Perspectives On 'Person-Centeredness' From Neurological Rehabiliation and Critical Theory: Toward a Critical Constellation

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Abstract

This interdisciplinary article addresses the putative gap between person-centeredness and the biomedical model of physiotherapy. We draw both from a primary qualitative study and philosophical praxis to critically evaluate person-centeredness. We suggest that because person-centeredness is difficult to define, conceptual clarification can hardly optimize person-centered practice. Rather, drawing on the Frankfurt school critical theorist, Theodor W. Adorno, we argue it is more helpful to accept its elusiveness as an anti-positivist 'constellation' of multiple ideas that critically guide practice. The original purpose of the qualitative investigation was to explore with informants a key question: What matters to them the most in their physiotherapy? The data was generated in 13 semi-structured focused interviews and analyzed using Interpretative Phenomenological Analysis. The findings demonstrate that both evidence-based and person-centered perspectives matter, but according to research they do not always fit together without difficulties. To address this, we suggest that the experiencing and meaning-making embodied person needs to be brought on par with the biomedical object-body of positivist physiotherapy. Person-centeredness recast as a critical constellation (as described in Adorno's magnum opus *Negative Dialectics*) works toward this goal because it addresses the narrowness of the biomedical model by drawing widely on human sciences—not excluding biomedicine—as a source of meaningful knowledge. It also draws attention to critical issues that are difficult to research using only biomedical methods. Recasting person-centeredness as a constellation therefore helps to create an awareness among practitioners and students about a variety of issues that might affect person-centeredness in clinical practice.

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Introduction

"Philosophy will not dispense with truth…but will illuminate the narrowness of scientific truth."

—Theodor W. Adorno[1]

Physiotherapy research has seen an increase in thinking outside the dominant biomedical model. Despite the development of critical thinking about physiotherapy, the assumptions of the still-dominant positivistic biomedical paradigm that values objective science above any other approach and sees the body-as-machine as a problem to be fixed, go unchallenged in the mainstream.[2-9] The dominance of what according to Max Horkheimer[10] might be called a traditional paradigm—one that draws on Cartesian science and positivism—is evident, for example, in how critical physiotherapy research is still grossly underrepresented in rehabilitation publications.[11] Physiotherapy research has largely concentrated on the effectiveness of interventions.[9] Effectiveness of interventions—the research aims of direct utility, generalizability and applicability—fit the ideal of positivism whereas critical transformative ideas that challenge physiotherapy's taken-for-granted conceptions and practices do not, not at least without resistance.

In this article, we assume for the sake of argument that there indeed is a gap, although not a necessary one, between the traditional physiotherapy paradigm and critical physiotherapy. We frame the gap in terms of the difficulty of fitting person-centeredness comfortably with evidence-based practice—keeping in mind that biomedical physiotherapy and evidence-based practice are not the same, but simply fall under the same positivistic paradigm. In our view, the uncomfortable relationship between person-centeredness and evidence-based practice is evident in the policy statement and glossary definition of evidence-based practice by the World Confederation for Physical Therapy (WCPT):

> **Evidence-based practice (EBP)—**is an approach to practice wherein health professionals use the best available evidence from systematic research, integrating it with clinical expertise to make clinical decisions for service users, [emphasis added] who may be individual patients/clients, carers and communities/populations. ...It involves complex and conscientious decision-making based not only on the available evidence but also [emphasis added] on patient characteristics, situations, and preferences. It recognises that health services are individualised and ever changing and involves uncertainties and probabilities.[12]

The policy statement, unwittingly perhaps, confirms that patient characteristics, situations, and preferences—arguably these pertain to person-centeredness—are something additional rather than integral to 'evidence' from systemic research that, according to the same statement, "includes, but is not limited to, meta-analyses, systematic reviews of randomised controlled trials (RCTs), individual RCTs, systematic reviews of cohort studies, individual cohort studies, outcomes research, systematic reviews of case-control studies, individual case-control studies, case-series and expert opinion."[12] We argue that the statement is problematic: evaluating which characteristics, situations, and preferences are relevant is still in the hands of the practitioner, keeping decision-making practitioner-led rather than person-centered or shared.

Our assumption of a gap is based on the simple

possibility that evidence-based practice is not always person-centered despite the ideal of the WCPT. We acknowledge that integrating evidence-based practice with person-centeredness can also be successful. However, we are interested in the possibilities of unsuccessful integration, because it offers a starting point for a critical ethical investigation.

Our approach is a collaboration between qualitative research and philosophy. We draw both from a primary qualitative investigation and critical philosophical inquiry. The aim is to find ways to address both practical and conceptual difficulties of person-centeredness.

INVESTIGATION AND INQUIRY

The empirical investigation was guided by a person-centered question: What might people who receive neurological rehabilitation find particularly meaningful in their physiotherapy?

The philosophical inquiry draws on the work of Theodor W. Adorno and takes a critical look at person-centeredness by asking: What does it mean, from a philosophical perspective, to put the person at the 'center' of physiotherapy practice?

