CLIENT-PRACTITIONER RELATIONSHIPS IN SPORT INJURY REHABILITATION

Guy Christopher David Little

Doctor of Philosophy

2nd July 2015

COLLEGE OF SPORT AND EXERCISE SCIENCE

VICTORIA UNIVERSITY

ABSTRACT

The relationships that clients form with their practitioners can influence treatment outcomes. Researchers have shown in numerous healthcare professions including psychology and physiotherapy that caring and collaborative relationships can lead to positive psychological and physical treatment outcomes, and poor relationships can lead to negative outcomes. Within sport psychology, there are fewer studies on client-practitioner relationships in comparison to other domains of psychology or healthcare. Researchers and practitioners have often favoured the investigation and application of mental skills (e.g., goal setting, imagery, self-talk) over the exploration and development of client-practitioner relationships. In the specific context of sport injury rehabilitation, there exist few studies or commentaries on client-practitioner relationships as interventions that can aid athletes' recoveries, transitions, and returns to sport. The aim of this thesis was to explore the relationships psychologists and physiotherapists have with injured athlete-clients and how these practitioners collaborate in sport injury rehabilitation. In Study 1, I interviewed 12 sport psychologists (five female, seven male) who worked in professional sport in Australia. From thematic content analysis of the interviews (Braun & Clarke, 2006) several findings emerged including: practitioners' identifying with athletes' pain, psychologists pacing one-to-one sessions to mirror the desired speed of rehabilitation and recovery, service providers (e.g., coaches, physiotherapists, athlete-mentors, performance directors) influencing the quality of injured athlete-psychologist relationships, and participants' issues working within multidisciplinary teams. To understand physiotherapists' experiences working with injured athlete-clients, in Study 2, I interviewed nine (seven female, two male) physiotherapists who work in private

practices and with professional sportspeople in Australia. Data analysis procedures were similar to Study 1, and from these processes, several key themes emerged including: limited training in psychology and rapport-building, challenges managing social and physical boundaries when travelling and working with injured athletes, practitioner incongruence, and issues dealing with difficult clients in rehabilitation. Some of the themes from Study 2 paralleled findings from Study 1. For example, practitioners in both samples had difficulties distancing themselves from clients' emotional pains and had problems within their relationships with other practitioners in multidisciplinary teams. There were also some differences in the themes from Studies 1 and 2. For example, physiotherapists had limited understanding and awareness of therapeutic relationships, whereas psychologists appeared to have considerable knowledge and understanding of this topic.

In Study 3, I explored the collaborative relationship between two practitioners, a physiotherapist and a psychologist, who have worked together for 12 years in sport injury rehabilitation. From interviewing both professionals individually, and completing interpretive phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009) of the data, I told each participant's story about the relationship and how they go about their collaboration. The participants' tales illustrate how these professionals have helped inform each other's practices and aided the quality of care they have provided to injured athletes. For example, the psychologist who participated in Study 3 shared her knowledge about human relationships and how this understanding could be used to help the physiotherapist's work with injured athletes. The physiotherapist passed on information about athletes' exercises to the psychologist so that the psychologist could explain to athletes, from a neuroscience perspective, why these exercises were useful.

The findings from these studies indicate that both psychologists and physiotherapists sometimes struggle in their relationships with injured athletes and that these practitioners' emotional states can be influenced by clients' emotional responses to injuries. In addition, the quality of client-practitioner relationships can be constrained within multidisciplinary systems. The results from these studies have implications for the education and training of physiotherapists, psychologists, and other allied health professionals who work with injured athletes, such as training in the development of therapeutic relationships and practitioner self-management in challenging rehabilitation circumstances.

DECLARATION

I, Guy Christopher David Little, declare that the PhD thesis entitled *Client-Practitioner Relationships in Sport Injury Rehabilitation* is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature:  Date: 2 July 2015

TABLE OF CONTENTS

DEDICATION

To the perfect exemplar of relationship, I am.

ACKNOWLEDGMENTS

When I was researching for this project I found a quote that excellently summarised how I felt about my journey:

Create ideas with humility knowing that behind the idea he calls his own are thoughts and efforts of many men.

W. A. Peterson

[redacted]

[redacted]

CHAPTER 1

INTRODUCTION

Injuries commonly occur in sport participation, and sport injury rehabilitation is often a challenging process, both physically and psychologically. Athletes can experience a range of responses to their injuries and the uncertainty of returning to pre-injury functioning and performances (Kolt, 2004). With the growing professionalisation of sport over the last 20 years, the economic and human costs of injuries seem to ever increase. Athletes often need to return to play (or work) as quickly as possible, and many factors can influence injury rehabilitation. The relationships that athletes have with support staff during these times are likely to be influential in their recoveries (Andersen, 2007; Brewer, Van Raalte, & Petitpas, 2007). Many researchers and practitioners have found that the relationships formed between clients and practitioners within healthcare (such as physiotherapy and psychology) are important for positive client outcomes. Some experts have suggested that the client-practitioner relationship is more important than the physical or psychological interventions practitioners use to facilitate client change (e.g., Andersen, 2004b; Castonguay, Constantino, & Holtforth, 2006).

Within counselling and clinical psychology, therapeutic relationships have been studied extensively. In numerous studies, the quality of client-practitioner relationships (from poor to good) is consistently associated with psychotherapy outcomes (from poor to good). In contrast, within the specific domain of sport psychology, research into client-practitioner relationships is relatively new. Traditionally, within applied sport psychology, investigators have developed and tested psychological interventions to equip sport psychologists with tools for use with clients rather than focusing on the

relational context in which psychological interventions occur (Tod & Andersen, 2012). Several psychologists consider that the relationship between clients and practitioners is the central mechanism for change in many helping professions, yet only a few sport psychologists have examined relationships within sport psychology practice (e.g., Andersen, 2004b; Stevens & Andersen, 2007a, 2007b; Tod, 2007b). Some understanding of client-practitioner relationships in sport psychology has been derived from studies in which bonds between service providers and clients were not the main focus.

Although research into client-practitioner relationships within physiotherapy is relatively new, this area has received more attention from investigators and commentators in this healthcare context than in sport psychology. Researchers have studied the associations between the relationships in rehabilitation and an array of outcome and adherence measures (see Hall, Ferreira, Maher, Latimer, & Ferreira, 2010). Relationships between clients and physiotherapists are associated with both physical and psychological treatment outcomes such as pain, disability, and depressive symptoms, quality of life and treatment satisfaction.

In physiotherapy there also exists several commentaries and qualitative studies in which researchers and commentators have discussed and examined various aspects of client-practitioner relationships such as communication, patient-preferences, and models of treatment. Although researchers have provided some understanding of these relationship processes through these studies, generally, within physiotherapy literature, there are only a few writings about relationship processes in action (e.g., case studies; Andersen, 2004b, 2007).

Nowadays, in today's sports climates, and particularly within elite sports, athletes often have access to psychologists as well as physiotherapists during injury

rehabilitation (Clement & Arvinen-Barrow, 2013). During injury recovery periods, psychologists often spend considerable time with athletes and can be close members of athletes' support networks (Clement & Arvinen-Barrow, 2013). Nevertheless, little is understood about sport psychologists' or sport physiotherapists' relationships with athletes and how these relationships play out within the context of injury rehabilitation. Understanding the dynamics of such relationships within sport psychologists' and physiotherapists' practices will be useful in advancing knowledge within both healthcare domains.

Trainee sport psychologists have reported learning more from academic writings that contain stories than empirical research studies (see Tod, Andersen, & Marchant, 2009). In this thesis, I used qualitative methods to provide tales of practitioners' experiences working with injured athletes that are accessible for novice and qualified healthcare professionals. Such narratives may help practitioners in developing high-quality relationships with clients.

CHAPTER 2

REVIEW OF LITERATURE

This chapter is organised into six sections. In the first section, I discuss key figures who have shaped investigations and practices in regards to client-practitioner relationships. In the second, I review the literature in psychology on client-practitioner relationships including research on relationships and outcomes, alliance ruptures, and alliances and therapy-related factors. In the third section, I briefly discuss research on professional relationships in various healthcare domains. In the fourth section, I review research and commentaries on relationships in sport psychology. In the fifth section, I review investigations and opinion pieces on client-practitioner relationships in physiotherapy. In the final section, I offer a rationale for the thesis and present the aims of this project.

Client-Practitioner Relationships

In many healthcare professions, the relationships between clients and practitioners are central within treatment. Researchers, theorists, and practitioners have explored the interpersonal connections in sessions and across treatments to understand the influences these relationships may have on treatment outcomes. Numerous physical and psychological outcomes are associated with the quality of client-practitioner bonds in healthcare contexts.

Unlike other interpersonal connections, the focus of therapeutic relationships is to help one member of the dyad; healthcare professionals enter therapeutic relationships to support clients to develop, grow, and heal. Although practitioners are likely to experience many benefits from therapeutic encounters, such returns are not central to sessions or treatments. Therapeutic relationships can be intimate; clients may share stories of hurts, expose broken body parts, and be vulnerable with practitioners.

Healthcare professionals can be privy to information, emotions, and trauma that may not have even been shared with their significant others.

Gelso and Carter (1985) have broadly defined the therapeutic relationship as "the feelings and attitudes that counselling participants [clients and practitioners] have towards one another, and the manner in which these are expressed" (p. 159). There is, however, little consensus on the definition of the therapeutic relationship, and researchers have used numerous terms inconsistently to describe client-practitioner relationships, or aspects of these relationships, including *therapeutic alliance, therapeutic relationship, working alliance, therapeutic bond, and helping alliance* (Martin, Garske, & Davis, 2000). Early definitions of the therapeutic relationship were housed in psychodynamic theory (Freud, 1912/1958a, 1912/1958b) and focused on the unconscious processes in the interactions between clients and psychoanalysts (e.g., Sterba, 1934). From Freud's perspective, relationships between clients and therapists are integral to client change. More recent conceptualisations of the therapeutic relationship (from mid to late 1900s) focus on specific factors, such as qualities of practitioners, clients, and the relational environment. For example, Rogers (1957/2007) suggested practitioners should offer therapeutic conditions towards their clients (e.g., being warm, empathic, and nonjudgemental), Bordin (1979) proposed that clients' ought to play an active role in treatment through collaborating with practitioners in therapy, and both Rogers (1946) and Bordin (1979) emphasised the importance of creating safe and nurturing environments in which client-practitioner interactions are situated. Three key figures (i.e., Freud, Rogers, and Bordin) have been particularly influential in the development of ideas about, and measurement of, therapeutic relationships. I now discuss each of these practitioners and their ideas in turn.

Freud

The interest in quality of relationships between clients and practitioners in healthcare professions can be traced back to Freud (see Horvath, 2001 for a discussion). Breuer and Freud (1893/1953), in the early days of psychoanalysis, noted that patients worked collaboratively with their doctors, by means of cooperative engagement. Freud (1912/1958a) considered that the relationship itself was a vehicle for client-change through the process of transference. According to Freud (1912/1958a), people's early (childhood) relationship experiences can shape their later ones; people can mirror their real or fantasised childhood bonds and associated patterns of interaction throughout adolescence and adult life. This phenomenon is known as transference. For example, an adult male who sees a doctor whose approach he finds distant and calculated may dislike this physician because he reminds the client of his methodical and detached father. Conversely, the same man could see a medical practitioner who is caring and concerned for him, and this professional could become, in the client's eyes, the fantasised parental figure he wished he had, but never did. Transference, however, is not limited to client-practitioner relationships. Researchers and practitioners who support psychodynamic theory consider transferential phenomena to occur in almost all human relationships (Andersen, 2004b; Andersen & Speed, 2011)

Freud (1912/1958a) considered transference as a defence mechanism, or resistance that protected a person's conscious mind from unresolved childhood memories. Through this mechanism, the unconscious processes (thoughts and behaviours) that emerge in the context of client-practitioner interactions are sources of information that therapists analyse to help clients resolve unconscious conflicts. Given the centrality of the bond between client and practitioner within this process, it is

understandable why Freud believed that the patient-practitioner relationship underpinned successful therapy.

Freud only briefly wrote about therapists' unconscious and conscious reactions (e.g., emotional, behavioural) to a client's transference. He viewed the process as problematic to therapy and recognised the importance of practitioners addressing and managing their responses within treatment. Building on Freud's ideas, early psychoanalysts acknowledged that the unconscious processes were bidirectional because therapists', along with clients', experiences could play out in client-practitioner relationships and shape interactions with clients. The phenomenon of countertransference encompasses both the outplaying of practitioners' early experiences on current relationships and their unconscious reactions toward clients' transferences. For example, a female client could view her female therapist as a mother figure and behave childishly (both verbally and nonverbally) within sessions. Based on the client's actions, the female therapist may then see the client as a daughter figure, and react by mothering the client. It is within the context of a client-practitioner relationship that transference and countertransference reactions occur and play out. These processes can inform therapists about their own and their clients' interpersonal histories, and practitioners' awareness of these processes can lead to the exploration of past relational patterns within the treatment context. The client-practitioner relationship, in which transferential reactions take place, can be a vehicle for client change and positive treatment outcomes.

Rogers

Carl Rogers (1951, 2007) suggested that people have the internal resources to change, develop, and grow, but nonthreatening and warm therapeutic environments can facilitate such personal development. In his book, *Client-Centred Therapy*, Rogers

(1951) indicated that helping relationships can have healing effects. He used the term *client* instead of *patient*; the latter was, and still is, a commonly used term to describe the passive recipient of care in psychotherapy or medicine. Rogers' use of *client* subtly moved the emphasis away from a medical model of treatment where authority and expertise were only in the hands of the professional. Instead, he emphasised collaboration and active client participation in treatment.

Rogers (1951) proposed that therapists could offer conditions in client-practitioner relationships that are adequate on their own to stimulate clients to heal and are more important than the specific techniques or modes used to bring about change. Specifically, Rogers (1957/2007) mentioned three conditions. The first, congruence, referred to therapists being genuine, without façade, and open to emotions and experiences that occur within the relationships with their clients. The second, empathy, related to the need for practitioners to understand, feel, and embrace their clients' inner worlds *as if* they were their own, "but without ever losing the 'as if' quality" (Rogers, 1957/2007, p. 243). The third, unconditional positive regard, can be described as professionals being nonjudgemental and having a warm acceptance of their clients.

Bordin

Bordin (1975, 1979) built on Greenson's (1967) psychodynamic conceptualisation of the therapeutic relationship. Greenson went to great lengths to differentiate transferential and non-transferential aspects of therapeutic relationships. He proposed a three-part model consisting of the real-relationship, transference, and the working alliance. Greenson considered the working alliance as the rapport patients have with their analysts that is nonneurotic (unlike the transference process) and is linked to patients' abilities to work within therapy. From this model, Bordin then developed a framework of the working alliance that could be generalised across multiple

psychotherapeutic modes of treatment, no longer housed in psychodynamic theory. Many researchers have developed measures of the alliance based on Bordin's conceptualisation, or variations of his model (see Horvath, 2000 for further discussion). Central to Bordin's model is the premise that the client is an active participant in the change process and his alliance framework consists of three interlocking components: goals, tasks, and bonds (Bordin, 1994).

Bordin (1975, 1979, 1994) proposed that collaboration between practitioners and clients to develop personally relevant and meaningful change goals is necessary for building initial alliances and is fundamental to the development of strong working alliances. For example, a client and therapist might agree the targets for treatment are for the client to live more readily in the present moment than he is currently and to reduce the time spent worrying about future events. Bordin (1994) suggested goals that are mutually constructed and understood would help develop trust and respect within dyads.

The therapeutic activities, or tasks, that clients undertake to reach their change goals both within and outside treatment sessions should be agreed on between clients and practitioners. According to Bordin (1994), the degree to which tasks are successful in moving clients towards their goals of treatment will depend on how well therapists link these exercises to clients' perceptions of their difficulties and their desires to change. In addition, Bordin (1979) considered the bonds between clients and practitioners grow from their collaboration within treatments and shared activities. He suggested that the depth and quality of these interpersonal connections would vary depending on the exercises and experiences clients and professionals share. Furthermore, Bordin (1994) stated bonds are "likely to be expressed and felt in terms of

liking, trusting, respect for each other, and a sense of common commitment and shared understanding in the activity." (p. 16).

The strength of the bonds between clients and practitioners can fluctuate over the course of therapy, and Bordin was interested in understanding the strains that may occur within working alliances. He suggested that the client-practitioner relationship is an arena where clients' troubles can be played out. These issues, if worked through collaboratively, could strengthen the therapeutic process and relationship or may weaken, and at worst rupture, the alliance. Bordin did not discuss specific strains in his writing, but others (e.g., Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011) have offered potential strain indicators, which include clients' disagreements with practitioners over goals and tasks, rushing or resenting compliances with goals or tasks, and unresponsiveness to interventions.

Client-Practitioner Relationships in Psychology

Following Freud's conceptualisation of transference and his claim that this phenomenon is the vehicle for therapy success, researchers have attempted to measure transference and countertransference in individual psychotherapy, despite the inherent difficulty of examining largely unconscious processes. Carter (1996) argued that clients are limited to assessing transference processes by post hoc verification (e.g., confirming transference through post-session interviews and discussions), and that therapists' perspectives are useful, because practitioners are both participants and observers in transferential processes. Investigators have developed and used self-report ratings of transference (e.g., Therapy-Session Check-Sheet; TSCS; Luborsky, 1971), countertransference emotions (e.g., Therapist Appraisal Questionnaire, TAQ; Fauth & Hayes, 2006) and behaviours (e.g., the Index of Countertransference Behavior, ICB; Friedman & Gelso, 2000). Some researchers have also drawn comparisons between

therapists' perceptions and forms of session data (such as transcripts) to measure countertransferential thoughts (see Hayes, Gelso, & Hummel, 2011 for a review). In their meta-analysis, Hayes et al. (2011) found that countertransference and therapy outcomes had a small, negative association (r = -16). The authors suggested that countertransference might have an antitherapeutic effect, and lead to poor client outcomes. Hayes et al. also reviewed studies in which researchers have studied the association between countertransference management and treatment outcomes. In their meta-analysis they found a large, positive (overall) effect (r = .56) and concluded that countertransference management is likely to assist in positive treatment outcomes.

Investigators have examined the links Rogerian qualities have with therapeutic outcomes. Researchers have shown that clients' perceptions of therapist-offered conditions within treatment are the strongest predictors of outcomes, and in separate meta-analyses, these therapist qualities have been shown to have small to moderate associations with treatment outcomes. The overall effect sizes (r) from these analyses were .31 (empathy; Elliott, Bohart, Watson, & Greenberg, 2011), .24 (congruence/genuineness; Kolden, Klein, Wang, & Austin, 2011), .27 (positive regard; Farber & Doolin, 2011). These results indicated that clients whose practitioners displayed Rogerian qualities were likely to have positive treatment outcomes. These correlations, however, may not accurately reflect the real effect of these interpersonal conditions. Elliott et al. (2011) criticised the quality of the instruments and methods used to measure these constructs. For example, the correlations between cognitive and affective measures of empathy are commonly weak and the associations between observer and client perspectives have only moderate positive correlations (see Elliott et al., 2011; Gurman, 1977). In addition, intercorrelations between measures of empathy, genuineness, and unconditional positive regard show that high proportions of variance

are shared between measures; the instruments that measure Rogerian conditions may have poor construct validity, or these three qualities may be difficult to distinguish from one another (Gurman, 1977). This latter point appears to make sense. Rogers suggested that the three therapist-offered conditions should be offered together as a coherent and consistent approach to caring for clients, and together represent a client-centred approach albeit difficult to measure in a reductionist manner.

Researchers in psychology have also examined aspects of Bordin's (1975, 1979, 1994) model of the working alliance and the association of these factors with psychotherapy outcomes. Tryon and Winograd (2011) found a positive, moderate overall effect size (r = .34) in their meta-analysis on the link between client-practitioner goal consensus and treatment outcomes. These investigators found a similar overall effect size (r = .33) in their meta-analysis of studies on the association between collaboration and psychotherapy outcomes. These findings suggest that clients will benefit from relationships that are characterised by clients and practitioners agreeing on the goals of treatments and working collaboratively to achieve those goals.

The majority of researchers who have examined therapeutic relationships and their associations with psychotherapy outcomes have done so using the working alliance concept. Although numerous investigators have used Bordin's conceptualisation of the alliance, many researchers have developed measures based on their own definitions or those of others (e.g., Anderson & Anderson, 1962; Orlinsky & Howard, 1975; see Elvins & Green, 2008 for a review). In general, researchers have found the quality of client-practitioner alliances to be positively associated with the quality of psychotherapy treatment outcomes in numerous studies in individual psychotherapy (see Horvath, Del Re, Flückiger, & Symonds, 2011 for a review) and couple and family therapy. Strong alliances are typically associated with positive treatment outcomes and weak alliances

are associated with no change after treatment, or people getting worse from treatment. These relationships seem to be small, but they are consistent. The magnitudes of the overall effect sizes (*r*) of alliance-outcome correlations from four meta-analyses on individual psychotherapy (i.e., Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000) range from .21 (Horvath & Bedi, 2002) to .275 (Horvath et al., 2011). The outcomes that researchers have assessed include anxiety levels (Gaston, Piper, Debbane, Bienvenu, & Garant, 1994), depression or depressive symptoms (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000), and interpersonal problems (Bachelor, 1991).

Although researchers have found small to moderate, but robust, relationships between the quality of alliances and treatment outcomes, some practitioners and investigators consider the influence of the alliance on outcomes to be greater than these effect sizes represent. According to Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, and Gallop (2011), the differences between research findings and clinical perceptions may be due to issues with the quality of alliance-outcome research. First, investigators have developed instruments to measure the alliance in favour of developing a definition for the concept; there are over 65 different measures of the alliance (see Elvins & Green, 2008) and no universally agreed upon definition. These instruments seem to measure variations of the concept, and potentially other relationship factors as well (see Horvath, 2011). For example, (Horvath, 2009) compared the four most commonly used measures, the California Psychotherapy Alliance Scale (CALPAS/CALTARS; Marmar, Gaston, Gallagher, & Thompson, 1989; Marmar, Weiss, & Gaston, 1989), the Penn Helping Alliance Scales (Penn/HAQ; Alexander & Luborsky, 1987), the Vanderbilt Psychotherapy Process Scale (VPPS; Hartley & Strupp, 1983), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). He found the shared variance

between these measures was less than 50%. This finding implies that, although there is moderate convergent validity, the scales are also measuring different aspects of alliances making cross-study comparisons difficult.

Second, researchers often collect insufficient assessments of alliances over treatments. For example, Crits-Christoph et al. (2011) reported that in 77% of studies in Horvath and Bedi's (2002) meta-analysis the alliance was commonly assessed in one single treatment session, or, if multiple sessions were assessed and the alliance averaged, then often the assessment score would be the mean of up to three sessions. According to Crits-Christoph et al. (2011), from the generalizability coefficients generated in their study, "adequate assessment of the alliance using multiple patients per therapist and at least four treatment sessions is crucial for fully understanding the size of the alliance-outcome relationship" (p. 267).

Third, Crits-Christoph et al. (2011) stated that practitioners often retrospectively reported on their alliances with clients. In such incidences, therapists are likely to generalise their experiences as good or poor, and their perceptions of their alliances could be heavily swayed by the outcome of their clients' treatments. Fourth, the majority of assessments used to measure treatment outcomes within alliance-outcome studies have been pencil and paper tests. Within Flückiger, Del Re, Wampold, Symonds, and Horvath's (2012) meta-analysis of 201 articles, 70% of outcome measures used were self-report tests. These assessments are easy to administer and analyse, but are unlikely to measure real-life behaviours and outcomes; these metrics seem somewhat arbitrary (see Andersen, McCullagh, & Wilson, 2007; Blanton & Jaccard, 2006 for further discussion). For example, a client may have scored 5 on the Beck Depression Inventory (BDI; Beck & Steer, 1987) at the start of therapy and after six weeks she scores 3. The change seems positive (a decrease in BDI score), but the

size of the change in depressive thoughts, feelings, and behaviour this self-report measure reflects is unclear.

Alliance Ruptures

Researchers have also examined what happens to treatment outcomes when alliances break down, and the influence of rupture-repair attempts on psychotherapy outcomes. Safran et al. (2011) conducted a meta-analysis in which they reviewed three studies (perhaps it should be called a mini-meta-analysis) investigating the relationship between rupture-repair occurrences and treatment outcomes. The authors reported a medium effect size (r = .24), which suggested rupture-repair episodes were positively associated with treatment outcomes. In another meta-analysis Safran et al. (2011) examined the influence of therapists receiving alliance-rupture-resolution training (through intervention training or from supervision) on patient symptoms. These investigators found that the training/supervision led to significant client improvements when making comparisons between clients' symptoms pre- and post- training (r = .65). Safran et al. (2011) also found that rupture-resolution training led to small, but significant improvements in patients' symptoms in comparison to clients whose therapists did not receive training (r = .19). The authors noted several limitations to these meta-analyses including the small number of published studies on alliance ruptures and repairs, the heterogeneity of study design, treatment type and length, and the limited client population that was tested. The studies reviewed did not examine the processes that led to rupture resolution.

Many clinical texts contain case study examples of how ruptures can be repaired, through different psychological practices, and researchers such as Safran and colleagues (e.g., Eubanks-Carter, Muran, & Safran, 2010, 2014; Safran et al., 1990; Safran & Kraus, 2014; Safran & Muran, 2000; Safran et al., 2011; Safran, Shaker, &

Muran, 2014) have developed models and training programs on how to repair ruptures (see Safran et al., 2014). Also, researchers have attempted to quantify the relationship between rupture resolution and treatment outcomes. Ruptures and repairs of alliances are complex processes, and unsurprisingly researchers have found large proportions of unexplained variance within meta-analyses, because there are probably numerous unconsidered variables within these studies. It is difficult to quantify relationships between ruptures, repairs, and treatment outcomes without presenting oversimplified versions of these associations.

Associations Between the Alliance and Therapy-Related Factors

Researchers have found associations between numerous personal factors and the quality of the relationships psychologists form with clients. Horvath and Bedi (2002) reviewed studies that examined therapy-related variables associated with the working alliance and identified both practitioner and client characteristics that help or hinder the development of working alliances. For example, practitioners who communicated openly; showed empathy; and were willing to explore client's stories, thoughts, and feelings in sessions generally built stronger working alliances than psychologists who were perceived to be nonempathic, displayed closed communication styles, and were reluctant to explore client-generated material. Furthermore, Horvath and Bedi (2002) identified client characteristics that can be detrimental to the development of working alliances, such as personality disorders, delinquency, homelessness, or drug-dependency. They also reported that clients with maladaptive (e.g., fearful, anxious, dismissive) attachment styles are difficult to build working alliances with, particularly within the early phases of treatment.

Summary

Researchers have conducted numerous studies on client-practitioner relationships in psychology. Results from meta-analyses consistently show small to moderate positive associations between the alliances (or parts of alliances) and treatment outcomes. Nevertheless, there are several limitations to the instruments that researchers have used to measure alliances, and there is also ambiguity regarding the alliance concept. In addition, investigators have found weak to moderate correlations between measures of Rogerian conditions (i.e., empathy, unconditional positive regard, genuineness). All of these issues contribute to the incomplete or distorted view of how strong the associations are between client-practitioner relationship and treatment outcomes. Nonetheless, when alliances break down, researchers (e.g., Safran et al., 2011) have shown that training in rupture-repair interventions can be useful in helping restore the bonds between practitioners and clients and can lead to positive treatment outcomes.

Client-Practitioner Relationships in Healthcare Domains

Over the last 40 years, research and commentary on client-practitioner relationships has extended from psychology into many other healthcare domains including medicine (Van Dulmen & Bensing, 2002), psychiatry (Gehrs & Goering, 1994; Priebe & Gruyters, 1995; Priebe & Gruyters, 1993; Priebe & McCabe, 2008), nursing (Forchuck & Reynolds, 2001; Moyle, 2003; Welch, 2005), occupational therapy (Morrison, 2013; Morrison & Smith, 2013), massage (Harris, Atkins, & Alwyn, 2010), and traditional Chinese medicine (Henley & Miller, 2010). In psychiatry, researchers have found the quality of the therapeutic relationship to be important in relation to a variety of treatment outcomes including symptom severity (Tattan & Tarrier, 2000), quality of life (McCabe, Priebe, Röder-Wanner, & Hoffmann, 1999), social functioning

(Neale & Rosenheck, 1995), and time spent in hospital over a 20-month follow-up period (Priebe & Gruyters, 1995). Within psychology, researchers have explored and discussed client-practitioner relationships in a relatively new domain: sport psychology.

Client-Practitioner Relationships in Sport Psychology

Sport psychologists are increasingly becoming members of athletes' support networks and multidisciplinary teams, as athletes, coaches, and sport organisations recognise the importance of psychological aspects of performance and athlete wellbeing. Such professionals may be one of injured-athletes' closest support personnel, and so the relationships sport psychologists form with athletes may influence their clients' performances, wellbeing, and recoveries.

Until recently, discussion and opinion pieces have been the customary way sport psychologists have engaged with the topic of relationships in practice (Tod & Andersen, 2012). There exists, however, a few researchers who have studied client-practitioner relationships in sport psychology. Tod and Andersen (2012) reviewed many of these studies recently, and in the following section, I have used several of their categories in discussing the opinion pieces and studies they evaluated along with more recent publications. Furthermore, in this section, I will use the term practitioner as an overarching term instead of psychologist, unless I am referring to studies in which registered, licenced, or certified (select the most relevant pronoun for your country) psychologists are used within samples, because several of the studies in this section have examined intern or sport psychology students' relationships and experiences.

Client-Practitioner Interactions

There exists little research on client-practitioner interactions in sport psychology. A few researchers have investigated this area and have typically asked both practitioners and clients for their views on interactions. Tod, Marchant, and Andersen

(2005) examined clients' and trainee practitioners' perceptions of their relationships within sport psychology practice. The researchers used Bordin's (1994) working alliance framework to analyse and interpret the findings. In this study, each of the seven trainees in the study consulted with a client on three occasions, and both the client and practitioner were interviewed individually after the first and third sessions. The researchers found that "paralleling working-alliance theory, participants differentiated between the friendly (or interpersonal bond) and the professional (goals and tasks) elements of their relationships. Both the athletes and trainees valued the collaborative efforts of the other parties" (Tod & Andersen, 2012, p. 283). Participants reported that a similar sporting background was not necessary for developing positive working alliances. Nonetheless, athletes indicated that shared sport experiences helped trainees communicate in a mutual language, and trainees reported that prior experiences in their clients' sports helped reduce their concerns about being ineffective practitioners (Tod & Andersen, 2012). Clients in the Tod et al. (2005) study reported strains within trainee-client relationships involving trainees not appearing to listen, imposing their values, not explaining their roles fully, and acting in ways that annoyed athletes.

Researchers have also examined the relational skills and qualities of a seasoned sport psychology practitioner. Lloyd and Trudel (1999) assessed the in-session content of 10 applied sport psychology sessions between a seasoned sport psychologist and his clients. These researchers focused on investigating verbal behaviours and the content of verbal exchanges within the sessions. Post-consultation interviews with clients revealed that good listening skills, sharing information at appropriate moments, and helping clients organise their thoughts were characteristic of the seasoned practitioner (Tod & Andersen, 2012). Yet, Tod and Andersen (2012) doubted the validity of these findings, and highlighted that research examining in-session behaviours (e.g., Lloyd & Trudel,

1999; Tod, Marchant, & Andersen, 2007) may influence what is said within sessions – the recorded meetings may not represent typical sessions between client-practitioner dyads because the practitioner and client could be on their best behaviour and athletes may feel uncomfortable disclosing sensitive information when sessions are recorded.

Although there are a limited number of studies on client-practitioner interactions in sport psychology, these two studies are useful in providing some information about in-session experiences for clients and practitioners and the difficulties and strains athletes and practitioners can encounter within their relationships. From reading these studies, practitioners could learn how to better navigate such relationship ruptures or repair them within training and practice.

Characteristics of Effective Practitioners

Researchers have sought to understand what characterises effective sport psychology practitioners. Investigators have asked various groups about their perceptions, including athletes (Anderson, Miles, Robinson, & Mahoney, 2004; Dunn & Holt, 2003), athletes and coaches (Gentner, Fisher, & Wrisberg, 2004; Weigand, Richardson, & Weinberg, 1999), sport psychologists (Simons & Andersen, 1995; Sullivan & Nashman, 1998), sport psychologists and athletes (Lubker, Visek, Geer, & Watson, 2008), and athletes, coaches, sport science and medicine administrators, and sport psychologists (Gould, Murphy, Tammen, & May, 1991). Researchers have used qualitative (e.g., Anderson et al., 2004; Dunn & Holt, 2003 Simons & Andersen, 1995), quantitative (e.g., Gentner et al., 2004; Lubker et al., 2008; Sullivan & Nashman, 1998), or mixed method approaches (e.g., Gould et al., 1991; Weigand et al.,1999) to answer their research questions. These researchers identified that practitioners are considered effective when they are perceived to have both good interpersonal skills and technical competencies, but ineffective when these skills are not evident (Orlick & Partington,

1987). Interpersonal characteristics that are important for practitioner effectiveness include being a good communicator (e.g., good listener, easy to talk to, uses athletes' language), being honest and trustworthy (maintains confidentiality), being empathic, treating all team members equally, earning athletes' respect, and fitting in well with teams. Researchers identified several service-delivery characteristics important in practitioner effectiveness, such as professionals being competent in psychological skills delivery; knowledgeable about the athletes' sports, sport environments, and the demands of training and competition; and able to select appropriate formats of service delivery, provide athlete-centred service delivery, feedback, counselling services (for issues in and outside of sport), and follow up with clients after sessions (Tod & Andersen, 2012).

Investigators have suggested that athletes perceive the interpersonal environment in which sport psychology professionals practice to influence practitioners' effectiveness. Dunn and Holt (2003) asked male collegiate ice hockey players (n = 27) their perceptions of the delivery of a sport psychology program and, specifically, their sport psychology consultant. Along with providing effective characteristics of the consultant, the researchers reported that athletes thought coaching staff's absence from sport psychology meetings was preferable because this enabled players to be open and authentic with the consultant and each other.

Athletes and coaches have provided their views on what may hinder sport psychology consultants' effectiveness (Tod & Andersen, 2012). If practitioners cannot meet on a regular basis with athletes, so that athletes' issues can be resolved or worked through, they are considered less effective. Tod and Andersen (2012) also indicated that coaches who are intimidating may negatively influence sport psychologists' abilities to develop trust with athletes and could prevent athletes from seeking out psychological

support due to concerns that coaches may pressure practitioners into sharing athletes' confidential information with them. Coaches have described characteristics and behaviours of poor practitioners; they felt irritated or threatened by practitioners who offered left field or dogmatic exercises, promised instant fixes without spending time getting to know the program, and went beyond their role and gave technical coaching (Partington & Orlick, 1987).

The findings from the aforementioned studies indicate there are numerous interpersonal qualities that are instrumental in practitioner effectiveness, but these characteristics need to be paired with technical competencies for successful service delivery. The research in this area could be useful for trainee and qualified practitioners to help them identify what characteristics and behaviours they need to develop to be effective. These studies offer limited information or data about the actual relationships and interactions practitioners have with athletes (Tod & Andersen, 2012).

Longitudinal Development Research

Tod and colleagues (Tod, 2006, 2007a; Tod et al., 2009; Tod, Andersen, & Marchant, 2011; Tod & Bond, 2010; Tod et al., 2005, 2007) have extensively examined the development of sport psychology practitioners and found that, with experience, these professionals recognise the importance of client-practitioner relationships within the helping process. For example, Tod et al. (2009, 2011) interviewed a cohort of Australian sport psychology practitioners on four occasions over a six-year period (the interviews commenced prior to their postgraduate training). These participants reported that, with experience, their understandings of the client-practitioner relationship developed in both depth and breadth (Tod & Andersen, 2012). In addition researchers have suggested that incidences, difficulties, or pivotal moments that practitioners encounter can alter the way professionals perceive relationships. For example, in a two-

year case study, Tod and Bond (2010) examined the development of a British novice sport psychologist, Anna. They reported that a difficult experience with a client challenged Anna's understanding of the importance of relationships. After this incident, Anna prioritised building relationships within service delivery and reported positive client-outcomes.

Tod and colleagues' studies are insightful in relation to the experiences that shape and develop practitioners' awareness of relationships in sport psychology. The results emphasize the importance these professionals place on relationships in practice. As Tod and Andersen (2012) made clear, the longitudinal research on client-practitioner relationships in sport psychology has only examined practitioners' and clients' perspectives, not actual relationships. Examining client-practitioner dyads over time, perhaps through observations, could be useful to understand the inter- and intra-personal processes and dynamics that develop as relationships grow.

Transference, Countertransference, and the Erotic

Freud (1912/1958a) suggested that transference in the client-practitioner relationship is the primary mechanism through which client change occurs in psychoanalysis. Fittingly, some researchers and practitioners have commented on transference and countertransference in sport psychology, but such discussions of these reactions are limited compared to the relatively strong presence in counselling and clinical psychology literature. Generally, investigators and commentators have examined and discussed this topic in brief and in the context of opposite-sex consulting (Henschen, 1991; Yambor & Connelly, 1991), service provision (Andersen, 2000b, 2005a; Poczwardowski, Sherman, & Henschen, 1998; Thompson & Andersen, 2012), practitioner training and supervisory experiences (Andersen & Williams-Rice, 1996; Thompson & Andersen, 2012; Van Raalte & Andersen, 2000), psychodynamic

supervision (Andersen, Van Raalte, & Harris, 2000; Thompson & Andersen, 2012), and client-practitioner relationships (Petitpas, Giges, & Danish, 1999). Researchers have discussed these processes through in-depth case studies and reflections on their own experiences in service delivery (e.g., Andersen, 2005b; Price & Andersen, 2000; Strean & Strean, 1998; Thompson & Andersen, 2012; Tod, 2007b) and supervision (Andersen, 2012, 2014a). Within these studies there are several stories and discussions that illustrate how these complex reactions play out in professional relationships. Investigators have offered examples of how practitioners can explore their reactions to clients or supervisors, and develop understanding of how these processes can influence client-practitioner and supervisor-supervisee interactions. The honesty of disclosures about personal challenges and weaknesses from these authors (and others, for example, Tod, 2007b) in their confessionary tales (Sparkes, 2002) is a rare occurrence within sport psychology literature, perhaps because practitioners fear that, if they were honest, they would be exposed as being incompetent.

Commentators in sport psychology have discussed the importance of managing countertransference reactions, but few sport psychologists seem to institute systematic practices or strategies to deal with countertransference. Winstone and Gervis (2006) found, from their survey of qualified sport psychology practitioners within the UK, that many professionals valued practitioner qualities associated with self-awareness and countertransference management, but a smaller percentage of their sample reported using strategies such as supervision and personal counselling to develop these skills. Several researchers and practitioners have suggested these practices are useful in developing self-awareness and identifying, learning from, and managing countertransference (see Andersen & Williams-Rice, 1996; Anderson, Knowles, & Gilbourne, 2004; Poczwardowski et al., 1998; Van Raalte & Andersen, 2000).

There is sparse research on the topic of erotic transference and countertransference in sport psychology (Andersen, 2005b; Little & Harwood, 2010; Stevens & Andersen, 2007a, 2007b; Strean & Strean, 2005). Andersen and colleagues (e.g., Andersen, 2005b; Stevens & Andersen, 2007a, 2007b) have discussed erotic transference and countertranference and used case studies to raise awareness of how these processes may unfold in sport psychology practice. Stevens and Andersen (2007b), in two case studies, illustrated different ways in which erotic transference and countertransference can manifest through denial or acting on desires. Both cases are helpful in developing practitioners' understanding of some of the psychological processes that may be prevalent, even when denied, within therapeutic relationships.

Professional Practice Literature

Commentaries and discussions on professional practice in sport psychology can be sources of knowledge on client-practitioner relationships. There are several sources of literature such as published journal articles (e.g., Thompson & Andersen, 2012; Tod et al., 2009), book chapters (e.g., Andersen & Speed, 2011; Marchant, 2010), and edited textbooks (Andersen, 2000b, 2005a; Hanrahan & Andersen, 2010; Hays, 2009) in which authors reflect on service delivery in sport and performance psychology. Within these sources, authors discuss the development and maintenance of interpersonal relationships in the context of service-delivery experiences. In perhaps the first edited book in sport psychology with a central focus on therapeutic relationships, *Doing Sport Psychology*, Andersen (2000b) presented a range of topics to help practitioners understand the nuances of service delivery. Authors gave real-life conversations and dialogue from sessions along with discussions between sport psychologists, athletes, and coaches as well as authors' interpretations of these exchanges. Several other texts (e.g., *Sport psychology in practice*; Andersen, 2005b) have followed a similar style to

Andersen's (2000b) book. Also, in one edited text, *Routledge Handbook of Applied Sport Psychology* (Hanrahan & Andersen, 2010), relationships (e.g., athlete-psychologist, coach-athlete, coach-psychologist, supervisor-supervisee) are a core theme throughout the various chapters of the book (Andersen & Speed, 2010). In one chapter, Marchant (2010) discussed the complexity of working with anxious athletes and emphasized the importance of getting to know the athletes with whom practitioners work rather than offering clients off-the-shelf interventions. He explained, from his experience helping anxious athletes, that practitioners need to understand the causes of athletes' anxieties, and this requires psychologists to offer interpersonal environments that welcome the discussion of emotions that are often labelled and viewed as negative, such as anxiety, in an open and nonjudgemental way. Through researchers' stories in edited texts like the ones described, practitioners can learn and identify with relationship experiences and apply this knowledge to their own circumstances and practices.

Practitioners have reported that professional practice literature and other non-research materials are useful for learning about relationships. For example, in Tod et al.'s (2009) study on practitioners' development, trainee psychologists said books that presented frameworks and discussed how to interact with clients (e.g., Egan, 2002) were useful in initially developing competence in working with clients. One practitioner reported that Egan's text gave her a framework for how to relate to clients. Once she had mastered this framework, she found that texts containing in-service client-practitioner interactions on specific topics were helpful, because she could see the application of the helping framework within these writings (e.g., Andersen, 2000b).

Processes in Developing Client-Practitioner Relationships

In their review chapter, Tod and Andersen (2012) presented ideas and specific suggestions for trainees and practitioners on developing relationship-building skills.

These suggestions were based on research and discussion from practitioners, educators, and researchers in sport psychology. Tod and Andersen gave suggestions on eight topics that 4,000 practitioners had identified in Orlinsky et al.'s (2001) study as being influential sources of professional development. These topics are, in descending order of importance: experiences with clients; personal therapy; supervision; reflecting on life experiences; collegial interactions; workshops, seminars, and training courses; theory and research; and being a supervisor. Some of these topics have acquired considerably more research attention than others. In the following subsection, I will review supervision and personal therapy, because these topics have received more thorough discussion in sport psychology than the other areas Orlinsky et al. identified.

Client experiences. Both educators and practitioners agree that experiences interacting with clients are important for developing relationship skills (see Stambulova, Johnson, & Linnér, 2014; Tod et al., 2007). Role-plays, however, may be a suitable platform for trainee practitioners to practice their relationship-building and other service-delivery skills particularly when they are anxious about working with athlete-clients, do not have the necessary skills to help clients with specific issues, or have their own issues that may influence client-practitioner interactions (Andersen, Van Raalte, & Brewer, 2000; Tod & Andersen, 2012; Tod et al., 2009; Tod et al., 2007).

Supervision. Van Raalte and Andersen (2000) have discussed the importance of supervision in helping practitioners identify and explore what they bring into relationships with clients including their needs, desires, and motivations. Tod and Andersen (2012) stated that, in supervision, practitioners are helped to reflect on the experiences they have with clients. The stories that are told and the focus of these experiences are likely to differ depending on the theoretical model that a supervisor adopts in supervision. For example, in psychodynamic supervision, the tales supervisors

and supervisees tell are likely to centre on relationship processes (e.g., transference, countertransference; see Thompson & Andersen, 2012). Whereas, in cognitive behavioural therapy (CBT), discussions are likely to focus on the technical interventions that practitioners deliver to clients (Van Raatle & Andersen, 2000). Recently, mindfulness has entered the supervision discourse (e.g., Andersen, 2012; Barney & Andersen, 2014; Thompson & Andersen, 2012). For example, Barney and Andersen (2014) offered examples of how they personally take mindfulness approaches to supervision and how mindfulness can benefit the relationships and interactions with supervisees within supervisory processes. I discuss interpersonal mindfulness in a later section.

Personal therapy. Several researchers and practitioners advocate personal counselling as a method of developing self-reflection, insight, and understanding of oneself as a person and a practitioner in sport psychology (Petitpas et al., 1999). From being a client in either actual therapy or in role plays, Petitpas et al. (1999) suggested practitioners are likely to gain a deep understanding of the client-practitioner relationship and the needs, values, and concerns they bring into these relationships. Findings from practitioner development studies (e.g., Tod et al., 2007; Tod & Bond; 2010) support these suggestions. For example, in Tod and Bond's (2010) case study of a practitioner's (Anna's) development over 2 years, Anna used her counselling experiences to more fully appreciate the trust clients have in practitioners when sharing their experiences. It appears from the limited research on this topic in sport psychology that only a few practitioners undergo counselling despite the benefits of this activity illustrated in several case studies. For example, Winstone and Gervis (2006) found in their survey on self-awareness and countertransference management that only a small proportion of respondents said they would use counselling for personal issues or self-

development. This finding seems paradoxical for psychologists who are likely to see the value of talking therapy for their clients, but appear reluctant to use it themselves.

Reflecting on life experiences. Trainees and practitioners have reported that interactions outside of formal training and service delivery can develop practice competence and provide opportunities to learn about relating with others (Tod et al., 2007; Tod et al., 2009). Trainees have reported that working in managerial or supervisory roles, speaking with people who communicate in another language, and being a client helped develop their communication skills. Experiences outside of formal training can be helpful in the maturation of relationship-building skills for sport psychologists.

The Neurobiology of Human Relationships

Recently, practitioners and researchers have written about neuroscience and relationships in sport and exercise psychology (e.g., Andersen, 2014b; Mannion & Andersen, 2015; Williams, 2014). These authors have used neurobiological explanations about why therapeutic relationships work, how abusive relationships function, and what these interpersonal connections do to the brain. Andersen (2014b) and Williams (2014) have also reported using the language of neuroscience when working with athletes and coaches in their in-depth, applied case studies. The review of this particular literature is especially relevant to Study 3 and requires substantial explanation. The neurobiology of human relationships, although discussed in the following section in regards to psychology practice, also provides a bridge that joins together physical and psychological processes that underpin almost all human relationships. I now turn to what neuroscience tells us about human relationships and how this knowledge offers some possible mechanisms to explain the effectiveness of therapeutic relationships.

Humans are social animals, and our brains are social organs. We are wired to connect with other people; positive interpersonal relationships can stimulate brain development and provide us with protection from real or imagined fears (Cozolino, 2014). We are also predisposed to respond quickly to stimuli that could harm us. Our nervous systems rapidly alert us to anything that could make us feel unsafe or threatened. Practitioners, in their relationships with clients, may soothe or exacerbate clients' fears, worries, and anxieties, and, consequently, may influence (for good or ill) treatment processes and outcomes.

Clients may enter professional relationships with healthcare practitioners with fears or concerns, and practitioners, in some cases, may induce or intensify such emotions. Clients may perceive professionals' nonverbal or verbal behaviours as threatening or dangerous, particularly if such movements, words, or expressions are similar to those used by people who have previously harmed them. For example, a client's brain may trigger a flight-fight-freeze response when her therapist says little and frequently stares off into space in session if, as a child, the client had an inattentive parent (Mannion & Andersen, 2015). Several brain areas are involved in orchestrating flight-fight-freeze reactions: the prefrontal cortex, brainstem, and limbic system. One structure within the limbic system that is critical to these responses is the amygdala; its main role is to evaluate, and create positive or negative associations with, external and internal stimuli to influence and regulate behaviour (e.g., whether to approach or avoid the stimuli; Cozolino, 2014). When the amygdala perceives a threat, it stimulates other brain areas to prepare the body for a fight-flight response (see Cozolino, 2014 for details). In such a reaction, our sympathetic nervous system is activated leading to increases in heart and respiration rates and muscle tension. These physiological changes are accompanied by emotional responses such as dread, anxiety, panic, or rage and can

feel physically (and mentally) uncomfortable (Mannion & Andersen, 2015). The amygdala's appraisals of stimuli are so quick that a response can be initiated before a stimulus has been consciously processed.

