Responsive learning: Learning from and with each other
A grounded theory

Caitlin Mary Harvey

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Abstract

Occupational therapists work collaboratively with parents of children needing support with their development. In delivering therapy intervention, a key role is to help parents learn about their child's condition, treatment options, and skills to enhance their child's development and participation in family life. Learning can impact parents' decisions regarding their child's treatment, commitment to services, and subsequent outcomes. Concurrently, therapists need to learn about families to provide tailored interventions and support, while ensuring appropriate use of health resources. This grounded theory research aimed to construct a theory explicating the process of learning between parents and occupational therapists who work with children.

This study is unique in that the process of learning is considered from the perspective of both parents and occupational therapists and in the use of multiple sources of data. Constructivist grounded theory methodology and methods were used to analyse data generated through 23 interviews, five filmed, routine therapy sessions, and nine photographs of learning resources provided to parents, with 11 parents of pre-school aged children and eight occupational therapists who worked with this client group. Data were analysed using constant comparative analysis. A dynamic, substantive theory of 'Responsive learning: Learning from and with each other' was constructed, with three theoretical categories: Establishing relationship, Partnering in learning and Integrating learning.

The key findings of this research are that learning between parents and therapists is a complex, dynamic, and bidirectional process where parents and therapists are learning from and with each other and responding to each other as needs, situations and contexts change, through a process of responsive learning. Learning described in occupational therapy literature relating to practice predominantly frames learning as unidirectional with clients learning from an expert therapist. In contrast, responsive learning acknowledges the expertise and leadership of both client and therapist—that they teach, and learn from, each other, and that learning needs are always situational, dynamic and in flux. How, and what, therapists teach cannot be considered in isolation from how, and what, parents need or want to learn, nor from how, and what, therapists must learn to engage with families to provide relevant intervention. A further key finding is that the learning process is deeply relational, where ongoing connection and partnership are crucial for mutual learning, moving forward together, and integrating learning into everyday life.

These findings will inform and challenge clinical practice, enhancing the learning experiences of occupational therapists and parents. They potentially extend beyond the specific practice context within which data were generated, to inform the practice of clinicians in all areas of health care. Understandings gained from this research may encourage more efficient, equitable, and effective engagement with clients in a range of health settings. This research also

has potential to advance improvements in health outcomes and better meet the needs of service users by prioritising establishment of collaborative relationships, embracing enhanced mutual learning strategies, and responding to learning in clinical practice.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Cait Harvey

Dated: 6 July 2022

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Chapter 1 Introduction

In learning you will teach, and in teaching you will learn. (Collins, 1999)

Learning, whether planned or incidental, is fundamental to the delivery of health care services (Colyvas et al., 2010; McKenna & Tooth, 2006). Within occupational therapy practice, education and learning as an intervention strategy is central to both client and family-centred therapy (Griffin et al., 2003; McKenna & Tooth, 2006). Parents of children requiring support with their development have additional learning requirements beyond learning about typical parenting issues, including learning about their child's condition and treatment options (Harrison et al., 2007; Steiner, 2011). For therapists working with children, a key role is to assist parents to meet their child's needs by helping them learn about their child's condition, available treatment options, and hands-on skills to enhance their child's development and participation in family life. This learning enables parents to participate in shared decision-making. Crucially, the learning impacts parents' decisions regarding their child's treatment, buy-in, and commitment to therapy, and achieving goals for, and with, their child (Griffin et al., 2003). Concurrently, therapists need to learn about families in order to provide tailored interventions and support, while ensuring appropriate use of health resources. Constructing a theory to explicate the process of learning between parents and occupational therapists is the focus of this research.

This grounded theory study explored the process of learning between parents and occupational therapists who work with children. Grounded theory was chosen as the methodological approach for the research as it is suited to exploring social processes (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014). The study was emergent in design, guided by the constructivist variant of grounded theory primarily based on the work of Kathy Charmaz (2014). Participants were 11 parents of pre-school aged children requiring ongoing occupational therapy to support their development (due to a range of medical conditions), and eight occupational therapists working with this client group. Data were generated through 23 intensive interviews, five filmed routine therapy session, and nine photographs of learning resources provided to parents. Using constant comparative analysis, the data were compared through an iterative analysis process, and categories and subcategories constructed to inform the developing theory.

This opening chapter introduces the aim and purpose of the research. Key terms are defined. The rationale and significance of the research and my motivation for undertaking this research is provided. The context in which the study is situated is outlined, including Te Tiriti o Waitangi (the Treaty of Waitangi) and its influence on delivery of health care for families. A description of the Aotearoa New Zealand health system and services available for children requiring support with their development is presented. Following, an overview of the thesis structure is provided.

Research Aim and Purpose

The aim of this research was to construct a substantive theory to explicate the learning process between parents and occupational therapists who work with children. The questions guiding the research were:

- What is the process of learning between parents and occupational therapists who work with children?
- What are the influences on that process and their consequences?

My intention was to bring together the perspectives of both parents and therapists, to better understand the process of learning, the influences on the learning process, and their consequences. The goal of this study is to assist occupational therapists to develop a deeper understanding the process of learning in the parent-therapist collaborative relationship. Developing knowledge of the learning process between parents and therapists has potential to improve the quality of interactions and collaboration to better meet the needs of service users and to encourage more efficient, equitable, and effective engagement with clients. This will ultimately benefit both parties and impact health outcomes. Such knowledge may also have broader relevance for other health practitioners and in a wider range of health care contexts. Learnings from this research may additionally be used to train clinicians, inform policy and health projects, and contribute to current discussions around working in partnership and collaborative practice in health care provision.

When considering learning between parents and occupational therapists, the child concerned cannot be ignored. As the part of the triad working together, the child is the purpose of the interaction between parent and therapist. However, the focus of this study is exploring the learning between parents and therapists. Although I will at times refer to the child as part of the triad with the parent and therapist, and the child is considered part of the context of the parent and therapist learning, they are not the focus in this study.

Defining Key Terms

Key terminology pertaining to occupational therapists and therapy, learning, and theory used in this research are presented here to introduce these concepts.

Occupational Therapists, Occupational Therapy, Occupation, and Co-occupation

Occupational therapists are registered health professionals who practice in a diverse range of settings, including hospitals and community-based health and education services. Throughout the thesis, occupational therapists are also referred to as ‘therapist’ or ‘OT’. All occupational therapist participants were female; therefore, may also be referred to by the feminine pronoun ‘she’ in this thesis.

Occupational therapy is the art and science of helping people participate in everyday living to their potential through occupations (Occupational Therapy Board of New Zealand, 2021). Occupations are the *"*everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life" (World Federation of Ooccupational Therapists [WFOT], 2021). The WFOT (2021) has defined occupational therapy as,

> a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

In Aotearoa New Zealand, Occupational Therapy New Zealand–Whakaora Ngangahau Aotearoa (OTNZ-WNA, 2021), the professional association of occupational therapists, supports the above definition. Further, co-occupation has been described as "a dance between the occupations of one individual and another that sequentially shapes the occupations of both persons" (Pierce, 2009, p. 203), and reflects the highly interactive nature of occupation, particularly that of parent and child.

Learning, Teaching, and Learners

In order to study 'learning', it is important to define it. Learning has been defined as "the act or experience of one that learns" (Merriam-Webster, n.d.-b). To learn is "to gain knowledge, or understanding of, or skill in, by study, instruction or experience"; "to come to be able", "to realise", or "to know" (Merriam-Webster, n.d.-a). Education and teaching is complementary to learning, although not synonymous with learning in itself. Knowles et al. (2005, 2015) defined education (or teaching) as an activity undertaken or initiated by individuals which is designed to effect learning, with the emphasis on the educator (or teacher) who is the agent of change.

Knowles et al. (2005, 2015) recognised differences in teaching and learning approaches for adults (nominally andragogy) and children (nominally pedagogy). This difference is important for the current study, where the focus is on the learning process between two adults—parents and occupational therapists. Pedagogy assumes learning is subject-oriented, with the teacher taking responsibility for the content and organisation of learning; implying education is the transmission of knowledge and creates learner-dependency. In contrast, andragogy is learner-centred, and recognises learners bring prior knowledge, experiences, needs, and interests (Knowles et al., 2005, 2015). The self-directed nature of adult learners is a key assumption of andragogy, with the learner oriented to apply new knowledge to life problems and to be in control of the learning process (Neufeld, 2006). Teaching and learning are useful interventions and embody core principles of occupational therapy practice (Greber &

Ziviani, 2010). A fundamental assumption in occupational therapy is that people learn through doing (Hagedorn, 2000). As such, teaching is a useful form of therapeutic intervention and has been a tool of occupational therapy since its inception (Greber & Ziviani, 2010; Hagedorn, 1995; Mosey, 1986).

Theory

Theories offer accounts or explanations for what and why something happens, and how it ensues. They serve several purposes in helping make sense of the world around us, including answering questions and explaining what we do and why (Thornberg & Charmaz, 2012). The aim of grounded theory research is theory construction (Charmaz, 2014). Grounded theories can be considered a postulated explication of a phenomenon. Most grounded theory studies produce substantive theories to understand a tangible phenomenon in a defined situation (Birks & Mills, 2015; Charmaz, 2014; Glaser & Strauss, 1967). As a grounded theory study, the aim of this research was to construct a localised, substantive theory grounded in the data generated to explicate the process of learning between parents and occupational therapists, using grounded theory methods (Birks & Mills, 2015; Charmaz, 2014).

Rationale and Significance of the Research

Teaching and learning, along with engagement in occupation—as a primary therapeutic tool, as well as the goal of occupational therapy intervention—have been core components and reoccurring themes in occupational therapy since the formation of the profession over 100 years ago (Bing, 1981; Fisher, 2013). The core assumption of occupational therapy that people learn through doing is still relevant today (Hagedorn, 2000). At the foundation of occupational therapy were ideas synonymous with those of educational philosophy. At that time, therapeutic processes and modes of treatment were similar to the process of learning and methods of education (Bing, 1981). Both the early proponents of occupational therapy and educationalists of that time, including John Dewey, held a humanistic view of the individual and agreed that engagement in occupation was fundamental to learning and development (Bing, 1981; Dewey, 1933; Schwartz, 1992; Yerxa, 1992). Dewey's notion of occupations as a method of learning by doing, along with his argument for meaningful experience rather than just skill building, parallels occupational therapy's fundamental appreciation of the therapeutic value of meaningful occupations (Coppola, 2012; DeFalco, 2010; Dewey, 1933). Dewey's learning by doing philosophy viewed occupation as a valuable instrument in teaching and learning (DeFalco, 2010; Schwartz, 1992), with Dewey (1910) arguing that people should "at the outset of any experience in learning … connect new topics and principles with the pursuit of an end in some active occupation" (p. 224).

In the earlier years, occupational therapy was described by Dunton (1920) as "a process of education" (p. 322), whereby the sick and injured, as part of their convalescence, were re-

educated or trained through engaging in occupations. That commonly involved teaching of arts and crafts, with an emphasis on the therapist teaching capabilities to help individuals change their life in a positive way (Bing, 1981; Roberts et al., 2008; Schwartz, 1992). Education has continued to be recognised as a primary occupational therapy treatment medium (McEneany et al., 2002) and 'educate' recognised as a key occupational therapy enablement skill to encourage growth and support change through participation in the occupations of everyday life (Townsend et al., 2013). Teaching is described as a tool of occupational therapy (Mosey, 1986), and a useful form of therapeutic intervention (Greber & Ziviani, 2010; Hagedorn, 1995).

Recognising the need to become more medically and scientifically oriented, a paradigm shift occurred in occupational therapy in the 1950s (Briller et al., 2016). Occupational therapists were concerned with their professional identity and wanted to disassociate from the image of being teachers of arts and crafts. Consequently, discussion of the teaching-learning process was largely jettisoned from common occupational therapy parlance, but not from use in practice (Mosey, 1986). Beyond the 1970s occupational therapists again acknowledged the teaching-learning process as a legitimate therapy tool and started considering the influence of existing learning theories (primarily psychology based) in occupational therapy practice (Flinn & Radomski, 2008; Hagedorn, 1992, 2001; Mosey, 1973, 1986). Despite this ongoing theme of teaching and learning, there has been little elaboration of the educational theories underpinning practice in occupational therapy literature. Further, there have been scant propositions or development of occupational therapy-specific teaching, learning or educational models, processes or theories, particularly substantiated by research.

Over time, fundamental changes in occupational therapy practice have shaped the context within which educational interventions take place. The trend has shifted from the predominance of a medical model to taking a holistic, client or family-centred approach toward both occupational therapy education and practice (Briller et al., 2016). The family-centred interventions occupational therapists currently provide when working with children create specific learning needs for both parents and therapists in order to work together. Family-centred care extends concepts of person-centred care to the whole family, recognises a child in the context of their unique family entity, and is widely regarded as best practice in child and family health (Edwards et al., 2003; Graham et al., 2009; Graham & Ziviani, 2021c). Family-centred practice acknowledges that all families are unique, with different strengths and resources that can be extended to benefit a child with the illness or disability, as well as other family members (Rodger, 2006). Family members are recognised as the constant factor in the care of the child, and are valued as experts on their child and family's strengths, needs, and values in the family-professional partnership (Colyvas et al., 2010; Edwards et al., 2003; Graham et al., 2009; Harrison et al., 2007; Jones et al., 2010; Rodger, 2006; Rosenbaum et al., 1998). The family-centred approach has challenged occupational therapists' traditional ways of working with, and

relating to, parents of children with disabilities (Graham et al., 2009). The traditional 'therapist-as-expert' model, where the family was a passive recipient of care is now considered passé (Harrison et al., 2007). Rather, parents function as collaborative partners with therapists in directing the path of intervention, sharing in intervention decision making, planning, and delivery (Hanna & Rodger, 2002; Harrison et al., 2007; Keiter Humbert et al., 2020a).

This collaborative approach can facilitate therapy outcomes which are more meaningful to both the child and family (Hanna & Rodger, 2002; Hinojosa et al., 2002). Including parents in their child's intervention can be cost-effective and also enhance the child's rate of progress by increasing the therapeutic support that a child has throughout the day (Steiner, 2011). Thus, it is imperative for parents to learn the information and skills they need to achieve this support. Recent developments in paediatric occupational therapy practice have recognised the importance of learning and teaching as a crucial part of collaborating with parents and delivery of specific family-centred intervention approaches, such as coaching and home therapy programmes (Dunn et al., 2012; Graham et al., 2009, 2010; Novak, 2011; Novak & Cusick, 2006; Novak et al., 2009). The implications for therapists include the expectation that therapists are proficient at establishing effective collaborative partnerships, communicating information to parents to encourage their active involvement, and equipping parents to participate in shared decision-making and gain practical skills to implement intervention at home and incorporate therapy into family routines.

Considering the presence of diverse contexts and perspectives when providing intervention for children and families, family-centred care has not been without its challenges (Keiter Humbert et al., 2020a). Critics have proposed that family-centred care has been seen as simplistic and idealistic (Brinker, 1992; Lawlor & Mattingly, 1998). Caution has been advised before accepting general templates of the nature of families because the definition of family is indeterminate, as all individuals have different—and at times conflicting—definitions of 'family' (Brinker, 1992). The depth of the clinician-family relationship and the understanding of family dynamics are dependent on families' willingness to enter into this relationship and, subsequently, the level of intimacy they allow (Brinker, 1992). Further, Brinker (1992) proposed that adopting a family-centred approach may impose a "greater intrusion into family life" (p. 307).

Lawlor and Mattingly (1998) identified several obstacles to creating collaborative partnerships with family members as part of a family-centred approach to occupational therapy practice. Considerable time is required to negotiate decision making with families, which may reduce the time spent on hands-on treatment and conflict with institutional pressures and expectations of time available. The need for active family participation in decision making and treatment may be precluded by the structure and nature of the therapy interactions on offer. Further, professionals maintaining an expert role and hierarchical position over parents, where

collaboration is equated to compliance, conflicts with the essence of family-centred care. These critiques point to the need for therapists to learn about the families they are working with in order to help build strong relationships for effective collaboration. This requires therapists to learn about and respect parents' existing knowledge, their priorities, circumstances, and lifestyle, in order to tailor services and interventions to individual families (Goldstein, 2013; Griffin et al., 2003; Harrison et al., 2007; Hinojosa et al., 2002).

There is a dearth of research that specifically examines the process of learning between parents and therapists, and how therapists may learn about each different family to tailor services to their needs. Furthermore, this study is unique in that it explores learning concurrently from both the perspective of parents and therapists, which other studies have neglected. Generating diverse data from interviews, observations, and photographs of learning resources allowed for providing rich details of the views, concerns, experiences, and actions of both the therapists and parents, separately and when working together, with regards to learning. This ensured the theory generated would hold relevance, resonance, and be useful within the studied context, and potentially beyond (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014).

Motivation for the Research

Researchers' professional experience often stimulates the initial research interest and motivation for a study (Holton, 2007). My motivation for undertaking this research arose from long-standing personal interests and professional concerns. I entered this study primarily as a practising occupational therapist, and as a parent myself. My interest in the study area stems from over 20 years of working as an occupational therapist with children and their parents in different clinical areas. Over that time, I developed a curiosity about the process of learning that takes place between clients and clinicians. When working with children, parents are vital—both because they know their child best and because the care and input that their child receives is ultimately reliant on their commitment and motivation to undertake the interventions offered, often as part of a home therapy programme.

I first considered parent education and the implications of how I worked with parents in the late 1990s when I was as a reasonably new clinician working with child burn survivors and their families. In the acute phase of treatment, while children were still hospital in-patients, I would spend significant time building a relationship with the family. I knew that I would have a long-term relationship with them and follow them as a main support person within the health system through several years of rehabilitation. I also knew that as part of their child's scar management treatment I was going to ask the parents to support their child to do potentially confronting things, including wearing compression garments and splints for prolonged periods of time. I invested time in teaching parents and their child about the burn injury, scarring, what to expect with longer term treatment, and that they would return to normal life activities in time.

