Inside the Clinic: Health Professionals’ Role in Their Clients’ Psychological Rehabilitation

Jill Tracey

Context: Health professionals (ie, physical therapists, athletic trainers) can play an integral role in the psychological recovery from injury. Objective: To examine health professionals’ perceptions of the roles they play and their influence on the psychological recovery of their clients. Design: A qualitative design using semistructured interviews that were transcribed and analyzed using interpretational analyses to reveal themes. Setting: 4 rehabilitation clinics specializing in sport- and physical-activity-related injuries. Participants: 18 participants (17 physical therapists, 1 athletic trainer) with a mean age of 36 years. Results: Using thematic coding of the interview data, general-dimension data themes identified were centered on the roles of rapport builder, educator, and communicator. Health professionals perceive that they play important roles in the psychological recovery of their clients in spite of a lack of professional training in psychology and strive to create a caring and supportive environment. Results demonstrate the perceptions of the roles they play and the influence they have on the psychological component of the recovery process. Keywords: rapport builder, educator, communicator

There is tremendous anecdotal and empirical evidence for the social support provided by health professionals (HPs) in the rehabilitation setting.¹⁻⁴ They potentially have a significant influence on the clients they work with from a holistic healing perspective. In previous research I found that athletes perceived physiotherapists and athletic trainers in particular as an integral part of their emotional and psychological recovery, with many reporting that they were somewhat dependent on the verbal and nonverbal communication in determining their emotional status during recovery. Athletes have identified the significance of health professionals in the recovery process,²⁻⁵ which leads to the need to focus on the perspectives of the health professionals regarding their roles and influence during rehabilitation. Injured people come into the rehabilitation process with varying degrees of vulnerability, and they often turn to the health professionals for guidance beyond physical recovery and can be assisted in their psychological recovery, as well.

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Helping injured people cope with the demands of rehabilitating from an injury has been identified as an important and integral role for health professionals. Health professionals must focus on the physical recovery of each individual, but many are also aware of the roles they play in the psychological recovery of the individual. Although many are likely aware of roles they play and recognize their impact on clients, they might not be aware of the specific mechanisms (and likely have not been specifically asked about their roles and influence), and identifying potential mechanisms has not been a main focus in previous research. Some of these professionals have recognized the need for more knowledge of psychological issues involved in injury rehabilitation and in some cases have voiced a desire to know more about how to help injured people deal with these issues. Unfortunately, little to no training is done on the psychological aspect of injury rehabilitation, although researchers continue to urge for more emphasis in education on knowledge of the psychology of injury and the use of psychological interventions in physical therapy and athletic training programs. It is possible and highly probable that there is a lack of both training and dissemination of information about the psychology of injury, and there is a need to address this with researchers and practitioners so that a stronger link can be built between theory and practice for the mutual benefit of everyone interested and invested in client recovery.

Although health professionals might lack formal professional training in psychology and counseling, previous researchers have determined that various health professionals acknowledge that they seem to have an influence, even if the type of influence has not necessarily been specifically identified. Perhaps what is needed is more knowledge translation from sport and health psychology through the curriculum during professional training, workshops, or professional-development seminars for practitioners to enhance their understanding of the psychology of injury. Disseminating this information might serve to enhance their awareness of the psychological component of injury recovery, which has been noted by several researchers as being important yet not frequently taken into consideration. In addition, in my consulting practice health care professionals have often commented to me regarding the need to understand more about the psychological recovery of their clients.

In one of the earliest studies on psychological rehabilitation, by Wiese and Weiss, a new link was forwarded concerning involvement with health professionals. They commented on the importance of the sports-medicine team of health professionals in the psychological rehabilitation of their clients. It is interesting that, although the importance was noted, the researchers indicated that the various health professionals “lack both the knowledge and skill concerning psychological rehabilitation.” Although many researchers over the years have discussed the important roles health professionals play, most notably social support, specific examination of the perceptions of the roles health professionals have on psychological rehabilitation has not been a focus of an investigation. We have evidence, however, that health professionals play a vital role through social support and guidance, along with evidence suggesting that they use various intervention strategies in their practices to assist in the rehabilitation process. The next logical step and the purpose of this exploratory qualitative study was to examine, through in-depth interviews, health professionals’ perceptions of the roles they
play and their influence on their clients’ psychological recovery. The exploratory nature of this investigation allowed for in-depth analysis of health professionals’ perceptions as we attempted to uncover potential mechanisms of influence to enhance our understanding of why health professionals are continually reported as being influential in the recovery process.3–5,11,15 The experiences of these professionals were examined because they have a wealth of insight into the rehabilitation process from a dynamic perspective.