Clients may experience freeze responses in their interactions with practitioners. This type of reaction can happen when they feel hopeless or unable to fight or flee. During this process a client's parasympathetic nervous system (PNS) is activated and leads her to feel flat, have reduced physical and mental functioning, and want to dissociate from others and her surroundings (Mannion & Andersen, 2015). People may not be cognisant of experiencing freeze responses because such reactions may be unconscious and manifest in relationships in indirect ways (e.g., boredom, tiredness; Mannion & Andersen, 2015).

Practitioners who offer consistent caring relationships to their clients can help reduce brain activity associated with fight-flight-freeze responses and aid brain development. By offering Rogerian qualities (empathy, genuineness, unconditional positive regard) in therapy, practitioners may be able to re-parent clients' brains through secure attachment relationships (Cozolino, 2010, 2014). Researchers have drawn parallels between Rogers' conditions and those of positive parenting – the interpersonal environments that facilitate the development of children's secure attachments. Investigators (e.g., Schore, 1994; Siegel, 2012) have proposed that secure attachments help develop brains in ways that optimise emotion and arousal regulation, help develop positive coping strategies, increase neural network integration, and improve immunological functioning. Just like parents, psychologists can help their clients develop new (or adjust previous) ways of social and emotional learning. Practitioners can also help clients become able to modify their thought patterns or their reactions and

take new perspectives on their real or imagined fears and anxieties, particularly by being empathic, genuine, and displaying unconditional positive regard.

One particular Rogerian quality that has received considerable research attention in interpersonal neurobiology is empathy. Many investigators acknowledge that empathy is a complex phenomenon at both a conceptual and a neurological level (Chartrand & Bargh, 1999; Decety & Jackson, 2004, 2006; Iacoboni & Mazziotta, 2007). Here, I provide a simplified overview of the neurological foundation of empathy based on current understanding and also discuss the dark side of empathy circuitry.

Cozolino (2014) proposed that empathy "is actually a *hypothesis* we make about another person based on a combination of visceral, emotional, and cognitive information" (p. 230). Empathy occurs through us creating internal representations of others' experiences (Decety & Grèzes, 2006). Researchers suggest that this process relies on mirror neuron systems in the brain. Investigators have found that these neurons are active in recognising and imitating others' behaviours (Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003; Iacoboni et al., 1999; Rizzolatti & Craighero, 2004). Researchers have discovered mirror neuron networks in the frontal and parietal lobes. These areas of the brain are involved in grounding real or imagined actions in space and time, which helps give actions context (Carr et al., 2003). Iacoboni (2008) proposed that, through specialised mirror neuron systems, people detect others' verbal and nonverbal displays of their inner states and use this information to create neurological replications of these conditions in the observer. For example, if we notice someone in pain, we can experience a simulation of pain, and similar neural networks that are activated within that person are stimulated within us (Saarela et al., 2007). Through our senses we perceive their signs of discomfort. These perceptions stimulate mirror neuron networks that activate the insula cortex, which in turn signals the body and the limbic

system to replicate the hypothesised sensations and emotions experienced by the person in pain within our body and mind (Siegel, 2007). According to Iacoboni (2008), super mirror neurons may help us determine whether the source of our internal experience is our own or is an internal representation of another's inner world. Empathy is the doorway to clients experiencing that they have been heard and knowing that their practitioners have felt their inner worlds. Empathy may allow practitioners to know how to develop safe interpersonal environments that reduce clients' fear responses so clients can explore their inner worlds and develop new ways of thinking and learning.

Problems with empathy. To be able to be empathic, one needs to maintain an awareness of one's inner world (self-awareness) while exploring one's internalised (hypothesised) state of another person. Sometimes self-awareness of one's inner state can be lost within the rapid back and forth between processing representation-based information and one's own feelings (Cozolino, 2014). During such processes, the boundaries of self and other may blur, and one's experience can end with identification or fusion with clients' emotions and internal experiences. When practitioners find themselves in this territory, they can end up vicariously experiencing clients' pains or joys as their own and losing the *as if* quality of empathy that Rogers (1957/2007) emphasised. When practitioners identify with clients' pains and traumas, they may experience what has become known as compassion fatigue, which is a feeling of deep sadness, suffering, or sympathy to exhaustion. Such emotions are paired with longing to relieve these feelings in another person (Tabor, 2011). Such an experience can be detrimental to practitioners' mental health as well as the therapeutic process.

Storytelling. In sport psychology and physiotherapy, stories are shared between clients and practitioners. Tales (both brief and long) about performance, injuries, body parts, recoveries, and interpersonal connections can be told within treatments

(Andersen, 2004b; Andersen & Speed, 2011). Narratives, voiced by practitioners or clients, have the power to soothe clients' fears or exacerbate them. An example of when stories can have therapeutic influence is when clients see practitioners after traumatic injuries. Under periods of stress and trauma (such as sport injuries), the right side of the brain can record the trauma unconsciously and inhibit left hemisphere activation. Often people who have experienced traumatic injury have incoherent stories about the trauma that can leave them with amygdalae that react in situations, or to people or places, that *may be* similar to their experiences. Telling stories within the context of therapeutic relationships that downregulate amygdalae activation in treatment can help integrate left and right hemispheres of the brain, help provide context for the unconscious memories, and form conscious memories about the traumas through activating hippocampi. This left-right hemispheric integration can then lead to cortical and subcortical integration. The conscious memories or stories told about the traumas can reduce the amygdalae's orchestration of fear responses by effectively informing them that these situations, although slightly similar to the traumatic events, are safe. One way that these therapeutic stories can be told is through consultation with an internalised model of a therapist.

Internalising the therapist. Clients can internalise representations of others that can be called upon, listened to, and used in their interactions with the real world. Researchers and practitioners have offered ideas on the neurological processes that underlie internalising helpful others, and, in particular, therapists (see Badenoch, 2008; Goldberg, 2001). Badenoch (2008) proposed that a warm, empathic relationship might facilitate the internalisation of the therapist as a caring internal object that can provide clients with a source of soothing and healing that goes beyond therapy sessions. For example, an athlete who has worked with an empathic psychologist to overcome her

fear of reinjury after an ACL reconstruction may internalise her therapist's voice and instructions. When she begins to feel anxious about exerting herself in training, she might hear her psychologist say, "Its okay Jane, your knee is ready for you to push it hard again." Such comments could soothe Jane's distress and anxiety away from the treatment sessions. By activating her prefrontal cortex where the internalisation of her therapist is stored, Jane's hippocampus can be involved and contextualise her experience. The hippocampus can then signal to her amygdala that she is not under threat.

The Mindful Therapist

Another recent theme discussed in sport psychology literature on client-practitioner relationships is mindful therapy (e.g., Andersen & Mannion, 2011; Mannion & Andersen, 2015) and supervision (Andersen, 2012; Barney & Andersen, 2014). In recent book chapters, Andersen and colleagues (Barney & Andersen, 2014; Mannion & Andersen, 2015) present commentary on the interpersonal neurobiology of mindfulness and discuss case studies of mindfulness in practice. People have practiced mindfulness for centuries (since *circa* 500 BC). This ancient practice has its roots in Buddhism and has been used as a formal therapeutic approach to healthcare since the 1970s (for a concise history of mindfulness see Mannion & Andersen, 2015). Within Western writings, mindfulness is considered a purposeful focus on the present moment, in which one is curiously aware of thoughts, feelings, and sensations in a nonjudgemental way (Epstein, 1995; Mannion & Andersen, 2015).

In psychology, mindfulness commentaries and interventions have predominately focused on helping clients develop mindful awareness to aid their psychological and physical health and their performances. More recently, researchers and practitioners have commented on the importance of therapists being mindfully present in

psychotherapy and expanded the application of mindfulness from the intra- to the inter-personal (e.g., Siegel, 2007, 2010; Wilson & Dufrene, 2008). In his book, *The Mindful Therapist*, Siegel (2010) discussed three conditions he considers as foundational to quality client-practitioner relationships; *presence*, *attunement*, and *resonance*, and he offered neurobiological explanations of how these processes may work. I now discuss these concepts briefly (for detailed discussions see Mannion & Andersen, 2015; Siegel, 2010).

Presence. Intrapersonal mindful awareness is the starting point for interpersonal mindfulness. Freud (1912/1958b) summarised a mindful stance in his suggestions on how to practice psychoanalysis, long before mindfulness was overly used as a psychotherapeutic approach or tool. Freud wrote:

> It rejects the use of any special expedient (even that of taking notes). It consists simply in not directing one's notice to anything in particular and in maintaining the same 'evenly suspended attention' in the face of all that one hears (p. 111).

At a neurological level, when we are present, we can experience increased neural firing in the left and medial prefrontal cortex, which is associated with an approach state of activation. Such neural activity allows us to move toward, rather than avoid, difficult situations (Siegel, 2010). Clients may perceive shifts in presence via mirror neuron networks; our verbal and nonverbal behaviours may be detected by clients and perceived as engaged or disengaged with them.

Attunement. When practitioners are mindfully present in therapy, they are undistracted by task-irrelevant stimuli and able to perceive information about their clients' inner worlds through the clients' verbal and nonverbal behaviours. Subjectively, mindful practitioners can feel a deep connection with their clients' experiences and their clients. This process of attunement is similar to the concept of empathy (Siegel, 2007,

2010). Attunement requires practitioners to be aware of their own internal states, and changes that might occur within themselves when with a client. This mindful self-attunement encapsulates our awareness of "our histories and our perceptual biases and how they may contribute to or restrict our cognitive, affective, behavioural, and interoceptive experiences, lest we confuse our issues with our clients' concerns" (Mannion & Andersen, 2015, p. 10).

Resonance. When practitioners are mindfully present and attuned to their clients' internal states, clients can experience resonance; they can *feel felt.* Siegel (2010) explained:

> In many ways we feel "close" or "heard" or "seen" by another person when we can detect that he has attuned to us and has taken us inside of his own mind. When we ourselves register this attunement, either consciously or not, our own state can change. . . . Beginning with a genuine sense of care and interest by the focus of the other's careful attention, resonance extends this positive interaction into a fuller dimension of the other being changed because of who we are . . . this is how two individuals become a "we." (p. 54-55)

When clients experience that their practitioners are accurately attuned to their internal states and are reflecting their internal experiences, resonance is occurring. Practitioners' resonance may provide adaptive models of coping that can be internalised by clients and emulated in their lives (Mannion & Andersen, 2015).

Summary

To summarise, from research in sport psychology, relationships are important to practitioners, athletes, coaches, and administrative staff for effective service delivery. Few studies, however, exist in which actual relationship experiences have been examined. Client-practitioner relationships have traditionally been an adjunct topic in

commentary and research in sport psychology, but recently case studies on these relationships have emerged in the published literature. Trainees value such case studies that bring to life service delivery and illustrate the centrality of relationships when working with athletes. Relationship-centric research and discussions in sport psychology have grown over the last two decades. This development, however, has stemmed from the work of a few psychologists and has gained little traction with many practitioners and researchers who discuss and investigate mental skill interventions rather than the instruments of these interventions (and arguably, from a psychodynamic viewpoint, the interventions themselves), the psychologists. Some of the findings from qualitative and quantitative studies show that many practitioners are not 'clued up' on relational processes such as transference and countertransference and that only a few deliberately engage in self-awareness management (e.g., supervision, personal therapy). Recent commentaries on interpersonal processes in view of neurobiological mechanisms provide a promising avenue for the future research and discussion of client-practitioner relationships.

Athlete-Psychologist Relationships in Sport Injury Rehabilitation

One area of therapeutic intervention in sport psychology is that of injury treatment and recovery. With the increased professionalisation of many sports in the last 20 years, the personal and financial costs of injuries are high. The elevated status of injury rehabilitation within professional sport comes with the necessity of high quality treatment. Although the majority of psychological interventions that researchers and practitioners have investigated and discussed in sport injury rehabilitation relate to mental skills development (e.g., imagery, goal setting, relaxation, stress-management; see Cupal & Brewer, 2001; Johnson, 2000; Theodorakis, Malliou, Papaionnou, Beneca,

& Filactakidou, 1996), a minority have focused on discussing sport psychologists and their relationships with injured athletes as interventions in rehabilitation.

The relationships that athletes have with sports medical personnel (such as psychologists) during their rehabilitation experiences are influential in athletes' recoveries (Andersen, 2007; Brewer et al., 2007). Brewer, Andersen, and Van Raalte (2002), in their biopsychosocial model of sport injury rehabilitation, proposed that social (e.g., social network, rehabilitation environment) along with psychological (e.g., cognition, behaviour, affect) and biological (e.g., endocrine, neurochemistry, tissue repair) factors will be influenced by characteristics of athletes' injuries (e.g., type, course, severity, location, history) and sociodemographic factors (e.g., age, gender, race/ethnicity, socioeconomic status). These characteristics will in turn influence immediate biopsychological outcomes (e.g., range of motion, strength, joint laxity, pain), and, eventually, rehabilitation outcomes (e.g., quality of life, readiness to return to sport; Kolt, 2004). Many researchers have investigated athletes' social support (e.g., Bianco, 2001; Johnston & Carroll, 1998; Podlog & Eklund, 2006; Udry, 1997) and found that social support can improve athlete-wellbeing by influencing (a) distress (Bianco, Malo, & Orlick, 1999), (b) athlete perceptions of isolation and reinjury fears (Podlog & Eklund, 2004), (c) motivation (Bianco, 2001) and adherence to rehabilitation programs (Evans, Hardy, & Fleming, 2000), (d) self-confidence (Magyar & Duda, 2000), (e) and treatment outcomes (Udry, 2001).

Commentators have discussed sport psychologists' roles in social support and some consider that these practitioners may be the closest members of athletes' social-support networks (Andersen, 2007; Clement & Arvinen-Barrow, 2013). Client-practitioner relationships in sport psychology can be intimate because athletes can often share their hopes, concerns, fears, and aspirations with psychologists. If athletes are

serviced within clubs or sporting organisations, they may see their psychologists several times a week and form particularly close relationships with them.

Apart from being identified as members of athletes' support networks and instrumental in social support through injury rehabilitation, there is little research and discussions on sport psychologists' relationships with injured athletes. There are several edited textbooks that are geared towards helping sports medical professionals to work effectively with athletes who have sustained injuries (e.g., Arvinen-Barrow & Walker, 2013; Crossman, 2001; Kolt & Andersen, 2004a; Pargman, 2007; Ray & Wiese-Bjornstal, 1999). Within these books, several authors have written chapters with discussions and guidance on integrating psychological skills within rehabilitation processes and counselling injured athletes, along with professional and ethical practice issues. Some writers have focused on the relationship processes or interactions between clients and practitioners within this context. These texts focus on: (a) developing communication skills to enhance the interactions with injured athletes, (b) understanding client-practitioner relationship experiences and processes, or (c) facilitating relationships that athletes have with others in support networks.

Researchers have shown that athletes (e.g., Francis, Andersen, & Maley, 2000), sport rehabilitation practitioners (e.g., Francis et al., 2000; Wiese, Weiss, & Yukelson, 1991), and sport psychologists (e.g., Petitpas & Cornelius, 2004) recognise that effective communication is important in rehabilitation. Accordingly, several authors have written book chapters about communication skills (Gordon, Potter, & Hamer, 2001; Wiese-Bjornstal, Gardetto, & Shaffer, 1999). Commentators have mostly offered guidance on understanding models of communication and provided suggestions on developing effective verbal and nonverbal communication skills. Some (e.g., Brewer et

al., 2007) have borrowed guidance from medical research findings, where communication in physical rehabilitation has received greater research attention.

Recently, a few practitioners have given attention to the application of counselling frameworks and discussion of the value of client-practitioner relationships (e.g., Andersen, 2007; Waumsley & Katz, 2013) in injury rehabilitation. For example, Waumsley and Katz (2013) offered an overview of various theoretical approaches (and associated skills) of working with injured athletes and suggested psychologists may want to use counselling psychology models when working with injured athletes. These authors emphasised the importance of fundamental counselling skills, such as active listening; observing; reflecting through paraphrasing, restating, and summarising; and immediacy (inviting discussion with athletes about one's own reactions) that go beyond the educational skills required for delivering mental skills training. The counselling sport psychology model and the educational sport psychology model are not mutually exclusive. Psychologists' appreciation of both frameworks could potentially aid their practices.

Andersen (2007) provided a detailed discussion on relationship processes in his chapter on collaborative relationships in injury rehabilitation. He offered case studies and commented on the relationship experiences and processes (transference and countertransference) within the two athlete-practitioner (one psychologist-athlete, one physiotherapist-athlete) dyads. In the studies, the role the client-practitioner relationship plays within rehabilitation comes to life. For example, in one case, Andersen reported how his relationship with an athlete, Emma, had similarities to her connection with her previous coach (who she would do anything for). In her enthusiasm to work with and for Andersen, Emma started to use the psychological techniques he had taught her in her races (although she was not instructed to do so) to mask pain, which led to a rupture in

her Achilles tendon, and consequently, the rupture and death of their therapeutic relationship. These case studies appear to be the only published stories of sport psychologists' relationship experiences working in sport injury rehabilitation.

Many professional athletes who sustain injuries are treated in the context of multidisciplinary teams (Wiese-Bjornstal & Smith, 1999) and have relationships and interactions with a range of professionals such as physiotherapists, surgeons, massage therapists, and psychologists who collectively provide assistance. Clement and Arvinen-Barrow (2013) have written about multidisciplinary approaches to rehabilitation, how to effectively develop teams within rehabilitation settings, the importance of holistic (physical and psychological) care in injury, and problems that may arise within multidisciplinary teams. Within their discussions, these authors suggested that practitioners could create sociograms (instruments used to measure social cohesion through mapping attractions and affiliations in relationship networks) of athletes' support networks to help develop and clarify roles, relationships, and interactions with those involved in athletes' recoveries (Clement & Arvinen-Barrow, 2013).

Summary

In summary, several commentaries exist about developing relationships with injured athletes. In particular, these discussions are geared towards helping practitioners communicate with athletes and explaining how professionals can adopt counselling-based frameworks to build working alliances in injury rehabilitation. Apart from two case studies within one book chapter (i.e., Andersen, 2007), there appears to be no other published opinion pieces or studies in which investigators explore psychologist-athlete relationship processes within injury rehabilitation. Similarly, beyond Andersen's case studies, there appears to be limited understanding of the strains, ruptures, repairs, and terminations of client-practitioner relationships in sport injury rehabilitation. There is,

however, a considerable body of research on client-practitioner relationships in injury rehabilitation within the practice area of physiotherapy.

Client-Practitioner Relationships in Physiotherapy

The primary goal of physiotherapy (also known as physical therapy) is the prevention and rehabilitation of physical injuries (Petitpas & Cornelius, 2004). Accordingly, the majority of training that physiotherapists receive relates to the assessment, treatment, and development of physical interventions. Nevertheless, over decades researchers and practitioners have recognised the importance of interpersonal processes that occur within physiotherapy treatment. In the following section, I review the literature on client-practitioner relationships in physiotherapy and discuss studies and commentaries that fall into two main categories: alliance-outcomes research and relationship processes. Within physiotherapy literature, terminology used for recipients of care varies. Some authors use the word patient, and others use the term client. When reviewing individual studies, I will use the term the authors use. For the purpose of this section of the literature review, the two words are interchangeable.

Alliance-Outcomes Research

In a similar vein to other allied health professions, the majority of researchers who have conducted quantitative studies on client-practitioner relationships in physiotherapy have explored the associations between the quality of these bonds (operationalised as the *alliance*) and rehabilitation outcomes. For example, Hall et al. (2010) reviewed 14 prospective studies (two of these studies used the same data set), in which researchers assessed alliance-outcome relationships in physical rehabilitation. The reviewed studies had either homogeneous therapist samples, such as only physiotherapists (e.g., Ferreira, Ferreira, & Maher, 2009) or occupational therapists (Higdon, 1997), or heterogeneous samples of practitioners within multidisciplinary

teams such as physiotherapists, occupational therapists, speech therapists, and neuropsychologists (e.g., Mirsky, 2002; Schönberger, Humle, Zeeman, & Teasdale, 2006; Sherer et al., 2007). Hall et al.'s review included diverse patient samples including those with musculo-skeletal conditions, brain injury, cardiovascular disease, chronic pain, as well as patients with multiple conditions (e.g., neck and shoulder pain, systemic disease, trauma). Hall et al. had insufficient data to pool and analyse the results across the studies because of differences in measurements of the alliance and treatment outcomes across studies with similar patient populations. Nonetheless, from analysis of the available data, the authors found the alliance was positively associated with patients' adherence to treatments (for those with brain injuries or multiple pathologies), patients' satisfaction of treatments (for those with musculoskeletal conditions), and patients' physical functioning (for both low-back pain and geriatric patients). Hall et al. concluded that there were positive associations between the alliance measurements and depressive symptoms for patients with cardiac conditions or brain injuries. This finding, however, was not consistent across all of the studies in which depression was measured as an outcome. In one study (i.e., Sherer et al., 2007) higher depression scores were associated with stronger therapeutic alliances. Sherer et al. (2007) reasoned that patients with greater levels of depression (perhaps depressive symptoms is the correct terminology here) could be more likely to bond with therapists than those with lower levels of depression (depressive symptoms), because the former are motivated to seek out helping relationships and become involved in therapies that decrease emotional distress.

There are several criticisms of the studies within Hall et al.'s (2010) review in regards to researchers' measurements of the alliance, which influences the strength of conclusions that can be drawn from alliance-outcome studies in physiotherapy. The

authors of four of the 14 studies either did not report when, during the course of treatment, they assessed the alliance or were unclear within their reports about when the alliance was measured (Hall et al., 2010). Seven different instruments were used to measure the alliance across the 14 studies (Hall et al., 2010). The quality of these measures varied, and only three of the instruments are validated for use in psychotherapy and none have been validated for use in physiotherapy settings (Hall et al., 2010). Some researchers developed and used their own alliance measures such as 5-item questionnaires that either have not undergone validity testing or had little or no clear theoretical guidance in their development. For example, Zaproudina, Hänninen, and Airaksinen (2007) measured "the therapists' ability to communicate, inform, and interact with patients during the treatment sessions… on a scale 0 to 5" (p. 435), the researchers provided little information other than the actual question to explain how they measured the alliance. Many of these issues would likely reduce the overall results of meta-analyses because several of the instruments used have suspect properties with the possible effect of underestimating the alliance's correlations with outcomes. Nevertheless, the alliance is clearly important in treatments, but the extent of the alliance's influence on outcomes remains unclear.

When patients have had contact with multiple care providers in rehabilitation, researchers have missed the opportunity to gain an understanding of the individual alliances patients had with various staff members. In two studies (Schönberger, Humle, & Teasdale, 2006a, 2006b) investigators only assessed the alliance between patients and their primary therapists (usually a psychologist) over the course of treatment. Also, Burns and Evon (2007) assessed the alliance by adapting questions in a patient-rated WAI from *therapist* to *support staff* to account for the three professionals who cardiac patients worked with closely. This measure provided a single score for the three

individual relationships that each patient had with their practitioners. It is, however, difficult to determine how a patient would rate her experiences if she liked one practitioner but not the other two. The alliance, by definition, is an individual concept, although recently it has been expanded to couples and family therapy (see Friedlander, Escudero, Annaington, & Diamond, 2011) and group therapy (see Burlingame, McClendon, & Alonso, 2011). From the use of Burn and Evon's adapted instrument, the quality of the relationships individual patients had with each practitioner within their team is unclear. Overall, the previous criticisms seem to reflect that within the reviewed studies, client-practitioner relationships are rarely the central focus of analysis or study-design. The alliance has been assessed (often poorly) along with numerous other factors to see what may influence treatment outcomes.

Researchers in physiotherapy have used outcome measures in alliance-outcome studies that seem more suitable and ecologically valid than the self-report tests often used exclusively by their counterparts in psychotherapy. The methods used in physiotherapy studies include objective, behavioural measures such as cardiovascular fitness, disability, speed of return to work, often in combination with subjective indicators of outcomes such as pain, mood, adherence to treatment, and treatment satisfaction (see Hall et al., 2010). From these various measures investigators have shown that client-practitioner relationships are important in therapeutic (physical and psychological) outcomes and clients' experiences in physiotherapy.

Relationship Processes

Results from qualitative studies support the perspective that client-practitioner relationships matter in physiotherapy (see Besley, Kayes, & McPherson, 2011 for a review). For example, Stenmar and Nordholm (1994) asked 187 Swedish physiotherapists what they considered the most important factors within successful

treatment. These practitioners considered that *how* they do therapy (e.g., building relationships through interaction) is more important than *what* they do (the physical techniques they use). In the following section, I present the major themes of relationship processes in physiotherapy that researchers have investigated mainly through qualitative inquiry and commentary. The relationship processes discussed include: patient-centred approaches, communication, relational context, congruence, roles and responsibilities, and transference and countertransference.

Patient-centred approaches. Researchers and commentators have focussed on understanding and developing relationships in physiotherapy, and these pursuits are in line with many investigators' suggestions that physiotherapists move from medical models of treatment towards *person-focused*, *client-centred*, *holistic*, or *human medicine* approaches to practice (Alexander, 1973; Bellner, 1999; Thornquist, 1992; Williams & Harrison, 1999). All of these terms, although they have some variations in meaning and application, appear to emphasise that clients are active agents, rather than passive recipients, in their rehabilitation experiences and that client-practitioner collaboration is necessary for effective treatments. Trends in client-centred psychotherapy and counselling (e.g., Bordin, 1979; Rogers, 1951) have influenced this shift in physiotherapy treatment. Practitioners and researchers have discussed patient- or client-centred care in physiotherapy since the 1970s (e.g., Alexander, 1973; Petitpas & Cornelius, 2004). For example, Alexander (1973) considered the importance of training doctors, nurses, and physiotherapists in a way that facilitates a whole-person treatment and encourages practitioners to focus on relating to patients as people (not just injured body parts), rather than being "'cool, dispassionate, and objective' professionals" (p. 391). Alexander, in his discussion, also recommended that physiotherapists should be trained in recognising their emotions and attitudes towards patients, understanding their

coping strategies, and building relationships with patients that activate and maximise the therapeutic effect of client-practitioner bonds. This stance is similar to Rogerian principles, and such client-centred conditions are advocated in numerous sources within the physiotherapy literature (e.g., Gyllensten, Gard, Salford, & Ekdahl, 1999; Kolt & Andersen, 2004b; Thornquist, 1992, 2006).

Some commentators in physiotherapy, however, appear to encourage medical models of treatment, and, in particular, relationships characterised by reductionist approaches to treatment, power differentials, and expert-novice dynamics. For example, Wagstaff (1982) provided instructions for physiotherapists on how to improve patient compliance using effective verbal communication and persuasion informed by research from social psychology. In his commentary, he proposed that, to maintain credibility, physiotherapists should *never* give the impression that they are deficient in any related area of knowledge or skill. This suggestion is extreme and seems highly engrained in an expert-novice dichotomy, in which a physiotherapist is the one expected to possess *all* relevant knowledge (or appear to have it even if they do not). Advising practitioners to conceal their limited knowledge implies that dishonesty, deception, and inauthenticity (in the name of maintaining an expert reputation) should be valued over honesty and genuineness about one's limits of competency. Perhaps these concerns are not ones that Wagstaff experienced in practice; his discussion comes from his perspective as a psychology lecturer not a physiotherapist. Other researchers and practitioners in physiotherapy, however, discuss the importance of reducing, not exploiting, power differentials (e.g., Bellner, 1999; Williams & Harrison, 1999), but investigators have found that, despite suggestions to move towards client-centred practiced, some physiotherapists still work within strict medical models of treatment (e.g., Bellner, 1999; Thornquist, 1992, 2006).

Researchers have found that formal education and professional practice influences trainee and novice physiotherapists' experiences of patient encounters. In particular, research on trainees' experiences indicates that their use of client-centred models may fluctuate during training with these developing practitioners embracing a strong client-centred stance after exposure to clinical practice. Dahlgren (1998) conducted interviews with two groups of students on two occasions: one group (n =14) in the second and last terms of their formal training programme and another group (n =16) in the last term of their programme and again after 18 months of clinical practice. She found that, during training, students moved from patient-centred to physiotherapist-centred approaches. After 18 months of clinical experience, trainee physiotherapists changed their conception from a physiotherapist-centred to a patient-centred view of experiencing the patient encounter. The authors suggested that trainees' limited patient-centred focus at the end of their courses could reflect a focus on physical-technical skills that minimised students' capacities to interact in patient-centred ways. It may be that once novices started working in the field they experienced the importance of collaboration in treatment and re-adopted client-centred frameworks.

Communication. Over the last 40 years, healthcare practitioners and researchers have investigated and discussed physiotherapists' communication and interactions with clients (Gallois et al., 1979; Hargreaves, 1982; Perry, 1975; Petitpas & Cornelius, 2004; Szybek, Gard, & Lindén, 2000; Talvitie & Reunanen, 2002; Thornquist, 1991, 1992; Wagstaff, 1982). In several studies on patient satisfaction with physiotherapy treatment, researchers have reported that patients' favourable experiences are often associated with therapists' effective communication styles and unfavourable experiences are frequently related to poor communication styles (e.g., May, 2001; Potter, Gordon, & Hamer, 2003). In Potter et al.'s (2003) study on what makes good physiotherapists, patients

reported that practitioners' abilities to communicate was one of the most important factors in treatment. Patients valued practitioners' interpersonal skills (e.g., listening, building trust and rapport with clients, being empathic, displaying positive body language), general manner (e.g., supportive, friendly, non-judgemental), and proficiencies in clearly explaining problems (e.g., using visual aids).

Physiotherapists' nonverbal behaviours have been the focus of a few studies and opinion pieces (e.g., Gallois et al., 1979; Hargreaves, 1982). Researchers and commentators (e.g., Hargreaves, 1982; Perry, 1975; Thornquist, 1991) have indicated that nonverbal behaviours constitute the largest component of physiotherapist-patient interactions and have suggested that physiotherapists are responsible for setting the communicative climate within their dyadic relationships. Accordingly, commentators have considered the importance of nonverbal behaviours and provided discussion on developing nonverbal skills. For example, Hargreaves (1982) offered suggestions on how physiotherapists can effectively manage eye contact, facial expressions, touch, gestures, and use silence and physical space in treatments. She indicated that practitioners ought not to rely on their experiences within the field to shape their nonverbal skills, but should instead actively learn and develop these competencies, which could facilitate quality relationships and treatments. In addition to discussions about nonverbal behaviours, researchers have reported practitioners' (e.g., Gordon, Hamer, & Potter, 2003) and clients' (e.g., Bassett & Tango, 2002) views on how to enhance physiotherapists' explanations with nonverbal behaviours (e.g., using visual aids) in treatment (see Besley et al., 2011). These suggestions and practices are in line with Rogers' (1961) tenets of client-centred therapy.

Only a few researchers have observed therapists and patients in their first encounters to see practitioners' nonverbal communication skills in action (e.g., Gallois

et al., 1979; Thornquist, 1991). These studies, however, contain methodological issues. In one study (i.e., Thornquist, 1991), a researcher was present during patient-practitioner interactions, and, in her report, she did not offer an explanation for, or acknowledge the influence this observation may have had on, the physiotherapist-patient relationships and the in-session behaviours she recorded. In another study (i.e., Gallois et al., 1979), investigators analysed only two 45-second video segments (one segment from the beginning of treatment and one from the end) within each client-therapist dyad's session. These researchers captured only a small portion of first-encounter interactions and provided limited insight into how and why nonverbal behaviours may have changed over the session.

Other researchers have examined the first encounters between clients and practitioners and investigated both verbal and nonverbal communication in relation to how therapists' underlying assumptions about treatment (reductionist or holistic) influences interaction in sessions (i.e., Thornquist, 1992), specific aspects of treatment (e.g., goal setting; Parry, 2004a), or challenging treatment circumstances. Difficult treatment contexts include long-term (6 months or more) musculo-skeletal injury rehabilitation (Øien, Steihaug, Iversen, & Råheim, 2011) and stroke therapy (Parry, 2004a, 2004b; Talvitie & Reunanen, 2002). The results of a large proportion of these studies suggest that in-session communication is complex and that physiotherapists have suboptimal skills in this area. For example, Talvitie and Reunanen (2002), using discourse analysis, evaluated nine videotaped stroke therapy sessions. They found that physiotherapists: (a) dominated interactions with their clients through their verbal communication, such as giving instructions and guiding their patients, (b) rarely discussed goals or purposes of exercises, (c) talked about exercises in a way that assumed the client had prior physiological knowledge, (d) had difficulty in

understanding patients' distorted speech, and (e) often assumed that patients agreed with their interpretations of patients' verbal utterances. The researchers suggested that the findings illustrate unequal role distribution and the use of authoritarian power during stroke physiotherapy.

Researchers and commentators have trained physiotherapists to enhance their communication skills. A small number of investigators (e.g., Ladyshewsky & Gotjamanos, 1997; Rubin, Judd, & Conine, 1977) have designed and carried out communication-training programs within physiotherapy and measured the effectiveness of these courses (see Parry, 2008 for a review). These interventions were generally successful in improving practitioners' communication skills, however, some studies have relied on practitioners' self-reports as measures of training effectiveness. Such results may not accurately reflect the communication improvements clients would experience from practitioners who have undergone training.

Relational context. In several studies, practitioners and patients have mentioned that numerous patient, practitioner, and environmental factors are important in relationships and interactions in physiotherapy. I now discuss these three categories in turn.

Patient factors. Patients come to physiotherapy with hopes, expectations, resources, and life experiences; all of these factors may influence the quality of patients' relationships with practitioners (Gyllensten, Gard, Hansson, & Ekdahl, 2000; May, 2001; Szybek et al., 2000). In a study on practitioners' perspectives of patient-physiotherapist interactions in psychiatric care, Gyllensten et al. (2000) found that professionals considered patients' physical and psychological resources (e.g., emotions, experiences, hopes, needs), either active or dormant, as important factors in the success of physiotherapist-patient encounters. In another practitioner-perspective study, 37

physiotherapists identified characteristics of difficult patients they have treated in private practice. Participants said the hardest patients to work with were those who are "passive, dependent, angry/aggressive, or think they 'know it all'" (Gordon et al., 2003, p. 56). Furthermore, in Gordon et al.'s study, physiotherapists said patient expectations such as unrealistic expectations of the therapist, the treatment (e.g., wanting a quick fix), or having expectations of what the treatment would consist of (e.g., number of consults required, type of suitable treatment), and not meeting those expectations, were challenging aspects of physiotherapy.

Other researchers have examined patients' perspectives of physiotherapy treatment and practitioner-patient interactions and found that patients' expectations of treatment processes and outcomes may influence the quality of encounters and interactions with physiotherapists (Bassett & Tango, 2002; Gyllensten et al., 2000; Hills & Kitchen, 2007; Potter et al., 2003). Patients who have not experienced physiotherapy before are likely to have limited understanding of treatments and low expectations about therapy (Bassett & Tango, 2002). Those who have had previous physiotherapy experiences have expectations of treatment processes and outcomes including the course of treatment, assessment, diagnosis, explanations, treatment techniques, exercises/self-management, and symptom relief (Besley et al., 2011). In this latter case, if treatments do not meet patients' expectations, patients are likely to be dissatisfied. For example, Hills and Kitchen (2007) found that patients were disappointed if they expected to have a certain type of treatment and did not receive it; participants were especially dissatisfied if they were not involved in making decisions about treatment options.

Physiotherapist factors. Characteristics and qualities of physiotherapists and how they engage patients in sessions are commonly reported in qualitative studies that

either explore practitioners' perspectives of important factors in physiotherapy interactions (e.g., Gyllensten et al., 2000) or patients' perspectives of treatments, relationships, and practitioner qualities (e.g., Gyllensten et al., 1999; Hills & Kitchen, 2007; May, 2001; Potter et al., 2003; Williams & Harrison, 1999). Practitioners consider that several factors play essential roles within patient-physiotherapy interactions. These factors include professionals' competencies, the variety of clinical experiences over their careers, life experiences that improve their abilities to understand their patients, specific training courses that improve knowledge, competency, interaction-skills, and both emotional and physical self-awareness (Gyllensten et al., 2000).

Hush, Cameron, and Mackey (2011) reviewed 15 studies on patient satisfaction in musculo-skeletal physical therapy and found that patients acknowledged several practitioner characteristics as important in treatment including physiotherapists' manner (friendly, caring, polite), professionalism (knowledgeable, skilful), competence (that inspired confidence), and effective communication skills (particularly therapists' abilities to clearly explain and educate patients about conditions and self-management).

Environmental factors. A few researchers have examined patients' experiences of physiotherapy (e.g., Hills & Kitchen, 2007; May, 2001; Potter et al., 2003; Williams & Harrison, 1999) and found that patients consider the structure of treatments, processes, and the treatment environment to influence the quality of patient-physiotherapist bonds (Besley et al., 2011). For example, in Potter et al.'s (2003) study, patients said that good physiotherapists create "a pleasant and welcoming environment within the physiotherapy practice" (p. 197). Hills and Kitchen (2007) reported that patients expressed a view that practitioners' flexibility and availability for appointments was important in their satisfaction. Patients mentioned they were unhappy with

treatment processes in which physiotherapists left them to do exercises on their own and were dissatisfied with treatment centres with limited or poor equipment and facilities.

Congruence. In their review, Besley et al. (2011) identified that researchers have found the agreement between physiotherapists and patients in regards to goals and diagnoses to be influential in therapeutic relationships. This finding seems consistent with Bordin's (1979) model of the alliance; practitioners and patients should collaborate on developing goals and tasks in treatments. Researchers have found that practitioners often leave patients out of goal setting processes. For example, Payton and Nelson (1996) examined patients' views of their physical therapy experiences. These investigators found that several patients were aware of the goals of therapy (often because these goals were obvious), but did not feel they were actively involved in setting goals within treatments. Physiotherapists should not assume congruence exists with patients on goals of treatments, because, as Payton and Nelson suggested, major errors can occur in patient care when such assumptions are made.

Physiotherapists' roles and responsibilities. Central to the physiotherapist-patient interactions are the roles and responsibilities of practitioners within treatment contexts. Both physiotherapists and patients have suggested that practitioners should identify and activate patients' resources and provide advice and guidance on self-management strategies to enable patients to take control of their health (Bellner, 1999; Gyllensten et al., 1999). For example, one practitioner in Gyllensten et al.'s (1999) study said, "physiotherapy is to a great extent about making people realize that they have the resources themselves, that they can accomplish a lot more themselves and take responsibility for themselves" (p. 100). Educating patients on their conditions, prognoses, diagnoses, treatment options, and self-management strategies is an aspect of activating patients' resources (Besley et al., 2011). Researchers (e.g., Bassett & Tango,

2002; Gyllensten et al., 1999; Hills & Kitchen, 2007; Potter et al., 2003) recommend that physiotherapists help develop patients' understandings of their conditions and knowledge of how to manage their injuries or illnesses.

Transference and countertransference. As within client-psychologist relationships, transference and countertransference are important components of client-physiotherapist relationships, and these processes need to be understood for their advantages and disadvantages. What is surprising is the limited discussion and commentary in physiotherapy on transference and countertransference, because these processes are present in almost all human relationships and are likely to influence interactions within healthcare practice (Andersen, 2004b). Only a couple of researchers and commentators have discussed transference and countertransference within physiotherapist-patient relationships (e.g., Andersen, 2004b, 2007; Szybek et al., 2000). Andersen (2004b), in his chapter *transference and countertransference*, discussed these processes and presented several case studies to illustrate these phenomena in action. Through these case studies, Andersen showed how transference might be positive and useful within client-physiotherapist relationships and for rehabilitation outcomes. Andersen proposed that, because transference and countertransference are ubiquitous phenomena, the role of healthcare professionals, supervisors, and teachers is to learn and teach how to use these processes to positive effect. Also, within his chapter, Andersen (2004b) discussed erotic transference. Clients may develop erotic feelings or thoughts about their practitioners, and practitioners may develop erotic feelings or thoughts about their clients. Andersen's discussion provided guidance for practitioners on how to monitor their relationships with clients for signs of erotic transference and countertransference and how to manage these situations when they arise.

Summary

In summary, several researchers have examined client-practitioner relationships in physiotherapy often alongside other factors that may influence clients' recoveries or experiences of treatment. When investigators have measured alliance-outcome associations, generally the quality of client-practitioner relationships is associated with objective indicators of treatment outcomes. Some caution has to be exercised when considering this conclusion because several of the alliance measures in physiotherapy are low quality. In qualitative studies, researchers have explored various relationship components (e.g., communication) within specific situations (e.g., initial meetings). The results from these studies have provided useful information about the quality of physiotherapists' relationship skills, but little is known about client-practitioner relationships or interactions in long-term rehabilitation scenarios. Several commentators and researchers have criticised physiotherapists' poor communication and relationship skills and have developed training programs to help practitioners enhance their skills. The effectiveness of these interventions is difficult to judge because researchers have relied on practitioners' self-reports as measures rather than real-time client-practitioner observations and comparisons. Only a couple of researchers have discussed transference and countertransference in relationships and provided guidance on understanding these relationship processes.

Athlete-Physiotherapist Relationships in Sport Injury Rehabilitation

Physiotherapists are frequently the healthcare practitioners who see injured athletes most within their rehabilitation processes; they are often the medical professionals who are with athletes from injury onset, through rehabilitation, and when athletes return to sport (Clement & Arvinen-Barrow, 2013). The relationships between injured athletes and physiotherapists can be intimate like those between injured athletes

and psychologists. The closeness that physiotherapists and athletes experience may come from sharing similar stories to those that athletes and psychologists tell, but these exchanges in treatments frequently have the added elements of close proximity and therapeutic touch (e.g., massaging, manipulation, taping; Andersen, 2007).

Apart from being identified as members of athletes' support networks and instrumental in social support through injury rehabilitation (see Bianco, 2001), there is little research and discussion on athlete-physiotherapist relationships. There are several texts aimed towards equipping sport medical practitioners with knowledge and skills to develop effective helping relationships (e.g., Pargman, 2007; Ray & Wiese-Bjornstal, 1999) and to collaborate with other professionals in sport injury rehabilitation (e.g., Clement & Arvinen-Barrow, 2013), and the authors have included physiotherapists within their target audiences. Although these texts provide useful commentaries on rapport building and counselling skills, there are few in depth accounts of physiotherapist-athlete interactions in the sport injury literature.

Rationale for the Thesis:

Significance of the Research and Contribution to Knowledge

Relationships are important in the treatments and outcomes of clients in numerous healthcare professions. There exists insufficient research and discussion on athlete-practitioner relationships and interactions to provide in-depth understanding of physiotherapists' and psychologists' bonds with injured athlete-clients. Furthermore, there is limited understanding on how psychologists and physiotherapists work together in sport injury rehabilitation. By examining client-physiotherapist and client-sport psychologist relationships during injury rehabilitation, I will extend the current (limited) knowledge of sport psychologists' and physiotherapists' helping relationships and their collaboration in sport injury rehabilitation.

Researchers and educators in sport psychology suggest that practitioners learn better from story-like, nonempirical writings than empirical studies (Andersen, 2004b; Tod et al., 2009). In this thesis, I used qualitative methodologies to provide descriptions and analyses that have human faces (Andersen, 2011); stories and experiences of clients and practitioners that are accessible to, and come to life for, readers.

Aims of the Thesis

The aims of this thesis were threefold. Each aim guided a single study to further knowledge within the area of relationships in sport injury rehabilitation. Specifically, the aims of the three studies were to:

1. Explore sport psychologists' relationships within sport injury rehabilitation and their perceptions of these relationships.
2. Explore sport physiotherapists' relationships within sport injury rehabilitation and their perceptions of these relationships.
3. Explore the relationship between a sport psychologist and a physiotherapist who work together to rehabilitate injured athletes.

CHAPTER 3

STUDY 1: SPORT PSYCHOLOGISTS' EXPERIENCES OF CLIENT-PRACTITIONER RELATIONSHIPS IN INJURY REHABILITATION

Introduction

The importance of the quality of relationships between clients and practitioners is well documented within psychotherapy (e.g., Horvath, 2001; Horvath et al., 2011; Martin et al., 2000; Sexton & Whiston, 1994). Researchers have established within both clinical and counselling psychology that the quality of the relationships developed between clients and practitioners are associated with a variety of treatment outcomes (see Horvath, 2001). In the specific context of sport psychology, however, there exists little research on professional relationships between athletes and psychologists.

A few researchers and commentators have engaged with the topic of client-practitioner relationships. Their research efforts consist of mainly discussion and opinion pieces (Tod & Andersen, 2012) or qualitative (case) studies. Practitioners and investigators have offered their advice on building rapport with clients (e.g., Andersen, 2000b), discussed the importance of relationships in sport psychology service provision (e.g., Andersen & Speed, 2010; Marchant, 2010), examined the relationship skills of seasoned practitioners (e.g., Lloyd & Trudell, 1999), presented cases of relationship processes (transference and countertransference; Stevens & Andersen, 2007b; Thompson & Andersen, 2012), traced psychologists' developments (and found that they came to value relationships more and more as they grew as practitioners; Tod, 2007a; Tod et al., 2009, 2011; Tod & Bond, 2010; Tod et al., 2007), and discussed the application of interpersonal neurobiology when working with athlete-clients (e.g., Andersen, 2014b; Williams, 2014).

The centrality of relationships has entered into the sport psychology literature, but not necessarily in a substantial way. Gaining an understanding of client-practitioner relationships, specifically the interpersonal processes that occur when psychologists interact with their athlete-clients, is likely to be useful in stimulating practitioners' self-reflection processes and guiding their practice behaviours. Also, learning from practitioners' experiences with clients could help supervisors reflect on their approaches to educating and supervising trainee practitioners and improve the quality of the relationships trainees have with clients.

One particular context that could be influential on the relationships practitioners have with clients is injury rehabilitation. Often when athletes incur major injuries they can experience crises, and rehabilitation periods can be filled with frustrations, setbacks, successes, and questions about their identities (Andersen, 2007). Little is known about how client-practitioner relationships function within this context beyond a couple of case studies within one book chapter (i.e., Andersen, 2007) – do these bonds help, hinder, or are they inconsequential to, injury recovery? Understanding what happens in relationships between injured athletes and sport psychologists and how these relationships function, can be challenged, may rupture, and may also be repaired could be useful for training psychologists to be able to develop quality relationships with athletes.

The purpose of this study was to explore the relationship experiences sport psychologists had with their clients, and specifically their experiences with injured athletes. This study was the first of three in which I investigated client-practitioner relationships and the factors that influence the relationship experiences practitioners have with their clients.

Method

Participants

I asked sport psychologists ($N = 12$) who had been practicing for at least two years postregistration within Australia to participate in this study. I considered two years postregistration as the logical cut-off point for two reasons. First, because the regulatory body for psychologists in Australia requires psychologists to have two years of supervision postregistration to be eligible for full college membership within an area of specialisation. This supervision must be provided by a psychologist who is a specialist in the area of practice in which the supervisee is seeking to specialise (e.g., sport). Second, the supervisory team and I decided that two years of work experience postregistration was sufficient to ensure that the participants had adequate experience to reflect on and discuss. The practitioners varied in terms of practice experience, which ranged from 3 to 37 years ($M = 12.7$; $SD = 10.8$). Psychologists' educational backgrounds varied. Four of the sample had completed a Master of Applied Psychology (Sport), and two had completed a Doctorate in Applied Psychology (Sport), in programs within Australia. The other six psychologists came from various training backgrounds including counselling, clinical, educational, forensic, and health psychology, from various countries (i.e., Australia, New Zealand, America). These participants had graduate diplomas (leading to equivalent of general registration in Australia), master degrees, or doctoral degrees. All participants regularly worked within sport in Australia and had experienced working with injured athletes. Some worked full-time in sporting institutions, and the majority worked as consultants in sport and saw athlete-clients through their private practices.

