

Self-reported therapeutic style in occupational therapy students

Tore Bonsaksen



Key words:

Intentional Relationship Model, therapeutic relationship, therapeutic modes.

Introduction: The client-therapist relationship has long been viewed as important for both the process and outcomes of occupational therapy. The recently developed Intentional Relationship Model introduced six therapeutic modes as different ways of relating to clients. Increasing students' awareness of modes, and increasing their skills in using them flexibly, has the potential of improving their subsequent practice as occupational therapists. This article aims to describe occupational therapy students' affiliation with the therapeutic modes in a variety of hypothesized practice situations. In addition, relationships between the students' affiliation with the different modes are explored.

Method: The study had a cross-sectional design. Data were collected from 31 occupational therapy students in Norway, using the Self-Assessment of Modes Questionnaire. Descriptive analyses, repeated measures ANOVA tests, and correlation analyses were employed in the analytic procedures.

Findings: The students identified the problem-solving mode to be their most preferred way of relating to clients, whereas the advocating mode was the least preferred. High affiliation with the problem-solving mode was significantly associated with low affiliation with the collaborating mode.

Conclusion: Several limitations indicate that caution should be taken when comparing this study with previous research. Nonetheless, differences between the results of this study and previous work on the therapeutic modes are of interest. Possible explanations for differences are discussed, as are implications for practice and research.

Introduction

The quality of the relationship between the client and the therapist is important for the therapeutic process, in which the client engages in meaningful occupations, as well as for the outcomes of therapy. This view is based on early work in this area, including theoretical discussions of the client-therapist relationship as a blend of competence and caring (Peloquin 1990) and qualitative studies of occupational therapists' awareness of and strategies in using different communication styles (Allison and Strong 1994). More recent work, post 2000, has included a survey-based search for a coherent definition of the therapeutic relationship, which has been described as 'a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy, and mutual respect' (Cole and McLean 2003, p49). In addition, occupational therapists' use of various modes of interaction has been described from both therapists' (Eklund and Hallberg 2001) and clients' viewpoint (Palmadottir 2006). Interestingly, Palmadottir (2006) proposed a typology of client-therapist relationships based on the ways in which clients perceived their occupational therapist to share power with and to be emotionally connected to them.

Adding further to this emphasis on the therapeutic relationship, a conceptual model addressing the relational aspects linked with the occupational therapy process was recently developed. The Intentional Relationship

Correspondence to: Tore Bonsaksen, Associate Professor, Oslo and Akershus University College of Applied Sciences — Faculty of Health Sciences, Department of Occupational Therapy, Prosthetics and Orthotics, Postbox 4 St. Olavs Plass, 0130 Oslo, Norway. Email: tore.bonsaksen@hioa.no

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Model (IRM) (Taylor 2008) stresses that interpersonal events — the significant actions and processes that go on between the client and the therapist — are always, and inevitably, charged with emotion, and with the inherent opportunity to solidify or undermine the client–therapist relationship. The occupational therapist should respond to such events by drawing from a large base of interpersonal skills, and combine these with an appropriate understanding of the client's characteristics and needs in relation to the situation at hand. In responding, the therapist will intentionally decide on a certain way of relating to the client.

The longstanding professional emphasis on the therapeutic relationship in occupational therapy has recently gained new momentum with the introduction of the IRM. So far, however, there is little empirical research related to this model and its applications in various contexts, including students in an educational context. Increasing students' awareness of their personal style of communication, and increasing their skills in using styles flexibly according to clients' needs, is important for their subsequent practice as occupational therapists (Brown et al 2011). Therefore, this study is concerned with the use of the IRM with this group of future practitioners.