For the empirical section, the first author (JA) conducted 13 semi-structured focused interviews and analyzed the material using Interpretative Phenomenological Analysis (IPA).[13-14] Four themes regarding the particularly meaningful aspects of physiotherapy were identified:

1. Being heard and listened to
2. Having positive physical experiences
3. Having out-of-the-ordinary physiotherapy sessions
4. Trusting the physiotherapists and their skills

After the empirical analysis, both authors engaged in a critical philosophical dialogue concerning the findings and their implications. We argue that the four themes do not only reflect aspects of person-centeredness but also traditional evidence-based physiotherapy. This finding worked as the basis of our philosophical praxis.

We acknowledge that many physiotherapy practices rely on numerical information about the human body and, therefore, physiotherapy needs quantitative science and knowledge; but there should also be room for critical interrogations. Our critique does not aim at dispensing with quantitative science. We argue, however, that because physiotherapy involves complex social and bodily interactions,[2-6,8,15] which demonstrate its intrinsic moral nature,[16] quantitative science does not suffice to encompass the practice of contemporary physiotherapy in its entirety.[3]

In our view, acknowledging that physiotherapy is dependent on both empirical knowledge and theoretical understanding does not help to move beyond the putative gap between the two but throws the gap into an even sharper relief. Therefore, instead of person-centeredness being an add-on to evidence-based practice, as the WCPT's policy statement seems to suggest, it should be recast in a critical and disruptive manner that draws attention to the dominance of positivism. To do so, we argue, person-centeredness should get rid of all its own traces of positivism. Positivism only recognizes knowledge that can be verified with quantitative scientific methods as valid.[17] Therefore, to scientifically affirm precise knowledge of what person-centeredness is falls under positivism. In contrast, to recast person-centeredness as critical of positivism means that physiotherapists should embrace the intrinsic ambiguity and complexity of

person-centeredness, both as a concept and a practice, and accept the possibility that unanimity about what person-centeredness is might be impossible to reach.

Adorno's thought is notoriously complex; it is impossible to be exhaustive of his work here. For our purposes, it is sufficient to understand roughly what Adorno means by 'negative dialectics' and 'constellations.' Adorno states that negative dialectics is not a method or a dogmatic world-view.[1] It is rather a critique of what he calls 'identity thinking.' Identity thinking, according to Adorno, seeks to know objects according to all the possible and correct classifications and concepts under which objects fall. Although we cannot think without identifying, Adorno argues, identity thinking is nevertheless problematic because it necessarily falls short of capturing the particularity of objects. Negative dialectics seeks to demonstrate the insufficiency of any given identification.[1] 'Constellations' relate closely to negative dialectics. Adorno suggests that instead of identifying an object with an overarching classificatory concept, concepts "enter into a constellation…[that] illuminates what is specific in the object, that which is burdensome or a matter of indifference to a classificatory procedure."[1(p162)] Constellations of concepts around objects, therefore, reveal more particular knowledge about the object.

STRUCTURE

We begin by explaining our starting point in two interrelated problems of person-centeredness: practical difficulties and conceptual difficulties. We suggest that because person-centeredness is difficult to define, clarification of person-centeredness as a standardized concept can hardly help to optimize person-centered practice. Rather, drawing on Adorno's magnum opus *Negative Dialectics*,[1] it is more helpful to think of person-centeredness as a 'constellation' that critically guides practice. We then explain our methodology and present the findings of the empirical work. Finally, we discuss the findings to further analyze person-centeredness.

We conclude that a critical constellation around person-centeredness aims at creating an awareness of the ever-present possibility of non-person-centered practice in physiotherapy by drawing attention to critical areas of physiotherapy scholarship. We invite readers to remain open to the possibility that conceptual clarifications and definitions are not, as Adorno argues, the be-all and end-all of knowledge.[1]

Should We Define Person-Centeredness? Moving From a Concept Toward a Constellation

Person-centeredness, patient-centeredness, client-centeredness: the way practitioners, researchers, and other stakeholders refer to the concept and practice vary. For the sake of clarity, we use 'person-centered' throughout this article to refer to all the related concepts. We return to the different meanings attached to person-centeredness below.

Person-centeredness has been approached in physiotherapy research from different points of view: goal-setting in rehabilitation,[18-20] developing assessment tools for evaluating person-centered practice,[21] considering disabled persons' and their families' perspectives,[22-23] communicating in a person-centered manner,[24] examining practitioner and student perspectives,[25-27] identifying the outcomes of implementing a person-centered framework,[28] and

developing person-centered skills through research-led drama.[29]

Person-centeredness has also been applied to telerehabilitation and passive assistive technology,[30-32] which represents a deviation from the more usual use of the term that describes different qualitative and psychosocial aspects of person-to-person care—as opposed to care standardized by technology—such as respecting and empowering patients as persons.[33-34]

Although there is less research on person-centeredness in physiotherapy compared to other areas of healthcare such as nursing, medicine, and mental health,[35] its varied implementation, as demonstrated above, shows that it has made its way into physiotherapy as a valued goal. There is also some physiotherapy research on person-centeredness that might be termed critical (we discuss some of this research below) but considerably less so compared to more conventional approaches. To understand what criticality might entail, Barbara E. Gibson provides a helpful list of central tenets: questioning the taken-for-granted, attending to power relations, and critiquing the dominance of positivism.[36] We return to these tenets in the discussion.

