

Narrative Exploration of Therapeutic Relationships in Recreation Therapy Through a Self-Reflective Case Review Process

by

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A thesis
presented to the University of Waterloo
in fulfillment of the
thesis requirement for the degree of
Master of Arts
in
Recreation and Leisure Studies

Waterloo, Ontario, Canada, 2012

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

This narrative inquiry explores therapeutic relationships in the practice of recreation therapy. Narratives were generated in Recreation Therapy's *self-reflective case review process* at Sunnybrook Health Sciences Centre—a process developed to support team engagement in reflections on their *therapeutic relationships*. In total, three self-reflective case reviews were explored, and for each case review, four layers of analysis occurred. The first two layers used *narrative analysis* to restory reflections of the case review leader (layer one) and then reflections within the recreation therapy team (layer two). The third and fourth layers used *analysis of narrative* to explore theoretical ideas from person-centred care emerging inductively in the text (layer three), and then to restory the previous narratives using a relational theory lens (layer four). Exploration revealed the self-reflective case review process also strengthens therapeutic relationships within the recreation therapy team. In the recreation therapists' narratives we hear relational notions of connection, disconnection, reconnection, mutuality, mutual empathy, authenticity, vulnerability, and support. This study engaged recreation therapists in an act of critical pedagogy as they engaged in critical self-reflection by exploring across layers of narrative that story their therapeutic relationships. The self-reflective case review process creates opportunity for the recreation therapy team to recognize, identify and name their experiences within therapeutic relationships, and to find their voices in the medical context of a hospital setting. When engaging in self-reflective processes, recreation therapy moves further away from treating individuals as objects, shifting practice toward connection and mutuality in therapeutic relationships.

Acknowledgements

I would first like to thank Dr. Susan Arai for all of her hard work and dedication to this research. Or as we call it, “Sue-pport”! You are inspirational, brilliant, and knowledgeable. Thanks for not giving me answers but instead steering me in the right direction. This allowed me to challenge myself, think critically, and had a great influence on the changes I have experiences throughout this research journey. I really appreciate your commitment to this research and I am very proud of the work we have done. Collaborating with you has been an amazing experience and I believe we work great as a team.

To the recreation therapy team at Sunnybrook, thank you so much for opening your hearts and minds to me and this research. I realize it can feel risky and vulnerable to put your selves out there in the spotlight. I admire your bravery and your enthusiasm for research and improving recreation therapy practice. You truly are leaders and educators in the field. It has been a pleasure working with you all and I hope to continue building our relationship in the future.

I would like to thank the members of my committee: Adrienne Gilbert and Sherry Dupuis. Adrienne, your dedication to research, improvements, and advocacy within therapeutic recreation is admirable. I feel honoured to have had you as a teacher, colleague, and a friend and have learned so much from you. And thank you for introducing me to theory, philosophy, and critical thinking at the end of my undergraduate degree.

Sherry, your work within the field of recreation and leisure studies and MAREP is impressive and innovative. It has been a pleasure being your student, colleague, and friend throughout my time here at Waterloo. I am honoured that you were on my MA committee and truly valued the ideas and feedback you offered which strengthened my thesis.

Thanks to the department of Recreation and Leisure studies for supporting me on this journey and helping me to find my passions. Specific thanks to Troy Glover, Sandy Devisser, and Tracy Taves for keeping me organized and providing me with many opportunities to learn and grow.

Next I would like to thank my family. To my mother Margery, you are my hero. Your strong and successful nature has helped me to become the woman I am today. I look up to you in so many ways—as a professional, teacher, researcher, mother, and friend. I hope that you are as proud of me, as I am of you. I love you.

To my father, thank you for believing in me. I will always remember that chat about being confident when I was young. I have often underestimated myself and through this process I think that I can finally see the potential that you saw in me, and I think you would be proud. I love you.

To my sister Marisa and my brother David, thank you for supporting me and loving me throughout this process and throughout my life. I have always looked up to you as role models and am proud of everything you have accomplished. I am so glad that we are such good friends. I love you.

Last but not least, to Phil, for your love, support, humour, advice, and care. I could not have done this without you. Thanks for listening to my presentations, giving me good and critical feedback, and reading over many documents. You are so good at calming me down when I am stressed or frustrated, supporting me when I am emotional, and thank you for being my best friend always. I love you with all my heart.

And to my friends all over the world, thanks for all of the love and support and believing that I can do this! Special thanks to my grad girls. You girls have been amazing motivators,

supporters, and friends. Cheers to those days in the coffee shops, to our runs that cleared our minds, to pub nights, to our chats about other life stressors, and to our chats about research stressors. I could not have done this without you girls. I am so glad I met you and cannot wait to continue our friendships. I guess I should also be thanking coffee and John Mayer for helping me to stay focused to work hard, haha.

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Prologue

This thesis describes the use of narrative methodology to explore therapeutic relationships and a self-reflective case review process developed by the recreation therapy team at Sunnybrook Health Sciences Centre (hereafter referred to as Sunnybrook). The phrases *Sunnybrook* and *recreation therapy* (also known as therapeutic recreation) are used in this thesis as they reflect the language recreation therapists used in their stories.

Throughout this thesis document I shift back and forth between “we” and “I”. When I say “we” I am referring to my advisor, Dr. Susan Arai, the recreation therapy team at Sunnybrook, and myself. The reason for doing so is because this research is a collaboration between the department of Recreation and Leisure Studies at the University of Waterloo and the department of Recreation Therapy at Sunnybrook. When I switch to “I” language is when I am referring to myself as the researcher in this study.

To begin, I situate myself in this study and describe how I came to be the researcher working with the recreation therapy team. One afternoon in the winter of 2010 I attended my therapeutic recreation seminar. I was in my last term of my undergraduate degree at the University of Waterloo and was trying to decide whether I wanted to work or go to graduate school. That day, Nancy Bowers-Ivanski, the manager of Recreation Therapy and Creative Arts Therapy at Sunnybrook was guest lecturing in our seminar. I had previously worked with Nancy and the recreation therapy team at Sunnybrook in Toronto during the spring term of 2009. It was then, when she lectured in my seminar, I discovered the research connection between the department of Recreation and Leisure Studies at the University of Waterloo and the recreation therapy department at Sunnybrook. Suddenly, many ideas for research spiraled throughout my

mind. Coincidentally, that evening as I sat on my couch and checked my email, I received a message from Troy Glover, the Department's Associate Chair of Graduate Studies. Troy wrote to recommend me to the graduate program. Right then I decided it was fate, and I applied to graduate school.

Once I was accepted for the master's program, I was eager to begin. Sunnybrook has about 1.2 million patient visits each year and is the largest single-site hospital in Canada (Sunnybrook Health Sciences Centre, 2012). I was a good fit for working with Sunnybrook. I had worked within the recreation therapy team in the past, was familiar with their programs, assessments, and evaluation tools, and I also knew the staff. I had knowledge of their research projects and was thrilled to work with such an enthusiastic team. Before entering the master's program I had looked at the previous research that Sunnybrook has engaged in and realized I was already passionate about the topic of therapeutic relationships. In my own life I value spending time with others, making connections, and developing relationships. We exist within a variety of relationships. Each relationship influences our lives and helps to enhance who we become as people. Therefore, I already valued therapeutic relationships in my own work, and was excited to further expand research on this topic.

It is now over two years later, I have finished my Master's degree. The changes I have gone through on this journey have been life altering. Working with the recreation therapy team at Sunnybrook was an amazing experience. This team is very passionate about what they do, and have a great interest in research to better their practice. They are very enthusiastic about engaging in research. Not only did most of the team participate in the case review processes, but nine of them offered to also be on the research team. The team's openness to expression and vulnerability was admirable. It is not easy to let someone in to observe your dialogue and

actions. The team was open to change and taking in new knowledge, which is all part of the research process. I was honoured to work with this team as they have previously contributed astounding work in recreation therapy.

During this study I became very involved in the team's stories. As a previous member of the recreation therapy team at Sunnybrook, I was able to appreciate and visualize their experiences clearly. However, my role was not to provide ideas and suggestions into their discussions, but rather to listen to their stories and understand their experiences with the individuals receiving care. As I listened I was able to imagine their actual experiences and the emotions they were feeling. Immersing myself in the research helped me to understand and experience recreation therapists' stories.

Throughout this process I have changed immensely. This study has made me aware of my own understandings of therapeutic relationships that I entered the field with and how they influence my attitudes and actions. This research has also created a shift in my understandings; as new understandings emerged I was able to establish meaningful and deeper understandings of experiences. Before entering into my Master's degree I highly valued person-centred philosophies which guided my behaviours and thought processes. In my second semester I took a course called *Critical Reflections on Disability, Illness and Leisure*, which taught me to look outside the box and challenge present understandings. Therefore, I have learned therapeutic relationships require a theoretical foundation more aligned with the experience. In this study we explore relational theory. Critical thinking has allowed me to constantly ask questions and has given me the inspiration to continually search for new knowledge.

I have gained an appreciation for research and have a deeper appreciation for its importance within recreation therapy. Through this research process I have also learned the value

of self-reflection in my work and in everyday life. It is important in anything I do to take a moment and reflect on the experience, bringing meaning and new light to it. Throughout the past two years my ways of thinking have changed from learning something and taking it in, to being critical, seeing different perspectives and searching for new knowledge. I have also realized the value of theory and its place in practice, as philosophical foundations guide what we do and how we think. I am still enthusiastic about recreation therapy and now have a new strong passion for research. I plan to pursue this passion for research in my future.

Chapter One: The Centrality of Relationships

Relationships in everyday life are essential to improving overall quality of life.

Relationships improve health and increase an individual's lifespan (Harvard Women's Health Watch, 2010). People involved in satisfying relationships are content, have fewer health problems, and live longer (Harvard Women's Health Watch, 2010). Clients receiving health care services often encounter many stressors and life changes. With these stressors comes a need for social support. A lack of social stimulation and interaction can lead to major health problems, such as depression (Harvard Women's Health Watch, 2010).

In the context of clinical practice, an individual's relationship with a practitioner is referred to as a *therapeutic relationship* and also known as a *client-therapist relationship* (Antoniou & Blom, 2006), *therapeutic bond* (Knei-Paz, 2009), *patient-clinician relationship* (Suchman, 2005), and *therapeutic alliance* (Langley & Klopfer, 2005; Overholser, 2007). Though different, many of these terms share similar qualities. Throughout this paper I will be using the term therapeutic relationship. The therapeutic relationship is intersubjective, meaning it is experienced and has an impact on both client and recreation therapist.

In healthcare settings, therapeutic relationships have a significant impact on client connectedness and health outcomes. Forchuk, Jewell, Schofield, Sircelj, and Valledor (1998) argue the goal of the therapeutic relationship is to, "promote health through the development of interpersonal, problem solving and community living competencies" (p. 198). Furthermore, Antoniou and Blom (2006) argue the relationship itself is therapeutic insofar as it has benefits of its own that help clients reach their goals and increase life satisfaction. In healthcare, the therapeutic relationship is a critical element in successfully determining and developing a program to meet and exceed the needs of the person receiving care. Often times these

relationships provide the foundation for a successful and rewarding program designed to serve the needs of the client (Rogers, 1958).

While considerable attention is given to therapeutic relationships in other health fields such as nursing or psychology, more research is required in recreation therapy. Recreation therapists build relationships and facilitate programs to support individuals to develop skills and increase quality of life through leisure activities. Therapeutic Recreation Ontario (2006) states that “the foundation of the Recreation Therapy profession is the establishment of authentic relationships with the individual receiving services...” (para. 4). Despite the merits of fostering closer relationships in professional contexts, in recreation therapy there is a lack of literature that looks at the detailed processes within these relationships. This research will enhance the field by providing recreation therapists with the opportunity to reflect on their own understandings and experiences of therapeutic relationships. This study incorporates the use of narrative methodologies with the aim of seeing how different theories offer different ways of exploring and understanding experiences (i.e., person-centred theories, relational theories). We do this by using the self-reflective case review process as a way to explore stories emerging about recreation therapists’ experiences within their therapeutic relationships. We also aim to understand how self-reflection can influence therapeutic relationships in recreation therapy.

The Need to Explore the Self-Reflective Case Review Process

The purpose of this narrative inquiry was to explore the self-reflective case review process, a process developed by the recreation therapy team at Sunnybrook for reflecting on, and understanding therapeutic relationships. The recreation therapy department at Sunnybrook has been exploring therapeutic relationships over several years. This began with a memory work study completed during their annual retreat in September of 2008. The project involved twenty

recreation therapists who each wrote both a positive and challenging memory from the therapeutic relationships they developed with their clients (Arai, 2009). The recreation therapists engaged in a reflective discussion around each memory, identified a number of themes that were similar across the group of memories, and discussed how each theme influenced the therapeutic relationship.

The team further explored their therapeutic relationships using an action research process (Lansfield, 2010), where further themes describing the therapeutic relationship emerged. Then the recreation therapy research team met and decided to put their research into practice and developed a series of reflection questions to guide their practice (see Appendix A). It was with this application of research that the *Self-Reflective Case Review Process* was created. As part of this case review process, a series of self-reflective questions are used to identify and understand influences and issues that arise within a therapeutic relationship. The case review process involves a recreation therapist bringing an experience with an individual receiving care at Sunnybrook to the group. The team then engages in discussion using the reflective questions to further explore and understand that experience. The team attempts to engage in this process once a month.

In previous recreation therapy research at Sunnybrook, studies have been done within a framework of person-centred care (Cantwell, 2000); however these more recent studies on therapeutic relationships reveal limitations of a person-centred care framework for working with challenges that arise in therapeutic relationships. Specifically, person-centred approaches do not adequately capture the social nature of relationships or address the impasses that occur. Here, relational theory with an emphasis on connection, disconnection, mutuality, boundaries, and

relational awareness (Jordan, Walker, & Hartling, 2004) proved to be more fruitful. Relational theory is described in more detail in Chapter Two.

Invoking Narrative Inquiry to Explore the Self-Reflective Case Review Process

Narrative inquiry explores stories about human experiences and discovers meanings within these experiences (Daly, 2007). This study used an interpretive approach which allows for exploration of a multiplicity of ways of knowing and experiencing therapeutic relationships. Denzin (2001) states that an interpretive approach engages the researcher and participants in “explaining the meaning of; interpreting; or conferring meaning” (p. 32). Within this study we engaged in interpreting the meaning of experiences within therapeutic relationships. Denzin and Lincoln (2008) argue rather than a single imperative truth, there are multiple interpreters and interpretations. Narrative inquiry provides an open space for multiple voices to be heard and does not seek a universal truth. Denzin and Lincoln (2008) define narrative inquiry as “a form of inquiry that analyzes narrative, in its many forms, and uses a narrative approach for interpretive purposes” (p. 649). Polkinghorne (1988) states that “narrative recognizes the meaningfulness of individual experiences by noting how they function as parts in a whole” (p. 36). Narrative was used to highlight stories and understandings of recreation therapists’ experiences in their therapeutic relationships (parts) and how discussion unfolds within the team (whole). Narrative looks deep into experiences to expose more than just what meets the eye (Clandinin & Connelly, 2000). These narratives may be used to help readers, including recreation therapists at Sunnybrook, to understand complexities within therapeutic relationships and reflect on their own understandings.

When we embarked on this study, we initially used Clandinin & Connelly’s (2000) three-dimensional space narrative inquiry to frame the study. A three-dimensional space narrative

enables participants to explore past, present, and future understandings of therapeutic relationship experiences. The three-dimensional approach also allows for the exploration of the social context in which the narrative occurs, and the interaction between personal and social influences (Clandinin & Connelly, 2000). This approach was used in the initial research design to frame the study and develop approaches to data collection. Drawing on the three-dimensional narrative approaches, the following research questions guided this study:

1. What knowledge arises for recreation therapists engaged in the self-reflective case review process?
2. How does knowledge from the self-reflective case review process influence recreation therapists' practices?
3. How do recreation therapists experience the self-reflective case review process, personally and socially?
4. How does the context shape understanding of:
 - a) the therapeutic relationship?
 - b) the self-reflective case review process?
5. How does relational theory shed light on therapeutic relationships in recreation therapy?

The first two questions represent continuity within recreation therapists' practice. Recreation therapists discuss their past experiences, present understandings, and knowledge that provides future possibilities within their relationships. Question three represents the second dimension of the three-dimensional approach emphasising personal and social interactions within the team's experience of the case review process. Question four represents the final dimension of the three-dimensional approach and considers the influence of place/context on recreation therapy practice at Sunnybrook. Lastly, question five invokes relational theory to further explore therapeutic relationships in recreation therapy.

Our research involved an observation of three different self-reflective case review processes. In each process a recreation therapist described an experience they had with an individual receiving care. The group then utilized the self-reflective case review questions to

help them explore meanings behind the experience (see Appendix A). This process was used across a diverse array of experiences. Immediately after observing and recording the case review process the team engaged in a thirty minute focus group about their experiences during the case review and how those experiences influence their practice. One to two weeks following each case review process and focus group, a leader of the case review was interviewed to further explore her experiences of the process.

As data analysis unfolded and consideration was given as to how to best represent the data, a decision was made to engage Polkinghorne's (2003) approach to analyzing narrative. Data analysis began to reveal that while Clandinin and Connelly's (2000) three dimensions were useful, some dimensions, such as context, were not strong within the dialogues. What was strong was how recreation therapists' theoretical understandings influenced the way they understood the therapeutic relationships explored in the case reviews. It also became evident that not only did the self-reflective case review process influence understandings of therapeutic relationships between recreation therapist and individuals receiving care at Sunnybrook, but there was also a shift occurring within the recreation therapy team itself. As a result, the research questions were revised according to insights that arose during the data analysis phase:

1. What knowledge arises for recreation therapists engaged in the self-reflective case review process?
2. How does knowledge from the self-reflective case review process influence recreation therapists' therapeutic relationships?
3. How do present understandings influence therapeutic relationships in recreation therapy?
4. How does relational theory shed light on therapeutic relationships in recreation therapy?
5. How does self-reflection influence understandings of therapeutic relationships in recreation therapy?

The first two questions represent recreation therapists' stories and reflections of their experiences within therapeutic relationships. Questions three and four offer different theoretical lenses for

looking at recreation therapists' experiences within their therapeutic relationships. Lastly, question five attempts to understand the importance of self-reflection in this process.

With this in sight we began a process of *restorying*. Restorying is the process of hearing stories, analyzing the stories with key elements in mind, and then rewriting the stories (Ollerenshaw & Creswell, 2002). The process of restorying invoked both *narrative analysis*--taking parts and puts them into a story—and *analysis of narrative* processes in which researchers collect stories as data and analyze them in relation to understanding theory and paradigmatic processes (Polkinghorne, 2003). Recognizing some of the limitations of theories such as person-centred care for fully understanding what occurs in therapeutic relationships, we then engaged in analysis of narrative to explore the theory underlying the recreation therapists' narratives and also restoried each case a second time using the lens of relational theory. We also used analysis of narrative to examine the influence of the self-reflective case review process within the recreation therapy team. This analysis revealed aspects of relational theory naturally arising in the team's conversations.

Self-Reflective Practice as an Act of Critical Pedagogy

Self-reflective practice encourages recreation therapists to reflect on their work to better understand their practice and improve their skills and programs (Miller & Pedlar, 2006). Our study involves a self-reflection process for recreation therapists, as they critically analyze experiences with individuals receiving care. Reflecting helps one to evaluate their thoughts and perceptions, as well as their understandings (Miller & Pedlar, 2006). Reflection also allows individuals to evaluate their current case review process and make changes if necessary. Self-reflective practice enables recreation therapists to generate their own knowledge and critical reflections for change.

When discussing the practitioner's reflections and influence of self-reflection on practice, Haasan, Hornibrook, and Pedlar (1998) said:

We faced challenges in the realization that what we had formerly assumed was the "best we could be" might not in fact be so. This meant that people had to be able to step back, reflect, and accept the results of their self-examination and criticism, as well as gain reassurance that they could alter their practice in ways that would bring them more fully into a relationship with the individual, a more truly patient focused approach. (p. 6).

Self-reflection and openness helped Haasen, Hornibrook and Pedlar (1998) to move through their research and get closer to their goals of understanding and change. Self-reflective practice acts as an alternative, where recreation therapists are not being told what to practice by institutional power or research but by their own reflections and professional enhancement.

Self-reflective practice is an act of critical pedagogy. Gur-Ze'ev (1998) states that "[t]he aim of Freire's critical pedagogy is to restore to marginalized groups their stolen 'voice,' to enable them to recognize, identify, and name the things in the world" (p. 466). In this context, the self-reflective case review process creates an opportunity for the recreation therapy team to recognize, identify and name their experiences within therapeutic relationships and to find their own voice in the highly medicalized context of the hospital setting. When engaging in self-reflective processes, recreation therapy moves away from treating individuals receiving care as objects needing to be fixed (a medical approach), and towards the act of engaging in mutual relationships with these individuals. Recreation therapists advocate for the equal treatment and respect for their clients. Therapeutic Recreation Ontario (2006) states, "As part of its advocacy, Recreation Therapy is committed to educating society about the rights and capacities of all citizens to participate in recreation and leisure" (para. 3). But there is also a need to turn the lens of exploration on ourselves—on our practice and on the ideas and theories we bring to practice. Critical pedagogy addresses issues of power within practice and this narrative research explores

insight and change in practice as an act of radical education. Foley (2001) defines radical education as “a fundamental departure from dominant practice or experience at one or more of the following levels: content, process, outcome, the relationship of education to other social processes.” (p. 72). Practitioners are faced with complex decisions concerning justice, democracy, and competing ethical claims (Kincheloe, 2008), and this is equally true for recreation therapists. Therefore, engaging in critical self-reflection provides opportunities for enhancing and deepening recreation therapy practice. In addition, as Kincheloe (2008) states, “education is always political” (p. 14) and there is a need to explore the limitations of theories and ideas we bring to practice. These ideas emerge in education and training through Colleges and Universities, as well as within the practices and culture of hospitals or long-term settings.

This study is an instance of praxis, as Gur-Ze’ev (1998) states “[p]raxis in education aims to bridge the gap between theory and transformational action that effectively transforms human existence.” (p. 467). Within the narrative layers of this study we use different theoretical perspectives to critically explore our experiences to create deeper meaning and understanding of our relationships within our practice. By doing this, we move away from objectifying individuals receiving care as well as tones that try to standardize practice; instead, we argue the importance of creating mutual relationships within care and creating space for the multiplicity of therapeutic relationships that recreation therapists engage in at Sunnybrook.

Critical reflections on power and language are also required within the context of research. In this narrative study, we are concerned about how power unfolds between therapist and individual receiving care. Some of the language of the medical model is still present in hospital settings labelling persons with illness and disability as sick or abnormal and placing focus on fixing and curing people (Devine & Sylvester, 2005). There are words used every day to refer to

people with disabilities and often they are negative, showing that something is wrong or missing or their bodies lack something (Titchkosky, 2003). Devine and Sylvester (2005) argue that while the medical model has helped people with disabilities to improve their physical functioning and help them to live in society, it has “compromised their quality of life by constructing disability as an unhealthy and unhappy personal condition” (p. 88). O’Keefe (2005) challenges medical model views with an ethic of care, which approaches the therapeutic process by viewing the client “as a growing person rather than as a diagnostic label hung on a disease” (p. 73). Therefore in this study we use *person-first language* and take up the American Psychological Association’s (2010) call to avoid using language that objectifies a person: by her or his condition (autistic, neurotic); uses pictorial metaphors (wheelchair bound); uses excessive and negative labels (brain damaged); and that can be regarded as a slur (cripple).

This person-first approach means we refer to *individuals receiving care* to describe individuals with whom recreation therapists engage at Sunnybrook. Patient and client are used at times in the literature review maintaining the original language used by the authors. In addition, some recreation therapists at Sunnybrook refer to individuals they work with as “residents”. Other recreation therapists describe individuals as clients. To be as inclusive as possible of all recreation therapists at Sunnybrook, we refer to individuals receiving care.

In addition, as noted in the prologue we use the term *recreation therapist* when referring to individuals employed by the recreation therapy department at Sunnybrook. We are aware that this term emphasises therapy and could be construed as reinforcing the medical model. However, as this thesis emphasizes, a number of theoretical approaches are taken up in the practice of being a therapist. In this study it is an intersubjective and relational approach to understanding

which connotes a very different involvement of the therapist and how power and relationship are invoked.

Synopsis

When reflecting on experiences it is important to go back to our roots. Sunnybrook began their collaboration with Recreation and Leisure Studies at the University of Waterloo in 1998. In light of the self-reflective journey that we embark on throughout this study, a discussion of Sunnybrook's past research and how they came to their research today is first provided in Chapter Two. Sunnybrook's previous research began by developing their foundation in a person-centred philosophy and as they have shifted towards exploring therapeutic relationships, there was a need to explore other theories which may help to shed more light. We move into a discussion of relational theory which describes the main concepts necessary to maintain a therapeutic relationship.

Chapter Three describes the methodology used in this study, narrative inquiry. Here the recreation therapy team and the research team at Sunnybrook are described in more detail. In this chapter, I also discuss researcher reflexivity, ethical considerations, and issues of quality in narrative inquiry.

