, Caitlin would greet John in the waiting room and then escort him through the main clinic suite and back to the second suite/PT gym where I would be waiting with the videtaping equipment. On the first day that I observed a session, I could hear John and Caitlin engaged in social conversation as they came down the hall toward the gym (C/J, 3/11/92). As they entered the gym area, Caitlin introduced me to John (whom I had only spoken to on the telephone heretofore) and I thanked him for agreeing to participate in the project. John is a tall man who looks slightly younger than his 36 years. He has a large build with a slightly protruberant belly (which he subsequently joked about from time to time). On this day he was wearing two of his "signature" pieces of clothing--a baseball cap which covers his medium length ash blond/reddish hair and a green and gold Colorado State University sweatshirt with letters C. S. U. emblazoned across the front.

John and Caitlin proceeded very naturally, although slowly, across the room toward a low mat table as John talked to me a bit about his own work in videoproduction while giving me some recommendations for my own taping. John speaks slowly and deliberately with occasional slurring or pauses as he searches for words. Even so, he has a remarkable vocabulary and a quick wit that became apparent as my observations continued. As John and Caitlin reached the mat table, they sat down together on the mat table side by

side with about two to three feet between them. John talks for a few minutes about the success of two of his earlier videoproductions (medical instructional programs) that had won awards at a recent videoproducers convention as Caitlin watches him and listens closely and offers occasional recognitions of his accomplishments such as "Great!" and "Pretty neat." This conversation about John's accomplishments seems to be directed toward both Caitlin and me and Caitlin asks John if his (previous) company had received any new business because of John's talents. He answered with some regret "...yeah, but not enough to pull me back onto the payroll--never enough" (C/J, 3/11/92, p. 2).

During this time Caitlin does not rush John to get started with treatment. Instead, she lets him proceed with this conversation which gives him a chance to share some of his past accomplishments with us. During the conversation, however, Caitlin has moved, almost imperceptably, to be seated on a low rolling stool about 4 feet in front of John and she leans forward attentively as John sits in the same place on the mat table holding and massaging his spastic left arm and hand. It is only after several minutes have passed and when there is a pause in the conversation that Caitlin says softly "...why don't we get started." She asks John to take off his sweatshirt (so she can observe his shoulder movements more closely and accurately) and says "I'm going to have you start out with the Codmans exercise to kind of warm up your shoulder a bit." Codmans exercises are relaxation and mobility exercises, done in standing with the arm dangling forward, with which John appears familiar. As John begins to rise, he asks if he can leave

the sweatshirt on while he is warming up and Caitlin replies "Sure." He also asks if he can use his other arm to help his left arm--something he says he has done at home sometimes--and Caitlin says "...first, let's just try it with the trunk and see how much relaxation you can get--if you need a little bit of assistance [with the other arm]-- then, that's OK" (C/J, 3/11/92, p. 3).

John, with the assistance of his cane, and Caitlin now move together toward the counter in the middle of the room, talking as they go. Caitlin asks about how often John is doing his Codmans exercises during the day and John answers "three times a day." Caitlin probes a bit more: "Do you do it....?" but John answers her before she completes the question. "Usually just before my shrugs [another exercise] and after I use my Thermofore [a heating modality]..." (3/11/92, p. 3). Then John continues to describe, as Caitlin had hoped, how he works his exercises into his daily routine.

Several features of the interaction in the vignette above stand out and also become apparent in the following vignette which describes the beginning the second session I observed. First, although the transition into treatment is certainly "organized" it does not seem tightly structured and hurried. Sessions inevitably begin with social conversation as John and Caitlin enter the room, which gradually "fades" into more therapist directed and treatment oriented activities and talk. There is often a period of time spent in gathering information from John about how his home exercises and activities have been going and how they are being integrated into his day. In the above vignette, although Caitlin clearly said "let's get started" to

signify movement from social conversation to educational and treatment activities, this signal seemed to come at a time when there was a natural pause in the conversation and it was not a stiff, loud, or hurried directive. In fact, *nothing* is stiff, loud or hurried here.

Caitlin shows an economy and fluidity of movement which John seems to follow. There is an economy, also, of her own vocalizations which are soft and unhurried and she speaks without dramatic inflections or changes in tone; in fact, she almost speaks in a monotone at times. John seem to know the "routine" or expectations enough that he, for instance, doesn't need instructions to get up and go to the counter to do his Codman's exercises--he just does it; in like manner, he anticipates Caitlin's question about his home routine before she completes the question and answers her as she had hoped he would. This kind of completion of sentences for each other and overlapping or connected conversation occurs frequently during treatment sessions.

Finally, Caitlin lets John have some control of the transition into therapy in this situation. She lets him proceed with a conversation of interest and introduction (to me) which he initiated at the beginning of the session. She doesn't insist on him taking his sweatshirt off immediately for the performance of the Codman's exercises. On the other hand, she does gently direct him toward a particular mode of his performing the exercises that she wants to observe before she let him try an alternative mode (assisting the left arm with the right arm). Thus there appears to be a negotiated co-construction of both

conversation and activity at the beginning of therapy as described in this vignette.

When I talked with Caitlin about these observations--about the transitions into treatment which, in some cases, made it hard to determine when treatment, per se, had begun--she suggested that this is something she does consciously: "Well, I think that's good for the patient. It's not like, 'Alright, let's hop on up here' [and get going]" (laughing) (C, 6/3/92, p. 3). In regard to the slowness, and deliberate yet fluid character of her movement, Caitlin laughed about how this contrasts with the way she is in her personal life; in fact, she said "...usually, I am just buzzing around all the time" and added that her husband can't keep up with her. Even so, she realized that she is different when she works with her patients:

> Now, I think, with patients, I'm a little different. I have to very consciously slow down. So maybe--because of my conscious slowing down, it [my movements] look very deliberate. (C, 6/3/92, P. 3)

When she is working with John, Caitlin said she purposefully does not move around much because of his "distractibility" and her desire to focus her full attention on what information is being exchanged between them. She gave me an example:

> I mean, for example, if I were waiting for him to take his sweatshirt off--or this or that--um, you know, he's distractible. So, if I was doing something else while he was taking his sweatshirt off--like getting other things lined up or that type of thing--I know that it takes him a long time to get his sweatshirt off, so I will use that time as an interactive

> time, not as a set up for this or that...[I'm] trying not to interfere with the kinds of information I get from him while he is taking his sweatshirt off. As you may notice, he tends to follow me around the room--where I go--so, I try to limit where I go and where I move and keep the focus on whatever information we're exchanging whether it be how he's sleeping at night, positioning, or whatever. (C, 6/3/92, p. 3)

So part of Caitlin's economy and slowness of movement in her interactions with John are attempts to diminish distractions in therapy and to allow her to "focus" on, or give her undivided attention to, what John is saying and doing at any given time in therapy. The types of "information" gathered or exchanged as John removes his sweatshirt are (a) observations of his function in this task of daily living, (b) observations of the quality of his shoulder and arm movements, and (c) reports of the pain or difficulty he is having with the task as he completes it. Let's see how these assertions and Caitlin's perceptions of her interactions with John are played out in the beginning of the second therapy session I observed (C/J, 3/18/92).

As Caitlin and John moved into the gym from the hallway, they were both bantering about their Irish backgrounds and what they did to celebrate St. Patrick's Day the day before. They talk about their family names and customs as they walk side by side toward a high treatment table near the entrance to the gym (see Figure 5). Interspersed with this conversation, Caitlin quietly asks John to take off his sweatshirt as she assumes a relaxed position standing with her back against the treatment table with her hands held together loosely in her lap. John moves to stand about five feet in front of her and

begins to remove his sweatshirt as the bantering about Irish customs and families continues.

At one point, John is encountering some difficulty in taking his sweatshirt off and he steps closer to Caitlin and extends his arm as if to ask her to take the shirt off for him. She doesn't move and quietly says "...can you, you pull that off on your own? I'm just seeing how, functionally, how you're doing as the arm changes and I can't do that if I help you..." (C/J, 3/18/92, p. 2). John proceeds to pull the sweatshirt off using his teeth and other arm for more assistance as Caitlin remarks "...still pretty limited movement [of the shoulder] as you take it on and off." John replies: "I move it as far as I need to." He holds the dangling sweatshirt up with his right arm extended toward Caitlin and she grasps the sweatshirt and, without removing her gaze from John, neatly folds the sweatshirt and holds it-- really "hugs" it--in her lap. As she does this, she begins to ask John about his arm position and pain at night when he is sleeping. John, seems to interpret this question as meaning it is time to lie down on the treatment table. He begins to walk toward Caitlin and the treatment table as she smoothly steps away and around John. They exchange positions, as square dancers might in a dosey-doe, and she places the sweatshirt on the nearby counter as the maneuver is completed.

As John positions himself in sitting on the table, Caitlin grasps some pillows from a nearby chair, holds them against her chest, and then stands next to the table about three to four feet away from John as they continue to talk about his home activities. During the course of this conversation, Caitlin signals with a small sweeping movement of

her hand toward the head of the table. With this, John moves to lie down on his right side, and they both work together, with the use of the pillows, to get John into a comfortable position for a heat treatment to his left shoulder prior to Caitlin starting some mobilization procedures. While they are working to find a comfortable position for John, the conversation moves from first talking briefly about how John's wife, Diane, is doing, to a return to some Irish storytelling. Caitlin tells John how much she enjoys his storytelling and hearing his life stories. John begins to sing (with a marked brogue) "When Irish eyes are smiling...." and tells Caitlin that he probably woke the neighbors with his singing last night. Caitlin says "It's good for them... reminds me of my brothers..." and John begins a chorus of "O, Danny Boy." Caitlin, smiling, is now placing the thermofore (a heating modality) on John's left shoulder and asks "Does Diane like celebrating the holiday with you?" They talk a bit about Diane again and during a pause in the conversation, without interrupting John, Caitlin gives him some instructions regarding the safe use of the thermofore at home and in the clinic.

There are several significant points to make about the scenario described above. First, it is only now that some observers might say that treatment has actually begun (with the application of the thermofore). In fact, a considerable amount of treatment in terms of information gathering and sharing has already occurred. Again there has been a smooth transition into the treatment session that has been characterized by fluidity of the conversation and activity and the minimalization (or economy) and slowness of movement on Caitlin's

part which John seems to follow. They seem to move in tandem at times as if they were partners in a dance. Caitlin is not "pushing" John in terms of hurrying him on to the table or to lie down and she is not limiting the conversation to topics directly related to his therapy. Their "social" conversation and listening to his stories are not taken as interfering with the business of therapy--they are part of it. There is not the pervasive bustle "to get on with it" and rush to be efficient, often at the expense of *hearing* the patient, so familiar in my observations in other rehabilitation clinics.

Although Caitlin clearly has certain things that she hopes to accomplish during each treatment session with John, she doesn't let her predetermined sequence of desired activities or time dictate what will actually happen during a session. Instead, John's presentation on a given day and his stated needs are are "put into the equation" at each session to come to a final determination of how to proceed and what needs most attention on that day. For instance, on this day, later in the session, John expressed concern about increasing spacticity in his fingers which was resulting in the poor fit of a splint that he uses for his hand and wrist at night (commonly referred to as a WHO or a wrist-hand-orthosis). Once expressed, Caitlin let John's concerns be a guide to treatment on that day and spent a considerable amount of time making recommendations and encouraging John to bring the splint to the following session so that she could evaluate it's current fit.

In the same unhurried manner, Caitlin lets John weave his life stories into the treatment session; in fact, she encourages and commends him on his stories. (We have seen this in the earlier

vignette with his stories about his videoproductions.) There is no evidence of blatant directives which say, in essence, "Now we're doing therapy and there's a time and a place for those other things." This contrasts with the all too familiar model of hurried "data collection" from patients through a rapid fire of questions from health care practitioners as they try to establish diagnoses and develop treatment regimens for clients with little attention to the stories that embody their illness and describe the social networks in which they live. Nonetheless, there are times when Caitlin will redirect John toward the "business" at hand although she usually does so in a way that is not abrupt or offensive. I will provide some examples of the forms such redirection takes with John shortly.

Finally, it is noteworthy that in this vignette Caitlin has brought Diane into the conversation twice during this brief period of time. In doing so, she explicitly recognizes that Diane is an important part of John's support system right now as well as someone who Caitlin will need to be a participant in John's ongoing therapy when regular PT sessions with Caitlin are no longer warranted or possible. The weaving of Diane into the conversation and activity of John's therapy will be discussed further in Chapter 5.

Before I move on, I would like to pursue and illustrate a few of the assertions above in more depth. I have spoken repeatedly of the fluidity of movement during the beginning of each of the sessions described above. I would like to share, first, one more example of the rhythmic association we have glimpsed between Caitlin and John as it occured in the midst of a treatment session. Second, I want to describe

a discrepant case--a time when this rhythmic association of movement and fluidity of conversation broke down. Such cases were so unusual that I believe they may act as "exceptions that prove the rule."

During a therapy session in late March (3/25/92), Caitlin was having John demonstrate his Codman's exercises to check on his technique since these were a very important part of his home exercise program. John moves to the counter in the middle of the room and supports himself with his right arm on the counter as he bends forward to let his left arm "dangle" (as loosely as possible given his hypertonic muscles in that arm) down toward the ground. He begins to demonstrate his inward and outward movements with his arm in this position. Caitlin is standing directly in front of John as she observes for a moment and then provides some pointers. She bends forward, as he has, to demonstrate the exercise; her face is about one foot from John's. As she mirrors his performance of the exercise she says softly,

> As you're in this position, you don't really need to work on this [showing the inward movement] since that's how your arm normally tends to posture. Just let, let yourself push out into this position [showing the outward movement] slowly and then rela-a-ax it back to the center. (C, 3/25/94, p. 4)

Then, still in her forward bent position facing John, Caitlin reaches forward to gently guide John's left lower arm in an outward movement as she softly says "...push o-o-out--and rela-a-ax. Push o-o-out--and rela-a-ax. Just let the arm da-angle. Relax at the shoulder up through here..." (C, 3/25/92, p.4). Shortly thereafter, Caitlin places her right hand on John's shoulder girdle and pivots slowly to stand at John's left side with her left arm lying directly next to his as they silently

perform the exercise in perfect unison for several repetitions. As John appears to get the rhythm of the exercise and Caitlin feels the relaxation and freeing movement in his shoulder girdle, she says "...that's it, that's great. Using a little bit of your trunk and each time getting a bit more range [of motion] each time with the arm itself" (C/J, 3/25/92, p. 4). As John continues with the exercise, Caitlin then rises to stand slightly behind and to his left side as he does a few more repetitions on his own while she observes.

This is one of many examples when it seemed that Caitlin is doing the exercises *with* John by making herself an extension of his body. There was a rhythmic synchronicity, a sort of choreography, between John and Caitlin as they moved smoothly and in tandem when Caitlin was mirroring John's movements and when they were doing the exercise side by side. In addition, Caitlin's voice and words at this time are soft, slow, and lyrical as if to mimic the rate, intensity, and flow desired in the performance of the exercise.

In contrast with the example above is the following segment of a treatment session during which, after a very fluid start, there is some communicative confusion between John and Caitlin that temporarily disrupts the flow of movement and conversation during treatment and leads to asynchrony and dissociation in the interaction. Caitlin is performing some scapular and shoulder joint mobilization procedures on John's left shoulder as he lies on the treatment table on his right side. These procedures are small movements of the involved joint structures that require that the practitioner grasp the joint surfaces firmly and yet move them in gentle oscillatory movements

which should not produce pain at the involved joints. During one particular maneuver, Caitlin is leaning against the treatment table next to John, and is leaning forward with her body between his left arm (which she is cradling against her chest) and his trunk. Her right hand is on left John's scapula (shoulder blade).

Caitlin begins to rhythmically rock John's arm and scapula forward and out from his body in very small increments. As she does this, she let's him know what he should and *should not* feel during this maneuver: "I'm going to just rock your scapula forward– feel that?" (C/J, 3/18/92, p. 6). John mumbles "yes" and then Caitlin asks "...any pain with that?" She is talking very softly and soothingly now, reminding John that this maneuver should not be painful and that he should let her know if it is painful so that she can "drop back." Eventually, John says "...right at the end of that one–that hurt a little." Caitlin immediately lowers the arm and and says "...okay, I'm just going to work in this range here. Are you still having any residual pain from your fall?" John answers that he does–but only in extreme stretch positions. As Caitlin continues to work rhythmically with John's arm, he sighs and says "...oooh, that feels good" but when he starts to wince a bit, Caitlin reminds him to relax as she drops back on the movement again. John says "I was almost asleep–you can't get much more relaxed than that." Just after this exchange and adjustment of the exercise procedure, John suddenly raises his voice, becomes more animated, and says, rather dramatically and with a grimace on his face, "...until suddenly this sharp, searing, jolt of pain comes through my shoulder." Upon hearing this, Caitlin immediately stops moving John's

arm, moves away from him (though still holding his arm) and looks directly into his eyes as she firmly questions him: "Are you acting right now or are you serious?" John looks at her, smiles and says "Why? Pretty good?" Caitlin, with a sigh of relief, says "...yeah" but she now assumes a much more formal and firm tone with him as she resumes treatment: "Alright, I'm gonna slowly move your arm up and I'd like you to tell me when you have pain" (C/J, 3/28/92, p. 6).

In this segment we see the extent to which Caitlin depends on John to give her honest and frequent feedback about what he's feeling so she can adjust her treatment accordingly. There was a physical closeness between John and Caitlin, a fluidity of movement, and smooth conversation about the therapy and what John should and was feeling, until John did his bit of "acting." When John acted as if he had pain that was not expected or consistent with the amplitude of the mobilization maneuver, Caitlin became momentarily confused. She did, however, respond to John's verbalization immediately and stopped the maneuver. She recognized both (a) the potential for his pain to be real, and (b) the potential that he could be acting which he has done for her (and me) on other occasions. This occurrence and moment of interactional confusion changed the tenor of the conversation and the nature of therapy activities for a short period during the rest of the treatment session. Caitlin created more physical and conversational distance between herself and John--she became more stiff in her posture and more firm and directive in her interactions with John for the next few minutes of therapy. What is also of note in this segment, and is relevant to another assertion I will make shortly, is that during

this time of extremely close physical contact between John and Caitlin, the conversation between John and Caitlin has revolved *only* around the physical therapy treatment--what Caitlin is doing, why she is doing it, and the gathering of feedback and treatment related information from John. There has been no conversation of a personal or social nature at all.

The rhythms of therapy with Marcia and Bill. In the above descriptions, I have focused on the smoothness of movement, the intermingling of treatment oriented and social/personal talk, and the general rhythms of transitions into, out of, and within therapy sessions drawn from observations of Caitlin and her client, John. These patterns also appeared during my observations of therapy sessions with Bill and Marcia. In all cases (five sessions with Bill, eight sessions with Marcia), there was what I call a "settling in period" at the beginning of therapy which extended from the time Caitlin came to get the client in the waiting room to the time actual exercise regimens or specific treatment techniques were initiated on any given day. During the settling in period, conversations usually centered around how things had been going in the client's day-to-day activities and what they had been feeling/doing, how their home exercise programs had been going, and a review of what had been accomplished or done to date at home and in therapy.

In the case of Bill, topics covered during the settling in period or the transition *into* therapy ranged from concerns he had about his work tolerance and performance in the pharmacy, to questions or comments he had about his home exercises, to conversations about

his family cottage "up north" or his attempts to return to golfing. Likewise, the closure of therapy sessions included an interweaving of treatment and more personal talk on similar topics in addition to confirmations about when future appointments would be.

As with John, these conversations almost always began and ended in the waiting room or hallways of the clinic as Caitlin and Bill walked side by side to and from the therapy gym. Consistent with observations from sessions with John and Caitlin, the settling in period was seldom hurried and there was a prolonged period of undivided attention and careful listening on the part of Caitlin as Bill talked about how things had been going for him. Across the five sessions I observed between Caitlin and Bill, the transition into therapy--that is, the period of time from the initiation of filming (usually when Caitlin and Bill had seated themselves in the therapy gym) to the beginning of formal instruction in or performance of a therapy exercise--ranged from four and one-half minutes (5/19/94) to a little more than twenty minutes (6/16/94) during a session when Bill expressed, at length, his concerns about the difficulties he was experiencing at work as a result of his disability.

During these periods of initial listening and conversation, Caitlin sat on a small rolling stool adjusted to the same height as that of the mat table on which Bill was sitting. She sat either directly in front of Bill or slighty to his right, leaning forward attentively as she either supported herself on her own knees or on a small rolling table on which she kept some paper, therapy supplies, and Bill's therapy chart. As she listened and talked with Bill, Caitlin watched him

intently and occasionally jotted notes to herself on her record. Such positional and other non-verbal expressions of careful listening and interest were not reserved just for the beginning or end of therapy sessions but were interspersed throughout sessions especially during transitions between exercise segments (segments devoted primarily to formal instruction in and performance of exercises).

A similar pattern of smooth transitions into and out of therapy sessions, characterized by (a) focused attention on the client displayed through verbal and non-verbal behaviors, (b) an interweaving of treatment and personal/social talk and (c) a fluidity and synchrony of movement between client and therapist, also held true in my observations of Caitlin and Marcia working together. In Marcia's case in particular, many therapy sessions concluded with a period of walking outside on uneven surfaces and practicing various aspects of golf. Returning to golfing activities without dizziness and losses of balance was a primary functional goal for Marcia. Not surprisingly, then, many of the transitional activities and conversations for Caitlin and Marcia concerned this topic as golf became part of treatment and treatment became part of golf. The purposeful integration of golfing types of activities into therapy reflected Caitlin's recognition of the meaning and importance of this recreational activity for Marcia and is one example of client centering in day-to-day practice.

To conclude this discussion of some of the rhythms of therapy, I would like to return briefly to an assertion discussed tangentially in descriptions of interaction between Caitlin and John during

therapy sessions. As I have already pointed out, one of the features of interaction I observed was a relatively easy and smooth interweaving of social/personal talk with more formal instructional/treatment or professional talk between Caitlin and John. As I explored this phenomenon in more depth, I came to realize that there were some "norms" or "rules" that seemed to govern or be reflected in interaction between John and Caitlin during dyadic therapy sessions. These norms for interaction had to do with *when* certain types of conversations were appropriate and were related to the degree of physical closeness or intimacy between John and Caitlin during the time that conversations were taking place--they are what I call the proxemic rules for discourse.

The proxemic rules for discourse in therapy sessions with John. Edward T. Hall (1966) has written extensively about the influence of space or interpersonal distance on the nature of human interaction, action, and interpretation of action, within various proxemic zones. Hall asserts that the patterns and forms of activity and interaction associated with and deemed appropriate in different zones are socioculturally and situationally defined. Based on my preliminary observations of relatively predictable relationships between interpersonal distance and the nature and content of talk during therapy sessions with John and Caitlin, I decided to explore this relationship in more detail.

Analysis of videotape data from the four dyadic therapy sessions I observed revealed three common interpersonal distance zones which seemed to be most related to the content of talk

between John and Caitlin. I called these zones the close, intermediate, and distant zones. The *close* distance zone represents times when John and Caitlin are less than 12 inches apart and there are frequent or extended periods of body to body contact. Periods of close interpersonal distance occurred most frequently during the completion of certain joint mobilization procedures or some of the more difficult passive range of motion exercises for John's shoulder. The *intermediate* zone represents times when Caitlin and John were approximately 12 to 24 inches apart with intermittent or some physical contact (e.g., during moderate or light exercise guidance or the taking of goniometric measurements of John's shoulder motion). The *distant* zone represents times when John and Caitlin were more than two feet apart; these times were the most prevalent in therapy and usually involved observation of exercises and various forms of discussion with minimal (e. g., a light touch with extended arm) or no physical contact.

With regard to the classification on conversation, I identified two broad categories of the content of talk which were prominent in therapy. The first of these I call the social/personal category. During these times Caitlin and John engaged in seemingly informal, though purposeful (as I will point out later), conversation about themselves, their lives, and the people and experiences that populated their lives. An example of this kind of conversation (described earlier in this paper) is the time when Caitlin and John were sharing stories about their Irish heritage and family customs and practices around St. Patrick's Day.

The second category of conversation I have called instructional/professional. These were times in conversation when talk focused primarily on teaching and assessment of John's learning, and the evaluation and treatment or management of his problems (e.g., the performance of certain exercises or ways of completing functional tasks). Talk during these times was most frequently initiated and often orchestrated by Caitlin (although, as I shall point out, this was not always the case) and was directed toward the attainment of specific therapy goals. Thus, periods of instructional/professional talk might be called *therapist register* (Cazden, 1988; Ek, 1990). Cazden (1988) has defined a register in this way:

> In the total repertoire of ways of speaking in any community, some of those ways will be identified with particular situations of use. The talk associated with occupational roles comes quickest to mind: the ways doctors talk or lawyers, or sports announcers when they are on the job. Varieties of language associated with such conditions of use are called registers. A register is a conventionalized way of speaking in a particular role, and is identified as a marker of that role. (p. 159)

In this particular situation--therapy sessions with John in the context of this clinical setting and specific expectations and goals for therapy--Caitlin's therapist register involved talk (and associated movement) that served a variety of functions: topic or activity selection and transitions, attracting and showing attention and interest, monitoring, verbal and non-verbal instruction, physical

demonstration, refining, correcting, questioning, confirming, and summarizing.

After identifying and defining the above categories of interpersonal distance and conversation, I selected two "typical" or representative therapy sessions (3/11/92 and 3/18/92) and reanalyzed and reevaluated the videotapes of those sessions paying particular attention to these two factors. The relationship between the interpersonal distance zones and the categories of conversation that emerged in this analysis is shown in Figure 10. The analysis revealed that (a) instructional/professional conversation was predominant in the sessions, (b) although instructional/professional talk was evident during interaction in any of the defined physical distance zones, personal/social conversation did *not* appear during times of close physical contact , and (c) across the two sessions, personal/social was most common during periods of distant (24" or more) contact between John and Caitlin (see Figure 10). In the latter case, it was almost as if the more personal conversations and sharing of selves and life stories during these periods served as a source of a different kind of intimacy and closeness.

For the sake of brevity, I hope that some of the descriptions of dyadic interaction provided earlier in this chapter can serve as exemplars of the distance-conversation relationships I have discussed above. For example, in the case in which Caitlin is helping John to relax and refine his technique in the performance of his Codman's (pendulum) exercises, the majority of that interaction took place in the close distance zone. And *all* of the talk during that

CONVERSATION

PHYSICAL DISTANCE	Social/ Personal	Instructional/ Professional
CLOSE (0-12")		3
INTERMEDIATE (12-24")	2	5
DISTANT (>24")	2	2

Session A

CLOSE		4
INTERMEDIATE	1	4
DISTANT	3	4

Session B

Figure 10. Proxemic Rules for Discourse for Caitlin and John. Relationship between the degree of interpersonal distance and the nature of therapist-patient conversation. Social/Personal = informal talk about lives, self; Instructional/Professional = information giving/seeking about problems,treatment, etc.; Close = frequent or extended physical contact; Intermediate = intermittent physical contact; Distant = minimal or no physical contact.

period of close face-to-face interaction and body-to-body contact was instructional. After review of the four videotapes of dyadic therapy sessions with John and Caitlin, I found only one clearly discrepant, yet instructive, case of social/personal conversation occurring during a time of close interpersonal distance as defined in this scheme. Close examination of this singular case provides further illustration of the proxemic rules for discourse in John's therapy sessions and demonstrates the response of participants when this norm for interaction is violated.

Toward the conclusion of one of the therapy sessions (4/8/92), Caitlin and John are doing some work to gain further abduction (outward movement) of his arm. Caitlin is kneeling on the floor next to the mat table where John is lying on his back close to her. As Caitlin moves John's arm into abduction, she reminds him to let her know when he has pain and feels as if he can't tolerate any further movement. As she nears the completion of the movement with John's arm, Caitlin begins to take a goniometric measurement of John's abduction range of motion. She holds John's left arm in abduction as she uses her right hand to reach toward his shoulder with the goniometer to measure his movement. John's left hand is resting against Caitlin's left cheek as the following exchange about a movie that tells the story of a young adult's life and rehabilitation after brain injury takes place:

J: (Softly) Did you see the movie "Regarding Henry"?

C: Yeah (Softly)

J: I saw it the other night.

C: Did you, did you like it?

J: Yeah. It was vaguely reminiscent of us...

C: I didn't think it was, uh, very realistic–in terms of his disability–like, his arm was dysfunctional and he was picking up his daughter. But, uh, it was good in terms of the personal stuff. (She completes the goniometric measurement.) Okay, today we got to about 98°, um, the most we've really gotten was around 100°. And, gradually, if you can try to work that past 90°, that would be real helpful. I'm gonna bring you back down to 90°--which, now, probably isn't going to feel like much of a stretch. (C/J, 4/8/92, pp. 8-9)

Here, the personal elements of the conversation during this period of physical closeness appear to make Caitlin somewhat uncomfortable. Although she doesn't ignore John's question and observation about the relationship between Henry and his physical therapist, Caitlin responds only briefly to John's inquiry. Relatively quickly she reacts to this breach in the norms for interaction by postural stiffening, an increase in volume, and then begins to shift the conversation by criticizing the lack of reality in the filmmaker's depiction of Henry's physical disability (a hemiparesis or weakness of one side of the body not unlike John's). This could also be an attempt to remind John of his need to be oriented to his own reality--to stress the importance of continuous recognition and monitoring of what he can and can not do realistically and safely given his current status. Soon

thereafter, Caitlin departs completely from the "Regarding Henry" conversation and shifts the conversation to the topic and task at hand--the measurement of and discussion about his shoulder abduction range.

This vignette of a violation of the distance-conversation norms usually evident in interaction between John and Caitlin may serve as another example of an "exception that proves the rule" but it also raises the question of *who* made the rules. This particular case illustrates a reaction by Caitlin to a violation of the norm with little response from John save his not continuing with the conversation. Perhaps his discontinuance of the movie discussion is part of his recognition of the violation but it is clearly Caitlin who initiates a topic transition and a shift in the conversation away from personal to instructional talk. Did Caitlin unilaterally impose or create these rules to maintain a patient-professional relationship with which she was comfortable when working with John? I contend that she did not. The bulk of the evidence from the four dyadic sessions between John and Caitlin suggests instead that Caitlin and John co-constructed these norms for interaction. At different times and in a variety of distance zones each of them had opportunities to control or shift topics--Caitlin was *not* the only participant determining what was to be talked about during therapy. This is a point I shall discuss in greater depth shortly.

An interesting and final note, however, is that I found no such consistent evidence for interpersonal distance/conversation norms in interactions between Caitlin and Bill or Marcia. There may be

several reasons for this observation, all of which point to the social and interactive negotiation and construction of these norms versus the unilateral imposition and universal application of some prescribed rules to govern patient-therapist interaction. In the case of Bill and Marcia, because of the nature of their problems there were few if any times when conversation and the work of therapy took place in the close interpersonal distance zone; instead most interaction took place in the intermediate and distant zones. In both of these zones there appeared to be a relatively easy interweaving of social/personal and instructional/professional talk although overall, as was the case with John, instructional talk predominated. In addition, neither Bill nor Marcia had as much organic brain damage as John nor did they present with the unique constellation of cognitive, perceptual, affective, and language impairments that John had. Their abilities to read and respond to subtle verbal, non-verbal, and contextual cues in face-to-face interaction were not as diminished or challenged as they were for John. Perhaps, in the cases of Bill and Marcia, there was no need to co-construct such norms for interaction to accomplish the work of therapy and to develop and sustain alliances.

In summary, I have suggested that one of the components of the rhythm of therapy for John and Caitlin was the co-construction of some proxemic rules for discourse which contributed to the creation and sustenance of an alliance and enabled participants to do the *shared* work of therapy.

Asking the Right Questions and Listening to Stories

For me, therapists' descriptions of respectful listening combined with a commitment to client centering imply that, in the context of therapy sessions, therapists must do two things if they are to be able create and sustain therapeutic alliances: they must ask the right questions of clients and they must listen to the client's stories. It is to these two interrelated features of interaction between Caitlin and her clients that I now turn.

For Caitlin, and the other therapists in this clinic, asking the right questions meant asking the patient about their needs, goals and hopes for therapy. It meant seeking information about what was meaningful and important to them and then using that as a "guide to therapy." Recall Kay's discussion about the work of establishing therapeutic alliances and client centering:

> It's finding out what is the language of this patient?, how does this patient think?, what turns this patient on?, how do I then communicate in their language and in their value system and bring something to them that's valuable? (K, 2/3/92, p. 13)

Such "finding out" demands that therapists seek the patient's perspectives on their problems and expectations for therapy in a variety of ways--not the least of which is asking questions that will provide (a) answers to the above questions, (b) insight into the patient's "value system", and (c) a starting point for the creation of alliances.

Of the three patients I followed in this study, Marcia was the only client with whom I was able to attend and videotape the first

evaluation and treatment session with Caitlin. This particular first encounter between client and therapist is peppered with questions directed at information gathering from the client as are most medical or health care interviews. But what I want to focus on in this analysis is the frequency and nature of questions directed at ascertaining the patients' perspectives about their problems and determining what their goals and expectations are for therapy.

The initial session began with introductions between Caitlin and Marcia, a discussion about which other members of the clinic team Marcia had seen thus far, the gathering of some background medical history and information, and a description by Caitlin of some of the areas of function that she, as a physical therapist, would be examining today as part of her screening evaluation with Marcia. Prior to initiating the evaluation, Caitlin asks the following question:

> But before I start my screen, I guess what I'd like to know is what you feel, functionally, are any problems that you're having/ um, that you haven't recovered fully/ since the accident and the kind of rehab that you've had so far? (C/M, 5/17/94, p. 2).

In response to this question, Marcia discusses several areas of concern--things that bother her or things that she can't do or with which she is having difficulty. Marcia begins by saying "Well, of course the balance thing bothers me..." and proceeds to talk about how she currently needs to use a cane for balance and stability in walking and how she would like to "get away from that." She describes dizziness and problems with balance when she has to turn

her head and gives an example of how this is bothersome even in conversations with friends at church. She says she is "afraid" to walk long distances or on uneven surfaces and stairs because of her balance problems and because she "gets tired." And finally, Marcia complains of shortness of breath.

During this time, Caitlin listens intently to Marcia, occasionally records some notes on a paper in front of her, and probes intermittently for more detailed descriptions of the nature or perceived source of the problem for Marcia. For example, in follow-up to Marcia's reports of fatigue with walking and shortness of breath, Caitlin asks a clarifying question:

C: Do you fatigue in terms of shortness of breath or does the left leg just feel tired?

M: No, I don't think that's too bad// [the leg]

C: (Nodding)

M: Right <u>now</u>/ I'm suffering from shortness of breath because I have just had a <u>terrible</u> cold and I'm just <u>finally</u> getting over that

C: Mmmm, and this isn't a good time of year to have <u>terrible</u> cold (shaking her head)

M: Mmm, <u>terrible</u> (shaking her head)

C: cause of the pollen counts

M: cough, cough, cough (spoken)

C: [Yeah, Hmmm

(C/M, 5/17/94, p. 3)

So, in response to Caitlin's pointed question about what *Marcia* perceives to be her greatest functional losses and problems, Caitlin has obtained a plethora of information to guide both her evaluation and treatment program. In addition, as shown in the transcript above, she took time to explore *what the patient thought* were the sources or contributing factors to her problem with fatigue or tiring. Such probing, when combined with listening, has the potential to validate the patient's perceptions and guide the clinical interpretation and decision making process. An alternative to this approach is the quick ("efficient") determination and assignment of therapist or physician defined sources of and labels for the patient's problem(s) (diagnoses). As an aside, the transcript above also illustrates the use of repetition ("terrible cold") in the latter part of the conversation, a linguistic strategy which can show ratifying listenership and serve conversational involvement among participants.

The information provided by Marcia in this *10 minute* discussion did not go unheard by Caitlin. As the conversation concludes, Caitlin recaps what she has heard so far and checks her perceptions with Marcia:

C: So you would say that your main functional deficits that you're feeling at this point, um, since the accident, is the balance and some limitations in your walking...

M: ⌈Mmm hmm and limitations in that I can't make every move that I used to make. You know how you just bend over to pick something up or get something off the bottom shelf down there...(demonstrating this movement from a sitting position on the mat table)

C: ⌊Uh hmm (recording notes)

M: ⌊I'm not so sure if I can get down there by the bottom shelf and get back up again

C: (Nodding) ⌈So-o-o, any functional movements that really require that kind of dynamic balance// you're not so sure about/ That's important to know because what I want to do is, is look at structuring the eval and, you know, rehab around areas of function that are a problem for you. I mean I might find other things/ but we want to really focus on areas that, um, are of concern for you. (C/M, 5/17.94, p. 5)

Here, in Caitlin's summary of what she has heard from Marcia so far (and her offer of conversational time and opportunity for additions or corrections), she also *makes the ideal of client centering explicit to the client.* Marcia's subsequent therapy focused to a large extent on the functional problems she described at the outset of therapy--diminishing her dizziness associated with quick head and body

movements, improving her balance, and increasing her endurance and safety in walking long distances, on uneven surfaces and on stairs.

Another direction that emerged for therapy in this first session was that of incorporating golfing type activities as one of several ways to work on some of the problems identified above. In response to a question about times when Marcia is experiencing difficulty with coordination in day-to-day and recreational activities, Marcia talks about her love of and desire to return to golf.

C: Any recreational activities you used to do that are difficult for you now?

M: (Nodding) Well// Golf...

C: Were you a golfer? (looking intently at Marcia)

M: Oh, ye-e-ah/ (Nodding)

C: Are you not able to go anymore?

M: I never did, I never did quite/ I was going to try that when we were in Texas/ I thought, well, we're down there where it's warm and I'd gotten myself up to where I can walk a little bit/ uh/ I'm gonna try that /???)/ Well, it was just so awful/ so I said forget this/ I'm gonna fall right on over on that golf course

C: (leaning in and nodding)

M: So I just decided I'd cool that for a little while

C: So it was more related to feeling off balance

M: Mmm hmm

C: (records a note)

M: But the last day we were down there, it was just about the first or second day of March, they opened up a new driving range.... (C/M, 5/17/94, p. 12)

At this point, Marcia continues to talk at some length about her limited and previously unsuccessful attempts to return to golf (including going to the driving range and almost falling). During this narrative, Caitlin leans forward on her rolling table toward Marcia and responds verbally (uh huh) and non-verbally (nodding) as she listens to Marcia. Intermittently, she asks a few follow-up questions about dizziness and unsteadiness as they relate to Marcia's playing golf. As the conversation concludes, Caitlin asks:

C: Is your husband a golfer as well?

M: Yes (nodding)

C: So that's something the two of you do together?

M: [Mmm hmm

(C/M, 5/17/94, p. 13)

This conversation about Marcia's desire to return to golf and her aborted attempts to do so thus far went on for almost two minutes. Caitlin sought information about what kinds of recreational activities were meaningful to her client and in the course of listening to her stories she learned of Marcia's dizziness and losses of balance when

trying to resume golfing, her fear of falling, and that this was a social activity that she did with her husband.

Overall, the initial evaluation session with Marcia was filled with inquiries and stories like those described above. Caitlin actively and frequently solicited information about what problems Marcia found functionally disabling and her perceptions about those problems. She listened to the stories Marcia told which served to illustrate and elucidate the exact nature of Marcia's concerns and difficulties. Caitlin's subsequent focus in therapy on the areas of greatest concern and most importance *to Marcia* is evidence that she *heard* and respected Marcia's needs and goals and used those as a guide to treatment and evaluation.

The needs and goals that Bill voiced most frequently had to do with being able to (a) return to work and manage the demanding tasks associated with his job as a pharmacist, and (like Marcia) (b) return to some recreational and social activities like golf and bowling without dizziness, nausea, and falling. Examples of Caitlin attending to these needs in therapy can be found throughout all of the five sessions I observed. Here I will provide two typical illustrations of this drawn from the third session will Bill (6/16/94).

In the following vignette and transcript segment, Bill has been working on some exercises which involve quick lateral head movements (like shaking your head "no") and work on focusing his eyes on a target that Caitlin is holding about three feet in front of him. As Bill completes the exercises, Caitlin asks about how he's feeling and about the amount of dizziness he is experiencing. Then,

very explicitly, she relates the exercise to Bill's work situation and his expressed needs in that environment.

C: Now put that [movement] in the work setting/ you, you have six customers there/ you just processed an order here/ you know, you're trying to hurry/ you whip around over here (she turns quickly to her right)/ scan the shelves (waving her arm in front of her face)/ come back and look down (she turns back to face Bill and looks down)/ and you're having to

B: Right (Nodding)

C: First, stabilize your eyes, second, get rid of the dizziness, and third// trying to process that order

B: But I can't show the customers that! (smiling)

C: Uh huh (smiling)

B: Then I hold onto the counter

C: hold onto the counter?

B: Well, yeah, why not? (???)

C: (Nodding) That's right.

B: If you see somebody filling your prescription and he's weaving all over/wait a minute/ what are you going to think?// No way baby!

C: (Chuckles and smiles)

(C/B, 6/16/94, p. 7)

This transcript segment begins with a very precise verbal and non-verbal (movement demonstration) description by Caitlin of the types of activities Bill has said he is involved in on a day-to-day basis at work. Caitlin's description is important because it lets Bill know that she has indeed heard what he has told her about the types of demands placed on him at work. Secondly, she connects the exercise they are working on to those demands; she imbeds the exercise in the context of work. Caitlin recognizes that the head shaking exercise in and of itself has the potential to seem insignificant (and even silly) if decontextualized or disconnected from the perceived needs of the client. The conversation also provides an opportunity for Caitlin and Bill to further discuss his needs at work, how this particular exercise might help him, and to talk and laugh about some of the strategies he is currently using to avoid excessive dizziness and losses of balance in the pharmacy.

Later in the hour as Bill and Caitlin move toward the end of this therapy session, Caitlin explains to Bill why she is adding some more difficult exercises to his program at this time; In doing so, she and Bill engage in a conversation about how golf maneuvers can mimic or replace some of these difficult exercises.

C: We're trying to give you a little more challenge to orientation (tapping her ear, indicating the vestibular system) and some movement stimulus at the same time

B: (Nodding) Okay

C: Did you get out golfing this weekend? (Smiling)

B: Yeah, nine holes! (mimicking a small golf swing)

C: Alright!

B: [Played lousy, my kids played with me

C: [Did you follow your ball? [with your head]

B: [Yeah

C: [After you hit it?

B: [Most of them

C: [And no staggering like that? (she leans and steps backward)

B: Ummm// hmmm, a little bit, not bad though, because I've been trying at home [/???/-describes some maneuver he's been doing at home]

C: That's good! (smiling) Made your own habituation exercises!

B: [Do that about ten times and then just sit down and just relax, wait about an hour, and do it again

C: [That's good! (smiling) That's the same thing as laying down and putting your head down (demonstrates mini hall-pike maneuver)

B: [Yeah, yeah, same thing almost, almost the same thing, not quite

C: [Only this is a much more important movement for you

B: [And uh, for me it is, cause when I hit the ball....

(C/B, 6/16/94, p. 10)

Bill goes on from here to talk about his game with his son this past weekend as they begin to walk toward the door leading out of the therapy gym and back toward the reception area. As they disappear from view, Bill says to Caitlin "Thank you, I appreciate all the work you do."

The transcript segment provided above shows how *both* Bill and Caitlin have contextualized the activities and exercises of therapy by connecting them to and imbuing them with the meaningfulness of the social and recreational activity of golf. Caitlin commends Bill on some of the challenging golf type movements he has been doing and suggests that they are "the same thing" as one of the exercises she has asked him to do to "habituate" the vestibular system to movement and to decrease his dizziness. Furthermore, she encourages him to continue with his modification of the hall-pike exercise because the golf maneuver he is doing "is a much more important movement" (meaningful) for him.

What I have tried to illustrate in the above descriptions of discourse and activity in therapy sessions with Marcia and Bill is (a) how Caitlin went about asking the types of questions that encouraged patients to share some of their stories and discuss their personal needs and goals for therapy, and (b) how she incorporated what she heard and learned from patients into treatment and the ongoing stream of conversation in therapy. These are descriptions, then, of one way in which Caitlin and her clients jointly constructed therapy.

Asking the right questions, however, is not just about seeking information about the patient's needs and goals, hopes and fears–it

is also about inviting patient participation in other aspects of decision making about care even beyond goal setting.

Asking questions to invite patient participation in treatment decisions. In the previous vignettes we start to see how patients can also be involved in choices about the design and nature of their treatment or exercise programs. In such cases, the patient's choices usually need be integrated with or balanced with recommendations or choices made by therapists regarding care for the client so that a coherent and maximally effective treatment program can be developed. I will turn again to some examples from Caitlin and John's work together to describe the types of questions and activities that invite patient participation in this particular aspect of therapy.

In one interview Caitlin discussed how she tried to invite John to be an integral part of the decision making about what they would do in therapy:

> My focus was (as if speaking to John)--what functions can't you do at home? What are you having trouble with? What is of most concern to you? (C, 3/30/92, p. 5).

Since John expressed most concern about his loss and slowing of fine motor [hand] and left arm function, she "...let that be a guide as to [one] area of focus in treatment" (C, 3/30/92, p. 5). Concurrently, Diane's (John's wife) concerns about John's function combined with Caitlin's observations suggested that a major problem area for John was his balance and safety in walking. Thus, Caitlin was faced with the need for balancing the patient's perceptions, needs, and goals

with those of the therapist (and Diane)--the need to focus on both of these areas to create a maximally therapeutic treatment program.

So Caitlin's early therapy program with John included several exercises and activities directed toward improving the mobility and function in his left arm and hand. At the same time, Caitlin tried to help John recognize a need for working on his balance and safety in ambulation. She stressed that work in this area was important so that he could be more efficient and safe as he began to walk out in the community again--getting out into the community was a goal expressed by John. Realizing that John would be unwilling to do a full series of routine exercises for strengthening of his leg at home, Caitlin selected a few simple, but essential, exercises to be done at home in this area. In therapy, Caitlin worked instead with him on what she called "higher level" (more complex) and personally enjoyable activities directed at improving John's left arm, leg, and walking function.

As therapy progressed, Caitlin realized that John would benefit from the use of an ankle-foot-orthosis (AFO--a plastic brace or support for his foot and ankle) and later a cane to improve his gait pattern, stability, and endurance in walking. She also realized that John did not think he needed these devices for safety in ambulation. Yet she wanted to have John involved in the final decision about whether or not these devices were helpful or necessary for his walking. In an attempt to address John's lack of recognition or denial of the need for, and his resistance to, the use of the AFO or the cane, Caitlin and John would go out for walks in the community. They

would walk on varying terrain, in various settings, up and down curbs and stairs. Sometimes they would use the AFO and cane--sometimes they wouldn't. Then Caitlin said she asked John:

> Where and when are you safe? Where and when can you clear your leg? [So you won't trip and fall] With or without the cane? With or without the AFO? (C, 3/30/92, p. 6).

Although the use of this approach with John required several therapy sessions, indoors and out, Caitlin felt this was an approach that kept the patient in the decision making process about his rehabilitation. At the same time, it permitted her to share her professional knowledge and experience with John so that he might consider her recommendations when making his choice about whether or not the use of a cane and ankle brace would make his walking easier and more safe.

Caitlin talked about how she believed this approach, which involved work to align patient perceptions, expectations and goals with actual performance and potential, differed from other prevalent models of providing recommendations or treatment prescriptions for clients:

> I think it's a different approach than going in and saying, you know, 'you have to wear this--this is what I recommend--go home and have a good day.'...[I] let him be real interactive in realizing the need for that decision. And in many patients, what I often do is videotape them and let them watch themselves... and then ask 'What do you think looks best? Where does your walking look the most normal? And...when do you feel the safest?' (C, 3/30/92, p. 6)

This is a prime example of one of the ways Caitlin worked to establish alliances and keep the patient at the center of the rehab process while still bringing her own professional knowledge and judgment to bear in decision making about care. The decisions regarding the direction and nature of care are not hers alone. Decision making is a mutual process that takes into account both the patient's perspectives and the therapist's professional knowledge and judgment as they jointly make *informed* choices about treatment. Involving the patient in such decision making is a time consuming process when compared to more authoritative or prescriptive models of clinical decision making and practice. Only in an environment where one has the time, patience, opportunity for extended engagement (e.g., more than one clinical encounter) and support for these kinds of activities does this participative approach to decision making become feasible. In this clinic, patient *compliance* with unilaterally (therapist) prescribed treatment recommendations is not the goal. Instead, patient *cooperation* in collaboratively developed treatment programs is the goal and it is the therapists' responsibility to ensure that patients have been invited to participate in decision making about their care. Patient non-compliance or non-cooperation is not seen as a patient-owned problem; it is a shared problem for the clinician and patient.

A brief and final example of the ways patients can be invited to participate in decisions about their care comes from another therapy session with John and Caitlin. John has been experiencing increasing stiffness and spasticity in his left arm which has

contributed to continued pain and declining function. In response to John's questions and complaints about this problem, Caitlin introduced several ideas for managing the problem one of which is the idea of using an air splint to help with relaxation and repositioning of his arm during a therapy session. In the following therapy session (two days later) when John continues to complain about some of these problems, Caitlin asks: "On Monday, I mentioned the air splint. Is that something you would be interested in trying?" John responds by saying he would be interested in trying anything "...if it's going to have any promise..." (C/J, 3/25/92, p. 8). John's statement is read by Caitlin as a question about the potential benefits or promise of the air splint treatment. Caitlin describes further what the air splint does and how some other patients have responded to this intervention in the past:

> I've had some pretty good success with it in the past, um, with people using it, you know, for about twenty minutes or a half hour once or twice a day, um, to decrease the spasticity and the real tight, stiff feeling in the arm. Um, and I think it'd be easy for you to get on by yourself as opposed to the WHO [wrist-hand-orthosis] that's kind of a challenge. And it's really pretty comfortable. It just totally supports the arm and the warmth of the air around it relaxes the muscles..." (C/J, 3/25/92, p.9).

Several features of this conversation are important. First, the idea of the air splint as one *of several* treatment approaches to the management of muscle spasticity is introduced on more than one occasion. This affords the opportunity for patient consideration of treatment options over time. Second, Caitlin *asks* John if the air

splint intervention is one he might be "interested in trying." This question does two things: it (a) lets the patient answer either "yes" or "no" to the question and have a say in what kinds of treatment they are willing to try or not try, and (b) encourages further inquiries from the patient about the pros and cons, potential benefits and disadvantages of the treatment approach. Asking such questions, providing options and choice about treatment approaches to be adopted, and providing detailed information to patients about alternative treatment approaches was a recurrent interactional pattern in my observations of Caitlin with her clients. For her, the invitation to patients to participate in decision making about their care was essential to the development of alliances and the realization of client centering. Furthermore, reciprocal teaching and learning between client and therapist was seen as a critical feature of therapy that helped participants establish and realize mutually acceptable and beneficial goals and approaches to treatment. Together these things permitted the patient to give "informed consent" for treatment; but this kind of informed consent is far more than signing a piece of paper on a dotted line after a health care provider has *told* a patient what they think is best for the patient from the provider's perspective.

Storytelling in clinical encounters. In the previous section, I have suggested that asking the "right" questions of patients and listening to their stories are interrelated features of discourse between Caitlin and her clients that serve the creation and sustenance of therapeutic alliances and the realization of client

centering. Now I would like to briefly discuss the unique features of stories and what they might bring to the dialogic mix in clinical encounters and then elaborate on the extent and nature of storytelling in the context of the therapy sessions I observed at Jones and Thompson.

Reiser (1985) has written

> Medical encounters begin with dialogue. Language transforms the experience of illness into subjective portraits painted by the patient. The patient's account of events leading up to the sickness, of sensations felt indicating something is wrong, of interpretations giving the symptoms meaning are all part of the patient's *story*. The patient's role as narrator in the drama of illness has declined in the twentieth century. (p. ix) (italics added)

Reiser goes on to attribute the decline in narration and storytelling in medical practice to the dramatic increase in "technologically centered," objective, scientific, and logico-analytic approaches to patient evaluation and treatment during this century and asks "where, then, is there room for the patient's story" (p. ix) in the midst of all this technology and it's products?

Bruner (1986) has postulated that there are two distinctive modes of thought, the paradigmatic or logico-scientific and the narrative, and suggests, like Reiser, that the former has often been taken as the preferred mode for interpreting and *explaining* the world and experience in twentieth century Western society. Bruner argues, however, that the narrative mode of thought and discourse provides a powerful format for the representation and interpretation

of the everyday experience and meaning making of individuals and can contribute uniquely to an *understanding* of our own world and experience as well as that of others. According to Bruner (1986), narrative does this because it locates experience in time and place and "must construct two landscapes simultaneously" (p. 14). Bruner calls these two landscapes the landscape of action and the landscape of consciousness and describes them as follows:

> One is the landscape of action, where the constituents are the arguments of action: agent, intention or goal, situation, instrument, something corresponding to a "story grammar." The other landscape is the landscape of consciousness: what those involved in the action, know, think, or feel, or do not know, think, or feel. (Bruner, 1986, p. 14)

If narrative and storytelling can help us to more fully understand these landscapes that constitute the subjective experience of others, then the telling of and listening to the stories of patients is a feature of interaction we might expect to appear in the context of a commitment to the development of therapeutic alliances and client centering. The realization of alliances and client centering would seem to be hindered, if not impossible, in the absence of some narrative depictions of the client's perceptions and experiences especially as they relate to their illness. Indeed, I found evidence of many stories or accounts of experience that took a narrative form in therapy sessions with Caitlin and all three of the clients I observed.

To describe some of these stories I will turn first to the initial evaluation and therapy session with Marcia. During this session, Marcia shared three primary stories with Caitlin: the first of these I

call the "polio story," the second is the "driving range story" (some of which has been recounted earlier in this Chapter), and, third, the "tablecloth story." All of these stories were situated in time and place and entailed a goal, either met, unmet, or partially met. They describe what was happening at a particular time in Marcia's life and how Marcia felt about what was happening. These stories lasted between one and two minutes each and were not interrupted (except for "back channeling" types of responses) by Caitlin.

The polio story appeared about 13 minutes into the session and was told in response to a question from Caitlin about her medical history of mild polio. Marcia began the story with a series of statements which located the story in time: "I was about five at the time..." and "Well, you know there was an epidemic going around...." As she continues, she adds the proviso "you know, I remember this [story] mostly by my parents retelling it..." (C/M, 5/17/94, p. 4). This particular story lasted almost two minutes and included a sub-story about a chiropractor who was involved in some of Marcia's care for the polio. Caitlin listened to the story carefully and then explained to Marcia that she would keep the information conveyed in the story in mind as she proceeded through her evaluation. Marcia's history of polio could influence her current level of function in several ways--either by residual weakness from the original episode or from new symptoms emanating from a newly recognized and defined post-polio syndrome. Thus, information derived from the story will serve as a guide to some of Caitlin's evaluation. But perhaps what is more important is that Caitlin let Marcia convey this information in the

embodied form of a story (which lasted almost two minutes) and went uninterrupted. It was as if Caitlin recognized that there is far more to be gained from a story than information--these are powerful representations of the patient's life and illness experiences. They deserve the respectful listening of therapists and provide opportunities for expanded insight into the patient's needs and goals as well as opportunities for mutal engagement during therapies.

I will describe in more detail another example of storytelling in this therapy session--the tablecloth story. This story lasts approximately one minute and arises toward the end of the evaluation session when Caitlin asks Marcia to perform what she knows will be a difficult maneuver. Both Caitlin and Marcia are sitting about three feet apart facing each other, Caitlin on her rolling stool and Marcia on the mat table while Marcia is taking a rest break after a series of tests have been completed. Caitlin leans in toward Marcia and says:

C: I want to see if you are able to get from the floor to standing?/ Do you do that usually with support on the furniture?/ or can you do it without the furniture?

M: (Begins to smile and chuckle)

C: You're laughing on that one/ You been working on that one too?

M: [(laughing)

With this inquiry, Marcia begins the tablecloth story:

M: Oooh// I think it was like way back/ in// February? or December? (rubbing her left knee) that I had knitted this [???]/ anyway, I had knitted this tablecloth/ and I promised my son I would send that to them for a wedding gift/ he had to go to Germany/ so... (C/M, 5/17/94, p. 15)

Marcia goes on to recount a story of how she debated (with herself) about whether or not she should have her husband help her do some "blocking" of the tablecloth on the floor. Ultimately she decided to "just do it myself" and got down on the floor where she "crawled all around pretty good" (C/M, 5/17/94, pp. 15-16). Then Marcia realized she had to get up:

M: and I got it all done and then I thought, Mmm Hmm?
C:]How am I gonna get up? (Laughing)
M: [(Laughing, coughs) But I did/ I crawled over to the davenport
C: (Nodding) So with, with something to hold on to//
M: [It was a go-o-od workout
C:]you could get up
M:]Oh yeah, when I got to the davenport I could pull myself up
C: (nodding)

(C/M, 5/17/94, p. 16)

Once again, this story was recounted by Marcia with very little talk from Caitlin during the story except as shown above toward the end of the conversation when they finish the story together, laughing about Marcia's dilemma as they do so. By listening carefully, Caitlin gathered valuable information, in story form, about Marcia's function, her independent style, her family, and one of her leisure activities or hobbies.

These three stories that Marcia and Caitlin shared are just some of many that were woven throughout therapy sessions with all of Caitlin's clients. In the case of Bill, most of the stories told revolved around golf, his cottage "up north", or happenings at work in the pharmacy. In the case of John, the stories were more varied and revealing in some ways and I believe this may be related to the prolonged length of time that John and Caitlin had worked together and his own personal style--he seemed to have a special gift for humor and storytelling. For example, during the first session I observed of Caitlin and John working together (3/11/92), John told a story about an episode at soup kitchen where he was working, a story about a friend who raised giant lops (rabbits with long ears which John called "ingrown hares"), and a story about pork shoulders at the local grocery store (joking about his own immobile shoulder). Early in the session on March 18, the day after celebrating St. Patrick's Day, both John and Caitlin shared several stories about their family customs and practices on that holiday. This was a time when both therapist and patient were telling stories with a common theme--it was a time filled with laughter and mutual disclosure.

In the last session I observed, John told several stories that provided valuable insight into his experience as a person with a life threatening and disabling illness. John's "Las Vegas story" evolved out of description about how he responded when his neurosurgeon told him, after his last operation, that he had a limited time to live and offered the following prescription: "Get out and enjoy life--do something you've always wanted to do" (C/J, 4/8/92, p. 2). Finally, John's "crips story" told of a barroom brawl and the swell of emotion and activity when he and a friend "who also happens to walk with a cane" overheard a customer tell the bartender that "he didn't want to be sittin' next to a bunch of crips" (C/J, 4/8/92, p. 5). These poignant and descriptive accounts of illness, shared in narrative form, provide insights into John's search for and creation of meaning in the context of his illness.

Patient's stories offered to clinicians, when listened to and heard, provide an unparalleled opportunity to gain new or transformed understandings of the needs and lived experience of patients who are ill. And I believe the interweaving of patient and therapist stories into therapy, as illustrated in the above descriptions, is an integral and extremely important part of the creation and sustenance of therapeutic alliances between Caitlin and her clients.