Method

This exploratory research was guided by 2 central research questions focusing on health professionals’ perceptions of the roles they play and their influence on the psychological recovery of their clients. The research questions were as follows:

- What are health professionals’ perspectives as to the roles they play in the psychological recovery from injury?
- What perceptions do health professionals treating injured people have of their influence on the psychological recovery from injury?

Participant recruitment involved contacting and meeting with the management team and owners at 4 clinics to discuss and explain the study. The clinics specialize in the treatment of sport- and physical-activity-related injuries, with most clients being athletes. All 4 clinics fully endorsed and supported the study. The management team and owners in turn informed their staff and asked for volunteers to participate in the study. In addition, they invited me to talk with the staff to explain the study, answer any questions or concerns they might have, and ask for volunteers. Participation was strictly voluntary, with no negative consequences from their employers if they chose not to participate. Ethics approval was secured through the research ethics board at my academic institution.

Eligible participants were full-time health professionals employed at the clinics who regularly treat injured people and were certified physiotherapists, athletic trainers, and 1 physiotherapy assistant (who was awaiting final certification for physical therapy). Eighteen health professionals from 4 rehabilitation clinics volunteered to participate in the study. The participants consisted of 12 women and 6 men with a mean age of 36 years. The number of years of experience as health professionals ranged from 1 to 29 (mean = 8.36, SD = 8.27). The participants were professionally trained and certified from a variety of academic backgrounds. The characteristics of the participants and pertinent demographic data are presented in Tables 1 and 2.

The participants completed a demographic form to gather information on education, certification, years of experience, and specialty. After completing the demographic form the participants were interviewed, with the interviews approximately 45–60 minutes in length. A semistructured-interview guide was followed based on previous interview guides I have used, literature on the psychology of injury that used guides,17–19 and qualitative methodology sources,20–23 allowing for follow-up questions to be asked based on responses to the initial questions. The semistructured-interview guide consisted of questions about the nature and development of the therapeutic relationship, the participants’ beliefs and evidence-based practice of
Table 1  Demographic Details of Health Professionals (HPs)

<table>
<thead>
<tr>
<th></th>
<th>Number of HPs</th>
<th>Years of experience (mean)</th>
<th>No. of clients treated per year (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapists</td>
<td>16</td>
<td>8.78</td>
<td>348.38</td>
</tr>
<tr>
<td>males</td>
<td>5</td>
<td>17.75</td>
<td>504.25</td>
</tr>
<tr>
<td>females</td>
<td>11</td>
<td>6.38</td>
<td>296.42</td>
</tr>
<tr>
<td>Athletic therapist</td>
<td>1</td>
<td>1.50</td>
<td>300.00</td>
</tr>
<tr>
<td>male</td>
<td>1</td>
<td>1.50</td>
<td>300.00</td>
</tr>
<tr>
<td>Physical therapy assistant</td>
<td>1</td>
<td>1.50</td>
<td>160.00</td>
</tr>
<tr>
<td>female</td>
<td>1</td>
<td>1.50</td>
<td>160.00</td>
</tr>
</tbody>
</table>

Table 2  Degrees, Diplomas, and Certificates Earned by Health Professionals (HPs)

<table>
<thead>
<tr>
<th>Education</th>
<th>No. of HPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>BS physiotherapy/physical therapy</td>
<td>17</td>
</tr>
<tr>
<td>CAT (certified athletic therapist)</td>
<td>1</td>
</tr>
<tr>
<td>Pedorthic technician</td>
<td>1</td>
</tr>
<tr>
<td>Orthopedic manual therapy</td>
<td>5</td>
</tr>
<tr>
<td>BA physical activity/kinesiology</td>
<td>6</td>
</tr>
<tr>
<td>BA other than physical activity/kinesiology</td>
<td>3</td>
</tr>
<tr>
<td>BS physical activity/kinesiology</td>
<td>3</td>
</tr>
<tr>
<td>BS athletic therapy</td>
<td>1</td>
</tr>
<tr>
<td>Master’s physical education/kinesiology</td>
<td>2</td>
</tr>
<tr>
<td>Pre-health diploma</td>
<td>1</td>
</tr>
<tr>
<td>Sports-medicine diploma/Sport physical therapy diploma</td>
<td>4</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>6</td>
</tr>
</tbody>
</table>

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the psychological impact of injury, their roles in the psychological rehabilitation of their clients, and the influence they believe they have on the psychological recovery of their clients. There were 9 questions asked initially:

1. How do you describe what the therapeutic relationship is between you and your clients?
2. Describe your experiences in treating injured people with respect to how you develop the therapeutic relationship between you and your clients.
3. How often (if at all) do you believe an injured person is affected psychologically by an injury when dealing with a moderate to severe injury?
4. What do you observe that leads you to respond the way you did in question 3?
5. a. Describe the characteristics of injured people who are most successful with rehabilitation.
   b. Describe the characteristics of injured people who are least successful with rehabilitation.
6. What is your perspective of the role you play in the psychological recovery of your clients from injury?
7. What influence do you believe you have on the psychological recovery from injury in the treatment of injured people?
8. Describe the techniques and/or strategies that you as a health professional use that you believe facilitate psychological recovery during the rehabilitation process.
9. What knowledge about the psychology of injury should health professionals have to facilitate the rehabilitation process?