Chapter Four presents the findings. For each of the three case review processes explored, four layers of analysis are presented. The first two layers used *narrative analysis* to restory reflections of the case review leader (layer one) and then reflections within the recreation therapy team (layer two). The third and fourth layers used *analysis of narrative* to explore theoretical ideas from person-centred care emerging inductively in the text (layer three) and then to restory the previous narratives using a relational theory lens (layer four). In the final section of Chapter

Four, we explore how the self-reflective case review process has influenced recreation therapy team relationships.

Chapter Five provides a conclusion to this study. I discuss theoretical, methodological, and practical implications of this study. I also describe the challenges I encountered during the research and what I might have done differently. I close with suggestions for future research and some new questions that have resulted from this study.

Chapter Two: Theoretical and Conceptual Framework

This chapter consists of a literature review to help frame and provide context for the study. Before I begin telling the story of Sunnybrook's research I contextualize recreation therapy practice within healthcare by first discussing the dominance of biomedical model theories. Much of Sunnybrook's work has been a movement away from the biomedical model and towards person-centred care and human becoming. This will become evident as the story unfolds of past research conducted by the recreation therapy department at Sunnybrook Health Science Centre with researchers from the Department of Recreation and Leisure Studies at the University of Waterloo. In this story, our shift toward relational theory for exploring therapeutic relationships is also described.

Moving away from the Biomedical Model

In healthcare, the biomedical model, also referred to as the medical model, remains as one of the theoretical foundations that drives practice. Sylvester (2005) argues the medical model defines health, policy, and practice in healthcare. The doctor is at the core of the medical model and "the center of power in health care is medicine's 'treatment team,' a collection of specialists who treat pathology or impairment" (Sylvester, 2005, p. 53). Many recreation therapy departments often are located within a medical setting, such as the recreation therapy department at Sunnybrook.

Thomas (2004) states that in medical sociology, disability is defined as a restriction or lack of ability to perform an activity in a normal manner. The term *normal* comes from what is common of the norm. The *normal* is centred and those said to be abnormal are "devalued and considered a burden or problem" (Linton, 1998, p. 22). Similarly, Linton (1998) criticizes the term disability, suggesting that the 'dis' implies the absence of ability. The "medical model

views the problem as deficits that are part of the individual. Hence, the model is inherently individualistic and deficit-based, seeking to fix what is wrong with the person” (Devine and Sylvester (2005) p. 89). Devine and Sylvester (2005) also state this frames “successful medical treatment” as that which “brings the disabled individual as close to the norm of able-bodied as possible” (Devine and Sylvester, 2005, p. 90). When looking at the challenges for recreation therapists working in a hospital setting, Lahey (1993) contends that “play becomes treatment and recreation a kind of ‘procedure.’ As a result, therapeutic recreation is brought to some hard questions about its professional purpose and identity” (p. 56).

O’Keefe (2005) argues that to actually care for an individual with compassion and respect we must move away from objectification and towards a relational concept of care. O’Keefe (2005) states that:

We will, no doubt, continue to find ourselves on the current playing field of health care service delivery for some time to come. If the language of *Storying, Visioning, Re-creating, and Reflecting on Efficacy* helps us to remain true to the spirit of person-centered care until a time when the environment supports that philosophy, the therapeutic process will indeed be better, not measured by external standards but by the interior moral compass that matters most. (Original emphasis, p. 82)

This movement away from objectification and the medical model has been at the heart of the Recreation Therapy team’s research and practice at Sunnybrook since 1998. This is described in the remainder of this chapter.

Recreation Therapy Research at Sunnybrook Health Sciences Centre 1998-2008

Research at Sunnybrook has made an impact in the world of recreation therapy. It all started back in 1998 when the recreation therapy team at Sunnybrook developed a partnership with Dr. Alison Pedlar of the Department of Recreation and Leisure Studies at the University of Waterloo. At the time, the recreation therapy team was led by Bernice Miller. Dr. Pedlar supported many graduate students to explore different aspects of recreation therapy practice at

Sunnybrook. For the next decade, ideas from person-centred care philosophy framed research in recreation therapy.

Beyond Traditional Assessment: Development of the Personal Leisure Profile

After incorporating a person-centred care philosophy more centrally in recreation therapy practice at Sunnybrook, the members of the recreation therapy department decided to revise their assessment tool. Being situated in a medical field often caused their work to become treatment focused (Hornibrook, 1998). There are still certain responsibilities that recreation therapists must complete within clinical settings that represent medical perspectives, such as the documentation of patient care (Rotteau, 2006). However, Hornibrook (1998) noted that traditional assessment tools did not allow therapists to get to know individuals and did not allow individuals to have freedom of choice in their care. A study completed by Haasen, Hornibrook, Pedlar, Tandon and Wright (1998) moved documentation towards patient-focused care by revisiting the recreation therapy assessment tool used by the recreation therapy team at Sunnybrook. As an alternative to traditional assessment, the *Personal Leisure Profile* (Haasen et al., 1998) was developed as:

A process for understanding a patient's leisure needs and preferences...It is anticipated that this process will provide the recreation therapists with an initial encounter that will provide a strong basis for a more patient-focused approach to recreation therapy throughout the patients' care (n.p.)

The *Personal Leisure Profile* recommends “the recreation therapist be truly present, use understandable language, ensure the individual understands the purpose, contribute and reciprocate, focus on a patients’ current reality and provide genuine opportunities” (Hornibrook, 1998, p. 100). The *Personal Leisure Profile* at Sunnybrook uses five questions as an initial conversation between a recreation therapist and an individual receiving care:

1. What do you enjoy?
(Addresses past/present leisure interests.)

2. What is it about that activity that you enjoy?
(Addresses characteristics of leisure pursuits.)
 3. Recently, what has brought enjoyment/happiness to your day?
(Addresses current leisure status.)
 4. What is stopping you from enjoying that activity?
(Addresses barriers to leisure involvement.)
 5. Is there something that you have always wanted to do?
(Addresses hopes and dreams.)
- (Miller & Bowers-Ivanski, 2009, p. 36)

Hornibrook (1998) also states the foundation for the *Personal Leisure Profile* was:

1. To develop a trusting, open and balanced relationship between therapist and patient;
 2. To gain an understanding of what leisure means to the individual at this moment in his or her life; and
 3. To obtain a mutually satisfying direction for future action
- (p. 109)

The *Personal Leisure Profile* is focused on recreation therapists initiating interactions with the individuals receiving care and developing a connection. Also, the leisure activities often discussed in these meetings emphasize a person's need for social interaction and relationship building, which many of the recreation therapy programs offer.

Beyond the Individual: Exploring the Meaning of Community

Research also focused on the idea of community and the importance of relationships and communication within the Sunnybrook environment. A study by Cantwell (2000) focused on the meaning of community for the residents on a cognitive support unit. When individuals move out of their homes and into Sunnybrook's long-term care facility their sense of community tends to change. Cantwell and Pedlar (2002) stated that moving into a residential facility may feel as if it is the end of any type of community life. Recreation therapy often addresses these issues by offering opportunities for residents to interact and increase their sense of belonging. Kleiber (1999) states that when experiencing a change like moving into a facility, leisure can help to maintain some continuity in one's life.

Results of the study indicated that community within the long-term care facility is developed from capacity building, contribution to the well-being of others, and social gatherings (Cantwell & Pedlar, 2002). Capacity building was evident in relationships between residents and practitioners where residents were encouraged to participate in programs where their personhood was increased. In other words, they knew they were respected and treated as equals. Residents also had opportunity to help others and were provided with assistance when needed (Cantwell & Pedlar, 2002). Lastly, many social gatherings were held “in the neighbourhood” which allowed residents and their friends and families to interact with one another (Cantwell & Pedlar, 2002). Many long-term care facilities make an effort to create enjoyable living experiences for residents (Cantwell & Pedlar, 2002). At Sunnybrook, units are referred to as neighbourhood streets and the residents view these neighbourhoods as their communities. Each of these aspects of the long-term care unit created opportunities for residents to belong to a new community in which they could begin to feel at home.

In this research, Cantwell (2000) also began to discuss the recreation therapist’s role. The recreation therapist moves from “*being with the person* to front-stage professional practitioners” (Original emphasis, p. 90). *Being with the person* means the recreation therapist understands what a person is experiencing and feeling and supports a sense of belonging within their environment (Cantwell, 2000). Also, maintaining personhood is important; personhood recognizes individuals as human beings with the therapist working to meet their needs. When personhood is supported then an optimal quality of life can be reached.

While their focus was on person-centred care, the importance of relationships was often described. As Cantwell stated, person-centred care *enlivens relationships* by giving residents a chance for socialization to develop strong relationships with other residents and with their care

providers. It also gave residents an opportunity to make a contribution to the programs and their community (Cantwell, 2000).

Cantwell (2000) also discussed the three different needs of the residents: comfort (compliments and kindness used to strengthen the therapeutic relationship), attachment (company of others), and inclusion (a sense of belonging for people with dementia). Each of these needs was satisfied through socialization in leisure programs. Cantwell stated “these interactions helped each person maintain a sense of identity in a world so often surrounded by confusion” (p. 101). Person-centred care also emphasizes the importance of involving patients and families in the treatment process and also views patients as persons rather than a diagnosis (Cantwell, 2000).

The Importance of Environment: Exploring the Meaning of Place for Relationships

A few years later, Wiersma (2003) compared the environments in a long-term care facility and a camp setting. Every year a group of residents from Sunnybrook participate in a camp program; during this experience they stay at a cabin up north for a few days. When describing the atmosphere at Sunnybrook, the residents stated that the hospital facility was confining, limited their choices, and was routinized (Wiersma, 2003). Residents also discussed a sense of disengagement from the hospital facility. Wiersma added that they were “simply living their time out until they moved out or passed away” (2003, p. 5). Residents stated the hospital facility also suppressed their self-expression.

Life at camp, however, had a very different sense of place. Camp was free, meaningful, and self-expressive (Wiersma, 2003). Camp involved many opportunities for choice and fewer restrictions. Residents also experienced a chance to self-reflect while also expressing themselves

in a variety of different ways. At camp, Wiersma (2003) described that residents became “different people and their personalities emerged” (p. 7).

While the way one portrays an environment depends on personal values and interpretations, Wiersma (2003) also noted relationships are defined by the place in which they develop, and the place is also defined by those relationships. “[s]ense of place refers to the interpretations and meanings of place, as well as the individual experience in place” said Wiersma (2003, p. 206). Each of these components work to create this sense of place: place, interpretations and meaning, relationship/role definitions, leisure experiences, self, and agency (Wiersma, 2003). Therefore, it is important that long-term care facilities look at these components to ensure residents are experiencing positive leisure, self-identity, and quality of life (Wiersma, 2003).

Next, in 2008 Wiersma and Pedlar looked deeper into how environments shape relationships. Their findings indicated relationships between staff and clients were more functional and focused more on tasks in the long-term care setting. Relationships at the camp setting were supportive and contained a sense of trust (Wiersma & Pedlar, 2008). Although functional relationships were necessary, residents described these supportive relationships at camp as being more valuable. Recreation therapy programs often take place in open leisure environments which enhance opportunity for the development of supportive networks. From the research the authors realized the importance of the environment when developing relationships (Wiersma & Pedlar, 2008). An open and free environment can change the nature of a relationship by providing a chance for the development of community and personhood (Wiersma & Pedlar, 2008).

*Development of Quality Indicators: Framing Recreation Therapy Experiences in
Person-Centred Care*

Research at Sunnybrook continued with the focus of person-centred care by developing a way to document leisure experiences that best reflect the individual's experience. Rotteau and Pedlar, working with the recreation therapy team at Sunnybrook, developed the quality indicators which interpret, understand, and communicate residents' experiences within the recreation and leisure programs (Rotteau, 2006). Rotteau and her colleague Nancy Bowers-Ivanski (2008) stated the "quality indicators (QIs) were developed to better capture the residents' experiences and maintain the integrity of patient-focused care" (p. 56). The first three of the quality indicators are focused on the individual or self-experience, while the remaining three consider the individual in the context of relationships. The quality indicators include:

- **Enjoyment** – when participating in programs, individuals are given a variety of choice and feel a sense of achievement and growth from these programs; leisure provides pleasure, relaxation, and fun, which all lead to a sense of enjoyment (Rotteau & Bowers-Ivanski, 2008).
- **Being yourself (believing in yourself)** –“a sense of identity and self-worth, which may be decreased upon entry into long-term care, can be enhanced through participation in leisure and recreation” (Rotteau, 2006, p. 87). Providing choice and opportunity in recreation and leisure increases self-expression and affirms one's self (Rotteau, 2006).
- **Developing yourself** – Recreation Therapy programs often offer opportunities for individual's to improve skills or develop new skills. Rotteau (2006) states that developing new skills and knowledge has positive impacts on one's quality of life. It is also proven that maintaining cognitive skills may help to decrease one's declining cognitive abilities (Voelkl, Galecki, & Fries, 1996).
- **Feeling like you belong** – being part of a community is connected to improved quality of life (Rotteau, 2006). In long-term care, residents live and interact with each other, so it is important to develop a sense of community for the residents. Leisure activities contribute to a sense of belonging by gathering people together (Rotteau & Bowers-Ivanski, 2008).
- **Meeting others (being with others)** – The chance to meet new people and interact with others creates a sense of belonging to a community. The environment is developed from the relationships within it (Wiersma, 2003). This means that being with others leads to a comfortable environment which represents a community.
- **Helping others** –Helping others gives the residents a chance to have a purpose, feel important, and have a role (Rotteau, 2006). To feel a sense of self-worth and

independence, it is important for the residents to be able to be needed and helpful so that they know their life has purpose and meaning. Helping others, mutuality, also builds community and develop relationships. In long-term care, a chance to help others can be crucial to improving quality of life as individual's are often receiving help from the institution, which can make them feel dependent (Williams & Roberts, 1995).

The quality indicators, like previous research at Sunnybrook, acknowledge the importance of social context for growth and development. The quality indicators play a crucial role in planning, implementing, documenting, and evaluating recreation therapy programs (Rotteau & Bowers-Ivanski, 2008) (see Figure 1).

In planning, recreation therapists use the quality indicators as goals for their programs. In implementing and documenting, recreation therapists observe participants with the quality indicators. Lastly, in evaluating programs the quality indicators are used to show if goals have been met.

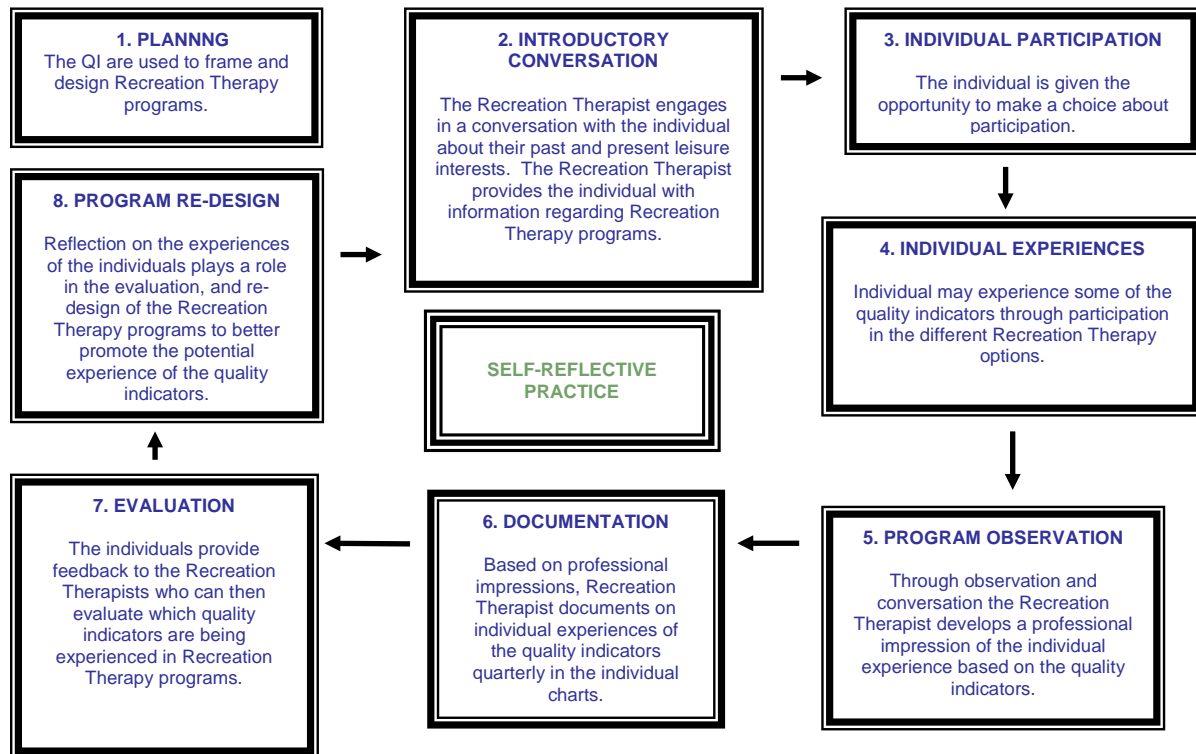


Figure 1. Enhancing patient-focused care through quality indicators in long term care (Rotteau & Bowers-Ivanski, 2008).

A Note on Client-Centred Care and Parse's Theory of Human Becoming

Underlying much of Sunnybrook's research in this first decade was the incorporation of Rosemary Parse's work on person-centred care. Person-centred care, also referred to as patient focused care, client centred care, and client focused care, was defined by Rogers (1952) as giving the individual receiving care a chance to be involved in their care, and establish a good relationship with their therapist. The therapist works with the person, without looking at them as a diagnosis that needs to be fixed and empathizes with them always striving to understand (Rogers, 1952).

Parse's (1996) theory of human becoming underlines the foundation of person-centred care, emphasizing a shift from treating people with a medical model approach, someone who is sick and needs to be fixed, to treating an individual as a person and recognizing people as having knowledge about their own health. This theory enhanced nursing's movement away from the medical model. The theory of human becoming is guided by nine assumptions. These nine assumptions were further integrated to form three assumptions on human becoming:

1. Human becoming is freely choosing personal *meaning* in situation in the intersubjective process of living value priorities.
2. Human becoming is cocreating *rhythmical* patterns of relating in mutual process with the universe.
3. Human becoming is *cotranscending* multidimensionally with emerging possibilities. (Parse, 1998, p. 29, emphasis added)

These three assumptions reflect the three major themes of human becoming: meaning, rhythmicity, and transcendence. *Meanings* are valued images, the content of something and the interpretation of that something (Parse, 1998). Meaning is related to the purpose of life and is

always changing (Parse, 1998). Quality of life is one of the main goals in person-centred care. *Rhythmicity* is the patterning of the human engaging in revealing/concealing, enabling/limiting, and connecting/separating; all of which are involved in everyday experiences (Parse, 1998). *Transcendence* is reaching beyond possibilities and towards change by describing one's hopes and dreams (Parse, 1998).

Human becoming states that quality of life and health is an ongoing mutual experience (Parse, 1998). When discussing quality of life, Parse (1994) states “the very word quality comes from the Latin *qual* meaning what and *qualities* meaning whatness. Whatness is the stuff or essence of something, in this case, the essence of life, the core substance that makes a life different and uniquely irreplaceable” (p. 16). Therefore, the ‘whatness’ or the essence of life depends on the person living that life, thus quality of life cannot be defined by health professionals, but rather by the individual receiving care (Parse, 1994). Therefore, alike to person-centred care is the notion that the individual should have input in their care and health. Rather than the medical model, which presents health professionals as the experts who develop the care plan and place the individual in treatment and programs, the individual is the one who knows what is best for their needs and therefore has input into their care plan. Also, meaningful experiences and values are always changing; therefore the individual receiving care should always have the chance to voice their opinions (Parse, 1994).

Mitchell (1990) describes her experiences of changing from traditional knowledge to the theoretical values of human becoming. Person-centred care involves opportunity for individuals to be involved in their care. Mitchell (1990) describes this change through a story about her interaction with a patient who said she was cold. Mitchell (1990) describes the transition in her perspectives:

Before using Parse's theory I do not think I would have tried to uncover the meaning of Mrs. C's coldness, and if I had, I probably would have focused on offering possible solutions based on my knowledge base. Guided by Parse's theory I believed only Mrs. C knew what was best for her coldness and my focus was on being with her as she changed the situation in the way she wanted. (p. 174).

Parse (1994) also states that the nurse must be truly present with the individual with preparation of plans and paying attention to details. Parse argues "being present is valuing the other's human dignity and freedom to choose within situations, and it is fundamental to living the art of the human becoming theory, the focus of which is the quality of life from the person's perspective" (p. 19). Central to the theory of human becoming is the notion of *freedom*. Parse (1998) emphasises the importance of an individual being free to make choices and being responsible for those decisions. In her practice Mitchell (1990) discusses how she used to attend rounds, a meeting where allied health professionals sit down and discuss a patient's functional and psychosocial abilities and limitations. Then the team decides which treatments and programs best meet the needs of their patients. Mitchell (1990) explains how the team focused on the patient as an object and how to eliminate problems. However, when Mitchell (1990) began to understand the theory of human becoming, she went into rounds differently. Mitchell (1990) presents notes to the team about the meanings, values, hopes, and dreams of the individuals. From this change, the team moved their focus from a problem list, to making decisions based on the individual's perspectives.

An individual and their family, as well as the nurse, "illuminate meaning, synchronize rhythms, and mobilize transcendence" (Parse, 1994, p. 18). Therefore, they work together as a team towards quality of life and health for the individual receiving care. Parse (1998) states that health is becoming, not good, bad, more, or less; "it's not the opposite of disease or a state that a human has but, rather, a continuously changing process that the human cocreates in mutual

process with the universe” (p. 33). Parse (1998) states that the goal of nursing is quality of life for persons, families, and communities. Parse (1998) also states that the nurse must be truly present with a person as they increase quality of life, meaning that the nurse accepts the person’s idea of quality. Parse (1998) argues that quality of life is unique to each individual and is the essence of their life. Pedlar, Hornibrook, and Haasen (2001) state that health care workers use the theory of human becoming to move away from the roles of telling, controlling, and power, and towards listening, participating, and allowing the client to direct their own care and health.

Recreation Therapy Research since 2007: The Transition to a Focus on Therapeutic Relationships

In 2007, the shift in recreation therapy research at Sunnybrook began when Dr. Susan Arai replaced Dr. Alison Pedlar at the University of Waterloo, and Nancy Bowers-Ivanski replaced Bernice Miller as the Manager of Recreation Therapy and Creative Arts Therapy at Sunnybrook. At the annual retreat in the fall of 2007, the recreation therapy team were reflecting on their practice and asked themselves ‘what are we curious about?’ This was when they decided to focus on the therapeutic relationship. They posted many ideas on the walls and at the end of the day felt that exploring the uniqueness of their therapeutic relationships with individuals receiving care at Sunnybrook was deemed the most important.

Memory Work: Exploring Connection and Disconnection in the Therapeutic Relationship

An additional hallmark of the transition in research was that research began to consistently involve the entire recreation therapy team. At their annual retreat in the fall of 2008 the recreation therapy team used memory work methodology to examine their therapeutic relationships (Arai, 2009). Memory work involves participants writing about and discussing

previous experiences (Lapadat et al., 2010). Prior to attending the retreat, recreation therapists each wrote two different memories from their therapeutic relationships with individuals receiving care, one positive and one challenging. On the day of the retreat, the twenty recreation therapists were split into four groups and discussed their memories, searching for common themes and unique aspects of their experiences (Arai, 2009). The following results come from the positive memory discussions.

The flow of the therapeutic relationship was the first common theme (Arai, 2009). Many of the recreation therapists discussed the fact that a therapeutic relationship takes time to unfold and develop. Each relationship also involved recreation therapists being “in the moment” with individuals receiving care, encompassing a fluid quality in the relationship (Arai, 2009). The recreation therapists also discussed how their relationships were deeper than therapeutic relationships, describing them to be similar to friendships (Arai, 2009). The recreation therapists found themselves wanting to be there for their clients and looking at them as a person, rather than a problem that needed to be fixed. Consequently, some found that viewing the therapeutic relationship as a friendship caused disconnect as clients became personally offended when a recreation therapist had to give time to other clients (Arai, 2009). Memories also described moments when individuals receiving care challenged boundaries, to the point where it disrupted the relationship.

Developing the therapeutic relationship consists of trust, respect and comfort in relationship; openness, unconditional acceptance and non-judgement; being in the moment of the resident; understanding the resident’s context of institutionalization and loss; residents leading and initiating in the relationship; being valued and cared for; mutuality in the therapeutic relationship; and being an advocate for the resident’s quality of life (Arai, 2009).

The recreation therapists also discussed themes around *recreation and the therapeutic relationship* (Arai, 2009). Recreation provides a different concept of time where time is not as task focused as it is in other allied health professions (Arai, 2009). Recreation therapy is also flexible, allowing for recreation therapists to go an extra mile when helping a client. Recreation is a “context for beginning and deepening of the therapeutic relationship” (Arai, 2009, p. 22). Recreation therapists describe recreation as a shared experience where they can connect with their clients. Recreation provides an open and informal environment that often involves social interaction. Recreation also provides hope and opportunities for finding meaningful roles in life (Arai, 2009).