Constructing Shared Language in Therapy

Stories have been called a universal language. They can serve, as I have tried to illustrate above, as a means for engaging interactants in conversation and for elucidating and understanding

the experience of others. But there are other linguistic tools or discourse strategies that have the potential to create connection between participants, foster conversational coherence, and provide for the development of shared understandings. In my observations and analysis of discourse in therapy sessions, I found evidence of work by participants to jointly construct shared languages (and potentially shared understandings) in therapy through the use of (a) metaphor and imagery, (b) repetition, and (c) what I will call "PT lingo." It is to these three features of discourse, which I will argue both facilitate and indicate the development of therapeutic alliances, to which I turn now.

The use of metaphor and imagery in therapy. In all therapy sessions I observed there was frequent evidence of the use of metaphor and imagery in conversations between clients and Caitlin and I became interested in exploring how metaphor was used in discourse in therapy and what functions it might serve. The nature and use of metaphor and imagery in language has been explored and discussed from a variety of disciplinary perspectives including anthropology, psychology, psychiatry, philosophy, psycholinguistics and sociolinguistics. It has been suggested that this figurative form of language can serve a variety functions including social (Sapir & Crocker, 1977), interactional (Tannen, 1989), cognitive processing and conceptual comprehension (Gibbs, 1992; Glucksberg & Keysar, 1990; Weiner, 1991). More recently, Ferrara (1994) has explored the potentially therapeutic functions of metaphor in her extensive and detailed analyses of discourse in psychotherapy sessions.

In her analyses, Ferrara (1994) focused on jointly created and extended metaphors and suggests that there are three primary ways that the creation and use of metaphor can contribute to the therapeutic nature of the speech event of psychotherapy sessions. First, she claims that the use of metaphor "constitutes a non-threatening way of talking obliquely about problems" (Ferrara, 1994, p. 129). Secondly, Ferrara asserts that

> ...metaphor distills and compresses thoughts and feelings, and allows for an economical condensation of themes. Metaphors provide a glimmer of understanding by summing up and generalizing global insights. (p. 129)

Thirdly, she points to the potential contribution of metaphor to the development of rapport and trust between therapist and client:

> ...metaphor is therapeutic when the mutual effort involved in creating and interpreting metaphor leads to the development of rapport between therapist and client. The successful working out, for example, of elaborate extensions of a metaphor fosters an atmosphere where participants come to trust that language can be used to advance mutual understanding. This rapport is in turn the basis for mutual endeavors. (Ferrara, 1994, p. 130)

In addition to these assertions, Ferrara suggests that metaphor is an important "sociolinguistic concern" insofar as it has an "inviting quality" which demands the attention of interactants and requires problem-solving and interpretational of work by participants (p. 131). Whether or not listeners accept the invitation of metaphor in conversation is what makes metaphor a sociolinguistic concern.

Long before I had encountered the work of Ferrara, I had completed my data collection and the majority of my data analysis and had formulated some of my own assertions about the uses of metaphor in the context of discourse between the physical therapist and her clients in this study. I felt that the creation and presence of metaphor in these interactions concurrently served several interactional, social, instructional, and therapeutic functions. The points of intersection between Ferrara's work and my own are most certainly of interest and I will return to a discussion of this later. But now, let me share some examples of discourse from therapy sessions to illustrate my observations of the forms and uses of metaphor in these particular speech events.

I turn first to some examples drawn from Caitlin's work with Bill. Toward the end of the first therapy session I observed, Caitlin and Bill have been talking about the need for him to continue with a daily program of walking for his general physical conditioning. In the course of this discussion, Bill interrupts Caitlin and, with some agitation and seeming personal frustration, talks again about his recurrent headaches which are a primary concern and functional problem for him.

B: See, right now I'm wearing a headband/ I'm wearing a hat right now

C: Yeah (sitting more erect and looking directly at him), feels like that, huh?

B: (Nodding)

C: And the hat just gets tighter and tighter

B: (Nodding and rocking forward and back) Tighter and tighter

C: Right, well our goal is to try and loosen the hat/ take it off altogether

B: Well I took a Motrin, so it's no problem/ but it's there

C: (Nodding)

(C/B, 5/5/95, p. 6)

Caitlin goes on from here to discuss some of the ways that they might work on diminishing Bill's headaches in therapy.

The above transcript segment illustrates several interesting features of the interaction. First of all, Bill interrupts Caitlin and introduces a topic change. Caitlin does not resist this shift in topic by trying to return to what she was talking about previously. Instead, she affirms that Bill's headaches are important enough to drop the topic of his walking program and engage in conversation about his headaches. Caitlin "accepts the invitation" of *Bill's metaphor*. She responds non-verbally and verbally to his description of his headaches as a headband and then a hat. She sits up and looks directly at him as she softly confirms that it "feels like that." She then extends the metaphor by suggesting (asking) that the hat seems to get "tighter and tighter." Bill responds with an exact repetition of her adjectival description of the hat--"tighter and tighter." Finally, Caitlin carries Bill's metaphor one step further by suggesting that a mutual goal for therapy could be to "loosen" or remove the hat. Although the hat for headache metaphor did not reappear in this

session as it came to a close, it did reappear in Bill's second therapy session in association with another descriptive metaphor for Bill's headaches: that of his talk of his headaches as his "old friend."

In the second session I observed with Caitlin and Bill, there were four distinct metaphors used in conversation during the hour-long session. Besides the headache metaphors described above, three other metaphors having to do with various exercises were introduced and jointly extended and transformed by Bill and Caitlin. The first of these appeared about 17 minutes into the session when Bill describes the feeling he experiences with certain maneuvers as the "sloshing" of water in a washing machine or bucket.

Bill has just completed one of his vestibular habituation exercises called a "hall-pike" maneuver. This exercise requires that he move quickly from a sitting position on the edge of the mat table to a side-lying position with his legs still dangling off the front of the table. Just as quickly, he must then move back to upright sitting and look straight ahead as he tries to focus his eyes on a target in front of him and maintain his balance. As Bill finishes the maneuver and looks straight ahead, Caitlin, who is sitting a few feet in front of Bill, softly says

C: How's that?

B: Okay, a little, yeah, yeah, yeah, that's the only problem I have/ feels like a washing machine there/ you know, like the water (waving his body in small circles), you know, buckets/ sort of slosh around a bit

C: (Smiling) Mmm hmm, It's very [???]/ that's kind of a good description of what's going on in there (pointing to her head and then moving her fists in a cyclic motion one above the other)

B: Yeah

C: The fluid, I mean everytime you move

B: Yeah

C: The fluid is

B: it feels like it's moving

C: Everytime you move, the fluid is being moved and that triggers the hair cells in the vestibular system (pointing to her head again)

B: Mmm hmm

(C/B, 5/19/94. p. 2)

In the above segment, Bill introduces a water image metaphor to describe his dizziness and response to one of his exercises. His metaphor invokes washing machines and the sloshing of water in buckets to try and explain what he is feeling. Caitlin commends Bill on this description (which she suggests is very much like what is actually happening in the semicircular canals of the vestibular system) and mimics the motion of water in a washing machine with her hands. Together, Bill and Caitlin extend and work with the metaphor with recurring references to "fluid" and movement.

Of interest is that this metaphor (or extensions and modifications of it) appears later in the session and are introduced by both Bill and Caitlin. At one point as Bill tries another exercise, he says: "I can still feel the sloshing" and Caitlin responds with a soft "can you?". Still later, Caitlin uses the water image to try and help explain what it is these exercises are doing and why it is important for Bill to let the water stop "swirling" between movements.

C: Imagine a little container with water (holding her hands out as if holding one)/ and you quick shift it this way (shifting to her right)/ and the water is moving around a little bit (moving her hands in circles one above the other as she did earlier)

B: Yeah

C: And you wait till that water settles down, and then shoo-o-oop you come back up (moving the container back to midline)/

B: (Nodding)

C: again and it shifts. If it's swirling all around and you just keep moving your

B: Oh no, that's not good

C: system [the vestibular system]

(C/B, 5/19/94, p. 3)

What is of note in the segments above (which were distributed across approximately four minutes of discourse in therapy) is that Caitlin has, once again, picked up on the metaphor *the client introduced* to describe something he was experiencing and has

woven that metaphor into the conversation over a period of time. As she does so, both Caitlin and Bill construct and transform, verbally and non-verbally, the water image in a variety of forms which help both Bill and Caitlin understand what is happening to him when he does some of his therapy exercises.

This particular way of using metaphor was a feature of discourse that Ferrara (1994) also observed in "successful therapeutic encounters" and she called this form or appearance of metaphor "ratification":

> ...typical of the successful therapeutic encounters that I recorded, however, is the frequent occurrence in which therapists, moments or minutes after a client's initial metaphor, bring that metaphor back into focus, either by repetition, synonym, or with semantically associated terms. This form I call *ratification* . What is communicated by such ratifications is that the client's word choice has been attended to and is deemed potent. When a client's own figurative language is held in consciousness for a while and then reemployed by a therapist, the message to the client is that metaphor is a valuable resource for understanding or insight. (p. 137)

With this analysis and description of metaphoric ratification in mind, I turn to another illustration of the dyadic exchange and construction of metaphor later in the same therapy session with Bill.

In the following exchange, Caitlin introduces a "high wire" metaphor to help describe the task of a walking on a line heel to toe and maintaining balance. Bill then engages and extends the metaphor as he introduces the "pole" used by tightrope artists into the image and Caitlin follows up on this extension in the ongoing

conversation. As Caitlin asks Bill to perform this "tandem walking" activity she reminds him that is a difficult task for him and that she will be nearby to assist if he needs her. They are standing side by side looking at Bill's written home exercise program as Caitlin says:

C: And I'm going to let you do it as if you're up on the high wire/ use <u>whatever</u> you need for balance (she stands in front of Bill and extends her arms out to her side)// arms out to the side

B: Where's my /???/ pole with the two weights on each end (acting as if he's holding a pole and balancing with it)

C: (Smiling) Yeah (chuckle) Is it weighted? Is that what/ I mean I knew the pole helped them but I didn't know it was weighted (mimics Bill's earlier action)

B: Well, they're, the pole's not weighted, but the pole's so <u>long</u>, it is a quite heavy pole you know, it pushes them /???/

C: Yeah (Nodding) Well, you just imagine yourself using that long pole...

(C/B, 5/19/94, p. 7)

At this point Bill begins to walking along a tape line on the therapy gym floor as Caitlin accompanies him by his side. They reach the end of the tape and turn around to return to the start point. As Bill is returning, Caitlin says:

C: Wow, you're doing wonderful with that big long pole!

B: Yeah, well, since I got a pole out there I can do it, well not really, but I can... (Bill completes the distance and turns around to face Caitlin)

C: Alright/ the stakes are getting higher/ let's bring the pole down to the side (brings her arms down to her side)

B: [I don't like that (brings his arms down)

C: [just, just resting them down at the side

B: Okay/ same thing?

C: [Mmm hmm (they begin to walk down the line together again)

(C/B, 5/19/94, p. 7)

Here we can again see the extended use of metaphor as Bill completes a difficult exercise. Bill accepted the invitation of Caitlin's high wire metaphor; Caitlin accepted, inquired about, and built on Bill's extension of the metaphor with the weighted pole image. The meaning of the metaphor was not static—it was interactively negotiated. There was also a great deal of movement and verbal repetition in this segment as both Caitlin and Bill jointly construct and use these metaphors. In addition to the movement repetition (arms out, arms balancing pole, arms down) that accompanied the linguistic repetition in this segment, a remarkable synchrony of movement was evident as Bill and Caitlin completed the activity walking side by side or turning to addressing each other at the end

of each trip down the tape. Collectively, these features of discourse contribute to an overall sense of engagement and enjoyment on the part of both Bill and Caitlin even though the actual task that Bill is working on is quite challenging for him given the nature of his vestibular dysfunction.

In the final minutes of this therapy session, the same improvisational yet fluid choreography is apparent as Caitlin and Bill complete some very challenging "footwork drills" on a grassy area just outside of the office. This segment illustrates once again the appearance and joint construction of metaphor, repetition, and movement synchrony in the flow of discourse as they combine to create a very real sense of involvement between participants--of a developing therapeutic alliance. Caitlin and Bill are facing each other, standing approximately three to four feet apart. Caitlin reaches to touch Bill softly on the arm and says:

C: We're gonna do a little footwork drill/ Alright?

B: Mmm hmm

C: What I want you to do is face me/ and as I go sideways I want you to go sideways/ as I go sideways/ If I go forward (moving in and touching Bill on the arm)/ I want you to go backwards

B: This is just like the cha cha cha!

C: Alright! Let's dance! (starts to move sideways) This way (points left)

B: (follows Caitlin)

C: This way (points right)

B: (follows Caitlin)

C: Quick turn around (turns around) Okay/ backwards

B: (turns around) ⌈That's no problem

C: ⌊we need a little music...

(C/B, 5/19/94, p. 8)

In this final segment, Bill introduces the concept of the footwork drill as a dance and Caitlin builds on that metaphor verbally and non-verbally as they complete these difficult maneuvers together. Bill and Caitlin continue their "cha cha cha" and various footwork drills for a few minutes, laughing and smiling as they do so, until they begin to walk back into the clinic side by side.

Thus far I have drawn on several extracts of discourse in a single session with Caitlin and Bill to illustrate how metaphor was used as a resource for the development of shared language and shared understandings between participants. The frequent appearance of metaphors in conversation during therapy sessions was not unique to Caitlin and Bill, however. The use of metaphor was a discourse strategy that was apparent in all therapy sessions I observed. Metaphors were introduced by both the therapist and clients. When clients introduced metaphors, Caitlin often engaged and extended the metaphor, ratifying the metaphor *and* the client as she did so. In addition, some metaphors were more enduring than others and were used across therapy sessions. I now turn to

excerpts from two different therapy sessions with John and Caitlin to illustrate the enduring metaphor phenomenon.

In a session on March 25, Caitlin has asked John to demonstrate an exercise that involves his trying to actively elevate his left arm and shoulder. Because of the nature of John's spasticity and loss of normal motor control, the movement that results looks something like the movement one makes as they try to start a lawn mower with a pull cord. In fact, in this session, John (quite appropriately) names the maneuver "the lawn mower start exercise." Caitlin chuckles at the name when first introduced and says "uh huh." A short time later, as John performs the exercise she uses the lawn mower metaphor to *correct* John's performance of the exercise. Such correction is inherently face threatening for John (Brown & Levinson, 1978, 1987; Cazden, 1988). But the use and extension of John's own metaphor as Caitlin attempts to get him to change the way he is doing the exercise may mitigate or soften this face threat.

C: When you do this [exercise] it's real important that you let it go real slowly/ and that's not a jump start.

J: You haven't started my lawn mower lately (smiling)/ it takes a jump start.

C: I know. But what's gonna happen if you if you do a jump start like that? What [muscle] are you stretching when you do that?

J: Pecs [pectorals].

C: And what's gonna happen when you do a quick stretch to your Pec?

(C/J, 3/25/92, p. 4-5)

Caitlin and John go on to discuss how quick stretching of his left pectoral muscles will increase his spasticity and tightness and how it is important to do this movement slowly. In the above excerpt Caitlin accepts the lawn mower description of the movement pattern as one that is applicable but tries, using the related terms "jump start," to modify the image to one that involves a slower movement than that typically associated with starting the lawn mower.

In a subsequent therapy session, the lawn mower metaphor appears again--first introduced by John, but later taken up by Caitlin. In a session on April 1 when Diane, John's wife, is also in attendance to learn some exercises, Caitlin is asked by Diane to clarify what kind of active motor control and movement John has in his left arm. In response to this question, Caitlin demonstrates the "lawn mower start" movement and, looking at John, says

C: Umm, you've got some gross/ like what we call/ kind of mass patterns of movement/ like if you try to lift the whole arm up to put it into the sleeve (demonstrates) or push it down, and it all moves out as [a unit

J: [Mmm Hmm

C: Okay? So/ mass patterns/ in terms of any kind of selective control/ mostly just your elevations and pulling back on the shoulder/ (Nodding, demonstrating the movement)/ umm, [that's not

B: [Like starting a lawn

C: [mower (mimics the movement)
[Ye-e-a-a-h (Smiles, chuckles)

(C/J/D, 4/1/92, p. 14)

In this excerpt, Caitlin introduces her own metaphor to describe the movement John has available in his shoulder and arm (getting into a sleeve). John does not respond to that metaphor but replaces it with the more familiar "lawn mower start" image which Caitlin affirms ("Yeah"). And a little later in the conversation she abandons her own metaphor and adopts John's metaphor instead when she asks John to demonstrate one of his exercises for Diane.

So here we see the use of a particular metaphor extended over two therapy sessions. We also see the interactional work involved in the joint construction and transformation of metaphors. Metaphors are not always accepted as presented--they can be rejected (Caitlin's sleeve metaphor), extended (jump start), or modified (slowing the lawn mower start) by interactants.

Metaphors can also be constructed and elaborated by more than two interactants. The session with John, Diane, and Caitlin offered several examples of how the three participants in this unique and difficult therapy/teaching session used metaphor as a resource for trying to develop a shared language and reach shared understandings about John's home exercise program. One such example occurred early in the session when Caitlin talks about an air splint she has ordered to help decrease the spasticity in John's arm.

C: (Turns to look at Diane) I put an order through/ for an air splint. Are you familiar with the air-splint?

D: (Shrugs, looks uncertain) Mmmm?

C: It's just like a sleeve.

D: Like a big water wing.

C: Yeah, and you can blow it up. And it didn't come in. I thought it would be in by today.

J: (Smiling) Will you give me two so I feel safer in the bathtub?

C: (Laughing and looking at John) Your little floaties...

(C/J/D, 4/1/92, p. 2)

In this brief segment, all participants are engaged in the construction and elaboration of a metaphor to describe the air-splint device for John's arm. At first it is an air "sleeve" (Caitlin), then it is a "water wing" (Diane) to be used in the bathtub (John), which makes it a "floatie" (Caitlin). Caitlin, Diane, and John use metaphor and humor to discuss a device that may, though potentially helpful, represents one more imposition in John and Diane's life. In doing so, they can obliquely and in a less-threatening way address the problem of increasing spasticity and declining function in John's arm. Furthermore, the joint construction of the metaphor is a collaborative effort; that is, all interactants accepted the invitation of the evolving metaphor. The use of metaphor seemed to encourage involvement and had the potential build rapport among participants.

As a final example of the use of metaphor and imagery in discourse in therapy I will draw on an excerpt from the initial

evaluation session with Marcia. Caitlin has been conducting some tests to assess Marcia's ability to use proprioceptive input (sensory information from the joints and muscles in her legs) to compensate for some of her losses in vestibular function. Such tests require that a patient stand on an unsteady, uneven, and non-firm surface as they work to maintain their balance. Caitlin uses a piece of foam for these tests. She stands close at Marcia's side and observes Marcia standing on the foam as she talks her through some of the tests. At one point she says:

C: Strange feeling isn't it?

M: Mmm hmm/ Like the earth is moving a little bit

C: ⌈Mmm hmm (nodding and moving to stand directly in front of Marcia)/ Alright (extends her hand to Marcia and helps her off the foam)/ step onto the solid ground and earth here/ (helps her off the foam) it feels so good...

(C/M, 5/17/94, p. 15)

In this excerpt, Marcia introduces the image of the earth moving. Caitlin validates Marcia's perception, extends the metaphor, and repeats the utterance "earth" when she offers to help Marcia the foam and onto "solid ground and earth".

In this section I have presented some examples of the forms and uses of metaphor and imagery evident in discourse in therapy sessions. My observations suggest that metaphor was a powerful

linguistic tool for the creation and sustenance of therapeutic alliances. The use of metaphors by participants almost always involved several of the features of interaction that therapists at Jones and Thompson described as necessary for the development of alliances: respectful listening, reciprocal disclosure, and mutual vulnerability (putting your description and interpretation on the line). I contend that the joint construction of metaphor is one of several features of discourse which can serve to build mutual understanding, rapport, and trust in the client-therapist relationship.

As I examined the use of metaphor in therapy sessions, another characteristic of discourse (and one that begins to emerge in the previous analyses focusing on metaphor), became apparent: the frequent use of repetition by participants. The prominence of repetition urged further exploration of the forms and functions of repetition in therapy sessions.

The forms and uses of repetition in therapy. Tannen (1989) has argued that the use of repetition in discourse is an important strategy for creating conversational involvement (Gumperz, 1982) and coherence, both of which serve the development of understanding or communicative competence among participants. Tannen (1989) describes four primary *functions* or uses of repetition in conversation, all of which serve coherence and interpersonal involvement. First, language *production* is fostered by the use of repetition; a speaker can produce more language, efficiently and fluently, when they repeat what they or others have

said. This use of repetition also allows a speaker to talk as they formulate what they wish to say next. Second, repetition or "redundancy in spoken discourse" (Tannen, 1989, p. 49) benefits *comprehension* by providing less new information on each pass or, as Tannen puts it, "by providing semantically less dense discourse" (p. 49).

Following Halliday and Hasan (1976), Tannen suggests that, thirdly, repetition fosters cohesion and *connection* through it's referential, linking, and tying functions. Through repetition, new utterances are linked to old and the relationship between ideas in discourse can be made apparent. Furthermore, repetition provides for connection or joint meaning making between participants in discourse by providing evidence of the speaker's attitude or evaluation regarding what is being discussed. For example, repetition of a certain phrase might suggest that the speaker feels something is important and signals this to the listener. While the above functions of repetition help create meaning in conversation, the fourth function, *interaction*, is one in which repetition is used to accomplish social goals, or for "simply managing the business of conversation" (Tannen, 1989, p. 51). Examples of repetition serving the interactional level of talk might include:

> getting or keeping the floor, showing listenership, providing back channel response, stalling, gearing up to answer or speak, humor and play, savoring and showing appreciation...., persuasion, linking one speaker's ideas to another's, ratifying another's contributions (including another's ratification), and including in an interaction a person who did not hear a previous utterance. (Tannen, 1989, p. 51)

It should be apparent that the function of repetition on the interactional level can overlap with functions that aid connection and meaning-making between participants and together all functions can act to create linkages or bonds between (a) parts of the discourse, (b) participants and the discourse, and (c) participants to each other, that is, repetition serves the creation of interpersonal involvement in conversation. It is the latter of these functions of repetition--the social endeavors of creating cohesion, connection, and maintaining interaction--that Ferrara (1994) focused on in her analysis of dyadic discourse in psychotherapy sessions. And it is these two functions that were of particular interest to me in my explorations of the creation and sustenance of therapeutic alliances in the context of physical therapy sessions. By focusing on the connection and interaction functions of repetition, I do not mean to ignore the other functions identified by Tannen (1989)--I will explore some of the production, instructional, and comprehension functions of repetition in chapters to come.

Beyond the functions of repetition, Tannen (1989) describes several *forms* of repetition. In conversation there can be both self- and other-repetition (allo-repetition). Fixity of form can vary along a scale from exact or whole repetition, to partial repetition, to repetition with variation, to paraphrasing. Along a temporal scale, repetition can be immediate or delayed within a speech event and can even be distributed across discourse in speech events separated in time. All of these forms of repetition appeared in discourse in the therapy sessions I observed but it is other-repetition, because of it's

intrinsic social functions, in which I was particularly interested when considering the development of alliances. Furthermore, the use of other-repetition in discourse is not unrelated to issues of face and politeness. Tannen (1989) suggests that repetition is a resource in talk that can serve positive face--the need for interactants to be understood and accepted and to have self-image appreciated and protected.

What follows are examples of the use of other-repetition drawn from sessions with Marcia, Bill, and John. These excerpts provide glimpses of various forms of repetition and illustrate some of the cohesion, connection, and interaction functions they serve in therapy.

The following examples come from the initial therapy session with Marcia. Of note in this *first* session is the frequency with which metaphors and other-repetition appear--this frequent appearance raises the question of whether these discourse strategies are used intentionally or voluntarily (though spontaneously) by the therapist (or clients) as part of the early work to create alliances.

The first example of repetition appears early in the session and has been discussed briefly earlier in this chapter. Marcia has been talking with Caitlin about how she fatigues much more easily than she used to (prior to the accident) but attributes most of her current difficulties to a "terrible cold." When she does so, Caitlin repeats Marcia exactly--both words and intonation--in her rejoinder.

M: Right now/ I'm suffering from shortness of breath because I have just had a terrible cold and I'm just finally getting over [that

C: [Mmmm, and this isn't a good time of year to have terrible cold (shaking her head)

M: [Mmm, terrible (shaking her head) [cause

C: of the pollen [counts

M: [cough, cough, cough (spoken)

C: [Yeah, Hmmm

(C/M, 5/17/94, p. 3)

Caitlin's exact repetition of Marcia's words can show ratifying listenership and suggest that Marcia's problem (her cold) is important. When this utterance is combined with Caitlin's non-verbal shaking of her head, it can also express empathy. Note that Marcia follows Caitlin's repetition with her own (Mmm, terrible) and also shakes her head as if to say "you got it!"

The following exchange takes place 33 minutes into the session as Caitlin seeks further information after Marcia once again complains that she fatigues more quickly and easily than she did before her accident. Caitlin asks:

C: Do you find you're taking rest breaks/ during the day/ not necessarily naps, but...?

M: [Mmm, not/ not a rest break/ more excuses to stop and have a cup of coffee (Smiling)

C: (Smiling, chuckles) [That's your definition of a rest break, huh?

M: [Yeah, that's my rest break (Smiling, chuckling)

In this segment it is Caitlin who introduces the term "rest breaks" as she inquires about the degree or extent of Marcia's fatigue and the impact that has on her daily routine. Subsequently, there is an alternating repetition of the term by Marcia, then Caitlin, and then Marcia as they settle on what "rest break" *means* for Marcia. This is a moment of constructing joint understanding for participants and provides considerable insight into Marcia's personality and lifestyle--she's not one for naps, likes to keep active, and enjoys her coffee and social exchange. Both Marcia and Caitlin are fully involved in the conversation and appear to enjoy (smiling, chuckling) the joint construction of this moment of sharing and insight.

A final example of repetition that illustrates the willingness of the therapist to hand over some control of the therapy session to the client occurs early in the second hour of the evaluation session with Marcia. Caitlin is asking Marcia to perform fairly difficult tests and maneuvers to evaluate the extent of her balance dysfunction. As she does so, she is always close to Marcia, ready to assist and stabilize her if necessary. When Caitlin introduces this last series of challenging tests, she warns Marcia that they may be hard to do and tells her to let her know if they need to discontinue any of the tests.

C: Now/ I need to tell you that these tests get progressively harder (smiling)

M: Mmm (smiling)

C: and if at any point you want me to stop or it just looks ridiculous/ 'You mean you want me to stand on my head with one leg out' (demonstrating an off balance maneuver on one leg)// you [can just tell me

M: [Yeah/ well] if you ask me to do that/ I'll just tell you/ this is ridiculous (waving her hands in front of her)/ forget it (smiling, [chuckling)

C: [(chuckling)

C/M, 5/17/94, p. 14)

In this segment, Caitlin pokes fun at herself and some of the maneuvers she may ask Marcia to perform. She also gives Marcia license to do the same and to discontinue the tests if they are too difficult. She says that if Marcia believes the maneuvers are "ridiculous" she should "just tell" Caitlin so she can modify or eliminate the test. Marcia then emphatically affirms that she will do so by repeating Caitlin; "if you ask me to do that, I'll just tell you, this is ridiculous, forget it." In this instance, repetition may serve some of it's interaction functions such as humor and play. But perhaps more importantly, the content of this utterance and repetition affords some control and power to the client in the evaluation session. It opens the floor for questioning of the therapist and the

procedures she is asking Marcia to complete and offers the opportunity to stop the tests at any time based on Marcia's request.

A clear indication that Marcia has heard this invitation to question the therapist and have a say in what happens in therapy occurs 20 seconds later when Marcia repeats Caitlin's "ridiculous" with variation ("foolishness") and makes an indirect request for more information about the purpose of the tests. In fact, Caitlin anticipates such a request:

C: What I'm doing is changing your base of support and the different sensory inputs that you use for balance so we can try to pick out what areas are triggering balance problems for you/ so I'm trying to real systematically look at that/ [plus I

M: [So, there is a reason for all this foolishness (smiling)

C: [There is (nodding and smiling)

(C/M, 5/17/94, p. 14)

Caitlin responds to Marcia's challenge and request with a smile and an offer of additional information before proceeding with additional tests. There is no defensiveness or friction apparent in these exchanges but clearly there has been interactional work to share power and control in therapy sessions across the participants. Such distribution of power could be contentious or difficult at best in many clinical encounters. But I suggest that the linguistic resources

of repetition (and metaphor), used liberally by Marcia and Caitlin in this first two hours of therapy, have helped to create therapeutic linkages (if not yet alliances) between Marcia and Caitlin that enable them to effectively and jointly accomplish the early talk and work of therapy.

I move now to some examples of the forms and functions of repetition in clinical encounters drawn from Caitlin's work with Bill. The first two of these examples have been presented earlier in the text but I will examine them now through the analytic lens of repetition. Recall the transcript segment when Caitlin commended Bill on an exercise he had developed for himself that mimicked a golf swing and which did the same thing as a less enjoyable and functional vestibular habituation exercise Caitlin had prescribed for Bill.

C: That's good! (smiling) Made your own habituation exercises!
B: Do that about ten times and then just sit down and just relax, wait about an hour, and do it again
C: That's good! (smiling) That's the same thing as laying down and putting your head down (demonstrates mini hall-pike maneuver)
B: Yeah, yeah, same thing almost, almost the same thing, not quite
C: Only this is a much more important movement <u>for you</u>
B: And uh, <u>for me</u>

it is, cause when I hit the ball...

(C/B, 6/16/94, p. 10)

Here we see Caitlin enthusiastically introduce the "same thing" phrase, which Bill repeats twice shortly thereafter. In this instance the use of repetition provides a chance for Bill to keep the floor for a moment and to savor and appreciate Caitlin's assessment and commendation about his self-developed exercise.

An example of bi-directional other-repetition comes from Bill's use of the metaphor of a "hat" for headache presented earlier. In this conversation, Bill first introduces the descriptive term "hat" to describe his headaches. Subsequently, Caitlin repeats the term "hat" several times as she explores the meaning of hat as headache for Bill. In her exploration, she offers one possible interpretation--that of a hat getting "tighter and tighter." In response, Bill *immediately* repeats Caitlin's description with exactly the same falling intonation.

B: See, right now I'm wearing a headband/ I'm wearing a hat right now

C: Yeah (sitting more erect and looking directly at him), feels like that, huh?

B: (Nodding)

C: And the hat just gets tighter and tighter

B: (Nodding and rocking forward and back) Tighter and tighter

C: Right, well our goal is to try and loosen the hat/ take it off altogether

B: Well I took a Motrin, so it's no problem/ but it's there

C: (Nodding)

(C/B, 5/5/95, p. 6)

In this segment, Caitlin's repetition of "hat" shows that she feels this description of his headaches as a hat is important and she signals this to Bill. Indirectly, she seeks an elaboration of his description: "Feels like that, huh?" Bill nods, but does not respond verbally. Then Caitlin offers a description--"tighter and tighter." Bill's immediate and exact repetition of this phrase (linguistically and paralinguistically) and his non-verbal nodding are both important. To me, this suggests Bill's agreement with or ratification of Caitlin's description. Indeed, in Ferrara's (1994) study of discourse in psychotherapy she found evidence that this sort of client-generated repetition, which she called "echoing," constituted "emphatic agreement in the therapy setting" (p. 113). Ferrara defined echoing as "the contiguous repetition of another's utterance or statement using the same downward intonation in an adjacency pair" (p. 113) and suggests that when a client echoes a therapist this represents an "instance of insight and empathy" (p. 111). She writes:

> Echoes occur when the therapist makes an interpretive summary about the client's experience, based on previous discourse by the client, and when the client wishes to signal emphatic agreement.... These echoings represent very important moments in therapy, when the therapist has made an insightful interpretation that is "spot on" and reflects the client's situation to such an extent that the client agrees, claiming the statement as his or her own. It is in fact therapeutic to be understood so thoroughly by another that

> you can emphatically agree with statements they make about your life. (Ferrara, 1994, p. 115)

Although Ferrara's work is drawn from psychotherapy, I suggest that the same kinds of repetition or echoes can and did occur in the context of physical therapy and are representations in discourse of moments of empathy and joint insight--they are illustrations of the transformation of shared language into shared understanding.

A final illustration of this particular form of repetition is drawn from the final therapy session with Bill. Prior to this segment, Caitlin is reviewing some of Bill's gains in therapy in the area of visual (eye movement) control when he moves or changes position. They both agree he has made substantial progress in this area although Caitlin reminds Bill that there will be continuing challenges for him in "real busy visual environments" like those he experiences everyday at work in his pharmacy. With this, Bill goes on to discuss some of these challenges and frustrations in his work situation, focusing his discussion on his use of the computer. The transcript below illustrates how the discourse builds through repetitions and iterations to an "echo" and a moment of insight.

B: Because I know at [work] I glance at my computer to see if it's been cleared yet or if it's been processed [an order]

C: [Uh huh

B: [I'll, I'll, I'll get ahead of the computer /???/. I'll be three steps ahead of it, and uh, they inserted a new step and it's been hard to master that

C: Uh hmm

B: Usually I master those things really quickly like

C: Mmm hmm, Does it prompt you? on the computer?

B: It will, but I don't wait, I can't wait for that. I got customers waiting, I've got to get those people out of there.

C: (Smiling) So you prompt the computer to hurry up!

B: I prompt the computer to hurry up

C: (Laughing, smiling)

(C/B, 7/5/94, p. 5)

In this excerpt we see frequent other-repetition of the terms "computer" and "prompt," but perhaps the most important instance of repetition occurs at the end of the excerpt when Bill echoes (with a pronominal shift) Caitlin's observation that Bill, in fact, is so fast that *he* prompts his computer, not the other way around! This is Caitlin's interpretive summary about Bill's style and drive in the workplace; it is a summary that is based on previous discourse in other sessions, this session, and this particular segment of the session. This interpretation truly does capture Bill's "way" as borne out in repeated discussions and observations and he emphatically and proudly agrees with Caitlin's description and interpretation.

Some additional, brief examples of the use of other-repetition are drawn from therapy sessions with John. Caitlin and John

frequently repeated each other and their repetitions serve to further illustrate the cohesion, connection, and interaction functions of repetition. In addition, these instances of repetition illustrate still another form of shared language that was especially evident in interaction between John and Caitlin--that of the use of "PT lingo" in discourse. In the following excerpt taken from a therapy session on March 11, John and Caitlin are standing side by side, bent forward at the waist, doing some "pendulum" (or Codman's) exercises together. John is trying to let his left arm relax and "dangle" as he gently swings it side to side in small arcs. John says:

J: The abduction and adduction exercises sometimes make my arm get tighter...

C: Yeah, that has to do with the spasticity in your Pecs (touching John's pectoral muscles with her left hand)// cause this movement kind of creates a quick stretch/ So, guiding it [with your other arm] is just fine

J: (Begins to guide his involved arm with the other; several movement repetitions)

C: Ye-eah/ Go-o-o-od. Slo-o-owly

J: (continues exercise) I need to establish a wider base (spreading his feet apart)

C: That's a pretty wide base! (Smiling, looking at John)

J: Yeah/ size 13 feet/ that's a wide base! (Smiling and looking at Caitlin)

(C/J, 3/11/92, p.3)

Toward the end of this segment of transcript , John introduces the term "wide(r) base" when he spreads his feet apart to create a larger base of support (which increases stability) as he does the pendulum exercises. Caitlin repeats his phrase and jokes with him about the degree of widening of his stance. In turn, John repeats her and extends the joke as he refers to his size 13 feet. Here we see the use of repetition showing ratifying listenership while also providing some humor and play in the interaction. In addition, the use of the term "wide base," like some of the other technical language or jargon that appears in the discourse (e.g., abduction, adduction, spasticity, Pecs), might not be considered everyday usage for someone describing a change in stance to increase stability. Yet physical therapists, and in this case, Caitlin *and* John, frequently and comfortably talk about the need for a "wide base" of support in a variety of activities. Finally, although it is not apparent in the transcript per se, there was a great deal of rhythmic synchronicity and movement repetition paired with the verbal repetition in the segment as John and Caitlin performed the pendulum exercise side by side.

The use of the term wide base (or modifications of it) appears again in a therapy session on March 25. The reappearance of the term or semantically related terms illustrates how repetition can tie previous discourse and ideas to current or new discourse (serving coherence) even as it serves to create interpersonal connection and encourages conversational involvement. In this segment, John is once again practicing one of his pendulum exercises and he spreads

his feet apart to widen his base of support as he begins the exercise. As Caitlin observes this she says:

C: Look out! (Laughs and steps out of John's way)

J: (Smiling) How do you think I maintain such good balance?/ I establish a wi-i-ide foundation!

C: That's about what I look like skiing going downhill/ a very wi-i-ide foundation. (Smiling, then bending forward at John's side to do the exercises in unison with him)// Slo-o-owly up and down/ as you come down let the arm dangle and relax

J: (Does several repetitions of the exercise with Caitlin and then rises) That feels great/ that feels just gr-r-eat/ to have it dangle that loosely...

(C/J, 3/25/92, p. 5)

In this particular exchange the talk about John's wide base of support is now talk of his "wi-i-ide foundation," but the meaning of the term and the interactive play involved in repetition of this term is preserved. In this case, as in the previous segment, it is John who introduces the actual use of the words which Caitlin then repeats and savors. In addition, the movement synchrony and repetition observed in the earlier session appear again as well.

Summary: Other-Repetition. Across therapy sessions with Marcia, Bill, and John, we have seen how various forms of other-repetition have encouraged conversational involvement and connection between therapist and client and how this feature of

discourse can contribute to the development of shared language, shared understandings, and the creation of therapeutic alliances. I do not want to suggest, however, that evidence of shared language, in and of itself, is evidence of shared understanding between interactants. Instead, I see shared language as a necessary but not sufficient condition for the development of shared understandings. There *can* be other-repetition without understanding. Metaphors *can* emerge and be explored in conversation without settling on mutually understood or compatible interpretations of those metaphors by participants. Even so, this does not diminish the *possibilities* these discourse strategies offer as participants seek the shared understandings essential to the sustenance of truly therapeutic alliances.

The shared language of "PT lingo" for John and Caitlin. As I observed John and Caitlin during therapy sessions I noticed the frequent and comfortable use of technical (anatomic and clinical) terminology by both John and Caitlin. This type of language is what I have called "PT lingo" and is illustrated in the transcript segment provided earlier in which John and Caitlin are doing pendulum exercises together. In that particular segment, the anatomic and clinical terms "abduction" (movement of the arm away from the body), "adduction" (movement of the arm toward the body), "spasticity" (abnormal and increased muscle tone due to nervous system damage), "pecs" (for pectoral muscle group on the anterior chest wall), and "wide base" (of support), appear in the conversation. The conversation flows naturally between John and Caitlin, there are

no misuses or apparent misunderstandings associated with the use of this language, and the use of these terms seems to create connection in the dialogue between participants.

I was interested in how and why this terminology was used in therapy since the nature and extent of this usage would not be considered normative in many PT-patient encounters. Most physical therapy students and practitioners are taught to converse with their clients using familiar terms and non-technical language so they don't confuse or clients by using language that is foreign or unfamiliar. Yet in every treatment session I observed with John and Caitlin, there was a significant amount of talk which involved the *mutual* use of PT lingo—there was talk about muscle groups and muscle tone, talk about specific movements, talk about orthoses and other splinting devices, and talk about goniometric ranges of joint movement, to name a few.

After observing numerous exchanges between Caitlin and John that involved the use of PT lingo, I asked both Caitlin and John about their use of this type of language during treatment sessions. Caitlin discussed this at some length with me during an interview.

> He's into that. He likes PT lingo. He's very interested. He's interested in learning about his body, he's interested in learning new terms. This is a guy who did video productions and would go in and learn all he could about the subject and then produce the videotape. And I noticed when I first started working with him—he would ask 'Well, what do you call this? How would you describe this problem?' I mean, I would not normally use some of those terms with some of the patients, but, yeah, he gets a kick out of that and he goes home and tells his wife in technical PT jargon what he's doing. But I've found

> that a lot of patients like to know the "real" word for this or that and then they use it with you kind of proudly. But with him especially–that helps make him more of a participant–is probably why I do it. I think early on with him I was explaining things in simple terms and I got the impression that, that I was talking down to him. So, after that I didn't talk so simply to him. (C, 3/30/92, p. 10)

This quotation suggests how John and Caitlin mutually constructed their conversational style, language usage, and interactions during therapy. John has told Caitlin stories about himself and his previous work as a videographer and she has listened carefully; she has taken into account his history of information seeking and interest in learning about topics and tasks of importance to him. Caitlin's words also indicate that she was attentive to John's needs and wants–his motivations, capabilities, and goals. In spite of the neuropsychologist's assessment, which suggested that understanding complex language patterns might be very difficult for John, Caitlin realized that John was both interested in and capable of learning such terminology and using it appropriately and meaningfully as he conversed with her and others. Finally, Caitlin was attentive to the need for genuine involvement and participation of the client in the discourse and activity of therapy. She got the impression that she was not engaging John in conversation–or inviting him to be a participant in therapy–when she talked to him "simply". So she adjusted the nature of talk to facilitate the development of an alliance and to encourage John's active participation in therapy.

The emergence and use of technical language in physical therapy with John was not a one-way street, however. For John,

coming to know PT lingo and using and sharing this language with Caitlin and others was both a point of connection between him and Caitlin and a source of pride. When I asked John about the use of medical terms and PT jargon during therapy, he responded proudly (as Caitlin might have predicted): "And I've learned it! That's part of my personality. If I hear something that I haven't heard before, I think it is interesting. I want to learn it" (J/D, 4/1/92, p. 7). Diane, who was with us at the time of this interview, added that John just "...loves details. His brain just really grabs on to certain things like that" (J/D, 4/1/92, p. 10).

Unsolicited, Diane also added that she had been the beneficiary of this willingness by therapists to be attentive to a client's interactional and learning needs and potential--their willingness to adjust communication in therapy on a moment-to-moment and client-to-client basis; in short, to work toward engaging in authentic conversations and the creation of alliances with clients. Diane explained that since she worked as an nurses' aide in a rehabilitation and transitional living center, she appreciated the fact that the clinic staff considered her knowledge and experience during conversations with her. As she put it,

> Both Caitlin and Kay were the two that I've been involved with the most. [They] were fantastic in not--I felt patronized by all the doctors--I would try to ask questions and I wouldn't get any straight answers because, it was like, they thought I wouldn't know what they were talking about and I would've! And these guys have been real direct. They've spoken to me on a level that I could understand and John at a level he could understand...that we could relate to. (J/D, 4/1/92, p. 8)

Here, Diane expresses gratitude for the fact that therapists with whom she and John have been working in this clinic have been attentive to the client's prior knowledge, experience, and their needs and, in doing so, have provided for the creation of shared language and meaning. This co-construction of language has recognized and respected the client's life stories, experience, and knowledge; clients are viewed as important and valued contributors to and determiners of the forms, styles, and functions of language used in therapy. And perhaps most importantly, clients *feel* valued and involved in therapy.

I contend that the appearance and use of PT lingo in therapy with John is an illustration of one form of shared language, interactionally negotiated and constructed, which serves the development of shared understandings and the creation and sustaining of therapeutic alliances. In this case, I also believe that it provides for negotiation and distribution of power in clinical encounters. As John appropriates or grows into the lexicon of the therapist, he also cultivates intellectual and professional affiliations and identity. He can use complicated and technical medical terms and language competently in conversations with the therapist, his wife, friends, and other health care professionals. In John's case, the learning and use of PT lingo in therapy by himself and Caitlin is a medium for connection, inclusion, and understanding instead of being a language of professional distance and power, exclusion, and confusion.

In this discussion I have focused on the use of PT lingo in therapy sessions with John and Caitlin where the use of such language served conversational involvement, connection between participants, and the creation and sustaining of a therapeutic alliance. As I will discuss later in Chapter Four, the use of medical and PT terminology in therapy can also serve educational purposes and goals. My observations of the use of clinical language in Caitlin's therapy sessions with Marcia and Bill suggest that, in their cases, this type of language served such educational purposes far more than the interpersonal connection functions on which I have focused on in this chapter.

Face Work and the Co-construction of Therapeutic Alliances

There is one final and pervasive feature of discourse in therapy sessions with all clients that I will discuss with respect to the creation and sustenance of therapeutic alliances. Recall that the therapists at Jones and Thompson believe that mutual respect and the development of a trusting relationship between therapist and client are integral to the establishment of therapeutic alliances. I contend that showing respect and the development of trust in clinical encounters is intimately bound up with what Goffman (1967) first called "face work." There was substantial evidence of face work by participants in therapy as they engaged in the interactional work of creating alliances. I turn first to a review of key concepts for understanding face work and politeness phenomena in interpersonal exchanges and then to examples of face work drawn from therapy sessions.

Face and politeness in interaction. Working from a concept of face derived from Goffman (1976), Brown and Levinson (1978, 1987) describe face as a public self-image that interactants want to claim for themselves. It is

> ...something that is emotionally invested, and than can be lost, maintained or enhanced, and must be constantly attended to in conversation. In general, people cooperate (and assume each other's cooperation) in maintaining face in interaction, such cooperation being based on the mutual vulnerability of face. (Brown & Levinson, 1987, p. 61)

Brown and Levinson (1987) go on to describe face as basic "wants" of members of any society and identify two primary aspects of face--*negative face* and *positive face* which they define as follows:

> negative face: the want of every 'competent adult member' that his actions be unimpeded by others.
> positive face: the want of every member that his wants be desirable to at least some others. (p. 62)

Thus, negative face consists of an individual's basic claim to "personal preserves", that is, a person's desire for and right to "freedom of action and freedom from imposition" (p. 61); and positive face is "the positive consistent self-image or 'personality' (crucially including the desire that this self-image be appreciated and approved of) claimed by interactants" (p. 61).

Face threatening acts (FTAs) are interactive acts that constitute a threat to face (Brown & Levinson, 1978, 1987; Coulthard, 1985). For example, acts that "belittle" or don't appreciate are positive face

threatening acts and acts that impose on another are negative face threatening acts. Various utterance forms used in response to face threatening acts create degrees of politeness in conversation and dictate the degree to which face is negated, maintained, or enhanced by participants in discourse (Brown & Levinson, 1978, 1987). Politeness that protects negative face (negative politeness) includes ways of linguistically and paralinguistically trying to reduce or eliminate inconvenience for or imposition on another. Politeness that maintains positive face recognizes the need (want) of individuals to have their self-image, achievements, and goals thought of as desirable–the need to have their "personality...ratified, understood, approved of, liked or admired" (Brown & Levinson, 1987, p. 62).

Both speakers and hearers can take face into account during interaction and Brown and Levinson (1978, 1987) suggest that a great deal of interactional work is devoted to attempts to mitigate or defuse FTAs which can occur "off the record" (indirectly) or "on the record" (directly). Part of this work involves the selection of an appropriate response to a FTA and, as Coulthard (1985) has written in summarizing the work of Brown and Levinson, "requires a calculation of the *weightiness* of the FTA and this depends not simply on the seriousness of the threat or imposition but also on the social distance and relative power of speaker and hearer" (p. 53).

These definitions of the concepts of face, FTA's, and politeness should make it clear that these interactional phenomena are very pertinent to consideration of the nature of interaction during therapy sessions. Although face must be attended to in *all* interactions, I

contend that this is particularly true in the context of commitments to the development of therapeutic alliances and the realization of client centered care in clinical encounters. The fact that most clinical encounters between patients and health care providers often begin with and are characterized by a difference in the social status and relative power of interactants, and the fact that illness and the need for health care is inherently face threatening for clients puts the onus on the therapist for recognizing, mitigating, or defusing face threats for clients in clinical encounters. Nonetheless, interactional face work by all participants is essential if mutual respect is to be gained, vulnerability diminished, and a trusting relationship between client and therapist developed.

Maintaining face and politeness in therapy. Some of the features of discourse described earlier in this chapter such as the sharing of stories, asking questions that invite patient participation in decision-making about treatment, other-repetition, and the co-construction and extension of metaphors, are resources in talk that can serve the preservation and enhancement of *positive face*. They help to establish intimacy and connection between participants and can indicate positive regard for interactants. As such, they constitute positive politeness. These strategies, used by both therapist and clients (though more frequently evident in therapist talk), indicate a recognition of the need for individuals to be understood and accepted and to have their self-image appreciated and protected.

Working from Brown and Levinson's (1978; 1987) research on face and politeness, Cazden (1988) claims that

> teachers inevitably engage in face threatening acts (FTA's). They constrain student's freedom and criticize their behavior and their work, often in public. (p. 162)

Although Cazden's claim is based on analysis of discourse in classrooms, it is pertinent to the analysis in discourse in therapy especially in a context where therapy is seen primarily as an educative endeavor--one that involves an emphasis on teaching and learning. Much of Caitlin's work with patients involves the (a) identification of patient problems or limitations, (b) development of therapy and exercise programs to address limitations, (c) instruction in exercises or other interventions to remediate patient problems, and (d) correction or refinement of exercise technique so that patients maximize benefit from their program. All of these everyday activities of therapy can constitute threats to face for clients. Identification of and attention to patient limitations in therapy is a threat to positive face. The introduction of exercises and other interventions into patient lives can be threats to both positive and negative face. Correction of patient technique in exercises or other activities can be viewed as criticism and threaten positive face. Furthermore, the activities of therapy described above necessarily occur in the context of the larger inherent threats to positive and negative face that illness and disability represent.

I turn now to some other excerpts from therapy sessions that illustrate Caitlin's interactional work to mitigate some the inevitable threats to face that occur in therapy. I focus first on efforts to

maintain positive face and second on efforts to reduce imposition on the client.

One of the most prevalent strategies for mitigating threats to positive face was the frequent provision of positive feedback to clients regarding their performance of exercises or their progress in therapy. Such feedback was not given undeservedly and was often used to soften directives or as pre-sequences to criticism or bad news. The following example is drawn from Bill's final therapy session. Caitlin is reviewing and summarizing Bill's progress to date in therapy as they negotiate what will stay in his home exercise program and what can be eliminated. In this particular segment they are discussing changes in Bill's visual control and gaze stability.

C: But I would say, in general, your visual control
B: ⌈It's better
C: ⌈I think
it's back to about 80 percent/ it fatigues a little easier
B: ⌈Mm hmm
C: ⌈and you
have trouble at fast speeds
B: ⌈Mm hmm
C: But, you're, you're, much better,
much better
B: ⌈Oh, I feel better.
(C/B, 7/5/94, p. 5)

In this excerpt, Bill suggests that his visual control has improved and Caitlin shows agreement by twice repeating Bill's "it's better" and emphasizing that it is, indeed, "*much* better." Even so, Caitlin tells Bill that his visual control is not 100%. This bad news is softened by her hedge "I think" and by her description of the nature of his problem as one in which his eyes fatigue "a *little* easier." Such hedges modify the force of negative statements and can serve to mitigate a positive face threat.

In similar fashion, at the beginning of Marcia's final therapy session, Caitlin begins a review of Marcia's progress and exercise program in this way:

> Now/ what I'd like to do today is, kind of, give you a summary of what GREAT progress you've made, and what areas I think you might want to keep working on as you continue your recovery.... (C/M, 7/7/94, p. 1)

Here Caitlin organizes and orders her statements in such a way that she prefaces a potentially face threatening statement with a face enhancing statement; she precedes information about areas that Marcia needs to continue working on and exercises she still needs to do with an emphatic recognition of the significant progress she has made during the course of therapy. Recognition of the imposition that continued involvement in an exercise program at home represents for Marcia is implied in the last clause in this sentence when Caitlin avoids issuing a direct imperative like "you should keep working on these exercises at home." Instead, Caitlin precedes her observations and recommendations by saying she will be

summarizing "what areas *I think you might* want to keep working on as *you* continue your recovery [without me]." This statement is an attempt to minimize imposition and suggests that Marcia (not Caitlin) will be in control of what she does or does not do. This is one form of giving "deference" (Brown & Levinson, 1987) which distributes power to and increases the status of the hearer relative to the speaker. As Brown and Levinson describe it,

> ...deference serves to defuse potential face-threatening acts by indicating that the addressee's rights to relative immunity from imposition are recognized--and moreover that S [speaker] is certainly not in a position to coerce H's [hearer's] compliance in any way. (1987, p. 78)

Numerous examples of Caitlin giving deference to clients and attempts to minimize the imposition that their home exercise programs might represent for them (while still encouraging *but not coercing* them to continue with them) appear in therapy sessions, especially as patients were finishing their course of therapy. This form of "negative politeness" is illustrated in the following excerpt from Marcia's last therapy session.

Caitlin has been reviewing Marcia's progress in many of her balance measures and activities. Marcia is sitting on the mat table and Caitlin is sitting on her rolling stool in front and to the left of Marcia. Between them on the mat table is Marcia's written home exercise program. Caitlin and Marcia are both looking at the program as Caitlin first suggests the elimination of certain exercises

(decreasing imposition) and then encourages Marcia's continuation of another exercise:

C: So, um, you might want to continue this one a little bit. I'm gonna circle the ones I'd like you to continue with, um, and just practice it two or three times a week/ trying to set a goal of getting to 20 seconds/ 30 seconds/ you know, four or five repetitions of that would be helpful for you. (C/M, 7/7/94, p. 4)

As Caitlin asks Marcia to continue with one of her balance exercises, she tries reduce the imposition by (a) suggesting that she "might want to continue" with the exercise a "little bit," and (b) asking that she practice the exercise "just...two or three times a week."

Likewise, on Bill's last day in therapy, an attempt by Caitlin to enhance positive face and then explicitly recognize and decrease imposition took this form:

C: But my feedback in regard to your balance is you've done so well on most of these [exercises] that you don't have to do many anymore. I don't want you to feel like you have to continue practicing one-leg standing for the rest of your life to get up to 30 seconds. (smiles, laughs)

B: (laughs)

C: This could just be a little warm-up before you go out and do your aerobic walk.

B: Mmm Hmm, okay. (C/B, 7/5/94, p.8)

While these excerpts illustrate Caitlin's attempts at the micro level to mitigate threats to negative face, there were also attempts to decrease imposition at a macro level. I contend that Caitlin's attention to clients' interests and goals and her work to integrate therapeutic movement into activities that were enjoyable and meaningful to clients is another form of face work. For example, in the cases of both Marcia and Bill, work on golf maneuvers became part of therapy. Building therapy activities around and in the service of a highly valued activity for clients has the potential to decrease the perceived degree of imposition that therapy and disability represents. It also has the potential to enhance positive face--it says to the patient that their wants and goals are valued and viewed as desirable by others.

A final example of face work in therapy at both the micro- and macro-level is drawn from the final session with Bill. On this warm summer day, Bill and Caitlin are outside on a grassy area near the clinic where Bill practices some of his golf swings (emphasizing quick follow through with his head to increase vestibular stimulation and challenge his visual control system). He talks with Caitlin about how he no longer gets dizzy when he does this, nor does he lose his balance or stagger. As Bill finishes, he hands the golf club to Caitlin. Then Caitlin asks Bill to give her a few tips on her golf swing.

C: Well, I should get some tips on why I don't swing/ I'll let you watch me once.

B: Bend your knees, get back on your heels// that's right.

C: I know the biggest problem is where I line it up. Sometimes it's here, sometimes it's here (moves the club a bit)

B: Oh no, you gotta pick the one spot

C: ⌉right in the middle

B: Bend your knees just a bit/ that's it

C: ⌉Right there?

B: ⌉There you go.

C: Well, I got the grip down though, did you notice that?

B: ⌉The grip? The grip looks good, you've got a strong grip, what they call a strong grip (walking in toward C) cause your right hand is /???/

C: (Swings)

B: Oo-o-o-oh, take it back (he walks toward C)/ You're good, don't get me wrong/ you can probably hit the ball farther than I do/ but (takes the club from C and demonstrates a swing) You know one lesson I learned / this was taught to me ⌉by /????

C: (watching Bill) ⌉Oh, yeah?

(C/B, 7/5/94, p. 11)

At this point, Bill gives Caitlin further instructions about stiffening her left arm and swinging more slowly and with a more controlled follow-through. He demonstrates another swing and then Caitlin tries again. As Bill observes her final try, he says "That's better, much better. You'll get farther distance too!" (C/B, 7/5/94, p. 12)

There are several noteworthy points to be made about this segment. Caitlin has shown deference to Bill and there has been a

dramatic shift in the more familiar Caitlin as teacher and Bill as learner roles. By asking Bill to help her with her golf swing, Caitlin changes Bill's status to that of superior and more knowledgeable participant in the exchange. Now Bill must formally teach; he must publicly criticize and offer suggestions to Caitlin on how to improve her golf swing. He mitigates his criticisms in several ways. First, he compliments Caitlin on her "strong grip." Second, he says "you're good, don't get me wrong. You can probably hit the ball farther than I do," which is followed by a series of instructions and recommendations for improvement. Finally, Bill commends Caitlin when she demonstrates a more controlled and fluid swing after a few repetitions.

Summary: Face and politeness. In this section I have introduced the concepts of face and politeness and discussed their importance in clinical interactions. The examples I have provided offer a glimpse of some, but by no means all, of the face work that goes on in therapy. In future chapters I will discuss face and politeness further as it relates to issues of (a) teaching and learning in therapy, and (b) being a transdisciplinary team.

I believe that attention to face and work to mitigate face threats in therapy is extremely important to the to the task of creating and sustaining therapeutic alliances and client centering. Attempts by participants to reduce or mitigate FTAs, both large and small, seems essential to attaining these ideals. At the micro-level, I claim that certain linguistic and paralinguistic features of discourse which mitigate face threats both provide for, and are manifestations

of, the kind of respectful listening, reciprocal disclosure, and trust that therapists describe as essential in therapeutic alliances. At the macro-level, a commitment to client-centering encourages attention to and respect for patient wants and goals. Seeking patient perspectives and taking them into account in therapy are ways of maintaining and enhancing positive face for patients. Likewise, avoiding unilateral imposition of therapist developed goals and treatment programs on patients respects their "rights to freedom of action and freedom from imposition" (Brown & Levinson, 1987, p. 61).

Conclusion

Therapeutic Alliances as Developmental Phenomena

Throughout this chapter I have discussed the creation and sustenance of therapeutic alliances. I have shown that alliances are not static or universal; instead they are dynamic and as variable as the clients and therapists who negotiate and co-construct alliances. Alliances are not created in single encounters with clients—they develop and are transformed as therapy continues. Recall Kay's words about alliances: "Alliances evolve gradually, they take time" (K, 9/15/94, p. 3). By their very nature and definition, therapeutic alliances are developmental phenomena.

A corollary to the view of therapeutic alliances as developmental phenomena is that they should come to look different (and be strengthened if all goes well) over time as therapists have multiple opportunities and extended periods of time to work with

particular clients. Indeed, this was proven to be true in my observations of Caitlin's work with Marcia and Bill. These were the two patients I was able to observe from the very beginning to the end of their therapy. By the conclusion of therapy for each of these clients, the flow of discourse and activity was more natural and fluid than it was at the start of therapy. There was evidence of greater shared knowledge about client's and therapist's own personal styles, likes, and dislikes, as a result of increasing disclosure and careful listening. In general there was a different *feel* about the interaction between therapist and client--exchanges seemed more comfortable and easy and there was more joint construction of sentences and ideas than earlier in therapy.

To illustrate this transformation in the nature of interaction between therapist and client, which I attribute to the development of an alliance, I will provide a few excerpts from the last therapy session with Marcia and Caitlin. In earlier parts of this chapter I have provided several excerpts from the first session (5/17/94) with Marcia; now I turn the final session on July 7, 1994. This was the eighth session I observed with Marcia and Caitlin, although there had actually been 12 treatment sessions distributed across the six weeks that Marcia was being seen at Jones and Thompson. In an effort to help the reader experience the flow, ease, and comfort I have discussed earlier, I will present these excerpts with little interruption by my own text or analysis. The reader will note, however, that many of the features of discourse discussed in this chapter appear in the following excerpts.