In addition to these 9, there were several follow-up questions for each participant. The questions were reviewed by a subsample of the management teams or clinic owners before the interviews commenced to offer an opportunity for them to make suggestions in case of possible misinterpretation of the questions and to ensure clarity of the questions. Interviews were audiotaped and transcribed verbatim to ensure accuracy.

Each interview was transcribed verbatim by 2 research assistants (RAs) trained in qualitative methods and interview transcription. One of the RAs served as a debriefer of the data and was instructed to review all transcripts for themes and patterns. I also reviewed the transcripts numerous times to identify themes and patterns emerging from the data. All transcripts were edited for any information that could possibly reveal the identity of the participant, a client, or the particular clinic, and a number was assigned to each participant.

**Data Analysis**

Data analysis incorporated an interpretational analysis forwarded by Tesch\(^2^2\) that allowed for themes and patterns to emerge as the data were content-analyzed. In addition, the recommendations from Miles and Huberman\(^2^3\) for analyzing interview data were used, because it was deemed appropriate for this type of data and has been applied in a sport psychology setting.\(^2^4\)\(^–^2^8\) Several levels of analyses were done with the interview data to thoroughly analyze them and to collapse coded information when deemed necessary to diminish redundancy and to make every attempt to display an accurate representation of the data. Data from the transcriptions were examined for pertinent categories through multiple levels of analyses using the words of the participants directly to form the categories. I outlined the analysis plan to review the data, and independently the RA and I performed all levels of analyses as follows:

1. Open coding: a word-for-word review to look for words and phrases to generate an initial list of commonalities and patterns.
2. Each participant’s data summarized for each of the questions: to continue looking for commonalities and patterns and expanding on the list from the first analysis.
3. A summary of analysis No. 2: combining each question across all participants to look for patterns.
4. Condensing of analysis No. 3: further review of data to add or omit relevant information. A broad list of themes was identified through this analysis.
5. Generation of overall themes: a review of the data to identify general-dimension themes.
6. Creation of a model based on the first-order themes, second-order themes, and general-dimension themes.

On completion of the first 5 steps of the analyses, I met with the RA to discuss the coding and themes that had been identified. This method of peer debriefing and open discussion serves to challenge potential biases and enhances the quality and strength of the findings. The codes and themes generated in the analyses were compared, and discrepancies were discussed at length to clarify the accuracy of the analysis and to challenge assumptions that might have been held by either myself or the RA. The patterns and themes we identified were quite similar, but clarification was required for a couple of the names of the initial second-order themes and general dimensions. None of the changes were major; rather, they involved clarifying the description of the theme. Through the many levels of analyses and thorough discussions between myself and the RA the process provided a clear picture of the patterns and themes.

Results

A diagram of the first-order themes, second-order themes, and general dimensions is presented in Figure 1. The research questions served as a framework, and thematic coding was used to examine the responses to the interview questions. An understanding was gained about health professionals’ perspectives of the roles they play and the influence they have on the psychological recovery from injury. Three general-dimension themes were generated from the data that centered on the roles of the health professionals as rapport builder, educator, and communicator. The general dimensions form the main section headings, with the first- and second-order themes explained within each general dimension. Overriding all 3 general-dimension themes is the participants’ perceptions of their influence on the psychological recovery from injury.

Rapport Builder

Participants were asked to define the therapeutic relationship and to explain the nature of how they develop it with their clients. This relationship was described as being based on the expectations of the clients and fostered by the interaction between client and health professional. Of the 3 general-dimension themes, rapport builder was highlighted as an integral component to establish initially before progress could be made toward being an educator and a communicator. Establishing rapport was described consistently as involving honesty, building trust, and professional credibility, and this was done by establishing their role as caregivers and sounding boards and learning about their clients’ personalities. By doing so the health professionals secured their role as a mediator of information and helped
find common ground with clients so that they could proceed through the rehabilitation process. This idea was illustrated by a comment from one of the health professionals:

I think it takes a while to get a good relationship between a patient in a clinical perspective. I mean there’s still trust into it because you’re still trying to get that—the common goal is to get them better. And I mean they’re trusting you that you’re doing what you can to get them better as fast as you possibly can. And honesty is big—I think honesty is important. (HP#2)