The recreation therapy team developed themes that *emerge from therapeutic relationships* (Arai, 2009). The memories revealed that therapeutic relationships are a vehicle for the quality indicators; “the therapeutic relationship is an important vehicle for the residents to experience aspects of their personhood including enjoyment, being yourself, and developing yourself; as well as community or social experiences of meeting others, feeling like you belong and helping others” (p. 26). Therapeutic relationships also help to increase resident’s empowerment by being valued and allows the resident to have a chance to direct and initiate recreation involvement (Arai, 2009). In terms of the recreation therapists’ perspective, positive therapeutic relationships are rewarding and lead to increased job satisfaction (Arai, 2009).

Lastly, the recreation therapy team discussed *endings in the therapeutic relationship* (Arai, 2009). These endings refer to when an individual passes away, is discharged from Sunnybrook, or is due to conflict in the relationship.

From this research a presentation presented at the Therapeutic Recreation Ontario annual conference portrayed themes from positive memories and themes from challenging memories

(Arai, 2009). The themes from the positive memories include *recreation therapist feelings of satisfaction within relationship*, *the qualities of being in relationship*, *perceptions of recreation therapist as unbounded*, and *perceptions of individual as unbounded* (Arai, 2009). The first theme describes the recreation therapists' feelings of satisfaction in relationships (Arai, 2009). Therapeutic relationships provided fulfilling experiences that were meaningful to recreation therapists (Arai, 2009). The second theme involves qualities of being in relationship: trust, respect and comfort; residents lead and initiate; being valued, cared for; and mutuality (Arai, 2009). The next theme, *perceptions of recreation therapist as unbounded*, states that recreation therapists went above and beyond their roles to help individuals receiving care (Arai, 2009). Being unbounded also meant that recreation therapists advocating for the resident's quality of life (Arai, 2009). In regards to the individual receiving care as unbounded, the following qualities were important for recreation therapists to have: openness; unconditional acceptance, non-judgement; being in the moment of the resident; and understanding institutionalization and loss (Arai, 2009).

When discussing matters stemming from challenging memories, the following themes were developed: *recreation therapist feelings of struggle in relationship*; *push-pull qualities of the relationship*; *perceptions of recreation therapist as bounded*; *perceptions of individual as bounded* (Arai, 2009). In the first theme, recreation therapists experienced feelings of struggle in relationships, such as: guilt, sense of failure, uncomfortable, unable to accept outcome, struggle with negative interactions, feeling manipulated, and feeling that boundaries have been challenged (Arai, 2009). These feelings made it difficult for recreation therapists to want to engage in relationships with individuals receiving care. The next theme, *push-pull qualities of the relationship*, suggested a number of characteristics: hesitation; lacking trust, suspicion; no

mutual respect; strained working relationship; communication breakdown; frustration by resident and recreation therapist; boundaries transgressed; and attempts at leverage and manipulation (Arai, 2009). A perception of recreation therapists as bounded involves a static expectation for the recreation therapist to solve problems (Arai, 2009). There is also an expectation that recreation therapists have positive interactions with others, like everyone, and engage in therapeutic relationships (Arai, 2009). Recreation therapists also have a belief that everyone has a right to leisure and are aware of institutional safety concerns within Sunnybrook (Arai, 2009). Recreation therapists perceived they needed more support to balance residents' needs, which is sometimes difficult (Arai, 2009). The final theme, perceptions of the individual as bounded, involves characterising the individual as: lacking insight of appropriate behaviours and impact of behaviours; as loners and not positive; having different values and ethical challenges; having a sense of entitlement and unrealistic expectations; and not all residents want help or therapeutic relationships (Arai, 2009).

After the memory work study, the team had more questions:

- What will help RTs to work through moments of struggle (dissatisfaction) and the push-pull in relationship?
- What are the limitations of person-centred understandings?
- What other theories will help us to better understand the therapeutic relationship?
- How can these questions be explored in the context of self-reflective practice?

These findings and questions from the memory work were then used to frame the recreation therapy team's next research project with Jessica Lansfield (2010).

Action Research and the Birth of the Self-Reflective Case Review Process

The next project after the memory work was a participatory action research study involving twenty-two of the recreation therapists at Sunnybrook and their understandings of their therapeutic relationships. This study was facilitated by graduate student, Jessica Lansfield. The

participatory action research method involved the recreation therapists in determining research questions, the process, data collection, and analysis. Lansfield's (2010) work with the recreation therapy team discovered *qualities* of the therapeutic relationship such as trust, respect, open communication, feelings of attachment, attempts to create positive change, collaboration, provision of support, emphasis on autonomy, and strategies to overcome challenges, reciprocity, leisure environment, flexible context, and "being in the moment" (p. 142). A number of characteristics that a recreation therapist possesses are active listening, a nonthreatening approach, effective communication, ability to develop rapport, attentive observation skills, problem-solving abilities, patience, and being present in the moment (Lansfield, 2010). Many of the recreation therapists argued that "therapeutic relationships enhance the quality of life of individuals receiving care by supporting their adjustment period, shifting their focus to the positive and living, and increasing their leisure involvement and sense of belonging and community" (Lansfield, 2010, p. 146). Similar to the findings from the memory work project (Arai, 2009), a list of aspects that set recreation therapy apart from other disciplines was a degree of reciprocity, a leisure-based context, flexibility of boundaries, and "being in the moment" (Lansfield, 2010). Reciprocity was defined as the acknowledgment that the recreation therapist could also benefit from the relationship (Lansfield, 2010). Flexibility of boundaries was mentioned, stating that boundaries are an important part of the therapeutic relationship and should be in place to avoid conflict, but parameters vary from person to person (Lansfield, 2010). Being in the moment means being truly present within a relationship. Being in the moment requires openness, acceptance, compassion, understanding, and flexibility within the therapeutic relationship (Lansfield, 2010).

After the team's work with Lansfield, the recreation therapy team decided to put their research on therapeutic relationships into practice. A subcommittee met and developed questions from the emerging themes of the past research. A variety of questions were developed under six categories (see appendix A for a chart of the themes and questions):

- building therapeutic relationships
- empowerment
- being professional
- evaluation
- termination/alteration of therapeutic relationships
- values

From these questions the self-reflective case review process was formed. The process is led by a recreation therapist who brings forward experiences from a therapeutic relationship with an individual receiving care at Sunnybrook. The experiences are shared with the team, the leader then presents themes that they wish to address, poses questions to the team, and the team engages in a group discussion.

Therapeutic Relationships and Relational Theory

When the recreation therapy team began to shift their research towards the topic of therapeutic relationships, limitations of person-centred theories in practice began to appear. Although previous theoretical understandings are important in recreation therapy practice, they are not always sufficient, for example when looking at therapeutic relationships. As the team's research moved into a focus on relationships, a different theoretical lens was needed to gain a deeper understanding of what was happening within their therapeutic relationships. We chose relational theory as the theoretical approach since it fits nicely with the research and values of the recreation therapy team as will be discussed in the remainder of this section.

One approach to relational theory emerged from the Stone Centre at Wellesley College in Wellesley, Massachusetts. Wellesley is “known for the thousands of accomplished, thoughtful women it has sent out into the world over 100 years-women who are committed to making a difference” (Trustees of Wellesley College, 2012, para. 1). Their approach to relational theory, also referred to as relational-cultural theory, is a feminist theory created within the field of psychology. Relational theory was developed from the Jean Baker Miller Training Institute, first created by Jean Baker Miller, and “has been further developed since 1978 by a collaborative group including founding scholars Jean Baker Miller, M.D., Judith V. Jordan, Ph.D., Irene Stiver, Ph.D. and Janet Surrey, Ph.D..” (Jean Baker Miller Training Institute, 2012, para. 3).

As the recreation therapy team noted during the fall retreat of 2007, there is something unique about their relationships with individuals receiving care. What they describe was their mutual presence in their therapeutic relationships with individuals at Sunnybrook. While other understandings emphasize the experience of the individual receiving care in the relationship (e.g., Rogers, 1958), relational theory states the goal of therapeutic relationships is to engage in mutually empathetic and mutually empowering connections (Biurski & Haglund, 2001; Jordan, 2000; Jordan, Walker & Hartling, 2004; Miller & Stiver, 1997; Walker & Rosen, 2004). When describing their therapeutic relationships, recreation therapists at Sunnybrook use words such as: mutuality, connection, non-judgemental and comfortable (authenticity), mutual respect, flexibility, empowerment, and boundaries (Arai, 2009). It was suspected that a relational lens on relationships would offer opportunities to move the team towards exploring the mutual nature of their experiences with individuals receiving care.

Relational theory provides a departure from earlier ideas about therapeutic relationships in which the therapist’s role was not considered in the healing process. While Rogers

acknowledged the therapist's role there were limitations in his conceptualisation which relational theory addresses. Rogers (1946) states that the therapeutic relationship involves a therapist who creates warmth, understanding, safety, and acceptance of the individual receiving care. Once these qualities are provided, the client will drop natural defences and will connect with the therapist. Rogers (1946) argues that time is to be the "client's hour" (p. 419), and that the therapist must make sure this is true. Rogers (1946) discusses the new view of the therapist:

The therapist must lay aside his preoccupation with diagnosis and his diagnostic shrewdness, must discard his tendency to make professional evaluations, must cease his endeavors to formulate an accurate prognosis, must give up the temptation subtly to guide the individual, and must concentrate on one purpose only; that of providing deep understanding and acceptance of the attitudes consciously held at this moment by the client as he explores step by step into the dangerous areas which he has been 'denying to consciousness (p. 421).

Relational theory states that people develop through their relationships with others (Jordan et al., 2004). The following are the foundational aspects of the relational model:

- Relational differentiation and elaboration, rather than separation, characterize growth.
 - Mutuality and shared power are markers of mature functioning.
 - Mutual empathy is an essential process in effective therapies.
 - Therapeutic authenticity is necessary for the development of mutual empathy.
- (p. 7)

A core assumption of relational theory is the notion of striving for health (Biurski & Haglund, 2001). Rogers (2007) argues unconditional positive regard is identified as a central aspect of the therapeutic relationship, but in relational theory this idea is extended to consider respect for the client's pursuit for health. Rogers (2007) defined unconditional positive regard as "the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client" (p. 243). In other words, there are no conditions for acceptance, the therapist likes the client for the person they are. There is no judgement involved, as the therapist accepts the positive and negative aspects of the client. An

unconditional positive regard “helps to create a safe, warm, tolerant, and accepting environment in the treatment setting” (Overholser, 2007, p. 71). The therapist cares for the client without judging the client’s thoughts, feelings or actions. Creating this feeling of acceptance increases the comfort in the environment which helps the client to meet his or her goals. This comfort allows the client to express him/herself more openly with the therapist, leading to the possibility of making changes. The idea of unconditional positive regard is viewed in a slightly different way within relational theory. Here, the individual receiving care is understood as in a process of continuously striving for health, even if those behaviours appear to be maladaptive (Biurski & Haglund, 2001). For example, an individual may engage in drug abuse which although appears to be negative, it may actually be the individual’s way of feeling health and escaping negative aspects in their lives. In some cases by seeing the client as striving for health, a therapist may redirect harmful behaviours and provide opportunities for meaningful activities that enhance their health. Biurski and Haglund (2001) state “when the therapist responds from this perspective, the patient can feel more real to himself and more trusting of his perceptions and his own experience” (p. 4). Within relational theory there is a constant flow between connection, disconnection, and reconnection. Many things in a relationship lead us towards and help maintain our connections with one another. Walker and Rosen (2004) define connection as “encounters characterized by interpersonal harmony, warm support, and pleasant feelings” (p.8). We all search for connections within our relationships. To experience connection within a relationship, many other relational characteristics must also exist: mutuality, mutual empathy, and authenticity (Walker & Rosen, 2004). These characteristics will be described in detail later in this section.

Sometimes *disconnection* occurs within a relationship, which we all have experienced before. As Jordan et al. (2004) say “disconnection is inevitable” (p. 55). Disconnection can occur from a lack of mutuality, power differentials, or boundary issues within a relationship (Walker & Rosen, 2004). Disconnection can be minor or it can be major, which can cause the relationship to eventually terminate. Jordan et al. (2001) say “often the clue to a disconnection is the drop in energy we feel in the moment” (p. 50). These moments of disconnection leave us experiencing sad or negative emotions (Jordan et al., 2004). Jordan et al. (2004) argue “relationships that fail to be mutual or adequately honor both people’s realities also push toward disconnection” (p. 51). When disconnection occurs we move away from connection.

Reconnection can happen after a disconnection has occurred and potentially can bring us back towards connection. When attempting to reconnect Jordan et al. (2004) states “we have the opportunity to first name the disconnection and explore the interaction pattern, what led up to it; to express our feelings and represent our needs and understandings; and to stay open to the experience of the other person” (p. 50). By expressing emotions and dialoguing about the sense of disconnection, each member of the relationship gains a mutual understanding of each other’s needs.

Mutuality is an essential characteristic of a relationship that leads to connection. Jordan et al. (2004) define mutuality as “profound mutual respect and mutual openness to change and responsiveness” (p. 3). Both members have equal importance and impact within the relationship. Miller argues that “for one person to grow in a relationship, both people must grow” (as cited in Jordan et al., 2004, p. 3). Therefore, to have a growth-enhancing connection, each individual must experience mutuality within the relationship. Miller and Stiver (1997) argue “a dominant group is not likely to create mutually empowering relationships, else it would not remain

dominant” (p. 49). Therefore, awareness of power differences will help recreation therapists work towards an exchange of mutuality and respect within therapeutic relationships.

Empathy is commonly described as a quality of therapeutic relationships but in relational theory it is defined differently. In defining empathy, Rogers (2007) claims it is “to sense the client’s anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it” (p. 243). Relational theory describes *mutual empathy* in which both people are affected by the other and this knowledge is appreciated by both people (Jordan, 2000). Mutual empathy stems from the concept of mutuality in that each individual experiences each other’s happenings. Mutual empathy involves an individual seeing that they have an impact on the other (Jordan et al., 2004). For that individual to know that they have made an impact on the other, they need to see and feel the other’s emotional response (Jordan et al. 2004). For example, if you told me your dog died, instead of responding in an empathetic way by saying my dog died too and I know what it is like, I would respond by showing you my emotions and stating that I can see it is a difficult experience. I would respond by showing you my emotions in response to your experience. I may reflect that I can see how sad you are. Affected by your sadness, I may also shed a tear as I experience your grief. By sharing emotions a client feels the therapist understands the importance of their experience and confirms their emotions—this is known as an experience of *mattering* (Jordan, 2000), in which there is healing in being able to move another person.

Once mutual empathy is developed, *trust* grows for client and therapist (Jordan et al., 2004). Relationships are impacted when support is unavailable and the client cannot trust they will grow from a connection. Trust is the ability to comfortably share personal information with another person and rely on their actions. Trust can also represent respect and honor in a

relationship where each person is true to the other and cares about them. Langley and Klopper (2005) describe trust as essential, “for the establishment and maintenance of a therapeutic alliance, stressing that without trust any intervention was unlikely to succeed” (p. 25). Once trust is established in the therapeutic relationship the client is able to believe the therapist will help them. Therapists say trust is the basis of the therapeutic relationship and is vital before any connections evolve (Langley & Klopper, 2005). Langley and Klopper (2005) state that if mistrust occurs it may cause relationships to diminish or terminate. Mistrust can develop from one person keeping distant, being unfriendly, and being unsupportive. Another issue could be miscommunications between client and practitioner creating a discrepancy in understanding (Darragh, Sample, & Krieger, 2000).

Authenticity in relational theory is similar to the characteristic of genuineness in therapeutic relationships. As discussed in an interview between Overholser (2007) and Rogers about client-centered care, a therapist must characterize genuineness by displaying honest interest in the well-being of the client. If the therapist allows feelings and attitudes to flow inherently, the client will develop a bond because the relationship becomes reciprocal. Genuineness within the therapist promotes authenticity within the client (Overholser, 2007). Since the therapist is open and pure, a client is able to act like themselves without feeling as if he or she needs to meet certain expectations. Relational theory refers to this as authenticity, where an individual represents their true experiences and also responds truthfully to others' thoughts and emotions (Miller & Stiver, 1997). Sharing experiences and emotions within a relationship connects us to one another and builds a trust within relationship. However, authenticity is not about total disclosure, “it is about a *quality of presence* that contributes powerfully to healing in connection” (Jordan et al., 2004, p. 67). Similar to mutual empathy which involves being

authentic, authenticity involves the therapist showing how the client has impacted her (Jordan et al., 2004). When therapists authentically represent themselves it moves relationships toward mutuality (Jordan et al., 2004). Being open and self-expressive in a relationship that is comfortable and safe leads towards stronger connection.

Power sharing is an important element of a relationship. Miller and Stiver (1997) argue “when power inequalities—whether real or assumed—are present, disconnections can readily occur” (p. 12). Walker and Rosen (2004) are aware that relationships in therapy often portray power differentials right from the start as the therapist is in a position of *power over*, but engaging in a relational therapeutic relationship immediately emphasizes sharing *power with* a client. *Power with* instead of *power over* which reflects the relational characteristic of mutuality (Walker & Rosen, 2004). Walker and Rosen (2004) express “because the therapy relationship exists in a cultural context where power is stratified and sinuously layered along multiple dimensions, the therapist and client must pay close attention to the enactments of power between them” (p. 32). Recreation therapists, such as the team at Sunnybrook, often work in areas such as hospitals where a hierarchy of roles exists. Therefore, recreation therapists must be aware of and avoid enacting power over their clients and acting as the expert. Walker and Rosen (2004) argue “unacknowledged, unnamed, and unexamined power differentials and imbalances create the greatest potential for disconnection and violation in therapy” (p. 154-155).

Boundaries are often thought of as a line that you cannot cross and involves setting rules. Setting boundaries can lead to differences of power in a relationship. Walker and Rosen (2004) caution therapists by stating “when the therapist can act unilaterally (and in perpetuity) to establish the terms and conditions of relationship, serious questions about power arise” (p. 15). Walker and Rosen (2004) suggest that the therapist should “initiate a conversation with the client

at the beginning of the relationship about mutual agreements: the terms and conditions that both parties need in order to make the relationship work” (p. 16). Relational theory looks at boundaries differently, as a place of meeting (Jordan et al., 2004). Boundaries are important within a relationship and are adapted depending on the relationship and the individuals involved. Jordan et al. (2004) state that boundaries refer to both members having the right to the following:

- Clarity – each person must be clear when expressing feelings and needs, and to be clear on who’s feelings and thoughts belong to whom.
 - Safety – therapist is responsible for the protection of the clients’ safety and for the relationship.
 - Never own needs – therapist should never use client to take care of their own needs.
 - Privacy and self-protection – both members have the right to privacy and self-protection. Learning how to say no and express discomfort. Both members must feel safe enough to stay in the relationship
- (Adapted from Jordan et al., 2004, p. 71-72)

In person-centred approaches, it is important to make sure not to take too much time to discuss a therapist’s personal problems, because it can cause clients to lose trust and respect for their therapist (Peplau, 1997). Similarly, relational theory states a therapist must not use the client to meet their own needs (Jordan et al., 2004). When deciding what information to disclose, it has to have a therapeutic purpose for the client, enhance connection, and move the relationship toward mutuality.

In more traditional understandings of therapy, some of these boundary issues are referred to as countertransference (Kahn, 1991). In traditional approaches the therapist is to keep these emotions out of the therapeutic relationship. For example, if a client shows anger instead of getting angry as well the therapist tends toward a neutral response (Kahn, 1991). In contrast, within relational theory therapists are able to show the impact of the client’s emotions. A therapist acknowledging their feelings and exploring what has happened within the relationship

can lead to a place of meeting where each member has a clear understanding of the other's experience.

When experiencing many of the characteristics mentioned above, one can gain a *relational competence*. Walker and Rosen (2004) define relational competence as “the capacity to move another person, to effect a change in relationship, or effect the well-being of all participants in the relationship” (p. 15). Having confidence in a relationship means that individuals value the relationship and have a strong connection with other individuals.

Summary

This chapter reflects the recreation therapy department at Sunnybrook's tradition of working within person-centred care philosophy and the potential of relational theory to expand our thinking about therapeutic relationships. Relational theory was described in detail, with a comparison to therapeutic relationship literature in other areas.

Chapter Three provides a detailed description of the methodology and methods used to collect, analyze, and display the data. I provide a description of participants in the study and how they were recruited. I also describe details of the different stages of my data collection process. Next, I discuss reflexivity and ethical considerations for the project. Finally, issues that may arise within narrative inquiry are discussed.

Chapter Three: Engaging in Narrative Inquiry

Narrative inquiry guides this story of therapeutic relationships. Narrative inquiry describes stories that organize human experience and make it meaningful (Daly, 2007) and enables multiple voices and stories to be explored. Polkinghorne (1988) states “studying narrative meaning is to make explicit the operations that produce its particular kind of meaning, and to draw out the implications this meaning has for understanding human existence” (p. 6). It is important to note that narrative does not copy but instead helps to make sense of reality (Daly, 2007). Often narrative follows a temporal sequence from past to present to future; narrative tends to make meaning of the past, is shaped from the present, and display hopes for the future (Daly, 2007). In this narrative inquiry we explored the self-reflective case review process focused on therapeutic relationships developed by the recreation therapy team at Sunnybrook. The purpose of this narrative approach was to explore different layers of understanding within recreation therapists’ stories about their experiences of therapeutic relationships.

The original narrative approach that we used was Clandinin and Connelly’s (2000) three-dimensional space approach. Three-dimensional narrative inquiry involves three parts: personal and social (interaction); past, present, future (continuity); combined with the notion of place (situation) (Clandinin & Connelly, p. 50). These three dimensions describe temporal matters, a personal-social balance between internal and external conditions, all which occurs in a specific place space (Clandinin & Connelly, 2000).

In following the steps for conducting a narrative study by Clandinin and Connelly (2000), it is first important to determine if narrative is an appropriate method to use. Narrative is suitable to this topic because it captures stories from a small number of individuals (Clandinin & Connelly, 2000), the recreation therapists at Sunnybrook. Also, narrative allows multiple voices

to be heard without any judgement, expectations, or final answers (Clandinin & Connelly, 2000). Therapeutic relationships vary from person to person and therefore cannot be described in a universal way. Narrative compliments the topic of therapeutic relationships as it does not search for one truth, but allows for many voices and experiences to be explored. Therefore, the recreation therapy team was open to sharing their experiences with each other in a comfortable place. This narrative approach enabled different voices and stories of the recreation therapists to be present. Also, narrative engages self-reflection, as the recreation therapists are sharing past stories and reflecting on the meaning of those experiences. Within narrative “a person is, at once, engaged in living, telling, retelling, and reliving stories” (Clandinin & Connelly 1989, p.11).

Temporal changes have occurred in the recreation therapy team’s movement from person-centred values to a growing need for relational theory to explore their understandings of therapeutic relationships. Since the recreation therapy team has been focused on self-reflective practice, these narratives supported the recreation therapists to reflect and have a deeper understanding of their experiences with individuals receiving care. This method used a critical lens in which the narrative brought about change in the way personal experiences are viewed (Daly, 2007). The narrative retorying in this study allowed for recreation therapists to work across layers to name, identify and explore therapeutic relationships and to use different theoretical lenses to further examine their practice. Narrative inquiry is aimed at understanding and making meaning of experiences (Clandinin & Connelly, 2000).

Narrative inquiry has been chosen for its alignment with self-reflective practice. Miller and Pedlar (2006) state that self-reflective practice involves a practitioner stepping back and reflecting on their experiences, leading to adjustments and improvements in their practice. This project provided the recreation therapists with an opportunity to engage in a reflection upon their

self-reflective case review process exploring therapeutic relationships. Schön (1983) discusses a concept of reflecting-on-action, which involves reflecting on the moment, constructing it, framing it within a context, processing it, and making decisions about how to change it. Gilbert (2010) argues that once you reflect regularly, you get to know yourself, which helps you to reflect in-the-moment. This study provides an opportunity to critically reflect on therapeutic relationships in a different way.

The Recreation Therapy Team at Sunnybrook

Participants in this study were drawn from among the twenty-two recreation therapists on the team at Sunnybrook. Recreation therapists at Sunnybrook are from a variety of different areas of the hospital: cognitive support resident care units, community support, geriatric day hospital, and mental health and physical support units (Lansfield, 2010). Most recreation therapists work in the Veteran's Centre part of the hospital and the majority are providing support to veterans. The Veteran's Centre hosts 500 residents who are veterans from the Second World War and the Korean War (Sunnybrook Health Sciences Centre, 2012). The Veteran's Centre is the largest in Canada and was established in 1948 (Sunnybrook Health Sciences Centre, 2012).

At the present time, the recreation therapy team consists of women who have been working together and engaging in research for many years. In 2010 the recreation therapy team developed the self-reflective case review process. The self-reflective case review process has been an ongoing reflective practice at Sunnybrook since 2010. The case review process was designed to enable the recreation therapy team to come together to reflect on challenges encountered in their therapeutic relationships. Each case review process involves one recreation therapist presenting a case about a therapeutic relationship with an individual receiving care at Sunnybrook and

inviting the recreation therapy team to dialogue about that case. Prior to each case review process the leader prepares material (see appendix F) by: reviewing the chart of the individual receiving care to write a brief review of his history (included Personal Leisure Profile highlights), choosing themes from the self-reflective case review template (see appendix A) to highlight, and compiling questions to pose to the team. This information is summarised and a copy is provided to the recreation therapy team. The summary is reviewed during the case review process, and the leader poses her questions to guide discussion.

