Building Therapeutic Alliance

How to strengthen relationships with patients, amplify interventions and improve outcomes

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Learning Objectives

- Define Therapeutic Alliance.
- Explain Self-Determination Theory using the 5-A framework and how it can improve therapeutic alliance.
- Evaluate patient situations and apply communication techniques which can facilitate improved therapeutic alliance.
- Analyze evidence that demonstrates a stronger Therapeutic Alliance may improve functional outcomes with physical therapy patients across practice settings.

What is a Therapeutic Relationship?

The coming together of PT and patient through intentions and attitudes that foster mutual engagement in the patient's rehabilitation. This enables professional and personal connections to be established, forming an affective bond based on rapport, respect, trust, and caring that is experienced by and for PT and patient.

What is Therapeutic Alliance (TA)

- It is the relationship between a healthcare professional and patient. It is the means by which a therapist and a patient hope to engage with each other, and effect beneficial change in the patient.

Present

- Reflects an individual's intent and ability to be and remain focused on the person and the situation at hand.
- Seek first to understand, then to be understood.

Genuine

- Being yourself - Remaining congruent with personal qualities and values, while also maintaining an attitude of acceptance.
- Being Honest
  - Transparent - Regarding impressions of the physical problem and the rehabilitation process; personal limitations in skill and knowledge; outcome expectations; expectations of the patient's participation; and the therapist's role and responsibilities.
  - Direct - Tone and manner of communication.

Invest in the Personal

- Interest in the person and a willingness to disclose about oneself.
- Disclosure is complicated by boundaries (professional and personal).

Committed

- Motivated to understand more about what patients are describing.
- Committed to action beyond due diligence.

The Clinician as a Person

- Emotional complexity.
- The effects of countertransference can influence them and how they interact with patients.
- They have a subjective experience with all the medical diagnoses they have seen.

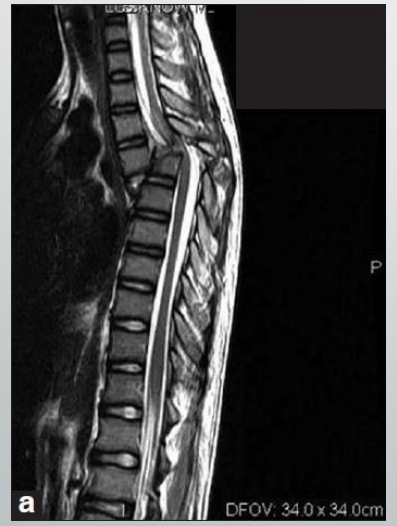
Meeting the Patient as an Equal

- Acknowledging power dynamics inherent to the therapeutic relationship.

Meeting the Patient as an Equal

Patient as a Person

- Understand the individual's experience of illness.
- They are a person,
- Not a diagnosis.

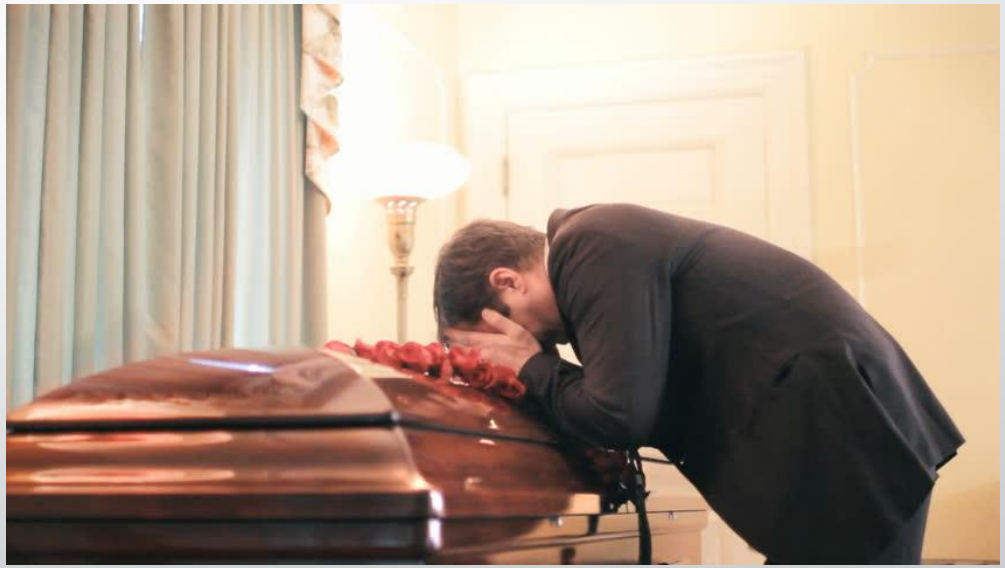


← Spinal cord injury

Alex →

Broad Biopsychosocial Framework

- Take into account the collective set of circumstances that influence an individual's disposition.



