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RESEARCH ARTICLE



# Responsive learning in practice: A grounded theory

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**ABSTRACT**

**Background:** Teaching and learning are core components of occupational therapy practice, with therapists commonly positioned as 'educating' the client. Despite its acknowledged importance, however, little attention has been given to developing discipline-specific learning theories that reflect current practice.

**Aim:** This research aimed to construct a theory explicating the process of learning that occurs between therapists and clients.

**Methods:** The study was conducted in the context of therapy provision to pre-school children requiring long-term intervention. Constructivist grounded theory methodology was used to analyse data generated through 23 interviews with 11 parents and eight occupational therapists who worked with them, five filmed routine therapy sessions, and nine photographs of instructional materials. A substantive theory of 'Responsive learning: Learning from and with each other' was constructed.

**Findings:** The learning process is complex, dynamic, and bidirectional, with participants learning from and with each other in response to changing needs, situations, and context. It is deeply relational, where ongoing connection and partnership are crucial for mutual learning, moving forward together, and integrating learning into everyday life.

**Conclusion and significance:** These findings reveal the importance of therapists establishing collaborative relationships, being cognizant co-learners with clients, and responding to learning in practice.

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## Introduction

Teaching and learning along with engagement in occupation have long been identified as core components of occupational therapy practice through which clinicians help people master, maintain, and generalize skills and knowledge to enable participation in everyday activities [1,2]. Within the occupational therapy literature relating to practice, learning is often framed as hierarchical and unidirectional, with the expert therapist teaching the learner client [3,4]. Accordingly, occupational therapists have been described as *facilitators of learning* [1] and to *educate* has been recognized as a key occupational therapy enablement skill [5], with the main focus being on designing learning opportunities from a didactic, therapist as expert teacher, perspective. Although Carrier et al. [6] acknowledged teaching and learning as a dynamic, interactive, two-way process and found the active involvement of clients and caregivers benefitted both learning and motivation [7], at the time of commencing the present research, this insight into the dual roles of therapist and client was not prevalent in other studies exploring learning in practice.

Learning theories from other disciplines (predominantly psychology) have been consistently applied to underpin occupational therapy practice. For instance, Bandura's social cognitive theory underpinned health education programming for older adults [8] and motivation-driven interventions in stroke rehabilitation [9]. Similarly, the Four-quadrant Model of Facilitated Learning (4QM)—a research-based and occupational therapy specific paediatric teaching and learning process—is informed by Vygotsky's social development theory [10]. Prochaska's transtheoretical model of behaviour change [11] has additionally been identified as one of several theories underpinning coaching approaches [12]. Researchers have also identified extant learning theory as underpinning client

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learning, including adult and transformative learning theory referred to in several studies [13–16]. For example, an andragogical approach of considering parents as adult learners has been proposed as a way of increasing efficacy of family intervention strategies when working with parents [17,18].

The importance of fostering learning in practice is increasingly validated in literature. For example, within the paediatric occupational therapy and early intervention literature opportunities for sharing information and learning has been recognized as crucial to collaborating with parents [14] and for delivery of specific family-centred intervention approaches, such as home therapy programmes and coaching [15,19,20]. On the whole, however, emphasis has been given to practical principles of learning and approaches to teaching [1,3,21]. A wide range of teaching strategies have been acknowledged when working with clients and caregivers, with conversing, explaining, and information sharing frequently endorsed [7,22,23]. Observation, modelling, and discussion have also been reported to be of value in demonstrating techniques and building parental confidence to implement therapy interventions independently [1,22,24]. At the outset of the present study, however, across the reported literature, how to facilitate client involvement in teaching and learning processes had been largely neglected. In addition, studies tended to look at teaching and learning from the perspective of the therapist or client in isolation, frequently drawing from a solitary mode of data generation.

The study reported here was driven by the primary author's questions about how and what influenced clients' learning, and a desire to further understand learning in practice contexts. The research sought to examine the process of learning between occupational therapists and parents of children receiving therapy from the perspective of both parents and therapists using multi-source data generation including interviews, observation, and resource evaluation for breadth and depth of understanding of learning in this context. The purpose of this research was to construct a theory to explicate the process of learning that occurs in naturalistic practice contexts. The questions guiding this research were: What is the process of learning between parents and occupational therapists who work with children? And, what are the influences on that process and their consequences?

## Methods

The constructivist grounded theory methodology adopted for this qualitative study enables investigation of interactions, actions, and processes that occur in social situations from the perspective, and in the context, of those who experience it [25,26]. Aligning with that methodological approach, a multi-phase literature review process was undertaken. It commenced with an initial review to gain familiarity with extant literature and identify gaps in knowledge of the learning process in occupational therapy practice, followed by targeted searches to explore emerging concepts and situate the findings within the broader literature [25,27]. The research methods were primarily informed by Charmaz's [25] constructivist grounded theory approach, in addition to other iterations of grounded theory, including adopting the terms initial, intermediate, and advanced coding for analysis as outlined by Birks and Mills [26] and Bryant's 'Pragmatist-cum-Constructivist' [28,p.56] perspective. Using an iterative process of engaging with the participants and the context, and conceptual analysis, the goal of grounded theory is to construct a substantive, explanatory theory directly abstracted from, or grounded in, relevant empirical data [25,26].