As there was a lot to learn, I gave information gradually and in different ways—verbally, providing written material, using pictures and a 3D skin model, and showing them what pressure garments and splints looked like before introducing them. Although I noticed other clinicians worked differently, I considered this education was time well spent so the child and parents were prepared for what was ahead and not surprised when potentially invasive interventions were introduced. Having prior understanding of the process of scarring helped them participate in decision making, gave them more control, and helped gain their commitment to seeing through expensive and time-consuming treatments, that would minimise the long-term physical and visual effects of the burn scarring on their child. It was satisfying experiencing the transition of control from myself to parents, when they began telling me what was needed and why, shifting my role to giving them access to what they needed, with minimal guidance.

After I started having children of my own, I began working part-time at a child development service, predominantly working in an upper limb clinic for children—a role I still have. Although a different client group, in this setting I similarly felt that parents needed understanding so they would buy-in to what I was asking them to do to benefit their child. In hindsight, my early approach with families was didactic—I had knowledge that they needed which I would 'teach' them. With more experience, and perhaps influenced by becoming a parent myself, my approach to working with parents changed. I focused more on learning about what worked for the child and their family life when asking parents to implement a therapy intervention into their daily routine. Over the years I continued to contemplate the learning that was happening between parents and therapists. My desire to further understand this process of learning and what influences it led me to this research.

Personal motivation can help enhance insights and overall findings (Bryant, 2021). Undertaking this research project as a doctoral researcher was a journey of personal exploration and growth. Constructivist grounded theory acknowledges and supports that researchers come to a project with prior professional experience and knowledge which will inevitably contribute to shaping the research (Charmaz, 2014). Throughout the research process I considered myself a co-constructor with participants of the data and research findings (see Chapter 4 Methods) (Charmaz, 2008a, 2014). Accordingly, I use the personal pronoun when discussing decisions I made and actions I took during the research. Reflective strategies were implemented throughout to safeguard from imposing my preconceptions on the data and to sensitise me to what might influence my interpretations (Birks & Mills, 2015; Charmaz, 2014). For transparency, the research process and decisions are discussed and critiqued throughout the thesis.

Context of the Research

This study was undertaken in Aotearoa New Zealand, with participants from two main regions, including two major metropolitan cities and several smaller towns. To situate the study

in Aotearoa New Zealand's unique bicultural environment, a brief historical overview and current perspectives on addressing health inequities are provided. Other socio-political factors influencing therapy service provision and parental involvement in their child's health care will also be discussed.

Situating the Research in Aotearoa New Zealand

This study was undertaken in Aotearoa New Zealand and, as such, acknowledges Te Tiriti o Waitangi (the Treaty of Waitangi) as the founding document for relationships between Māori and the Crown (Wyeth et al., 2010). Te Tiriti o Waitangi was signed on 6 February 1840 and reflected both commercial and humanitarian interests. It called upon both parties (Māori, the original inhabitants and Pākehā, the primarily British immigrants) to work together, and in partnership, for the benefit of the community (Drury, 2007). Te Tiriti consisted of three articles and was written in both English and te reo Māori (the Māori language). There are acknowledged discrepancies between the Māori and English versions resulting in both parties having different expectations of the relationship (Wyeth et al., 2010). The three articles in the Māori version were articulated as kāwanatanga (governorship), rangatiratanga (chieftainship), and ōritetanga (equality). Ōritetanga underpins expectations that Māori have equal access and standards of health as non-Māori, and that any disadvantages are addressed (Wyeth et al., 2010). Whilst I have not found specific literature relating to inequities in the particular area of this study, health inequities between Māori and non-Māori have been consistent for decades. Accessibility and utilisation of healthcare by Māori is reduced at all stages of care, indicating a strong need for the role of occupational therapy in the health and well-being of whānau Māori (extended family or family group; in the modern context the term is sometimes used to include friends[1]) (Jansen et al., 2009; Wyeth et al., 2010).

In the health sector, te Tiriti principles guide the way Māori health care issues are responded to by all health care practitioners, with a strong focus on aiming to reduce health inequities for Māori. Part of this aim is to ensure partnership in working with Māori, to develop strategies for Māori health gain, and appropriate health and disability services; participation of Māori in all aspects and at all levels of health and disability services; and protection to ensure Māori have at least the same level of health as non-Māori, while respecting Māori cultural values (Ministry of Health, 2014). These principles also form the fundamental basis of all health research, including this study, and the key relationships required with Māori. Therefore, all health research in Aotearoa New Zealand is of interest to Māori (National Ethics Advisory Committee, 2019). Wyeth et al. (2010) argued that "advantages of conducting health research that is acceptable, accountable and relevant to Māori include helping gain knowledge towards improving outcomes and reducing such disparities" (p. 307). Therefore, it is important to recruit Māori participants to all health-related research to ensure the findings are acceptable to and

[1] All Māori-English translations are from Moorfield (2011) unless otherwise indicated.

useful for Māori, and thus support culturally appropriate, safe, and responsive practice (Hopkirk & Wilson, 2014). Hence, consultation, guidance, and support are key components in development of research in Aotearoa New Zealand involving Māori participants (Silcock & Hocking, 2021; Wyeth et al., 2010). Consequently, consultation with Māori advisors throughout the research process was employed to optimise the opportunity for Māori participation and to inform subsequent analysis.

Political Context: Government Legislation and Health Strategies

Family-centred care is not just a health professional imperative—it is given weight by legislation. When the study commenced, there were several current initiatives focusing on working with families and children with special needs, supported through the Aotearoa New Zealand government (Ministry of Health, Ministry of Social Development, and Ministry of Education). These initiatives encourage empowering families to manage their own health needs and promote a family-centred system in which families are active partners with health care professionals and involved in all aspects of decision making and treatment provision in health care. The New Zealand Health Strategy (Ministry of Health, 2000, 2016) and the New Zealand Child Health Strategy (Ministry of Health, 1998) described national policies for the improvement of child health outcomes. More recently, a cross-government family-centred taskforce, Whānau Ora (Manatū Hauora [Ministry of Health], 2010; Ministry of Health, 2015b) was jointly implemented by the Ministry of Health, Te Puni Kōkiri (Ministry of Māori Development), and the Ministry of Social Development. This initiative integrates health, education, and social services, and places whānau at the centre of service delivery. Although focused on Māori, it aims to improve outcomes for all Aotearoa New Zealand families. Further, in the document—A window on the quality of Aotearoa New Zealand's health care 2019: A view on Māori health equity (Health Quality & Safety Commission, 2019)—parents highlighted the importance of relationship with clinicians, built through communication and taking into account individual differences. Practice guidelines from the Good Start in Life Project (Office for Disability Issues, 2020), a collaborative cross-government action research focused on whānau and services working together, and enabling children and their families to be in the 'driving-seat' to be able to achieve their goals and aspirations. As such, occupational therapists should be looking at the needs of whānau as a whole (Occupational Therapy Board of New Zealand, 2015c).

There are additional governmental influences on therapists' approach to working with families. Concerning the needs and rights of children with disabilities, the Disability Support Service Strategic Plan 2014-2018 acknowledges that early intervention is critical to achieve improved outcomes for children with disability and their families, aiming to give families choice, and to support families to be "aspirational for their disabled child" (Ministry of Health, 2015a, p. 2). Further, the Code of Health and Disability Services Consumers' Rights (Health

and Disability Commissioner, 1996) grants a number of rights to all consumers of health and disability services in Aotearoa New Zealand, endorsing their right to choice as well as respect, effective communication, and the right to information. The responsibility for meeting these obligations is placed on health service providers. Additionally, children's rights under the United Nations Convention on the Rights of the Child (United Nations: Human Rights, 1990) are endorsed by the New Zealand Government (2015), of which, particularly relevant to this study and occupational therapists, is a child's right to reach their full potential.

Within the occupational therapy profession, the Occupational Therapy Board of New Zealand, in discharging its responsibilities under the Health Practitioners Competence Assurance Act (Ministry of Health, 2003), sets out guidelines for working with individuals and their families, through the Code of Ethics for Occupational Therapists (Occupational Therapy Board of New Zealand, 2015a) and Competencies for Registration and Continuing Practice (Occupational Therapy Board of New Zealand, 2015b). These mandates acknowledge the client's role in their family and stipulate involving family in therapy provision if this is the client's choice (Occupational Therapy Board of New Zealand, 2015a). Guidelines are also provided around working with, enabling, empowering, collaborating, communicating, building respectful relationships, and helping clients develop "their skills and teaching them processes for learning" (Occupational Therapy Board of New Zealand, 2015b, p. 4). When considering the future direction of occupational therapy in Aotearoa New Zealand, the Occupational Therapy Board of New Zealand (2015c) has suggested a move to focus more on 'family' rather than 'client', focusing less on one individual and more on the family unit. This seemingly indicates that perspectives advanced under a biculturalism agenda have been adopted by institutions.

Health Care Provision for Children and Families in Aotearoa New Zealand

The focus for this study is on parents with pre-school aged children and occupational therapists working with this client group. As in other countries, in Aotearoa New Zealand services for children generally adopt a family-centred approach where the child and family are viewed as interdependent and where the entire family, not just the child, is considered the primary client (Colyvas et al., 2010; Rodger, 2006). Services supporting pre-school aged (0-5 years) children who need assistance with their development are commonly referred to as 'early intervention services'. Services vary within different regions across Aotearoa New Zealand and where several services are available in an area, often parents can choose the service they prefer to access for their child. Many early intervention services are home-based, with therapists visiting families in their home environment and therapy being incorporated into everyday life and family co-occupations (the socially interactive activities and routines shared by the child and their family such as feeding, dressing, bathing, playing) (Dalvand et al., 2015; Dunlea, 1996; Olson, 2004; Pierce, 2009). However, some services are clinic or centre-based, with parents carrying through therapy intervention at home as part of a home programme, generally

developed in partnership with the therapist and parent. Therapists may also visit and work with young children in their other natural environments, such as day care centres or early childhood education centres.

Within early intervention services in Aotearoa New Zealand there is generally the intent of continuity of care, with the same therapist working with the same parent and child for extended periods of time. Depending on the service, appointments may vary between weekly to monthly, with an expectation of active parental participation in their child's therapy during the visit and using a home programme between visits. Not only are there different settings and therapists involved who might influence learning in different ways, but learning may also vary according to the service provider accessed by parents. Some early intervention services use a transdisciplinary approach where physiotherapists and occupational therapists share cross-over roles. In this research, all the therapist participants and therapists working with the parent participants were occupational therapists, even though several worked in a transdisciplinary role such as a visiting neurodevelopmental therapist (VNT).

Therapy services for all New Zealanders are largely government funded. The Ministry of Health funds services for children with congenital special needs, and services for children with injuries acquired as a result of an accident are funded through the government's Accident Compensation Corporation (ACC), at no cost to the parent. At the time of the study, Ministry of Health funded child development services were often provided within or alongside paediatric or community health services through local hospitals, run by regional District Health Boards (DHBs). In some areas there were alternative early intervention services, funded fully by the Ministry of Education or in part by charitable trusts (Ministry of Education, 2011). Self-funded private services were also available in some areas. When a child reaches school age, early intervention services generally transition children with long-term needs to school based therapy support, which is another arm of influence in the ongoing management of the child and their condition. Supporting positive learning for parents when children are pre-school aged arguably establishes a basis for families to support their children as they progress through to school.

Structure of Thesis

Chapter 1 has presented an introduction to the research, including the aim and purpose of the research undertaken. I have provided an overview of the rationale for the research. The significance of this study and its potential contribution to extant knowledge is proposed. I highlighted my personal background and motivation for undertaking this research. The background context has been established with a discussion about the cultural and political context of the study, and an explanation of early intervention service provision for children and their families in Aotearoa New Zealand.

Chapter 2 presents a review of the literature informing this study. The place of literature review in grounded theory studies is reviewed and the multi-phase literature review undertaken is outlined. I present a pre-research review of occupational therapy literature considering teaching and learning theories influencing occupational therapy practice, both historic and current. This is followed by a review focusing on teaching and learning in paediatric occupational therapy and early intervention literature, and a broader scoping review that provided an overview of the body of knowledge of client education, teaching and learning in the occupational therapy literature. The chapter establishes that there has been limited research similar in nature to this study and further endorses the need for this research.

Chapter 3 details the methodological positioning of this study. An overview of constructivist grounded theory methodology is presented, followed by the theoretical background, underpinning philosophy, and epistemological positioning of the research. Constructivist grounded theory is identified as the specific variant of grounded theory employed in this study and key components of grounded theory research are outlined.

Chapter 4 outlines the design of the study and specific research methods used. Ethical considerations; the grounded theory methods including the process of sampling and participant recruitment; data generation using interviews, filming of routine therapy sessions, and photographs of learning resources; strategies and stages of data analysis and theory construction are explained.

Chapters 5, the first of five chapters presenting the findings from this research, introduces the theory of **Responsive learning: Learning from and with each other**, constructed during this research, in diagrammatic form. This is followed by an overview of the three theoretical categories of the theory, and their subcategories. These are explicated in greater detail in the following four findings chapters.

Chapters 6-9 present the research findings. The three theoretical categories and their subcategories and properties are explicated across four chapters. In Chapter 6, the first theoretical category, **Establishing relationship,** and its two subcategories—**Connecting** and **Crossing the relational threshold—**are outlined. The second theoretical category, **Partnering in learning** and its three subcategories are presented across two chapters. In Chapter 7 **Partnering in learning** and the first two subcategories—**Getting on the same page** and **Tailoring learning—**are discussed. The third subcategory of **Partnering in learning**, **Getting on the same page again**, is outlined in Chapter 8. In Chapter 9, the third theoretical category, **Integrating learning** and its subcategories—**Crossing the independence threshold** and **Moving on—**are presented.

Chapter 10 presents a discussion of the theory of **Responsive learning: Learning from and with each other** and its significance and place within extant literature. The implications of this

study for further research possibilities, clinical practice, and education are considered and proposed. Finally, reflections are provided on the limitations, quality, and strengths of the research.

Summary

Impelled by my longstanding curiosity about the learning processes implicit in my occupational therapy practice with children and their parents, and informed by the emphasis placed on family-centred care at a governmental and professional level, I initiated this grounded theory study. In this chapter I have introduced the research and my aim of constructing a substantive grounded theory that will explicate the process of learning between parents and occupational therapists who work with children. Contextual influences, in particular the commitment to addressing health disparities endured by Māori over many decades, and the provision of free therapy services for all New Zealanders, are outlined as an initial measure to enable readers to interpret the relevance of the study findings to other settings.

Chapter 2 Literature review

Introduction

In this chapter I present my literature review process and the knowledge base that informed the design of the study, data generation, and analysis. I begin by considering the role of literature review in grounded theory research and the position taken on the use of literature in this study. Next, the multi-phase literature review process used is outlined. The first three phases of the literature review process are then presented. First, I discuss the history of teaching and learning in occupational therapy and outline the learning theories that have influenced practice over time. Second, I consider extant research pertinent to teaching and learning in family-centred therapy, along with the key concepts that influence occupational therapy practice. Third, I present the results of a scoping review of teaching and learning in wider occupational therapy contexts. I conclude this chapter with a summary and justification of the need for this study to address a gap in extant literature.

Targeted literature searches were also undertaken during data analysis, and once data analysis was completed, the categories identified, and theory constructed to place the research findings in the context of current knowledge (Charmaz, 2014; Glaser & Strauss, 1967). The findings of these subsequent literature searches are presented in the discussion Chapter 10 to support the critique of my findings.

The Place of Literature in Grounded Theory Research

The place of literature review in grounded theory has been a subject of much debate, from both an ideological and practical perspective (Birks & Mills, 2015; Charmaz, 2014; Dunne, 2011; Giles et al., 2013; Holton, 2007; Lempert 2007; Thornberg & Dunne, 2019). When grounded theory was first introduced, Glaser and Strauss (1967) held firm that researchers should enter a study uncontaminated from, and unconstrained by, existing theories and knowledge, as *tabula rasa,* or a blank slate. This was to avoid imposing preconceived ideas on data, thereby resulting in grounded theories derived from pure induction (Charmaz, 2014; Lempert 2007). The strategy proposed to achieve that end was avoidance of conducting a literature review prior to data collection. Although Glaser and Strauss later diverged from their stance on this (Glaser & Strauss, 1967; Ramalho et al., 2015; Strauss & Corbin, 1990), earlier variants of grounded theory accordingly advocated delaying consultation of extant literature until data analysis was complete (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Strauss and Corbin (1990, 1998; Corbin & Strauss, 2015) subsequently adopted a more liberal stance and acknowledged that researchers brought considerable background in professional and disciplinary literature. They argued, nonetheless, that there was still no need to review all of the

literature initially and cautioned that literature could hinder the researcher's creativity and constrain theory development (Thornberg & Dunne, 2019).

These original proscriptions of the classic grounded theorists have been challenged; particularly as grounded theory methodology has developed. For instance, Dey (1993) argued that, "in short, there is a difference between an open mind and an empty head. To analyse data, we need to use accumulated knowledge, not dispense with it. The issue is not whether to use existing knowledge, but how" (p. 63). It is now recognised that knowledge of their field is generally held by researchers, and this leads them to their research topic. Further, delaying literature review is not always possible, practical, or, arguably, conceptually useful (Bryant, 2017; Charmaz, 2014; Lempert 2007; Thornberg, 2012). Many grounded theorists argue that a lack of familiarity with relevant literature is both unlikely and untenable, and that it is unrealistic and contrived to pretend otherwise (Charmaz, 2014; Clarke, 2005; Dunne, 2011; Lempert 2007; Thornberg, 2012). Charmaz (2014) encouraged use of literature throughout all phases of grounded theory research. Consistent with constructivist and pragmatist philosophy, she recognised that researcher familiarity with literature influences, informs, and augments the research by alerting the researcher to gaps in theorising, as well as the ways the data may tell a different story (Charmaz, 2014; Kenny & Fourie, 2015; Lempert 2007). Thus, in contemporary grounded theory, literature can also be considered a data source and tool to stimulate thinking, enriching data analysis and theory construction (Birks & Mills, 2015; Charmaz, 2014).