The issue of trust was emphasized by many of the health professionals as they related it to part of the nature of their profession; they tend to spend a lengthy amount of time per session with each client. In addition, they are required to touch the client for purposes of diagnosis and for various treatment protocols. Both the time and the touch aspects were described as important component in establishing rapport. One health professional with many years of experience commented on this point with the following:
Well I think that [time] is a real big part of it, the fact that our interactions tend to be longer [than the amount of time typically spent with physicians], in terms of each individual session and then probably a number of different sessions, so it allows much more time for relationship building . . . and that [touch] is a big, big part of it and certainly one of the areas of real concern and caution. And then again to turn that other hat, when you are dealing with people, [for example], I may put my hand on your shoulder as a gesture of support for you, but depending on your background, your ethnicity, your socialization, or whatever you may see that as a real affront and so you have to really be careful with the touch component. (HP#3)

This health professional went on to say that there are people who appreciate the occasional hand on a shoulder as a sign of support but that it was best to err on the side of caution. Another health professional referred to the role of caregiver and sounding board while at the same time dealing with the unique personalities of the clients:

I would say it obviously varies from person to person because everybody’s different. So it depends on the client and how open they are. So sometimes it’s very difficult to establish any sort of your relationship, but usually I would say that’s rare. Usually once someone starts coming and you see them more regularly, obviously your relationship gets more close, the more you see them. And I think it just becomes established by probably how any relationship becomes established, so first through small talk. And then getting more comfortable with them, opening up to you about maybe not only their injuries. So like I said, it’s obviously more than just their injury. Sometimes it becomes trying to almost counsel them in a way through other parts of their life or how their injury is affecting them through other parts of their life. (HP#7)

Many health professionals commented on the nature of the relationship they build with clients that in part involves how “you relate to [them] on a personal level” (HP#9), making “a personal as well as a professional connection” (HP#6), having an awareness “of who they are and . . . mapping personalities and adjusting my personality to fit theirs” (HP#2). They tend to view the process as a team effort that requires a connection to be made to get to know each individual, to try to find common ground through which they will work in concert to develop a treatment plan through unique methods of relationship building. The caring and supportive environment they work to create can serve as an influence on the client, who feels “safe” and whose cares and concerns are heard by health professionals who take the time to talk with the client. A comment by one of the health professionals highlights this point about their influence:

You are having an impact. I know of some situations before where athletes have been told by specialists that they were done for the year, or for their career, or whatever, and then the individual comes to you and they seek a clarification and you are not going to contradict or reverse what someone else has told them, but maybe taking the time to explain. You know I have had a couple of occasions where people have come back to me afterward and said,
“You know I really appreciated the fact that you took the time to explain that to me. It was a bitter pill to swallow, but I have a better understanding now of why it has to be that way.” But before, somebody else was too busy or didn’t take the time. (HP#3)

The key mechanisms of influence stem from the importance placed on building rapport and the “3 Ts of influence”: those of trust, time, and touch. Many health professionals used the term *trust* as essential to building rapport and having a positive influence, as well as spending adequate time to help clients through the process of rehabilitation through effective communication. Touch was also reported as a strong influence as discussed earlier. By virtue of the nature of the profession, these factors serve to influence the relationship between health professional and client. This point is reflected in the following:

I think we have a huge influence, because of the people that we are and because the person is coming here again, you are establishing that relationship. If they’re looking for help, right there you become influential. They have the utmost respect for you and that’s going to influence them, so if you cut it off as a physical thing and are not aware of the psychological side of things. . . . I think again it comes from the relationship. You’ve established the relationship, and you’re going to influence them, and people are influenced by us, that’s just the way it is. People are influenced by the people we are and the profession we have. (HP#18)

A final component of the rapport-builder theme was the role the health professionals described as “salesperson.” Several of the health professionals referred to the initial phase as the concept of setting up a contract, which involves gaining the client’s trust and demonstrating knowledge to the client to enhance compliance. The health professionals firmly believe that maintaining professionalism is priority number 1, because they must establish credibility through demonstrating their competence and understanding of the physical therapy process, assessment, and treatment. A health professional with many years of experience highlighted the salesperson role well in the following:

We are actually salesmen—salespeople first and teachers second. So you come in, I assess you. I have to demonstrate to you that I have expertise. I have to demonstrate to you that I am a decent enough [person, so that] you’ll listen to me. You have to like me for some reason at some level, and then I have to tell you what’s wrong and sell you on how you should get better. And if I can’t sell you on how you are going to get better than the rehab cycle won’t work. (HP#2)

