Head, heart and hands: Creating mindful dialogues in community-based physiotherapy

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ABSTRACT

The relationship that develops between a physiotherapist and the client's family/care team in community-based healthcare is complex and needs to be managed with subtlety and care, not only for the client's wellbeing, but also for the professional and personal involvement of the physiotherapist. Hermeneutic phenomenology was used to explore the lived experience of relationships that developed between five participating physiotherapists and their 'family care teams' (involving five clients, eight family members and five carers). Analysis of qualitative data arising from semi-structured interviews and a focus group revealed that these physiotherapeutic relationships evolved as the clients, families and carers allowed their therapists to learn about them. Complex ways of making meaning were interpreted by the participants, involving advanced usages of language, such as poetic expression and metaphor. The place of mindful and responsive interpersonal connection within evolving physiotherapy relationships is under-appreciated. The physiotherapists used complex and innovative forms of interaction to enhance communication with their clients. Deeper understanding of these issues within physiotherapeutic interactions could contribute towards the development of composite relationship-treatment approaches to physiotherapy practice and the development of enhanced therapeutic relationship skills in undergraduate and continuing physiotherapy education.

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INTRODUCTION

In this paper, we argue that the relationship that develops between a therapist and a client requiring longer term therapy in home settings is complex and needs to be managed with care and subtlety. The importance of this issue was emphasised in the description by a physiotherapy student of the emotional response he felt on witnessing the immensity and difficulty of the life situations faced by people with chronic and complex health problems in our community, and the positive effect that well-planned physiotherapeutic interventions could have on a client's quality of life on many levels (Blayney, personal communication, 2008). The student's response highlights both the hidden nature of the personal health care problems faced by a significant number of people in our community and the importance of the personal engagement that occurs when a physiotherapist 'comes to call'. The purpose of this paper is to summarise a qualitative research project that set out to explore the complexity of these relationships between community physiotherapists, their clients and the families and carers of those clients. The research project's focus was delineated by the following research questions:

1. How do community based physiotherapists interpret relationship-centred care within the dynamic and ongoing therapeutic relationships they develop with clients, their families and carers?
2. How do clients, their families and carers, interpret and manage these ongoing relationships with community based physiotherapists?

Lying within the interpretive paradigm, this research project concentrated on people involved in real world activities and relationships, increasing the visibility of that world. The focus in this project was on the relationship between the community-based physiotherapist, the client, the family and the carers involved in chronic and complex health care (the 'family care team') in New South Wales, Australia.

> *If the aim of rehabilitation is to work collaboratively with patients to maximise their integration into the community, then we propose that the research agenda needs to address the lived experiences of patients within and outside the physiotherapy setting.* (Gibson and Martin 2003 p.350)

Hermeneutic phenomenology was selected as the overarching methodology for this project. Phenomenology is the study of lived experience or the 'lifeworld' (van Manen 1990). It is experience of the world as lived by a person, not reality as something separate from that person (Valle et al 1989). Hermeneutics has been described as '… a reflective practice of unmasking hidden meanings beneath apparent ones' (Kearney 1991 p.277, as quoted in Crotty 2003). The combination of phenomenology and hermeneutics allows for a deep study of lived experience, as interpreted by the participants.

Literature Review

Since the 1990s, 'evidence-based practice' and its principles have been increasingly promoted within the physiotherapy literature (Schreiber and Stern 2005). While it is generally accepted that physiotherapists should centre their attention on the promotion of the clients' comfort and function in terms of body posture and movement, physiotherapists may be tempted to focus exclusively on physicality and its measures as this provides a good fit with evidence-based practice. In health care, with increasing demands for accountability, physiotherapists are under pressure to practise in ways that are seen to be objectively and measurably effective. They may, therefore, perceive that paying attention to clients' social and emotional needs might imply the use of merely passive clinical treatments in a world where only active physical treatments should be used for physiotherapy (Wallin et al 2008).

