A Powerful Therapeutic Alliance to Overcome Barriers Treating a Patient with Complex Neurological Dysfunction in Acute Care Physical Therapy

Karlie Bless, PT, DPT; Kent E. Irwin, PT, DHS, MS, GCS; Elizabeth Campione, PT, DPT, CLT-LANA
Midwestern University, College of Health Sciences, Physical Therapy Program, Downers Grove, IL

INTRODUCTION

- Eighteen percent of scheduled acute care physical therapy appointments do not occur secondary to patient refusal mainly due to decreased patient motivation and a negative rapport with the physical therapist (PT).[1]
- A therapeutic alliance is referred to as a positive working relationship between a healthcare provider and a patient.[2]
- The eight key elements of a therapeutic alliance include patient expectations, personalized therapy, partnership, therapist roles and responsibilities, congruence, communication, relational aspects, and other influencing factors.[3]
- An internal health locus of control consists of a patient's perception of complete control of health outcomes, while an external health locus of control involves a patient's perception that outside forces, such as destiny, have control on health outcomes.[4] An external locus of control can lead to lack of motivation.[5]
- A strong patient-PT alliance can significantly increase patient participation, providing an opportunity for improved therapeutic outcomes.[6]

- **Purposes of this case report**: (1) to demonstrate how a positive therapeutic alliance created resilience to overcoming internal and external barriers in treating a patient with complex neurological dysfunction in the acute care setting, (2) to describe how the treating PT achieved a positive therapeutic alliance with the patient, and (3) to bridge the gap between the relationship among a strong therapeutic alliance, health locus of control, and therapeutic outcomes in the literature.

CASE DESCRIPTION

- The patient was a 27-year-old female admitted to an acute care facility from an outside hospital (OSH) for further evaluation and workup secondary to experiencing progressive sensorimotor polyneuropathy of unknown etiology.
- The patient underwent a sleeve gastrectomy procedure three months earlier and had a history of nutritional deficiency.
- Patient's functional mobility deteriorated from fully independent in all ADLs and IADLs to maximum assistance.
- Patient sustained a fall with physical therapy at the OSH which led to a lack of trust in working with PTs.
- The patient's goals included decreasing pain and increasing strength in her lower extremities in order to regain independence in ADLs and IADLs.

INITIAL EXAMINATION

ICF Model Evaluation

HEALTH CONDITION Unknown		
BODY STRUCTURE AND FUNCTION	**ACTIVITY**	**PARTICIPATION**
Impairments: • Decreased force generating capacity in (B) wrists, hips, knees, and ankles. • Neuropathic pain upon AROM/PROM, tactile stimulation, and weight bearing • Lack of sensation on plantar aspect of feet (medial and lateral plantar nerve involvement)	**Ability:** • Rolling • Reaching • Maintaining independent sitting at EOB (trunk control) **Limitation:** • Manipulating objects • Self-care activities • Supine to sit • Sit to stand • Bed to chair	**Ability:** • Speaking • Directing care to family members **Limitation:** • Independent eating • Ambulation • Work related activities: sit to stand, prolonged standing, manipulating a keyboard, etc.
ENVIRONMENTAL FACTORS		PERSONAL FACTORS
Supportive: • Wrist splints and PRAFOs administered • Therapeutic alliance with PT **Limitation:** • Lack of diagnosis • Therapy department lacking bariatric equipment • Lack of communication between health care providers		**Supportive:** • Family support **Limitation:** • Morbid obesity • Family resides in a different state • Displayed resistance to therapy/distrust in therapy • Depression • Lives alone • Learned helplessness • External health locus of control

- **Mobility:**
  - Side-lying to supine*:* Independent
  - Supine to sit: Maximum assistance x 2
  - Bed to chair: Total assistance via Hoyer lift
- **Psychological status:** Patient displayed characteristics of depression such as a flat affect, minimal talking, lack of participation in the evaluation, and alluded to lost hope of recovery

INTERVENTIONS

- Patient and family education on clinical condition, results of evaluation, clinical reasoning to determine POC, HEP, and importance of compliance.
- Preventative techniques: splinting of (B) wrist and ankles, PROM from family, Hoyer lift assist from bed to chair, and frequent positional changes.
- Progressive UE and LE strengthening
- Functional mobility training
- Discharge planning

OUTCOMES

- Patient was seen for 11 PT sessions
  - Minimal strength improvements
  - Achieved goals of supine to sit with moderate assistance x 1 and sit to stand with maximum assistance x 2
  - Remained functionally limited
- **AM-PAC "6 Clicks"**
  - Exam: 10/24; DC 8/24 (MCID = 3.3-5.1).[7]
- **Numeric Pain Rating Scale**
  - Exam: 7/10 in hands and feet; DC: 6/10
- Patient displayed increased willingness and motivation to participate in therapy.
- Patients was more agreeable to the progression of new and existing exercises and demonstrated adherence to the HEP.
- Patient demonstrated buy-in to PT treatment and respect shown to PT.
- Patient was agreeable to transferring to an inpatient rehabilitation facility to continue therapy.

DISCUSSION

- This case demonstrates the power that a strong therapeutic alliance can have on a patient's willingness to participate in physical therapy, as those with a high external locus of control are not willing to participate in therapy.
- Physical therapy education was critical, as it demonstrated the therapist's investment in the patient and establishes the trust necessary for formation of a therapeutic alliance.[8] Education can also improve a patient's self-efficacy, as it empowers patients to participate.[9,10]

CONCLUSION

- This case report identifies strategies to be used by acute care PTs to successfully form a therapeutic alliance. Interactions in this case demonstrate the need for PTs and other acute care providers to emphasize the importance of creating a therapeutic alliance with patients. In this case, a therapeutic alliance was successful in increasing the patient's internal health locus of control, thus improving motivation to participated in her medical care.

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