Other grounded theorists, including Thornberg (2012), have more recently promoted the concept of an 'Informed Grounded Theory', which refers to "a product of research as well as the research process itself, in which both the product and process are thoroughly grounded in data by grounded theory methods while being informed by existing research literature and theoretical frameworks" (p. 249). Arguing from a constructivist position and pragmatist epistemology, Thornberg additionally advocated for using pre-existing knowledge in a sensitive, creative, and flexible way. Aligning with Thornberg, Charmaz (2014) also viewed pre-existing knowledge as an advantage rather than an obstacle or threat. They thus rejected the notion of pure induction and challenged the dictum to delay literature review, while cautioning that an informed grounded theory approach assumes and requires a critical, reflective stance. My research was based on Charmaz's constructivist grounded theory, and adopted Thornberg's notion of an informed grounded theory.

Researchers begin a study with a baseline theoretical sensitivity about a topic reflecting their unique personal, professional, and experiential history (Birks & Mills, 2015). This a priori knowledge can be used as sensitising concepts, or ideas that spark thinking about a topic to initiate lines of inquiry (Charmaz, 2014). Charmaz (2014) attributed the notion of sensitising concepts to the work of Blumer (1969), who described them as "directions along which to look" (Blumer, 1954, p. 7). Sensitising concepts are suggestive, rather than prescriptive, providing a

general sense of guidance and arm researchers with tentative ideas to pursue and questions to raise about their research topic (Bryant, 2017; Charmaz, 2014). Charmaz saw them as points of departure for developing, rather than limiting ideas. Sensitising concepts also lay the foundation for the analysis of research data, and when coding and developing theoretical categories from the data (Bowen, 2006; Charmaz, 2014). For this study, my sensitising concepts were derived from my personal knowledge, assumptions, experiences, and ideas gleaned from the review of relevant literature. Conducting an early literature review was useful for providing rationale and identifying sensitising concepts for the study. Thereafter, literature was used throughout the duration of the study to sensitise me to emerging concepts, and to guide and inform the theory being constructed.

However, extant theoretical concepts and ideas from literature in the substantive field have to earn their way into the grounded theory (Thornberg, 2012). Thus, remaining alert to sensitising concepts and scrutinising their influence is important (Charmaz, 2014). To safeguard against imposing my preconceptions and to remain open to, and grounded in, the data, I used constant reflexivity. That involved engaging in self-monitoring strategies including undertaking a pre-supposition interview to become aware of my preconceived ideas, writing a reflective journal, memoing, and discussions with my research supervisors through all stages of the research (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014; Lempert 2007; Thornberg, 2012). These strategies are discussed further in the Methods, Chapter 4.

Multi-Phase Literature Review

Literature has significance at all stages of grounded theory studies, including "to enhance theoretical sensitivity; as data during analysis; and as a source of theoretical codes" (Birks & Mills, 2015, p. 22). Grounded theory is not a linear process, and like many aspects of grounded theory methodology, the literature review was also iterative (Ramalho, 2019). Thornberg and Dunne (2019) identified three phases of literature review in grounded theory: initial, ongoing, and final. Each phase is targeted and purposeful, fulfilling a distinct and important function in the research process (Thornberg & Dunne, 2019). My literature reviews reflected these three phases. The initial literature review phase is outlined in the following sections of this chapter. The two subsequent literature reviews undertaken during data analysis (ongoing literature review) and after theory construction (final literature review), were specifically guided by concepts and categories in the theory. These are predominantly reported in the Discussion, Chapter 10.

The initial literature review commenced prior to data generation to gain familiarity with extant knowledge, to inform data generation (the questions I asked participants), and guide data analysis, and so I could enter the study as an informed listener and observer to what participants were saying and doing (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014; Thornberg, 2012).

The initial literature review also orientated me to the field of study, provided a sound rationale for the research, and ensured the research would make a meaningful contribution, fulfilling university research proposal requirements (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014; Urquhart, 2007). There were three stages to the initial literature review. First, to gain a baseline understanding of teaching and learning theories relevant to occupational therapy practice, I reviewed prominent occupational therapy texts to identify learning theories in use, both historic and current. Second, I searched paediatric occupational therapy and allied health early intervention literature. This search yielded few studies specifically focused on occupational therapists teaching parents or caregivers, and their own learning, emphasising the gap in the knowledge base informing therapists' actions and reasoning in teaching and learning when working with parents. Third, to gain a broader overview of knowledge of client education and teaching and learning in occupational therapy literature in general, I undertook a scoping review. All of these generated sensitising concepts as I entered the research.

Ongoing literature review was undertaken during data analysis. Adopting the logic of theoretical sampling in this phase, I was guided by raw data (including interview and observational data); and codes, concepts, questions, and ideas developed during data analysis (Thornberg & Dunne, 2019). Several authors support theoretical sampling of the literature, when directed to do so by the data, arguing that reviewing the literature will further the analysis by returning to the empirical field, and the provisional codes, concepts, and theory construction, with a new lens and new questions (Birks & Mills, 2015; Thornberg & Dunne, 2019). Accordingly, I used the notion of an ongoing literature review, engaging with literature as ideas and concepts emerged from data analysis and theory construction, with ideas either earning their place or being discarded (Birks & Mills, 2015; Charmaz, 2014; Thornberg, 2012). Iterative movement between data and literature was directed by the principles of theoretical sampling (Birks & Mills, 2015; Charmaz, 2014; Thornberg & Dunne, 2019). For example, I had not appreciated at the outset that embodied learning would be part of the learning process. As analysis of observational data progressed this became increasingly evident in the ways that parents and therapists were using their bodies to demonstrate to each other what they meant and to support learning. The need to understand embodied learning, and explain what I was seeing in the data, required me to delve into the literature. Other emergent ideas were discarded when they proved not useful to theory construction after being subjected to scrutiny (Thornberg, 2012).

As there was a time delay between the initial literature searches and finalising construction of my substantive grounded theory, it was pertinent to undertake a final review of more recent literature related to my findings. I thus returned to the literature to compare and substantiate the theory, categories, and concepts with relevant extant literature and research, and to situate the findings in the context of current knowledge, a feature of, and interwoven with,

theoretical coding in the latter stage of analysis (discussed in Chapter 4 Methods and Chapter 10 Discussion) (Birks & Mills, 2015; Bryant, 2017; Bryant, 2021; Charmaz, 2014; Glaser & Strauss, 1967; Thornberg & Dunne, 2019). This also served to highlight the contribution of this research to the field (Thornberg & Dunne, 2019). An overview of the multi-phase literature review undertaken is presented in Table 2.1.

Table 2.1

Outline of the multi-phase literature review

Search	Purpose	Timing	Method	Reported
Initial literature reviews:				
1. Review of teaching and learning in occupational therapy texts, and learning theories drawn on, historically and currently.	To identify prominent leaning theories occupational therapists draw on.	Pre data generation	A selection of prominent occupational therapy texts reviewed (1973-2014)	Chapter 1. Introduction Chapter 2. Literature review
2. Review of teaching and learning in paediatric and early intervention literature.	To identify important studies, gaps in literature, and provide a rationale for the research. Fulfilment of university and ethics requirements.	Pre data generation	General search strategy	Chapter 1. Introduction Chapter 2. Literature review
3. Review of broader occupational therapy literature on client education, teaching and learning in occupational therapist practice.	To generate a broader overview of extant occupational therapy research and literature and fill gaps in earlier literature search.	During early data generation	Scoping review framework described by Arksey and O'Malley (2005).	Chapter 2. Literature review
Ongoing literature review:				
4. Literature searched during data analysis and once the theory was constructed.	To engage with literature that became relevant during data analysis, which I had not anticipated at the outset. To inform data analysis.	During data generation and analysis	Guided by data analysis and theoretical sampling (Birks & Mills, 2015; Thornberg & Dunne, 2019).	Chapter 4. Methods Chapter 10. Discussion
Final literature review:				
5. To situate my theory in extant literature.	To locate, evaluate and defend the theory. Theoretical coding (Birks & Mills, 2015; Bryant, 2017)	Post theory construction	Targeted literature search guided by categories and concepts in the theory.	Chapter 4. Methods Chapter 10. Discussion

The focus of all phases of the literature review was teaching and learning with clients or parents in the therapy context, as opposed to teaching and learning for occupational therapy students. The majority of studies included in the literature reviews had occupational therapist

representation. However, a multidisciplinary approach is common in early intervention services, where occupational therapists work closely or in an interdisciplinary role with other health professionals, including physiotherapists and speech language therapists. Consequently, in reporting the literature, I use the terms occupational therapists, therapists, practitioners, service providers, and professionals interchangeably, reflecting the broad use of terms in the studies reviewed. When referring to parents, I use the terms parent and caregiver interchangeably, as these words are used synonymously in the literature.

Teaching and Learning in Occupational Therapy Practice

A review of occupational therapy literature was undertaken to develop sensitivity to the learning theories and theorists informing occupational therapy practice over time. A selection of prominent general occupational therapy textbooks published since the 1970s (1973-2014) were examined. The questions guiding the review were:

- How has teaching and learning with clients been addressed in occupational therapy literature?
- What learning theories have occupational therapists drawn on when working with clients?

The texts were reviewed in chronological sequence. Sensitising concepts gained from this process helped me discern what I was hearing, seeing, and interpreting, informing data generation and analysis. An overview of the occupational therapy texts reviewed, and their general description of learning is presented in Table 2.2. The table contents are arranged in chronological sequence to provide an overview of when and how learning and education has been introduced or described to the profession, and by whom.

Teaching and Learning in Occupational Therapy Textbooks Over Time

As outlined in the introduction chapter, teaching, and learning, along with engagement in occupation, has been a reoccurring theme in the occupational therapy profession since its foundation over 100 years ago (Bing, 1981; Fisher, 2013). Both have been considered core components of occupational therapy practice—to help people master, maintain, and generalise skills and knowledge to everyday activities (Bing, 1981; Fisher, 2013; McEneany et al., 2002; Schwartz, 1992). A fundamental assumption of occupational therapy (and consensus amongst various learning theories) is that a natural way for people to learn is through doing (Hagedorn, 2000; Townsend et al., 2013). Learning through doing has been repeatedly identified as an essential therapeutic tool underlying most, if not all, occupational therapy interventions (Flinn & Radomski, 2008; Greber & Ziviani, 2010; Hagedorn, 1995; Mosey, 1986).

Table 2.2

Overview of occupational therapy texts reviewed

Author	*Textbook* / Chapter Title	Description of learning
Mosey (1973, 1986)	*Activities therapy*	Teaching-learning process Acquisitional frames of reference
	Psychosocial components of occupational therapy	Teaching-learning process
Hagedorn (1992, 1995, 2001)	*Occupational therapy: Foundations for practice, models, frames of reference and core skills*	Educational model/ Process of education
	Occupational therapy: Perspectives and processes	Educational model/ Process of education
	Foundations for practice in occupational therapy (3rd ed.)	Process of education Educational primary frame of reference
Flinn and Radomski (2008)	*Occupational therapy for physical dysfunction* (6th ed.). Learning	Learning as essential therapeutic tool Teaching-learning process
Hoffmann (2009)	*Skills for practice in occupational therapy*. Educational skills for practice	Educational intervention
Greber and Ziviani (2010)	*Frames of reference for pediatric occupational therapy* (3rd ed.). A frame of reference to enhance teaching-learning: The four-quadrant model of facilitated learning.	Four-quadrant model of facilitated learning
Luebben and Royeen (2010)	*Frames of reference for pediatric occupational therapy* (3rd ed.). An acquisitional frame of reference	Acquisitional frame of reference
Helfrich (2014)	*Willard and Spackman's occupational therapy* (12th ed.). Principles of learning and behaviour change	Principles of learning and behaviour change Learning theories underpinning occupational therapy practice
Berger (2014)	*Willard and Spackman's occupational therapy* (12th ed.). Educating clients	Educating clients—health literacy; information needs; conveying information

Despite the centrality of teaching and learning throughout the profession's history, there has been little elaboration of the educational theories underpinning practice in occupational therapy literature. Some of the texts reviewed focused on approaches to teaching, with a more practical rather than theoretical base (Berger, 2014; Flinn & Radomski, 2008; Hoffmann, 2009; Mosey, 1973). Educational knowledge was identified as a therapeutic tool and practical strategy (Berger, 2014; Flinn & Radomski, 2008), and as a framework for approaching and planning educational interventions (Hoffmann, 2009). Few contemporary occupational therapists have proposed occupational therapy specific teaching, learning or educational models, processes, or frames of references, and earlier propositions pertaining to teaching and learning were largely unsubstantiated by references and research (Greber & Ziviani, 2010; Hagedorn, 1992, 1995, 2001; Mosey, 1973, 1986). Only one occupational therapy specific, research-based teaching and learning process appears to have been developed—the four-quadrant model of facilitated

learning (4QM)—a child focused model of facilitated learning, which is claimed to be generalisable (Greber & Ziviani, 2010; Greber et al., 2007a). More recent editions of the same textbook have added minimal additional content or progression (Helfrich, 2014; Stern, 2009).

Anne Mosey (1973) appears to have been the first occupational therapy scholar to have published about a 'teaching-learning process'. She described teacher attributes and principles of the teaching-learning process more indicative of practical teaching strategies to design adequate learning experiences for patients. Her initial introduction of this process was not based on any identified learning theories. It held a paternalistic tone, with Mosey (1973) stating, "the therapist tells the patient how he can best make use of each learning situation" (p. 43). In a later text, Mosey (1986) elaborated the teaching-learning process and introduced an 'acquisitional frame of reference' as a structure for linking various, unspecified learning theories, the reality aspect of purposeful activity, and the process of acquiring skills or subskills of an activity needed for successful interaction with the environment. In addition, Mosey (1986) introduced so-called operant conditioning (behavioural learning theory) as the most common theory of learning, and the foundation for the acquisitional frame of reference. Although she acknowledged the underpinning influence of Piaget (1964) (stages of cognitive development) and the cultural and social influence on learning, her claims were largely unsupported by references and unsubstantiated.

Notwithstanding these deficits, Mosey's (1973, 1986) work continues to be evident in more contemporary occupational therapy literature, and other authors have also referred to a teaching-learning process or approach in practice (Flinn & Radomski, 2008; Greber & Ziviani, 2010; Luebben & Royeen, 2010). In more recent times, the acquisitional frame of reference has been proposed as being, at a fundamental level, synonymous with the teaching-learning process (Luebben & Royeen, 2010). Further, Mosey's notion of an acquisitional frame of reference has been expanded by subsequent authors who acknowledged the influence of psychologists including Skinner, Pavlov, and Thorndike's behavioural learning theories, and Bandura's social learning theory (Flinn & Radomski, 2008; Greber & Ziviani, 2010; Greber et al., 2007a; Luebben & Royeen, 2010).

Mosey (1986) argued that there was no one comprehensive theory of learning and urged occupational therapists—like other professions—to make use of whatever collective knowledge was available and of value to a particular teaching situation. She further described the principles of learning as a "collection of generalisations distilled from various theories of learning" (Mosey, 1986, p. 219). The theme of borrowing from other learning theories was echoed by Rosemary Hagedorn (1992, 1995), who wrote about an 'educational model' and 'process of education' as a foundation for occupational therapy practice. She later described an 'educational primary frame of reference' (Hagedorn, 2001). She too acknowledged that occupational therapists have borrowed from other learning theories and educational models to develop a

repertoire of educational strategies and skills used in practice. Although she outlined several learning theories and theorists influential to occupational therapy practice, she provided few references to substantiate these claims.

More recently, there is evidence of Mosey's (1973, 1986) earlier explanations of the teaching and learning process being used in current occupational therapy practice. For instance, the 4QM was proposed as a way of organising and implementing a client-centred teaching-learning approach (Greber & Ziviani, 2010; Greber et al., 2007a, 2007b, 2007c, 2011). Although developed to inform teaching-learning approaches with children, the authors claimed it had potential to be applied more broadly (Greber et al., 2007a). The model consists of four clusters of learning strategies and guides therapists' selection of teaching and learning approaches to meet different learning needs throughout the skill acquisition process. Each quadrant informs a different learner need (task specification; decision making; key points; autonomy) and accounts for direct and indirect, and facilitator and learner initiated, learning strategies (Greber & Ziviani, 2010; Greber et al, 2011). The authors drew on theoretical principles of occupational therapy, the acquisitional frame of reference, and techniques used in facilitated learning to formulate a teaching-learning approach to occupational therapy intervention in which the therapist assumes the role of facilitator of learning, progressing from leading (facilitator initiated) to fading (learner initiated) (Greber & Ziviani, 2010; Greber et al., 2007a). The seminal work of developmental psychologist Lev Vygotsky (1978) was specifically identified as influencing this model; namely, a person-centred approach to learning, the zone of proximal development (distance between the actual developmental level and level of potential development i.e., amount of learning possible), and progress towards autonomy. Facilitator support (scaffolding) provided a basis for understanding facilitation of learning in occupationally directed interventions (Greber & Ziviani, 2010; Schunk, 2008). In a further study exploring the perspectives of experienced occupational therapists' use of the 4QM, Greber et al. (2011) found that they considered teaching-learning approaches core to their practice (irrespective of their area of practice). However, therapists did not identify a clear process to guide implementation of these approaches and lacked a deep understanding of the learning process. Regardless, they argued that the 4QM offered participants a pedagogically based tool which enhanced therapist decision making by providing a theoretical scaffold.