No Agreed-Upon Meaning

In this section, we address the tension between conceptual complexity on the one hand, and the resulting lack of normative content (ie, lack of an evaluative standard for behavior and action) on the other. Currently, both physiotherapy and healthcare in general lack unanimity on the meaning of person-centeredness.[35] Leplege et al have identified four possible meanings: addressing the person's specific and holistic properties; addressing the person's difficulties in everyday life; considering the person an expert on their own condition, emphasizing participation and empowerment; and respecting the person 'behind' the impairment or the disease. They argue that the vagueness of the concept and the possible clashes between different definitions are problematic—so much so that they suggest we ought to keep the values but stop using the term.[33]

Another conceptual problem arises with new technologies, such as telerehabilitation.[30-31]This raises the question whether person-centeredness ought to be redefined in the new context. In addition to the different understandings among physiotherapists, there are also varying understandings among different stakeholders such as patients and decisionmakers, which brings further conceptual ambiguity.[35,37] Dukhu, Purcell, and Bulley argue that the lack of a standardized definition reflects the complexity of the concept of person-centeredness and makes meeting expectations of person-centeredness in physiotherapy problematic.[38] The problem they point out can be formulated in philosophical terms as an impassable aporia: the concept of person-centeredness lacks normative content, but its very own conceptual complexity restricts clarifying its normative content. How indeed do physiotherapists meet expectations of person-centeredness, if they do not know what the expectations are? However, it is equally problematic to standardize a definition because it would standardize the practice—one size fits all—which is exactly contrary to the person-centered ideal of encountering each person as a unique individual.

Might a clear definition be of any help? Jesus et al argue that "it is unlikely that person-centredness can be optimally attained without improved conceptual clarification."[35(p2)] Gzil et al argue similarly that what rehabilitation needs is not "more person-centredness," because "person-centredness is less a way forward for rehabilitation than it is a considerable challenge

requiring not only greater conceptual clarity but also methodological advance."[39(p1623)] Both of these conclusions are, however, equally unhelpful because physiotherapy practice does not pause to wait for clearer conceptual definitions for optimizing person-centeredness. Moreover, conceptual clarification does not in itself guarantee person-centered practice because a standardized definition might not work in all possible situations.

We are not saying that we ought to abandon concepts and definitions. Rather, we need another way of thinking about defining person-centeredness that is more pragmatic, contextual, and open-ended. In our view, a complex concept that refers to a complex practice is best defined in multiple different ways—as a constellation of concepts transforming *ad infinitum*—and used in variable ways in various contexts. We will return to the idea of constellations shortly.

ACCEPTING ELUSIVENESS: LOOKING BEYOND REDUCTIONISM…

We argue that accepting the conceptual elusiveness of person-centeredness is a critical device to draw attention to the dominance of positivism and its problematic criteria for knowledge. Positivism rejects metaphysics as meaningless, and elevates empirically-observed verification and quantitative science to the criteria of truth.[17] Seeking a clear definition of person-centeredness, and refusing to tolerate conceptual ambiguity, resonates with positivism and Wittgenstein's famous statement that "[w]hat we cannot speak about we must pass over in silence."[40(p89)] Instead, to disrupt positivism's conceptual reductionism (since reductionism is problematic when it comes to complex concepts and practices), we suggest that person-centeredness ought to look beyond reductionist definitions and conceptualizations.

As we indicated above, current research has not reached unanimity on what person-centeredness is. Perhaps unanimity is unreachable because person-centeredness is a whole complex of ideas, concepts, definitions, understandings, and practices that interact in different situations, with various people, and in different cultures in many ways. Attempting a standardized definition necessarily simplifies person-centeredness and whitewashes difference by silencing discourses that deviate from the standard.

…TOWARD A CONSTELLATION OF CONCEPTS

We do think that it is helpful to have some kind of idea of how to approach person-centeredness. We suggest that person-centeredness can be thought of metaphorically as a 'constellation' of concepts (definitions, ideas, understandings, meanings, connotations) that surround an object (person-centeredness). Adorno uses Walter Benjamin's41 metaphor of constellations (that ideas are to objects what constellations are to stars) to critique 'identity thinking' that claims to have grasped particulars by categorizing them under universals: to putatively know the object is to attach all possible correct classifications to it.1 However, Adorno argues, categorization does not reveal truth but instead loses sight of particularity because the concept of the object and the object are not the same (not identical). Adorno suggests that constellations stay true to particularity by approaching objects as a process necessarily bound to history (time and place). Therefore, constellations are not universally fixed and they tell us more about objects than standardized definitions. As Adorno writes:

> Cognition of the object in its constellation is cognition of the process stored in the object. As a constellation, theoretical thought circles the concept it would like to unseal, hoping that it may fly open like the lock of a well-guarded safe-deposit box: in response, not to a single key or a single number, but to a combination of numbers.[1(p163)]

Gillian Rose provides a helpful explanation of how Adorno intends to use constellations: "To examine something by a 'constellation' means to juxtapose a cluster of related words or connotations which characterise the object of investigation without implying that the concepts used are identical with their objects."[42(pp116-117)] Adorno uses constellations, Rose explains, because the object cannot be captured by simply attaching a concept to it. Rather, she further elaborates, "a *set* of presentations may best approximate it [original emphasis]."[42(p17)]

In the next section, we explore the possible 'presentations' that might enter into a constellation around person-centeredness in physiotherapy.