Validate

- To support the truth of a statement, perception, emotion or action.
- To prove something is acceptable.

Individualize the Treatment Approach

- Taking into consideration the unique constellation of physical, psychological, social and cultural experiences, as well as the specific needs and goals, of each patient.

Sharing of Power and Responsibility

- Sharing power and responsibility - Patient noncompliance and dissatisfaction with care were attributable to some failures on the part of the health care provider
  - Failing to regard the patient as an expert in their illness.
  - Not providing adequate information or explanations.
  - Not reaching consensus through negotiation.

Giving of Self

- Expanded personal investment of mental, emotional and physical energy and involves actions that occur inside and outside of the direct patient-therapist interaction.

Compassion vs Empathy

- Empathy is the psychological identification with or vicarious experiencing of the feelings, thoughts or attitudes of another.
- Compassion is the feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering.

Using the Body as a Pivot Point

- The primary point of contact between and a PT and a pt is via their body.
- Touch will often inform and guide treatment.

Clarify Physical Problems and Provide Solutions

- Assessment, explanation, and solutions that are congruent with patient experiences.
- Trust is built when the solutions are effective.

Facilitate Connection to the Body

- Knowledge about and awareness of the body, especially as it pertains to the injury or condition, and is necessary for successful rehabilitation.
- Awareness of the body enables patients to actively contribute to the process.
- Patient can the information to guide treatment and make decisions, becoming their own therapist.

Use of Touch to Bridge the Gap

- Not only he body of the patient, but the body of the PT as well.
- Touch is a part of:
  - Assessment procedures
  - Specific treatment techniques
  - When cueing patients to their bodies
- Positive vs negative perceptions to touch.
- Informed Touch.

Trust

- Firm belief in the reliability, truth, ability, or strength of someone.
- Components:
  - Trust in the PT a professional.
  - Overlap between professional and personal trust.
  - PT's trust in the patient.

Respect

- Acknowledgement of a person's inherent importance or value.
  - Their knowledge.
  - Their experience.
  - Their bodies.
  - Cultural difference.
- All while maintaining a state of non-judgement.

Trust in the Professional

- Professional trust is the confidence that the PT's intention is to help them achieve their rehabilitation goals without causing undo physical or psychological harm.
- Credibility lays trust that PT's have knowledge and necessary skills.

Overlap of Professional and Personal Trust

- Confidence that they will not be judged and so that they can say whatever they want/need.

Caring

- Concern or regard for the well-being of another person.
- An emotional investment in the patient's health; they put their patients' best interests at the forefront.
- Patients also care about the PT.