The dynamic development of building rapport with clients through the unique strategies used by this group of health professionals is reflected in their roles of mediator and salesperson who systematically find common ground through which to develop the therapeutic relationship. This unique relationship is the springboard that leads to the large educator role on which they base most of the rest of the process with their clients.
A second predominant theme that emerged from the data was the concept of the health professional as educator. There were many comments made regarding the role they play in helping the clients set and work toward goals in their treatment, and the perspective most often referred to was one of helping their clients help themselves recover successfully. Several health professionals described themselves as “teachers first.” Approaching the rehabilitation process this way was described as creating a dynamic of “equality” and “empowerment” whereby health professionals facilitate an environment for clients to be active participants in their recovery. Several health professionals described this as a preferable way to work with clients, saying that it helps reduce passivity and potential malingering on the part of the clients. In addition, health professionals have received positive feedback from clients who have told them that they appreciate the fact that they take the time to teach and explain the physical aspect of their injury and sometimes also show them the anatomy and mechanics of the injury. The role of educator is illustrated by the following:

I will always go through my assessment and then I will always get an anatomy textbook or the skeleton and show the patient what is going on. I make that a priority. I can’t be, “Oh you’ve got a rotator-cuff tendinitis.” They’re going “Where is my rotator cuff? I know my shoulder hurts, is that the same thing?” So I get out the book and show them the book and I explain everything and then they go, “I think I understand what is going on and what the cause of the problem is.” I like that they can understand things better. (HP#9)

For many health professionals, explaining the anatomy of the injury was noted as a beneficial element in their professional practices. One health professional sets the stage for the educator approach from the beginning and stated, “I get the skeleton out, I get the anatomy book out and show them what’s going on, and then they’re like ‘Oh yeah, that actually makes sense’” (HP#12). Another health professional also referred to the educational role by describing her “bottom line”:

I usually educate them with regard to either using a model or an anatomy book and say “this is where your dysfunction is” or “this isn’t really what’s working well. . . . This is what I think is going on, this is how I think I can help you.” (HP#16)

Many health professionals viewed this approach as an effective way for clients to take responsibility for their recovery, which they referred to as “owning their rehabilitation,” while in partnership with the health professional.

In addition to the explanation of the anatomy of the injury, the health professionals also made many references to the emotional and psychological aspects of the rehabilitation process. They recognized their potential impact on the emotional and psychological state of their clients, and they do try to help those who feel vulnerable during the recovery phase and, when they feel it is necessary, try to reduce their fear of reinjury. In some cases the health professionals reported that they use a combination of showing the clients on a model or demonstrating on
their injured area for the purpose of “reintroducing the vulnerable position and showing them that their arm is okay in that vulnerable position” (HP#11). There is an important process operating here wherein the health professional is trying to reduce fear, while at the same time they are building confidence in the client. This idea connects to the touch component discussed earlier with helping people emotionally. This is described by a health professional who said,

I was told once by a physio that . . . he believes that physios have a much easier access emotionally and psychologically to patients than psychologists and psychiatrists do because patients allow us to touch them. And so the barrier that might take you several sessions to break through, I can sometimes break through in 4 or 5 minutes. Now that being said, I have to say there comes a lot of responsibility because . . . we are not trained to be psychologically helping people per se. We do play on their emotions and so I would say it’s a big impact. (HP#2)

There was a strong contention from many of the health professionals that helping a client heal was a holistic process. A health professional with a few years of experience said, “Your clients tell you a lot of different things, and you have to help them emotionally with their injury” (HP#8). While their job is to treat and facilitate the physical healing process, they do recognize that a person’s healing involves healing physically, psychologically, and emotionally. Although it might sound disconcerting to hear health professionals describe themselves as “salespeople” or say that they “play on their clients’ emotions,” an explanation of the tone and context might be helpful. Neither comment was meant in a derogatory manner. In the case of the use of the term salesperson, the health professional was referring to the idea that health professionals sometimes have a limited amount of time in which to present information during an assessment in a competent, professional manner to encourage the client to comply. In the case of the second comment, the health professional explained that this meant more that he feels a strong sense of responsibility that the client has put faith in him as a professional. He takes it very seriously and considers it his professional responsibility to be aware of how emotionally invested clients are likely to be about their treatment.

The third component of the educator theme is that of treatment and how the health professionals approach treatment options. Because they establish themselves in the context of educators entering into a contract with clients whom they want to be participatory in their rehabilitation, they view treatment options as teaching clients to take responsibility for their recovery and engaging them in the process. Most of the health professionals described themselves as teachers, and one added to that sentiment by saying, “We are a problem solver, that’s what makes us professional. We are problem solvers not technicians” (HP#2). He went on to discuss his belief that most physiotherapists view themselves as teachers first, with technical aspects within their teaching. As health professionals treating and teaching their clients they reported how they combine their observation skills with teaching exercise programs to provide the clients with a complete understanding of the rehabilitation process. One health professional described this course of action in the following:
I look for differences in how they are moving, difference in how they’re tolerating treatments, differences in their compliance with home exercise programs, differences in their reporting to me pain levels subjectively or functional levels subjectively. So I guess it’s more of sort of an observation and an ear for what they’re reporting. (HP#17)

Based on this gathering of information, the health professionals move forward in educating and treating the clients with as much information as possible to discuss and provide the most effective treatment plan. All these methods of working with clients strongly speak to their role as educator and connect to the third major theme and how they take that information and communicate it effectively to their clients.