Underpinned by pragmatism and social constructionism, using this methodology situated participants as active in co-construction of the theory with the researcher [25,28]. To ensure the theory is grounded in the data, rather than researchers' assumptions and preconceived ideas, reflexivity is crucial [25]. Reflexivity strategies used included the primary researcher undertaking a presuppositions interview to explicate potential influences on the study, keeping a reflective journal, memoing, and regular research meetings to justify decisions and explain the logic of analysis and findings. Nonetheless, as constructivist grounded theory fully implicates researchers in every stage of data generation, analysis, and theory construction [25], we acknowledge the study was coloured by our personal and professional perspectives, experiences, and theoretical preconceptions. As a research team, we acknowledged that we collectively came to this study with various experience as occupational therapists including extensive experience working and undertaking prior research with parents, two of us as parents ourselves, and all working in academic roles as pākehā (non-Māori New Zealanders) in New Zealand. The primary author conceived the study for her doctoral research and carried out all stages of the research including recruitment, data generation, data analysis and theory construction. The other authors contributed to guiding the research through all stages as doctoral supervisors.

### *Ethical considerations*

Ethical approval was gained from the Auckland University of Technology Ethics Committee (15/111), along with approval for research and cultural endorsement from the

locality District Health Board. The primary considerations were gaining informed consent and preserving the anonymity of the participants. Therefore, specific service names and locations are not disclosed, and pseudonyms are used in reporting.

This study was undertaken in New Zealand, where, as part of ethical conduct researchers are required to integrate and demonstrate in their research design and conduct responsiveness to Te Tiriti o Waitangi—the founding document of New Zealand that calls upon Māori, the original inhabitants, and Pākehā, the primarily British immigrants, to work in partnership for the benefit of the community [29]. Consequently, as pākehā (non-Māori New Zealanders) researchers, engaging in cultural guidance was key through all stages of the research to ensure it would be acceptable, accountable, and relevant to Māori and make it easy and safe for Māori to contribute to and participate [30,31].

### Participants: sampling and recruitment

Parents of pre-school children and occupational therapists involved in on-going therapy were recruited from two large regional paediatric services and a community service providing both home and outpatient clinic-based therapy in two large cities and surrounding regions. Parent participants were recruited using an intermediary, before contact was made by the primary researcher (with parent permission) to discuss participation. Parents known to the primary researcher through her clinical work were excluded from the study to protect the therapeutic relationship. Occupational therapists were recruited through the primary researcher's professional networks. Although some occupational therapist participants were known to the primary researcher, she did not have any authority over them, so issues of institutional power did not arise. Informed choice about participating was supported by verbal information, comprehensive information sheets and opportunities to ask questions. Consent forms were signed before data generation.

Purposive sampling was used initially to select diverse participants [25,26]. After development of preliminary categories, theoretical sampling guided recruitment and data generation, enabling seeking variation in participants, following up on leads, deriving information to fill out properties and explicate categories, and checking and validating concepts as the theory was constructed [25]. Both sampling strategies contributed to ensuring the credibility, relevance and usefulness of the theory [28].

Eleven parents of children (0-six years old) requiring ongoing therapy participated in the study. Parents had been working with an occupational therapist for 11 months on average and most were visited at home on a weekly to monthly basis. Three parents self-identified as Māori and eight as New Zealand European. There was one father. The eight female occupational therapists who participated had an average of 20.5 years' practice experience (range 3–36 years), with an average of 14 years' experience working with children and families. Participant demographics and research involvement are presented in Tables 1 and 2.

### Data generation, analysis and theory construction

Generating rich data and triangulating data from multiple sources can strengthen a grounded theory as the studied phenomenon is considered in different ways and from multiple perspectives [32]. Intensive semi-structured interviews (21 in-person, two by telephone) were undertaken (average duration 65 min). Two parents and two occupational therapists participated in a second interview (average 37 min) to check resonance of the theory with their experiences during the final analysis stage. A flexible interview guide was used during interviews. As the study progressed and guided by theoretical sampling, while remaining open to new leads, the open-ended, participant-centred nature of earlier interviews shifted towards seeking focused data to develop, elaborate, refine, and test

**Table 1.** Parent participants' demographics and their participation in the study.

| Participants | Ethnicity | Months using therapy services | Location of therapy | Interview/s (*n*) | Filmed therapy session | Photos of learning resources |
|---|---|---|---|---|---|---|
| Lisa | NZ European | 6 | Centre | 1 | – | – |
| Sarah | NZ European | 21 | Centre | 2 | – | – |
| Louise | NZ European | 12 | Home | 1 | – | – |
| Tara | NZ European | 6 | Home | 1 | Yes | – |
| Vandella | NZ European | 6 | Home | 2 | Yes | Yes |
| Toni | NZ European | 20 | Home/clinic | 1 | – | – |
| Polly | NZ European | 22 | Home | 1 | – | – |
| Samantha | NZ European | 4 | Home | 1 | Yes | Yes |
| David | Māori | 4 | Home | 1 | Yes | – |
| Dolly | Māori | 2 | Home | 1 | Yes | Yes |
| Anika | Māori | 20 | Home | 1 | Yes | – |

**Table 2.** Therapist participants' demographics and their participation in the study.

| Participants | Years as practicing occupational therapist (OT) | Years of experience working with children | Interview/s (*n*) | Filmed therapy session/s (*n*) |
|---|---|---|---|---|
| Annie | 13 | 5 | 1 | – |
| Jayne | 33 | 33 | 1 | – |
| Michelle | 36 | 14 | 2 | – |
| Marisa | 8 | 6 | 2 | 1 |
| Kerry | 10 | 9 | 1 | – |
| Nicole | 3 | Less than 1 | 2 | 2 |
| Caroline | 36 | 25 | 1 | – |
| Laura | 25 | 20 | 1 | 2 |

Key for Tables 1 and 2: Names are pseudonyms to protect the identity of participants.
Information correct at first contact with participant when demographic information was collected.

categories and fill conceptual gaps to understand to aid theory construction [25,33]. All interviews were audio recorded, transcribed verbatim and coded for analysis.