A Constellation Around Person-Centeredness In Physiotherapy

Leplege et al's work briefly summarized above provides a helpful shorthand about the meanings that have been attached to person-centeredness in general. In this section, we discuss research in rehabilitation that has emphasized critical ideas that might enter a constellation around person-centeredness, such as care and compassion;[43] empowerment and shared decision-making;[44] drawing attention to contextuality, justice, and how power operates;[45] promoting relationality;[46] and 'tinkering' with person-centered rehabilitation.[47] The research we discuss below emphasizes collaboration from two intertwined perspectives: care and justice.

ASSEMBLING CRITICAL IDEAS AROUND PERSON-CENTEREDNESS

MacLeod and McPherson suggest that more attention needs to be paid to care and compassion: if physiotherapy leans too heavily on advancing techniques as ends in themselves, physiotherapy may fail at person-centeredness. The authors argue that care and compassion facilitate psychological, spiritual, and social wellbeing, and that a compassionate perspective might guide practitioners toward care that is truly person-centered, empathetic, and collaborative.[43]

Ward et al also emphasize collaboration but from the point of view of empowerment. They found in their qualitative study on person-centeredness that physiotherapists emphasize the need to empower patients through education to enable shared decision-making.[44]

Durocher et al found that practitioners understand person-centeredness in different ways, recognizing that while respecting autonomy is important, not all patients have it. The authors argue that "autonomous action is mediated through relational, social, cultural, economic, contextual, situational, and political dimensions, and that power circulates in its enactment" drawing attention to how autonomy is constrained or enabled, and how circumstances promote or prohibit justice.[45(p297)]

Bright et al's autoethnographic study highlights relationality and collaboration as the basis for person-centeredness. They argue that person-centeredness

entails listening and 'being with' rather than 'doing to' patients.[46]

Finally, Gibson et al suggest that the idea of 'tinkering' is potentially a useful way to approach person-centeredness. Tinkering involves a continuous questioning of what to do, what might be the best, and what might person-centeredness mean in different situations and moments of care.[47]

The research above forms a constellation: care and compassion;[43] empowerment and shared decision-making;[44] drawing attention to contextuality, justice, and how power operates;[45] promoting relationality;[46] and 'tinkering' with person-centered rehabilitation.[47] This sketch of a constellation gives an idea of what person-centeredness might include, but should remain open-ended so that countless other understandings might enter into it.

CONSIDERING POSSIBLE BARRIERS

We suggest that a constellation around person-centeredness should also consider possible internal and external barriers that might have an adverse effect on implementing person-centeredness. As examples, we briefly introduce three studies that have addressed barriers to person-centeredness in the context of physiotherapy.

In an autoethnographic reflection on person-centeredness in the biomedical paradigm, Mudge et al argue that person-centeredness not only causes potential clashes between patient perspectives and expert knowledge but also leaves physiotherapists unprepared for the emotional labor caused by a number of factors. These are: 1) having to practice in a person-centered manner in challenging situations, such as dealing with patients who have potentially unrealistic goals; 2) lacking tools to recognize patients as experts worth collaborating with; and 3) lacking flexibility to assign or assume responsibility with changing situations.[48]

Another barrier that practitioners might experience is lack of time and resources. Durocher et al's study on discharge planning found that person-centeredness is considered too time-consuming when time, resources, and services imposed by health policies are already constrained.[45]

A study by Philips et al also exemplifies possible barriers. The authors found that the role of the patient-as-professional has a potential to improve healthcare delivery and person-centered care, but not all patients want to be involved or have the capacity to be involved on the level that the patient-as-professional role requires. On the other hand, those who can and want to be involved demand more time from practitioners than often is available.[37]

These possible barriers are of course not exhaustive of the practical problems of person-centeredness. What they do demonstrate is that conceptual clarification is not sufficient to address all of the possible difficulties of implementing person-centeredness. Consider the three examples of barriers and how they might be overcome:

- Mudge et al's analysis suggests it might be helpful to clarify the relationship between biomedical knowledge and patient perspectives, and to consider how to negotiate between the two perspectives. In such negotiation, conceptual clarifications might prove useful; but so might challenging the taken-for-granted assumptions of both person-centeredness and the biomedical paradigm.

- In turn, the barrier Durocher et al perceive—time and budgetary constraints—is not reconciled simply on a conceptual level but rather requires drawing attention to the macro-level of rehabilitation: social, economic, and political constraints.