A more holistic understanding of health and disability is needed to assist people with complex health care needs, whose presentations may fall outside the available research evidence (Jones et al 2006). A narrow physical focus may neglect the value of a more patient-centred approach where individual context and meaning play a decisive role in the therapeutic relationship, especially for people living at home with chronic and complex health issues. Many physiotherapists utilise professional 'craft' knowledge, which draws on the therapist's subjective interpretation of the situation, in contrast with evidence-based knowledge, which relies on more explicit and objective propositions (Higgs et al 2004). There is a need to accept and integrate an increased awareness of such professional craft knowledge, particularly within the area of community-based physiotherapy practice, where therapists depend on a wider range of skills and knowledge than has been traditionally claimed for physiotherapy (Heckman and Cott 2005).

Emotional and social aspects of a person's life need to be fully integrated into the physiotherapy approach if people are to be assisted to achieve outcomes that promote a client's overall well being (French and Sim 2004). In a study regarding expert physiotherapists, Jensen et al (2000) reported that a person-centred approach, which included the use of good listening skills by the therapist, allows an increased understanding to develop of the social and psychological context of the patient's world, rather than just focusing on physical diagnosis. Patient outcomes can be improved when patient circumstances and preferences are taken into account (Jones 2004). Person-centred approaches towards the physiotherapeutic process necessarily involve full exploration of the agendas of all involved stakeholders (Brown et al 1986) to develop a mutual understanding of the problems, priorities and goal setting (Brown et al 1989). In this study, stakeholders included clients, family members and carers. Berwick (2009) proposes that

> *In most circumstances, people would, and should be able to, amend the subject - "patient-centered care"- to include the experience of family and loved ones of their choosing: patient- and family-centered care (p. 560).*

Over the past decade or two, there has been an increase in the amount of private consultative physiotherapy work done with people, who live at home but suffer chronic and complex health care problems (Struber 2003). Struber noted that the emphasis in physiotherapy is increasingly focusing on community access, continuity of care and integration of services, rather than hands-on treatment. Assisting people with health care needs to remain in their own homes is desirable for many people in our community and may contribute to coping with the increasing problems of our ageing society. However, the situation of visiting a client in their home on a long-term basis needs to be better understood if this aim is to be achieved.

Recently, concern has also been expressed regarding the issue of power imbalances occurring between the therapist and their client (Edwards et al 2010). Efforts to impose a rigidly constructed therapy model upon clients can be seen as problematic; especially in the light of professional time constraints and the altered power balance (Heckman and Cott 2005). Person-centred health care approaches have been seen as a means to address this problem (Edwards et al 2010).

The term 'patient-centred healthcare' may also be known as 'person-centredness' or 'relationship-centred care'. It involves the development of reciprocal, interpersonal relationships between health professionals and patients, to assist with collaboration in efforts to improve health (Australian Commission on Safety and Quality in Health Care 2010). The community-based physiotherapist is presented with the need to relate to, and co-operate with, the client's way of living and being, if they are going to be able to contribute effectively to the development of that person's wellbeing. This requires subtlety and flexibility and an acute sensitivity to the intimacy of these clinical interactions.

> *Our intimacy with patients is based predominantly on listening to what they tell us, and our trustworthiness toward them is demonstrated in the seriousness and duty with which we listen to what they entrust to us…* (Charon 2006 p.53)

METHODS

Participant Selection

This research involved one to three interviews with members of five family care teams (see Table 1 for details of the composition of each family care team). The primary criterion for inclusion of participants was the requirement that the participants should be participating in an ongoing process of community-based physiotherapy with a physiotherapist in private practice or a not-for-profit organization. This decision was made in the interests of accessing longer-term physiotherapeutic relationships.