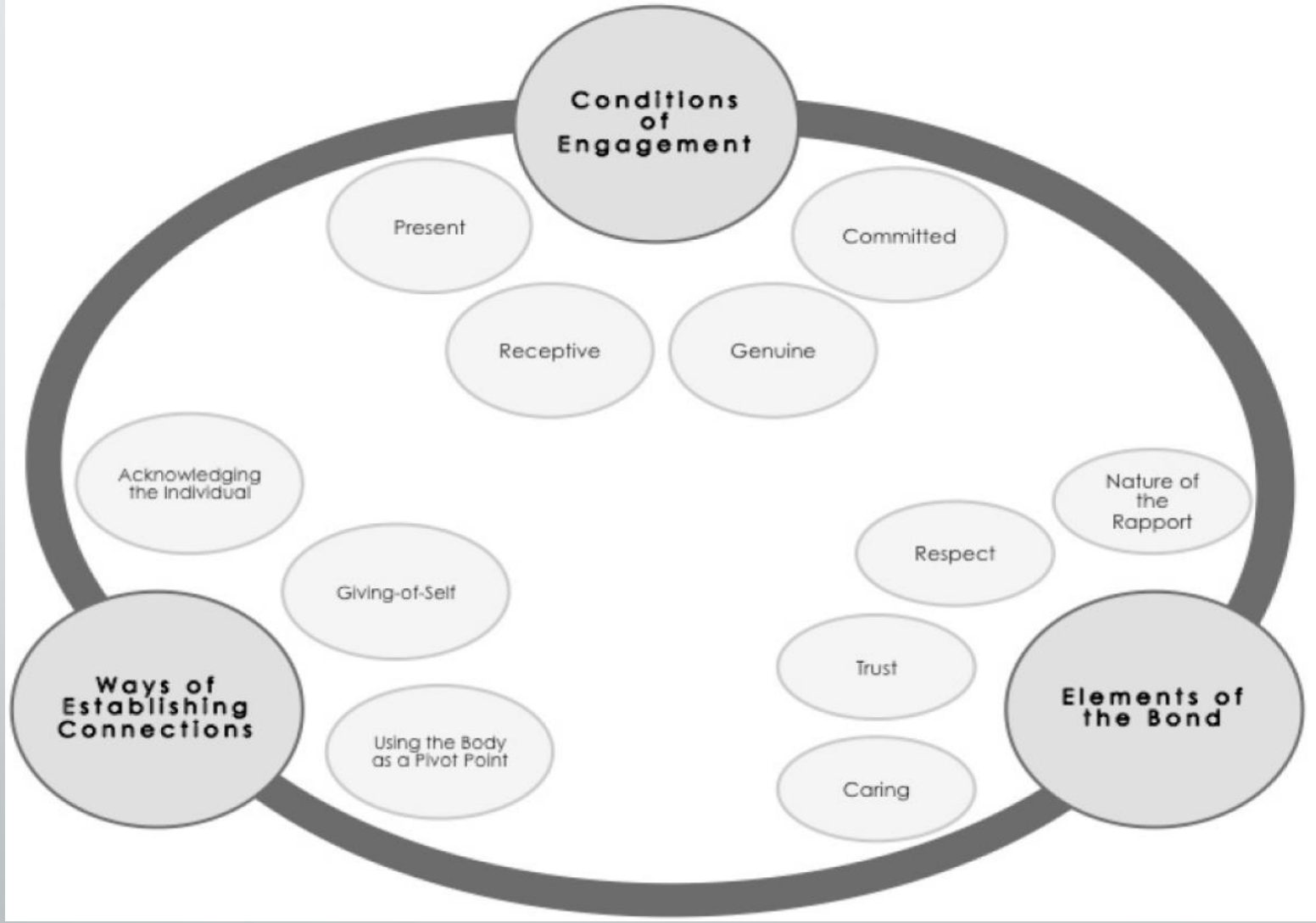
Trust in the Patient

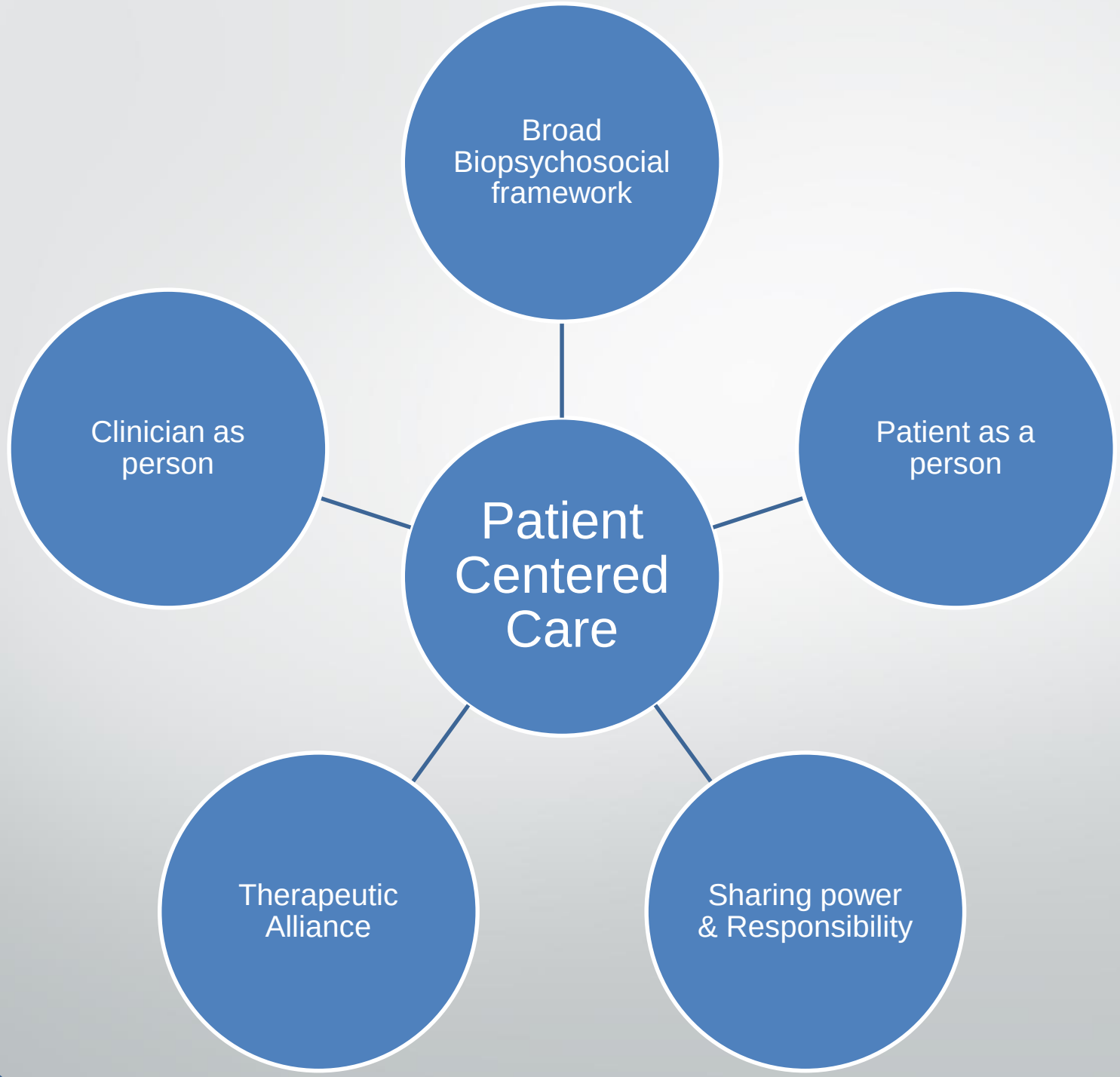
- Confidence in the integrity of the patient's intentions and actions.
- Being wary of ulterior motives.
- Trust the patient has the ability to judge their symptoms and can respond appropriately.