Procedures

Recruitment. Following approval from Victoria University's Faculty of Arts, Education, and Human Development Research and Ethics Committee to conduct the study, I used an Internet search engine to find registered psychologists who worked in sport in the Melbourne, Brisbane, and Sydney metropolitan areas. The names of registered psychologists are in the public domain on clinics' or personal websites. I sent emails to psychologists to ascertain their interest in taking part in my study (see Appendix A). I attached a file to each email that explained the study (its purposes and risks, as well as detailing what would be expected of the participants; see Appendix B). The email invited participants to contact me, or my supervisors if they had questions or wished to participate. Contact with other psychologists came through professionals who worked alongside psychologists. Some participants heard about the study through word of mouth and, consequently, contacted me to discuss the study further. I aimed to have a sample size between 8 and 12 participants. I originally contacted 24 psychologists; 7 declined the invitation to participate, 5 did not respond to the invitation, and 12 participated.

The interview guide. I developed the interview guide in view of the research questions with the purpose of understanding participants' training experiences (because educational backgrounds vary widely across Australia and the world) and psychologists' experiences working with clients. Two registered sport psychologists vetted my initial interview guide that consisted of 16 questions. These psychologists are both experienced at working with injured athletes and have published book chapters and research articles on relationships within healthcare professions. Over the course of data collection, I refined the initial interview by removing two questions (i.e., Did you have any experiences playing sport? Did you/do you still participate in sport; what were your

experiences in sport?) and merging two questions into one (i.e., how and when did you first become interested in psychology? and how and when did you first become interested in sport psychology? to how and when did you first become interested in psychology or sport psychology?). This process streamlined the interview guide and eliminated questions that were redundant (see Appendix D for a copy of the interview guide I used in the final interview).

Interviews. I interviewed the 12 participants individually at their workplaces, at coffee shops, or at their homes. At the beginning of the interviews, I gave participants opportunities to ask any questions before they gave both written and verbal consent to participate. I asked the psychologists introductory background questions about their histories (e.g., where they studied, how long they had been in their current roles), and followed with general inquiries about their experiences of relationships with clients, and then asked about their encounters with injured athletes (e.g., interpersonal communication patterns; professional relationships with clients; their thoughts, feelings, and behaviours associated with those relationships). I used elaboration and clarification probes and made further requests for information to deepen my understanding of their experiences and the stories they shared.

Data Analysis

Data preparation. Data analysis began when the interviews were transcribed verbatim. Bird (2005) has proposed that transcription is an act of interpretative data analysis in itself; the process is more than just transforming sounds into written words, because meanings are created and developed by the person transcribing (Braun & Clarke, 2006; Lapadat & Lindsay, 1999). Although transcribing verbatim is a lengthy process, researchers have suggested that the time spent developing detailed transcripts is

worthwhile because it informs early stages of the data analysis process (Bird, 2005; Braun & Clarke, 2006).

Thematic content analysis. After completing the transcription process, I began thematic analysis of the content of the interviews. For the current study, I followed the recommendations of Braun and Clarke (2006), who suggested a six-step method of thematic analysis (i.e., familiarisation with the data, generation of initial codes, searches for themes, reviewing themes, defining and naming themes, producing the report). The following section outlines how these steps were followed.

Stage 1: Familiarisation with the data. I underwent a process of immersion with the data that involved me repeatedly reading the transcripts to familiarise myself with their contents. While thoroughly reading the transcripts, I actively searched for patterns and irregularities. Consequently, I developed a list of ideas and reflections about the data throughout the familiarisation process.

Stage 2: Generation of initial codes. Following familiarisation with the data, I made initial codes or raw-data meaning units. Codes are "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998, p. 63). The codes represented features of the data that seemed relevant to answering the research questions (Braun & Clarke, 2006). Within the process of coding, I organised the data by arranging codes into meaningful groups or categories (Braun & Clarke, 2006) and coded the transcripts by working through an electronic copy of each interview. I highlighted sentences and phrases to identify data segments, and inserted comments summarising my thoughts about a particular data segment. Finally, I used NVivo™ software to organise my themes and to generate a matrix of codes for each participant (Miles & Huberman, 1994).

Stage 3: Searches for themes. I then organised similar coded data units together into potential groups or themes and organised them into larger overarching categories. At this point in the analysis process, I developed an initial thematic map using NVivo™ software to display the potential thematic categories and the associations and overlaps between themes. I then assigned the codes under particular themes and further developed the draft of the thematic map.

Stage 4: Reviewing themes. During this process I applied Patton's (1990) criteria to judge the themes: internal homogeneity (the data within themes should unite in meaning) and external heterogeneity (each theme should be distinct in meaning from another; Braun & Clarke, 2006). I revisited the coded data segments for each theme, examining them in their original contexts (i.e., within the page of the relevant transcript) where necessary to see whether they were coherent with the story being told (Braun & Clarke, 2006; Patton, 2002). I then developed a refined thematic map and revisited the coded data segments and reflected on whether this new map represented the meanings conveyed from the data set as a whole (Braun & Clarke, 2006).

Stage 5: Defining and naming themes. After my supervisors and I were in agreement that the thematic map represented the data set, I refined the themes and subthemes further. I developed essence-phrases for each theme, representing each in one or two short sentences. This exercise facilitated clarity within the thematic categories and helped me see what designated themes were justified or whether further deliberation on the current themes and subthemes was needed. I then developed a narrative of the data set by revisiting the raw data meaning units under each theme-heading and organising and summarising them into a coherent story. By reflecting on the narrative of the data set, I scrutinised for inconsistencies of themes within the broad story. This process led me to some minor changes and renaming some of the themes.

Stage 6: Producing the report. Braun and Clarke (2006) suggested that the task of producing a thorough report "is to tell the complicated story of your data in a way that convinces the reader of the merit and validity of your analysis" (p. 93). By carefully selecting quotations and going beyond mere description of the data, I produced an analytical argument that supported the data in answering the research questions. I also used two theories of human relationships (psychodynamic) and perspectives (interpersonal neurobiology) to interpret and explain the data.

Research Credibility

I considered several factors to ensure the credibility of data collection, data analysis, and representation of the data within this first study and throughout this thesis. In the following section I detail personal information on my background, that is, the experiences I brought to conducting this research, and the measures I took to enhance the credibility of the data collection, data transformation, and data analysis processes.

The researcher. Patton (2002) recommended that qualitative researchers should acknowledge their experiences, training, perspectives, and any other information that may have influenced their collection, analysis, and interpretation of data. Patton encouraged this process because it helps in understanding the instrument of the research – the researcher.

Education and research experience. Following the completion of my undergraduate degree in psychology, I went on to complete a Master Degree in the Psychology of Sport and Exercise. In both my undergraduate and postgraduate courses, I studied and used qualitative methods (more so in my master's course). I opted to take qualitative methods training within my master's course because of my new interest in qualitative inquiry. I had considerable exposure to experimental methods and quantitative analyses throughout my undergraduate degree in a mainly experimental

psychology school, and I was intrigued to learn more about qualitative methods that seemed well suited to answer the research questions I wanted to ask in sport psychology. For my master's thesis I conducted a qualitative research project by examining elite junior slalom canoeists' experiences and perceptions of their parents' involvement in their sport experiences. After my master's degree, I worked as a teacher of A-Level psychology and a teaching assistant in a secondary school. I also started up my own business as a sport and exercise consultant and commenced training as a sport psychologist working mainly with youth athletes and coaches. From my contact with players and coaches, I developed my professional one-on-one interpersonal skills – a process that I believe has enhanced the quality of interviews I conducted in the current research.

Sport injury experience. In a personal communication with a professor and psychologist, I was reminded that graduate students in psychology often study themselves in one form or another. For me, specialising in injury rehabilitation processes would help me understand my experiences of injury and possibly provide some future help for others who sustain injuries.

I played rugby between the ages of five and 19 years. My teen years were plagued with injuries; on one occasion, I had 22 months away from sport. My rehabilitation experiences were marked by several fantastic interactions with professionals who cared for me (and my body), along with a few difficult and traumatic encounters. On one occasion, a surgeon did not refer me for follow-up treatment after surgery for a broken ankle, and, subsequently, I was left to my own devices to *fix myself*. Throughout my injuries, I experienced how some practitioners were attentive to my psychological issues (e.g., low confidence, frustrations) as well as my injured body parts, whereas others were much more medically focussed on my physical damage.

Fascinated by the influence that healthcare professionals can have on others' physical and psychological healing processes, I wanted, through my research, to understand more about *people-as-interventions*, hoping to help professionals be the best interventions they can be. Within this project, I reflect on my encounters with practitioners in my own periods of rehabilitation and inject my own commentary of how these experiences influenced the relationships I had with participants. In addition, I comment on my development as a researcher over the course of this project.

Trustworthiness procedures. In addition to the rigorous data analysis procedures previously mentioned, I employed three main processes to ensure that the methods used within this study were thorough (Patton, 2002). Qualitative methodologies and analyses do not lend themselves to simple tests of validity (Miles & Huberman, 1994), but prominent researchers have suggested other techniques to ensure trustworthiness of data (e.g., Denzin & Lincoln, 2005; Patton, 2002). I employed four trustworthiness procedures for Study 1: interview training, pilot interviews, member-checking processes, and peer-review processes.

Interview training. Before I conducted any pilot interviews for Study 1, I underwent interview training with my first principal supervisor (I had three principal supervisors over the course of my studies). This process consisted of two sessions in which I interviewed colleagues individually with my supervisor present. My supervisor provided advice and feedback in vivo. We debriefed at the end of these meetings, and during the discussions the interviewees voiced their opinions on how they felt the interview process went. I used this feedback to guide my behaviours and questions for the subsequent interviews. The sessions focused on helping me practice and develop skills necessary for conducting quality in-depth interviews such as empathic reflection, summarising participants' statements, and an array of listening skills (Minichiello,

Aroni, & Hays, 2008). The training also aimed to help me display characteristics that Rogers (1951, 1957/2007) stated are important for effective talking therapies, such as developing trust with participants, displaying empathy, and creating an interpersonal space in which participants' feel safe to tell their stories. The training enabled me to show care and concern for the stories participants shared with me, and I believe this interest helped participants provide additional information beyond their initial responses.

Pilot interviews. I conducted pilot interviews using an initial interview guide. The purposes of the pilot interviews were threefold:

1. To determine if the questions and the requests for information elicited sufficient depth of responses from participants.
2. To further refine my interview skills (e.g., developing the effective use of clarification and elaboration probes).
3. To familiarise myself and develop my confidence within the interview setting.

I had previous experiences conducting interviews in research studies and applied sport psychology consultations, but most of my clients and participants were aged between 13 and 25 years. The prospect of interviewing people older than me, and with greater experience in working in sports injury than I had, was somewhat daunting. The supervisory team and I were in agreement that the interview guide used in the pilot interviews was well developed, and I used this same guide, without amending it, in my first interview in Study 1.

Member-checking and peer-review processes. I gave all participants opportunities to read their transcripts for accuracy and add, modify, or delete content (Patton, 2002). Several participants were satisfied with their interviews and did not wish to read their transcripts; others edited their texts, as they deemed appropriate. In

addition, my supervisor, co-supervisor, and I reviewed raw data meaning units, subthemes, themes, and higher-order themes to assess whether there was consensus among the research team (Morrow, 2005).

Results and Discussion

I present the results from Study 1 under the headings of themes and subthemes developed from the data analysis process. Here, and in the subsequent chapters, some details within the quotations have been necessarily altered to ensure athletes, practitioners, clubs, institutions, or organisations could not be identified. The ages, locations, sports, injuries, and genders of athletes were changed when necessary. Within quotations in the following chapters, parentheses have been used to identify participants' actions (e.g., smiles, pauses, laughs) to supplement what the participants said. Furthermore, square brackets provide explanations where necessary (e.g., what a specific sport-term means) or to help the flow of the quote. Of the 12 practitioners interviewed, one psychologist (Participant 6) appeared to have little in common with the other professionals in the sample. Due to these differences, I present Participant 6 as a special case towards the end of the results and discussion section.

Although the focus of this study is client-practitioner relationships in injury rehabilitation, participants shared with me about their stories and experiences working with a range of clients. I draw on examples and tales from the various spheres of participants' work as well as specifically discussing how their relationships with athletes function within sport injury rehabilitation. There are several overlaps in the themes presented and these overlaps are denoted.

Building Relationships

From asking practitioners about their relationships in formal training and early interactions with clients, participants shared their experiences developing relationships

with athletes. In this section, I discuss psychologists' encounters *hanging out* within sports, holding back from quick interventions, the relationship qualities that they discussed and displayed, and several challenges they faced building and developing relationships with athletes.

Hanging out. The majority of practitioners spoke about how spending time in and around training and competition (e.g., collecting balls, helping the coaches where necessary) and having informal interactions with athletes and coaches was influential in their relationship experiences with athletes. By hanging out, psychologists said they were able to integrate within teams, build relationships, and develop a sense of belonging. Participant 1 talked about how, through his conversations on the sidelines at soccer, he built relationships with injured athletes who were at training, but had "nothing to do." He worked with one experienced player who had a knee injury. The work Participant 1 did with this particular player led to other team members accepting and respecting him:

> He [injured player] was super-compliant, he had heaps of respect for me, and he had actually got me really integrated with[in] the group [team], because he was respected by the players and the way he would treat me he would be [say] "G'day Jarrod, how are you mate?" And [he] would take his time [to talk to me]. So, people were like, "Who's this guy? He must be alright." (Participant 1)

Andersen, Van Raalte, and Brewer (2001) have written about the importance of sport psychologists spending time within service delivery contexts and how this process can be useful for athletes (in developing familiarity with practitioners) and practitioners (in reducing service delivery anxiety). From an interpersonal perspective, hanging out makes sense; people trust caregivers who are consistent and available. Athletes are likely to want psychologists they can trust with their fears and anxieties, explore their

internal states with, and rely on for help, particularly when feeling emotionally and physically vulnerable (e.g., when injured).

Psychologists, however, may hinder their opportunities to build relationships with athletes if practitioners are anxious about hanging out. One participant said she experienced anxiety when spending time at a rugby club during her first year of practice, and subsequently she questioned her career choice. She commented:

> I did a lot of hanging around, and it was a very overwhelming environment where I devalued myself. . . . So, I was thinking, "What am I even doing here? Do they want me here?" and so, I started . . . questioning, "Have I done the right thing doing sports psychology?" (Participant 2)

Participant 2's doubts regarding the value of sport psychology practice and of hanging out could relate to her being unsure of her own abilities, effectiveness, and value as a practitioner. Such experiences are common among beginning therapists who often feel acute anxiety and experience confusion about how to become effective helpers (Skovholt & Rønnestad, 2003). Her apprehension may also be related to feeling unproductive when hanging out. Andersen (2000a) has discussed that novice practitioners can find hanging out difficult because they sense that hanging out is essentially doing nothing, whereas, Andersen argues hanging out is a pathway into service delivery. Either way, these anxieties are likely to negatively influence the connections that practitioners form with (injured) athletes. One way that psychologists can reduce their anxieties when hanging out is having some focus or goals (e.g., observe how players communicate with each other and their coaches) to help them feel their times at training and competitions are purposeful.

Holding back. Many psychologists said that they desired to *fix* clients. A major part of practitioners' developments during formal training was learning to hold back

from quick solution-focused approaches, build relationships with clients, and listen to them. Participant 11 mentioned:

> Some people really have to change a lot to be able to do those things [build relationships] because a lot of us have a bit of a *righting reflex*, don't we? We're gonna want to fix things, and the best way of fixing things is to tell people what to do (laughs). Get straight in there. And, that's not what we wanna do.

The *righting* or *fix-it reflex* is a theme that parallels research findings of practitioners' early experiences in counselling (e.g., Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003) and applied sport psychology (e.g., Tod & Bond, 2010) and flows through many of the interviews. Sport psychologists may want to offer suggestions and interventions to help (and fix) athletes early on in their relationships. A couple of participants said that, as novices, they were quick to offer advice when helping injured athletes, because they felt pressure to help athletes to return to sport as quickly as possible. Psychologists (e.g., Andersen & Speed, 2010; Marchant, 2010; Petitpas, 2000), however, have reiterated that dedicating time to develop rapport at the beginning of relationships can inform future work that is idiosyncratic and more effective than a quick, one-size-fits-all approach. These authors have also suggested that quality client-practitioner relationships can be therapeutic for athletes and help facilitate client change.

Practitioner qualities. Psychologists communicated, through their reported behaviours towards clients, various levels of Rogers' (1957/2007) client-centred characteristics. From their stories, psychologists appeared to show different levels of empathy and genuineness towards their clients and particularly towards those who sustained injuries. For example, when discussing one of his first experiences dealing with an injured athlete, Participant 1 said:

> I remember walking in there [the changing rooms] and seeing this guy [with a dislocated shoulder] and thinking to myself, "Geeze! I'm gonna cry." I'm watching this guy go through it [the athlete's second shoulder dislocation in a year], and my heart is breaking for him.

This practitioner's emotional response may have occurred because this injury was one of the first he had encountered, or because he really felt his client's pain, or both. In contrast, Participant 5 seemed not to be negatively affected by his clients' emotions. He said:

> I don't know whether it's because of my training or because it's my personality, but I have a genuine empathy for people in that situation [an injured athlete crying in session], but at the same time, it doesn't particularly upset me. So, I guess what that does for me is that I'll really feel for the person in front of me, and I want to understand what they're going through. But, at the same time, I'm not so emotionally drawn in that I can't think clearly about it.

The different degrees of empathy these practitioners displayed may reflect two different responses; Participant 1's response appears to be the natural, human response (wanting to cry over someone else' pain), whereas Participant 5 appears to have a professional response, in which he maintains distance from his client's feelings and experience. I was not surprised to hear of these contrasting situations, and they could reflect different supervisory models and training approaches that emphasised what could be a suitable reaction in this context. These dissimilarities may also indicate variances in practitioners' experiences and abilities to regulate their emotions; at the time of the interviews, Participant 5 had 10 years of experience postregistration, whereas Participant 1 had only 3 years. It could be that Participant 5, unlike Participant 1, was able to feel his client's pain *as if* it was his own and not lose the "the 'as if'

quality" (Rogers, 1957/2007, p. 243). Participant 1, however, seemed to identify with his client's emotions. I discuss empathy and identification further in the section, *favourable and unfavourable relationships and experiences*.

Challenges in building relationships with clients. Participants mentioned several challenges to building high quality relationships with athletes that came from psychologists' experiences working within the context of sports teams or organisations. Practitioners' responses reflected issues that prevented clients, or hindered their abilities to, trust psychologists when they were injured. These problems were the perceived stigma of service provision, concerns over limits of confidentiality, and system constraints on relationships.

Stigma. Some practitioners, who worked within sporting clubs or organisations, reported that athletes would be reluctant to communicate with them and approach them for services, and these reservations appeared to be fuelled by organisational members' (e.g., athletes, coaches, support-personnel) perceptions of what psychologists do. One participant said:

> It's not just the players; it's the coaching staff and everything too. I remember working in one particular organisation where they called it "the walk of shame" from the players' room to when they went to see the psychologist in their room. That's a pretty bad term to be using (laughing). And so, I try and be very mindful whenever I go into an organisation and [an] environment like that. I even . . . say, "Look, don't think [of] me as a psychologist really. Think of me as a mental skills coach." (Participant 11)

By this psychologist framing his role around mental skills, he may gain contact with athletes who would otherwise be put off by the title *psychologist*. Athletes, however, who really need help (e.g., those who have relationship issues, eating disorders,

depression, anxiety) may not seek his advice or counsel. Also, this participant, by avoiding using the term psychologist, might reinforce the misunderstanding that sport psychology is only about performance enhancement (for a discussion see Andersen, 2009). Consequently, he could leave athletes uncertain as to who can help them with other psychosocial difficulties they may face. As a suggestion, this practitioner could educate the athletes with whom he works on the range of services psychologists provide and how these are likely to benefit health, wellbeing, and performance.

Concerns over confidentiality. Practitioners said that athletes were often reluctant to trust them because they feared that information shared in sessions would be passed on to others, which may influence their future team selections and careers. This was a particular concern for psychologists who worked in institutions or sport organisations rather than private practice, because, as Participant 11 said, "They [athletes] think, 'well your allegiance is gonna be with the team.'" Participant 3 also commented:

> That's a big challenge, being able to deal with guys that have a certain degree of scepticism around who you are and what you're trying to do, allowing themselves to be vulnerable in that space, and then understanding confidentiality. Because for some of them, they need to be very mindful of coaches, selectors, or whatever having access to this kind of information.

Andersen et al. (2001) have explained why athletes may be concerned with sport psychologists maintaining confidentiality. Often athletes expect practitioners, who appear to have close relationships with coaching staff, to share information with coaches. In addition, in some organisations, such as in American intercollegiate athletic departments, athletes may sign confidentiality waivers and give permission for professionals to discuss their issues and performances. To help athletes trust them,

psychologists said that they clarified the boundaries of confidentiality, such as what will be shared, with whom, and under what circumstances, and educated athletes on why information sharing could be useful to their recoveries. These two suggestions were among those Andersen et al. offered. One suggestion that Andersen et al. did not discuss was practitioners disclosing personal information. Participant 11 said:

> Another way of doing it [developing trust] is self-disclosure, so you self-disclose something about yourself and so that you're saying, "Look, I trust you. How about you kind of trust in me?" That's tricky and you certainly don't wanna be doing too much too early (laughs). So, like – to be pretty careful about what you do there.

Perhaps, through self-disclosure, the personal vulnerability that a psychologist might extend to a client could help their clients also share. This exercise could be an example of modelling; practitioners show athletes (by example) the behaviours that they want them to adopt. Such role modelling appears to be consistent with Participant 11's psychoeducational approach. This practitioner, along with the majority of the sample, seemed to be cautious about the personal information they shared with athletes and clients. Those from the clinical and forensic training backgrounds appeared to be the most reserved, which is understandable because these clients may be at risk of using psychologists' personal disclosures to harm (e.g., stalk) practitioners. Others, who were trained in sport psychology programs, said that supervisors would often ask the question "whose needs are being served?" through their disclosures. Participants said these queries were aimed at getting practitioners to reflect on their motivations for sharing information (e.g., were practitioners serving their own narcissistic needs to be liked or to be seen as worthy of attention).

Relationships constrained by the system. A couple of psychologists discussed how, when working within multidisciplinary teams, organisational protocols influenced their relationships with athletes. Practitioners said they felt marginalised within rehabilitation processes, and they mentioned that the quality and effectiveness of their practice was limited by the little time they had to build relationships with injured athletes. Participant 7 commented:

> They're [the rehab staff are] acknowledging there's a psychological component to it [the athlete's injury]. But, I'm not a key figure in the whole process; when it all goes pear-shaped they might bring me in. And, often then it's too late – I don't really have a relationship with the athlete. The relationship is with the physio . . . and they'll take much more notice of what these other people [support staff] have to say.

Psychologists appeared to be frustrated at the seemingly reactive referral processes within multidisciplinary systems. A couple of practitioners said they would be called in at the last moment, with perhaps expectations that they can fix athletes' psychological problems quickly. They felt that other professionals did not understand psychological service provision, underestimated the time and resources required for effective interventions, and placed little value on sport psychology. These participants said that having limited time to build relationships with athletes restricted the effectiveness of the work they could do together. Also, psychologists thought that athletes were more likely to trust and listen to lay or basic psychology advice from professionals with whom athletes had frequent contact rather than from themselves, despite these colleagues having limited understanding of the psychology of rehabilitation. This finding makes sense in view of attachment research; we trust those who are stable caregivers, are around more often than not, and have already given or

shown us care (Ainsworth, Blehar, Waters, & Wall, 1978). Psychologists, however, could counteract reactive referral systems through proactively communicating with coaching staff about the importance of early referrals, taking opportunities to meet potential athletes (e.g., at training sessions), setting up regular one-to-one appointments with athletes, as well as developing preventative models of practice by offering injury prevention interventions and mental skills training.

Favourable and Unfavourable Experiences and Relationships

Practitioners had a range of experiences working with injured and noninjured clients that were favourable or "good". The majority of favourable and enjoyable experiences for practitioners were working with noninjured athletes; perhaps because working with injured athletes can be frustrating, exhausting, and may not be meeting practitioners' unconscious needs. Several psychologists emphasized that most, if not all, of the relationships with their clients were good or favourable, and only a few clients were difficult, frustrating, or challenging to work with. One practitioner said that all her experiences working with athletes have been good. This psychologist has an acceptance-commitment therapy approach. Perhaps this framework guided her to interpret each experience with injured athletes as valuable in their unique contributions to clients' recoveries (and her professional development) and to approach these athletes in nonjudgemental ways.

Many practitioners reported that their relationships were enjoyable when they felt valued and appreciated by clients. Some said that clients showed their gratitude through endearing comments, and others felt valued when athletes came to see them on their own accord rather than being referred by coaches. One practitioner mentioned his awareness of transference-countertransference reactions within one of his favourable

client-relationship experiences working with a physically injured (nonathlete) client. Participant 1 said:

> The reaction I was having to her was one of gratitude because it was nice to be loved, and I got the sense of, "Ah she really likes me." And, my interpretation was she always valued [me]. So, it was really stroking my professional ego. So, my emotional reaction to her was very much, "I like working with this lady, I want to help her as much as I can, I want to help her through it." And, I really felt a sense of a grandson-type transference or countertransference to her; I felt I wanted to help this lady metaphorically across the road.

This psychologist seemed to understand how these dynamic processes were playing out in the context of his relationship with this client. This practitioner's awareness of transference and countertransference are likely to relate, at least in part, to the psychodynamic training he received during his course and the ongoing psychodynamic supervision he was receiving. It is unsurprising that few practitioners mentioned these processes at play in their relationships. Even though there are substantial writings in sport psychology on relationships that cover transference and countertransference in some way, shape, or form (e.g., Andersen, 2005b; Andersen & Speed, 2010; Stevens & Andersen, 2007a, 2007b; Thompson & Andersen, 2012), many studies on the psychology of relationships in sport are geared towards understanding coach-athlete relationships (e.g., Davis, Jowett, & Lafrenière, 2013; Lorimer, 2009; Jowett, 2005; Jowett & Ntoumanis, 2004) and seem to draw on cognitive rather than psychodynamic frameworks.

Specifically related to sport injury rehabilitation, a few psychologists spoke about favourable experiences working with athletes, in which rehabilitation processes were "pretty straightforward", such as when athletes healed quickly, sustained injuries

that required minimal surgical procedures, or were adherent to their rehabilitation programs. Others enjoyed working with athletes on exploring athletic identity and future career options after serious injuries primarily because the athletes engaged with the activities, collaborated with the psychologists, and found their time with psychologists beneficial. Several practitioners said they had favourable experiences with injured athletes when working collaboratively with other professionals in multidisciplinary teams (MDTs; see later section, *working with others*). Some mentioned they enjoyed relationships with athletes characterised by open communication and trust, and the ability to work together on idiosyncratic issues. For example, Participant 11 said:

> He [injured rugby player] spoke to me very honestly about his lack of confidence in his body and all of those kinds of things and how he was concerned about that. We addressed all of that. So, I really built up his efficacy with respect to his own body and belief[s]. . . . So, when he actually returned to play he was not only just physically primed, but he was kind of psychologically primed, and he played well from day one.

Participant 11's client appeared to trust him enough to be vulnerable and open with his concerns and work collaboratively for a solution. From this quote, this psychologist seems proud of his work and keen to demonstrate his expertise. Practitioners are likely to feel the reward of helping others, and their efforts may be particularly noticeable when athletes return from injuries. Some people may enter the profession for moments like the one described by Participant 11, and may bask in reflected glory of their (clients') achievements.

In regards to motivations, only a few practitioners in the sample seemed to have extensively explored and reflected on their drives to work in sport psychology. Most

gave surface-level responses on wanting to work in sport and help people. A couple of participants, however, said that they entered sport psychology to fix, deal with, or understand their own sport performance issues. For example, Participant 1 said that, because a coach marginalised him as a junior athlete, he wanted to, "work with athletes and help them survive experiences that were shit like mine." Perhaps the other practitioners were not comfortable sharing with me their personal motivations for entering sport. Conversely, practitioners' limited reflections on their motivations to enter psychology or sport is understandable in view of current perspectives. Often underlying motivations and reasons for behaviour are unconscious, not easy to access, or difficult to recall (Cozolino, 2010; Mahrer, 2005). Psychologists have mentioned that underlying motivations can influence the way practitioners relate to their clients (see Andersen, 2007; Cozolino, 2014), and supervision and counselling can be useful avenues in which to explore these motivations.

Practitioners influenced by clients' internal states. A couple of psychologists' enjoyable and difficult experiences and relationships working with injured athletes appeared to be influenced by their clients' internal states. Practitioners said they were enthusiastic and attentive when their athletes were engaged in sessions and rehabilitation processes, compliant, and optimistic about their returns to sport. Participant 2 commented, "You could tell that he [injured athlete] was engaged in the process. So, I think that made me more engaged, more present, probably more . . . giving of myself." Conversely, participants talked about feeling hopeless, catching their clients' depression (perhaps depressive feelings or depressed mood is more accurate), or being emotionally drained from working with athletes who had experienced traumatic long-term injuries. Participant 9 stated:

> It's exhausting for the athlete, and it can be exhausting for those of us, *me* (laughs), in that position of holding on to the hope, and holding on to the discipline, and holding on to the motivation to work on something when you know the outcome is a long way away.

In both Participant 2's and Participant 9's quotes, it appears that these practitioners are empathic towards their clients, but, they seem to lose the 'as if' quality of empathy that Rogers (1957/2007) discussed. In neurobiological terms, researchers suggest empathy occurs from creating internal representations of others' states using our mirror neuron systems (Cozolino, 2014; Iacoboni, 2008). We can replicate another's emotional states within our brains and nervous systems, and we can feel their pain, hurt, or joy as if it were our own; their internal state is also re-presented inside of us. In these circumstances, practitioners may not be able to differentiate from their internal representations of their clients' pain or optimism and their own pain or optimism. This source misattribution may be the downside of our usually helpful empathy circuits in our brains (Cozolino, 2014). Those who may be particularly empathic towards their clients may heavily experience their clients' distress when they are distressed and be extremely elated when their clients are elated. In Participant 9's case, along with a few other participants, this source misattribution appeared to lead to compassion fatigue – exhaustion from wanting to relieve their clients from pain, sadness, and suffering (Tabor, 2011). Counselling or psychotherapy can be useful for practitioners to identify and reflect upon their own internal states and learn to differentiate between their pain and joys and their internal representations of their clients' pain and joys (Cozolino, 2014). This process may help practitioners to effectively care for themselves and athletes who are distressed.

Frustrations at athletes who returned too soon. Several practitioners said that

their unfavourable experiences with injured athletes included occasions when athletes went against medical advice and returned to sport too quickly. Often, these premature returns resulted in the exacerbation of existing injuries. Psychologists who spoke of these scenarios appeared to have similar reactions to athletes' noncompliance to rehabilitation programs. Practitioners were frustrated or could not comprehend why clients would not adhere to their exercise regimes. Participants would apparently withhold their emotions in front of clients:

> Again, that [the athlete getting reinjured] brings up frustration for me. I don't show that to the athlete, but again it's working with that athlete. So, if you know that they are doing extra work, extra training outside of the rehab process, you've got to be caring about that with them and understanding that their goal is to get back on the field as quickly as they can. (Participant 10)

This quote demonstrates the potential conflict between practitioners' expressions of their concerns about clients' approaches to their recoveries and professionals' empathy. This psychologist appears to hide her concerns about athletes' overtraining behaviours in favour of expressing what she deems to be a suitable emotional reaction to her client's desire to return to sport. Rogers (1957/2007) talked about practitioners needing to offer three therapeutic conditions (empathy, genuineness, unconditional positive regard) together for effective client change. It appears that this participant may be extending one, but not all of these conditions to her injured athletes. Possibly, this practitioner is trying to withhold the extent of her emotional responses to maintain the focus of the therapeutic process on her clients' emotions and experiences. If she were truly genuine and transparent about her frustrations, her comments could compromise her client's perceptions and experiences of empathy and unconditional positive regard. If she were completely empathic, the internalisation of her client's emotions could

become the focus in sessions and may also diminish her ability to offer suitable advice or be psychologically available for her client. It is important for practitioners to display empathy, but also for them to explore ways to express any genuine concerns about clients' approaches to their recoveries with care.

Career-termination. Several psychologists said that it was challenging working with athletes for whom career-termination was a consequence of their injuries. Most psychologists were empathic towards athletes who would have major life-adjustments from having to retire from sport or from incurring a disability caused by injury. One practitioner, Participant 9, discussed her frustrations working with an injured athlete in his transition out of sport. The client appeared to reject the advice from medical and coaching staff that, after receiving multiple head injuries, he should end his career in sport. She said she had difficulties working with this athlete outside of the rehabilitation context because he had "personality quirks and was high maintenance as an athlete." She also mentioned that this client's resistance to leave the sport was particularly difficult to work with, "The frustration for me in part came from the fact that I, and the whole system, recognised he wasn't gonna ever be the athlete he thought he would be." Within sessions, Participant 9 further explained that for weeks she had to "slow down the pace" of the sessions, go over and over terrain that they had previously covered, because her athlete did not appear to understand that, due to the risk of further head trauma, he needed to move on from his sport. She discussed the thoughts she had when working with this athlete:

> [I thought] "I could be doing something more important right now." Because we're talking about an athlete who never had a chance, and I'm having to sort of walk through this process. So, when I think about what my expectation of getting through the process was, this was not meeting it. And, it was hard over

> time to maintain empathy to what was going on, at its core. I was just, "Let's go get you on to your next part of life, because I need to get on with other things that are going on here [in her job role], but I can't leave you until you're ready [to move on], so I'll stay."

I found Participant 9's honesty refreshing, and she appeared to be genuinely aware of, and not afraid to voice, the emotions she experienced working with this athlete. It seems that this psychologist's impatience, frustration, and diminishing ability to be empathic with her client, were tied up in her expectations that this athlete would move past the denial stage of the grieving process (Kübler-Ross, 1969) quicker than he actually did. Participant 9's experience highlights how psychologists' expectations may lead them to emotionally *check out* on their clients prematurely, perhaps before athletes are ready to accept their loss of athletic identity and move on from their athletic careers. This example shows how difficult it can be maintaining working alliances when clients and practitioners appear in different places and seem to want to work at different speeds. Petitpas (2000) discussed a practice model that he uses with clients, in which he recommends other practitioners to "*pace before you lead*" (p. 36) by attending or matching what athletes are focusing on before trying to take them in new directions. This model may be particularly useful for practitioners to adopt within injury rehabilitation, particularly to help maintain the collaboration that Bordin (1994) suggested is imperative for effective working alliances.

Relationship challenges

Psychologists identified situations that challenged: (a) how they related with athletes, (b) their emotions, or (c) their future work with clients. In the following subsection I discuss several subthemes under these broad categories.

Feeling responsible to fix athletes. A few psychologists mentioned that

managing clients' frustrations within rehabilitation were challenging experiences. One practitioner discussed how an athlete, who had intense back pain after a spinal injury, appeared to channel his anger toward her:

> He'd take the anger out on me, and I guess I had pressure from the medical staff, you know, to give him some strategies to cope, but he wouldn't take on board anything because he was just so angry. And, I couldn't move him past the anger. (Participant 2)

In this quote, the psychologist appears to feel pressure from herself, and from others, to fix her client. In addition, her statement that *she* could not move him past the anger suggests that she perceived his ongoing anger as a personal failure. In such circumstances, his ineffective recovery may damage her sense of self-worth and her identity as a good psychologist. The way athletes respond emotionally to practitioners can be useful information in regards to the transference reactions that might be taking place. For example, the athlete might be angry with the psychologist because he is projecting his frustrations with others or his injury on to her. If practitioners are focused on *doing* interventions at the expense of *being* attentive and listening when athletes are in distress, psychologists may miss information that could build their alliances and inform their work within athletes' rehabilitation programs (Petitpas, 2000).

Nonface-to-face contact. One psychologist stated that, due to geographical limitations, he frequently had to work with injured athletes over the phone or Internet. He found these consultations more challenging than face-to-face interactions:

> The ones I struggle with the most is when you're not face to face, when you're not sitting with each other, when you're not looking at each other. It's a big challenge because it seems like it's hard to get that quality of engagement, and

> it's almost like it's easier [for athletes] to be a bit more dismissive [about their emotional experiences]. (Participant 3)

This psychologist's struggle to feel connected with clients and work with them over the phone or Internet makes sense in view of writings in interpersonal neurobiology (e.g., Cozolino, 2010, 2014), interpersonal mindfulness (e.g., Hick & Bien, 2008), and communication in sport psychology (Burke, 2010). Nonverbal communication is a rich source of information for both practitioners and clients. When people are face-to-face, mirror neuron systems are active and help in developing internal representations of another's internal states. These inner models allow us to be empathic and also experience someone's empathy toward us (we can *feel felt*; Siegel, 2010; see Chapter 2, p. 37). These systems are unlikely to work as well without visual information, because mirror neurons are active in observation and primarily exist in visual-motor pathways in the brain (Iacoboni, 2008). Clients may be dismissive over the phone or Internet because they may not experience practitioners offering warm and safe interpersonal spaces for them to share their thoughts and feelings. For dyads that already have strong ties, however, the sound of a practitioner's voice may reduce an athlete's anxiety through the recognition of a familiar and caring other. Where possible, face-to-face connections with injured athletes would provide the nonverbal communication athletes might miss over the phone. Nevertheless, psychologists in this sample spoke about consulting with athletes who were hundreds, and sometimes thousands, of kilometres away. Audio-visual communication technologies such as Skype™ and FaceTime™ may allow for rich nonverbal communication at a distance. Given the prevalent use of such technologies, the limitations of working over the phone may be less important than they once were.

Reinjury. Practitioners expressed that working with athletes after they had reinjured themselves was challenging for several different reasons. Participants' various explanations seemed to be linked to the emotional reactions they experienced when working with reinjured clients. One practitioner said following clients' directions in session and helping them explore the reasons for continuing in sport was difficult:

> I'll see people [and], the chronic nature of their pain is more that they'll probably have numerous injuries over maybe a five to seven-year period . . . which in itself is challenging because . . . at different points through that process, you've got people saying, "Why am I doing this? Why do I keep putting myself through this process or this trauma or whatever, and is it going to be worthwhile in the end?" But the client might want to go there and may need to go there . . . and just be able to process that, and they need someone to be able to go there with them to assist them in processing that, and that's a big challenge. (Participant 3)

Following clients' directions in session, and exploring athletes' questions about their injuries and reasons for playing sport, can be uncomfortable for practitioners. This uneasiness may originate from psychologists being unable to answer athletes' existential-like questions and having less control over the direction of the sessions (and, as a consequence, what emotions they may encounter) compared to when working in a psychoeducational capacity. Participant 9 also found working with athletes who had reinjured themselves difficult, and talked about managing her emotional responses:

> It never is good when an athlete gets injured, but in that case [reinjury], your heart just goes out to them. I obviously had to manage my own stuff around that because if I fall apart, the athlete's not gonna go anywhere, but both of us managing that emotional response to get on with whatever it is that we wanna do.

It appears that Participant 9 sees her emotional response as influential to the client's treatment outcomes. The idea that psychologists act as models of emotional regulation for their clients is something that has appeared several times within different interviews and may reflect practitioners' perceptions of the need to be "professional" and hold clients' traumas and emotions and not fall apart while doing so. I discuss this theme further in the following section.

Managing Oneself

Several practitioners talked about the importance of "managing themselves" in their relationships with injured athletes, and participants often made this reference in terms of managing their emotions when in sessions. Participants said they experienced a range of emotions when working with injured athletes, such as frustration, anger, sadness, joy, and happiness, but suppressed their true emotional reactions when frustrated with athletes' rehabilitation processes or when sad after athletes got reinjured. Participant 10, when talking about being frustrated with an athlete's rehabilitation process, said:

> The athlete wouldn't see that emotion [frustration] from me at a level that internally I'm experiencing because I don't think that's appropriate. But again, the athlete would hear that in my caring for them, so again, saying things like, "that sounds really frustrating, and I understand that it's a frustrating situation." So, just again, validating that experience. I don't think it's my place to say, "Well, I'm frustrated too with the whole process," because it's not my journey; that's their journey. It's their experience.

Although psychologists appeared to be empathic to their clients' experiences, withholding of emotional reactions to help maintain the focus on client change appears in contrast with Rogers' (1961) suggestion of being genuine. Genuineness is when

practitioners are honest with clients about their thoughts and feelings and model the values of honesty and self-reflection to the client. This holding back of emotional responses may communicate to athletes incongruence (nonverbal behaviours may not match verbal messages), which in turn may confuse clients as to whether their practitioners care for them or not.

Some participants said it was important to display emotional states to clients that were positive; even if these feelings were not genuine emotional experiences. Practitioners also expressed that modelling emotional control and showing optimism to injured athletes were important actions in rehabilitation and should take precedence over emotional expression. Participant 7 said:

> It [is] a bit false, almost in a way, if I was talking to the athlete about coping skills, or resilience, and being optimistic, and all those sorts of things, [and] I was getting very frustrated, and I was showing signs of being very emotional. . . . I'm very mindful of my role, and that I can model some of the positive coping behaviours. . . . [It] doesn't mean not caring.

Perhaps, by displaying these positive coping strategies, Participant 7's clients will imitate and internalise his models of coping. Although this approach seems pragmatic, it may also prevent clients sharing further emotions or emotional content, because in such circumstances clients may not *feel felt*, or welcomed by practitioners to discuss their emotions.

One participant considered emotional control to be a necessary skill for psychologists. Participant 3 commented:

> The importance of a lot of what we do is trying to help people be aware of their emotions and help manage yourself [themselves] regulate [those emotions], and if we can't do it ourselves, then it's a bit of an indictment on ourselves.

In this quote, this psychologist appears to adopt a psychoeducational approach and communicate the value of role modelling as a didactic tool. Participant 3 seems to express, in Freudian terms, an active superego that suggests one is a poor practitioner if one cannot regulate one's emotions. Perhaps this punitive superego has developed from him internalising his supervisors' models of practice or could reflect his experiences in sport cultures that have reinforced the idea that displaying emotions such as sadness and fear shows mental weakness (see Tibbert, Andersen, & Morris, 2014). Alternatively, this quotation could reflect this practitioner's awareness of the need to regulate his emotions around injured athletes. Although it was not a focus of our interview, Participant 3 did mention that he had significant injuries that led him to retire from sport.

Nevertheless, the importance that participants in the sample placed on expressing their emotions within practice seems to be different to reports of practitioners' emotional reactions in other domains of psychology. Pope, Tabachnick, and Keith-Spiegel (1987), in their analysis of a national survey of psychotherapists in the USA, found that the majority (89.7%) of practitioners told their clients when they were angry with them, and 56.5% reported that they had cried in the presence of a client. Psychotherapists said these behaviours occurred infrequently; most practitioners reported that these behaviours occurred *rarely* or *sometimes*. The difference between Pope et al.'s (1987) findings and those of the current study, in regards to the reported expression of emotion and self-disclosure of emotional states, could be due to several reasons, the majority of which relate to differences between sport psychology and psychotherapy. These include: (a) the content of therapy sessions (e.g., talking about recovering from a broken leg may not trigger the same emotional response as a psychologist talking to a client who has been raped); (b) practitioners' formal training

concerning their awareness of, and reflections on, their emotions; (c) the norms of expression of emotions (e.g., it is acceptable to cry or express sadness in therapy, but not in a sporting environment); or (d) practitioners not wanting to share their real emotional expressions and experiences with me, a student researcher.

Managing and Working with Others

A few participants suggested they were responsible for managing others' relationships in injury rehabilitation. These included the interactions that: (a) service providers initiate with injured athletes, (b) athletes initiate with service providers, and (c) noninjured athletes have with injured athletes. I discuss these different communications and relationships in turn.

Managing client communications with other professionals. Participants spoke of issues of information sharing when working with other professionals within institutions, clinics, or team environments. Often other staff members asked psychologists for information that clients had shared with psychologists in confidence. Participant 4 mentioned she thought there was a delicate balance between sharing information with other support staff and maintaining client confidentiality:

> If you are also somebody that goes [says to other staff], "I can't talk to you about it, it's confidential," then how is that helping the client at the end of the day and how are you actually forming the relationships [with other professionals] about knowing? . . . It expands out not just building a relationship with the client, but when you are operating in a system, how do you navigate that system appropriately?

This practitioner is aware that withholding client information from other service providers may be detrimental to the athlete's wellbeing, but also to her working relationships with other professionals in the MDTs. Sharing information about athletes'

rehabilitation processes could facilitate recoveries and help professionals and others within athletes' social support networks to understand athletes' needs and how they can help meet them. Participant 4 also stressed the importance of psychologists educating practitioners on the restrictions of information sharing and confidentiality and the problems that occur when practitioners do not respect these boundaries. She mentioned:

> You need to educate people about what those [confidentiality] boundaries are, and you need to pull people into line when it's been used inappropriately. So, I've been in situations where colleagues have approached the client, they've known from general health information that this particular athlete was seeing a GP [General Practitioner] or had some stuff going on that they were getting some external assistance with, so confronted them, and using the power differential got the information out of them, highly, highly, highly confidential, highly traumatic information. So, got it out of athlete on the spot. [And I said,] "Well, you've just re-traumatised that athlete."

Psychologists have explicit ethical codes about maintaining confidentiality, and often this strict information keeping can be seen by other practitioners as withholding secrets or trying to maintain power within the context of other practitioners. The reality is that, within MDTs, psychologists are likely to have private, sensitive information shared with them because athletes know that it will be kept in confidence. Other support-personnel may not be held by such ethical standards of maintaining confidentiality and might expect information flow between staff to be bidirectional.

One participant, who had considerable experience working in MDTs, said that psychologists should help other practitioners care for athletes in rehabilitation. She mentioned that physiotherapists and other staff members would often refer athletes to

psychologists when athletes cried. It seemed like, in her opinion, other professionals needed to learn to care for athletes as people and manage their emotional wellbeing:

> [We need] to help physios in particular manage the emotional sides of things rather than react . . . like . . . somebody cries on the table, everybody has a little chuckle about it, "Oh, the crazy person. Psych! She's yours!" Where you know what, "She's not crazy, crying's normal, and if you could manage it, it [she] wouldn't have to be sent over to me." (Participant 9)

It appears from this quote that, within this particular MDT, other service providers have inadequate skills (or an unwillingness) to work with distressed athletes. Yet, physiotherapists who work in sport organisations can spend considerable time with athletes and build close relationships with them. Athletes may confide in physiotherapists before they approach psychologists for help, particularly if sport organisations have reactive referral systems to psychologists. Through professional development activities, psychologists could help up-skill service providers such as physiotherapists on interpersonal skills, mental health awareness, and psychologists' roles. These activities could help develop systems of caregivers around athletes to assist them in dealing with the anxieties, fears, and depressive thoughts they may encounter when in rehabilitation. If athletes perceive that they have an interpersonal network in place that is supporting them, their brains could be positively affected; it is possible that warm, caring interpersonal relationships across MDTs may downregulate and soothe injured athletes' anxieties.

Helping athletes understand the system. Two participants talked about helping clients understand how the multidisciplinary system in injury rehabilitation worked, especially in regards to information sharing within this process. Participant 9 said:

> A lot [of] times it's about helping the athlete manage the system of rehab and

> why it would be good for me to be talking with the physio, because I can help the physio understand some resistance, or help the athlete get in for sessions.