Five community-based physiotherapy participants were randomly selected from the Yellow pages and practitioner information provided by the Australian Physiotherapy Association. These participants were chosen from a spread of geographical areas across the state of NSW from the Blue Mountains to the coast, in order to gain a variety of different community perspectives and a ratio of male to female therapist participants was chosen

Table 1: Participant profiles of 'family care team' members

Client	Client's age range	Family care team members interviewed	Living arrangements	Client's health issues
JACK	20's	- Mother - Father - Carer - Female Physiotherapist: (25 years community experience, 32 years total physiotherapy experience)	- Home - Family care - Paid care.	Severe acquired brain injury
JENNY	30's	- Mother - Father - Carers x 2 - Male Physiotherapist: (19 years community experience)	- Group home - Day programme - Family visits	Severe developmental disability
DENNY	30's	- Carer - Male Physiotherapist: (7 years community experience)	- Home - Paid care	Spinal cord injury and acquired brain injury
ERIN	50's	- Husband - Female Physiotherapist: (7 years community experience, 24 years total physiotherapy experience)	- Home - Family care - Paid care	Severe acquired brain injury
ERIC	90's	- Wife - Daughter - Female Physiotherapist: (29 years community experience, 50 years total physiotherapy experience)	- Home - Family care	Dementia with mobility problems

to be similar to that of the total physiotherapist population. Clients with a variety of medical conditions were selected from within the active client-bases of the above five physiotherapists. The participating physiotherapists were given examples of possible types of health conditions and carer setups, which might be useful for the research project and the therapist then suggested some possible family care teams who may fit these guidelines without being adversely affected by the research process. Exclusion of family care team participants occurred for ethical reasons where it was felt that potential participants might be vulnerable to intrusion by the research process.

The clients participating in this project had different chronic healthcare issues involving significant movement difficulties. Further complexity was presented by the way these clients were able to communicate. In some cases, the participating clients had communication and short-term memory difficulties. This was accommodated within the interview process to allow as full an interview experience as possible.

Eight family and five carer participants were selected from across the practices of the five physiotherapists, on the basis of their willingness to participate and their availability. In some situations, families requested to have the interview conducted together with the client, rather than individually. This occurred particularly in situations where cognition or communication for the client was difficult. In the same way that a person-centred approach ideally respects the wishes and vulnerability of the people receiving physiotherapy attention, it was considered that any research process into this social phenomenon should provide the same detailed and respectful care (McCormack 2003).

Research procedures

Ethics

Ethical approval for this research was gained from the Ethics in Human Research Committee, Charles Sturt University, New South Wales, Australia (Protocol no: 2008/175). In the case of a client participant being unable to given informed consent,

their legal guardian determined these issues and signed on their behalf (Graneheim 2001). Client and information anonymity and confidentiality were carefully maintained and pseudonyms are used in the findings.

'Bridling' prior knowledge and experience

The first author is a community-based physiotherapist with a particular history and understanding of the world, which must necessarily affect the research process. In such practitioner-research, it was felt necessary to articulate something of those experiences early in the process so that the researcher could be consciously aware of any bias that might affect the research project. As Van Manen (1990) argued, "If we simply try to forget or ignore what we already "know", we might find that the presupposition persistently creeps back into our reflections" (p. 47).

Prior to conducting the interviews, a cameo auto-ethnography for the first author/primary researcher was prepared to more clearly explore their person/therapist/researcher aspects. The first author also participated in two interview-like dialogues with an experienced research colleague. A reflective diary was used to document these reflections, along with the development of the research project. Rather than attempting to 'bracket' prior knowledge and viewpoints (Husserl, 1963), it was considered to be more congruent with the chosen methodology of hermeneutic phenomenology, to adopt Dahlberg and Dahlberg's (2004) alternative term of 'bridling' one's pre-knowledge. They describe 'bridling' in terms of the researcher's attitude of reflection inhabiting an intimate stance in relation to the research phenomenon but allowing space for consideration of that same phenomenon. The researcher applies "the same sensitivity and open attitude towards the phenomenon and its meaning, as the horse riders of the Spanish riding school practice, when they bridle their horses and make them dance" (Dahlberg and Dahlberg 2004 p 272). There is an implicit note of 'respect given'. In this way, prejudices were acknowledged, with the likelihood that any interpretations were more likely to be open and transparent.

Data collection

A general interview guide assisted the flow of initial interviews. Guiding questions covered topic areas about background, the first physiotherapy meeting, how the attending community-based physiotherapist interacted with the client and the family care team and development of the physiotherapeutic relationship.