**Communicator**

The intricate process of developing rapport and educating the client throughout the rehabilitation process involves a great deal of communication. This theme of being a listener was common with the health professionals, and they reported on the importance of taking the time to truly listen and to be understanding and empathetic throughout the process. There was a strong sense among the health professionals that they had to learn about each person, because they recognized that each person has a unique personality and way of responding to an injury, so they recognized that they needed to know about the person and not simply the injury. A health professional identified this unique phase in the following description:

You have to find out things about that person. The most obvious thing is to find out what their problems are, to listen to them, let them talk to you about what their concerns are, but also to put that in to context as to finding out why that’s important to them or how important it is. (HP#9)

Another health professional noted, however, that it often took time and experience to build this understanding:

I think at first I was so focused on finding out what the problem is that I didn’t care so much about who the person was. But I think as time went on, you start to realize that the person is the integral part of the problem, and if you’re not understanding how they’re individually responding to the situation, then you can’t understand the problem fully either. (HP#13)

Learning about and listening to each client and making the effort to find out about physical and psychological components of the person and how the injury is affecting him or her were reflected in the preceding comments from the health professionals. These comments speak to the importance of communication in the rehabilitation process and how the relationship between health professional and client can serve to empower clients to take personal control of the recovery, which in turn can help build their confidence and possibly enhance their motivation to recover successfully. Helping clients feel more confident and possibly more motivated was described as being done by taking the time to talk with clients and listening to them regarding the injury, prognosis, and treatment, as well as their fears.
and concerns. These issues relate to the mechanisms of influence referred to earlier as the 3 Ts: trust, time, and touch. Health professionals who are willing to foster this development and demonstrate that they genuinely care about each individual through talking, listening, and touch might be more influential in garnering clients’ attention and willingness to listen and comply with treatment.

Some of the health professionals reported on their role in providing reassurance as they build the relationship with their clients, and they see the reassurance they provide and being an “encourager” as a method to help build confidence. One of the health professionals discussed this role as a form of validating the experience of a particular client:

I got a guy and he’s going to [World Championships], and he blew his knee out. So he was out for Worlds, but I mean I think we spent a half hour just understanding where he was coming from, what he had to do in his sport. I knew a little bit about it, but nothing in terms of the positions and the movements and stuff like that. And by the end of, he was very happy that I didn’t really treat him but I took the time to learn. And to really understand what he was going to have to do. (HP#1)

The health professional could have treated the injury alone, but his knowledge and experience allowed him to recognize that he needed to handle this vulnerable athlete very carefully and with patience and to communicate about how this injury was affecting his life beyond simply the physical problem. Many health professionals described having this type of experience and were unanimous in their belief that to be effective communicators and competent professionals, a great deal of patience and understanding were required.

The final theme within communication is patience and the ability of the health professionals to balance understanding a client’s needs with explaining the reality of the injury and what will be required for a successful recovery. A few reported that it was sometimes difficult to be the bearer of bad news but knew it was their professional responsibility to be honest and to thoroughly explain the nature of the injury and what the client must do to maximize the potential for a complete recovery. Through education and communicating effectively, a health professional described the balance as being about “nurturing people. [They] are coming in with problems that are affecting their lifestyle and are in pain. So they need help essentially, and so that’s our job to provide that in a powerful manner for them” (HP#3). “A powerful manner” is an interesting way to describe the importance of combining genuine understanding and the realism of telling them accurately what the issues are with respect to their injury through effective communication.

**Discussion**

Through the framework of the 2 research questions and because of the 3 general-dimension themes that emerged from the interviews with the health professionals, there is a link to the previous literature with respect to the social support they provide throughout the rehabilitation process. Although this group of health professionals did not use the term social support per se, the roles they play and the influence they have on client recovery from both a physical and a psychological
perspective is substantiated in this study. Experiencing and progressing through
the recovery process can be a difficult challenge for individuals. It is natural for
many to seek support from those with whom they feel a close association, whether
it be a friend, family member, teammate, or coach. As has been noted by research-
ers, however, not everyone wants to talk about their injury with coaches, nor do
they find them to be terribly influential during rehabilitation. Rather, they seek dif-
ferent types of support from health professionals (ie, emotional, informational)
through the different support networks, exchanges, and appraisals described by
Bianco and Eklund.