By educating athletes on how MDTs work, how information flows, and how best to work with systems in place, Participant 9 has helped athletes manage themselves and their interpersonal relationships with others in rehabilitation, maximising opportunities for treatments, services, and (potentially) their recoveries. Practitioners, however, said that MDTs appear to have a hierarchical structure of service providers. One psychologist said, "We are low on the totem pole" and perceived that other practitioners undervalue psychologists and their (potential) contributions to athletes' rehabilitation experiences. In Study 3, I give an example of a psychologist who earned the respect of other service providers within a MDT and worked effectively in collaborative relationships with support staff in sport injury rehabilitation.

Managing expectations that other athletes have of injured clients. One psychologist discussed a case where she had to manage other athletes' responses to, and expectations of, an injured athlete. She explained that teammates might have limited understanding of athletes' injuries (particularly when injuries do not have visible accruements or signs) and this limited knowledge can influence the quality of relationships teammates have with injured athletes. Participant 9 said:

> So, we get to this concussion piece and managing him, because again, concussion, there's no evidence of anything wrong. So, already he's not performing on the team, but the other people on the team are wondering why he isn't there [at training or competition]. You know, and there was this undercurrent of, "You suck to begin with and [now] you're not even showing up." So, we had to do a fair bit of managing some pretty insensitive and hurtful remarks.

Psychologists can activate and educate athletes' social support networks, because of their frequent contact with injured athletes (Clement & Arvinen-Barrow, 2013). Practitioners, with athletes' consents, can also facilitate information sharing with other players or athletes to prevent damage to injured athletes' social connections within their sports.

Special Case: Participant 6

In this section, I present one practitioner who appeared to have little in common with other psychologists in the sample in regards to his views of relationships in practice and psychology. After discussion with my supervisors, we decided to treat Participant 6 as an outlier. His views were divergent, and my experience interviewing him was radically different to my encounters with, and reactions to speaking with, the other psychologists in this sample. I give a brief synopsis of Participant 6, a personal reflection on my experiences during and after the interview with him, and detail what I learned about client-practitioner relationships in injury rehabilitation from my encounter with Participant 6.

Synopsis. Participant 6's practice orientation appeared to be a psychoeducational approach towards empowering his clients. He helped them understand their cognitions and behaviours through teaching them principles about behaving in positive ways. For example, he said, "Once you understand these simple principles, then I find people leave me feeling better, because they now have a strategy." He suggested by learning to act in a positive way, clients' mental states (e.g., mood) could be influenced positively. He also indicated that clients could be empowered in a short period:

Participant 6: I see people once and almost never have to see them a second time.

Guy: Okay.

Participant 6: They must always get better, once.

Guy Yeah. Okay.

Participant 6: And most of my time is teaching them what I call . . . basic psych.

Participant 6 clarified, "Everybody [who] comes to me, they got to get better, and after once. The only time it's not after once, it's addiction or relationships. Or mentoring. Otherwise it should be once." I was surprised at the brevity of client contact that Participant 6 perceived was necessary for client change. To me his comments seemed to have a messianic flavour in that it appeared he could give his clients an explanation of the mind that was radical, easy to understand, and that could be applied to almost all of life. After only a short period of time, clients could leave him *feeling* better. I will come to the distinction between feeling better and getting better in my personal reflection.

Participant 6 expressed that people should leave sessions with psychologists better off than when they arrive:

Participant 6: And you might know . . . in the Psych registration, there is not one requirement that should make people better. You're not allowed to shag your clients, you have to make sure you follow all these protocols, but there's not one requirement that people get better. That was a real worry for me.

Guy: Yeah.

Participant 6: If say . . . if I'm accrediting you to being an electrician, guess what that number one requirement be?

Guy: Like (pauses)

Participant 6: That you fix problems.

Guy: Yeah. Fix it. Yeah.

This idea that psychologists should fix people was not explicitly stated by other psychologists; some appeared to have *fix-it* motivations and others suggested that a natural *righting reflex* (perhaps adopted by lay helpers; Rønnestad & Skovholt, 2003) should be avoided. I initially agreed with his statement, and thought, on the surface, this idea made sense; psychologists are in the business of helping people get better. I, however, was unsure whether it was realistic for a psychologist to *fix* every client, especially if he or she did not listen to his or her clients. Participant 6 said:

> I spend most of my counselling talking. People say you're supposed to be listening. I stop and listen to what's your problem; pain, and they say, "I wish I was more motivated" . . . And they have all these 'if only's'. So, I stop and give you [basic psychology]. So, they tell me the problem; I give them [basic psychology]. . . . Then I put it to them: "Now I've given you a feedback, what do you think you're doing?" And then, because they're now no longer judging themselves, they're more rational.

This psychoeducational and quick, solution-focused approach appeared to leave little room for clients to talk at depth about their issues, concerns, or presenting problems, which is common in most talking (and listening) therapies. Participant 6 stated that he was not motivated by financial gain from one-to-one sessions and felt that other psychologists might be, and, hence, why some psychologist would have multiple sessions with clients:

> So, that's one reason why, again, in personal counselling, I don't charge, because I'd hate it to be in my vested interest to get them [clients] to come back. . . . So, my goal is that I'm not needed. Whereas, you know, if your goal is, well, like I saw one guy who said, "Oh, the first time you do your evaluation." I said,

> "So, you mean they've seen you for an hour and they get no better?" [He said,] "I'm just evaluating." . . . They have to wait another week before anything. Well, that's what you do. I have problems with that, but then again that's my biases.

Although wanting to avoid overservicing clients is an admirable stance, there are apparent dangers in underservicing clients particularly if practitioners do not gain clear understandings of clients' problems (e.g., severity), needs, and reasons for seeking treatment or advice. It seemed that Participant 6's desire to educate and empower people superseded his want or need to understand and connect with them on a deep, therapeutic level.

The work Participant 6 did with injured athletes seemed to follow a similar educational path. He would often identify athletes' maladaptive coping strategies and illuminate these issues in a simplistic, empowering manner:

> See, when I get injured . . . my natural instinct is to do what's going to make it worse: sulking, complaining to the doctor, not taking my medication, not doing my rehab, taking too much alcohol. Whatever it is that's going to make my rehab worse. Whereas, I've got to say, "Hang on, what don't I want to do? Well, I don't really want to understand my injury. I don't want to talk about tomorrow, because I want to go over yesterday." Now, once you understand these simple principles, then I find people leave me feeling better, because they now have a strategy. And, who does this strategy come from? Them.

Personal reflection. Participant 6 was charismatic and welcoming, and he engaged me in conversation quickly. I felt at ease being with him because he was funny and spoke energetically. I felt drawn towards what he was talking about; he was enthusiastic and passionate. My mirror neurons were firing, and I was internalising his

energetic state. I did not ask many questions, because, perhaps like his clients, I did not have the chance to. He started by telling me about his personal philosophy and approach to psychological practice, that he acknowledged, is very different to other psychologists'. He said to me, "There's no judgement of what your perceptions are, and if you think what I'm saying is a bunch of bull, my ego hates it. But, I can understand it, because 95% of the psychological community aren't saying what I'm saying."

During the interview, Participant 6 showed me exercises, and gave me opportunities to perform them, to illustrate his psychoeducational strategies. He also offered examples of people he worked with and cited several professional sportsmen and women who he had helped with his interventions. I felt that he was helping me understand myself. The principles he was teaching me were so simple, and I was amazed that I had not thought about these ideas and concepts before.

I left the interview with Participant 6 feeling empowered to affect change in my life. I *felt* better knowing that *I* had the power to make myself better with a new understanding I had of myself. Not long after getting back from my interview, however, I realised that I had been caught up in the excitement of the experience and that my actions did not seem to influence my emotions in a positive way. Perhaps I misinterpreted Participant 6's advice or, possibly, my experience was similar to his clients'; they are drawn in by the feel-good factor of understanding oneself in a simple way in one session and then realise that this emotional high and insight does not last for long. I realised that, of course, navigating the difficulties of life is more complicated than the basic principles Participant 6 expressed during our time together.

Concluding remarks. From just a 2-hour conversation with Participant 6, I felt empowered, excited, and (temporarily) happy. From just talking to me and educating me (this was not a therapy session), I wondered how Participant 6's clients must feel. I

considered whether they only see him once because they get better, or perhaps (like me) the feeling of empowerment wears off and there is no space or relationship to explore substantial issues such as deep thoughts, anxieties, and other emotions further. My experience interviewing Participant 6 showed me the potential power of personalities in professional relationships; one can be charmed with charisma for a while before one gets a whiff of snake oil.

Summary

Within Chapter 3, I presented themes developed from interviews with 12 psychologists who work in sport. Participants shared their experiences of building relationships with injured (and noninjured) athletes. In particular, these professionals discussed their experiences *hanging out* in sports, the challenge of holding back their *fix-it* reflexes, and the use of client-centred qualities in their interactions. Psychologists reported various challenges in building relationships with injured athletes including facing the stigma that is sometimes linked to (sport) psychology, being marginalised in rehabilitation processes, and receiving reactive referrals from other professionals.

Psychologists reported a range of favourable and unfavourable relationship experiences when working with injured athletes. Practitioners expressed their enjoyment of working with athletes (and multidisciplinary team members) who valued them, had *straightforward* rehabilitations, or collaborated in the tasks and goals of treatment. Participants were also frustrated with athletes who did not listen to their advice or sought psychological support from other multidisciplinary team members. Only a few psychologists, however, were aware of the needs and motivations they brought into their relationships with injured athletes and how these may have influenced their interactions.

Several psychologists discussed the importance they placed on managing themselves in their professional relationships. Some participants considered modelling emotions and coping strategies for injured athletes (even if these emotions or strategies were incongruent with practitioners' internal experiences) to be important within client-practitioner relationships. Participants also discussed the need to establish boundaries with other professionals in regards to the information they shared about injured athletes. Some psychologists said they supported athletes' relationships with other health professionals and teammates to aid athletes' recoveries.

Within Chapter 3, I also presented a special case of a charismatic psychologist who had a different standpoint on client-practitioner relationships to the other participants in the sample. I discussed my experiences interviewing this charismatic professional and how he influenced me. Further discussion of the results from Study 1, and how they relate to the following two studies presented in this thesis, can be found in Chapter 6.

CHAPTER 4

STUDY 2: SPORT PHYSIOTHERAPISTS' EXPERIENCES OF CLIENT-PRACTITIONER RELATIONSHIPS IN INJURY REHABILITATION

In the specific healthcare context of physiotherapy, several researchers have examined client-practitioner relationships. Some investigators have focused on understanding what treatment outcomes are associated with client-practitioner relationships and the strength of these associations (see Hall et al., 2010 for a review). As discussed in Chapter 2, researchers have found that aspects of the working alliances between clients and practitioners are associated with physical (e.g., cardiorespiratory fitness, weight loss; Burns & Evon, 2007; speed of return to work; Schönberger, Humle, Zeeman et al., 2006), and psychological (e.g., depressive symptoms; Schönberger, Humle et al., 2006b) treatment outcomes in physiotherapy. Researchers have used qualitative or mixed methods to understand client-physiotherapist relationships. Such efforts have primarily focused on examining specific relationship processes, such as verbal and nonverbal communications (e.g., Gallois et al., 1979; Parry, 2004a, 2004b; Thornquist, 1991, 1992), and commentators have added to the discussion of these topics (e.g., Alexander, 1973; Hargreaves, 1982; Petitpas & Cornelius, 2004).

Andersen (2004b, 2007) has provided in-depth accounts of physiotherapists' and clients' professional relationship experiences through case studies, and he has discussed psychodynamic processes relevant to client-practitioner relationships within sport physiotherapy. Apart from Andersen's (2004b, 2007) work, few studies have been conducted in client-practitioner relationships within the specific context of sports physiotherapy. Within athletes' sport science support teams, physiotherapists have substantial influences on athletes' rehabilitation outcomes. Physiotherapists are often the closest members of injured athletes' support networks (Andersen, 2007; Clement &

Arvinen-Barrow, 2013); athletes can have regular sessions with physiotherapists and often share information in a confidential environment while practitioners care for athletes' injured bodies (Andersen, 2007). Understanding sport physiotherapists' experiences and perceptions of their past and present professional relationships with their clients, the training they have received in regards to interpersonal aspects of treatment, and the challenges they have faced within injury rehabilitation could be useful in developing best-practice guidelines within this specific healthcare context. In this study, I explore sport physiotherapists' relationship experiences with injured athletes.

Method

Participants

I asked 49 sport physiotherapists within Australia to participate in this study. Forty declined, and nine accepted the invitation to participate. The nine participants varied in their years of experiences from 2 years to 35 years (M = 11.8; SD =10.2). Participants studied physiotherapy at a range of institutions across Australia Three practitioners took postgraduate pathways (following a human movement, sport science, or physical education undergraduate degree) and the remaining six did undergraduate courses to become physiotherapists. Of the nine participants, three had completed a master degree in sport physiotherapy or doctor of philosophy. All participants worked within sports clinics in the Melbourne metropolitan area and were regularly working with injured athlete-clients through their clinics or from regularly servicing sports teams, clubs, and organisations. Practitioners also saw a variety of clients, from general and sport populations, during their working weeks.

Procedures, Data Analysis, and Researcher Credibility

Victoria University's Faculty of Arts, Education, and Human Development Human Research and Ethics Committee approved this study. The procedure, data analysis process, and details of researcher credibility for Study 2 are the same as Study 1 (see pages 62–70 for details).

Results and Discussion

The results for Study 2 are presented under the headings of the themes and subthemes developed from the data analysis process. There are several crossovers in themes within the data that are identified, and the reader is directed to related sections of the results and discussion for further information. Participants spoke about their relationship experiences working with various clienteles, and not all the stories participants offered me were related to sport injury rehabilitation. In this section, I primarily focus on practitioners' experiences working with injured athlete clients, but also mention physiotherapists' perceptions and experiences of working with injured clients in general.

To begin exploring participants' stories, I first wanted to understand their backgrounds and motivations to become sport physiotherapists. I asked practitioners about their experiences playing sport and how they eventually came to study and train as sport physiotherapists.

Motivations to Enter the Profession

Similar to Study 1 and other studies on sport psychologists' development (e.g., Tod et al., 2009), many of the participants offered superficial motivations for entering practice, and most were unaware of how these motivations could play out in their relationships with clients. The majority of participants said they enjoyed playing sport growing up, and several mentioned that encounters with physiotherapists for sport-

related injuries during these times sparked their interest in pursuing physiotherapy as a career. A few practitioners commented that physiotherapy was an ideal occupation to align several of their interests (e.g., sport, anatomy, working in a team context):

> I remember having almost an epiphany around year nine when I spent a couple of sessions going to a physio myself because I played a lot of baseball. . . . I remember thinking that it was pretty cool what they did: they got to work with people who played sport, and understood sport, and got to help me with my recovery, and got to be almost part of the team. And, knowing that it was always sort of a science thing, and I was sort of a science kind of brain, but also working with people in sport as well. So, [that's] what got me hooked initially. (Participant 5)

In addition to marrying her interests in and enjoyment of sport and anatomy, Participant 5 seemed fond of being a physiotherapist because she would be part of a team. Possibly her interest in sport physiotherapy reflected unconscious desires to be like the athletes she could work with and to maintain a sense of her athletic identity; if she could not *be* an athlete, at least she could (almost) *feel like* one.

A couple of participants discussed the influences physiotherapists had on their early lives and, consequently, on their career choices. One practitioner spoke of his experiences receiving treatments from physiotherapists:

> Throughout my junior and even senior footy years, you'd [I'd] end up in there [at the physio] occasionally. And, I just was always impressed and grateful, I suppose, for the help that I received and the fact that they made a difference. So, yeah, I just liked the idea of doing the same in kind.

Participant 8's story has parallels to Andersen's (2007) case study of Guillaume, a young swimmer who injured his shoulder and had treatment from a physio called

Margaret, a caring, middle-aged woman. They had a great working relationship that was characterised by unconscious transference; Guillaume's mother had passed away, and he longed for a mother-like figure, and Margaret's motherly-like approach to her practice was heightened when taking care of Guillaume (possibly because she did not have a son herself). Perhaps, along with Guillaume, Participant 8 internalised his physiotherapists' models of care and went on to study physiotherapy because he wanted to be like his carers. Participant 8 could have wanted to resemble his physiotherapist for several (nonexhaustive and nonexclusive) reasons: (a) to express gratitude for what he had received by doing similar work for others; (b) to have others feel similar gratitude for him; and (c) to make others feel as good as he did from the care of his physiotherapists.

Other practitioners in the sample said that they entered physiotherapy because it seemed like a fun profession. Several also mentioned that they, like participants in Study 1, had more motivation to work with professional or recreational athletes than the general public. Participants said they had found sportspeople were more motivated, adherent, and positive about their rehabilitation experiences than other clients whom physiotherapists treated in their private clinics. These practitioners, however, faced challenges working with injured athletes. I discuss these issues later in the chapter.

Training in Relationships and Rapport

To understand physiotherapists' experiences in building relationships with injured clients, I asked participants about their formal training experiences. The majority of practitioners recalled their formal training in rapport building. One participant, however, said she did not receive education in this area, "It was never taught to me, and I don't know if they teach anything like it now." (Participant 9) The level of training that participants received in bedside manner and building relationships

appeared to vary considerably and is likely due to the different courses participants studied and the range of institutions that practitioners attended. Physiotherapists remembered studying topics such as professional behaviour, communication, and ethics and relationships. In these subjects, students reported learning how to deal with medico-legal cases, conduct interviews and intake assessments, understand clients' nonverbal behaviours, develop self-awareness of their own nonverbal behaviours, and structure welcoming work environments. Participant 5 commented:

> I remember sort of having lectures on how you might set up (pauses) yeah, that's right, [the] interview processes, we did, that it's much less formal if you don't have a table between you and your person if you're setting that up that it might be nicer to – like we are sitting side-by-side to get something out of someone, and body language, and all that sort of stuff.

It seems like the training this practitioner described was centred on developing an awareness of proxemics and nonverbal behaviours and minimising the power differentials between practitioners and clients that can occur through the way physiotherapists structure their treatment environments. Physiotherapists educated in the United Kingdom have reported that they received similar training in psychology (Arvinen-Barrow, Penny, Hemmings, & Corr, 2010). Such education appears consistent with commentators' suggestions to physiotherapists (e.g., Hargreaves, 1982) and physicians (e.g., Silverman, Kurtz, & Draper, 2005) on how to display attentive, warm nonverbal behaviours to facilitate the development of collaborative relationships with clients.

Most participants said they learned more about relationships on placements from observing senior physiotherapists, imitating their supervisors, and building rapport through trial and error than they did in classes or lectures. Only a few practitioners

offered their perceptions of their training courses in rapport building at university. Participant 8 stated, “It [training in ethics and relationships] certainly helped,” whereas Participant 2 said her course in communication was “a waste of time” because she perceived she already had the necessary skills to communicate effectively with clients. Participant 2, however, believed that the subject was a worthwhile component of training for some. She commented, “Obviously some people needed it. So, other students, when we went out on prac [placements], couldn’t do that stuff that seemed to come quite naturally to me.” She suggested that those who needed the training were often undergraduates who entered physiotherapy courses straight after school, whereas she had taken a postgraduate route into physiotherapy after a first degree, in which she had already gained life experience and learned how to interact with people in professional settings. This finding parallels research in sport psychology that suggests social experiences and interactions outside of formal training can be instrumental in service delivery competence (Tod & Andersen, 2012; Tod et al., 2007). Participant 2’s confidence in her ability to communicate, however, is not an assurance that she actually had the necessary skills to communicate effectively with clients prior to her physiotherapy course. Andersen and Stevens (2007) have suggested that overly confident trainees, particularly those who appear not to doubt their abilities and perceive they have all the relevant knowledge, may be dangerous to their clients. Such students may have inflated opinions of their abilities, not have developed reflective practices, or not have learned from their mistakes.

One practitioner mentioned that her experiences in relationship-building classes were boring. Participant 1 said, “I think it’s [rapport building] a very hard thing to teach, and theoretically, it's very dry, and no one really took it very seriously.” Participant 1 further explained why she did not enjoy the topic:

> Physios, they have blinkers on. The end goal is there. We all know what we're interested in, and we all know what we like to study. Early on when you've got these airy-fairy sort of subjects that are talking about, "Let's define rapport, Let's role play." . . . We had to be there. So, we were there, but it was very minimal effort [that we] put in. There was very minimal attention. . . . I think physios are a lot more scientifically minded. . . . They do really like the scientific, "This is what this is. This is what this does," rather than, "Let's build rapport." It frustrates them a little bit.

This quotation appears to reflect a misunderstanding of what can be considered as "scientific." It appears that, in this participant's opinion, psychological topics such as rapport building are not scientific, backed by research, or valuable in comparison to the hard sciences such as anatomy and physiology. Perhaps, Participant 1's views reflect that she was given little evidence for why rapport building is essential and how rapport functions in her formal training. In the future, educators of trainee physiotherapists could use recent neuroscience evidence to provide an explanation of the importance of building quality relationships (i.e., what happens on a neurological level) between clients and practitioners in an evidence-based and empirical way (e.g., Cozolino, 2010; Siegel, 2010). Such knowledge may appeal to students who enjoy learning about anatomy and physiology.

Initial Experiences with Injured Clients

Most practitioners discussed their initial experiences with clients, often talking about their first encounters with the clients they saw without direct supervision. Many, but not all, physiotherapists said that they felt anxious in these initial experiences and relationships. Participants said they were more likely to experience anxiety when treating injured athletes or clients in private practice rather than in hospitals, because

practitioners perceived they had less support and experience in clinics than in hospital systems. Participant 5 commented:

> I was confident because we'd spent a lot of time at university doing the hospital-based stuff, and there was a lot of support there [in hospitals] when you got stuck. I remember thinking [with] my first few [private] clients, "Oh my! They're actually paying money to see me, and for my time, and they're paying the same money to see me and have my time . . . as they could be seeing the physio next door who's got 20 years [of] experience!"

These findings parallel those of novice counsellors', psychotherapists', and sport psychologists' experiences. For example, Skovholt and Rønnestad (2003) reported that novice practitioners (in counselling and psychotherapy) are likely to experience acute anxiety, self-consciousness, and fear the unknown. They also seek approval of, or information from, peers or senior practitioners to cope with these fears and anxieties. The majority of participants in Study 1, and all participants in Tod et al.'s (2009) study, said they experienced anxiety regarding their competencies as (sport) psychologists. From these findings, it seems that experiencing anxieties about service delivery competence is common among novice practitioners, and physiotherapists may benefit from being exposed to and heeding the advice of researchers in mainstream and sport psychology (e.g., Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003; Tod, 2007a) on how to manage such anxieties. These results also indicate that participants were more anxious with, and felt more pressure to help, the paying clients (often with sport injuries) in private practice than in other contexts, such as hospitals. Such experiences of heightened anxiety could relate to practitioners' concerns around being perceived as imposters and not worth their clients' money. This theme also appears in research on novice and seasoned sport psychologists' experiences (Andersen & Stevens,

2007; Tod & Bond, 2010; Williams & Andersen, 2012). Practitioners' anxieties in these contexts could suggest they may have benefitted from more guidance, practice, or reassurance than they received in their training to build confidence within these specific practice areas. One of two participants, who said they were confident in their initial experiences working on their own and with sports injuries, mentioned she had several work experience opportunities in sport. These experiences were uncommon for students at her level of study. She commented:

> I was really lucky. As a student, I had a lot of exposure to work experience in different sporting events and worked a lot for teams. So, I had already had a lot of experience dealing with people. Working in a sporting club, for example, a football club, you get exposed to everything, so all personalities, and a very large range of injuries. . . . When I graduated, I was pretty confident with my ability to treat the basic stuff. So, I wasn't really that stressed about it. (Participant 1)

Along with having exposure to a variety of injuries and types people, Participant 1 received constant feedback from senior physiotherapists who allowed her to take the lead in treatments during these work experience opportunities. This regular guidance and instruction may have minimised her initial anxieties as a trainee and could have been instrumental in facilitating the development of her confidence in her capabilities as a practitioner.

Fix-it reflex. Similarly to practitioners in Study 1, two participants talked about their expectations of healing or fixing clients in their early years of practice. Both physiotherapists' perspectives changed over time. Participant 4 said:

> [At the start] I was full of enthusiasm, and I was quite shocked when I couldn't [fix people]. So maybe that was an ego thing, or maybe I just, because I've had

> four years of them [physiotherapy educators] telling me [in training] that, "Physios are great, they're really good at what they do, blah, blah, blah." In fact, sometimes they're not. We haven't got all the answers. So, maybe it was just my ego needing to be knocked back a peg or two.

This practitioner was hopeful and optimistic about the difference she was going to make to her clients' lives. This physiotherapist's statement has parallels to the experiences of novice counsellors and therapists, who, early in their careers, often report being enthusiastic and having unrealistic expectations of their abilities to help others (Skovholt & Rønnestad, 2003). Perhaps, during participants' training, educators reinforced such high expectations through unrealistic and overly positive portrayals of the profession. Both Participant 4 and Participant 8 expressed how their perspectives on treatment and their expectations of themselves evolved over their careers. For example, Participant 8 said, "Back then, you're trying to cure everything, but the more you do it, the more you realise that you can't cure everything." This practitioner's statement appears similar to the themes discussed by Skovholt and Rønnestad (2003) who reflected on career development stating that, "it takes time [for practitioners] to get to a place where 'realistic' replaces 'idealistic'" (p. 54).

Building Relationships

Physiotherapists shared their stories about how they developed relationships with their injured clients, the skills that they considered important to build rapport, and the challenges they faced in their relationships. First I discuss the reasons (some) physiotherapists offered for developing relationships with their clients.

Reasons for building relationships. Several participants suggested that building rapport helped clients develop trust in their expertise, which in turn helped clients' compliance and adherence to rehabilitation programs. Participant 7 said:

> I think it [building relationships] is a very important part of physio. I think if your relationship with the client is not there, then your physical treatment isn't gonna work. The first thing you [’ve] got to do is to get the client on your side. For them to trust you and to buy into your treatment otherwise they're not gonna get better.

Participant 7 appears to value the connections he has with his clients and sees those relationships as important for positive treatment outcomes. The language that he and other practitioners used when describing clients’ adherence levels sounded business-oriented. Practitioners used terms such as *investing* or *buying into* treatments. The word choices could reflect the business aspect of physiotherapists’ treatments; all of the participants worked in private clinics for third parties. This context may influence the way they see relationships with clients. One hopes that this language use does not represent practitioners who see clients as business entities rather than people. From the data, however, it seemed that several physiotherapists’ efforts to build rapport were linked to persuading clients, through selling their treatments, to *get on board* with treatment programs. Participant 7’s description of persuading clients may reflect his need to be in control of treatment sessions. This desire could indicate a strategy to manage anxiety as a novice physiotherapist (less than three years of practice experience postregistration). Researchers have reported that practitioners who work in sport experience a need for control early in their careers. For example, in a case study of a sport psychologist’s development, Tod and Bond (2010) described how the participant felt she needed more control over service delivery at the start than at the end of her supervised training. These findings, and ones from other studies (Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 2003), along with commentaries from practitioners (Andersen & Stevens, 2007), emphasize that novice professionals could

enhance their effectiveness if they develop their understanding of their anxieties and needs for control in client-practitioner relationships.

Relationship skills. Participants identified the skills they used and thought were important in building rapport with clients. Several physiotherapists also offered stories about their relationship experiences, and these tales revealed practitioners' relationship-building skills.

Listening to clients' expectations of treatment. All participants discussed the importance of listening intently to their clients' presenting problems, their concerns, and the stories they wished to share in treatment sessions. Physiotherapy clients favour such skills and recognise them as qualities of good practitioners (see Gyllensten, Hansson, & Ekdahl, 2003; May, 2001; Potter et al., 2003). Several practitioners considered that it was important to listen to people's expectations of treatments in initial consultations and manage those expectations. For example, Participant 9 said:

> So, I would immediately say to them, "Okay, what's your expectation of seeing me today?" Some of them are really stumped that anybody would ever ask that. But, what it does, it helps to find why they're seeing somebody [a physiotherapist]. . . [and] it [asking clients' for their expectations] directs what you should answer. It's not all about putting your hands on people and treating them. So, I think setting expectations with patients is really important.

It appears from this quotation that this practitioner is taking a collaborative approach to treatment by listening to her clients' expectations, but she seems to manage clients' expectations and persuade them to go about treatment her way (i.e., follow her expertise). She does not appear to want to adapt her behaviour or treatment to clients' needs as might be reasonably expected in collaborative models of treatment or effective working alliances (see Bordin, 1994). This practice could be problematic if not

communicated clearly to clients. For example, Potter et al. (2003) found that patients reported bad experiences with physiotherapists when clients had conflicting opinions, and perhaps expectations, with their therapists about treatments and when therapists had "preconceived ideas about the course of treatment required" (p. 199). Perhaps ways in which practitioners can manage clients' expectations could be explicitly discussed in training. Such education could help physiotherapists communicate clear, collaborative messages with their clients that are geared towards developing goals and tasks together as Bordin (1994) recommended in his working alliance framework.

Self-disclosures. A few practitioners mentioned they shared information about their lives outside of physiotherapy and listened to their clients' personal stories to build rapport. Some participants, like the majority of psychologists in Study 1, said they were cautious about disclosing personal information with their clients. One participant talked about telling personal stories with her clients, but also getting advice in return:

> Oh, my poor patients do hear about my life (Guy laughs), whether it's the fact that I've got a new kitten, or what I'm doing on the weekend, or last night's cricket game; whatever I think they might have an interest in. . . . I get all sorts of tips from my patients too (Participant 5 laughs). What I fish out, I've got cat trainers who are telling me how to train my cat. I've got gardeners helping me with my garden . . . I just try and find someone's passion that would get them comfortable, and I think you get a better relationship with them. (Participant 5)

This physiotherapist appears to be open to share personal information about her life, and consequently her clients seem to feel comfortable about disclosing information about their lives too. In this quotation, she appears to be trying to find *commonality* with her clients. By discovering what her clients are passionate about, and showing an interest in their hobbies, she wants to interact with her clients as people and not just body parts.

This quotation appears to reflect a holistic approach to practice (Kolt & Andersen, 2004b) and seems to be in line with psychologists' (e.g., Andersen & Speed, 2010; Rogers, 1957/2007) and physiotherapists' (e.g., Hargreaves, 1982; Thornquist, 1991) understandings of therapeutic relationships. Furthermore, in the reciprocity of the disclosures between this practitioner and her clients, she appears to gain tips, advice, and information. She seems to place them in positions of authority in which she respects their knowledge and (relative) expertise. Her clients' advice and stories appear to be gifts in response to her interest, care, and time.

Another physiotherapist, who worked regularly within a sport team, said it was important for him to disclose information regarding his sport experience to help build rapport with his clients:

> You ['ve] got to let them into your life a little bit. Tell them what you've been doing. . . . You're just trying to build that common experience I guess. I think it's important (pause) I mean, I try and show them that I like to be a sportsman as well. So, when they're in the gym, you try and show them your elite traits as well so they respect you as a sportsman. (Participant 7)

Similarly to Participant 5, Participant 7 wants to find commonality through a mutual interest in sport. From this quotation, however, it seems that this common ground is used as a playing field for competition; he appears, to a degree, to be trying to compete with his clients (several of whom may be injured) in the gym. Often people who have sporting backgrounds are competitive, and a comfortable way for many sport physiotherapists to relate to clients may be through competition. Although practitioners can perceive competitive efforts as a way to build rapport and motivate clients, physiotherapists, however, need to be aware of how clients could perceive such actions. For example, competition in rehabilitation could lead clients to feel down and perhaps

helpless as they make comparisons with a fit and healthy (noninjured) practitioner. Such interactions may also detract from clients seeing, and feeling the positive affect from, self-referenced improvements. Psychologists (e.g., Mannion & Andersen, 2015) recommend that practitioners who work in sport and exercise settings reflect on their behaviours and ask themselves to consider who is being served by their actions. If, after reflection, competition is used to fulfil a physiotherapist's narcissistic needs (e.g., trying to gain respect as someone who is similar to the players) or reduce anxieties (e.g., so that they feel comfortable and a part of the culture of the club and the elite sport context), then the practitioner could gain assistance, perhaps through psychological supervision, on how to understand and manage these needs and possible pathologies in practice.

Confidence versus congruence. A few practitioners said that being confident when giving instructions or offering diagnoses in treatments influenced the trust that clients had in them as physiotherapists. One participant commented:

> When I was less confident . . . you could tell your patients . . . weren't fully committed to what your cause was. And, you'd go back, and you'd look it up, and you're like, "Did I give the right advice? Was that right?" You think, "Yeah, actually [I] had told them all the right things, but I hadn't sold it well." . . . If I think of the best physios I know, they are really very good communicators and very good at just showing they know exactly what's going on. . . . So, having that confidence and that authority is really important. (Participant 5)

It seems that this participant may think it is necessary for physiotherapists to manage clients' impressions of them, and appear confident so that clients commit to treatments. Clients will probably not trust practitioners who seem unskilled (same as in sport psychology, see Tod and Andersen, 2012), but they may also be sceptical of

physiotherapists whose verbal and nonverbal behaviours seem inconsistent (e.g., they are talking confidently, but their hands are shaking). Some commentators (e.g., Cozolino, 2014) have suggested that humans have finely tuned mental processing systems that can rapidly assess discrepancies in verbal and nonverbal communications, which may lean clients towards holding positions of distrust towards incongruent practitioners. Professionals may prize being confident and appearing to have expertise over being honest about their limitations of competence. This stance seems to be encouraged by a few commentators in physiotherapy (e.g., Wagstaff, 1982), who appear to suggest that professionals should maintain or accentuate expert-novice differences that are engrained in medical models of treatment. Some participants, instead, mentioned that they were confident enough to say, "I do not know," to admit they had limited knowledge, or inform clients when they had concerns about rehabilitation progress. Such behaviours seem in line with client-centred practices. Although Rogers (1957/2007), when outlining his therapeutic condition of genuineness, did not directly discuss whether or not practitioners should voice their emotions or thoughts to their clients, he suggested that professionals would benefit from discussing these reactions with clients, supervisors, or colleagues if these internal processes get in the way of therapists showing empathy or unconditional positive regard.

Reading people. Participants spoke of the skill of reading clients' verbal and nonverbal behaviours, and some physiotherapists referred to the importance of analysing clients' personality types, taking such understanding into account in treatment, and adapting one's approach to practice (language, persona) depending on the client's personality. One participant said:

> When you see a lot of people a week you get very good at picking up what type of person they are. And, that's that relationship that you form. So, some people

> like to be told what to do and you have to be bossy with them, then that's what you have to do. But that won't work for a different athlete, you've got to either back off a bit or how you respond with injuries with them has to match their personality. (Participant 6)

From this quotation, Participant 6 seems sensitive to her clients' personalities. She is aware that she must adapt her style of interaction depending on the person in front of her. Being flexible in their approaches to practice and displaying different aspects of their personalities are physiotherapist qualities that experienced practitioners have recognised as important within client-physiotherapist interactions (see Gyllensten et al., 1999). Although it appears that Participant 6, and other practitioners, are trying to enhance their relationships with clients (by being aware of clients' personalities), it seems that these physiotherapists may group their clients in categories that are relatively simple and possibly restrictive. Such classifications could potentially limit how practitioners understand, relate to, communicate with, and treat their clients. I discuss physiotherapists' views on personality further in the section, *Managing Clients and Rehabilitation Processes*.

A few participants discussed how their ability to read clients would help determine the information they would share within treatments. For example, Participant 9 said she was open with her personal response to a client who had an unusual treatment for an injury (I have represented the conversation below):

> Client: "I didn't have an operation."
>
> Participant: "What the fuck do you mean you didn't have an operation?" Excuse me on the tact (talking to Guy).
>
> Client: "Don't you know?"
>
> Participant: I go, "No!"

> Client: "Oh, well they said that you're good [I didn't need an operation]."
>
> Participant: You know, like [I said], "Alright, tell me about it." (Participant 9 laughs) 'Cause sometimes it's not worth hiding it. I just went, "I've never done one [rehabilitated a similar injury without a surgical procedure]."
>
> Client: "Yes that's okay, I understand that not many people have."
>
> Participant: "Alrighty, we'll do this together!" But also, I already picked from her, she was calm, she was relaxed; me saying I didn't know was fine. She wasn't a nervous nelly, if she [was] . . . I would've never said that to her. (Participant 9)

Being able to read clients' verbal and nonverbal behaviours appears to help practitioners determine their levels of self-disclosure, particularly in regards to their uncertainty around how they will go about treatments. Participant 9's approach towards working with this particular client appears to be collaborative, honest (about her competence and experience with this treatment), and congruent. She, however, may have taken a different approach if her client was nervous perhaps to avoid exacerbating the client's anxieties.

Empathic and firm. Several of the practitioners emphasised the importance of being empathic towards their clients, and their definitions of empathy appeared to vary. This finding is unsurprising given that empathy is a complex concept and that researchers and practitioners have defined it in many ways (see Decety & Jackson, 2004, 2006; Rønnestad & Skovholt, 2003). A couple of physiotherapists seemed to differentiate empathy from sympathy. For example, when hearing clients introduce their injuries in session, one participant said, "Just a little bit of empathy, but not, 'Poor you,' just that little bit of, 'Oh, that mustn't have been easy.'" (Participant 2) Rønnestad and Skovholt (2003) have suggested that the ability to regulate emotional involvement is the

difference between an empathic and sympathetic response. This practitioner seems to avoid emotional overinvolvement and overidentification with clients (characteristic of a sympathetic response) and, as Rogers' (1957/2007) suggested, she is able to maintain an "as if" (p. 243) quality of her (empathic) reaction. For a couple of physiotherapists, their displays of empathy seemed to be accompanied by firm approaches towards clients' noncompliances in injury rehabilitation. Participant 4 commented:

> I think [it's important] that you're empathetic. You're open to whatever they have to say without judgement. You offer them the best clinical information you can about their pathology and how to manage it. If they want to get on board with that . . . and comply with suggestions – because "I'm not going to nurse you through it. You have to do this, and every week you come, and I'm going to check that you've done it, and I'll be able to tell if you haven't. . . . And, if you haven't, don't bother coming".

This quotation, to me, seems like a juxtaposition of a nonjudgemental, empathic approach towards clients and a judgemental, authoritarian approach towards treatment compliance. It appears that this practitioner, and several others who emphasised the importance of active rehabilitation (discussed later), contrast their warm, nonjudgemental approach with a strict disciplinary approach; one that, at times, comes across as punitive. The mixed message that I perceived could potentially be confusing for clients who may struggle to relate to a practitioner who sends divergent interpersonal messages and seems both warm and cold.

Appreciate what you are asking clients to do. In relation to building an empathic understanding of his athletes' experiences, one practitioner said that it was important for him to do the exercises that he was asking his clients to do. He said:

> I remember one physio giving me the advice of trying to do everything that you

> are telling them [athletes] to do. Whether it's doing the ice bath, or doing the weight program, or the physio program; try and do it so you know how it feels. I think that is really important that you know what it's like for them to do what they're doing. (Participant 7)

From this quote, it appears that this practitioner wants to deeply empathise with his clients' experiences of their rehabilitation and exercise programs. Putting himself in his clients' shoes could be a useful way for this participant to understand the demands athletes place on their bodies. There is a risk that this behaviour could be motivated by physiotherapists' unconscious or conscious desires to be *like* their athletes. Many entered sport physiotherapy to work in sport (a context they previously enjoyed), and some appeared to want to maintain their athletic identities through practising physiotherapy. Perhaps educating practitioners and helping them develop an awareness of such potential conscious (or unconscious) motivations for behaviour within treatments would be useful for physiotherapists to understand and manage their behaviours and desires within their relationships with clients.

Managing the Boundaries of Relationships

Many practitioners talked about their awareness of social and physical boundaries of their relationships with injured clients. Participants discussed their perceptions of boundaries, their boundary behaviours, and situations in which their boundaries were compromised. The majority of examples physiotherapists gave related to their experiences working with injured athletes.

Social boundaries. Participants had different views on the social boundaries they established with their clients. These variances were apparent through the language they used to describe their relationships and how they would relate to clients outside of the work environments. Some participants talked about being great friends with long-

standing clients or clients they had helped with substantial injuries, and others suggested they were *friendly* with their clients. When working in sport teams, several practitioners discussed their boundaries concerning socialising with players. Some commented that they would not socialise with athletes outside of their working environments, and others said that they would go for a drink (or two) with players. The participants I interviewed seemed cautious about their social boundaries. One practitioner stated:

> So, you're not trying to build a friendship; you're trying to build a professional rapport. Basically, in the code of ethics it says that you should not have a personal relationship with them. So, I think you have to be very careful that you don't fraternize. In a team, sure, you go out and you have a drink, but you have one drink and then you leave. You don't go out all night and end up coming home whacked [drunk]. (Participant 4)

This practitioner thinks physiotherapists should be cautious about merging their personal and professional selves. The various opinions in this sample in regards to socialising with clients may reflect practitioners' differences in age and years of experience. Participant 4 had considerable experience working within teams and with injured athletes and perhaps knew of, and learned from, the difficulties of managing social boundaries. Other, younger and less experienced, practitioners (than Participant 4) seemed to be confused about their boundaries with clients. For example, Participant 6 commented:

> I suppose, your relationship is like a therapist and a patient and it's got, it's always got a bit of formality to it, but the trouble is, that, I think, as you treat people for longer, you have like a dual relationship with them and you need to differentiate, are they your friend or you're just friendly? So, I think, it's the

> dual relationship of, well, I've seen them for seven years I'd almost wanna go out and have a coffee or a beer with them. . . . That's the challenging thing, where that line is.

This quotation reflects a physiotherapist's difficulties of managing boundaries with long-term clients. Often, as several participants described, practitioners can get to know athletes well during treatment times; perhaps through sharing stories in conversations and because of the close proximity and intimacy in which they work and interact (Pratt, 1978). Knowing where to draw boundaries with athletes can be challenging for physiotherapists working with athletes with long-term injuries, as well as when working with athletes on the road.

Travelling with athletes. Several participants had experiences travelling and staying with teams or individual athletes for competitions. Practitioners spoke of occasions when they had to share rooms with clients or lived in the same apartment complexes as athletes over competition periods. One physiotherapist discussed an experience travelling and living in the same apartment with an injured athlete who she was helping rehabilitate and get ready for a major competition. Participant 4 said that working with this athlete was particularly difficult. She commented:

> It was really stressful. And, I think, because there was a lot of other surrounding stuff that was going on, like [relationship issues] that I was getting pulled into, I felt really uncomfortable. It's always difficult when you want to maintain a boundary and distance if you are living with an athlete. (Participant 3)

This practitioner was involved in circumstances that were beyond her professional role as a physiotherapist. Being in the same location and in close proximity (perhaps emotionally as well as physically) may have led the client to share his problems with his physiotherapist because she had witnessed some of these issues

within their living quarters. Such experiences are a reminder that setting or maintaining time and space boundaries when travelling can be useful for practitioners to feel comfortable and avoid challenging dual-relationship dilemmas.

Other physiotherapists seemed self-assured with managing their boundaries when travelling. Participant 9 said she was confident because she has had years of experience working in a particular sport and understood how the team functioned. Psychologists in sport have written about their experiences travelling with athletes (Brown & Cogan, 2006) and working away at major competitions (e.g., Andersen et al., 2001; Haberl & Peterson, 2006). Such reflections on ethical behaviours may be useful for physiotherapists to learn how other practitioners have managed their personal and professional selves in these circumstances. Although these writings are great beginnings, seasoned physiotherapists' accounts of working outside of clinics and within sport environments could be useful to help physiotherapists manage the specific boundaries associated with sport physiotherapy. Perhaps researchers may be interested in experienced practitioners, like Participant 9, sharing their knowledge and stories on navigating the difficult terrain of working and travelling with athletes so that, in the future, physiotherapists can avoid wrong turns when working in close proximity to athletes and away from home.

Managing Clients and Rehabilitation Processes

Practitioners talked about the difficulties they faced during rehabilitation processes, such as clients being noncompliant to exercise programs and experiencing setbacks. Several participants spoke about how their understanding of clients' personalities influenced clients' rehabilitation programs, how they managed clients' noncompliance, and how they negotiated setbacks in long-term rehabilitation experiences. I discuss these themes in turn.

Personalities or types of clients. A couple of physiotherapists said they thought personality could influence adherence to rehabilitation programs. One practitioner spoke of two kinds of athlete who she believed would be noncompliant to exercise regimes:

> So, you do have those two different personalities; ones you've got to pull back and really give them the hard words, "Don't do that because you will –." And, there's the ones, "You need to get moving. You need to do this because, otherwise, nothing's gonna happen." (Participant 1)

The distinction Participant 1 makes is between clients who are susceptible to overtraining and those she needs to motivate to do exercises. This categorisation of nonadherent clients seems simplistic and incomplete. Although these groupings may have some face validity, they do not seem to reflect traits or ideas about personality that are consistent with research on personality correlates associated with appraisal, stress, and coping during injury rehabilitation (see Grove & Cresswell, 2007 for a review). Several participants within the sample appeared to have limited understanding of personality and the different psychological factors that could influence adherence to exercise programs. This finding is unsurprising given most practitioners said they received limited training in psychology or psychological aspects of rehabilitation. Perhaps personality and rehabilitation correlates should be targeted for further training to help practitioners develop their knowledge of client-characteristics and how these factors may influence adherence and compliance to rehabilitation programs.

One participant talked about being able to read clients and understand their personality types so that she could predict whether clients would be compliant or noncompliant to treatments:

> Being able to pick personality types and be able to sort of guess what they're going to do . . . helps. Because, at least you've got an honest relationship. So, you can say, "You shouldn't be running for the next week. I know you're going to try. Can you at least keep it to grass? Don't run on any flats." Or, "Can we get you on a cross-trainer?" So, I think it's really important to build a rapport with your people and try and bargain with them. Cause if you sit there and go, "No. You can't do it," when both people know that it's going to happen, then you're not going to get the result either. (Participant 1)

From this quotation, Participant 1 appears to be trying to collaborate and negotiate with her clients regarding their rehabilitation programs and seems to value the importance of rapport within this process. The importance of clients being involved in realistic goal setting for rehabilitation is well documented in general physiotherapy (see Parry, 2004a). What was revealing, however, from Participant 1's interview was the projection of her own tendencies to overtrain when injured on to her clients. She stated:

> I identify with that sort of personality 'cause I'm that personality. I've got a shoulder strain, and I shouldn't have swum last week. Well, it was fine to swim, but I probably shouldn't swim three days in a row. When I say I probably shouldn't have, I know I shouldn't have done it. But, I weighed up the pros and cons, and I did it anyway, and re-injured [myself] which is fine. I knew the risks, I took the risks, and it's a bit sore. Now, I'm dealing with it, it's okay.

From this quotation Participant 1 appears to be aware of her own personality and her tendencies and dispositions regarding injury rehabilitation. She, however, does not seem to be cognisant that she could be projecting her own approaches or ideas towards her clients and their treatments. It may be that physiotherapists could benefit from

training in how their personal preferences and behaviours may influence their relationships, assumptions, and interactions with their clients.

Managing noncompliance. Participants discussed the different strategies they used within their relationships with clients to try and facilitate adherence to exercise rehabilitation programs. Most practitioners emphasised the importance of active rehabilitation, a few asked participants to return only when they had regularly completed their exercises, and others took hard-line, authoritative approaches.

Communicating the importance of active rehabilitation. When clients had not completed their required or agreed upon exercises, practitioners said they would often explain why exercises are important for clients' recoveries. Some did this using metaphors or analogies. One participant commented:

> I'll try and educate them. 'Cause I think that . . . unless patients understand why you're asking them to do something, they just think, "Well, they're just giving me something to fill my time in. It's not going to help." Whereas, if they sort of figure out why you're doing something or why you want them to do something then they're more likely to (pauses) at least think about doing it. (Participant 1)

Researchers have found that clients consider good physiotherapists to be practitioners who give explanations and reasons for treatments (Potter et al., 2003). Perhaps several participants in this study thought that, by clearly explaining to their clients the need to do exercises in rehabilitation, their clients would understand the importance of their exercises in the context of their treatments and would want to perform them. I was surprised that most of the practitioners expressed that, when faced with noncompliant clients, they would provide further information, explanations, or education rather than explore the reasons for noncompliance. Only a few participants talked about asking clients why they did not do their exercises or trying to understand

their clients' experiences that could have contributed to them skipping exercises or not completing their exercise programs (e.g., considering factors such as limited sleep, stress, diet, relationship issues). The few who tried to understand reasons for noncompliance seemed to be taking holistic, rather than reductionist, approaches to treatments. Such client-centred stances are encouraged in numerous commentaries in physiotherapy (e.g., Hargreaves, 1982; Kolt & Andersen, 2004b; Petitpas & Cornelius, 2004), but did not appear to be adopted by all practitioners in the sample.