- Finally, the barrier Philips et al perceive—that patients are not necessarily willing or capable of making decisions—might again be reconciled with some conceptual clarification: sometimes person-centeredness might mean that the professional assumes decision-making responsibility. However, in our view, adding an opposite definition (practitioner-led practice) to person-centeredness only further highlights that person-centeredness is complex, and neither its definition nor the solutions to its practical problems are reconciled by reducing the complexity to a standardized definition.

In some cases, it may even be more helpful to approach person-centeredness by thinking what it is *not* rather than affirming what it is. To argue that person-centeredness *is not* paternalistic practice that treats persons as mere means or standardized objects is less disputable than to argue that person-centeredness *is* necessarily one thing or another. This observation offers some shared ground for a diversity of discourses, even disagreement and criticism, that might enter into a constellation around person-centeredness.

In the following two sections, we introduce the empirical work that we suggest demonstrates some of the complexity of person-centeredness discussed above. We then discuss the findings *vis-à-vis* constellations and person-centeredness.

The Empirical Work

The empirical data was originally generated for the first author's master's thesis.[49] The question that guided the empirical work was: What do people receiving neurological physiotherapy find particularly meaningful in their rehabilitation?

Research ethics approval was obtained from the first author's institutional review board.[49] The first author obtained consent from each participant for the interviews. She also obtained permission from each participant to re-use and re-analyze the data for the current article. The data provided useful material for the purposes of this article on what person-centered aspects might matter to people in neurological rehabilitation, which then guided our philosophical inquiry (explained below) that asks: What does it mean, from a philosophical perspective, to put the person at the 'center' of practice?

The data was generated by the first author with 13 informants, each of whom participated in a semi-structured focused interview. The interviews took place in a privately-owned rehabilitation center in Finland that provides publicly-funded outpatient rehabilitation for people with long-term neurological impairments. All of the informants received rehabilitation in the center. They were recruited by asking each physiotherapist employed in the rehabilitation center (n=12) to recruit one or two of their clients who were willing to share their experiences and had specialized knowledge of rehabilitation (=informant).

The informants were between 24 to 67 years of age. Seven were men and six women, and all had a long-term neurological condition including cerebral palsy, stroke, spinal cord injury, multiple sclerosis, and

muscular disease. The informants had physiotherapy 1 to 3 times per week. Eight of them had been going to physiotherapy for more than 15 years, two of them less than 10 years, and three less than 18 months. In addition to physiotherapy, two informants had occupational therapy twice a week, two met with a neuropsychologist once a week, and one received lymphatic therapy. The duration of the interviews was between 45 to 90 minutes. The first author anonymized and transcribed the recorded interviews. The anonymized transcript was 142 pages (single-spaced). The first author then analyzed the material using Interpretative Phenomenological Analysis (IPA), described by Smith et al.[13-14]

The aim of IPA is to help researchers gain detailed understanding about how informants make sense of a phenomenon and how they attach meaning to experience.[13-14] IPA was chosen because of its methodological openness that allows researchers to approach phenomena without prior theoretical assumptions. IPA is described as 'double hermeneutic' because the interpretation process assumes that while the informants are trying to make sense of their experience, the researcher is trying to make sense of the informants' meaning-making. Therefore, the resulting knowledge is a co-constructed meaning between both the researcher and the informant, and the researcher has an active role in the process of meaning-making.[13-14] IPA is also described as ideographic. Ideography pays attention to specific recurrent details in informants' meaning-making.[13-14]

The first author, who conducted the interviews, also analyzed the data in order to ensure continuity between the interviews and interpretation, which helps in paying ideographic attention to detail. During the entire process from interviews to interpretation, the possible effects of specific neurological impairments to communicating experience (both verbally and in an embodied manner) were taken into account. The first author is a physiotherapist with considerable experience in neurological rehabilitation, which aids in understanding these possible effects. We would like to point out that the researcher's subject-position as a physiotherapist also shapes the co-construction and interpretation—for example, which additional questions are asked or which quotations are selected as representative of the discussion. However, acknowledging the subjectivity of the researcher is not a methodological flaw. Rather, it is integral to qualitative research and, when recognized and reflected upon, it plays an important part in data co-construction.

INTERVIEW PROCESS AND ANALYSIS

The first author designed a semi-structured interview process that aimed at creating a safe conversational environment. The interviews started with unstructured chatting about rehabilitation to set a comfortable atmosphere. The initial conversation then guided the order in which the semi-structured questions were raised by the interviewer, reflecting the co-constructive aims of IPA. The semi-structured questions provided a basis for the interviews that were further guided by the details the informants raised. During the interviews, spontaneous stories and off-topic conversation were allowed.

The thematic analysis was done in the following steps:

1. Reading the transcriptions while listening back to the audio and writing down remarks about the way informants are telling the story, while paying ideographic attention to emotions and recurrent descriptions, and also choosing quotations that describe the stories told. In

transcription and analysis, attention was paid to pauses and expressions that are relevant to the data, such as laughs and sneers.

2. Preliminary collecting and grouping together recurrent stories and details from the interviews.

3. Identification of themes in the preliminary groupings.

4. Ensuring the consistence of the analysis by reading the transcriptions through once again while keeping the themes from step three in mind, simultaneously refining, defining and naming the themes.