While the rhetoric of teaching and learning has been ongoing in the occupational therapy profession, the scant development of educational and learning theory within the profession's literature and only partial engagement with more recent learning theories was insufficient to inform my study. Therefore, I looked to the original sources of the educational theorists and theories identified from these texts.

Learning Theories Informing Occupational Therapy Practice

As a profession, occupational therapy has continually borrowed from the knowledge and learning theories of other disciplines, predominantly psychology (except for educator Malcolm Knowles, 1973). These learning theories (commonly behavioural, cognitive, and social learning) have been applied to occupational therapy practices and frames of reference and are used to underpin occupational therapy interventions and practice. Only the more recent texts have made attempts to provide citations, references, and research of prominent learning theories underpinning learning in occupational therapy practice—as a therapeutic approach (Flinn & Radomski, 2008); a facilitated learning model (Greber & Ziviani, 2010); an acquisitional frame of reference (Luebben & Royeen, 2010); and providing principles of learning and behaviour change (Helfrich, 2014). A summary of the learning theories and theorists referred to in the occupational therapy texts reviewed are outlined in Table 2.3.

Table 2.3

Learning theories and theorists referred to in key occupational therapy texts

Learning theory/theorists	Occupational therapy reference
No specified learning theory/theorist	Berger (2014); Mosey (1973)
Behavioural learning theory e.g., Skinner's operant conditioning (backward/forward chaining); Pavlov's classical conditioning; Thorndike's (1874-1949) connectionism (Law of Effect); Watson (1917); Tolman (1932, 1958); Guthrie (1935); Hull (1951)	Hagedorn (1992, 1995, 2001); Helfrich (2014); Luebben and Royeen (2010); Mosey (1986)
Developmental learning theory e.g., Piaget's (1952) stages of cognitive development	Hagedorn (1992, 1995, 2001); Mosey (1986)
Cognitive learning theory e.g., Bruner's (1966) theory of instruction	Hagedorn (1992, 1995, 2001)
Cognitive-behavioural learning theory e.g., Gagné (1977) cognitive-behavioural hierarchical structure for learning application in skill acquisition; Prochaska's (1992) motivational transtheoretical model of intentional change.	Flinn and Radomski (2008); Hagedorn (1992, 1995); Helfrich (2014); Hoffmann (2009)
Social and social cognitive learning theory e.g., Piaget (1970); Bandura's (1965, 1977) self-efficacy theory	Flinn and Radomski (2008); Hagedorn (1992, 1995, 2001); Helfrich (2014); Hoffmann (2009); Luebben and Royeen (2010)
Constructivist learning theory e.g., Rogers (1983); Bruner's (1961) experiential and problem-based learning	Hagedorn (1992, 1995); Helfrich (2014)
Humanist learning theory e.g., Perry's (1970) 9 positions of adult learning; Knowles' (1978) adult learning theory/andragogy	Hagedorn (1992, 1995, 2001); Hoffmann (2009)
Socio-cultural learning theory e.g., Vygotsky's (1978) person-centred collaborative approach to learning	Greber and Ziviani (2010)

As demonstrated in Table 2.3, behavioural, cognitive, constructivist, and social learning theories were commonly referenced in the occupational therapy texts reviewed and are the focus of the following discussion. While there is consensus that learning is important, there are differing views as to the causes, processes, and consequences of learning, and overlap is often evident. Understanding historical information provides useful background for understanding current learning theories (Schunk, 2008). During the first half of the 20th century, researchers developed two main learning theories: behaviourist and cognitive theories. These have roots in early philosophical positions including empiricism (stemming from Aristotle, 384-322 BC who wrote "what we have to learn to do, we learn by doing", cited in Hagedorn, 2000, p. 67) and rationalism (stemming from Plato, 427-347 BC) (Hrynchak & Batty, 2012; Schunk, 2008).

Behavioural learning theories contend that learning does not necessarily include internal events (thoughts, beliefs, feelings); rather, emphasises the environment and the association of stimuli with responses and consequences in line with the empirical position which viewed experience as the only source of knowledge (Schunk, 2008). American psychologists Edward L. Thorndike (1874-1949) and John B. Watson (1878-1958) supported an objective scientific psychology studying observable behaviour, which lead to an emphasis on behaviourism as the dominant psychology of learning in the first half of the 20th century in the Western world (Helfrich, 2014; McInerney, 2014).

In contrast, similar to the rationalist notion that knowledge is derived through reasoning and reflection on knowledge already held in the absence of overt behaviour, cognitive theories stress association between cognition and beliefs. Cognitive learning places emphasis on learners' information processing as a central cause of learning in an internal mental process of "construction, acquisition, organisation, coding, rehearsal, storage in and retrieval from memory" (Schunk, 2008, p. 17), through which knowledge and skill are acquired. Cognitive learning theories by psychologists Jerome Bruner and Robert Gagné were identified as influential to occupational therapy practice (Hagedorn, 1992, 1995; Helfrich, 2014). In particular, Bruner's (1960) learning theory viewed learning as an active process in which learners construct new knowledge by organising and categorising information involving three synchronous processes—acquisition of new information, transformation, and evaluation (Johnson, 2019; Knowles et al., 2015). Bruner contributed a theory of cognitive development which differed from other stage-based theories of cognition and proposed that with instructional support even young children can learn difficult concepts (Bruner et al., 1966; Schunk, 2008). He additionally contributed a theory of instruction (Bruner, 1966) and was one of the founding influences on constructivist learning (Helfrich, 2014).

Based on cognitive principles, Robert Gagné (1985) formulated a cognitive-behavioural instructional theory of conditions of learning which influence behaviour. This encompassed first, specifying the type of learning outcome (intellectual skills, verbal information, cognitive

strategies, motor skills, or attributes); second, nine phases of learning grouped in three categories (preparation for learning; acquisition and performance; and transfer of learning); and third, the events of learning or factors that make a difference in instruction (Schunk, 2008). More recent information processing models have been concerned with the cognitive mechanisms by with information is processed, acknowledging active involvement of the learner and the importance of personal meaning in learning—how learners select, organise, and integrate incoming experiences with existing knowledge (Flinn & Radomski, 2008; Knowles et al., 2015; McInerney, 2014; Schunk, 2008). Such informational processing is a constructivist approach to learning (McInerney, 2014).

More recently, social cognitive learning theorists have asserted the notion that much human learning occurs in a social setting (Bandura, 1986; Schunk, 2008). Albert Bandura's research on observational learning challenged behavioural conditioning theories. He found people could learn by merely observing others perform activities and, in doing so, acquire knowledge, beliefs, attitudes, strategies, and skills (Schunk, 2008). Several occupational therapy texts (Flinn & Radomski, 2008; Hagedorn, 1992, 1995; Helfrich, 2014; Hoffmann, 2009; Luebben & Royeen, 2010) have taken up this line of thinking, referring to Bandura's (1977) social learning theory and self-efficacy model.

Cognitive learning theories have been critiqued for failing to capture the complexity of human learning. In particular, there has been a shift away from environmental influences and towards human factors as explanations for learning and, consistent with constructivism, a focus on learners and how knowledge is constructed rather than acquired (Schunk, 2008). Several occupational therapy texts refer to the influence of constructivism on occupational therapy practice (Hagedorn, 1992, 1995; Helfrich, 2014), with Hrynchak and Batty (2012) describing constructivist learning theory as "a refinement of cognitive learning theory" (p. 797). The ideas of the pragmatists—including psychologist William James (1842-1910) and philosopher, psychologist, and educational reformer, John Dewey (1859-1952)—were precursors to constructivist thought, and have also influenced learning theory (Reich, 2009). Constructivist learning is an active process wherein theoretical knowledge and practical understanding are constructed over time and modified, transferred, applied, and expanded on in different experiences and situations as learners make sense of new information through evaluation and reflection (Hunter & Krantz, 2010; Peters, 2000). As learners process new information and integrate it with existing understandings, a new cognitive structure forms that is unique to them, based on their own process of learning (Hrynchak & Batty, 2012). This thinking is in line with adult learning principles (andragogy) described by Knowles et al. (2005, 2015), rooted in humanist and pragmatist philosophy. Further, the socio-cultural emphasis Lev Vygotsky (1978) placed on the role of social mediation of knowledge construction, through interactions between

people and their environment and with facilitated support, is central to social constructivism (Kolb, 2015; Schunk, 2008).

Contemporary learning theories adopt differing perspectives, and as such differing definitions of learning, and endorse different approaches or strategies to encourage learning in clinical practice (Neufeld, 2006). Neufeld (2006) (an occupational therapist) argued that educating without a clear theoretical foundation is haphazard and makes it difficult to achieve learning objectives. Thus, considering the difference and similarities between different approaches to learning has implications in occupational therapy practice. However, learning theories agree that the differences amongst learners and in the environment can affect learning, meaning that learning should be approached individually, depending on the needs of the learner as well as their preferred approaches to learning or learning style (Bradshaw, 2011; Neufeld, 2006). An additional consideration is that learners are at different stage of readiness to change, as outlined by James Prochaska's (2013) 'transtheoretical model of intentional change' (Flinn & Radomski, 2008; Helfrich, 2014; Hoffmann, 2009; Neufeld, 2006; Prochaska et al., 2015). An overview of the influence of different learning theories in occupational therapy practice is summarised in Table 2.4.

Summary of Occupational Therapy Literature Review

As suggested by Neufeld's (2006) overview, my own review of prominent general occupational therapy texts from the past 40 years highlighted the importance of learning in occupational therapy practice. I found that occupational therapists have historically adopted an eclectic approach to the profession's understandings about learning as reflected in the contemporary use of a wide range of theories. In all the texts reviewed, theories from other disciplines (predominantly psychology) were drawn on and absorbed into occupational therapy practice, rather than occupational therapy specific learning processes. Only one occupational therapy derived learning model was found (Greber & Ziviani, 2010). Although somewhat surprising, particularly with the history of acknowledging teaching and learning as a valuable intervention tool in occupational therapy practice, this could be considered from two opposing perspectives. On one hand, adopting learning theories from other professions and applying them to occupational therapy practice and frames of reference could be considered as being resourceful, and a reflection of the pragmatic underpinnings of the profession (Hooper & Wood, 2002; Ikiugu & Schultz, 2006). Conversely, continually referring to the same learning theories is perhaps indicative of a lack of progression to further understand, explore, and develop our own profession specific theory of learning—one addressing the unique needs and nuances of teaching and learning within occupational therapy specific spheres and practice.

Table 2.4

Learning theories: Definitions, strategies, and theorists (adapted from Neufeld, 2006)

Learning Theory	Assumption	Principal Theorists	Educational strategies picked up by occupational therapists
Behavioural	Concerned with behaviour change. Learning occurs when behaviour is acquired or modified by conditioning.	Burrhus Skinner (behaviourism) Edward Thorndike (theory of connectionism) John Watson (behaviourism)	Targeting behaviours. Positive reinforcement for desired behaviours. Chaining (breaking task into small steps).
Cognitive	Concerned with information processing (attention, memory, judgement, problem-solving). Learning is a permanent change in the internal cognitive structures for acquiring, remembering, and using knowledge.	Robert Gagné (conditions of learning)	Breaking task into parts. Aiding transfer of learning to activities or occupations in varied contexts (e.g., focus on task outcome rather than body movement).
Cognitive-behavioural	Concerned with the psychological aspects of social interactions. Learning is a change of perceptions and attitudes.	Albert Bandura (social cognitive theory) James Prochaska (transtheoretical model)	Observation. Modelling. Persuasion. Mastery experiences. Increasing self-awareness. Teaching meta-cognition (thinking about thinking) for self- monitoring of performance.
Humanist	Concerned with the emotional and motivational aspects of human nature and theories. Learning is development of the self or maximising human potential.	Carl Rogers (human potential) Malcolm Knowles (adult learning)	Grading activities to build motivation and competence. Active learning strategies (e.g., providing resources for self-directed learning), and including learner in planning and evaluation of learning experience. Experiential learning
Sociocultural	Concerned with meanings (historical, cultural, and institutional) in relation to learning and identities. Learners are social beings who construct meaning and learn through interactions and participation. Learning is a change in the ways of thinking and talking.	John Dewey (pragmatism) Lev Vygotsky (socio-historical) Jerome Bruner (discovery learning)	Mentoring. On-the-spot guidance to develop autonomy and competence. Experiential learning. Opportunities to integrate new learning with previous knowledge.

Furthermore, learning theories occupational therapists have drawn on, and texts reviewed, consistently put forward a unidirectional perspective, framing learning in practice whereby the therapist (the teacher) is an expert with specialist knowledge who teaches the client

(the learner). Additionally, the same learning theories were drawn on and applied in an apparently indiscriminate way across a range of different client populations—including paediatric focused texts, general foundations of practice, and physical focused texts, without consideration of the unique learning needs or characteristics of these populations. This highlights the need for further research in this area and supports the study's aim to construct a theory explicating the process of learning between occupational therapists working with parents to support development of their children.

Paediatric Occupational Therapy and Early Intervention Literature

This focused literature review was concentrated on parent education, and teaching and learning in paediatric occupational therapy within the wider early intervention literature. The aim of the review was to establish what was already known, to identify gaps in the literature, and support a rationale for this research. The review was undertaken in August 2015, prior to enrolment in the PhD and before data generation commenced. The Cumulative Index to Nursing and Allied Health Literature (CINAHL) database was searched using the search terms outlined in Table 2.5. No date limits were applied but only papers written in the English language were included.

Table 2.5

Results of initial literature search

Search Term Combinations	Number of Papers Found	Number of Papers Reviewed
occupational therapy AND parent	687	-
occupational therapy AND parent* AND educati*	199	-
occupational therapy AND parent AND educati*" (parent* changed to parent to take out parenting education)	63	40
occupational therapy AND early intervention AND education	107	27
occupational therapy AND parent* AND learn*	80	13
therapy AND parent* AND learn*	67	3
Total number of papers identified for review (includes duplicates):		**83**

As early intervention therapy is often undertaken as part of a multidisciplinary team approach, the wider allied health and early intervention literature was of interest, particularly where occupational therapists were represented. Several papers without obvious occupational therapy representation were deemed to be relevant to occupational therapy practice and were also included. The search identified a range of empirical studies and conceptual articles. References lists of key papers were searched, adding to the number of papers included in the review. The findings are reported thematically in relation to the research questions.

Parent Education and Learning in Family-Centred Care

Literature from before 2000 commonly used the term 'parent education'; thus framing the 'therapist-as-expert' and the family as passive recipients of care (Hinojosa et al., 2002; Lawlor & Mattingly, 1998). However, Mahoney et al. (1999) offered a broad definition of parent education as "the process of providing parents and other primary caregivers with specific knowledge and child-rearing skills with the goal of promoting the development and competence of their children" (p. 131) and sparked dialogue and debate around the function and place of parent education in early childhood special education literature (Kaiser et al., 1999; Mahoney et al., 1999; Winton et al., 1999). In response, Winton et al. (1999) argued that the term 'parent education' was passé with potentially offensive connotations. First, the term 'parent' does not acknowledge extended families or other caregivers. Of note, more recent studies refer to caregivers, not parents, perhaps showing an awareness of being inclusive of different family structures (Campbell & Ehret-Coletti, 2013; Colyvas et al., 2010; Salisbury & Cushing, 2013; Sawyer & Campbell, 2012). Second, the definition of 'education' implies a process of 'training' conveying a formal, "one-way flow of information from one who knows (the professional expert) to one who does not know (the parent)" (Winton et al., 1999, p. 159).

'Parent-professional collaboration' was offered as a more accurate term, in highlighting the importance of two-way sharing of information to help parents achieve outcomes for their children (Winton et al., 1999). As each family is different, assumptions about what they need individually cannot be made; therefore, learning from parents is key. Furthermore, unless professionals take time to learn from parents about their situation, they cannot know how to help them (Winton et al., 1999). Acknowledging effective collaboration between parents and professionals is needed for learning, Kaiser et al. (1999) offered a revised definition of 'parent education':

> Parent education is a communicative act—that is, it is *bidirectional* (both the parent and the professional participate in the exchange of information), *transactional* (both the parent and the professional change their behaviour in response to what is expressed during communication) and based on *shared purpose and focus of attention* (the purpose and the focus are defined by the parent and the professional at the beginning of the communicative act and may change in the course of the interaction). (p. 174, emphasis original)

They concluded that the foremost goal of this bidirectional, transactional exchange of information was strengthening positive relationships between parents and children and promoting positive outcomes for children with disabilities and their families. Thus, the provision of information needs to take into account the needs of parents for specific content, method of information delivery, and culture of individual parents (Kaiser et al., 1999).

Subsequently, the term parent education appears to have fallen out of favour, and the focus shifted to therapists and families working as collaborative partners in family-centred interventions (Goldstein, 2013; Graham et al., 2009; Hanna & Rodger, 2002; Harrison et al.,

2007; Hinojosa et al., 2002). In keeping with adult learning theory, to be effective therapists need to understand a parent's needs and educational perspective—including learning style, prior knowledge and experiences—in order to successfully collaborate (DeCleene et al., 2013; Goldstein, 2013; Hamilton, 2005). Rosenberg et al. (2013) acknowledged that central to collaboration, parents and therapists each bring complementary contributions of knowledge and expertise to the therapeutic process. Parents hold knowledge of their family structure and their child, and therapists hold knowledge of diagnoses, potential therapy interventions, and likely outcomes. Accordingly, parental input helps illuminate what their child does in daily life and how they do it, and therapist input can illuminate why a child participates as they do (Rosenberg et al., 2013).

