Implementing a Client-Centred Approach in Rehabilitation: An Autoethnography

Purpose: Client-centred practice is widely considered a key element of rehabilitation. However, there is limited discussion of how it should be implemented. This study explored how client-centred practice was operationalised during a clinical trial of innovative goal-setting techniques.

Method: This study drew on principles of co-autoethnography. The personal experiences of three clinical researchers were explored to identify insights into client-centred practice, and seek understanding of this within the broader socio-cultural context. Data were collected through group discussions and written reflections. Thematic analysis and coding were used to identify the dominant themes from the data.

Results: The primary way that client-centred practice was operationalised was through listening in order to get to know, to uncover and to understand what was meaningful. Four strategies were identified: utilising mindful listening, allowing time, supporting clients to prioritise what is meaningful and viewing the therapists' role differently.

Conclusion: Whilst technical competence in rehabilitation is important, our study suggested a starting point of 'being with' rather than 'doing to' may be beneficial for engaging people in their rehabilitation. We have highlighted a number of practical strategies that can be used to facilitate more client-centred practice. These approaches are consistent with what clients report they want and need from rehabilitation services.

Introduction

Client-centred (or patient-centred) care is a concept that has been much debated in rehabilitation [1]. Client-centredness is considered by some to be central to good, or perhaps moral, clinical practice [2,3] although is not always evident in practice [3]. However, to date it has defied clear operationalisation, even though the concept appears important and makes intuitive sense [4]. One reason for this may be that there is neither a universal definition for, or model of, client-centred practice [5]. Hammell suggested that client-centred practice, as defined by clients, is primarily about the relationship between the client and the rehabilitation provider, rather than the specific intervention that is delivered [3]. Key features of this relationship reported in the literature include respecting client values, preferences and needs, and a supportive and caring relationship between client and professional that prioritises empowerment and power-sharing [5,6]. In addition, LePlege and colleagues stated that the client's "competence and expertise must be acknowledged" [5, p. 1558] within this relationship. Such features are intrinsically linked to the interpersonal skills of the therapist, and the therapist's recognition of client values [3,7]. Being valued and respected by clinicians and having the sense of working collaboratively with them are factors influencing satisfaction with care in a variety of clinical contexts [8-10]. While this literature indicates that the client-clinician relationship is a key aspect of client-centred practice, there has been limited research exploring the core elements of client-centred care and how these may be operationalised. This raises questions about how clinicians can recognise and encourage client-centred practice if it is not well understood.

There is a lack of literature focusing on clinicians sharing their subjective experiences about being clinicians. This may be due to professional insecurity, a sense of wanting to preserve mystery or lack of confidence in what may be perceived as opinion-based

research[11]. As an emerging qualitative research method that allows authors to write in a highly personalised style [12], autoethnography has the capacity to enable clinicians to draw on their experience to extend understanding of a phenomenon which may otherwise remain elusive to themselves and the clinical and academic community.

This autoethnography arose from our experience as clinical researchers providing rehabilitation in an atypical clinical setting. It was undertaken by three researchers (FB, PB and SR), each an allied health professional (speech-language and occupational therapists respectively), each with over ten years' experience in neurological rehabilitation. We were employed as clinical researchers on a randomised controlled trial (RCT) investigating the effectiveness of novel goal-setting interventions for people with TBI. Details of the interventions can be found elsewhere [13,14]. The RCT took place in three centres in New Zealand. Participants were randomly allocated to one of two intervention groups, or a control group. Each of the participants in the treatment groups received eight weekly intervention sessions of 60 to 90 minutes carried out by one of the clinical researchers. Participants were assessed by blinded research assistants before and after the intervention period, and at three and twelve months after completing the intervention. The results of this RCT are not yet known as it was ongoing at the time of writing. The data discussed in this autoethnographic study explored the clinical researcher's experience of taking part in the RCT and is based on focus groups and written reflections. These data were collected and analysed independently of the data collected for the purposes of the RCT, which focused on participant experiences and other outcomes.