Five routine therapy sessions were filmed with six parents (two parents were present at one session) and three therapist participants for observational data. Two of the therapists were filmed twice while working with different parents to explore how therapists tailored their approach to different parents. To manage the observational data, dialogue was transcribed verbatim with different voices colour coded and details including direction of conversations, gestures, body movements, use of objects and the environment, and the responses of those involved to support learning noted, thereby making it like a script. Using an observation guide informed by earlier interviews and theoretical sampling, iterative analysis was undertaken by viewing the film, while simultaneously chunking (starting a new row in the table when each incident, or the issue of focus, shifted) and coding the data, and comparing with interview data [34,35]. Gaps identified in the data and concepts were checked and further explored with theoretical sampling in subsequent interviews.

The inclusion of observations proved invaluable to revealing insights that were not apparent in interviews, which added depth to the findings and theory construction. For example, analysis of the observational data, revealed multiple layers of learning happening simultaneously. Rapid shifts between learning and tending the relationship with parents and therapists continually responding to each other, one another's learning needs and what was happening in the moment was noted. This informed concepts in the theory constructed including *Partnering in learning* and subcategory *Getting on the same page again*, and supported the key concept of the theory, *Responsive learning*.

Nine photographs of learning resources such as tailored instructions provided by therapists to parents were taken at three parent interviews. Because the photographs were taken during the interview, whilst taking the photographs, participants were asked directly about the process of tailoring the resource, usefulness of the material to their learning and the meaning it held for them. This was captured in the interview audio recording and coded accordingly. Essentially the photos were a visual record of an extant document given to parents to convey information to support learning. As such, they were also analysed as documents with analysis focused on content and how it was conveyed while comparing it with what the parent said during the interview, and against other data, theoretical categories, and the theory as a whole [25,36].

The grounded theory methods used to analyse the data and construct the theory included constant comparative analysis; three stages of coding (initial, intermediate and advanced); memo writing and diagramming; and theoretical sampling as categories and subcategories were constructed to inform the developing theory [25,26]. Constant comparative analysis is an iterative, recursive process whereby data generation, coding, and analysis of data occur simultaneously from the first interview, continuing throughout the research process until the grounded theory is fully integrated [25,26]. In this study, concurrent data generation and analysis was fundamental to maintain the focus on developing concepts from the data, and consideration of how and where to generate further data to expound the categories with theoretical sampling [25,37].

Initial coding was undertaken in the early stages of data analysis and focused on examining the data in detail. It involved line-by-line coding to name (or code) fragments of data reflecting participants' concerns or actions [25,26]. *In vivo* codes were also used, which kept language grounded in participants' voices by using their words, such as 'hooking'. All codes were interpretive, tentative and open to modification and refinement during constant comparative analysis [25].

Intermediate coding involved focused coding and categorizing [26]. In focused coding, the most salient initial codes with more theoretical centrality were developed into a smaller number of focused codes. Some initial codes were subsumed into focused codes, or new focused codes were constructed to account for the data. Tentative categories were then constructed by grouping related focused codes as conceptual patterns were identified, while continuing with close engagement with the data [26,28]. These theoretical categories were multi-dimensional and consisted of subcategories, which collectively explained a broader concept. To enhance development of conceptual depth and breadth, categories were refined by explicating their properties (or

characteristics), dimensions (variations in the data), and the conditions they operated under [26].

Finally, advanced coding procedures, including use of storyline (narrative presentation of the theory) and theoretical coding (including situating the new grounded theory in a broader context and body of knowledge), served to integrate the grounded theory at a high conceptual level and enhance its explanatory power [25,26]. The coding stages guiding analysis and theory construction are outlined in Figure 1.

As shown in Figure 1, in line with constructivist grounded theory, three main theoretical categories (each with subcategories and properties) were constructed—*Establishing relationship*, *Partnering in learning*, and *Integrating learning*. An abstract core category was constructed as the most significant code, relating to and accounting for more data than the other categories, subsuming the higher-level categories and explicating the properties and connections between them [25,37]. The core category, and the title of the substantive grounded theory, became *Responsive learning: Learning from and with each other*.

## Findings

The findings of grounded theory research, including this study, are presented as a theory and understood as an interpretive explanation of processes in the studied world, grounded in the data, which potentially has wider applicability [25]. Accordingly, the substantive theory of *Responsive Learning: Learning from and with each other* presented below is interwoven with the data from which it was constructed.