In the development of the IRM, six distinct ways of relating were identified from interviews with and observations of expert therapists (Taylor 2008). These ways of relating are referred to as the therapeutic modes, and they are described in more detail in previous publications (Taylor 2008, Taylor et al 2009, Taylor et al 2011). In the *advocating* mode, the therapist ensures that the client gains access to the needed resources in order to participate in valued occupations. In the *collaborating* mode, the therapist strongly adheres to the principles of client-centred practice and involves the client in all aspects of the therapeutic process. The *empathizing* mode refers to the therapist making every effort to fully understand all facets of the client's experience. The *encouraging* mode is expressed by the therapist explicitly applauding the client's performance, in order to promote the client with the hope and courage needed for him or her to proceed with the current occupational engagement. In the *instructing* mode, the therapist is likely to assume a teacher-like role, educating the client about issues considered to be important for his or her occupational participation. Finally, the therapist using the *problem-solving* mode will rely on logical reasoning in the relational approach to clients.

Research on the IRM and its applications is in an early phase. The first empirical study investigated the use of therapeutic modes in a sample of 563 practicing occupational therapists in the United States (Taylor et al 2011). The researchers found the encouraging mode to be most frequently used, whereas the empathizing mode was least used. This pattern of mode use was largely the same for therapists working with children, adults, or elderly clients. However, therapists who encountered challenging emotions and behaviors in their clients generally used all modes more frequently than those who did not, and, in particular, the instructing and problem-solving modes were used.

So far, studies of occupational therapy students' affiliation with the therapeutic modes have not been published. The educational program in Oslo, Norway, recently included a seminar with skills training related to the use of IRM as part of the 'Mental Health and Participation' module for undergraduate occupational therapy students. The seminar provided the possibility for conducting this study of the students' affiliation with the therapeutic modes.

In the skills training, the students were instructed to role play a client–therapist interaction based on a previously assigned mental health case study. The role plays were performed in groups of three, where the students in a rotating sequence tried out the roles of client, therapist, and (non-participating) observer. Directly following each of the three role plays, the students would discuss what had taken place in the interaction between the client and the therapist (interpersonal events); how the therapist had responded to the events (use of therapeutic modes); and whether or not the therapeutic response — or shift in response — had made an impact on the following interaction. The skills training session aimed at providing the students with some initial experience with and subsequent reflection upon interaction in the client–therapist relationship, and with the intentional use of therapeutic modes as a way to shape one's response to interpersonal events.

Aim of the study

The present study empirically investigates how occupational therapy students perceive their affiliation with the therapeutic modes. In addition, the extent to which the students' preferences for therapeutic modes are intrinsically linked with one another is explored.

Method

This was a cross-sectional design study of the preferred therapeutic modes in undergraduate, second-year occupational therapy students in Norway.

Participants and response rate

All students (N = 74) undergoing the 'Mental health and participation' module of the Occupational Therapy undergraduate programme at Oslo and Akershus University College in the autumn of 2012 were eligible participants in the study. In total, 31 students (41.9%) completed and returned the questionnaire to the researcher. This being an anonymous survey, sociodemographic data that, used in combination, could identify the respondents were not collected. However, the student cohort as a whole consisted of 13 men (17.6%) and 61 women (82.4%). The mean age in the cohort was 24.6 years. At the time of the study being conducted, the students had not yet participated in practice placement as part of their occupational therapy education.

Instrumentation

The Self-Assessment of Modes Questionnaire was designed to help therapists identify the mode(s) of relating to clients

that they feel are natural or comfortable to them, as well as to identify the types of responses that are uncomfortable (Taylor 2008). The assessment is comprised of 20 short clinical vignettes. A set of different therapist responses to each of these vignettes are listed, all of which are explicitly described as plausible therapeutic actions. The respondent is instructed to check for one (and only one) of the possible response descriptions that he or she feels most inclined to follow in the given situation. Each response option represents one of the therapeutic modes.

Procedure

The students were appropriately informed by the researcher about the aims and procedures of the study, 1 week prior to data collection. The information emphasized that the collected data would be anonymous and would only be used to describe the preferences for therapeutic modes on an aggregated group level. In addition, it was emphasized that participation in the study was optional. No benefits were related to individuals' participation and, conversely, no disadvantages were related to non-participation. The students who decided to participate in the study were also given a choice as to whether to return the questionnaire either directly to the researcher or anonymously, to the researcher's mailbox. The participants completed the questionnaires immediately after the IRM skills training session.