While working with participants on the interventions in this study, we spent time reflecting on how we engaged participants in order to deliver the intervention they had been randomised to as opposed to the specific goal-setting interventions we delivered. Our reflections suggested our previously held belief, that our former approaches to rehabilitation

were truly client-centred, was incorrect. This realisation prompted us to adopt a more systematic approach to explore how we delivered intervention in our new context, what was different, and how this appeared to impact on client engagement. As a result, we conducted an autoethnographic study in which we, as clinical researchers, were the participants. In the interests of clarity, we refer to ourselves as researchers throughout this paper, while our clients involved in the RCT are referred to as participants.

The purpose of the study was to unpick the nuances and mitigating factors which arose during our reflections so we could better understand where, why and how our view of ourselves, our practice and our clients had changed. In this paper, we specifically focus on our reflections of client-centred practice, and how we operationalised it within the context of a clinical trial to facilitate engagement in rehabilitation.

Methods

Research Approach

Autoethnography is an "autobiographical genre of writing and research" [15 , p.739] that uses the self as the basis for exploring broader socio-cultural issues [16,17]. Autoethnography is a tool that has been used to explore the role of researchers [18,19] and clinicians [20]. It facilitates exploration of personal perspectives, resulting in comprehensive understanding of experience [16]. Sparkes described autoethnography as an attempt to take the reader into the intimacies of the author's world [18].

Autoethnographies incorporate three components, *auto*, *ethno* and *graphy* [15,21]. *Auto*, the self, involves critical reflection and consideration of the self as an active agent in a

situation. *Ethno* requires consideration of the social and cultural environments within which the study was situated. *Graphy* is the process of constructing the story, of incorporating personal experiences and reflections with the socio-cultural story [21]. Coia and Taylor suggest it is the process of "writing about one's self, exploring the past in the effort to understand the present, and prepare for the future" [21, p.7]. Writing is commonly the primary tool adopted in both data collection and analysis [12]. Autoethnographic studies involve an iterative process of data collection and analysis [15,17] with personal narrative, the most common product [12]. This study used principles of co-autoethnography [21], where the experiences of three researchers were jointly used to construct an autoethnography.

Data Collection

Data was obtained through two sources: group discussions (four over five months), which were jointly moderated, audio-recorded and transcribed for analysis; and written reflections which were analysed during and between focus groups. The initial group discussion focused on exploring why, and how, we were working differently with our clients as discussed above. Following the initial group discussion, each researcher completed a written reflection based on the primary theme of the focus group discussion. These were shared electronically through Google documents [22] and each researcher commented on each other's reflections within the document. This written reflection then formed the basis of the next group discussion and this approach continued throughout data collection. Each discussion was approximately 45 minutes long and each written reflection was approximately 400-600 words. The discussions occurred via teleconference as one of the researchers (PB) was based in a different city. All three researchers were present for all discussions and contributed equally with written reflections. This process occurred in an iterative manner and resulted in four written

reflections and four focus groups in total. Written reflections and group discussion transcripts provided the data for this autoethnography and are referred to as such throughout this paper.

Data Analysis

Thematic analysis was used to identify the primary themes that emerged from the data. Coding of the key themes occurred after each cycle of data collection – group discussion, and written reflection. Patterns were looked for in all of the data sources, thus providing triangulation [21]. The coding of all transcripts was completed independently by the first and second authors. There was regular comparison of the emergent themes, and in cases of disagreement, this was resolved through discussion between all three members of the study team. Ongoing data collection and analysis were considered complete when one core theme continually emerged from the data. Throughout the study, the emergent themes were checked against the literature relating to these themes [21], in order to compare and contrast them and to enrich the iterative evolution of data.