During the fall retreat in 2011, Dr. Susan Arai and I met with the team and engaged in a dialogue about their next research interests. The recreation therapists were also introduced to relational theory for the first time. The team engaged in an activity where they applied the concepts of relational theory to memories drawn from their previous memory work research (Arai, 2009). The team worked with the theory and indicated that they found it helpful in understanding the therapeutic relationships described in these memories in a different way. They naturally began to use the terms within their language. This was a starting place with further potential for exploring these concepts in the context of their experiences within therapeutic relationships at Sunnybrook.

The team had engaged in approximately five self-reflective case review processes before I began this research project. The recreation therapy department had planned to engage in one case review process per month, however in some months, time did not allow for the case review process to occur due to other large events and activities in which the Sunnybrook team was involved. However, before the research began, the team already had three recreation therapists scheduled to lead a case review process. Those three leaders agreed to have their case review processes involved in the research.

During the fall retreat a research team was chosen to assist me through the research process. The recreation therapy team at Sunnybrook have been working as partners with researchers from the University of Waterloo in a number of projects. In the team's research with Lansfield (2010), recreation therapists were active participants in the research process due to the fact that a participatory action research process was being used. Even though I did not use a participatory action research process, the research team assisted me with sections of the project. At the fall retreat of 2011 we offered some areas where volunteers could assist with the research, and recreation therapists volunteered based on their interests. The research team consisted of 10 people:

- a main contact who communicated between the Sunnybrook recreation therapy team and myself
- 3 recreation therapists who assisted with the development of the focus group and interview guides
- 4 recreation therapists assisted with data analysis
- 5 recreation therapists assisted with the results
- 3 recreation therapists assisted with preparing and presenting a presentation for the annual Therapeutic Recreation Ontario conference
- 4 recreation therapists will assist in writing articles to be published

The Process of Gathering Narratives

The data collection began in January of 2012. The methods used for data collection were observation of the case review, focus groups with case review participants, and interviews with each case review leader. The first case review was held on January 24th, 2012, the second on January 30th, 2012, and the third on March 1st, 2012. Approximately 12 recreation therapists attended each of the case review process.

The observation process involved sitting in on each of the three self-reflective case review processes. The case review process was audio recorded and in addition, I observed the team's discussions and interactions with one another and took reflective notes. My notes consisted of

common stories within the team's discussions, recreation therapists' emotions, and what I saw happening.

Focus groups took place immediately after each case review process. The focus groups involved recreation therapists engaging in a discussion about their experience during the case review process. Discussion in focus groups is effective in exploring why people think or feel the way they do (Krueger, 1994). Focus groups typically consist of seven to ten participants who have a common characteristic (Krueger, 1994), such working in the recreation therapy department at Sunnybrook. Recreation therapists who attended the case review that day were invited to stay for the focus group afterwards. Recreation therapists stayed after each case review process for the focus group, with the exception of a few who had to leave due to other commitments. The focus groups were held immediately after the case review processes since the recreation therapists would already be in attendance and it would make it easier for them to reflect instantaneously on their experiences of the case review process. The atmosphere of a focus group is comfortable, creating opportunity to share ideas and perceptions (Krueger, 1994). Kamberelis and Dimitriadis (2005) argue that "focus groups often produce data that are seldom produced through individual interviewing and observation and that result in especially powerful interpretive insights" (p. 903). Focus groups allow participants to gather ideas and express themselves through their conversations with others. During the discussions, ideas were either triggered from responses or were added onto responses. Kamberelis and Dimitriadis (2005) state, "[f]ocus groups foreground the importance not only of content, but also of expression, because they capitalize on the richness and complexity of group dynamics" (p. 903).

Some focus groups occur after a program ends (Krueger, 1994), such as the focus groups used in this study which were implemented immediately after the self-reflective case review

process had concluded. Specifically for this study, the focus groups were used to understand what recreation therapists experienced during the case review process, new knowledge gained from their experiences, and how engaging in a case review process affects practice. Although interviews were also conducted with the recreation therapists who led the case review processes, focus groups allowed for recreation therapists to discuss their views of the process, as well as to learn from other's responses. Another important element of a focus group is that it decenters the role of the researcher which eliminates the power difference between the researcher and the participants (Kamberelis & Dimitriadis, 2005). This was done by providing opportunities for recreation therapists to voice their thoughts and provide information about their experiences within the case review processes, instead of me writing my assumptions about what was happening in the case reviews processes. This provided participants with more ownership of the research, which allowed them to be fully immersed in the process.

I facilitated the focus groups by posing questions and then the recreation therapists engaged in discussions about their experiences. The focus groups were audio recorded to capture the discussions among recreation therapists and were approximately thirty minutes in length. The following are the questions asked during the focus groups:

1. What was it like to participate in the case review process?
2. What learning did you take away from the process?
3. How will it inform your practice?
4. How has the exploration of relational theory been helpful in the case review process?

One of the strategies for successful focus group discussions is pilot testing the focus group interview (Krueger, 1994). I sat down with my supervisor, Dr. Susan Arai, and we analyzed the process and the questions. We also came up with some prompts to enhance the flow of the discussion. The second step to the pilot test is inviting select representative of the targeted audience to review the questions (Krueger, 1994). Three members of the research team reviewed

the focus group questions that Dr. Arai and I developed and provided us with feedback. The third step occurs after the first focus group and involves the researcher taking notes on what was successful and on what needed changing (Krueger, 1994). After the first focus group I realized that the questions and prompts were useful in facilitating discussion.

Narrative interviews were then conducted with each case review leader one week following the case review and focus group process. Interviews are the most common process for gathering stories in narrative inquiry (Polkinghorne, 2003). My first interview was held on January 31st, 2012, with Laura. Megan's interview took place on February 6th, 2012. My interview with Carly was held on March 15th, 2012. Each interview was audio recorded and was one hour in length. The narrative interview is a method used to stimulate participants' expression of experiences and perceptions on a specific topic through telling stories (Jovchelovitch & Bauer, 2000). The interview is less formal as it represents a conversation that is probed by the researcher when necessary. The perspective of the participant is best displayed through their own words and stories (Jovchelovitch & Bauer, 2000). Once the interviews are conducted they are then transcribed and are further discussed with the participants, as part of an ongoing narrative process (Connelly & Clandinin, 1990). Within our study, I interviewed the three recreation therapists who led the case review process and displayed the narratives to my research team for further review. As I reflected on my first experience of conducting interviews, I realized that when doing narrative interviews it is important to engage in storytelling with participants, as Glover (2004) did by asking participants to tell a story of their experience.

The interview questions were designed from the three-dimensional narrative inquiry (Clandinin & Connelly, 2000) approach (see Table 1). These questions were also approved by the research team.

Table 1

Research Questions and Interview Questions (Based on the Three-Dimensional Space Narrative Structure)

Research Questions	Interview Questions
<p>What knowledge arises for recreation therapists engaged in the self-reflective case review process? How does knowledge from the self-reflective case review process influence recreation therapists' practices? (past, present, future)</p>	<ul style="list-style-type: none"> • What did you take away from the self-reflective case review process? • What did you find challenging about the case review process? • How has the self-reflective case review process changed your practice? • How does the case review process support your practice as a recreation therapist?
<p>How do recreation therapists experience the self-reflective case review process, personally and socially? (personal and social)</p>	<ul style="list-style-type: none"> • What are your perceptions, feelings, and hopes for your therapeutic relationships? • What other perceptions, feelings, and hopes for your therapeutic relationships are indicated within your interprofessional team? • How are these perceptions, feelings, and hopes similar or different to your own?
<p>How does the context shape the self-reflective case review process? (Situation/Place)</p>	<ul style="list-style-type: none"> • How does the environment (place) you work within influence your therapeutic relationships? • How does the environment (place) you work within influence your participation in the self-reflective case review process?
<p>How does relational theory shed light on therapeutic relationships in recreational therapy?</p>	<ul style="list-style-type: none"> • How has the exploration of relational theory been helpful in the self-reflective case review process? • How does relational theory help you to understand your practice?

Narrative Analysis

The data analysis began as the stories in the case reviews unfolded. Clandinin and Connelly (2000) refer to the stories told during data collection as field texts. After the first case review process in January I sat down and immediately transcribed the audio recording. Then I read over the field texts and recalled my memories of the case review process, and pulled out the main stories. My first interview with Laura was only one week after the case review process, and the interview was done to further understand Laura's experiences within the case review process.

I also developed a few questions about the main stories and added them to the interview guide to clarify that I understood the main stories appropriately. By asking these questions I made sure that my interpretations of what was happening within the case review process were sound. This same approach was carried out for all three case review processes.

Once all of the data was transcribed, I created a word document for each case review which contained the case review process observations, the focus group, and the interview to that specific case review process. I then used NVIVO (QSR International, 2011), a qualitative research database that assists with organization and analysis. NVIVO was used to create nodes for the three-dimensions of the space narrative: continuity, interaction, and situation (Clandinin & Connelly, 2000).

Defining the dimensions (derived from Clandinin & Connelly, 2000), *interaction* includes the *personal* experiences of storyteller (internal conditions, feelings, hopes) and *social* interactions of storyteller with people and environment (conditions in environment, other people's intentions and points of view). *Continuity* describes the *past* (looking back) and *present* experiences and feelings of the storyteller, and events to occur in the *future* (possible experiences to come). *Situation* describes a notion of *places* in which the storyteller's experiences occurred (context, physical landscape).

Specific to this study the dimensions include:

- Interaction: the *personal* – personal experiences and feelings of the recreation therapists (i.e., frustrations, moral issues)—and *social* – Interaction of recreation therapists with people (e.g., other residents, family, staff, recreation therapists).
- Continuity: *past* experiences with an individual receiving care or similar experiences with different individuals, *present* or current challenges, feelings and experiences, and *future* hopes for connection.
- Situation: notions of *place* or context in which therapeutic relationship took place (Warrior's Hall or on a specific unit)

Then I sat down with a nice cup of coffee and began the analysis. I read through the transcripts one by one and designated dimensional nodes to the stories. The first read through of case review one involved looking for interaction experiences, the second read through looked for continuity experience, and the final read through looked for notions of place. Then this process was repeated for both the second and third case review material (case review process observations, focus group, and interview).

Once the first draft of the restorying process was complete, I checked back with the recreation therapy team for clarification and verification. I travelled to Sunnybrook to meet with three recreation therapists on the research team whom had offered to help me in the data analysis process. Clandinin and Connelly (2000) state that collaborations in narrative research involve actively including the participants in the research process as it unfolds. This collective approach is common to the recreation therapy research between Sunnybrook and the University of Waterloo. I sent the recreation therapists the stories ahead of time, along with the following questions to reflect on:

1. When you read through all of the sections on pages 2-7, what do you think of the overall flow of ideas? Does it resonate with your ideas about what the research attempts to capture? What do you think of the structure?
2. In the section *The Restorying of the Case*, I drew from the case conference transcripts and pieced together a representation of the case being discussed. How might this description be made clearer? Are there any places where we need to provide more information so that the reader can really feel the quality of the relationship?
3. What other details of the story did you wonder about or remembered being discussed (if you were there)?
4. In the section, *Relational Restorying of the Case*, the focus is on the RT and client (or clients if others are involved). I have pulled out ideas from the team's conversation and made the connections to relational theory. What resonates with you in this section? How might we make the descriptions clearer to the reader? What other ways does relational theory connect to the conversations in the case review process and the story?
5. In the section titled *Relational Restorying of Recreation Therapy Team Relationship* the focus is on how RTS describe the case review process and relationships within the team. What did you think of the application of relational theory to how the process fosters

growth in team relationships? How is relational theory helpful in understanding disconnection within the recreation therapy team?

6. Where might we need to rewrite sections of the document to enhance growth and relationship within the team? In other words, what sections of the document sound like advice giving, finger pointing, judgment or blaming and may lead to disconnection?
7. Any thoughts about the first section, *Reflections on the Self-reflective Case Review Process*, or the last section, *Reflections on the Influence of Space and Context*?

When I returned from Sunnybrook, I sat down to discuss the analysis process with my Advisor, Susan Arai. As we talked through this process, and about the clearest way to represent the data, we began to explore the idea of restorying in more depth. We decided that the three-dimensional inquiry, especially the influence of space and context, did not provide the analytical strength required to best reflect the team's stories. We realized that something different was emerging in the research. Although there were aspects of the three dimensions within the recreation therapists' stories, deeper meaning of the experiences within therapeutic relationships appeared to be influenced from present understandings and theories.

To be able to see the influence of these present understandings, the process of restorying was used. Clandinin and Connelly (1990) state restorying creates further meaning within stories. Restorying is the process of hearing stories, analyzing the stories with key elements in mind, and then rewriting the stories (Ollerenshaw & Creswell, 2002). Clandinin and Connelly (1989) discuss reflective restorying, which is a restorying of an event that allows reflection of that event by looking at it from a different perspective. Clandinin and Connelly (1989) state that in narrative a person is reliving their stories by sharing and reflecting on their experiences.

I began the process of restorying and this marked the shift to incorporating both analysis of narrative and narrative analysis as described by Polkinghorne (2003). In *narrative analysis* "researchers collect descriptions of events and happenings and synthesize or configure them by means of a plot into a story or stories" (Polkinghorne, 2003, p. 12). Polkinghorne (2003) states

that the outcome of narrative analysis is a story that unites experiences and creates meaning to those experiences. This study presents the story of therapeutic relationships. Each case review process involved taking parts of the observation notes, focus group transcripts, and interview transcripts and compiling them into a restorying. From data provided by each case review leader a restorying of the therapeutic relationship occurred. Then, from the team's discussion a restorying of the therapeutic relationship was also developed. Polkinghorne (2003) claims "the final story must fit the data while at the same time bringing an order and meaningfulness that is not apparent in the data themselves" (p. 16).

In contrast, in *analysis of narrative* "researchers collect stories as data and analyze them with paradigmatic processes" (Polkinghorne, 2003, p. 12). Paradigmatic analysis then "results in descriptions of themes that hold across the stories or in taxonomies of types of stories, characters, or settings" (Polkinghorne, 2003, p. 12). Paradigmatic analysis involves exploring the stories and identifying general notions or concepts (Polkinghorne, 2003) including those which are: (a) inductively derive concepts from the data; and (b) derived from the application of previous theory to the data to determine whether instances of these concepts are to be found (Polkinghorne, 2003). In this study we used both types of paradigmatic search. Approach (a) was used to pull out language already within recreation therapists language which is rooted in person-centred care, theory of human becoming, and the medical model. Then we used approach (b) by applying a relational lens to the original restorying to highlight concepts of relational theory, while also providing possibly descriptions of the happenings within therapeutic relationships.

To summarize, as data analysis unfolded we decided on the following structure (described with Laura's case review process, but applied to the other 2 cases as well):

1. A first narrative was created which restoried Laura's case review process. This story is a summarized description of the field text (Clandinin & Connelly, 2000). The story consisted of the Laura's presentation of the case and her relationship with the individual receiving care. This was a process of **narrative analysis**.
2. A second narrative was then created which represents how the team restoried Laura's case when they began to dialogue about therapeutic relationships. This was a process of **narrative analysis**.
3. A third narrative restories the team's dialogue in the second narrative and explored the ideas emerging inductively in the text (**paradigmatic approach a**). Here we heard the emergence of a variety of theoretical ideas including person-centred care, Parse's theory of human becoming, interspersed with medical language and insight. This represents the introduction of **analysis of narrative** in the analysis process.
4. For the fourth narrative, I then sat down with a coffee, took these notions, and again restoried the previous narratives, this time using a relational theory lens. This was a process of **analysis of narrative**. To help shed light on the challenges presented in the case reviews we also applied **paradigmatic approach (b)** in this second restorying. Here, we looked for areas of the recreation therapists' experiences that represented notions of relational theory.

Narrative is a reflective research process, as stories and people involved shift and change over time (Clandinin & Connelly, 1990). From each story an individual interprets and gains meaning from it in their own way. These stories have been written and rewritten many times, reflecting the ever changing quality of narrative.

Reflexivity

Reflexivity is a crucial aspect of research when completing a qualitative study. Dupuis (1999) argues researchers in leisure studies need to follow a reflexive methodology to carry out interpretivist qualitative research. Unlike positivist, scientific research, qualitative research gives the opportunity to become involved in the study and experience the lived experiences of participants. By being reflexive, the researcher reflects on the participants' experiences and their own life experiences (Dupuis, 1999). Since the topics we choose to research reflect our interests, it is impossible to keep the self out of the research (Dupuis, 1999). Relationships are important to me and are a main interest in my life. A deeper and more comprehensive understanding of what the research topic means to different people and how they experience it in different contexts can only be enhanced by incorporating the self in the research (Dupuis, 1999).

I involved myself in the study by reflecting on my own life and experiences. This helped me to better understand the culture of relationships at Sunnybrook. Involving the self in the research is crucial for supporting our understandings and better represents the experiences of our participants (Dupuis, 1999). Throughout the findings some of my own interpretations and understandings are revealed within the narrative stories.

During the data collection and writing process I took notes about my experiences. Clandinin and Connelly (2000) state that the narrative inquirer's stories are open for analysis and retelling. Roberts and Sanders (2005) state researchers mainly study a subject with which they have previous experience. Reflecting before research involves the researcher looking at their own interests and values and seeing how the project relates to their own lives. As I discussed in the prologue, I value therapeutic relationships in my work and have previously worked with the recreation therapy team at Sunnybrook. Our own life experiences and culture affect how we

choose our topics and subjects and therefore it is important to acknowledge these connections. Roberts and Sanders (2005) state that not only is it important to reflect on one's own reasons for entering the field but also reflecting on the resources that allowed this connection to occur. I completed my undergraduate degree at the University of Waterloo in therapeutic recreation and therefore was already connected to many of the professors in the department, including my supervisor, Dr. Susan Arai. Also, I previously worked in the recreation therapy department at Sunnybrook. I value relationships in my life and therefore find the topic of therapeutic relationships very important in the health care community. I also am a reflexive person as I often look back at experiences and discuss them with others. Clandinin and Connelly (2000) argue that it is impossible for narrative inquirers to keep their personal views and stories silent. Therefore, a researcher may reveal their lived stories and feel vulnerable about it, but it will strengthen the results of the research.

I kept a reflexive journal throughout this research process to keep track of any thoughts that came up in the moment that could be important in the results. Documenting ideas and experiences served as a reference point to help me remember what was happening in those specific moments. Connelly and Clandinin (1990) state that during narrative inquiry a researcher's notes act as an active recording of their interpretations and constructions of the events. Journaling also helped me to reflect on my ideas and perceptions of the research. Lastly, while analyzing the data and composing the results, I reflected in my journal as well as incorporated pieces into the narrative.

Ethical Considerations

Creswell (2009) states that it is important for researchers to “protect their research participants; develop a trust with them; promote the integrity of research; guard against

misconduct and impropriety that might reflect on their organizations or institutions; and cope with new, challenging problems” (p. 87). Therefore, the following details were considered.

In the fall of 2011 I received ethics clearance through the Office of Research Ethics at the University of Waterloo (file # 17642). This study also received ethics clearance through Sunnybrook Health Sciences Centre (file #407-2011). This is important in preventing harmful risk to the participants (Creswell, 2009).

Since each member of the recreation therapy team was invited to participate in this study (as little or as much as they desired), the entire team was informed of the self-reflective case review dates, and were given an information letter that included details about the study (see Appendix B). Those recreation therapists who attended at least one of the case review processes read and filled out a consent form before the meeting commenced (see Appendix C). A separate consent form was filled out before the interview with the leader of each case review process (see Appendix D). In March 2012 after all of the data collection was complete, a letter of appreciation was sent out to all of the recreation therapy team, thanking them for their participation in the study (see Appendix E). These forms contained information about the study, contact information for any further questions, information about ethics clearance, and required consent from the participants signature at the bottom verifying their consent.

In terms of confidentiality, all names remain confidential and pseudonyms have been used throughout this thesis document. The recorded data has been stored in a secure space with protected passwords within the department of Recreation and Leisure Studies at the University of Waterloo. The only people who viewed the transcripts were my advisor Dr. Susan Arai and myself. Anonymity is not feasible in this study since each of the recreation therapists at Sunnybrook knew about each other’s participation in the research, as did my advisor and myself.

All participants were informed that they have full rights to withdraw from the project at any time. This protects the participants from any risk or harm that the study may cause them.

Issues of Quality in Narrative

When performing narrative inquiry, researchers must remember that participants are narrators of their own voices and stories (Chase, 2005). Therefore, we are not searching for correct answers or a universal truth of therapeutic relationships. Also, a researcher must not assume that all participants will tell their stories right away and therefore they must be prepared to invite them to story tell (Chase, 2005). In other words, the researcher must be open to this possibility and be prepared to prompt interviewees into being the narrator. The questions a researcher asks must be broad and open to invite a personal narrative story from the participant.

There is an issue of voice in narrative where the researcher uses too much of their own voice to portray the participants' voices (Chase, 2005). Even though it is important to include the researcher's voice in the narrative, it is important to make sure that the researcher's voice does not outshine participants' stories.

Polkinghorne (2007) argues that "validity threats arise in narrative research because the languaged descriptions given by participants of their experienced meaning is not a mirrored reflection of this meaning" (p. 480). However, the narrative can attempt to reflect real experiences by the participant telling their stories as close to real life as they can, and the researcher represents their stories in the best way possible.

Also from the participant's perspective, resistance can occur when revealing personal stories to someone they do not know very well (Polkinghorne, 2007). Participants may alter their stories to reveal positive self-images; therefore trust needs to exist between the researcher and participant. Even though I already knew the recreation therapy team, some of them still may

have felt hesitant in revealing their emotions or experiences with me. The recreation therapy team at Sunnybrook is very involved in their research, and therefore are open to sharing emotions and stories. However, there is a chance they could have left some stories out to protect their professional image or their colleagues' images. Another way to make the participants feel comfortable is the researcher's attention to body language, such as an open listening stance (Polkinghorne, 2007). Researchers also need to allow participants time to reflect on and express their stories (Polkinghorne, 2007).

Lastly, it is important to provide opportunities for readers to have their own interpretations of the researcher's interpretations (Polkinghorne, 2007). Therefore, researchers may state that their interpretations are significant, but they must be aware they are not the only possible interpretation. As I stated earlier, our interpretations in the restorying part of the findings are suggested possibilities for understanding interactions within the team's therapeutic relationships.

Summary

Narrative inquiry guides this study of therapeutic relationships as we describe stories that organize human experience and make it meaningful. Recreation therapists engaged in a fall retreat where they chose the three case review leaders as well as a small research team to assist me in the research process. The data was collected using observation, focus groups, and narrative interviews. In regards to reflexivity, I engaged in journal writing throughout the research process and incorporated some of my experiences and previous knowledge into the narrative story. Ethical matters were discussed and offered to the participants, such as protecting participants from harm, submission of the project to The Office of Research Ethics at the University of Waterloo and at Sunnybrook, letters of consent, confidentiality, and the right to withdraw from the project at any time.

The data analysis process was long but meaningful. As we moved away from the three-dimensional space narrative and toward the process of restorying, a deeper understanding of what was happening within therapeutic relationships began to unfold. Chapter Four presents findings of this study and is written in narrative layers.

Chapter Four: Discoveries and Dialogues in (Re)storying the Case

Three case review processes, led by Laura, Megan, and Carly, were explored in this study and are described in the following sections. The findings for each case review are presented in four narrative layers.

1. A first narrative consisting of the case review leader's presentation of the case and her relationship with the individual receiving care (narrative analysis).
2. A second narrative representing the team's restorying of the case when they began to dialogue about the recreation therapists therapeutic relationship (narrative analysis).
3. A third narrative restorying the team's dialogue explored the theoretical ideas emerging inductively in the text (analysis of narrative, paradigmatic approach a).
4. A fourth narrative, restorying the previous narratives using a relational theory lens (analysis of narrative, paradigmatic approach b).

Before we begin it is important to note the language used within these findings and the process used for interpretation. In terms of interpretations, for each case review process the first two stories (narrative analysis) are a summarized restorying of the recreation therapists experiences. Consequently the restorying stays as close as possible to text of the original transcripts. The first two narratives reflect language used by the recreation therapy team. This language was used by the team and found in the data collected from the observations, focus groups, and interviews. In contrast, the third and fourth restorying (analysis of narrative) involves my own interpretations of their experiences and incorporates my use of theoretical language from person-centred and relational approaches applied to recreation therapists' stories.

In the final sections in this chapter, I provide overall reflections from recreation therapists' on self-reflective practice and the case review process. I then provide a discussion of the implications of the case review process for relationships within the recreation therapy team itself. In these recreation therapists' narrative reflections echo themes of relational theory—in their voices we hear notions of connection, disconnection, reconnection, mutuality, mutual empathy, authenticity, vulnerability, and support.