One to three, hour-long, semi-structured home-based interviews were held with participants and/or family care team groups, as requested by particular families. The use of semi-structured interviews for this project encouraged the participants to express themselves more freely by asking questions in an unstructured style (Minichiello, 1995). After the individual and group interviews were completed, the participating physiotherapists were also brought together for an hour-long focus group to further discuss emerging themes from the interviews. The recorded interviews and focus group voice files were transcribed verbatim by a typing agency, familiar with the required confidentiality. All the transcripts were subjected to close reading and interpretation and data was organised with the assistance of N-Vivo software.

Data analysis

Qualitative research uses an inductive process to generate ideas from the data, in direct contrast to the deductive process of knowledge generation of quantitative research, which "begins with the idea and uses the data" to test a constructed hypothesis (Holloway 1997, as quoted in Thorne 2000). The philosophy underlining qualitative processes of data analysis emphasises a reflective and reflexive process prior to, during and after data collection. Initially, "chunks of data' were named in terms of the metaphoric and poetic content of the phrases within them and using the words within those phrases for coding labels. Careful identification of these thematic networks (Astride-Stirling 2001) moved the organisation of themes from 'basic' to 'organising' and finally to the deduction of 'global' themes (See Table 2: Findings and meanings analysed from the data).

Table 2: Findings and meanings analysed from the data.

Mindfulness	Dialogue	Responsiveness
Home-based healthcare is 'work'.	Emotional connection assists the therapist:	Therapists use composite forms of interaction, for example:
The therapist needs to blend in with the family care team.	- To connect and resonate with family care team members	- Letting the conversation flow whilst mentally highlighting issues of concern and waiting for important issues to emerge.
Family carers try to work as teams.	- To identify an individual's meaning	
Relationship-centred healthcare evolves.	- To promote and advocate well being for clients and carers.	- Creating conversation for clients with no speech and little voluntary movement to create a rich sensory experience for the client.

Enhancing trustworthiness and credibility

Throughout this research project, we were guided by Guba's four criteria of credibility, transferability, dependability and confirmability to assess trustworthiness in qualitative inquiry (Guba 1981). These criteria while paying respect to the history and place of quantitative research have been developed specifically for the qualitative paradigm of research. A variety of overlapping research methods were used to provide dependable findings, including interviews, focus groups and reflective journaling by the researcher. Honesty and depth of information was encouraged by gradually developing trust and confidence between the researcher and participants. Member checking was conducted informally by checking the themes discovered in first interviews in later interviews with the concerned participants. Findings of the project were 'thickly' described, allowing the reader to understand the phenomenon being studied. By using a 'phenomenological nod' of agreement to confirm that

resonance, readers will be able to compare elements of the findings with their own experience.

FINDINGS

The research findings revealed that therapeutic relationships are highly complex phenomena. The physiotherapists were particularly mindful and sensitive to the human dimension of their clients and families, taking care not to fall back into a strictly biomedical approach. They adopted an open attitude towards their clients and family care teams that demonstrated respect for the individuality of the people involved and a willingness to cope with ongoing complexity, accepting that there can be no final interpretation of the issues being faced.

Home-based healthcare is 'work'

Different members of the family care team reported that they have to work at the relationship with their therapist and each other, feeling that such effort is important to the outcome of the therapy. Clients, families and carers perceived the health care process at home as their 'work', whether they were paid or unpaid.

> *Oh it's a form of work, there's no question. It is work for me because it's something I've got to do. It must be done, you know* (Eric's wife, Marie).

Home-based health care provides an example of the integration of paid and voluntary workers in a workplace. In this situation, the home functionally becomes a workplace. For the physiotherapist, this raises issues regarding occupational health and safety for carers as well as the usual concerns for client and family safety and wellbeing. For the family, their home is becoming a workplace for visiting health carers and they may be asked to change the way they live in order to accommodate the workplace needs of those healthcare workers.

Blending in

Families and carers were quite definite about their need for therapists to blend in with the family care team. Home-based healthcare is a difficult, complex and exhausting caring 'job' that extends through day and night. The provision of healthcare by visiting healthcare workers can be intrusive.