In line with family-centred care philosophy, working with young children with disabilities and their families requires a triadic approach recognising the child, parent, and therapist in partnership. Studies with occupational therapist representation have explored early intervention practices (Salisbury & Cushing, 2013), home visits (Klein & Chen, 2008), coaching (Friedman et al., 2012) and teaching (Sawyer & Campbell, 2012) caregivers, and the contributions of parents and therapists in assessment of children (Rosenberg et al., 2013). In what is collectively referred to a triadic approach in these studies, practitioners work collaboratively with and through the parents or caregivers to enhance their capacity to promote their child's growth and development, with intervention focused within everyday activities and routines of the child and family. The practitioner assumes a role akin to an observer and coach, scaffolding parents' learning using a variety of adult teaching and learning practices (Friedman et al., 2012; Klein & Chen, 2008; Salisbury & Cushing, 2013). Triadic interactions can involve the therapist teaching the caregiver, and the caregiver then teaching the child (Sawyer & Campbell, 2012). This, however, arguably reflects a hierarchy rather than a balanced triadic relationship.

In a quantitative multidisciplinary study involving occupational therapists, Salisbury and Cushing (2013) compared triadic and clinician-led therapy practices in early intervention home visits through reviewing videotape data. They found that triadic intervention promoted increased caregiver engagement in the intervention sessions, while maintaining a focus on the child. However, regardless of the traditional or triadic approach, the intervention was predominantly led by the early intervention provider (therapist). The researchers omitted considering how differences in service delivery approaches impact opportunities for caregivers to learn and the resulting outcomes to all involved (Salisbury & Cushing, 2013). Other studies acknowledging a triadic approach also appear to only consider a unidirectional didactic perspective of learning, with a hierarchy where the therapist (provider) teaches and the caregiver is the recipient of learning (Colyvas et al., 2010; Harrison et al., 2007; Sawyer & Campbell, 2012).

Subsequent studies have shown that active involvement of parents and a positive relationship between child, therapist, and parent promote learning and a successful parent-therapist partnership (Broggi & Sabatelli, 2010; Harrison et al., 2007; Hinojosa et al., 2002; Piggot et al., 2002). Uniquely, Harrison et al. (2007) used interviews to explore the perspectives of nine mothers regarding their experiences working with and learning from their child's therapist. Similar to other studies, learning was presented in a hierarchical and unidirectional context, where the therapist taught the mother who implemented the strategies suggested. Parents were found to predominantly learn by observing the therapist working directly with their child, reflecting a traditional approach to intervention with the parents assuming a more passive role. Mothers who actively participated in their child's therapy, perhaps not surprisingly, found active involvement more helpful than passive observation. Likewise, Hinojosa et al. (2002) found that occupational therapists felt they were more effective when parents participated in their child's therapy programme and that working with parents, more than any other aspect of intervention, had the greatest impact on children's progress.

However, Harrison et al. (2007) found the main influence on mothers' learning was their subjective experience of their relationship with the therapist. Learning was more effective when mothers felt the therapist had a genuine bond with their child and viewed the child as more than just a client. Learning was further enhanced when a positive relationship between the mother and the therapist was present, with the relationship described by some participants of this study as more like a friend or family member rather than a client. This is reflected in other studies where the close professional relationship established between therapist and caregiver has been perceived by some as a friend, teacher (Edwards et al., 2003), or "just like family" (Lawlor & Mattingly, 1998, p. 264). Harrison et al. argued, therefore, that time spent building relationships with the entire family is as productive as 'hands-on' therapy time. This highlights the need to consider the relationship between the triad of child, parent, and therapist, and the way it may impact learning.

Other studies have shed more light on the impact of relationship and parental involvement in therapy and, potentially, learning. In an Aotearoa New Zealand grounded theory study, Piggot and colleagues (2002, 2003) explored perspectives of parents and therapists on parental adjustment to having a child with cerebral palsy and participation in home programmes. Piggot et al. (2002) found parents needed to know that therapists held care and concern for their child, and to have some shared history with them, before developing a level of honesty and trust in the partnership to enable sharing of information. However, therapists' and parents' perceptions of the relationship were not always consistent. Thus, despite valuing the trusting relationship with the parents that they perceived, therapists seemed unaware that some parents did not openly share feelings or concerns with them, such as not being able to take on activities at home, for fear of offending and being reluctant to "rock the boat" (Harrison et al.,

2007, p. 84; Piggot et al., 2003). Further, Klein et al. (2011) found that parents did not always perceive information in the way professionals expected, with not all information being deemed relevant or meeting their learning needs. The conflicting perspectives in these studies point to the value of exploring the perspectives of both parents and therapists concurrently when seeking to understand the process of learning in this relationship, as I aim to do in this research.

Educational Strategies Embedded in Family-Centred Care

Proponents of family-centred care and research into its effectiveness feature ongoing reference to parents as learners and having learning needs, and strategies therapists employ to impart that learning. An overarching assumption is that parents are not only experts on their child; they can also learn to become experts on the delivery of their child's therapy. The reliance on parents developing expertise rests on recognition of family members as the constant factor in the care of the child and valuing them as experts on their child and family's strengths, needs, and values (Edwards et al., 2003; Graham et al., 2009; Harrison et al., 2007; Jones et al., 2010; Rodger, 2006; Rosenbaum et al., 1998). In occupational therapy literature, the concept of parents as experts is common (Edwards et al., 2003; Graham et al., 2009; Graham et al., 2015; Harrison et al., 2007; Novak, 2011; Rodger, 2006). An expert is considered someone who has gained experience and learning through different levels, to a point where they can respond to situations automatically or intuitively (King et al., 2009). Graham et al. (2015) explored parents' understanding of play as an everyday occupation for children with cerebral palsy. They found parents commonly experienced burden when trying to incorporate therapy into their child's play. However, as parents practiced their therapy skills, they came to automatically think about therapy and play simultaneously; for example, automatically reminding their child to use their affected limb. Graham et al. attributed this to parents becoming experts in their child's therapy, reminiscent of the progression from novice to expert practitioner in Dreyfus and Dreyfus' model of skill acquisition (adapted by Benner (1984) in nursing and wider health literature) (Allen & Prater, 2011; Leighton & Johnson-Russell, 2011; Romano, 2009a, 2009b).

Implementing family-centred interventions includes teaching parents in an individualised manner which Kaiser and Hancock (2003) proposed included facilitating parents' choice of when to learn new skills; and "teaching parents strategies that are empirically based, well-matched to their child's developmental needs, and intended to be implemented in naturally occurring interactions" (p. 9). The individualisation of education provided, incorporation of therapy into natural family routines, and establishment of relationships were found to promote family-centred care in Edwards et al.'s (2003) grounded theory study of factors that encourage or inhibit a family-centred approach to occupational therapy intervention, from the perspectives of both families of children with special needs and occupational therapists. To achieve these factors, each family needed to be viewed as a unique entity with specific individual needs. However, family-centred care is not always straightforward. Limited time, in terms of length

and frequency of therapy sessions, was identified as a barrier to achieving family-centred care, with time dictating the form of education provided to parents. Some caregivers valued educational handouts to refer to after the therapy session, so they could focus on practicing techniques during the therapy session (Edwards et al., 2003).

Other studies also support focusing learning and therapy toward embedding therapy in family routines, in order to maximise learning opportunities for the child (Sawyer & Campbell, 2012). Recommendations of how to achieve that include increasing caregiver competence through teaching them skills and strategies to use with their children (Colyvas et al., 2010), therapists understanding family patterns and perspectives, and treating children as developing occupational beings within the context of co-occupations with the parents (Price & Miner, 2009). Price and Miner (2009) suggested using teaching strategies such as scaffolding and narrative reinterpretation to facilitate parents' competence and confidence in everyday tasks, while also warning therapists to be aware of parents' individual learning requirements and the skills they already have within their context.

Home programmes are another educational strategy routinely used to augment direct therapy (Novak, 2011; Novak & Cusick, 2006; Novak et al., 2009). There is evidence that goal-directed occupational therapy home programmes are an effective supplement to hands-on direct therapy to achieve increased doses of intervention; for example, upper limb therapies for children with cerebral palsy (Sakzewski et al., 2014). However, implementing home programmes is reliant on parents learning what to do in between therapy visits. Assumptions about a unidirectional flow of information are again evident in Novak and Cusick's (2006) advice that collaboration with and support of parents to implement therapy interventions at home involves building rapport, listening, sharing, learning, and provision of parent education. Parents need to learn about potential interventions, buy into the agreed intervention, learn the practical skills of implementing the intervention at home, and incorporate it into family routines. Occupational therapy specific studies examining this learning process and parents' and therapists' contribution to it are lacking.

Supplementing these longstanding perspectives on educating parents, coaching practices have become increasingly prevalent within paediatric occupational therapy literature. Coaching is an evidence-based, family-centred intervention approach that promotes adult learning, parent-directed goals and solutions, with the aim of building parents' capacity to identify and implement interventions during life routines (Dunn et al., 2012; Foster et al., 2013; Graham et al., 2010). Different coaching approaches have been described, including strengths-based coaching (Dunn et al., 2012), solution-focused coaching (Baldwin et al., 2013), and, based on the research of Graham et al. (2009, 2010, 2013, 2014), occupational performance coaching (OPC). Although coaching-based approaches rely on parent learning, learning per se is not at the forefront of literature pertaining to parent coaching. For example, Graham et al.

(2014) claimed that although information is provided to parents when needed, "OPC is not primarily an instructional or educational approach" (p. 190).

Despite learning not being at the forefront in coaching literature, Graham et al. (2014) found that learning featured in mothers' experiences of OPC to an unexpected extent. Mothers learned about themselves and their children in a different way, learnt new strategies, acquired new skills, became aware of existing knowledge, developed insight and felt more empowered, leading to positive change in their child's and family life (Graham et al., 2010, 2014). In addition to what the mothers' identified as learning, I suspect they were also learning a process of problem solving through the actual coaching process, which they could apply in other situations independently. Adult and transformative learning theory are briefly touched on in some coaching studies (Foster et al., 2013; Graham et al., 2010, 2014; Graham et al., 2016). For example, Graham et al. (2014) concluded that occupational performance coaching may promote transformative learning processes for parents, resulting in improved capacity to support their child's occupational performance in everyday life. However, these authors provide limited explanation as to how learning might occur.

Research into Therapists Supporting Parental Learning

The professional literature acknowledges that both learning and imparting knowledge are complex processes. Professionals are reported to provide the bulk of information verbally to parents of disabled children (DeCleene et al., 2013; Pain, 1999), often reinforcing this with written information (Griffin et al., 2003; Pain, 1999; Sharry et al., 2002). Observation, modelling, and discussion have also been reported to be of value in demonstrating techniques and building parental confidence to implement therapy interventions independently (Barton & Fettig, 2013; Colyvas et al., 2010; Harrison et al., 2007; Hinojosa & Anderson, 1991; Klein & Chen, 2008). Parents of children with special needs continue to be identified as needing to learn about their child's condition and treatment options, and to have ongoing learning requirements beyond typical parenting to give them sufficient knowledge to both plan and feel in control of their family's life as their child develops (Harrison et al., 2007; Pain, 1999).

Despite longstanding recognition of parents' learning needs, studies within early intervention disciplines specifically focusing on health practitioners teaching parents or caregivers, and parents learning, are limited. My initial search located just four studies with occupational therapy representation that specifically relate to parents learning and therapists teaching parents of young children. The only occupational therapy specific study looked at identifying strategies early intervention occupational therapists use to teach caregivers (Colyvas et al., 2010). Conversation and information sharing were the prominent teaching strategies used, with incidental learning occurring more frequently than explicit teaching (Colyvas et al., 2010). The other three allied health studies explored factors influencing mothers' learning from therapists (Harrison et al., 2007), and therapist perspectives on teaching caregivers and use of

teaching strategies (Campbell & Ehret-Coletti, 2013; Sawyer & Campbell, 2012). Although caregiver participation was highlighted as beneficial to learning in these studies, the relationships between the caregiver, child and therapist were only considered in one study (Harrison et al., 2007). Only one study considered mothers' perspectives (Harrison et al, 2007) and the others addressed the therapists' perspective rather than the teaching strategies preferred by families and caregivers. All the studies were unidirectional and viewed the therapist as holding knowledge and skills that needed to be passed on to the caregiver.

Three of these studies (by the same group of researchers) were limited by their quantitative methodologies. For example, Colyvas et al. (2010) used archival videotapes of therapist-carer interaction to compare strategies used to teach caregivers in both traditional and participation-based service approaches, focusing on the frequency of strategies used, but not the effectiveness of teaching. Sawyer and Campbell (2012) used a nationwide on-line survey of therapists in the United States to explore early interventionists' perspectives on teaching caregivers. They found a preference for use of multiple teaching strategies and selection factors based on therapist experience and preference, and perceived caregiver benefit. However, the use of a survey limited participants to selecting options offered to them, potentially precluding other innovative strategies being identified. Additionally, teaching strategies selected by practitioners were based on contrived situations, which limited the generalisability of the study. Further extending these two studies to determine the extent to which providers were able to illustrate and correctly label various caregiver-teaching strategies after attending a training session, Campbell and Ehret-Coletti (2013) also used videotapes as data. The videos were made to fit a specific brief and not necessarily representative of real-life situations.

There were also contradictory findings amongst other studies using various methodologies and data sets. For example, in self-report studies, practitioners expressed concordance with, and use of, teaching strategies, despite observation showing infrequent use of caregiver teaching (Fleming et al., 2011; Sawyer & Campbell, 2012). Furthermore, when observed, practitioners working with young children frequently worked with the child and infrequently taught caregivers (Campbell & Sawyer, 2007; Colyvas et al., 2010). In contrast, when data were collected through interviews and surveys, practitioners reported that they taught caregivers (Klein & Chen, 2008; Ridgley & Snyder, 2010; Sawyer & Campbell, 2012). This suggests that the results of self-report studies about caregiver teaching may reflect ideal or optimal practice. It also suggests that findings relying on only one data source may be inaccurate, and points to the importance of gathering different types of data to build a more accurate picture, which my study does (using interview, observational data, and photographs of learning resources).

Summary of Early Intervention Literature Review

The review of paediatric occupational therapy and early intervention literature revealed limited studies exploring the learning process occurring between occupational therapists and parents of children receiving therapy. Those that did invariably assumed a didactic perspective and hierarchical approach of therapist-teaches-parent to learning. Studies were reported from the perspective of the therapist or parent in isolation, not accounting for the perspectives of both parents and occupational therapists. Most studies took a practitioner perspective, with only a few from parents' perspectives. Most studies identified also drew from a solitary mode of data generation. Only one study was identified from a New Zealand context.

My research was designed to overcome some of the observed deficiencies in published literature. Specifically, I sought to examine the process of learning between occupational therapists and parents of children receiving therapy from the perspective of both parents and therapist concurrently. Additionally, I adopted a strategy of multi-source data generation including interviews, observation, and resource evaluation for breadth and depth of understanding of learning in this context.

The Broader Occupational Therapy Literature

As the review of the paediatric occupational therapy literature yielded few studies specific to teaching and learning between parents and occupational therapists, I sought a broader overview of the profession's knowledge of client education, teaching, and learning. Scoping reviews, which have been described as a reconnaissance activity, are suited to this task (Arksey & O'Malley, 2005; Davis et al., 2009; McKinstry et al., 2014). They provide a rigorous and transparent method of literature review used to map and describe the extent, range, and nature of literature in a field of study, enabling identification of gaps in the evidence base, research, or knowledge (Arksey & O'Malley, 2005; Colquhoun et al., 2010). The scoping study framework described by Arksey and O'Malley (2005) was selected to review literature on client or patient learning specifically within occupational therapy literature.

The review was conducted in September 2016. Literature directly related to the research questions was identified, including papers exploring aspects of a teaching and/or learning process across the scope of occupational therapy practice with both adults and children. To identify and select relevant articles to include in the review, the following process was followed. The CINAHL, Medline, PsychInfo, Educational Resources Information Center (ERIC), and Allied and Complementary Medicine (AMED) databases were searched, using the search terms outlined in Table 2.6. No date limits were applied.

Table 2.6

Results of scoping review literature search

Search Combinations	Number of Papers Found	Number of Papers for Abstract Review
Client AND education AND occupational AND therap* NOT student*	721	52
Teaching strateg* AND occupational therap* NOT student*	74	11
Parent* AND education AND occupational therap* NOT student	193	6
Occupational therap* AND parent* AND learn	193	1
Patient education AND occupational therap* NOT student*	955	48
Total included in abstract review		**118**
Papers included in scoping review (after abstracts reviewed)		72
Additional papers found through manual search		15
Total papers included in scoping review		**87**

Multidisciplinary articles were included where occupational therapy had significant representation. Articles with an academic focus on teaching students, which are not relevant for this review, were excluded by adding "NOT student" to the search terms. Papers were also excluded if written in a language other than English.

Extensive review of all titles and available abstracts identified a range of different types of papers; including empirical studies of different methodologies as well as conceptual papers, which were all included in the review. Seventy-two relevant papers were initially identified, with some overlap with the previous literature search. A further 15 papers obtained through manual searching of reference lists of key papers were added during the analysis stage. In total, 87 papers were included in the review. The included papers were exhaustively reviewed, analysed, and organised using a data extraction table. Articles were categorised according to type of paper (reviews, research, article) and focus, such as educating patients, education programmes, and teaching/education strategies. New categories were added during the analysis process as required. When reviewed, if a paper was deemed irrelevant to the search, it was discarded.

Findings of the Scoping Review

Providing education for clients is considered a central role of occupational therapists, and generally regarded as key in clinical relationships in health care practice (DeCleene et al., 2013). McKenna and Tooth (2006) suggested that health practitioners are constantly engaged in client education and that client education is an important intervention in itself. Client education within occupational therapy practice takes place in many contexts and in different ways: formal, informal, planned, incidental, with individuals or in groups, face-to face, and through written

materials (Griffin et al., 2003). In a survey of treatment media used by Australian occupational therapists working in adult physical dysfunction settings, McEneany et al. (2002) found that the most frequently used treatments were education and counselling, with three quarters of participants using them often or most of the time, rating these ahead of more hands-on interventions. Although client education is fundamental and a foundation of occupational therapy practice (McKenna & Tooth, 2006), there is limited extant research on the effectiveness of client education, client's experiences, and how provision of client education supports learning.