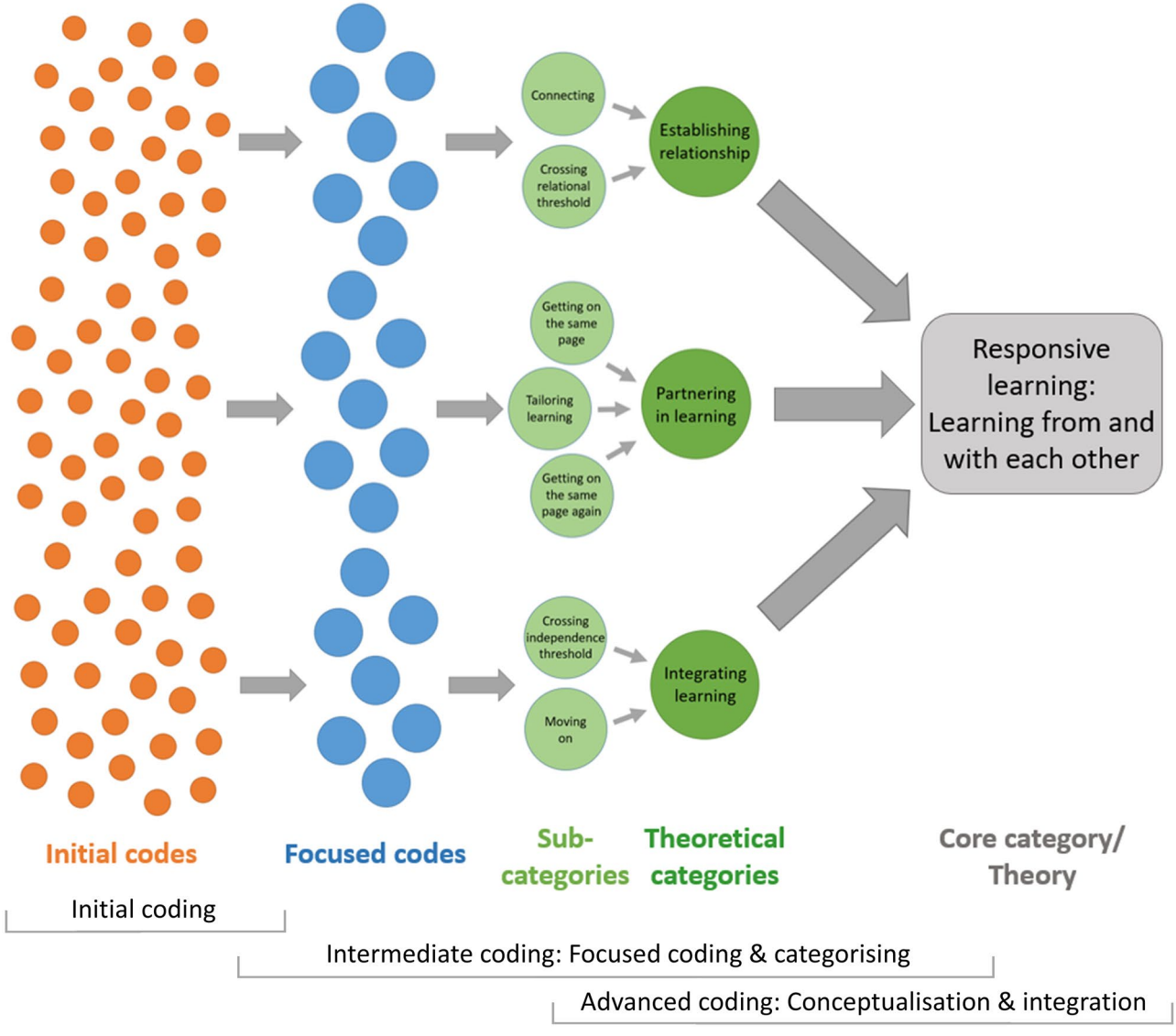


**Figure 1.** Diagrammatic representation of the theory construction: Developing theoretical categories and theory [38,p.82].

### The theory of responsive learning: learning from and with each other

The theory of *Responsive learning: Learning from and with each other* (Figure 2) explicates how, throughout the therapeutic process, parents and therapists are continually learning from and with each other and responding to each other and what they are learning as they work together. The theory can be viewed longitudinally over the course of therapy, for a therapy session, or for each individual issue that is being addressed. The key findings are that the learning process is deeply relational, bidirectional and responsive.

The theory has three main categories which could also be viewed as phases. First, *Establishing relationship* includes connecting and crossing the relational threshold. That leads to the second category, *Partnering in learning*, with the responsive processes of getting on the same page, tailoring learning and getting on the same page again. Those processes result in the third category, *Integrating learning*, with crossing an independence threshold and moving on. The spiral running through the model represents the dynamic nature of learning and the moment-by-moment oscillation between a *relating* focus and a *doing* focus in response to the learning need, what is happening in the moment, and the people involved as they build on learning. There is more emphasis on the relational aspects initially, merging into more emphasis on doing once they are over the relational threshold and proceeding with therapy.

### Establishing relationship

The first phase of *Establishing relationship* involves *connecting* and crossing the *relational threshold*. Investing time in establishing a relationship was important to both parents and therapists as it influenced subsequent interactions, learning and ongoing therapy. To that end both parents and therapists showed a friendly interest in each other as they started learning about each other. For some parents, an important part of *connecting* was learning how their child responded to the therapist.

> For me to trust somebody I've got to see how he [child] reacts around people. And, if he likes them, then that's alright. If he's happy, then I'm happy. (Tara, Parent)

Both therapists and parents used hooking strategies to draw each other into a therapeutic partnership, from both a relating (feeling comfortable with each other) and doing (projecting and instilling confidence) perspective. Some therapists described specific strategies including showing parents what they could achieve with the child and demonstrating their competence and trustworthiness as a therapist. Jayne (OT) explained,