> Monday, the nurse will come,
>
> Tuesday, yes, the girl to clean will come,
>
> Wednesday, yes, the nurse,
>
> Thursday (big sigh)… nobody,
>
> Friday, yes the nurse will come and your life, you know, people coming in and out for our good.
>
> Have to get out of bed, quick, quick, because you've got to be ready, then they might not come for another hour or two yet, but still, you've got to be prepared in case (Eric's wife, Gwen).

Carers and families reported that they appreciated the therapist's ability to quietly blend in with the family's situation and routine. It assisted them to relax, trust and interact with the physiotherapy process. One family carer described the experienced therapist's ability to blend in; *She just fits in, that's all I can say she just fits in* (Eric's daughter, Marie).

Such blending into a client's situation contrasts with physiotherapy conducted in more institutional settings where patients and health professionals frequently perceive healthcare as being centred on the requirements of the healthcare system (Titchen 1998). 'Blending in' seemed to allow these therapists to retain more humane qualities, in order to promote the level of communication needed for home-based styles of healthcare interaction. The physiotherapists in this study also reported that they took part in a variety of non-clinical activities as part of their interaction with their clients and their families, for example, joining in with a daily ritual activity like a quiz or crossword puzzle or offering to post a letter on the way to another appointment.

Relationship-centred physiotherapy care within the home evolves

Relationship-centred care within the home was enacted by all the participants and *evolved* as people allowed their therapists to learn about them within their home and community. Families spoke of their appreciation of the human side of the relationship they formed with their physiotherapist:

> *It's personal, your life is personal.*
>
> *You've got to have a bit of a relationship before you can get very far but it starts that way, showing that you're interested to know what's happened and interested in how it might effect now.*
>
> *She just took an interest and so genuine you know. … Yes, from the outset, she was really interested in me,*
>
> *I don't mean me, but in the person*
>
> (Comments by Marie, an elderly woman looking after her husband, Eric at home).
>
> *... You kind of get to know their social situation and you get to know some of their personal quirks and beliefs and some of the things that are really important to them and then it kind of just evolves* (Denny's therapist, Adam).

Most of the care provided to clients at home happens when the physiotherapist is not there. Physiotherapists can only know about these events if the client, family and carers confide in them. Trust is required.

Emotional connection is important

An emotional connection within the developing physiotherapeutic relationship was considered by all participants to be important for trust in the relationship to be developed and maintained. One client said; *She cares about me as a person* (Erin).

Emotional connection assisted the therapists to find words, which:

- Connected and resonated with their listeners
- Identified the meaning that people ascribed to clinical interactions
- Promoted and advocated well being for clients and their carers.

It could possibly be said that the physiotherapist has to 'feel their way' through the clinical conversation in order to achieve these aims within the human relationships that they develop with all the members of the family care teams.

'The fellow traveller'

There was a strong sense of journey in many accounts that enabled several participants to make sense of the ongoing relationship. One therapist described the notion of being or feeling like a fellow traveller:

There's always the poignant reminders of how life used to be and what life is now; the photos on the wall, seeing them in their home, the struggle of it all, the loss of it all. I never devalue that. I never ignore that. You're travelling that road with them (Jack's therapist, Karen).

Heckman and Cott (2005) also described 'the homecare journey as an opportunity to liberate people from their physical, social and environmental restrictions' (p 278) and noted that this is different for each person.

The physiotherapist 'being there' mattered to families. Participants spoke of the difficult times that they had experienced and the presence of their attending physiotherapist through those times, giving hope to the client and their family.

Jack has been through some, I won't say horrendous, probably horrendous for us but necessary for Jack. Jack was in calipers from his hip to his foot (Comment from Jack's mother).

The physio gives you hope, that not only Jack's life could improve but also ours, because the more mobility Jack gets, the better off we all are. We're not picking him up and carrying him into the bedroom or the toilet. (Comment from Jack's father).