Twenty-six minutes into the session, Marcia has just completed some postural correction exercises she has learned for her neck and upper back. She says to Caitlin:

M: Yeah, I seem to feel better when I'm doing that [sitting up straighter]

C: And that's great! That's just what you want because you look a lot better/ and younger! (Smiling) when you're sitting up

M: (Chuckling) Oh, as soon as you say younger, you know that makes me do it (Laughing)

C: (Laughing) That's right! Well, it's really true though/ I mean/ you look healthier/

M: which is true/ yeah.

(C/M, 7/7/94, p. 7)

Shortly after this, Marcia and Caitlin prepare to go outside to work on some of the more challenging balance activities she has been doing on uneven surfaces.

C: And we're gonna head outsi-i-ide.

M: (Folding and putting her exercise program in her purse)

C: So did/ you have a very active morning? In terms of/ you know// physical activity?

M: This morning? No.

C: Are you tired at all?

M: (rising to stand) [No, I just ran in to K-Mart to get a few things first, then I went and had my hair done, then I went to recycle some papers, then I did my grocery shopping, then I came home...

C: (Chuckling, grabs the top of her head, laughs)

M: Then all these people started stopping! [at her house] (starts to walk toward door with Caitlin) and I said, aaah get /???/ out of my way!

C: YOU had a lot to do before one o'clock/ in the afternoon!

(C/M, 7/7/94, p. 8)

Once outside, Caitlin and Marcia proceed with some balance drills on a grassy surface near the clinic. Marcia shows that she is still experiencing some difficulties with walking in a straight line when she has to move her head. As she practices this procedure, Caitlin walks by her side to provide assistance if necessary. Marcia says to Caitlin,

M: I wa-a-ander a little bit (chuckling)

C: (chuckling) But, but you're stable, a little left drift

M:]a little left drift/ just a little wobble (chuckles)

(C/M, 7/7/94, p. 9)

As Marcia and Caitlin start walking back into the clinic, about 45 minutes into the session, they stop at the foot of a long flight of

stairs. When Marcia first began working with Caitlin, she had to walk up stairs "marking time" (moving one foot up and then the other to meet it on the same step) and using railings for pulling herself up and balancing. Caitlin asks Marcia to walk up this set of thirteen stairs so that she can observe how Marcia is doing with this everyday task that was so challenging for her before. Marcia climbs the stairs, this time using a reciprocal gait pattern, and barely touches the railing during her ascent as Caitlin follows close behind her. As they get to the top, Caitlin says

C: That was thirteen steps!
M: [It was? Just a good thing it wasn't fourteen! (laughing)
C: [(laughing) That was ve-e-ery smo-oo-oth
M: Yeah, see I can do thirteen pretty good, but after I've done it a couple of times
C: [You're tired out
M: [it's work.
(C/M, 7/7/94, p. 12)

In the final minutes of therapy, Caitlin asks Marcia if she has any further questions about her therapy. In response to this offer, Marcia seeks advice on whether or not she might be able to resume some bicycling when she visits her son on the west coast at the end of the summer. Caitlin and Marcia talk at some length about the

types of trails or surfaces Marcia might ride on and the types of bicycles that would be safest for her. Finally, after suggesting that this may indeed be a possibility with some careful practice sessions prior to the trip, Caitlin offers this advice:

C: I think you might want a helmet on (touching Marcia's arm and chuckling)

M: (chuckling) I'm not going to fall off and hit my head

C:]No

M: I'm not going to fall off <u>period</u>!

(C/M, 7/7/94, p. 14)

Fifty-five minutes into the session, Marcia starts to gather her things and Caitlin and Marcia say their good-byes.

M: Oka-a-ay (Marcia extends her hand to Caitlin)

C: Wel-l-l, (extending her hand to Marcia; hearty handshake, smiling)/ <u>it has been wonderful</u> working with you

M: Well, it's been good working with you, because <u>I do feel</u>/ a lot of people said/ 'are you taking? Still taking therapy? Do you think it's doing any good?'/ And I said 'If I didn't I wouldn't be doing it!'

C: Mmm Hmm (nodding)

M: I said, 'yes, I can see marked improvement.'

C: Good, and that's important

M:]For my balance especially.

C: [And I think you're gonna continue to recover. I mean you're obviously out there/ pushing your limits everyday and trying new things and that's great! /???/ It's nice to have somebody so motivated

M: (nodding) [So (reaching to stroke Caitlin on her shoulder), hopefully you wont see me back, right?

C: No, but I do want you to keep in touch/

M: [Okay/

C: [Give me a call, let me know, you know, what you're up to

M: (nodding) [Alright. I'll do that. What days do you?/ You aren't here everyday though...

(C/M, 7/7/94, p. 14)

With this, they discuss Caitlin's work schedule at the clinic as they start to walk out of the therapy gym side by side. Marcia says,

M: So when I call, I'll call you on Tuesday of Thursday (tapping Caitlin's left hand). Well, it's good to work with you.

C: You too.

(C/M, 7/7/94, p. 15)

Marcia then turns to me and says good-bye and both Caitlin and Marcia talk about me as their "silent partner" as they leave the room talking and laughing.

This final therapy session, and the last segment in particular, evokes and a feeling of the parting of friends. There is ample evidence in the above transcript excerpts of not only the various features of discourse I have focused on in my discussion but also, I claim, evidence of a trusting and engaging relationship grounded in mutual respect. This is a vision of a therapeutic alliance.

Therapeutic Alliances and Client Centering: What the Clients Say

One lingering question remained: did the patients feel as if they had been listened to, respected, and invited to participate in therapy as they worked with Caitlin? Did they feel like they were a partner in therapy and part of an alliance? I turn finally to some of the clients' responses when I asked them about this and their general perceptions of their work with Caitlin.

John and Diane talked about this in a joint interview on April 1, 1992. Diane spoke first about how they had initially considered having John receive therapy at home because of some transportation difficulties. But this would have required a change in therapists which John and Diane were not interested in. As Diane stated, "It just wasn't an option for us. We were already hooked into here and the comfort was there" (D, 4/1/92, p. 7). To this, John, struggling a bit for descriptors, added:

> She has been great, she has been just great. I hate her Alma Mater but I think she's good. We have, we have--we actually

> have fun together in our patient-therapist relationship. She has given me a lot of confidence to--she has given me a lot of confidence to go--I lost the words (starts to whistle).... Uh, I've heard tell that Caitlin may be one of the best therapists in town and I'm willing to believe that. She establishes a confidence in you, she makes you--she made me believe in myself to a point where [when] I thought I couldn't get past the pain, to believe that I could. And I went past the pain, and I went the distance that I had to go. And, um, she's been real nice to work with. (J, 4/1/92, p. 7)

A little later, John talked more about Caitlin's friendly yet professional manner.

> She's a great therapist. I like her a lot. Of all the so-called professionals that I've met through this entire trial and tribulation--the whole thing--through the accident, through the diagnosis, through the operation, through everything, Caitlin's probably the most memorable and most professional [person] that I've met. (J, 4/1/92, p. 7)

When Bill was asked a similar question, he offered a response indicative of his direct, objective, and factual approach. Of interest is the observation that this aspect of Bill's personal style was reflected in the way therapy was co-constructed with him. It had a very different "flavor" than therapy sessions with John and Marcia. This is as it should be if an individual's characteristics and needs are truly being considered in therapy as alliances are co-constructed. Bill summarized his experience with Caitlin in this way:

> Well, Caitlin has done a great job as far as I'm concerned.... She did a good job. She showed me where I had my weaknesses and where I could still do things to get better. And I still practice with it [the home exercise program]. (B, 7/5/94, p. 10)

Marcia's response to my inquiry was more expansive, and focused first on the willingness of the therapists at Jones and Thompson to listen to her. In discussing this she talked about what she thought helped people connect with each other and drew on her own experience as a parent and a self-employed business woman.

> I think as a parent, and as a woman who had a large group...of women [working] under me, you have to be a good listener. If you're so busy thinking about what you're going to say next instead of listening to what the other person is saying--and I think this is what I found very true here--they're very willing, very eager to listen to what you have to say. And, uh, I suppose that's the only way you can really learn how you can help someone. How do you know if you can help, or how do you know what they're expecting to learn--to, um, gain--by your treatment if you don't listen to them, you know. I would imagine, in fact it would be easy for a therapist to have their goals for you. I'm sure Caitlin had some goals for me--that she was hoping I could do that faster or she was thinking I could do that longer or something. But she just encouraged me to do things I wanted to do. And then she's quick to praise you and say you're doing a good job too. Even though I'm seventy-three years old, I still like to be told that I'm doing a good job! (M, 6/30/94, p. 14)

So Marcia felt listened to and respected. She recognized that Caitlin had considered Marcia's goals and wants before her own. And she valued the encouragement and praise that Caitlin had offered during therapy.

I contend that these feelings of authentic respect and appreciation expressed by the patients with whom Caitlin worked were engendered by her on-going interactional work to create and sustain therapeutic alliances, to realize the ideal of client centering,

and frequently and genuinely to invite patients to participate in their care. Even so, therapists cannot build alliances alone–patients are also engaged in this work and their collaboration and participation shapes the nature and developmental trajectory of the alliance and the forms of client centered care that emerge. Together, participants negotiate the degree to which an alliance will be truly therapeutic and whether health care can be transformed from the mere provision of treatment to the art of caregiving.

Arthur Frank (1991) discusses his perceptions regarding the distinction between the provision of treatment and the "caregivers art" based on his personal experience with illness in his book *At the Will of the Body.*

> The caregiver's art is finding a way to allow the ill person to express his needs. Eventually a balance must be worked out between what the ill person needs and what the caregivers are able to provide. In order to find that balance, caregivers, whether professional, family, or friends, must help the ill person figure out what he needs. Only then can they negotiate what they are prepared to provide. It takes time for an ill person to understand her needs. The caregiver cannot simply ask "What do you need?" and expect a coherent reply. (p. 47)

Here, Frank (1991), like Brody (1987) and the therapists at Jones and Thompson, points to the importance of *time* in the transformation from treatment to caregiving. He goes on to suggest that

> Most medical staff do not have the time to be caregivers, and many do not have the inclination. They provide treatment, which is no less important than caregiving, but it is not at all the same. (p. 49)

Finally, what makes treatment different from caregiving for Frank (1991) is the willingness of people to listen to, hear, and respond to the ill person's unique experiences and perceptions as they construct care.

> I reserve the name "caregivers" for the people who are willing to listen to ill persons and to respond to their individual experiences.... When the caregiver communicates to the ill person that she cares about that uniqueness, she makes the person's life meaningful. And as that life story becomes part of her own, the caregiver's life is made meaningful as well. Care is inseparable from understanding, and like understanding, it must be symmetrical. (p. 48)

I suggest that the work of creating and sustaining therapeutic alliances at Jones and Thompson, which we have glimpsed through the interactional work of Caitlin and her clients, is about transforming the relationship between therapist and client from one of treatment and transmission of professional knowledge to one of caregiving and mutual transformation of participants. It is about listening, figuring out needs, balancing, and seeking understanding and symmetry in the relationship. These things sow the seeds of mutual respect and trust. They have the potential to enable participants to realize an alternative construction of power in clinical encounters than those most commonly attended to (i.e., the power assymetry between health professional and patient). Power in client centered *care* cannot be unilateral, dominating, or coercive; rather, power must be negotiated and shared, affirming and, thus, potentially healing.

THESIS
6

THE WISDOM OF PRACTICE: SITUATED EXPERTISE, TEACHING AND LEARNING IN A TRANSDISCIPLINARY REHABILITATION CLINIC

VOLUME II

By

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Chapter 4
RECIPROCAL TEACHING AND LEARNING IN THERAPEUTIC ENCOUNTERS

Introduction

One of the primary components of client centering identified by therapists at Jones and Thompson was an emphasis on client and family education (see Table 1, p. 87). The therapists believe that teaching and learning are essential elements of care and they view therapy as an educative endeavor. They see education as a tool that serves client enablement and empowerment. It should be obvious from the discussion in Chapter Three, however, that teaching and learning were not seen as unidirectional phenomena in therapy; instead, the educative dimension of therapy was understood to be reciprocal, reflexive, and interactive. Therapists are both teachers and learners in therapy. What they learn about and from their patients shapes what and how they teach in therapy. It also has the potential to shape who they are as teachers. Likewise, clients are viewed as both teachers and learners. And it is through this reciprocal relationship that the groundwork for mutual growth and transformation of participants is laid.

Although many authors have discussed the importance of teaching in physical therapy clinical practice (Chase, Elkins, Readinger, & Shepard, 1993; Jensen, et al., 1990, 1992; May, 1983; Morrow, 1989, Sluijs, 1991), few have examined the nature of teaching and learning between therapist and client in face-to-face encounters in clinical settings. The centrality and importance of educative activities as part of client centering and client empowerment encouraged a closer look at the nature of teaching and learning between Caitlin and her clients in therapy. The questions that guided this part of my study and analysis were:

1. What are the therapists' beliefs about teaching and learning in clinical practice? How did they develop and how have they evolved over the years?
2. What is the nature of teaching and learning as it occurs in physical therapist-client encounters in this clinic?
    a. What is taught?
    b. How is it taught?
    c. What is learned?
    d. How do we know something has been learned? What is the evidence that learning has occurred?
    e. Who is teaching? Who is learning?
    f. What enhances or constrains or impedes teaching and learning?
3. How does client and family education serve client enablement and empowerment?

Therapy as an Educative Endeavor

Teaching, Learning, and Empowerment

Recall Kay's words as she shared her perceptions about the difference between treatment oriented approaches to care and education oriented approaches to patient care:

> You can continue to see them [clients] for approximately $100.00 an hour or you can educate them.... I think our whole treatment philosophy is an empowerment model--how do we empower the client? How do we give them the information and the tools [they need]? You know the whole experience of disability is so disempowering...that the therapeutic philosophy has to be empowerment. That you teach people how they can be back in the driver's seat again. And that takes a tremendous amount of education. And you have people coming to you with all different levels of sophistication so that you can't have a standard educational approach, or you can't have ready-made exercises [written programs] that you just hand out and say, 'here, do ten of these.' I mean that approach to physical therapy is anathema here. (K, 2/3/92, p. 3)

Here, Kay describes her beliefs about the relationship between client education and empowerment and points to an important corollary of an education oriented approach to care combined with a commitment to the development of therapeutic alliances; therapy and educational programs must be *individualized* to address each client's unique problems and needs. It is only through therapist knowledge of the learner (client) that individualized programs can be developed and teaching strategies selected that best meet the needs of the learner as well as the demands of the content to be learned.

Caitlin believed that the therapist's role as teacher was so important that she often talked about therapist-client relationships as "teacher-client relationships" (C, 1/27/92, p. 4, 6). As discussed in Chapters Two and Three, Caitlin believed that purely treatment oriented (or cure-focused) approaches to therapy encouraged patient disengagement and disempowerment in health care encounters. This contrasted with her commitment to foster client "...*learning* about the tools to manage his recovery or to manage his disability. That's a real difference in my mind..." (C, 1/27/92, p. 5). Time and again, Caitlin reiterated her belief that clients' knowledge about their disorder, their problems, and the tools to manage their disability was empowering for clients and family members or other care givers. Recall Caitlin's observation about the knowledge John had gained through therapy (and his own experience) about his problems and how to manage them. Such knowledge was empowering in her view:

> ...note...how in tune he is with his own treatment, his own requirements. Whether it's instructing somebody to assist him or whether he's doing it—he knows a lot about...what works for him and what doesn't...and that is empowering, in my mind—versus the patient not having any idea.... (C, 4/2/93, p. 6-7)

Other staff members shared Caitlin's and Kay's views. During a meeting I had with the staff of Jones and Thompson, speech and language pathologists, occupational therapists, physical therapists, social workers, and the neuropsychologist concurred that they viewed their mission as one that centered on education. In response to this discussion, Caitlin contrasted the emphasis placed on

educative activity in this clinic with that she had observed in other clinical settings:

> But you look at a lot of clinic settings and it's not at all the case [education as high priority]. It may be a fourth or fifth level type mission but it's not a, an important part of their practice. (C/Group, 12/3/92, p. 2)

In a later interview, Susan suggested that it is not only the degree of emphasis placed on educative activities that differentiates practice at this clinic from other places she had worked; the *form* of educational activities also differed. In the following quotation, Susan talks about what Marcia might have experienced had she gone through a cognitive retraining program at a clinic where Susan used to work.

> You know, if she would've gone somewhere else like Johnson Rehabilitation Center, they would've put her through workbooks, and they would've read paragraphs to her and asked her questions to see if she could remember them, they would have read her word lists and had her repeat [them]. And the research shows that drilling memory for memory's sake--drilling with lists, drilling with paragraphs, drilling with sentences--doesn't do it. Teaching people <u>real life compensations</u> through using those drills is another story. That's basically what I try to do in a short amount of time--is to say, these are some things you can do to meet <u>your</u> needs. (S, 7/28/94, p. 12)

Susan's words point to a belief expressed by all members of the team--that in order to be truly educative the activities of teaching and learning in therapy should be attentive to and directed toward

the client's needs and situated in the context of meaningful "real life" activities. To achieve this aim, therapists must listen to and learn from the clients about the meaning and nature of tasks they need or want to be able to do on a day-to-day basis.

Susan gave some examples of how she situates teaching, learning, and assessment as she works with clients on tasks they need to complete in community settings as well as in the clinic. In the following example, Susan talks about going to the grocery store with a client recovering from a head injury. She also talks about how she tries to integrate her work on cognitive and language processing skills with the work of other therapists on the client's team (e.g., physical therapists) who might be working on balance and vestibular rehabilitation activities. The latter aspect of her work is an illustration of the transdisciplinary approach to care espoused by clinicians at Jones and Thompson.

> ...I'm out in the community [at Kemp's grocery] with them [the client]. And it might be cognitive [work] from my perspective--that I want to see if they can, you know, remember to do the five things at Kemp's and be able to visually scan [shelves] and find everything in a time-efficient way. But then I might also add that component that might challenge their vestibular system...and see what compensations they use.... I might be asking them to visually scan but I might also see how quickly they can move and I try to see if they can incorporate those fast head movements or their picking things up [from low shelves] in the community.... (S, 7/28/94, p. 9)

So therapists at Jones and Thompson see teaching and learning as an integral and on-going part of their work with clients. And they

suggest that their efforts as teachers will be hindered unless accompanied by concurrent efforts to (a) learn from and about their patients and (b) embed the tasks of therapy in the situations and contexts in which they will be used by clients. In this respect, clients become the therapists' teachers. Close examination of interaction between Caitlin and her clients reveals the ways in which individual patients teach her and how and what she learned from them; much of the discussion in this Chapter will focus on such interaction. But before I move to this closer level of description and analysis, I want to talk more generally about what therapists say they have learned from clients over years of clinical practice.

Therapists Learning from Clients

Beyond knowledge and insight gained regarding the beliefs, needs, hopes, goals, and characteristics of individual clients, therapists at Jones and Thompson also claim that they have learned more global lessons from numerous clients over years of clinical practice. In fact, many of these lessons are reflected in the philosophic commitment to client centering at this clinic. These are "untaught lessons" (Jackson, 1992) that cumulated and evolved and that have become important guideposts for therapists in their everyday practice. The lessons were not learned from a single client or incident nor were they results of formal instruction. Even so, they have contributed to therapist development and have shaped beliefs about, and the nature of, their clinical practice and teaching.

Examples of learning from clients were provided by Kay and Caitlin. Kay highlighted one of the lessons she learned through her

work with patients with "complex disassociative disorders" (hysterical disorders). Almost one half of her case load is comprised of work with such clients who come to the clinic originally because of physical disability and then find they also need to address psychiatric problems. Kay said she has learned the "art of patience" and the importance of time in rehabilitation from these clients (K, 2/3/92, p. 9). As she put it:

> I think very quickly, and one of my problems with my colleagues and my clients is that if I move and talk as quickly as I think, it's very unsettling for them. And those clients have taught me how to slow down a little bit and let the change process unfold rather than be steamrollered by me. (K, 2/3/92, p. 10)

One of the practice-transforming lessons that Caitlin learned from clients she worked with who had sensory-perceptual and cognitive impairment has been discussed in Chapter Three. Recall that Caitlin

> ...learned to never question the patient's perceptions regarding something they're experiencing. I think that's one of the things I have really learned over the years.... (C, 6/3/92, p. 3)

Upon further questioning about this, Caitlin confirmed that it wasn't any single incident or client that taught her this lesson. Instead,

> ...it was more over years of experience and realizing that not only patients, but individuals in general, perceive things differently. And it's not our role to question how they're perceiving things...it's not productive to question what they're

> experiencing. You just need to understand where they are at and try to work from there. (C, 8/16/94, p. 4)

This lesson does not translate into solipsism or total relativism for Caitlin; if it did there would be no call for teaching directed toward changing perceptions to those more closely aligned with others' with whom clients with sensory-perceptual-cognitive impairments must interact daily. As Caitlin suggested, this was a matter of accepting another person's current sense of their world (rather than denying it) and working from there in therapy. It is part of the non-judgmental listening to the patient discussed in Chapter Three.

> You can't deny someone else's feelings. It's what they are experiencing. But you can try to alter that experience over time.... You respect that [their perceptions] and just try to gradually stretch the window.... (C, 8/16/94, p. 5)

It is this work to respect and then "stretch the window" that requires reciprocal teaching and learning in therapy sessions. I turn now to a closer examination of the nature of teaching and learning in therapy sessions with Caitlin and her clients.

The Structure of Therapy Sessions Directed Toward Educational Goals

Christopher Clark (1995) has written that

> Teaching is like a story, like a journey. Story and journey are familiar patterns with infinite variations. Each story and each journey is special, distinct from all others. Yet all stories share some common features, as do journeys. (p. xv.)

My observations of therapy sessions revealed both of these aspects of teaching in therapy sessions; there was a familiar pattern or structure to most therapy sessions and yet there was still variation within sessions and across clients with respect to the forms that face-to-face interaction and instruction took. I will first discuss the familiar--the pattern that emerged across therapy sessions with clients. This is what I call the structure of therapy sessions. It is not, however, a rigid or inflexible structure. It was a structure (or an organizing framework) that was systematic yet malleable and flexible as situations called for improvisation and as participants co-constructed therapy. After describing the general pattern of therapy sessions, I will move inward with a closer lens and provide illustrative examples of the specific features I identify that comprise the pattern.

Although this structure appeared across all therapy sessions I observed, the most highly structured sessions occurred early in Caitlin's work with Marcia and Bill and during the triadic teaching session with John, Diane, and Caitlin. The overall structure of the early sessions with Marcia and Bill is illustrated in Figure 11. This figure provides a "wide angle picture" (Erickson, 1981, p. 154) of the speech situations (therapy sessions) in which the speech events and speech acts of therapy are embedded (Hymes, 1972). These sessions typically consisted of ten distinct segments organized around specific types of activities. Transitions between segments were marked by changes in position and posture of participants as well as changes in the nature of talk. The first three of the segments represented

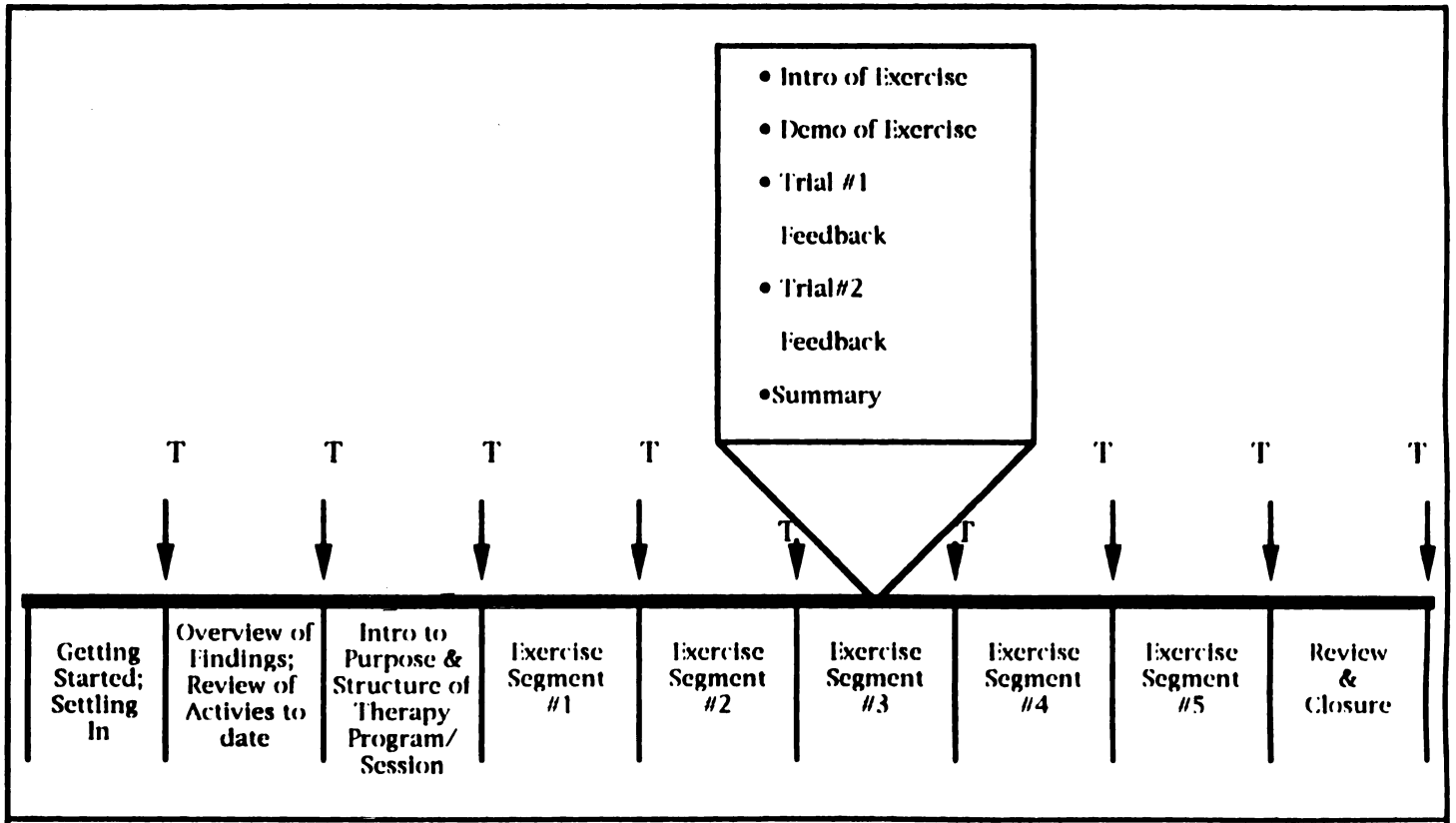

Figure 11. Overall structure of therapy sessions (the speech situations) and exercise segments. Demo = Demonstration; Eval = Evaluation; Intro = Introduction; T = Transition

various forms of preparation for the therapy session.

First, there is what I have called a "getting started" and "settling in" period. This period typically began as Caitlin went to get the patient in the waiting room and continued through the time they walked into the therapy gym and the first few minutes of therapy. It included everyday conversation about the weather, how things were going for the client in general, and other types of introductory exchanges of a social-personal nature. In the second segment, Caitlin provided an overview of her evaluative findings to date and the meaning of these findings for the patient in terms of function. For instance, since both Bill and Marcia presented with vestibular dysfunction, Caitlin would talk about how this problem contributed to their dizziness and affected their ability to maintain balance and stability when they moved in certain ways. In later sessions, this segment of the session focused on an overview of reevaluation findings or on progress made to date in therapy and home exercise programs.

The third segment, like the second, was largely directed by Caitlin insofar as she held the floor for much longer periods of time than the patient in these segments. In this segment, Caitlin introduced the purpose and goals of (a) the entire therapy program, and/or (b) the purpose and goals for what would be done in therapy that day. Following these three preparatory segments, there were several exercise segments each of which had a familiar internal structure (what Yinger, 1979, calls "routines"). The number of exercise segments varied from session to session depending on the

types of exercises being performed and the response of the patient to the exercises or activities. In the initial sessions with Bill and Marcia, there were five exercise segments each organized around a different exercise to be done in therapy and later at home by the client.

The internal structure of the exercise segments is summarized in Figure 11. In most cases, the activities in exercise segments occurred in the sequence shown below:

1. Introduction to the exercise
    (a) Name of the exercise.
    (b) Purpose of the exercise (rationale for the exercise).
        (i) What it does or is meant to work on.
        (ii) How it might improve everyday function.
    (c) Instructions for performing the exercise.
        (i) Review of written exercise program sheet.
        (ii) Verbal instructions.
2. Demonstration of the exercise by Caitlin.
3. First exercise trial by client with therapist guidance.
4. Feedback on exercise trial.
    (a) From the client--how it felt.
    (b) From the therapist--how the client performed.
5. Second exercise trial by client.
6. Feedback (as above).
7. Summary of purpose of exercise; reiterate relation of exercise to everyday function.

This internal structure of exercise segments, like the external structure of the therapy sessions, was not inflexible. It could vary

according to patient understanding and performance of, or tolerance for, particular exercises; that is, in some cases only one exercise trial and feedback session was possible, in others a third trial might be warranted and included. Even so, the overall pattern of activities within exercise segments remained remarkably similar. In addition, there was a pattern in which the exercise segments were ordered. Most often, exercises that were less challenging or more familiar to the client preceded those that were potentially more challenging or difficult for the client.

The final segment of the session consisted of a review of what had been done and discussed in therapy that day and closure of the session. Closure occurred in the therapy gym and as Caitlin escorted clients back to the waiting area of the office and included discussion about the scheduling of future appointments.

A pattern similar to the one described above was also evident in the joint therapy-teaching session with John and Diane. The structure and timeline for that session is shown in Figure 12. The triadic therapy session consisted of nine distinct segments. The first three segments were forms of preparation for the following six exercise segments. Included in the preparation segments were (a) a three-way conversation about a wrist and hand splint the patient was using at home ("getting started"), (b) a therapist monologue that laid out the purpose of the session, the goals for the session, and a summary of John's progress in therapy during the past month, and (c) a demonstration and instruction segment during which Caitlin completed and described all the exercises she was going to introduce

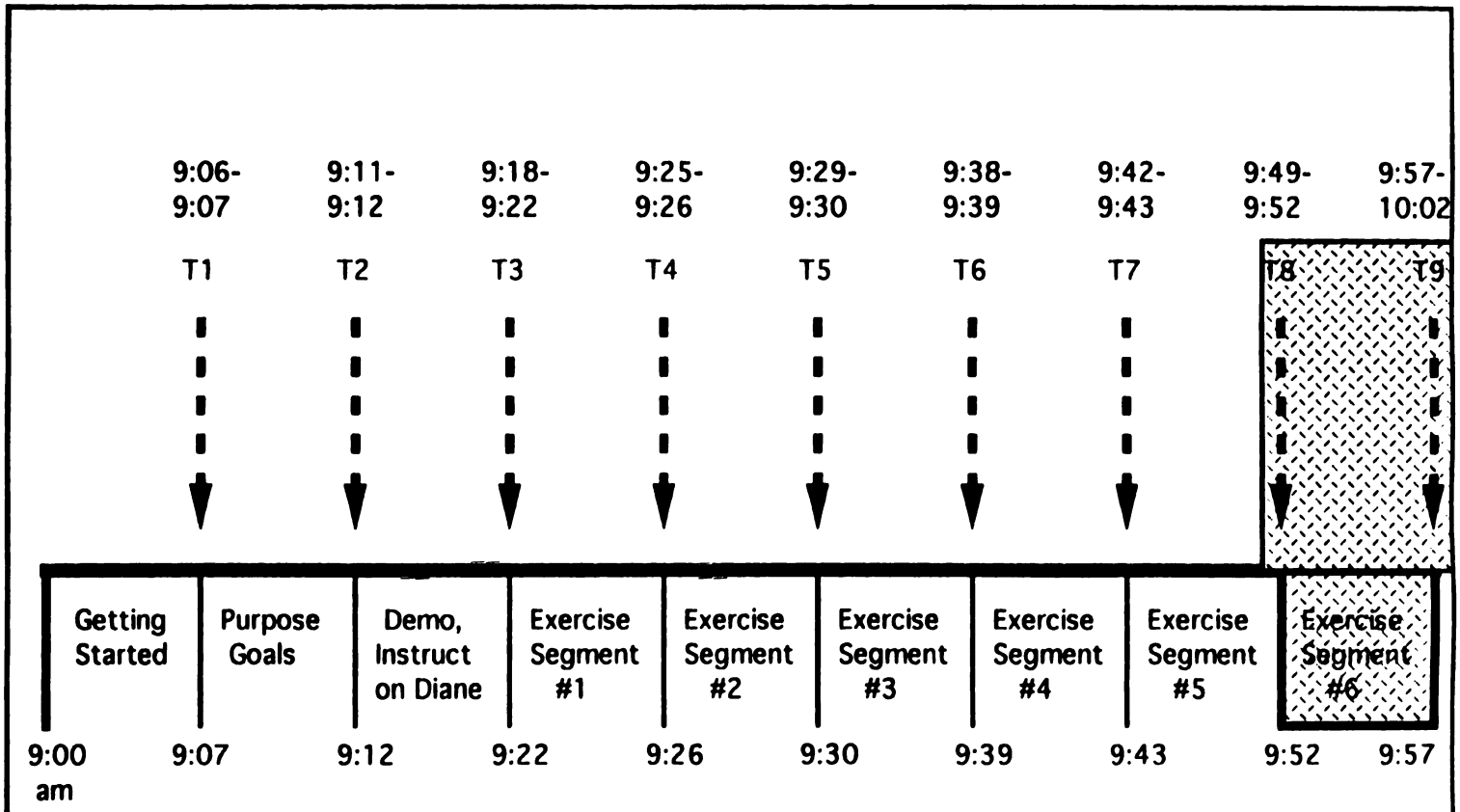

Figure 12. Structure and Timeline of Triadic Therapy Session (the speech situation).
Demo = Demonstration; Instruct = Instruction; T = Transition

during the session *on Diane* so that Diane could feel what they were going to be doing with John.

With one exception (exercise segment four), each of the exercise segments included the same structural and functional components. At the beginning of each segment Caitlin would introduce the name and purpose of the exercise. Then she would demonstrate the exercise on John as Diane observed. During this time, Caitlin would offer suggestions to Diane regarding exercise technique and discuss the expected outcomes for and response to the exercise. In addition, Caitlin used this demonstration period as a time to coach John about the type of *objective* (not personal) feedback that Diane would need from him so that she could adjust her technique according to his needs.

This initial period of Caitlin as therapist-teacher, Diane as observer-student, and John as patient-student was followed by a brief transitional period during which Caitlin and Diane would physically exchange places and roles in relation to John. As this positional change and role redistribution occurred there was a shift in the participant structures (Phillips, 1972) (or interaction patterns between participants), but all of the activities of the group still centered around the particular exercise being completed. In the second exercise trial, Diane acted as John's therapist (assisting him in the performance of the exercise) while continuing in her role of student or learner. Caitlin became the observer as she continued her role as instructor and coach, and John maintained his role of patient and would on occasion act as assistant instructor as he provided tips

to Diane regarding her exercise technique. As each exercise segment was concluded, feedback regarding the exercise was exchanged between all three participants.

In the case of the triadic therapy session which lasted more than an hour, the transition out of the last exercise segment occurred abruptly when conflict arose between Diane and John regarding her performance of the most difficult and painful exercise for him. The transition out of the segment included some of the elements of the review and closure segment I described earlier in Marcia and Bill's therapy sessions, but they were more rushed and were still imbued with the lingering effects of the interactionally volatile and challenging last exercise segment. In Chapter Five I describe and analyze this particularly challenging exercise segment in greater detail. For now, having provided a wide angle view of the structure of therapy sessions, I turn to some illustrative examples of the talk and activity within the segments of therapy sessions I have identified.

Segment Two: Overview of Therapist Findings and Observations

An example of the therapist providing an overview of evaluative findings and the meaning of these findings for the client is drawn from the first therapy session I observed with Bill. Caitlin had completed an initial evaluation with Bill two weeks before this session and on this day she discusses her findings with Bill in great detail. She starts the conversation with the following organizing statement:

> What I would like to start out with, Bill, is to give you a kind of overview of my findings--an idea of where I think we can go from a physical therapy point of view.... (C/B, 5/5/94, p. 1)

With this introduction, Caitlin then completed a detailed review of the four primary areas of impairment that were revealed in her examination: (a) vestibular dysfunction with associated impairment of visual-ocular control, (b) impaired dynamic balance, (c) mild weakness and loss of muscular endurance on the left side of the body, and (d) severe headaches associated with vestibular dysfunction, visual and cognitive demands at work, and stress. As she reviews each of these areas, she relates the findings to Bill's complaints and functional disabilities. For instance, as Caitlin talks about one of areas she would like to focus on in the early stages of Bill's therapy program she discusses how vestibular and visual dysfunction can make his work in the pharmacy difficult at best.

> Initially, what I'd like to focus on, um, is the vestibular and visual component of the program. Visual stability we'll call it. Stabilizing your eyes and vision while moving your head. And this is so important for you when you're scanning the shelves in the pharmacy. (C/B, 5/5/94, p. 2)

As she continues, Caitlin launches into an in-depth instructional segment about the vestibular system, complete with prepared figures of the semicircular canals in the inner ear (the vestibular system sense organ) and a handout that she shares with Bill.

> When I talk about the vestibular system, I just want to orient you a little bit. I know you've had all your pharmacy

> background and anatomy and that, but, uh, I just want to refresh [your memory]. (C/B, 5/5/94, p. 3)

Here, Caitlin explicitly recognizes Bill's past education and experience in a health care field and softens the face threatening aspects of the exchange (which have to do with potential asymmetries in knowledge) with her hedges "I just want to orient you a *little bit* " and "I just want to *refresh* ." Finally, as a segue into the next part of the therapy session, Caitlin concludes the instructional session on the vestibular system with another summary of her findings and discussion of why work in this area will be emphasized early in Bill's therapy.

> And that's the role of the vestibular system. And it's working, but it's being challenged. It's not working 100% like it should be. And so that's why we're gonna be focusing on that a little bit.... (C/B, 5/5/94, p. 3)

What appears in this particular segment of therapy is Caitlin's (a) use of *advance organizers* (Ausubel, 1968; Mayer, 1979) and her (b) attempts to build instruction and foster learning by activating and working from existing schemata (Anderson, 1984). Advance organizers and schema activation provide for ideational scaffolding by (a) creating logical relationships between new information or ideas being presented, and (b) linking prior knowledge and experience with new information. Caitlin's work to explain and relate her evaluation findings to the functional deficits the patient is experiencing, as well as her recognition of Bill's prior knowledge of

anatomy and physiology are examples of the latter type of advance organizer. Her work to create (a) a "map" of where therapy is heading, and (b) set out the purposes of and framework for therapy activities, are examples of the former type of organizer and can be seen in both this segment of therapy sessions as well as segment three to be discussed next.

Segment Three: Introduction to the Purposes and Structure of Therapy Sessions

An example of Caitlin introducing the structure and purpose of what will be done in therapy comes from the initial evaluation session with Marcia. This therapist monologue occurs six minutes into the videotaped part of the session after introductions have been completed and Caitlin has gathered some information about Marcia's history as it relates to her accident and her current complaints. Marcia reports that she has had physical therapy before--both in the hospital and as an outpatient immediately following her accident. Her therapy at that time was directed primarily toward management of her orthopedic problems (fractures and loss of joint mobility and strength) and restoring enough functional mobility and ambulation for her to get around the house and complete some basic activities of daily living (e.g., self-care, bathing, dressing). Caitlin then talks about (a) how the focus of the physical therapy evaluation today will differ compared to Marcia's previous experience in physical therapy, and (b) what she hopes to evaluate in therapy today.

> The focus of my evaluation is a little bit different from what they were working on at the hospital, in that I'm going to be

> looking more from the neurologic perspective and trying to look at areas [of function] that may be involved after a head injury like you had. So areas that involve brain functioning especially. And they [the tests] may involve looking at your coordination, and some higher level balance skills, vestibular function and how your eyes are working and how you do with head movements–how oriented you are with and without vision. So, I'll be looking at some general categories of what we call neurologic function. My main focus will just be to try to screen where some problem areas might be so that I can make recommendations to you. But before I start my screen, I guess what I'd like to know is what you feel, functionally, are and problems that you're having, um, that you haven't recovered fully, since the accident and the kind of rehab you've had so far. (C/M, 5/17/94, p. 2)

Here Caitlin explicitly lays out what she hopes to "look at" in therapy today and why evaluation of these areas of brain function might be important to evaluate given Marcia's current complaints. Although Caitlin clearly has a plan for therapy today (which she has shared with Marcia), she still ends with a request for further information from Marcia about what she perceives to be her greatest areas of functional disability. Such information guides Caitlin's selection of tests to be performed in therapy. It helps her decide whether certain areas of the evaluation need to be emphasized or eliminated. Thus, her plan is tentative and flexible–it can and will change as the session progresses and further information is gathered from the client.

A similar kind of introduction to and rationale for a specific exercise or activity occurred repeatedly within what I have called exercise segments and is to a description of the internal features of exercise segments that I now turn.

The Structure of Exercise Segments

As discussed earlier there were usually several exercise segments within a therapy session. In the case of Marcia's evaluation session, these segments were times when particular test activities were introduced and completed as opposed to instruction in a specific exercise per se. Even so, the internal structure of the test segments was similar enough to exercise segments to classify and describe them in the same way. I will provide first an example of an exercise segment with Bill and then a test segment drawn from the evaluation session with Marcia.

The following vignette is drawn from Bill's first regular (post-evaluation) session in therapy on May 5, 1994. Caitlin has prepared and provided a written home exercise program for Bill. On the first page of the program, a series of exercises titled "Visual Exercises" are described. The home program and Caitlin's verbal introduction of this category of exercises sets forth the overall purpose of the exercises:

> HOME EXERCISE PROGRAM FOR BILL MAXWELL: These exercises are designed to promote recovery and adaptation of your vestibular, visual and balance systems. Perform exercises at least twice per day for optimal results. Remember that your symptoms may get a little worse before they get better as you are challenging your vestibular and balance systems. Remember to concentrate on the task and complete each exercise for the full duration of 1-2 minutes.
> A. VISUAL EXERCISES
> PURPOSE: To improve gaze stability during head movement. (B/HEP, 5/5/94, p. 1)

As Caitlin introduces each of the five visual exercises listed on the first page of this written program she points to the program and names the exercise. For example, as they start the third exercise she says: "visual vestibular interaction. We'll call this times two viewing." (C/B, 5/5/94, p. 5) Caitlin then asks Bill to read the instructions and talks about what this exercise works on and how it might be important for his work. In her discussion she first talks about how a person's gaze needs to be stable when their head moves so they are able to focus on objects around them even when the objects and the person's head is moving. Caitlin talks about how this is important for Bill when he looks back and forth from his computer screen to his customers to his shelves in the pharmacy as Bill nods knowingly. After this discussion, Caitlin rises from her stool to stand in front of Bill and demonstrate the exercise. She holds a business card with star drawn on the back of it at arm length in front of her face. As she moves her head side to side, she moves the "target" in the opposite direction. As she does this she reminds Bill that his goal is to "keep the card in focus."

Following this demonstration, Bill rises and completes the moving target exercise (trial one) as Caitlin stands nearby. She watches his eyes for evidence of abnormal movement and is prepared to assist him if he gets dizzy. After a minute Bill stops and Caitlin asks "How did that feel? Any dizziness?" Bill answers "not much" but says that he has a hard time keeping the card and his head moving in opposite directions. They laugh about this and talk about how it is "like rubbing your stomach and patting your head."

Caitlin asks Bill to try the exercise again (trial two) and encourages him to move his head "a little bit faster this time, if you can." Bill completes the exercise again and at the conclusion Caitlin gives feedback to Bill regarding his gaze stability and speed of head movements during the exercise. Finally, she reiterates the purpose of the exercise and it's relation to everyday activities: "This is real similar to some of the driving demands you have when your start looking in your mirrors" (C/B, 5/5/94, p. 5).

In the above vignette we have seen all the elements that typically comprise an exercise segment: (a) introduction of the exercise, including the exercise name, purpose, and functional relevance, (b) demonstration of an exercise, (c) two exercise trials accompanied by exchange of feedback about performance, and (d) a summary or review of the exercise and it's purpose.

In the evaluation session with Marcia, these same features appeared in the context of conducting a test as opposed to instructing the client in an exercise. Even though the primary purpose of this session is evaluation there are similar types of instruction occurring during the completion of testing procedures. For example, as Caitlin introduces a test of Marcia's strength in her anterior thigh muscles, she says

> ...this is a functional test of the strength in your quadriceps muscle (tapping Marcia's anterior thigh). It's a real important muscle when you walk. I helps keep your knees from buckling. (C/M, 5/17/94, p. 10)

Likewise, Caitlin gives Marcia feedback on her performance on the tests they complete during the session. For example, after a series of tests on reaction time and motor response speed, Caitlin enthusiastically commends Marcia on her performance on those tests:

C: Definitely within normal limits on your response speed! Quick draw! (smiling and pretending to draw a pistol)

M: Okay! (smiling and pretending to draw a pistol)

(C/M, 5/27/94, p. 12)

I conclude with a vignette from the final testing (exercise) segment for Marcia on her first day of therapy. This vignette illustrates (a) how the structure of exercise or test segments is flexible and can change according to situational demands, (b) the extent and nature of reciprocal teaching and learning that can occur in the context of a single exercise segment, (c) summarization of therapist findings, and (d) a transition into the final segment of most therapy sessions--review and closure.

Caitlin is concluding the most challenging tests for Marcia--tests of positional and movement sensitivity that indicate the extent of vestibular dysfunction. When Marcia reports significant dizziness and nausea during one of the tests, Caitlin discontinues testing and then talks with Marcia about why she might be experiencing such symptoms. In doing so, she deviates from a planned task sequence within the segment and instead engages in a lengthy conversation

with Marcia about the vestibular system as she further explores the exact nature of her symptoms.

M: (Moves from supine to sitting on the mat table with Caitlin's assistance)

C: Any dizziness?

M: Yea-a-ah, real dizzy, like I was gonna throw up.

C: ⌈Yea-a-ah⌋, is that still present?

M: (3 second pause) Getting better.

(C/M, 5/17/94, p. 16)

With this feedback from Marcia, Caitlin discontinues testing and removes an apparatus from Marcia's head and eyes that magnified Marcia's eyes and helped Caitlin monitor visual nystagmus during the testing. As she does this, she kneels close to Marcia on the mat table and then says, softly

C: Oka-a-ay. Now you know why I save that one till the end. Um, what that test showed is what we call positional sensitivity.

M: Uh hum

C: ⌈And, um, it looks at the vestibular system which picks up a sense of motion. It's our gravity monitor. And, uh, sometimes after certain types of head trauma, there can be mild damage to the little inner ear organ (holding her hand to her ear) that is the vestibular system's kind of sense organ.

M: Uh huh

C: And that can make you more sensitive to changes in positions. Did you notice any problems initially with rolling over in bed? Sitting up? Um, that caused dizziness for you? Any positional changes that cause dizziness for you? (Caitlin moves off the mat table to sit in front of Marcia on a stool)
(C/M, 5/17/94, p. 16)

In response to these probes and information, Marcia talks about some of the difficulties she has been having with her balance in walking on grassy and uneven surfaces and her moving up and down in the kitchen when she has to load the dishwasher or get pans from low cupboards and shelves. Caitlin then describes some of the abnormal test findings with Marcia's vestibular system and summarizes her clinical findings and impressions:

C: So, the vestibular system plays a role in balance, and I think that for you, along with the weakness in that left leg (pointing to Marcia's leg), and I think those things are kind of working together to...[produce your problems]. (C/M, 5/17/94, p. 17)

With this, Marcia begins to talk about some of her feelings of "losing it" over the past few months. At this point, she seems to be relieved to find out that there is a reason for the symptoms she has been experiencing and says that before she learned about the vestibular system and what it does she thought she was just a "little loony."

M: It's like just losing it for a minute? I can remember that. You know, in my therapy, I'd say, 'you know what? Sometimes when I'm walking around, I just get the idea I'm losing it!' She said [the therapist], 'what do you mean?' And that's probably what it was.

C: (Nodding)

M: I didn't really know// I thought (pointing to her head, rolling her eyes and smiling)// is there something wrong with my head?

C: (laughing)

M: Because I'd walk along and think, ge-e-e, I'm gonna lose it here (holding onto the mat table and weaving a bit)

C: (Nodding and chuckling) It's your sense of balance, your sense of orientation which isn't quite normal// Well, um this kind of concludes the assessment screen/ and you've been a trooper. It's been a real long screen and you've gone through a lot of tests.... (C/M, 5/17/94, p. 17)

The above excerpts from an exercise/testing segment with Marcia illustrate both the structural dimensions of the segment that I highlighted earlier *and* the more flexible and dynamic dimensions as therapist and client teach and learn from one another as the segment proceeds.

The Final Segment: Review and Closure

The transcript above illustrates the beginning of a transition into the review and closure segment of the initial evaluation session with Marcia. The remaining six minutes of the session were devoted to more summarizing of what had been done (in this case, found) in therapy that day and what kinds of therapy might be helpful in the future. In the following excerpt Caitlin makes some recommendations regarding the nature and extent of therapy she believes would be beneficial for Marcia.

C: I think that you would benefit from doing some continued strengthening of the left leg and some vestibular habituation and balance exercises. I would foresee that we might want to go twice a week for about six weeks and see where we can get and if we get some real noticeable changes and it's worthwhile// um, my approach is to give you some home exercises and to monitor those when you come in and see how you're doing with those and try to keep upgrading those over the six weeks. And my focus, again, I think would be on vestibular function, strengthening, and balance.

M: Mmm hmm (nodding)

C: You've obviously made a lot of gains since your initial accident and injury.

M: Yeah, when I think back...

C: Yeah, but it seems that you want to be a little more functional than you are now and I think that it might be realistic for you

> to think about getting back into golf and to be more stable and functional with your walking. (C/M, 5/17/94, pp. 17-18)

After this, Caitlin and Marcia discuss Caitlin's plans to correspond with Marcia's neurologist regarding her findings and to suggest a short course of therapy for Marcia. They talk about days of the week and times that might work for Marcia in terms of scheduling appointments as they walk out of the therapy gym and toward the receptionists desk and waiting area.

Bill's session on May 5, 1994, also closes with a review of what was accomplished in therapy on that day and planning for the next session.

> The next time I see you, we'll review how these exercises went for you and we're going to go over these (showing Bill the second page of exercises in his written home program). So, I'd like you to read through them. Not today, when you go home--just before I see you next time.... (C/B, 5/5/94, p. 6)

After a final discussion about Bill's headaches and how they might address that problem, Bill and Caitlin set some dates and times for Bill's next sessions. As they rise and begin to leave the gym, Caitlin gives Bill the business card with the star target on it to take home with him for his work on his visual control exercises.

In this section, I have reviewed the pattern or structure of therapy sessions that was apparent in the great majority of my observations of Caitlin working with her clients. It was a pattern that centered around four forms of instruction: instruction about the

sources and causes of the patient's problems, instruction about and demonstration of evaluation procedures or exercises, guided practice of exercises with reciprocal feedback about performance and assistance as necessary, and instruction about the rationale for doing exercises and how they might relate to the patient's everyday function and goals. Ultimately, the goal was for patients to independently perform their exercises without Caitlin's feedback and assistance and to integrate therapeutic movements into everyday patterns of functional activity that held meaning for the client.

Caitlin's Beliefs About the Structure and Nature of Teaching and Learning in Clinical Encounters

Since this pattern was so prominent in therapy sessions, I was interested in whether or not Caitlin was aware of the pattern that emerged. Did she preactively plan therapy sessions that were structured in this way? If so, why? What beliefs or theories did she have about teaching, learning, and learners that might influence to the way she went about teaching in therapy sessions? How had these beliefs developed? Where did they come from? Within therapy sessions, what kinds of interactive thoughts or decisions did she make that influenced the structure of therapy sessions? I posed these questions to Caitlin in an interview in August 1994.

First, I asked Caitlin if she had any organizational scheme she used for introducing individuals to and instructing them in their therapy programs. Caitlin's response matched some of my

observations regarding the initial overview of findings (segment two) and the introduction of the purpose of the therapy program (segment three).

> Well, if I have an exercise program developed, I always try to initially give them [the patient] and overview of the exercises in terms of general categories [of exercises] because I know once you get into the exercises themselves the patient can get lost in the details--you know, each little thing and what to do. So, I try to give an overview and say we need to cover X with regard to A, B, and C [problem areas]--these are the problem areas that I saw in your evaluation. And I always try to give a rationale for why we're going to cover A, B, and C, and to find out about their level of commitment to A, B, and C.... [I discuss] what it's going to take to see any change. I think that's one real important organizational structure [I use]. (C, 8/16/94, p. 13)

So, Caitlin feels that is important to provide a review of her findings and an overview of the broad categories of exercises or activities the patient will be working on in therapy before proceeding to instruction in specific exercises. She also emphasized her commitment to providing a rationale for exercises--discussing why the exercises are important in terms of the problem areas for the patient. Later in the interview, Caitlin added: "I think having some scheme of organization that makes sense helps the patient--because otherwise they can get overwhelmed." When I asked Caitlin how she came to develop this particular organizational scheme which she felt would make sense to the patient and help them, she responded that she adopted this structure based on her experience in classroom and clinical teaching.

> Well, some of it has to do with my experience in classroom teaching. I think that in [classroom] teaching I try to provide the big picture and then go in and do some of the pieces and then go back out to the big picture. And you always review before you bring in new points--you tie old points to new points--you keep trying to bring it back to where they [the learners] are. I try to do the same thing with clients as I do with classroom teaching. That [classroom experience] and feedback from patients and patient's families over the years. You know, you just don't get so much of that blank stare like when they come in the next time and don't have any idea. You learn after that to try something different. (C, 8/16/94, pp. 14-15)

After experiencing the "blank stare" of patients and students in the classroom, Caitlin adopted a teaching strategy that involves first providing the "big picture," then moving to some of the "pieces" that comprise the picture, and then returning to the big picture. Caitlin feels this strategy creates a framework for understanding the relationship between exercises (or smaller pieces) and the patient's problems and function. By moving from the outside (big picture) inward, and then back outward she hopes to help patients and students alike see how pieces of the puzzle relate to and create the whole. In the case of clients, the whole is their disorder, problems, and the functional disability these things are producing. The pieces are the exercises that have the potential to alter the impact and extent of the problems and decrease disability. Caitlin directs considerable effort toward keeping practice on pieces or components of performance linked to the context of full, everyday performance. At first she does this conceptually. Later, as we have already seen in

Chapter Three, she actually incorporates and encourages the patient to incorporate therapeutic exercises into naturally occurring, everyday, meaningful activities. Caitlin believes constant efforts to contextualize the activities of therapy are critical for patient learning and therapeutic change.

In addition, Caitlin suggests that she believes it is essential to "tie old points" or information to new; to work from the existing experience and understandings of learners as she works to enlarge or transform those understandings or alter that experience. This cannot be done alone; it requires that the therapist find out "where the learners are." Caitlin must constantly assess and reassess client understandings and performance as she and the client co-construct therapy as an educative endeavor.

Caitlin discussed how individual clients influence and participate in the construction of therapy. In the following quotation she draws on her work with Bill to describe her general beliefs about how teaching and learning in therapy sessions and exercise segments should be organized.

> ...In terms of going through the exercises, it just depends on each particular individual. But I try to start out with the easy ones that they can handle at first and work into the ones... that are more challenging. So, like, for vestibular exercises, Bill's visual exercises were pretty easy for him to comprehend and follow through with initially--not overwhelming. I mean if you start asking somebody to do some of the positional exercises right away and get them real dizzy... [you lose them]. You've got to kind of move into those--move into the more challenging exercises gradually. That's probably my organizational flow.... And as I introduce a new one [exercise or category of exercises], I always review, before I introduce the new one. I

> say 'okay, last week we did the visual exercises. Are they going okay? Do you have any questions?' And we try a few. And [then I say] now, we're going to move into this. So I kind of try to tie one to the other. And I always try to get the patient to each time bring in their own exercise sheet so they can make notes on their sheet. (C, 8/16/94, pp. 13-14)

With respect to the last statement, both Bill and Marcia almost always brought their written home exercise programs with them to therapy and frequently had penciled notes on the program about how the exercises were going for them. They would then share and discuss their notes with Caitlin in response to her questions about how the exercises were going.

The above quotation illuminates Caitlin's beliefs about the need for the building and scaffolding of instruction. Caitlin feels it is essential to start exercise programs with exercises that are beneficial but not overwhelming to the client. These are exercises that are relatively easy to understand, complete, and tolerate. They are able to be learned and completed with initial but relatively limited assistance and guidance from the therapist. To start therapy sessions and programs, Caitlin selects exercises that she feels the client is more likely to learn easily and without negative effects (e.g., increased pain, dizziness, or nausea). These are exercises that should allow the patient to move fairly rapidly to independent performance of the exercises and experience early success in the therapy programs. Later, exercises that are more challenging and require more assistance and guidance from the therapist are introduced. These are often exercises that extend or incorporate elements of

previous and less complicated exercises. The ultimate goal is that by the time therapy is discontinued, guidance from the therapist is no longer necessary and the patient is able to assume full responsibility for the completion of therapeutic exercises in the context of their daily routines and tasks.

As the interview continued Caitlin reemphasized her belief in the importance of "providing a rationale" for exercises to patients. To Caitlin, if an exercise does not have some relationship to the patient's ability to function as they need or wish, then there is no reason to do the exercise. She felt it was her job to help patients recognize *and experience* the link between what could seem to be an isolated and unrelated exercise and the functional demands of clients' lives. In previous excerpts we have seen how, on numerous occasions, Caitlin tied Bill's visual and vestibular exercises to the requirements of his work as a pharmacist. Bill's ability to return to work on a full-time basis was a key concern for him. Caitlin used the example of Bill to talk about what she felt could happen if she *did not* provide a rationale for exercises and link them to function and meaningful tasks for the client.

> ...Could you imagine telling someone who wasn't as bright as Bill...to do all these visual exercises? And they go back to their spouse and say 'this lady must be crazy--I mean why does she want me doing all these little spot checks with my eyes?' I just think it's real important to tie in rationale all the time. (C, 8/16/94, p. 15)

Caitlin's commitment to providing a rationale for exercises is part of her effort to prevent the activities of therapy from seeming remote

and disconnected from the everyday activities and needs of the client. Her belief that she must constantly work to embed exercises done in therapy in the context of their usefulness (use and meaningfulness) for clients suggests that she is attentive to the need for the activities to be situated, contextualized, and authentic for the client if learning is to occur. The importance of such contextualization and authenticity of activity as a powerful framework for learning has been emphasized by Brown, Collins, and Duguid (1989) working from an epistemology of social constructivism and the theoretical and philosophical perspectives of Vygotsky (1978) and Dewey (1916; 1938). Such authentic activity is no less important in motor learning than in cognitive learning--the two are intimately related.

Finally, Caitlin discussed how important she felt reciprocal feedback and questioning were as patients moved toward increasing independence in their therapy programs. She felt such feedback was important to the development of self-evaluation and self-monitoring for learners and that this was particularly true for patients with various forms of cognitive and sensory-perceptual impairment that can make accurate self-assessment difficult at best.