Creating distance. A couple of physiotherapists talked about asking clients who had not completed their exercises to only book appointments when they had done them. Participant 8 said:

> So, an everyday example might be a patient that [who] was asked to do a range of exercises, didn't do them, came back no better. At which point, I don't get upset anymore. I just say, "Well, this is what you need to do." . . . "Make a time for two or three weeks," for example. "If you haven't done your exercises, postpone it," like, "I don't want to see you until you actually do, because we can't progress you."

This physiotherapist said that he previously felt the pressure to fix clients' problems, but a few years into his practice realised that he could not be responsible for clients' actions outside of sessions. Perhaps asking clients to defer their appointments until they have done their exercises keeps this participant's anxiety at bay. This strategy may also serve as his way of encouraging clients to pursue active rather than passive roles in their rehabilitation experiences. The message that his clients might perceive, however, could be one that relates to punishment. By creating distance the practitioner might be perceived as communicating the following to clients: *I am not interested in you until you exercise. You have been bad; you don't get to see me until you have been good*.

(Re)establishing authority. One participant commented on his experience working with young athletes within a team context. He said he took a hard-line approach with their noncompliance to rehabilitation programs. He stated:

> I think you can't take any of their crap, really. Because a lot of the time they'll try to get out of doing things or they'll try and do an easier option. So probably, you just got to be a bit stronger and just [say], "This is the way we're gonna do it." (Participant 7)

It seems like this practitioner is trying to take control of the rehabilitation process and he comes across as almost like an authoritarian parent-like figure to the young athletes with whom he works. Players seemed to try to take shortcuts in rehabilitation, and perhaps establishing control is the only way that this physiotherapist can get athletes to adhere to their rehabilitation programs. This method seems to contrast the patient- or client-centred approaches that can minimise power differentials between clients and practitioners and encourage collaboration within goal setting and treatment plans (Kolt & Andersen, 2004b). It may be that youth athletes need more guidance from professionals than adult athletes require, but such direction in rehabilitation programs should be delivered (with care) within the parameters of client-centred frameworks.

The majority of subthemes regarding noncompliance seem to reflect a current that flows through the data within this study. Practitioners show their intentions of collaboration using client-centred practices within rehabilitation (through emphasising the importance of active rehabilitation), but still try and work within conflicting medical models of treatment. For example, participants involved clients in their rehabilitation programs through active roles (doing exercises), but they did so in ways that reflected an expert-novice dynamic (e.g., *we will work together, but you have to do what I say*).

When noncompliance occurred, most participants seemed to reiterate why the exercises were important rather than exploring why clients were not doing their exercises. Perhaps this tension is a reflection of practitioners' training. Physiotherapists may have learned collaborative approaches through units in university courses about patient-centred models of practice. Although these models could be touched upon through the course of study and placements, trainees may get dissimilar messages from different supervisors or educators as to which models to adopt. Trainees may internalise their various supervisors' models of practice and refer to them at different times in their own encounters with clients (see Barney & Andersen, 2014 for further discussion). Drawing on their different internal representations and trying to integrate educators' suggestions into a consistent model is possibly difficult and confusing for both practitioners and clients.

Managing long-term injuries. Practitioners shared stories about long-term clients who they had seen either due to a single injury that took several months of recovery (e.g., Achilles' tendon rupture) or several injuries over a prolonged period of time. In the following section, I discuss how participants responded to and managed clients' setbacks and rehabilitation slumps. The clients discussed in this section, although most are from sport contexts, are not all (professional or recreational) athletes.

Setbacks. Practitioners spoke of ways they would help clients who experienced setbacks. Physiotherapists acknowledged clients' pains and frustrations, showed that they cared through nonverbal behaviours (e.g., hand on the shoulder), got second opinions (e.g., referred clients to another physiotherapist or medical practitioner to get further information before they offered diagnoses or prognoses), and were "positive." Participant 8 said:

> Well, sometimes it's simple as just a hand on the shoulder. But, I try . . . and be relatively positive. So, I don't let on too much until I know what's happening, until I've got an idea. And then, even then, I try and be relatively positive and go "This is what we need to do." Just talk about what we need to do on the interim, the short term. Inevitably, the question[s] will come, "When can I? Does this mean? How long?" All those sorts of things. In the early [injury] phases, I just say, "I'm not sure" or, "Let's just see what happens."

Participant 8 appears to show a compassionate and empathic response of reassuring touch and, accompanying his empathy, he seems to want to stay optimistic for his clients by remaining focused on the rehabilitation processes. It could be useful for clients to stay task-oriented while experiencing frustration, anger, or distress because of setbacks. Clients, however, may want to discuss their experiences with a practitioner. If physiotherapists are heavily focused on the task of rehabilitation, they could miss opportunities to talk with clients about their thoughts and feelings (e.g., uncertainties, fears) regarding their experiences during these processes. This participant also appeared to avoid directly answering questions that clients may pose regarding timeframes of their returns to sport. He explained his caution:

> I don't like to give timeframes too soon because it's almost like you're held to that. So you come in, you've rolled an ankle, . . . and you'd ask me, "How long it will be until I can run again?" And, I'll say, "Three weeks." And, then it gets to four weeks, and you're not running. . . . [You might say,] "Well you told me three weeks!" So, I don't – and it's really hard because it's case-by-case dependent – everyone's different. (Participant 8)

Practitioners who avoid giving timeframes can prevent clients setting their expectations on returning to sport in normative time periods and being disappointed

with practitioners for making promises they cannot keep. The uncertainty around timings could be unsettling for clients who desire a timeframe on the likely course of recovery. Perhaps, if practitioners do not already, they could clearly communicate their reasons for not offering timeframes to avoid the potential for clients to interpret their reluctance as incompetency or dishonesty. Other participants said, when they had sufficient information about how long an injury would take to rehabilitate, they would make sure they offered timeframes to athletes. For example, Participant 3 commented:

> If you know it's going to be a really long-term rehab, I think the best thing you can do for someone is be really honest. . . . Sit them down and say, "This is going to be really tough, and this is why I think this will take this long, if it is any quicker I won't hold you back you know, but just be prepared to achieve these points before moving forward, and this is why." (Participant 3)

From this quotation, Participant 3 wants to offer estimated return to sport timeframes for long-term injuries. The explanations she gives about returns to sport seem to allow for setbacks. It appears that physiotherapists, who often see clients more frequently through rehabilitation periods than other service providers, may have to manage the information given to clients by other practitioners (such as surgeons) regarding clients' return-to-sport timeframes. Providing thorough explanations and outlining goals that need to be achieved before returning to sport (e.g., particular physical competencies) seems to clarify the process of rehabilitation for clients and perhaps alter their expectations (influenced also by surgeons' or other medical professionals' opinions) of the speed of their rehabilitation processes.

Practitioners also said they were honest with clients about how difficult they think rehabilitation processes can be, normalised athletes' experiences, and outlined the

frustrations their clients may experience throughout their rehabilitation periods. Participant 3 commented:

> I think if you know there is going to be hiccups, or might be hiccups . . .even going [saying], "This might get really tough, when you get to the stage of being pain free, it's going to be incredibly frustrating, and I know you are going to want to run." . . . So, I guess giving them that permission that when they get there, and they feel completely crap about the situation, that they don't feel bad and that [they know] it is actually really common. . . . You want them to feel like they can say to you, "I'm having a really shit day, and I really want to run, and why is it taking so long?"

The information that this participant shares with her clients seemed to serve several functions. By discussing what her clients may feel like during their rehabilitation periods, Participant 3 shows that she is empathic to her clients' experiences. This information enables clients to *feel felt* (Siegel, 2010) by their physiotherapist when they come to difficult stages of their rehabilitation experiences. It also seems that talking about potential frustrations could normalise clients' experiences and help them understand that the feelings they have at different points in their rehabilitation processes are common. At a neurobiological level, normalising experiences may help reduce fear responses, because such information can help athletes know that other athletes have been challenged, but have overcome similar difficulties. In addition, by sharing information about emotions and frustrations, Participant 3 appears to invite clients to talk about their experiences throughout the rehabilitation process, and, perhaps by showing an empathic response towards their injuries, she sets the tone for an honest and open working relationship.

***Dealing with rehabilitation slumps*.** Participants talked about working with clients who perceived they were not making progress in rehabilitation from long-term injuries. One participant referred clients to their previous accomplishments (recorded in therapists' notes, pain diaries, or activity diaries) to show clients their successes since injury onset. Another practitioner's comments appeared to reflect that her emotional journeys in rehabilitation often followed her athletes' experiences. Participant 3 said:

> You go through it with them you're like, "Yay! Everything's good, everything's going really well, and they're on track, and that must mean that I must be doing a great job!" and you do, you go with them and so when they are not doing well you think, "Ok, so have we pushed them too far? Have we missed something? If it is something about their injury that isn't going well, what might we have missed? And, if it's something not about their injury, do they need a break from rehab?

From this quote, this practitioner seems to ride the rollercoaster of emotion with the athlete. For this physiotherapist, the rehabilitation journey is one experienced by both practitioner and client. Following (or mirroring) her clients' emotions and their experiences, when things are *going well*, appears to reinforce this participant's view of her competency, whereas her clients' lows seem to lead her to doubt her abilities as a physiotherapist. Practitioners may not be able to distance themselves from their clients' experiences especially when they have invested a considerable amount of time working with clients over long rehabilitation periods. Through struggling to develop the "as if" (Rogers, 1957/2007, p. 243) quality of empathy that Rogers discussed (e.g., to feel the clients' discomfort and frustration with the rehabilitation process *as if* it was her own, but not losing the *as if* quality), physiotherapists may overidentify with their athletes' emotional experiences when helping them rehabilitate from long-term injuries.

Enjoyable Relationships

Along with challenging experiences in long-term rehabilitation processes, several practitioners said that their most enjoyable experiences in physiotherapy were treating clients over a prolonged period of time, particularly because they developed deep relationships with clients. One physiotherapist enjoyed working with clients who presented with complex injuries:

> Absolute favourites are probably the ones where you don't always initially know exactly what's going on to start with. So, you've gotta get your head in the book for that person you've got in. So, you commit some of you to it as well and then it's quite fun exploring that with them. . . . But, they're always really great to work with because they're learning with you as well . . . they do your homework as you ask, when you ask. They commit to it. They get great outcomes." (Participant 2)

From this quote, Participant 2 seems to enjoy the rehabilitation process when she and her clients partner together and both invest time and effort into the healing process, form collaborative working alliances, and hone in on the tasks and goals of therapy, as Bordin (1979, 1994) suggested. She seems to prefer when she and her clients learn (and in her case, problem solve) and develop their knowledge as part of the treatment process. Other practitioners said they enjoyed working with clients who were interested in their treatments (e.g., they asked questions), receptive to physiotherapists' treatment ideas, compliant, and affable. Perhaps these preferences reflect the ease with which physiotherapists can work with clients who are similar to them, who respect their authority as professionals, and who want to please them.

Another participant spoke about a deep connection she built with an athlete from diagnosing an injury that several practitioners overlooked. Her client seemed to value and appreciate her competence:

> Everyone had sort of said, "Oh, it's probably just a muscle strain, blah, blah, blah." And I thought, "Oh, crap! I think she's got a fracture," and she did, and we caught it before she would have to have serious intervention, like it was actually a fairly big deal because it was so severe. . . . [So] Picking up something that hopefully has made a really important impact in [her] their life going forward. Yeah, it does create that bond. . . .She's retired from being an athlete, and we're still friends. So, not because of my clinical diagnosis, but probably just . . . the bond that you form through that stuff. (Participant 3)

Participant 3 seemed to experience a sense of confidence from displaying her competence through identifying a serious injury that other professionals had not detected. It appears her competence influenced the relationship she has with her client. The bond that Participant 3 talks about could be formed by the client's gratitude towards Participant 3's consideration of her pain. This physiotherapist, like the psychologists in Study 1, enjoyed it when clients showed their appreciation for her skills. Her enduring relationship with this particular client is a reminder that deep emotional connections can form in injury rehabilitation. The extension of her relationship outside of treatment and into friendship parallels client-practitioner relationships in Andersen's (2004b, 2007) case studies of the client-practitioner encounters of Guillaume and Margaret (see Andersen, 2007), and Evelyn and Miguel (see Andersen, 2004b). The extensive emotional connections within these cases were evident in the various transferential and countertransferential processes that Andersen described; these conscious and unconscious reactions influenced the thoughts, feelings,

and behaviours of both the clients and practitioners. Physiotherapists would benefit from being aware of (a) the influence that their interpersonal connections with clients have on them, and (b) their motivations to continue client-practitioner relationships beyond treatment.

Difficult Clients

Practitioners shared their perceptions of clients, or groups of clients, whom they found difficult to work with and provided examples of how they reacted in these encounters. Several of the stories practitioners told seemed to be consistent with previous research regarding difficult physiotherapy-clients in private practice (i.e., Gordon et al., 2003). Physiotherapists' tales included experiences working with those who seemed to know-it-all, withheld information about injuries, or had psychopathology (or associated symptoms).

Clients who know-it-all. Several physiotherapists spoke of athletes who were demanding in what they wanted from treatment sessions. Such clients had often learned about anatomy and physiology as well as treatment techniques through previous studies or treatments in physiotherapy or related professions (e.g., osteopathy). For example, Participant 6 commented on one athlete who was demanding in sessions:

> She knew so much, and she'd had so much treatment that she kind of directed a lot of the sessions from a hands-on point of view. So . . . she was the one who was like, "Well, I want you to do this," or, "Can you do this?" Rather than letting me sort of direct what I'd like to do in the sessions. So, I remember that being quite unfavourable and, you kind of feel a bit negative towards that person as a whole.

It seems that this participant felt that her client's experiences and assertiveness usurped her expertise. This relationship seemed strained because Participant 6 perceived a

power-struggle with her client over who was directing the treatment. Researchers have suggested that strains in relationships can provide opportunities to develop and strengthen working alliances (Bordin, 1994; Safran et al., 2011). Perhaps by communicating, in a sensitive way, her perceptions and difficulties with being instructed by her client, this practitioner could have reorientated the treatment towards collaboration through agreement in the tasks and goals of their sessions together.

Withholding information. Practitioners worked with athletes who withheld information about, or tried to hide, injuries. In these circumstances, physiotherapists felt considerable pressure to help athletes recover in unrealistic timeframes. I discuss expectations that coaches and players have for physiotherapists to fix athletes further in the section, *Working with Others*. Some athletes withheld information from physiotherapists about treatments they had with other professionals. One participant discussed an athlete who she treated for several years and who was secretly seeing other practitioners for treatment. She said:

> I think that you can get a really good outcome for that person [injured athlete] when you have that rapport, and you have that good relationship, and they know that you'll do anything to help them even if it means referring to someone else, you know. But, I think that also needs to be reciprocal. That's when it works well, [it] is when the person is communicating with you, and if they wanna go and see someone else, great. But, you actually need to know. And, if you don't have that rapport, and so, if someone's jumping around and physio shopping, or seeing different doctors, and having injections, [and] even you don't know about, it's actually really hard to manage someone. But, then, the accountability or responsibility of them getting better they still want that to lie with you. (Participant 3)

From this quote it seems like this participant feels almost betrayed by her client; she has invested in the healing process and relationship and has expectations that the client would be honest with her about his concurrent treatments. She expects clients to honour her trustworthiness and care in their relationship by offering similar qualities in return. Perhaps this practitioner feels that this client's actions undermine her competence as a physiotherapist and his (injury) case manager.

Psychological disorders. Several participants spoke of their difficulties working with clients who they perceived to have psychological disorders. Practitioners did not appear to differentiate psychological disorders from psychological symptoms. Gordon et al. (2003) reported similar findings for physiotherapists in private practice. These results, along with those from the current study, may reflect the limited training physiotherapists receive in psychology and psychopathology.

Some practitioners said that it was difficult to work with patients who seemed depressed and to listen to their emotion-laden stories. Physiotherapists reported that they found it hard to stay positive for their clients and felt "emotionally drained" and "sucked dry" after treating clients who had either depression or severe injuries. It seems that physiotherapists in this study may have identified with their clients' internal states (e.g., pain, depressed mood) and embraced them as their own.

One practitioner reflected on her experiences treating clients with anxiety. She appeared to be aware of the limitations of her training and did not feel competent working with clients who had physical injuries accompanied by anxiety. She said:

> The people who have anxiety as a diagnosed entity [and] that require medication, all that sort of stuff, I struggle with them. Because, physios, we get a lot of training in the schematic body. We know our muscles, tendons, joints. We know that stuff inside out. The psych side of it, we don't have much

> training, we don't have much insight. We can't implement all those sort of strategies to treat that, whereas anxiety does affect our treatment a lot. (Participant 1)

Many injured athletes and nonathletes present with anxiety (and other psychological difficulties) related to their physical injuries and are often more likely to disclose emotionally-laden stories and feel comfortable expressing their emotions with physiotherapists than with other healthcare practitioners. This preference may be due to athletes having more contact with physiotherapists than other professionals during their rehabilitation experiences (Clement & Arvinen-Barrow, 2013). It would be useful for physiotherapists to be trained in managing such disclosures. Perhaps future education programs or professional development courses could equip physiotherapists to support clients and help them manage their psychological difficulties. Such training could benefit both physical and psychological treatment outcomes for physiotherapy clients.

Dealing with difficult clients – referring on. Several practitioners mentioned they referred clients to other physiotherapists when they did not get along, were not compatible, or thought other practitioners could provide better help:

> One of the good things about a practice like this [sport clinic] is that no one is precious about keeping their patients. So, if for any reason you see someone (pause) it just didn't gel either way; or they've got an injury you think that someone else in the clinic will do a better job with; or they're a personality that they'll do a better job with or age, gender, it doesn't matter. The good thing about here [in the clinic] is that we all cross-refer. (Participant 3)

For this physiotherapist, referrals seemed to serve as a strategy to deal with difficult clients by not dealing with them. Reflecting on this process, it made sense to have a speedy referral system that best helped clients' recoveries. Difficult clients, however,

may perceive being referred to another practitioner as not being wanted, particularly if they have been passed on to other practitioners before because they are difficult to work with or care for.

Working with Others

Physiotherapists discussed the difficulties they faced in rehabilitation when working alongside other healthcare professionals or athletic support staff. These problems often influenced the relationships they had with these service providers or their abilities to effectively treat clients.

Managing misdiagnoses. Several participants talked about managing other professionals' misdiagnoses of clients' conditions, and how they communicated such issues with clients. A few physiotherapists were frustrated with doctors or surgeons who overlooked their suggestions for further investigations in complex cases, which either resulted in recoveries that were slower than expected, or led to athletes returning to sport prematurely and, consequently, reinjuring themselves. Participant 3 said, when discussing a case where a GP did not want to investigate a potential abnormality any further, "I felt really frustrated on a personal level, but I felt, to be honest, a bit disrespected that he didn't value enough of my opinion and what I'd given him–the signs–to warrant, at least ruling it out." It seems that power differentials and hierarchical dynamics akin to those seen in medical models of client-practitioner relationships are experienced within practitioner-practitioner relationships. Physiotherapists appeared to feel that doctors or surgeons who did not follow their suggestions for further testing undermined their professional competence and showed limited trust in their judgements. Participants seemed to perceive that these medical practitioners treated them as if they had inferior knowledge and understanding of injuries. Consequently, physiotherapists

who worked in private practices, and who voluntarily made referrals to these professionals, frequently stopped referring to these practitioners.

Fix-it expectations of clients and staff. Participants who worked within sport teams talked about coaches' and athletes' expectations of physiotherapists' abilities to fix injuries quickly. This finding parallels the results of Study 1; sport psychologists said they perceived pressure from athletes and staff to fix clients' psychological problems rapidly. One practitioner in the current study talked about travelling with an athlete, and how, from previous treatment and management of the client's injury, both the coach and athlete expected a similar experience in following competitions. Participant 3 commented:

> So, my first kind of involvement [with the athlete], even though it was a little bit intense–was full on pressure–because it was a good outcome, you leave with a good picture in your mind's eye of how it all went. And, so then the next time something went wrong there was this expectation that like, "Last time you fixed it, so now you can fix everything." And so, I was going away for an extended period of time with the team, [and] there was that same level of on-call intensity and expectation 24 hrs a day, 7 days a week, which was pretty exhausting.

Participant 3's situation was particularly complicated because she did not establish clear service-delivery boundaries during her first trip away with the team. Consequently, both athlete and coach expected her to provide services to the athlete whenever he needed it. This story and other practitioners' experiences could be useful vignettes for novice practitioners to study to help them develop an awareness of their boundaries of service when travelling with teams, and establish clear boundaries early on in their professional relationships with clients.

Many sport physiotherapists practice within multidisciplinary teams in some form or another. Practitioners in this study spoke about their relationships with other professionals to whom they refer clients (e.g., surgeons or GPs), but did not give much information about other practitioners with whom they work within injury rehabilitation. Understanding the relationships and interactions between healthcare professionals within this context could be useful for trainees and qualified practitioners to help them understand effective teamwork in injury rehabilitation. Providing an exemplar of strong collaborative relationships between practitioners could be beneficial for physiotherapists. Such information could accompany researchers' (e.g., Clement & Arvinen-Barrow, 2013) advice on developing effective multidisciplinary teams in injury rehabilitation. In Study 3, I provide two cases studies of practitioners who have worked together in sport injury rehabilitation for over a decade.

Summary

Within Chapter 4, I presented themes developed from interviews with 9 physiotherapists about their relationships with injured athletes. Participants' experiences of formal training in relationship building differed; some recalled having little or no training, and others said they received training in ethics, awareness of nonverbal behaviours, and proxemics. Physiotherapists also differed in their perceptions of the utility of this training, but the majority of participants said they learned more about client-practitioner relationships on placement than in formal training sessions. Most physiotherapists' initial relationship experiences with clients were anxiety provoking, and the majority found their first encounters with sport injury clients to be particularly daunting. Also, in these initial relationships with clients, physiotherapists had high expectations of their abilities to *fix* clients. Some participants stated that their helper roles in client-practitioner relationships changed over time from idealistic to realistic.

Physiotherapists, like the psychologists in Study 1, showed little understanding of the motivations or needs they brought into their client-practitioner relationships and how these factors may influence interactions with injured clients.

Physiotherapists had various reasons for spending time building relationships with injured clients, but many focused on getting clients to trust in their processes within treatments. Participants said they listened (but not necessarily acted on) clients' expectations of treatments and disclosed personal information to build rapport. Some professionals seemed to use relationship skills in ways that may have been detrimental or confusing for clients. These skills included practitioners masking their limited confidence, being both empathetic and judgemental, and making simplistic categorisations about clients based on limited understanding of personality.

Physiotherapists had different views on the social boundaries within client-practitioner relationships. Some discussed facing challenging circumstances because they had not established, or found it difficult to establish, clear boundaries or roles (e.g., when travelling with injured athletes). Others were confident in their abilities to maintain relationship boundaries from many years of experience working within teams.

Participants discussed how they managed the various relationships and situations they encountered when working with injured clients. In particular, when faced with noncompliant clients, professionals educated clients on the importance of active participation in recovery, punished them through creating distance, or re-established authority in the client-practitioner relationship. When working with clients with long-term injuries, physiotherapists comforted athletes who experienced setbacks, varied in the information they shared about return-to-sport timeframes, and some mirrored the emotions of their injured athletes throughout rehabilitation processes.

Physiotherapists reported that they enjoyed working with injured athletes with whom they could partner in rehabilitation processes and disliked working with clients who were directive and appeared to *know-it-all* in treatments. These professionals encountered problems with coaches and support staff who had unrealistic expectations of physiotherapists' services in injury rehabilitation. Physiotherapists also discussed difficulties working with clients who withheld information about injuries or other (previous or ongoing) medical treatments. Several participants said they referred difficult clients onto other practitioners. Further discussion of the results from Study 2, and how these findings relate to those from Study 1 and Study 3, can be found in Chapter 6.

CHAPTER 5

STUDY 3: PRACTITIONERS WORKING TOGETHER IN SPORT INJURY REHABILITATION

The results from Study 1 and Study 2 indicate that physiotherapists and psychologists typically experience both challenges and successes in their relationships with injured athlete-clients. Several of the participants' difficulties related to working with other professionals in injury rehabilitation settings. Participants in both Study 1 and Study 2 expressed that the expectations of others, such as performance directors, multidisciplinary staff members, coaches, and other athletes, influenced the quality of the relationships they had with clients. In Study 1, psychologists mentioned they were often marginalised within support teams, and other staff members appeared to have unrealistic expectations of their abilities to *fix* athletes' injuries quickly. Consequently, practitioners expressed frustration at having little time to develop rapport with athletes and felt that referrals from other support staff were later than necessary. Accordingly, these late referrals limited psychologists' effectiveness in helping their clients. Furthermore, in Study 1, several psychologists mentioned the difficulty of working within support teams in which some staff members did not respect the boundaries of confidentiality regarding information communicated between psychologists and athletes. For example, some professionals expected information that athletes had shared with psychologists to be readily available to them.

Participants in Study 2 had diverse referral networks, and some frequently referred clients to other professionals. Several physiotherapists said they had stopped referring clients to practitioners who misdiagnosed their clients or overlooked their concerns for clients' conditions to the detriment of their clients' health.

In the third study, I investigated what interprofessional collaboration in injury rehabilitation can look like as a means to assist practitioners to navigate multidisciplinary environments and appreciate the potential advantages of collaborative relationships. The aims of Study 3 were to explore the professional relationship between a physiotherapist and psychologist who have worked together with injured athletes over a prolonged period and to understand how this alliance influenced relationships and treatments with shared clients. By exploring their interpersonal backgrounds, relationship development, influence on and support for each other's practices, and perspectives on client-practitioner/practitioner-practitioner relationships, my aim was to provide a representation of an exemplary collaborative professional relationship in sport injury rehabilitation. In this chapter, I present two practitioners' stories of their relationship as case studies and discuss them in view of the neuroscience of (therapeutic) relationships, interpersonal mindfulness, and research on interprofessional collaboration.

Method

Participants

I asked a sport psychologist (with 12 years' experience) and a sport physiotherapist (with 23 years' experience) within Australia to participate in the study. At the time of the interviews, the two practitioners had been working together for 12 years. Both participants have had extensive experience working with elite athletes in sport injury rehabilitation through various sporting organisations and their own private practices. These practitioners did not take part in Study 1 or Study 2.

Procedure

Recruitment. Victoria University's Faculty of Arts, Education, and Human Development Human Research and Ethics Committee approved the study. Following

this approval, I asked a psychologist who has trained many sport psychologists in the Melbourne metropolitan area whether he knew of any sport psychologists who worked closely with sport physiotherapists. The psychologist introduced me to Jane (pseudonym), a psychologist, whom he thought might be interested in my research. Jane appeared enthusiastic about my study, and she requested written information (see Appendix I). Subsequently, Jane agreed to participate, and also discussed a colleague who might be interested in my study. Following Jane's recommendation, I then contacted Anna (pseudonym; see Appendix I), a physiotherapist, who was interested in the study, and she agreed to take part.

Interviews. Both practitioners chose to be interviewed (individually) at their work environments. At the beginning of each interview, I gave the participants opportunities to ask any questions before they provided written and verbal consent to participate. I commenced with questions about how they became involved in their professions and followed with requests for information about their collaboration. I asked for stories regarding the development of their professional relationship, the interactions they have with each other, and their treatments with shared clients. I used elaboration and clarification probes and made further requests for information to deepen my understanding of their experiences and the tales they shared with me. The interview with Jane lasted 85 minutes, and the interview with Anna lasted 108 minutes. After the interviews concluded, I thanked the participants for their time and reminded them of the opportunity to discuss the interview content with a registered psychologist identified on the information sheet (see Appendix I).

The interview guides. The guides for the interviews with the sport psychologist and sport physiotherapist differed (see Appendices K and L). Two registered (sport) psychologists reviewed each interview guide to see whether the topics were suitably

aligned with the research questions and, where necessary, to suggest modifications to questions to elicit deeper responses than my original approaches. Both psychologists are experts in sport injury rehabilitation. These practitioners had worked with injured athletes and published academic book chapters and research articles on relationships within healthcare professions, including physiotherapy. I based the guides on the results from Studies 1 and 2, and, after I interviewed Jane, I adapted some questions from the initial guide to use in the interview with Anna. For example, I had 35 questions in the interview guide for Anna (see Appendix L) compared to 18 questions when interviewing Jane (see Appendix K). There are two reasons for the increase in number of questions I asked Anna, whom I interviewed after Jane. First, I had previously met Jane, and I knew I would have little trouble getting to talk in detail about her experiences working with Anna. Due to my confidence in Jane's ability to lead me in conversation, I developed general questions that could direct Jane towards thorough answers that would be supported by my use of effective questions for elaboration and clarification purposes. I knew that, being unfamiliar with Anna, I might require more detailed queries to elicit information than I needed for Jane. Second, from my interview with Jane, I was aware of a variety of themes and questions that I wanted to ask Anna. Consequently, I developed 17 additional questions to ask Anna as well as refining several of the previous questions I had asked Jane. New questions included specific requests about their collaboration as well as issues Anna might have encountered working with Jane. For example, I included queries such as, What would you say are your boundaries of practice? Is there any overlap with Jane? And, Have there been any issues in communication when working with Jane? Despite the difference in the interview guides, in both interviews I followed the participants and gave them space to tell their stories.

Data Analysis

After the audio file for each interview was transcribed verbatim, I began interpretative phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009). IPA is a methodological stance on gathering, reading, and representing (normally) interview data with a focus on understanding individuals' experiences and how they perceive and talk about objects and events (Smith & Eatough, 2006; Smith & Osborn, 2008). When using IPA, researchers describe participants' stories and experiences in detail and offer interpretations of individuals' tales. Smith (2004) stated that the goals of IPA are twofold: (a) for the participant "to make sense of their personal and social world" (p. 40), and (b) for the researcher "to make sense of the participant trying to make sense of their personal and social world." (p. 40).

The principles of IPA are based on the work of philosophers Heidegger (1962) and Husserl (1999). Both of these thinkers advocated alternative perspectives of knowledge to positivist paradigms based in phenomenology, hence the name. Papathomas (2011) suggested that Husserl and Heidegger thought, "an individual's personal reality should be accessed through first person accounts of lived experience." (p. 50). IPA, therefore, involves understanding and representing personal experiences rather than objective statements of people and events (Smith & Osborn, 2008). As a researcher, my aim was to immerse myself in the participants' worlds as much as possible through familiarity with their stories and the intended meanings of their words, phrases, and tales.

There is no one correct way of doing IPA. Researchers (e.g., Smith et al., 2009; Smith & Osborn, 2008) have proposed several practices that can be used in the analytic process. For example, Smith et al. (2009) have encouraged researchers to be innovative in the ways they conduct their analyses, and Smith and Osborn (2008) have suggested

that analysis is a personal procedure because the interpretation involves the researchers' interactions with the data throughout the process. The techniques I used within my analyses are similar to those Smith et al. and Smith and Osborn identified.

The interviews were transcribed as soon as was practically possible, which enabled me to read the transcripts quickly after the conversations so that my analyses could be rooted within the participants' stories, as told by them. I read the texts to check the accuracy of the transcription process and then re-read the transcripts to develop familiarity with the data and to gain impressions of the stories as whole units. I added annotations representing the initial themes to paper copies of the transcripts and concurrently highlighted areas that were of particular relevance to the research questions. I also made several comments regarding Anna and Jane's responses and detailed my thoughts about the content and tone of their answers. I re-read the transcripts, considered my annotations, and formulated the initial comments and notes into conceptual themes through inductive analyses. I also conducted deductive analyses by considering several theories, frameworks, and concepts associated with human relationships and practitioner development, including the work of Cozolino (2010, 2014) and Siegel (2010). These authors have brought together the neuroscience of psychotherapy, interpersonal mindfulness, and a comprehensive theory of human relationships (i.e., psychodynamic theory) in their discussions on human (specifically client-practitioner) relationships. These frameworks are foundational to any study of the interpersonal dynamics of the helping professions, and two of them, interpersonal mindfulness and neuroscience, are revolutionising how we understand therapeutic processes in medicine, psychotherapy, social work, occupational therapy, and beyond. I wrote a narrative account of the interplay between my interpretative activity with the

data and the participants' accounts of their experiences within injury rehabilitation by reviewing and interpreting Anna and Jane's stories through these lenses.

Research Credibility

The researcher. Details regarding the researcher are identical to those outlined for Study 1 (see pages 66-68).

Trustworthiness procedures. The processes (interview training, pilot interviews, member-checking, and peer-review methods) for Study 3 were similar to those described in Study 1 (see pages 68-70) and also used in Study 2. I used several additional procedures in relation to interview training that enhanced the credibility and the quality of the interviews in Study 3.

Interview training. I gained over 30 hours of individual interview experience from conversations in Study 1 and Study 2. My reflective log of the interviews and the discussions and debrief sessions with my supervisors in Study 1 and Study 2 enhanced my understanding of myself as an instrument of qualitative research within rehabilitation settings. Furthermore, by the time I started collecting data for Study 3, I had developed my knowledge of interpersonal neurobiology and skills in neuropsychotherapy (an approach to talking therapy informed by principles of neuroscience; Rossouw, 2014), which enhanced the interpersonal skills I used in the interviews in Study 3. I attended two professional development courses on neuropsychotherapy (18 hours in total), and I was able to practice and gain feedback from role-plays, in which I used my relationship building skills. Consequently, in Study 3, I felt I was a more competent researcher than when I began Study 1, and this confidence helped me feel connected, on an interpersonal level, with the two participants. My experience, confidence, and presence with Anna and Jane in the

interviews may have helped them disclose details in their personal stories that otherwise may not have been shared with me.

My supervisors acted as critical friends throughout the interview and analysis processes. I was able to discuss and debrief about my experiences with my (first) principal supervisor in our regular weekly meetings. This activity of reflection and discussion gave me opportunities for doing preliminary data analysis, developing further questions, evaluating my interviewing techniques, examining my reflective log, and exploring my researcher-participant relationships.

Similar to Study 1 and Study 2, I adapted the content of the participants' stories to minimise the chance that Anna or Jane would be identified through their stories. I altered many details such as sports, illnesses, and injuries, to reduce this risk and to maintain coherent tales.

Jane's Story

"Ah, well, there's all sorts of real health benefits to me and to Anna of . . . having a good, trusting professional relationship. Yeah, I don't want to live out here all by myself."

Jane

Jane's Interpersonal History

Jane grew up on a farm. Her parents, particularly her mother, were welcoming and gave time and energy to people in need who lived in her area. Jane seemed to readily adopt her mother's model and regularly assisted her friends. She appeared to prioritise people and relationships in her life, at times, to her detriment. For example, she would often spend hours talking with friends at her kitchen table and then have to rush to complete her cycling training.

Jane had competed extensively as a professional cyclist and worked as a cycling coach. During her time competing, Jane crashed and sustained a spiral fracture in her femur that required several surgical procedures. She was in rehabilitation for a year before it was apparent she would not return to her sport. While in rehabilitation, Jane decided to enrol at university and study to become a psychologist. She took psychology and philosophy as her majors in her undergraduate degree and then completed a master's degree in applied psychology, specialising in sport psychology. During her initial time at university, she encountered difficulties adjusting from being a professional athlete and coach to becoming a student who coached as a means to pay for university. Feeling that her body was struggling to adjust to university life (e.g., she found it difficult sitting for long periods of time) and sensing the loss of athletic identity, she sought help from a psychologist who she consulted throughout her time at university.

Jane's psychologist apparently had an existential framework. During their sessions, Jane explored her identity and tried to answer deep questions she had as a consequence of retiring from cycling. Jane's encounter with her psychologist seemed to be influential in how she approached her clients and has shaped the framework she uses as a practitioner. Jane said she frequently explores existential questions with clients and colleagues. Jane also conveyed how her choice to study philosophy with psychology has helped fashion her thoughts about relationships. She said:

> That [philosophy] probably had a really big influence on me . . . on how I see people, because, I see people in a context. So, from a systems point of view, it's all about the interrelationships with all those different parts. And . . . when we have a lot of information flow, systems tend to be healthier. Closed systems tend to be unhealthy. So, I've got a systems perspective that everything sits in.

Jane contrasted her systems standpoint with the one she was offered in mainstream psychology. She was frustrated that, in the majority of psychology she encountered within her studies at university, the unit of analysis was often at the level of the individual rather than the individual within a context. Jane's adoption of a systems perspective is telling of her desire to understand and support people holistically and influences the way she works with other professionals. One particular example of Jane's approach is her collaborative relationship with a physiotherapist, Anna.

When Jane met Anna: Working in a Multidisciplinary Team

Jane encountered Anna when she joined the multidisciplinary team at a local elite athletics club. Anna had several years' experience working at the club before Jane joined, and Jane's arrival at the club coincided with a weeklong trip away with the team and support staff for a competition. During their trip, the support staff lived together and started to develop quality relationships. Jane said, "We formed quite a close-knit group

of professionals, so there was the massage therapist, the physiologist, the high performance manager, the coaches, the athletes obviously; [we] were all sort of in [it] together working towards excellence."

When Jane arrived at the club, other professionals like Anna were supporting athletes in ways that seemed to be within a psychologist's remit. She thought that the perceived overlap related to the difference in her approach to psychology service provision and working with others compared to the previous psychologist employed at the club. Support staff explained to Jane that the other psychologist aligned himself with the coach and did not integrate well with the sport science support team. Perhaps other staff members were helping athletes in ways (i.e., unofficial lay-counselling roles) that otherwise would have been performed by a psychologist. Jane recalled the initial problems she encountered when she entered the team:

> I suppose initially there was a little bit of bumping into each other professionally because they've been used to doing lots of mummy-type support, and there seemed to be a little bit of competition about who loved who the most. That was my observation . . . they [the support staff] were all loving that [attention and support] for their own little selves . . . whether you want to say it's ego or just everyone loves to be loved, and . . . so of course, when I walked in where that was sort of gonna be my role, there was a little bit of discomfort, but I just sort of cruised through – I didn't say anything initially.

Jane appeared to pick up some transference and countertransference between athletes and the support staff. She first built rapport with her colleagues before she addressed these dynamics. She valued the importance of hanging out with her colleagues, getting to know them, and understanding the context in which they were working. Soon enough, practitioners opened up to her about their problems and wanted

to use her expertise. She felt comfortable, once her relationships with the other practitioners were strong, to delicately address the boundary issues that she had noticed:

> Initially, I mean, I was the new kid on the block, and so I had to do a lot of just hanging out with the other professionals, being really respectful, answering questions. They had lots and lots of questions, and then, gradually, we could have those more difficult conversations, particularly when I thought there were boundary issues, whether it's stepping out of their expertise, a physio, or a massage therapist, or whatever [whoever it] be and really [delving] in to some dangerous area of giving advice without probably that being helpful.

To illustrate her point, Jane told me about an incident that happened early on in her time at the club when one member of staff found herself out of her depth with an athlete who became suicidal on a competition trip. Jane had spoken to the practitioner about the importance of setting boundaries; she appeared to pick up that this individual, and other professionals, had close relationships with some athletes, and she explained in psychodynamic terms that they seemed to be acting "mommy-daughter, best-friendy." The particular member of staff chose not to act on Jane's recommendations, and ended up in a distressing situation that required Jane's professional assistance. This incident seemed to be a formative experience for not only this practitioner, but also for the support team, which helped them develop clearer professional boundaries and systems for referral:

> So, in a way, it was through sort of the odd little crisis that opened the door for those conversations about . . . professional boundaries . . . there's a friendly camaraderie, but at some point, you don't go beyond that. We actually said, "Oh, it might be a good idea if you talked to Jane about that." And so, developing the language around referral within the team, when I walked into a

> team that wasn't used to having . . . a psych or (pause) but, that evolved, and I was really respectful about their expertise. And, over time, they became more respectful about mine.

After this particular incident, Jane found that support staff, such as Anna, would refer their athletes to her and would ask advice on their relationships and interactions with other members of staff or athletes. Jane's care for the people in her team was apparent in the way they viewed her support:

> I think they found that I was calm; I was logical. I'm safe to be with, and I think that [is] really important, being safe. I then became a nice stable energy when the coaches were losing it and a stable energy when they all are losing it.

Jane seemed to help colleagues look at the interpersonal situations that they found themselves in and support them in understanding their motivations behind their actions. Jane first built solid relationships with her colleagues before she felt she could call them up on difficult interpersonal issues. Jane seemed to be influencing the culture of the team; practitioners wanted to understand how to be effective within their roles and called on her interpersonal expertise to help them. Jane developed a close and collaborative relationship with one professional within the team during this time – Anna.

Working with Anna

Jane had been working with Anna for 12 years, and they frequently referred clients to each other and worked collaboratively with athletes in rehabilitation. Jane talked intimately about her relationship with Anna; she spoke about what she enjoyed, what she found difficult, and how they worked together towards athletes' recoveries.

Jane and Anna would often see their shared clients independently, but they talked frequently about clients and their treatments. Given that, in Study 1,

multidisciplinary staff members often expected psychologists to share more information than they felt comfortable disclosing, I was curious to know how Jane and Anna figured out what information to share with each other while still respecting confidentiality agreements. Jane said that she would always ask clients what would be okay to share with Anna, and it seemed that Anna understood and appreciated the confidentiality agreements Jane had with athletes:

> Anna would tell me things, but she has no expectation that I'm going to give out any information that's not necessary for her part of the process. So, she might say, "Look, I'm just concerned about so and so, now don't tell me anything, but I'm just letting you know. Is there anything I need to know in relation to what I'm doing here?"

Jane provided an example of how their information sharing worked in practice. Both Jane and Anna were helping an athlete rehabilitate who had shoulder surgery and was anxious about whether the rehabilitation process would get his shoulder and arm functioning well. Jane was aware that this athlete would react strongly to any uncertainty regarding the recovery of his injured joint. Jane spoke to both Anna and a medical practitioner, who was also involved in the athlete's rehabilitation, to help them develop a consistent approach to the language they used in treatment. Jane suggested words and phrases that they would use in sessions to help the athlete feel confident:

> We have an athlete that tends to worry a lot about an injury. . . . We know that the language that Anna will need to use is, "Yep, this is going really well" because he would absolutely grab on to any, absolutely any, possibility for it not to get [better]. . . . So, we have to be really all on the same page.

Jane also spoke about the value of supporting Anna's work with athletes and her sessions with them. By having an understanding, through communicating with the client

and with Anna, of what exercises athletes were supposed to be doing, Jane had a clear picture of athletes' rehabilitation programs. She checked in with athletes' compliance levels and helped them maintain their motivation. Jane supported Anna's work by developing an understanding of the mechanics of the exercises. This knowledge enabled Jane to provide explanations and reminders to clients of the purpose and importance of their physical exercises within their psychology sessions. Jane discussed a client she shared with Anna. He was the athlete mentioned above who had a shoulder reconstruction. Often before major competitions, this athlete's shoulder would flare up due to increased general tension in the muscles around his shoulders. She said she could support Anna's work by:

> Having a deep enough knowledge of the mechanics of what work he's needing to do that she set . . . and what impact it's gonna have in the future on performance. And . . . of course my knowledge of how we all hate rehab and how we actually do it anyway, and how we can keep [athletes] self-motivated to keep them doing [it], even when we [they] don't like it. So, you can see how those things marry beautifully together. Because, one of the biggest issues, as far as I can see, for physios, is people don't do the exercises, probably . . . no different to psychologists [and] people not doing their homework.

Jane mentioned the benefits of Anna supporting her work with athletes. Anna reinforced Jane's efforts by reiterating how important psychological areas were, such as checking whether clients had been doing psychological homework, asking clients whether they had spoken to Jane about issues that they brought up, or helping clients do psychological and behavioural exercises. For the athlete who had the shoulder reconstruction, Jane said that Anna reinforced relaxation techniques that would help him prepare for competition:

> The work that Anna and I did together was both of us backing each other up on the importance of continuing all the more boring parts of maintaining a bunch of rehab [exercises] . . . but, also teaching him how to, coming through mainly progressive muscle relaxation, . . . be more aware earlier of when he was getting too much muscle tone than needed and changing the force to be put through the shoulders in the last part of the preparation before a major competition.

Jane said that regular communication about their clients facilitated their collaborative efforts in injury rehabilitation. They frequently discussed clients, and, if they encountered any difficulties within athletes' rehabilitation periods, they would try to find solutions together:

> If we can't work something out, if something isn't making sense, if somebody is not progressing the way that they [should be] . . . we just brainstorm. We'll try and nut out what needs to be happening that isn't happening, what is happening that doesn't need to be happening, [and] what are we not quite getting right in helping this person move to the next point.

Jane and Anna learned, developed, and tackled cases together. Anna's openness to learning and discovery is a trait that Jane respected. She identified that both she and Anna are interested in accessing the latest literature and continually developing as professionals. Sharing a focus on continual learning and growth are part of how Jane and Anna support each other in their pursuits of professional and self-development through difficult and honest conversations:

> I think what's quite nice is we can have critical frank conversations. So, if we didn't think something was quite right, we could both say it without fear of offense . . . and I think that's . . . been, I'd say, it's been a hallmark of our relationship right since back in 2003, 2002. . . . A decade of really having some

> difficult conversations at times, which requires a high level of trust and each other's goodwill and . . . motivation.

Jane offered me a story that explained her point. When Anna and Jane worked at the athletics club, Jane noticed that some older male athletes were giving Anna attention, and Anna was responding to what appeared to be the athletes' erotic transferences. Jane told Anna what she saw and explained the dynamics of the situation, as she perceived it. Reflecting on that conversation Jane said, "If we didn't have a high level of trust that'd be really insulting to say, potentially." Jane and Anna have a deep, mutual trust that enables them to point out each other's mistakes. I wondered how difficult it was for Anna to have Jane pinpointing her interpersonal issues. Jane told me the relationship was reciprocal; Anna identified Jane's interpersonal problems, or areas in which she thought Jane could better manage herself as a professional. Jane shared how it felt when Anna brought up some concerns with her:

> I think both of us . . . actually want to be really good at what we do, and we don't want to be deluded. So, . . . it stings because obviously you don't want to be getting things wrong, [but] I think that that's far outweighed by the desire to know about what needs to be improved.

Jane's trust in Anna to point out her weaknesses and help her develop as a professional went beyond her trust in her as an excellent practitioner. Jane told me that she also respects Anna's character and how she cares for clients:

> Anna is unbelievably fastidious, great diagnostician. Look . . . I wouldn't have [the] relationship with her that I do if she wasn't a good physio. I might have a friendship with her outside of [work], but I wouldn't refer anyone to her unless I thought she was excellent. . . . I have a very, very high regard for her expertise and her commitment. I suppose, if you looked at the three Cs, she has

> commitment; she has competence, and she has character. . . . I like people to have the character part, [that] is really important. Because, that character is ethics; it's putting the client first; it's honesty; it's professional integrity, and it's respecting other people's expertise.

Jane and Anna seemed to be on the same page; they valued their relationship and that they could work together closely to provide the best rehabilitation experience possible for their clients. Jane appeared comfortable with identifying Anna's difficult interpersonal issues, and (in return) Jane was happy for Anna to point out her weaknesses. They seemed to trust each other to respectfully address concerns in ways that helped them develop as people and professionals. As the interview with Jane came to a close she said, "Ah, well, there's all sorts of real health benefits to me and to Anna of . . . having a good trusting professional relationship. Yeah, I don't want to live out here all by myself." Anna and Jane's collegial relationship seemed to provide social interaction and support that Jane might not receive from others within the team. Being the psychologist, Jane would be part of the team, but not one of them. She cared for the team's psychological health throughout trips away, and having an ally in Anna was a critical support in what could be a lonely place for a psychologist.