Data analysis

The completed questionnaires included three instances of 'double responses' where the participant had indicated a preference for two different modes as a response to the same item description. In these cases, the participant's response was coded as missing. Six more items had genuinely missing responses, resulting in a total of nine missing responses in the final dataset. This constituted 1.5% of the total amount of data, which was considered acceptable.

Data were entered into SPSS software (IBM Corp. 2010), which was also used for the statistical analysis. Frequencies for the use of each of the therapeutic modes were calculated. In order to determine the participants' relative affiliation with the modes, the frequency of each response mode was divided by 20 (number of items) and multiplied by 100, resulting in six variables containing the percentage score for each mode. Descriptive analyses using mean values (M) and standard deviations (SD) were performed on these variables to assess the students' relative affiliation with each of the therapeutic modes. A one-way repeated measures analysis of variance (ANOVA) was used to assess differences in the students' affiliation with the modes. Bivariate correlation analysis (Pearson's r) was used to assess associations between the six therapeutic modes. Statistical significance was set at $p < 0.05$. However, due to the small sample size, borderline trends ($p < 0.10$) were noticed and reported.

Ethical considerations

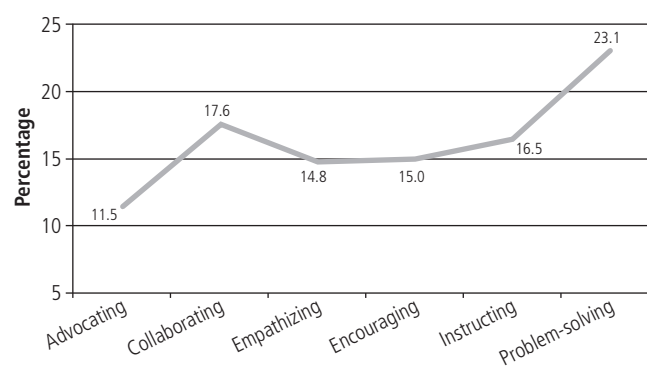
The study was conducted according to standard ethical guidelines for research (World Medical Association 2008) and did

Table 1. Relative affiliation (means and standard deviations) with the therapeutic modes in the sample (N = 31)

Therapeutic modes	Mean (M)	Standard Deviation (SD)
Advocating.....	11.5%	7.3%
Collaborating.....	17.6%	9.7%
Empathizing.....	14.8%	8.3%
Encouraging.....	15.0%	9.4%
Instructing.....	16.5%	8.0%
Problem solving.....	23.1%	10.1%

Note: The sum of mean scores adds to 98.5% due to nine missing responses.

Fig. 1. Affiliation for therapeutic modes in the sample (N = 31).



Note: Values are mean percentage affiliation with the modes.

not require formal research ethics approval. Participation in the study was voluntary and anonymous. Informed consent to participate was implied by the participants' completion of the questionnaire.

Results

Affiliation with therapeutic modes

The results from the descriptive analysis are provided in Table 1, and are illustrated in Fig. 1. The students most strongly identified with the problem-solving mode and identified least with the advocating mode. The repeated measures (within-subjects) ANOVA confirmed that some modes of relating were preferred response alternatives in comparison to other types of responses ($F [5, 26] = 6.60, p < 0.001, \text{partial } \eta^2 = 0.56$). The pairwise comparisons revealed two statistically significant differences; that is, between the problem-solving and the advocating mode (mean difference = 11.6, $p < 0.001$), and between the problem-solving and the empathizing mode (mean difference = 8.2, $p < 0.05$). Despite the students' close to equal preference for the empathizing and the encouraging modes, the pairwise comparison of the problem-solving and the encouraging modes did not reveal a significant difference between the two modes.