> I think the interactive feedback is really critical. I try to make sure I do that through it [each exercise] and at the end as well. I think self-evaluation of the client [about their performance] is as important as my feedback. So I always try to make sure I get that. (C, 8/16/94, p. 15)

Caitlin feels that eliciting feedback from the patient is as important as her giving feedback to the client about their performance. She suggests that the development of the client's ability to self-evaluate and monitor hinges on this interactive exchange. Such exchanges also have the potential to reveal discrepancies between client and therapist perceptions with regard to exercises, activities, or situation definitions (Wertsch, 1984). Gross discrepancies in situation definitions between therapist and client require that participants work toward convergence of and consensus on their definitions if the interaction is to be sustainable. Especially in the case of patients with brain damage and associated cognitive-perceptual dysfunction, this often requires that the therapist work to gradually "pull" the client's definitions into more alignment with the therapist's definitions. Such alignment is no small challenge and clearly makes the work of therapy the work of reciprocal teaching and learning.

Summary and Interlude

In the preceding sections of this chapter, I have discussed some of the "familiar patterns" (Clark, 1995, p. xv) of teaching as they appeared in therapy sessions with Caitlin, Marcia, Bill, and John. I have also described some of Caitlin's beliefs about teaching and learning and considered how they are reflected in the patterns of therapy sessions. Now I wish to turn to the "infinite variations." As Clark points out, stories of teaching and learning, though they may have a familiar form, each have features that are special and that make them distinct from all others.

In the next sections of this Chapter, I focus on one version of a story about John and the nature of teaching and learning in therapy sessions with him. Recall that, as a result of his brain damage, John had the most severe cognitive and perceptual impairments of the three clients who participated in this study. Such impairments create special pedagogical challenges for teachers and interactional and learning challenges for all participants. In further exploring the nature of teaching and learning in therapy with John, I draw heavily on the work of Vygotsky (1978) and his construct of the zone of proximal development (and related concepts) as a framework for analysis.

The Zone of Proximal Development in Therapy

I have found the zone of proximal development (ZPD) as put forth by Vygotsky (1978) a useful construct for examining and understanding attempts by rehabilitation professionals to be educators. As clinical teachers their primary aim is to promote and enhance learning and development for their clients and the caretakers who are part of the client's life system. The idea that the construct of the ZPD might have descriptive and explanatory power for an analysis of teaching and learning in clinical settings percolated out of data collected through interviews, observations, and close analysis of discourse in therapy sessions. I wanted to explore whether or not the construct of the ZPD could provide a meaningful framework for understanding the complex interactional work going

on during therapeutic interventions and conversations between the therapists and clients in this clinic.

In the service of this discussion of the ZPD in therapy, I will first present a brief overview of Vygotsky's sociohistorical theory. This is the foundation on which the construct of the ZPD rests. The overview will be followed by some descriptions and definitions of the ZPD. Second, I will present vignettes and analyze selected segments of discourse from therapy sessions with John, Caitlin, and John's wife, Diane, from the lens or conceptual framework of the ZPD on the micro level and from the perspective of sociohistorical theory on the macro level.

Vygotsky's Sociohistorical Theory of Learning and Development

The Zone of Proximal Development is a phenomenon described by Vygotsky (1978) as a corollary to his *General Genetic Law of Cultural Development*. The general genetic law of cultural development is an integral component of Vygotsky's sociohistorical theory that sought to describe and understand the development of higher mental functions or psychological processes in humans. Thus, a review of some of the key concepts of Vygotsky's sociohistorical theory seems necessary for a more complete understanding of the ZPD. The concepts I will review for the purposes of this analysis include: (1) the multiple dimensions or domains of the development of higher mental processes, (2) the social origins of mind--the general genetic law of cultural development, (3) the importance of semiotic mediation in the process of internalization hypothesized by

the general genetic law of cultural development, and (4) the zone of proximal development and the need for dynamic assessment.

The Dimensions of Development. Vygotsky's extensive research, theorizing, and writing was done in the early twentieth century when prevailing views of human development focused on either ontogenetic (or individual and biologic) development and phylogenetic (or evolutionary) development. Although Vygotsky did not view these two dimensions of development as unimportant, he was critical of theories of mental development that posited a single factor or force that directed development. Vygotsky felt that attention to the phylogenetic and ontogenetic dimensions of development was particularly important for an understanding of the development of elementary psycho-physiological processes, but he felt that these dimensions of development were insufficient to explain the development of the higher psychological processes that are distinctively human.

For Vygotsky, *higher* mental processes originated in social interaction and involved (a) voluntary regulation of environmental stimuli (vs. Pavlovian environmental autostimulation), (b) conscious realization of and reflection on mental processes, and (c) the use of sign systems (e.g., language) as a mediational tool for higher mental functions (Luria, 1971; Vygotsky, 1978; Wertsch, 1985). The complexity of such functions or processes suggested that additional developmental dimensions or levels of analysis and contribution were essential to understand the formation and structure of higher mental processes.

The four developmental dimensions proposed by Vygotsky are shown in Figure 13. Vygotsky felt that what was missing in previous accounts of the development of higher mental processes was attention to human history on multiple levels--evolutionary history (phylogeny), general history (both societal and cultural), individual history (ontogeny) and, at the microgenetic level, the history of the evolution of a specific mental concept or higher psychological process itself (microgenesis). In short, he felt that we could not understand complex mental processes without examining their genesis and history with careful attention to the contributions and interactions of several developmental dimensions or forms of history. Luria (1971) restates Vygotsky's premise as follows:

> ...we must consider the historical nature of man's psychological processes...the higher psychological processes cannot be understood as a direct function of the brain. [Vygotsky] adopted the position, which was truly significant for that period, that in order to understand the substance of higher psychological processes in man, it is necessary to go beyond the limits of the organism and to search for the roots of these complex processes in the historically formed environment, in the communication of child with adults, in the objective relations among objects, tools and language which have been laid down in the course of social history. In short, we must seek the roots of such higher psychological functions in the mastery of general, human, historically formed experience. (p. 260)

Vygotsky's attention to history was indeed "truly significant for that period" since his view conflicted with the principle of *synchronicity* so prominent in the predominant scientific and objectivist approaches to understanding phenomena. In psychology and other human sciences,

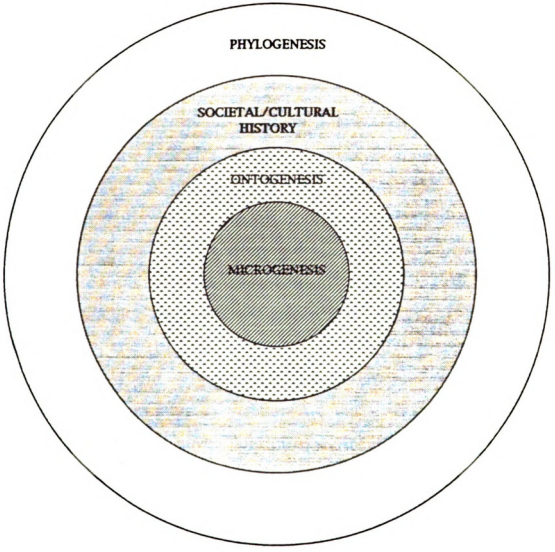

Figure 13. Developmental Dimensions in Vygotsky's Sociohistorical Theory. (Adapted from Gavelek, 1991)

this principle had translated into attempts to formulate universal laws of human development. In contrast, Vygotsky's theory and approach (his "genetic method") was *diachronic* and sought to understand phenomena *with* regard to time and history. This theory and approach translated into notions of cognitive relativity or relationality--notions that were inconsistent with prevailing thought in developmental psychology at that time.

Returning to Figure 13, Vygotsky's critical addition to existing models of human mental development was his identification and description of the historical dimension of development which included societal and cultural history. Vygotsky suggested that the transmission and transformation of such history took place through social interaction (often in the form of instruction) and was mediated through the use of tools. These tools included (a) "technical" tools or the objects/artifacts of a culture which were directed toward "outward" activity in the environment, and (b) "psychological" tools or sign systems which were directed inward and were means of influencing and regulating internal activity or thought (Vygotsky, 1962; Wertsch, 1985). Examples of sign systems that serve as psychological tools are language and writing, mathematical and symbolic notation systems, mnemonic devices, art, and diagrams to name a few (Vygotsky, 1981a; Wertsch, 1981, 1985). Such sign systems can both create and convey meaning. Vygotsky, who was particularly interested in the role of speech and language in psychological development, proposed that the use of sign systems facilitated and *transformed* mental functioning in humans (Vygotsky 1981b; Wertsch, 1981, 1985.). Thus, it is the historical dimension of

development that highlights the importance of semiotic mediation and analysis in Vygotsky's sociohistorical theory.

In addition, education and instructional activity are brought into the foreground and become integral parts of Vygotsky's theory of learning and development within the historical dimension of development. As Moll (1990) puts it,

> Vygotsky regarded education not only as central to cognitive development but as the quintessential sociocultural activity. That is, he considered the capacity to teach and to benefit from instruction a fundamental attribute of human beings. (p. 1)

Interestingly, although it is the historical dimension of development that is one of Vygotsky's primary contributions to theorizing in developmental and educational psychology, he spent much of his life observing and describing human development in the ontogenetic and microgenetic dimensions. Vygotsky felt that through the study of individual development on these levels one could best observe the interrelated and simultaneous operation of the "natural" (biologic) line of development and the "social" or "cultural" line of development (Vygotsky, 1962, 1978). And it was the interaction and association of these lines and dimensions of development that was of prime interest to Vygotsky as he sought to understand the relationship between individual learning and the development of higher psychological processes.

Description of the microgenetic dimension of development requires "microgenetic analysis" which has been most thoroughly discussed by Wertsch and Stone (1978), Wertsch (1985), and Zinchenko

(1981; 1985). Microgenetic analysis might be best described as a short-term longitudinal case study in which an investigator studies the unfolding or development of a specific cognitive activity or concept during a single observation of an individual. Vygotsky posited that through careful observation and analysis of such activities and concepts in *formation* --in the process of change ("genetic analysis")--we could best understand the nature and structure of the final product (Vygotsky, 1978).

Both the ontogenetic and microgenetic dimensions of development and levels of analysis should be familiar to physical therapists and other rehabilitation professionals who are charged to be constantly evaluating and adapting therapeutic interventions to the ever-changing and evolving performance of their patients in various skill and knowledge domains.

In summary, Vygotsky's developmental dimensions and method of genetic analysis requires that an analysis of the development of human mental functions (a) focus on process and not just product or object analysis, (b) attempt explanation not mere description of a phenomenon, and (c) consider all four developmental dimensions or genetic domains in explanations of developmental phenomena and outcomes (Scribner, 1985; Vygotsky, 1978; Wertsch, 1985). In general, then, Vygotsky's sociohistorical theory urges psychologists and educators to widen their "viewing angle" and challenges us to work to understand the broader contexts within which and through which learning, knowledge construction, and psychological/cognitive development take place.

The General Genetic Law of Cultural Development. Keeping in mind the definition of higher psychological processes as those that are "social in their origin, mediated in their structure, and voluntarily directed in their functioning" (Luria, 1971, p. 261), Vygotsky devised *the general genetic law of cultural development* to describe the *process* of the development of higher mental functions:

> Any function in the child's cultural development appears twice, or on two planes. First it appears on the social plane, and then on the psychological plane. First it appears between people as an *inter* psychological category, and then within the child as an *intra* psychological category. This is equally true with regard to voluntary attention, logical memory, the formation of concepts, and the development of volition.... [I]t goes without saying that internalization transforms the process itself and changes it's structure and function. Social relations or relations among people genetically underlie all higher functions and their relationships. (Vygotsky, 1981, p. 163) [italics added]

In this genetic law of cultural development, Vygotsky introduces the notion of internalization--the "internal reconstruction of an external operation" (1978, p. 56). According to Vygotsky, internalization is the mechanism through which social activity influences and determines the formation of the mind. Vygotsky insisted that the process of internalization was not simply a copying or direct incorporation of what had been experienced or "transmitted" socially on the external plane; rather, the transfer inward of functions involves a series of transformations such that the external activity is reconstructed and incorporated into *new* functional systems within the individual that are *qualitatively* different than their predecessors. In apparent response

to this admonition, some scholars have chosen to use the term "appropriation" instead of internalization to avoid the potential for conceptualization of the process as one of sheer social and cultural transmission (as opposed to transformation) (Harre, 1986; Rogoff, 1990).

The general genetic law of cultural development is shown schematically in Figure 14. In this view of mental development, social interaction, instruction, and learning can be taken to *lead*, foster or "pull" development. This view contrasts with Piagetian notions in which development leads learning as illustrated by Piagetian conceptions of "readiness" to learn (Piaget, 1963; Piaget & Inhelder, 1969). For Piaget, social interaction and external activity or experience is *facilitative* of capacities that are already residing in and developing naturally in the individual. Moreover, Piaget suggested that cognitive development proceeded chronologically in invariant, irreversible, and universal stages and sequences.

For Vygotsky, in contrast, social interaction and experience in the cultural-historical milieu surrounding human activity is not only facilitative, it is *formative* in the construction of human thought. That is, higher level mental functions are *constituted* from and through social interaction; mind is emergent through human interactions and "maturation per se is a secondary factor in the development of the most complex, unique forms of human behavior" (Vygotsky, 1978, p.19). That is, maturation is a necessary but not sufficient condition in the development of higher mental functions.

In addition, as John-Steiner and Souberman (1978) have written,

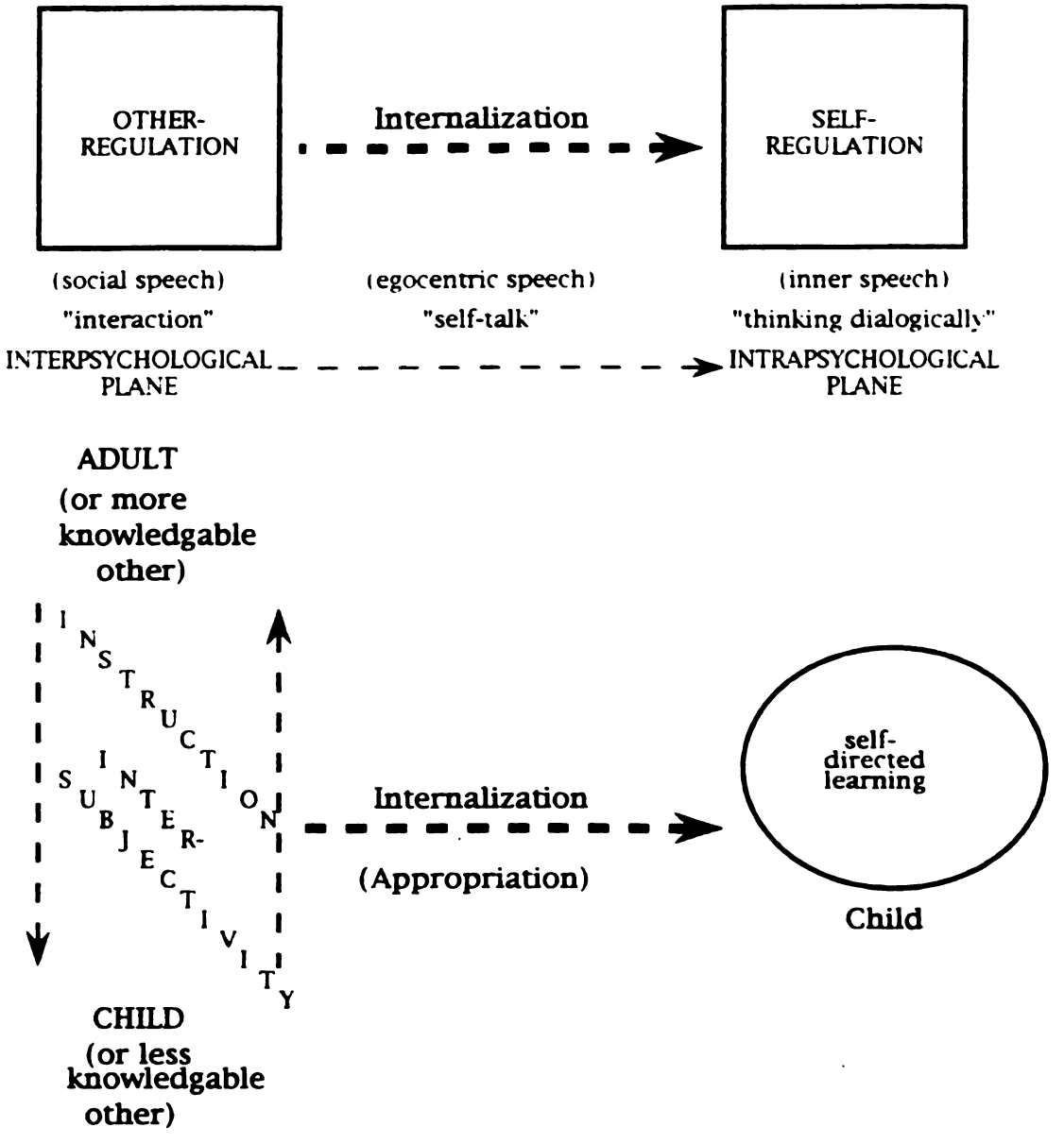

Figure 14. Schematic of Vygotsky's General Genetic Law of Cultural Development. (Adapted from Gavelek, 1991)

> Vygotsky argues that because the historical conditions which determine to a large extent the opportunities for human experience are constantly changing, there can be no universal schema that adequately represents the dynamic relation between internal and external aspects of development. Therefore, a functional learning system of one child may not be identical to that of another, though there may be similarities at certain stages of development. (p.125)

Thus, Vygotsky's belief in several intertwined dimensions of development and in the social construction of mind (including his general genetic law of cultural development) introduces the possibility of a variety of developmental trajectories, sequences, timelines, and destinations for humans in terms of their higher psychological processes. Given this, sociohistorical theory and the general genetic law of cultural development also permit consideration of ongoing learning and continuing development of higher mental functions and psychological processes beyond the confines of childhood and adolescence and beyond the constraints of biological and neurologic maturation and function. For physical therapists and other rehabilitation professionals working with brain-injured adults (like John) this is a particularly appealing and true to life way to think about, and possibly explain, some of the individual transformations observed in adult patients, in spite of neuroanatomical, neurophysiological and medical or surgical findings that would suggest learning and development of specific functions (physical, cognitive, and social) might be severely impaired and *permanently* lost.

To close this discussion of the general genetic law of development, I want to present one more description and clarification of the law and

the process of internalization that has been provided by Harre (1980, 1985, 1986). Harre's description is pertinent and will be useful for examination of data I will present shortly. It also helps me to think about the kinds of processes that might be occurring when individuals, context, and content interact in zones of proximal development.

Harre (1980,1985,1986) has described and Gavelek (1991) has interpreted Vygotsky's "space", along two dimensions--a public/private dimension and a social/individual dimension--creating four quadrants (see Figure 15). Quadrant I, the public-social quadrant, is an external quadrant in which communication, activity, instruction, and *thinking* are occurring between people. In quadrant II, the social-private quadrant, individuals *appropriate* ways of thinking and speaking from others. At this point, the appropriated ways of speaking and thinking (or strategies) are no longer visible but they have originated socially in interaction with others. In quadrant III, the private-individual quadrant, the transformation and reconstruction that is so important to Vygotsky occurs; an individual begins to incorporate a learned form, process, or strategy by experimenting with it in the context of their own experience. Through this experimentation, they *invent* a particular system or way of using that information or learned form--their own unique application--from which they create new applications or knowledge. Finally, in quadrant IV, the individual-public quadrant, an individual's thinking (now transformed) becomes public and can be observed externally through actions, speech or writing. The publication or sharing of an individual's thinking with others brings the process

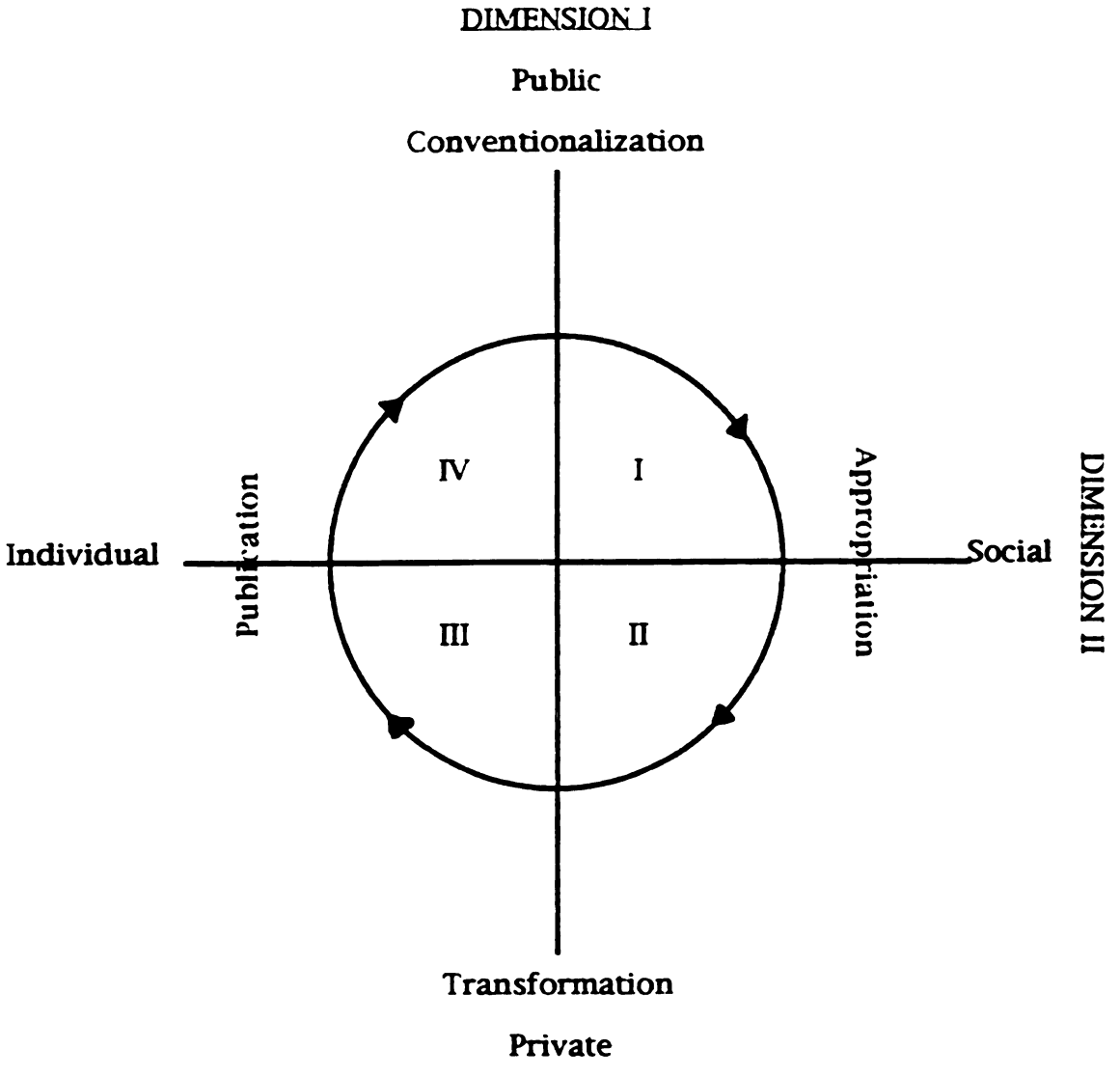

Figure 15. "Vygotsky's Space". A schematic of the process of individual movement between the inter-psychological and intra-psychological planes. (Adapted from Harre, 1986; by Gavelek, 1991)

back into the social domain and opens the door to conventionalization.

The process described above, though depicted schematically in Figure 15 as a circular process, is envisioned as an iterative and dialectic process. As Vygotsky (1978) wrote, "development, as often happens, proceeds here not in a circle but in a spiral, passing through the same point at each new revolution while advancing to a higher level" (p. 56).

The Importance of Semiotic Mediation. As mentioned earlier, Vygotsky was convinced that the use of tools by humans was an essential activity for the development of higher cognitive functions. He claimed that tools (outward and inward directed--technical and psychological) shape the ways that humans interact with the physical and social world at the same time that they act as "mediational means [to] reshape and redefine the tasks and mental functioning involved" in such activity (Wertsch, 1989, p.18). A key element in the process of social interaction, internalization and enculturation described by Vygotsky is the use of sign systems or "psychological tools" (Vygotsky, 1962, 1978) and Vygotsky was particularly interested in the role of the sign systems of speech or language--of semiotic mediation of activity--in the process of internalization and the development of higher psychological functions. As Wertsch (1989) has written,

> ...semiotic mediation exists on the interpsychological as well as the intrapsychological plane. Indeed, it is precisely because the *same* general mediational means are employed on the social and individual planes of functioning that the transition from the former to the latter is possible. (p. 19)

Thus, language and speech serve both social and individual functions and are mediational tools that provide for the merging of speech and thought in interpersonal and intrapersonal dialogue.

Consistent with the unity of thinking and speech reflected in Vygotskian theory, Vygotsky proposed *word meaning* as an appropriate unit of study for coming to understand the relationship between thinking and speech and transformations that occur between interpsychological function and intrapsychological function (Vygotsky, 1987). A focus on word meaning as a unit of study requires that we consider both the structure and function of speech and directs investigators, myself included, to close analysis of discourse between individuals (speech on the interpsychological plane) as a potentially rich source of data as we seek to better understand verbal mediation on the intrapsychological plane and the development of higher psychological processes. Such development, Vygotsky posited, was facilitated in instructional (semiotically mediated) encounters by the identification and creation of a *zone of proximal development* for learners. And it is to this construct that I finally turn.

The Zone of Proximal Development and Dynamic Assessment. Vygotsky had an intense interest in *how* individuals (children, in particular) become "what they are not yet" and he introduced the concept of the ZPD to address issues related to (a) assessment of abilities and (b) instructional practices important to an understanding of learning, cognitive development, and psychological growth (Vygotsky, 1978; Wertsch, 1985). To my way of thinking, the ZPD is Vygotsky's most concrete attempt to deal with the complex relationships between

learning, instruction, and development--relationships of extreme importance to *all* educators, including health care practitioners like those in my study who are committed to the learning and development of their patients in several domains (e.g., psychomotor/physical, cognitive, affective or social-relational).

Vygotsky (1978) defined the ZPD as

> ...the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers. (p. 86)

This definition requires that, for each child or learner, at least two developmental levels be determined in order to identify a ZPD: the *actual developmental level* and the *level of potential development.*

For Vygotsky, the actual developmental level of a child or individual describes or represents mental functions that are already established. Such functions are often assessed or measured with static assessment procedures such as intelligence testing or developmental profiles that provide a single snapshot of what a child (or individual) can do on their own, at a particular time, as measured with a tool that is unchanging as assessment or evaluation proceeds (or standardized). In his paper, The Problem of Age, Vygotsky (cited in Minick, 1987) suggests that many static assessment procedures provide what he calls *symptomatic* assessment which "focuses on behaviors and characteristics... that are typical of children of a particular psychological type or developmental stage." Vygotsky points out that such

assessments often provide no more information than that which is self-evident; they don't help explain or predict development, nor do they guide intervention or provide insight into unfolding developmental processes. Since Vygotsky was most interested in the *processes* of development and where the child was *going*, assessment of the actual developmental level of a learner is only a small part of establishing the ZPD.

In contrast, assessment of the level of potential development (which is independent of the actual level of development) is a crucial element in the identification of the ZPD since according to Vygotsky (1978),

> ...the actual developmental level characterizes mental development retrospectively, while the zone of proximal development characterizes mental development prospectively.... The zone of proximal development defines those functions that have not yet matured but are in the process of maturation, functions that will mature tomorrow but are currently in an embryonic state. These functions could be termed the "buds" or "flowers" of development rather than the "fruits" of development. (pp. 86-87)

Measurement of the level of potential development provides for identification of the "buds" of development and helps to guide instructional practice in the service of a child's learning and development. Assessment of potential development requires "dynamic" (or fluid–not static or standardized) and "diagnostic" assessment; such assessment cannot occur without social interaction and involves careful and ongoing observation of a learner's performance or problem solving in an activity that they are unable to complete on their

own but are able to do with the guidance and collaboration of a more knowledgeable partner. As Vygotsky put it, "that which the child turns out to be able to do with the help of an adult points us toward the zone of the child's proximal development" (Vygotsky, 1978, p. 68). Dynamic or diagnostic assessment permits observers or instructors, be they classroom teachers or clinicians, to make recommendations that are most likely to facilitate development--to create instructional contexts that enable learning and provide for further development so that what a child or individual "can do with assistance today she will be able to do by herself tomorrow" (Vygotsky, 1978, p.87).

It is through the notion of the ZPD that Vygotsky (1978) most explicitly sets forth one of his most important theses about the relationship of learning, instruction, and development: that "good learning is that which is in advance of development" (p. 89) and that "good" instruction proceeds ahead of development and provides for learning that "awakens and rouses to life an entire set of functions which are in the stage of maturing, which lie in the zone of proximal development" (Vygotsky, 1934, cited in Wertsch, 1985, p. 71). Furthermore, Vygotsky (1978) suggests that learning *creates* the ZPD and that certain forms of instruction and interpersonal interaction are particularly facilitative of development:

> ...an essential feature of learning is that it creates the zone of proximal development; that is, learning awakens a variety of internal developmental processes that are able to operate only when the child is interacting with people in his environment and in cooperation with his peers. Once these processes are internalized, they become part of the child's independent developmental achievement. (p. 90)

Here, Vygotsky reminds us that learning and cognitive development are distinctly *social* processes, accomplished through human activity and interaction mediated through language. And instructional environments—created by teachers and teaching--represent opportunities for the identification and creation of zones of proximal development and, ultimately, the advancement of development.

Even so, not all instructors seize this opportunity nor do many instructional and assessment practices or instructional environments afford this opportunity. In classrooms, lectures, recitation, directives, or seat-work provide little or no opportunity for (a) close interaction, dialogue, and collaboration between instructors-learners or peers (b) assessment of potential levels of development, (c) identification and creation of zones of proximal development, and, thus, (d) the design of educational interventions that focus on emerging functions and provide a context and means for advancing development. Alternatively, educational environments and practices that provide for demonstration, modeling, sensitive listening and assistance, leading questions, and guided participation and collaboration between learners and more knowledgeable others create opportunities to develop social systems or contexts in which the ZPD can be identified and constituted through teaching-learning partnerships (Vygotsky, 1978, 1987).

Although Vygotsky did not provide detailed prescriptions about the specific forms of collaboration and assistance he thought would create a ZPD and engender individual development, he did suggest that intersubjectivity, co-construction of meaning, and shared understanding between learner-teacher partners are requisite for movement in the

ZPD. Wertsch (1984), in an attempt to extend and clarify Vygotsky's theoretical accounts of the ZPD and intersubjectivity, invoked the notion of *situation definition.* Wertsch defines a situation definition as "the way in which a setting or context is represented... by those who are operating in that setting" (p. 8). He argues that

> the notion of situation definition is needed in any complete account of the zone of proximal development, because collaboration in this zone typically involves the adult's representing objects and events in one way and the child's representing them in another. (p. 8)

That is, a ZPD is characterized at the outset by discrepant situation definitions by participants.

Wertsch (1984) goes on to suggest that the major changes or *qualitative* developmental transitions that occur in the ZPD involve a "process of giving up an existing situation definition in favor of a qualitatively new one..." or a *situation redefinition* (p.11). Such situation redefinitions are best achieved through intersubjectivity which provides for sharing, understanding and negotiation of situation definitions. This implies, as Vygotsky suggested, that intersubjectivity involves coming to agreement about *meaning* and permits a convergence of teacher–learner conceptions about objects, events, activities or tasks (Vygotsky, 1987). Establishing intersubjectivity, however, is no small task and often requires the adult's (or more knowledgeable other's) sensitive listening and dialogue to identify and negotiate a situation definition that can be understood and accepted by interlocutors–a definition that may not be the adult's (teacher's) but

that may define the potential level of development of the child or learner.

As we might expect, Vygotsky was most interested in the use of language--semiotic mediation--as a tool for creating both intersubjectivity and zones of proximal development. In this sense, his *focus* was largely on the use of oral and written language as a mediational tool (although he did not disregard other sign systems such as gesture, proxemics, etc.). More recently, as research on human development has proceeded, particularly with infants and very young children, other scholars have encouraged increased attention to non-verbal aspects of communication as an important element in the development of intersubjectivity and shared meaning (Rogoff, 1990; Trevarthen, 1980, 1989). I believe the explicit addition of non-verbal interaction to this equation is beneficial and warranted (and not inconsequential in my own analysis of linguistic, paralinguistic, kinesic, and proxemic features of discourse in clinical settings); it urges attention to the physical and emotomotivational aspects of interaction--to synchrony or asynchrony of interaction--created by the communicative transactions that surround and penetrate utterances. As I have suggested in Chapter 3, I believe such features of interaction are critical to the development of intersubjectivity, especially with patients with brain injury and various forms of organically based cognitive and language impairment. Although the term "intersubjectivity" was not used by therapists at Jones and Thompson, I believe their descriptions of therapeutic alliances point to the importance of the development of

intersubjectivity between client and therapist for the creation and sustaining of such alliances and the realization of client centering.

One further note on the concept of intersubjectivity that is pertinent to this analysis of interaction in therapy involves Rogoff's (1990) interpretation and extension of intersubjectivity. Rogoff, in her attempts to understand cognitive development and psychological growth, focuses on

> ...thinking as functional effort to solve problems and on development as progress in skill, understanding, and perspective regarding problems and their appropriate solution, as defined by the local culture. [Such] a problem-solving approach places primacy on people's attempts to negotiate the stream of life, to work around or to transform problems that emerge on the route to attaining the diverse goals of life. (pp. 8-9)

Given the definition of thinking as problem-solving directed toward the attainment of goals, Rogoff argues that in this conception of human thinking "the traditional distinction between cognitive, affective, and social processes becomes blurred" because "human goals involve other people and carry feelings with them" (p. 9). Thus, Rogoff reminds us that the shared meaning so critical to intersubjectivity involves "cognitive, social, and emotional interchange" that permits a "sharing of purpose and focus among individuals" (p.9). I present Rogoff's interpretation of intersubjectivity because I feel it is helpful for my description and analysis of the complex interactional work that is going on in the therapeutic encounters I have observed as clinicians, patients, and family members try to negotiate and work toward specific rehabilitation and life goals established in light of the physical and

cognitive impairment, social/relational disarray, and emotional upheaval that results from brain injury.

Last, but not least, a comment on various conceptions of the ZPD that have emerged since Vygotsky's initial description. In many cases, the ZPD has been taken as an individual difference variable--a variable that can simply be attributed to the individual–a zone that is determined solely by the child or less knowledgeable other. I hope the foregoing discussion has prevented such an impoverished interpretation of the ZPD. Vygotsky and Vygotskian scholars frequently remind us that the ZPD is constituted by several agents and factors (Moll, 1990; Rogoff, 1990; Tudge, 1990; Vygotsky, 1978; Wertsch, 1985). Among these are (a) the learner or individual "knower" in development, (b) the mediating agent (more knowledgeable other–adult or peer), (c) the knowledge domain or task and the problem-solving demands of an activity, and (d) the historical, social, and institutional contexts in which the above are imbedded (see Figure 16). As I attempt to address questions about the existence, creation, nature, and constitution of ZPD's through discourse in therapy, I will try to acknowledge and discuss all of the above contributions to the zone of proximal development.

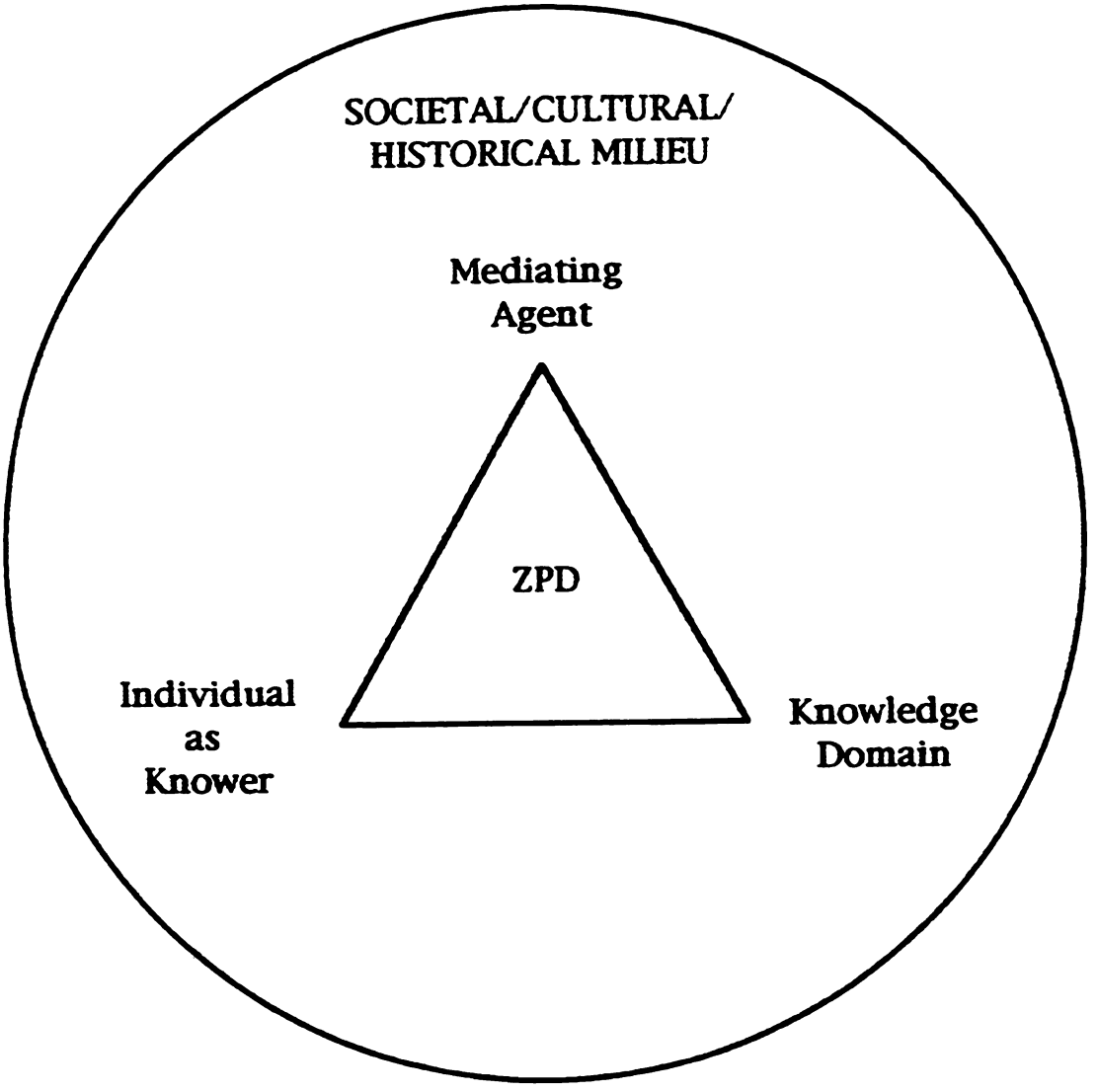

Figure 16. A Schematic of Contributions to the Zone of Proximal Development. (Adapted from Gavelek, 1991)

Returning to the Clinic: The Zone of Proximal Development in the Discourse of Therapy

Like Vygotsky who argued for an enlarged and interrelated view of developmental dimensions and processes, Hymes (1972) has encouraged an enlarged an embedded view of human interaction. He reminds us that when we seek to understand and interpret interpersonal communication it is important to recognize the nesting of *speech acts* (Austin, 1962; Coulthard, 1985; Searle, 1969), that is, ways of creating action or doing things with words (e.g., establishing intersubjectivity, identifying and creating ZPD's), within larger contexts that create the medium for interpretation by both participants and observers. According to Hymes (1972) speech acts are embedded in speech events, which are embedded in speech situations, which are embedded in speech communities. To analyze and theorize about discourse at the level of speech acts, we must consider and draw on the knowledge and meaning held in these other levels. Thus, previous descriptions of this clinical community and the beliefs and cultural norms for action held by members of the community provide the backdrop for the analysis of discourse presented here. Naturally, even these levels are nested in others which, in turn, create additional media for interpretation. For instance, this particular speech community is nested in the larger frames of the health care system in the United States which is historically entrenched in Western philosophical thought about medical practice, disease, and illness. For the purpose of this

analysis, however, I focus primarily on the levels and contexts for interpretation described by Hymes (1972) (see Figure 17).

The speech community is comprised of the clinic associates and clients at Jones and Thompson, P.C. The speech situations are hour-long dyadic therapy sessions with John and Caitlin and one triadic therapy session with John, Caitlin, and Diane. The speech events are selected segments within therapy sessions with John. In the following discussion and analysis of discourse in these speech situations and events I may return to claims, concepts, and data discussed earlier or anticipate discussion yet to come--but I will view them through the conceptual lens of the ZPD and associated concepts.

Recall the clinic associates' description of client centering, which demands attention to the *life needs* of patients as a guiding principle for clinic staff in the provision of care. Their descriptions of client centering bear a family resemblance to the concept of intersubjectivity described by Rogoff (1990), which requires the creation of shared meaning, purpose, focus, and goals between interactants. Even so, the enactment of this philosophy of care grounded in client centering is no simple task, as analyses of interaction between client and therapist reveal.

Of particular importance for this analysis of teaching and learning in therapy is the emphasis on client and family education, and the goals of client enablement and empowerment to enhance self-sufficiency. Here, the belief that therapy is an educative endeavor--that teaching and learning (and individualized educational programs) are essential elements of care--becomes apparent. Furthermore, the overarching

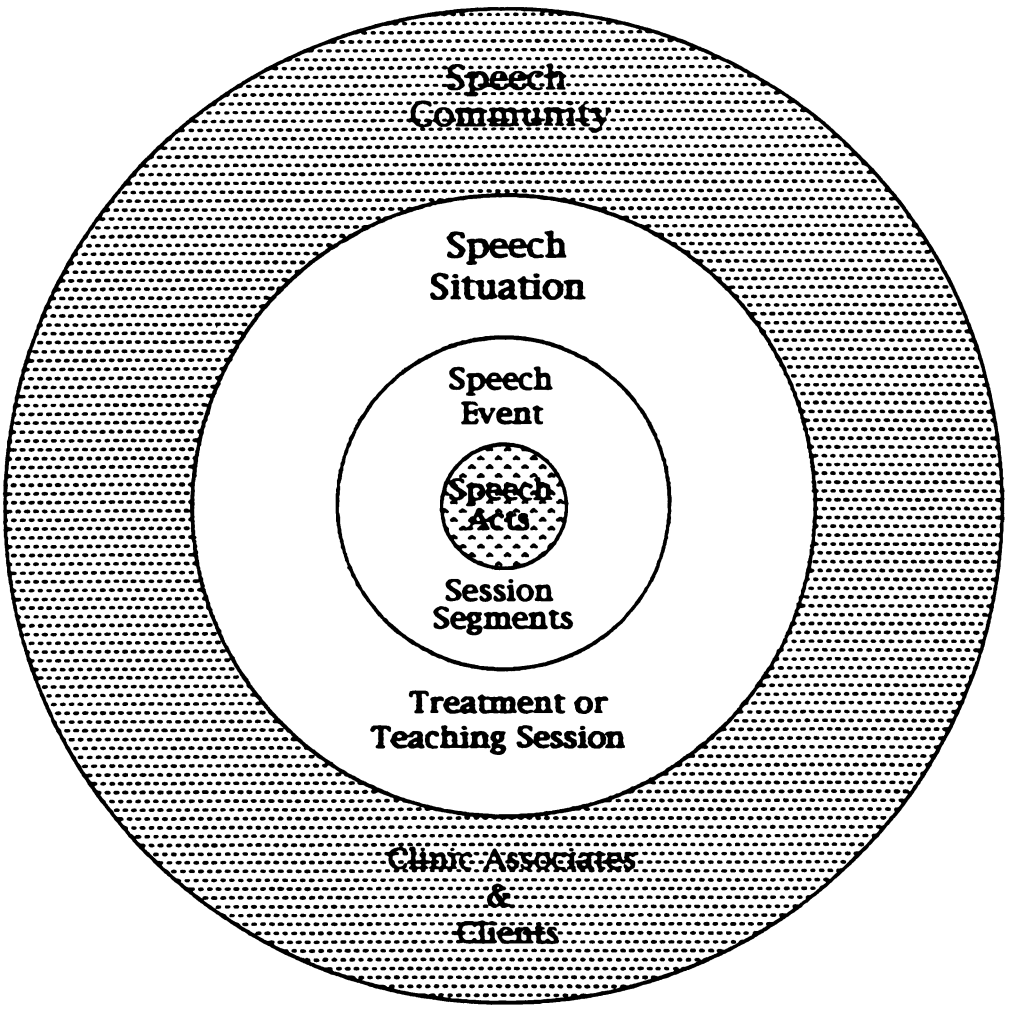

Figure 17. The Nested Context for the Analysis of Discourse in Physical Therapy Sessions in a Transdisciplinary Rehabilitation Clinic. (After Hymes, 1972)

goal of assisting patients in movement (development) from points where they are dependent on others to accomplish meaningful and necessary activities, to points where they are independent in solving cognitive, movement, or social problems they will encounter in their daily lives is highlighted. This broad goal most certainly evokes images of clinicians working (in collaboration with patients and considering situational and knowledge demands) to identify, monitor, create, and work within client zones of proximal development so that individuals become able to accomplish tasks which they were unable to do without assistance previously.

In addition one of the facilitators of client centering is especially salient to this discussion--establishing therapeutic alliances. Creating and nurturing therapeutic alliances is essential for and mediates entry into the lifeworld (Habermas, 1987; Mishler, 1984; Schutz & Luckmann, 1973) of clients and their caregivers. Recall that Kay identified some of the key questions that need to be answered to provide for the establishment of a therapeutic alliance:

> It's finding out ... What is the language of this patient? How does this patient think? What turns this patient on? How do I then communicate in their language and in their value system and bring something to them that's valuable? (K, 2/3/92, p. 13)

Armed with information provided by the answers to these questions, I suggest that therapists should have the tools to come to shared understandings and situation definitions from which they can work--to develop and strengthen therapeutic alliances--to identify, create, and

move about in the "navigational space" (Rogoff, 1990) of each client's ZPD.

Once established, therapeutic alliances aid the process of bringing the patient's and family's expectations for performance into alignment or balance with the patient's ability to perform, so that discrepant situation definitions are minimized or serve as points of departure for situation redefinitions. Again, recall that Kay described this balancing or alignment (or situation redefinition) as requiring that therapists

> ...address the client's and family's expectations for performance and make that match the client's ability to perform so there's not that discrepancy. [This means] ... you have two choices; you can either work to increase the client's performance or you can modify expectations--and in most cases you're doing both. (K, 2/3/92, p. 7)

Such balancing would seem to require assessment of the actual and potential levels of development of clients. Still, the question of how such balancing might be achieved--of how ZPD's might be defined and created--in the complex, everyday world of interaction in this clinic environment, remained to be explored.

In order to understand how the philosophy of client centering and it's related components and facilitators fit with the theoretical construct of the ZPD and the related notions of situation definition and intersubjectivity, it is helpful to put on the telephoto lens and focus on the speech situations, events, and acts that represent this philosophy in action. In this way we can analyze interactions between therapist and client that might be instantiations of the work to identify,

create, and navigate in zones of proximal development in physical therapy with John.

Static and Dynamic Assessment

There were numerous examples in therapy sessions of ongoing dynamic assessment of John's learning and development by Caitlin. This is not to say that static and standardized assessment was not also done in this clinic–it was. One example of the latter was John's neuropsychological screen completed by Don in late summer 1991.

The results of that neuropsychological screen were not encouraging. In brief, John showed distractibility and impulsivity and demonstrated a limited awareness of his deficits with poor self-report of his functional abilities and disabilities. Testing also demonstrated marked impairment in "pattern analysis, sequencing, concentration and visual memory" (D, Report, 9/30/91, p. 4). Overall, the findings of the neuropsychological examination suggested that John would have extreme difficulty in accurate problem identification and solving and would also have problems in "correctly assessing non-verbal and subtle emotional aspects of interpersonal exchanges" (D, Report, 9/30/91, p. 4).

The tests which were part of John's neuropsychological screen were standardized, static assessments in which their was little or no collaboration with or guidance of John by the evaluator during the administration of the tests. The interest was in how he performed without assistance of another. The findings outlined above, then, can be taken to represent John's *actual level of development* in the cognitive, sensory-perceptual, and affective domain at the time of assessment. This level of function in these domains was superimposed over, or

combined with, motor and perceptual problems noted by Caitlin at the time of her initial physical therapy assessment of John: a left visual field deficit, moderate weakness and loss of coordination of the left hand/arm, leg and trunk, mild balance deficits, and an abnormal gait (walking) pattern that became increasingly unstable as John walked any distance and became fatigued.

Collectively, then, I suggest that the impairments described above reflect John's actual level of development at the time physical therapy and other rehabilitation services were initiated. Had Caitlin taken this level of development as her only guide to the design of treatment interventions and instructional endeavors she might have made slow progress with John at best. But, as I will try to show shortly, Caitlin worked hard to identify John's potential level of development so her teaching and his learning could be directed toward moving well beyond his current developmental level. This does not mean, however, that she could ignore some of the disappointing information provided about John's actual level of development. He, like similar patients, had very real organically based deficits which, in all likelihood, would never be totally overcome. Instead, I contend that Caitlin took information about John's actual level of development into account and then used this as a base from which she employed ongoing dynamic assessment to test the limits of organically based dysfunction and John's learning and developmental capacity. In analyses to come, I will illustrate Caitlin's ongoing efforts to dynamically assess John's potential development as they collaboratively worked to solve movement problems he was encountering.

Returning to the Speech Situations

One of the sessions described in this analysis (and further in Chapter 5) is a teaching session that involves a triadic clinical encounter between Diane, John, and Caitlin--a session I have called "walking the tightrope." This is a difficult session for Caitlin since she is attempting to serve two clients concurrently as she fulfills her duties as a member of a transdisciplinary team. During this session, Caitlin is trying to work with Diane and John to achieve therapeutic goals for both physical therapy and social work--and the two are inextricably interwoven.

The primary goal for physical therapy involves instruction in the execution of some exercises in which both John and Diane must participate to help John regain motion and function and prevent the development of chronic pain and disability which could negatively influence the quality of their lives. The ultimate goal is to move the locus of care from the clinic to the home--to provide for less dependence on health care providers and greater self-sufficiency. But in John's case, such self-sufficiency does not mean total independence; rather, some exercises and functions (though not all) still require assistance from Diane even though they no longer require the assistance of a physical therapist or other health care provider.

The primary goal for counseling (and PT) is to help John and Diane more fully understand each other, in the context of John's impairments, so that they can cooperate in activities at home and support each other --physically, socially, and emotionally--during this difficult time.

In the triadic speech situation, Caitlin is "walking the tightrope" in a number of ways beyond dealing with the challenge of serving as a

social worker and PT concurrently. There are several interactional problems that she (and John and Diane) must deal with as Caitlin tries to establish an environment that encourages cooperation, creates intersubjectivity, enables learning for Diane and John, and permits the achievement of instructional success; in short, that creates a ZPD.

First, Caitlin and the other participants are, necessarily, interacting in the context of some of John's persistent perceptual and cognitive deficits. Among these are continued difficulty in (a) seeing "big pictures" or recognizing patterns in occurrences, (b) problem identification and problem solving, and, last but not least, (c) attending and responding to subtle emotional nuances and contextualization cues that contribute to or create meaning in interactional exchanges. Second, prior to the session, John has expressed concern regarding Diane's ability to adjust exercise intensity and amplitude according to his non-verbal and verbal feedback. In other words, he is afraid that Diane will hurt him and has verbally indicated a lack of trust in her ability or willingness to respond appropriately to his feedback. Thirdly, in a previous teaching session (which Caitlin labeled a failure) John has demonstrated a tendency to "lash out" with personal attacks rather than provide objective feedback to guide Diane in the performance and modification of exercises. Such utterances (attacks) constitute positive "face threatening acts" (FTAs) (Brown & Levinson, 1978) for Diane or threats to her positive self-image. Finally, Diane has admitted to personal discomfort and impatience (expressed as personal distancing) with John when confronted in this way and has expressed some skepticism about whether or not John will let her participate in the

completion of the home exercise program. Diane feels that she is treated as if she is imposing on John rather than trying to help him; such imposition constitutes a negative face threatening act (Brown & Levinson, 1978, 1987) for John.

Given the above, we can well imagine the pedagogical and interactional challenges that such a session presents. Caitlin must concurrently identify and seek to stretch the ZPD's of both John and Diane, cognitively, physically, and socially in the service of rehabilitation goals. And things don't always go well--which is what makes this speech situation particularly interesting and illuminating. The creation of intersubjectivity among participants and zones of proximal development for learners in this speech situation requires substantial interactional work.

The other speech situations examined in this chapter are dyadic encounters between John and Caitlin which occurred in March and April, 1992. Therapy at this time was directed primarily toward dealing with problems related to John's left shoulder pain and loss of mobility with concomitant regression of left arm and hand function. This pain and loss of function was affecting John's ability to complete his normal activities of daily living.

The Speech Events

As discussed earlier in this chapter, therapy sessions tended to divide into several segments or speech events. These speech events were typically organized around (a) preparatory/introductory activities associated with each therapy session, (b) the completion of specific

exercises/movement patterns or instruction about such exercises, and (c) session closure activities.

In the case of the triadic therapy session, the speech event analyzed most closely was one of several exercise segments (units) and the transitions into and out of that segment (see Figure 12, p. 284). Of note is the fact that the segment analyzed was the last exercise segment for the session and it is also the segment during which Caitlin was instructing Diane on the most difficult and painful exercise to be done at home with John.

Caitlin anticipated some pedagogical and interactional challenges during the triadic clinical encounter, especially with the last exercise. This is not surprising, since, as mentioned earlier, the historical backdrop for this session was a previous teaching session, held approximately one month earlier, that "failed." According to Caitlin, in the previous session it became apparent that John and Diane were unable to work together cooperatively due to (a) John's shoulder pain and (b) interactional difficulties between John and Diane around giving and responding to feedback about the exercises as they progressed. Subsequently, Caitlin waited to schedule another joint teaching session until John's pain had decreased to a level she perceived to be manageable for both him and Diane. In addition, she spent a portion of several treatment sessions with John prior to the second teaching session integrating conversation about Diane into the dialogue as she prepared for the next triadic session. This preparation consisted of a change in the frequency and nature of conversation (social-personal, rationale, instruction regarding feedback) about and around Diane and

the purpose of this group activity as the training session approached. (See Table 2.)

I propose that Caitlin's efforts to prepare for this potentially volatile and pedagogically challenging teaching session--and the very difficult exercise segment (speech event) at the conclusion of the session--reflect not only her search for the ZPD's of both John and Diane with respect to this particular task/activity (which implies ongoing dynamic assessment of potential levels of development), but also her efforts to create and stretch ZPD's through learning and the use of particular instructional strategies. Among these strategies are the *gradually* increasing instructional talk in treatment sessions with John before the teaching session, the progressive introduction of more difficult exercises within the session, and work before and during the session to (a) create shared purpose and situation definitions among participants, and (b) conduct ongoing assessment of the potential levels of development (relationally, cognitively, and physically) for both John and Diane so that interactional cooperation, learning, an therapeutic goals could be realized (see Table 2). In analyses to come, I will try to demonstrate some of this work at the level of discourse between John, Caitlin, and Diane.

Table 2. Frequency and Nature of Conversation About Diane During Five Treatment Sessions with John.

Session	Social/ Other	Rationale/ Purpose	Nature of Feedback
#1 - 3/11/92	2	2	
#2 - 3/18/92	2	2	1
#3 - 3/25/92 (pre-session)		3	2
#4 - 4/1/92 (triadic session)		6	5
#5 - 4/8/92 (post-session)		3	2

Social/Other = casual conversation about Diane. Rationale/Purpose = reason, purpose for Diane's involvement in program; encouraging John's cooperation. Nature of Feedback = nature of feedback necessary to facilitate positive interaction between John and Diane; commentary on John's perceptions re movement/ pain.

The ZPD in Discourse between John and Caitlin

Vygotskian theory posits that semiotic mediation is an important and integral part of the process of internalization and working in zones of proximal development. Language provides a medium or tool through which intersubjectivity and zones can be created and sustained and learning and development fostered. In the following analysis I provide some examples of what I take to be the development of a shared language, both verbal and non-verbal, between John and Caitlin. This shared language creates and provides for shared meaning and learning and development. I have discussed some of these features of discourse in the chapter on therapeutic alliances but I examine them now through the lens of the zone of proximal development.

Developing a Shared Language: Verbal. As discussed in Chapter Three, John and Caitlin frequently and comfortably used "PT lingo" in therapy sessions. I found this interesting since physical therapy students and practitioners are usually taught to converse with their clients using familiar terms and non-technical language. Recall, also, that the neuropsychologist's report had suggested, indirectly, that extended logical thinking and analysis and understanding of complex language patterns might be very difficult for John. In spite of these admonitions, Caitlin realized that John was both motivated and capable of learning such terminology and using it meaningfully as he conversed with her and others (and presumably with himself internally). For John, coming to know PT lingo and share this language was a source of pride, evidence of his learning and development, and a point of connection between him and Caitlin. Thus as he grew into the lexicon,

he also grew into the intellectual and professional lives of his physical therapist and other health care personnel with whom he interacted. What follows are a few excerpts from treatment sessions that illustrate the use of this shared language, and I would suggest, the co-construction of meaning, purpose, and goals that permits movement in, and of, the zone of proximal development for John.

This first excerpt might be considered an instructional segment: Caitlin and John have been working on exercises to improve the movement of his shoulder. Such exercises are typically followed by goniometric measurement (a measure of joint motion using a tool like a protractor with moving arms) of shoulder movement to assess progress. After taking a measurement of shoulder abduction (which is disappointing to John since it doesn't represent a lot of improvement over the previous week's measure), Caitlin explains to him why this movement is difficult for him.

C: The problem is, John, that when I, when we, normally raise our arm up (demonstrating the abduction movement they have been working on) out to the side and up overhead/ in order to get that/ that head of this humerus into that joint (grasping the humeral head)/ we just roll/or we rotate (demonstrating external rotation) a little bit in order to get up there. Can you see as I'm lifting how that rotates a little bit? (demonstrating abduction combined with external rotation with her arm)

J: Uh huh (nodding, he demonstrates the same movement with his other arm)

C: If you can't rotate, there's too little/ there's a ridge right on the top here (palpating the intertubercular groove of the humerus and the acromion process) and the head of the humerus kind of hits it, you know, meets it/ and it can kind of impinge up there and that can cause a lot of pain. So without the rotation, I wouldn't expect to get anymore than 100°/ and we're at about that, 98°. So until we can get a little bit of rotation, like so (moving his humerus into external rotation)/ we're not going to be getting a lot higher... that's why rotation is so important.
(J/C, 3/25/92, p. 7-8)

Here is a very detailed explanation of why John's movement in shoulder abduction is limited; the explanation includes a discussion of goniometric measures and an anatomy lesson. It also details the purpose of some of the more difficult exercises (external rotation) that John and Caitlin have been working on together. Of note is how Caitlin keeps referring to the attainment of more shoulder movement as a shared endeavor by using the pronoun "we" frequently as opposed to "you" and "I". She even corrects her usage in this respect one time. Cazden (1988), in her discussion of classroom discourse, has suggested that the use of inclusive pronouns by teachers is one strategy that serves to mitigate teacher authority. The use of such pronouns may serve a similar purpose in therapist-patient discourse. Still, the use of "we" can sometimes be construed as condescending or patronizing in conversation--but in this case it does not appear to be, since John and Caitlin truly *do* work together to gain mobility in John's shoulder.