Authoethnographic Narrative

A narrative emerged from the themes identified during data analysis. Text was integrated from the spoken and written reflections of all three researchers and combined to create the narrative presented in the Results section of this paper. A significant amount of data was incorporated into this; where phrases were taken verbatim from the discussions or the written reflections, the text has been italicised. As the narrative is a co-autoethnography and incorporates the voices of three researchers, the pronoun 'we' has been used in place of 'I'.

Rigour

Strategies to enhance rigour were: sensitivity to context; completeness of data; reflexivity on behalf of the researcher; and practical utility [23]. Sensitivity to context was sought through intentional reflection on our ways of working within different clinical contexts. Completeness of data was maintained through collation of written reflections, transcriptions of focus groups, coding by multiple researchers and coding records. This promoted auditability. In addition, the results section includes a significant amount of raw data from focus groups or written reflections demonstrating transparency and further promoting auditability. As a co-autoethnography, with some data collected jointly, it was inevitable that we influenced each other's thinking. We took steps to minimise this, including completing initial written reflections individually, and independent coding of all data by two researchers. We also attempted to look at the data from more than one viewpoint - from the outside as researchers and from the inside as participants. Our stories shared many similarities, but there were differences and tensions also. After working together for two years on the research study, we knew each other well. We felt that we may not have been able to reflect as deeply as we did without each other's input [21].

Results

Primary Themes

The key categories and emergent themes of each round of data collection were; 1) seeing active and mindful listening as a therapeutic tool, 2) the importance of allowing time, 3) supporting clients to prioritise what is meaningful and 4) viewing our (the therapist's) role

differently. The route to realising these core aspects of client centred practice is detailed in the following narrative, which serves to illustrate the raw data alongside our interpretation.

Autoethnographic Narrative

Where We Came From – Our Previous Ways of Working. When we reflected on our predominant ways of working before the study, we agreed we would have strongly argued that previously, we actively focused on being responsive to the person's life and beyond rehabilitation when designing rehabilitation plans. *However, as we started to look critically at these past ways of working, the pressures of the systems we worked in (in multiple countries), their overt and covert rules and expectations became apparent. It is important to understand how we viewed our previous roles as this influenced what became evident to us while participating in this autoethnographic study of our practice.*

The priorities of the health system in which we worked before commencing the study, common to public health systems in many countries, played a powerful role in *how we prescribed and provided rehabilitation.* Although we would have argued that it was not the case in our own practice, the pressures of *rapid discharge from hospital, return to work and funding issues* resulted *in a tick-box mentality,* with a *reductionist focus on 'process'.* This meant we missed what now seemed vital aspects of rehabilitation, such as allowing people the *time to find out for themselves the abilities and capacity of their changed mind and body.* We were influenced by our perceptions of what was *un/realistic given the demands of the service*; this limited what we explored when setting goals and talking about expectations of rehabilitation and the future. The demands of the services we worked for engendered us with *a sense of urgency* and even *impatience* when it came to developing relationships with our clients.

Our dominant model of care was assessment-based and deficit-driven. Taking this approach meant we often missed key information such as what was of most importance to our clients, what was meaningful and how they viewed themselves in light of their injury or illness. Not infrequently, this seemed to result in *dissatisfied therapists and dissatisfied clients*. Our relationship with clients was driven by the need to *assess, prescribe and treat*. We perceived that our roles were prescribed to us, and we in turn prescribed a role and a set plan to our clients. We now believe that we played *lip service* to goal setting in our previous roles. We were often *setting goals for people*, goals that worked with what our service could offer. *Safety, length of stay and discharge took priority*. We now question whether this urge to process our patients quickly within the system could have a detrimental effect in the longer term, thereby reducing the overall efficiency of the healthcare system we were trying to maintain. Our previous way of working meant that we focused on what people *could not* do, in order to establish safety issues and priorities, rather than having a strengths-based approach which allowed people to be *aspirational, to think 'big'*. We *did not feel encouraged to think bigger, aim higher or find out our client's dreams*.