There is a general consensus that social support can be beneficial, and some
suggest that health professionals can be among the most important sources of sup-
port throughout the rehabilitation process. Udry did not find a significant
indication that social support influenced adherence to rehabilitation but did note
that the support was beneficial throughout recovery. Based on the results of the
current study and the important function the health professionals can serve with
respect to social support, the specific roles identified in the current study (rapport
builder, educator, and communicator) demonstrate the caring, supportive role they
try to foster in the therapeutic environment. In addition, the health professionals
highlighted the importance of building rapport with their clients. This relates to a
point made by Bricker Bone and Fry, who found greater adherence to rehabilita-
tion when clients felt they had an alliance with their health professional.

Although there is growing evidence from previous research of the important
roles health professionals play in the recovery process, the types of roles have not
necessarily been specified until the current study. The educator role was empha-
sized by the participants, and this has not been specifically identified in earlier
research, pointing to a unique feature of this study. It can be argued that to be an
effective educator, communicating well is a prerequisite. The participants were
clearly aware of this connection and were adamant about the importance of com-
munication. Researchers have found strong evidence in a number of studies of the
importance of communication with clients and the impact effective communica-
tion can have on facilitating a helpful therapeutic relationship. In par-
ticular, Ninedek and Kolt and Weise and Weiss noted the critical role various
types of health professionals play in communicating with and motivating their
clients. Weise and Weiss made a strong case for how important communication is
and suggested that sport psychology consultants work with athletic trainers (in the
case of their participant pool) to facilitate more effective communication and
to incorporate the use of psychological skills in the process. An unanticipated
result that stemmed from the current study relates to this idea of having sport
psychology consultants working with the health professionals. The management
team and owners of a few of the clinics have invited me to be a part of their ongo-
ing educational program to help disseminate the results of the study and to serve
as a facilitator to these professionals to educate them on the complexities of the
psychological aspect of injury recovery and the use of intervention strategies in
their practice. By serving in this role, the objective is to assist in the knowledge
translation being recommended to enable the health professionals to advance their
training and understanding of the psychological aspect of injury recovery.

Several health professionals in the current study commented that although
they were not specifically qualified to meet the psychological needs of their
clients, they employed skills of empathy and active listening and attempted to create an environment in which they encouraged clients to develop and use coping mechanisms such as relaxation, goal setting, and mental imagery. Although health professionals are not formally trained to meet psychological needs from a professional counseling perspective, the therapeutic relationship can serve as a strong influence on the basic psychological needs of clients, at least with respect to issues such as reducing anxiety and fear, developing coping strategies, and communicating to clients that they are cared for in a genuine way. It is understandable that health professionals might feel that they are clearly in a position where they must try their best to meet the needs of clients; this can appear as a “give it your best shot” approach. The reality for many, though, is that their training is not in psychology or counseling, and most rely on basic psychology courses taken during undergraduate education and for some additional seminars on the psychology of injury and rehabilitation attended at professional education workshops. A couple of health professionals had referred clients to counseling professionals, and a few had referred clients to sport psychology consultants in cases when they knew the assistance that might be required was not part of the scope of their practice. The health professionals were keenly aware that they are not counselors but do believe that the genuine caring and supportive environment they foster might at least in part help meet the needs of their clients. This point clearly identifies a strong need for knowledge translation between researchers and practitioners and lends further support for bridging theory to practice in the rehabilitation setting.

When we examined the influence the health professionals have on their clients’ psychological recovery several points emerged from the interview data. As highlighted in the preceding section, social support was demonstrated as influential. Building rapport and social support can “kick-start” the process whereby other influences are possible. In a study by Gould et al.19 examining how athletes cope with season-ending injuries, the support from the health professionals was given as a facilitating factor in the rehabilitation process. This finding was similar to a point mentioned by Robbins and Rosenfeld,2 who identified health professionals as more influential than the coaching staff. Both of these studies noted that the health professionals served as a motivating factor, along with Ninedek and Kolt,8 who commented that the motivation factor coupled with the influence of helping clients set realistic goals can be a strong influence in providing a therapeutic environment that fosters healing. The results of the current study support these findings and provide further description of the influence health professionals have in motivating their clients to persevere through rehabilitation.

