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Abstract

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Keywords

Communication, therapeutic use of self, education

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**Qualitative Analysis of Occupational Therapists' Reflective Notes on
Practicing Their Skills in Building and Maintaining Therapeutic Relationships**

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ABSTRACT

Previous research has shown that occupational therapists have increased their self-efficacy for using self intentionally in therapeutic encounters. However, experiences related to such changes have not yet been explored. The authors developed a therapeutic use-of-self training workshop to support the confidence and competence of practicing occupational therapists in using the Intentional Relationship Model and possibly enhancing their self-efficacy for therapeutic use-of-self. The purpose of the study was to explore the experiences of practicing occupational therapists in transferring learning from a training workshop focused on the therapeutic use-of-self into real world practice. Thirteen occupational therapists participated in the workshop and subsequently completed between one and four reflection notes. These notes were subjected to qualitative thematic analysis. The findings were organized into four themes: therapeutic relationship reasoning, engrained previous learning, reflection on/in action, and level of skills in conducting reflection. Reflection skills seemed to be essential for establishing and developing therapeutic relationships; practicing such skills needs to be facilitated by the work environment through emphasis on reflective practice and mentoring.

The therapeutic relationship is a fundamental aspect of occupational therapy (Kielhofner, 2009). Occupational therapists use their 'self' therapeutically to establish and maintain relationships with their clients throughout the occupational therapy process (Polatajko & Davis, 2015). Solman and Clouston (2016) identified a gap between knowledge and practice of therapeutic use-of-self as an occupational therapy

tool and highlighted a need for further education and training. Occupational therapists are trained to understand the significance of the therapeutic use-of-self, and educational systems have a variety of views as to how to educate students to acquire the related skills. Limited evidence exists discerning a consensus on how occupational therapists develop and learn to regulate their skills in therapeutic use-of-self (Taylor et al., 2009).

Intentional Relationship Model

Taylor (2008) developed the therapeutic use-of-self application in occupational therapy by introducing the Intentional Relationship Model (IRM). The IRM establishes six therapeutic modes that can be employed intentionally by occupational therapists to establish and maintain therapeutic relationships with their clients. The six therapeutic modes include advocating, collaborating, empathizing, encouraging, instructing, and problem-solving. The advocating mode acknowledges the socio-environmental influence of disability and thus the role of the therapist is to respond to the physical, social, and environmental barriers facing the client. In the collaborative mode, the therapist engages the client in all aspects of the therapeutic process, including setting expectations, reasoning and decision-making. When empathizing, the therapist aims to fully understand and demonstrate their understanding of the client's experiences. In the encouraging mode, the therapist works to instill hope, and build resilience and determination to explore and participate. The instructing mode involves the adoption of a teaching style. Finally, in the problem-solving mode the therapist uses logic and reasoning to influence the client (Taylor, 2008). The therapist needs to apply the modes flexibly and reflexively with a range of interpersonal skills and an awareness of interpersonal events arising in the therapeutic space. An experienced and successful therapist is able to shift between modes based on the client's needs and the current therapy situation.

Reflection

Therapeutic use-of-self requires the therapist to engage in self-reflection. Reflective practice is recommended by the Royal College of Occupational Therapists (2019) in the United Kingdom (UK). Reflection involves a high level of metacognition to be aware of what is happening, analyze it, link it to other factors related to the event, interpret the response according to one's own behavior, indicate what has worked and what has not, identify the next step, and check the action again (Bond et al., 1985). Schön (1984) described two types of reflection: reflection in action and reflection on action. Reflection in action is mindful awareness enabling the therapist to act intentionally and with immediacy within a scenario. Reflection on action involves thinking about an event that has happened and planning a future response. According to Bandura (1997), a person needs to feel confident and able in order to act on prior learning. To be motivated for action, people need to feel they have the performance skills to achieve their goals through that action, and this is what he called self-efficacy (Bandura, 1997). Vax and colleagues (2012) found that having more education was associated with higher work-related self-efficacy in occupational therapists working with patients with mental health diagnoses. Schwank et al. (2018) and Fan et al. (2020) found that students may enhance their self-efficacy for using their 'self' therapeutically when skills were learned and practiced for 10 months and 16 months, respectively. The experience of learning

therapeutic relationship skills, however, remains under-studied. How education is transferred into practice, how learning and reflection is experienced, and how the learner develops self-efficacy, is unknown.