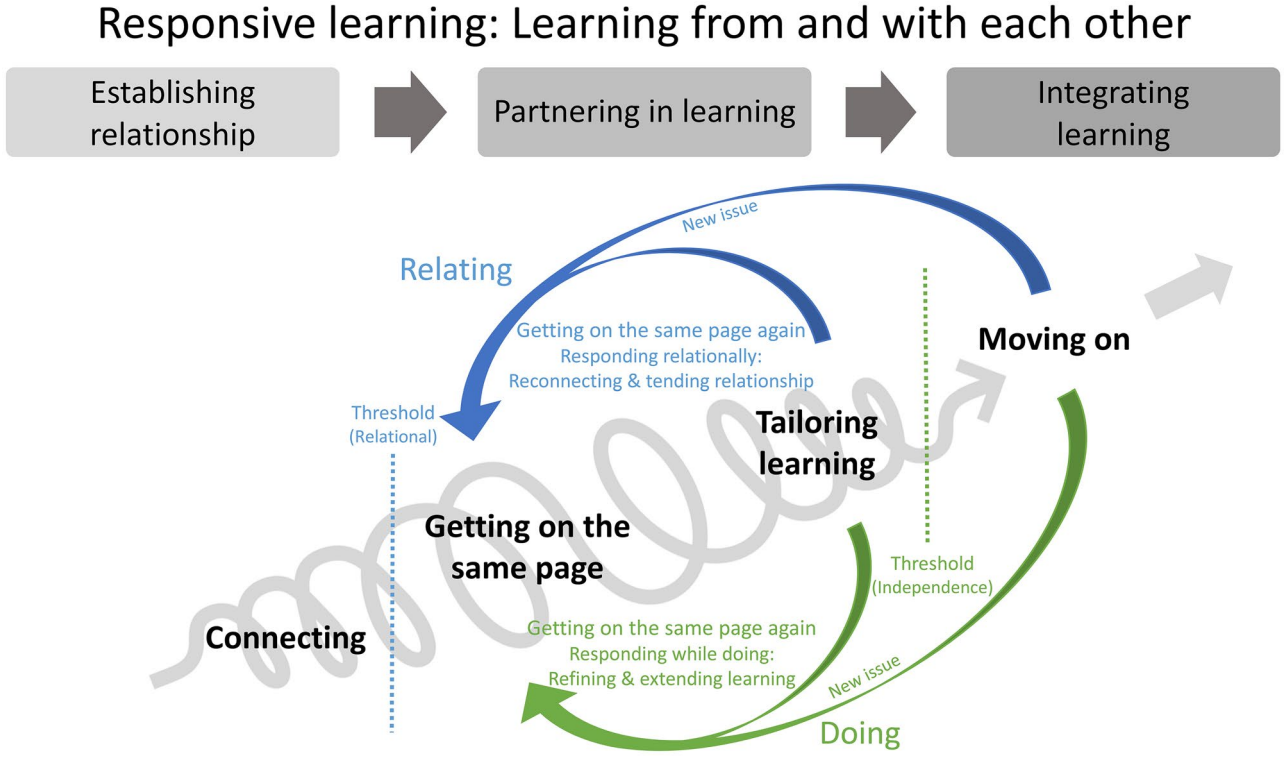


**Figure 2.** Diagrammatic representation of the theory of *Responsive learning: Learning from and with each other* [38,p.95].

> When we model a technique that works well, we've kind of got them. It's kind of like a hook. You've got to make sure you get the right hook.

Parents learning about therapy, feeling reassured that their child was comfortable with the therapist and seeing what the therapist could achieve with their child often instilled confidence and trust in the therapist, influencing their willingness to cross the relational threshold and move forward with therapy. Crossing the *relational threshold*, for both parents and therapists, was experienced as feeling more comfortable with each other. For example, Toni (Parent) explained that as she got to know the therapist and came to trust her, 'I lose the wall.… I feel more comfortable with her [therapist]'. Therapists described knowing parents were 'in' as a partner in therapy when they noted a shift in their manner.

> I could see changes after that—we've [parents] been heard, we're okay now, we can carry on. They [parents] seem more relaxed. (Caroline, OT)

Parents characterized crossing the threshold as increased engagement in therapy, having an inherent bond with their therapist and trusting the therapist unreservedly. After crossing the relational threshold, parents were unanimously reluctant to connect with a new therapist—even if only temporarily. Several parents had strong reactions to potentially losing a known and trusted therapist and some perceived working with someone new as a potential stumbling block. Dolly (Parent) explained,

> At the moment I feel like we're on track, like there is progress and I feel like if we had to start all over again it would almost feel like a setback. You'd feel like they [OT] were abandoning you.

Rationale for this reluctance were based on both the investment and emotional effort required to connect and learn with a new therapist; and the implications of a new therapist needing to learn about them, where their child was at with treatment, and what had already been done to get there. Of note, parents referred to therapists they were working with and liked by name. In contrast, therapists with whom no relationship had been forged were referred to less personally such as 'the first one' (Sarah, Parent). On rare occasions, failure to connect and cross the relationship threshold became a make-or-break situation, where some did not proceed with therapy at all.

### Partnering in learning

The second phase, *Partnering in learning*, is where doing therapy together happens. Partnering in learning involves a responsive recursive cycle of *getting on the same page*, *tailoring learning*, and *getting on the same page again*. In the observations of therapy sessions captured in the filmed data this partnering in learning cycle was occurring frequently.

*Getting on the same page* includes learning how to work with each other—learning that is revisited and built on over time as needs change. One aspect of getting on the same page is finding common ground by establishing things like mutual understanding and expectations of the relationship and therapy. For example,

> The OT told me that, 'I'm here to do my job, not to tell you what to do with your child'. And she knows where I stand, and I know where she stands. (Tara, Parent)

A key tenet of this aspect of the theory is recognition that both parent and therapist alike are *learning from and with each other*. Caroline (OT) explained to parents,

> We're learning together. You [parent] know your child. I know some things. Let's put it together.

Another aspect of getting on the same page is building mutual working knowledge. For example, parents needed to learn what they can expect from therapy and what is expected of them, about their child's condition and available interventions, how to navigate the health system, and how to integrate therapy into everyday life. To work effectively with families, tailoring services and interventions to their needs, therapists needed to build knowledge of 'how you can best work with a family and child' because 'what works for one family is not going to work for the next' (Michelle, OT). This included learning how the family functions, their priorities, what they already know, and what they want to know. Jayne (OT) considered,

> What do you [Parent] know already? And, how would you like me to build on that with what I know?… Because sometimes they [parents] know more than us. They know all the insides out and upsides downs.

*Tailoring learning* involves parents and therapists working and doing activities together, often mirroring each other's body movements and responding to meet learning needs in the moment. Intentional teaching and learning strategies are used by both as information, knowledge, and hands-on therapy skills are shared, including explaining, demonstrating, observing, embodied experience and practising. For instance, Louise (Parent) explained how she learned by observing the therapist.