Many of the health professionals reported that they thought that part of their role as educator and communicator is to motivate through challenging their clients to push themselves when appropriate to progress. The concept of challenging clients is an interesting one and was mentioned by Bricker Bone and Fry,5 who found that athletes preferred their athletic trainers to support them by challenging them:

Athletes perceived that their ATCs [certified athletic trainers] are providing an important source of social support by requiring them to engage in challenging rehabilitation exercises. . . . When an ATC challenges athletes with harder or more sport-specific tasks, athletes’ beliefs in the rehabilitation program escalates. (p163)
The health professionals in the current study reported their focus on a balance of knowing when and how to be empathic along with challenging clients, and being able to do this requires that they establish a comfortable professional relationship of trust and support. This relates to a point made by Ninedek and Kolt\textsuperscript{8} regarding how motivation can be increased through effective communication by encouraging clients to develop a more internal focus of control (the idea that people have an ability to take control over their recovery process). Encouraging clients to accept and take personal responsibility for their recovery has been suggested by numerous researchers as beneficial\textsuperscript{3,19,24,31} with Udry\textsuperscript{29} suggesting that instrumental coping (ie, finding out about their injury, making attempts to alleviate sources of stress and discomfort, listening to the advice of health professionals) can serve a facilitative function in the recovery process. The health professionals provided support for these points through their comments about clients who tend to recover more successfully as those who “accept their injury,” “take responsibility for their rehabilitation,” and “want to learn about their injury” so that they can assist in their own recovery.

The comment made by Ninedek and Kolt\textsuperscript{8} referring to the impact health professionals can have through communication on the recovery of athletes was supported in the current study in that the health professionals reported that their influence was in part a result of the climate they created in the rehabilitation setting. They believed the open communication, along with the supportive, caring environment, assisted in helping clients’ “mindset,” or attitude toward their recovery, which the health professionals attributed to the lengthy amount of time they tend to spend per session with each client. This time factor was noted by Bricker Bone and Fry\textsuperscript{5} in their study on injured athletes’ perceptions of the social support from certified athletic trainers. Whether the time spent, as valuable as the health professionals believed it to be in the current study, had an impact on adherence to rehabilitation was not ascertained in the study. It is important to reemphasize a finding regarding social support and adherence by Udry,\textsuperscript{29} who did not find that social support correlated with adherence but did find that social support was beneficial throughout recovery in general. Because the health professionals spend more time per session with clients (compared with the relatively short time typically spent in consultation with physicians and surgeons), they felt they were better able to influence the overall physical and psychological recovery of their clients.

In light of the nature and design of the study, a couple of limitations must be mentioned. Although we tried to be aware of potential biases, there might have been some nonetheless. Accurate representation of the words and experiences of the health professionals was attempted through careful attention to their responses to questions and through the analyses; however, interpretation might include researcher bias. In addition, the years of experience among the health professionals varied quite a bit, and it was difficult to ascertain the amount of their clinical experience. Similar to a limitation noted by Ninedek and Kolt,\textsuperscript{8} clinical experience was a challenge to quantify. Two health professionals might have a similar number of years of experience but have vastly different levels of experience in dealing with injured athletes. For the current study, overall years of experience were used, but variability was entirely possible and must be taken into consideration.
In conclusion, this study explored the perceptions health professionals have with regard to the roles they play and their influence on the psychological recovery of their clients. Valuable insight was gained through the interviews with the health professionals, which revealed many interesting findings about the roles and influence health professionals perceive themselves to have on the psychological recovery of their clients, which they believe happens in part by purposefully attempting to establish a caring and supportive environment. The health professionals clearly articulated that they believe they do play a significant role in the overall recovery of their clients and have an influence through their unique roles of rapport builder, educator, and communicator on the psychological recovery from injury. In addition, these roles serve to augment the mechanisms of influence health professionals referred to earlier as 3 Ts of influence, those of trust, time, and touch, which can have a positive impact on the rehabilitation process. Building trust with clients through a concerted effort to take time to listen and to genuinely demonstrate care when touching clients appropriately during assessment and treatment conveys a sense of caring that is a unique feature of the healing professions.

As has been noted by previous researchers, health professionals have highlighted an interest in learning more about psychological skills and how to employ them in their practice to better facilitate the recovery process for their clients, but they also recognize that they lack the knowledge or training in how to apply these skills with their clients. This finding was consistent in the current study and further provides support for the recommendation of Wiese et al. and Heaney that sport psychology consultants work with the many health professionals both to help them apply basic skills and to support the work of sport psychology consultants. Based on the specific roles identified in this study, it is recommended that health professionals gain this specific knowledge and understanding during their training if at all possible to better facilitate the recovery process for their clients. In a pleasant, unplanned result of the current study, some of the health professionals, managers, and owners made a specific request that I serve in this role. Because many researchers have commented on the significant roles these professionals can play, coupled with the support from this study, it is highly recommended that sport psychology professionals and various health professionals make a commitment and move to action, or continue to coordinate if already doing so, to offer the best possible recovery process for all injured people.

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References