Associations between therapeutic modes

The results from the bivariate correlational analysis are provided in Table 2. Higher affiliation with the problem-solving

Table 2. Associations (Pearson's r) between the six therapeutic modes (N = 31)

	Advocating	Collaborating	Empathizing	Encouraging	Instructing
Collaborating	-.34				
Empathizing	-.26	-.08			
Encouraging	-.25	-.15	-.22		
Instructing	-.11	-.21	-.21	-.13	
Problem-solving	.20	-.38*	-.17	-.28	-.30

* $p < 0.05$

mode was associated with lower affiliation with the collaborating mode ($p = 0.036$). Borderline significant trends were found for negative associations between the advocating mode and the collaborating mode ($p = 0.066$) and between the instructing mode and the problem-solving mode ($p = 0.096$).

Discussion

Preference for therapeutic modes

We were not surprised to find that some modes were preferred above others. Theoretically, a preference for therapeutic style corresponds with the therapist's underlying personality and his or her stable and enduring ways of relating to others (Taylor 2008). It was expected that the second-year students participating in this study would have already developed some self-knowledge related to their personal ways of relating. In addition, the skills training performed immediately before completing the questionnaire was aimed at providing a stimulating experience with the use of self in a clinical-like setting. Thus, the students were prepared to respond to questions concerning their relationship style in various situations, as addressed with the Self-Assessment of Modes Questionnaire (Taylor 2008).

There was a preference for the problem-solving mode in this sample (see Table 1 and Fig. 1). The sample being occupational therapy students may indicate intrinsic values related to trying to help others find ways to resolve problems in their occupational lives. Such a formulation of the professional ethos is supported by the outline of the undergraduate programme in occupational therapy at Oslo University (Oslo and Akershus University College 2011), and may give rise to a preference for problem solving as a way of relating to clients. The second most preferred mode, the collaborating mode, is also emphasized in the educational programme as a central value underpinning the work of occupational therapists (Oslo and Akershus University College 2011).

However, the preference for modes in this sample were somewhat different from those expressed in Taylor et al's recent study (Taylor et al 2011). In this study of practitioner occupational therapists in the United States, the encouraging mode was the most preferred therapeutic style, whereas this mode came fourth in the present study. Different samples may contribute to explain the variations between the studies. Students who have little experience from practice may feel drawn towards a problem-solving response type more often than experienced practitioners. The problem-solving approach,

although a sound approach to use in relationship to clients, may have some similarities with the technical rationality underpinning a medical model mindset: The client has a defined problem, and if the therapist can help resolve the problem, the client will be 'fixed'. This represents a type of clinical reasoning

(procedural reasoning) where the therapist tends to rely on abstract procedures rather than deep, contextualized understanding, and this has been shown to be frequent in novice occupational therapy practitioners (Mitchell and Unsworth 2005). Therapists with more experience from occupational therapy practice, on the other hand, may be less oriented towards fixing one defined problem in a quick and efficient way, and may rely more on occupation-focused models emphasizing the client's performing of occupations in a specific, personalized context (conditional reasoning) as the main agent of change and development (Kielhofner 2008, Mitchell and Unsworth 2005). For experienced therapists, thus, providing support and encouragement for the client's doing appears to be appropriate.

It is possible that the context of the study had an impact on the advocating mode being the least preferred mode in this sample. At the time the study was conducted, the participating students were about half-way into the 'Mental health and participation' module, during which issues relating to advocating for the provision and use of resources had received little attention. Traditionally, the students' adoption of an active, collaborative, empathetic, and supportive style of communication in the here-and-now relationship with the client has been more emphasized during this module (Oslo and Akershus University College 2011). If the students perceived unequal value being placed on the different therapeutic modes by the faculty teaching in the module, this may have had an impact on their responses to the questionnaire items, regardless of the anonymity granted to all participants. The tendency of responding in line with what is perceived as socially desirable is a common source of bias (Kielhofner 2006, Polit and Beck 2004).