The talk in this brief segment is fairly technical (supported by non-verbal gestures and touch). Anatomical terms, movement names, and goniometric measures given in degrees are all part of the language used by Caitlin as she discusses John's limited progress (on this day) with him. What remains to be seen is if, and how, John appropriates, transforms, and publishes such terminology or talk in a way that demonstrates understanding or shared meaning--this would indicate that internalization has occurred and that movement in a zone of proximal development has been achieved. Here are some more excerpts from a single treatment session that illustrate the use of this terminology and the interaction of the therapist and the patient around the terms and through this shared language.

Early in a treatment session, Caitlin and John are working on some familiar "pendulum" exercises. Both John and Caitlin are bent forward at the waist and Caitlin is standing next to John mirroring his movements as he tries to let his arm hang freely and complete inward and outward movements.

J: The abduction and adduction exercises make my arm get tighter...

C: Yeah, that has to do with the spasticity in your Pec's (touching John's Pectoral muscles)//cause this movement kind of creates a quick stretch. So guiding it [with your other arm] is just fine.

J: (Begins to guide his involved arm with the other; several movement repetitions)

C: Ye-eah/ Go-o-o-o-d. Slo-o-owly

J: [I need to establish a wider base

(spreading his feet apart)

C: That's a pretty wide base! (smiling and looking at John)

J: Yeah/ size 13 feet/ that's a wide base!

(C/J, 3/11/92, p. 3)

In this excerpt we observe the use by either Caitlin or John of the following technical terms or PT jargon: abduction, adduction, spasticity, Pec's (pectoral muscle group on the anterior chest wall), and reference to a wide base of support. Yet the conversation flows naturally between them, there are no misuses or misunderstandings associated with this usage, and the use of these terms seems comfortable and creates a point of connection in the dialogue between participants. In addition, the use of linguistic repetition in the discourse appears here (wide base); this is a strategy that Tannen (1989) has argued is important for creating conversational involvement of participants and coherence in discourse, both of which serve the development of understanding and communicative competence among participants. That is, repetition can facilitate the development of intersubjectivity and the creation of shared situation definitions. There are frequent examples of repetition in discourse (serving several functions) which occur in the "walking the tightrope" session to which I referred earlier and to which I will turn shortly.

During both of the above scenarios John and Caitlin have been operating in what Hall (1966) would call intimate and personal distance zones (physical contact to 2 feet) in terms of closeness of contact

between interactants. As I will return to later in this analysis and discussion, while this physical closeness might contribute to the development of intersubjectivity, I believe it does so for John and Caitlin *only* when specific rules regarding the nature of talk during periods of close physical contact are observed and adhered to during patient-professional interaction. During close physical contact between Caitlin and John, talk is almost always characterized by the use of technical or professional terms and is oriented toward instructional goals.

Finally, I will call attention to something I mentioned only briefly in introducing the above scenario: Caitlin not only stood close to John during the execution of the desired movement patterns--she *mirrored* them--and as they completed the pendulum exercise in tandem there was a rhythmic synchronicity and reciprocity of both their movement and conversation. Later I will analyze such synchronicity and reciprocity and suggest that this is a kinesic feature of interaction that facilitates the establishment and maintenance of intersubjectivity between John and Caitlin at the same time that it is an external manifestation (or observable product) of the achievement of intersubjectivity.

In summary, the small segment of discourse described above illustrates the use of several interactional tools which I believe help participants to create and maintain intersubjectivity; such intersubjectivity is essential for the development of therapeutic alliances and permits, but does not ensure, the creation and stretching of a ZPD. The interactional tools of which I speak include: (a) the use of

shared verbal language (words, numbers, and their *meaning*), (b) verbal repetition, (c) the observance of an unwritten but understood rule between communicants about the nature of talk during times of close physical contact, and (d) a shared movement language, usually evidenced in rhythmic synchronicity of movement (both patterns and pacing) and repetition of movements.

There are numerous examples of the use of "PT lingo" between John and Caitlin in my data and ample indication that talk using such language represented shared meaning. There is, however, one other moment in conversation that I would like to present briefly in support of this assertion because I think it is a view on the external (interpsychological) plane of the appropriation and transformation of language and thought (Harre, 1986; Vygotsky, 1978) that are occurring on the intrapsychological plane for John; that is, I believe this is a moment when normally invisible processes becomes visible.

This moment occurs in a conversation during the triadic teaching session. Diane has directed a fairly challenging question to Caitlin (but intended partially for John's benefit) about what types of motor control and movement patterns are currently available to John with his involved arm and hand.

C: (Looking at John) Umm, you've got some gross/ like what we call kind of mass patterns of movement/ Like if you try to lift the whole arm up to put it into a sleeve (demonstrates mass shoulder elevation with elbow flexion, forearm pronation) or push it down (demonstrates mass extension) and it all moves

out as[a unit

J: [Mmm Hmm

C: [Okay? So/ mass patterns/ in terms of any kind of selective control/ mostly just your elevations and, uh, pulling back on the shoulder/ (nodding, demonstrating the movement)/ umm, That's not

J: [Like starting a lawn mower (mimics the movement)

C: Ye-e-a-a-h (Smiles, chuckles softly)

(C, J, D, 4/1/92, p. 14)

Here, I believe John has appropriated a way of thinking and knowing about the types of movements available to him with his arm. He shows that he understands the forms of movement available to him and demonstrates the specific pattern of movement about which Caitlin is speaking (Caitlin has used PT lingo and then the metaphor of putting an arm into a jacket or shirt sleeve to describe this pattern). John experiments with this "learned" form in the context of his own experience and presents an alternative way of conceptualizing and using that information or learned form; for John, mass patterns of movement and loss of active selective control of motion for elevating his arm is "like starting a lawn mower." In fact, this is a very accurate depiction of John's movement pattern when attempting to elevate his arm, and Caitlin picks up on the lawn mower metaphor later in conversation as a point of departure for further instruction *and learning* about the types of shoulder and arm motions that John exhibits.

As discussed in Chapter Three, the use of PT lingo in therapy is an example of how John and Caitlin mutually constructed the nature of their interaction in therapy. Caitlin was engaged in ongoing dynamic assessment with John. Although the neuropsychologist's report suggested that John would have difficulty with complex language forms and patterns, Caitlin took an active, interactional approach to assessing John's potential for learning and development; she identified, created, and stretched John's zone of proximal development for in this area. John indicated that he was interested in learning the language of physical therapy. Caitlin observed that John became more of a participant in conversations when they exchanged PT lingo. John was able to move from initial instruction by Caitlin in the words and meanings of PT lingo, to guided use of this language in the context of therapy sessions, to a point where he could freely and correctly use PT lingo in conversation with Caitlin and others in a variety of contexts. Caitlin's interactional work to develop this shared language and meaning system between John and herself was essential to development of a therapeutic alliance, a sharing of purpose, and the stretching of zones of proximal development.

A final example of Caitlin attempting to determine actual and potential levels of development and creating a shared language and understandings comes from the triadic therapy session. In this session one of the primary instructional goals was for Diane to learn some new exercises to do at home with John. Before proceeding with demonstration of exercises with John and having Diane try the exercises on John, Caitlin chooses to demonstrate the exercises first on Diane. She

has Diane experience the exercise movements herself as Caitlin describes what she (Caitlin) is doing, what Diane should be feeling, and what John might be feeling as the exercises are completed. In addition, Caitlin makes recommendations to Diane about the types of physical responses she should make to verbal and non-verbal feedback from John (e.g., decreasing pressure or changing hand positions if a certain movement is uncomfortable for John).

Fairly early in the session, Caitlin asks Diane to become the patient and John to become the "watcher" and "assistant teacher" as Caitlin demonstrates and discusses the exercises and mobilization techniques with Diane. As Diane lies down on the treatment plinth and Caitlin prepares to begin demonstration and instruction, Caitlin asks Diane: "Are you involved in doing any range of motion [exercises] or anything like that at the living center?" (C/J/D, 4/1/92, p. 6). Diane responds that she has done some exercises with patients before but not in the recent past. Diane's initial response combined with Caitlin's ongoing questioning and dialogue with Diane as she proceeded through the demonstration with Diane helped Caitlin to adjust the form, level, and intensity of her instruction to Diane's experience with, and actual and potential knowledge about, human structure, function and dysfunction, and John's response to and tolerance for the exercises.

Developing a Shared Language: Non-Verbal. In Chapter Three I provided illustrations of various forms of non-verbal exchanges between John and Caitlin and suggested that therapeutic alliances and intersubjectivity between them have been created and sustained through some of the kinesic and proxemic features of discourse during

therapeutic encounters. The "flow" or fluidity during therapy sessions with John and Caitlin was much more than just the words and verbal exchanges between them. This flow was supported by (a) what I called a rhythmic synchronicity and reciprocity (or repetition) of movement that surrounded and penetrated much of what was being said (and in some cases, eliminated the need for something to be said), and (b) relationships between the nature of conversation and the use of interpersonal space--what I called the proxemic rules for discourse during therapy sessions. Naturally, during the course of therapy, there were moments of asynchrony and violation of the rules; but such moments were few and far between and it is those difficult times or discrepant cases that actually helped to focus my attention on what might be happening during the "good" times.

The times in therapy when John and Caitlin moved together, sometimes as seeming extensions of each other, are important moments of reciprocal teaching and learning. Caitlin is learning from John; John is learning from Caitlin. They demonstrate a rhythmic synchronicity that is both integral to, and a manifestation of, their shared non-verbal and movement language and meaning systems. Concurrently, the linguistic and paralinguistic features of talk by Caitlin (e.g., intonation and prosody) often contribute to the rhythmic synchronicity as she speaks in a low pitch, softly, and slowly, making her words match the rhythm and amplitude of the movements she and John are performing. I believe this rhythmic association--this "movement conversation"--contributes, in no small part, to intersubjectivity, situation redefinitions, and movement in the zone of proximal development. Caitlin, as the

"teacher" works hard to foster this shared language and meaning but John is a very big part of the equation; John is also a teacher and Caitlin listens to, observes, and learns from him just as she hopes John will learn from her.

The examples and descriptions of the rhythms of therapy provided in Chapter Three also point to Caitlin's recognition of her role as a mediating agent in creating a zone of proximal development for John (although she would not use these words to describe what she is doing in therapy). It is, after all, the more knowledgeable or capable other who carries a great deal of responsibility for the movement of the less knowledgeable or less capable other in the navigational space of the ZPD. In this case, we might think about Caitlin's work with John toward linked goals for cognitive and motor development. Caitlin creates a movement conversation; she adjusts the nature and frequency of her movement patterns to provide for, support, and pull John's learning about focusing (attention) and about body positions and movements that will enable him to function physically with less pain and difficulty. She is a model, a guide, a collaborator. She actively tries to identify and operate at John's level of potential development in this knowledge domain--at the edge of the zone of proximal development. She is trying to create an instructional environment that will pull John toward self-regulation and the attainment of certain forms of motor control and independent function. Today he needs assistance; tomorrow perhaps not.

In summary, I claim that a non-verbal language has been co-constructed by John and Caitlin--a touch, proxemic, and kinesic

discourse that is characterized by rhythmic association of movements between the two and by the adoption of, and adherence to, particular rules about interpersonal distance and physical contact and forms of conversation in the context of dyadic therapy sessions. The construction of this non-verbal language seemed to be ongoing throughout the therapy sessions I observed. It serves as a resource for creating and maintaining connection and collaboration between the interactants, for the negotiation of shared meaning and understanding (establishing intersubjectivity and therapeutic alliances), for dynamic assessment of actual and potential levels of development, and, thus, for identification and stretching of zones of proximal development.

In the final section of this Chapter, I will briefly depict and discuss some of the activity and discourse in the triadic "walking the tightrope" session. In this difficult session, involving Caitlin, John, and Diane, I believe we can view some of the very real challenges of trying to identify, create, and work in several ZPD's concurrently; in this case, the interwoven cognitive, social-relational, and physical ZPD's of John, Diane and Caitlin.

Navigating in the Landscape of Multiple Zones: Interaction, Negotiation, Teaching, and Learning in the Triadic Clinical Encounter

Recall that this particular therapy session is specifically devoted to instruction of Diane in some exercises that she has been asked to do with John at home. This sounds simple enough; such instructional activity is an everyday occurrence for many therapists and family members working with patients with chronic impairment and disability. But now recall the historical and contextual backdrop for this session

and the instructional and interactional challenges for the therapist (and other participants) as they try to negotiate and navigate their way through this rocky landscape. The work of navigation is accomplished through discourse as participants attempt to identify, create and move through ZPD's toward therapeutic goals that require cognitive, physical, and social learning and development. It is to some specific examples of how this occurs that I now turn.

Given the purpose of the session, it is not surprising that a considerable amount of talk in the session is in what I have described earlier as therapist register. The fact that Caitlin is talking in therapist register, however, does not preclude variability in style--individualized ways that the functions of the register are carried out. Any untrained observer can recognize such variations in style when observing different professionals talk (e.g., teachers, physicians, or therapists) in ways that are consistent with their occupational roles and duties but that vary substantially across individuals. In my analysis of the triadic session, and in particular, of a very difficult speech event at the end of the session (see Figure 12, p. 284), two features of the discourse became prominent: the participant's (especially Caitlin's) use of linguistic and paralinguistic repetition to serve various functions, and the use of several politeness strategies to minimize (to the extent possible) face threatening acts (Brown & Levinson, 1978). These features of discourse represent part of Caitlin's style; they describe style variations of an experienced therapist committed to client-centering who is seeking intersubjectivity and cooperation among participants in the service of instructional and therapeutic goals. Caitlin recognizes that

movement in cognitive and physical ZPD's is dependent on the simultaneous creation of convergent relational ZPD's among participants. The use of repetition and interactional work to maintain politeness and mitigate threats to face help to create such ZPD's. For the purpose of the final part of this analysis, I focus on the use of self- and other-repetition in the event, keeping in mind that other repetition can also help to preserve positive face for interactants. A more thorough analysis of issues of face and politeness in the session is presented in Chapter Five.

The Use of Repetition Within the Speech Event. In Chapter Three, I discussed how the use of the conversational strategy of self- and other-repetition as can serve a variety of functions in discourse (e.g., language production, comprehension, connection, and interaction). Most importantly, repetition serves the creation of conversational involvement and coherence (Gumperz, 1982; Tannen, 1989). Together, conversational involvement and coherence are important resources for the development of shared understandings and intersubjectivity. In the following analysis I will present a few examples self- and other-repetition in the speech event and consider the forms they take and the functions they might serve as participants navigate in multiple and shifting ZPD's.

Caitlin and John repeated each other and themselves far more frequently than did Diane throughout the entire therapy session and the speech event of interest. This does not seem surprising given that John and Caitlin have had many more opportunities to develop a shared language in the context of therapy sessions than Diane has had. (Recall

that Diane has only attended one other therapy session with Caitlin and John during this latest course of physical therapy.) Diane did not talk very much throughout this particular segment nor did her non-verbal behaviors suggest close involvement. There were, however, several attempts by the therapist to engage Diane or capture her gaze by either a soft touch, positional change, gesturing, or the use of repetition. An example of Caitlin's use of self-repetition and other-repetition of Diane is provided below. Diane asks Caitlin a clarifying question:

D: This is a real touchy issue/ and we even had a huge debate before we saw Dr. Grant.// The difference between range of motion and functional range?

C: (Looking at Diane, nods)
Uh huh, right// Range of/ i-in terms of active function?

D: Yeah.

C: [Yeah.

Here, Caitlin is checking to make sure that she understands Diane's question and shows ratifying listenership that is created by her repetition, direct gaze at Diane, her nodding, and her verbal recognition ("right") of the importance and complexity of the difference between these two terms and the need for discussion about this. In this case, Caitlin repeats Diane's words "range of" (implying "motion") almost immediately and repeats Diane's "functional range" with word variation but similar intonation. Furthermore, Caitlin immediately repeats Diane's "yeah" exactly, even down to the same loudness, pace, and intonation. In

the above example Caitlin's use of repetition appears to serve the functions of interaction and connection with Diane, including evaluation--this *is* an important issue for Diane, Caitlin, and John to discuss.

As the discussion around this question proceeds, Caitlin directs her answer to both Diane and John in recognition of Diane's implied request for mediation of this "debate." In her response, Caitlin uses self-repetition (of movement descriptors) that appears to serve production, interaction, instruction and comprehension functions. At the same time, she repeats the terms used in Diane's question which appears to serve a connection function as well: that is, it (a) connects the current discourse to the earlier question, (b) provides further evidence of Caitlin's attitude about the importance of the topic and the need for clarification, and (c) connects participants in the discourse. Interestingly, as John becomes involved in the conversation, he paraphrases Caitlin's description of the kind of movements he can perform with his arm and kinesically repeats a movement that Caitlin demonstrated several times during the conversation.

Throughout the last exercise segment Caitlin demonstrates self-repetition when she provides descriptions for Diane of the type of pressure and rate of movement she wants Diane to use during the performance of the exercise. These repetitions take various forms and are distributed frequently and consistently through the talk. They provide evidence for both Diane and John that doing the exercise in this way is important--not only for success with the exercise itself (gaining shoulder motion without significant discomfort) but also for success in achieving interactional harmony during the performance of the exercise;

these successes are interdependent. Recall that one of John's concerns about Diane's participation in the exercise program was that she would push too hard or fast on her arm; and one of Diane's concerns was that John would lash out at her if she did not perform the exercise as Caitlin does. The following is one of many examples of instructional discourse that involves this sort of repetition.

Caitlin is just beginning to demonstrate the extremely difficult external rotation movement that she wants Diane to do with John and which she has purposefully left until last in this session. Based on prior knowledge and experience *and* dynamic assessment of John and Diane throughout the session, she knows she is beginning to nudge up against the "edge" of their ZPD's, both physically and relationally. John has just asked Caitlin to proceed with the exercise because the arm is beginning to bother him after being held in abduction for a while during a conversation with Diane about technique.

C: Ye-e-a-a-h (looking at John, nods, then looks at Diane)
Yeah, he's not used to being in that position// and then,
um/ ever so-o-o gently
(starting to move the arm into external rotation)

J: I don't like my fingers this way (John reaches over and pulls his fingers out of flexion placing them around Caitlin's fingers)

C: (Smiles at John and chuckles, turns gaze back to Diane)
And then/ just ever so-o gently and slo-o-owly/ bringing that arm [down/

J: [Hmmmm, [o-o-o-h

C: [Ve-e-e-ry slo-o-ow// Now, he had no exter-/ no rotation this direction at the start/ three weeks ago. We've got maximum/ on a good day/ about 20 degrees. So/ don't expect to roll him down to the ground in a, you know, arm wrestling position/ 'cause he doesn't have it.

All of the descriptors used to instruct Diane about moving John's arm gently and slowly were uttered in a low pitch, very softly, and with many vowels drawn out. Thus, there is prosodic as well as word repetition which, in combination, provide emphasis and create images of the type of pressure or force, touch, and rate with which Caitlin wants the exercise done. These self-repetitions most certainly serve comprehension and evaluative functions and could also serve as assurances to John that Diane has been thoroughly instructed in performance of the exercise. The question that remains, however, is whether Diane can now perform the exercise as instructed--first with Caitlin's guidance and then without her assistance.

Interestingly, when Diane begins to perform the exercise shortly after Caitlin's demonstration and preliminary instruction, John becomes the instructor and repeats (with variation) and paraphrases (using imagery) some of Caitlin's performance descriptions:

J: (As Diane moves in close to do the exercise)
Hon/ listen/ The -- touch -- of -- a -- butterfly -- OK?
(Diane grasps John's hand and arm)

Pretend you're one of those little light moths/???/

D: Okay.

and a little later in the segment:

J: Aa-a-ah. Ever so-o lightly....

As mentioned earlier, this type of self and allo-repetition occurs frequently throughout the time that Diane is completing the exercise and receiving instruction and feedback from John and Caitlin about her performance. For instance, at another time, Caitlin was trying to describe for Diane how to do some small oscillatory mobilizations with John's shoulder to aid relaxation using descriptors like "...real gentle up and down", "not too far/ just some real small movements", "just real gentle pressure." These instructions are then repeated with variation by John: "just by pushing down/ rhythmically/ and slowly/ just very shallow/ very shallow." As noted earlier, such self and allo-repetitions (in this case, John repeating Caitlin) appear to serve production, comprehension, evaluative, and interactional functions.

It is important to note, however, that while Diane is the object of much of this repetition (in her role as the "student" of Caitlin and John during this session), she does not participate in the repetition nor does she say much at all during this particular segment. The connection between participants during repetitions in this exercise segment appears to be between John and Caitlin, not Diane, in spite of the interactional effort that Caitlin has devoted to trying to "pull her into" the conversation

(often through non-verbal means such as a light touch, a nod, eye contact, etc.). Diane's lack of involvement in the discourse at this time could be related to several co-mingled factors all of which might constitute an "overstretching" or "overstepping," if you will, of complex and interwoven ZPD boundaries. These factors include (a) participant perceptions about the appropriate role relationships of teachers and students and associated discourse rules about who speaks and who listens, (b) Diane's feelings of being an outsider or foreigner with respect to the patient-therapist relationship that Caitlin and John have developed over time (i.e., the therapeutic alliance that has been evolving is between John and Caitlin, not Diane and Caitlin), or (c) Diane's response to being the recipient of frequent negative and positive face threatening acts during the session. According to both Caitlin and Diane, Diane's response to such threats is usually one of social distancing which seems to be evidenced in this session by her quiescence and relative lack of verbal and non-verbal involvement during the instructional session. Although Caitlin works in several ways to mitigate face threats for Diane in this session, she is unable to overcome or defuse all of them. Nonetheless, other-repetition of Diane by Caitlin in the speech event is one strategy for attempting to preserve positive face for Diane. A detailed analysis of face and politeness in the speech event is provided in Chapter Five.

Summary

In this section of this Chapter I have described and explored how the development of shared language, both verbal and non-verbal, and the use of the conversational strategies of repetition and politeness in moment-to-moment, face-to-face interaction in clinical encounters might

serve the establishment of intersubjectivity, provide a framework for dynamic assessment, and permit the identification, creation, and stretching of ZPD's among participants. It is obvious that this is no simple endeavor. And it becomes increasingly difficult as more participants are involved therapy activities as in the triadic session with John, Caitlin, and Diane. Navigating in multiple and shifting zones of proximal development is a challenging task. But it is a task that must be part of everyday rehabilitation practice when therapy is seen as a relational and educative endeavor and when the goals of therapy are for clients realize and continue to stretch their developmental potential. In this analysis I have attempted to portray the work of an experienced therapist with her clients through the conceptual lens of the ZPD and related concepts. I claim that, indeed, this a useful construct for understanding the work of therapists and clients as they work toward goals of learning and increasing independence.

Conclusion: What the Clients Say They Learned in Therapy

Therapists at Jones and Thompson expressed a belief that therapy was an educative endeavor and that the success of therapy hinged, in large part, on the learning and development of the client. In Chapters Three and Four much of the discussion focused on therapist learning from clients. I was also interested in what clients felt they had learned and how they had changed as a result of their rehabilitation experience in this clinic. In particular I was interested in what they felt they had

learned through their work with Caitlin. I posed this question in concluding interviews with Marcia, Bill, and John.

All of the clients suggested that they had learned useful strategies for managing their impairments and improving their function in day-to-day activities. Of special interest was the emphasis they placed on the importance of learning about *why* they were experiencing some of their problems. Knowing *why* they had the problems they did and then learning how they could independently manage those problems was viewed as empowering. It was part of healing.

I turn first to the words of Marcia, who shared her initial skepticism about whether or not therapy would be useful. Her skepticism appeared first when her regular physician suggested that Marcia see a neurologist for consultation regarding her persistent and bothersome symptoms related to her head injury. Marcia tells the story best.

> He [her physician] said, um, 'I would like to suggest that you go to a neurologist and have a complete neurological work-up.' And, uh, I'm not very fond of going to doctors, so I said to him, 'well, what would that be?' 'Well,' he said 'they would probably be able to tell you the cause, or why you have this forgetfulness or whatever.' And I said, 'okay, so they could tell me why I'm crazy? And what are they gonna do about it?' He said 'probably nothing.' And I said, 'thanks a lot, never mind, I won't go to the neurologist.'
> (M, 6/30/94, p. 6)

Here, Marcia suggests that simply knowing why she was experiencing memory difficulties, dizziness, and balance problems, was not something

she was interested in or concerned about. Instead, she wanted something *done* about it.

Ultimately, when her symptoms continued she did consult with a neurologist who referred her to Jones and Thompson for further evaluation and therapy. When the physician suggested that she go to Jones and Thompson, Marcia retained her skepticism about whether further testing and therapy would be of any use.

> I said, 'Okay, so what are they gonna do? Other than maybe telling me why I'm so dizzy or why I'm so this or that or why I can't think straight. What can they really do about it?' And he said, 'they have a number of therapists there and they're very good' and he said 'I really feel that'...he said, 'you know, you can always quit, but I think you'll really find that they get at the root of your problem and help you.' And I said, "okay." So I came here.
> (M, 6/30/94, p. 7)

In the end, however, Marcia's skepticism about the need for learning about the reasons for her problems turned to appreciation:

> And I've been very happy I did! Because my balance is considerably better, and I, uh, think although I'm not one to dwell very much on what's wrong with me and why I feel this way,...I definitely feel that I have gained a lot of knowledge [about that]. And it did make me feel better to know that something could be done. And Caitlin was very good about explaining the vestibular system and how there are different things that make you unbalanced and make you dizzy. So, I felt that knowing there was some...reason for my dizziness--other than just a head injury--or it came from a head injury, but [it] could be corrected--was very helpful. I felt that she, uh, you know, with her testing showed what's the root of where my problem was. That it wasn't all in my walking, or it wasn't all in my head, it was a combination....
> (M, 6/30/94, p. 7-8)

This quotation illustrates a dramatic shift in Marcia's attitude about the importance of knowing *why* she is experiencing the problems she is--the importance of learning about the sources of her symptoms. Earlier she talked about how she didn't really care why she had symptoms, she just wanted something done for them. Now, Marcia recognizes that knowing *why* contributes to being able to do something for the problem. It has helped her to learn what *she* can do to have more control over her symptoms and, in turn, compensate for or reduce her disability. In this chapter and others, there is ample evidence of Caitlin's teaching about the "why's" of (a) client's symptoms and problems, (b) evaluation procedures used to identify sources and measure the extent of those problems, and (c) therapeutic exercise and activities. Caitlin's emphasis on providing a rationale to patients is about the why's of therapy. So this is one of the lessons of therapy for Marcia.

Finally, Marcia added that another valuable lesson she learned through therapy was how to be more aware of her abnormal postural habits. Such self-awareness combined with knowledge about alternative postures to reduce muscular stress ("what to do about it") were also viewed as very helpful by Marcia.

> And, uh, I think that one of the most important things that I have learned....I found that, um, since the accident whenever I was sitting reading--I'd find myself sitting like this (demonstrating a slouched posture). [With] my shoulders pulled way forward, my head pulled way forward. And I thought <u>why</u> do I sit like that? And I could feel...I was pulling with my muscles. I didn't know why. And she [Caitlin] said, 'you know, your whole back has to be straightened out and everything to get your head back there where it belongs.' And to get me to

> work on that, I thought was very important because I sort of knew I was doing it but I didn't know what to do about it. I had gotten into a really bad posture so that my neck and head hurt all the time. (M, 6/30/94, p. 10)

Through her learning about the "why's" of her problems, and what she could do about them, Marcia was "back in the driver's seat again" (K, 2/3/92, p. 3). This was what therapists at Jones and Thompson said education oriented approaches to care are all about.

Bill, too, found that he learned about the nature and source of his problems and what he could do to compensate for and overcome them. First, he talked about what he learned about himself through Caitlin's assessments.

> ...She started asking me to do things which I just took for granted I could do—and I couldn't really do them the way I wanted to.... I found out that I couldn't walk a straight line...I was going to the right, although my sense of perception was that I was going a straight line. But I was going to the right—so I had to learn to pull back. That was interesting.
> (B, 7/5/94, p. 9)

Here, Bill describes his learning about his problems and ways to compensate for or correct them as "interesting." He then talks about Caitlin's "lesson" as the home exercise program he worked on with Caitlin and the benefits of some of those exercises for him.

> Caitlin...explained what she was gonna try to do and gave me somewhat of a lesson to carry with me. And I didn't know if it was gonna work.... [But] the dizziness is pretty well gone from all the exercises I've used and my eyes are better..... the eye

> control is, is improved 90%. I have very little problem now. I couldn't hardly gaze at that wallpaper and walk and look at it at the same time. That was bad news. But now I can do it and it stays still--it don't move.... I think that the constant little things that she made out for me to do--that helped. Now I don't like that balance beam thing [exercise], but I can see the value in it. I can walk farther than I did before. I'm containing my balance better. (B, 7/5/94, pp. 9-10)

So Bill, like Marcia, was not sure whether therapy would be helpful for him. And he didn't necessarily like all the exercises he had to do in therapy or at home--some of them were quite challenging. But he did come to see the value in them and he followed through with exercises at home and in his everyday activities: "She showed me where I had my weaknesses and where I could still do things to get better and I still practice with it [the exercise program]." (B, 7/5/94, p. 10) Finally, Bill appreciated how the exercise program and work on the "little things" had translated into changes in his ability to play golf and return to that activity he enjoyed so much.

> My golf score's not much better (smiling and chuckling). [But]...I can follow the ball better now. I wouldn't even follow the ball before. Now I'm starting to follow it and as a result I know where the ball is going finally. 'Cause I'd look up before and my whole field would move...and then come back. It was unusual. I've never had that experience before. Now, I don't fall over like I almost did the first couple of times [I tried to golf]. (B, 7/5/94, p. 9-10)

Bill learned the rationale for therapy. He understood the connection between the work on "little" exercises to improve eye control and gaze stability and changes in his ability to play golf without feeling

dizzy and falling over. These were some of the lessons he learned from Caitlin and they were lessons Caitlin worked hard to teach.

For John, perhaps the most important thing he learned from Caitlin was to "believe" in himself and to know he could "go the distance." For him, the patient-therapist relationship he developed with Caitlin, and the learning of PT lingo, exercises, and strategies to manage his pain and maintain function, all boiled down to cultivating a sense of belief in himself and control in the face of his life-threatening and disabling illness. This is where the combination of therapeutic alliances and education converge to empower clients.

> She has been just great.... We have, we have--we actually have fun together in our patient-therapist relationship. She has given me a lot of confidence to--she has given me a lot of confidence to go--I lost the words (starts to whistle).... She establishes a confidence in you, she makes you--she made me believe in myself to a point where [when] I thought I couldn't get past the pain, to believe that I could. And I went past the pain, and I went the distance I had to go. (J, 4/1/92, p. 5, 7)

He went the distance--buoyed by the confidence instilled through his work with Caitlin.

Chapter 5

ON BECOMING AND BEING A TRANSDISCIPLINARY TEAM: THE SOCIAL CONSTRUCTION OF CLIENT-CENTERING

Introduction

The professionals in this clinic expressed a commitment to being a transdisciplinary team in which members of the team were able to "just do everybody else's work to some extent" (K, 2/3/92, p. 8). The vision of a transdisciplinary team articulated by staff members in this clinic involved a sharing of responsibility, thinking, knowledge, and experience (i.e., a sharing of professional expertise) among team members working with a particular client and their caregivers so that *all* members of the team were working, on behalf of the client, to solve problems and achieve both discipline-specific and transdisciplinary goals. In short, roles and disciplinary boundaries between various professionals were viewed as semi-permeable and flexible as team members engaged in joint problem-solving and worked together toward therapeutic goals established for and with clients. The construction of a transdisciplinary approach to care, which is inevitably *social* , was seen as a facilitator for the day-to-day enactment of the philosophic commitment to client-centering among professionals in this clinic. The potential affordances and

challenges, benefits and risks, associated with becoming and being a transdisciplinary team raised intriguing questions for me as I completed this study of situated expertise, interaction, teaching and learning in a private rehabilitation clinic.

Guiding Questions

The part of my study directed toward understanding how a transdisciplinary approach to care was constructed in this particular clinic was guided by seven questions:

1. What does being a transdisciplinary team mean to the professionals in this clinic?
2. How and why did a transdisciplinary approach to care emerge or evolve in this clinic?
3. How have the individual members of the team and the collective team developed over time?
4. What is the nature of interprofessional teaching and learning? How do team members learn about the disciplinary knowledge and expertise of others?
5. How is such knowledge appropriated, transformed, and used as therapists construct a transdisciplinary approach to care on a day-to-day basis?
6. What does being a transdisciplinary team mean for the clients in this clinic?
7. How does a transdisciplinary approach to care enable or contribute to client-centering? Or does it?

It is to these questions I will turn after a brief historical perspective on the development of health care and educational teams in the United States during the latter half of the twentieth century.

Historical Perspectives

Calls for the development of interdisciplinary teams and increasing collaboration among health care professionals have been stimulated by several co-occurring and interwoven trends over the past few decades. On the one hand, technological advancement in biomedicine and associated increases in the availability and complexity of medical or therapeutic interventions for patients contributed to the rise of specialty-oriented practice in both medicine and rehabilitation. This trend, in combination with calls for "professionalization" and autonomy by new or emerging health professions (and professionals), encouraged division of knowledge and labor among practitioners and valued professional independence over interdependence or collaboration among health care practitioners.

At the same time, however, there were rumblings of discontent with the historically pervasive and reductionist biomedical model of medicine, grounded in Cartesian thought and mind-body duality, which encouraged physicians and other health care practitioners to focus on the treatment and cure of *disease* which is an organic, biological phenomenon that can be defined in terms of somatic and physiological variables. An underlying assumption of the biomedical model is that the absence of biological dysfunction or disease is the equivalent of health.

Proponents of an alternative biopsychosocial model of medicine (e.g., Engel, 1977; Kleinman, 1980) and health care urged consideration of the patient's *illness* --a term and concept which encompassed the social, psychological, cultural, and behavioral dimensions of disease as well as the biological. A biopsychosocial model of medicine demands that physicians and other health professionals pay attention to socioculturally constructed concepts of illness, health, and wellness when evaluating patients and designing treatment interventions. It argues for an enlarged view of the problems encountered in clinical practice and encourages health care practitioners to seek a more holistic understanding of the complaints, perceptions, lives, and needs of patients and their caregivers. Such an understanding, it is suggested, can often only be realized through drawing on the disciplinary expertise and perspectives of multiple clinicians working with a particular patient and, perhaps more importantly, by soliciting and taking into account patients' perspectives and beliefs regarding their illness (and their definitions of health) when constructing and carrying out plans of care. Within the biopsychosocial model or framework, then, the need for multiple perspectives regarding patient problems or concerns becomes more prominent and the need for health care teams and increased interprofessional communication and collaboration on behalf of and with patients is highlighted.

What is a team? Several definitions and conceptualizations of medical, rehabilitation, or educational teams have been advanced; among these are unidisciplinary, multidisciplinary, interdisciplinary,

and transdisciplinary teams. Although there are some common characteristics of teams across these conceptualizations (e.g., comprised of two or more individuals, most have an identifiable leader, task orientation, collaboration is expected), there are some important distinctions. Unidisciplinary or intradisciplinary teams are teams comprised of several members from the same discipline or profession. For example, there may be physician teams or nurse teams who have responsibility for particular components of medical or health care for a patient (e.g., an "Intravenous" or "IV" team) (Bulger, 1985).

Multidisciplinary teams have been described as teams consisting of individuals from several disciplines in which each member's efforts and contributions to patient care are discipline-specific with little or no direct communication among practitioners (Melvin, 1980; Rothberg, 1985). According to educational philosopher Hugh Petrie, multidisciplinary teams or projects

> ...simply require everyone to do his or her own thing with little or no necessity for any one participant to be aware of another participant's work. (Petrie, 1976, p. 9)

In health care, while multidisciplinary practice offers a wide array of professional services for patients, it also has the potential to contribute to fragmentation of care that can create confusion for patients and their families or, at worst, lead to health threatening situations for patients (e.g., drug interactions or overmedication).

In contrast, interdisciplinary teams are typically described as two or more individuals representing a variety of disciplines who are working together on a common task toward a common goal (Gillespie, Fitz, & Gordon, 1989). Members of such teams assume responsibility for their own disciplinary contributions or provision of services and, in addition, assume responsibility for the group effort on behalf of the patient (Melvin, 1980; Rothberg, 1985). To do this, members of the team must be in close communication with each other regarding goals for clients and the nature of services being provided. Regularly scheduled team meetings or other opportunities for formal interaction are characteristic of interdisciplinary teams. Team planning regarding services to be provided, treatment program design, and treatment modification for clients based on input from various professionals is the goal and expectation for many interdisciplinary teams in medicine and rehabilitation (McClelland & Sands, 1993). In interdisciplinary efforts, then, "different participants need to take into account the contributions of their colleagues to make their own contributions" (Petrie, 1976, p. 9).

The notion of transdisciplinary teams and models of this form of service delivery first came into being in response to the challenges of providing services for high risk infants (Hutchison, 1978) and children with multiple disabilities in educational settings (McCormack & Goldman, 1979). Such children often require a variety of medical and rehabilitation services to enable and maximize educational opportunities at school and home. Although there are some commonalties between interdisciplinary and

transdisciplinary teams, there are also some differences. Perhaps the most important of these is that in transdisciplinary teams the provision of indirect services, as opposed to exclusively direct services, from providers is possible and even encouraged (Giangreco, 1986; Woodruff & McGonigel, 1988); that is, a provider who is not a bona fide representative of a particular discipline or profession can still *indirectly* provide services that would normally be provided by another professional. This model of service delivery is most easily conceptualized in the case of work with children with multiple disabilities in the schools. In such situations, the teacher, in consultation with health care workers, may be the indirect provider of physical therapy services, speech and language services, and so on in the classroom. Thus, the teacher "becomes" a physical therapist in some respects, but what physical therapy is or might be, is transformed by the situational demands of the classroom, the curriculum, the instructional goals of the teacher, the learning needs of the student, and the person providing the service. In order for the provision of indirect services to occur appropriately and effectively without a negative impact on students, clients, or providers, there must be a commitment among team members to teach one another, learn from each other, and work together *across disciplinary boundaries* so that a unified service plan can be implemented and the needs of clients optimally met (Woodruff & McGonigel, 1988).

Becoming a transdisciplinary team or accomplishing the goals of transdisciplinary approaches to the provision of services, whether

in educational settings or health care settings, involves some special requirements, risks and challenges. Among these are (a) the need to negotiate role transitions and boundaries since the provision of indirect services does *not* involve the total release and "takeover" of another provider's role and responsibilities (Garland, McGonigel, Frank & Buck, 1989; Nietupski, Scheutz, & Ockwood, 1980); closely related to this is (b) the need for participants to preserve their professional identity, feel secure in their own discipline, and be "true" to their own profession's norms of conduct and obligations in the context of transdisciplinary approaches to care; and (c) the need for common ideals and goals to which members of the group are committed. The latter is what Petrie (1976) has called "idea dominance," which provides a recognizable and central focus for the work of the group. Petrie also claims there is an important epistemological concern or challenge for interdisciplinary and transdisciplinary teams: participants need to learn the "cognitive maps" of other disciplines if they are to be able to reach understanding and shared meanings about the work in which they are jointly involved and the situations which they jointly interpret and act upon or within. He suggests that a "necessary condition" for the success of such teams is that

> the participants learn the observational categories and key terms of each others' disciplines. This knowledge is then tacitly used in an interpretive way on the problems facing the group. (Petrie, 1976, p. 14)

When this condition, among others, is met, according to Petrie (1976), members of the team can answer "yes" to the question: "Do you see what I see?" (p. 9).

The special challenges associated with interprofessional interaction around role negotiation and transformation, distribution of disciplinary knowledge and expertise across team members, maintaining professional identity while concurrently releasing components of that identity or partially assuming alternate professional identities, seem critically important for the successful construction of transdisciplinary approaches to care and yet have not been systematically investigated. These challenges encourage participants to grapple with some central questions that have to do with professional obligations: (1) What is sufficient or adequate knowledge and competence in areas of professional practice? and (2) What are ideal and appropriate relationships among co-professionals in practice settings especially when dealing with shared problems and clients? (Ozar, 1993). Ozar argues that careful consideration of these questions, among others, creates a framework for understanding a profession's norms for conduct and can provide guidance to practitioners regarding interprofessional communication, ethical decision-making and action in everyday practice.

> Each profession...has norms, usually implicit and unexamined, concerning the proper relationship among members of the same profession in various matters and also between members of different professions when they are dealing with the same clients. Some of these relationships are dictated by a professional's obligation of competence, that is, the requirement that a professional not practice beyond his or her

> competence. This obligation clearly requires a professional to seek assistance from other, usually more specialized professionals when a particular matter requires expertise that the first professional does not possess. But other aspects of coprofessional relationships, which are not matters of practicing within one's competence, are also governed by professional norms.
>
> It would facilitate the practice of most professionals, especially in a world in which increasingly more work is becoming specialized and thus assigned to exclusive expert groups, if the accepted standards of interaction among professionals were more clearly grasped by them and their clients alike. So this is another topic of careful consideration, though one rarely addressed carefully.... (Ozar, 1993, p. 170)

These are topics and questions that *were* carefully considered and grappled with on a day-to-day, client-by-client basis by members of the transdisciplinary team(s) in the clinic I was studying. Thus, close observation and analysis of team members working to construct a transdisciplinary approach to care in the context of practice and a communal commitment to client-centering became another focus of this study--one that had much to do with situated expertise, teaching, and learning in this rehabilitation clinic and one that may contribute to a deeper understanding of the nature of transdisciplinary teams and professional development in health care settings.

Constructing a Transdisciplinary Approach to Care

Why Transdisciplinary?: The Importance of Client-Centering

As discussed in earlier chapters, there was a communally adopted core belief in and commitment to providing client-centered care among clinic associates at Jones and Thompson, P.C. The ideology of client-centering is a central and guiding tenet for practitioner action and interaction in this clinic; this multifaceted "philosophy of care" represents the collective and individual ideals and values of clinicians and creates norms for action. It describes a sociocultural system of beliefs that helps to create the clinic environment in the broad sense and serves as a framework for interpretation and understanding of the daily work of clinicians. Descriptions and definitions of the transdisciplinary team arose out of descriptions of this broader philosophy of care. Table 1 (p. 87) provides a summary of the key components and facilitators of client-centering as conceptualized by members of this clinical community.

Being a transdisciplinary team was most often described by clinic associates as a *facilitator* of client-centering; it enabled multiple professionals to work on each other's behalf toward functional goals, established in collaboration with clients, which frequently transcended narrow discipline specific tasks or goals. When therapists invited clients to participate in goal-setting and asked the kinds of questions of patients illustrated below they would get very different answers and goal statements than they might otherwise have constructed. The following is an example of a typical

question used to elicit the patient's perspectives on their difficulties or disabilities and involve them in establishing goals for therapy. This example is taken from Caitlin's initial evaluation session with Marcia:

> Before I start my screen [screening evaluation], I guess what I'd like to know is what YOU feel functionally are any problems that you're having...[things] that you haven't recovered fully since the accident...? ...Because what I want to do is look at structuring the eval and rehab around areas of function that are a problem for you. I mean I might find other things, but we want to really focus on areas that, um, are of concern for you. (C/M, 5/17/94, p. 2, 4)

The types of goals clients would establish for therapy, which served as guideposts for therapeutic interventions, most often had to do with overcoming barriers to full participation in work, home, social, or leisure activities in which they were previously involved. For instance, Marcia wanted to return to her previous level of activity in her church community as one of her goals. For her, this meant participating in social events, community service activities, serving on committees, and being able to walk up the stairs at church without getting tired, using railings, or losing her balance. She described her current status and frustration with respect to the latter activity as having to go up and down stairs "the old lady way" (C/M, 5/17/94, p. 12).

To achieve Marcia's broad functional goal of returning to full activity in the community, a variety of component or supporting skills and functions would need to be addressed including language

processing and memory skills, certain other perceptual and cognitive functions, and physical performance factors including strength, balance, coordination, and endurance. Work on such areas to enhance performance and make the attainment of Marcia's goals possible could, in some constructions of patient care with multidisciplinary teams, be allocated rigidly to particular professionals (e.g., a speech and language pathologist, a neuropsychologist, a physical therapist) who could work on particular tasks in isolation from the context in which they were going to be used and without the benefit of knowledge regarding what other health professionals are working on with the patient. But such a construction is antithetical to both client-centering *and* transdisciplinary teaming; in the view of the therapists at Jones and Thompson, such approaches have the potential to (a) disconnect therapy activities from the ultimate aims of the therapy, (b) decontextualize therapeutic activities and strip them of the meaning they hold for clients in terms of functional needs, (c) limit opportunities for practice of various tasks and strategies in a variety of therapy situations with a variety of people, and (d) limit the development of shared responsibility for and investment in attainment of patient goals across team members so that all participants are working to support and extend the work of others on behalf of the client. Client-centering and being a transdisciplinary team involve an expanded vision of what therapy is about for both patients and therapists:

> It's a different way of looking.... We're looking at getting patients back to functional lives out in the world and that's a bigger view than just trying to improve knee range of motion. (C, 8/16/94, p. 6)

These therapists believe that their work to help clients reintegrate into their lives at home, at work, and in the community encourages--in fact, demands--a transdisciplinary approach to care because particular components or aspects of activity (physical, social, psychological, cognitive) cannot and should not be dissected away from the contexts in which those substrates become meaningful for the client and contribute to activity and everyday function in their lives.

I hope the foregoing discussion suggests the futility of trying to establish unidirectional or causal relationships between client-centering and becoming and being a transdisciplinary team. Instead there seems to be a bi-directional and reflexive relationship between client-centering and being a transdisciplinary team; that is, transdisciplinary teaming, which is a social endeavor, is as much a facilitator of client-centering as the commitment to client-centering is a foundation and a facilitator for the development of a transdisciplinary team. And client-centering in this clinical setting, where many clinicians usually participate in caring for patients with multi-system dysfunction, is socially constructed through the interaction and activity of team members, including the patients themselves.

Numerous authors have claimed that a necessary, though not sufficient, element for the creation and sustenance of interdisciplinary or transdisciplinary teams is a central idea, task, or common goal for activity which is seen to be larger than any one individual's contribution and is therefore believed best achieved collectively rather than individually (Gillespie, Fitz, & Gordon, 1989; Hutchison, 1978; Grinnell, 1967; Oerlove & Sobsey, 1991; Petrie, 1976; Woodruff & McGonigel, 1988). For this group of professionals, client-centering is the epitome of this central idea; the communal adoption of this philosophy or ideology creates both a foundation and framework for the cohesion and collaboration that is implicit and explicit in descriptions of what it means to *be* a transdisciplinary team in this clinic. In addition, client-centering provides a motivation for *becoming* a transdisciplinary team; it makes this difficult activity meaningful and thus impels therapists to learn from one and other through their everyday work so that they might realize their ideals. In doing so, team members are continuously engaged in both their own professional development and the development of the team as a collective.

The process of *becoming* a transdisciplinary team and the process of *being* a transdisciplinary team are two dialectic and reflexive processes that are on-going for clinicians at Jones and Thompson, P.C. Although these processes are ineluctably intertwined, I will initially separate them for the purpose of clarity in this discussion. I recognize, however, the hazard in such a rhetorical device since it has the potential to create the conceptual

separation of learning (what some might call "becoming") from doing (what some might call "being") which is typical of transmission-acquisition-application models of instruction, learning, and transfer. I hope that by the end of the discussion such a separation will be viewed as artificial and implausible and not supported by the findings of this study. For the clinicians in this clinic, becoming and being a transdisciplinary team are co-occurring educative and developmental activities firmly tied to everyday practice.

On Becoming a Transdisciplinary Team

The notion of, or commitment to being a transdisciplinary team was itself emergent as the clinic and clinicians were developing and coming together over the years. Recall that the clinic history dated back 15 years and in it's initial years consisted of a small group of three clinicians: a social worker, a neuropsychologist, and a physical therapist. It was only after a core group of experienced therapists representing a diversity of disciplines had gathered that the clinicians realized they were constructing a transdisciplinary approach to care and began to call themselves a transdisciplinary team. That is, the clinic owners and staff didn't originally embark on this venture suggesting that they would *be* a transdisciplinary team. As a social worker, Kay, put it, the idea was not "born with the clinic" (K, 9/15/94, p. 7).

Kay and other informants were quick to point out that some of the foundation or stimulus for the development of the team "happened before the creation of it...these were experienced, master therapists with long histories of working with other health care

professionals" (K, 9/15/94, p. 8). The therapists who came to work in this clinic had previous experience as members of interdisciplinary or multidisciplinary teams in other settings. This previous experience was part of each therapist's learning about (a) what was "good or not so good" (K, 9/15/94, p. 8) about different teams, and (b) disciplinary knowledge, roles, and responsibilities of practitioners in health professions other than their own. Thus, therapists brought this knowledge and their conceptions about health care teams and other disciplines with them as they began to work with each other in the context of this clinic. These beliefs, born of experience, were the seeds for the development of a transdisciplinary team.

Several therapists suggested that what they had observed and experienced in previous work settings were structural rather than functional interdisciplinary teams. They expressed discontent with other models of teams they had encountered in which there was formal communication among individuals on the team via regularly scheduled meetings and yet there was limited "uptake and use" of information in each other's therapies or encounters with the patient. One physical therapist described this as the problem of "reporting out" of test results and patient status in team meetings without any communal follow-up, assumption of shared responsibility, or active response to and integration of that information across therapies (C, 8/16/94, p. 5). Furthermore, staff members expressed frustration about institutional and administrative mandates which required that services in different disciplines could only be provided directly.

Therapists also expressed concern that some of these mandates were driven by financial considerations for the institution or particular departments within institutions rather than the best interests of the client and cost effectiveness. As one of the speech pathologists put it,

> You know, I think a lot of organizations' budgets dictate who does what [who provides what services for clients]. Because the more revenue for your department, the more staff you can have, and the more power... (B, 12/3/92, p.3).

In effect, most therapists seemed to be describing their earlier learning about interdisciplinary teams and the disciplinary activities and knowledge of other members of the team as an "apprenticeship of observation" (Lortie, 1975); that is, they had many opportunities in previous practice settings to observe and hear about what other team members were doing in therapy with particular patients, but there were relatively few invitations to collaborate with or *participate* in the work of other professionals as they worked to achieve therapeutic goals for clients.

When asked, then, about what becoming and being a transdisciplinary team meant to them, most therapists echoed Caitlin's response which also touched on what it *was not* :

> One of the things that has helped me tremendously is working with the transdisciplinary team and much closer with the social worker and the speech pathologist and the neuropsychologist [than before]. They have brought me to a whole different perspective on my patients than what a PT normally comes from. And if you're transdisciplinary--truly transdisciplinary--you start getting a much broader perspective. We're always trying to consult with each other about what is happening

> within each other's therapies and to *help each other.* Looking at problems from a multi-systems perspective or multi-discipline viewpoint is *very* different than just reporting out your findings. It's a different way of looking at the patient. And we're looking at getting patients back to functional lives out in the world and that's a bigger view than just trying to improve knee range of motion. (C, 8/16/94, p. 5-6)

Here, Caitlin suggests that she gained new perspective and insights about her patients as well as the work of other professionals through her *close* work with other members of the team. But what does "close" describe or entail that differed from Caitlin's previous experience and that provided for the *learning* which created a broadened view of patient's problems and a willingness to alter and expand her everyday practice of physical therapy?

Interview and observational data demonstrated that there were many opportunities for close work among team members which provided a context for learning about the disciplinary perspectives and expertise of others. These included: (a) formal weekly team conferences; (b) informal dialogue and discussions, both written and oral, about clients; (c) review of written artifacts such as clinic reports on clients; (d) observation of other therapists' work or co-participation in screening evaluations or therapy sessions; and (e) increasing participation of therapists in the roles of other professionals via the provision of indirect services for clients when the provision of direct services is determined to be unnecessary, redundant, or unacceptable to a client. Collectively, these activities provided apprenticeships of participation (Lave & Wenger, 1991; Rogoff, 1990) in the disciplinary work of others (to varying degrees)

for the professionals in this clinic and were integral to the process of becoming a transdisciplinary team. Some authors have suggested that who you are becoming or what you are becoming--the identity one is crafting--shapes what you learn and become knowledgeable about (Lave, 1995; Lave & Wenger, 1991). These clinicians were actively engaged in the work of *crafting a collective identity* as a transdisciplinary team. I believe that this collective identity work was a powerful stimulus for learning from each other and was intertwined with transformed conceptions about one's individual professional identity as well new understandings about the professional identities of practitioners in disciplines other than one's own.

Characteristics of the Clinic and Staff: Human and Institutional Resources Supporting a Transdisciplinary Team. Before discussing each of the apprenticeships of participation identified above, I want to make a few additional points about some key characteristics of the clinic setting and the clinicians which, I believe, have much to do with the business of becoming and being a transdisciplinary team. It may go without saying, but the small size of the clinic (physically and in terms of personnel), staff stability and longevity, and the considerable experience and expertise of clinic associates were perceived by therapists as extremely important affordances to the development of a transdisciplinary approach to care. Clinic brochures and promotional materials describe some of these features for patients or other individuals or agencies who might refer patients to Jones and Thompson, P.C.

> At Jones and Thompson, there are no "departments" separated by hallways or buildings, so communication and teamwork are not impeded by size or architecture.
>
> Clients can be assured that they will always be seen individually in quiet treatment areas by therapists chosen from a staff of ten who together have acquired more than 150 years of professional experience (Brochure 1, 1992, p.1).

And a more recent brochure states:

> Not only do our clients benefit from the experience of each therapist, but they also benefit from the consistency and reliability that comes with longevity: our dedicated associates have been part of the Jones and Thompson team for many years. So patients with long term disabilities are assured of continuity of care....
>
> Because we are a relatively small team which is not part of a large medical infrastructure, we have the freedom to maintain flexibility in our approaches to solving client's problems. Each client's progress is then measured against transdisciplinary outcomes that are function rather than disability based (Brochure 2, 1994, p. 2).

The fact that promotional materials for Jones & Thompson, P. C. (of which there are very few) highlight these features of the clinic setting and characteristics of the clinic associates emphasizes the perceived importance of these features to clinicians in providing a context for the creation and sustenance of a transdisciplinary team and achieving the ideals of client-centering.

The descriptions in these brochures was borne out by numerous observations and interviews with several therapists. For

example, Caitlin pointed out how size and stability of the group facilitated communication among members:

> ...I think that in a small group like that, that's stable, as opposed to a big institutional setting, it's much easier to communicate.... Especially early on [in the course of therapy] with clients, we tend to touch bases with each other several times during the week regarding the client. (C, 8/16/94, p. 7)

In addition to the substantial experience of clinic associates which engendered security in their own disciplines and respect among members of the team, Kay also suggested that the diverse but positive "personality mix" was a characteristic of staff which contributed to the development of a transdisciplinary team (K, 9/15/94, p. 8).

Finally, therapists felt very strongly that the type of work the therapists were involved in on a day-to-day basis--work with clients with disabilities seeking to regain function and return to their "real lives" at home, at work, in the community--encouraged a transdisciplinary approach to care. In such environments, the tasks patients need to accomplish and the goals toward which patients and therapists are working are "...contextualized and complex, they don't exist in isolation, so neither can the services" (K, 9/15.94, p. 9). Susan, a speech and language pathologist, also felt that the willingness and ability to do each other's work to some extent grew out of the team member's commitments to (a) client-centering and (b) articulating and embracing what she called more "global goals" for patients. For her, this type of work required goals not necessarily

owned by one therapist (or discipline) or another, but shared by all members of the team including patients.

> You know, the way I see a transdisciplinary focus [is] it's not just my goal. If I'm really helping a client learn how to compensate [for their impairments] in *their life* --and actually meeting all of the goals of *their life* --it has to be an integral part of all therapy all of the time. So, we...really focus on those more global goals.... Instead of me working on this goal [and] you working on that goal, it's kind of like we all own things and share our perspective on it. (S, 7/28/94, p. 6-7)

Thus, shared investments in the accomplishment of goals deemed meaningful to clients that transcended disciplinary goals or boundaries was part of everyday practice for these clinicians. Such investment and goals provide yet another impetus for professional learning and development and the creation and sustenance of a transdisciplinary team. These investments and commitments are foregrounded during team meetings.

Apprenticeships of Participation: Formal Team Meetings. Team conferences are held weekly to discuss client needs, problems, and progress and establish or revise goals for therapy as appropriate. Most time in conferences is directed toward those clients requiring multiple services whether direct or indirect. The focus of these conferences is on joint problem solving and team goal setting for or with the client. When I asked Kay about what I called formal team meetings (the fact that they were scheduled at a particular time on the same day each week led me to call them "formal"), she laughed and said they were really "anything BUT formal". She characterized

the conversation in these conferences as "gender constructed" (all but one member of the team is female); conversation is "overlapping and interruptive" in a natural way and there is active "group problem solving" with "lots of thinking out loud" by participants (K, 9/15/94, pp. 9-10). Kay felt that the latter features of activity and discourse in the clinic--joint problem solving and thinking out loud when doing so--in a variety of situations were the most pervasive and powerful way that team members came to know about other's thought processes, disciplinary knowledge and everyday work.

Rogoff (1990) posits that apprenticeships in thinking, which involve "guidance and participation in culturally valued activities" (p. 8), are extremely important facilitators of children's cognitive, social, and emotional development. She points out that apprenticeships in thinking which are necessarily apprenticeships of participation and social in nature, are extremely important facilitators of development *across the life span* . I would suggest that apprenticeships in thinking is an apt description for many of the joint activities in this clinic and have much to do with the learning and development of professionals as they go about their daily work. Rogoff's descriptions of her assumptions regarding thinking, development, and the relationship between these two processes, draws attention to some of the regular features of activity at Jones and Thompson, P. C. which could contribute to personal and professional growth for transdisciplinary team members over time. Rogoff broadly defines cognition and thinking *as* problem solving:

> I assume that thinking is functional, active, and grounded in goal-directed action. Problem solving involves interpersonal and practical goals addressed deliberately.... It is purposeful, involving flexible improvisation toward goals... (Rogoff, 1990, p. 8).

Furthermore, Rogoff regards development as

> ...transitions of a qualitative (as well as quantitative) nature that allow a person to manage more effectively the problems of everyday life, relying on resources and constraints offered by companions and cultural practices to define and solve problems. ...development involves the appropriation of the intellectual tools and skills of the surrounding cultural community. ...development is assumed to proceed throughout the life span, with individuals' ways of thinking reorganizing with successive advances in reaching and contributing to the understanding, skills, and perspectives of their community (Rogoff, 1990, p. 11).

Thus, the recurring and purposeful activity and interprofessional dialogue directed toward collective problem identification and solving on behalf of clients in the service specific goals, creates a rich cultural context for learning and the development of enlarged perspectives, deeper understandings, and improved or expanded clinical expertise among members of this clinical community.