Reflective writing is one strategy for practicing reflection in action and reflection on action (Schön, 1984). Reflective writing enhances cognitive processing and possibly influences the learning and ability to apply knowledge and skills (Finlay & Gough, 2003; Hedy et al., 2010; Koshy et al., 2017). Transformative learning theory (Mezirow, 1995; 1996) states that adult learners develop habits of thinking that shape their viewpoints about the world. A variety of factors, including education and culture, influence these thinking habits. Mezirow (1996) proposed that a person could transform their thinking by reflecting on and testing assumptions that have become habit. Scharff and colleagues (2017) highlighted the value of thinking about learning and using reflexive writing to facilitate adult learning. Others have also used reflective writing as a means to explore the experience of participants in applying their knowledge (Hoover, 1994; Rauduvaitė et al., 2015).

Aim of Study

The authors developed a therapeutic use-of-self training workshop to support the confidence and competence of practicing occupational therapists in using the IRM intentionally and possibly enhancing their self-efficacy for therapeutic use-of-self. The aim of this study was to determine how occupational therapists' learning about the therapeutic relationship based on the IRM transferred to their clinical practice. Researchers hoped this understanding would help them to develop more effective training materials and strategies for increasing clinicians' therapeutic use-of-self.

Methods

A qualitative design was adopted to explore how practicing occupational therapists transferred knowledge from a training workshop into practice through the analysis of participants' written reflections about their therapeutic encounters.

Recruitment

The study focused on practicing occupational therapists to ensure participants would have the opportunity for reflection and to put their learning into practice. An invitation letter was sent through Oxford Brookes University to the occupational therapy leads for dissemination among their team. Occupational therapists were asked to contact the principal investigator directly and indicate in their consent form whether they would be interested in attending the workshop and participating in the study. Occupational therapists were able to attend the workshop even if they chose not to participate in the reflective exercises or the study.

Training Workshops

Four workshops were held in two cities in the UK. Each workshop was a full day with 10–12 participants attending each session and an overall total of 44 participants. The workshops adopted a mixed-methods approach using interactive lectures, vignette discussions, and sharing of practice experience. The workshop covered three main topics:

1. An introduction to the IRM's components: client and therapist characteristics, inevitable events in therapy, and therapeutic reasoning
2. An introduction to reflection in action and reflection on action
3. Reflective practice and cues about how to use the IRM in practice

Participants were taught to use the IRM and to be observant of their own practice. They were asked to think reflectively during and after an encounter with a client of their choice. Participants were invited to be aware of their own cognitive/emotional processes, especially when engaged in therapeutic relationships and trying to implement their learning from the workshop.

Data Collection

Participants were instructed to write one to four reflections about an encounter with a client over a four-to-six week period after the training workshop. Participants were encouraged to consider reflection in action (which happens during the therapeutic encounter) and on action (which happens once the therapeutic encounter is over; Schön, 1984). They could choose all the reflections to be in relation to one selected client or in relation to different clients. Participants were asked to send their reflection notes as an attachment to an email. Participants were asked to date and label their first, second, third, or fourth reflections to show the duration of the practice after the workshop. The researcher used a de-identification code to link the reports upon receipt.

The authors developed a reflective tool based on the components of the IRM to cue the therapists what to consider when reflecting about their therapeutic encounter. The reflective tool guided participants to think about a list of items related to the client, the therapist, and the events of therapy. For example, did the client show any of those characteristics mentioned; did any of the described events happen during the therapeutic encounter; which therapeutic mode did the therapist use; what was the therapist's rationale for using the mode; and what was the therapist's reasoning behind shifting modes?

Ethics

Ethical approval code: 2014/38 was granted by the Health Research Authority in the UK, and Oxford Brookes Faculty of Health and Life Sciences Research Ethics Committee.