Anna's Story

"I think maybe physios just don't have any idea of what sport psychologists can do or how they can help with the management of a patient"

Anna

Entering (Sport) Physiotherapy

Anna became interested in physiotherapy at a young age after receiving treatment from physiotherapists for sport and other injuries during her childhood. Anna participated in physiotherapy work experience in her school years and was motivated to pursue physiotherapy as a career. After completing her degree in physiotherapy, Anna gained employment in a public hospital and worked on outpatient rotations. This position was an ideal opportunity for Anna to gain more one-on-one time with clients compared with what other posts, such as inpatient (hospital ward) work, would allow; Anna enjoyed having quality time with people. Anna then worked abroad for a year, and, upon returning, she began working within a private practice associated with a professional sport club. This opportunity started Anna's journey into sport physiotherapy. She said that her work in sport has grown organically. Anna now runs her own private practice, and she estimated that 80% of her clients are athletes.

Anna's Approach to Practice

When I called Anna to discuss the study, she told me that several clients have told her that she is different to other physiotherapists, and I was intrigued to know why. In our interview, she said she is self-employed and sees one client at a time. She told me that clients have had experiences of being one of three or four people seen by a physiotherapist simultaneously. Anna explained why she does not work using a multiclient model and instead sees clients individually:

> That's [multiclient model] just an awful way to work from a stress point of view and from a conscience point of view. And always watching the clock . . . that was for me, unpleasant, but now . . . the person walks in, and then it's their time. I know there're no distractions, and it's just really focusing on what they're doing in their exercises, and how they move, and having the time to really assess properly, and listen to them. . . . So, I can be more present when I'm working with the people.

It was clear that in previous work environments Anna had been dissatisfied with the care she could give her clients. Anna wanted to give her full attention to her clients and focus on meeting their needs rather than rushing through their sessions and exercises. Working for herself, she could care for her clients in the manner that she would prefer to be treated. It seemed important to Anna that her clients felt heard and understood within her sessions, not just physically treated. She said:

> So, that's important to me as a physio that they feel that at least someone gets it [someone understands their pain, or frustration, or sadness], and I may not be able to always help them, but if they feel . . . that I get it, that I've listened to it, that's a big deal.

Anna appeared to have a holistic approach to treatment that involved listening to her clients and recognising their pain and hurt. She also had an adaptable style of practice in which she treated people as individuals, was flexible in her approach to clients, and took into account each client's personality. She further clarified her flexible and responsive (not prescriptive) approach to her clients, "So, it's sort of a fly-by-the-seat-of-your-pants [approach] really." Anna seemed to adapt to be the physiotherapist who she perceived her clients' needed her to be.

I asked whether Anna had any formal training in rapport building or establishing therapeutic relationships. She recalled that during her time at university she learned about some aspects of psychology (e.g., the stages of grieving, internal and external locus of control). Anna spoke about her awareness of having minimal training in psychology or having skills that psychologists have. She also had clear ideas about when she would refer clients to psychologists, such as when clients were showing signs of stress, when they were not coping well with injury, or when they might benefit from talking through their successes. She appeared to have functional clarity in regards to her boundaries of competence as a physiotherapist. It became apparent as we spoke that some of her appreciation of her parameters of practice came from a difficult, yet pivotal, experience with a client, in which she had assistance from Jane. This incident occurred not long after Jane and Anna met.

Anna Meets Jane

Anna did not expect to work closely with Jane when Jane arrived at the club. Anna had not worked closely with a sport psychologist before. Anna recalled when Jane started at the club, and Anna spoke about the same weeklong trip that Jane discussed when the whole athletics team (including staff members) went away for a competition. Before she went into the details of the trip she said, “It still makes me feel tense even thinking about it now.” I quickly realised that Anna was the professional Jane talked about in her version of events. Anna told me that she thought the club was “pretty unprofessional” back in the days of her trip because she had to share a room with two athletes. One night she woke up to one of the athletes crying hysterically. Anna went over to the athlete and comforted her. They went downstairs to talk, and the distressed athlete told Anna that she had been physically abused. Anna recalled, “She was just sobbing, and I was just holding her, and I’d just felt completely out of my depth.”

Unbeknown to Anna, Jane had been speaking to the athlete and keeping an eye on her during the team's time away. Anna, not knowing what to do, called Jane and asked for advice, particularly because the athlete was in an unstable state. She recollected:

> I was out of my depth because the athlete started saying things to me like, "If you go out, I might do something to myself." She was really quite bad. So, I was talking, and Jane was giving me some advice. . . . And then, it all sort of worked out, and nothing bad happened. Yeah. So, it was very good having some sport psych support there.

After the incident, Anna was highly critical of herself. She frequently questioned her judgement and wondered whether she should have done things differently. Anna said:

> I thought I didn't handle it very well, and, as a professional, I could've kept my distance more. But, then I was thinking, "God! I was there in the room. What am I supposed to do? Ignore someone who was crying hysterically?" (Pause) Because that's not [right]. (Pause) I don't see that as my role as a team physio, but as a human.

Anna clearly valued and appreciated Jane's advice during and after the incident. This event was the impetus to open the door for conversations between Anna and Jane about managing difficult clients, developing an awareness of boundaries of competence, and understanding relationship dynamics. This event marked the start of Anna and Jane's collaborative collegial relationship.

Working With, and Learning From, Jane

Anna enjoyed spending time with Jane and other female support staff stating, "It was good . . . to have that female support too when you're in a male-dominated environment." Anna mentioned that there was sexism within the team; coaches would make remarks to her such as, "I wish you weren't married," and she spoke of one male

athlete she treated who used to hit on her "all the time." Anna had several conversations with Jane about how to deal with coaches and athletes who were flirtatious. Together they came up with ideas of what Anna could say in response to these comments. For example, Anna told me what she had said to the athlete who would hit on her frequently:

> The thing that really worked best with him was when I said to him, "John, every time you say something like that I don't know if you're coming to see me because I'm a good physio or because you're trying to get me to go out with you. And, I feel really bad with this." . . . He was better after that.

Anna continued by explaining how conversations with Jane helped her understand the interpersonal dynamics in the team and deal with the aforementioned flirtatious athlete and other difficult or sexist male staff:

> I think that was probably the first time we started discussing the power differential and that he [the athlete] regained power by making [it] into something, sort of, [with] sexual connotations. . . . That was good to learn, because I've noticed that with [my] dealings with coaches . . . You'll be talking about an injury, and they'll say something flirtatious, and you have to try and get them back on track.

Anna mentioned she still has issues with a particular coach, but she manages her relationship with him effectively by working with Jane. She indicated, "So, it's [discussions with Jane] helped me in working out how to deal with him best."

Anna's work with Jane to understand interpersonal interactions did not stop at managing the dynamics with flirtatious athletes. Jane helped her become aware of and learn "a lot about the power differential in the patient-physio relationship." Anna stated, "We don't learn anything about that at uni." She commented that she understood that

physiotherapists can be in positions of power, and they can misuse their influence to control athletes. Anna and Jane had explored the management and balance of the power dynamics between clients and therapists together, along with the motivations and desires professionals can have for working with athletes. Anna told me that Jane, over time, had helped her to see that practitioners who take credit for athletes' performances can be fulfilling their own needs and self-gratifying desires and potentially abusing the power differentials between them and their clients. She commented:

> I've seen other health professionals, usually strength and conditioning people, I must say, take the credit for the athletes, or the coach taking credit for the athlete's performance. And, it's all about them. And so, Jane [has] sort of helped me get a better understanding of that over the years.

I was about to ask Anna how she applied the knowledge she had developed from working with Jane when she told me about a conversation she had with an athlete on the morning of our interview. He had come into the session and shared with Anna that he had achieved a personal best over the weekend, and he attributed his success to Anna's intervention. Anna said to him, "It's got nothing to do with me. I'm a part of this process, but you've done the work." It seemed that Anna denied her helpfulness to try and limit the athlete's dependency on her and foster his autonomy. In her reaction, however, she seems to refuse his compliment and declaration of his appreciation of her knowledge, expertise, and care. It appeared that she was trying to avoid coming across like some of her clients' coaches who take credit for their athletes' performances.

Anna learned through her discussions with Jane how the language she used could influence the clients with whom she works. Together, the practitioners would come up with common words or phrases to say to an injured athlete, often to minimise the performer's anxiety about the rehabilitation process and treatment outcomes. Anna

gave me the same example as Jane had given to illustrate their use of a shared language. She explained that a javelin-thrower, who had an operation to stabilise his shoulder, had previously seen a physiotherapist who would say things like, "Your shoulder's slipping" to describe her concern of excess movement in his shoulder joint. Anna talked about her understanding of how an athlete could perceive such a statement and that she and Jane would use different words compared to the other physiotherapist:

> So, I would never, ever use that word. . . . Rather than *slipping* . . . I['d] say things like, "We need to improve the control here." So, as opposed to pathological, [shifting] more to [the] proactive, *improve the control*. So, a big difference, I believe, in the psychology of it all. "I don't have good control. I can improve my control." Versus, "My shoulder's slipping. Something's structurally wrong; I can't do anything about it."

Anna developed her awareness of, and sensitivity to, the influence language could have on people's perceptions from checking in with Jane about what she was saying to clients, getting feedback from her, and adjusting her words and phrases where necessary. Her own experiences as a patient also appeared to have contributed to Anna's understanding and her careful use of her words when with clients. Anna was diagnosed with an ovarian cyst, had surgery, and gained a serious infection. After a week of treatment, a doctor said to her, "I'm worried that your cyst is resistant to the treatment we've given you." Anna spent a couple of weeks processing this comment. She appeared frustrated at the language the doctor used, which sounded insensitive. Following this experience, Anna empathised with clients who had been exposed to practitioners' careless use of words, and she was motivated to learn from Jane how to be effective in caring for clients with their difficulties and traumas. After the interview, I reflected on what Anna had said about her experience of having a cyst. Her story

seemed to have parallels with Jane's; both of them had been close to death (i.e., Anna had a cyst and severe infection, Jane experienced a major fracture with several complications that took years to heal) and had survived. Anna said, "We call ourselves the Cockroach Club, hard to kill off." Jane and Anna seemed to have more than a mutual interest in working together for clients' wellbeing (and wanting to care for their clients); they had a deep bond regarding their similar life experiences. Anna mentioned they would enjoy reflecting on their experiences together and, with Jane's interest in existentialism, they would explore deep and meaningful questions and ideas, such as living with purpose.

Anna and Jane supported each other through difficult times; they seemed to help one another through their traumatic experiences. I was getting the impression that Jane provided care and reassurance for Anna in her practice and wondered whether this support was reciprocal. Anna said:

> I sometimes feel like she supports me more because she's the psychologist, I think. So, from a friendship point of view, I try to balance that out. You know what I mean? It's probably the sport psychologist [who] supports the team members rather than the physio supporting the sport psychologist in the work context. That's sort of how the roles are. Although, I'll support what she's doing, if I know about it. I will back her up from that point of view, but, in a friendship thing, it's different.

Anna further explained that they are "mutually supportive" in their friendship, but professionally, Jane supported her more than she supported Jane. Anna appeared to downplay her role as a support agent for Jane, similar to the way she expressed that she does not take credit for athletes' performances. I asked how she thought she supported

Jane in their collegial relationship and friendship, and Anna discussed several ways in which she helps Jane.

Working Together: Anna Helping Jane

Anna told me how she thought she influences Jane's practice as a psychologist. Anna said that she provides Jane with information about her clients and their contexts that Jane would not otherwise obtain. Jane would ask questions about clients' injuries, and Anna could advise her on clients' conditions and prognoses. Also, from being in more regular contact with athletes than Jane (Anna would attend training and have one-on-one sessions with them more frequently than Jane), Anna would give Jane interpersonal information about athletes, such as their relationships and interactions with coaches:

> I'm sort of a bit more at the coalface and see what the coaches do. Or [and Jane will ask], "What's that coach like . . . with other athletes? What have you seen?" 'Cause I travel with them. So . . . the coaches and myself . . . we'll be in the same apartment or whatever for the week. So, we'll see the ins and outs and what the coaches are like, and so, I can give her some insight into that. So, if we're working in a sport, I'll tell her different things that sort of give her more of an idea of the culture.

Anna's regular contact with athletes and coaches seemed helpful for Jane in understanding athlete-clients' situations and their contexts. Anna's time at the club was particularly useful when she witnessed athletes experiencing crises or difficult situations and alerted Jane to these incidences. She told me about an occasion when a performance director humiliated an athlete in front of his team for his recent underperformance after returning from injury. Anna described the call she made to Jane to tell her what had happened:

> So, I was able to ring Jane. I said, "Hi, just a heads up. This was said. I thought it was appalling, just so you know" . . . . I don't know when she was talking to him [the athlete] or anything 'cause it's all confidential what she says, but I was able to let her know because I thought that was just horrible, and unwarranted, and unnecessary. And [it was] probably just a week before a [major] competition and probably not helpful at all for someone who was wanting to get back to their best.

Jane had spoken to the athlete after the incident and was able to provide reassurance to Anna when, sometime after the event, Anna had been working with the athlete and he shouted aggressively at her in front of several athletes and members of staff. Anna called Jane to discuss what had happened, and Jane was able to explain that she was not the intended recipient of his outburst, "Jane . . . just said, 'There's other stuff that's going on. I know who he's saying that to, and it wasn't supposed to be to you. It's not you.'" I wondered how Anna felt about Jane not being able to share (due to confidentiality reasons) more information than she did about the causes of the athlete's outburst. She did not seem to mind and deeply trusted Jane and Jane's work. She commented, "I trust her such that if she says to me, 'That's got nothing to do with you. That's something else.' I don't need to know what it is. I just trust that that's the case and go, 'Okay.'"

Anna was essentially the eyes for Jane, when Jane was not in the team environment, and she also was a listening ear when Jane needed to talk. Anna mentioned that she thought Jane had difficult aspects of her work as a psychologist. Anna would often listen to Jane, debrief with her, and help her in decision-making processes:

> ‘Cause sometimes she’ll ring up if she’s having a vent about something, and I know the ins and outs of the sport politics, and some psychologist has done something diabolical and, you know, from those political positioning type of things. And, we’ll just talk about it, and . . . she’ll ask about, “What do you reckon about this?”

It was apparent from Anna’s accounts that there was reciprocity of care between Anna and Jane; they helped each other in their roles as professionals. Anna and Jane clearly assisted one another in developing as practitioners because they seemed to want to share their knowledge, understanding, and interests for the benefit of the other.

Growing Together

From Anna’s perspective, both she and Jane want to explore and grow as people and practitioners. Anna said that they talked about numerous topics, and Jane encouraged Anna to investigate mindfulness, and Anna did a mindfulness course. She mentioned, “We [Jane and I] talk about being mindful . . . during the working day. . . . Being mindful with your treatment as well, or focus[sing] the attention in and then expanding it.” Although Anna said she was attentive to her clients’ needs before she met Jane, exploring mindfulness and practising mindful presence had been useful for her in developing her concentration during sessions with clients.

Jane would also discuss with Anna her interest in neuroscience and neuropsychology and how these areas are relevant to physiotherapy. Anna said that, after her discussions with Jane, she now explains to her clients why exercises are important in rehabilitation from a neuroscience perspective:

> I talk to them about . . . setting down neural patterns in their brain, and that’s why the therapeutic exercise is so effective, and that’s why, if you practice your

> correct postures and so on, it will be easier when you need it [the correct movements] for your sport.

It was obvious that, in wanting to grow as professionals, Anna and Jane learned from each other's specialisms and respected each other's perspectives and opinions on their practices. Anna said that sometimes Jane would correct her, and they could have challenging conversations that were uncomfortable. Anna would often be self-critical after these chats with Jane. She mentioned:

> So, it can push some buttons of mine 'cause Jane can be honest with me, and I know she's being honest to help the patients or whatever, but it can push my personal buttons. But, that's alright, because I know I'll work out what's going on if I feel a certain reaction.

Anna was insightful about her responses to Jane's comments and said she thought that being criticised as a child influenced how she perceives and reacts to Jane's constructive criticism.

Anna Shaping the Team

Anna explained that she uses the awareness of interpersonal interactions and dynamics she has developed through her work with Jane to influence and inform the way other professionals view behaviours of staff and athletes. She often notices other people using unhelpful language or when professionals, in athletes' support networks, seem to misuse their power and authority to influence athletes:

> There's been a flow on effect [from working with Jane] 'cause I've been able to talk to the coaches as well, the athletic coaches. I had a discussion just last week with one of the coaches about the strength and conditioning guy who's really getting into people's heads. It's just not good. [He's] creating a dependency, and then they have to see him, and he says things to people, to patients like, "Well,

> guy, I'm sorry. You're not ready to work with me because you don't truly believe in my process."

Anna also talked about how she has used her influence, and the trust clients have in her, to help athletes when they approach her at competitions with injury concerns. She spoke about one athlete who had a tight hamstring before a race, and she taped it:

> I just thought he was just tense. I didn't think anything was wrong with it at all. So, I said, "This is what I'm going to do. We'll only need to do it for a few minutes, and it will be fine. I'm certain it will be fine this afternoon," and just put that idea in his head. "And then we're going to put some tape on, and this afternoon you'll have full range of motion" . . . And, it was exactly as I said. So, I just see no harm in doing that if someone's just uptight and just, "The tape will do this. It will release the muscle tension there and so on." So, a little bit of placebo, but used to the benefit of the patient.

Perhaps this athlete trusted Anna's judgement and certainty in the way she spoke about her treatment. Her placebo was showing her athlete that she cared; consequently, he had faith in her actions. Anna knows that her actions and words can change athletes' mindsets. She gave me another example of this influence. She said that she would often see athletes who seemed anxious about competing with an injury, even if it was minor. She would normalise their experiences, reduce their anxieties, and leave them feeling confident heading into competition. She said:

> They'll say, "I don't know if I'm going to do well [in competition]." . . . So, I'll just talk about my experience, "Well, interestingly enough, over the last 10 years, nearly everyone goes out and gets PBs [personal bests]." So, you actually don't know [exactly]. So, . . . I guess that's psychology stuff.

Anna sounded well equipped to support her athletes as people and professionals. From integrating and applying her knowledge and skills about how people move, think, and interact she could support them in similar ways that she was (and is) supporting Jane, and how Jane was (and is) supporting her.

Discussion

Within this study, I explored the longstanding professional relationship between a physiotherapist and psychologist who have a longstanding and somewhat unique relationship in their work together with injured athletes. I gained an understanding of how this alliance influences their practices and relationships with shared clients, colleagues (e.g., coaches, sport science support staff), and each other. The collegial relationship between Anna and Jane has enhanced their abilities to be effective, therapeutic practitioners. Jane's interactions with Anna have helped Anna develop as a psychologically informed physiotherapist. Through Anna's insight into the culture of sport organisations and situations, Jane is better able to consider her clients' contexts within her treatments and learn about physical rehabilitation processes. In the following section, I discuss the relationship and the stories Anna and Jane tell each other and the influences these interactions and tales have on them, their clients, and their colleagues. I consider these stories and interpersonal messages in view of the neurobiological underpinnings of therapeutic relationships (e.g., Cozolino, 2010, 2014) and interpersonal mindfulness (e.g., Mannion & Andersen, 2015; Siegel, 2010). I also discuss Anna and Jane's teamwork in view of research on interprofessional collaboration.

Both Anna and Jane communicate with their clients through stories, and these tales come in many forms. They tell (brief) narratives about injuries, clients' journeys within treatment, and athletes' recoveries. They also tell stories through their actions;

the way they *are* within their professional relationships says something about how they value their clients. Anna and Jane are interested in mindfulness and applying mindful practices within their client encounters. In the following paragraphs, I talk about three core conditions that Siegel (2010) presented in his book, *The Mindful Therapist* and that Mannion and Andersen (2015) discussed in relation to applied exercise psychology: presence, attunement, and resonance (see Chapter 2, p. 35–37 for details). I consider how these interpersonal and intrapersonal conditions appear evident within Anna and Jane's interactions with their clients.

The Mindful Physiotherapist and Psychologist

When a practitioner is present with her clients, she is attentive to her own thoughts, feelings, and behaviours as well as her clients' verbal and nonverbal messages (Mannion & Andersen, 2015). Anna talked about being present with her clients and feeling frustrated when she worked in conditions that hindered her focus on them. Researchers have found that mirror neurons help people recognise and imitate others' behaviours (e.g., Iacoboni et al., 1999; Rizzolatti & Craighero, 2004). Iacoboni (2008) suggested that specialised mirror neuron systems function to detect others' verbal and nonverbal displays of their inner states and use this information to create a neurological replication of these states in the observer. In Anna's case, she is receptive to hear and care for clients' stories of their brokenness. Perhaps for some clients her presence is likely to translate to neurobiological and social messages (on conscious and unconscious levels) that they do not expect. Anna's clients seem to anticipate that she will treat only their broken body parts rather than caring for them holistically as injured people.

Anna and Jane's presence could help them understand their clients' experiences as well as potentially influence their clients' perceptions of their care for them. Through

specialised mirror neurons systems people can develop an internal representation of another's internal states and a conscious awareness of these states, which is a process called interoception. Through this activity, people can differentiate their pain from others' pain (Mannion & Andersen, 2015; Siegel, 2010). These interpersonal mindful processes may have allowed Anna and Jane to display the Rogerian quality of empathy and enter their clients' (injured) worlds without considering their representations of clients' experiences of pain, anxiety, and frustration as their own.

Both Anna and Jane seemed to want their clients to *feel* listened to and understood in sessions. Anna clearly wanted her clients to know she treated them as people, not body parts. In interpersonal mindfulness, Siegel (2010) described resonance as when a client *feels felt* by his practitioner. Anna, in her story, seemed to express her desire to be attuned to clients. When she experienced this level of interpersonal connection, her clients would also feel her attunement to them, and Anna would perceive their understanding of her care and concern for them.

The interpersonal conditions that Jane offered her clients are similar to those she extended to her colleagues. Her openness and warmth helped the development of her collegial alliance with Anna and the quality of teamwork, and transparency with interpersonal issues, within the multidisciplinary team at the athletics club. Jane's athletes and colleagues view her as a safe and secure person to assist them when they experience stress and anxiety. When things seemed to be swaying in the storm of elite competition for the athletes and coaches in her team, Jane was the stable shelter; her presence appears therapeutic. Cozolino (2010) suggested that the interpersonal (therapeutic) conditions that Rogers (1961, 1957/2007) recommended practitioners adopt are similar to those considered as optimal conditions for parenting (e.g., warmth, acceptance, unconditional positive regard). Much like a secure attachment formed

between parent and child, a safe therapeutic relationship can help clients minimise the need to be defensive, decrease the likelihood of experiencing shame, and can maximise "expressiveness, exploration, and risk taking" (Cozolino, 2010, p. 37). Perhaps Jane's extension of Rogerian conditions helped her colleagues approach her with their issues without fear of judgement and with the knowledge that Jane accepted and respect them as practitioners and people.

To gain respect from and to develop quality relationships with her colleagues, Jane spent considerable time hanging out at the athletics club before she raised her concerns about the interpersonal issues between support staff and athletes. Researchers and practitioners have emphasised the importance of sport psychologists hanging out within new practice environments (e.g., Andersen, 2000a; Andersen & Speed, 2010), and hanging out was important for participants in Study 1. Spending time to get to know athletes and staff and helping them to "become comfortable with their presence" (Andersen, 2000a, p. 4) can build rapport. Once Jane had built quality relationships with her co-workers, she exposed their interpersonal issues in a gentle way. She delicately told stories of unfavourable relationship situations to staff members (often indirectly), which perhaps were subtle warnings for her colleagues as well as opportunities for them to discuss their own difficulties and for Jane to provide advice where necessary. Perhaps her approach to developing relationships made Anna feel welcome to bring her struggles with the unstable athlete to Jane.

Jane made her colleagues aware of interpersonal issues through stories she told about interactions from a psychodynamic perspective. Anna and Jane worked together on understanding the erotic transference and countertransference reactions that were occurring between Anna and her clients, particularly those athletes and staff members who were flirtatious with her. Commentators (e.g., Little & Harwood, 2010) have

expressed that psychologists have given little research attention to understanding potential sexual boundary violations and erotic transference and countertransference within sport psychology despite the looser boundaries of practice and perhaps heightened risk of sexual boundary crossings in comparison to other domains of psychology practice (see Andersen et al., 2001; Stevens & Andersen, 2007a, 2007b). Within physiotherapy, researchers have conducted surveys of sexual activity between practitioners and clients (e.g., Ang, Cooper, & Jenkins, 2010; Cooper & Jenkins, 2008; Soundy, Jenkins, Cooper, & Stubbs, 2013), but have paid little attention to interpersonal dynamics that may precipitate practitioners' engagement in sexual relations with clients. The small samples of practitioners in Studies 1 and 2 represent a wide variety of institutions and university courses across Australia, but only a few participants appeared to be aware of such dynamics or willing to talk about such a taboo topic. It seems, from the results of this research, it is rare for physiotherapists and psychologists who work in sport to have awareness of erotic transference and countertransference.

Throughout Anna and Jane's stories, their professional relationship and friendship is characterised by trust. Anna trusted Jane to give her information about their shared clients that could inform her treatments, and Anna understood Jane's confidentiality expectations. Some psychologists in Study 1 said that they had issues with multidisciplinary staff, including physiotherapists and coaches, who wanted information about injured athletes and did not respect confidentiality agreements between psychologists and athletes. Anna and Jane's relationship is a model of how information (and clients' stories) can be shared effectively within rehabilitation teams. For example, Jane clarified her limitations of sharing, and Anna showed respect by not pressuring Jane to pass on information.

Stories to Support Clients

Anna and Jane's close collaboration, particularly in the language they used and the stories they told when working with injured clients, helped athletes to experience consistent stories regarding their injuries. Both Anna and Jane told brief narratives of clients' injuries that were designed to soothe. For example, with their client who experienced excessive range of movement in his shoulder, both Anna and Jane used words that emphasised his control over his recovery and eased the athlete's anxiety about structural problems with his shoulder that his previous physiotherapist had suggested. It would seem logical that at a neurobiological level Jane's orchestration of a shared, consistent language may have had positive effects within their client's brain, which potentially reduced the activation of neural pathways associated with fear from the previous physiotherapist's choice of words. When the earlier physiotherapist used the term "slipping" this could have activated the client's limbic system, letting him become aware that his body, career, and hope for a return to his sport may be threatened. Anna and Jane's emphasis on control over the injured body part, through the words they shared with the athlete, could have resulted in the downregulation of the fear response and increased the activation of neural circuits in the right prefrontal cortex. These neurobiological changes may have helped the client to think logically about his injury and perhaps feel safer, and more in control, than before.

Anna used the knowledge passed on by Jane, and the information she gained from her own experience, to influence the culture around (injured) athletes. Anna's understanding of the influence language can have on individuals including herself may have enriched her clients' experiences in sport and in rehabilitation. By pointing out unhelpful ways coaches and support staff use language and the possible motivations behind such language use, such as wanting control over athletes or fostering dependence

rather than encouraging independence, Anna made others aware of their behaviours and facilitated practitioner-change to benefit athletes.

Stories to Support Each Other

The stories Anna and Jane told that support each other's practice seem to fit into three categories: systems, sexism, and solutions. With Jane's interest in understanding people and their contexts from a systems perspective, the contextual information Anna often quickly relayed to Jane, from having frequent contacts with athletes and support staff, helped Jane consider the cultural milieu in which athletes exist. Researchers (e.g., Miller, Riley, & Davis, 2009) have identified that the timely and complete transfer of information is important in effective emergency healthcare teams. It seems that the timely transfer of client-information from Anna to Jane (in nonemergency situations) helped Jane modify her interactions with clients, investigate relationships further, and, ultimately, better assist clients.

Within the cultural context of elite athletics, Anna and Jane experienced sexism from colleagues, often in the form of derogatory comments, sexual innuendos, or being excluded from male-to-male interactions. These experiences brought Anna and Jane closer together because they faced the same battle. Shared stories of interactions with staff members and athletes helped Jane and Anna manage these difficulties and the interpersonal dynamics. Anna and Jane played different roles in their united approach to this issue. Jane informed Anna of how best to manage athletes based on her awareness of colleagues' or athletes' psychological states, and Anna was the eyes and ears for Jane to understand the cultural context and use this information to give the best possible suggestions to Anna. Their interdependence in this issue helped them navigate the sport culture and shaped the interpersonal interactions better than if they approached this task alone.

Anna and Jane worked together to find solutions when they experienced difficulties in helping clients advance in their recoveries. Their collaboration in problem solving facilitated consistent and informed approaches to rehabilitation. Anna and Jane educated each other on their areas of speciality to provide a collaborative interprofessional practice in which they made co-operative decisions on courses of action. They reinforced each other's work; for example, Jane emphasized the importance of doing physical exercises and used her knowledge of motivation to help clients to identify and overcome barriers to adherence. They also helped each other develop quality relationships with clients (e.g., Jane informed Anna on interpersonal processes, Anna told Jane about client-coach issues that she witnessed). Researchers have found that these practices occur in other instances of interprofessional collaboration. Sinclair, Lingard, and Mohabeer (2009), in their ethnographic study of interprofessional collaboration in a hospital rehabilitation unit, found that practitioners frequently exchanged patient information (in formal and informal ways), co-learned/taught, and showed collaborative leadership and decision-making. Commentators and researchers (e.g., Behm & Gray, 2012; Kraft, Blomberg, & Hedman, 2014; Sinclair et al., 2009) promote these characteristics as effective practices within interprofessional teams.

Anna and Jane's collaboration has more of an interdisciplinary than a multidisciplinary flavour. Sheehan, Robertson, and Ormond (2007) defined multidisciplinary teams as those where "professionals each work within their particular scope of practice and interact formally" (p. 18) whereas, "interdisciplinary teams are characterized by greater overlapping of professional roles, formal and informal communication and shared problem solving for the good of the patient." (p. 18). Researchers and commentators, mainly from nursing and medicine, have suggested that

interdisciplinary teams can be more effective than multidisciplinary teams because they better allow for collaborative, holistic, person-centred approaches (Behm & Gray, 2012). Within the sport psychology literature, however, commentators (e.g., Clement & Arviven-Barrow, 2013) have suggested that sport medicine practitioners, including physiotherapists and psychologists, should develop and be involved in multidisciplinary teams. These authors have provided little substantive guidance on how these groups of professionals should function as units, other than suggesting that members introduce themselves at formal team meetings. The results from the current study provide examples and specific direction for professionals on how to interact, make decisions, and develop relationships with one another while caring for injured athletes collaboratively.

Sharing Stories of Personal Experiences

Anna and Jane shared narratives about the ways they help each other personally and professionally outside of their work together. Anna supported Jane by listening to Jane's stories of difficult situations that she faced within her work. Anna mentioned that Jane found it useful to debrief after troublesome cases, and Anna felt good that she could support Jane in this way. Jane listened to Anna's personal experiences and discussed these with her. Anna and Jane's personal communication, beyond their work roles, has been important in the development and maintenance of their relationship and their continued collaboration. Researchers (e.g., Kraft et al., 2014) have found that professionals who work in rehabilitation teams value having personal, rather than purely professional, relationships with other team members, and practitioners considered collaboration was strengthened when professionals had known one another for extended periods.

Although Anna and Jane welcome each other into their personal lives, they appear to have boundaries to their relationship. They seem to be good friends, and relate to each other on a deep level, but spend little time together outside of work. Developing and maintaining professional and personal boundaries within collegial and client-practitioner relationships has been a recurring theme running throughout the studies reported in this thesis. These participants' stories of their challenges of establishing and keeping boundaries when working in sport may be useful for practitioners to help them reflect on their boundary behaviours and personal and professional selves.

Anna and Jane have similar personal stories and interest in discussing existential ideas. From their experiences battling illnesses and injuries, they reflect on meaning in life. Through their interactions with each other, Anna and Jane remind themselves how they have value and purpose that transcends them as individuals and is rooted in helping others. Their shared stories of purpose also inform their approaches to practice. Glen (1999) suggested that professionals in interdisciplinary teams should communicate their values to other members to aid interprofessional collaboration. Disclosing and understanding one another's values can help practitioners articulate and challenge their underlying assumptions about human existence and health, which may result in conflict. Anna and Jane communicate openly about their professional beliefs and values, and their views seem similar. Their shared perspectives of the world are likely to contribute to cohesion in their (mini) interprofessional team.

Researcher in the Research Process

In the following section, I discuss my encounters with Jane and Anna, and I reflect on my thoughts and feelings during these interactions. I consider my experiences in view of interpersonal neurobiology, and I explain how conscious (and unconscious)

processes might have influenced my approach to data collection and analysis as the instrument of qualitative research.

My experience with Jane. I had met Jane on several occasions, in group-contexts, and I found talking with her easy. I thought she would be a suitable participant for one of my studies. Knowing that Jane was an experienced psychologist and well versed in client-practitioner relationships, I felt that, with little guidance, she would provide the stories and answers I needed for my third study.

I entered our interview with more anxiety than I had anticipated. My nerves were influenced by a conversation I had with Jane over the phone a few weeks before the interview. We discussed the details of the study, and Jane spoke about some of her ideas relating to my research topic. She talked about systems theory and, in particular, how she considered one-to-one relationships from a systems perspective. After this conversation, I was confused. I thought I might need to change my questions to account for her interest in the contexts of interpersonal relationships. I took my anxieties about having questions unrelated to Jane's interest in systems theory to my (first) principal supervisor. He reassured me and helped reduce my limbic system activation by reminding me that my job was to "let Jane tell her story."

Allowing myself to listen to Jane's story in our interview was difficult because my expectations frequently occupied my attention. I knew about Jane's interest in the neuroscience of psychotherapy and mindfulness and that she applied her knowledge of these areas in her interactions with clients, and I anticipated that Jane would discuss these topics more explicitly, and in more detail, than she did. I noticed on a few occasions that this preoccupation with my expectations of Jane pulled me psychologically out of the room, and at times I was not fully present with Jane. These incidences were sometimes met with Jane's confused facial expressions. Possibly she

had detected that I had taken a mental vacation from our discussion, and her responses captured my attention and brought my focus back to the real, rather than my imagined version of, Jane.

After the interview, I was frustrated that I had not guided Jane to get the answers I expected from her. Once I had read the transcripts, I realised that I had rich data from Jane's stories, but she had spoken about concepts, terms, and relationships in different ways than I had anticipated. During a meeting with my (first) principal supervisor, I reflected on my anxiety around not getting *good-enough* data from my interviews. He highlighted that, from previous discussions about interviewees, I seemed to expect almost all of my interviewees to be like my first participant in Study 1, Jarrod. My encounter with Jarrod had led me to set high hopes of my interviewees. Jarrod spoke easily about client-practitioner relationships for 2 hours, and he opened up to me about his personal experiences and difficulties in practice. Once I had identified and discussed my expectations with my supervisor, I tried to be mindful of these expectancies as I developed, repeatedly read, and redeveloped Jane's tale. I also tested my thoughts about Jane against the knowledge I had of her to ensure that I was not guided by my expectations when writing Jane's story.

Interviewing Anna and writing her story. From talking to Anna on the phone, and from hearing about her in my interview with Jane, I expected Anna to be a warm, psychologist-like figure from the get go. I found the initial interactions with her were different than how I had pictured them. Again, my expectations influenced my experiences. At the start of our interview, Anna looked uncomfortable. Perhaps my internal confusion (reality versus fantasy) played out in mixed verbal and nonverbal messages (e.g., a sceptical raise-eyebrow facial expression accompanying what may have sounded like a nonjudgemental tone of voice) that caused her to mirror my

confusion. Anna might have been attuned to my confusion, and she could have made an internal representation of my inner conflict and expressed that mirrored state externally. I think, as I began to focus on *really* listening to Anna, I started communicating that I appreciated her sharing her story with me. Coming back to being present with her, I became comfortable in our exchange, and she began to disclose information with me that I felt privileged to hear. She told me about her experience of her cyst even though I had not expected her to speak of such details with me. Maybe, despite my initial apprehensions, I had offered an interpersonal environment in which Anna felt safe to tell her stories.

When writing up Anna's tale, my (first) principal supervisor recognised that I had brought myself into Anna's story much more than I had in Jane's. I explored my reasons for including so much of my voice in Anna's narrative. I came up with several (not mutually exclusive) reasons. First, I had expected Anna's story to be like Jane's. When Anna gave me little information about her childhood or her reasons for entering her chosen career, I was anxious that her tale and Jane's story would appear too distinct within my thesis. Initially when analysing Study 3, I was still looking for themes and commonalities as I did in Study 1 and Study 2 rather than focussing on representing each participant's story as a distinct case. I was concerned that the initial differences I saw between Anna and Jane's tales would represent my poor interviewing skills; I felt that, if I left the stories as they were, I would be found out for being an incompetent researcher. Andersen and Stevens (2007) have discussed that psychologists can feel underprepared or incompetent and suggested that being aware of such anxiety can be beneficial to psychologists' practices. Reflecting on my worries about not having *good-enough* data, I realised I added my thoughts, opinions, and fantasies (the latter identified by my supervisor, a psychodynamic therapist) to bolster my analysis. Having my voice

present in Anna's story decreased my anxieties because I was able to present two stories that fitted neatly together, and represented what I thought was coherent and quality research.

Another reason for wanting to add my own voice in Anna's story was that she impressed me. She was a therapeutic physiotherapist and a (good) lay psychologist, and I found myself wanting to comment about the feelings and thoughts I had about her. I used words like *fascinated*, *impressed*, and *surprised* within my first draft. Martin (2007) suggested that, "stories are performative: through them we initiate, suggest and call for responses" (p. 54). For me, telling Anna's story seemed to drive me to express surprise and praise. Perhaps, through articulating my reaction, I wanted to lead others to respond in a similar way. I sought to show how surprised I was about meeting such a physiotherapist, and I desired to applaud her efforts for doing a great job in caring for her clients (here I go again with the hyperbole). By bringing my commentary out of Anna's story, I would reduce the influence that my imagined view of Anna's skills would have on readers, giving them more space to make up their own minds about her.

One other possibility of wanting to appear in Anna's story is that Anna represented the physiotherapist I wished I had when I experienced several athletic injuries in my teens. During my athletic career (a short one at that), I had encounters with various physiotherapists, all of whom were not fully competent practitioners. Furthermore, these professionals did not have Anna's awareness of the psychological aspects of injury rehabilitation. Perhaps my desires to be in Anna's story represented my latent desire to be treated by a physiotherapist like Anna. I mourned not having someone who would understand my injuries (both the physical and the psychological ones) and care for me and my fears and anxieties about returning to sport.

Telling Anna's story, and exploring the reasons for wanting to play a central role in her tale, was therapeutic for me. Martin (2007) said, "the story-telling process can have a transformative effect in the sense of self of both the participant and researcher." (p. 53). Through entering Anna's story, I felt like it helped me re-write my past hurts and shape my future, leaving behind previous anxieties related to my injury experiences and what I considered to be inadequate care from my rehabilitation staff. Cozolino (2014) has discussed how people's past hurts can be healed in secure-attachment relationships because such bonds are characterised by interpersonal conditions that promote neuroplasticity; in healing relationships people can reorganise their brains and co-construct new narratives of their pasts, presents, and futures. Being part of Anna's story (in an imagined way) seemed to help me construct a new tale of my injury experiences, in which I was cared for by a therapeutic practitioner.

After studying Anna and Jane, I had learned more about myself (such as my desires, expectations, and perceptions of what the research process should be) compared with what I knew when I started Study 3. Being aware of my hopes, the potential reasons for my expectations of interview content, and the ways that Anna and Jane told their stories was useful in reflecting on the data-analysis process and would be valuable in my approach to clients and participants in future practice and research. Providing interpretations of my narrative choices seemed to be helpful to understand myself further as a researcher in sport injury with suboptimal experiences of my own athletic injuries. Perhaps one reason for doing this research was to heal or re-story my own narrative of injury and rehabilitation. As my (first) principal supervisor wisely forewarned shortly after I met him, "Doctoral students in psychology usually end up studying themselves."

Summary

In Study 3, I explored the longstanding relationship between a physiotherapist and psychologist who collaborated in sport injury rehabilitation. Their work together was informed by interpersonal neuroscience, mindfulness, and psychodynamic principles. These practitioners shared their expertise with each other, and their shared knowledge informed their approaches to relationships with athletes and sport science staff and also shaped their individual treatments. Both participants practiced mindful awareness, reflected on their needs and motivations that they bring into client-practitioner relationships, managed the boundaries of confidentiality within their collaborative relationship, and confided in each other for advice when presented with complex injuries or rehabilitation processes. The trust that these participants had in one another, which developed over the course of their relationship, enabled them to challenge each other to reflect on their behaviours and interactions with injured athletes and colleagues to ensure athletes' needs were the focus of the rehabilitation processes. Overall, these practitioners provide an exemplary model of collaboration in sport injury rehabilitation.

CHAPTER 6

GENERAL DISCUSSION

I explored sport psychologists' and sport physiotherapists' relationships with injured athletes and their experiences working with other professionals in injury rehabilitation. Participants shared openly about their specific experiences. I also learned about their rapport building skills and their interactions with noninjured and nonathlete clients. In the following section, I present a discussion of participants' relationship experiences and compare how the current research relates to previous literature. In this discussion, I propose applied implications based on the current findings. I then offer some methodological considerations and suggestions for future research. To conclude, I discuss my experiences as the researcher in the research process.

Relationships

The majority of relationship experiences that practitioners reported were positive. In particular, the psychologists and physiotherapists I interviewed enjoyed working with injured athletes when recoveries were straightforward (e.g., minimal setbacks, nonsurgical interventions) or when clients (along with themselves) were motivated and engaged in treatments and partnered in healing processes. The relationships that practitioners formed in these circumstances paralleled Bordin's (1994) conceptualisation of effective working alliances. These client-practitioner interactions seemed to be characterised by collaboration on the task and goals of treatments and involved strong bonds based on mutual liking and trust.

Participants also enjoyed working with injured athletes who valued them and their competencies. Conversely, professionals did not enjoy relationships in which clients undermined them or their skills. Furthermore, practitioners may have sought fulfilment of their own needs in their professional relationships with injured athletes

(e.g., the desire to be liked or needed). Many participants were somewhat blindsided to how such needs played out in their interactions and relationships with injured athletes. At times, practitioners pursued fulfilment of their desires to the detriment of therapeutic relationships and athletes' recoveries. This finding is one of several difficulties psychologists and physiotherapists faced in their professional relationships with injured athletes and, together, they reflect challenges experienced on intrapersonal, interpersonal, and organisational levels. I discuss these different levels at which challenges occur by commenting on practitioners' limited training in psychology and professional relationships, client-centred approaches, and work with other professionals and the applied implications that relate to these themes.

Applied Implications

The findings from this research project have several implications for training and practice within sport psychology and physiotherapy. I discuss these implications under three headings: limited training in psychology and relationships, client-centred approaches, and working with other professionals.

Limited training in psychology and relationships. From the results of Study 2 and Study 3, physiotherapists had little training in developing professional relationships, personality, and mental skills. These findings are consistent with published literature, in which researchers have reported that physiotherapists have limited education in psychology, and particularly in mental skills training (e.g., Arvinen-Barrow et al., 2010; Francis et al., 2000; Wiese et al., 1991). It seems that physiotherapists would profit from an intentional focus in their training and ongoing professional development on psychological topics (e.g., personality and working with clients with psychopathology) and therapy skills such as rapport-building; establishing and maintaining social and emotional boundaries; and understanding needs, motivations, and transference-

countertransference reactions in their professional relationships. Physiotherapists who receive training in these areas would be better equipped to build high-quality working alliances with clients than they are currently.

Arguably, physiotherapists would also benefit from supervision or guidance from registered psychologists when applying their training in managing relationships within the context of injury rehabilitation. Psychological supervision could help physiotherapists develop their knowledge, reflect on their actions, provide discussion about interactions, and help recognise when injured athletes may need to be referred to psychologists for further assistance. Such support could help improve collegial relationships; facilitate referral networks; reduce potential for dual-role conflicts, discipline "turf wars", and practitioner isolation; and enable holistic client-care (see Study 3). Furthermore, there is considerable scope for physiotherapists and psychologists to communicate about their competencies, intentions to use others' discipline-specific knowledge in treatments, and potential role-overlap.

For psychologists and physiotherapists to work closely together in the manner described above reflects an interdisciplinary model of healthcare. This interdisciplinary framework can help to bridge the gap between services and allow for smooth handovers to other professionals. For example, a physiotherapist who is well informed about psychological fundamentals (like Anna in Study 3) will likely understand whether an athlete is anxious, will be able to actively downregulate the athlete's anxiety, and could discuss the potential benefits of psychological assistance from a registered psychologist if necessary. The interdisciplinary framework, however, is one of several models in which healthcare practitioners may work. Some practitioners may choose to work independently and have strongly defined boundaries of practice that demarcate healthcare into discrete and seemingly independent fields. Irrespective of the models in

which practitioners develop professional competencies, managing relationships with clients is a non-negotiable. That is, relationships management is a necessary, but not necessarily sufficient, condition of healthcare treatment.

In regards to psychologists specifically, many participants seemed to have limited understanding of relationship processes. Although the majority of psychologists within Study 1 and Study 3 had training in building rapport, few appeared aware of or attuned to their motivations and needs in their professional relationships. For example, of the 13 psychologists I interviewed, only two seemed to have thoroughly reflected on their own motivations to enter sport psychology and how these desires played out with their clients. These two practitioners had psychodynamic training and had extensively self-reflected on their personal stories and histories. I was surprised that few psychologists spoke about transference and countertransference, despite writings on these processes in the sport psychology literature (e.g., Stevens & Andersen, 2007a, 2007b; Strean & Strean, 1998, 2005) and a growing and relevant body of knowledge in neuroscience that indicates (a) people's brains are shaped by past experiences and relationships, and (b) relationships have the potential to heal or damage our brains (see Cozolino, 2014). Healthcare practitioners, regardless of their particular roles, could benefit from exploring how their own relationships play out in their current interactions with clients. Such self-reflection on personal motivations is likely to help practitioners foster quality therapeutic relationships through increasing their awareness of their desires in relationships and reminding themselves (through reflection) to serve their clients' needs rather than their own.

Another way that practitioners can develop their knowledge about how their pasts influence their current relationships is through trained colleagues sharing their understanding of psychodynamic principles. For example, in Study 3, Jane (a

psychologist with psychodynamic training) helped Anna foster quality professional relationships with athletes and co-workers. Anna and Jane's informal discussions about transference, countertransference, and power differentials within client-practitioner relationships helped Anna develop awareness of her reactions to athletes' erotic and other transferences. From these conversations, Anna was able to address these issues in her relationships with injured athletes and colleagues. Researchers who have investigated interprofessional collaboration endorse such informal knowledge transfer (e.g., Behm & Gray, 2012; Kraft et al., 2014; Sinclair et al., 2009), and unofficial exchanges may be a context in which practitioners feel comfortable to share observations and transference or countertransference concerns.

In addition, explicitly addressing erotic transference and countertransference in formal training could be useful for student-practitioners to help them understand conscious or unconscious processes in interactions that involve emotional or physical proximity and sexual attraction. Sexual attraction is common in physiotherapy and sport psychology. From survey responses, researchers have found that 74% of (n = 233) male and 41% of (n = 706) female physiotherapists (i.e., Cooper & Jenkins, 2008) and 35% of female and 45% of male sport psychologist respondents (i.e., Petrie, Tebbe, & Greenleaf, 2005) reported being sexually attracted to clients. In addition, many trainee and qualified physiotherapists are unskilled in managing sexual feelings, boundaries, and boundary violations in their practices (see Ang et al., 2010; Cooper & Jenkins, 2008). Discussions around normalising attraction and distinguishing attraction from sexual actions should be beneficial in creating open, nonjudgemental discourses about this topic in training environments. Awareness of these processes might also help healthcare practitioners identify and manage attraction and minimise the risk of

professionals crossing or violating sexual boundaries with clients (Little & Harwood, 2010).