Caitlin, like Kay and other therapists, felt that the activity of joint problem solving which occurred in team meetings (what she called "staffings") was a powerful tool for her own learning about the disciplinary perspectives and work of the other members of the team. As previous quotes suggest, she found that the communal

involvement of practitioners in this activity contrasted with her previous experience in other rehabilitation clinics:

> ...Our staffing [team meeting] wasn't a traditional staffing format where you sit back and give a report on your discipline's findings. Range [of motion] is this, balance is this, and you note improvement in this...and then you have neuropsych list their tests and findings. That's a traditional report in staffings. And our staffings are much more problem-based staffings. So, there's a problem that has arisen [for a client] and you look at it with different people bringing in their perspective on the problem and how it's impacting the client from their discipline's perspective.... And I'll say to the speech pathologist...'what can I do to help?' (C, 8/16/94, pp. 6-7)

Here, Caitlin suggests that through the problem-oriented nature of the discussion with multiple perspectives brought to bear on particular problems, members of the team learn to *see* ("look at") a client's problem with a less myopic, single discipline based view. In addition, team members try to figure out how they can "help" each other achieve team goals for clients within their own therapies. For instance, Caitlin asks the speech and language pathologist(s) how she can incorporate the use of certain memory training cues and cognitive strategies into the activities she is working on with a particular client. Conversely, the speech and language pathologists may ask the physical therapists how they can incorporate relaxation or vestibular habituation activities into what they are working on with clients.

Beyond goal setting, problem identification and problem solving, another focus of formal team meetings, especially in the

early phases of work with clients, is on deciding what kinds of services are warranted or desired for clients and who will be the providers of those services. That is, the question of *Who is team?* or *Who will be team?* is addressed.

Who is team? Kay, a co-owner of the clinic and a social worker, is often the designated team leader with respect to the task of determining initial team make-up although she is not the sole arbiter of such decisions--other clinicians *and patients* do have a voice in who will provide what services for a particular client. Kay, however, is often the first clinician to receive and review referral information on new clients or to interview new clients. These initial encounters help her to formulate early, though not unchangeable, impressions about what services may be useful for a particular client and who might best provide such services.

According to Kay, team membership shifts according to several factors: (a) the needs and wishes of the client (e.g., the severity, extent, and nature of the client's problems and what they perceive to be their areas of greatest need); (b) negotiation among therapists about the extent of overlap and the outer limits of disciplinary knowledge and skill; (c) the schedules and availability of particular therapists; (d) perceptions about which therapists would be a "good match" for the client in terms of personalities; and (e) reimbursement issues (i.e., what kinds of services are likely to be covered by third party payers for this patient's problems) (K, 9/15/95, p. 10-11). As these factors are considered, determinations regarding who will be part of a client's team and what services will

be provided directly or indirectly are reached. An initial team for a particular client is then identified and screening evaluations of the client are scheduled with each of the therapists providing services. The end result of this process is a team whose structure or makeup varies from client to client and whose membership can still shift (a) according to findings of screening evaluations or (b) as therapy progresses and certain services are determined to be warranted or, alternatively, no longer necessary.

To elucidate further some features of this team identification or selection process, I will first describe the makeup of each of the transdisciplinary teams for the clients I followed during the course of my study and then discuss some of the factors considered in determining each client's team configuration. Recall that there were four client participants: John, and his wife Diane; Marcia; and Bill. Three of these clients had brain injury with a range of impairment and disability from severe (John, who had a malignant brain tumor) to mild (Bill, who had a mild head injury and vestibular dysfunction), and an age range from 36 to 73 years. Diane did not have a brain injury but was a participant in the study because she was involved in physical therapy sessions with John from time to time and received counseling services from a social worker. Figure 18 illustrates the make-up of the transdisciplinary teams that worked with each of these clients. The starred team member is the individual who provided the majority of direct services for each client and who also provided indirect services on behalf of other members of the team. In the case of the three patients with brain

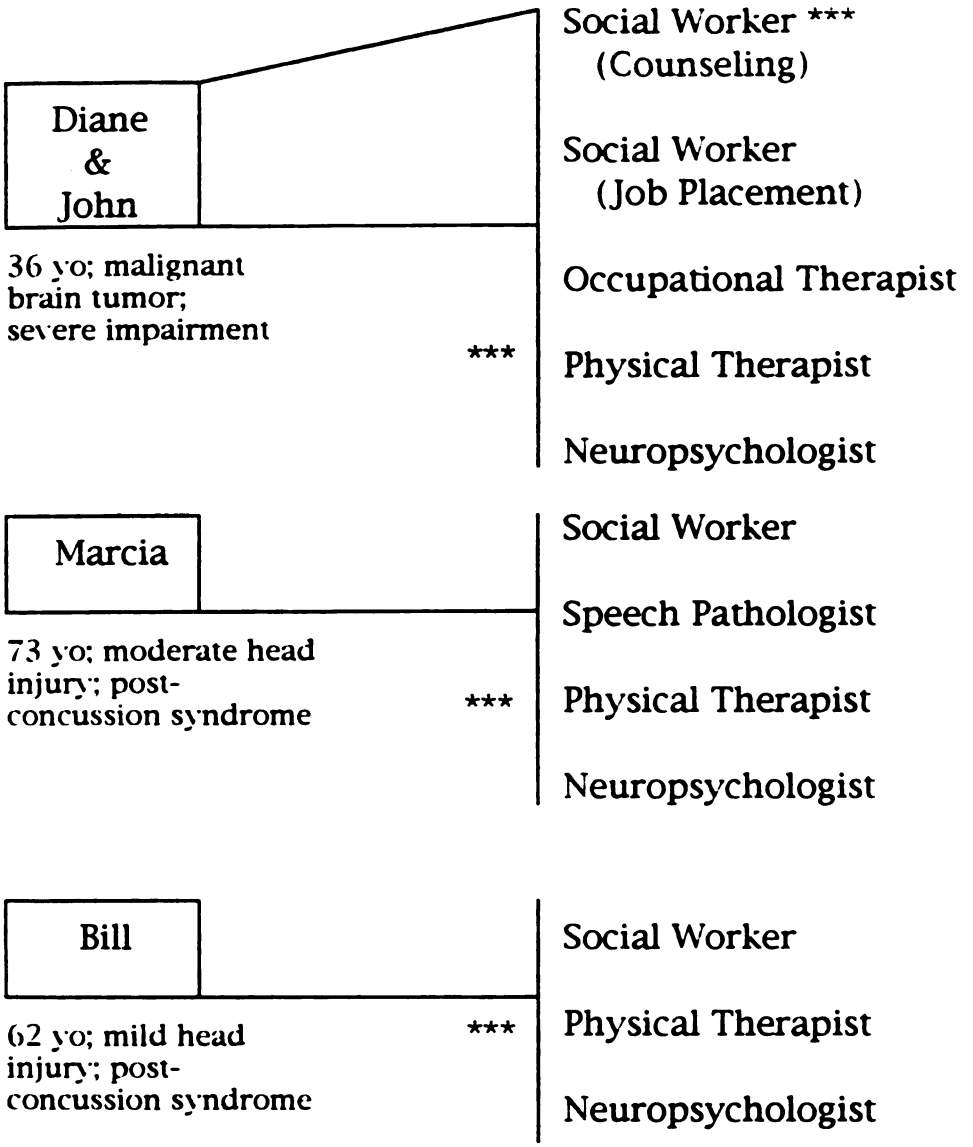

Figure 18. Client Participants and Their Teams. The starred team member is the individual who provided the majority of direct services for each client and who also provided indirect services for other members of the team.

injury, this individual was the physical therapist, Caitlin. But how were the members of these teams selected and what factors drove decisions about who would provide direct or indirect services at any given time during the course of therapy?

John and Diane's Team. I speak of John and Diane and their team together since there was a great deal of transdisciplinary work on behalf of both of these clients going on throughout the same period. The fact that John and Diane were receiving different services concurrently created special challenges and problems for clients and team members from time to time, but also provided for a more realistic and holistic approach to caring for and trying to understand the complicated needs of this husband and wife who were facing the physical dysfunction and the social and emotional upheaval of John's life-threatening illness together on a daily basis.

Diane was seen primarily by Kay for direct services related to her counseling needs. These included needs related to pre-existing and evolving marital tensions and needs related to understanding and living with John's altered or declining cognitive, perceptual, social, and physical function as a result of his brain damage. Diane also attended occasional physical therapy sessions with John and Caitlin when she was learning about exercises to be done at home with John.

John was seen primarily by Caitlin because most of his concerns centered on his difficulty with declines in specific physical functions including loss of strength and movement control in his left leg impairing his ability to walk and get around, and pain, loss of

motion and strength affecting his ability to carry out some of his routine daily activities. John was seen intermittently by Caitlin as his condition warranted over a period of approximately three years.

Although John was evaluated by the neuropsychologist, most of the findings from that evaluation were used diagnostically or to inform the understandings of other team members working with John on a regular basis about his unique cognitive and perceptual problems. John did not receive regular services from the neuropsychologist nor did he receive counseling services from the social worker. With regard to the latter, John was simply not interested in receiving such services and refused to participate even though Diane had encouraged his involvement in sessions. This situation, combined with the fact that Caitlin was the primary therapist who interacted with both John and Diane concurrently, meant that Caitlin was sometimes called upon to provide indirect counseling services as she tried, through discourse and activity in therapy sessions, to facilitate understanding and cooperation between the them.

Finally, both Kay and Nina, an occupational therapist, worked with John intermittently for relatively short periods of time when he required assessment and assistance with community or job placement (e.g., working in God's Kitchen or in videoproduction) or with particular daily care activities at home. During times when Kay and Nina were not providing direct services for John, Caitlin continued to take account of their findings and recommendations and

tried to support and extend their work during physical therapy sessions.

Marcia's Team. Marcia was seen first by Kay who upon the completion of her initial social work interview found that Marcia described symptoms that were suggestive of cognitive, language, motor, and balance problems that fit a profile of patients who have sustained mild to moderate head injuries. These findings indicated that Marcia might benefit from screening evaluations and possibly services from neuropsychology, speech and language pathology, and physical therapy. At the same time, Kay noted that her findings suggested that Marcia had a "...personality style which eschews 'giving up' or acknowledging emotional distress.... Instead she just "soldiers on" using humor..." (K, M report, 5/2/94, p. 2). In support of this interpretation, Kay quotes Marcia in her report:

> If I had a different personality I probably would withdraw from the world given my symptoms and fear of making a fool of myself. However, I just keep going regardless. At board meetings I say the wrong things so people are always correcting me. But I don't mind. I can't stand inactivity. I want to keep involved in life (K, M report, 5/2/94, p. 2).

Kay's recommendations for services, therefore, did not include counseling through social work, since dealing with the "psychological interpretations" of her problems did not appear to be a key concern for Marcia. Instead, Kay concluded that Marcia was a

> ...very pragmatic woman. If the team has specific interventions that offer a possibility of reducing her symptoms or allowing

> her to compensate better, she will be interested in pursuing treatment. (K, M report, 5/2/94, p. 2-3)

This observation was confirmed time and again throughout Marcia's screening evaluations and therapy sessions; even by Marcia herself in an interview with me:

> Because I will work on something that I see that I need.... they are what I do want to improve. Like it just bugged the heck out of me that I had to go up and down steps one at a time. And I thought if I'm gonna learn anything,...if I'm gonna do anything, I'm gonna get that leg strong enough to pull me up to the next step, and not walk, you know, wiggle waggle, back and forth (demonstrating a zig-zag pattern with her hands and chuckling). (M, 6/30/94, p. 12)

In his initial evaluation of Marcia, the neuropsychologist found some mild deficits with encoding of auditory data, memory, and sequential reasoning and suggested that Marcia might benefit from some cognitive rehabilitation with the speech and language pathologist. When the speech and language pathologist first saw Marcia, she found that Marcia had already initiated some of the kinds of activities and had begun to use some of the kinds of strategies which she would normally teach patients with Marcia's problems. Susan scheduled a single follow-up session to reinforce what Marcia was already doing and to introduce a few more alternative strategies to help her with the memory, word finding, and organizational tasks which were frustrating and problematic for her. After that session, Susan concluded that Marcia did not seem "...interested in nor a candidate for formal cognitive/lang. (sic)

treatment as she is managing her daily challenges" (S, M report, 5/9/94, p. 2). She added that she would "review and discuss" her findings with Caitlin, who it now appeared would be providing the majority of direct services since the physical functional challenges associated with Marcia's "post-concussion syndrome" were obviously her major concern.

Thus, Caitlin was the primary direct provider of services for Marcia during the two months she received therapy at Jones and Thompson, P. C. During therapy sessions treatment was directed primarily toward balance, coordination, strength, posture, and motion deficits that were creating functional problems for Marcia in terms of her ability to participate in regular home, social, and other community activities. Caitlin also became the indirect provider of cognitive rehabilitation and other services from time to time as issues pertinent to these needs arose in physical therapy sessions. In a later interview, Caitlin used the case of Marcia to illustrate how client-centering is related to the construction of teams. Marcia was not interested in counseling services, so they were not provided. The team members let Marcia determine how much time she would spend with the speech and language pathologist and they directed their attention and most services to the areas of primary concern for Marcia.

> Okay, well we're not recommending social work. We'll let her make the decision about whether she wants some short term speech intervention, and her obvious focus was physical and that's where we'll focus and offer services. And I think that's client-centered rehab. As opposed to a team sitting back and

> saying, 'Okay, Ma'am, you're going to have speech two times a week, counseling once a week and PT... .(C, 8/16/94, p. 9)

This description of client-centered "rehab" is reminiscent of Kay's earlier explanation of why listening carefully to the client and what they want is so important in the construction of teams: "...so we're not providing services that they [the clients] haven't requested...in ways that aren't going to fly" (K, 2/3/92, p. 7).

It is noteworthy to point out, however, that Marcia's beliefs about (a) what issues should or should not be raised in *physical therapy*, and (b) the areas of expertise of the therapists with whom she was working, also shaped the nature and content of exchanges in therapy sessions. This is demonstrated by a comment and probe Marcia directed to me in an interview after telling a story about some persistent and puzzling problems she was having with long-term memory.

> I was gonna say something about this to Caitlin but I think it's out of her area of expertise...I don't know if anyone can explain this to me? (M, 6/30/94, p. 13)

In response to this question, (and resisting the urge to be Marcia's therapist myself) I suggested that Marcia might still want to ask Caitlin or Susan about this concern since they, in fact, might be able to offer some explanations for her continued problems with long term memory and offer some guidance about ways to manage them. Marcia responded to my suggestion with a query which indicates, once again, how the client's beliefs and expectations about therapist

knowledge and their areas of expertise might influence what is discussed and done in therapy sessions. Because I had raised Susan's name, Marcia recalled that she had worked with her on some memory (encoding and recall) strategies during a therapy session:

> Yeah, like how to remember what I was doing or something... But isn't she basically the speech...? I thought they were recommending I saw her for speech, but maybe they weren't. (M, 6/30/95)

Both of these comments and questions illustrate how Marcia's beliefs about what speech and language pathologists or physical therapists know and do affect what issues might be raised and addressed in therapy sessions. Although Marcia had worked with Susan briefly on some types of "cognitive rehabilitation," she was apparently unaware of the extensive training and knowledge that speech and language pathologists have in the area of cognition and language acquisition and processing. Thus she may not have raised or discussed all of her concerns regarding her attention and memory when working with Susan. Marcia did believe, however, that work on memory was *not* something that physical therapists did ("...I think it's out of her area of expertise") and therefore she may have limited conversation or questions about her distractibility and memory loss during her sessions with Caitlin. In this sense, because of her own expectations and beliefs about therapist knowledge and skill, Marcia may have had questions go unasked and unanswered; that is, she may not have been a full beneficiary of the transdisciplinary approach to care offered in this clinic.

In summary, the construction of Marcia's team further illustrates the role of (a) the patient's perceptions regarding their needs and goals (client-centering), and (b) their beliefs about the types of expertise and help clinicians have to offer, in the process of determining "who is team," who will provide direct or indirect services for a particular client, and what issues or questions are raised in the course of therapy.

Bill's Team. Of the three patients followed during the course of this study, Bill had the mildest symptoms and deficits as a result of his head injury. Nonetheless, the problems he encountered with headaches, concentration, short-term memory, dizziness, and balance made his return to work as a pharmacist in a busy drugstore extremely difficult and he sought help from a neurologist who referred him to the mild head injury program at Jones and Thompson, P. C.

Bill was seen first by Kay and Caitlin for a screening evaluation. Evaluation findings provided evidence of mild vestibular dysfunction, problems with visual-ocular-reflex (VOR) control, and mild strength and balance deficits. Such problems are often responsive to physical therapy and Bill, Kay, and Caitlin determined that a brief intervention to address these areas could be of benefit. In addition, and perhaps most importantly for Bill, it was determined that Caitlin could also try to help Bill learn some headache prevention and management techniques. Because the patient's history and screening evaluation indicated that Bill's headaches might be triggered, in part, by visual-spatial processing problems,

Kay recommended that Bill be evaluated by the neuropsychologist for further assessment of visual processing and attentional systems to ascertain the specific nature of these problems. Finally, it was determined that counseling or psychosocial services for Bill were not indicated nor desired by the client at the time of the initial evaluation. As Kay wrote in her report to the neurologist,

> There seemed no evidence of hysteria, malingering, or other emotional issues clouding his presentation of symptoms. He was a very straightforward individual who gave a clear history and description of symptoms that is compatible with post-concussional headaches (K, B report, 4/14/94, p. 2).

Two weeks after the initial screening, Bill was evaluated by Don who found some mild but specific problems on visual-spatial orientation and pattern matching tasks. Don also noted that when "struggling" with the neuropsychological tests, Bill exhibited some frustration and "an obvious stress response."

> During the test, Mr. Maxwell's respiration became deeper and more irregular, his shoulders and neck tightened, and a tremor in his right hand increased in strength. He reported being upset and even used uncharacteristic profanity. (D, B report, 4/29/94, p. 1-2)

Don was concerned that such stress responses could exacerbate Bill's headaches when he was involved in tasks that were demanding in terms of visual-perceptual processing such as scanning shelves and counting pills at the pharmacy.

Don's findings in the neuropsychological evaluation were consonant with those of Caitlin, and it was felt that Bill's visual-spatial processing deficit and his concentration problems when he had headaches were "functionally related" to the vestibular and VOR problems seen by Caitlin earlier. For this reason, Don suggested that Caitlin could "incorporate ameliorating and compensating elements" directed toward addressing visual-spatial processing difficulties into Bill's vestibular therapy program (D, 4/29/94, p. 2). Thus, Caitlin became the provider of direct physical therapy services for Bill and an indirect provider of some neuropsychological services and consultation.

Apprenticeships of participation: Informal dialogue among team members. Informal "meetings" between team members occurred frequently and easily in this clinic. These encounters were usually stimulated by questions therapists had for each other or issues they wanted other team members to be aware of that arose in the context of a treatment session with a client. Communications occurred in both written and oral forms. If a given therapist wasn't available for consultation at a particular time, notes would be written and placed in their mailbox or put on their desk or office door. Alternatively, therapists encountered each other throughout the day in hallways, the receptionist's area, or other gathering places like mailboxes, the photocopying area, or the staff break area. Patients pass through many of these areas on the way to therapist offices or the therapy "gym" so that members of the team would usually know when a particular client was in the clinic. Since all therapy sessions

in the clinic were scheduled for 50 minutes to an hour, the busiest times in these gathering areas or passageways was close to the change of each hour throughout the day. Informal conversations could be as brief and simple as inquiries about how a client was doing with part of their program or goals, or extended and complicated as therapists engaged in joint problem solving as issues emerged for shared clients.

The physical environment of this clinic provided frequent opportunities for dialogue among therapists on behalf of clients. As discussed earlier, this was a small clinic with closely nested offices and several central work and traffic areas through which clinicians would pass several times per day. Office doors were left open except when therapists were working with clients and therapists would frequently stop in each other's offices for brief chats regarding clients. Although I observed these brief office chats on several occasions, I was usually unable to clearly hear the conversations. Caitlin, however, provided some specific examples of the types of information shared among therapists during informal consultations about clients.

In the case of Marcia, Caitlin found that Kay's insights about this client based on her extensive initial interview were very helpful as Caitlin considered her approach to therapy with Marcia:

> ...even though Kay didn't see her after that [initial interview], I got information from Kay about who this woman is, what her interests are, what she's invested in, and how she may approach rehab--she's not passive, she's not a 'cure me' type--she's going to be a 'take charge' person. Give her as much information as you can and let her run with it kind of person.

(C, 8/16/94, p. 9)

This information and Kay's initial impressions were most certainly borne out in the course of Marcia's therapy and proved very useful to Caitlin as she began to work with Marcia in designing a therapy program suited not only to Marcia's clinical needs but also to her personal style.

In the more difficult case of John and Diane, some of the information shared by Kay with Caitlin both formally and informally was invaluable as Caitlin tried to interpret the complex and shifting needs of this husband-wife pair and the interaction between John and Diane especially in joint teaching/therapy sessions like that described in previous chapters.

> I know from her [Diane's] interaction with Kay--and I think this is the importance of the team--that...Dr. Grant never took her [Diane] aside and said 'this is what you can expect from John's recovery--he will get more motor return, he won't get this'--he never spelled out expectations for what's going to be happening in a month or four months from now. And that really bothered her. So I think she [Diane] was kind of looking for that information and I had the background information from Kay to know that...obviously this was a source of frustration at home--about how much function he [John] had or didn't have--and was it ever going to change? (C, 4/2/93, p. 5)

Armed with such "background information" from Kay about the lack of guidance provided to Diane about John's functional prognosis from his physician, Caitlin could more easily recognize, interpret and

respond to probes and questions from Diane that had to do with her (and John's) need to be informed about what the future might hold.

Finally, Caitlin talked about the value of a recent informal conversation she had with the neuropsychologist regarding a client who was difficult to "figure out."

> Like I had a head injury screen on a client about a month ago and there was so much dramatics--so many things didn't seem to balance out in this patient--the whole eval just didn't seem to make sense to me. In this case Don was able to give me his neuropsychological findings and interpretations and help me understand how that [his findings] will make it different when you treat the patient and how you need to approach a patient like that....You know, without that kind of consultation I would have a patient like that in the past and be confused; you know, you'd just be shaking your head thinking what am I going to do with this patient? (C, 8/16/94, p. 8)

Caitlin characterized this "consultation" as a time when she talked with Don about some of her observations and impressions of this "confusing" client and Don did the same. Then they engaged in joint problem identification and solving to try and plan an approach to physical therapy treatment with the patient which was built around recognition of some of the unique neuropsychological problems for the client and that might concurrently address therapeutic goals that cut across the disciplinary boundaries of physical therapy and neuropsychology.

These are examples of the types of information and insights exchanged between team members in informal, though purposeful, dialogue in the course of their day-to-day work with shared clients.

In addition to face-to-face interaction, several therapists mentioned that they communicated with each other informally via the passing of notes and that this, too, was part of their learning about other therapist's disciplinary knowledge, work, and concerns. Susan, for example, remarked on the variety of opportunities in the clinic for learning from other therapists while engaged in practice: "...just talking with each other, writing notes to each other, [reading] case notes,...observing, and [doing] co-treatments" (J, 7/28/94, p. 8).

Because many of the clinic associates work part-time at Jones and Thompson, and because some of their work with clients will occur outside of the clinic (e.g., in a client's home, workplace, or elsewhere in the community), the passing of written notes has become a regular activity for many of the therapists in the clinic. As Susan put it,

> And so more and more I get notes from Emily that tell me something about what she's done [with a client], or notes from Katherine, or notes from Karen, who say things like, you know, Steve tried this with his planner, or he used a tape recorder for this...and then there's a lot more interaction between us and that...is really good. (S, 7/28/94, p. 8)

Thus, the passing of brief notes between therapists is another mechanism for maintaining regular communication between team members and learning about what is happening in various therapy sessions that relates to transdisciplinary goals for shared clients.

Apprenticeships of Participation: Review of Written Artifacts--Clinic Reports. Therapists suggested that one of the ways they came to learn the terminology and language of other team members was

through reading their clinic reports or "case notes." In short, this activity was seen as one tool for entry into the lexicon and lexical meaning of other disciplines. Written clinic reports included initial evaluations and diagnostic reports as well as progress reports and case notes from team members working with shared clients. They also included correspondence to and from referring physicians by various team members and previous medical records. Review of written reports was especially critical when, for instance, a direct provider (e.g., an occupational therapist) was rendering some indirect services that might traditionally be considered the professional domain of a speech and language pathologist. In such cases, therapists would carefully review diagnostic and consultative reports to assist them in the provision of indirect services for clients. Not infrequently, the terminology or a recommendation used in a clinic report from one team member would appear later in discourse (in a similar or related form, if not exactly quoted) between another team member and the shared client. The transformation or translation of terms from other disciplines and the *appropriate* use or "publication" (Harre, 1986) of those terms during indirect therapy could be one indication that internalization (Vygotsky, 1978) or appropriation (Rogoff, 1990) of key concepts has taken place and that learning and development has occurred at the microgenetic and ontogenetic level for a therapist.

I will use an example of discourse between Caitlin and Bill to illustrate what I believe to be such appropriation, transformation and publication. Recall that Bill was the patient with mild head

injury who was seen by the neuropsychologist on two occasions for testing and recommendations regarding headaches and some apparent visual-perceptual problems that were impeding his work as a pharmacist. The clinic report sent to Bill's physician by the neuropsychologist (and reviewed by Caitlin) described Bill's impairments and their influence on his everyday function at work in this way:

> In my interview with Mr. Maxwell I learned that he has been compensating for a number of changes in his visual perceptual processing which have occurred since his accident. He finds he must make a special effort to concentrate harder when transferring numbers from his pharmaceutical stock into his computer. He also finds that his spatial orientation to the stock on shelves depends on special visual attention. Shelf arrangements and aisle arrangements he has been working with for decades can be confusing to him.... Overall, the symptoms Mr. Maxwell describes were classical indicators of parietal lobe dysfunction. Testing on visual-spatial orientation and pattern matching tasks verified the problems...[and] he had an obvious stress response while struggling with the test problems.... I think Mr. Maxwell has a visual-spatial processing deficit often seen after trauma to the right parietal cortex. This is undoubtedly related to the vestibular problems seen by [the physical therapist] in an earlier evaluation in our office. (D, B Clinic Report, 4/29/94)

Based on team evaluations, recommendations, and the client's perceived needs, Caitlin, the physical therapist, was asked to incorporate "ameliorating and compensating elements" identified in the neuropsychology sessions into Bill's vestibular therapy program. During a subsequent physical therapy session with Bill, an extended discussion about the neuropsychologist's findings and

recommendations emerged when Bill was talking about some of the difficulties he was having at work with short-term memory, headaches and concentration which had resulted in his need to check all his work twice in effect "doubling all the work I do" (e.g., counting pills twice for each prescription) (B, 5/5/94. p.1).

B: I never did that before.

C: [When you count pills, uh, Bill, are you doing...? (circling hand on small table between them)/ you probably have a system?

B: I always count in five's, that's right. (nodding)

C: You have little sets (circling hand) and you do the sets and you flip them in there (pushing the back of her hand across table)

B: (nodding) Yeah, Yeah. I always do it that way. If it's over a hundred, I count the hundred first and put that out of the way and count the balance.

C: [Well this kind of gives me a chance to bring in what Dr. Jones found, and I think he talked to you a little bit about it/ but it's real relevant to your work task and it ties in with the vestibular problem. And that is/ what we call visual perceptual/ difficulty. Um, and that is, in our brain we kind of have a map of where things are in space...

B: Hm mm (nodding)

C: And, and, uh, we can categorize things, in space (moving hand in circle in front of her face)

B: Uh hmmm (nodding)

C: um, not, not so much verbally categorize them, but.../ I know exactly where my bedroom is, and what the layout of my bedroom is, and I can walk that in the dark (waving hand forward in front of her face in an S pattern)

B: Uh hmmm (nodding)

C: YOU know your supply room and the shelves (reaching backward toward imaginary shelves) and where everything is

B: Mostly, unless some guy changes it on me which/ that happens every once in a while

C: (chuckling, smiling) really throws you for a loop

B: But we can adapt to that

C: Right, um, now when you're running into problems with visual perception, or you compensate for a while and then the system says "I'm exhausted" (dramatically, leaning forward), you know, "I've been working hard at this all day..."

B: (nodding slowly)

C: which usually I don't have to work at, and now I can't do it any longer. And then you start getting a little confused about where things are... in space

B: about where things are located, yeah, from one day to another day

C: Right

B: [And

C: [And couple that with having a little bit of disorientation from your vestibular problem/ the dizziness

B: [That'd give me a problem

C: [yeah, yeah, yeah (softly). Um, even when you think about something as simple as categorizing your pills...

B: [Hm hmm

C: You set aside sets (gesturing with hand as before) and you know you need fifteen sets, and you probably, before, felt like you could just glance and know what that was

B: [Hm hmmm

C: [you know, (???) and that's difficult when you've got a headache to do

B: [EXTREMELY (nodding slowly) difficult...

C: (nodding)

B: because you don't want to make that one mistake.

C: (nodding) You're in a job where you can't make that one mistake aren't ya?

(B/C, 5/5/94, p. 2-3).

As illustrated by this transcript segment and the earlier clinic report, the physical therapist has transformed the terminology of the

more formal neuropsychologist's report into dialogue with Bill about his visual-spatial perceptual problems and the influence of these problems on his headaches and work. Although the words are somewhat different, the grammatical structure and syntax is different as dictated by the communication situations, and the audiences to whom the words are directed are different, the *meaning* of "visual-spatial processing deficit" and it's perceived impact on his work is retained and is congruent across both representations. This segment also illustrates the crossroads between *becoming* and *being* a member of a transdisciplinary team--an intersection traversed frequently by professionals in this clinic.

Apprenticeships of Participation: Co-participation in the Activities of Therapy. Finally, therapists had opportunities to observe and work with other team members during (a) "screening" evaluations and reassessments of clients during "head injury clinics," and (b) joint therapy or "co-treatment" sessions with patients. According to therapists, evaluation activities amounted to joint problem identification and solving by clinicians with clients. Joint therapy sessions involved efforts to collaboratively develop solutions to problems a particular patient and/or therapist was encountering. In the latter case, for example, an occupational therapist and a physical therapist might work together with a client to address the client's difficulties with a self-care task. In such a case, the physical therapist would focus on the physical demands of the task for the client (e.g., what kind of strength, movement, coordination, or balance they needed to accomplish the task) while the occupational

therapist might focus on the environmental demands of the task and make recommendations regarding modification of the environment or the use of assistive devices that would make accomplishment of the task less difficult and more accessible to the client. In this scenario, both therapists would work together to bring their professional knowledge and expertise to bear on the patient's problem. In doing so, the likelihood of solving the client's problem and reaching a "global" therapeutic goal is increased. In addition, through this process of joint activity, dialogue, and problem solving, therapists' thought processes and tacit knowledge can become apparent and accessible to each other.

During the course of the study I did not attend any of the head injury clinics in which therapists worked together conducting screening evaluations or participating in follow-up assessments with clients who had been seen at Jones and Thompson. Unfortunately, these clinics were conducted at a clinical site (a large rehabilitation center) other than the one to which I had obtained access and consent to conduct my study. Even so, several therapists described the nature of interaction and collaboration among therapists, clients, their families, and physicians during head injury clinics.

Therapists from Jones and Thompson have a long history of involvement with the head injury clinic at the rehabilitation center since they were among the first providers of outpatient services for these types of clients in this geographic area. The clinic is coordinated by the rehabilitation center and by physicians who see many of the head injury patients in the area. It is held weekly and

"the whole team attends" or "anybody that is working with the client" (C, 8/16/94, p. 10). According to Caitlin,

> ...the philosophy was [that] if the patient was being seen [in the clinic] and if the physician referred the patient to our offices, then we're going to be there on site--discussing, reporting, recommending.... It's a time for team staffing with the doctor and with the patient and their family. (C, 8/16/94, p. 10)

Attendance at the head injury clinic, therefore, was a regular activity for those therapists who worked largely with this population of clients at Jones and Thompson, P. C., including Caitlin. It was also a highly valued activity in terms of making team decisions about initiating, reinstating, increasing or decreasing services for clients seen in the clinic:

> Those are really important meetings for the patient and family and us...to hear about progress as well as to tackle anything that's coming up from the patient's view--like jobs, driving, liquor--that's a forum for discussing those issues. It's important especially with clients who are having some problems with rehab. (C, 8/16/94, p. 11)

In the activities described as apprenticeships of participation thus far, teaching and learning about another team member's disciplinary expertise is an integral dimension of everyday practice. Thus, commitment to becoming a transdisciplinary team provides for a particular kind of *social engagement* between practitioners oriented around particular problems with clearly developed goals for the activity. Such engagement offers numerous opportunities for

"guided participation" (Rogoff, 1990) in the situated clinical reasoning and practice of therapists from different health professions and creates fertile ground for reciprocal teaching and learning. So too, does *being* a transdisciplinary team.

On Being a Transdisciplinary Team

Although obviously interwoven with the processes of becoming a transdisciplinary team, there appeared to be two main activities that could be considered essential for the enactment of a transdisciplinary approach to care on a day-to-day basis: (a) the process of negotiation about role boundaries and who should provide direct versus indirect services for clients, and (b) increasing participation of therapists in the roles of other professionals via the provision of indirect services for a particular client when direct services were deemed to be unnecessary or unacceptable for a client.

Negotiating Role Boundaries. At the outset, I want to explicitly recognize some of the hazards of using the boundary metaphor to discuss the phenomenon of the transdisciplinary team and the areas of disciplinary expertise of team members. I use the metaphor because I find it useful and team members used it in their discussions. A hazard, however, is that boundaries can be thought of as rigid separating structures (as in walls) or unchanging and inviolable dividing lines between countries or groups of people or objects. I hope the discussion thus far has made it clear that by using the boundary metaphor I do not mean to suggest, nor do the clinicians in the clinic believe, that disciplinary boundaries are rigid, static, or fixed. Most things that are rigid and fixed are not the stuff

of negotiation. Instead, disciplinary boundaries in this sense are dynamic and shifting--like the team itself--similar to the boundary between land masses created by a river. As clinicians learn and develop, as different clients progress or regress, as external and internal situations or demands fluctuate, so, too, can these boundaries change--especially along the edges. Nonetheless, they don't cease to exist.

Therapists had to engage in constant negotiation about what they perceived to be semi-permeable disciplinary boundaries as they attempted to distribute responsibility for the accomplishment of therapeutic goals. This negotiation usually involved what sociologists have described as role expansion, exchange, release, and support (Garland, McGonigel, Frank, & Buck, 1989) and, according to therapists, often occurred in the context of the formal team meetings described earlier. This is not to suggest, however, that identification and negotiation of disciplinary boundaries didn't occur through informal interactions. Client progress was constantly being dynamically assessed as therapy sessions proceeded; as client needs changed and different issues arose, decisions had to be made about the discontinuance of one kind of direct service and the transfer of responsibility for continuing work in that realm by another therapist. Thus, the shifting needs of clients, especially characteristic of patients with brain and head injury, demanded that negotiation of role boundaries occur frequently and informally as well as in weekly team meetings.

Legitimating Participation. Drawing on the work of Lave and Wenger (1991), concerning what they call "legitimate peripheral participation, it is noteworthy that the identification of and negotiation about disciplinary boundaries among these therapists is an educative but risky endeavor. Discussion and negotiation about boundaries is what *legitimates* the participation of one professional in activity traditionally associated with another profession. At the same time, this negotiation establishes the limits of legitimate participation; that is, it defines what would be *illegitimate* (or undesirable or unethical) participation in the role and responsibilities of another therapist. This negotiation, which occurs through discourse and activity, is negotiation about the *division of participation* between therapists and the degree of *access* a learner (therapist) will have to participate in the role of an expert from a profession other than his or her own.

Negotiation is necessary because there are very real limits to the extent and degree of participation a therapist providing indirect services can have in another's professional practice. That is, there are legal, ethical, epistemological, practical and personal limits on the amount and forms of participation that are appropriate. Thus, therapists in this practice community never become *full* participants in the practice of another professional--they only become *fuller* participants. And the evolution from legitimate peripheral to fuller participation is one that has involved an extended period of working together and numerous opportunities for learning among these professionals in the context of clinical practice.

Therapists at Jones and Thompson had to *learn* to negotiate boundaries and how to be a transdisciplinary team. The willingness and desire to do this, of course, is tightly bound up with the communal commitment to client centering among clinic associates. Caitlin talked about her transition to being a member of a transdisciplinary team in this way:

> I guess that one thing you have to learn when you go from a multidisciplinary to a transdisciplinary approach--is not to have so many boundaries around what you do--that other people can do a little of what you do and, in the end, the patient can benefit from that. (C, 8/16/94, p. 9)

Here is the learning about *letting go* or role release and exchange (Garland et al., 1989) that is risky insofar as it touches on the uniqueness of a professional identity assumed by a practitioner and often cultivated by professional education programs. As numerous authors have pointed out (Eraut, 1994; Goode, 1969; Kennedy,1987; Merton, 1960; Parsons, 1968; Pellegrino, 1983) one of the recurrent claims of professions is that they have a unique and distinct body of knowledge and practice. At one extreme of this boundary negotiation continuum would be the inflexible and exclusionary stance all too familiar in turf battles between members of health professions or other interrelated professional groups. At the other extreme is the abandonment of claims to special areas of expertise and contribution to health care and the loss of a distinct professional identity. Neither of these extreme positions recognizes that there are negotiable areas of overlap as well as uniqueness of professional knowledge and practice among health care practitioners--that

clinicians can be, and increasingly need to be, interdependent versus totally independent if the complex needs of patients (with chronic disability in particular) are to be optimally addressed. So, this is learning that just traversing disciplinary boundaries does not necessarily weaken or lessen a professional's knowledge or skill or sense of identity; it simply provides for greater opportunity to learn about, support and extend the work of other members of the team in the service of client goals that are inherently transdisciplinary. The negotiation is *not* about losing one's own identity--it's about *crafting another identity* (Lave, 1995; Lave & Wenger, 1991); an identity larger than any individual--the collective identity of the transdisciplinary team. The identity of the transdisciplinary team does not subsume individual professional identities; rather it is cognizant of and complementary to those identities and is taken on as part of one's professional identity in this particular community of clinicians (see Figure 19). That is, therapists can say "I am an occupational therapist *and* a transdisciplinary team member" in one breath.

One feature, then, of being a transdisciplinary team is investment in this collective identity and in each other's work with clients. Recall Kay's earlier description of the transdisciplinary team: "We talk about our team being transdisciplinary...because we just do everybody else's work to some extent" (K, 2/3/ 94, p. 7). A corollary to this investment is that there is less need to haggle over who does what in specified areas of client evaluation and treatment. For example, the neuropsychologist and both speech and language

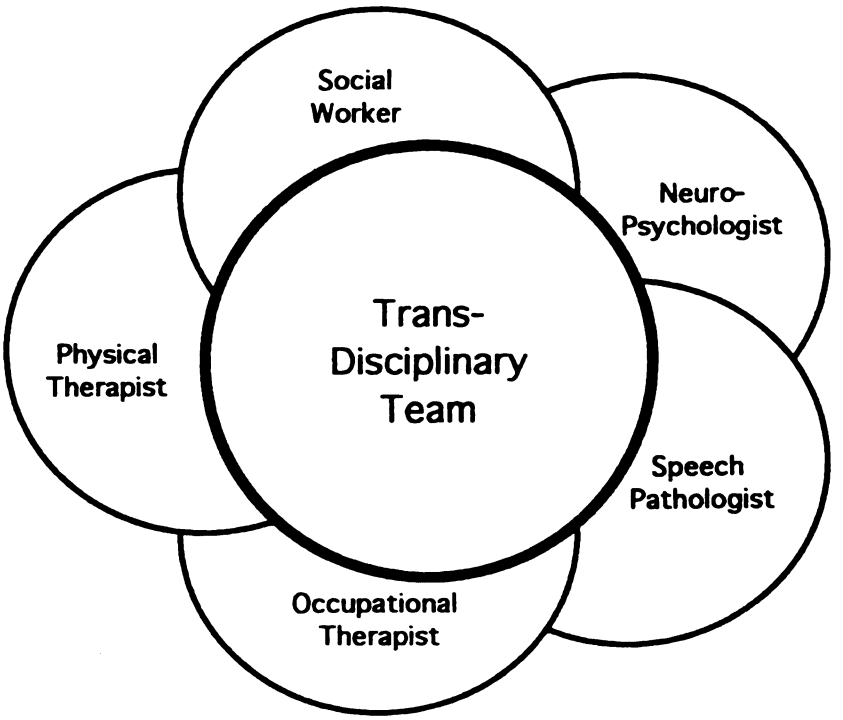

Figure 19. Conceptual representation of individual and collective identities of the transdisciplinary team. There are unique professional identities and areas of disciplinary knowledge, areas of recognized overlap of disciplinary knowledge and skill, and a collective identity as a transdisciplinary team.

pathologists have substantial training and expertise in assessment of cognitive function. Together these individuals developed a protocol for screening of cognitive function in patients with head injury which can be completed by any one of them if needed. As Susan put it,

> Dr. Jones typically does the cognitive testing but I have too. Dr. Jones and Barb and I were the ones who developed what testing should be completed for the cognitive portion of the screen. Don does most of it but I've done some of it. So, you know,...it just depends on who is free. (S, 7/28/94, p. 9)

Any one of these individuals, all of whom were instrumental in the development of the "cognitive portion" of the head injury screening evaluation, could complete that part of the screen as the situation demanded. This does not mean, however, that a physical therapist might be asked complete this portion of the examination. The knowledge and skill required for administration and interpretation of such cognitive function tests is deemed to be outside of the area of expertise and practice of the physical therapist although physical therapists in this clinic are most certainly able to understand the results of tests and use those findings to inform and guide the development of physical therapy treatment programs for clients.

Determinations about what therapists can and can't do in the context of working with various clients--or the degree to which they can traverse disciplinary boundaries--are made through dialogue among members of the team as well as through the flow of discourse and activity in client-therapist treatment sessions. In the triadic therapy session described in Chapters Three and Four, Caitlin

recognized when she was moving into an area of counseling practice (marital conflict resolution) that she didn't think she could handle. When observing the videotape of that particular session, Caitlin remarked about how, in a particularly volatile exercise segment after she had let John and Diane "fence it out a little bit", she became uncomfortable and decided that their "fencing act" was becoming counterproductive (C, 4/2/93, p. 10). At that point, when she observed John deliver a positive face-threatening utterance to Diane, Caitlin said "I knew I just had to change the subject there--back to instruction" (C, 4/2/93, p. 10), which she did. Such recognition of one's limits--professional, personal, educational--is critical for the successful and ethical enactment of a transdisciplinary approach to care. As Caitlin reminded me, "...it's also important to, kind of, respect your own boundaries as to what you can handle and can't handle" (C, 8/16/94, p. 10).

Identifying and respecting one's own and other's professional boundaries is essential to the process of negotiation about disciplinary boundaries; if such limits or boundaries didn't exist, there would be no need for negotiation. One interesting discussion that shed light on the dynamics of negotiation around being a transdisciplinary team occurred during a meeting I had with the clinic associates after my initial round of data collection in 1992. I met with the staff during a lunch meeting one cool December day to talk with them a bit about my study to that point and to ask some follow-up questions regarding some findings and emerging assertions. This session, in effect, was one of my opportunities to do

what Lincoln and Guba (1986) call "member checks" as one way of enhancing the "trustworthiness" of my data and interpretations. In the course of the meeting I asked therapists to talk more about the notion of the transdisciplinary team, the problems and possibilities associated with the intermingling of disciplinary roles suggested by this notion, and how they determine or negotiate disciplinary boundaries in the context of trying to be such a team. This request engendered a playful response from several of the associates:

Emily: (Looking at Kay, smiling) It's getting real hard to keep her out of P.T. because she's getting real good at it (laughter from Emily, Kay, Caitlin and others)

Kay: But when I step over the li-i-ine/ I know it (smiling, looking at Emily)

Eliz: Well, that's one of the issues I want to raise/ you know/ how do you draw those lines?/ In, in a transdisciplinary team?/I think it might be an issue/ based on what you're just saying now

Kay: [She asks me to stop handing out lumbar cushions! (chuckling, looking at Emily)

All: (Lots of laughter around the table)

Kay: That I don't know what I'm doing and not to do that anymore! (laughing)

All: (Loud laughter)

Caitlin: We say but/ KAY/ we're not a social worker/(laughter) you can handle all this stuff

All: (laughing)

Barb: But/ I think the other thing is/ that we know each other well enough/ tha-at (clears throat) were not so turf-minded to begin with

Nina: (Nodding along with others) Hm Hmm, Yeah

Interestingly, this conversation focused on the difficult and potentially contentious business of setting the outside limits of what therapists could do without "stepping over the line" or violating boundaries of their own or other's personal comfort or disciplinary knowledge and practice. Yet the humor, mirth, smiles, and knowing glances associated with the telling of the story suggested that therapists worked to manage such issues in ways that could direct energy away from potential internecine conflict to cooperation even as therapists recognize and discuss personal or professional limits on what they can or are willing to do; they all "know each other well enough" to be able to discuss limits in ways that don't engender conflict or hurt. In fact, at no time during the course of the study did I observe or hear therapists "haggling" or arguing over who could or would do what with clients.

With regard to shifting disciplinary boundaries, Caitlin shed light on two additional factors that figured in negotiations about who could and would do what with clients. The first of these was the extent of therapist familiarity with and learning about others' work as they were becoming part of the team; and the second factor was the existence or degree of a therapeutic alliance between certain

therapists and clients. In an interview Caitlin talked about how, in her early work with the team, she felt fairly uncomfortable about sharing some of the traditional counseling functions she had previously associated with social work and which she had, in the past, left to social workers. This transition was more difficult for her than, for instance, coming to know about and intermingling of occupational therapist/physical therapist roles, because her previous experience in rehabilitation centers had not provided many opportunities for direct observation of social work (it usually occurs behind closed doors) nor had she had a chance to discuss, in detail, client issues with social workers.

> Certainly, in terms of the counseling end of it, at first, I was real uncomfortable with that.... Kay said bring any comments to me about what [issues] come up in therapy, um, that may need to be discussed [by Kay and that client]. Understand that she [the client] might be much more comfortable discussing that [issue] with you than me because you're in there providing hands-on care and she's found a comfort range with you...And so, in that way, she's [Kay] saying 'it's okay, you can do a little bit of social work, together let's understand what's motivating this person, and why they might be more comfortable talking to one person as compared to the other.' (C, 8/16/94, p. 10)

Caitlin says that assuming what she considered to be counseling functions was "uncomfortable" for her "at first" although today she considers it a natural and regular part of her therapy sessions. Many of the clients with brain and head injury with whom she works are seen by multiple therapists, including social workers. As members of a transdisciplinary team, therapists and clients are encouraged to

share information and insights with each other so that everyone has the benefit of the other's perspective as they work to construct a client-centered approach to care that requires a holistic view of client function and needs. Caitlin became more comfortable with her role and responsibilities as a transdisciplinary team member as she became increasingly engaged, over time, in activity and dialogue with other professionals in this clinic. Her prolonged engagement afforded numerous opportunities to learn more about the work of other professionals and how she could support, extend, or indirectly provide some of those services.

The quotation above also portends the role of therapeutic alliances in determinations about (a) the kinds of information exchanged between client and therapists and therapist-therapist, (b) who provides what services for clients, and (c) the extent and nature of direct and indirect services being provided. Therapeutic alliances were discussed extensively in Chapter Three and it should come as no surprise that they have something to do with how a transdisciplinary approach to care is constructed for each client. In the quotation above, Caitlin uses the linguistic form of reported speech to describe how Kay gave permission--even encouraged--Caitlin to take on some counseling functions. Caitlin suggests that Kay told her that patients might be more "comfortable" discussing an issue with Caitlin than Kay at first because of the "hands-on" nature of care in physical therapy and the patient's finding a "comfort range" with Caitlin.

This "comfort" description is reminiscent of other descriptions of therapeutic alliances and recognizes some of the special affordances of physical therapy with respect to the development of such alliances. Not the least of these are opportunities for the use of touch and movement as a resource for the development of therapeutic relationships between therapist and client and the increased frequency with which clients usually see physical therapists as compared to counselors or social workers. That is, many clients being followed for physical therapy will come to the clinic, at least initially, more than once per week while clients being seen by social workers are most commonly seen once per week or less frequently depending on their needs. An additional point that cannot be overlooked is the societal stigmatization associated with receiving counseling (or mental health or psychological services) (Ferrara, 1994) versus receiving physical therapy services. This stigma could influence a client's interest in or willingness to receive social work services. The latter was one reason, among others, that John elected not to participate in counseling throughout his course of therapy at Jones and Thompson. All of these factors--hands-on care, frequency of interaction between client and therapist, reticence of the client to be involved in counseling, and the development of a therapeutic alliance--were undoubtedly parts of how Caitlin became an indirect provider of counseling services for John in addition to being a direct provider of physical therapy services.

Recall how Caitlin valued the trusting relationship she was able to develop with John as his therapy progressed in the early phases of rehabilitation.

> During that second month...he started to gradually go downhill.... I'm so glad that I had that first month [of success] with him because I think that he trusted me and trusted my judgment. (C, 3/30/92, p. 2)

Caitlin was very aware of John's frustrations during this downhill period and was able to talk with him about them. This was not the case with other care providers or his wife.

In light of John's unwillingness to discuss his deficits or problems with others, including his wife and his physicians, it was interesting that John was willing to talk about these things with Caitlin. In a relatively short period of time, Caitlin became his health professional consultant and listener--a phenomenon that was recognized by Caitlin, Kay, John and Diane. One day, as I was sitting in the waiting room of the clinic next to Diane, she talked to me about a recent visit to the doctor with John during which he just kept telling his doctor that he was "just fine." Diane expressed frustration over this representation since she had been observing and struggling with John's functional decline over the past few months and wanted to talk seriously with his physician about her concerns. When I shared this piece of conversation with Caitlin, she wasn't surprised and responded, "...see, he'd never say that to me. Instead he'd go into this long list of, you know, well this and this and this...[is wrong]" (3/30/92, p. 5). Of course, Caitlin had spent a lot of time in therapy working to help John

feel comfortable enough to share his concerns with her so that they could both be aware of and work to overcome his problems.

In addition, Caitlin understood the importance of her role as a listener, counselor, and advisor for John in the absence of his use of other potential support systems or individuals at this difficult time.

> He will discuss more with me about the 'what ifs'--what if the CAT scan shows that it's growing, or 'what am I gonna do, you know, if I start losing function in my leg like I did in my arm', and about some of the anger and sense of loss. And I often encouraged him to set up an appointment with Kay, but he's never, never had any kind of counseling with Kay because he's not accepting of that. And his wife says to Kay that he doesn't discuss any of the feelings with her that he does with me; so, in that sense, it's therapeutic even for him to be coming in [to physical therapy] because he can start facing the issues. (C, 3/30/92, p. 4)

This quote resonates with the concept of the transdisciplinary team described by Kay earlier:

> ...providing support for the grieving that goes with that [loss]--that's not just something that happens in my office--that's something that happens throughout the team. (K, 2/3/92, p. 8)

In this case, the recognition of loss and grieving that John needs to go through is occurring, at least to some extent, in conversation with Caitlin since he denies access to his concerns and feelings to others. There has been discussion among team members (in this case, Diane, Kay, Don and Caitlin) about John and Diane's situation and needs.

Collectively the team has recognized a problem and assumed shared responsibility for dealing with it in a way that is most comfortable and acceptable to John.

The enactment of a transdisciplinary approach to care, the requisite sharing of information among members, and the comfort that both John and Diane felt with their therapists (team members) was reflected in their own testimonies offered during an interview. First, Diane:

> As far as my interactions with all of the therapists--they've been real supportive of me. They realize the bind I'm in as far as not being able to be the prophet in my own land. And my voicing my complaints and concerns to them-- they eventually take them to John--but in different forms. And the point is addressed but it's not coming from me and I don't get the backlash. (D, 4/1/92, p. 2)

Diane recognizes the advocacy that therapists provided for her as part of the team and describes how her concerns were expressed "in different forms" to John as he completed his therapy. This approach to a difficult situation also recognizes John's wishes. The team doesn't insist that John see Kay or another therapist for counseling but they try to insure that important issues are addressed as he interacts with other members of the team.

As John talked about his therapy with Caitlin he also mentioned how comfortable he felt discussing things with her:

> The therapy has been...[providing a list] a) enlightening, b) very impressive [pausing to search for words]...gee, I had a... c, d, and e, and I can't think of them now. It's been

> enlightening, it's been inspiring, it's been--I'll come up with it in a minute... She [Caitlin] has been great, she has been just great. I hate her Alma Mater but I think she's good. We have,we have--we actually have fun together in our patient-therapist relationship.... I can talk to her about therapy and *anything else* . [italics added] (J, 4/1/92, p. 5,7)

When I asked John and Diane specifically about whether or not they felt like they were at the "center" of the rehabilitation team during their affiliation with the therapists in this clinic they both responded positively. John said that he felt they did a "fantastic job" of considering his needs and trying to help them: "It's always been their attitude that they're here to help me" (J, 4/1/92. p. 5).

In spite of their overwhelmingly positive impressions of their care at the clinic overall, favorable evaluations of their therapists, and their appreciation of a transdisciplinary approach to care, there was one situation in which John did not feel that his needs or abilities had been fully or fairly considered. This case deserves special attention because it is a vivid example of the tension that exists between making the needs and goals of the client central and respecting professional judgments that may not always be aligned with the patients hopes or expectations. In addition, it points out some of the difficulties associated with negotiating disciplinary boundaries and determining who will provide what services for clients.

As mentioned earlier, in response to John's interests and needs for social activity, Kay had developed a volunteer position for John working at "God's Kitchen" a few times a week. After some time

in this position, John, with the encouragement of some of his friends at the kitchen, had asked the supervisor if he could prepare a special menu and a Chinese meal for approximately 100 people. At the request of the supervisor, the clinic team had been asked to assess John's ability to perform this task before he responded to John's request. Diane, too, had urged an evaluation of this request. Kay asked Nina, the occupational therapist who knew John and had worked with him sporadically, to complete a worksite evaluation (a common procedure for her and occupational therapists in general) and report back to the team that would then make a recommendation to the supervisor. The end result was a negative recommendation to the supervisor because of safety and liability concerns.

Caitlin, who first told me of this decision, said that it had made John very angry because he felt that his right to confidentiality had been breached and because Nina (and Kay and the rest of the team) had not acted as his advocate in this particular situation. As Caitlin put it,

> His safety in the kitchen, um, has been brought up several times by his supervisor and by those who observed him. And so, Nina thought that [his preparing a large meal] really wasn't safe. Nina made the decision but the team reinforced it.... He viewed that as someone trying to put controls on him...and the whole thing just came out real negative in his viewpoint. (C, 3/30/92, p. 7)

When I asked John and Diane about this incident, an interesting dialogue followed which I am going to share in it's

entirety. This dialogue demonstrates the tensions mentioned above, it illuminates how the transdisciplinary team interacted around this issue, and finally, it permits John's own words to explain why the team was unable to recommend that he be allowed to take on this very challenging, though inviting, task.

Diane: (Looking at John) This goes outside of PT, but how about Nina in OT--what are your feelings with her? Miss Buttinski as he calls her.

John: Naa, I don't have the most positive things to say about Nina. She got her nose into something she didn't know anything about.

At this point Diane turned and directed the conversation to me and explained that John was a very good cook but that sometimes all of the "information coming into John's mind is not very accurate" and he can "overestimate" what he can do (D/J, 4/1/92, p. 4). This is what the neuropsychologist and Caitlin had referred to as John's difficulty in making accurate and safe judgments about what he could or could not do. According to Caitlin, "...he just doesn't see his deficits right now. And I don't know how much of it is organic and how much of it is that he's just not at the point, psychologically, of ccepting the disability" (C, 3/30/92, p.8).

Then John and Diane picked up their discussion about na's assessment of God's Kitchen:

Diane: So Nina's job was to go in and, kind of, look at the things he *couldn't* do. And he had a lot of resentment toward that.

John: Well, she had no idea what I could or couldn't do, so she had no judgmental ability.

Diane: She was looking at what was safe for you to do.

John: I know that. Everyday I work where I do dangerous things; I walk across wet, slippery floors, I operate

Diane: [But that's not always the best judgment, John.

John: Sometimes you just have to do what you have to do. You can't always stop and say, ooooh, there's a wet floor, now I ought to go out of the building and walk all the way around to the back door to avoid that wet spot. Instead you just walk through that wet spot cautiously. Sometimes you have to grab the knife by the blade backwards. Sometimes you have to chop something faster. Sometimes you have to grab something that's hot and burn your hand just a little bit. Most cooks have kitchen fingers (indignantly).

Eliz: But you like your work there?

John: I like my work there. They could utilize my capacities a little further and that's why I'm butting heads with them right now.

Diane: (Looking directly at John) Well it was kind of a group decision with Nina, Kay, and myself--and the fact that God's Kitchen has their own staff for those kinds of things. You're there as a volunteer to help in other ways.

John: They do. And God's Kitchen staff has said--'Yes, we'd like to have you do that.'

Diane: But the head of God's Kitchen didn't.

John: (Mumbling) This is not the place to talk about it.

Diane: (Turning to me) He really struggles whenever Nina is brought into any situation because...

John: I was convinced that Nina created a problem that didn't exist. She doesn't really know what I can do in the kitchen any more than you know (looking at me) what I can do in the kitchen.

Diane: I'm going to change the subject. (D/J, 4/1/92, p. 5)

At this point Diane turned to me and mentioned that John sometimes struggled with the fact that the individuals working with him share information among themselves about John as part of the transdisciplinary approach to care. She felt that it was her responsibility to remind John that "...this is a team approach and that team members are going to hear about things if it affects a decision that they've been asked to make" (D, 4/1/92, p. 6).

Several of the reasons for this discrepant case and the tensions around this episode become apparent in John and Diane's discussion. First of all, John had become accustomed to the clinic team serving as his supporter and advocate and yet, in this case, they were unable to acquiesce to his desires. Instead, the team, acting on Nina's information and recommendation, used their collective professional judgment and power to prevent John from

participating in an activity. The team's decision stood in opposition to John's goals and desires; such a decision is antithetical to client centering and was a problematic but non-controversial decision for the team given this situation. The team believed John's own safety was at risk.

John is a 36 year old man, facing an almost inevitable death within a relatively short time, denied his independence, his "usefulness," his ability to contribute as fully as he would like in this endeavor, and denied his choice and desires in this matter. This episode reflects a time when the team was unable to align the hopes, expectations, goals, and desires of the client with the client's potential for performance and the professional judgments of the therapists. Often this alignment requires give and take from all involved. In this situation the therapists' *did take seriously* the view and wishes of the client; they understood that John really wanted to prepare this meal and Nina went into the workplace to assess John's ability to do so without potentially negative consequences. The team *could have* suggested the activity was unrealistic from the outset based on information about John's performance in other settings and his cognitive difficulties with problem solving; they did not. But this is a situation in which the clinic team ultimately was unable to recommend that John be permitted to prepare the meal. They invoked their expertise, status, and power for what *they* perceived to be the best interests of the client in the long run.