The results of the study showed relatively large variations within the sample, related to the preference for each of the therapeutic modes (see Table 1). Recent research on listening and communication style preferences among occupational therapy students in Australia similarly suggested that variation within groups is likely (Brown et al 2011). In this study, the students had a preference for communication styles that would be more closely related to the empathizing mode, as described by Taylor (2008). Our data, on the other hand, showed that the empathizing mode was the second of those least preferred by the students, a result in accordance with the results from the American survey (Taylor et al 2011). The value of empathetic response-giving among practicing occupational therapists should not be disregarded — an empathetic style of attentiveness and care for others' feelings and emotions is consistent with core values of the profession

as a whole (Brown et al 2011, Haertl 2008). At the same time, it is possible that the empathizing mode is a challenging mode, as it requires the therapist to 'acknowledge and "sit with" negative emotions and difficult client circumstances' (Taylor et al 2011, p12). Previous findings related to verbal interaction between occupational therapists and their clients showed that this was more common among therapists who had advanced training in psychodynamic psychotherapy (Eklund and Hallberg 2001), which may also speak to the complexity of demands related to this mode.

The advocating mode was not addressed in the previous study of therapists' use of modes (Taylor et al 2011). As a result, our findings related to this mode have no comparison in the existing literature, and more research is needed to inform about the use of this therapeutic mode in particular.

Associations between therapeutic modes

The largely negative associations found between the six therapeutic modes (see Table 2) were given as an effect of the study design: as the variables used in this study pertained to the use of each mode *relative* to the use of the other modes, frequent use of one mode would automatically result in less frequent use of other modes. However, the size of the correlation coefficients provided us with some ideas as to how preferences for different therapeutic modes can be intrinsically related.

The only association that reached the standard level of statistical significance was the association between high affiliation with the problem-solving mode and low affiliation with the collaborating mode (see Table 2). This indicates a tendency of students who viewed themselves as rational thinkers and problem-solvers to emphasize this personal quality in their relationship with clients, while perhaps paying less attention to collaborating with the client about defining and addressing the problem. Conversely, students who viewed themselves as attentive to the client's perspective of his or her situation would make much use of this particular quality in forming their relationships to clients, perhaps at the expense of logically conceptualizing and reasoning about the client's occupational problems in the situation — and looking for salient solutions to them. Adding this to the knowledge about the frequent use of *both* the problem-solving and the collaborating modes in the sample, as evidenced from Table 1, a view of two sample subgroups with different orientations toward the client–therapist relationship comes forward.

These combined results point to a possible crude distinction between the 'problem-solvers' and the 'collaborators' among the students. The former group appears to be more concerned with addressing the task or problem to be resolved, whereas the latter places more value on building and maintaining the relationship with the client. A distinction between task-oriented and relations-oriented group roles has frequently been put forward in the group dynamics literature (Forsyth 2006). Similarly, it has been applied in the group psychotherapy literature (for example, MacKenzie 1990, Yalom and Leszcz 2005) as well as in occupational therapy when addressing the dynamics between participants in occupational therapy groups (Cole 2012).

Strengths and limitations

The study was limited in several ways. Firstly, the sample size was small. As a result, there was a potential for making Type II errors: that is, errors relating to not having sufficient statistical power to detect effects that exist in the data (Field 2013). The small sample also allowed each participant to substantially influence the sample mean scores; essentially meaning that the sample may not represent the population well. Consequently, the results actually obtaining statistical significance may have been caused by Type I error (Field 2013). The small proportion of the student cohort that chose to participate in the study added to this error potential.

Secondly, the sample was not defined with respect to sociodemographic variables. This was a necessity in order to maintain the participants' anonymity, but had the obvious disadvantage that the authors were unable to specifically state the characteristics of the persons that our data had come from. Potentially, over-representation of male or mature students may have influenced the results of the study. The results may similarly have been influenced by the study context. The participants, who were students enrolled in a mental health course, may have felt inclined to respond in certain ways that they believed would be considered appropriate. In addition, as the student role implies being a novice to the practice of occupational therapy, their responses to the practice situations described in the assessment may have been characterized by ambiguity rather than clear preferences.