We were working within bigger agendas which impacted on our relationships with clients. We unintentionally *positioned ourselves as experts* during interactions between ourselves and clients, resulting in a *paternalistic approach* to engagement. We controlled information –timing and contents of meetings and discharge reports. *We restricted our practice to what we thought was within our role.* If complex issues were identified, we told ourselves that *it was someone else's role* to deal with them, even if this meant these issues did not get addressed.

Our old ways of working were well established, they were habitual and entrenched; even if they did not always sit easily with us. The following quote highlights most effectively how we have changed in relation to our old ways of working:

You know, I thought I was doing it before but I was not even scratching the surface (R1.)

New Ways of Working. Reviewing our written reflections helped us realise there was a philosophy of practice that underpinned the different strategies we were using in the study, when working with our clients. We were encouraged, required even, to focus on developing a therapeutic relationship, to seek to be truly client-centred, to take time to get to know our clients and allow them to get to know us. *Working in an environment where client-centred practice and the therapeutic relationship were prioritised, significantly altered our practice. It meant we were* thinking more holistically about how we were working. *This also meant that* we felt freer to be with the person, *not do to the person.* We were taking time to truly get to know them and their perspective, without enforcing our perspective. *We viewed our roles differently. We felt a* stronger sense of ourselves as enablers, rather than service providers. *This reinforced the need to* be alongside the person*, to try and establish a relationship with shared power and expertise. We* started with what was important to the person, without any other agenda.

We perceived the primary strategy we used to work differently was the way we listened – this was an active process of listening to get to know people, to uncover and to understand what was really meaningful to them. We used a number of methods to do this, depending on the person and their perceived needs. These are summarised in table 1, and explored in more detail in the following text. Taking this approach helped us keep our focus on the person.

---Insert Table One here ---

Listening to get to know, to uncover and understand what is meaningful. Truly listening appeared to enhance our relationship with clients. We now consider it an under-rated tool in routine practice. *The participants told us that it was good to talk, but it was wonderful to really feel listened to. We could do this because we were able to listen mindfully* – not having to worry about rehabilitation schedules or our 'to do' lists, *not thinking about having to get discharge sorted in a week.* The ability to listen mindfully did not happen automatically – it was something we had to discipline ourselves to do, and it was where our practice philosophy was pivotal in focusing us on what we were doing and why. We *listened to uncover and understand their current context, the direction in which they wanted to go, future goals and the values that underpinned their goals.* Listening to the clients' stories meant that we were *focusing on what the person we were working with wanted to do, and the way they wanted to do it.* We did this in a space that was controlled by the client, rather than a process driven by the clinician. We thought about what the client told us, 'read between the lines', used silence, and identified areas for further discussion in order to uncover and identify the main issues. This was a constant process that occurred throughout the intervention period. *We aimed to spend enough time working out what their story was, together with the participant, before we started to "intervene".*

We often spent several sessions unpicking and uncovering what the actual current issues were for this person. The number of sessions this took differed for every person. We went into these early sessions asking ourselves questions which guided what we listened for. These included: *Who is this person? What is their lifestyle? What do they feel they have lost? What are their dreams for the future? It felt strange to do so much talking and not any doing,* but it actually helped us, together, *come up with a solution that felt more truly therapeutic.*

We then tailored our intervention to match, rather than thinking "what is their impairment and how can I fix it"?

We felt that we got different information when *we just listened*. An important component of this was *encouraging people to know that they were the experts in their own lives. When we really listened in that mindful way, that was the message we were sending them. This helped them to take a different direction, or find their hope. Listening appeared to encourage clients to believe that the control was with them. They came to realise that these were their goals and what they wanted to do, not something that the physiotherapist or occupational therapist wanted them to get done.*

We now consider active listening *a therapeutic tool rather than a means to an end for assessment and prescription. Listening and talking took on a primary role in our intervention. It replaced assessing and doing – techniques that had dominated our earlier ways of working. Because we showed a genuine interest in people's hopes and dreams and did not immediately dismiss them, this helped the client value them, which in turn enabled them to work towards these hopes and dreams. It was so powerful, the act of having that conversation, just being there with an open mind to inquire.*