'Sacred space'

Emotional connection assisted therapists to identify the meaning that people ascribed to clinical interactions. All the participants perceived that therapy presented an intrusion into the home, even though it may be a necessary one. One therapist poetically described the home as sacred space:

Going into someone's own space is very different. This is their private domain. This is sacred space for them. This is the area they have always been able to escape to and now we are taking therapy into that area (Jack's therapist, Karen).

Within the physiotherapy literature, Heckman and Cott (2005) described this process from the physiotherapist's perspective as 'entering a world different from that in which they had been trained' (p. 277). From the client and family members' point of view it may be viewed rather as 'you have entered my world' or even 'you have intruded into my place and my space', even if that client and family requested the visit. The physiotherapists in the focus group all recognised that they had to *always remember why I am here* (Jack's therapist, Karen). This awareness seemed to also be related to the accountability that the therapists felt towards the health system generally, as well as to the client and their family. However, the mindful awareness of being a 'visitor' in someone else's home clearly contributed to that recognition.

'The glorified visitor'

Emotional connection assists the therapist to promote and advocate well being for clients and their carers. Carers and families have to cope with difficult situations and sometimes seemingly unreasonable demands from clients. All carers and families reported that the therapist played a significant role in the modelling of caring behaviours to family care team members. The therapist in the role of 'guest' and 'visitor' may be seen as a gentle and considerate person who can provide mentoring for family care team members. Subtlety is required to play out such a delicate role. One therapist described himself as a glorified visitor:

Look I'm in a glorified position, I go there, and I do something he really likes doing, physical stuff and walking. I'm there for an hour and he likes my role in his care, so he's probably nicer to me than to his carers. I do like to stick up for the carers. When he's being unreasonable I'll say "Look, it's probably not that fair to have a go at them (Denny's therapist, Adam).

In such a situation the physiotherapist is clearly doing more than simply providing physical therapy. There is clearly a more holistic caring role being enacted in this situation and setting. Certainly, many families and carers spoke of the caring qualities of their physiotherapists.

Relationship-treatment approaches to practice

The physiotherapists were attentive and responsive at different levels within the communication process. This involved the customising of interaction for the client's, the family's and the carer's needs and abilities. The physiotherapists used complex and innovative forms of interaction to enhance communication and interaction with their clients. Examples of this include:

- Letting the conversation flow whilst mentally highlighting issues of concern and connection to the therapeutic process or while waiting for important issues to emerge;

  If a person thinks that she's being listened to, that helps, no matter what the subject is and being the focus of their attention, that helps because other little side things will be noticed while you're focused on the person doing something. Yes, it's just being the focus of attention I suppose (Eric's wife, Gwen).

- Creating conversation for clients with no speech and little voluntary movement and supplementing this 'virtual interaction' with physical and visual cues to create a rich sensory experience for the client;

In a situation when they can't respond, I ask any question that I would ask you, you know, how are you, what did you have for dinner, did you have visitors today? I try to explain what the plan is, what's going to happen and where we're going and how long it's going to take. I also try to make physical contact, using voice and touch. I try to keep an eye on her face because her face will tell me how things are going. I try to make eye contact or she will look in the direction where sounds are coming from. Sometime she'll turn her head when the carer and I talk. I don't talk to staff about her. I have a conversation with Jenny and I keep eye contact with Jenny but I listen to what the carers say while I try to maintain the conversation with Jenny (Jenny's therapist, John).

Such interpersonal engagement promoted improvement of the client's wellbeing and reassured and supported carers and family. It can also assist to build the integrity of the therapist's ethical standing and morale within their job and their community.

DISCUSSION

The focus of this project explored the complex relationships that develop between the stakeholders directly involved in community-based healthcare. Within this research, the term, family care team was used to organise the interview processes but also viewed the participants within client-centred care groups. Clinically, health professionals, when talking to family and carers, in an effort to acknowledge their care and effort,

often use the term "the team" colloquially. We argue that we need to take that notion more seriously and incorporate it into the basic fabric of our thinking as health professionals.