Data Analysis and Trustworthiness

Thematic analysis strategies were used (Guest et al., 2012), and investigator triangulation was applied to ensure the rigor of the analysis (Guba, 1981). Two occupational therapy researchers were involved in data analysis to enhance the

credibility (Chilisa & Preece, 2005). The first author, the workshop leader, performed the analysis independent from the second researcher involved in the analysis. The second researcher involved in data analysis had no role in the workshops, though was familiar with the workshop content and reflective practice. The second researcher provided alternative perceptions of the reflective notes and probed for further clarification on what the participants wrote about their feelings and cognitive processes. Therefore, the second researcher's involvement helped strengthen the research integrity (Lincoln & Guba, 1985). To ensure the quality of the analysis process, the two researchers developed a protocol for data analysis. The two researchers read and re-read the reflections, wrote notes, and examined their meaning to ensure credibility (Anney, 2014). To exercise the similarities and differences in interpreting the participants' reflective notes, the two researchers engaged in ongoing, in-depth discussion. Both researchers identified the codes and then discussed with the other to modify and finalize them. Both researchers identified the final themes separately and then met for discussion.

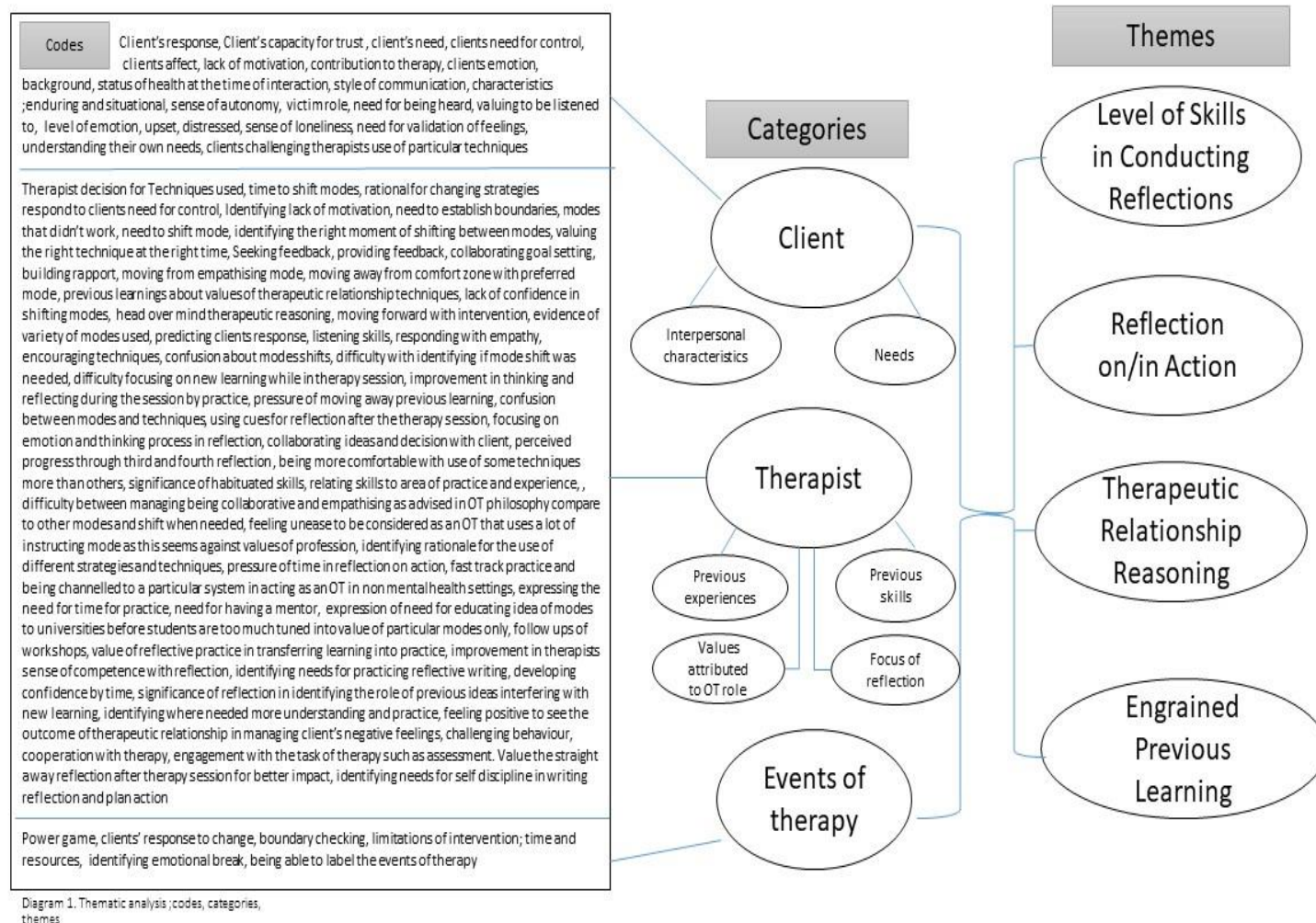
The researchers applied multiple strategies to ensure dependability. The two researchers involved in the analysis continuously reflected on their thinking processes and used peer debriefing as a strategy of enhancing credibility during their meetings. A third researcher, also an occupational therapist, engaged in reviewing the analysis, and assessing the coherence of themes, and exemplar quotes. Research coding occurred twice with a one-month interval between analysis and then categories were identified (Cohen et al., 2011; Tobin & Begley, 2004). Any inconsistencies that arose from these separate analyses were addressed and the researchers came to final agreement about the results (Ary et al., 2010).