This particular story illustrates several important points about client-centering. First, client centering is *not* an "anything goes" approach to serving the needs of patients and their families. Client centering, when understood as working to see things from the patient's perspective and taking serious account of the view and wishes of the client, does not mean that everything and anything a client wants or needs will be the only guide to decision making about care. The client is not *always* in the best position to make decisions for themselves about certain matters. In fact, this can often be the case with clients with particular forms of organic brain damage that affect perceptual and judgement processes. As Purtilo (1988) points out, the dilemma of aiming to respect the patient's wishes and then having to overrule them in some instances forces members of rehabilitation teams to struggle with what it means to be beneficent and how to construct beneficence in day-to-day practice.

> Beneficence long has been held to include acts which contribute positively to the welfare of others, as well as acts intended to prevent or remove harm.... Writers [in medical ethics] sometimes suggest that beneficence is realized largely by honoring patient preferences; being beneficent actually places the rehabilitation team members squarely back into the lap of being guided by the candidate's [patient's] wishes, hopes, and desires. But even the most competent person can make poor choices under conditions of disequilibrium and high uncertainty, such as those characteristic of rehabilitation candidate's situations. Philosophers have long argued that fundamental respect for persons may--in carefully prescribed situations--require that the agent *not* be guided *entirely* by an individual's desires or wants. The rehabilitation team's judgement of what is optimum for the candidate indicates that team members act as if they hold such a belief. [italics added] (p. 320)

Purtilo (1988) goes on to point out that when rehabilitation teams do not concur with or honor the patient's wishes, they act paternalistically. Such action "poses a moral challenge" (p. 320) for members of rehabilitation teams, especially those like the team at Jones and Thompson with their abiding commitment to client centering.

> Having decided that it is beneficial to alter the outcomes articulated by the patient, team members act paternalistically.... Paternalistic behavior is justified by the conviction that an individual's wishes may be overruled in the name of more fully benefitting or preventing harm to the person. This differs from coercion, which is the practice of overruling an individual's wishes without the intent to more fully benefit or prevent harm to the person. In the context of the rehabilitation team, paternalistic behavior poses a moral challenge by it's presumption that the team's judgement should (in some cases) take precedence over the candidate's. Coercion is never justified. (p. 320)

This moral challenge is not taken lightly at Jones and Thompson. The story of John and God's Kitchen is an illustration of the struggle to balance the principle of patient autonomy (so central to the concept of client centering) and the moral standard of beneficience when it is defined broadly to include acts intended to prevent or remove harm for the client. Team members would have liked to honor John's wishes but found they were unable to do so. They understood John's anger and frustration about their judgement but still felt justified in making the recommendation that they did. In doing so, they

recognize that respect for clients can be expressed in more than one way. As Purtilo (1988) states,

> An expression of respect for persons by the rehabilitation team involves both respect for their welfare as reflected in their choices and, in rare instances, their welfare *instead* of their choices. [italics added] (p. 321)

In addition, it is important to keep in mind that most clients, after all, do come to this clinic (and health professionals in general) seeking and expecting advice and guidance regarding matters of concern. This story about the denial of (but not disregard for) John's wishes illustrates how client centering as expressed in it's idealized form cannot always be realized. Nonetheless, it is still important to have ideals toward which members of this clinical community could, and did, strive.

The story of God's Kitchen is also a story about some of the difficulties that inhere in efforts to be a transdisciplinary team and making judgments about professional boundaries. In this particular case, Caitlin, John's primary caregiver and confidant--the team member with whom John developed a therapeutic alliance--appears to have little voice in this decision although she expressed support for the decision to other team members, John, and me. Instead, Nina was asked to conduct the worksite evaluation--a task that is most commonly within the purview of occupational therapy. As the evaluator, Nina carried primary responsibility for this decision in John's view. But John perceives Nina be an intruder (or at least an interloper) in his rehabilitative care. Unlike Caitlin, Nina, though

known to John, has not had many opportunities to work with John or to establish a long-term relationship or therapeutic alliance with John. Finally, at least according to the dialogue between John and Diane, Nina's focus ended up being primarily on what John *couldn't* do rather than on what he *could* do safely within the God's Kitchen setting, which only added insult to injury.

It is impossible to say whether the outcome in terms of John's perceptions about this team decision would have been different had Caitlin been asked to conduct the worksite evaluation instead of Nina. Worksite evaluation *is* one area, however, where the work of physical therapists and occupational therapists sometimes overlap. No matter what, it is highly unlikely that the final team decision would have been different. John's own word's in the dialogue above (in combination with the team's awareness of John's cognitive, perceptual, and physical problems) demonstrate the precise reason for the limitations placed on him in this work setting. John had a history of falls, some of which resulted in impairment and further disability. He was experiencing functional decline in his ambulation and in the use of his arm and hand. He appears to have either an organic and/or psychological inability to recognize and accept some of his limitations and to make wise judgments about some of his activities—his "can do's" and "can't do's." His own safety and the safety and liability of others hung in the balance.

Increasing participation: From peripheral to fuller participation. I have suggested that there were two main activities that seemed to be an integral part of *being* a transdisciplinary team on a day-to-

day basis: (a) negotiating disciplinary boundaries or legitimating participation and (b) increasing participation in the work of other therapists via the provision of indirect services. The *movement from peripheral to fuller participation* in the practice of other professionals is exemplified in the provision of indirect services for clients. There are several examples of discussion about, and the provision of, indirect services by the therapists in my data. In the case of the three clients with brain injury followed in this study, the physical therapist was the individual who provided most of the direct *and* indirect services (see Figure 18, p. 402).

Being an indirect provider: The case of Bill. For Bill, Caitlin provided direct physical therapy services in the form of a vestibular rehabilitation program, and indirect services related to neuropsychology and social work. In the latter realm, Caitlin worked with Bill to identify and negotiate for some alterations in work demands and tasks that would enable him to return to his job as a pharmacist. Such job evaluation and placement activities are sometimes considered the domain of social workers and/or occupational therapists. But the members of Bill's team had determined that his greatest needs could be addressed in physical therapy and, by his own admission, Bill was most interested in receiving physical therapy services to assist his return to work, not other interventions.

Some illustrative examples of Caitlin working with Bill on needs that might otherwise have been managed in social work come from Bill's first and third therapy sessions with Caitlin. Realizing that

some of Bill's primary concerns relate to the difficulties he is encountering as he tries to return to his previous level of work in the pharmacy, Caitlin explores the specific nature of Bill's problems, the requirements of the job, and the expectations that Bill has for his own performance at work. Bill explains that the biggest problems he is having are with (a) the development of headaches and fatigue as his hours at work accumulate, (b) difficulty concentrating and handling multiple demands at one time, and (c) an inability to be as efficient as he once was because he needs to recheck all his work. The latter problem is a key concern because of Bill's commitment to serving his customers with a minimum of delay as they wait for prescriptions. Bill's high expectations for his performance at work are made clear early in his conversation with Caitlin:

B: I get upset with myself/ that's probably one of my problems/ I cannot see doing something half way

C: You want to do it right

B: (Nodding) I want to do it right

C: (Smiling, Nodding) I can relate to that...

These high expectations make the problems Bill is encountering at work extremely frustrating. In the first therapy session Bill describes some of his frustrations to Caitlin:

B: Yeah, I'm backing up now. Now I've got other people waiting. I'm supposed to have those people out of there already and they're not, and now I've got three more people coming in. So load doesn't, doesn't get ⌜easier

C: ⌊No-o, and you have time demands placed on you by the number of clients, ~right?~

(Nodding) ⌊And I start counting 'em and say, come back in ten minutes, come back in eight minutes, /???/

C: I had one filled yesterday and they said come back in twenty minutes (smiling)

B: I've done that too, but it, but I've done that so seldom before that it bothers⌜ me

C: ⌊Right (nodding)

B: /???/

C: So you're used to being very efficient⌜// with your orders

B: ⌊Um, ⌊Yes, I like being ordered (gesturing with his hand as if slicing a cake)

(B/C, 5/5/94, p.2)

In response to Bill's descriptions of his problems, Caitlin offers an explanation of why Bill is having some of these problems and relates them to the area of the brain affected by his injury. She goes on to suggest that there is "good news" however; that recovery of function is a possibility with carefully chosen activities to stimulate or "challenge" that area of the brain without "overloading" it. And

not overloading may involve some alterations in his regular patterns of activity at work.

C: Well, the good news is that there is capability for some recovery and plasticity there but we have to choose the right activities to challenge that area of the brain

B: Okay

C: You are challenging it at work everyday, but what we feel is that you probably are overloading it, and that overload is contributing to your headaches

B: [Hmmmm

C: And then when you have a headache and you don't stop working// you just work

B:]No I can't (shaking head)

C: twice as haaard [to get the orders

B: [Twice as hard to] make up for it

C: So, when we look at headache management, I think we're gonna be looking at trying to teach, um, some simple relaxation techniques that you can do throughout your day to get a check on, on your body, and how it's responding to the level of demands

B: (Nodding) [Okay, I'll go along with that

C: To take a few, as Dr. Jones likes to call them, brain breaks, you know, just five minutes periodically through your workday of not having to/ I don't know if they have that scheduled or if you can request it/ but of being able to stop some of the visual

and spatial processing demands/ just enough so you can recharge your batteries

B: (Nodding) Well, if they want to keep me, they'd better

(B/C, 5/5/94, p.3)

In this transcript segment, Caitlin is introducing information and treatment strategies that could also be addressed by the neuropsychologist and social worker. She discusses, once again, some of the neurobiological reasons for Bill's problems and suggests "brain breaks," a treatment approach advocated by the neuropsychologist. Caitlin also inquires about the possibility of having regular rest periods scheduled throughout the day at work and later she asks Bill to follow-up on this possibility with his employer. Of note is the use of the pronoun "we" or "we're" several times in this relatively brief segment which suggests that Caitlin is speaking for the other members of Bill's team as well as herself when she makes suggestions or recommendations to Bill.

During Bill's third physical therapy session Caitlin was called upon to engage in additional social work types of activities--further inquiry, counseling, instruction, and advocacy regarding concerns Bill had about his work and his employer. This was a difficult session for both Caitlin and Bill. Bill had not been to therapy for several weeks because of a call to jury duty. Now, as he was returning to work he was experiencing increasing demands in terms of the number of hours his employer wanted him to work and, not surprisingly, the frequency and intensity of his headaches also increased. Bill was

frustrated and angry. On this particular day, then, the first 20 minutes of the hour long therapy session were devoted almost exclusively to listening and responding to Bill's concerns in this realm. The following transcript segments serve to illustrate Bill's frustrations and Caitlin's interactional work to make her way through this counseling session.

As the session begins, Bill is sitting on the edge of the mat table facing Caitlin. Caitlin is sitting on a rolling stool approximately three feet away from Bill. When Bill starts to express his frustration about his increasing hours at work, Caitlin leans forward with her hands clasped loosely in her lap. She looks directly at Bill and listens intently as he talks.

B: And I'm up to 45 hours a week now and I really don't like that /???/

C: Now you, you've said this to them recently? That you'd like to drop back to 30?

B: Oh, I've approached them with it// '30 hours is not enough'

C: It's not enough for them, or you?

B: /???, mumbling/

C: What would be the consequences if you dropped back to 30?

B: Probably a loss in pay of about 15 to 20 percent, the money doesn't matter /???/

C: Would they drop your medical insurance?

B: (Nodding) They'd drop my medical insurance. /???/

C: Hmmm (Nodding, chin in hands) Is it in your contract that you have to be above 40 hours per week?

B: Aaaah (with frustration), there's no contract you sign/ it's their general/ hiring principles or employment principles...

(B/C, 6/16/94, p. 1)

And a little later:

B: And by 8 o'clock at night, hey I'm (shaking head)/ I wolf down two more 800 milligram Motrin, and there is still

C: [Big time headache//

Are they aware of your disability?

B: [Oh yes, Oh [yeah

C: [since your accident

B: Yes// We-e-ell, they could care less/ 'are you showing up? Good', that's it, close the door (with frustration) /???/ They don't care.

C: My question is/ are they aware of some of your limitations or are you kind of fooling them/ [and working hard, looking good

B: I'm, I'm doing the work

but to do that work, I'm pushing myself twice as hard as I usually do.

(B/C, 6/16/94, p. 2)

At this point, Bill talked about how he had worked this hard before when he was self employed but at that time he hired an assistant to

help with cashier responsibilities and some other small tasks in the pharmacy that didn't require a licensed pharmacist. He says his current employer has been unresponsive to his requests that they consider hiring an assistant; as he put it, "it just annoys me." Investigating the possibility of hiring a helper is a suggestion Caitlin has made before to Bill and here she inquires about whether or not this is a negotiable issue:

C: So do you think you could negotiate that with them? Especially if you had

B: They won't do it (Lifting and shaking his head)

C: But what if you had written notification from your physician about the residual disability which you have which, you know, includes the problems with vestibular function/ headaches/ and processing

B: Well I've

C: Do you think that would be a tool for you to negotiate with? Because I would be

B: I will try, I could, I could try with Dr. Stevens/???/

C: I would be more than happy to document/ some of the

B: Would you?

C: problems that you've had and how you're trying to compensate but that they're still there/ and are going to need to be dealt with/ and recommending reduced hours for work so that you can be functional at work without severe headaches and, um, without so much overload on your system /???/

(B/C, 6/16/94, p. 2-3)

As this conversation proceeds, Bill agrees that correspondence from Caitlin might be helpful and that he will discuss these issues with Dr. Stevens when he sees him next week. It's apparent, however, that Bill's pride in his work and his strong work ethic makes it difficult for him to approach both his physician and employer with requests for changes in his work load:

B: See, I'm not lazy, [I wish, I wish you guys could/
C: [I know you're not]
B: see me work
C: [I believe you're not lazy!/ I'll bet you're in there just cranking out those, those prescriptions!

(B/C, 6/16/94, p. 3)

In response to these conversations and negotiations, Caitlin prepared a letter to Bill's physician describing his progress in physical therapy thus far and making recommendations regarding his work situation. She knew that most employers require recommendations from a physician with respect to alterations in work status for employees. Her concern and advocacy for Bill--*and* her activity in the realm of both physical therapy and social work--were expressed in a letter sent to Dr. Steven's prior to Bill's next visit with him.

> I am writing to update you on Mr. Maxwell's progress in physical therapy.... He has demonstrated excellent compliance with [his] home program and is making gains in balance, dizziness level reduction, and gaze stabilization. Headaches, however, continue to be intense and a functional problem for Mr. Maxwell at work. He has not been successful at implementing any pacing strategies and pain management techniques in the work setting. He has high expectations for his work performance and is frustrated by his inability to meet these expectations secondary to disabling headaches. During his most recent PT visit, we discussed headache triggers in the work setting and possible solutions to reduce triggers.
>
> I would highly recommend that Mr. Maxwell reduce his work hours per week or discuss with his employer the possibility of a cashier to assist him at the store. Given the frequency and intensity (level 8 out of 10) of his headaches, he has legitimate concern about his ability to work at his current pace and duration (10 hour workdays).... I believe that work modifications and changes in work schedule would be...effective methods to address headache reduction.... Please feel free to contact me if you have any questions or want to discuss my recommendations. (C letter, 6/16/94, pp. 1-2)

As a result of this correspondence and follow-up discussions with Bill's physician and employers, Bill's hours at the pharmacy were reduced to a more tolerable level. Unfortunately, he continued to have problems with headache management and ultimately required a brief medical leave from work to bring his headaches under control. In the meantime he continued to work on vestibular habituation, visual-spatial activities, and pain management techniques so that recurrence of his headaches and dizziness would be less likely when he returned to work. In correspondence to Bill's physician at the time of his discharge from therapy, Caitlin noted Bill's desire to return to work but reiterated her belief that his

return to work might "...be more successful if cashier help is provided by his employer or if work hours are reduced" (C, B letter/report, 7/7/94, p. 2).

This example of Caitlin providing indirect services traditionally associated with social work is but one of many observations of the provision of indirect services in this clinic. It is an illustration of the physical therapist enacting a role within a role--assuming some, though by no means all, of the counseling, educational, negotiation, and advocacy functions often left to social workers--in the service of client centering and in the context of a transdisciplinary approach to care.

Being an indirect provider: The case of Marcia. For Marcia, Caitlin provided direct physical therapy services and also provided some indirect services in (a) speech and language pathology (cognitive retraining) after direct services had been discontinued, and (b) social work (counseling and education about the effects of head injury and post-concussion syndrome). As with Bill, the client's wishes regarding the nature of services desired and her perceived needs were taken into account in negotiations about who would be on Marcia's team. As noted earlier, Marcia was a very independent, pragmatic and results-oriented individual who was not interested in counseling about the psychological and cognitive effects of head injury nor in receiving social work or extended speech and language or services. Marcia's characteristics, needs, and preferences were identified early by the clinic team. In her initial report Susan noted that Marcia had self-initiated activities that could help her improve

or compensate for altered cognitive and language functions. For this reason the team agreed to limit formal treatment with the speech pathologist. Susan noted in her report, however, that she would discuss Marcia's needs in this area with Caitlin so that she could reinforce and incorporate some cognitive/language rehabilitation strategies in her physical therapy program:

> Discussed Treatment Options: (1) Use of planner system to increase organizational control. (2) Involvement in a challenging language based activity to learn how to compensate for higher level word finding deficits. Marcia was not interested in a more sophisticated journal system. She has begun to take 1-800 calls for the local Crisis Line which will give her the opportunity to practice alternate ways to express herself when word finding issues become apparent.... Will review findings and discuss with Caitlin. May not be interested in nor a candidate for formal cognitive/language treatment as she is managing her daily challenges. (S, Clinic Report, 5/9/94)

Indeed, Marcia's primary goals were to realize improvements in her balance, strength, endurance, and her ability to walk and return to other recreational activities (e.g., golfing) without needing a cane. For this reason, Caitlin provided the majority of direct services for Marcia but occasionally incorporated teaching and activities that might have otherwise occurred in the speech pathologist's or social worker's office. Caitlin was willing and able to do this via consultation with other members of the team regarding their findings on screening evaluations and via their suggestions for activities or information helpful for Marcia.

Being an indirect provider: The case of John and Diane. In John's case, Caitlin experienced the greatest challenges in providing indirect services. Although John's wife, Diane, was seeing a social worker (Kay) on a regular basis for counseling regarding (a) dealing with the cognitive, perceptual, affective, and physical problems associated with John's brain damage, and (b) addressing preexisting marital tension and conflict over which this medical problem has been superimposed, John was not at all interested in receiving such counseling services. He was, however, a willing participant in physical therapy and sometimes discussed marital or relational issues with Caitlin in the context of treatment sessions. Thus, for John, Caitlin was a listener and confidant and she also tried to provide some counseling to encourage more harmonious relations between John and Diane at home. Indirectly, Diane is also Caitlin's client since she is an assistant to John at home. Caitlin must educate *both* John and Diane about John's impairments and ways to reduce or overcome them. She must seek cooperation between John and Diane with various facets of his physical therapy program so that they can work together to effectively manage some of John's functional limitations at home and in the community. Enhanced understanding and cooperation between John and Diane was one of the *transdisciplinary* goals for this couple and it was particularly important for the accomplishment of some physical therapy goals.

The need for Caitlin to act as facilitator, educator, counselor, and mediator became especially prominent as she approached the joint instructional/therapy session I have discussed in part, in earlier

Chapters, and which I have called "walking the tightrope." In this particular session, Caitlin is walking the tightrope insofar as she is really serving two clients during this session and, as a member of a transdisciplinary team, she is trying to work toward therapeutic goals for both physical therapy and social work (counseling) which are inextricably interwoven. The primary goal for physical therapy involves successful instruction in the execution of exercises in which both John and Diane must participate to help John regain motion and function and prevent the development of chronic debilitating pain. The goals for counseling (and secondarily PT) are to help John and Diane understand each other and John's impairments and needs more fully so they can cooperate in activities at home and support each other during this difficult time. The ultimate goal is to move the locus of care from the clinic to the home--to lay the groundwork for less direct dependence on health care providers and greater self-sufficiency, personal control and, thus, empowerment in the face of John's disabling illness. And even beyond beliefs about the importance of educating and empowering clients to care for themselves, financial and ethical issues also push for the need to help clients become less dependent on health care providers. In the case of patients like John with chronic disability, gaining independence often means shifting the provision of care from the provider to members of the family; thus, the patient is still dependent on someone else for aspects of their care but the locus of care shifts to the home. Decisions about to whom, when, where, and how such shifts in care should occur are usually negotiated between health

care providers, their patients, and the patient's family members or other caregivers. Such negotiation has been ongoing prior to the "walking the tightrope" session and continues throughout it and beyond as I shall show.

Caitlin is walking the tightrope in other ways as well. There are several interactional challenges that she (and John and Diane) must deal with as she tries to encourage cooperation and achieve instructional success. First, John has organically produced cognitive, perceptual, affective, and communicative problems by virtue of his fronto-temporo-parietal brain damage as a result of his tumor, neurosurgery, and subsequent radiation therapy. Recall that he has difficulty in (a) seeing "big pictures" or recognizing patterns in occurrences, (b) problem identification and solving, and (c) attending to, interpreting, and responding to subtle emotional nuances and contextualization cues within social situations and interpersonal interactions. Second, John has openly expressed concern regarding Diane's ability as a "therapist" as opposed to Caitlin whom he has come to know and trust with regard to her ability to adjust exercise intensity and amplitude according to his verbal and non-verbal feedback. Thirdly, in a previous teaching session John has demonstrated a tendency to "lash out" with personal attacks rather than objective feedback to guide Diane in the performance and modification of exercises. Such utterances (attacks) constitute positive face threatening acts (Brown & Levinson, 1978, 1987). Finally, Diane has admitted to personal discomfort and impatience (expressed as personal distancing) with John when confronted in this

way and has expressed skepticism about whether or not John will let her participate in the completion of his home exercise program. Diane feels that she is treated as if she is imposing on John rather than trying to help him; such perceived or real imposition constitutes a negative face threatening act (Brown & Levinson, 1978) for John.

So Caitlin anticipated some pedagogical and interactional challenges in this joint teaching session where Diane would be learning about and practicing exercises to be done at home with John to help maintain mobility, improve function, and decrease pain in his left arm. These were exercises John was unable to do without assistance and Caitlin felt that Diane's involvement was critical for several reasons:

> I think it's critical that she can help him out because there are a lot of points about maintaining...[range of motion and function] and just keeping him out of that pain and frozen shoulder... that she can do, that he can't. Plus, he's not an initiator. (C, 3/30/92, p. 4)

With regard to the latter observation, Caitlin explained that John did not always follow through with his exercises independently at home and this was another reason she felt Diane's participation in the home program was desirable. She added, however, that "I've sold him on two or three main exercises that he'll do regularly and at least that's a start" (C, 3/30/92, p. 4).

Caitlin was acutely aware of the tension between John and Diane, in particular as it related to giving and taking feedback (suggestions, constructive criticism). She knew that John was very sensitive about perceived or real criticisms from Diane or Caitlin;

likewise, Diane was sensitive about John's criticisms of her. By her own admission, Diane's response to John's criticism was often to get upset, angry, or frustrated and withdraw from the situation to the extent possible. She talked about this mode of response in an interview on the day of the joint therapy session: "I have to watch my attitude too, because I'm just the kind of person that will say--Well, okay, (throwing up her hands) and walk away" (D, 4/1/92, p. 2). This description was borne out in the previous attempt at a joint therapy session with John and Diane that Caitlin deemed to be premature and less than successful. Finally, Caitlin herself was concerned about and sensitive to comparisons John might make between Diane's and Caitlin's performance as an exercise assistant.

All of these tensions and previous events urged a cautious and thoughtful approach to this potentially volatile triadic therapy/teaching session. Caitlin wanted to avoid the recurrence of an unsuccessful and disturbing session this time around; so did Diane. As Caitlin put it, Diane had

> ...made it real clear...um, that she didn't want to come in on a joint session with him until (a) he was out of just total pain centered behavior, and (b) he was ready to let her do some movement. Because he had had previous sessions with her in there when, you know, every time she would touch him he would blow up at her. (C, 6/3/92, p. 4)

Preparing for the joint therapy session. Caitlin assumed counseling functions in a variety of ways during treatment sessions with John (and John and Diane) and it is to descriptions of her work to provide this indirect service that I now turn. Caitlin knew she

would need to do several things *in preparation* for the upcoming session if there was to be a chance for success. First, she would need to help John reach a point where his arm and shoulder pain was diminished enough that he would be willing to let Diane work with him. Second, she would need to reiterate and reinforce the rationale for and purpose of Diane's involvement in John's home exercise program--she would need to help John recognize and accept that Diane's participation was not only necessary but important to the realization of *his* goals. And third, Caitlin needed to instruct and counsel John on the type of feedback that would be helpful and appropriate when he and Diane were working together. And so, as early as three weeks prior to the joint session, Caitlin began preparing for this potentially explosive session.

Caitlin's preparation for the joint session was accomplished through (a) continued physical therapy to decrease pain and improve mobility in John's arm and shoulder, and (b) an artful but not entirely conscious weaving of Diane into dialogue during treatment sessions preceding, including, and following the joint teaching session. In the latter case, the preparation consisted of a change in the frequency and nature of conversation about and around Diane as the joint session approached and was completed. When I first shared this particular part of the analysis with Caitlin, she was unaware ("I did?") of the way she had worked, interactionally, to try and "counsel for success" prior to and during the session; that is, she went into these sessions knowing what she had to try and accomplish but was

not entirely aware of how she went about this in her interaction with John during therapy.

The frequency and types of preparation through conversation for this session are shown in Table 2 (Chapter 4, p.345). I analyzed the nature (content) of conversation about or surrounding Diane during each of the five treatment sessions I observed with Caitlin and John. Three primary categories or classifications of conversational content emerged from the analysis: social or personal conversations about Diane, discussions of rationale for Diane's involvement in John's home exercise program and the purpose of the joint session, and coaching regarding the nature of feedback that would need to be given to facilitate positive interactions and outcomes during the joint therapy session and subsequent home exercise sessions.

These categories are best described by examples of the conversations themselves. But before I provide examples of the categories and nature of conversations, an examination of the frequency data in Table 2 is interesting in and of itself. Note that in the early sessions, Diane was woven into conversation during therapy less frequently and in a less formal, instructional way than during the session immediately preceding the joint session, during the joint session (which obviously would require a lot of discussion around Diane since she was there), and in the session following the joint session. In addition, during the latter three sessions when the therapeutic and instructional aims toward which Caitlin, John, and Diane were moving become prominent, social conversations about

Diane are absent. This shift in the nature and frequency of certain types of conversation suggests the perceived urgency of the pedagogical and counseling demands Caitlin is facing in the joint therapy session.

The following are some illustrative examples of the types of conversations I have called "social/personal," "rationale/purpose," and "nature of feedback" in this analysis. In the social/personal category, an example comes from the second session I observed with John and Caitlin. This session took place the day after St. Patrick's Day and throughout the session there were several times when John and Caitlin engaged in lighthearted bantering about their Irish backgrounds, family names and customs, and what they did to celebrate the holiday. At one point as John and Caitlin were working to find a comfortable position for John for his heat and motion treatments, the conversation moved from inquiries and discussion about how Diane was recuperating from an earache to Irish storytelling. During the conversation, Caitlin tells John how much she enjoys his storytelling--"You're a great storyteller"--and hearing his life stories. In response, John begins to sing (with a marked brogue) "When Irish eyes are smiling" and tells Caitlin he probably woke the neighbors with his singing last night. Caitlin says "It's good for them, reminds me of my brothers..." and John begins a chorus of "O Danny Boy." Caitlin, smiling, now places a heat pack on John's shoulder and brings Diane into the conversation by asking "Does Diane like celebrating the holiday with you?" The conversation then continues around Diane's participation in the festivities as the heat treatment is

initiated (FNs, 3/18/92, p.3-4). This example of social/personal conversation involves Diane in several ways (i.e., inquiring about her health and her involvement in the holiday celebration) but there is no direct discussion about her participation in John's home therapy program nor is there instruction about the nature of feedback needed to make her involvement beneficial for both John and Diane.

On another occasion, Caitlin combines more formal and direct preparation for Diane's involvement in the session with social/personal conversation about Diane as shown in the following excerpt from my fieldnotes on March 11.

> Now Caitlin begins some gentle mobilizations of the shoulder, telling John what she is doing. She remarks that this is a maneuver she had tried to show Diane a while ago but, at that time, John had too much pain. Caitlin talks to John about what she is doing as she completes the maneuvers: This is the one for getting some mobility in your scapula back here, feel that? John answers, Uh huh and Caitlin continues, And this is the one--probably in another four sessions--about two weeks--I'm gonna ask her to come in and schedule and we're gonna let her assist with this. John comments that Diane wanted to come to this session but that she's been sick. Caitlin responds, She's been working so hard... and John talks about how many hours Diane is working and how he can't talk her out of it. They continue to talk together about Diane and both express concern for her. (FNs, 3/11/92, p. 7)

The above example includes social/personal conversation about Diane and hints of what I have called the rationale/purpose category of conversation.

The latter category includes the formalities of scheduling the teaching session, discussing the reason for Diane's involvement in

John's ongoing therapy at home and why her participation was important, and finally, encouraging John's cooperation with her involvement. Examples of this category of conversation range from simple statements like "...this [exercise] is so hard for you to do--that's why I want to teach Diane to help you with this..." (C, 3/11/92, p. 9), to very thorough and complete explanations like the following on March 18 as Caitlin completes some shoulder mobilization procedures with John and takes advantage of a conversational opportunity, afforded by John, to discuss the need for the teaching session:

J: I wish I could do that [maneuver-exercise] at home.

C: It's one of the things I'm going to show Diane when she comes.

J: She'll separate my shoulder.

C: I'm doing two things right now...(describing them in depth)... these would be easy things for Diane to do. Do you feel like you would be willing to let Diane try some of these techniques with you?

J: Not until you have absolutely confirmed that she has learned them correctly.

C: Okay--but once she is instructed? You know she's real sensitive to not wanting to hurt you and so long as you communicate in a calm manner with her then she...

J: [She's real sensitive to doing things to help me/ but her time is so valuable...(???, slurred and soft). (C/J, 3/18/95, p. 7-8)

In this example, several features of the conversation point to the interactional and pedagogical challenges Caitlin anticipates in the joint session. It illustrates the kinds of concerns that John has about Diane's performance of the exercises with him ("She'll separate my shoulder") at the same time providing an example of the kinds of face threatening remarks and invidious comparisons John is likely to make to Diane during the joint session. It also shows how Caitlin was working to have John understand the need for and purpose of Diane's participation in his home exercise program and hints at the type of coaching she repeatedly gives John regarding the nature of feedback that necessary to make John and Diane's home therapy activities a truly collaborative and successful effort.

As one might expect, the most lengthy and elaborate laying out of the purpose of the joint session and the reason for Diane's involvement occurred on the day of the joint teaching session. Near the beginning of the session, Caitlin thoroughly reviews John's progress to date in therapy in relation to the goals they have been working toward and talks about how Diane and John both have important roles to play in the continuation and extension of that progress once John discontinues his regular therapy sessions in the clinic. The following is a slightly condensed version of this segment taken from fieldnotes and transcripts from that day.

C: (Looking at John) Our purpose today was to explain to Diane some of the stretching techniques and relaxation techniques that she can help you with. (Looking at Diane) There are several that he's been doing real consistently on his own at home and the follow-up has been good, but there are also several other exercises that are just, uh, you know, impossible

for him to do himself and relax the arm and get a decent stretch on the shoulder, um, but the...(looking back at John) the carryover of the one's you're doing on your own, I think, has really paid off, because our three main goals in doing this intensive...therapy were, one (directing her gaze back to Diane), to get him out of the painful syndrome that he really was in...that was a big main goal because when one extremity starts really bothering you and becoming painful--all of a sudden it really starts limiting your activity--so that was one goal...(turning to John) Would you agree? That's been successfully addressed?

J: (Nodding) Oh, of course.

(C/J/D, 4/1/92, p. 4)

In the foregoing excerpt, Caitlin is explicitly stating the reason for Diane's involvement in the teaching session and subsequent exercises to be done at home. In addition, I believe she is very deliberately trying to reassure Diane, and remind John, that he has made significant progress and is no longer in the same painful zone or syndrome that he was in during the previous unsuccessful attempt to get Diane involved in therapy.

Caitlin resumes her introductory monologue as she then directs her attention to John:

C: The second goal was to um, increase your active assistive range [of motion]...what I mean by that is, you know, assisting with the other extremity, um, to three quarters of the range, and still be pain-free. (Looking at Diane) And we're close to that...(turning back to John) in the reaching up over your head, you're almost there (demonstrating each of the movements) and in your abduction you're not quite there yet and your rotation has improved a little bit, but those are the two--out to the side and rotation--that I'm gonna be showing you (turning back to Diane). Um, those are real tough ones for him to stretch on his own because his Pec is tight, his biceps is tight, so it's

> hard for him to get out there and stretch that. (Turns back to John) But you've made good strides toward that goal and I definitely see...increases in pain-free range.
> (C/J/D, 4/1/95, p. 4)

In this segment Caitlin again reviews John's progress on the second goal established for therapy and discusses how Diane might help John to fully achieve that goal with continued work at home. In addition, she uses the shared "PT lingo" (Pec, biceps, abduction, etc.) with which both John and Diane are now familiar.

Finally, Caitlin reiterates the third therapy goal they have been working toward and reemphasizes the importance of Diane's assistance in John's home exercise program.

> C: (Looking at John) Then the third goal is to be able to effectively and independently use that arm at home. And that's everything from doing your own inhibition or relaxation of that spasticity, maintaining the range, and maintaining whatever muscle function you have in your shoulder girdle--the elevation and the circles that we've talked about. (Turning briefly to Diane) So, I've been trying to emphasize, all the way through, (turns back to John) the things that <u>you</u> can do <u>at home</u> so that you don't get back where you were in January...and trying to give <u>you</u> as many tools as I can for you to do that. But I think Diane (returning her gaze to Diane) is going to play a real important part in achieving that third goal. In managing, um, that arm effectively, maintaining that range that we've gained and keeping you out of the painful zone.
> (C/J/D, 4/1/92, p. 5)

Several things are of note in this extended discussion which, though monopolized by Caitlin, portends the triadic nature of conversations to come later in the session when dialogue will move back and forth

among the three participants. Here we begin to see attempts by Caitlin to involve and support both John and Diane in the session in the way she addresses each of them frequently and alternately through her gaze and words. In fact, if we speed up this segment of videotape and watch Caitlin's head and gaze, viewers might feel as if they are watching a spectator at a tennis match!

Additionally, although the primary purpose of the monologue is to summarize John's progress to date and to restate the rationale for Diane's involvement in the program, Caitlin directs considerable attention to complimenting John, in front of Diane, on his individual work and notable improvement during this course of therapy. This seems to be particularly important since the incorporation of Diane into John's home exercise program has the potential to be both threatening and disempowering to John who must now accept that there are some activities and exercises he is simply unable to do without the assistance of his wife. One way to diminish, but not eliminate, this potential disempowerment is to (a) have John retain responsibility for completion of several activities to be done independently, and (b) commend him for his participation and progress in physical therapy thus far.

The structure of the joint teaching session was described in depth in Chapter Four (see also Figure 12, p. 284) and was clearly designed to try and put John and Diane at greater ease about their activities together during the session itself and later at home; that is, the structure of the session served both instructional and counseling purposes. And although it was planned and controlled to some

extent by Caitlin, it was not an inflexible structure. Recall that first, Caitlin spent a considerable amount of time reiterating the purpose and rationale for the session. Second, she demonstrated the various techniques she was going to teach Diane--*on Diane*--so that John could *observe and comment* and Diane could *feel* what was intended with each exercise in the program. Third, in each of the six exercise segments, Caitlin first demonstrated an exercise on John while instructing Diane in that particular procedure and, finally, Diane would complete the exercise with John as Caitlin provided further coaching and instruction for both of them. Much of Caitlin's guidance throughout the joint teaching session was devoted to providing counseling about the nature of feedback and the types of responses to feedback that would help to ensure success with the exercises and facilitate positive interaction between John and Diane.

As can be seen in Table 2, discussions about the nature of feedback were most prominent in the actual joint teaching session, but were also prevalent in the sessions immediately preceding and following the joint session. One example of this category of conversation comes from the part of the triadic session when Caitlin is demonstrating various maneuvers on Diane. In this segment, Caitlin talks extensively about techniques that Diane can use to increase the effectiveness of exercises and avoid pain for John. This part of the session, however, is meant to do more than help Diane get a feel for how to do and adapt the exercises to John's needs. During this time, John has been assigned the role of observer and coach by Caitlin and he stands at a nearby counter as he closely watches Diane

and Caitlin at work on the treatment table. Thus, this segment of the session is also meant to assure John that Diane has been thoroughly instructed in performance of the exercises. Furthermore, it is meant to distribute responsibility for appropriate feedback and responses to feedback to both Diane and John; Diane carries a responsibility to be sensitive and responsive to John's feedback and pain and John carries the responsibility for giving Diane timely, objective, and positive feedback to Diane as she completes the maneuvers. The following excerpts from this segment illustrate some of Caitlin's bi-directional counseling and instruction about the exercises and the nature of feedback and responses to be exchanged between Diane and John:

> (Caitlin to Diane) Whenever, on him, whenever you do a stretch or whenever you move an extremity or just the shoulder girdle here (touching Diane's scapula)--it's real important to let it go slo-o-owly. If you've got muscles that have increased tension, if you let it go quickly they like to spasm on you (demonstrating a spasm of the biceps in response to quick stretch).
> (C/J/D, 4/1/92, p.6)

Later, after further demonstration and instruction with Diane, Caitlin says:

> So we've kind of relaxed the muscles around the shoulder girdle and stretched out in this direction--trying to get his upper Trap [Trapezius muscle] to quiet down and then trying to get some mobility in that--in the scapula back there. Okay? (Diane nods) Now I want you to kind of notice one thing, 'cause he's real sensitive about this. Now, whenever you're doing range and supporting the arm--notice how I'm pulling that shoulder up and away from the joint a bit? (Diane says Mmm Hmm and Caitlin continues) That's called distraction and it's

> real subtle--and what you're doing is just kind of--if you saw the joint in the socket--I'm just pulling it out a little from it--because any kind of jamming in there, for him, is real painful... (Caitlin glances at John for confirmation and then says emphatically)...and he's supposed to be telling you--before it gets to the point of pain...that's the tough part. This is about the range we're getting [with John right now].
> (C/J/D, 4/1/92, p. 7)

So, Diane has a responsibility for going slowly with the exercises, for sensing and responding to resistance or spasm in muscles, and for listening for John's verbal indications of when he is getting into painful ranges. And John has responsibility for telling Diane, objectively and non-emotionally, when she needs to "let up" or "drop back" with a movement.

One other brief excerpt from the triadic therapy session should serve as a final illustration of conversations focused on the nature of feedback as Caitlin, John, and Diane work together to make their way constructively rather than destructively through this difficult session. In the following example, Caitlin has just completed a demonstration of a particular relaxation and stretching maneuver on John. She then asks Diane to try it and they switch places. Diane sits down next to John on the mat table and begins to adjust her grasp on the shoulder as Caitlin gives her some verbal guidance.

C: If you just, sort of, cup around the shoulder girdle and just start doing real slow rotations with him, you know, start out

kind of small// and then gradually increase in range// especially trying...

J: (Grimaces and mumbles something unintelligible)

D: What's up John?

In response to Diane's question, John indicates that his arm and hand is slipping off the pillow and Diane and Caitlin work together to get him repositioned. As Diane resumes the treatment Caitlin gives some further instructions quietly. Shortly thereafter, John begins to give Diane some feedback about her performance of the exercise.

J: Hon[ey]// it feels like// (Diane looks up at Caitlin, smiling but shaking her head with some apparent frustration) I'm just telling you/ since I'm the one getting therapy/ it feels like a bit too much pressure...

C: (Looks back and forth between John and Diane, then reaches in between them and touches Diane softly on the back of her hand) No, that was good. That was good objective feedback/ that's good to give.

J: It feels like you're pulling a bit harder [than Caitlin], other than that the position feels great.

C: Okay, why don't you do a couple more and then just end in, in the stretching and pulling downward. Can you feel though, as you do them, that the muscles start to kind of ease up and relax and you can get more range?

D: (Nodding)

C: That's the idea (approvingly).
(C/J/D, 4/1/92, p. 9)

In the above segment, John gives feedback to Diane about her performance of the exercise and it is Diane who is needing some encouragement to accept this kind of objective feedback from John that is both appropriate and necessary for their success together. Her early reactions of frustration (non-verbal) are undoubtedly rooted in past experiences which have included less than objective feedback from John.

It is interesting to note that there is considerable face-work (Goffman, 1967) going on here by both John and Caitlin as the potential for threats to positive face for Diane is increased when she is trying an exercise and receiving instruction and feedback about her performance. The amount of face-work by participants that pervades the entire session, and especially the most difficult exercise segment, is indicative of the volatility of the triadic encounter and will be discussed in greater detail shortly since I believe it is an important feature, at the level of discourse, of the counseling work being done in this session. Suffice it to say, at this point, that in this particular segment John intersperses the use of familiar terms (Hon[ey]) and several "hedges" (Brown & Levinson, 1978, 1987) to try and mitigate the face threats to Diane that are almost inherent in the act of his giving her feedback. In fact, the provision of *objective* feedback (as opposed to subjective or personal feedback) encouraged by Caitlin is one, of many, attempts to try and diminish, but not

overcome, the inherently threatening nature of this situation for Diane. To make matters worse, Diane's past negative experience with John in a similar situation serves to heighten her sensitivity to *any* feedback that she may interpret as very threatening when cast with the memory of previous "bald-on-record" (Brown & Levinson, 1978, 1987) threats to face. Thus, even when provided with relatively appropriate feedback from John, Caitlin has to work to help Diane accept (touching her on the hand, "that was good") and respond to such feedback without frustration.

So the weaving of Diane into conversations during therapy sessions has taken various forms and served a variety of functions during the five treatment sessions I observed with John. As a final note, Table 2 shows that Caitlin's interweaving of conversations about and around Diane into therapy and her work toward Diane's permanent role in John's daily therapy routine at home, did not end with this one joint teaching session. Caitlin spent a considerable amount of time in follow-up to the joint session during John's next therapy appointment one week later. The following is a small sample of her inquiries about the session that were paired with continued instruction and counseling.

C: How did you feel that went with Diane? Good?

J: Yeah// real well.

C: And what's the follow-up been? Have you guys...? Have you done any type of daily stretching with Diane?

J: I do daily stretching on my own, but not with her// not yet. We are talking about getting it going into a daily regimen or every other day type of regimen...

C: ...I'd really like to encourage you guys to find the routine and get started on it. My question I want to ask you, though, is after that instruction// do you feel more comfortable with her and her hands on? 'Cause your complaints before were that you didn't feel comfortable...

J: Yeah, I feel much more comfortable...

(C/J, 4/8/92, p. 1)

So, the battle isn't won; but strides have been made toward reaching some collectively agreed upon team goals established with and for John and Diane.

The greatest challenge: The hardest exercise for all. Perhaps the most difficult and yet instructive example of Caitlin trying to provide indirect counseling services in concert with physical therapy came toward the end of the triadic therapy session with John and Diane. I conducted a close analysis of face-to-face interaction in the session and the last exercise segment, in particular, because it seemed that this joint therapy/teaching session provided a unique opportunity to explore some of the special challenges associated with client centering, establishing therapeutic alliances, and enacting the notion of a transdisciplinary team in a situation in which the patient (John) isn't the only client being served and the "therapist" (Caitlin) isn't the only therapist with a voice and role. Ek (1990) has written:

> By paying close attention to moments of conflict, the rules that otherwise guide the interaction and that now have been violated can be made visible. This is one way of learning about what organizes smooth interaction. (p. 107)

Thus, I felt that analysis of this speech situation and event in which tension and conflict were palpable might help me better answer some of the questions I had raised about patient-professional interaction and expressions of practitioner expertise in everyday practice. Specific questions for the analysis of discourse in this interactionally complex and potentially volatile context centered around seeking clues regarding how the therapist attempted to manage the therapy session (issues of control, power, status, and role emerge here), seek mediation and intersubjectivity (alliances and understandings) between participants, and achieve transdisciplinary and educational goals (provide for learning to occur) in the framework of a philosophic commitment to client centering.

The framework for this analysis is borrowed from Hymes (1972) and has been introduced earlier in Chapter Four (see Figure 17, p. 335). Using Hymes' framework of nested contexts for the analysis of discourse, then, the speech community is comprised of clinic associates and clients at Jones & Thompson, P.C., the speech situation is the triadic teaching session with John, Caitlin, and Diane, and the speech event is the last exercise segment in the session and the transitions into and out of that segment (see Figure 12, p. 284). Of note is the fact that this is the segment during which Caitlin is instructing Diane on the most difficult and painful exercise to be

done at home with John. The fact that the most difficult exercise was left until last was no accident. In a videotape viewing of the session with Caitlin, she said that she consciously introduced easier and less painful exercises early in the session so that Diane and John could experience initial successes and then she began to introduce more difficult exercises toward the end of the session. As she put it:

> I wanted them to experience a point where there was pain so that (a) he could learn to give her good feedback, and (b) that she could not just drop her hands off and say 'Oh, okay, I don't want to touch you anymore.' So that she could know how to handle that--how to grade down what she was doing. So I knew I had to bring in some of the harder ones [exercises]. (C, 4/2/93, p.1)

So the stage was set. And it was the (a) potential interactional volatility of the triadic session, (b) efforts of the therapist to address problems as they arose and to defuse situations prior to and during the session, and (c) attempt to realize multiple therapy goals in a single session, that encouraged close analysis of the speech events and speech acts embedded within this speech situation.

Specific structural characteristics of the speech situation and events were revealed by the analysis and these have been described earlier (Chapter 4). For the purposes of this discussion, however, I will focus on a more detailed description of the transitions into and out of the last exercise segment (#6 in Figure 12) and the nature of interaction during these transitions and the final speech event itself. Of particular interest was how and whether the therapist and other participants could achieve and sustain conversational involvement

and coherence (Gumperz, 1982) in the context of this final instructional segment with the most difficult exercise. As analysis proceeded, certain characteristics of the discourse emerged and became prominent such as (a) the use of repetition by the participants, (b) the pervasiveness of positive and negative threats to face in the speech event, and (c) the varied responses to such threats by participants. These features of discourse, which have been introduced and discussed previously in relation to the development of therapeutic alliances (Chapter 3), became the primary foci for the analysis reported here. Thus, while other features of discourse were not discounted or ignored, the above aspects of interactional work took center stage.

The frequent use of repetition, which Tannen (1989) has suggested is a resource in talk that can serve positive face, and politeness strategies or attempts to mitigate threats to face (Brown & Levinson, 1978, 1987) by participants, seemed especially pertinent. The therapy session, in and of itself, is face threatening in many ways: Diane is being asked to give of her time and effort (imposed upon) to learn these exercises and do them daily with John who has been only minimally supportive and cooperative with this kind of intervention before. Furthermore, Diane does not hold the relative power, status, or social distance that the therapist does in this situation, yet she is being asked to assume the role of therapist. John is being asked to accept that he is unable to perform some of these movements independently and thus needs Diane to do these sometimes painful exercises with him (which is both an imposition

and potentially disempowering). In addition, the re-definition of roles and relationship between John and Diane required by the situation may be inherently face threatening for John. If Caitlin is limited or unsuccessful in her attempts at fostering involvement, cooperation, and learning of the home exercise program, then her skill as a therapist, counselor, and educator (her positive face) is also threatened. Finally, and perhaps most importantly, John and Diane's ultimate dilemma is that John's life threatening and disabling illness can be considered one of the greatest threats to freedom from imposition that exists in human lives. And even though therapists in this clinical community seek to diminish these threats to the extent possible, they can really only act in the context of them.

As issues of repetition and face and politeness became the focus of analysis, more specific research questions were formulated: What are the forms of repetition used in this speech event and what functions do they appear to serve? What types of face threatening acts (FTA's) appear in the discourse and how do participants manage these linguistically? And finally, connecting back to some of the primary research questions, what functions might these linguistic and paralinguistic phenomena serve in relation to (a) creating and sustaining conversational involvement and therapeutic alliances between participants, (b) providing an educative experience that fosters learning (c) client centering and empowerment, and (d) transdisciplinary teaming?

The Structure of the Speech Event. Throughout the session transitional periods between exercise segments were marked by postural and positional shifts--mostly by Caitlin and Diane--and changes in the talk that signaled the end of work on one exercise and introduction of the next exercise to be attempted. The general structure of exercise segments and associated transitions described earlier (Chapter 4) was maintained in the last exercise segment (#6) and the structure of this speech event will now be described in more detail.

The transition into the final exercise segment (T8 in Figure 12) during which the most difficult and painful exercise for John was being introduced included a period of warm-up for John during which he demonstrated a part of the exercise he was able to do himself by using his normal arm and hand to assist his non-functional and painful arm. In addition, as Caitlin changed position to assume her role of demonstrator-therapist-instructor, she discussed the importance of this particular exercise and the need for Diane's involvement in the completion of the exercise. At the same time she commented on how difficult and painful the exercise could be for John, emphasizing the need for small, slow, gentle movements. These preparations, reflect the concern that the therapist had about the potential difficulties and problems that might arise in the segment and may be "pre-sequences" (Brown and Levinson, 1978) designed to mitigate face threatening acts between John and Diane before they occur. The reiteration of the need for Diane to be involved in the exercise is protective of Diane insofar as this asks John to let Diane be

involved and to cooperate with her to accomplish what is a difficult task. The reminder to Diane of the need for gentle work during the exercise is protective of John and addresses a previously expressed concern that Diane will push too hard. Even though these reminders may be attempts to avoid face-threatening acts between John and Diane, the therapist herself is committing a negative face threatening act by imposing on both John and Diane through her request that they be involved in this exercise program.

Finally, the three minute transition into the exercise segment included a conversation, mostly between Diane and Caitlin (although there was some participation by John verbally and non-verbally), in response to a question by Diane regarding the differences between the meaning of the terms "range of motion" and "functional range" as they relate to John's involved arm. According to Diane, this was an issue of a previous "huge debate" between John and Diane during a recent visit to the neurosurgeon's office.

> This is a real touchy issue. And we even had a huge debate before we saw Dr. Grant. The difference between range of motion and functional range? (D, 4/1/92)

This is a clear request for information and counseling; Diane seeks help from Caitlin in two respects: (a) understanding these terms and what they mean with respect to expectations for recovery of function and reduction of pain in John's arm, and (b) settling the debate about these terms and their meaning by calling on Caitlin's knowledge, status and power.

When the therapist viewed the videotape record of this discussion, she remarked that reports from Diane (that had been shared with her social worker and Caitlin) reflected concern about the lack of information and guidance that Diane had received from the neurosurgeon about what to expect with John in terms of recovery of function.

> I know from her [Diane's] interactions with Kay--and I think this is the importance of the team--that...Dr. Grant never took her aside and said 'this is what you can expect from John's recovery--he will get more motor return--he won't get this back'--he never spelled out expectations for what's going to be happening in a month or four months from now. And that really bothered her. So, I think she was kind of looking for that kind of information. And I had that background information from Kay to know that and...this was a source of frustration at home--about how much function he had or didn't have--and was it ever going to change? (C, 4/2/93, p. 5)

So, as a member of John and Diane's transdisciplinary team, Caitlin had some background information from Kay about some of Diane's concerns and frustrations that helped her interpret Diane's question as a plea for information, clarification, and mediation. Caitlin saw her response to Diane's question as (a) an attempt to fill an information gap, (b) a chance to clarify expectations about what John could or couldn't do at the moment and about what he might or might not be able to do in the future, and (c) an opportunity to reduce some of the frustration associated with uncertainty and differing perceptions between John and Diane about these terms and their meaning with respect to his functional abilities.

The exercise segment itself focused on the teaching and learning of a specific exercise to improve John's range of motion in shoulder external rotation. The basic structure and content of exercise segments described earlier (Chapter 4) was maintained with a few variations. Throughout the segment John was lying on his back on a large mat table and Diane and Caitlin moved around him working either from positions sitting or standing near his head or positions kneeling or sitting near his left shoulder and arm. During the time that Caitlin was acting as therapist-demonstrator, explicit information was provided to Diane about what she could expect (or not expect) in terms of range of motion with the exercise. During the times that Caitlin was both therapist and observer, she reemphasized of the need for Diane to be involved in this exercise, reminded John about the type of feedback that would help Diane with accomplishing the exercise and adjusting intensity to John's tolerance, and asked questions and gave answers about technique issues between Diane and Caitlin and Diane and John.

In the transition out of the exercise segment (T9, Figure 12), there was a fairly abrupt closure to the segment when Caitlin attempted to stop a volley of positive face-threatening acts delivered by John toward Diane after he experienced some discomfort when Diane was doing the exercise. At first, however, Caitlin did not get involved in this volley or "fencing act" as she called it; instead she observed how John and Diane might work their way through this difficulty--perhaps as she calculated the weightiness of the face threatening acts and tried to determine whether, how, or when she

might need to bring her role, status, and power to bear in this situation. As Caitlin put it:

> I thought some of that [work to get through a hard part of the exercise] was a little bit positive and just let it go for a while...their defensiveness was not something I could totally defuse, I felt,...and I was just going to let them fence it out a little bit unless it became counterproductive to what I was trying to instruct them on. (C, 4/2/93, p. 9-10)

Thus, Caitlin initially elected to let Diane and John try to respond to each other and resolve some of the conflict without her direct intervention. Nonetheless, when the following segment of talk occurred, Caitlin did intervene and began to close the exercise segment:

John: I saw/ I saw her arm/ and her whole body over here// while you stay back there/ I know she was sort of [laying across that arm...

Caitlin: [(Moving away from head of table near J & D to side) [That's good, [Diane. You know even

John: Aaaah. That's good/thank you/that's good/ stop.

Caitlin: now even, even though right now/ he's real tight and tense/ you know/ fighting you/ you still got about 10 to 15 degrees of rotation/ which is good

Diane: (looks at C and nods)

Here, Caitlin *does* intervene and turns the conversation back toward instruction at the same time that she attempts to mitigate the positive face threatening act directed at Diane by commending her about the range of motion she achieved during the exercise. Caitlin's decision to intervene was based on her discomfort with the threat to Diane's self-image especially when it involved a comparison to her. This was something that Caitlin had encountered on several occasions with John. In the viewing session, Caitlin described her thoughts this way:

> You see, he's implying something about her size and herself there. I knew I just had to change the subject there... back to instruction. He compared her to me a lot and I was not comfortable with that. (C, 4/2/93, p. 10)

This is indeed a sticky situation. The whole speech situation and event invites John's comparison of Diane (the novice) to Caitlin (the expert) and John often made those comparisons verbally explicit which was uncomfortable for both Diane and Caitlin. In this case, Caitlin chose to ignore John's statement and tried to diminish the threat to Diane's positive face as she returned quickly to instructional or treatment talk (therapist register) (Cazden, 1988; Ek, 1990) and moved toward closure of the exercise segment.

When John continued to complain about Diane's technique following this episode, Diane and Caitlin almost concurrently concluded the exercise segment verbally and non-verbally. Diane released John's arm and rose from the mat table to stand at John's head with one foot on the mat table and her right hand on her hip.

Diane: John, I was just lifting up and down like she said.

Caitlin: OK John, why don't you roll on over to the side here
(Sweeping her arm over her head and
toward the side of the mat table)
and come on up to sitting.

John: (Begins to roll up to sit) [Uuhh.

Diane signals an unwillingness to continue with the exercise through her positional and postural change and facial expressions as she tries to regain positive face by claiming that she was just doing as told and attributes her negative face threat to John (her imposition and hurting him) to Caitlin. This is a way of trying to minimize her responsibility for the face threatening act. Perhaps this is also a way of reminding John and Caitlin that she, too, was being imposed upon. Caitlin, responds to this interaction with the imperative "you roll on over..." directed at John. This negative face threatening act is mitigated slightly by the preface of "why don't."

The transition out of the exercise segment (T9, see Figure 12) is also the conclusion for the entire therapy session. This five minute transitional sequence included several activities: opportunities for questions and answers about the exercise program; a summary of what had been discussed and accomplished in the session; demonstration and review of exercises that John was doing independently at home and commendations from Caitlin regarding John's completion of and improvement with these exercises; and an

explicit recognition by Caitlin of the imposition that the exercise program represented for both John and Caitlin and an attempt to minimize that imposition to the extent possible by asking that they complete the exercises only once per day.

The Use of Repetition Within the Event. Self and allo-repetition was observed frequently during the segment analyzed. Since it has been suggested that repetition can serve the creation of coherence and interpersonal involvement in conversation (as well as positive face), and secondarily the establishment of therapeutic alliances, all of which could serve counseling and educational goals in this session, a close analysis of the forms and functions of repetition in the segment was of interest. Who was repeating who? How? When? And serving what purpose?

Caitlin and John repeated each other and themselves far more frequently than Diane. Overall, Diane did not talk much throughout the segment nor did her non-verbal behaviors suggest close involvement. There were, however, several attempts by the therapist and John to engage Diane or capture her gaze by either a soft touch, positional change, gesturing, or the use of repetition. Some examples of Caitlin's use of self-repetition and repetition of Diane's words are provided here. Diane asks the clarifying question described earlier:

Diane: This is a real touchy issue/ and we even had a huge debate before we saw Dr. Grant.// The difference between range of motion and functional range?

Caitlin: (Looking at Diane, nods)

Uh huh, right// Range of/ i-in terms of active function?

Diane: Yeah.

Caitlin: Yeah.

Caitlin is checking to make sure that she understands Diane's question and shows ratifying listenership that is created by her repetition, direct gaze at Diane, her nodding, and her verbal recognition ("right") of the complexity of the difference between these two terms and the need for discussion about this. In this case Caitlin repeats Diane's words "range of" (implying "motion") almost immediately and repeats Diane's "functional range" with variation ("active function"). Furthermore, Caitlin immediately repeats Diane's "yeah" exactly, even down to the same intonation and loudness. In the above example the repetition appears to serve the functions of interaction and connection.

As the discussion around this question proceeds, Caitlin directs her answer to both Diane and John in recognition of Diane's implied request for mediation of this "debate". In her response, Caitlin uses self-repetition that appears to serve production, interaction, and comprehension functions and at the same time she returns to repetition of the terms used in Diane's question which appears to serve a connection function; that is, it (a) connects the current discourse to Diane's earlier question, (b) provides evidence of Caitlin's attitude about the importance of the topic and the need for clarification, and it (c) connects participants in the discourse. Interestingly, as John become involved in the discourse, he

paraphrases Caitlin's description of the kind of movements he can perform with his arm and kinesically repeats a movement that Caitlin demonstrated several times during the conversation almost exactly.

Caitlin: (Holding John's hand/wrist and gently working to open the spastic hand - directs her gaze to John) Um, right now, the only active motor control you have in that arm is that movement that you've got at the shoulder girdle, right? (Demonstrates movement)

John: Mmm

Caitlin: Umm, you've got some gross/ like what we call/ kind of/ mass patterns of movement/ Like if you try to lift the whole arm up to put it into the sleeve (demonstrates) or push it down, and it all moves out as a unit (demo)

John: Mmm Hmm

Caitlin: OK? So/ mass patterns/ In terms of any kind of selective movement control/ mostly just your elevations and/ uh/ pulling back on the shoulder/ (Nodding, demonstrating) umm/ that's not

John: Like starting a lawn mower (mimics movement)

Caitlin: Ye-e-a-a-h (Smiles, chuckles) That's not real functional/ active movement/ Umm, I would classify your arm function right now as/ as a gross assist/ and I don't mean to use that word gross/ grossly/

[but I mean it in terms of moving in mass patterns (turns gaze to Diane while still holding John's hand)

Diane: [(Moves gaze from John to Caitlin, nods briefly)

Several things are of interest in this explanatory, teaching, and mediation segment. First, there is recurrent use by Caitlin of various linguistic forms of descriptors of movement which I have called "PT lingo" such as motor control, movement control, mass patterns, gross movement patterns, gross assist, functional movement. The repetitive use of these terms seems to serve language production functions (it gives Caitlin a bit of time to figure out how to review this information with John in a way that presents clinical reality but is not deprecating) and comprehension functions. Although some readers might ask about the appropriateness of the use of these terms with John and Diane, as I have pointed out earlier, the use of technical terms or PT lingo is habitual in interactions between Diane, Caitlin, and John because of Diane's experience as a rehabilitation aide and because John has expressed an interest in learning PT terminology. Subsequently, John uses PT lingo with pride to describe his problems and exercises to others and Diane feels she is not being talked down to, that is, her experience and knowledge are being respected.