We found *spending the time at the beginning, doing the groundwork, doing the uncovering, discussing past, current and future interests and priorities meant that we were both excited and engaged.* Taking this approach, *listening to the vision that they had for themselves in the future – did they have a vision? Were they stuck? – looking at the patterns in their life and what was meaningful,* this all helped us get to know the person. *By focussing on what they wanted to do and the way they wanted to do it, we were telling them from day one that their goals were important.* When we took this time, it meant that *the goals we focused on were meaningful goals – we did not immediately* stop goal setting *when someone muttered something that vaguely resembled a goal. We took the time to get to know*

the person and what was meaningful to them. We actively made that our goal for the initial stages.

We took care to record all the goals, hopes, dreams and plans that they mentioned– not just the ones we thought they could achieve or that we could work on. We found this really useful to look back on as we prepared for each session. We could point out the patterns and how they linked to form the big picture. This could help them get to know this new self or reconnect them to the self they had forgotten. Often they were not able to see the patterns and our role was to help illuminate them. Knowing what was meaningful to the participant appeared to result in the formation of a partnership in which significant progress could be made. This also created an environment in which barriers could be examined in partnership and safety. *Uncovering what was meaningful felt much more valuable and empowering than assessing.*

However, this process was not necessarily tidy. With one participant, one researcher (R2) felt like it was a dance:

"One step forward, half a step to the side, another step forward, one step back … if I pushed him to set the goal, then the intervention might have failed and we'd spend several weeks getting back to where we were. So I just took my time. Getting to know him, finding out more about his fatigue, this dark cloak that seemed to overwhelm him. Getting to know why he was reluctant to think too much about the future. To rush into getting that goal onto paper made me feel like I would be rushing him through that process; that he needed to be able to meander through, with guidance, safely, at his pace (albeit with a bit of gentle nudging)". This process was similar to unpeeling an onion - *as we peeled away layer after layer, it became obvious to us where we needed to start.*

When we discussed our approach with colleagues who worked in regular clinical settings, *we frequently were told "we do not have time to do that". In reality, we did not have a lot of time either yet we seemed to be getting results. Our belief now is that you do not have time **not** to do it. If you have only got a few sessions, then spend half of them doing this – building the relationship, listening to your client and working out what is meaningful to them - and you might actually achieve some meaningful outcomes.* How many times had we delivered a block of therapy previously, and at the time of discharge, neither party was happy with the outcome because we had not taken the time to get to know the person and what their hopes, fears and motivators were? And often the duration of that block was many weeks, often more than the eight weeks we had with our participants. *We were taking time to build trust before we did anything else which meant when we did start working toward goals; the trust was more likely to stay throughout the process.*

We found once time has been spent uncovering what was important, more rapid progress could be made as clients were fully engaged. *Often, when we got to the 'real' goal-setting stage, we could do this fairly quickly – the person was on board and trusted us enough to go through the process. We knew how to explain things in a way that would make sense to them. This meant that when we started the intervention, we were three steps along the way. We were less likely to have to go back several steps later in the intervention process.*

Role change was required to work in this way, moving from being an expert clinician to more of a coach, handing back power to the client. We were able to do this because we had discovered that it was safe to do so; it did not make us less effective, just the opposite. *One of the tenets behind this approach was we wanted to set people up with skills that existed beyond us, we wanted to be dispensable. We hoped that when the intervention finished, they could maintain their own goal setting in a way that was satisfying to them. This was a*

broader perspective than we had in the past. In previous roles, panic would have started to rise when we felt that the rehabilitation episode was solely our responsibility. Even though, within this study, we were limited in what we could do – each participant was only allocated eight sessions - the sense of panic that we would not get what they wanted done was no longer there. Our responsibility was to support people to develop those skills. By being asked the right question, they came up with answers themselves.