Initially, the researchers analyzed the reflections of each participant by coding the data in two stages: horizontally, across the participants; and then vertically for each participant from the first through final reflections. There were challenges to this as the participants had submitted an unequal number of reflections. The researchers used three main points of focus to analyze the participants' reflective notes: using therapeutic relationships skills and knowledge by reflecting on clients' characteristics and needs, the event of therapy or therapists, and the therapists' skills, knowledge, and experience. These concepts mirrored the reflective tool. Some reflections indicated the process of reflection had happened during the encounter with the client, even though it was written later; however, others indicated the process of reflection took place after the event of therapy.

In the second stage of analysis, the researchers investigated the meaning of the participants' subjective experiences at the interpretive level, and through this process the final shared themes emerged (Vaismoradi et al., 2016): therapeutic relationship reasoning, engrained previous learning, reflection on/in action, and level of skills in conducting reflections. See Figure 1 for an overview of the thematic codes, categories, and themes.

The categories related to client, therapist, and events of therapy demonstrated how participants reviewed their own decision-making in building and maintaining their therapeutic relationships. This, therefore, formed one theme: therapeutic relationship reasoning. Participants reflected on their previous learning and experiences and the way they contributed to their thinking and feeling during interactions with their client. Therefore, this idea shaped another theme: the impact of engrained previous learning on the current practice and transferring learning from the training workshop to practice. The participants focused parts of their reflective process on their interactions with the clients during and after the sessions. Therefore, the time the reflection occurred formed the third theme: reflection in and on action. Finally, an additional theme related to the depth and focus of reflection itself was identified. The researchers found evidence of different levels of attention to details, and illustration of the thinking process in the written reflections. This was interpreted as the skills of participants in reflection and writing reflective notes that led to identifying the last theme: level of skills in conducting reflection.

Figure 1

Overview of Thematic Codes, Categories, and Themes

Results

Of the 44 participants at the workshops, 13 (two males and 11 females) agreed to carry out the reflective practice. Three completed all four reflective writing exercises over four weeks. The remaining ten participants completed one-to-three reflective exercises. The age of the participants ranged from 20 to 50 years, and their experience ranged from 1 to 30 years. Six of the participants worked in an adult mental health setting, and seven participants worked in adult physical health. See Table 1 for a description of the participants' characteristics.

All participants were familiar with reflective practice and a few were familiar with the IRM. None of the participants were actively using the IRM in their practice. All participants reported they were familiar with using reflection and reflective writing.