Nature of rapport

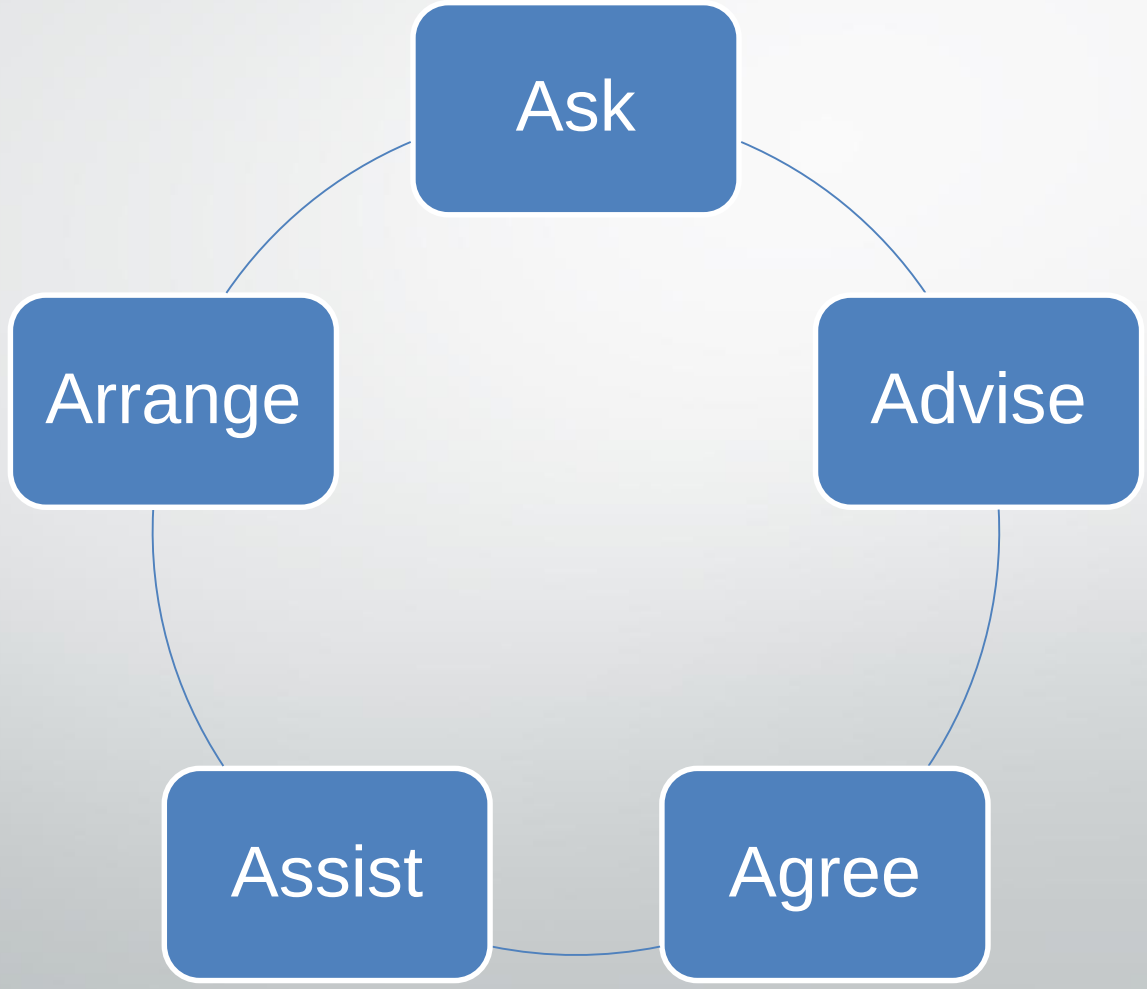
- Rapport is grounded in PT's responsibility to provide care to their patients and uphold a duty of care.
- Imbues a friendly quality that reinforces a sense of ease.
- Directly interact in sessions that last longer, are more frequent, and span over a longer period.

Therapeutic Relationship Framework




Broad Biopsychosocial framework
Clinician as person
Patient as a person
Patient Centered Care
Therapeutic Alliance
Sharing power & Responsibility

5A Framework and Self Determination Theory



The way you LIVE is what builds alliance

- **L**isten
- **I**nquire
- **V**alidate
- **E**xplain

Show Me The Evidence!

Mind-Body

- Neuroendocrine mechanisms between mind and body (HPA-axis)
- Loneliness modulates genes, increases inflammation, changes immune responses
- Mind-body activities decrease depression, improved ADLs and improved functional mobility for patients with CVA

How do you measure alliance?

- Research was conducted to find a tool that conceptualized and measured alliance
- There were many concepts and no tool measured them all
- The Working Alliance Inventory was found to be the most comprehensive
- The Vanderbilt Scales and California Scales were also valid

Instructions: In the next set of items are sentences that describe different ways a person might think or feel about his or her counselor or therapist. We realize that your thoughts or feelings may undergo changes over a period of time, but we would like to know your views or feelings as of right now. Please use the following response scale:

1	2	3	4	5
strongly disagree	disagree	neutral	agree	strongly agree

1. My therapist and I understand each other.
2. We have established a good understanding of the kind of changes that would be good for me.
3. I feel that my therapist appreciates me.
4. I believe the time my therapist and I are spending together is not spent efficiently.
5. I believe my therapist likes me.
6. What I am doing in therapy gives me new ways of looking at my problem.
7. I feel my therapist cares about me even when I do things that he/she does not approve of.
8. My therapist does not understand what I am trying to accomplish in therapy.
9. I am confident in my therapist's ability to help me.
10. I feel that the things I do in therapy will help me to accomplish the changes that I want.
11. My therapist and I trust one another.
12. I disagree with my therapist about what I ought to get out of therapy.
13. I believe my therapist is genuinely concerned for my welfare.
14. We agree on what is important for me to work on.
15. My therapist and I respect each other.
16. The things that my therapist is asking me to do don't make sense.