In the following sections the recreation therapists at Sunnybrook have shared with us insights gained from their experiences and they have taken the risk to share with us their questions, concerns, and challenges. They had the courage to make themselves vulnerable and to share their experiences in the context of self-reflective practice so that they may grow as individual practitioners, as a team, and so that the profession of recreation therapy may also benefit. Narrative research is made powerful when participants are able to truthfully share the complexities and nuances of their experience. In the narratives that follow it is possible to see the recreation therapy team at Sunnybrook has done just that. In this case they share with us insight into the complexities and challenges within therapeutic relationships occurring in the context of recreation therapy at Sunnybrook. In the knowledge shared, the reader is able to gain much and as such, there is a need to hold the text with respect and non-judgment, and with the same openness the recreation therapy team at Sunnybrook has taken in their approach to sharing their narratives with us. As a researcher privileged to engage with this team I strive to do just that and hope it is reflected in the text that follows, and that readers will hold the text in the same way.

Laura's Case Review Process

One sunny, bitterly cold, winter day in January, members of the recreation therapy team at Sunnybrook gathered during their lunch break to engage in a self-reflective case review

process. Laura, the leader of the case review process who works in community support, presented her experiences and challenges with an individual named Mr. B. Laura provided a brief summary of Mr. B to her fellow recreation therapists, including a description of his history and her experience of their relationship. Laura chose this case because most often her experience with clients was not one of frustration. With Mr. B she found this to be a challenge she experienced and was curious about. She also knew it was a challenge for many other team members who encountered Mr. B and thought it would lead to fruitful discussion.

Restorying Laura's Therapeutic Relationship with Mr. B

Mr. B is an 84 year old man who recently moved to Sunnybrook in August 2011. He is “[a] fairly new resident to Sunnybrook, Mr. B speaks highly of his new home.” Mr. B is:

eager to socialize with everyone. He enjoys speaking with everyone including staff, residents and visitors. His eagerness to partake in conversation has been viewed at times as disruptive and over bearing. When communicating with others Mr. B often interrupts the conversation; at times asking questions that are inappropriate (i.e., too great a focus on their nationality).

Mr. B often attends Warrior's Hall events. Warrior's Hall is a common area where individuals receiving care and their family and friends come together as a community to enjoy daily entertainment provided by the recreation therapy department. Mr. B used to be an entertainer and therefore has tried many times to join in on the performances in Warrior's Hall; however, “[t]his would cause several residents watching to yell at Mr. B “to sit down.” As well as other various comments that I couldn't write here [in case review notes]” and would upset many individuals in the audience.

Laura also described Mr. B as at times disruptive and overbearing—he often interrupts conversations and makes inappropriate comments about people’s race. This pattern of interrupting is something Mr. B himself describes as being noted by others:

He says himself that throughout his life he’s been told to stop interrupting. So that’s another hard point too that you’re trying to be accepting of his behaviour and trying to keep in mind, well it could be a preliminary example of dementia, but at the same time he’s saying himself “Ya, well, I was like this throughout my life”.

Laura described, “[t]his behaviour has caused arguments with other residents. Several arguments disruptive enough for the need of an incident report. His behaviour has also resulted in several residents and family avoiding him.” Many staff at Sunnybrook previously discussed removing Mr. B’s privileges to partake in Warrior’s Hall events, but Laura believed this consequence would be devastating to his quality of life. Further, Laura noted, “[t]here are residents however whom Mr. B has developed a positive relationship with. They are accepting of his behaviour, letting him know when he is interrupting and enjoy his outgoing nature.”

Trying to understand how Mr. B engages with others, Laura looked to his chart and noted with surprise that it did not contain a lot of details about his medical history. She later learned from the recreation therapist who works directly with Mr. B that he has a history of stroke and depression.

During the case review, Laura stated that the themes she wished to highlight were *building therapeutic relationships* and *being professional*. She then highlighted the following questions from the case review template she wanted to focus on:

Building Therapeutic Relationships:

How can I better relate to this individual?

What strategies can we employ to maintain the therapeutic relationship?

Whose needs are being met in therapeutic relationships?

Being Professional:

How do I make my practice, approach, demeanor non-threatening and positive?

How do I cope with challenges in my therapeutic relationship?

After reading the summary and questions to the team, Laura began the group discussion:

I'd like feedback in terms of the best way to relate to this individual whom myself I find difficult to relate with and I can understand how other residents have the feelings that they do. But at the same time still being able to build a therapeutic relationship with this individual and help him build... relationships with other veterans as well in a positive way.

Later in the case review, Laura shared a story of an experience with Mr. B that took place in Warrior's Hall. Laura was in charge of running the program that day. In one moment during the program, Laura was engaged with one individual while also keeping an eye on the entire group to make sure everything went smoothly and safely. Suddenly Mr. B snapped his fingers at her, "Can you go make some copies of that for me?" he demanded. In the moment, Laura paused in her conversation with the other individual to reply to Mr. B. "No I can't do that right now," she stated. "Well why not? What else are you doing?" challenged Mr. B. Laura tried to explain to Mr. B that the photocopier was in another area and she could not leave Warrior's Hall, but he kept insisting she make him copies.

He won't let it go. He'll just go on. And you almost have to just walk away because there's no convincing [him] of why you can't do it that way, like he's just going to keep at it. And you walk away feeling badly...like I might as well have gone to make copies and come back in the time that it has taken me to address it... but then again if you start doing stuff like that then...

When Laura finally said, "No" she walked away feeling badly and wondered to herself:

Should I have just made the copies? It might have been faster than standing there arguing with him. But then if I start doing things for him whenever he wants, he will take advantage of that. I just want him to respect me.

When Mr. B is so tenacious with his demands, Laura noted she often takes a step back to reflect on the situation:

in the past and I find myself when he makes a request, I almost have to step back sometimes and ask myself “is it a realistic or reasonable request or not?” Because I have to question myself, if it was someone else who I don’t find as difficult to work with, would I have no problem doing it for them. And, is it because of who it is that I have my back up right away and I’m looking for a reason to say no?... and that’s not professional either... but it is hard dealing with him in terms of making him realize that his request isn’t reasonable

The challenge of this therapeutic relationship also comes from negotiating it within the context of a larger network of relationships within Warriors hall. Laura noted it is at times awkward having to be so blunt to state clear boundaries with Mr. B when he is in a group context but also it is done for the sake “*of his own safety, being too vocal.*” At times, responses to Mr. B from other residents include physical responses, verbal responses and making fun, or avoidance. Also when overhearing Mr. B in conversation with other individuals and speaking in a way that is racist, she also wonders about her duty to protect other residents:

Do you intervene or do you just sort of let it go? Like at what point is it our role to almost referee what he’s saying, or do we...is that just something that a companion might have to deal with and we just sort of leave it at that...

The Team Restories Laura and Mr. B’s Therapeutic Relationship

Conversation with the team then unfolded. After hearing Laura’s story, Jill immediately shared her own experience of Mr. B:

I have daily interactions with this resident as well, and just personally myself I find it very difficult working with him because of all the comments he makes about nationality and his disruptive behaviour in Warriors Hall where there’s entertainment going on and him just being really, [he] really likes to stand out, and when you’re in a group he starts shouting and introducing himself. So I did meet with the social worker that is on his unit about strategies, that I could maybe allocate certain sections for him to sit in during the entertainment so he’s less disruptive. And also gaining a better understanding of really is it his medical needs, or is it his personality that’s overbearing. So that helped me a little bit

with understanding what it is that he has issues with. And it seemed like, it's mostly his stroke which I'm surprised that it's not indicated in his charts or his medical history.

At the heart of this conversation was a question about the causes of these challenging interactions, the role of the therapist, and how to support positive change. Many recreation therapists agreed that being direct with Mr. B is helpful. Elisa stated that in the past when she developed boundaries with an individual with whom she worked it often led to more respect within their relationship. Being direct meant telling Mr. B when he was being rude, or being stern or saying “no” to him. Rachel expressed how another recreation therapist had described this experience, “She said you have to be painfully direct with him. Like where you and I would think you were sort of at the line, be even clearer than that.” Paige noted her discomfort with establishing boundaries:

That's what makes it uncomfortable because that's not a typical therapeutic relationship that we would have with residents where we so clearly have to define boundaries. And I think it becomes even more challenging because the message can sometimes be new to him every time because he has, there's some cognitive deficits there, right. So you know it's not like you're really seeing any gains in being so forthright. And you know if it's awkward for you to do, it's always going to be... like that's always going to be difficult for you to do.

This was made even more difficult, the group described, because these conversations with Mr. B have to occur immediately because of his memory and processing abilities, and often occur in a group setting which raises challenges of not wanting to embarrass Mr. B. Also as Paige described:

I think sometimes because it happens in such a public place, you feel like you're being judged by everyone else on your...how professional you are or your ability to manage situations. You're being judged by all these people, you're being put in a spotlight where you could fail very easily and that's uncomfortable.

Rachel shared a story where she had to be blunt and say no to Mr. B to lay down boundaries. Rachel brought Mr. B to her office, along with the recreation therapist of his unit and

a creative art therapist. Rachel described how they tried to negotiate a solution with Mr. B but he was not taking no for an answer. Rachel described, *“He called me several names after that.”* As a result of this, Rachel noted that despite suggestions to try, reasoning and setting boundaries with Mr. B, at times it may not work.

Jill connected with Rachel’s experience as she discussed how Mr. B will say to others *“Oh, she’s mean to me, she’s very rude to me.”* Jill worried that when family members and other residents hear him saying that, they will see her as incompetent. *“So that way we can’t really be THAT strict with him for him to have that negative feeling towards us. Right because we see him every day”*, Jill stated.

The recreation therapists discussed how it felt awkward to address issues in front of other people, as they were afraid it would affect their relationships with others. Paige expressed her concerns to the team:

I think sometimes because it happens in such a public place, you feel like you’re being judged by everyone else on your...how professional you are or your ability to manage situations. You’re being judged by all these people, you’re being put in a spotlight where you could fail very easily and that’s uncomfortable.

Natalie noted that developing a thick skin has helped her in interactions with Mr. B. She described a similar experience where she could not accommodate Mr. B. Afterwards Mr. B told other people Natalie does not listen to him. Natalie reassured the team that individuals receiving care, families, and staff know the recreation therapy team is very accommodating and therefore would not think any differently of them when observing a disagreement with Mr. B. When referring to the way she experienced his rudeness, she explained that *“although those comments hurt, you just kinda have to just let it fly because the next week he liked me again.”*

Laura noted that Mr. B is *“sporadic”* and *“sometimes he does get it.”* She also described trying to understand Mr. B better to know how to respond, *“think that’s what makes it hard*

because it's hard to understand whether or not its dementia or if it's just his personality." Laura also wondered about ways to increase consistency in the messages that Mr. B receives from staff and posed the following question to the team, *"What strategies could be implemented to ensure all staff members are reinforcing the same message, once we determine what that message is?"* The team discussed providing Mr. B with options and how that was met with *"it's his way or the highway"*. When he becomes fixated and makes racist comments, the team talked about explaining to him how his words impact others, or intervening in the conversation to protect the other person. They also talked about opportunities they have created for Mr. B to engage in a sing-a-long. When one recreation therapist shared a story about helping one man to understand other residents, Laura noted:

that's a good idea. And I do find that he does have the understanding that in some situations if he acts a certain way he's putting himself at risk. Like for example, he was in Warriors Hall and there was a gentleman from Third Street who is a heavy smoker and had come down while they were in quarantine and he [Mr. B] said "if I mention to him that he should probably go back upstairs he's probably going to punch me". And he was correct. So he does have the foresight sometimes to know who to leave alone, and yet in other situations he doesn't. But that's a good idea in terms of explaining that there's those types of health concerns throughout.

The team explored patterns in their experiences with Mr. B and discussed finding consistent ways to connect with Mr. B and sharing that information within the team in Mr. B's chart. Laura noted relief as she felt an openness return:

Laura – because I battle sometimes with what makes an incident? Like what should it be...because each time I walk though Warriors Hall, every day, it could be something that I overheard or...then I'd be constantly charting. But at the same time, there's been times where it has turned into nothing, and other times where I should have charted it.

Rachel – I always think the rule of thumb is, if the hair on your back on the neck stands up, chart it.

Laura – That's pretty well every day.

Rachel – Then chart it.

Laura – Ok, and I'd like to say, that's not the case. And I find it's to the point now and that's where I wanted to bring it today, once I enter the room my hair goes...nothing's happened! I find these strategies will help me go in with an open mind.

Analysis of the Team's Restorying

The recreation therapists were supportive of each other's therapeutic relationships. Many recreation therapists discussed similar experiences with Mr. B, which helped Laura know she was not alone in her struggles with Mr. B. We can see this as a moment of empathy. Roger's (2007) defines empathy as occurring when one's experiences are clear to the other, and the other can express they understand their experience.

Person-centred care involves thinking about the individual first and helping them to meet their needs (Rogers, 1952). Human becoming asks us to focus on the essence of the individual's life, and for Mr. B they understood that this was connected to his previous career as an entertainer. Dialogue between team members represented person-focused philosophies, as the team discussed how to meet Mr. B's needs, such as helping him interact with others and negotiating his involvement in a sing-a-long. As Mitchell (1990) describes, human becoming involves focus on the meanings, values, hopes, and dreams of the person.

The team also discussed improving Mr. B's quality of life and supporting him to have the freedom to choose his leisure experiences. As Parse (1998) describes freedom is central in quality of life. The recreation therapy team discussed the significance of Mr. B choosing his own activities. Laura explained how some staff suggested removing Mr. B from Warrior's Hall events, but Laura expressed to the team how this could be detrimental to his quality of life.

The team discussed strategies to negotiate challenging interactions with Mr. B, such as being direct and creating boundaries. They discussed their shared experiences and a more

consistent way of responding to Mr. B that might help. Invoking person-centred understandings, boundaries include parameters of time, place, purpose, expectations, and power (Lansfield, 2010).

As Parse (1998) describes, *rhythmicity* is the patterning of the human engaging in revealing/concealing, enabling/limiting, and connecting/separating; all of which are involved in everyday experiences. As the team attempted to understand and make sense of Mr. B's actions and to find the best way to support and engage him, they explored whether his ways of connecting (which led others into a rhythm of separation) was connected to a medical condition which might influence his ability to be aware of the impact of his actions and words, and to remember this during subsequent interactions. This dialogue was part of a larger attempt to make sense of interactions with Mr. B, as his actions were at times sporadic and he did show an ability to understand and shift his interactions on occasion. The team questioned whether the challenge experienced by Mr. B was rooted in a medical concern or in personality and individual difference. During the case review process Jill asked the group, "*I wonder if ever on the unit he's had an assessment cognitively. Just so that we know where he is, is it dementia that's affecting him? Or does that have nothing to do with it, it's just his personality.*" Discussing Mr. B's medical needs and challenging behaviours reflects medical discourse and a focus on conditions and limitations but in the context of a person-centred approach. While medical insight is helpful in understanding variations in individual rhythms and influences recreation therapy practice, it does not guide it. The recreation therapy team was concerned with Mr. B's health concerns and how it influences his communication and behaviour with others. The team saw Mr. B's rhythmical patterns of interaction as a barrier to his leisure and therefore wanted to better understand his behaviours so that they could help facilitate his participation in recreation therapy

programs. Whereas in the medical model, people with disabilities are referred to as something to be fixed and lacking health (Diedrich, 2007); here, the medical is used for understanding to support appropriate accommodation.

Dialogue also reflected the team's awareness that Laura's relationship with Mr. B occurred within a web of other relationships (residents, family, recreation therapy, and other health disciplines). The team worried about how their challenges with Mr. B could negatively affect their relationships with other residents. Discomfort with being as direct and blunt with Mr. B as they had to be led to concerns with how they might be perceived by others, and their degree of professionalism. It makes sense that in these moments countertransference might arise, in which the therapist's personal feelings influence their therapeutic relationship (Kahn, 1991). In this situation, the recreation therapist might fear her other relationships might be affected by her interactions with Mr. B and decrease her willingness to be direct and blunt.

Relational Analysis Restorying Laura and Mr. B's Therapeutic Relationship

Laura began her case review by commenting about her desire to *enhance her connection* with Mr. B. Increased connection involves making changes to increase a sense of well-being for both members of the relationship (Baker, Miller, & Pierce Stiver, 1997). However, Laura was having difficulties maintaining her connection with Mr. B and expressed her need for the team's support in doing so. The first sense of *disconnection* within the therapeutic relationship occurred when Mr. B demanded Laura make copies for him immediately. The suggestion offered to Laura was to be more direct and firm with Mr. B by saying "no I can't right now." There is the potential here for Mr. B to feel misunderstood by Laura. By saying "No", this would further contribute to the disconnection that is already present in the relationship.

How might we understand Mr. B's actions from a relational perspective? We might view Mr. B's actions as an attempt to *strive for health* (Biurski & Haglund, 2001). Mr. B may have wanted to make copies to share with his friends, therefore enhancing his connection with them. His request could also have been an attempt at connection with Laura. We may also see this in terms of power in relationship. In relationship, there is often a *notion of power* that separates individuals from each other. For the recreation therapist, power is held in their professional role and further reinforced by their alignment with the clinical team. Miller and Stiver (1997) state "whenever one group of people has power over another, this creates disconnections and violations of the relationships between the members of the two groups" (p. 49). When power is not shared the relationship lacks mutuality (Walker & Rosen, 2004). Mr. B's insistence of his being entitled to many things may be viewed as an attempt to equalize his sense of power in relationship. When one's position allows them to have power over the other, mutuality is unable to survive (Jordan et al., 2004). *Sharing power* allows both members of the relationship to see their influence on the other (Walker & Rosen, 2004).

However, this experience lacked a sense of *mutuality* in the interaction. At the time, Laura had been engaged with other participants and while acknowledging Mr. B was not able to fulfil his request at the time. Mr. B seemed unable to understand why his request was not a priority for Laura. Mr. B might have also felt misunderstood and disconnected from Laura. This lack of mutuality in understanding may lead to a sense of disconnection (Jordan et al., 2004) with each not understanding how the other could not take in their experience. In some ways it may leave each individual feeling as if they are not seen by the other. A sense of *mutuality* helps to create feelings of empowerment, increase self-worth, and the desire to maintain the connection (Miller, 1988). When mutuality is absent, disconnection is experienced.

In this interaction there are also moments where there is the potential for each person to feel a sense of humiliation. When Mr. B is demanding and arguing with Laura in front of others and says things about the recreation therapists to other people there is, these *humiliating interactions* may cause a shift in power in the relationship, moving away from the concept of mutuality (Jordan, 1986). In these interactions there is a push-pull arriving in the relationship—one individual wants to pull the other into meeting his demands and the other, feeling embarrassed, may wish to move away from the interaction in that moment. This is also a moment of disconnection.

A relationship can move from disconnection to reconnection by an individual making experiences known to the other individual, who then responds in a way that leads to a better connection (Walker & Rosen, 2004). Even though Mr. B was unable to communicate his experiences, since this case review Laura has reflected on how she creates space for Mr. B during interactions. Laura has shifted the rhythm of their interactions so that she engages Mr. B when she is able to focus all of her attention on him (rather than engaging and asking him to wait a period of time before she can be fully present with him). By creating space for Laura and Mr. B to engage with each other in relationship, it enhances their ability to engage with mutuality in their experiences. In comparison to how *boundaries* are understood in person-centred approaches, in relational understandings they act as a place of meeting, rather than a line that cannot be crossed (Jordan et al., 2004). Boundaries are about both sides having the right to safety, self-care, mutuality, equality, and respect.

Within the shared space of meeting created by the boundaries of the therapeutic relationship, it then becomes possible to negotiate differences and conflict. Relational theory states that it is more effective to state your limits rather than setting them because they may

change (Jordan et al., 2004). When a client is encroaching on a therapist's boundaries or vice versa, discussing together about solving the problem can create *connection*. Discussing emotions of discomfort encourages the growth-enhancing nature of the therapeutic relationship.

Boundaries give one the ability to “authentically represent one's needs and feelings in a context that holds some promise of mutuality” (Jordan et al., 2004, p. 69). If Laura discussed boundaries with Mr. B, she could explain that she feels uncomfortable when he demands things from her and when he speaks down to her. By sharing these feelings with Mr. B he might be more understanding of her feelings and this could increase their connection. Therefore, instead of a power dynamic, this respectful way of stating boundaries allows for a more genuine and mutual relationship (Jordan et al., 2004). It is important that each individual within the relationship feels safe, is comfortable clarifying their feelings, and has the right to privacy (Jordan et al., 2004).

Megan's Case Review Process

The recreation therapists at Sunnybrook gathered for their next self-reflective case review process. This time it was about Megan's experiences with an individual named Jake. Megan works on a cognitive behavioural unit. Megan provided a brief summary to her fellow recreation therapists of Jake, including his history, and described an experience of her relationship with Jake. Megan noted that she chose the case because of the complexity that experiences of dementia add to the dynamics of the therapeutic relationship. Megan noted she had experienced a push-pull in relationship, and while her experience and knowledge of medical aspects of dementia allows her to step back she thought the case would be interesting to discuss with the team.

Restorying Megan's Therapeutic Relationship with Jake

Jake has a history of aggressive behaviours thought to be associated with his dementia, as well as a history of alcohol abuse. Megan discussed that details of his medical history was unclear. As Megan described, for a long period of time Jake had chosen to isolate himself in his home and he, “*spent his days watching TV, drinking and talking with his wife.*” After the death of his wife in 2009 Jake was noted to have experienced cognitive decline. Jake had been placed in other medical and long term care facilities before arriving at Sunnybrook. During that time there had been police involvement and he was later admitted to Sunnybrook on a Form 1. Jake has five step-children from his 30 year marriage with his wife, but they mostly do not visit him at Sunnybrook. Megan described seeing one of Jake's step-children arrive at Sunnybrook for a visit with Jake:

I did see the family once. I did see them come in once because they walked in and Jake was screaming and yelling obscenities. And they had walked onto the unit, turned around and walked out. Kind of like a “I'm not dealing with this.”

Megan noted that Jake was often agitated and demanding. To clearly give the team a sense of her experiences with Jake, Megan provided the following examples of what time with Jake is like:

Jake spends the mornings in his room quietly watching movies on the Turner Classic Movies channel. Once lunch is over, Jake begins to become agitated. He starts to yell out “come here. I said come here dammit.” Jake will then wheel himself out of his room and begin yelling at everyone he sees. This includes residents, staff, and visiting family members. Jake does not like being ignored and will often hit out at someone when they haven't responded to him as quickly as he would like. He also becomes verbally abusive. On one occasion, which unfortunately isn't just one, another resident was sleeping in a chair in the unit living room. Jake yelled at the sleeping resident, “hey, you there. Come here.” The resident did not respond. Jake shouted at the resident again, wheeled up to the resident, and slapped him across the face twice. The sleeping resident woke up and punched him in the face.

As a result, Megan noted that other residents on the unit do not like Jake. When Jake begins yelling, Megan noted that, *“the other residents will make comments about Jake, leave the living room area and go back to their rooms, or when he is wheeling by, they will kick at his chair or shove his chair in another direction.”*

Megan noted that Jake enjoys talking to staff but within a few minutes he becomes verbally and occasionally physically abusive towards the staff member. He also, *“becomes very angry if the staff are talking with other residents on the unit.”* In addition, Jake often yelled at the unit staff when he wanted something. Megan described Jake’s behaviour as a push and pull; *“he wants your attention but doesn’t want your attention. How he wants to be with you but doesn’t want to be with you. How he wants to talk with you but then he pushes you away. How he might want to join in on something and then offends everyone and manages to push them away.”*

Megan stated three themes she wished to highlight during the case review process: *building therapeutic relationships, being professional, and evaluation.* Next she posed eight questions to the recreation therapists present at the meeting:

1. How can you be present in the moment with the individual?
2. How do you cope with challenges in your therapeutic relationship?
3. How do you assert your power without compromising the individual’s self-respect?
4. What do you do when your professional boundaries are crossed?
5. How do you provide positive experiences for the individual?
6. What concepts from relational theory apply to this case?
7. How might relational theory help continue movement in this relationship?
8. How would this be helpful in your practice?

The experience Megan shared with the team was when she tried taking Jake off of the unit to give other staff and other individuals living on the unit a break from Jake’s disruptive behaviours. Megan took Jake to Warrior’s Hall and he yelled at everyone he came across, *“This fucking asshole is going too God damn slow. Get the fuck out of my way you shit.”* Megan

explained to Jake he could not talk to others that way and if he did not stop swearing they would have to return to the unit as they had discussed prior to leaving the unit. *“I’m sorry, I’ll be good.”* Jake replied. However, once Megan began pushing Jake in his chair again, he started yelling, *“You’re pushing me too slowly, get a move on!”* Once at Warrior’s Hall, Jake was verbally abusive to other individuals around him as well as to the volunteers who served the coffee. Unfortunately, Megan had to return Jake back to the unit.