Several general occupational therapy studies concerning what and how occupational therapists are teaching clients have been reported. These include running group education programmes such as providing information for carers of children with special needs (Stewart et al., 2010), arthritis health education (Ashe et al., 2005), and specific joint protection education for people with arthritis (Niedermann et al., 2012; Niedermann et al., 2011). Pre-surgical group education run by occupational therapists has been shown to help reduce anxiety and empower clients by making the unknown familiar (O'Brien et al., 2013; Spalding, 2000; Spalding, 1995, 2003). Individual client education has also been provided by occupational therapists including strategy training to teach stroke patients ways to compensate for impairments (van Heugten et al., 1998), self-care training (Guidetti & Tham, 2002), and teaching transfer skills to older adults (Carrier et al., 2011). All these studies reported a unidirectional flow of information from therapist to client.

Several studies of information provision and methods of teaching used by occupational therapists revealed a wide range of teaching strategies identified in different contexts when working with clients directly (Carrier et al., 2011; Guidetti & Tham, 2002), as well as caregivers (Colyvas et al., 2010; Gustafsson et al., 2010). A range of methods (e.g., observing, conversing, explaining, demonstrating, modelling, therapist-client interaction, client practice, providing feedback, questioning); tools (e.g., gestures, equipment, visual aids, written and verbal instructions); and intensity adjustments (e.g., directedness, duration, frequency and pace) were strategies used by the therapists in teaching clients (Carrier et al., 2011; Colyvas et al., 2010). Of these, conversing, explaining, and information sharing were the predominant teaching strategies (Carrier et al., 2011; Colyvas et al., 2010). Numerous studies have focused on written educational material which can serve as an adjunct to verbal education (Griffin et al., 2006; Sharry et al., 2002), and "enable clients to learn at their own pace, absorb information over time and share information with significant others" (McKenna & Scott, 2007, p. 103). Such studies have highlighted the need to ensure information is clearly presented (McKenna & Scott, 2007) and is relevant, evidence based, and matches the client's literacy skills (Atwal et al., 2011; Griffin et al., 2006).

Both passive and active learning has been seen to occur during therapy sessions, with passive learning occurring more prominently. For instance, one study found incidental learning occurred more often than explicit teaching, with caregivers of children passively engaged through observation of the therapist (Colyvas et al., 2010). Despite this, involving clients as a teaching strategy has been suggested to benefit their learning. Colyvas et al. (2010) suggested that involving children and caregivers encouraged caregiver participation in the child's occupational therapy intervention, and the opportunity to practice, clarify, and provide feedback, so they could continue independently between therapist visits. Another study similarly found teaching methods encouraging adult clients' active involvement were used infrequently, which they proposed limited opportunities to foster client motivation and self-efficacy, thereby potentially affecting the efficacy of occupational therapy intervention (Carrier et al., 2011). This is perhaps reflective of different therapist approaches when working with children and parents versus the adult population.

Other studies have focused on choice of teaching content or enabling occupational experience rather than choice of teaching strategies. Carrier et al. (2011, 2012) suggested that therapists' limited training, knowledge, and experience in pedagogy restricted their ability to see the complexity of teaching situations and to select teaching strategies to teach different types of content and could diminish teaching effectiveness. However, Guidetti and Tham (2002) advocated for creating a relationship based on mutual trust, adjusting interventions based on individual clients' need for experience and practice to improve their occupational competence. Although Carrier et al. (2012) acknowledged teaching and learning as "a two-way, interactive and dynamic process" (p. 261), all of these studies still reflected a unidirectional, didactic perspective of therapist teaching client, and overlooked how to encourage client involvement. This is a surprising gap in the literature, given that in the client-therapist context there are at least two people involved in the learning process.

Consistent with the earlier literature review, there was a notable absence of specific reference to learning theory, with only a few authors identifying educational or learning theory as underpinning client learning. One study acknowledged the role of experience in learning, along with transformative learning as an adult learning theory to explore processes of change towards disease management, such as when learning to manage a new diagnosis requires exploration of old disease perspectives and shaping new ones (Ashe et al., 2005). As reported earlier, other authors identified the influence of learning theorists, such as Vygotsky's influence on the development of the 4QM (Greber et al., 2007a, 2011) and Bandura's social cognitive theory influence in health education programming for older adults (Cook, 2004). However, the majority of studies did not acknowledge learning theory, which reflects a gap in the occupational therapy literature in identifying the theoretical underpinning of learning approaches.

Of the papers reviewed, there was a predominance of quantitative studies of client education and learning, which may account for gaps in understanding. Quantitative research has a deductive focus, testing hypothesis; whereas qualitative research focuses on investigating and understanding social phenomena and the experiences and perspectives of people themselves (Savin-Baden & Major, 2013), which is arguably better suited to studying learning in clinical settings. Further, studies tended to look at teaching and learning from the perspective of either the clinician or the client, not both—of the three that did capture both perspectives, none were child or parent focused (Carrier et al., 2011, 2012; Spalding, 2003; van Heugten et al., 1998). Consistent with occupational therapy textbooks, the scoping review revealed that researchers have tended to address learning as a hierarchical, unidirectional process with a didactic flavour of therapists providing knowledge for clients or caregivers to learn. The lack of consideration given to therapists learning from clients was a surprising gap in the research and is not consistent with client or family-centred practice. Further, there was limited exploration of how learning occurs and a general lack of reference to educational or learning theory underpinning client learning. These findings highlighted the need for research in this area, particularly acknowledging that therapists and clients learn from each other.

Summary

In this chapter, the place of the literature review in a grounded theory study and the search strategy used for the initial and subsequent literature reviews were presented. The results of each of the initial three literature searches undertaken to inform the study design were presented. Consideration of the literature confirmed that the occupational therapy profession has repeatedly drawn on extant education and learning theories from other disciplines and there has been scant development of a learning theory in the profession's context. That absence persists despite parent or client education being recognised as a fundamental occupational therapy intervention strategy for over a century. There remains a dearth of research in the area of teaching and learning processes throughout the occupational therapy literature, particularly addressing the needs of both occupational therapists and the people they work with. There is a clear need for research addressing the process of learning between occupational therapists and clients to further the knowledge and understanding in this area. The methodology underpinning this research is outlined in the next chapter.

Chapter 3 Methodology

Introduction

This chapter provides an overview of constructivist grounded theory, the qualitative methodology used for this research. First, I present the rationale for selecting grounded theory, followed by a summary of the theoretical constructs and perspectives used as the lens through which this research was approached. I then outline grounded theory methodology, and its different versions as they developed chronologically, with specific reference to constructivist grounded theory and its suitability for this study. The key theoretical and epistemological underpinnings of this study, including pragmatism, symbolic interactionism, social constructivism, and social constructionism which have influenced the development of grounded theory methodology, and which inform constructivist grounded theory, are then discussed. Essential grounded theory methods are presented, with the specific application of the methods further discussed in Chapter 4 Methods. The chapter concludes with considerations for evaluating a grounded theory.

Rationale for Selecting Grounded Theory

A qualitative methodological approach was fitting for this study to enable investigation of the meaning of social phenomena as experienced by people themselves (Malterud, 2001; Savin-Baden & Major, 2013). I considered several qualitative methodologies before selecting grounded theory, and specifically constructivist grounded theory, because its focus, purpose, and application are well suited to the aim of the study: to construct a substantive theory to explain the process of learning between parents and occupational therapists, and the influences on and consequences of that process. Grounded theory is a qualitative research methodology with a particular focus on interaction, action, and processes that occur in social situations with the aim of generating a theory to explain them (Charmaz, 2014; Corbin & Strauss, 2015; Glaser & Strauss, 1967; Savin-Baden & Major, 2013; Stanley & Creek, 2003). Differing from other qualitative research methodologies, the purpose of grounded theory is generating theory, using empirical data in an iterative process of engagement with the research context and conceptual analysis (Bryant, 2009; Charmaz, 2014; Glaser & Strauss, 1967; Savin-Baden & Major, 2013). Using grounded theory methods enables researchers to move beyond description to create a study that has in-depth and insightful findings and to construct new knowledge in the field of study (Charmaz, 2014; Glaser & Strauss, 1967).

As a clinician, it was personally important that my research would make a useful contribution to inform clinical practice and ultimately benefit people using health services, to which grounded theory lends itself well. Bryant (2017) argued that sound grounded theories can not only be “taken back to the initial setting and used to inform practices, procedures, and

policies" (p. 345), they can also be "taken as working hypotheses or theories for potential extensibility to other settings" (p. 345). Grounded theories are not intended to be speculative, neither are they intended to be viewed as universal explanations (Bryant, 2017). Most grounded theories are initially offered as substantive theories addressing defined issues in specific substantive areas (Bryant, 2017; Charmaz, 2014). However, with further development grounded theories have the potential to move into the realm of formal theory which has wider application across multiple substantive areas due to higher levels of abstraction and generalisation of concepts (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014; Glaser & Strauss, 1967). Glaser and Strauss (1967) explained that both substantive and formal theories "may be considered as "middle-range" as they fall between the "minor working hypotheses" of everyday life and the "all-inclusive" grand theories" (Glaser and Strauss, 1967, p. 32). Further, Charmaz (2014) argued that grounded theories have potential to 'travel' within and across disciplines, professions, and contexts.

Research Lens: The Theoretical Foundations of the Study

Qualitative researchers use several lenses when conducting research, including personal, philosophical, theoretical, and strategic; each with practical implications for the design and conduct of the research, as well as analysis and interpretations of data (Creswell, 2007; Lincoln & Guba, 2013; Savin-Baden & Major, 2013). Constructivist grounded theory acknowledges that researchers come to an inquiry through the lens of their particular disciplinary assumptions and theoretical perspectives, and draws on certain philosophical understandings about the nature of being in the world and knowledge (Charmaz, 2014; Conlon et al., 2013). Explicating the methodological choice and the theoretical perspective, ontology and epistemology make transparent the researcher's philosophical position, world view, and values underpinning the study and supports insights into decisions that guide the choice of research methodology and methods. Therefore, explaining the lenses through which the research was approached enhances the rigour and credibility of the study (Birks & Mills, 2015; Breckenridge et al., 2012; Lincoln et al., 2011; Savin-Baden & Major, 2013; Ward, Hoare, et al., 2015). A summary of the terminology, theoretical constructs, and approaches informing this research is given in Table 3.1.

Table 3.1

Summary of theoretical constructs and perspectives used in this study

Construct	Definition	Perspective Adopted in Study
Paradigm	A framework for making order of the chaos of social life and how problems should be understood and addressed. (Crotty, 1998; Grant & Giddings, 2002; Kuhn, 1970)	Qualitative research Interpretivism Naturalistic inquiry (Bowen, 2008; Charmaz, 2014; Grant & Giddings, 2002; Savin-Baden & Major, 2013)
Methodology	How knowledge can be acquired about the world. (Lincoln & Guba, 2013)	Constructivist grounded theory (Charmaz, 2014)
Ontology	Philosophies addressing the nature of reality or truth. Inextricably linked with epistemology. (Crotty, 1998; Savin-Baden & Major, 2013)	Relativism Subjectivism (Charmaz, 2014; Charmaz & Bryant, 2010; Guba & Lincoln, 2001; Savin-Baden & Major, 2013)
Theoretical perspective	Philosophical stance informing the methodology. A way of looking at the world and making sense of it. Provides a context for the research process and grounding its logic and criteria. (Crotty, 1998)	Pragmatism* Symbolic interactionism (Charmaz, 2014; Crotty, 1998)
Epistemology	Philosophies addressing the nature of knowledge and how we come to know what we know. (Crotty, 1998; Savin-Baden & Major, 2013)	Social constructivism Social constructionism Pragmatism* (Charmaz, 2014)

*Charmaz (2014) identified pragmatism as both an epistemological underpinning of all grounded theory and a theoretical foundation with which constructivist grounded theory is specifically aligned.

Methodology: Constructivist Grounded Theory

Constructivist grounded theory was the chosen methodological approach. Charmaz (2014) argued that "grounded theory serves as a way to learn about the worlds we study and a method for developing theories to understand them" (p. 17). As a qualitative research methodology, grounded theory fittingly enabled investigation and explication of a social phenomenon from the perspective, and in the context, of those who experience it, while bringing a focus on interaction, action, and processes that occur in social situations (Birks & Mills, 2015; Charmaz, 2014; Malterud, 2001). Qualitative research, specifically grounded theory, is particularly well suited to occupational therapy research, exploring the complexity and richness of occupational therapy practice—given that the profession is concerned with the practical and socially constructed meanings people attribute to their day-to-day occupations (Ballinger, 2004; Stanley & Creek, 2003). Using an iterative process of engaging with the participants and the context, and conceptual analysis, the goal of grounded theory is to generate a substantive, explanatory theory directly abstracted from, or grounded in, relevant empirical data (Birks & Mills, 2015; Bryant, 2009; Charmaz, 2014; Corbin & Strauss, 2015; Glaser & Strauss, 1967). Thus, grounded theory represents both a method of inquiry and the resultant product (Chun Tie et al., 2019).

Development of Grounded Theory

The historical development of grounded theory reveals the theoretical perspectives that formed its foundations and the emergence of different grounded theory perspectives over time. Understanding these different perspectives guided decisions about the particular version of grounded theory that was used in the present study, and shaped the methods that were adopted. The historical development of grounded theory is, therefore, summarised in this section.

Grounded theory methodology derives from the diverse intellectual traditions of each of its American founders; Barney Glaser's positivism from the University of Columbia, and Anselm Strauss' pragmatism from the University of Chicago (Charmaz, 2001, 2009). Glaser and Strauss (1967) first articulated grounded theory in their seminal text, "*The Discovery of Grounded Theory*". They refocused qualitative inquiry on methods of analysis and advocated developing explanatory theories from research grounded in qualitative data (Charmaz, 2014). Glaser's training in survey research gave grounded theory its systematic approach, positivist leanings, and procedural language. Meanwhile, Strauss was strongly influenced by the writings of George Herbert Mead (1934) and Herbert Blumer (1969), bringing pragmatism, symbolic interactionism, and field research to the methodology (Charmaz, 2000, 2014; Thomas & James, 2006). Thus, Strauss is seen to have contributed to the "notions of human agency, emergent processes, social and subjective meanings, problem solving practices, and the open-ended study of action to grounded theory" (Charmaz, 2014, p. 9).

Although Glaser (2007) maintained that grounded theory in its original form did not have a particular theoretical perspective, the respective schools of thought became increasingly apparent in Glaser and Strauss' later, separate writings (Strübing, 2007). Glaser's writing focused on grounded theory method and what constituted grounded theory. Although it has been argued that 'Glaserian' or 'classic grounded theory' is consistent with pragmatism (Birks & Mills, 2015; Nathaniel, 2011), acknowledgement of both pragmatist and symbolic interactionist perspectives underpinned Strauss' iteration of grounded theory methods in his collaborations with Juliet Corbin (Birks & Mills, 2015; Corbin & Strauss, 2008, 2015; Licqurish & Seibold, 2011; Strauss & Corbin, 1990, 1998). In contrast to the open-ended, fluid approach evident in 'The discovery of grounded theory' (Glaser & Strauss, 1967), the first two editions of Strauss and Corbin's (1990, 1998) texts had less emphasis on emergence and more emphasis on directive techniques, giving instructions about how to do grounded theory. However, they were criticised for being rigid and prescriptive by favouring additional technical procedures, potentially forcing data and analysis into preconceived categories, rather than emphasising emergent theoretical categories (Charmaz, 2014; Charmaz & Thornberg, 2020; Glaser, 1992; Uri, 2015).

Building on the original work of Glaser and Strauss (1967), grounded theory has evolved into different versions (Birks & Mills, 2015; Bowers & Schatzman, 2009; Bryant,

2017; Charmaz, 2014; Clarke, 2005; Clarke et al., 2018; Strauss & Corbin, 1990). While there are many points of convergence, such as the goal of theory generation and use of constant comparative analysis, they are differentiated by their philosophical positions and methodological directives such as use of literature, coding procedures, analysis, and theory development (Bryant, 2017; Chun Tie et al., 2019; Kenny & Fourie, 2015). Pragmatism and symbolic interactionism, with emphasis on structure and process, continue to be acknowledged as theoretical perspectives underpinning the approach of more contemporary grounded theorists.

Kathy Charmaz and Adele Clarke (both students of Strauss) have had significant influence in the development of contemporary versions of grounded theory. Charmaz (2000, 2006, 2014) developed constructivist grounded theory, while Clarke's (2005; Clarke et al., 2018) situational analysis is an extension of grounded theory to engage in the complexities of real-world situations, and drew on constructivist grounded theory and Strauss' (1993) ecological social worlds and arena theory. Informed by postmodernist thinking, situational analysis uses three types of mapping—situational, social worlds/arenas and positional mapping—in combination with a Foucauldian discourse analysis of power, and "accounts for the material environment, non-human actors, discourses, and structural elements that shape and condition the studied situation" (Charmaz, 2014, p. 220; Clarke et al., 2018; Mills et al., 2007; Uri, 2015). Recently, Corbin acknowledged the influence of such contemporary thought as a reason for her shift from an objectivist leaning to taking a constructivist stance, arguing the co-construction of meaning between researcher and participant as implicit in data generation (Birks & Mills, 2015; Corbin, 2009; Corbin & Strauss, 2008, 2015). Thus, grounded theory is seen as flexible, with potential for development, shifts, change, and further evolution. I identified constructivist grounded theory as most appropriate to use for this study. The core tenets of constructivist grounded theory and the reasons for this decision are explained next.