Table 1

Participants' characteristics

	<i>n</i>	%
Years of Experience		
<5	6	47
6-20	5	38
>21	2	15
Area of Practice		
Community Mental Health Adults	3	23
Hospital Mental Health Adults	3	23
Community Physical Health Adults	4	31
Hospital Physical Health Adults	3	23

Therapeutic Relationship Reasoning

Participants focused on presenting their reasoning for use of modes and switching between modes. Three participants linked the idea of a particular selected mode to the inevitable events of therapy, with one participant reflecting, “. . . the nature of the session meant that there was both strong emotion and intimate self-disclosure due to sharing the history of the injury . . .” Others selected modes by linking them to the characteristics of the client:

Patient X seemed more low in mood and distracted than on the previous two visits. He was also more confused than I had witnessed before . . . I listened to him and watched his facial expressions and body language carefully and adapted my approach accordingly.

Participants who completed more than one reflection indicated progress in considering both clients and the inevitable events of therapy. With subsequent reflections, participants identified links between different elements of the IRM: “At this week’s session I was aware of certain interpersonal events, . . . her own situational need was for control and any meaningful change would only be possible through developing trust.”

In the first reflection, participants reflected that it was difficult to identify which mode would be the most suitable for the client within the context of the therapy. Further reflections presented insight into the strength of their preferred mode regardless of the client’s need or the context of the therapy event.

The IRM helped me reflect on my own strategy, highlighting that the default mode I tend to use is encouragement and empathy . . . reflecting on the clients’ enduring interpersonal characteristics has helped me to be more mindful about using a ‘default’.

Switching modes was viewed as essential for the success of the therapeutic relationship. However, identifying when to switch modes was challenging. Only the three participants that completed four reflections showed confidence in relation to selecting modes and switching between modes.

My reflections here are on the power of the therapeutic relationship, the importance of being in the right mode, and the IRM, has, I think, helped me to develop and analyze my therapeutic relationship . . . helping develop my personal causation as a therapist in very positive ways by providing another feedback loop to help me make my practice more known to me.

Participants acknowledged their improved confidence in using self as a therapeutic tool, and the contribution of their new learning and practice in this process that contributed in developing their self-efficacy.

Engrained Previous Learning

Participants who had less clinical experience highlighted that their previous learning, mostly from their university training, was an obstacle where information was contradictory to their learning from the workshop: “I prefer not to use the instructing mode as I don’t believe it is as client-centered”. Participants with less experience appeared to give more importance to modes that aligned with values applied from their educational programs, such as client centeredness. The collaborative and empathizing modes were perceived to be more client-centered than instruction and problem-solving, with one participant noting, “I have learned that using the collaborating mode to plan an activity builds the service users’ confidence to participate in the activity because it empowers them to make a choice rather than being informed what to do.” The content of these reflections illustrated how previous educational values influenced therapeutic use-of-self in practice.

Reflection on/in Action

A noticeable difference was evident among participants with more experience in application of the information learned from the workshop. The participants with more experience found difficulty in changing habituated patterns of therapeutic communication. One participant who worked for a long period in a single setting stated, “On reflection I believe that my notes read very much as problem-solving although it is not possible to approach end of life issues without collaborating and using empathy.”

Reflection in action, in particular, appeared to be more difficult than reflection on action, after the session. Participants with more experience presented their abilities through reflection in action, while those with less experience tended to present their reflections on action in their reflective task. An experienced occupational therapist commented, “During this session I felt that I had an increased awareness of the strategies I was using and was consciously thinking about these during the session, perhaps because the training was fresh in my mind.” Being able to reflect during the session, rather than afterwards, required more skills and practice. The participant mentioned she was able to reflect in action and attributed this to the training and reflective writing that she had partaken in as part this study.

Level of Skills in Conducting Reflections

There were participants who appeared more skilled in reflective writing than others. The higher level in writing reflections was demonstrated by less descriptive and more insightful writing, as the following examples demonstrate: “By understanding the client’s needs through analyzing behavior and then carefully picking a mode, I believe I was able to produce a more effective approach that directly meets discussion;” “Somehow I need to try and have some time to spend reading back over what we learned;” and “I felt relatively confident using the approach, however it made me want to go and read through the handouts given to further pick out skills.” Participants who demonstrated increased proficiency with reflection were more proactive in identifying and addressing learning needs by planning for further reading and learning.