Lastly, the assessment has not yet been psychometrically validated. The use of an English language assessment in a Norwegian student cohort also indicates that the results should be considered tentative, as the students' responses may have been influenced by possible errors in their interpretations of the questionnaire items. However, English is the second language for students who have a Norwegian background. In addition, a substantial amount of the curriculum for students in the 'Mental Health and Participation' module is in English, and the authors, therefore, expected that most students had an adequate understanding of the language. It is possible that the low level of study participation among the students (41.9%) was related to the burden of completing an English language assessment. Moreover, low participation rates could also be partially understood with reference to the students' limited knowledge about the IRM and the therapeutic modes.

The study design had both similarities and differences in comparison to the one previous study on the topic (Taylor et al 2011). One important difference concerned the instruments used for capturing the participants' preference for the therapeutic modes. Taylor et al (2011) used a questionnaire comprised of statements related to each of the modes (except for the advocating mode) to which the participants responded by endorsing one of the four response alternatives, ordered from 'never or almost never' to 'always or almost always'. This strategy produced scales for each therapeutic mode and measures of their internal consistencies. Importantly, this measure allowed each

participant to state their preference for each mode as independent from their preference for the other modes. The present study, in contrast, asked the participants to indicate only one of the response alternatives listed in the assessment. Hence, the questionnaire used in this study measured the participants' relative affiliation with the modes. Thus, the comparisons made between the two studies should be considered with caution.

One additional quality of this study, however, was the correlation analysis employed. This procedure added some insights into the associations between the uses of different modes, this being an aspect of mode affiliation that has not been previously explored.

Implications for practice and research

For future occupational therapy practice, the systematic inclusion of the therapeutic use of self in occupational therapy education may result in the students having a more solid base of knowledge and skills for establishing productive relationships with a greater variety of clients. Implementing models like the IRM may increase students' awareness of their preferred ways of relating to clients; increase their knowledge about the strengths and cautions related to these ways of relating; and add to their courage and willingness to explore unfamiliar ways of relating to their clients. In the context of the present study, this implies that students with a clear preference for 'collaboration' may need to monitor themselves vigilantly when relating to insecure or confused clients, who may need a more directive therapist. Conversely, students with a strong preference for 'problem solving' may need to pay particular attention so that this preference does not lead to emotional disengagement and lack of empathy with the client (Taylor 2008).

The IRM is a relatively new conceptual model of occupational therapy practice, and, to date, only one previous study exists that empirically has investigated the use of therapeutic modes in a sample of occupational therapy practitioners. The professional emphasis placed on the therapeutic relationship, in conjunction with the lack of research driven by a consistent theoretical framework, creates a need for more research on the therapeutic relationship and its use in occupational therapy. In particular, there is a need for developing, testing, and disseminating assessments related to the IRM. This will enable researchers to investigate the validity of its concepts and its practical usefulness in a variety of both clinical and educational settings. In turn, comparative, correlational, as well as longitudinal research on the therapeutic relationship can be conducted within a consistent framework, which may be an advantage to the further development of the profession.

Conclusion

This study showed that undergraduate occupational therapy students had the strongest preference for the problem-solving mode, whereas the advocating mode was the least preferred.

Students who had a strong preference for problem-solving as their way of responding were less inclined to have a preference for the collaborating mode. The results are based on a fairly small sample of young students with little or no clinical experience, but the preference for the problem-solving therapeutic mode may be viewed as a procedural type of clinical reasoning being expressed in the students' shaping of their relationship with the client.

Key findings

- Undergraduate occupational therapy students were most inclined to use the problem-solving mode of relating to clients, and least inclined to use the advocating mode.
- Students with a strong preference for the problem-solving mode of relating were less inclined to use the collaborating mode, and vice versa.

What the study has added

The study adds to the occupational therapy literature on the therapeutic use of self, and to the literature on the IRM model in particular. Specifically, it adds to the knowledge in this field by exploring how students identify their preferred ways of responding in a variety of hypothesized practice situations.

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Research ethics: Ethics approval was not required for this study.

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