A further recommendation for training comes from the results of Study 2. Several physiotherapists said they had insufficient training in understanding and working with clients who have mental illnesses. The Australian Physiotherapy Association, as a professional body, might need to consider the benefits of further training in working with clients who present with both physical and mental issues such as depressed mood, depression, anxiety, and other psychopathologies. People with physical injuries often have comorbidities with psychological disturbances, and athletes (despite often being viewed as more optimistic, enthusiastic, and motivated than the general population) are not exempt from such difficulties. This recommendation is distinct from physiotherapists treating such issues, but relates to physiotherapists being attuned to and understanding clients' experiences (doing so can be therapeutic in itself) and developing confidence in working with clients with mental health challenges. Being aware of the signs and symptoms of psychopathology could help physiotherapists to (a) make timely referrals to psychologists for treatment, (b) consult psychologists to provide guidance on how best to manage clients, and (c) work collaboratively with psychologists in joint treatment sessions. Furthermore, Andersen (2004a) has written about identifying and understanding psychopathology for physical and manual therapists. This discussion chapter, for example, could be a useful reference text for physiotherapy students and practitioners. Other resources such as mental health first aid training (see https://mhfa.com.au) could be used to equip practitioners with relevant knowledge.

In addition, specific training for both student and registered physiotherapists in counselling skills could be valuable in helping clients within physical treatments. To be

clear, I am not suggesting that physiotherapists attempt to resolve their clients' psychological issues. Physiotherapists need to refer clients to trained psychologists for such assistance. I am proposing that additional training in counselling skills should assist physiotherapists in building rapport with clients; developing in-depth understandings of clients' difficulties; and listening attentively to clients' needs, concerns, and fears. Mastering these skills is likely to positively influence working alliances and consequently clients' treatment outcomes.

Several suggestions I have made regarding physiotherapy training may be time consuming and unrealistic if integrated within existing physiotherapy courses. One efficient way to integrate these ideas in formal training or professional development is through interprofessional education; IPE. IPE occurs when two or more practitioners from different disciplines learn alongside, from, and about each other to optimise client care through collaboration (Freeth, Hammick, Koppel, Reeves, & Barr, 2002). The World Health Organization (WHO; 2010) encourages the use of such models, and IPE is used within several training courses at universities (e.g., Curtin University, Victoria University) and healthcare settings (e.g., Australian Capital Territory Health; see Stone, 2009) in Australia. Researchers (e.g., Kraft et al., 2014) and commentators (e.g., Behm & Gray, 2012) have reported that both interprofessional education and collaboration (in their many forms) help practitioners provide holistic client-care and expand their knowledge of the benefits of disciplines other than their own. For example, physiotherapists could work with psychologists in supervisory relationships or within multidisciplinary team contexts (like Anna and Jane in Study 3) to help develop communication and counselling skills and awareness of symptoms of psychological disorders. Also, psychologists who work with injured athletes could learn from physiotherapists about their clients' physical injuries and treatments. Jane and Anna's

example of collaboration in Study 3 highlighted the benefits of being aware of how each other's discipline can dovetail to provide holistic care.

Client-centred approaches. The Rogerian style of therapy, with a focus on empathy, unconditional positive regard, and genuineness, is usually explicitly taught to psychology students (see Study 1), and trainees of other talking therapies (e.g., general counselling, social work). In Study 2 and Study 3, physiotherapists did not report being taught Rogerian characteristics at university, but some (particularly Anna in Study 3) seemed to be therapeutic practitioners and may have learned to adopt these qualities from interactions with other professionals, such as Jane. Practitioners and researchers (Kolt & Andersen, 2004b; Petitpas & Cornelius, 2004) have emphasised the need for physiotherapists to develop and display these qualities to their clients.

In the current research, a Rogerian characteristic that some practitioners seemed to struggle to show injured athletes was genuineness. Several participants in Study 1 and Study 2 appeared to send mixed interpersonal messages to their clients. In Study 1, a few psychologists were arguably withholding emotional reactions to athletes' behaviours or emotional material discussed in session. Also, a couple of physiotherapists in Study 2 appeared to flip between empathic and punitive states or offer seemingly collaborative frameworks within treatments, but eventually persuaded, or exerted control over, clients. In line with Rogers' description of genuineness, the client-centred approach should be natural and without façade. People are quick to notice discrepancies and inconsistencies in others' actions and opinions, and clients who encounter professionals who seem to be client-centred, but really are not, are likely to be confused and hesitant to trust their healthcare professionals. In some cases, such perceived incongruences may cause strains or ruptures in relationships.

Participants who showed dissonance in interpersonal messages may be oscillating between medical and client-focused models of practice. The models of practice that professionals (particularly physiotherapists) adopt in actual practice contexts are unlikely to be as clear-cut as theoretical client-centred or medical frameworks. Some inconsistences, however, may be a product of professionals being trained in client-centred practices within specific or discrete units of study, rather than this orientation being threaded intentionally across physiotherapy courses. For example, if students are only exposed to collaborative models within elements of courses, rather than these frameworks being constantly reinforced throughout their training, professionals may graduate with inconsistent or conflicting practice models that manifest as incongruent interpersonal messages for clients. Researchers could examine educators' models of practice within training programs and their understanding of client-centred models. These investigators could contribute toward developing programs of study that encourage practitioners to adopt consistent, collaborative, and holistic approaches towards physiotherapy treatments.

In regards to empathy, psychologists and physiotherapists described in Study 1 and Study 2 how working with athletes who sustained long-term injuries can be physically, mentally, and emotionally draining. Often borne out of their empathic responses to clients' pain and joys, practitioners identified with clients' emotional states, and some appeared to experience compassion fatigue. When professionals experience compassion fatigue they can become irritable, numb to clients' pains, hardened to their clients' troubles, and physically ill themselves (see Portnoy, 2011). These consequences are likely to inhibit the positive influences client-practitioner relationships can have on athletes' recoveries. Psychologists and physiotherapists should be trained in recognising and managing compassion fatigue to prevent this

condition from negatively influencing their capacities to assist clients. In addition, personal psychotherapy and counselling are useful ways for practitioners (both physiotherapists and psychologists) to help develop awareness of their own internal states and to help differentiate these from their representations of their clients' inner worlds. These processes may provide protective effects against compassion fatigue.

One area of training that practitioners have found useful in helping them maintain a client-centred focus in their work with injured athletes is mindfulness. In Study 3, both Anna and Jane did training courses, and now regularly practice, mindfulness. In their interactions with clients, Anna and Jane try to stay present, attuned, and resonant with their clients and their experiences. Mindfulness training could be useful to help healthcare practitioners focus on their clients and pay attention to their inner experiences while in treatment sessions. Being in the caring presence of a nonjudgemental mindful other is therapeutic (Siegel, 2010; Wilson, & Dufrene, 2008). Clients' anxieties and fears are likely to be reduced when they perceive that practitioners are present and engaged with them (Rossouw, 2014). Practitioners, however, can easily lose focus during sessions and throughout their days where they are interacting with multiple clients and professionals. The premise of mindfulness training is to notice when one loses focus and bring attention back to the current moment. The awareness of one's awareness can help practitioners regain focus and become present again in their relationships after attention has wandered.

Clearly, the fundamental differences between physiotherapy and psychology treatments need consideration when tailoring specific training on client-practitioner relationships and suggesting client-centred models of practice for sport physiotherapists and psychologists. First, the primary goals of physiotherapy and psychology treatment differ. Physiotherapy is primarily concerned with promoting, regaining, and maintaining

physical health, whereas psychology is mainly concerned with promoting, regaining, and maintaining psychological health. Client-centred approaches should manifest themselves differently in psychological or physiotherapy treatments. Some researchers (e.g., Szybek et al., 2000), however, have suggested that physiotherapists adopt psychotherapeutic models of practice. Nevertheless, physiotherapists do not need to follow a counselling model of treatment to be client-centred practitioners. Furthermore, specific training for physiotherapists in client-centred practices and relationship skills could be tailored to physiotherapy through role plays and exercises that are based within the constraints of normative physiotherapy sessions (e.g., approximately 30 minutes, focus of session on physical injury rather than counselling-style sessions).

Working with other professionals. Participants within all three studies had issues working with other professionals in multidisciplinary teams. In particular, both psychologists and physiotherapists reported that other professionals influenced their relationships with injured athletes. For example, in Study 1, seemingly reactive referrals of clients from coaches and physiotherapists to sport psychologists late in athletes' rehabilitation programs put sport psychology practitioners under substantial pressure to *fix* athletes in the absence of deep relationships with athletes. Marchant (2010) discussed the importance of sport psychologists taking time to understand clients' needs to provide quality idiosyncratic interventions and tailored treatments rather than quickly offering a one-size-(rarely)-fits-all approach. More timely referrals or systems that encourage communication and better collaboration among professionals may help healthcare practitioners care for injured athletes in the best ways possible.

In Study 3, however, Anna and Jane's collegial relationship showed that professionals can co-operate and provide a unified, caring approach towards clients. Such an approach seems consistent with researchers' (e.g., Clement & Arvinen-Barrow,

2013) suggestions on collaboration in sport injury rehabilitation. Healthcare practitioners could learn from Anna and Jane's effective communication with each other and with clients. Both Anna and Jane seemed knowledgeable about the other's area of competence (and the limits of their own) and reinforced each other's work within rehabilitation sessions. From their stories, there are clear benefits to cross-discipline education and awareness in rehabilitation, and, as mentioned earlier, this process could be encouraged in training through formal and informal means. For example, within multidisciplinary teams, allied healthcare professionals could run a series of professional practice presentations informing colleagues from various disciplines about their professions, their contributions to client care, and the resources needed to perform their roles effectively. Practitioners could also exchange information in informal conversations about clients, but they should be mindful and respectful of others' boundaries of confidentiality. Practitioners would need a spirit of openness for these suggestions to be effective.

To summarise, based on the current findings there are several implications for the education, training, and practice of psychologists and physiotherapists that could benefit the development of strong, collaborative professional relationships in sport injury rehabilitation. Some of these training suggestions (e.g., developing awareness of relationship processes, practicing mindfulness) are ways in which practitioners can sharpen themselves as the instruments of care within their specific healthcare practices. In addition, self-care techniques, for example, to recognise and manage the effects of compassion fatigue, can help practitioners continue to be emotionally and intellectually attuned to the needs of injured clients. Furthermore, learning from and with other professionals and working collaboratively in rehabilitation can be beneficial to the quality of relationships with clients and, most importantly, client outcomes.

Furthermore, there is space for practitioners, managers, and performance directors to create healthy and effective systems within organisations that value relationships and collaborative, client-centred approaches to rehabilitation.

Methodological Considerations

There are several positive aspects of the current research. First, through qualitative inquiry, I could represent psychologists' and physiotherapists' experiences and tell their stories in accessible ways for other practitioners. Some researchers believe that sport psychologists often learn more from stories than other forms of research or empirical studies (Andersen, 2004b; Tod et al., 2009). By including practitioners' quotations in all three studies, and using a case study approach in Study 3, professionals may be able to remember some of the stories and themes of this research and apply this knowledge to their practices.

Throughout my experiences learning about client-practitioner relationships, I put into practice the relational qualities that I was studying. I tried to be a self-reflective researcher who displayed Rogerian characteristics and was inquisitive about, and welcoming of, participants' stories. A positive outcome from my approach was that practitioners talked openly about their experiences and often for longer than both they or I anticipated. Although I attempted to be a client-centred investigator, there were several encounters with participants in which my expectations influenced my attentiveness to professionals and their stories. As a novice researcher, I (like other novice practitioners) experienced performance-related anxieties. My concerns around collecting quality data and accurately representing participants' tales at times manifested in my psychological absence at times during conversations. These incidences may have influenced how comfortable participants were with sharing information. Consequently, practitioners may have withheld stories or details when I

appeared to be mentally distant and not attuned to them. These errors, although potentially detrimental to the research process, stimulated discussion, self-reflection, and guidance in developing my interpersonal skills and skills as a researcher (see Study 3).

Another limitation relates to only interviewing participants once. I may have gained richer data about participants' difficult relationships if I interviewed or met with them more than once. It is understandable that, despite showing Rogerian qualities, practitioners may not have necessarily trusted me to talk about their most frustrating and challenging experiences. As I have mentioned several times throughout this thesis, attachment researchers (e.g., Ainsworth et al., 1978) have indicated that people trust others who are consistent caregivers. Participants may have refrained from talking about their difficult experiences because they feared I would be judgemental about their thoughts, feelings, or actions. Perhaps having multiple interviews with participants, or hanging out within their sport contexts, would have given me opportunities to show consistent care for them and their tales and consequently facilitated participants' storytelling.

The sampling methods used for the three studies can be considered as both a strength and weakness of the current research. The participants who took part in these studies were interested in the topic of client-practitioner relationships and willing to talk about their experiences. These volunteers valued professional relationships. Some said, after the interviews, that the opportunity to discuss their practices was a useful self-reflection exercise. As researchers (e.g., Winstone & Gervis, 2006) have found, a small proportion of practitioners are likely to be self-reflective and use such skills to manage their professional relationships. Perhaps, through talking with self-reflective practitioners, I heard more of the *good* stories about relationships in injury rehabilitation

and less of the *bad* and the *ugly* than I expected. The inherent difficulties of a self-selecting sample and a potentially limited range of experiences, however, are hard to overcome.

One drawback of the current research is that I only collected practitioners' stories. Gaining athletes' perspectives was beyond the scope of this thesis, but would be especially useful to aid understanding of athletes' perceptions of client-practitioner relationships and their influence on recoveries. Researchers who have investigated social support in sport injury rehabilitation have found that athletes' perceived support is more important to their recoveries than their received support (e.g., Bianco, 2001). Providing insight into how athletes perceive the quality of care they receive from practitioners during such challenging times would be beneficial. In addition, investigators may consider in the future triangulating data sources (e.g., client, psychologist, physiotherapist) to provide multiple perspectives on professional relationships and collaboration.

One criticism that can be levelled at letting participants tell their stories in interviews (particularly Study 2), rather than guiding the process in a structured way, was that I gained information about general injury rehabilitation perhaps at the cost of in-depth reports on sport injury rehabilitation. Participants in Study 2 worked in private practices and saw many types of client; they frequently talked about experiences with nonathletes. Although I developed a rich understanding of the different people physiotherapists treat, perhaps I could have modified my interview guide or have been more directive to gain further details about their experiences working with injured athletes.

Future Research

I have several recommendations for future research that could expand knowledge and understanding about client-practitioner and practitioner-practitioner relationships in sport psychology and physiotherapy, specifically in injury rehabilitation. The design of Study 3 was retrospective; two practitioners reflected on the relationship they have had over 12 years of working together. Longitudinal designs could be used to allow for stories to be told as client-practitioner relationships develop. For example, researchers could trace the evolution of professionals' relationships with injured athletes from injury onset through to their returns to sport. Such investigations may illuminate the relationship processes, challenges, and strains that occur over time and provide trainees with examples of how practitioners build, manage, and grow in relationships with athletes. Furthermore, investigators should explore the interactions and relationships between other healthcare practitioners, athletes, and coaches in this manner.

Within the current research, interpersonal relationships (e.g., client-practitioner, practitioner-practitioner) were influenced by the cultural contexts of sport organisations and multidisciplinary team environments. Researchers have reported similar findings in studies on mental toughness and overtraining. Investigators have found that cultural definitions of mental toughness appear to influence individuals' overtraining behaviours and that players' and staff members' (i.e., club culture's) expectations about athletes' abilities to cope with pain had negative repercussions for athletes' rehabilitation experiences (Tibbert et al., 2014). Investigators could examine how client-practitioner relationships (such as athlete-psychologist, athlete-physiotherapist, athlete-physician) are moulded by cultural expectations and norms within sporting environments. Such knowledge could be useful in understanding the social forces that shape client-

practitioner relationships and rehabilitation systems within sport. These findings could also help in developing environments that facilitate athletes' recoveries.

Furthermore, investigators could provide further stories of expert practitioners' professional relationships. In Study 3, I told the story of two experienced professionals (Stage 5 of 6) according to Rønnestad and Skovholt's (2003) model of counsellor development. Although these practitioners are proficient in their techniques and relationships, other psychologists and physiotherapists, who have practiced for longer than Anna and Jane, could provide stories of their relationships with injured athletes over their careers. Life histories (see Runyan, 1982, 2006) of seasoned practitioners who, according to Rønnestad and Skovholt's framework, are in the senior professional phase (Stage 6 of 6) and have had 20 to 25 years (or more) of experience could be beneficial additions to the injury rehabilitation research literature.

Along with qualitative studies, researchers could also use mixed method approaches, such as surveys or questionnaires, to collect both qualitative and quantitative data about practitioners' relationship-skill awareness, training, and experiences. Such investigations could allow for researchers to capture a larger sample of professionals than would be possible through solely using interviews. Furthermore, behavioural observations of clients and practitioners could elicit insights into client-practitioner relationships *in situ*. If these investigations were accompanied by client and practitioner interviews, such data triangulation could provide rich information in regards to effective and ineffective behaviours in client-practitioner relationships in sport injury rehabilitation. In addition, experiments may be able to offer some causal links between relationship characteristics or practices and injury rehabilitation outcomes. Such findings would provide an empirical basis from which researchers could direct training and education in service provision within sport injury rehabilitation. For example, a

study based on an interpersonal mindfulness training intervention for practitioners may provide useful insight into the potential links between psychological presence, attunement, resonance and psychological or physical treatment outcomes in injury rehabilitation.

In summary, research into client-practitioner relationships in sport injury rehabilitation is in its infancy. Researchers who are interested in developing knowledge and understanding of client-practitioner relationships in sport injury rehabilitation should first pursue qualitative inquiry, such as those investigations I have previously highlighted. Findings from these studies would provide a useful foundation on which other modes of investigation can be built.

Researcher in the Research Process

Finally, I have reflected on how my research and the relationships I had with supervisors, participants, and myself, have shaped me as a researcher (and, potentially, changed my brain). From my own experiences as an injured athlete and as a trainee sport psychologist, I entered my doctoral studies with an understanding that relationships are important in healthcare. Throughout my studies, I have thought deeply about the responses I would give to the questions I asked participants. For example, as I have explored practitioners' motivations for entering the profession, I too have examined my motivations for entering my doctoral studies and the field of sport psychology. I realised that I was partly motivated to study sport injuries to understand myself and heal my past. This latter motivation only became apparent in the process of Study 3 when I attempted to enter Anna's story through my extravagant reinforcements, because I had found a physiotherapist that I wished I had in my youth.

I have learned from the experiences of qualified healthcare practitioners and internalised stories of how these carers developed and maintained their relationships

with their clients. The participants' tales of the good, the bad, and the ugly of client-practitioner relationships will guide me in helping others to be *good-enough* practitioners and researchers. I have also internalised models of my supervisors, and I go to these representations when needed. For example, all three supervisors (in their own ways) possess Rogerian characteristics in spades, and at times of confusion and stress, they helped downregulate my anxieties about being a *good-enough* researcher.

Conclusion

The aims of this thesis were to explore sport psychologists' and physiotherapists' relationships with injured athletes and to provide a case study of a collaborative relationship between a psychologist and a physiotherapist who work together to rehabilitate injured athletes. By using qualitative methodologies I was able to gain rich data of practitioners' encounters with injured athletes and learn about the joys, frustrations, and challenges they faced within these relationships. The majority of participants enjoyed working with injured athletes and shared many examples of strong working alliances within rehabilitation. These participants also encountered several challenges and frustrations, and their difficulties were on intrapersonal (e.g., compassion fatigue), interpersonal (e.g., athletes usurping practitioners in treatment), and organisational (e.g., reactive referral systems) levels. Further training in relationships (for physiotherapists and psychologists) and psychology (for physiotherapists) and bringing organisational constraints to the attention of relevant parties (e.g., multidisciplinary team members, performance directors, managers) could help practitioners improve the quality of relationships they have with athletes and other practitioners. As a consequence, such measures could positively influence athletes' recoveries.

I have made several recommendations that could improve the quality of client-practitioner relationships in sport injury rehabilitation and, hopefully, treatment outcomes. Although several of the suggestions made from these findings are sport-specific, the results could benefit professionals working in injury rehabilitation outside of sport contexts. Furthermore, the key recommendation central to the current findings relates to practitioners' philosophies of care. Many researchers and practitioners advocate client-centred healthcare. This approach, however, requires a fundamental shift from medical models of treatment (i.e., client is a relatively passive recipient of care) to frameworks that embrace clients as active participants and collaborators within their treatments. As was evident in the current research, client-centred practices seemed to be an add-on for some professionals, which can manifest as dissonance within interpersonal messages to clients. Based on the current findings, for practitioners to aid injured athletes' recoveries, training within institutions and in professional development courses should shift towards encouraging practitioners to adopt client-centred philosophies rather than teaching adjunct client-centred practices.

REFERENCES

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Alexander, D. A. (1973). Yes, but what about the patient? *Physiotherapy, 59*, 391–393.

Alexander, L. B., & Luborsky, L. (1987). The Penn Helping Alliance Scales. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325–366). New York, NY: Guilford Press.

Andersen, M. B. (2000a). Beginnings: Intakes and the initiation of relationships. In M. B. Andersen (Ed.), *Doing sport psychology* (pp. 3–16). Champaign, IL: Human Kinetics.

Andersen, M. B. (Ed.). (2000b). *Doing sport psychology*. Champaign, IL: Human Kinetics.

Andersen, M. B. (2004a). Recognising psychopathology. In G. S. Kolt & M. B. Andersen (Eds.), *Psychology in the physical and manual therapies* (pp. 81–92). Edinburgh, Scotland: Churchill Livingstone.

Andersen, M. B. (2004b). Transference and countertransference. In G. S. Kolt & M. B. Andersen (Eds.), *Psychology in the Physical and Manual Therapies* (pp. 71–80). Edinburgh, Scotland: Churchill Livingstone.

Andersen, M. B. (Ed.). (2005a). *Sport psychology in practice*. Champaign, IL: Human Kinetics.

Andersen, M. B. (2005b). Touching taboos: Sex and the sport psychologist. In M. B. Andersen (Ed.), *Sport psychology in practice* (pp. 171–192). Champaign, IL: Human Kinetics.

Andersen, M. B. (2007). Collaborative relationships in injury rehabilitation: Two case examples. In D. Pargman (Ed.), *Psychological bases of sport injuries* (3rd ed., pp. 219–236). Morgantown, WV: Fitness Information Technology.

Andersen, M. B. (2009). Performance enhancement as a bad start and a dead end: A parenthetical comment on Mellalieu and Lane. *The Sport and Exercise Scientist, 20*, 12–14.

Andersen, M. B. (2011). Who's mental? Who's tough and who's both? Mutton constructs dressed up as lamb. In D. F. Gucciardi & S. Gordon (Eds.), *Mental toughness in sport: Developments in research and theory* (pp. 69–88). New York, NY: Routledge.

Andersen, M. B. (2012). Supervision and mindfulness in sport and performance psychology. In S. Murphy (Ed.), *The Oxford handbook of sport and performance psychology* (pp. 725–737). New York, NY: Oxford University Press.

Andersen, M. B. (2014a). The (sport) psychologist in spite of himself. In P. McCarthy & M. Jones (Eds.), *Becoming a sport psychologist.* (pp. 87–95). New York, NY: Routledge.

Andersen, M. B. (2014b). Working with an anxious and psychologically abused athlete: A mindful, neuropsychotherapy approach. In P. J. Rossouw (Ed.), *Neuropsychotherapy: Theoretical underpinnings and clinical applications* (pp. 193–208). Brisbane, QLD, Australia: Mediros.

Andersen, M. B., & Mannion, J. (2011). If you meet the Buddha on the football field, tackle him! In D. Gilbourne & M. B. Andersen (Eds.), *Critical essays in applied sport psychology* (pp. 173–192). Champaign, IL: Human Kinetics.

Andersen, M. B., McCullagh, P., & Wilson, G. J. (2007). But what do the numbers really tell us?: Arbitrary metrics and effect size reporting in sport psychology research. *Journal of Sport & Exercise Psychology, 29*, 664–672.

Andersen, M. B., & Speed, H. D. (2010). Therapeutic relationships in applied sport psychology. In S. J. Hanrahan & M. B. Andersen (Eds.), *Routledge handbook of applied sport psychology: A comprehensive guide for students and practitioners* (pp. 3–11). Abingdon, England: Routledge.

Andersen, M. B., & Speed, H. D. (2011). The practitioner and client as storytellers: Metaphors and folktales in applied sport psychology practice. In D. Gilbourne & M. B. Andersen (Eds.), *Critical essays in applied sport psychology* (pp. 87–104). Champaign, IL: Human Kinetics.

Andersen, M. B., & Stevens, L. M. (2007). On being a fraud. *Sport & Exercise Psychology Review, 3*(2), 43–46.

Andersen, M. B., Van Raalte, J. L., & Brewer, B. W. (2000). When sport psychology consultants and graduate students are impaired: Ethical and legal issues in training and supervision. *Journal of Applied Sport Psychology, 12*, 134–150. doi:10.1080/10413200008404219

Andersen, M. B., Van Raalte, J. L., & Brewer, B. W. (2001). Sport psychology service delivery: Staying ethical while keeping loose. *Professional Psychology: Research and Practice, 32*, 12–18. doi:10.1037/0735-7028.32.1.12

Andersen, M. B., Van Raalte, J. L., & Harris, G. (2000). Supervision II: A case study. In M. B. Andersen (Ed.), *Doing sport psychology* (pp. 167–179). Champaign, IL: Human Kinetics.

Andersen, M. B., & Williams-Rice, B. T. (1996). Supervision in the education and training of sport psychology service providers. *The Sport Psychologist, 10*, 278–290.

Anderson, A. G., Miles, A., Robinson, P., & Mahoney, C. (2004). Evaluating the athlete's perception of the sport psychologist's effectiveness: What should we be assessing? *Psychology of Sport and Exercise, 5*, 255–277. doi:10.1016/s1469-0292(03)00005-0

Anderson, A. G., Knowles, Z., & Gilbourne, D. (2004). Reflective practice for sport psychologists: Concepts, models, practical implications, and thoughts on dissemination. *The Sport Psychologist, 18*, 188–203.

Anderson, R., & Anderson, G. (1962). Development of an instrument for measuring rapport. *Personnel Guidance Journal, 41*, 18–24. doi:10.1002/j.2164-4918.1962.tb02226.x

Ang, A. Y., Cooper, I., & Jenkins, S. (2010). Sexual professional boundaries: Physiotherapy students' experiences and opinions. *New Zealand Journal of Physiotherapy, 38*, 106–112.

Arvinen-Barrow, M., Penny, G., Hemmings, B., & Corr, S. (2010). UK chartered physiotherapists' personal experiences in using psychological interventions with injured athletes: An interpretative phenomenological analysis. *Psychology of Sport and Exercise, 11*, 58–66. doi:10.1016/j.psychsport.2009.05.004

Arvinen-Barrow, M., & Walker, N. (Eds). (2013). *The psychology of sport injury and rehabilitation*. London, England: Taylor & Francis.

Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy: Theory, Research, Practice, Training, 28*, 534–549. doi:10.1037/0033-3204.28.4.534

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: Norton.

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology, 68*, 1027–1032. doi:10.1037//0022-006X.68.6.1027

Barney, S. T., & Andersen, M. B. (2014). Mindful supervision in sport and performance psychology: Building the quality of the supervisor-supervisee relationship. In Z. Knowles, D. Gilbourne, B. Copley & L. Dugdill (Eds.), *Reflective practice in sport and exercise sciences: Contemporary issues* (pp. 147–159). London, England: Routledge.

Bassett, S. F., & Tango, S. M. (2002). Mäori people's experiences of being physiotherapy patients: A phenomenological study. *New Zealand Journal of Physiotherapy, 30*, 30–40.

Beck, A. T., & Steer, R. A. (1987). *Beck Depression Inventory manual*. San Antonio, TX: Harcourt Brace.

Behm, J., & Gray, N. (2012). Interdisciplinary rehabilitation team. In K. L. Mauk (Ed.), *Rehabilitation nursing: A contemporary approach to practice* (5th ed., pp. 51–63). Sudbury, MA: Jones & Bartlett Learning.

Bellner, A. L. (1999). Senses of responsibility: A challenge for occupational and physical therapists in the context of ongoing professionalization. *Scandinavian Journal of Caring Sciences, 13*, 55–62. doi:10.1111/j.1471-6712.1999.tb00515.x

Besley, J., Kayes, N. M., & McPherson, K. M. (2011). Assessing therapeutic relationships in physiotherapy: Literature review. *New Zealand Journal of Physiotherapy, 39*, 81–91.

Bianco, T. (2001). Social support and recovery from sport injury: Elite skiers share their experiences. *Research Quarterly for Exercise and Sport, 72*, 376–388. doi:10.1080/02701367.2001.10608974

Bianco, T., Malo, S., & Orlick, T. (1999). Sport injury and illness: Elite skiers describe their experiences. *Research Quarterly for Exercise and Sport, 70*, 157–169. doi:10.1080/02701367.1999.10608033

Bird, C. M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry, 11*, 226–248. doi:10.1177/1077800404273413

Blanton, H. , & Jaccard, J. (2006). Arbitrary metrics in psychology. *American Psychologist, 61*, 27–41. doi:10.1037/0003-066X.61.1.27

Bordin, E. S. (1975, September). *The working alliance: Basis for a general theory of psychotherapy*. Paper presented at the annual meeting of the Society of Psychotherapy Research, Washington, DC.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252–260. doi:10.1037/h0085885

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13–37). New York, NY: Wiley.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. doi:10.1191/1478088706qp063oa

Breuer, J., & Freud, S. (1953). Studies on hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 397–402). London, England: Hogarth. (Original work published 1893)

Brewer, B. W., Andersen, M. B., & Van Raalte, J. L. (2002). Psychological aspects of sport injury rehabilitation: Toward a biopsychosocial approach. In D. I. Mostofsky & L. D. Zaichkowsky (Eds.), *Medical and psychological aspects of sport and exercise* (pp. 41–54). Morgantown, WV: Fitness Information Technology.

Brewer, B. W., Van Raalte, J. L., & Petitpas, A. J. (2007). Patient-practitioner interactions in sport injury rehabilitation. In D. Pargman (Ed.), *Psychological bases of sport injuries* (3rd ed., pp. 79–94). Morgantown, WV: Fitness Information Technology.

Brown, J. L., & Cogan, K. D. (2006). Ethical clinical practice and sport psychology: When two worlds collide. *Ethics & Behavior, 16*(1), 15–23. doi:10.1207/s15327019eb1601_3

Burke, K. L. (2010). Constructive communication. In S. J. Hanrahan & M. B. Andersen (Eds.), *Routledge handbook of applied sport psychology: A comprehensive guide for students and practitioners* (pp. 315–324). Abingdon, England: Routledge.

Burlingame, G. M., McClendon, D. T., & Alonso, J. (2011). Cohesion in group therapy. *Psychotherapy, 48*, 34–42. doi:10.1037/a0022063

Burns, J. W., & Evon, D. (2007). Common and specific process factors in cardiac rehabilitation: Independent and interactive effects of the working alliance and self-efficacy. *Health Psychology, 26*, 684–692. doi:10.1037/0278-6133.26.6.684

Carr, L., Iacoboni, M., Dubeau, M. C., Mazziotta, J. C., & Lenzi, G. L. (2003). Neural mechanisms of empathy in humans: A relay from neural systems for imitation to limbic areas. *National Academy of Sciences, USA, 100*, 5497–5502. doi:10.1073/pnas.0935845100

Carter, J. A. (1996). Measuring transference: Can we identify what we have not defined? *Journal of Counseling Psychology, 43*, 257–258. doi:10.1037/0022-0167.43.3.257

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy, 43*, 271–279. doi:10.1037/0033-3204.43.3.271

Chartrand, T. L., & Bargh, J. A. (1999). The chameleon effect: The perception-behavior link and social interaction. *Journal of Personality and Social Psychology, 76*, 893–910. doi:10.1037/0022-3514.76.6.893

Clement, D., & Arvinen-Barrow, M. (2013). Sport medicine team influences in psychological rehabilitation. In M. Arvinen-Barrow & N. Walker (Eds.), *The psychology of sport injury and rehabilitation* (pp. 156–170). London, England: Taylor & Francis.

Cooper, I., & Jenkins, S. (2008). Sexual boundaries between physiotherapists and patients are not perceived clearly: An observational study. *Australian Journal of Physiotherapy, 54*, 275–279. doi:10.1016/S0004-9514(08)70007-2

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). New York, NY: Norton.

Cozolino, L. (2014). *The neuroscience of human relationships: Attachment and the developing social brain* (2nd ed.). New York, NY: Norton.

Crits-Christoph, P., Gibbons, M. B., Hamilton, J., Ring-Kurtz, S., & Gallop, R. (2011). The dependability of alliance assessments: The alliance-outcome correlation is larger than you might think. *Journal of Consulting and Clinical Psychology, 79*, 267–278. doi:10.1037/a0023668

Crossman, J. (2001). *Coping with sports injuries: Psychological strategies for rehabilitation*. New York, NY: Oxford University Press.

Cupal, D. D., & Brewer, B. W. (2001). Effects of relaxation and guided imagery on knee strength, reinjury anxiety, and pain following anterior cruciate ligament reconstruction. *Rehabilitation Psychology, 46*, 28–43. doi:10.1037/0090-5550.46.1.28

Dahlgren, M. A. (1998). Learning physiotherapy: Students' ways of experiencing the patient encounter. *Physiotherapy Research International, 3*, 257–273. doi:10.1002/pri.149

Davis, L., Jowett, S., & Lafrenière, M. K. (2013). An attachment theory perspective in the examination of relational processes associated with coach-athlete dyads. *Journal of Sport & Exercise Psychology, 35*, 156–167.

Decety, J., & Grèzes, J. (2006). The power of simulation: Imagining one's own and other's behavior. *Brain Research, 1079*(1), 4–14. doi:10.1016/j.brainres.2005.12.115

Decety, J., & Jackson, P. L. (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews, 3*, 71–100. doi:10.1177/1534582304267187

Decety, J., & Jackson, P. L. (2006). A social-neuroscience perspective on empathy. *Current Directions in Psychological Science, 15*, 54–58. doi:10.1111/j.0963-7214.2006.00406.x

Denzin, N. K., & Lincoln, Y. S. (2005). *The SAGE handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Dunn, J. G. H., & Holt, N. L. (2003). Collegiate ice hockey players' perceptions of the delivery of an applied sport psychology program. *The Sport Psychologist, 17*, 351–368.

Egan, G. (2002). *The skilled helper: A problem-management and opportunity-development approach to helping* (7th ed.). Pacific Grove, CA: Brooks/Cole.

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*, 43–49. doi:10.1037/a0022187

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review, 28*, 1167–1187. doi:10.1016/j.cpr.2008.04.002

Epstein, M. (1995). *Thoughts without a thinker: Psychotherapy from a Buddhist perspective*. New York, NY: Basic Books.

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2010). Alliance ruptures and resolution. In J. C. Muran & J. P. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 74–94). New York, NY: Guilford Press.

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2014, August 25). Alliance-focused training. *Psychotherapy*. Advance online publication. doi:10.1037/a0037596

Evans, L., Hardy, L., & Fleming, S. (2000). Intervention strategies with injured athletes: An action research study. *The Sport Psychologist, 14*, 188–206.

Farber, B. A., & Doolin, E. M. (2011). Positive regard. *Psychotherapy, 48*, 58–64. doi:10.1037/a0022141

Fauth, J., & Hayes, J. A. (2006). Counselors' stress appraisals as predictors of countertransference behavior with male clients. *Journal of Counseling and Development, 84*, 430–439. doi:10.1002/j.1556-6678.2006.tb00427.x

Ferreira, P. H, Ferreira, M. L, & Maher, C. G, et al. (2009). *The therapeutic alliance between physiotherapists and patients predicts outcome in chronic low back pain.* Paper presented at the 10th International Forum on Primary Care Research on Low Back Pain: LBP Forum X 2009, Boston, MA.

Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 59*, 10–17. doi:10.1037/a0025749

Forchuck, C., & Reynolds, W. (2001). Clients' reflections on relationships with nurses: Comparisons from Canada and Scotland. *Journal of Psychiatric and Mental Health Nursing, 8*, 45–51. doi:10.1046/j.1365-2850.2001.00344.x

Francis, S. R., Andersen, M. B., & Maley, P. (2000). Physiotherapists' and male professional athletes' views on psychological skills for rehabilitation. *Journal of Science and Medicine in Sport, 3*, 17–29. doi:10.1016/s1440-2440(00)80044-4

Freeth, D., Hammick, M., Koppel, I., Reeves, S., & Barr, H. (2002). *A critical review of evaluations of interprofessional education* (Occasional Paper No. 2). Retrieved from: http://www.hsaparchive.org.uk/rp/publications/occasionalpaper/occasionalpaper02.pdf

Freud, S. (1958a). The dynamics of transference. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99–108). London, England: Hogarth. (Original work published 1912)

Freud, S. (1958b). Recommendations to physicians practicing psychoanalysis. In J. Stachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 111–120). London, England: Hogarth. (Original work published 1912)

Friedlander, M. L., Escudero, V., Annaington, L., & Diamond, G. M. (2011). Alliance in couple and family therapy. *Psychotherapy, 48*, 25–33. doi:10.1037/a0022060

Friedman, S. M., & Gelso, C. J. (2000). The development of the inventory of countertransference behavior. *Journal of Clinical Psychology, 56*, 1221–1235. doi:10.1002/1097-4679(200009)56:9<1221::AID-JCLP8>3.0.CO;2-W

Gallois, C., Bent, A., Best, M., Dwyer, J., Fitch, S., Jack, M., & Kalman, R. (1979). Non-verbal behaviour in same-sex and mixed-sex physiotherapist-patient interactions. *Australian Journal of Physiotherapy, 25*, 5–9. doi:10.1016/S0004-9514(14)61221-6

Gaston, L., Piper, W. E., Debbane, E. G., Bienvenu, J. P., & Garant, J. (1994). Alliance and technique for predicting outcome in short- and long-term analytic psychotherapy. *Psychotherapy Research, 4*, 121–135. doi:10.1080/10503309412331333952

Gehrs, M., & Goering, P. (1994). The relationship between the working alliance and rehabilitation outcomes of schizophrenia. *Psychosocial Rehabilitation Journal, 18*, 43–54. doi:10.1037/h0095517

Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist, 13*, 155–243. doi:10.1177/0011000085132001

Gentner, N. B., Fisher, L. A., & Wrisberg, C. A. (2004). Athletes' and coaches' perceptions of sport psychology services offered by graduate students at one

NCAA Division I university. *Psychological Reports, 94*, 213–216. doi:10.2466/PR0.94.1.213-216

Glen, S. (1999). Educating for interprofessional collaboration: Teaching about values. *Nursing Ethics, 6*, 202–213.

Goldberg, E. (2001). *The executive brain: Frontal lobes and the civilized mind*. New York, NY: Oxford University Press.

Gordon, S., Hamer, P., & Potter, M. (2003). The difficult patient in private practice physiotherapy: A qualitative study. *Australian Journal of Physiotherapy, 49*, 53–61. doi:10.1016/S0004-9514(14)60188-4

Gordon, S., Potter, M., & Hamer, P. (2001). The role of the physiotherapist and sport therapist. In J. Crossman (Ed.), *Coping with sports injuries: Psychological strategies for rehabilitation* (pp. 62–82). New York, NY: Oxford University Press.

Gould, D., Murphy, S., Tammen, V., & May, J. (1991). An evaluation of U.S. Olympic sport psychology consultant effectiveness. *The Sport Psychologist, 5*, 111–127.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis* (Vol. 1). Madison, CT: International University Press.

Grove, J. R., & Cresswell, S. L. (2007). Personality correlates of appraisal, stress, and coping during injury rehabilitation. In D. Pargman (Ed.), *Psychological bases of sport injuries* (3rd ed., pp. 53–78). Morgantown, WV: Fitness Information Technology.

Gurman, A. S. (1977). The patient's perception of the therapeutic relationship. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 503–543). New York, NY: Pergamon Press.

Gyllensten, A. L., Gard, G., Salford, E., & Ekdahl, C. (1999). Interaction between patient and physiotherapist: A qualitative study reflecting the physiotherapist's perspective. *Physiotherapy Research International, 4*, 89–109. doi:10.1002/pri.156

Gyllensten, A. L., Gard, G., Hansson, L., & Ekdahl, C. (2000). Interaction between patient and physiotherapist in psychiatric care – the physiotherapist's perspective. *Advances in Physiotherapy, 2*, 157–167. doi:10.1080/140381900750063427

Gyllensten, A. L., Hansson, L., & Ekdahl, C. (2003). Patient experiences of basic body awareness therapy and the relationship with the physiotherapist. *Journal of Bodywork and Movement Therapies, 7*, 173–183. doi:10.1016/s1360-8592(02)00068-2

Haberl, P., & Peterson, K. (2006). Olympic-size ethical dilemmas: Issues and challenges for sport psychology consultants on the road and at the Olympic games. *Ethics & Behavior, 16*(1), 25–40. doi:10.1207/s15327019eb1601_4

Hall, A. M., Ferreira, P. H., Maher, C. G., Latimer, J., & Ferreira, M. L. (2010). The influence of the therapist-patient relationship on treatment outcome in physical rehabilitation: A systematic review. *Physical Therapy, 90*, 1099–1110. doi:10.2522/ptj.20090245

Hanrahan, S. J., & Andersen, M. B. (Eds). (2010). *Routledge handbook of applied sport psychology: A comprehensive guide for students and practitioners*. Abingdon, England: Routledge.

Hargreaves, S. (1982). The relevance of non-verbal skills in physiotherapy. *Australian Journal of Physiotherapy, 28*, 19–22. doi:10.1016/S0004-9514(14) 60774-1

Harris, P., Atkins, R. C., & Alwyn, T. (2010). Evaluating a complementary therapies clinic: Outcomes and relationships. *Complementary Therapies in Clinical Practice, 16*, 31–35. doi:10.1016/j.ctcp.2009.06.005

Hartley, D. E., & Strupp, H. H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. In J. Masling (Ed.), *Empirical studies of psychoanalytic theories* (Vol. 1, pp. 1–37). Hillsdale, NJ: Analytical Press.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy, 48*, 88–97. doi:10.1037/a0022182

Hays, K. F. (2009). *Performance psychology in action: A casebook for working with athletes, performing artists, business leaders, and professionals in high-risk occupations*. Washington, DC: American Psychological Association.

Heidegger, M. (1962). *Being and time*. Oxford, England: Blackwell.

Henley, R. C. A., & Miller, S. D. (2010). Possible applications of psychotherapy outcome research to traditional Chinese medicine. *Journal of Complementary and Integrative Medicine, 7*, 1–13.

Henschen, K. (1991). Critical issues involving male consultants and female athletes. *The Sport Psychologist, 5*, 313–321.

Hick, S., & Bien, T. (Eds). (2008). *Mindfulness and the therapeutic relationship*. New York, NY: Guilford Press.

Higdon, L. (1997). *Patient hostility, the working alliance, and treatment outcome in a work hardening center.* (Unpublished doctoral thesis), Finch University of Health Sciences/Chicago Medical School, Chicago, IL.

Hills, R., & Kitchen, S. (2007). Satisfaction with outpatient physiotherapy: Focus groups to explore the views of patients with acute and chronic musculoskeletal

conditions. *Physiotherapy Theory and Practice, 23*, 1–20. doi:10.1080/09593980601023705

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology, 56*, 163–173.

Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*, 365–372. doi:10.1037/0033-3204.38.4.365

Horvath, A. O. (2009). *Conceptual and methodological challenges in alliance research: Is it time for a change?* Paper presented at the Society for Psychotherapy Research European Division, Bolzano, Italy.

Horvath, A. O. (2011). Alliance in common factor land: A view through the research lens. *Research in Psychotherapy: Psychopathology, Process and Outcome, 14*, 121–135.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (1st ed., pp. 37–69). New York, NY: Oxford University Press.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*, 9–16. doi:10.1037/a0022186

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223–233. doi:10.1037/0022-0167.36.2.223

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139–149. doi:10.1037/0022-0167.38.2.139

Hush, J. M., Cameron, K., & Mackey, M. (2011). Patient satisfaction with musculoskeletal physical therapy care: A systematic review. *Physical Therapy, 91*, 25–36. doi:10.2522/ptj.20100061

Husserl, E. (1999). *The idea of phenomenology* (L. Hardy, Trans.). Dordrecht, Netherlands: Kluwer Academic.

Iacoboni, M. (2008). *Mirroring people*. New York, NY: Farrar, Straus, & Giroux.

Iacoboni, M., & Mazziotta, J. C. (2007). Mirror neuron system: Basic findings and clinical applications. *Annals of Neurology, 62*, 213–218. doi:10.1002/ana.21198

Iacoboni, M., Woods, R. P., Brass, M., Bekkering, H., Mazziotta, J. C., & Rizzolatti, G. (1999). Cortical mechanisms of human imitation. *Science, 286*, 2526–2528. doi:10.1126/science.286.5449.2526

Johnson, U. (2000). Short-term psychological intervention: A study of long-term-injured competitive athletes. *Journal of Sport Rehabilitation, 9*, 207–218.

Johnston, L. H., & Carroll, D. (1998). The provision of social support to injured athletes: A qualitative analysis. *Journal of Sport Rehabilitation, 7*, 267–284.

Jowett, S. (2005). On repairing and enhancing the coach-athlete relationship. In S. Jowett & M. Jones (Eds.), *The psychology of coaching* (pp. 14–26). Leicester, England: The British Psychological Society.

Jowett, S., & Ntoumanis, N. (2004). The coach-athlete relationship questionnaire (CART–Q): Development and initial validation. *Scandinavian Journal of Medicine & Science in Sports, 14*, 245–257. doi:10.1111/j.1600-0838.2003.00338.x

Kolden, G. G., Klein, M. H., Wang, C. C., & Austin, S. B. (2011). Congruence/genuineness. *Psychotherapy, 48*, 65–71. doi:10.1037/a0022064

Kolt, G. S. (2004). Injury from sport, exercise, and physical activity. In G. S. Kolt & M. B. Andersen (Eds.), *Psychology in the physical and manual therapies* (pp. 247–268). Edinburgh, Scotland: Churchill Livingstone.

Kolt, G. S., & Andersen, M. B. (Eds.). (2004a). *Psychology in the Physical and Manual Therapies*. Edinburgh, Scotland: Churchill Livingstone.

Kolt, G. S., & Andersen, M. B. (2004b). Using psychology in the physical and manual therapies. In G. S. Kolt & M. B. Andersen (Eds.), *Psychology in the Physical and Manual Therapies* (pp. 3–8). Edinburgh, Scotland: Churchill Livingstone.

Kraft, M., Blomberg, K., & Hedman, A-M. R. (2014). The health care professionals' perspectives of collaboration in rehabilitation – an interview study. *International Journal of Older People Nursing, 9*, 209–216. doi:10.1111/opn.12020

Kübler-Ross, E. (1969). *On death and dying*. New York, NY: Touchstone.

Ladyshewsky, R., & Gotjamanos, E. (1997). Communication skill development in health professional education: The use of standardised patients in combination with a peer assessment strategy. *Journal of Allied Health, 26*, 177–186.

Lapadat, J. C., & Lindsay, A. C. (1999). Transcription in research and practice: From standardization of technique to interpretive positionings. *Qualitative Inquiry, 5*(1), 64–86. doi:10.1177/107780049900500104

Little, G., & Harwood, C. (2010). Enhancing our understanding of the potential violation of sexual boundaries in sport psychology consultancy. *Journal of Clinical Sport Psychology, 4*, 302–311.

Lloyd, R. J., & Trudel, P. (1999). Verbal interactions between an eminent mental training consultant and elite level athletes: A case study. *The Sport Psychologist, 13*, 418–443.