A common theme across the reflections was learning from the reflection and considering preparation for future interactions. Participants valued a complete reflective process that enabled them to develop action plans for improving their skills. "I wish to develop my therapeutic reasoning and application of the IRM through reflection as soon as possible following an intervention in order to be concise and accurate evaluating my own strategies and modes next time."

Participants appreciated practicing reflection and its significance in developing confidence in shifting modes: "I was surprised how confident I felt in shifting modes intentionally during a session as previously I have felt uncomfortable trying to change my approach." Building competence was seen in participants who did more than one reflection, although almost all identified a need for deeper learning via supervision or collegial discussion. Time limitations and heavy workload were repeatedly mentioned as an obstacle in executing the reflective writing.

Discussion

Establishing and maintaining therapeutic relationships with clients is a complex process. The aim of this study was to explore how therapists transferred learning from one IRM training workshop to occupational therapy practice. The results indicated that all elements of Taylor's (2008) IRM model (clients' characteristics, the inevitable events of therapy, and therapists' skills) were important aspects of therapeutic reasoning. Participants of this study presented their therapeutic relationship reasoning in their written reflections. It was evident that participants at the early stages of transferring their learning from the training workshop into practice focused on one or two elements of the IRM rather than all contributing factors in therapeutic relationship reasoning. Taylor (2008) and Schell and Schell (2008) also indicated that less experienced therapists address the therapeutic/clinical reasoning less holistically. All participants of this study mentioned a range of years of experience in utilizing their knowledge and skills in building and maintaining their therapeutic relationship with their clients. All participants wanted to develop confidence in utilizing and switching between modes. This may be due to a higher level of familiarity with other therapeutic relationship skills compared to the IRM. Participants with difficulty including one or more elements into their therapeutic reasoning had been an issue regardless of the years of experience. Most of the participants were not holistically considering all elements in their therapeutic relationship reasoning as it may have not been the focus of their practice. While participants showed improvement in self-efficacy in application of the learning into practice, they were not satisfied with competency.

Moon (2004) stated that a person's experience has a significant role in their learning. Taylor (2008) indicated experience assists the therapist to develop awareness of the modes and to develop competency in shifting the modes as needed in establishing a therapeutic relationship. This study supported that experience contributes to the application of learning to practice. Experience refers to both years of practice and to depth of experience in the area of practice. For example, six of the participants working in the field of mental health also appeared to be more comfortable with the idea of switching between modes as needed. This may be due to the nature of practice, and

skills that are developed to establish and maintain therapeutic relationships in mental health settings. Problems in building rapport, and establishing therapeutic relationships are considered as sequential in treating mental illnesses (Stockdale et al., 2011).

The results identified the impact previous education and values have in establishing a right or wrong approach to developing therapeutic relationships. In diverging from the medical model, which more often instructs and advises clients, the occupational therapy profession valued and emphasized the clients' contribution to the intervention (Royal College of Occupational Therapists, 2015). In educating occupational therapy students, emphasis is placed on empowering clients to have a say in their intervention plan (Ripat et al., 2013). This may be interpreted as if certain therapeutic modes such as instructing and problem solving in particular are not valued within the occupational therapy profession. Educating clients, caregivers, and family is a great part of health care (Stonecypher, 2009; Williams, 2008) which is often implemented through instructing and problem solving modes. Although therapists may rely primarily on a humanistic approach to interventions and therapeutic interactions with clients, there are instances when they need to educate clients in acquiring new skills. For example, if a client needs an alternate method to prepare food, instruction such as the therapist showing the client how to use a new wheelchair in the kitchen may be required, even though the goals were established using a collaborative approach.