The Team Restories Megan and Jake’s Therapeutic Relationships

After hearing this story, one recreation therapist noted *“it’s not your relationship, he’s like that with everybody.”* Megan understood that it is not personal with Jake but also noted that *“even though it’s not personal, you can only put up with so much abuse.”* In attempt to understand experiences with Jake better, many recreation therapists began to ask questions and make suggestions. *“So if you were to ignore him when he’s swearing what would happen?”* Elisa asked during the case review. *“It just gets worse. But then if you pay attention to him, it gets worse too. I mean you’re in a no win situation”* Megan replied. Rachel offered a suggestion for connecting with Jake. *“Have you tried or does he have the ability to reminisce about the good old days? Or did he have any?”* Megan discussed a time when Jake shared a story about his past job at the liquor store. Even though Jake does reminisce on occasion, Megan explained how he does not talk about his personal life or his family. Also, when Jake does reminisce it does not last long and he moves very quickly into either demanding a drink, or abusive language. The team also inquired about whether it would be possible to connect with Jake through leisure such as his interest in horse racing, or watching TV. Tiffany suggested Megan try watching a movie or television show with Jake and then conversing during and afterwards with him about what they had watched. Megan responded that she tried that:

But then he wants a drink, and he wants something to eat, and then you're not doing it fast enough and you're not providing the right thing or the drink is too cold, or the drink is too warm. Or there's too many ice cubes or there's not enough ice cubes.

Megan explained Jake's inconsistencies when trying to calm him down when he is agitated. One time she took him outside to the gardens and when he was agitated she was able to calm him down. However, this strategy does not always work with Jake, Megan explained:

The way this gentleman is, is that you might have something that works the one day and you're thinking "oh great! That's like in my toolbox for a way to work with him the next day" and the next day it doesn't work. And it doesn't work for another 4 or 5 months.

She also described her attempt to be direct with Jake:

If it does get to the point where he's too disruptive we have said, "we don't like being spoken to that way"...he'll be like "Oh sorry, sorry, I didn't mean to say that" But then he just, after a few minutes it will stay friendly and then...it's like a cycle.

Tammy wondered whether it would help if Megan were to attempt to show she understands Jake's agitation. "Does anyone ever say when he calls someone something they're like 'oh I know how you feel. Sometimes I have days where I hate someone'?" Tammy said.

Megan explained:

Ya, I like to think we are pretty good on our unit. I'll take something that he says sometimes and turn it around on him. Not in a negative way but kind of like a "Ya, we see where you're coming from" type of thing. The staff, I feel respond pretty well to him. It's just very difficult after a while, 'cause I mean the nurses are there on the unit for 8 hours at a stretch and some cases you're being abused those entire 8 hours.

As described in this quote, Megan notes how difficult it can be for staff when Jake is abusive especially when in his presence for long periods of time. "Has that ever been discussed about upping the meds?" Rachel asked. Megan replied:

Ya the doctor...doesn't like doing anything like that. 'Cause it's a chemical restraint. And everything they were doing, like locking the wheelchair and everything, nothing was working because he can get out of it everything that he was in...

Megan stated that the philosophy of her unit does not support the idea of using strong medications, as it could have a negative effect on Jake's quality of life. As Megan described:

He was really quiet when he came, but he was so hopped up on Haldol. And the philosophy of [cognitive behavioural unit] is not to chemically restrain everyone. You usually have the 2 week honeymoon period as all the meds are going out of their system and then they wake up.

Talking further about Jake's quality of life, Megan posed the question to the team, "how do you assert your power without compromising the individual's self-respect?"

you don't want to always send him outside or to his room or to the quiet room. You want him to have time in all the areas of [cognitive behavioural unit]. So if some of the guys aren't there because they are off with family members or whatever, we'll just sit with him and chat in the living room or the dining room, wherever he happens to be. But if it does get to the point where he's too disruptive you're just...we have said we don't like being spoken to that way, whether its nursing staff or the patient care manager on the unit has had to say that to him a few times.

Similarly, other recreation therapists wondered about whether it might be helpful to work with Jake's anger:

Tammy- I almost feel like if that's what he wants to be, is angry, then in that moment just keep talking about his anger, "ok you're calling me..." Like just reflect back at him. Just keep talking about his anger then if that's what he wants to talk about.

Megan – Mm hmm

Tammy – So that when he's calling you names just reflect back, "ok that's an interesting terminology, why are you calling me that?" Just keep talking about what he wants to talk about.

Rachel – Which is about being present for him right?

Tammy – Ya, and then maybe find ways where you can replace that anger with something else. He's obviously getting something out of being angry. Replace it with something else to get the same results.

Megan noted that for Jake this seems like a “*lifetime pattern*” and the team also talked about the change that Jake must experience moving from ten years of isolation in his home to being at Sunnybrook:

It is an overwhelming environment you think if he didn't leave his apartment for 10 years, only to see his wife. I don't know that you can change the environment that much. It's already a smaller environment but I wonder if that triggers some of his behaviours, too much stimulation.

Analysis of Restoring Megan and Jake's Therapeutic Relationship

As Parse described, a person-centred approach and human becoming involves “cocreating *rhythmical* patterns of relating in mutual process” (p. 29). The challenge in this therapeutic relationship is that the rhythmical pattern that Jake is drawing those around him into is the cyclical of the push-pull relationship. In these exchanges, Jake is extremely agitated. Jake has effectively drawn the people around him into an experience of verbal and physical abuse, and at times his removal from the situation (e.g., from programming in Warriors Hall). The challenge that Megan and others describe, is that of stepping back from his attacks, to structure interactions differently by establishing boundaries (e.g., discussing appropriate behaviours, and talking about the consequences of his behaviour for others and for himself), and engaging Jake in a different rhythmical pattern. The challenge is also that following staff attempts, a new rhythmical pattern with Jake will often be short-lived, and then he begins yelling again. In addition, an attempt to shift the pattern that works in one moment may not work in another moment.

The team discussed talking with Mr. B about appropriate behaviour before he leaves the unit, and also letting him know that if he begins to yell and swear at people, he will be taken back to the unit. This is done with the hopes of Mr. B being able to continue to participate in groups and spaces such as Warrior's Hall. Freedom of choice and quality of life are central to

person-centred approaches (Parse, 1998). The team recognizes the importance of Jake participating in activities and the value of his freedom of choice and expressed concerns about the potential impact on his quality of life if they began to isolate him. In this interaction they recognize that taking freedom away from Jake involves a sense of power over and dominance.

The central need in person-centred care is quality of life (Parse, 1998), and we can hear this at the core of the teams concerns. Cantwell (2000) states that maintaining personhood means to treat one as a human being and best meet their needs. One of the needs Megan attempted to meet was increasing Jake's quality of life. Specifically, within the discussion about increasing medications Megan was worried that would decrease his quality of life. In attempt to understand Megan's experiences with Jake the team explored many different ways to engage Jake, and Megan was able to share her experiences with those approaches. The team explored with Megan Jake's past leisure needs (alcohol and TV) and how that could be used in his therapy. The team wondered whether Jake's challenges with communication (i.e., swearing, angry outbursts) were connected to his experience of dementia and if medication could help. They also explored his history and the extent to which this has been an ongoing challenge for Jake. The questions and suggestions for how to engage Jake were many, and once exhausted the team explored whether there was a connection to his diagnosis of dementia and whether a pharmaceutical intervention would be possible or helpful for Jake. . Whereas the medical model is deficit-based and seeks to fix what is wrong with a person (Devine & Sylvester, 2005; O'Keefe, 2005), this team explored medical aspects to understand his actions and explore the extent to which a medical condition was influencing his experiences. The team wondered if medication could help Jake to communicate with others, therefore providing him with opportunities to participate in leisure. Here medical insight is used to influence the team's recreation therapy practice, not to guide

practice and decision-making. As Parse (1952) describes, the therapist works with the person, without looking at them as a diagnosis that needs to be fixed and empathizes with them always striving to understand.

The team also wondered if Jake needed to be with him in his anger; in other words to explore the *meaning* of his anger. They also noted that Jake had spent 10 years isolated in his home, and then more recently had been in several institutional settings before arriving finally at Sunnybrook. Perhaps here the team was beginning to explore personal meaning in person-centred care. As Parse (1998) describes, meanings are related to finding purpose in life and are always changing. There is room to wonder here how Jake has been able to make meaning and adjust to changing meanings in his life.

Relational Analysis Restorying Megan and Jake's Therapeutic Relationship

Perhaps Jake's words and actions are a way of *striving for health* by showing that he was impatient to get to a place that he may like, or swearing was a way for him to ask for help. Understanding that undesirable behaviours can be a quest towards health allows for connection and understanding within a relationship (Biurski & Haglund, 2001). Connected with this, in the absence of an ability to adjust with the meaning of his life anger may be a healthy attempt at communication. Further, this can also represent Jake's exertion of power (i.e., when demanding things such as drinks and snacks) in attempt to regain a sense of control over his life. Power sharing is important because it allows people in the relationship to feel they can impact one another and moves them towards connection (Walker & Rosen, 2004).

Megan's experiences with Jake help shed light on the challenges of maintaining connection with clients whose experiences of dementia, stroke or other brain injuries, and life histories bring into the relationship rhythmical patterns that challenge the relationship. In experiences where

Jake is agitated and lashing out and swearing at Megan, nurses, residents or volunteers there appears a lack of mutuality of *respect* in the relationship. If the push-pull rhythm in the relationship gets put into motion, this can further disconnect Megan and others from Jake. Megan has noted that she tried to step back and understand that it is not personal, and that other experiences of Jake's (present experience of dementia, past experiences) are contributing to this interaction.

In Megan's experience we hear many attempts to *connect* with Jake: asking him about his past and attempting to reminisce with him. He shared some stories with her, but then immediately closed up and began demanding things from her. Once he began to connect, he seemed to quickly become disconnected again. In these moments of disconnection, there are moments of reconnection as Megan and the nurses have responded authentically in the moment to Jake's comments. At times, Jake does acknowledge Megan when he apologized for being rude to her, which possibly shows a sense of mutuality and a small moment of connection. As Miller and Stiver (1997) describe, in moments of growth and connection, one must represent their true experiences and feelings, and respond authentically to thoughts and feelings of others.

Megan attempted to *mutually empathize* with Jake when she showed that she recognized his anger. Mutual empathy involves an individual sharing how another story influenced them through their emotions. One must provide the opportunity for the other to see, know, and feel that they have been moved and touched (Jordan et al., 2004). Therefore, authenticity and vulnerability are necessary for mutual empathy to exist and enhance the connection (Jordan et al., 2004). Because of the disconnection within their relationship, it was difficult for Megan to be authentic and vulnerable with Jake. It was also challenging for Megan to show that Jake's experiences impacted her because he does not share experiences and feelings with Megan. While

an unequal distribution of support and mutual understanding causes disconnection within the relationship (Jordan et al., 2004), we can see in this relationship where small moments of reconnection are made.

Carly's Case Review Process

It was early March and the recreation therapy team gathered for another case review process. The third case review was led by Carly, a recreation therapist who works on a physical support unit. Carly discussed her relationship with Bob. Carly provided a brief summary to her fellow recreation therapists of Bob, including his history, and described her experience of her relationship with him.

Restorying Carly's Therapeutic Relationship with Bob

Until recently, Bob had been caregiving at home for his wife who had dementia. He had also experienced a stroke two years prior. Carly noted that about a year ago, Bob had been admitted to Sunnybrook after a fall in his home and was later admitted to the Veterans Centre at Sunnybrook. He is a 90 year old Veteran with a medical history of osteoporosis, vascular dementia, hypertension, emphysema, stroke, and a spinal cord compression. Bob describes his relationship with his wife and children as "100%" and enjoys spending time with them. He also enjoys listening to music, bingo, reading his daily newspapers, dancing, and watching his classic television programs in his room. Currently he likes to attend the entertainment in Warrior's Hall.

Carly described how Bob began to engage in hoarding behaviours after his stroke in 2010. He collects used newspapers, used coffee cups, and used tissues, sometimes gathering them from the garbage can. He also has been caught taking clothes and food from other individuals who live on his unit, and also rummaging through the medication cart. Bob has also been hoarding food which a recreation therapist noted has resulted in experiences of food poisoning. Bob has been

assessed by psychiatry staff and a connection has been made between his hoarding behaviour and his experiences while serving in World War II. Staff on the unit clean his room often, removing many of his collected items, which agitates Bob. As Carly describes:

Staff continually reminds resident that hoarding food can be dangerous but resident stated “I am 90 years old and I have never been sick and I will not get germs from the newspapers from the garbage. I ate dirty food in the war and I was fine. I’m alive and kicking!

When members of Bob’s family told him not to hoard newspapers and cups, he stated “*that he collects the newspapers for the memories.*” When staff addresses his hoarding he immediately denies it or becomes embarrassed.

Carly stated Bob also gets agitated when his food is not hot. In circumstances such as this, he has previously been abusive towards staff when his needs are not met quickly enough. As Carly describes:

whenever he gets his food from the cart, from the normal lunch cart or dinner cart, he doesn’t find it very warm. So he wants it hot, hot, hot. But obviously the PSP or the activity aids or nurses are helping other residents he just gets wound up and gets mad and he starts yelling to the point that he’s abusive and using profanity and cursing.

At times, Bob also instigates or makes fun of other residents in his unit. Carly also described Bob as disruptive, often interrupting people, and fidgety. She described his relationships with other on the unit noting that he is:

disruptive in unit recreation therapy groups as he has a short attention span. He also tends to talk over the other residents whenever someone is trying to express themselves. The other residents feel a little apprehensive at times when the resident passes by as they are not sure what his remarks will be at the moment.

Carly stated the themes she wanted to highlight in her case review process were *building therapeutic relationships, empowerment, and being professional.* The following are the questions

she posed to the team under each theme, followed by questions relating to concepts within relational theory:

Building Therapeutic Relationships:

1. How do I create a positive foundation for my therapeutic relationship?
 - a. (i.e. What kind of actions, communication?)
2. How can my therapeutic relationship evolve?
3. What are the priorities for the individual within this therapeutic relationship?

Empowerment:

4. What can I do ensure this resident has an opportunity to exercise his control?

Being Professional:

5. How do I cope with challenges in my therapeutic relationships?

Relational Theory:

6. What concepts from relational theory apply to this case?
7. How might relational theory help continue movement in this relationship?
8. How would this be helpful in your practice?

Carly described that Bob has obsessive tendencies which kept him busy each day. As a result, interactions between Carly and Bob are short and sporadic. Bob often engaged in hoarding newspapers and rummaging through garbage pails. In terms of sanitation, Carly worried about Bob's safety as well as the safety of others at Sunnybrook. However, she tried not to make him feel ashamed or embarrassed when she caught him doing these behaviours. As she describes:

What we've been doing is that if we see him [hoarding] we try to redirect him and we try to approach him in a very patient-focused way. At the beginning a couple months ago people were saying "no, no, don't touch that" because they were worried.

Carly posed the following question to the team:

How do I create a positive foundation for my therapeutic relationship? Like what kind of actions, communications? Since he does have a short attention span, he tends to perseverate, and he's always touching something. And you can't hold a conversation. He says "I'm going places, see ya." And he's not rude. sometimes, it's just you can't make him focus. And so that's something that I find challenging and the other staff as well.

The Team Restories Carly and Bob's Therapeutic Relationship

When reflecting on Carly's experience of approaching Bob while he is rummaging through garbage pails, some members of the team noted they had also observed Bob's hoarding and

taking items from the coffee stands. Other members of the team began to ask questions to try to understand Bob's hoarding in more depth. Carly described the compulsive nature of Bob's actions and also the connection to anxiety that Bob experiences.

Carly described that a few months ago staff were saying, “*no, no, don't touch that because they were worried.*” “*And then he's more upset,*” Tiffany added. “*More upset and also he's not a child... you know you need to respect him,*” Carly explained. Natalie noted, “*When you catch him, it's like he's embarrassed about it.*” “*My approach is always like 'oh you know, what are you exploring?' 'Cause that's the thing we all said please don't tell him 'don't do that' because he's an adult, he's 90 years old'*” Carly replied. Carly and other staff try to redirect Bob, drawing his attention to a meal or other activity, when they see he is about to rummage through garbage or take things from carts in the corridor. At times this is not successful, and Carly raised concerns about letting it go when his hoarding will compromise his health (i.e., when he about to use a used tissue he found in the garbage). Rachel suggested tamper proof garbage pails so it would be more difficult for Bob to get into them. Several staff noted this will not work because he is able to roam widely in his wheelchair to other sites to collect things. Paige replied:

I don't think that's your job...What I'm thinking of is... 'Cause you say you're having a hard time engaging him because he's fidgety or his short attention span...how can you engage with him? And things that you can do. And I know, like in my head I'm thinking folding towels and I think he's a bit above that, but something that had purpose to it, is clean, and gives him a sense of...he's got stuff like there's still tangible things there.

“*He could hand out calendars*” Amanda suggested. “*That's a good idea*” replied Rachel.

The team continued to discuss how to redirect Bob's hoarding behaviours. Jill recommended:

You know what I do like that idea that Paige had, where we give him a box or something or a bag or something, so that he can fill that box up for the day. At least we know what he's hoarding and what he has in there. And then someone can see what it is.

“This will make your life easier. Like present it as that instead of ‘this is your limit of collection for the day’” Paige added.

Earlier in the month Carly was also given an idea from a colleague of giving Bob something tactile like a ball to hold on to overcome his fidgety and impulsive behaviours. The team agreed this was a good idea and encouraged Carly to try it. The team also suggested one-to-one walks with Bob. Carly described that he enjoyed saying hello to people as he moved through the hospital.

Carly posed another question to the team, *“how can my therapeutic relationship evolve?”* Carly noted, that *“he always says hi to me”* and when she sees Bob rummaging in something she will ask Bob *“what are you exploring?”* She also noted her concern for his safety and she tried to approach Bob with the intention, *“we just want to make sure you’re okay, there’s some things that are dirty”* or to explain to Bob why he she needs him to leave certain items where they are:

you know you shouldn’t really take...because we kind of need it...and then you touch it and other residents can’t use it. And then we have to buy more.” And he goes, *“Okay, I won’t do it again. Just don’t tell anyone, please”... and I mentioned that to the team because I said “I think he’s thinks he’s still going to be transferred.”* Because when he heard that he might be transferred he says *“don’t, don’t take me out of here, I don’t want to leave. I don’t want to go to another unit.”*

When reflecting on her own feelings of uncertainty Carly stated, *“I guess for myself I just wanted to make sure that it was okay to just have those small moments. Which I usually know that...but should I be doing more?”*

Carly then posed the question to the team, *“under empowerment, what can I do to ensure the resident has opportunity to exercise his control?”* She noted that Bob does not like to be watched. Later, in the interview, Carly emphasized what was important to her in supporting an individual:

I think that it shouldn't be that it's just them wanting to participate. But if they...the resident should feel comfortable to say you know "I'm really not enjoying this" or "I don't want to participate in this anymore, it's not really for me" that they should be okay to express that and not feel like there's repercussions or that they think they are going to hurt your feelings or something like that. So hoping that the resident always understands that we're here because "we want to improve your quality of life through...through recreation therapy or whatever you would like to let us help you facilitate. But if we're not please feel free to tell us" or if you're not agreeing with that or something, it's open that they shouldn't feel like they're apprehensive to freely express themselves. Good or bad, I think that's important.

Analysis of the Restorying of Carly and Bob's Therapeutic Relationship

Carly discussed how she tried to approach Bob in a *patient-focused* way by empowering him to make choices and be independent. This value stems from the theory of human becoming by Parse (1998) which focuses on the ideas of freedom and autonomy. One must have the freedom to choose and contribute to daily activities, because that individual is the one with the knowledge of their own quality of life (Parse, 1998). Carly wanted to make sure that Bob had the freedom to do what he pleases but in a safe manner.

Most of the discussion within the team was about redirecting Bob's hoarding and stealing. Therefore, much of the team's conversations focused on minimizing his fidgeting and hoarding, and redirecting him toward other engagements. Some examples were a box to collect his things in to contain his hoarding and staff could keep an eye on the contents to ensure Bob's safety. When the focus is on stopping or reducing behaviours it is related to medical ideas of treating impairments (Sylvester, 1998), when it is attached to concern for safety and self-harm the emphasis is on the quality of an individual's physical health. A concern for quality of life emphasizes the essence of life, the core substance that makes life meaningful (Parse, 1994). Parse (1994) states that quality of life cannot be defined by health professionals, but rather the individual receiving care. Carly stated she hoped Bob would feel comfortable to express to her if

he were unhappy with something. Carly wanted to make sure he knew she was there to help him improve his quality of life. This shift to Bob's expression of his needs connects to the notion of human becoming.

The challenge then becomes one of a concern for Bob's physical health, and the emphasis that a person-centred approach places on being present and "valuing the other's human dignity and freedom to choose within situations" (Parse, 1994). There is a further challenge in Bob's engagement in hoarding and encroaching on the property of other persons. Here the notion of individual rights to safety and freedom and the complexity of supporting individual's meanings, values, and hopes come into play. This also warrants further exploration in the context of trauma and how Bob makes sense of his earlier war experiences and how these memories have been integrated and continue to play out in his daily life.

Relational Analysis Restorying Carly and Bob's Therapeutic Relationship

Carly contemplated whether she was spending enough time with Bob. She claimed she spends more time with other residents, and therefore feels as if something is missing from her relationship with Bob. She wondered if she needed to spend more time with him. The team suggested things they could do together, such as handing out calendars. It is important that these experiences have an opportunity for Carly and Bob to *enhance their connection*, and must be meaningful to both individuals. Engaging in a mutual experience gives an opportunity for each member to be *authentic* by sharing thoughts and feelings (Jordan et al., 2004). Also, mutuality acknowledges respect for one another and an openness to change (Jordan et al., 2004). Through mutual empathy, "by deepening the understanding of each person's experience, we move from 'difference,' which is still a self-centered perception, to an authentic connection to the *person*; this moves the relationship" (Jordan et al., 2004, p. 176, original emphasis).

As several members of team discussed Bob's engagement in hoarding, there was an attempt to approach Bob in a way that would not embarrass him. Interactions which lead to a feeling of embarrassment or where shameful feelings arise, what the Stone Centre refers to as an experience of humiliation, leaves one to feeling inadequate and undeserving of connection (Jordan et al., 2004). Carly avoided approaching Bob and telling him to stop certain behaviours. Instead she asked him what he was doing and chatted with him about his intentions for rummaging in the garbage and tried to support him offering a safer and more sanitary option. At another time, Carly was able to explain to Bob why she needed him to leave the item he was about to take. Bob was able to take this in and share with Carly his concern that she not tell on him because he did not want to be transferred. This allowed Carly and Bob to partake in *power sharing* within the relationship. Mutuality involves mutual respect and openness to change, and that both people must grow within a relationship (Jordan et al., 2004). Jordan et al. (2004) state that mutuality "is helpful in guiding movement out of power or control struggles. When each person feels that they are having an *impact* on the relationship, we are moving from a 'power over' to a 'shared power' or 'power with' paradigm" (p. 176).

When Carly explained what was important to her within the relationship, the opportunity to share and be *authentic* was significant to her. Jordan et al. (2004) say that "a therapist's emotional presence is *an important source of information* for clients and a *resource for growth* in the therapy relationship" (original emphasis, p. 67). Could expressing these values to Bob lead to a stronger connection? What does Bob want in a relationship? Is there a past experience that is preventing him from connecting? Carly also stated the importance of Bob *connecting* and sharing with her by expressing his emotions and explaining when he's unhappy with something.

Also, the ability for both members to share with each other and their openness to change allows for *mutuality* in the relationship (Jordan et al., 2004).

Relational Understandings of Team Relationships in the Case Review Process: Implications for Self-Reflective Practice

Members of the recreation therapy team described that the self-reflective case review process informed their practice by deepening their understanding of the value of self-reflection and processing. Laura, the leader of the first case review process, described her case as less overwhelming once she was able to focus on the main issue:

It made me focus on truly what it was that I was having an issue with and sort of gave meaning to it. And like, for example, looking at the themes and saying ‘you know what, I really need to look at building therapeutic relationships and being professional’. So rather than having this overwhelming problem that you couldn’t really get a sense of, like it could get so frustrating at times, and it made you ‘k you know what I’m going to look at what theme I need to address, what questions do I need to look at that pertain to this case itself?’ and sort of break it down into measurable ways that I can look at the situation in more of a positive light in that there can be things that can be implemented to make it have a more positive, a positive relationship in the future.

Laura’s reflection stated that the case review process helps her to explore her emotions and experiences and focus on what is most important. Megan stated, “*I think that’s exactly it putting your emotions aside, looking specifically at what themes need to be addressed, rather than having your emotions cloud the situation. I think that provided a lot of clarity to finding solutions and strategies.*” Paige made a similar comment:

I think I learned that sometimes it’s good to take a step back...to try to take a step away from the emotion of the person or the incident and to look at it more, I guess, practically or to try and see it from a different point of view. It’s so easy to get caught up in the emotion of it, right?

Miller and Pedlar (2006) state that self-reflection involves stepping back and reflecting on experiences which leads to adjustments and improvements in practice. Therefore, within the case

review process the recreation therapy team have the opportunity to self-reflect on their experiences and further deepen their understanding of the interactions within their therapeutic relationships.

Laura also realized that self-reflection in daily practice can be beneficial:

It's not a time consuming approach it just takes a little bit of time. And I think it made me realize too, the more I get to know the themes and the process in itself, the more beneficial it will be to myself in the future that it might not necessarily mean that I have to sit down and type this all out and look at it, it could just be that I take a moment to reflect myself and think "ok well what themes do I need to address here? What do I really need to look at?" and then go from there.