> She [OT] would often demonstrate it with her own body, not just talk about it or show it on Sophia [child]—she'd do it herself.

To encourage collaboration, therapists invited parents to have a go or invited parents to 'let's try this together' (Michelle, OT). Some parents initially found this 'a bit daunting' (Dolly, Parent), at times invoking a sense of performance anxiety, especially early in the relationship when, for many parents, working with a therapist was a new learning experience. However, with experience of learning and working together, parents generally became increasingly comfortable doing things with and in front of the therapist. Louise (Parent) explained, 'It took time to build up my confidence of doing things and getting into the swing of things—it's a bit more natural now'. Together, they also discussed how learning and therapy could be incorporated into everyday routines and context to make life easier. For instance, Jayne (OT) asked parents, 'How can we fit that into the things you're doing already?' and 'What are the things that you think are really important to do?'.

*Getting on the same page again* is the crux of the theory and shows the recursive, responsive nature of learning in practice. As parents and therapists respond to each other and changing learning needs there is oscillation between a *relating* focus (blue/upper arrows, Figure 1), as therapists and parents reconnect and tend their relationship; and a *doing* focus (green/lower arrows, Figure 1), where they concentrate on meeting presenting learning needs to refine or extend learning. This oscillation was evident throughout interactions. For instance, at the beginning of each session, getting on the same page again generally involved re-connecting relationally through engaging in social conversation, while learning about what has transpired between visits and finding common ground from which to begin the doing part of the session.

Getting on the same page again from a *relating* perspective is key to maintaining the relationship, working collaboratively and learning from each other to keep moving forward with therapy. This involved intentional efforts by both the therapist and parent as they tended and invested in their relationship on a frequent and ongoing basis. For example, therapists took time to tend the relationship by being positive, encouraging, and pointing out progress, while encouraging persistence, preparing parents for doing the next step or suggesting an alternative way to do things to support learning. Nicole (OT) explained her approach,

> I'll say to Mum, 'Oh it's fantastic that he's doing this. This is such great news'—really give them positive feedback.… And then say, 'Oh the next step to this could be', and then demonstrate what it is.

Parents also made efforts to tend their relationship with the therapist. Those receiving home-based therapy for their child generally wanted therapists to enjoy coming, and to feel welcome and comfortable in their home. Some practical ways parents did this was by tidying up and racing 'around with the vacuum cleaner, so the floor was clean before the therapist arrived' (Polly, Parent).

To tend the relationship, at times parents and therapists also moderated their responses to each other by gradually revealing or even withholding information to protect the relationship. One way therapists did this was by taking time and care in gently preparing parents for what was coming up, especially when learning about something new might be difficult or overwhelming in some way, for example by 'talking about [new equipment] a little bit before actually bring that in' (Michelle, OT). Sarah (Parent) shared that although things the therapist did 'annoyed' her, keeping the relationship was important, so to 'make that work', she would sometimes tolerate what they were doing and 'just bite [my] tongue and let them' keep going.

Getting on the same page again from a *doing* perspective involves responding to each other's needs, questions, and cues. This included both parents and therapists clarifying understanding, refining tasks or providing more information to build working knowledge to support and extend learning. For example, when parents struggled, therapists responded by reframing instructions or information in a different way or used analogies to support and extend learning. Marisa (OT) explained,

> Sometimes you think that a parent understood something, but then as you talk more about it, it's, 'No, actually, you haven't understood this'. And you need to back track and start again or start from a different angle.

To literally get on the same page again, therapists would often provide a tailored home programme, 'written instructions' (Samantha, Parent) or 'homework' (Vandella, Parent) to reinforce learning, use as a resource between visits or share learning with other family members. Ending sessions on a positive note, provision of written material (e.g. home programme or session summary), planning the next visit, clarifying mutual expectations of what each would do between visits, was a way of getting on the same page again from both a relating and doing perspective as they parted ways after each appointment.

### *Integrating learning*

The third phase, *Integrating learning*, is when an *independence threshold* is crossed, where knowledge, understanding, acceptance or a skill has been gained or mastered, and learnings have been integrated into everyday life and practice. Over time, most parents gained confidence in what they were doing, and some made their own iteration of what they had learned to better suit themselves and their child. Therapists often noticed a shift in parents' confidence or, for example, that the parent had moved on or 'gone on and done something' independently, because 'they've obviously got it' (Caroline, OT). At times, therapists even noticed that 'I'm not needed anymore' (Marisa, OT). Therapists also integrated what they had learnt from into their own practice.

> All of these little things that they [parents] can teach you about—what they have tried that hasn't worked, what has worked. You're building up this book of knowledge. It's going to help the next family. (Nicole, OT)

Part of integrating learning is also *moving on*. Often moving on means re-entering the partnering in learning cycle to get on the same page again to address a new issue. This involved responding to changing learning needs as the relationship evolved. Generally, parents' initial learning needs included wanting reassurance they are accessing the right service, with someone who can help them manage their child's health needs. However, over time learning needs often become more specific, such as wanting to learn how to teach their child to go down the playground slide without their foot becoming stuck. For instance, like other parents, Samantha explained how her learning needs changed over time from needing to learn how to position her child progressing to focusing on learning regarding activities they could enjoy doing together.

> At the beginning it was really practical, hands-on—what should I do? How can I help him [child]? He was needing his body to be placed and positioned in so many ways. And now it's much less hands-on and more about him and I and what we can be doing together.