After the empirical work, both authors engaged in a critical philosophical dialogue in the collaborative spirit of Frankfurt School critical theory,[10,50] led by the second author. Our philosophical praxis draws on Adorno's work and the idea of philosophy as the "practice of theory as critical thought."[16(p59)] The aim of our collaboration is to avoid reducing theory and practice into dichotomous sides serving one another, which maintains a separation between the two.[51] We maintain that a fruitful collaboration that might move beyond a gap between theory and practice requires mutual respect and recognition between disciplines, and acknowledges the specificity of knowledge that each discipline requires and offers.

Results: What Might Matter the Most In Neurological Rehabilitation

We identified four themes across the informants' accounts regarding what was particularly meaningful to them in their physiotherapy:

1. Being heard and listened to

2. Having positive physical experiences

3. Having out-of-the-ordinary physiotherapy sessions

4. Trusting the physiotherapist and their skills

The themes were prevalent across all accounts regardless of informant age, gender identities, or diagnostic group. The quotations have been translated from Finnish, staying as true as possible to the original intentions and tone of the statements.

BEING HEARD AND LISTENED TO

The first theme, being heard and listened to, includes both *auditory* and *tactile* aspects (informants 1–4, 7, 8, 13). Auditory listening was described in terms of not being listened to, which led to having to do unfit exercises that could cause pain. Not being listened to was also described in terms of the physiotherapist's inflexibility when choosing exercises. One informant aptly reflected the inability to listen and inflexibility:

"…And there are unfortunately many among physios who don't listen or they listen like 'yeah, yeah,' but then they continue anyway the same, even if you've just said that that style, to me, you have to do those movements in a slower pace, that my body can't take it. […] Then they are just like, 'okay,' and it takes a moment and they return to the same routine. That I don't like. Because that shows that they don't listen. Instead they think they are the physio and know what to do and do it in their deep-seated way." (informant 2)

Tactile listening through hands-on techniques was described as something that helps ease symptoms.

Finding the right level between softness and firmness of touch was mentioned as an important skill of the physiotherapist. Tactile listening through touch was also described as an indispensable component of the physiotherapist's skills:

"Because of my illnesses it's a very peculiar way that people need to handle my body. Especially depending on the strength of pain, it differs from session to session, how to handle me. We've had to learn with [my physiotherapists] how to take care of me. It's constant detective work all the time." (2)

"What would be bad here [pondering]. That [xxx] isn't my physio anymore. S/he was truly brilliant. You have no idea how good s/he was. S/he only had to touch. Years of experience. […] A physio who doesn't have professional skills at all. That would be quite bad. You can immediately tell, exactly from the touch. You sense quite a lot from touch. Now I know what the matter was with a bad physio I had. S/he didn't have professional skills. (informant 3)

A relationship that is based upon listening and understanding was described as an important basis for successful rehabilitation. The following quotation describes a good relationship with the physiotherapist in terms of good chemistry and listening skills:

"We are here in a very intimate relationship with the physio. If the chemistry doesn't work, then nothing works […] It's not about whether I like the other or not but that we understand each other. In other words, that the other knows how to listen." (2)

Being heard and listened to can also consist of respecting the wish to delegate decision-making to the physiotherapist, as one informant stated:

"Well that's his/her professional knowhow, I think it is enough for me that, at least what I've learned coming here for rehabilitation, that they are professionals." (informant 8)

In sum, being heard and listened to consists of listening and respecting wishes about choosing appropriate exercises, listening to the body through appropriate touch and hands-on techniques, showing that the physiotherapist is able to listen, having a good relationship based on listening, and also respecting the wish to delegate decision-making to the physiotherapist. Being heard and listened to were considered important in creating and sustaining collaborative relationships in physiotherapy.

HAVING POSITIVE PHYSICAL EXPERIENCES

The second theme, having positive physical experiences, consists of advancing and achieving functional goals, having a feeling of overcoming difficulties, having tried one's best and given one's all, and having the physiotherapist there to support (informants 5, 8–13). One informant described a functional advancement, the first steps after having a stroke, as an impressive experience that gave hope:

"Well, I guess the first thing that I find really memorable is when we took my first steps with the physio, like, walked so that s/he held my hand and I held her/his neck and then we just walked on. That was a really impressive experience, like [it] made me think that maybe one day this will happen even without help." (informant 10)

Having the feeling of achieving functional goals can also manifest in small advancements. One informant exemplified a small advancement in strength exercise as a positive experience:

"And then there was, for example, that we have done those arm exercises and we were able to add a small additional weight to my right hand. That was really something." (informant 11)

The role of the physiotherapist in having positive

physical experiences was described as 'being there' and supporting. One informant fittingly described both the feeling of having given everything and the role of the physiotherapist:

"Well, the best possible result of a single exercise session would be, and one that I've actually reached many times here, is that I've given all I got and that my physio has been there by my side very focused, supporting me." (11)

To summarize, having positive physical experiences was described as memorable, and discussing the memories often inspired the informants to further narrate their experiences. Having positive experiences can be something extraordinary but also something quite modest. Importantly, the physiotherapist was viewed as having an important supporting and motivating role.