Several of the participants valued collaborating, encouraging, and empathizing modes, which were favored over instructing, advocating, and problem-solving modes. Shifting modes that were valued and emphasized with occupational therapy education, to modes less valued and emphasized, challenged the therapist's beliefs about their role in the entire occupational therapy process. In relation to the advocating mode, however, responsibilities and strategies may receive less importance in occupational therapy education. Dhillon and colleagues' (2010) study regarding advocacy in occupational therapy practice indicated that the advocating role has been based on therapists' experience and in encountering situations when clients required advocacy. It seems that this aspect of the occupational therapy role has been less clearly addressed in the literature of the profession. How to present the advocating role in the therapeutic relationship, and related strategies and techniques used by occupational therapists, seem to be more experiential than based on education at the university. That could perhaps explain why the participants in the current study applied this mode in their reflection to a lesser degree. Stover (2016) emphasized medical necessity of the advocating role for occupational therapists. Potentially, engaging in an advocating role would be best demonstrated through the advocating mode. Valuing the necessity of an advocating role, however, is not enough; there is a need to educate occupational therapists to learn to use the advocacy mode.

The idea of using all modes when needed and developing strong therapeutic reasoning skills to shift between modes requires practice as well as an understanding of the rationale for choosing them. Some of the participants' previous education and learning

may have placed emphasis on certain modes over others. Empathy, for example, has been considered a fundamental skill that identifies a good therapist (Brown et al., 2010; Christiansen, 1977; Jamieson et al., 2006; Peloquin, 1995; Taylor, 2008).

Whilst the use of empathizing techniques is necessary in interactions with clients, remaining in the empathizing mode for extended periods can lead to dependency and prolong the intervention (Taylor, 2008). Longer, time-consuming interventions are not desirable in most free delivery health service systems. It is necessary to shift between the different modes of recovery depending on the needs of the client or the stage of therapy. However, participants indicated confusion about the use of empathizing techniques and the use of the empathizing mode during therapy. Health care professionals are instructed to use empathy as a central feature of their relationships with clients. Three participants reported feeling less comfortable with emphasizing the importance of all modes and shifting among them, due to their previous learning of the high value of empathy. This may have inhibited them from shifting between modes when it was necessary. Jacoby et al. (2010) explained the phenomena of previous learning interfering with the more recent learning as proactive interference. The confusion in using the empathizing mode may also be explained by the process of moving from the lay use of words to the specialized meaning depicted in the mode. For instance, 'encouraging' as a mode may be interpreted as rewarding or reinforcing. Relearning the meaning of 'encouraging' as a technical term in the IRM and the related techniques may be suppressed by the common use of the word in lay language. To integrate the new technical learning and professional use of a word requires knowledge and rehearsal of that knowledge in practice. The written reflections demonstrated two kinds of confusion in the application of words. Firstly, there was a tendency to move between the lay and the professional use of words. Secondly, the words used to indicate techniques within each mode and the mode itself were used interchangeably. For example, participants noted using the 'encouraging' mode only because they were using an encouraging technique like the verbal praise 'well done'. This was a lay use of the word encouragement instead of the encouraging mode, which according to the IRM has a broader meaning with related strategies. From a linguistic point of view, this could be similar to the negative transfer of previous learning into new learning of a term and its meaning (Odlin, 2003).

Participants differed with respect to their ways of thinking about and applying the process of reflection. Four participants showed a greater ability to consider elements of the IRM within their therapy sessions alongside their existing knowledge of occupational therapy, by unfolding what was happening and later reflecting on it. Others were more focused on individual elements with fewer identifiable links between the element and the bigger picture of what was happening in the therapy session. Several factors may have contributed to this difference. For example, the participants' previous experience with reflection and the model they used may have differed from what was presented at the workshop. Although the workshop presented Gibbs' (1988) reflective cycle as an example of a framework for structuring reflective practice, the researchers did not emphasize this model so the participants relied on previous experience of reflective practice. Also, as most of the participants provided fewer than three reflections, caution

must be taken in evaluating participants' ability and skills in the processes of reflection and reflective writing. Other elements such as time, belief in the value of reflection, and motivation may have contributed to the quality of the details in their reflections.