Over time, the relationship developed and changed as parents became more able to assert themselves and identify their specific needs, often taking more of a lead in the therapy for their child. Anika (Parent) explained,

> We're at the point where the OT asks me—what do I want to work on? Then I tell her—I think we need to work on muscle tone and helping with her left side a bit more.

At times, parents and therapists move on altogether. Ending well was important for both the relationship and supporting learning when moving on, whether therapy was no longer needed and they were discharged, or to ease the transition to new relationships and integration with another service. For some therapists, tending the relationship extended to protecting parents' future relationships with new clinicians by, for example, gradually withdrawing or actively supporting parents' learning about and transition to another service by doing a joint visit.

## Discussion

The theory of *Responsive learning: Learning from and with each other* proposes that learning between parents and occupational therapists is both deeply relational and a complex, dynamic, and two-way process. Establishing relationship by connecting and crossing the relational threshold is fundamental to successful partnering in learning and engaging in doing therapy. Ongoing connection, relationship and partnership are shown to be key for working collaboratively, meeting changing learning needs, moving forward in therapy and integrating learning into practice and life. Further, learning is bi-directional and responsive. Therapists and parents are learning from and with each other and continually responding to the presenting situation and what they learn as they work together. While components of the theory align with extant literature, theory and therapy approaches, the theory encapsulated as a whole is novel and adds insights into how leaning occurs between parents and therapists as they work in partnership through a process of responsive learning. In the following sections, consistent with grounded theory, we integrate aspects of the theory with relevant, contemporary literature and situate the findings within the context of current knowledge [25–27].

The theory emphasizes *Establishing relationship* and collaboration to work in partnership and support learning. It provides insight and explanation into how these were actioned as parents and therapists learned from and with each other, responding to each other to tend the relationship and to keep moving forward with learning and therapy. Relationship has previously been found to support reciprocal learning and to facilitate collaboration to assist practitioners in providing responsive and individualized intervention with families [39,40]. Relationship and learning have also

been recognized as key to family engagement and participation in therapy [39,41]. Learning and developing knowledge are acknowledged as essential to family-centred care and empowering parents to participate as collaborative partners with health practitioners in their child's care [42,43]. Other studies have reported links between fostering a positive and trusting relationship [44], developing a therapeutic alliance [45], and knowing (or learning about) clients as unique individuals to promoting engagement with services [46,47]. It has been suggested that time spent building trusting relationships with families should therefore be prioritized as it is potentially as useful as time spent on therapy [48,49]. Conversely, lack of responsiveness or inattention to the parent-therapist relationship risks disengagement from therapy [50].

The identification of a *relational threshold* as fundamental to successful *partnering in learning* and engaging in doing therapy in this theory is consistent with results from other studies. For example, when exploring meaningful therapeutic relationships, Keiter Humbert et al. [51] described *tipping points* as breakthrough moments within the relationship and therapeutic process, such as achieving a therapeutic goal. Other tipping points, such as clients disclosing personal information, strengthened connection between therapist and client, enabling the therapist to learn more about the client, their challenges and how to support them. Similarly, they found that forming a connection contributed to finding *common ground*, which is part of *Getting on the same page* in the theory. Reflecting the essence of mutual learning in the theory of Responsive learning, therapists also experienced tipping points as moments of realization of their own learning that brought greater insight about clients and their challenges [51]. Phoenix et al. [52] found that developing safe and supportive parent-therapist relationships contributed to parents' willingness to share information, ask questions, and raise concerns which would support therapist learning. Of note, reaching agreement about families' needs and how to move forward with therapy was similarly labelled as *being on the same page* [52], a component of *Partnering in learning* identified in the theory.

As part of responding to learning and changing needs, the notion of ongoing tending or sustaining the relationship by both parties frequently *getting on the same page again* relationally also finds support in previous literature. Effective engagement with parents has been reported to require therapists to be intentional about relationship and to take time and be alert, attuned to, and responsive to parents' needs to provide opportunities for learning and change [50,53,54]. Although the general focus of other studies was the impact of cultivating engagement in therapy through relationship and not learning per se, responses involved therapists using learning strategies including listening, involving parents in therapy sessions, monitoring and responding to signs of disengagement [46,47]. This research brought to light the relational work of both parents and therapists in sustaining the therapeutic partnership. While previous understandings of forging a therapeutic relationship are generally presented as therapist driven [55–57], efforts made by a clients to connect and sustain a positive relationship with clinicians have similarly been described by Egan et al. [58].

Aligning with the bidirectional, reciprocal and responsive nature of *learning from and with each other* throughout the theory, parents and therapists have previously been described as *learning from one another* [39] and therapists have been framed as 'co-learners in the rehabilitation learning process' [16,p.482]. Families and clinicians have variously been described as assuming roles as both teacher and learner [59] and co-learning described as 'sharing the roles of expert and novice, teacher, and learner' [60,p.353]. The co-construction of knowledge achieved through actively sharing information has been identified as contributing to beneficial therapeutic alliances, enabling working collaboratively and encouraging shared problem-solving [57]. Being responsive to parent learning needs is reiterated in other studies. Aligning with reports of parents wanting effective communication and responsiveness from health care providers [61], therapists have been urged to engage in ongoing communication to learn and gauge parents' level of understanding, current learning needs, preferences, priorities, and readiness for information to effectively tailor the type and amount of information provided and to recalibrate shared goals accordingly [41,55,62,63].

Despite therapists being encouraged to provide opportunities for mutual learning and to tailor exchanges in meaningful ways within reciprocal partnerships, therapists' role as teachers rather than learners continues to be emphasized [14,17,64]. Although therapist learning was apparent during the therapy session observations and indirectly in interviews, most therapists in this study struggled to articulate what they learnt from parents, suggesting some were unknowing learners and largely not alert to the significance of their own role as learners in the practice. Elevating therapists to knowing, intentional cognizant co-learners may make a difference in initial and ongoing partnering with clients and, potentially, outcomes.