Relational theory states *relational awareness*, which refers to an understanding of one's actions and the impact they have on the other individual and the relationship as well as the effect of the other individual on the self, is an important aspect of enhancing a relationship (Jordan et al., 2004). Therefore, constant reflection on the self, the other, and the relationship are all equally important within a therapeutic relationship to maintain a strong connection. Also, a relationship is mutual and therefore involves thinking about self and other. Miller once said, "in order for one person to grow in a relationship, both people must grow" (as cited in Jordan et al., 2004, p.3).

The recreation therapy team expressed the importance of the opportunity to support one another when challenges occurred within their practice. Amanda expressed how the case review process was a great opportunity to connect with her team:

I think that sharing with peers too, may not often get an opportunity to do because you may be talking to your team but other people may see the resident or have the same experiences so it's good to have this kind of opportunity, right?

Tiffany reflected on the meaning of support, "*I got a sense of a feeling of support. That people were trying to support Megan and that sort of come together and really rack our brains on how we can help her through the situation*". Natalie discussed how teams from different units can gain resources from other teams:

Like this might be new for your team but other teams have had this and have dealt with it and you know, what Amanda's unit might do is different from what Paige's unit might do, which is different than Elisa's...and obviously different things work with different people, right?

Carly also discussed her experience as the leader of the third case review process and the support of her team:

I think the review process is helpful to know that other RTs said they either express themselves that they have similar experiences or maybe not necessarily with the same resident but they know the challenges and they can be empathetic or bring you support or try to bring some knowledge. And so I thought that was helpful.

Supporting each other in these experiences developed their relationships with one another in what Jordan et al. (2004) refers to as a *growth-enhancing connection*.

As the recreation therapists listened and engaged in dialogue together, they discussed how the process felt safe and non-judgmental, with each individual feeling safe enough to express themselves. *"It's also nice to know that...people are not judgmental in what we're saying. Or how we are dealing with the situation. So we feel safe to express our opinions"* Jill expressed. *"I think that everyone was sincere and honest in their own opinions as well. Not just how you were feeling but how maybe some of the strategies we had that maybe could help"* stated Elisa. An environment which provides safety and a sense of non-judgment allows each individual to be *authentic*. To be authentic means to fully represent oneself within a relationship (Walker & Rosen, 2004).

The team also reflected on how the case review process was a useful resource for developing ideas and sharing experiences in their own relationships. *"I think that it's good because you've heard all of these great ideas right of different problem solving solutions that you might be able to tap into when you need them"* Liz expressed. *"It does force you to reflect*

on how you'd react, and how you'd respond when you're faced with that situation" Rebecca concurred. Carly reflected on her feelings of endorsement that she's doing a good job:

It was okay to not feel like you had to solve something or realize that sometimes it's something that takes time. Things that I already realized but it's nice to hear from someone else and not realizing "ok maybe I'm not doing my job or I'm not sort of looking into it more and spending more time or quality or should I have been doing something else?" and you can hear other people's feedback or their experience on their unit.

Within the case review process, the team's description of their shared experience describes mutual empathy. *Mutual empathy* builds connection by showing others, through thoughts and emotions, that their experiences had an impact on you (Jordan et al. 2004). Within the case review process recreation therapists, especially the leader of the cases, felt their colleagues' emotions and heard similar stories to their own, which represented mutual empathy and helped each individual to feel connected to one another.

During the case review process with Laura, the recreation therapy team offered suggestions for connecting and developing a relationship with Mr. B. They engaged in exploration and suggesting ideas in an environment where they felt safe to express themselves to each other. These shared suggestions specifically left Laura feeling optimistic and hopeful for the future. She describes her experience by saying:

I think from my perspective I feel hopeful because I feel supported. So that there's actual tangible solutions that we are going to put into place that may help in the future. So having a sense of feeling hopeful because of the support of the team and the actions that we take.

The shift to *mutual empathy* occurred when the recreation therapists stated they *felt* Laura's frustrations—the team displayed that Laura's experiences had an emotional impact on them. Seeing the other recreation therapist's emotions in response to Laura's story and how they were affected by her experiences, left Laura with a sense of feeling understood. Showing experiences impact each other is known as *mutual empathy* (Jordan, 2000). Actively responding to another's

thoughts and feelings and bringing forward one's own feelings, rather than just listening, leads relationships toward connection and growth (Miller & Stiver, 1997).

The process of any relational engagement also involves ongoing moments of disruption and repair. Occasionally during the case review process a recreation therapist suggested a strategy Laura did not agree with, was hesitant about, or had tried before. Recreation therapists responded in a supportive way, with mutual empathy, and Laura felt more comfortable continuing to describe her experiences. This process helps one to feel comfortable sharing with the other and adding more to the dialogue (Miller & Stiver, 1997).

The team also described their experiences of *vulnerability* during the case review process. Laura stated she felt discomfort with being in the spotlight. At first, she was hesitant to share her experiences with Mr. B and feared her team would not think of her experiences as challenging. When discussing the act of asking for support, Jordan et al. (2004) state, "we feel most vulnerable when we let people directly know about our need" (p. 34). Laura reflected on these feelings:

I think the main thing that I took away from it was a reinforcement that I wasn't alone with my concerns. And also with that, a sense of more hope that there are strategies that can be put in place so we can enhance that relationship...I guess the process itself it was...you almost feel like you're putting yourself out there and I think that it's a little disheartening at first because you're like I should have, after years of training, I should have the skill base to deal with any situation...Its sort of like putting yourself at another higher level of vulnerability that personally I'm not used to...And I guess just putting yourself in the spotlight is also a little bit...can be nerve wracking sometimes when it's not in a positive frame. And not that it's negative when you're looking and putting a case out there that you're seeking help with.

Vulnerability is commonly felt within a relationship but may be important in moving towards connection. Feeling vulnerable can be related to the desire to be authentic (Miller & Stiver, 1997). Feeling vulnerable can also lead to a fear of rejection. Miller and Stiver (1997)

suggest “women have come to believe that authentic expression of who they are will not be acceptable or valued by the people they care about”(p. 149). Therefore, being authentic can feel very risky at times but can be worth the risk (Miller & Stiver, 1997). Laura stated that as the discussion progressed she felt better about herself since the team affirmed her feelings and worked together to support her:

But I have to say as we, as the discussion progressed I felt better and better myself. You know what there's others that have had similar situations, oh like there's another situation and another suggestion that came out of it that I hadn't thought of and it could work. So it sort of reinforced that it is a team effort too, so it's not just myself solely facing this difficulty but there are others that have experienced the same thing that feel the same way I am. So I felt it brought the team together to look at possible solutions that can be beneficial to everyone. So that was...I walked away feeling very positive.

This sense of support allowed Laura's relationship with the team to grow—it provided opportunity for *growth enhancing experience*. Laura gained comfort with her team as she shared experiences with Mr. B, creating opportunities for hope, new learning, and growth in connection (Jordan, 2001). Miller and Stiver (1997) state:

Because each person can receive and then respond to the feelings and thoughts of the other, each is able to enlarge both her own feelings and thoughts *and* the feelings and thoughts of the other person. Simultaneously, each person enlarges the relationship (original emphasis, p. 29).

Throughout the case review process growing mutuality, authenticity, and connection leads to growth enhancing relationships within the team. *Mutuality* was present in the case review process, as the recreation therapists had respect for one another and were open to change (Jordan et al., 2000). Each individual listened to each other's experiences and feelings, and were open to learning new ideas they could use in the future. Within the case review, Laura was not the only one gaining strategies and resources from the case review. Other recreation therapists described being able to take what they learned to use in their own practice. Rebecca realized not only was

she helping out her colleague but she too gained something from the experience: *“Well I guess collectively we’ve been discussing one strategy, that if it works with this particular resident, we could continue to use it with future residents. With other residents who are also exhibiting similar behaviours.”* These mutual experiences establish *growth-enhancing connections* between recreation therapists as each of their contributions and openness to change allow new opportunities to arise (Walker & Rosen, 2004). From these conversations and continual support, there exists opportunity for relationships to constantly change and grow (Walker & Rosen, 2004).

Opportunities for growing connection and growth enhancing relationships may be found even in more challenging case review processes. In Laura’s case review, many members of the recreation therapy team had an experience with Mr. B from which they could draw. In contrast, Megan’s colleagues did not have previous interactions with Jake. They attempted to provide ideas from experiences of relationships with other individuals; however, each suggestion had been tried by Megan. Near the end of the focus group Rebecca noted, *“It seemed almost uncomfortable actually, for me anyways because I felt like there was no solution. We’re having trouble finding a solution.”* *“Ya, disappointing”* agreed Elisa. Members of the team stated they felt they failed because they were unable to find solutions to Megan’s challenges. They noted concern that they had disappointed her. Their body language was tense, they had worried expressions on their faces, and they said they felt bad about not being able to help Megan. Elisa offered Megan some encouragement:

Well hopefully this makes you feel, you know good about what you’re doing because all of us are sitting here and none of us can think of anything else. That’s a lot of ears around the table” said Liz. Elisa stated her feelings of hopelessness, *“I don’t know...it’s sad to say but I think even after everybody’s input and stuff, you realize that we are just never going to meet this resident’s needs.”*

A relational perspective provides a different understanding of support and connection the team did offer Megan. The recreation therapy team helped Megan know they understood her relationship with Jake was challenging. They were also able to join with Megan in feelings she may experience as she thought about Jake's situation, an offering of *mutual empathy*. "Ya and it is kind of upsetting to think that this man's living like this" Liz said, "I felt sorry for him in a way" Rachel added. Elisa shared her frustration with her own difficulty of not being able to connect with Jake in the case conference. This may have provided Megan with an opportunity to confirm her own experience and also feel connected with Elisa. As Walker and Rosen (2004) describe, *mutual empathy* involves one expressing emotions to show they have been moved by the other's experience. Sometimes listening is all one can do. This connects people and provides a sense of encouragement and connection.

Through dialogue the recreation therapy team was able to move more deeply into understanding aspects of the experience Megan was having with Jake. Elisa also offered an observation that reflected a tension or dilemma Megan may have felt:

You're not having any therapeutic relationship or a relationship for that matter, right? To me that would be a dilemma. Like you're supposed to provide care, good care, and yet you're being abused and you're like well "I'm not going to take that." So it's almost like its preventing you from actually doing your job basically. Right?

In the case with Jake, it was not important to find a solution, but it was important to understand Megan's experiences with this resident and for her team to support her in her relationship with Jake. Moving away from the need to find solutions allows the team to further *enhance connections* with each other. Megan commented on the importance of the team's support and understanding, and that she felt happy with the case review process.

I think it was just good to have discussed this gentleman. And...you know walk away with the sense that yes even though...there's not anything we can do for this man, there are going to be moments that you can have with him. 'Cause he is trying to connect when he's

like, “hey you come here.” And even though he might be pushing you away one minute later, he still wants that connection to some extent. Right? So...yes we might not have come up with any solutions but I think it was still important and meaningful to have discussed him.

Connecting together, empowering each other, mutual growth, self-expression are all aspects of a growth-enhancing connection (Miller, 1988). Miller (1988) argues:

It is not a question of giving and getting, nor helping and being helped, nor being dependent upon and dependent. It is an interaction in which both people enlarge and therefore want more of the same – and want the connections that make for such enlargement” (p. 3).

This capacity for enlarged connection was described in Carly’s case review. The team concluded the case review by reflecting on their experiences. *“I think that there’s also a piece of learning from the expertise of each other. You know this sort of cognitive physical support, knowledge transfer”* Rachel stated. Amanda agreed, *“It is interesting when you look at the different units and how they deal with different issues.”* Rachel added, *“We’re one part of the solution, right? That the whole team needs to work on this.”*

Within each case review process, we can also see how relational theory can help us to understand where an impasse may be forming. During the case review Carly described her concern about enhancing her connection with Bob. Through the case review, Carly was able to confirm from her team that Bob was enjoying his time in Warrior’s Hall. Carly stated, *“I think what’s helpful is that I know that for those who are covering Warriors Hall downstairs they can say that he seems to be really enjoying himself and that’s great!”* This was also reinforced by many of the recreation therapists present for the case review. Carly reflected on her overall experience stating, *“I definitely feel supported so thank you...and it’s encouraging to know that as you said just reaffirming that...this does happen to almost everyone in different ways.”* *“You’re doing a good job!”* Paige insisted.

However, Carly also reflected that there were a few times during the case review process when she felt misunderstood:

I could feel that some could get what I'm saying, and others I just felt like "well you should be doing this" or you know "it isn't about spending lengths of time in program, not all of them come" and I felt that way is like saying that I didn't know that.

Carly felt misunderstood when she tried to say she wanted to increase the quality of interactions with Bob, not necessarily the quantity. These misunderstandings changed the momentum of the case review. Sometimes advice giving can cause a *power difference* and can lead to *disconnection* within a relationship. Advice giving can leave the other person with a feeling of "you're doing it wrong." It causes disconnection because one feels lesser than the other. Miller and Stiver (1997) state "disconnections occur whenever a relationship is not mutually empathetic and mutually empowering" (p. 51).

In these moments of impasse, it is important to explore the mutual experiences of disconnection and rupture in relationship. Carly described feeling torn because she really wanted to say something to clarify herself so the case review process stayed on the right track. However, she did not want to deprive her colleagues of the opportunity to speak. Carly reflected on these feelings:

I'm a type of person that would just let them share and then I wouldn't probably try to explain because I knew it [the case review process] was being recorded at the same time when people were on a roll I didn't want to interrupt them, I think that's kind of rude, and I kind of sit back and try to process too, so.

However, not clarifying herself led her to feelings of disconnection:

I was trying to express to the team that, maybe their interpretation was I felt disconnected [from Bob]. And not everyone thought that but I felt like a few of them did and hence maybe that's why they made comments saying that 'it's okay to have these moments or bursts', which I was trying to say...I kind of want to have a more enhanced [connection]. .

Disruptions and disconnection are a natural aspect of relationships. Processing in that moment can be essential in the case review experience. In a context of safety, mutual empathy, and shared vulnerability processing involves discussing feelings and experiences that are happening in the moment to arrive at *mutual* understanding of the disconnection. The movement toward reconnection lies in the mutual dialogue that unfolds. For example, during the case review, Rachel suggested Carly shadow one of her colleagues who worked on a cognitive support unit:

Would it be helpful for you, because in my view he seems more cognitive, that there are lots of cognitive issues, to shadow one of the RTs in cognitive support? Just to get a sense of how they interact and are just present for those people. Because it seems for me like it's difficult for you to think that those five minute intervals are enough.

Carly described that this comment really upset her and she felt her colleague was saying she was incompetent in her job. Carly expressed her feelings after the case review, “*I felt like ‘I can’t believe that was just said’ and I actually had some other people after me... said they couldn’t believe that statement was made...they didn’t agree with that.*” This led to *disconnection* between Carly and Rachel. Reconnection was made after the case review process. Carly approached Rachel because she was left feeling uneasy about the comment and expressed her feelings to Rachel. Carly reflected on that experience:

It was good for me to speak to her because she totally said that’s not what she meant and she didn’t realize what she said and how she said. She realized that she just thought how she said it because that’s, she was trying to think why she would say that, but she didn’t mean that. She said, “oh my god that’s the opposite of what I think.”

Carly stated it was important for her to receive clarification from Rachel after the case review. As Miller and Stiver (1997) describe, one must be able to make one’s experience known and the other must respond in a way that moves towards connection. Rachel clarified her comments were not intended to hurt Carly’s feelings and she did not mean she was incompetent.

After their conversation, Carly and Rachel were able to feel *reconnected* and their relationship was strengthened.

The recreation therapy team discussed how the self-reflective case review process gave an opportunity for the team to build their connections with one another. We are all born with the desire to love and care for others, and to contribute to their growth while also growing in ourselves (Miller & Stiver, 1997). Miller and Stiver (1997) express we have “a need to connect and the need to contribute in a meaningful way, to be competent, productive, and creative, optimally flow together” (p. 11). This flow in their relationships helps the recreation therapy team to support one another and work together to be successful in their practice.

Reflections on my Experiences with the Research Process

When experiencing the self-reflective case review processes, I became engaged with the team and sensed frustrations within their relationships. I was able to check out my perceptions during the interviews with individuals. The team is very dedicated to connecting with the individuals they work with and strives to help them meet their needs and be satisfied with their daily lives. However, when practitioners described instances when individuals receiving care were rude or aggressive towards them, I thought to myself that it would be difficult to connect or even want to have a relationship with the individuals described. Within the conversations of the case review processes I could see the passion in the team in their efforts to help others and their continued efforts to keep connecting. I believe the strength of the self-reflective case review process is that it encourages reflection and develops meaning within therapeutic relationships in practice.

I did however feel confused within the process. To me, the purpose of the case review process was to reflect on their therapeutic relationships. At times it seemed the team was reflecting on their relationships, but the process seemed to focus on helping the individual receiving care and at times, seemed to take on a problem-solving approach by looking for and offering ideas. The case review process was developed to explore recreation therapists' experiences and the meaning of the experiences for both therapist and individual. Recreation therapists also discussed how they want to enhance their connections with individuals. Understanding and reflecting on the moments of impasse and disconnection within the relationship may create a deeper understanding of the relationship and interactions between recreation therapists and individuals receiving care. With this understanding we can better connect with individuals receiving care, and can move towards engaging in mutual experiences with them. Perhaps also focusing on the goals of the relationship is important too, as the relationship is a mutual experience that influences both members.

Within this research, I have acknowledged the idea of sharing power within the collaboration between the two departments (Recreation and Leisure Studies at the University of Waterloo and Recreation Therapy at Sunnybrook). As relational theory suggests, *power with* instead of *power over* reflects mutuality within a relationship (Walker & Rosen, 2004). Throughout this study I have been cognisant of my use of power to stay connected to the team at Sunnybrook. Within the findings, we attempted to keep the recreation therapy team's voices within the restorying. These stories reflect their experiences and without these original voices, the power would appear to be unidirectional. In other words, if the voice in this study was only mine then I would hold the power. On a further note, when the findings turn into my own interpretations through a relational theory lens, there is potential for me to have power over the

recreation therapy team. To avoid this, I offer possible ways of looking at experiences in a new light. I am aware that I am not an expert and do not have the answers, and therefore offer an alternative perspective to the recreation therapy team. I have also tried to be open to their words and interpretations, and have tried to avoid making assumptions. I am aware that the team may experience feelings of vulnerability throughout this process as they are providing their stories for review. I too have felt vulnerable at times, as my interpretations and writing reveal aspects of myself. I also hesitate when being reflexive as I try to avoid causing tension within my relationship with the team. Throughout this process I have learned a lot about relationships and value my relationship with the recreation therapy team at Sunnybrook. I hope to continue in a mutual relationship with the recreation therapy team in the future.

Chapter Five: Conclusion

When exploring experiences, theory helps to deepen understanding. Through the narrative layers we are able to see the importance of theoretical underpinnings, and how those shape our understandings and our reflections on experiences. The first two layers of restorying provide avenues for reflecting on the therapeutic relationship experiences themselves. The third layer offers an interpretation of the first two layers using theories of person-centred care and human becoming and their roles in practice. These understandings influence the way recreation therapists engage and dialogue within the case review process. The fourth layer uses a relational lens to explore the impasses within relationships and offers other possible insights into the experience. When looking across the three layers you can see how different theoretical backgrounds influences thought processes and actions, and provide different ways of looking at experiences.

This study marks a shift to critical self-reflective practice. Self-reflective practice is important as taking a step back can really enhance practice. This study is an example of stepping back and looking from different theoretical perspectives at therapeutic relationships. This narrative study is an act of critical pedagogy as it addresses issues of power in practice. The recreation therapy team is able to engage in practices aligned with the philosophy and theories of recreation therapy rather than guided by the practices of a medical model. In this study, the use of theory in practice has been reflected on through the layers of restorying. Practitioners have an opportunity to step back and see the influence theoretical understandings have on their language and actions. It is important that we recognize the potential limitations of theoretical foundations by engaging in critical reflective processes, such as the narratives in this study. Different theoretical perspectives offer strengths to different areas of practice. Through this study we can

see how relational theory offers a different perspective. By applying a relational lens to our experiences, we have a different way to explore moments of disconnection and impasse within therapeutic relationships.

As we advocate for the equal treatment and freedom for individuals receiving care (Therapeutic Recreation Ontario, 2006), we must be aware of, and careful about our use of, power in relationships. As Jordan et al. (2004) argue, when one's position allows them to have power over the other, mutuality cannot endure. Therefore recreation therapists sharing power with individuals receiving care and colleagues, being vulnerable and open when impacted by the other, provides mutual experiences that shifts power relationships and moves relationships toward connection. Mutuality involves respect and openness to change, which establishes growth-enhancing connections within relationships (Walker & Rosen, 2004). Sharing power and enabling both individuals to influence one another and the relationship is at the heart of a strong connection. Therefore, uses of power such as laying down boundaries and setting rules may begin to lessen mutuality in relationship and disconnect recreation therapists from individuals receiving care. Miller and Stiver (1997) argue "a dominant group is not likely to create mutually empowering relationships, else it would not remain dominant" (p. 49).

This study acknowledges the **complexity of therapeutic relationships** in recreation therapy practice. Therapeutic relationships not only involve relationships between recreation therapists and individuals receiving care, but also exist among the members of the recreation therapy team. Through team relationships recreation therapists gain support and growth enhancing connections. This self-reflective case review process not only gives the opportunity for enhancements of therapeutic relationships with individual's receiving care, but just as

important is the enhancement of the connections within a team. These team relationships are important for maintaining a supportive workplace and offering quality care to individuals.

This study helps to **move recreation therapy further from the medical model**, continuing a process initiated during the first ten years of recreation therapy research at Sunnybrook. Through *analysis of narrative* we are able to deepen our understanding of the application of person-centred and relational theory approaches to understanding therapeutic relationships. In the narrative layers that unfolded we can hear how medical insight may be used to understand the experiences of individuals we establish therapeutic relationships with and the relational dynamics that are created. By reflecting and understanding our co-constructed relationships with individuals receiving care, recreation therapists are able to move away from objectifying individuals and fixing a patient, we move towards connecting with individuals with an approach of mutuality in relationship focused on enhancing quality of life.

Theoretical Implications

As stated earlier, when looking across the narrative layers one can see how different theories provide different insight into processes and actions. These theoretical ideas provide us with different ways of looking at our experiences. Specifically to this study, relational theory offers a perspective that potentially leads to a deeper understanding of experience within therapeutic relationships.

Also, as the recreation therapy profession shifts from a person-centred care approach to a relationship-centred approach (Gilbert, personal communication, Wednesday June 30th, 2012), relational theory adds further insight into therapeutic relationships, which Therapeutic Recreation Ontario (2006) states is an important part of recreation therapy practice.

Relational theory offers a description of therapeutic relationships to new and current practitioners in the field of recreation therapy. By describing the relational characteristics of a therapeutic relationship, one can attempt to apply this knowledge to their practice to build connection with individuals receiving care.

Methodological Implications

This study provides an example of how research and theory together informs practice. The use of narrative restorying and a relational lens allows the possibility to look at recreation therapy practices in a new light. Narrative provides opportunities for many voices to be heard and does not provide just one truth or one answer. Since relationships are different from person to person there cannot be a universal truth. Therefore, this narrative can only offer possible insights into disconnection and impasse occurring in relationships.

Narrative methodology also deepens understanding of therapeutic relationships and brings to light the many voices of the recreation therapy team at Sunnybrook. Narrative enabled recreation therapists to tell their stories and hear experiences of their colleagues. Narrative is self-reflective in that when one tells a story, they then read it and reflect on it. It also enables one to hear similar stories and from that reflect on their own experiences. Narrative methodology is a creative way to interpret experiences and make meaning from them. We express emotions and gain knowledge through stories. Therefore, stories help us to understand experiences and derive meaning through them. By telling and reflecting on our experience we are able to gain knowledge and create meaning from those experiences.

In recreation therapy, practitioners work towards helping others and make meaning in their lives. Therefore, to make meaning we must reflect on our stories to learn and grow from them. Without reflection, we are unable to understand our experiences and make changes in the best

interests of our practice and the individuals we work with. I encourage other recreation therapists to use narrative methodology to make meaning of their experiences, whether it is in their practice or in experiences with individuals receiving care. Accordingly, Therapeutic Recreation Ontario (2006) argues that “through on-going self-reflective practice, Recreation Therapists critically examine their personal and professional competencies to ensure best practices” (para. 5).

Through narrative storytelling one can reflect on their personal and professional qualities and the influence they have on their practice.

Narrative provides an avenue for outside readers to relate and engage in the research. They become part of the story and can see the real picture. Becoming immersed in the narrative allows the reader to create meaning and interpretations of the experiences within the stories. This is important since narrative does not offer one conclusion, but encourages multiple interpretations of the meaning of experiences. Through the use of stories, readers are able to visualize therapeutic relationships in recreation therapy, and read real examples of impasses and their possible relational explanations.