Diversity in writing reflections and presenting skills in reflective thinking can have multiple interpretations. This may be due to a lack of previous training experience in reflective practice outside of the training workshop. The short section that was allocated to reflection during the workshop could be another potential reason for some of the more superficial reflections that were submitted. The findings of a study by Knightsbridge (2019) showed that occupational therapists indicated limited skills or understanding of reflective practice. Hilliard (2006) identified how commitment to the reflective exercises is necessary for effectiveness. Davis (2003) also identified that the most significant element of poor reflective practice was the absence of motivation due to limited resources, support and appreciation for reflective practice. Participants of this study indicated that time limitations were a barrier in committing to the reflective writing process, although all participants valued reflection and reflective writing for their learning. Demands on time and workload were identified as obstacles for reflection- in-practice by occupational therapists in other studies, too (Knightsbridge, 2019; Bennett et al., 2003; McCluskey, 2003)

Participants who made several written reflections demonstrated a high level of success in implementing the learning from the workshop (Zubizarreta, 2009). Evidence supports the positive impact of reflective learning in clinical practice in terms of nurse–patient relationships (Naber & Wyatt, 2014; Tashiro et al., 2013). The findings of this study also showed participants who continued reflective exercises by submitting four reflective notes demonstrated further learning and mastery in transferring their knowledge of the training workshop into their practice with confidence. Occupational therapists in Taylor's (2009) study showed the more experienced therapists were the ones able to shift among modes intentionally. The current study indicated that training workshops followed by in-depth reflective writing may improve an occupational therapist's skills in implementing strategies for intentional shifting of modes.

The element of intention to use a particular mode or technique as described by Taylor (2008) was evident in all reflections. However, reflection about the implications of a particular technique or mode used in the therapeutic relationship appeared to be difficult. Participants chose a mode or technique with the intention of responding to what was happening during therapy, but they did not always reflect on the result of that decision. Being constantly mindful about one's own action needs practice. To master a demanding metacognitive task, knowledge and practice are essential (Israel, 2007). However, within a busy work environment, integrating new learning about building and maintaining therapeutic relationships is a demanding and complex cognitive task.

Limitations

The workshop was held for one day owing to the participants' limited availability. This led to few opportunities for practice, particularly in relation to the reflective exercises. Only three participants completed the full four weekly reflection over a period of four to

six weeks. Although the number of overall reflections was sufficient for qualitative analysis, evaluating changes in the participants who did not submit all four reflections was difficult. While evidence suggested potential differences between the experienced and novice therapists, and in relation to participants' area of practice, this matter was difficult to analyze in depth due to the small sample size. Readers need to consider putting the findings of the current study into the context of the participants' health system and environment when judging the transferability of the findings. Further research to investigate the effects of the training on the outcome of the therapeutic relationship process is recommended.

Implications for Occupational Therapy Education

The findings of this study indicated the importance of university education in establishing the values given to a variety of modes in therapeutic relationships. Therefore, emphasis a more comprehensive education in the knowledge of modes and related applied skills in the undergraduate curriculums may be an essential step forward. For further training of current practitioners, follow-up discussion sessions and an accessible online forum may assist occupational therapy practitioners from different backgrounds and experiences to deepen their learning. A longer workshop may facilitate more in-depth analysis and discussion. Moreover, reflection as a skill seems to be essential for being mindful and intentional when establishing and developing therapeutic relationships. Workshops with more opportunities to learn and practice reflection may be an essential addition to future workshops in this topic.

Conclusion

The findings of this study suggest therapists value learning and practicing strategies and skills that can support the development and maintenance of therapeutic relationships. However, as it is a complex process, practitioners need to be supported by their work environment to facilitate reflection for practising the intentional therapeutic use-of-self. Occupational therapists who have greater opportunity, motivation, and capacity for pursuing reflective exercises found it useful for developing their confidence in transferring their learning from the workshop to practice. More value and time allocated to reflective practice may ensure more confidence in implementing the IRM in practice. Occupational therapy leaders in practice may consider providing support for such training workshops and facilitating follow-up mentoring for their staff.

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