The use of the term 'family care team' may assist in promoting the acceptance and integration of 'outside' carers and health professionals into the family home by the client and their family. It describes the efforts made towards co-ordination of the prodigious efforts required for home-styled healthcare, carried out away from the easier sources of materials and services provided in hospitals and health centres. Clients and families face difficult challenges when they have to deal with the day-to-day intrusiveness of complex healthcare problems into their home setting (Strauss and Corbin 1988).

There is a strong argument for including the processes of home-based healthcare within our more general definitions of *work*.

> *Unless we include the views and voices of clients and unpaid carers and broaden the concept of the healthcare workplace to include communities and homes, we may miss many problems and their solutions* (Ward 2007, p. 104).

Sennett (1998) proposed that legible work contributes to a person's character and Frank (2002) proposed that the use of this concept should be extended to people within illness processes. Families dealing with complex healthcare needs appear to motivate each other and organise their lives to accommodate and deal with a great complexity of issues, appointments and different healthcare professionals. Their entire lives and those of all the other members of that family, and sometimes friends as well, can be totally absorbed by these processes in a manner similar to the way that more conventional paid work absorbs the time and energy of people.

When reflecting on the question of how we practise physiotherapy, it is important to realise that interaction between therapist and clients, carers and family members occurs reciprocally and con-jointly (Ek 1990). Being with someone in a quiet thoughtful way, listening to hear their story without judgement, waiting for (interpersonal) signals to show (therapists) a way to proceed; all these activities have elements of mindful waiting and responsiveness.

'Mindfulness' is often represented as a characteristic of meditation, incorporating an ability to stay 'in the present moment'. In this research project, we have also used the term 'mindfulness' to refer particularly to the sensitive 'taking care of' and 'taking responsibility for' how an interpersonal interaction proceeds. This attitude requires an ongoing awareness of 'how things really are' for the person that they are assisting. It also requires the therapist to be 'present' and focused on the other person throughout their interaction.

The word, 'responsive' can be used within health care discourses in different ways. The use of the word 'responsive' within this paper does not refer to 'responding to an issue' but rather indicates a deepening of the interpersonal relationship between the physiotherapist, the client and their family care team, to more truly collaborate with them in the provision of physiotherapy care. Such responsive processes were identified as being dependent on the physiotherapists' ability to combine their own inner reflective dialogue and relational dialogue with other members of the family care team.

In this way, physiotherapists can be key members of both family care teams and externally located medical health care teams and rehabilitation teams. From their transient and 'guest' position within the family care team, the physiotherapists in this study provided mentoring and guidance to the members of that family care team and acted as a point of connection between the client's family care team and other health professionals, for example the local doctor or community health nurse.

This research project has focused on privately funded, home-based physiotherapy for people with significant ongoing healthcare issues. This may limit the application of the findings to other contexts of physiotherapy, for example, publicly funded home-based physiotherapy. However, that limitation may be tested by the responses of clinical physiotherapist readers as they process the findings in this paper. Future efforts to research the perceptions of stakeholders in physiotherapeutic relationships can increase our understanding of physiotherapeutic relationships.

CONCLUSION

It is important to think about how we practise as well as what we practise. Such reflective thinking and the reflexive action that can follow may have implications for ourselves as people as well as therapists, and can assist us to develop satisfying work lives with our clients and their families. Creating mindful dialogues with and from within practice situations involves the use of our heads, hearts and hands. It is person-centred care. It is also relationship-centred care. Responsiveness and mindfulness are very necessary components of that physiotherapy care.

KEY POINTS

- The families and carers in this project viewed themselves as carrying out part of the rehabilitation and health care programme in the home environment and the therapist needed to make a conscious effort to blend into this setting.
- For the participants in this study, relationship-centred care within the home was enacted and evolved as the clients and their carers allowed their therapists to learn about them within their home and community.
- The participants reported that emotional connection assisted the therapist to connect and resonate with their clients and carers, to identify the meaning that people ascribe to clinical interactions and to promote and advocate for the wellbeing for clients and their carers.
- The physiotherapists used various relationship-treatment approaches to customise mindful and responsive dialogues for and with their clients and family care teams.
- The mindful dialogue approach to therapeutic relationships and care reflected in this project has relevance across professional relationships.

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