Implications for Practice

Narrative research provides participants with an opportunity to reflect and can be used in recreation therapy for future research or even in activities with individuals receiving care. This study shows that in recreation therapy, reflections are crucial in informing practice and specifically in developing therapeutic relationships. Awareness of the significance of reflection could encourage recreation therapists to engage in self-reflection in their practice and daily lives.

From the findings, recreation therapists are encouraged to find opportunities to reflect on their own experiences within therapeutic relationships and receive possible explanations for their own impasses. The findings in this study provide examples for readers to understand the

theoretical aspects of person-centred and relational theory. By understanding experiences in relationships, recreation therapists can better connect and create meaning within their relationships with individuals receiving care.

A supervisor or manager in recreation therapy might take this study and reflect on their own team's reflective processes. Perhaps this study might inspire them to engage in a similar process of reflection with their recreation therapy team. It also might give a manager a reference point if any challenges arise among the team in respect to therapeutic relationships.

These findings may possibly provide a recreation therapy team with a deeper understanding of their experiences with individuals receiving care. The findings might provide awareness with the importance of building therapeutic relationships and how they may enhance their practice. With the significance of self-reflection in this study, recreation therapists might be encouraged to begin or continue their own self-reflective process, both individually and as a team.

Limitations of the Study

One of the changes that I would have made in this study was the interviews. My narrative interviews were very formal. Next time I would not have a question guide, I would just have topics to discuss and I would let the conversation flow. I may have gotten more rich data if questions encouraged participants to tell their stories.

Another important note is there is a diverse array of experiences and relationships shared within the case review processes; therefore we cannot simply come to one answer as to what is happening within therapeutic relationships. Each relationship is unique as are the individuals involved within them. However, Polkinghorne's approach seems to emphasize explanation and the search for why. Polkinghorne (2003) states narrative analysis "begins with questions such as

‘How did this happen?’ or ‘Why did this come about?’ and searches for pieces of information that contribute to the construction of a story that provides an explanatory answer to the questions” (p. 15). The goal of narrative analysis is “the explanation needs to satisfy the subjective needs of the reader of the report to understand how the occurrence *could* have come about” (Polkinghorne, 2003, p. 19, emphasis added). It is important to note here that within this study it is not an explanation of the answers, but possible relational perspectives of experiences. In self-reflective practice we are never searching for answers, rather we reflect to create deeper understandings of experiences.

Each of the self-reflective case review processes, focus groups, and interviews were audio recorded. This could have been a limitation to the study because since recreation therapists were aware that their voices were being recorded, they may have been hesitant in sharing experiences in the fear that they would be judged not only by their team but by outside readers who may come across this study in the future. This also was a limitation because the recreation therapists were aware of the recorder and was hesitant of any type of conflict or clarification during the case review processes.

Another limitation is that the study explored therapeutic relationships from the perspective of recreation therapists. We do not have insight from individuals receiving care about their experience of the therapeutic relationships discussed. Consequently we were unable to fully examine mutuality and the experience of the two individuals connected in the therapeutic relationship.

Future Research

Building from the limitations identified in the previous section, future research could consider both members of the therapeutic relationship simultaneously. This research would

attempt to discover the meaning of the therapeutic relationship from both recreation therapist and individual receiving care. Paralleling both perspectives could add to an understanding of the relationship and provide a deeper meaning of the therapeutic relationship.

Future research could also explore what other facilities/homes use self-reflective tools in recreation therapy practice? Are these processes similar to the self-reflective case review process at Sunnybrook? A study could explore what self-reflective processes are being used by recreation therapists. This could be done by providing a survey or engaging in focus group discussions at each long-term care facility to learn about and compare the different self-reflective processes at each facility. Also, once a process is found for reflecting on therapeutic relationships at another facility/home, a similar study to this one could be done to further understand recreation therapists' experiences with individuals receiving care.

Another question I asked myself, what do experiences in therapeutic relationships look like in different areas of recreation therapy practice and with different populations? This could be done by approaching different facilities/homes that offer recreation therapy services. Some of these facilities could be long-term care, community, and independent services. Recreation therapy programs are offered to a variety of individuals with disabilities, some examples are children with autism or individuals with visual impairments. How do different populations experience therapeutic relationships?

My next question concerns the perspectives of individuals receiving care. What is the meaning of the experiences that individuals receiving care encounter in therapeutic relationships? What do individuals receiving care value in therapeutic relationships? This study could attempt to understand what individuals receiving care value in therapeutic relationships. Similar to this study, a narrative would be appropriate because it provides opportunities for many

individuals to share their experiences. Individuals would have the opportunity to share their experiences within therapeutic relationships and engage in a process of understanding those experiences.

Recommendations for Recreation Therapy and the Self-Reflection Case Review Process

Relational theory offers the potential for deeper meaning of experiences within therapeutic relationships. That being said, I propose some potential new reflection questions within the self-reflective case review process (to be added to the template in Appendix A):

- How can a connection with an individual receiving care be enhanced?
- In these impasses, where do we see the individual receiving care attempting to strive for health? How can that perspective assist us in understanding individual experiences?
- Where do we see connection and disconnection happening in this experience? What is creating this sense of disconnection? How can we move towards reconnecting with the individual?
- How does a relational understanding of boundaries offer us opportunity to connect with individuals receiving care?
- How might mutuality be enhanced in this experience?
- Where might there be a notion of power within the therapeutic relationship or experience? How can we share power in these experiences?
- What was the nature of the humiliating interaction that led to disconnection? How can we reconnect after a humiliating interaction has occurred?
- How am I influencing the therapeutic relationship?

- Do I feel vulnerable when being authentic with an individual receiving care? When do I feel most vulnerable? What is needed to feel less vulnerable? Does it appear that the individual feels vulnerable? How might I remain authentic in the relationship? How might that authenticity move towards connection?

Another topic of concern that arose during the final defence for this thesis was the term *individuals receiving care*. This term suggests that the care relationship is unidirectional, as the individual is getting care from others. These ideas originate from a person-centred perspective which focuses on the individual, but also looking at the individual from a medical standpoint, stating that they need to receive care. This causes a tension within the language of the relational discussion of this study (as the stories are relational but this term is not). However, with our new understanding of relationship as being a mutual experience, there is a need to find a relational way to describe the individuals that we work with in recreation therapy.

My next recommendation is to focus the discussions within the case review process on understanding the experiences occurring within relationships. By beginning the case review process with topics such as medical history, it moves the discussion away from a focus on the relationship. What seems to be missing from the discussions is what the individuals are trying to express. Why might they be engaging in certain thoughts and actions? Perhaps understanding what is happening within those impasses and disconnections can move us towards a mutual understanding of our therapeutic relationships. Relational theory offers a perspective that enhances a focus on these areas.

Critical self-reflection provides the opportunity for the recreation therapy team to engage in radical education. In other words, recreation therapists develop and build their practice through self-reflective processes among their team. The next step may be for the recreation

therapy team to take this study further by looking across each of the narrative layers and reflect on the entire process as a whole. Then the team could come together and reflect on their thoughts and insights as they look across the four layers of restorying provided in the Findings.

A Final Reflexive Note

Self-reflection is valuable in understanding experiences and is a crucial part of recreation therapy practice. By reflecting we are able to explore experiences and attempt to understand their meaning. Through self-reflection recreation therapists can enhance their connections with individuals receiving care, while also improving their practice and the services that they offer. I encourage everyone, even if you are not in recreation therapy, to constantly reflect in life to continue to understand ever-changing human experiences to bring deeper meaning to these experiences.

In this narrative study I learned to let my creativity shine. My language changed as I moved from positivist to interpretive, objective to subjective, and passive to active. My heart has always been in interpretivism, but it was challenging to look beyond past learning embedded in my mind and be open to a new understanding.

To the recreation therapy team at Sunnybrook, thank you so much for opening your hearts and minds to this research. I realize it can feel risky and vulnerable to put your selves out there in the spotlight. I admire your bravery and your enthusiasm for research and improving recreation therapy practice. You truly are leaders and educators in the field. I hope that you continue to self-reflect and be critical of your work, as I believe it will lead you towards deeper understanding of your experiences and will assist you in providing great services to the individuals you work with.

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Appendix A – Self-Reflective Case review Process

Building Therapeutic Relationships	Empowerment	Being Professional	Evaluation	Termination/Alteration of Therapeutic Relationships	Values
<p>1. <i>Establishing</i> 2. <i>Maintaining</i> 3. <i>Evolving</i></p>	<p><i>Choice</i> <i>Decision-making</i></p>	<p>1. <i>Me</i> 2. <i>Institution</i> 3. <i>Individual</i> 4. <i>Families</i> 5. <i>Ethics</i> 6. <i>Professional Group</i></p>			
<p>What are the steps I take to be connected with the individual? ¹ How does focusing my approach on the whole person impact the building of the therapeutic relationship? ¹ How do I create a positive foundation for my therapeutic relationship? (i.e. What kind of actions, communication?) ¹ Who is the relationship benefitting? And how is the TR relationship</p>	<p>What can I do to ensure individuals have an opportunity to exercise control? How do I involve the individual in making a decision with leisure plan? How do I facilitate or encourage the individual's choice in my practice?</p>	<p>How do I make my practice, approach, demeanour non-threatening and positive? ¹ What strategies do I use to protect my home life? Self-reflection on how I relate ¹ How do I cope with challenges in my therapeutic relationship? ¹ How do I leave work at work? ¹ How do I deal with compassion fatigue? (my reflection) ¹ What do I find challenging in my therapeutic relationships? ¹ How do I meet another's (resident, family member, staff) expectations when they conflict with the institution's rules and/or regulations? ^{1,2,3,4,5,6} What can I do to heighten</p>	<p>What steps do I take to create safe experiences? How do I recognize who is receiving beneficial outcomes? RT/resident; resident/resident? What do I need to do to ensure individuals have positive outcomes in programs/in general? How do I determine that the individual's needs are being met? How do I ensure that the program continues to be</p>	<p>How do I know when it is time to terminate a therapeutic relationship? How do I deal with the loss of a therapeutic relationship as a result of a death? How has the termination of my therapeutic relationship impacted me personally and/or professionally? How do I deal with the</p>	<p>How are my values different than those of the individual? How are my values impacting my interactions with individuals receiving care? How is using a holistic approach vital to my practice and to the individual? How do I</p>

Building Therapeutic Relationships	Empowerment	Being Professional	Evaluation	Termination/Alteration of Therapeutic Relationships	Values
<p>beneficial? ² How are needs being met in the therapeutic relationship? ² What strategies can we employ to maintain the therapeutic relationship? ² How do I know that this is a strong therapeutic relationship? ^{2,3} What are the priorities for the individual within this therapeutic relationship? ^{2,3} How can my therapeutic relationship evolve? ³ How can I relate better to this individual? Relationship with Individual Understanding ³ How do I make myself available to the individual? ^{1,2,3}</p>		<p>individual, family and staff awareness of other benefits in RT involvement? ^{1,2,3,5,6} Who do I communicate with when there are conflicts in my therapeutic relationships? ^{1,2,5,6} What do I do when my professional boundaries are crossed? ^{1,2,5,6} How do I maintain a professional boundary? ^{1,2,5,6} What supports do I have in my decision-making? ^{1,2,6} How do I negotiate and resolve different expectations (individual/family) in my therapeutic relationships? ^{1,3,4} How do I deal with counter-transference? ^{1,3,4,5} How do I meet individual expectations when they conflict with the family's expectations? ^{1,3,4,5} What strategies do I use to address external forces in my therapeutic relationships? (relationship w/ residents) ^{1,3,4,5,6} How do I assert my power without compromising the</p>	<p>meaningful to the individual? - Goals/Needs/Supports How do I create/provide positive experiences for the individual? How do family members play a role in Recreation Therapy? What tools/evaluation methods am I using to ensure the needs of the individual are met?</p>	<p>termination or alteration of a therapeutic relationship that results from a transfer or change in condition? How do I feel when external influences lead to termination of the therapeutic relationship? How do I ensure that I terminate a therapeutic relationship in a professional way?</p>	<p>communicate when there are conflicts in my therapeutic relationships?</p>

Building Therapeutic Relationships	Empowerment	Being Professional	Evaluation	Termination/Alteration of Therapeutic Relationships	Values
<p>How can I be present in the moment with the individual? Self-reflective practice ^{1,2,3} Whose needs are being met in therapeutic relationships? ^{1,2,3} How do I facilitate or encourage the individual's choice in my practice? ^{1,2,3}</p>		<p>individual's self-respect? ^{1,3,5} Why is a stronger relationship occurring with one resident over another? ^{1,3,6} How am I able to absorb/deflect issues? ^{1,5} What are my personal/professional boundaries? (self-reflective practice) ^{1,5,6} How do I feel when our practice is not understood/ recognized as meaningful or unique? ^{1,6} How do I obtain and/or provide support when dealing with challenges in my practice? ^{1,6}</p>			

Appendix B - Letter of Introduction

January 2012

Dear members of the Recreation Therapy team,

This letter is an invitation to participate in a study that is exploring the self-reflective case review process in Recreation Therapy at Sunnybrook Health Sciences Centre. The title of my project is “*Exploring a Self-Reflective Case Review Process on Therapeutic Relationships: A Relational Narrative from Recreation Therapy*”. This letter is an invitation to consider participating in a study I am conducting as part of my Master’s degree in the Department of Recreation and Leisure Studies at the University of Waterloo under the supervision of Professor Susan Arai. As you know, Susan and I have been working in close collaboration with your recreation therapy team to design this study. I would like to provide you with more information about the details of the project that we have collectively decided upon and what your involvement would entail if you decide to take part.

Over the years, your recreation therapy team at Sunnybrook Health Sciences Centre (SHSC) has been focusing research on therapeutic relationships. Therapeutic relationships have played a significant role in the quality of care for residents at SHSC. Self-reflection provides you with an opportunity to analyze your experiences with clients. The purpose of this study, therefore, is to further understand what recreation therapists (RTs) take away from the self-reflective case review process. By using this self-reflective case review process, each RT will explore the meanings of their experiences with clients while also developing their personal practice. This study involves three case reviews in the months of January 2011, February 2012, and March 2012.

All participants in the case review process will be asked to participate in:

- **the case review process as you have on other occasions.** The only difference will be that I, Carrie Briscoe, will be observing and audio-recording each of the case reviews. Data from the case review will be included for data analysis and direct (verbatim) quotes may be used in reports.
- **a 30 minute focus group** facilitated by me immediately following each case review. Three focus groups will occur (one following each case review process). The focus group will be audio-recorded. The focus group will discuss what occurred during the process, what the recreation therapists will take away from it, and how it affects their practice. To support the findings of this study I may use direct (verbatim) quotes from the discussions.

In addition, if you are the *leader of one of the case review processes* you will be asked to also participate in:

An interview approximately one or two weeks after the case review process has occurred. This interview will be approximately one hour in length and will also be audio-recorded. The interview will discuss what the leader took away from the process, any challenges that occurred, new ideas

that arose, where relational theory fits into the process, how the process has affected one's practice, and how the environment influences the process.

From the results of this study we hope to share knowledge arising from the self-reflective case conference process in Recreation Therapy. The study will explore how knowledge arising from the self-reflective case conference process influences recreation therapists' practices. Lastly, the study will discuss how theory informs self-reflective practice. By improving the self-reflective process, recreation therapists (RTs) will be able to understand the meaning of the experience they have with their clients, as well as strengthen these relationships through deeper understanding. Therefore, I would like to include you in my study because you are actively involved in the recreation therapy department at SHSC and have been previously involved in the past research on therapeutic relationships and self-reflective practice.

You may ask Susan, Nancy, Joseanne, or myself, Carrie, questions about the research at any point during this process. Participation in this study is voluntary. If you decide to participate, you will take part in a case review and a 30 minute focus group immediately after the case review process. If you are a leader of the case review process you will also be asked to participate in a face-to-face interview that will last for approximately one hour. The interview will take place in a mutually agreed upon location. You may decline to answer any of the questions in both the focus group and the interview if you wish. You may withdraw from the study at any time by notifying me, Carrie Briscoe, and there will not be negative consequences if you decide to do so. With your permission, the case review, focus group, and interview will be audio recorded to facilitate collection of information, and will later be transcribed verbatim for analysis. Upon completion of this study, an executive summary will be provided to the recreation therapy team for discussion. All information you provide is considered completely confidential. Your name will not appear in the thesis or any reports resulting from this study. To support the findings of this study I may use direct quotes from the discussions. However, a pseudonym will be assigned for you to protect your identity. Data collected during this study will be retained for one year. Only I and my supervisor, Dr. Susan Arai, will have access to the data. There are no known or anticipated risks to you as a participant in this study.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me, Carrie Briscoe, at 226-789-3801 or by email at cbriscoe@uwaterloo.ca. You can also contact my supervisor, Professor Susan Arai at 519-888-4567 ext. 33758 or email sarai@uwaterloo.ca, or Joseanne Spiteri at 416-480-6100 extension 2459 or email joseanne.spiteri@sunnybrook.ca, or Nancy Bowers-Ivanski at 416-480-4136 or email nancy.bowers-ivanski@sunnybrook.ca.

I would like to assure you that this study has been reviewed and received ethics clearance through the Office of Research Ethics at the University of Waterloo (file # 17642). However, the final decision about participation is yours. If you have any comments or concerns resulting from your participation in this study, please contact Dr. Susan Sykes, Director of the Office of Research at 519-888-4567 Ext. 36005 or ssykes@uwaterloo.ca. This study has also received ethics clearance through Sunnybrook Health Sciences Centre (file #407-2011) and any concerns may also be directed to Tiffany Tassopoulos, Coordinator of Research Ethics at 416-480-6100 ext 88144.

I hope that the results of my study will be of benefit to the recreation therapy department at SHSC, other therapeutic recreation departments not directly involved in the study, as well as to the broader research community. We very much look forward to working with you and thank you in advance for your assistance in this project.

Yours Sincerely,

Carrie Briscoe
MA Candidate, Department of Recreation and Leisure Studies

Joseanne Spiteri (on behalf of the Recreation Therapy team at Sunnybrook)
Recreation Therapist, Sunnybrook Health Sciences Centre

Nancy Bowers-Ivanski, MA
Manager of Recreation Therapy, Sunnybrook Health Sciences Centre

Susan Arai, Ph. D.
Faculty Advisor & Associate Professor, Department of Recreation and Leisure Studies

Appendix C – Informed Consent Form for Case Review and Focus Group

- I have read the information presented in the information letter about the study “*Exploring a Self-Reflective Case Conference Process on Therapeutic Relationships: A Relational Narrative from Recreation Therapy*” being conducted by Carrie Briscoe of the Department of Recreation and Leisure Studies at the University of Waterloo.
- I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.
- I am aware that the case review process will be audio recorded and that Carrie Briscoe will be present as an observer.
- I am aware that the focus group will be audio recorded to ensure an accurate recording of my responses.
- I am also aware that direct (verbatim) quotes from the case review and focus groups may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous.
- I was informed that I may withdraw my consent at any time without penalty by advising the researcher.
- I am aware that this project has been reviewed by, and received ethics clearance through, the Office of Research Ethics at the University of Waterloo (file # 17642).
- I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the researcher, Carrie Briscoe, at (226) 789-3801 or by email at cbriscoe@uwaterloo.ca or her Advisor Dr. Susan Arai at (519) 888-4567 ext. 33758 or by email at sarai@uwaterloo.ca, or Joseanne Spiteri at 416-480-6100 extension 2459 or email joseanne.spiteri@sunnybrook.ca, or Nancy Bowers-Ivanski at (416) 480-4136 or email nancy.bowers-ivanski@sunnybrook.ca.
- I am also aware that my concerns may also be directed to the Director of the Office of Research Ethics, Dr. Susan Sykes at (519) 888-4567 ext. 36005 or ssykes@uwaterloo.ca. This study has also received ethics clearance through Sunnybrook Health Sciences Centre (file #407-2011) and any concerns may also be directed to Tiffany Tassopoulos, Coordinator of Research Ethics at 416-480-6100 ext 88144.

With full knowledge of all foregoing, I agree, of my own free will, to participate in the case review process and the focus group.

YES NO

Participant Name (please print): _____

Participant Signature: _____

Witness Name (please print): _____

Witness Signature: _____

Date: _____

Appendix D – Interview Informed Consent Form

- I have read the information presented in the information letter about the study “*Exploring a Self-Reflective Case Review Process on Therapeutic Relationships: A Relational Narrative from Recreation Therapy*” being conducted by Carrie Briscoe of the Department of Recreation and Leisure Studies at the University of Waterloo.
- I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.
- I am aware that I have the option of allowing the interview to be audio recorded to ensure an accurate recording of my responses.
- I am also aware that direct (verbatim) quotes from the interview may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous.
- I was informed that I may withdraw my consent at any time without penalty by advising the researcher.
- I am aware that this project has been reviewed by, and received ethics clearance through, the Office of Research Ethics at the University of Waterloo (file # 17642).
- I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the researcher, Carrie Briscoe, at (226) 789-3801 or by email at cbriscoe@uwaterloo.ca or her Advisor Dr. Susan Arai at (519) 888-4567 ext. 33758 or by email at sarai@uwaterloo.ca, or Joseanne Spiteri at 416-480-6100 extension 2459 or email joseanne.spiteri@sunnybrook.ca, or Nancy Bowers-Ivanski at (416) 480-4136 or email nancy.bowers-ivanski@sunnybrook.ca.
- I am also aware that my concerns may also be directed to the Director of the Office of Research Ethics, Dr. Susan Sykes at (519) 888-4567 ext. 36005 or ssykes@uwaterloo.ca. This study has also received ethics clearance through Sunnybrook Health Sciences Centre (file #407-2011) and any concerns may also be directed to Tiffany Tassopoulos, Coordinator of Research Ethics at 416-480-6100 ext 88144.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this interview.

YES NO

Participant Name (please print): _____

Participant Signature: _____

Witness Name (please print): _____

Witness Signature: _____

Date: _____

Appendix E- Letter of Appreciation

April 2012

Dear members of the Recreation Therapy team,

I would like to thank you for your participation in this study. As a reminder, the purpose of this study titled “*Exploring a Self-Reflective Case Review Process on Therapeutic Relationships: A Relational Narrative from Recreation Therapy*” is to further develop the self-reflective case review process within the recreation therapy department at SHSC. By enhancing this tool, each recreation therapist will be able to understand the meanings of their experiences with their clients while also developing their personal practice. The data collected during the case reviews, focus groups, and interviews will contribute to a better understanding of self-reflective practice in recreation therapy, which may in turn lead to the understanding of the meaning of experiences within the therapeutic relationship.

Please remember that any data pertaining to you as an individual participant will be kept confidential. If you are interested in receiving more information regarding the results of this study, or if you have any questions or concerns, please contact me, Carrie Briscoe, at (226) 789-3801 or by email at cbriscoe@uwaterloo.ca. If you have indicated that you would like a summary of the results I will send this to you by email when the study is completed. The study is expected to be completed by August 2012.

If you have any questions regarding this study, or would like additional information, feel free to contact me by phone at (226) 789-3801 or by email at cbriscoe@uwaterloo.ca. You can also reach my supervisor, Dr. Susan Arai, by phone at (519) 888-4567 ext. 33758 or by email at sarai@uwaterloo.ca, or Joseanne Spiteri at 416-480-6100 extension 2459 or email joseanne.spiteri@sunnybrook.ca, or Nancy Bowers-Ivanski at (416) 480-4136 or email nancy.bowers-ivanski@sunnybrook.ca.

This study has received clearance from the Office of Research Ethics at the University of Waterloo (file # 17642). Your concerns may also be directed to the Director of the Office of Research Ethics, Dr. Susan Sykes at (519) 888-4567 ext. 36005 or ssykes@uwaterloo.ca. This study has also received ethics clearance through Sunnybrook Health Sciences Centre (file #407-2011) and any concerns may also be directed to Tiffany Tassopoulos, Coordinator of Research Ethics at 416-480-6100 ext 88144.

Yours Sincerely,

Carrie Briscoe
MA Candidate, Department of Recreation and Leisure Studies

Josanne Spiteri (on behalf of the Recreation Therapy team at Sunnybrook)
Recreation Therapist, Sunnybrook Health Sciences Centre

Nancy Bowers-Ivanski, MA
Manager of Recreation Therapy, Sunnybrook Health Sciences Centre

Susan Arai, Ph. D.
Faculty Advisor & Associate Professor, Department of Recreation and Leisure Studies

Appendix F – Case Review Template

**Recreation Therapy
Case Review Template**

Therapist Name:

Unit: _____

Date:

Part One

1. Resident/Patient History (10 minutes for 1. 2. 3)

2. PLP Highlights

3. Case Highlights

4. Theme(s) to be highlighted:

- Building Therapeutic Relationships
- Empowerment
- Being Professional
- Evaluation
- Termination/Alteration of Therapeutic Relationships
- Values

5. Questions Posed to Team: (35 minutes)

6. Discussion (please complete following review)

7. Follow up (5-10 minute discussion at next review)

Please complete and submit to Nancy within 1 week of presentation of follow up.

Part Two

The last 30 minutes needs to be completely dedicated to the following focus group questions.

1. What was it like to participate in the case review process?

2. What learning did you take away from the process?

3. How will it inform your practice?

4. How has the exploration of relational theory been helpful in the case review process?