Correlations between communication and therapeutic alliance

- Positively correlated clinician interaction styles included:
  - Being comforting
  - Being communicative
  - Asking patients questions

Correlations between communication and therapeutic alliance

- Verbal factors with strong positive correlations:
- Exploring the patient's/client's disease and illness experience
- Discussing options/asking patient's/client's opinions
- Encouraging questions and answering clearly
- Explaining only what the patient/client needs to know

Correlations between communication and therapeutic alliance

- Verbal factors with strong negative correlations:
- Advice giving (especially if unsolicited or not pertinent)

Correlations between communication and therapeutic alliance

- Non-verbal factors with strong negative correlations:
- Orientation (45 degrees or 90 degrees toward patient/client)
- Asymmetrical arms
- Crossed legs
- (All are closed postures. Remember: Be open)

Correlations between communication and therapeutic alliance

- Non-verbal factors with strong positive correlations:
- Healthy eye contact (read the situation, don’t stare and be intimidating)

Correlations between communication and satisfaction with care

- Language reciprocity
- Being professional
- Sympathy and supportive talk
- Non-verbal assertiveness
- Ability to decode body language
- Shared laughter
- Ability to encode voice tone
- Time spent discussing prevention
- Affiliativeness

Correlations between communication and Dissatisfaction with care

- Dominant physician
- Avoiding negative communication

Rebuilding following rupture

- 42 y/o male who had a CVA and now dense L hemiparesis. He had been experiencing incontinence and demanded to use toilet. He was assisted to toilet with PT using the toilet transfers to practice set-up and execution of transfers as well as sitting balance. His mother, while waiting outside the bathroom, “fired” the PT due to “wasting” his PT session.

PT personality traits that influence patients/clients

- The Big 5 personality traits are:
- **Openness -** People who like to learn new things and enjoy new experiences usually score high in openness. Openness includes traits like being insightful and imaginative and having a wide variety of interests.
- **Conscientiousness -** People that have a high degree of conscientiousness are reliable and prompt. Traits include being organized, methodic, and thorough.

PT personality traits that influence patients/clients

- **Extraversion** - Extraverts get their energy from interacting with others, while introverts get their energy from within themselves. Extraversion includes the traits of energetic, talkative, and assertive.
- **Agreeableness** - These individuals are friendly, cooperative, and compassionate. People with low agreeableness may be more distant. Traits include being kind, affectionate, and sympathetic.
- **Neuroticism** - Neuroticism is also sometimes called Emotional Stability. This dimension relates to one's emotional stability and degree of negative emotions. People that score high on neuroticism often experience emotional instability and negative emotions. Traits include being moody and tense.

PT personality traits that influence patients/clients

- Only neuroticism was found to have an effect.
- Low neuroticism was associated with better treatment outcomes in patients/clients with chronic disease. It as also associated with decreased chances of burnout as well as increased sense of satisfaction with life.

PT personality traits that influence patients/clients

- Being male was also found to be positive for treatment outcomes.
- Experiencing life events was also positive (a life event in the research included: marriage, bereavement, and retirement)

PT personality traits that influence patients/clients

- Therapist age, education, and years of working experience were not significant.
- Tools like communication training might supplement reflection.
- The authors believe that self-awareness and reflection training would be needed.
- Could one frame this as the therapist effect?

What is the therapist effect?

- Therapists account for 3-7% of the overall effect in patient's/client's disability scores in two RCT. So it's not what the treatment was but who was providing it.
- In psychotherapy research: between therapist variability in patient outcomes were assessed with high performing and low performing therapists. The discrepancy in outcomes between HP and LP increased as the treatment duration increased.
- Take home point: If you are a high performing therapist with knowledge of communication skills, then you have a method to improve patient outcomes without adding interventions.

Fatigued and refusing to participate

- 48 y/o female who had L CVA and R hemiparesis with UE more affected than LE. She began refusing all therapies in the afternoon because she wants to rest. She had been making significant progress, but that slowed down when she started refusing PM therapies.

What does the research say about patients/clients in the rehab setting?

- Rehab patients reported valuing the attributes of their physical therapists more than the amount or the content of the physical therapy they received.
- They valued empathy and care.
- They reported that their physical therapists were a source of motivation.

What does the research say about patients/clients in the rehab setting?

- The rehab experience was reported as new and foreign.
- They appeared to focus on what was familiar to them, that is, personal attributes of those they interacted with.

That's great, but does it make a difference in outcomes!?