Lorimer, R. (2009). Coaches' satisfaction with their athletic partnerships. *International*

Journal of Coaching Science, *3*, 55–64.

Lubker, J. R., Visek, A. J., Geer, J. R., & Watson, J. C. (2008). Characteristics of an effective sport psychology consultant: Perspectives from athletes and consultants. *Journal of Sport Behavior, 31*, 147–165.

Luborsky, L. (1971). *The therapy session checksheet: A method for maximizing psychotherapists' research capacity*. Unpublished Manuscript.

Magyar, T. M., & Duda, J. L. (2000). Confidence restoration following athletic injury. *The Sport Psychologist, 14*, 372–390.

Mahrer, A. R. (2005). What inspired me to become a psychotherapist? *Journal of Clinical Psychology, 61*, 957–964. doi:10.1002/jclp.20168

Mannion, J., & Andersen, M. B. (2015). Mindfulness, therapeutic relationships, and neuroscience in applied exercise psychology. In M. B. Andersen & S. J. Hanrahan (Eds.), *Doing exercise psychology* (pp. 3–18). Champaign, IL: Human Kinetics.

Marchant, D. (2010). Anxiety. In S. J. Hanrahan & M. B. Andersen (Eds.), *Routledge handbook of applied sport psychology: A comprehensive guide for students and practitioners* (pp. 260–269). Abingdon, England: Routledge.

Marmar, C. R., Gaston, L., Gallagher, D., & Thompson, L. W. (1989). Alliance and outcome in late-life depression. *Journal of Nervous and Mental Disease, 177*, 464–472.

Marmar, C. R., Weiss, D. S., & Gaston, L. (1989). Towards the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1*, 46–52. doi:10.1037/1040-3590.1.1.46

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438–450. doi:10.1037/0022-006x.68.3.438

Martin, V. (2007). Dialogue in the narrative process. *Medical Humanities, 33*, 49–54. doi:10.1136/jmh.2007.000246

May, S. J. (2001). Patient satisfaction with management of back pain. *Physiotherapy, 87*, 4–20. doi:10.1016/s0031-9406(05)61186-8

McCabe, R., Priebe, S., Röder-Wanner, U. U., & Hoffmann, K. (1999). Therapeutic relationships and quality of life: Association of two subjective constructs in schizophrenia patients. *International Journal of Social Psychiatry, 45*, 276–283. doi:10.1177/002076409904500406

Mental Health First Aid Australia. (n.d.). *Mental health first aid*. Retrieved from https://mhfa.com.au

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. London, England: Sage.

Miller, K., Riley, W., & Davis, S. (2009). Identifying key nursing and team behaviours to achieve high reliability. *Journal of Nursing Management, 17*, 247–255. doi:10.1111/j.1365-2834.2009.00978.x

Minichiello, V., Aroni, R., & Hays, T. N. (2008). *In-depth interviewing: Principles, techniques, analysis* (3rd ed.). Sydney, NSW, Australia: Pearson.

Mirsky, J. E. (2002). *Anger expression, working alliance, and treatment outcome following multidisciplinary chronic pain treatment* (Unpublished doctoral thesis). Illinois Institute of Technology, Chicago, IL.

Morrison, T. L. (2013). Individual and environmental implications of working alliances in occupational therapy. *British Journal of Occupational Therapy, 76*, 507–514. doi:10.4276/030802213X13833255804676

Morrison, T. L., & Smith, J. D. (2013). Working alliance development in occupational therapy: A cross-case analysis. *Australian Occupational Therapy Journal, 60*, 326–333. doi:10.1111/1440-1630.12053

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*, 250–260. doi:10.1037/0022-0167.52.2.250

Moyle, W. (2003). Nurse-patient relationship: A dichotomy of expectations. *International Journal of Mental Health Nursing, 12*, 103–109. doi:10.1046/j.1440-0979.2003.00276.x

Neale, M. S., & Rosenheck, R. A. (1995). Therapeutic alliance and outcome in a VA intensive case management program. *Psychiatric Services, 46*, 719–721. doi:10.1176/ps.46.7.719

Øien, A. M., Steihaug, S., Iversen, S., & Råheim, M. (2011). Communication as negotiation processes in long-term physiotherapy: A qualitative study. *Scandinavian Journal of Caring Sciences, 25*, 53–61. doi:10.1111/j.1471-6712.2010.00790.x

Orlick, T., & Partington, J. (1987). The sport psychology consultant: Analysis of critical components as viewed by Canadian Olympic athletes. *The Sport Psychologist, 1*, 4–17.

Orlinsky, D. E., Botermans, J. F., Rønnestad, M. H., Ambühl, H., Avila-Espada, A., Bae, S., . . . Wiseman, H. (2001). Towards an empirically grounded model of psychotherapy training: Four thousand therapists rate influences on their

development. *Australian Psychologist, 36*, 139–148. doi:10.1080/00050060108259646

Orlinsky, D. E., & Howard, K. I. (1975). *Varieties of psychotherapeutic experience: Multivariate analysis of patients' and therapists' reports.* New York, NY: Teachers College Press.

Papathomas, A. (2011). *Disordered eating in sport: Narrative's turn* (Unpublished doctoral thesis), Loughborough University, Loughborough, England. Retrieved from https://dspace.lboro.ac.uk/2134/9084

Pargman, D. (Ed.). (2007). *Psychological bases of sport injuries* (3rd ed.). Morgantown, WV: Fitness Information Technology.

Parry, R. H. (2004a). Communication during goal-setting in physiotherapy treatment sessions. *Clinical Rehabilitation, 18*, 668–682. doi:10.1191/0269215504cr745oa

Parry, R. H. (2004b). The interactional management of patients' physical incompetence: A conversation analytic study of physiotherapy interactions. *Sociology of Health and Illness, 26*, 976–1007. doi:10.1111/j.0141-9889.2004.00425.x

Parry, R. H. (2008). Are interventions to enhance communication performance in allied health professionals effective, and how should they be delivered? Direct and indirect evidence. *Patient Education and Counseling, 73*, 186–195. doi:10.1016/j.pec.2008.05.029

Partington, J., & Orlick, T. (1987). The sport psychology consultant: Olympic coaches' views. *The Sport Psychologist, 1*, 95–102.

Patton, M. Q. (1990). *Qualitative research and evaluation methods* (2nd ed.). Thousand Oaks, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Payton, O. D., & Nelson, C. E. (1996). A preliminary study of patients' perceptions of certain aspects of their physical therapy experience. *Physiotherapy Theory and Practice, 12*, 27–38.

Perry, J. F. (1975). Non-verbal communication during physical therapy. *Physical Therapy, 55*, 593–600.

Petitpas, A. J. (2000). Managing stress on and off the field: The Littlefoot approach to learned resourcefulness. In M. B. Andersen (Ed.), *Doing sport psychology* (pp. 33–43). Champaign, IL: Human Kinetics.

Petitpas, A. J., & Cornelius, A. (2004). Practitioner-client relationships: Building working alliances. In G. S. Kolt & M. B. Andersen (Eds.), *Psychology in the physical and manual therapies* (pp. 57–70). Edingburgh, Scotland: Churchill Livingstone.

Petitpas, A. J., Giges, B., & Danish, S. J. (1999). The sport psychologist-athlete relationship: Implications for training. *The Sport Psychologist, 13*, 344–357.

Petrie, T., Tebbe, C., & Greenleaf, C. (2005). Sport psychologists' sexual and nonsexual boundary violations with client-athletes. *ISSP 11th world congress of sport psychology: Promoting health and performance for life, CD-ROM*. Sydney, NSW, Australia: International Society of Sport Psychology.

Poczwardowski, A., Sherman, C. P., & Henschen, K. P. (1998). A sport psychology service delivery heuristic: Building on theory and practice. *The Sport Psychologist, 12*, 191–207.

Podlog, L., & Eklund, R. C. (2004). Assisting injured athletes with the return to sport transition. *Clinical Journal of Sport Medicine, 14*, 257–259. doi:10.1097/00042752-200409000-00001

Podlog, L., & Eklund, R. C. (2006). A longitudinal investigation of competitive athletes' return to sport following serious injury. *Journal of Applied Sport Psychology, 18*, 44–68. doi:10.1080/10413200500471319

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42*, 993–1006. doi:10.1037/0003-066X.42.11.993

Portnoy, D. (2011). Burnout and compassion fatigue: Watch for the signs. *Health Progress, 92*(4), 47–51.

Potter, M., Gordon, S., & Hamer, P. (2003). The physiotherapy experience in private practice: The patients' perspective. *Australian Journal of Physiotherapy, 49*, 195–202. doi:10.1016/S0004-9514(14)60239-7

Pratt, J. W. (1978). A psychological view of the physiotherapist's role. *Physiotherapy, 64*, 241–242.

Price, F. L., & Andersen, M. B. (2000). Into the maelstrom: A five-year relationship from college ball to the NFL. In M. B. Andersen (Ed.), *Doing sport psychology* (pp. 193–206). Champaign, IL: Human Kinetics.

Priebe, S., & Gruyters, T. (1995). Patients' assessment of treatment predicting outcome. *Schizophrenia Bulletin, 21*, 87–94.

Priebe, S., & Gruyters, T. (1993). The role of the helping alliance in psychiatric community care: A prospective study. *Journal of Nervous and Mental Disease, 181*, 552–557.

Priebe, S., & McCabe, R. (2008). Therapeutic relationships in psychiatry: The basis of therapy or therapy in itself? *International Review of Psychiatry*, 521–526. doi:10.1080/09540260802565257

Ray, R., & Wiese-Bjornstal, D. M. (Eds.). (1999). *Counseling in sports medicine*. Champaign, IL: Human Kinetics.

Rizzolatti, G., & Craighero, L. (2004). The mirror-neuron system. *Annual Review of Neuroscience, 27*, 169–192. doi:10.1146/annurev.neuro.27.070203.144230

Rogers, C. R. (1946). Significant aspects of client-centered therapy. *American Psychologist, 1*, 415–422. doi:10.1037/h0060866

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Boston, MA: Houghton Mifflin.

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (2007). The necessary and sufficient conditions of therapeutic personality change. *Psychotherapy: Theory, Research, Practice, Training, 44*, 240–248. doi:10.1037/0033-3204.44.3.240 (Reprinted from *Journal of Consulting Psychology,* 1957, Vol. 21, 95–103)

Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*, 5–44. doi:10.1177/089484530303000102

Rossouw, P. J. (2014). Neuropsychotherapy: Towards a theory of brain-based therapy. In P. J. Rossouw (Ed.), *Neuropsychotherapy: Theoretical underpinnings and clinical applications* (pp. 1–20). Brisbane, QLD, Australia: Mediros.

Rubin, F., Judd, M., & Conine, T. A. (1977). Empathy: Can it be learned and retained? *Physical Therapy, 57*, 644–647.

Runyan, W. M. (1982). *Life histories and psychobiography: Explorations in theory and method*. New York, NY: Oxford University Press.

Runyan, W. M. (2006). Psychobiography and the psychology of science: Understanding relations between the life and work of individual psychologists. *Review of General Psychology, 10*, 147–162. doi:10.1037/1089-2680.10.2.147

Saarela, M. V., Hlushchuk, Y., Williams, A. C. de C., Schürmann, M., Kalso, E., & Hari, R. (2007). The compassionate brain: Humans detect intensity of pain from another's face. *Cerebral Cortex, 17*, 230–237. doi:10.1093/cercor/bhj141

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research, and Practice, 27*, 154–165. doi:10.1037/0033-3204.27.2.154

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy, 51*, 381–387. doi:10.1037/a0036815

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology, 56*, 233–243. doi:10.1002/(SICI)1097-4679(200002)56:2<233::AID-JCLP9>3.0.CO;2-3

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*, 80–87. doi:10.1037/a0022140

Safran, J. D., Shaker, A., & Muran, J. C. (2014). Research on therapeutic impasses and ruptures in the therapeutic alliance. *Contemporary Psychoanalysis, 50*, 211–232. doi:10.1080/00107530.2014.880318

Schönberger, M., Humle, F., & Teasdale, T. W. (2006a). The development of the therapeutic working alliance, patients' awareness and their compliance during the process of brain injury rehabilitation. *Brain Injury, 20*, 445–454. doi:10.1080/02699050600664772

Schönberger, M., Humle, F., & Teasdale, T. W. (2006b). Subjective outcome of brain injury rehabilitation in relation to the therapeutic working alliance, client

compliance, and awareness. *Brain Injury, 20*, 1271–1282. doi:10.1080/02699050601049395

Schönberger, M., Humle, F., Zeeman, P., & Teasdale, T. W. (2006). Working alliance and patient compliance in brain injury rehabilitation and their relation to psychosocial outcome. *Neuropsychological Rehabilitation, 16*, 298–314. doi:10.1080/09602010500176476

Schore, A. N. (1994). *Affect regulation and the origin of self: The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.

Sexton, T. L., & Whiston, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist, 22*, 6–78. doi:10.1177/0011000094221002

Sheehan, D., Robertson, L., & Ormond, T. (2007). Comparison of language used and patterns of communication in interprofessional and multidisciplinary teams. *Journal of Interprofessional Care, 21*, 17–30. doi:10.1080/13561820601025336

Sherer, M., Evans, C. C., Leverenz, J., Stouter, J., Irby, J. W., Jr., Lee, J. E., & Yablon, S. A. (2007). Therapeutic alliance in post-acute brain injury rehabilitation: Predictors of strength of alliance and impact of alliance on outcome. *Brain Injury, 21*, 663–672. doi:10.1080/02699050701481589

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. New York, NY: Norton.

Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York, NY: Norton.

Siegel, D. J. (2012). *Developing mind: How relationships and the brain interact to shape who we are*. New York, NY: Guilford Press.

Silverman, J., Kurtz, S. M., & Draper, J. (2005). *Skills for communicating with patients* (2nd ed.). Oxford, England: Radcliffe.

Simons, J. P., & Andersen, M. B. (1995). The development of consulting practice in applied sport psychology: Some personal perspectives. *The Sport Psychologist, 9*, 449–468.

Sinclair, L. B., Lingard, L. A., & Mohabeer, R. N. (2009). What's so great about rehabilitation teams? An ethnographic study of interprofessional collaboration in a rehabilitation unit. *Archives of Physical Medicine and Rehabilitation, 90*, 1196–1201. doi:10.1016/j.apmr.2009.01.021

Skovholt, T. M., & Rønnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 30*, 45–58. doi:10.1177/089484530303000103

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39–54. doi:10.1191/1478088704qp004oa

Smith, J. A., & Eatough, V. (2006). Interpretative phenomenological analysis. In G. Breakwell, C. Fife-Schaw, S. Hammond, & J. A. Smith (Eds.), *Research methods in psychology* (3rd ed., pp. 11–20). London, England: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, England: Sage.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to methods* (pp. 53–80). London, England: Sage.

Soundy, A., Jenkins, S., Cooper, I., & Stubbs, B. (2013). Sexual professional boundaries perceived by undergraduate and graduate physiotherapists: A cross sectional survey. *Physiotherapy, 99*, 298–304. doi:10.1016/j.physio.2012.12.005

Sparkes, A. (2002). *Telling tales in sport and physical activity: A qualitative journey*. Champaign, IL: Human Kinetics.

Stambulova, N., Johnson, U., & Linnér, L. (2014). Insights from Sweden: Halmstad applied sport psychology supervision model. In J. G. Cremades & L. S. Tashman (Eds.), *Becoming a sport, exercise, and performance psychology professional: A global perpective* (pp. 276–284). Abingdon, UK: Routledge.

Stenmar, L., & Nordholm, L. A. (1994). Swedish physical therapists' beliefs on what makes therapy work. *Physical Therapy, 74*, 1034–1039.

Sterba, R. F. (1934). The fate of the ego in analytic therapy. *International Journal of Psychoanalysis, 115*, 117–126.

Stevens, L. M., & Andersen, M. B. (2007a). Transference and countertransference in sport psychology service delivery: Part I. A review of erotic attraction. *Journal of Applied Sport Psychology, 19*, 253–269. doi:10.1080/10413200701314003

Stevens, L. M., & Andersen, M. B. (2007b). Transference and countertransference in sport psychology service delivery: Part II. Two case studies on the erotic. *Journal of Applied Sport Psychology, 19*, 270–287. doi:10.1080/10413200701314011

Stone, J. (2009). *Interprofessional collaborative practice (IPCP) – Definitions and terminology: Attempting to speak the same language.* ACT Health. Retrieved from: http://www.health.act.gov.au/professionals/allied-health/inter-professional-learning

Strean, W. B., & Strean, H. S. (1998). Applying psychodynamic concepts to sport psychology practice. *The Sport Psychologist, 12*, 208–222.

Strean, W. B., & Strean, H. S. (2005). Commentary on Chapter 10. In M. B. Andersen (Ed.), *Sport psychology in practice* (pp. 193–198). Champaign, IL: Human Kinetics.

Sullivan, P. A., & Nashman, H. W. (1998). Self-perceptions of the role of USOC sport psychologists in working with Olympic athletes. *The Sport Psychologist, 12*, 95–103.

Szybek, K., Gard, G., & Lindén, J. (2000). The physiotherapist-patient relationship: Applying a psychotherapy model. *Physiotherapy Theory and Practice, 16*, 181–193. doi:10.1080/095939800458631

Tabor, P. D. (2011). Vicarious traumatization: Concept analysis. *Journal of Forensic Nursing, 7*, 203–208. doi:10.1111/j.1939-3938.2011.01115.x

Talvitie, U., & Reunanen, M. (2002). Interaction between physiotherapists and patients in stroke treatment. *Physiotherapy, 88*, 77–88. doi:10.1016/s0031-9406(05)60931-5

Tattan, T., & Tarrier, N. (2000). The expressed emotion of case managers of the seriously mentally ill: The influence of expressed emotion on clinical outcomes. *Psychological Medicine, 30*, 195–204. doi:10.1017/S0033291799001579

Theodorakis, Y., Malliou, P., Papaionnou, A., Beneca, A., & Filactakidou, A. (1996). The effect of personal goals, self-efficacy, and self-satisfaction on injury rehabilitation. *Journal of Sport Rehabilitation, 5*, 214–223.

Thompson, C., & Andersen, M. B. (2012). Moving toward Buddhist psychotherapy in sport: A case study. *The Sport Psychologist, 26*, 624–643.

Thornquist, E. (1991). Body communication is a continuous process. *Scandinavian Journal of Primary Health Care, 9*, 191–196. doi:10.3109/02813439109018517

Thornquist, E. (1992). Examination and communication: A study of first encounters between patients and physiotherapists. *Family Practitioner, 9*, 195–202.

Thornquist, E. (2006). Face-to-face and hands-on: Assumptions and assessments in the physiotherapy clinic. *Medical Anthropology: Cross-Cultural Studies in Health and Illness, 25*, 65–97. doi:10.1080/01459740500514489

Tibbert, S. J., Andersen, M. B., & Morris, T. (2014). What a difference a "mentally toughening" year makes: The acculturation of a rookie. *Psychology of Sport and Exercise*. Advance online publication. doi:10.1016/j.psychsport.2014.10.007

Tod, D. (2006). *Service-delivery expertise in student sport psychologists.* (Unpublished doctoral thesis). Retrieved from Victoria University Library Catalogue. (vic.b1685730). Available from http://www.vu.edu.au/library

Tod, D. (2007a). The long and winding road: Professional development in sport psychology. *The Sport Psychologist, 21*, 94–108.

Tod, D. (2007b). Reflections on collaborating with a professional rugby league player. *Sport and Exercise Psychology Review, 3*, 6–11.

Tod, D., & Andersen, M. B. (2012). Practitioner-client relationships in applied sport psychology practice. In H. Sheldon & S. D. Mellalieu (Eds.), *Professional practice in sport psychology: A review* (pp. 273–306). New York, NY: Routledge.

Tod, D., Andersen, M. B., & Marchant, D. B. (2009). A longitudinal examination of neophyte applied sport psychologists' development. *Journal of Applied Sport Psychology, 21*(Suppl.1), 1–16. doi:10.1080/10413200802593604

Tod, D., Andersen, M. B., & Marchant, D. B. (2011). Six years up: Applied sport psychologists surviving (and thriving) after graduation. *Journal of Applied Sport Psychology, 23*, 93–109. doi:10.1080/10413200.2010.534543

Tod, D., & Bond, K. (2010). A longitudinal examination of a British neophyte sport psychologist's development. *The Sport Psychologist, 24*, 35–51.

Tod, D., Marchant, D., & Andersen, M. B. (2005). United we stand, divided we fall. *ISSP 11th world congress of sport psychology: Promoting health and performance for life, CD-ROM*. Sydney, NSW, Australia: International Society of Sport Psychology.

Tod, D., Marchant, D., & Andersen, M. B. (2007). Learning experiences contributing to service-delivery competence. *The Sport Psychologist, 21*, 317–334.

Tryon, G. S., & Winograd, G. (2011). Goal consensus and collaboration. *Psychotherapy, 48*, 50–57. doi:10.1037/a0022061

Udry, E. (1997). Coping and social support among injured athletes following surgery. *Journal of Sport & Exercise Psychology, 19*, 71–90.

Udry, E. (2001). The role of significant others: Social support during injuries. In J. Crossman (Ed.), *Coping with sports injuries: Psychological strategies for rehabilitation* (pp.148–161). New York, NY: Oxford University Press.

Van Dulmen, A. M., & Bensing, J. M. (2002). Health promoting effects of the physician–patient encounter. *Psychology, Health & Medicine, 7*, 289–300. doi:10.1080/13548500220139421

Van Raalte, J. L., & Andersen, M. B. (2000). Supervision I: From models to doing. In M. B. Andersen (Ed.), *Doing sport psychology* (pp. 153–165). Champaign, IL: Human Kinetics.

Wagstaff, G. F. (1982). A small dose of common sense: Communication, persuasion and physiotherapy. *Physiotherapy, 68*, 327–329.

Waumsley, J. A., & Katz, J. (2013). Using a psychological model and counselling skills in sport injury rehabilitation. In M. Arvinen-Barrow & N. Walker (Eds.), *The psychology of sport injury and rehabilitation* (pp. 171–184). London, England: Taylor & Francis.

Weigand, D. A., Richardson, P. A., & Weinberg, R. S. (1999). A two-stage evaluation of a sport psychology internship. *Journal of Sport Behavior, 22*, 83–104.

Welch, M. (2005). Pivotal moments in the therapeutic relationship. *International Journal of Mental Health Nursing, 14*, 161–165. doi:10.1111/j.1440-0979.2005.00376.x

Wiese, D. M., Weiss, M. R., & Yukelson, D. P. (1991). Sport psychology in the training room: A survey of athletic trainers. *The Sport Psychologist, 5*, 15–24.

Wiese-Bjornstal, D. M., Gardetto, D. M., & Shaffer, S. M. (1999). Effective interaction skills for sport medicine professionals. In R. Ray & D. M. Wiese-Bjornstal (Eds.), *Counseling in sport medicine* (pp. 55–74). Champaign, IL: Human Kinetics.

Wiese-Bjornstal, D. M., & Smith, A. M. (1999). Counseling strategies for enhanced recovery of injured athletes within team approach. In D. Pargman (Ed.), *Psychological bases of sport injuries* (2nd ed., pp. 125–155). Morgantown, WV: Fitness Information Technology.

Williams, D. E. (2014). Going slow before you can go fast: A journey into performance anxiety through the lens of psychodynamics and neuroscience. In P. J. Rossouw (Ed.), *Neuropsychotherapy: Theoretical underpinnings and clinical applications* (pp. 209–234). Brisbane, QLD, Australia: Mediros.

Williams, D. E., & Andersen, M. B. (2012). Identity, wearing many hats, and boundary blurring: The mindful psychologist on the way to the Olympic and Paralympic games. *Journal of Sport Psychology in Action, 3*, 139–152. doi:10.1080/21520704.2012.683090

Williams, S., & Harrison, K. (1999). Physiotherapeutic interactions: A review of the power dynamic. *Physical Therapy Reviews, 4*, 37–50. doi:10.1179/ptr.1999.4.1.37

Wilson, K. G., & Dufrene, T. (2008). *Mindfulness for two: An acceptance and commitment therapy approach to mindfulness in psychotherapy*. Oakland, CA: New Harbinger.

Winstone, W., & Gervis, M. (2006). Countertransference and the self-aware sport psychologist: Attitudes and patterns of professional practice. *The Sport Psychologist, 20*, 495–511.

World Health Organization, Department of Human Resources for Health. (2010). *Framework for action on interprofessional education & collaborative practice* (WHO/HRH/HPN/10.3). Retrieved from World Health Organization website: http://www.who.int/hrh/resources/framework_action/en/

Yambor, J., & Connelly, D. (1991). Issues confronting female sport psychology consultants working with male student-athletes. *The Sport Psychologist, 5*, 304–312.

Zaproudina, N., Hänninen, O. O. P., & Airaksinen, O. (2007). Effectiveness of traditional bone setting in chronic neck pain: Randomized clinical trial. *Journal of Manipulative and Physiological Therapeutics, 30*, 432–437. doi:10.1016/j.jmpt.2007.05.004

APPENDIX A: INVITATION TO PARTICIPATE IN STUDY 1

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

Dear_____,

My name is Guy Little, and I am a PhD student at Victoria University. I am researching client-practitioner relationships in sport injury rehabilitation. I am writing to you to enquire if you would be interested in taking part in a study for my PhD project. I appreciate that your time is valuable and that you have a busy schedule, but I was wondering if you would be willing to give me approximately 60 minutes of your time to tell me about your experiences working with clients as a physiotherapist? My project is titled **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of client-practitioner relationships**. I have attached an 'Information to Participants' form to this letter, which has further information regarding my PhD project and the specific study I would like for you to consider participating in. You will also find enclosed a consent form for return in the prepaid envelope that, if you feel that you would like to take part, you can return to me at the above address.

I appreciate that, with the nature of your occupation, you may work a variety of hours throughout the week. If you do decide to take part in my study, I would make sure that I am flexible to meet you at a time and place convenient for you.

If you have any questions regarding the research, or would like to know more about it, please do not hesitate to contact me by phone or email (details provided above). I can also send you the information and consent forms electronically if you let me know your email address.

I look forward to hearing from you,

Kind Regards,

Guy Little

APPENDIX B: INFORMATION LETTER STUDY 1

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project titled: **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of client-practitioner relationships**.

The project is being conducted by PhD research student Guy Little, and is supervised by Professor Mark Andersen and Associate Professor Harriet Speed, School of Sport and Exercise Science, Victoria University. This research project is funded by a Victoria University International Postgraduate Research Scholarship.

Project explanation

We are looking to gain a detailed understanding of the professional relationships that sport physiotherapists and sport psychologists form with their clients.

Researchers have shown that relationships formed between clients and practitioners within helping contexts (such as sport physiotherapy and sport psychology) are important in influencing client outcomes. Within both sport psychology and sport physiotherapy, research into client-practitioner relationships is a relatively new arrival. Currently, we do not have a clear understanding of the experiences of practitioners and clients in regards to their professional relationships within sports injury rehabilitation contexts.

The project consists of 3 studies. This study (study 1) will explore sport psychologists' experiences of professional relationships with their clients.

What will I be asked to do?

Your participation will be in Study 2 of the research project and will involve you being interviewed by the student researcher, Guy Little, about your experiences of client-practitioner relationships in sport psychology. The interview is likely to last between 1 to 2 hours. **Please note: to be eligible to participate in Study 1, you must have been registered as a psychologist for at least two years and have had experience working with injured athletes.**

A number of questions will be asked during the interview these will include: Demographic details (e.g., age), training history, practice history, previous experiences of professional relationships with clients, and current experiences of professional relationships in practice.

There are no right or wrong answers in the interview – we want to gain an understanding of your experiences. You can choose not to respond to a particular question if you wish. Participation is entirely voluntary and you are free to withdraw your consent to participate at any time without providing a reason and without any consequences.

What will I gain from participating?

Your participation in this research will probably not provide any direct benefits to you. Your responses, however, may contribute to the training of new psychologists in the future.

How will the information I give be used?

Your responses within the interview will be analysed along with other participants' responses. Together these responses will be represented in a study for the student researcher's (Guy Little) Doctoral thesis and the findings from the study, including quotes from what you have said, may be used within academic journal articles, conference presentations, and book chapters. Your responses, however, will remain strictly confidential and any personally identifiable information you have provided will be removed or changed to protect your confidentiality.

What are the potential risks of participating in this project?

It is possible that you may experience some feelings of discomfort when discussing your experiences of relationships with clients that were difficult, unpleasant, or did not end well.

Please note that:

- You do not have to discuss any topics you do not wish to discuss.
- Your participation in the research is entirely voluntary and you are free to take a break or stop participating at any time, without providing a reason or explanation.
- Your responses will be kept strictly confidential (the recording of your interview will be stored securely in a locked facility)

If you do encounter any distress from participating in this research project you are welcome to contact a registered psychologist, Associate Professor Gerard Kennedy on 03 9919 2481, for a free psychology consultation.

How will this project be conducted?

If you agree to participate in this research study, please complete the enclosed consent form and return it to the research team using the enclosed prepaid envelope. A member of the research team will contact

Guy Little	Prof Mark Andersen	Dr Harriet Speed
PhD candidate	Chief Investigator	Associate Investigator
Victoria University	Victoria University	Victoria University
ph: 0420551265	ph: (03) 9919 5413	ph: (03) 99195412
guy.little@live.vu.edu.au	mark.andersen@vu.edu.au	harriet.speed@vu.edu.au

you to schedule the interview session. If you wish to seek additional information about the research, you can phone or email a member of the research team at any stage.

We remind you that participation is entirely voluntary and you are free to withdraw your consent at any time.

Who is conducting the study?

We thank you in advance for assisting us in this research. Any queries about your participation in this project may be directed to any of the investigators listed above. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

APPENDIX C: CONSENT FORM STUDY 1

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:
We would like to invite you to be a part of a study that explores sport psychologists' experiences of client-practitioner relationships.
CERTIFICATION BY PARTICIPANT

I, (Name) _____ of (Suburb)_____
certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in interviews for the research titled **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of client-practitioner relationships** the study being conducted at Victoria University by PhD candidate Guy Little, and supervised by Professor Mark Andersen and Associate Professor Harriet Speed.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by Guy Little and that I freely consent to participation involving the below mentioned procedures:

- Answering questions in an individual interview about previous and current experiences of client-practitioner relationships with clients who have sustained sport injuries and you have worked with them on their recoveries.

- Your participation in this stage of the research will involve you being interviewed on your own about your experiences and the interview is anticipated to last between 1 and 2 hours. I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way. I have been informed that the information I provide will be kept confidential.

Signed:

Date:

Any queries about your participation in this project may be directed to the student researcher:
Guy Little 0420551265 guy.little@live.vu.edu.au
If you have any queries or complaints about the way you have been treated, you may contact the Research Ethics and Biosafety Manager, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4148.

V:1106 1 of 1

APPENDIX D: INTERVIEW GUIDE STUDY 1

- How and when did you first become interested in psychology or sport psychology?
- Tell me about your role models that have may have influenced your psychology practice/ how do you think they have influenced your practice?
- Tell me about your professional relationships with clients especially those you have seen over extended periods of time.
- What do you consider central to your professional relationships with clients?
- Tell me about your experiences with your clients in your training years.
- Compare your views of professional relationships between clients and practitioners when you started training to your current views. Do you notice any differences?
- What would you say are the skills or assets that you use in building relationships with your clients?
- Tell me of some of your recent relationship experiences with clients.
- Tell me some stories about your professional relationships with injured athletes.
- Compare your work with injured athletes to general public. Do you notice any differences?
- Please give me an example of one of your most rewarding experiences working with athletes in relatively long-term injury rehabilitation.
- What has been your least rewarding experiences working with athletes in relatively long-term injury rehabilitation?
- What was your communication like with the client during this time?
- Please tell me about any frustrating experiences of relationships with clients in sport injury rehabilitation.

Probes:

- What happened to you when that occurred?
- What did/do you think about that?
- Tell me more about that.
- What was your response to that?
- Can you give me an example?
- Can you describe that a bit more for me?
- What did you do after that?
- What happened after that?
- Does that happen often?

APPENDIX E: INVITATION TO PARTICIPATE IN STUDY 2

Guy Little
School of Sport and Exercise Science
Footscray Park Campus
PO BOX 14428 MELBOURNE
VICTORIA 8001 AUSTRALIA
PHONE: 0420551265
Guy.little@live.vu.edu.au

Dear _____,

My name is Guy Little, and I am a PhD student at Victoria University. I am researching client-practitioner relationships in sport injury rehabilitation. I am writing to you to enquire if you would be interested in taking part in a study for my PhD project. I appreciate that your time is valuable and that you have a busy schedule, but I was wondering if you would be willing to give me approximately 60 minutes of your time to tell me about your experiences working with clients as a physiotherapist? My project is titled **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of client-practitioner relationships**. I have attached an 'Information to Participants' form to this letter, which has further information regarding my PhD project and the specific study I would like for you to consider participating in. You will also find enclosed a consent form for return in the prepaid envelope that, if you feel that you would like to take part, you can return to me at the above address.

I appreciate that, with the nature of your occupation, you may work a variety of hours throughout the week. If you do decide to take part in my study, I would make sure that I am flexible to meet you at a time and place convenient for you.

If you have any questions regarding the research, or would like to know more about it, please do not hesitate to contact me by phone or email (details provided above). I can also send you the information and consent forms electronically if you let me know your email address.

I look forward to hearing from you,

Kind Regards,
Guy Little
PhD Candidate
Victoria University

APPENDIX F: INFORMATION LETTER STUDY 2

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project titled: **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of client-practitioner relationships**.

The project is being conducted by PhD research student Guy Little, and is supervised by Professor Mark Andersen and Associate Professor Harriet Speed, School of Sport and Exercise Science, Victoria University. This research project is funded by a Victoria University International Postgraduate Research Scholarship.

Project explanation

We are looking to gain a detailed understanding of the professional relationships that sport physiotherapists and sport psychologists form with their clients.

Researchers have shown that relationships formed between clients and practitioners within helping contexts (such as sport physiotherapy and sport psychology) are important in influencing client outcomes. Within both sport psychology and sport physiotherapy, research into client-practitioner relationships is a relatively new arrival. Currently, we do not have a clear understanding of the experiences of practitioners and clients in regards to their professional relationships within sports injury rehabilitation contexts.

The project consists of three studies. This study (study 2) will explore sport physiotherapists' experiences of professional relationships with their clients.

What will I be asked to do?

Your participation will be in Study 2 of the research project and will involve you being interviewed by the student researcher, Guy Little, about your experiences of client-practitioner relationships in sport physiotherapy. The interview is likely to last between 1 to 2 hours. **Please note: to be eligible to participate in Study 1, you must have been registered as a physiotherapist for at least two years and have had experience working with injured athletes.**

A number of questions will be asked during the interview these will include: Demographic details (e.g., age), training history, practice history, previous experiences of professional relationships with clients, and current experiences of professional relationships in practice.

There are no right or wrong answers in the interview – we want to gain an understanding of your experiences. You can choose not to respond to a particular question if you wish. Participation is entirely voluntary and you are free to withdraw your consent to participate at any time without providing a reason and without any consequences.

What will I gain from participating?

Your participation in this research will probably not provide any direct benefits to you. Your responses, however, may contribute to the training of new physiotherapists in the future.

How will the information I give be used?

Your responses within the interview will be analysed along with other participants' responses. Together these responses will be represented in a study for the student researcher's (Guy Little) Doctoral thesis and the findings from the study, including quotes from what you have said, may be used within academic journal articles, conference presentations, and book chapters. Your responses, however, will remain strictly confidential and any personally identifiable information you have provided will be removed or changed to protect your confidentiality.

What are the potential risks of participating in this project?

It is possible that you may experience some feelings of discomfort when discussing your experiences of relationships with clients that were difficult, unpleasant, or did not end well.

Please note that:

- You do not have to discuss any topics you do not wish to discuss.
- Your participation in the research is entirely voluntary and you are free to take a break or stop participating at any time, without providing a reason or explanation.
- Your responses will be kept strictly confidential (the recording of your interview will be stored securely in a locked facility)

If you do encounter any distress from participating in this research project you are welcome to contact a registered psychologist, Associate Professor Gerard Kennedy on 03 9919 2481, for a free psychology consultation.

How will this project be conducted?

If you agree to participate in this research study, please complete the enclosed consent form and return it to the research team using the enclosed prepaid envelope. A member of the research team will contact you to schedule the interview session. If you wish to seek additional information about the research, you can phone or email a member of the research team at any stage.

We remind you that participation is entirely voluntary and you are free to withdraw your consent at any time.

Who is conducting the study?

Guy Little	Prof Mark Andersen	Dr Harriet Speed
PhD candidate	Chief Investigator	Associate Investigator
Victoria University	Victoria University	Victoria University
ph: 0420551265	ph: (03) 9919 5413	ph: (03) 99195412
guy.little@live.vu.edu.au	mark.andersen@vu.edu.au	harriet.speed@vu.edu.au

We thank you in advance for assisting us in this research. Any queries about your participation in this project may be directed to any of the investigators listed above. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

APPENDIX G: CONSENT FORM STUDY 2

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:
We would like to invite you to be a part of a study that explores sport physiotherapists' experiences of client-practitioner relationships.

CERTIFICATION BY PARTICIPANT

I, (Name) _____ of (Suburb)_____

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in interviews for the research titled **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of client-practitioner relationships** the study being conducted at Victoria University by PhD candidate Guy Little, and supervised by Professor Mark Andersen and Associate Professor Harriet Speed.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by **Guy Little** and that I freely consent to participation involving the below mentioned procedures:

- Answering questions in an individual interview about previous and current experiences of client-practitioner relationships with clients who have sustained sport injuries and you have worked with them on their recoveries.
- Your participation in this stage of the research will involve you being interviewed on your own about your experiences and the interview is anticipated to last between 1 and 2 hours.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Date: / /

Any queries about your participation in this project may be directed to the student researcher:
Guy Little
0420551265
guy.little@live.vu.edu.au
If you have any queries or complaints about the way you have been treated, you may contact the Research Ethics and Biosafety Manager, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4148.

APPENDIX H: INTERVIEW GUIDE STUDY 2

- How and when did you first become interested in physiotherapy or sport physiotherapy?
- Tell me about your role models that have may have influenced your physiotherapy practice/ how do you think they have influenced your practice?
- Tell me about your professional relationships with clients especially those you have seen over extended periods of time.
- What do you consider central to your professional relationships with clients?
- Tell me about your experiences with your clients in your training years.
- Compare your views of professional relationships between clients and practitioners when you started training to your current views. Do you notice any differences?
- What would you say are the skills or assets that you use in building relationships with your clients?
- Tell me of some of your recent relationship experiences with clients.
- Tell me some stories about your professional relationships with injured athletes.
- Compare your work with injured athletes to general public. Do you notice any differences?
- Please give me an example of one of your most rewarding experiences working with athletes in relatively long-term injury rehabilitation.
- What has been your least rewarding experiences working with athletes in relatively long-term injury rehabilitation?
- What was your communication like with the client during this time?
- Please tell me about any frustrating experiences of relationships with clients in sport injury rehabilitation.

Probes:

- What happened to you when that occurred?
- What did/do you think about that?
- Tell me more about that.
- What was your response to that?
- Can you give me an example?
- Can you describe that a bit more for me?
- What did you do after that?
- What happened after that?
- Does that happen often?

APPENDIX I: INFORMATION LETTER STUDY 3

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project titled: **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of practitioner-client relationships**.

The project is being conducted by PhD research student Guy Little, and is supervised by Professor Mark Andersen and Associate Professor Harriet Speed, School of Sport and Exercise Science, Victoria University. This research project is funded by a Victoria University International Postgraduate Research Scholarship.

Project explanation

We are looking to gain a detailed understanding of the professional relationships that sport physiotherapists and sport psychologists form with their clients.

Researchers have shown that relationships formed between clients and practitioners within helping contexts (such as sport physiotherapy and sport psychology) are important in influencing client outcomes. Within both sport psychology and sport physiotherapy, research into practitioner-client relationships is a relatively new arrival. Currently, we do not have a clear understanding of the experiences of practitioners and clients in regards to their professional relationships within sports injury rehabilitation contexts.

The project consists of 4 studies. This study (Study 3) will trace the development of professional relationships between a physiotherapist and a sport psychologist (and their shared clients).

What will I be asked to do?

Your participation will be in Study 3 of the research project and will involve you being interviewed individually on several occasions by the student researcher, Guy Little, about your experiences of your relationships with other members of an injury rehabilitation team and clients that you have worked together with. The interviews will last approximately 60 minutes.

Please note: to be eligible to participate in Study 3 as a practitioner, you must have been registered as a psychologist or physiotherapist for at least two years and have had experience working with injured athletes. To be eligible to participate as an athlete-client, you must have been competing in elite or sub-elite sport and be receiving support from both a psychologist and physiotherapist who are also willing to participate in the study.

A number of questions will be asked during the interview these will include: Demographic details (e.g., age), training history, previous experiences of professional practitioner-client relationships, and current experiences of the relationships with the other member(s) of the rehabilitation team.

There are no right or wrong answers in the interview – we want to gain an understanding of your experiences. You can choose not to respond to a particular question if you wish. Participation is entirely voluntary and you are free to withdraw your consent to participate at any time without the need for a reason and without any consequences.

What will I gain from participating?

Your participation in this research will probably not provide any direct benefits to you. Your responses, however, may contribute to the training of new physiotherapists and psychologists in the future.

How will the information I give be used?

Your responses within the interviews will be analysed along with other participants' responses. Together these responses will be represented in a Doctoral thesis for Guy Little, the student researcher, and the findings from the study, including quotes from what you have said, may be used within academic journal articles, conference presentations, and book chapters. Your responses, however, will remain strictly confidential and any personally identifiable information you have provided will be removed or changed to protect your identity.

What are the potential risks of participating in this project?

It is possible that you may experience some feelings of discomfort when discussing your experiences of relationships within injury rehabilitation that were difficult, unpleasant, or did not end well. Also, it is possible that you may recall difficult events that have occurred within the rehabilitation process.

Please note that:

- You do not have to discuss any topics you do not wish to discuss.
- Your participation in the research is entirely voluntary and you are free to take a break or stop participating at any time, without the need for reason or explanation.
- Your responses will be kept strictly confidential (the recording of your interview will be stored securely in a locked facility)

If you do encounter any distress from participating in this research project you are welcome to contact a registered psychologist, Associate Professor Gerard Kennedy on 03 9919 2481, for a free psychology consultation.

How will this project be conducted?

If you agree to participate in this research study, please complete the enclosed consent form and return it to the research team using the enclosed prepaid envelope. A member of the research team will contact you to schedule the interview session. If you wish to seek additional information about the research, you can phone or email a member of the research team at any stage.

We remind you that participation is entirely voluntary and you are free to withdraw your consent at any time.

Who is conducting the study?

Guy Little	Prof Mark Andersen	Dr Harriet Speed
PhD candidate	Chief Investigator	Associate Investigator
Victoria University	Victoria University	Victoria University
ph: 0420551265	ph: (03) 9919 5413	ph: (03) 99195412
guy.little@live.vu.edu.au	mark.andersen@vu.edu.au	harriet.speed@vu.edu.au

We thank you in advance for assisting us in this research. Any queries about your participation in this project may be directed to any of the investigators listed above. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

APPENDIX J: CONSENT FORM STUDY 3

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:
We would like to invite you to be a part of a study that explores a sport psychologist's and a sport physiotherapist's experiences of practitioner-client relationships and practitioner-practitioner collaboration.

CERTIFICATION BY PARTICIPANT

I, (Name) _____ of (Suburb) _____

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in interviews for the research titled **Working alliances with wounded warriors: Sport physiotherapists' and psychologists' experiences of practitioner-client relationships** the study being conducted at Victoria University by PhD candidate Guy Little, and supervised by Professor Mark Andersen and Associate Professor Harriet Speed.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by **Guy Little** and that I freely consent to participation involving the below mentioned procedures:

- Answering questions in individual interviews about previous and current experiences of your relationships with the two other members of the rehabilitation triad involved within this study.
- Your participation in this study will involve you being interviewed individually on several occasions about your experiences and each interview is anticipated to last about 60 minutes.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Date: / /

Any queries about your participation in this project may be directed to the student researcher:
Guy Little
0420551265
guy.little@live.vu.edu.au
If you have any queries or complaints about the way you have been treated, you may contact the Research Ethics and Biosafety Manager, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4148.

APPENDIX K: INTERVIEW GUIDE PSYCHOLOGIST STUDY 3

- Did you have any experiences playing sport?
- Did you/ do you still participate in sport? What were your experiences in sport?
- How and when did you first become interested in psychology?
- How and when did you first become interested in sport psychology?
- Tell me about your role models that may have influenced your psychology practice/ how do you think they have influenced your practice?
- Tell me about your professional relationships with clients especially those you have seen over extended periods of time.
- What have your experiences been of injuries?
- What about your experiences of injury rehabilitation?
- What have your previous experiences been regarding the professional relationships you have had with clients undergoing injury rehabilitation?
- How long have you been working with your current client?
- Tell me about your experiences with your current client.
- What do you see as the role or roles that you play in your current client's rehabilitation process?
- How would you describe your relationship with your current client?
- How long have you been working with/alongside your current physio?
- Tell me about your experiences with/alongside your current physio.
- How would you describe your relationship with your current physio?
- What do you see as the role or roles that your physio partner plays in your client's rehabilitation process?
- What do you think makes your physio good at what he/she does?

Probes:

- What happened to you when that occurred?
- What did/do you think about that?
- Tell me more about that.
- What was your response to that?
- Can you give me an example?
- Can you describe that a bit more for me?
- What did you do after that?
- What happened after that?
- Does that happen often?

APPENDIX L: INTERVIEW GUIDE PHYSIOTHERAPIST STUDY 3

Personal:

- The beginning: how did you get into physiotherapy?
- What motivated you to work in sport?
- How do you build rapport with your clients?
- How do you view your relationships with your clients?
- Often clients share a lot of information with their physiotherapists. What do they share with you?
- On the phone you said that your clients tell you that you are different to other physios; what makes you different?
- What would you say is your model of practice?
- What are your core beliefs and models that underpin your practice? How do they manifest themselves/what does this look like when working with a client?

Working together

- How did you meet Jane and how did your professional relationship begin?
- Discuss/reflect on the development of your relationship over time (13 years)
- What was/is the referral process like to Jane and from Jane?
- What is the exchange of information between you like?
- How do you manage limits of information that you can share through confidentiality agreements? How do you find that?
- What do you like about working together?
- Tell me about the influence you felt your close working relationship with Jane had on the culture of the organisations that you worked in. Did you notice any changes pre/during/after [influence of relationships]
- What would you say are your boundaries of practice? Is there any overlap with Jane?
- Tell me about the long-term injured athletes you have worked together with Jane?
- Have there been any difficult or frustrating experiences in your working relationship? Can you tell me about these times?
- What would you say has been enjoyable about working with Jane?
- Have there been any issues in communication with Jane?
- What would you say are your practice boundaries/overlap?

- How do you think you have facilitated/helped Jane's role or competence working in rehab?
- How do you think Jane has helped you in your role as a physiotherapist? How you relate to clients?)
- What knowledge do you share about relationships?
- How does your client intake and rehabilitation process work?
- Tell me about your favourite case that you have worked with Jane on. What about the person or process did you like?
- Walk me through an example of an athlete that has seen both you and Jane for long-term rehabilitation.
- How do you deal with setbacks or re-injury with your clients and with Jane?
- How do you think your collaboration influences athletes' rehab?
- What are the interpersonal qualities that you consider Jane has that make her good at working with athletes?
- Do you think your relationship with Jane is a good example of practitioner collaboration? Why?
- Can you give me examples of difficult clients that you have worked with together in rehab? How have you metaphorically navigated that difficult landscape?
- What do you think you have that means that you work well together that other multidisciplinary teams do not?
- What is your philosophy/approach to practice and client-practitioner relationships?