Constructivist Grounded Theory

Constructivist grounded theory was first articulated by Kathy Charmaz (2000, 2014), a student of both Glaser and Strauss, who juxtaposed constructivist grounded theory and the original Glaser and Strauss (1967) version by referring to the latter as objectivist grounded theory, in part due to Glaser's positivist leanings (Charmaz, 2000, 2009). She placed objectivist and constructivist grounded theory on a continuum. Located at one end is the 'tabula rasa', objectivist, position of the researcher as a neutral observer and value-free expert (Charmaz, 2014). In contrast, constructivist grounded theory adopts a relativist ontology, viewing knowledge and reality as subjective, multiple, and socially constructed, and explicitly sees the research as a construction (Charmaz, 2009; Thornberg, 2012). Data, analysis and theory are, therefore, not seen as discovered; rather, as being co-constructed between researcher and participants (Charmaz, 2014; Savin-Baden & Major, 2013; Thornberg, 2012). Constructivist grounded theory takes a reflexive stance to acknowledge subjectivity and researcher

involvement in the construction and interpretation of data, and allows for a priori knowledge and researcher sensitivity to the social process under investigation (Birks & Mills, 2011; Charmaz, 2014; Murray et al., 2014). In this way, the constructions of data and theory in this study are acknowledged to be coloured by my own personal and professional perspective, prior experience, and theoretical preconceptions. These existing orientations are considered sensitising concepts and are acknowledged to influence the analysis and interpretive process, viewed as providing points of departure for developing, rather than limiting, ideas (Charmaz, 2014; Conlon et al., 2013). The resulting theory is understood as an interpretive explanation of processes in the studied world, which potentially has wider applicability (Charmaz, 2009, 2014).

Although I considered the other main variants of grounded theory, constructivist grounded theory methodology was a logical choice for this study as, in addition to a fit with the aims of the study, it resonated with my personal world view. Constructivist grounded theory is consistent with the naturalistic inquiry paradigm, where researchers appreciate multiple constructed realities through studying real-world situations as they unfold naturally (Bowen, 2008; Charmaz, 2014; Savin-Baden & Major, 2013). Studying a real-world process in its natural setting lent itself well to exploring, and explaining, the complex process of learning between parents and occupational therapists who work with children unfolding in real life, as it supported insights into contextual factors associated with learning (Charmaz, 2014). Constructivist grounded theory appealed to my world view that we are all (researchers included) influenced by our experiences and to pretend otherwise is naïve. I agree with Dey's (1993) statement, "it is better to make ideas and values explicit rather than leaving them implicit and pretending they are not there" (p. 229). Constructivist grounded theory fully implicates researchers in every stage of the research, including data generation, analysis, and theory construction, and situates participants as active in co-construction of the theory (Charmaz, 2014; Conlon et al., 2013). In contrast, to me, Glaser and Strauss' (1967) notion of approaching grounded theory by putting aside priori assumptions felt contrived.

Constructivist grounded theory differs from earlier versions of grounded theory in considering analytical strategies as emergent (Charmaz, 2014, 2017b). It offers a flexible set of methodological tools and guidelines encouraging researchers to follow leads derived from their empirical data rather than pre-set procedural frameworks or applications (Charmaz, 2014), which appealed to me. I was concerned that using procedural applications for analysis, such as Corbin and Strauss' axial coding, might force analysis into pre-set directions, unnecessarily limiting openness to other emergent analytical possibilities by following leads in the empirical data (Charmaz, 2014; Strauss & Corbin, 1990, 1998). Further, Clarke's situational analysis, with its focus on organisational levels of analysis and structural relationships and processes between different social worlds, moves analysis beyond participants' actions and experiences

(Clarke, 2005; Clarke et al., 2018). This was not suitable for answering my research questions and, with its focus on organisational structures rather than people, did not fit with my research focus of the learning process between parents and occupational therapists.

Charmaz (2014) advocated for grounded theory as a flexible approach and supported the pragmatic perspective of using what works in your research (K. Charmaz, personal communication, September 25, 2017a). She described a constellation of methods and acknowledged that all variants of grounded theory offer helpful strategies for generating, managing, and analysing qualitative data. Although I primarily adopted Charmaz's variant of grounded theory, I realised that in answering my research questions I might encounter diverse situations and experiences amongst families and occupational therapists. Responding to Charmaz's pragmatic guidance, where relevant, I found much to learn from other grounded theorists and iterations of grounded theory and drew on these theorists' writings to inform and deepen my thinking. In addition to Charmaz, the more contemporary iterations of Birks and Mills (2015) and Bryant's (2017) "Pragmatist-cum-Constructivist" (p. 56) position were particularly influential and are reflected in the study.

Theoretical Perspective: Pragmatism and Symbolic Interactionism

Pragmatism, coupled with symbolic interactionism, are key philosophies underpinning grounded theory (Stern & Porr, 2011). Grounded theory methods grew from the pragmatist view that human life consists of process and change, and the symbolic interactionist perspective that social interaction is dynamic and open-ended (Charmaz, 2014). Influenced by these perspectives, grounded theory is a research methodology accounting for human action in the context of problematic situations encountered in a changing world; a way to understand what is problematic, what is important to people, and the process of events or actions implemented to make change and to achieve resolution (Hunter & Krantz, 2010).

Pragmatism and Grounded Theory

The term pragmatism is derived from a Greek word 'pragma', denoting action; and from which the words 'practical' and 'practice' originate (James, 1907; Stern & Porr, 2011). The philosophy of pragmatism was first introduced in North America in the late 19th century by Charles Sanders Pierce. Early proponents, including Pierce, William James, and John Dewey, challenged the notion of absolute truth and were described as being both constructionist and critical (Crotty, 1998; Reich, 2009). George Herbert Mead was also considered a pragmatist philosopher, as well as a predominant influencer of symbolic interactionism (Crotty, 1998). The term 'pragmatism' was popularised by James (1907) (Bryant, 2009; Stern & Porr, 2011; Strübing, 2007).

Hickman (2009) described Dewey's pragmatic model of truth as being basic to the philosophical tradition of pragmatism. From Dewey's perspective, truth was viewed not as

discovered or invented, but constructed as a by-product of the process of problem solving. Central to Dewey's action-oriented theory of knowledge was the role of prior experience in guiding future practice (Corbin & Strauss, 2008; Morgan, 2020). Pragmatists saw a close relationship between knowledge and everyday action (Corbin & Strauss, 2015; Jeon, 2004). For Dewey, knowledge always concerned the relationship between actions and their consequences (Biesta, 2010). Accordingly, pragmatism has been described as a 'philosophy of action', whereby meanings emerge though practical actions to solve problems (Charmaz, 2014; Cutchin, 2004; Ikiugu & Schultz, 2006; Strübing, 2007), with people engaging in a continual process of practice, inquiry, and adaptation in the constantly changing social world (Corbin & Strauss, 2015; Jeon, 2004). James and Dewey viewed people as active and creative beings, "interwoven into the fabric of their social and physical environs" (Hooper & Wood, 2002, p. 41). It is through their experiences, actions, and interactions with the environment that people come to know and understand their world (Bryant, 2009; Charmaz, 2009, 2014; Corbin & Strauss, 2015). As such, the environment and society both direct and constrain human activity in particular ways, rendering reality as open to multiple interpretations (Charmaz, 2009, 2014). These perspectives align with my own assumptions about occupational therapy as a problem-solving process, where outcomes are monitored and learning generated in specific practice situations is carried forward to inform later actions.

As a dominant intellectual discourse in the early 20th century, many disciplines adopted pragmatist tenets, including occupational therapy (Hooper & Wood, 2002). For instance, the emphasis on occupation and doing in occupational therapy is consistent with the value of action in pragmatism, where the pragmatist view is that ideas are meaningful only in the context of the action they produce—particularly where activities are directed towards solving problems (Ikiugu & Schultz, 2006; Mead, 1934). Furthermore, pragmatists hold that knowledge grows through change and adaptation, which is in line with the work of occupational therapists (Breines, 1987). The consistencies between and influence of pragmatism on both the foundations of occupational therapy and grounded theory methodology further supported the choice of adopting grounded theory as the methodology for this occupational therapy focused study.

Hooper and Wood (2002) argued that the pragmatist view of knowledge has mistakenly been interpreted as merely "doing what works" (p. 42). Rather, the pragmatist perspective sees knowledge as the product of a cyclical process of inquiry and reflection—looking at the practicality of an action, its intended consequences and its effects (Dewey, 1938b; Hickman et al., 2009; Hooper & Wood, 2002). Dewey's (1933, 1938b) concept of inquiry assumed inquiry to be a general aspect of human experience which people use when their habitual behaviours and ways of thinking are not sufficient to deal with a problematic situation. It involves "a dual process of reflection, first on the nature of the problem itself, and then on the likely

consequences of acting on the potential solution" (Morgan, 2020, p. 66). The point of inquiry is to convert those reflections into actions. There is a cycle created where the outcome of the action and interpreted consequences leads to revised knowledge and beliefs, thereby generating new actions and further consequences, and so on (Morgan, 2020).

Dewey further argued that formal research was simply a more careful, self-refinement of inquiry as a common form of human experience (Morgan, 2020). For Dewey (1938a), any experience is integrated with past, present, and future; and the life-long, evolving process where what is learned in one situation becomes instrumental in understanding and dealing effectively with subsequent situations. Dewey also proposed 'the experimental theory of knowledge', where all knowledge is considered provisional, being judged according to how useful it is for individuals or within a set of confines (Bryant, 2009). As such, a further central idea of pragmatism is that meaning, or the truth of an idea, lies in its possible consequences (Hickman, 2009). From a pragmatist perspective, therefore, the consequences of people's constructions of meaning should be constantly evaluated to see if they contribute to human growth and well-being (Hickman et al., 2009). Grounded theorists align with this notion, considering the extent to which research produces conceptual innovations and theoretical insights that prove useful as key criteria for evaluating the research (Bryant, 2017; Charmaz, 2014).

Bryant (2017) explained that "what GTM [grounded theory method] and pragmatism have in common is a concern with people's engagement with the world, reliant on detailed observation and insight, followed by never-ending and iterative efforts to comprehend, persuade, and enhance" (p. 346). Pragmatism has been identified as a theoretical foundation with which constructivist grounded theory is aligned (Charmaz, 2014). The dual emphasis on action and meaning in the pragmatist tradition aligns with constructivist ideas of meaning making from action. The emphasis on actions, meanings, and language in generating and analysing data fosters an openness and curiosity about the world, as well as an empathetic understanding of the research participants' own communicated meanings, actions, and worlds (Charmaz, 2014). In constructivist grounded theory, this empathy helps move the study beyond a descriptive account towards constructing interpretive renderings of the world. Constructivist grounded theory thus retains the "fluidity and open-ended character of pragmatism" (Charmaz, 2014, p. 339), where leads in the data are followed and efforts are made to render explicit perspectives of both participants and researcher, and the inherent implications. As such, grounded theories are intended to produce theoretical insights that prove useful in informing practices and make a practical difference in the studied context (Bryant, 2009, 2017).

Pragmatist Influence on Grounded Theory Methods

There are continuities between pragmatism and constructivist grounded theory (Charmaz, 2017b). The influence of specific pragmatist concepts on grounded theory methods is apparent, such as Mead's concept of emergence and Pierce's concept of abduction (Charmaz,

2014, 2017b). Mead's concept of emergence recognises that the present reality differs from the past and that new aspects of the present experience result in new interpretations and actions (Charmaz, 2014). This grounded theory study was emergent in design. Responding to pragmatist underpinnings it was acknowledged that unexpected concepts might arise through constructions of data and analysis that could not have been anticipated in advance. These concepts would then influence and guide the direction of further iterative data generation and analysis. Thus, applying ideas about emergence can lead grounded theory researchers in useful, often unanticipated, directions to understand their data and construct their theory (Charmaz, 2008b, 2014; Kenny & Fourie, 2015). The addition of an observational element to this study is an example of emergence in the research methods (discussed in Chapter 4, Methods). Also reflecting the pragmatist concept of emergence, I applied the grounded theory strategy of theoretical sampling to follow up new leads, test ideas, and fill gaps in the data when unexpected concepts or insights emerged during data generation and analysis (Charmaz, 2014; Kenny & Fourie, 2015).

Abduction is a type of reasoning used in grounded theory that builds on the pragmatist tradition of problem-solving. Abduction is a process for creating new ideas to aid problem solving, by which useful explanations can be developed (Charmaz, 2014; Richardson & Kramer, 2006; Strübing, 2007). In constructivist grounded theory, "abduction allows for intuitive interpretations of empirical observations and creative ideas that might account for them" (Charmaz, 2008b, p. 157) in the iterative approach to analysis. Charmaz (2008b) claimed grounded theory is emergent because it is both inductive and abductive. However, opinions differ as to whether reasoning in grounded theory is purely inductive (Glaser & Strauss, 1967), inductive and deductive (Corbin & Strauss, 2008; Reichertz, 2010), abductive alone, or, indeed, involves varying combinations (Gilgun, 2019; Strübing, 2007; Ward et al., 2016). What distinguishes abduction from other types of reasoning is the production of new insights through generating a tentative hypothesis to explain observations which requires an element of inspiration extending beyond the formal logic of induction (Morgan, 2020).

The abductive reasoning process used in grounded theory involves elevating data to a conceptual level by using data to iteratively induce and then test, refine, modify, select, reject ideas and concepts (deduction), or put existing ideas together in new ways to examine, understand, and explain the data to develop theory by entertaining all possible explanations of data to reach the most plausible explanation (abduction) (Charmaz, 2008b; Clarke et al., 2018; Kennedy & Thornberg, 2018; Ward et al., 2016). Accounting for emergent findings using this abductive process elevates the level of abstraction of the analysis, and extends its "theoretical reach" (Charmaz, 2008b, p. 168). Thus, in an iterative circular process, abduction, induction (data generation and constructing codes), and deduction (testing, verifying, or discarding tentative hypotheses to account for data and deciding where to seek further data to develop and

check ideas for theoretical sampling) all have a role in grounded theory analysis and theory construction (Strübing, 2007; Ward et al., 2016). Tavory and Timmermans (2019) outlined,

> Abduction, as Pierce noted, thus provided less certainty than induction, and both were less secure than deduction. And yet, abduction is the only form of inference that has any innovative potential: where deduction tests a rule, and 'induction seeks for facts', 'Abduction seeks a theory'. (p. 537)

However, Bryant (2017) asserted that, abduction is a "far more important—indeed essential—aspect" in theory generation (p. 269). In this study, the pragmatist logic of abduction was acknowledged as key to theory construction.

Symbolic Interactionism and Grounded Theory

Although pragmatism is held as a prominent underpinning of grounded theory, symbolic interactionism has also had significant influence in the methodology's historical development (Bryant, 2017; Charmaz, 2014; Corbin & Strauss, 2008). Symbolic interactionism is a theoretical perspective derived from pragmatist traditions—both focus on action and meaning (Charmaz, 2014). The connections between pragmatism and symbolic interactionism are so close that Crotty (1998) suggested that "symbolic interactionism is pragmatism in sociological attire" (p. 62). Charmaz (2014) described symbolic interactionism as,

> A dynamic theoretical perspective that views human actions as constructing self, situation, and society. It assumes that language and symbols play a crucial role in forming and sharing our meanings and actions. Symbolic interactionism views interpretation and action as reciprocal processes each affecting the other. This perspective recognises that we act in response to how we view our situations. (p. 262)

Charmaz acknowledged that symbolic interactionism and grounded theory methods fit, complement, and can advance each other, describing them as a potential "theory-methods package" (p. 277).

Numerous scholars contributed to the intellectual foundation of symbolic interactionism, many coming from pragmatist perspectives, including George Herbert Mead, Herbert Blumer, and John Dewey (Blumer, 1969). Symbolic interactionism adopted Mead's notion that meaning was a constitutive part of society (Bryant, 2017; Mead, 1934). Blumer was concerned with symbolic interactionism as a sociological theory and research approach (Jeon, 2004). According to Blumer (1969), the symbolic interactionist perspective sees meanings as social products, formed in the context of social interactions; constructions or reconstructions "formed in and through the defining activities of people as they interact" (Blumer, 1969, p. 5; Charmaz, 2014; Crotty, 1998; Jeon, 2004). Blumer emphasised the importance of interpretation and saw interpretation and action as arising from interaction (Charmaz, 2014). Blumer described three simple premises central to the symbolic interactionist perspective:

1. We act toward things based on the meanings that the things have for us. Such things, or symbols, include: words (used to represent feelings, ideas etc.); physical objects (e.g., a cross may represent faith); acts (e.g., looking someone in the eye, winking, gestures); other people; categories of people (e.g., friends, institutions); activities of others; and

situations individuals encounter in daily life (e.g., using a stick as a walking aid rather than using it as a tool to get coconuts off a tree).
2. The meanings of such things are derived from, or arise out of, social interactions; that is, we create our own meanings for things around us through our interactions with other people (such as a therapist showing a child and parent how the child can use a stick to walk independently).
3. Meanings are handled in, and modified through, an interpretive process when we deal with things we encounter; and our actions are influenced by these interpretations. (Blumer, 1969; Charon, 1998; Savin-Baden & Major, 2013; Skeat, 2010)

Essentially, there is no one way to do or see things—people intentionally act towards situations and objects in a way that has meaning to them. Similar to the pragmatist perspective, individuals are considered active, creative, and reflective, and continually engaging in a process of interpretation and definition while progressing from one situation to another, acting in response to their view of situations (Charmaz, 2014; Eaves, 2001).

Symbolic Interactionist Influence on Grounded Theory Methods

In line with Blumer's three premises, Charmaz (2014), in explaining the constructivist approach to grounded theory, highlighted the interpretive and processual nature of symbolic interactionism, as well as its focus on dynamic relationships between meaning and actions. She acknowledged that symbolic interactionism addresses the active processes through which people create and mediate meanings and reality through interpretation, action, and interaction. Like most symbolic interactionists, she believed it is impossible to separate researcher from participant in the generation of data (Birks & Mills, 2015; Charmaz, 2014). To understand the world being researched, participants' actions and interactions must be analysed, and researchers need to engage with participants in their natural context and see things from their point of view (Blumer, 1969). By entering the worlds of those being studied, meanings can be interpreted and understood (Eaves, 2001; Jeon, 2004; Savin-Baden & Major, 2013). Qualitative research methods such as those employed by grounded theorists are, therefore, essential to gaining insights into the views, knowledge of, and meanings, people attribute to their world (Blumer, 1969).