HAVING OUT-OF-THE-ORDINARY PHYSIOTHERAPY SESSIONS

The third theme, having out-of-the-ordinary physiotherapy sessions, consisted of surprises and changes in routine that were found meaningful and memorable (informants 4, 5, 7, 8, 10). Routine can be changed, for example, by trying out new equipment. The quality and diversity of equipment was also mentioned as motivating. One informant mentioned in a dialogue the prospect of trying out new technologies:

Informant: *"You know I have tested the, I don't know what it was but they say they are getting one here, that virtual-reality system so that I could try that out, too."*

Interviewer: *"Do you like that kind of thing, trying things out?"*

Informant: *"Yeah." (4)*

Surprises and changes in routine can also simply consist of doing something spontaneous. One informant described granting wishes about the content of physiotherapy among the usual routine. The following quotation demonstrates aptly all of three themes we have discussed so far:

"I asked that we could do stairs. There are six floors. So my goal is to exercise to attain my goal. We're going all the way up I said, and so we did. That was a wonderful thing. It's like nice variation." (informant 7)

One informant described a physiotherapy session that took place by the beach over a cup of coffee as overwhelmingly wonderful:

"I remember when [xxx] was my physio. S/he said that s/he'll visit my home and then we can walk to the beach and take some coffee with us. We'll go to the beach and take coffee with us. BRILLIANT! Absolutely wonderful, absolutely over-wonderful!" (informant 5)

The third theme of having out-of-the-ordinary physiotherapy sessions is more difficult to summarize because it involves spontaneity. Out-of-the-ordinariness can consist of small changes in routine such as trying out something new (for example, new equipment). It can also consist of listening to wishes and making a simple change of plan to do something the rehabilitee wants to do. It can also be something that is quite ordinary but made extraordinary—and possible—because it is done in the context of physiotherapy, such as walking to the beach to have a cup of coffee.

TRUSTING THE PHYSIOTHERAPIST AND THEIR SKILLS

The fourth theme was trust (informants 5, 7, 11, 13).

More than half of the informants (1-3, 5-11) brought up trust indirectly in the wish to be able to see the same physiotherapist as long as possible which, according to research, is an aspect of building trust.[52] Trust toward the physiotherapist was described as consisting of both technical skills, and sharing and caring, which relates closely to the first theme of being heard and listened to. One informant described trust in terms of skills in assisting transfers, which also pertains to tactile listening we described above:

"When I get on the plinth or a tilt table with [my physiotherapist] I don't doubt for a second that s/he would ever let me fall. It's very important. At the same time when I'm looking, for instance, for a personal assistant, then when the assistant lifts me for the first time I can sense from it whether I can trust or not. It is super-important to have trust [in physiotherapy]." (informant 12)

Trust as sharing and caring also relates to listening and building good relationships in physiotherapy. One informant described trust in terms of building a close relationship with the physiotherapist:

"We have the opportunity with the physiotherapist to have a situation, where we meet twice a week and become close, like then we share things. When it's congenial and stuff. Whether things are bad or good, when you share them, let's say that there's never too many people who care." (informant 6)

To summarize the final theme, trust both toward the skills and the person of the physiotherapist was considered as an important aspect of building a good relationship. Trust toward the service-providing facility in which the physiotherapist is employed was also mentioned by some of the informants as important. Trust toward the service provider was viewed as something that is reflected in the skills and professionalism of the physiotherapist, for example, in how the working environment affects the way physiotherapists encounter patients. Trust toward the service provider was also described in terms of practical matters, from the physiotherapist being on time, to booking future sessions, and having a friendly atmosphere.

Discussion: Toward Critical Physiotherapy

To reflect the complexity of person-centered physiotherapy in the light of the empirical work, we suggest that the four themes we identified reflect physiotherapy as *both* evidence-based and person-centered.

The first theme (being heard and listened to) includes psychosocial values such as listening, supporting, respecting autonomy, and touching that conveys emotions. On the other hand, technical hands-on skills were also found important.

The second theme (positive physical experiences) can be looked at from a biomedical perspective that focuses on achieving measurable outcomes. On the other hand, measuring advancement can motivate, and achieving goals brings up hope and emotions such as joy.

In the third theme (out-of-the-ordinary sessions), surprises and variation motivate to achieve biomedically set goals. They also create emotional memories, which reflects physiotherapy's social and affective aspects.

The final theme (trusting the physiotherapist) is related to both biomedical skills and 'having good chemistry.' The final theme demonstrates that the biomedical and the psychosocial are intertwined in clinical practice.