- Patients with brain injury: two studies found a significant positive association between therapeutic alliance and:
- Adherence
- Employment
- Physical training
- Depression reduction
- Therapeutic success

Connecting despite confabulation

- 17 y/o male with TBI following MVA. He is ambulatory but impulsive and at a high risk for falling. He speaks English and Spanish but has been speaking an incoherent hybrid of both with non-words.

Rehab Outcomes

- One study found a positive correlation between therapeutic alliance and program adherence, but not disability, productivity, or depression.
- However this study measured therapeutic alliance after one week

Building when blind and flat affect

- 55 y/o male following an anoxic brain injury was left with a flat affect and cortical blindness. His physical functioning was minimally impaired.

Rehab Outcomes

- Patients with musculoskeletal injuries: a study found a significant positive association between TA and:
- The patient's global perceived effect of treatment
- Change in pain
- Physical function
- Patient's satisfaction with treatment
- Depression reduction
- General health status

Rehab Outcomes

- In geriatric patients with various deficits therapeutic alliance had a significant positive effect on:
- Physical function
- Depression reduction

Rehab Outcomes

- Working alliance had a positive effect on the Oswestry Disability Index and Roland-Morris Disability Questionnaire.
- W.A. had an effect on the outcome of pain reduction, pain interference, and physical functioning directly after treatment, at the end of therapy, 3 months after therapy, and 6 months after therapy.

Rehab Outcomes

- It's unknown to what effect diversity of interventions opposed to the amount of and quality of communication during interventions had upon the results of patient's perceptions of W.A.

My Favorite Evidence

- Enhanced Therapeutic Alliance Modulates Pain Intensity and Muscle Sensitivity in Patients With Chronic Low Back Pain (CLBP)

  AL group = IFC with limited TA
  SL group = Sham IFC with limited TA
  AE group = IFC with enhanced TA
  SE group = Sham IFC with enhanced TA

TA with CLBP

- Enhanced TA consisted of the first 10 minutes each participant was questioned about their symptoms, lifestyle, and cause of condition. It was enhanced through active listening, tone of voice, non-verbal behaviors (such as: healthy eye contact, appropriate physical touch) and empathy phrases (such as: I can understand how difficult CLBP must be for you)
- Physical therapists were trained on scripts and had video examples from a clinical psychologist

TA with CLBP Results

- AE (IFC & Enh. TA) = decreased pain intensity and increased pain pressure sensitivity at a clinically meaningful difference for these outcomes (PI-PNS and PPT/ 3.1 pts and 2.09 kg/cm^2/s)

- SE (Sham IFC & Enh. TA) = had better results than AL (IFC & lim. TA). The difference was not significant, but it is a noteworthy difference if only for the implication that it holds.

TA with CLBP Results

- There was no difference between therapists which demonstrates that individual differences did not influence the placebo effect.
- So, if the therapist can adhere to a script then they can achieve better outcomes without innate TA building skills.

TA with CLBP Limitations

- Positive effects in enhanced groups may have been more willing to please their PT (social desirability bias)
- There was not a "no treatment" control group
- A young and moderately disabled sample (avg age = 30 y/o and Oswestry scores avg = 22 pts)
- Tested immediate effects of TA vs long term

TA with CLBP Author's Remarks

- "The implication for practice would be to consider TA another therapeutic agent. In my estimation this is not quite what it means. It is a set of actions that if implemented with awareness can enhance every intervention."

How to handle limited trust of the pt

- 61 y/o female s/p L AKA due to vascular concerns. Stalls by talking every session. Left the rehab unit with her previous PCA, did cocaine with PCA, and fell. Determining what is truthful with her is challenging. Now she is telling you that she has back pain from her sciatic nerve and if she had surgery the openings in her spine would leave her paralyzed from the neck down.

Does our education prepare us?

- Used with every patient/client
- Improves outcomes
- Low cost
- Where does this best fit into the educational model?

TA being implemented into Education

- Throughout the year
- One larger lecture
- Prior to or following their first internship

Barriers to instructing TA

- Experience
- Variety of the experiences
- Recognition of dynamics to the interaction
- Those instructing may have limited understanding
- Clinical vs didactic responsibility

The way you live is what builds alliance

- **L**isten
- **I**nquire
- **V**alidate
- **E**xplain

Questions?

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