Crossing an *independence threshold* as learning is integrated into everyday life and practice is consistent with other research findings. For example, similar to the independence threshold, parents in research on occupational performance coaching (OPC) reported reaching a *turning point* as a moment of learning transformation with a shift in perspective or acknowledgement of insight gained [13,65]. *Getting on the same page again* was key to responding to the nuances and progression of parents' learning needs and increasing capacity to take the lead in the direction and focus of therapy. Hurtubise and Carpenter [16] similarly found that as parents acquire knowledge and skills, they transition from observing, copying, and practising to actively taking initiative in modifying or adapting an activity to suit their child's responses.

There is alignment between the focus on *partnering in learning* in the theory and recent reported approaches in practice towards collaborative relationship-focused approaches, co-constructing plans, promoting autonomy, and applying change strategies to real-life situations [41,66,67]. Such approaches include various coaching approaches including OPC [12,19] and use of tools such as the 'F-words life wheel' [68]. Building and sustaining relationships are also at the core of contemporary practice models. For instance, building and sustaining relationships are central to the proposed triadic guide for occupational therapy incorporating the Canadian Model of Occupational Participation (CanMOP) [69] shaping how practitioners think about occupation, a Collaborative relationship-focused practice approach [70], and the Canadian Occupational Therapy Inter-Relational Practice Process (COTIPP) Framework [71] which proposes processes and actions for promoting occupational participation. However, the theory of Responsive learning is not an intervention approach per se, nor is it dependent on any one intervention approach or practice model. Rather, intervention approaches are conceptualized as being embraced within the overarching theory which has potential to provide a research-based description of how collaborative relationships could be established and sustained in practice through a process of responsive learning. In providing an integrated explication of *Responsive learning* from initiation of a therapeutic encounter to its conclusion, the theory has a broader scope, including *Establishing relationship* and crossing the relational threshold that are foundational to *Partnering in learning* with ongoing effective therapeutic engagement and working collaboratively, leading to *Integrating learning* into life and practice.

## Methodological considerations and further research

This research was undertaken using the criteria of credibility, originality, resonance, and usefulness as a quality reference point and to evaluate the grounded theory [25,37]. To enhance rigour and credibility, care was taken to plan the study with congruence between its purpose, methodological approach, and grounded theory methods used [25,37]. Credibility was strengthened through inclusion of diverse participant groups (parents and occupational therapists) and the triangulation of data generation sources (interviews, filmed therapy sessions, and photographs of learning resources) which added depth to the data and theory. Presentation of this original grounded theory demonstrates how the theory, concepts and categories, and connections between them, are grounded in the data, and discussions explain how the theory has been situated within extant literature. Resonance was considered within the research process through theoretical sampling, and by checking the theory with participants to confirm and validate concepts during theory construction, as well through discussion with occupational therapists, health professional colleagues, and service managers in various forums. These discussions revealed resonance with the theory and concepts within it, its potential usefulness in everyday practice, and potential applicability in other situations, different clinical settings and contexts, including for training health practitioners, supporting clinical and professional supervision, and informing service development projects. Further, the theory uses language and concepts that resonated, and which people (including parents) immediately picked up and readily used regardless of their role, position, and context.

In terms of limitations, this research was undertaken over an extended time period (seven years) as the first author's doctoral research and is reporting data that are several years old. However, as it was exploring the process of learning, not specific intervention approaches, the essence of the theory in unlikely to be affected. In constructivist grounded theory, researchers acknowledge their role as part of the research process and co-constructors of data and theory with participants [25]. Therefore, another researcher may have constructed a different theory with the same participants. Participants were recruited from four services in two large cities (and surrounding districts) in New Zealand. It cannot be known if a study undertaken in a different location, with a wider variation of participants, would have produced similar results. Although genuine efforts were made

to ensure Māori had opportunity to participate in this research and Māori views are reflected within the findings, only three Māori parents participated. These low numbers are acknowledged as a limitation. Further, there were no Māori therapist participants who may have added a different perspective.

The focus of this research was on learning between the dyad of parent and occupational therapist, in what was actually a triad relationship of parent-child-therapist. Further research focusing on the child-parent-therapist triad of learning and with different client groups in different contexts and on specific aspects of the theory within and beyond occupational therapy would extend this work and examine the potential generalisability of this theory.

## Conclusion and implications for practice

The theory of *Responsive learning: Learning from and with each other* adds new insights into how leaning occurs in practice as therapists and clients work in partnership through a process of Responsive learning. While aspects of the theory align with extant literature in the health fields, theory and emerging therapy approaches, none entertain the described process in its entirety.

The process of Responsive learning is deeply relational. To sustain relationship, collaborate and provide relevant information and interventions, both the client and clinician need to connect and learn from and with each other on an on-going basis, by responding to learning, each other, and change along the way. Although therapists often feel pressure to work quickly to achieve therapy goals, the theory supports prioritizing and investing time into establishing, and sustaining collaborative relationships, and responding to learning to gain value from therapy.

Learning is bidirectional and responsive. Therapists and parents are learning from and with each other and continually responding to the presenting situation and what they learn as they work together. Clinicians are encouraged to be intentional about learning from their clients by being cognizant and responsive co-learners in order to effectively partner with clients and work collaboratively to meet their needs.

Understandings gained from this research may encourage more efficient, equitable, and effective engagement with service users in a range of health settings. Including the theory of *Responsive learning: Learning from and with each other* in training of clinicians and in professional education may support learning to enhance collaborative relationships in practice and enhance service delivery and client participation in therapy.

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No potential conflict of interest was reported by the author(s).

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