We suggest that when evidence-based and person-centered practice are successfully integrated, they are often intertwined—as they were in the themes we identified—to the extent that the lines between them may become blurred. As the researchers of a study on occupational therapy aptly conclude: effective person-centered practice means that "the clients expect from the professional to be an authority with regard to biomedical issues and to be a partner with regard to psycho-social issues."[53] We agree, and are not suggesting, therefore, that the biomedical paradigm is irredeemably incompatible with person-centeredness; it is not a matter of choosing between paradigms.[54]

A NETWORK OF STAKEHOLDERS

Rehabilitation is a complex and constantly evolving and transforming practice, and it involves a whole network of stakeholders. In his article on person-centeredness, Christopher D. Ward poignantly suggests that rehabilitation should not be reduced to a linear process of 'effects and causes' that is organized around the individual, and that the needs of 'carers' would be accounted for separately in the process.[55] According to Ward, "clinical problems tend to be dynamic rather than static, changing their form, their content and their meaning in response to social influences. Hence problems come to 'belong' to someone in addition to the identified 'patient'."[55] Rehabilitation is indeed a complex *assemblage*—a Deleuzian expression for thinking in constellations—of practices, concepts, and ideas.[56-57] Therefore, it is not the person alone at its center, because rehabilitation is a social complex of practices that involves both the immediate stakeholders—patients, practitioners, family, and friends—and the macro-level of hospitals, politics, economics, and taken-for-granted norms.

Because rehabilitation is complex, we suggest that any conceptual work, or applying a framework of any kind in this context, ought to be flexible/reflexive. Any conceptual work ought to be an open-ended discourse evolving and changing with the demands of each context.

CONSTELLATIONS AS A CRITICAL MODEL

We offered the idea of constellations to better capture the complexity of person-centeredness and to challenge the covert positivism that manifests in person-centeredness as the need to identify and classify.

Constellations might also offer a helpful critical model to think about rehabilitation on a broader scale: thinking in constellations allows for critical research aims—questioning the taken-for-granted, attending to power relations, and critiquing the dominance of positivism[36]—to be taken more seriously as meaningful sources of clinical knowledge because constellations draw on multiple sources of knowing, not excluding biomedicine. If critical perspectives beyond the biomedical continue to be excluded from any serious consideration as guidance for clinical practice,[11] and if 'persons' are conceptualized in physiotherapy simply on a biomedical basis, concentrating on symptoms and impairments, then the 'person' cannot really be at the 'center' because the biomedical paradigm does not alone account for what it *means* to be a person.

To put it differently, because physiotherapy is still mediated by the positivist paradigm that largely excludes views outside of its ideal of science, person-centeredness remains secondary to it (although not entirely excluded) because the positivistic ethos captures human experience only from its own narrow point of view.

In contrast, thinking in constellations recognizes the need to pay attention to issues that require insight from multiple sources: social and political sciences, medicine, humanities, philosophy, ethics. In our empirical work, the experiencing and meaning-making-embodied persons provided a valuable source of knowledge. We suggest that such knowledge has as much practical value to physiotherapists as quantitative or biomedical knowledge about the human body. Therefore, we suggest bringing qualitative, philosophical, and embodied understanding on par with the biomedical to form constellations around both person-centeredness and evidence-based practice, and to drive physiotherapy toward a critically informed future.

Conclusions

We have argued that thinking person-centeredness through the idea of constellations is more helpful than fixing a definition or a procedure for person-centeredness. The latter would be exactly counter to individualized—or person-centered—care because, simply put, different issues affect different people.

However, whether 'person-centeredness' describes what we have recast as a constellation remains an open question. If the practice that physiotherapists now refer to as 'person-centeredness' is in reality an extremely complex practice, is it possible to place the person (alone) at its center? Does 'centeredness' describe the complexity and dynamics of rehabilitation? Or does thinking through constellations actually 'decentralize' person-centeredness? Does the discourse placing the person at the 'center' make the person a target of rehabilitation rather than an active participant (person at the center *versus* person and practitioner side-by-side)?

A STARTING POINT FOR DISCUSSION

We cannot hope to answer these questions here. Therefore, we suggest that person-centeredness can only work effectively as a starting point for critical discussion, but never be the conclusion. Physiotherapy still needs something to guide its ethics and morals, and 'person-centeredness' seems to have entered healthcare discourse to stay. It will do for now to mark the kinds of moral practices that seek to challenge paternalism. However, we suggest that physiotherapy needs more, not fewer, items to add to the constellation around 'person-centeredness.'

TEACHING THE COMPLEX SOCIOLOGY OF REHABILITATION

To capture the complexity of person-centeredness, physiotherapy would benefit from a greater understanding of the complex sociology of rehabilitation, which we suggest should be integrated into pre- and post-qualification education and continuing professional development. By 'complex sociology' we refer to the countless intertwined issues that potentially affect persons in (or at the 'center' of) rehabilitation. The complex sociology includes, for example, the following:

- Patient as the embodied expert of rehabilitation
- Knowledge and experience of the practitioner
- Continuing collaboration and negotiation between patient and practitioner expertise
- Interaction between different practitioners, patients, and family members

- Interaction of emotions, affect, and bodies (bodies touching, moving, and being moved both emotionally and in space and time)
- Physical and discursive spaces and places, and no-places and other-spaces
- International political economy of rehabilitation and functioning
- Understanding of how power relationships, inequality, inequity, injustice, ableism, racism, ageism, sexism, heteronormativity, geography, and demography operate in a constellation around person-centeredness.

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