Secondly, although Diane initiated the question about the difference between range of motion and function, Caitlin's reply to this question is directed primarily to John and only secondarily to Diane. But given the complexity of the situation, the background

information that Caitlin has about Diane's concerns, and the sociohistorical context of the speech event, it is reasonable to interpret Caitlin's shift as attention to contextualization cues that suggest what she was to do at that moment in the interaction. Caitlin reacted to Diane's question by answering to John and throughout her response she had to walk another tightrope--trying to help Diane by clarifying terms, providing information that may or may not have been provided by physicians, and mediating a debate; and trying to help John and herself (achieve therapy goals) by discussing John's current level of function with him in a way that was honest but sensitive, that would attempt to provide for matching of knowledge schemata between the participants (matching performance and expectations), and that would encourage increased understanding and cooperation between Diane and John.

Finally, a shared movement discourse emerges in the above segment of talk when John repeats the exact movement that Caitlin has been discussing and demonstrating. The movement of scapular retraction and elevation of the arm is demonstrated at the same time that John and Caitlin describe them using images of everyday activities; Caitlin describes the movement as trying "to lift the whole arm up and put it into the sleeve" and John describes the movement as "like starting a lawn mower." Evidence of a shared movement discourse in the form of John's non-verbal repetition of movements Caitlin was demonstrating for Diane occurred on several occasions during the exercise segment and transitions. Such self and allo-repetitions could serve several functions. Comprehension could be

served by providing less dense movement discourse for both Diane and John. Connection between John and Caitlin is established and their repetitions of movements suggests that these are important movements to do or be aware of. Finally, John's repetition of movements that Caitlin produces shows participatory listenership and serves interaction and social functions.

Throughout the exercise segment Caitlin demonstrates self-repetition when she provides descriptions for Diane of the type of pressure and rate of movement she wants Diane to use during the performance of the exercise. These repetitions take various forms and are distributed frequently and consistently through the talk. They provide evidence for both Diane and John that doing the exercise in this way is important. Recall that one of John's concerns about Diane's participation in the exercise program was that she would push too hard or too fast on his arm. The following is one of many examples of this sort of repetition. In this case, Caitlin is just beginning to demonstrate the external rotation movement that she wants Diane to do with John. John has just asked Caitlin to proceed with the exercise because his arm is beginning to bother him after being held in abduction for a while during a conversation with Diane about technique.

Caitlin: Ye-e-a-a-h (looking at John, nods, then looks at Diane)
Yeah, he's not used to being in that position// and then,
um/ ever so-o-o gently
(starting to move arm into external rotation)

John: I don't like my fingers this way (John reaches over and pulls his fingers out of flexion placing them around Caitlin's fingers)

Caitlin: (Smiles at John and chuckles, turns gaze back to Diane) And then/ just ever so-o gently and slo-o-owly/ bringing that arm down/

John: Hmmmm, o-o-o-h

Caitlin: Ve-e-e-ry slo-o-ow// Now, he had no exter-/ no rotation this direction at the start/ three weeks ago. We've got maximum/ on a good day/ about 20 degrees. So/ don't expect to roll him down to the ground in a, you know, arm wrestling position/ 'cause he doesn't have it.

All of the descriptors instructing Diane to move John's arm gently and slowly were uttered in a low pitch, very softly, and with many vowels drawn out. Thus the prosodic features of the repetitions act to give emphasis and create images of the type of pressure or force, touch, and rate with which Caitlin wants the exercise done. These repetitions serve comprehension and evaluative functions and also can serve as assurances to John that Diane has been thoroughly instructed in how to perform the exercise.

Interestingly, when Diane begins to perform the exercise shortly after Caitlin's demonstration and instruction, John becomes the instructor and repeats (with variation) and paraphrases (using imagery) some of Caitlin's performance descriptions:

John: (As Diane moves in to do the exercise)
Hon/ listen/ The -- touch -- of -- a -- butterfly - OK?
(Diane grasps Johns hand and arm)
Pretend you're one of those little light moths /???/
Diane: Okay.

and a little later:

John: Aa-a-ah. Ever so-o lightly...

As mentioned earlier, this type of self and allo-repetition (John repeating Caitlin) occurs frequently throughout the time that Diane is completing the exercise and receiving instruction and feedback from both John and Caitlin. For instance, at another time, Caitlin was trying to describe for Diane how to do some small oscillatory movements with John's shoulder to aid relaxation using descriptors like "...real gentle up and down," "not too far/ just some real small movements," "just real gentle pressure." These instructions are then echoed by John: "just by pushing down/ rhythmically/ and slowly/ just very shallow/ very shallow." As noted earlier, such self and allo-repetitions appear to serve production, comprehension, evaluative, and interactional functions and may be evidence of John's learning about his problem and his exercises.

When Caitlin observed these repetitions and John's feedback and instruction to Diane on tape, she indicated that she was aware of her use of repetition as an instructional strategy. She also discussed

another belief she held about the importance of self-knowledge and a sense of control as tools for empowering clients:

> The other thing to note with that too, is, is how in tune he is with his own treatment--his own requirements--whether it's instructing somebody to assist him or whether he's doing it [the exercise]. He knows a lot about, you know, about what works for him and what doesn't--how much pressure, you know, and that is empowering--In my mind--versus the patient not having any idea what triggers [pain] and when is enough. (C, 4/2/93, p. 7)

Returning to my observations about the pervasiveness of repetition in this segment, I believe it is important to note, however, that while Diane is the object of much of this repetition (in her role as the student of John and Caitlin), she does not participate in the repetition nor does she say much at all during the segment. The connection between participants during these repetitions is primarily between John and Caitlin. Diane's lack of involvement in the discourse at this time could be related to several co-mingled factors: (a) participant perceptions about the appropriate role relationships of teachers and students, (b) Diane's feelings of being an outsider or foreigner with respect to the patient-therapist relationship that Caitlin and John have developed, or (c) Diane's response to being the recipient of continuous negative and positive face threatening acts. According to Caitlin and Diane, Diane's response to such threats to face is usually one of social distancing which seems to be evidenced in this session by her quiescence and relative lack of verbal and non-verbal involvement during the instructional session. The latter

hypothesis brings us to an examination of face threatening acts within the session and participant responses to them.

Issues of Face and Politeness in the Speech Event

Some issues of face and politeness (Brown and Levinson, 1978, 1987) that arose during the exercise segment have already been touched upon in the description of the structure of the segment and have been discussed earlier in Chapter Four. The following text provides more specific examples of face threatening acts that were evident during the session and that were embedded in a joint therapy session which was face threatening in and of itself. It is important to keep in mind that it is usually in the participant's best interest to maintain face and foster communicative cooperation. In this situation Caitlin, in particular, was interested in trying to encourage cooperation between John and Diane so that effectiveness of the home exercise program might be enhanced. But John and Diane also had to devote a fair amount of interactional work to maintaining face during the session. To review, the questions that drove the analysis of face and politeness in the segment were: What are the types of face threatening acts that appear in the discourse and how do the participants attempt to manage these threats to face and create and sustain involvement during the speech event?

One attempt by John to diminish or mitigate an imposition or negative FTA for Diane (being told repeatedly how to perform an exercise) has already appeared in earlier discussion:

John: Hon/ listen/ The -- touch -- of -- a -- butterfly - OK?

John uses the "familiar" term "hon"(ey) to preface his instructions and then softens a directive with an interrogative at the end of the sentence and the use of a metaphoric image versus a command.

Shortly thereafter, the use of an inclusive pronoun may be an attempt by John to mitigate an on-record FTA that represents both a negative and positive face threat to Diane.

John: We're looking for butterflies here// instead of wr-r-estling me like an alligator (teeth clenched, non-verbal pain behaviors)

What is uncertain here is whether John's use of "we're" is referring to a partnership between Diane and John as they go through the exercise, or to the partnership of Caitlin and John as Diane's teachers. Given the directness of the positive face threat that comprises the rest of John's sentence, he may have been referring to himself and Caitlin. If so, this utterance becomes a "bald on-record FTA"; that is, a face threat in which there is no attempt by the speaker to mitigate the threat. Such threats are not uncommon in John's talk and can probably be partially explained by the nature of the injury to the right hemisphere of his brain. Injuries such as John's are characteristically accompanied by a variety of perceptual, affective, attentional, and communicative impairments which can include anosognosia (lack of recognition or denial of illness or impairment), problems in recognition and expression of emotion, impaired comprehension in conversation (e.g., literal interpretations),

pragmatic impairments in communication (difficulty with social, interactional aspects of language such as turn taking, topic maintenance, eye contact, etc.), and production of language that is inappropriate or confabulatory. All of these organically produced impairments can contribute to what is often perceived and described as "social inappropriateness" in interpersonal exchanges by patients with right hemisphere damage. Thus we can read and see in John's talk and behavior some of what normal interaction requires, especially with respect to the subtleties of managing face in conversation, that are now difficult for him. But although there are some organically produced problems in interaction for John, we can also see that he still recognizes *some* times when face is threatened and is involved in *some* efforts to mitigate threats to face.

Nonetheless, in this case, Caitlin assumes a greater responsibility than she might otherwise have, to work to manage and defuse situations when unmitigated face threats are delivered by John. Thus, in response to the "alligator" frontal attack delivered by John, Caitlin quickly attempts to turn the conversation from this personal attack back to instructional talk.

Caitlin: (Standing near John's head, leans in and looks directly down at John, smiling)
Just real/ real specific feedback, John// 'far enough' or 'a little pain there'

Caitlin reminds John of the kind of objective and non-personal feedback that will be most helpful to Diane so that she can modify exercises appropriately and so that she will be willing to perform the exercises with John. In effect, Caitlin tells John that his alligator statement is not acceptable and uses her status and power (which is emphasized by her position in standing above John's head looking down at him) to try and control the situation and mitigate the positive face threat for Diane.

In another example of a positive FTA (a threat to positive self-image) directed at Diane during the most openly volatile part of the exercise segment, John attempts to defuse the act to some extent initially and Caitlin, after observing the interaction between Diane and John, eventually asserts her authority as she tries to redefine the situation as one of understanding and cooperation, teaching and learning.

Diane: (Begins external rotation exercise)

John: Aaaah! Geees! WAY TOO MUCH weight on it!/
(Diane lets up on arm some)
I'm sorry. That's my accurate feedback.

Diane: [OK.

John: You put way too much weight on it. You had your whole upper torso laying on it for a second!

Diane: [No I did not...

John: I was watching you

Caitlin: OK. I want you to ease up just a little bit and try to use some real gentle pressure from your hand // It gives you an idea of just how sensitive he is.

Diane: (Nods, rolls eyes)

Caitlin: That's the hardest motion for him. He yells at me when I do it, so don't feel bad.

Diane: (Looking at John) My upper torso didn't move, John, so...

John: (Looks away in frustration)

Caitlin: That's just the perception/ when you're so tight and painful it feels like// even a little movement...

I provide this extended segment of the transcript so that the reader can get clear image of this difficult exchange and a full sense of the intricacies of managing this volley of face threatening acts. Working sequentially through the segment, we first note that John's immediate apology and comment about giving accurate feedback (which is what he has been *told* to do by Caitlin) is his attempt to mitigate the positive face threat for Diane. Concurrently, Diane releases her pressure on the arm and then says "OK" softly as a hearer's attempt to mitigate the imposition of pain (a negative FTA) for John.

It is interesting to note that Caitlin does not jump into the conversation immediately as she seems to (a) observe the interaction between John and Diane at this difficult moment and lets them try to manage the situation, (b) calculate the weightiness of the FTAs being leveled, and (c) considers her response as she prepares to head off

conflict between John and Diane. In fact, when Caitlin later viewed this segment of the videotape and was asked why she did not respond immediately, these were the kinds of thoughts she described:

> I thought it was kind of interesting the way he worded it, you know, 'I'm sorry,' so he was aware that he had come up too strongly at her but that 'was accurate feedback.' And the thing I tried to prep him on is accurate feedback and don't generalize to something else, just talk specifically about what she did that was uncomfortable. So I thought some of that was a little bit positive and just let that go. (C, 4/2/93, p. 9)

When Caitlin does reenter the conversation, she issues an imperative, "I want you to ease up..." to Diane which she softens with a "hedge" or indirectness ("...just a little bit..."). This utterance, which affirms John's observations and suggests that Diane can and should reduce her pressure, is combined with more instruction about the amount of pressure Diane should use in performing the exercise and represents an assertion of Caitlin's authority and an effort to turn the situation back to teaching and learning.

The mediational and instructional talk that follows includes several "It's OK" messages directed to both John and Diane as Caitlin tries to defuse the situation (restore face), increase understanding between participants, and provide for continued involvement in the exercise program. Caitlin reiterates that this is the hardest exercise for John and he is, indeed, sensitive--it's OK, John *and* Diane. Furthermore, she tells Diane that John has yelled at her before during this exercise--it's OK, Diane, it happens to me too.

Caitlin's description of what she was trying to do with these statements is to "take some of the blame away" for what had happened:

> I said 'don't feel bad' about that, you know, that is going to be his most painful movement, um, and you just have to take it easy and if it's too much, just ease up and don't feel bad about that. I wanted to take some of the blame away from her.... (C, 4/2/93, p. 10)

Finally, when Diane denies John's accusations about the use of her torso during the exercise, John looks away in frustration and Caitlin responds with another it's OK John and Diane message: "That's just the perception/ when you're so tight and painful it feels like // even a little movement...". That is, No, Diane, you didn't lean your torso on his arm but John might feel like you did. Yes, John, I believe that you did experience discomfort with the movement. With respect to the latter affirmation of John, Caitlin emphasized how important she thought this message was:

> That pain is the pain that they're [John is] experiencing...and I thought that was something that was real important to communicate. I don't think that she believes some of the, you know, I just think she thinks that he is really exaggerating everything versus that was real to him, [it is] what he was feeling. (C, 4/2/93, p. 13)

These descriptions of the participants making their way through this very difficult segment by attending to and trying to maintain face and conversational involvement illustrate the interactional complexity of this volatile triadic encounter and show

how speakers and hearers must work to read the situation moment-to-moment and adjust utterance form and content according to their readings.

In addition, in this segment, as well as in others, when the situation appears to shift toward potential personal conflict between John and Diane and away from the goals of teaching, learning, and cooperation established for the session, then Caitlin exerts her status, authority and power as therapist in order to control or manage the session even though this exercise of power is, in some ways, antithetical to the concept of client-centering. This, then, is yet another time that Caitlin must walk a tightrope--a tightrope between her own commitments to establishing alliances, client centering and empowering clients, on the one hand, and exercising authority, power, and control in the treatment session when there is tension and conflict between family members. It seems clear that there were times in this therapy session when Caitlin reached her limits with respect to her ability to act as counselor and mediator when issues emerged that she perceived to be beyond her scope of expertise and practice--issues that were much larger and more complicated than the need for cooperation with an exercise program. And these were times when she used her status and power as therapist to avoid open conflict and control and manage the session.

As a final note, Caitlin does attempt to mitigate the larger negative FTA that the imposition of the joint home exercise program represents for John and Diane in their lives. Caitlin responds to a

question from Diane at the end of the session about how many times per day they should do the exercises:

C: Well, the things that I showed you// if you could get it in once a day/ and get, you know, a fairly good stretch/ I mean, we're talking maintaining that arm out to the side for five minutes while you're doing it/ That would be great// Um, I would ideally do it twice a day/ But, um, you know with your schedule....

Here, Caitlin explicitly recognizes the imposition that the home exercise program represents, especially for Diane given her work schedule, and Caitlin compromises (or mitigates this face threat) by asking that John and Diane do this set of exercises once per day rather than twice. She follows with the proviso, however, that once a day is adequate as long as John is continuing to do other exercises on his own. Thus the imposition that the exercise program and John's condition represent for him is not raised in the conversation analyzed here although these issues have been negotiated previously by Caitlin and John during other therapy sessions.

In Summary. The findings of this close analysis of face-to-face interaction point to the interactional complexity and multidirectional nature of communication in triadic clinical encounters. In this encounter there was underlying marital tension between the patient and his wife that factored into the nature of talk during the session, and constant role shifts were being negotiated. The situation itself

presented a significant challenge to the communicative competence of all participants. What becomes apparent when the discourse during the session is examined closely, is that *all* participants are working very hard to read and make sense of the situation and then making communicative choices, consciously or unconsciously, which influence *what* happens moment-to-moment in the session and *who* the participants are in relation to each other. At any given moment the therapist may need to act as careful observer of non-verbal behavior, as listener, learner, mediator, instructor or guide. So too might the patient and his wife.

As analysis of the talk in this complex session proceeded, two prominent features of the discourse emerged and were examined more closely: (a) the uses of repetition by the participants, and (b) the ways that face threatening acts were dealt with by the participants. The frequent use of repetition in multiple forms serving multiple functions was seen as a linguistic and kinesic resource for creating coherence in the discourse and generating interpersonal involvement of participants. Such interpersonal involvement could influence the outcome of the session and serve goals of developing therapeutic alliances and gaining cooperation between interactants so that collaboration in the teaching session and continued participation in a home exercise program could be realized. In the segment of talk described and analyzed, the use of repetition in conversation was a prominent feature in the therapist's and patient's talk; repetition was not used much by Diane who, overall, appeared less involved verbally and non-verbally in the session.

The achievement of teaching, learning, counseling, and cooperation goals and the outcome of the session were also felt to be linked to the ways that speakers and hearers attempted to interactionally mitigate or diminish the many positive and negative face threatening acts that occurred throughout the session. Several of these face threatening acts were described and the speakers and hearers responses to them were analyzed. Various forms of utterances were noted in response to threats to face, some more effective than others in maintaining or protecting face. When face threatening acts between patient and wife persisted or did not appear to be mitigated or defused, the therapist exercised the authority invested in her by her role, status, and social distance in this situation and would shift the talk back to instructional talk or to therapist register (Cazden, 1988; Ek, 1990).

Conclusion

In this chapter I have pursued several questions about the meaning of being a transdisciplinary rehabilitation team at Jones and Thompson, P.C.: What is a transdisciplinary team? How and why did this notion evolve in this and other clinical practices? How did therapists learn and develop as individuals as they became members of a transdisciplinary team? How did the team develop collectively? What are some of the problems and possibilities in transdisciplinary approaches to care? How is this approach to care constructed and sustained in day-to-day clinical practice? What's in it for participants? How does being a transdisciplinary team serve the ideal of client-centering?

As these questions were raised and explored, new or related ones emerged, some of which remain unanswered and beg further investigation. Even so, my preliminary exploration has convinced me that becoming and being a transdisciplinary team in this clinic is far more than an organizational goal or entity that serves as a *mechanism* for client-centering; it is more than a structural means to a clinical end. Instead, it is a shifting, interactional, relational, and social phenomenon, organized around practice, that serves as a site for on-going teaching, learning, and development among professionals in this clinic on behalf of clients.

The communal adoption of a core commitment to client-centering provides an important and necessary, but not sufficient, element for the creation and sustenance of a transdisciplinary approach to care. Since the ideal of providing client-centered care for patients with chronic disabilities is seen to be larger than any one individual's contribution and is believed to be best achieved collectively, this ideal motivates the activity of becoming and being a transdisciplinary team; it gives meaning to practice and impels these professionals to learn from each other and act together as legitimate participants in each other's disciplines to some degree (Lave, 1989; Lave & Wenger, 1991).

This is indeed a learning community; learning and development are fundamental communal activities carried on in a culture that provides for a sharing of focus, direction, and purpose. Jointly, the shared commitments to client-centering *and* being a transdisciplinary team describe a sociocultural system of beliefs that

encourage and create numerous opportunities for practitioners in this clinical community to continuously engage in many forms of activity, dialogue, joint problem solving, reflection, and "deliberative interpretation" (Eraut, 1994) which many researchers have suggested are crucial to learning and development in a variety of situations (c.f., Burbules, 1993; Lave & Wenger, 1991; Rogoff, 1990; Schon, 1983, 1987). As these professionals craft their identities (Lave, 1995) as clinicians *and* as a transdisciplinary team, they are co-participants across a spectrum of activities--described in this paper as the processes of becoming and being a transdisciplinary team--that provide a varied and inevitably social and fertile ground for learning, and personal and professional transformation and development. These activities provide for legitimated and "differently located partial participations" (Lave & Wenger, 1991) by members of this community in the clinical practice of others.

Working from another, but related, analytic perspective borrowed from Rogoff (1990; 1995), I believe the activities I have described as the interwoven processes of becoming and being a transdisciplinary team, provide a glimpse of what Rogoff calls three "inseparable, mutually constituting planes" for analysis of development that correspond with community, interpersonal, and personal processes: apprenticeship, guided participation, and participatory appropriation (Rogoff, 1995, p. 139).

The first of these processes, apprenticeship, is a model or metaphor for development in the plane of community activity. As Rogoff describes it:

> In apprenticeship, newcomers to a community of practice advance their skill and understanding through participation with others in culturally organized activities.... Apprenticeship involves more than [expert-novice] dyads. Apprenticeship relates a small group in a community with specialization of roles oriented toward the accomplishment of goals that relate the group to others outside the group. The small group may involve peers who serve as resources and challenges for each other in exploring an activity, along with experts (who, like peers, are still engaging in activities with others of various experience). Apprenticeship as a concept...focuses on a system of interpersonal involvements and arrangements in which people engage in culturally organized activity in which apprentices become more responsible participants...[I]t encourages the recognition that endeavors involve purposes (defined in community and institutional terms), cultural constraints, resources, values relating to what means are appropriate for reaching goals..., and cultural tools such as maps, pencils, and linguistic and mathematical systems. (Rogoff, 1995, p. 143)

Thus, on this plane of analysis, the contributions of *community* activity (which is culturally defined and organized) to development is foregrounded. In my descriptions and analysis of the transdisciplinary team in this clinic, apprenticeships of the form that Rogoff describes occurred for practitioners in their early professional training and experience but continued and were extended (even transformed) as they entered and became an integral part of this particular clinical community (a sub-culture, if you will) characterized by it's own distinct system of beliefs and values, cultural and institutional resources and constraints.

Rogoff (1990, 1995) uses the term "guided participation" to refer to activity on the interpersonal plane in sociocultural analysis of human development. This plane draws attention to

> ...the processes and systems of involvement between people as they communicate and coordinate efforts while participating in culturally valued activity. This includes not only the face-to-face interaction...but also the side-by-side joint participation that is frequent in everyday life and the more distal arrangement of people's activities that do not require copresence (e.g., choices of where and with whom and with what materials and activities a person is involved). The 'guidance' referred to in guided participation involves the direction offered by social and cultural values, as well as social partners; the 'participation' in guided participation refers to observation, as well as hands on involvement in an activity. (Rogoff, 1995, p. 142)

Rogoff further clarifies that her use of the term "guided participation" involves interpersonal "engagement in *some* aspect of the meaning of shared endeavors, but not necessarily in symmetrical or even joint action" (p. 147) [italics added]. That is, collaborative decisions and arrangements about the types or extent of involvement of individuals in particular activities is also part of guided participation; thus, guided participation is "...an interpersonal process in which people manage their own and others' roles, and structure situations (whether by facilitating or limiting access) in which they observe and participate in cultural activities" (p. 148).

At Jones and Thompson, P.C., many of the everyday activities associated with becoming and being a transdisciplinary team reflect the forms of interpersonal engagements suggested by Rogoff's description of guided participation. These include (a) opportunities for observation, side-by-side practice, and joint practice in therapy gyms, offices, hallways, or screening clinics, (b) formal team meetings and discussions about "who is team" for different clients and the

level and extent of direct or indirect services to be provided by members of the team (i.e., activities devoted to negotiation about role boundaries and what is or what isn't legitimate participation), (c) informal and regular dialogue (in both written and oral forms) among professionals about their disciplinary perspectives on shared client's needs, and (d) review of written artifacts and each other's clinic reports by members of the team.

Finally, on the personal plane of sociocultural analysis of development, Rogoff (1995) focuses on the concept of "participatory appropriation." According to Rogoff,

> ...*participatory appropriation* refers to how individuals change through their involvement in one or another activity, in the process of becoming prepared for subsequent involvement in related activities....participatory appropriation is the personal process by which, through an engagement in an activity, individuals change and handle a situation in ways prepared by their own participation in a previous situation. This is a process of becoming, rather than acquisition...(p. 142).

In this view, individual learning and development are dynamic and on-going processes of appropriation and transformation (versus transmission, acquisition, and mental internalization) ineluctably linked to participation in socioculturally situated activities. Being and becoming are woven together in a complex and ever-changing web of meaning and shared activity. Furthermore, Rogoff (1990;1995) points to the extraordinary importance of participation, *mutual work to achieve shared understandings of situations* , and

jointly constructed goal-directed activity in human development through her descriptions of participatory appropriation.

> Participation involves creative efforts to understand and contribute to social activity, which by it's very nature involves bridging several ways of understanding a situation. Communication and shared efforts always involve adjustments between participants (with varying degrees of asymmetry) to stretch their common understanding to fit with new perspectives in the shared endeavor. Such *stretching to fit* several views and to accomplish something together *is* development and occurs in the process of participation. (Rogoff, 1995, p. 153)

For me, these descriptions evoke multiple images of the everyday activities of the professionals *and clients* at Jones and Thompson, P.C. as they dynamically, interactively, and socially construct transdisciplinary approaches to care and client-centering. I believe participatory appropriation is an omnipresent phenomenon in this clinic and can be seen perhaps most clearly in some of my descriptions of therapists becoming and being indirect providers of services for clients, and in descriptions of Caitlin making her way through therapy sessions with various clients as she stretches to fit perspectives other than her own in the shared endeavor of client-centering.

The analysis in this chapter concerning becoming and being a transdisciplinary team *member* and a transdisciplinary *team,* suggests the futility of separating the co-occurring processes of learning and development on the community, interpersonal, and personal planes. All of these planes of analysis deserve attention

and are either brought into the foreground or allowed to operate in the background for purposes of analytic or descriptive clarity.

In telling some of these stories, I have focused on analysis at the level of discourse but tried to frame these microanalyses in the larger sociocultural context in which they are imbedded and through which they can be interpreted by both participants and readers. Like Rogoff, sociolinguists have also emphasized the importance of attention to multiple layers in understanding human intention, interaction, and action. In this respect, I again find Gumperz's (1982) concept of "communicative competence" pertinent to discussions and analyses presented in this and other chapters. Gumperz defines communicative competence as

> ...the knowledge of linguistic and related communicative conventions that speakers must have to create and sustain conversational cooperation, [which] thus involves both grammar and contextualization.... Knowledge of...discourse level [contextualization] conventions reflect prolonged interactive experience by individuals cooperating in institutionalized settings in the pursuit of shared goals in friendship, occupational and similar networks of relationships. Once established, such conventions come to serve as communicative resources which,...facilitate communication and enable individuals to build on shared understandings which eliminate the need for lengthy explanations.... This knowledge is of a kind that cannot be easily acquired through reading or formal schooling. Face to face contact in situations which allow for maximum feedback is necessary.... In real life situations, learning of discourse strategies is most successful when outside conditions exist which force interlocutors to...stay in contact.... (Gumperz, 1982, p. 209)

The prolonged interactive work among members of this clinical community over a period of many years to enact and realize their commitments to client centered and transdisciplinary approaches to patient care, provides, I believe, a vision with a face of what Gumperz has described above. It offers a glimpse, in real life situations of how a discourse community evolved and matured, of how individuals within that community can and did become communicatively competent, and of conditions and activities that foster learning and development.

Thus far, I have suggested that the findings of this exploration of the meaning and construction of a transdisciplinary team are congruent with, and contribute to, an understanding of learning through practice articulated in the analytical perspectives of (a) legitimate peripheral participation (Lave & Wenger, 1991) and (b) Rogoff's (1990, 1995) concepts of apprenticeship, guided participation, and participatory appropriation. Both of these analytic perspectives are grounded in an epistemology of social constructivism, and informed by the theoretical framework of sociohistorical theory (Vygotsky, 1962, 1978), which posits an intimate relationship between sociocultural practice and higher mental function and individual development, and the philosophical perspective of Dewey's (1916, 1938) social pragmatism. Vygotsky and Dewey both emphasize the importance of social activity and semiotic mediation in learning and development and stress that the nature of the social medium and of activity both influence the degree

to which experience is educative for participants. As Dewey (1916) has written:

> ... any social arrangement that remains vitally social, or vitally shared, is educative to those that participate in it. (p. 6)
>
> The social environment consists of all the activities of fellow beings that are bound up in the carrying on of the activities of any one of it's members. It is truly educative in its effect in the degree in which an individual shares or participates in some conjoint activity. By doing his share in the associated activity, the individual appropriates the purpose which actuates it, becomes familiar with its methods and subject matters, acquires needed skill, and is saturated with its emotional spirit. (p. 22)

For me, these words and the images they convey are not just theoretical or philosophical formulations distant from everyday practice; I suggest that such a "truly educative" environment and forms of "vitally shared" activity can be found in the clinical community I have described, and are perhaps best understood through examination of participant's efforts to construct a client centered approach to care and their ongoing engagements in the dialectic of becoming and being a transdisciplinary team.

Chapter 6
SUMMARY AND CONCLUSIONS

Reflections on the Journey

As I started this research endeavor I spoke of it as an inviting yet uncertain journey. In Chapter One I talked about life experiences that impelled me toward the questions that encouraged this journey. Now I would like to share my reflections on this portion of the journey and consider the following questions: What was I trying to learn about? What were my initial research questions? How were my questions transformed during the course of my study? How did I try to answer the initial and emergent questions? Who did I meet along the way? What did they teach me? What did I learn and how have I changed as a result of this endeavor--as a clinician, as a teacher, as a researcher, and as a person. Finally, I want to consider what others might learn from my learning--what are the potential contributions of my findings to the disciplines of educational psychology and physical therapy and other related fields and disciplines?

What Was I Trying to Learn About?

The overarching question that guided this research endeavor was: "What is the nature of interaction between an experienced (or

master) physical therapist and patients with brain injury in the sociocultural context of an interdisciplinary rehabilitation clinic?" As the title of this dissertation suggests, my quest to explore this question was fueled by the words of Lee Shulman (1987) who urged educational researchers and others to seek, explore, and share "richly developed portrayals of expertise" (p. 1) which could help practitioners, researchers, and policy-makers better understand the wisdom of practice. Such investigations and contextualized portrayals, he argued, were an overlooked but extremely important contribution to the "knowledge base" for teaching. Although Shulman's words were directed primarily toward the educational community, there were also appropriate to other professional communities as well. In physical therapy, practitioners, researchers, and educators alike were struggling to describe a knowledge base (or domain as I prefer to call it) for the profession yet we had virtually none of the types of portrayals of which Shulman spoke. I felt such portrayals were desperately needed and held great promise for physical therapy and other related fields.

As expected in all qualitative inquiry and in ethnographic research in particular, the broad question that framed this investigation spawned many others during my three year engagement in the study. New questions, informed by my experience in the field, emerged; existing questions were transformed, extended, or refined as the journey continued. As I came to know the clinicians and clients who participated in my study and to understand the cultural beliefs and norms for action among

practitioners in this clinic, I realized that this system of beliefs--what they called their philosophy of care--served as a powerful framework for interpretation of my observations of clients and therapists at Jones and Thompson, P. C. Thus, some of the key components of the multifaceted philosophy or ideal of client-centering became sites or starting points for further exploration of the day-to-day interaction and the wisdom of practice in this clinical community.

The new questions that emerged were questions about (a) the nature of therapeutic alliances in therapy, (b) the nature of teaching and learning in patient-therapist encounters, and (c) the nature and construction of transdisciplinary approaches to care in a rehabilitation clinic. I asked: "What do these notions or concepts, described by therapists as central commitments in their everyday practice, look like at the local level of face-to-face interaction?" In pursuing these questions, my focus, was on how these features of client-centering were interactionally realized or transformed in therapy with special attention to the work of a master physical therapist, Caitlin, and three of her clients with brain injury.

How Did I Try to Answer the Questions: The Paths I Traveled

I completed an ethnographic and microethnographic study at Jones and Thompson, P. C. that spanned almost three years. The initial phase of the study in 1992 focused first on describing the culture of the small private rehabilitation clinic in which Caitlin worked and where the client participants received outpatient therapy services. This phase of the study involved frequent and

regular observation in the clinic setting and formal and informal interviews with professional staff and the clients (John and Diane) whom I followed in the first round of data collection. Secondly, in the initial phase of the study I collected videotape recordings of five therapy sessions with John, a patient with a brain tumor and resultant chronic disability, and Caitlin. One of these sessions was a joint teaching session with John, his wife, Diane, and Caitlin. Throughout 1993, I continued to analyze the data collected in 1992 and collected some additional data in the form of videotape review sessions with Caitlin. In addition, I completed advanced coursework in discourse analysis to aid my interpretation of existing data and to prepare me for further data collection and analysis with other clients.

A second phase of data collection and analysis began in Winter 1994. This consisted of the collection of additional observational and interview data with clients and therapists. Two more clients, both of whom had sustained head injuries and had post-concussion syndrome, were followed during this phase of data collection and an additional 14 hours of videotape data from Caitlin's therapy sessions with Bob and Marcia were obtained. Cataloguing and analysis of videotape conversational data was completed working from Hymes' (1972) theoretical framework of ethnography of communication and following procedures described by Erickson and Shultz (1981).

These, then, were the methods and procedures I used, or the paths I followed, to address the questions I had raised and that developed as the work proceeded. Along the way I met some

remarkable individuals who have made tremendous contributions to my own learning and development. It is that learning I share with others through this manuscript. The clinicians whose stories unfold in this dissertation are a group of very experienced rehabilitation professionals whose collective disciplinary knowledge and expertise spans neuropsychology, occupational therapy, speech and language pathology, social work, and physical therapy. There are also stories of clerical staff at Jones and Thompson. And finally, there are the stories of three clients with brain injury of various forms and varying degrees of severity: John, Marcia, and Bob. As a result of their injuries, these individuals faced major disruptions in their lives. Their joint work with Caitlin, a physical therapist, to regain function and construct an altered but ongoing and rich life story is where I focused my attention most closely in this investigation.

What Did I Learn?

What insights did I gain as a result of this journey? What did I learn about situated expertise and the wisdom of practice? One thing I learned is that this wisdom does not just reside in an individual. During my time at Jones and Thompson, I observed wisdom as expressed and shared by a community of practitioners, wisdom as articulated and embodied by individual practitioners, and, finally, the wisdom of clients facing illness and chronic disability. All of these forms and expressions of wisdom contributed to an ever evolving collective wisdom of practice shared by Caitlin and other clinicians.

Beyond that large lesson, I learned a great deal about how clients and therapists work to jointly construct a client-centered approach to care in this rehabilitation clinic. Now I turn to a brief summary of some of my key findings and claims with respect to the three aspects of client-centering that I explored in greatest depth in this study.

Therapeutic alliances and client centering. Creating and sustaining therapeutic alliances between clients and therapist was deemed to be essential to the realization of the ideal of client-centering. Therapeutic alliances provided a relational framework within which and through which a client centered approach to care could be constructed. According to therapists, the development of truly therapeutic alliances required relatively extended periods of time with clients, respectful listening, and reciprocal disclosure between client and therapist. All of these things were believed to contribute to the reduction of feelings of vulnerability in therapy and the development of a mutual trust in clinical encounters.

The above are descriptions provided by therapists of what a therapeutic alliance requires and should be. My observations and analyses help us to go a step further; they help us to understand how some of these ideals might be realized or constrained at the level of face-to-face interaction between therapists and clients. I identified several features of discourse that appeared in therapy sessions with Caitlin and John, Bob, or Marcia, that I claim provided for the creation and sustenance of therapeutic alliances and, concurrently, client centering. Among these were the asking of questions that

actively sought patient perspectives regarding their illness, needs, and goals. Beyond asking these questions, therapists must take the patient's response to such questions into account as they jointly construct goals and plans for therapy. Caitlin also asked questions that invited genuine patient participation in decision-making about the nature of treatment in therapy. Asking these questions and then incorporating patient perspectives and wants into the development of therapy programs is one form of respectful listening.

Caitlin and her clients also shared stories about themselves, about illness experiences, about their families and friends during therapy. Listening to and offering stories in the context of therapy was important. Such stories, often absent or cut short in many clinical encounters, provided an opportunity for shared insight regarding the subjective experience of the storyteller and were a form of mutual disclosure in therapy.

There was substantial evidence to suggest that Caitlin and her clients constructed a shared language in therapy that served the development of the shared understandings so critical for the creation of a therapeutic alliance. Shared language was both a verbal and non-verbal phenomenon. It was evident in the fluid rhythms of therapy and the overall movement synchrony between clients and Caitlin--the kinesic and proxemic features of interaction. In the verbal realm, shared language and the development of shared meanings was evident in the use of metaphor and other-repetition, and, in the case of John, "PT lingo." My observations suggest that other-repetition and the joint construction and use of metaphor were

powerful and frequently-used linguistic resources for the development of (a) conversational involvement and connection between interactants and (b) shared understandings. Caitlin's use and extension of client-generated metaphors in therapy is especially important and, combined with repetition of clients' words, is another manifestation of respectful listening.

Finally, I suggest that attention to face and politeness in therapeutic encounters is integral to the co-construction of therapeutic alliances. Although all individuals in all social encounters must engage in interactional work to preserve or maintain face, this becomes particularly important in clinical encounters with patients with chronic impairment and disability. The illness experience and the status of "patienthood" is inherently face threatening. My observations suggest that the work of the therapist to linguistically mitigate or defuse face threatening acts served the development and sustenance of therapeutic alliances. Furthermore, I claim that work to preserve or enhance face for clients occurs on several levels in therapy: at the micro-level we see linguistic and paralinguistic work to maintain face. At a more macro-level, eliciting and taking into account the clients' perspectives, needs and goals in the development of therapy goals and programs enhances positive face. In addition, inviting patient participation in decision-making about the forms and extent of therapy programs mitigates the threat to negative face that a unilaterally developed and prescribed treatment regimen represents for a client.

Teaching and learning in therapy. The therapists at Jones and Thompson viewed therapy as an educative endeavor. As such, their role and responsibility to the client centered on teaching and fostering client learning and development. They felt that client education was the key to client enablement and empowerment. If the development of therapeutic alliances was largely about therapist learning from clients, then constructing therapy as an educative endeavor was largely about client learning from therapists. As the title of Chapter Four suggests, however, teaching and learning in therapy were reciprocal activities. The work to develop therapeutic alliances (therapists learning from clients) does not stand apart from the work of client education and empowerment (clients learning from therapists).

My observations of Caitlin and her clients as they worked to achieve educational goals revealed general patterns of interaction and a structure of therapy sessions that appeared in Caitlin's work with all three clients. Even so, there was flexibility and variability within that structure that allowed for individual patient's educational needs and goals to be addressed. The external and internal structure of therapy sessions that emerged was one that was clearly a reflection of Caitlin's beliefs about teaching and the nature of learning. Among these beliefs was the need to help learners see the relationship between what Caitlin called the "big picture" and the "little pieces" of therapy. Caitlin adopted several teaching strategies, evident in session structure, to establish the relationships between the whole and parts for learners. Among these strategies were (a)

the use of advance organizers, (b) dynamic assessment of prior and emergent knowledge, (c) the use of reciprocal feedback regarding performance as a tool for improving client self-monitoring and regulation, (d) efforts to provide a rationale for all the activities of therapy and to constantly connect therapy exercises to the situations and contexts for their use, and finally, (e) efforts to embed therapeutic movements (exercises) into everyday and meaningful activities for clients.

The structure of therapy sessions that emerged consisted of three preparatory segments which I called (a) getting started and settling in, (b) overview of findings and review of activities or learning to date, and (c) introduction to the purpose and structure of therapy for that day or session. These preparatory segments were followed by a variable number of exercise segments, each of which was organized around instruction in and performance of a specific exercise or series of related exercises. There was a recurrent, though not inflexible, internal structure to exercise segments as well. Most exercise segments consisted of an introduction to the name and purpose of the exercise, a demonstration of the exercise, two consecutive trials (with several repetitions) of the exercise both of which were followed by therapist and client feedback regarding exercise performance, and lastly, a summary and review of the exercise critically including further discussion of the rationale for and usefulness of the exercise with respect to the client's impairments and their goals for therapy. Following exercise

segments, therapy sessions closed with a segment I called "review and closure."

Many features of teaching and learning within therapy sessions (as well as the development of therapeutic alliances) could be interpreted as efforts to construct a constructivist approach to teaching in therapy. I take this interpretation a step further by describing and analyzing some of these features through the conceptual lens of Vygotsky's (1978) construct of the zone of proximal development. I suggest that much of the interactional work of developing therapeutic alliances and fostering learning and development of clients in therapy can be described and understood as work to (a) create intersubjectivity between participants, (b) conduct ongoing dynamic assessment of actual and potential levels of development, (c) engage in instructional practices that provide for guided practice and collaboration to promote learning, and (d) thus, create and stretch zones of proximal development for clients.

Becoming and being a transdisciplinary team. According to therapists at Jones and Thompson, the construction of a transdisciplinary approach to care was one of the facilitators for the day-to-day enactment of their philosophic commitment to client centering. The vision of a transdisciplinary team articulated by clinic associates suggested that disciplinary boundaries (in terms of roles, responsibilities, and knowledge) became semi-permeable and flexible as team members shared their professional expertise and worked together to solve problems with and for clients. Such a vision requires that team members constantly learn from each other

as they construct this approach to care. Thus, if therapeutic alliances were about therapists learning from clients, and therapy as an educative endeavor was about clients learning from therapists, becoming and being a transdisciplinary team is about therapists learning from each other.

My data suggest that becoming and being transdisciplinary team is an iterative and dialectic process--a developmental phenomenon that I argue occurs on several planes concurrently. Borrowing from the work and analytic perspectives of Lave and Wenger (1991) and Rogoff (1990, 1995), I analyze the process of becoming and being a transdisciplinary team in this clinic at the levels of community, interpersonal, and personal processes. In doing so, the concepts of apprenticeship and movement from legitimate peripheral participation to fuller participation in a community of practice (Lave & Wenger, 1991) as well as guided participation and participatory appropriation (Rogoff, 1995) informed my analyses.

Opportunities for apprenticeships and guided participation in the expert practice (and thus, cognition) of other team members occurred through (a) formal or regular team meetings about shared clients, (b) informal dialogue among team members (either orally or via written exchanges of notes), (c) review of written artifacts and the clinic reports of other therapists, and (d) through co-participation in screening evaluations and treatment sessions with clients on some occasions. In addition, the negotiation of role, knowledge, and practice boundaries also contributed to therapist learning about the disciplinary expertise of others and was an essential activity with

respect to legitimating the participation of a professional in some of the disciplinary work of another. This negotiation frequently involved determinations about who would provide direct or indirect therapy services for clients and typically took place in team meetings.

Finally, I suggest that the work of therapists to provide indirect services for clients (i.e., to provide some services for clients that are not the exclusive purview of their particular profession), are instantiations of movement from legitimate peripheral participation to fuller (though never full) participation in the disciplinary practice of professionals from disciplines other than their own. My data include examples of Caitlin providing indirect services in counseling and neuropsychology for Bill, indirect services in speech and language pathology for Marcia, and indirect services in counseling and social work for Diane and John. It is in the last of these cases that some of the risks and challenges of constructing a transdisciplinary approach to care are best elucidated.

What Can Others Learn From My Learning?

How might what I have learned on this journey contribute to theory, research, and practice in communities of interest? In answering this question, I want to consider what the findings of my study might contribute to knowledge in the communities of physical therapy and educational and developmental psychology, although I hope my findings can also inform research in other health care fields and disciplines such as medical anthropology and sociology.

Physical Therapy. When I started on this journey, I expresses concern about the paucity of richly developed portrayals and representations of physical therapy practice and mastery grounded in research in our own profession. First and foremost, then, this study contributes a detailed, contextualized, embodied, and storied portrait of physical therapy practice and clinician wisdom and mastery. The study focuses on the nature of practice and mastery in neurologic physical therapy through close and extended examination of the work of an experienced therapist with adult patients with brain injury in an interdisciplinary rehabilitation clinic. There are no such portrayals in the physical therapy literature currently. Thus, I hope that this portrayal contributes to physical therapy practice, theory, research and education in several ways.

In terms of research, this investigation and report suggest the promise of qualitative approaches to inquiry in understanding expertise in physical therapy and the complexity of everyday practice. More specifically, it can help to inform the physical therapy research community about ethnographic and microethnographic approaches to research. Knowledge of such approaches to inquiry can help the research community reconceptualize questions of importance to the field; that is; with such approaches we can ask questions that heretofore went underinvestigated or uninvestigated. This is one of my greatest hopes and one of my greatest commitments in the remaining years of my practice as a physical therapy educator and researcher--to invite more physical therapists

to learn about and consider qualitative approaches to inquiry as they ask and seek answers to questions of importance for the profession.

My findings also contribute to ongoing research and emerging theory about the nature of mastery in physical therapy. Jensen and her colleagues (1990, 1992) have initiated a series of qualitative case studies in this area. Thus far, their published findings have focused on attribute dimensions of novice versus experienced therapists working in orthopedic physical therapy. Even so, there are interesting parallels between their findings that master therapists (a) are intensely focused on their clients during therapy, (b) collect and actively use both illness and disease data in their work with patients, and (c) feel that teaching is one of their most important clinical skills (Jensen, et al., 1990, 1992). Continued investigation of the day-to-day interaction of experienced or master physical therapists with patients with a variety of disorders and disabilities can help to enlarge, refine, or modify emerging conceptual frameworks regarding the nature of expertise in physical therapy.

My initial investigation with a specialist in neurologic physical therapy working with patients with brain injury suggests that there are some features of her work and interaction with patients that converge on those observed by Jensen and her colleagues (1990, 1992). If these features appear across therapists in a variety of settings working with a variety of patients, this is very interesting indeed. Such findings have the potential to contribute to the development of theory about the nature of expertise in physical therapy practice. Even so, a conceptual model or theory of expertise,

though helpful, can obscure the local actions and interactions of therapists and clients as they construct expertise in everyday clinical practice. My study contributes a detailed and situated description of some of these features of expert practice at the level of discourse in clinical encounters. Thus, it can help to ground emerging theory about mastery in physical therapy in the particulars and exigencies of day-to-day clinical practice.

In addition to offering glimpses of expertise through close analysis of discourse, my study urges researchers, practitioners, and health care policymakers to continuously examine and consider the "big picture" as well. It points to the importance of examining and understanding the historical and sociocultural contexts that surround and penetrate the work of physical therapists in descriptions of the particular. Therapist and client action and interaction in clinical settings must not and *can not* be considered as phenomena separate from the institutional and sociocultural contexts in which they occur.

This is a particularly important observation at this time in the history of health care in the United States. Currently, there are dramatic shifts occurring in the health care delivery system such as the growth of managed care, the corporatization of health care agencies and institutions, and the creation of extensive provider networks affiliated with large corporations or agencies as opposed to the maintenance and development of free-standing, privately owned clinics (like the one in which this study was conducted). Such changes create societal and institutional climates for health care that are uncertain and unfamiliar to many practitioners and clients, and

that we know very little about in terms of the impact on health care practitioner-patient interaction and clinical outcomes.

These changes have and will continue to result in alterations in day-to-day practice for clinicians. They have the potential to substantially influence the experience of patients and practitioners as they re-construct health care in a changing environment to which they are unaccustomed. For example, in emerging systems for health care delivery and reimbursement there are increasing restrictions on the amount of time and number of "visits" allotted for patients and therapists to work together. The findings of this study invite the question of whether a change in the amount of time a therapist has to interact with their clients one-on-one (in a single visit or over several visits) might influence the nature and development of (a) therapeutic alliances, (b) the achievement of educational goals for therapy, and (c) the realization of client centered approaches to care. This is just one of many multifaceted questions that arise and deserves further investigation.

I suggest that constant consideration of the "big picture", then, as well as the particulars of patient-therapist interaction can provide a richer and more enlightened understanding of physical therapy practice and what *enables, constrains, and constitutes* practitioner wisdom and mastery. Such understanding can and should inform decision-making about health care policy and physical therapy practice and education.

Finally, from a methodological perspective, I argue that a more comprehensive and integrated view of the interactional phenomena

that comprise and create health care encounters and that provide insight into clinician expertise, can be gained through the use of a combination of ethnographic and microethnographic approaches to research in this area.

As a physical therapist educator and practitioner I have been changed by my engagement in this study. Thus, I hope that what I have learned along the way can also contribute to or change other physical therapists' thinking about practice and physical therapy education in several ways. For practitioners and educators alike the findings of my study elucidate some of the complexities of practice that have not, as yet, been thoroughly described in our literature. This is not to say they have been completely unrecognized--they have. But they have not been articulated through systematic examination of face-to-face interaction between therapists and clients and therapists and the other health professionals with whom they interact on a regular basis. The findings of this study urge us to question or abandon unidirectional or therapist-centered models of interaction. Instead, they urge us to consider the transactional and improvisational nature of the joint construction of therapeutic encounters.

In my own teaching over the last few years, I have been able to share some of the results of this study with students, researchers, and practitioners. The availability of these data and the insights they provide have changed the way I teach and the way I practice. In the classroom, these data enable me to go beyond (a) the presentation of linear models of practice and clinical decision-

making, (b) admonitions to students and practitioners to encourage patient participation in care, (c) proclamations of the importance of teaching and learning in clinical encounters, and (d) expressions of the importance of being a member of a team in rehabilitation practice. Now, via contextualized stories and vignettes drawn from day-to-day practice, I can provide "real-life" examples of how a master therapist, clients, and other members of a rehabilitation team engage in clinical decision-making, jointly participate in therapy, teach and learn from each other, and socially construct team practice. I can invite listeners and readers to experience, reflect on, and interpret the experience of others in a way that was not possible before. Such experience and reflection can provide invaluable opportunities for learning and transformation of both teachers and learners. Thus, I hope the stories told in this dissertation will be shared with others and be used as a resource for engaging physical therapists and physical therapy students in ongoing reflection about the nature of their own and others' practice.

Educational and Developmental Psychology. What do the findings of my study contribute to disciplinary knowledge in educational and developmental psychology? First, this study provides a detailed illustration and examination of adult learning and development in a context other than formal educational settings like schools and universities. It describes the nature of teaching, learning, and interaction in a community of practice organized around a commitment to education as a central aspect of clinical care. This study provides glimpses of masterful teaching as well as

moments of insight and learning as they are revealed through discourse between clients and an experienced physical therapist. It also reveals both situational, personal, and interpersonal affordances and constraints on learning and development in the context of day-to-day practice with patients with brain injury in a rehabilitation clinic.

Working from the theoretical perspective of sociohistorical theory and a variety of related analytic perspectives such as situated cognition (Brown, Collins, & Duguid, 1989), legitimate peripheral participation (Lave and Wenger, 1991), the zone of proximal development (Vygotsky, 1978), and participatory appropriation and guided participation (Rogoff, 1995), this study closely examines the nature of (a) clinician learning from clients, (b) client learning from clinicians, and (c) clinicians learning from clinicians. My findings suggest that these theoretical frameworks and analytic perspectives can help us to examine and understand learning and development in this setting. Conversely, I hope my findings can contribute to the refinement and ongoing development of these perspectives or concepts in an embodied and situated way.

Finally, the findings of this study point very strongly to the importance of the relational and moral dimensions of teaching and learning in this clinical setting. It urges researchers and educators in educational and developmental psychology to attend to these aspects of interaction as they examine the social construction of learning and learning communities in a variety of settings.

Chapter 7
EPILOGUE

Finishing the Stories

Through my years of work on this study I carried the stories of these clinicians and patients close to my heart and my mind. In this dissertation I have invited others to share the stories of these remarkable individuals. It seems fitting to end this manuscript with an epilogue that provides a vision of the ongoing and larger stories of the participants who invited me to share in their lives during the period of this study. As Bateson (1989) has written, life is a "composition"--a work in progress. Here, then, I offer a glimpse of the clients' and clinicians' evolving, often unpredictable and improvisational compositions of life.

The Clients

John and Diane. I last saw John and Diane in April 1992. For approximately two and one-half years after that, John continued to defy the predictions of his physicians and experienced a period of relatively stable function and minimal tumor growth. He returned to some of his work in videography and worked for a period of time at a local high school in media services. During this time, Diane continued to see Kay for marital counseling and John saw Caitlin

intermittently for consultation as different functional needs arose at work or home.

In early Fall of 1994, John suddenly took a turn for the worse. His tumor had begun to enlarge rapidly and he experienced a significant decline in his physical function combined with increasing alteration in his cognitive and perceptual status. He began to have frequent episodes of falling that resulted in a variety of injuries including a fractured clavicle, bruises, and joint sprains. His ability to get around safely by himself and to care for himself without assistance became increasingly impaired. His amiable and social personality began to change and he became more distant and sometimes belligerent.

In early October 1994, John and Diane came to see Caitlin for a reevaluation and consultation. They wanted to maintain as much function and mobility as possible while ensuring John's safety in his everyday activities. According to Caitlin, this was very difficult therapy session for all involved. John was pallid and withdrawn with his old spark gone. He was no longer able to provide an accurate history of his functional problems. He wanted to show Caitlin how well he was still doing with his walking and transfers but was unable to do so without assistance and severe losses of balance.

By the end of the session, Caitlin had to recommend that a wheelchair be rented or purchased to ensure John's safety as he went out into the community and that a referral for a home health aide be made to assist with some of his basic self-care activities. This is what Diane had known and what John did not want to hear.

Now he heard it from Caitlin--his confidant, his consultant, his friend. It was a very hard realization for John and, according to Caitlin, toward the end of the session he "just broke down."

In the following weeks John called Caitlin on a weekly basis for advice and support. Toward the middle of November he accepted hospice care. John passed away in late November of 1994.

Caitlin wrote to let me know of John's death: "He was a great guy--I will miss him a lot. They sang 'Bridge Over Troubled Waters' at his funeral. I could almost hear him singing along."

Marcia. Marcia continued to make progress with her balance, strength, endurance, and functional activities after therapy with Caitlin was concluded although she is still bothered by some neck and upper back discomfort from time to time. Marcia corresponds with me at Christmas time each year. In her last letter, sent from their winter retreat in Texas, Marcia said she and her husband try to walk about three miles on the beach every day. They play golf frequently and Marcia is able to walk nine holes, although she said she usually "gives in" and takes a cart if they are playing eighteen holes. Marcia said she occasionally experiences some balance losses when walking on hills and uses a rail to climb stairs or goes "left foot down, right foot up." In spite of some lingering problems, Marcia frequently expresses thankfulness for the help she received and the extent of her recovery after the accident. As she put it in her last letter: "But heh, I'm thankful God spared our lives and when home I enjoy serving Him by volunteering."

Bill. Bill had a more difficult time than Marcia after the conclusion of his therapy. Although his dizziness and his vestibular, visual, and balance problems were much reduced, he continued to experience problems with headaches at work and home. His physician suggested a medical leave of absence. Bill took a leave of absence until December 1994 when, according to Bill, "I talked my doctor into letting me go back to work." Bill resumed working at the pharmacy and although he continued to experience some headaches they were not so frequent or severe that they impaired his ability to do his work. Unfortunately, in October 1995 Bill began to experience increasingly severe headaches that affected both his work and sleep and that didn't seem to respond to medication or the use of an ice-pack. In mid-January 1996, Bill was once again forced to take a medical leave of absence from work. He continues to want to return to full-time work and hopes to work through 1997 before retiring, although he is beginning to question whether he will be able to do this. In his last correspondence which detailed this history, Bill concluded by saying "other than that, I feel great--well, almost."

The Physical Therapist: Caitlin. In Fall 1994, Caitlin learned that she was pregnant with twins. She continued to work at Jones and Thompson through January 1995 and to teach for the physical therapy program at a local university until she was admitted to the hospital to try and prevent the premature birth of the babies. The twins were born approximately six weeks prematurely in late March and spent the first month of their lives in the neonatal intensive care unit of the hospital. When they finally came home in May, both of

the girls were on continuous monitoring during this early and uncertain period of their lives and required round-the-clock care from, Caitlin, her husband, and other caregivers until September of 1995.

During this time, Caitlin did not work at Jones and Thompson or the university and devoted all of her time to caring for her four young children. In September she returned to part-time teaching at the university. More recently, as the infants near their first birthday Caitlin has been "weighing where I want to focus my energies professionally." She has been talking with Kay about returning to Jones and Thompson and resuming her involvement in patient care in a variety of capacities. She is interested in expanding her work with clients to include fitness screenings for patients with neurological disorders and would like to be more involved in consultation, education, and program development for facilities and practitioners who provide services for patients with disability due to stroke or other forms of brain and head injury.

Caitlin's babies are progressing nicely with their development, although as is expected with premature children, they are on a slightly different developmental timetable than other children of their age.

The Clinic Staff and The Clinic Itself. After a period of uncertainty about the viability and future of the clinic as dramatic shifts took place in the health care community around Jones and Thompson, the clinic survived and continues to operate and attract referrals for services for a unique group of clients with challenging

clinical problems. They continue to serve patients with a variety of neurological impairments and are especially recognized in the community for their work with patients with mild to moderate head injury like Marcia and Bill.

There have been a few changes in staff at the clinic. As mentioned earlier, Caitlin is not working at Jones and Thompson at present but hopes to return as a clinic associate in some form in the near future. One of the social workers left the practice in 1994. Finally, Don is looking toward discontinuing his work in the clinic and devoting more of his time to his artwork and work at the university. Another neuropsychologist has become an associate at the clinic and brings with him expertise in the assessment and management of patients with various forms of dementia. Thus, this my be an area of expansion of services and clientele in the future.

ENDNOTES

1. Pseudonyms are used throughout to protect the identity of the participants.

2. A Physiatrist is a physician who specializes in the field of physical medicine and rehabilitation.

3. Throughout the text I refer to professional staff at Jones and Thompson, P. C. as therapists since this is how they referred to themselves collectively. This includes physical therapists, occupational therapists, speech and language pathologists, social workers, and the neuropsychologist. When a distinction between therapists is necessary, I refer to the therapist by name or their professional title.

4. Vestibular system dysfunction is a common sequelae of traumatic head injury. The vestibular system is a complex neuroanatomical-neurophysiological system comprised of a sensory end-organ in the inner ear (the semicircular canals or vestibular labyrinths). It acts, via neural connections and in combination with the visual system and joint and muscle receptors, to help individuals orient themselves in space, maintain upright, balanced postures and movements without dysequilibrium, and stabilize gaze when the head moves (control nystagmus). Vestibular system dysfunction can often be diminished or compensated for through certain types of positional sensitivity, ocular control, and other vestibular habituation exercises. Such exercises are used in physical therapy programs for patients with this type of problem.

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