Doing things differently. Measuring the effects of working in this way was not the aim of this paper, this being the objective of the trial we were employed on. However, our sense was that this way of engaging people in rehabilitation was a positive experience for our clients, and it certainly was for us as clinicians. The main study is still in progress therefore we are unable to determine the impact on outcomes, and such investigation is clearly required. However, feedback from participants indicated that people seemed to be achieving more than the daily 'doing' we inflicted on our patients for months on end in other settings.

Discussion

Rehabilitation has been described as a "black box" [24, p.S121] and a "Russian doll" [24, p.642], something with many layers and variables that impact on outcomes. This paper has explored one aspect of rehabilitation – the process of engaging in a client-centred way. It is suggested that this area deserves more attention in research and clinical practice.

We believe that the way of working outlined in this autoethnography was a truly client-centred way of working. The analysis suggested that key elements to this approach included listening in order to look for meaning and maintaining a focus on the individual. Prioritising and taking the time to do this appeared pivotal in keeping the individual at the

centre of the rehabilitation process. This approach was based on a philosophy underpinning the intervention study that prioritised engaging and empowering the participant. Taking this approach was consistent with what clients have been shown to prioritise in rehabilitation – services that are individualised, strengths-based and that encourage their active participation in identifying needs and goals [25]. Cott argued that this was dependent on the quality of the clinician-client relationship and having an organisational context that supported and prioritised these things [2].There are several barriers to implementing client-centredness of this nature in clinical practice. These include organisational culture [25] and dominant models of practice [3,24]. In our experience, there is a genuine desire to focus on what matters to the individual, but this may be constrained by the organisational culture. Health resources are often limited with a subsequent focus on waiting list management and stretching existing resources. While healthcare providers commonly state they are client-centred, as we did prior to moving to our new context, the focus is commonly on how the individual can move through the service as quickly and efficiently as possible [10]. Many rehabilitation services also work within a medical model of practice which has been criticised for its focus on trying to cure impairments rather than considering the individual [26]. In addition to the dominant medical model, research agendas and professional training in many disciplines have focused on what Hammell termed "technical" rehabilitation skills [3, p.151] – specific modes of assessment and treatment. This focus may be prioritised over person-centred skills such as caring and engaging [3], skills that rehabilitation clients considered more significant than a therapist's technical skills [3,8,27] The combination of a focus on technical rehabilitation skills and services, along with a dominant medical model may be to the detriment of the person at the centre of the rehabilitation episode – the client. Services should seek to balance technical rehabilitation skills with a "human approach"[28, p. 91] focused on the individual and their needs, and either may be emphasised differently

depending on the individual client [28] . Within this autoethnographic study, it was not possible to extrapolate how the actual intervention being tested impacted on how we engaged participants, and whether it was the specific interventions themselves, or instead the philosophies underlying the interventions, that promoted this approach to rehabilitation.

It has been suggested that approaching rehabilitation from a holistic perspective, intentionally focused on the individual, promotes client-centred care [29]. A move toward a client-centred, caring, strengths-based approach may help rehabilitation be more individualised and promote engagement in rehabilitation [6,30]. It is possible that starting by getting to know the person and their story, and maintaining a focus on working alongside a person, rather than doing to, may be one way to operationalise a client-centred approach to rehabilitation.   Shifting the focus from "what can I do for this person" to "who is this person and what do they need" may be a strategy that promotes a client-centred partnership with shared power.

Limitations and Strengths. This approach does have some limitations. It involved reflecting on a way of working that was outside normal clinical practice. We acknowledge the limitations imposed by the contexts many practitioners work in may challenge their ability to implement changes in their practice. As a qualitative, self-report study, it is ideographic and not generalisable. It is also recognised that there are limits to self knowledge, meaning we may not have been aware of all the strategies we were using, and our analysis may have been limited by our assumptions, conscious and subconscious [31]. It is not known if the findings would be true for other researchers in clinical research, or for clinicians working in other settings. We were also blinded to the feedback of our participants as to whether they experienced our approach to engagement as different or better other than what they revealed in our sessions. Finally, there appeared to be relatively limited information in the literature on

how to perform autoethnographies, particularly co-autoethnographies, especially when compared to other more established qualitative research methodologies. This presented challenges in designing and implementing the study although the available literature was constantly referred to in order to ensure we were consistent with what has been written about the methodology. Despite these limitations, this study has contributed to the literature on client-centred care by approaching this concept in a novel way. Approaching client-centredness from the perspectives of several clinical researchers, while also considering the context in which the interaction between client and clinician takes place, offers a different perspective to this concept. The exploration and illumination of tacit knowledge has hopefully helped bridge the theory-practice gap that is an ongoing issue in healthcare research [32-34].

Conclusions and implications for practice

The therapeutic approach we reflected on drew on a number of skills and approaches that are often assumed and taken for granted in the practice of rehabilitation field. Listening, for example, is something that therapists do constantly throughout the day. However, it is not common to hear it described as a skill with the different components of listening unpacked and examined [35-37]. Our clinical experience suggests it is uncommon to reflect in such depth about how therapy is delivered, or on concepts such as therapeutic engagement. Many practitioners engage in supervision, and this may be an appropriate forum for exploring how the practitioner addresses issues such as engagement. Similarly, autoethnography may be a tool that helps some reflect on their practice, connecting personal experiences with context (culture) [38]. Through writing and telling (each other) our own stories we have found

renewed purpose and meaning in our practice. It has reconnected us to our theoretical roots in a way that is reflective and meaningful, and has revealed many subtleties we were unaware of. We believe that it has made us better clinicians and illustrated to us that working alongside clients is potentially far more powerful than current dominant approaches recognise. While there is a lot of rhetoric about client-centred care, we would argue that many services are not operating in a client-centred way. A fundamental shift in the way we engage in rehabilitation and work in partnership with our clients is necessary if the rhetoric that abounds about client centred practice is to become reality.

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Table I: Key strategies and techniques for listening to get to know, to uncover and to understand what is meaningful

Strategy	Specific techniques
Seeing active and mindful listening as a therapeutic tool, a valid intervention in its own right	▪ Prioritising listening ▪ Allowing silence ▪ Listening for the story – the past influences, the current context and the future dreams ▪ Listen for what's not said, delving below the superficial ▪ Asking questions and allowing time for the answers
Allowing time	▪ Taking the time to build the relationship with the individual ▪ Spending a lot of time initially in the preparatory work of getting to know each other and talking about what is going on ▪ Trusting that taking this time initially will help the therapy process ▪ Taking time to evaluate progress throughout the intervention ▪ Moving at the pace of the client, reading their cues and monitoring their readiness to progress
Supporting clients to	▪ Helping them uncover what is important, often through "just talking"

prioritise what is meaningful	▪ Guiding, not controlling or directing, allowing the client to be the expert. ▪ Encouraging them to value and prioritise what is important to them ▪ Looking for patterns within their goals and linking them to their bigger hopes and dreams ▪ Recording everything for them ▪ Helping the individual (re)discover the power of hope
Viewing our role differently	▪ Seeing ourselves as facilitators ▪ Sharing the power, seeing the person as the expert, not us ▪ Supporting rather than doing ▪ Focusing on preparing the person to keep going with their goals and dreams once we finish ▪ Helping the individual see themselves as experts with the control

Implications for practice:

- At face value, clinical practice may appear to be client-centred. However, critical reflection of existing practice suggests that in reality, it is not well operationalised.
- Prioritising getting to know the client, their story and what is meaningful to them appears fundamental to client-centred practice. A number of strategies may facilitate this process, including mindful listening on the part of the clinician and allowing time.
- Structures and processes need to be instituted to support implementation of client-centred practice.
- Autoethnography is an approach that may support clinicians' to reflect on their practice.