Considering the implications of these understandings for research, in essence, symbolic interactionism is concerned with the subjective meanings people attribute to experiences and the symbols they use to convey those meanings—how people define events and reality; how they act according to their beliefs; and the experiential aspects of human behaviour (Eaves, 2001; Liamputtong, 2013). I was concerned with the personal experiences of the participants in this study, and the meanings these experiences held for them (Carter, 2019; Charmaz, 2014). Charon (1998) argued that words are the most important symbols. Because language and its symbols play a central role in forming and sharing meanings and actions, they therefore inform the research process (Charmaz, 2014). Through interviews and observations, I sought to find out how participants experienced and defined their world, the processes they used to make sense of

their situation (including the use of symbols such as words, gesture, and physical demonstration in communicating and learning), the meanings they held, and how their interpretations influenced what they did (Skeat, 2010; Stanley & Creek, 2003).

In constructivist grounded theory, the role of the researcher is acknowledged in the co-construction of data and meaning making between participants. As such, the symbolic interactionist emphasis on language and meaning goes beyond just focusing on that of the participants of the study. It also provoked awareness of my own language and meanings as a researcher and how this shaped what I asked, saw, and reported (Charmaz, 2014). Constructivist grounded theory recognises that researchers begin a study with a baseline theoretical sensitivity about a topic and guiding interests, reflecting their unique personal, professional, and experiential history (Birks & Mills, 2015). Researcher reflexivity is thus critical in constructivist grounded theory and was engaged in during this study as a tool to guard against forcing preconceptions on the data (Charmaz, 2014).

Epistemology: Social Constructivism and Social Constructionism

Social constructivism and social constructionism are the epistemological underpinnings of this research. There are close connections between pragmatism and constructivism (Reich, 2009). The ideas of the early pragmatists, including Pierce, Dewey and James, have been identified as precursors to constructivist thought (Reich, 2009). Constructivism is also believed to have grown out of developmental and educational psychology, particularly learning theory described by Piaget (1964) relating to childhood development stages and Vygotsky (1978) where knowledge is individually constructed through experience and social relationship (Aburn et al., 2020; Ward, Hoare, et al., 2015; Young & Collin, 2004). Hunter and Krantz (2010) argued that "Constructivist learning theory is situated within a larger constructivist epistemology … that acknowledges multiple, socially constructed truths, perspectives, and realities" (p. 208). At the core of constructivism is the notion that people actively construct, rather than discover, their own individual knowledge, meaning, and reality relative to their experiences (Dolittle & Camp, 1999; Schwandt, 2000). These constructions help individuals make sense of experiences and are continually tested and modified in light of new experiences (Schwandt, 2000). Like pragmatism, constructivism provides a basis for generating practical, resourceful solutions to problems, and meaning relevant to individuals, rather than constructions for the sake of constructions (Reich, 2009).

Constructivism is considered an ontologically relativist and subjectivist stance (Charmaz & Bryant, 2010; Guba & Lincoln, 2001). Relativism is apparent in the constructivist perspective when, given a backdrop of shared understandings and even in relation to the same phenomenon, people may construct individual meaning in different ways, resulting in multiple realities and perspectives which shift and change under different conditions (Charmaz, 2014;

Charmaz & Bryant, 2010; Gibson & Hartman, 2014). Therefore, constructivism views knowledge as subjectively shaped by individual constructions (Charmaz, 2014).

There is, however, more than one kind of constructivism (Hickman et al., 2009; Reich, 2009). Constructivism has been described as a continuum, with social constructivism situated in the middle between cognitive constructivism—with its reliance on cognitive processing at one end, and radical constructivism—with its strong subjectivist orientation at the other (Dolittle & Camp, 1999; Reich, 2009). This study takes a social constructivist stance, in that it recognises social interaction and intersubjectivity in constructing individual reality (Reich, 2009). Prefixing constructivism with 'social' situates the epistemology in a social context and suggests the mode of meaning generation (Crotty, 1998; Ward, Hoare, et al., 2015). According to social constructivism, there are social causes for the way individuals conceptualise reality, with knowledge being a personal construction, based on social experience (Dolittle, 2001; Gibson & Hartman, 2014). Social constructivists thus emphasise the co-construction of meaning within a social activity; and that while knowledge or reality is individual, it is often constructed between people through shared social experience and social negotiation of meaning (Dolittle & Camp, 1999). This is fitting in constructivist grounded theory, which assumes the researcher is part of the research process and the generation of data is a co-construction between researcher and participants (Charmaz, 2014; Charmaz & Bryant, 2010).

There has been some confusion and ambiguity with the terms social constructivism and social constructionism in relation to grounded theory, with the terms used interchangeably, synonymously, or at times subsumed under the generic term of 'constructivism' (Andrews, 2012; Bryant, 2017; Ward, Hoare, et al., 2015; Young & Collin, 2004). Although predominantly referred to as constructivist grounded theory (Bryant & Charmaz, 2007; Charmaz, 2000, 2001, 2008b, 2012, 2014; Charmaz & Bryant, 2010; Puddephatt, 2006), Charmaz (2008a) has also referred to her version of grounded theory as constructionist grounded theory, as have others (Ward, Hoare, et al., 2015). While there are differences, the two are closely related. Constructivism has been described as an "individualist understanding of the constructionist position", whereas social constructionism "emphasises the hold our culture has on us: it shapes the way in which we see things and gives us quite a definite view of the world" (Crotty, 1998, p. 58). According to social constructionism, individuals do not construct interpretations in isolation, but with an inevitable historical and sociocultural dimension and influence on constructions and knowledge development (Aburn et al., 2020; Andrews, 2012; Hickman et al., 2009; Schwandt, 2000). Social constructionism is about the social, collective dimension of generating meaning and socially constructed knowledge (Aburn et al., 2020; Andrews, 2012; Crotty, 1998; Young & Collin, 2004), which "emphasises the socially interactive basis through which common knowledge is constructed and reconstructed" (Ward, Hoare, et al., 2015, p. 454). Thus, the social context and relationship is at the centre of meaning making in social

constructionism, as opposed to the individual but socially mediated knowledge construction inherent to social constructivism (Aburn et al., 2020; Crotty, 1998; MacKinnon, 2005).

Although Charmaz named her variant as constructivist grounded theory, she acknowledged it has its roots in social constructionism (Charmaz & Bryant, 2010). When introducing constructivist grounded theory in the 1990s, she wanted to differentiate her approach from the conventional social constructionism of the 1980s and 1990s, with which she was dissatisfied, as researcher subjectivity was absent rather than acknowledged (Charmaz, 2014). A further reason she chose to use the term 'constructivist' was to "acknowledge subjectivity and the researcher's involvement in construction and interpretation of the data" (Charmaz, 2014, p. 14). Arguing that "subjectivity is inseparable from social existence", Charmaz (2014, p. 14) stated that her position aligned with the social constructivist perspective at that time. However, she has acknowledged that social constructionism has evolved since the inception of constructivist grounded theory and described her more recent position as "consistent with the form it takes today" (Charmaz, 2014, p. 14). She recognised that there are strong "currents of social constructionism in constructivist grounded theory, as are its links to social constructivism" (Charmaz, 2014, p. 14). It seems that the constructivist grounded theory articulated by Charmaz adopts a social constructivist perspective framed by social constructionism. In this way, knowledge and reality constructed by individuals is subjective, but knowing and learning are viewed as embedded in social life, thus emphasising "social contexts, interaction, shared viewpoints, and interpretive understanding" (Charmaz, 2014, p. 14).

Although this research is framed by both social constructivist and social constructionist epistemology, like many other grounded theorists, and Kathy Charmaz herself, I use the overarching label of 'constructivist grounded theory' to describe the variant of grounded theory that has guided this study. In line with Charmaz's (2014) constructivist version of grounded theory, the emphasis on social processes and social influence in social constructivism and social constructionism fit well with the aims of the research—to understand the process of learning between parents and occupational therapists. Whilst appreciating the wider social context in which people's understandings arise, in line with the social constructivist perspective, I viewed participants in this study as individuals with their own unique subjective experiences, knowledge, and realities. As the researcher I was part of the study, coming with my own individual realities, perspectives, and experiences, as both a parent and an occupational therapist.

In constructivist grounded theory, data and analyses are both viewed as emergent social constructions between participants and researcher (Bryant & Charmaz, 2007; Charmaz, 2014). The research process and product are shaped by the researchers' interaction and emergent co-constructions with participants, based on shared understandings (Charmaz, 2014). Undertaking constructivist grounded theory involves a relationship of reciprocity with participants (Mills et

al., 2006). As such, this grounded theory study explicating the process of learning between parents and therapists is informed by, and in turn will inform, both individual and wider social knowledge. Stemming from grounded theory's pragmatist roots and symbolic interactionist influences, the study was open-ended and interactive, shaped by emergent processes and flexibility to follow abductively reasoned ideas and theoretical directions in the data (Charmaz, 2014). Therefore, in line with constructivist grounded theory, the process and resulting theory of learning from this study were, furthermore, considered an emergent construction (Charmaz, 2014).

Essential Grounded Theory Methods

Grounded theory methods guide researchers to generate innovative and insightful conceptualisations as grounded theories which explicate a phenomenon from the perspective and in the context of those who experience it (Birks & Mills, 2015; Bryant, 2017). Central to grounded theory is analysis of action and processes. The emphasis is on theory construction, rather than description and analysis for identifying themes, which is the focus of other qualitative research methods (Bryant, 2017; Charmaz, 2014). Although application of grounded theory methods differs between the versions of grounded theory, there is consensus amongst grounded theorists regarding salient characteristics and the methods essential to the research design in order for the final product to be considered a grounded theory. These include constant comparative analysis, memoing, theoretical sampling, data saturation, and abstraction of conceptual ideas which leads to theory generation (Birks & Mills, 2015; Bryant, 2021; Charmaz, 2014; Glaser & Strauss, 1967; Strauss & Corbin, 1998; Ward et al., 2016). In constructivist grounded theory, the key components leading to theory construction are: reflexivity; theoretical sensitivity; constant comparative analysis; data generation; coding, categorising, and theoretical integration of data; memo writing; theoretical sampling; and theoretical saturation or sufficiency (Birks & Mills, 2015; Charmaz, 2000, 2009, 2014). These key tenets are described as follows:

> **Reflexivity:** As constructivist grounded theorists acknowledge that the research process and product is influenced by the researchers' experiences, perspectives, privileges, positions, interactions, and geographical locations, reflexivity is crucial as a strategy to recognise and scrutinise the researchers' taken for granted assumptions, decisions and interpretations, and their potential influence during the study (Birks & Mills, 2015; Charmaz, 2014).
>
> **Theoretical sensitivity:** As researchers become immersed in the data and consider multiple perspectives, make comparisons, follow leads, question the data, and build on ideas, their theoretical sensitivity to analytical possibilities increases and they develop their ability to recognise and extract elements from the data that have relevance for

developing theory, which brings analytical precision to theory construction (Birks & Mills, 2015; Bryant, 2021; Charmaz, 2014).

Constant comparative analysis: An iterative, recursive process where data generation and analysis of data occur concurrently from early in the research, continuing until the grounded theory is fully integrated (Birks & Mills, 2015; Charmaz, 2014; Strauss & Corbin, 1998).

Data generation: Data are viewed as intentionally generated and co-constructed between researcher and participants for the purpose of theory construction, rather than being collected (Charmaz, 2014; Mills et al., 2006).

Coding, categorising, and theoretical integration of data: Three stages of coding are used to transform data into analysis (initial coding), to categorise data (intermediate or focused coding), and to theoretically integrate the data (advanced or theoretical coding) to construct a theory explicating a phenomenon (Birks & Mills, 2015; Charmaz, 2014).

Memoing: Memos are written continuously and are tools for recording of thoughts, feelings, processes, ideas, questions, analytical insights and decisions in relation to all aspects of the research from the start of the research to final sorting, and help keep the research grounded in the data (Birks & Mills, 2015; Charmaz, 2014; Glaser, 2013).

Theoretical sampling: The purpose of theoretical sampling is to generate further data to yield the greatest theoretical return to enable checking, qualifying, following up on leads, addressing gaps identified within and between categories, and explicating categories as the grounded theory is constructed (Birks & Mills, 2015; Charmaz, 2014; Strauss & Corbin, 1998).

Theoretical sufficiency: Theoretical sufficiency is considered achieved when new data and analysis do not add to the theoretical explanation of categories, subcategories, and the theory (Charmaz, 2014; Dey, 1999).

The application of these methods in this study is outlined in Chapter 4 Methods.

Evaluating Grounded Theory

A key issue in all variants of grounded theory, and particularly from a pragmatist perspective, is the extent to which the "substantive research produces conceptual innovations and theoretical insights that prove useful" (Bryant, 2017, p. 244). From a pragmatist perspective, theories should be constructed from the iterations between engaging with the research setting and conceptual analysis. Grounded theories should be judged against the circumstances from which they were developed, and "theories and concepts are best considered in terms of their usefulness rather than their truthfulness" (Bryant, p. 2009, p. 20) in practice and in the practical difference they make to people's understanding and actions (Bryant, 2017;

Bryant & Charmaz, 2007; Charmaz, 2014; Dewey, 1938a). Further, all claims to knowledge should be seen as provisional and modifiable in light of further developments and experiences (Bryant, 2009, 2017).

Specific criteria for evaluating quality of research differ between different versions of grounded theory (Charmaz & Thornberg, 2020). For example, Glaser (1978) discussed evaluating grounded theories in terms of concepts such as fit, work, relevance (grab), and modifiability. Considering Dewey's pragmatist view of knowledge as instrumental, theories can be considered as tools to be assessed for their practical utility in certain situations, initially against the context from which they were derived (Bryant, 2017; Dewey, 1938a; Reich, 2009). Grounded theories can have immediate impact on people's actions as they can 'work' as a useful tool within a specific context (Bryant, 2017, 2019); and are often proven to be of "great practical use long before the theory is tested with great rigor" (Glaser & Strauss, 1965, p. 293). Furthermore, the reason for a grounded theory 'working' is that it 'fits' with the context and resonates (or has 'grab') with those in that context who come to use it to enhance their everyday practice (Bryant, 2017). Charmaz (2014) offered the following criteria of credibility, originality, resonance, and usefulness to evaluate grounded theories:

> **Credibility:** Includes having sufficient relevant data to ask incisive questions about the data, making systematic comparisons throughout the research, and developing a thorough analysis. Researcher methodological self-consciousness and reflexivity of their influence and methodological decisions is essential throughout the research process (Charmaz, 2017b; Charmaz & Thornberg, 2020).
>
> **Originality:** Includes establishing the significance of the research in offering new insights (Birks & Mills, 2015; Charmaz & Thornberg, 2020).
>
> **Resonance:** Theories have greater value if derived from, and therefore grounded in, data relevant to the intended area of application (Birks & Mills, 2015; Glaser & Strauss, 1967). The grounded theory constructed should represent participants' experiences, provide deeper insights, and make sense to participants and others who share their circumstances (Charmaz, 2014; Charmaz & Thornberg, 2020).
>
> **Usefulness:** Relates to knowledge development and application. It includes revealing pervasive processes and practices, contributing new lines of research, and clarifying research participants' understandings of their everyday life (Charmaz & Thornberg, 2020).

Charmaz (2014) argued that "a strong combination of originality and credibility increases resonance, usefulness and the subsequent value of the contribution" (p. 338) of the theory. A reflection on the quality of the grounded theory constructed during this research using Charmaz's criteria will be presented at the conclusion of the Discussion, Chapter 10.

Summary

In this chapter I have outlined methodological, theoretical, and epistemological underpinnings that informed the research. Constructivist grounded theory was identified as the variant of grounded theory methodology guiding this study and considered against other variants of grounded theory. The foundations of pragmatism and symbolic interactionism as the theoretical perspectives, and social constructivism as the epistemological position underpinning this grounded theory were discussed. Key components of grounded theory methods were presented, concluding with consideration of evaluating grounded theory research. The following chapter builds on this foundation by explaining how the research methods were utilised as the theory of **Responsive learning: Learning from and with each other** was constructed.

Chapter 4 Methods

Introduction

This research aimed to construct a theory to explicate the process of learning between parents and occupational therapists who work with children. In this chapter I outline the research methods used in this study and highlight the constructivist grounded theory procedures used in data generation and analysis to illustrate how I implemented the study's methodological foundations. The chapter opens with positioning myself as researcher. Next, I explain the ethical and cultural considerations influencing this research. Then, I outline the application of grounded theory methods in this study including constant comparative analysis, sampling and recruitment strategies, and introduce the participants. This is followed by a description of the process of data generation and management of the data generated through interviews, filmed observations of routine therapy sessions, and photographs of learning resources provided to parents by therapists. Next, I outline the methods and stages of data analysis and the process of theory construction. I finish by explaining how I report the theory in the results chapters. I use the first-person pronoun throughout this chapter, thereby identifying my active role as the researcher. While primarily informed by Charmaz (2014), the methods were also informed by Birks and Mills (2015), Bryant (2017) and others, as fitting.

Positioning Myself as Researcher

Using constructivist grounded theory, my role as researcher in shaping both the research process and product was not minimised. Charmaz's approach recognises that researchers hold priori knowledge and sensitivity to the social process under investigation (Birks & Mills, 2015; Charmaz, 2014; Murray et al., 2014). Therefore, from the outset I acknowledged that I came to the research as an occupational therapist and parent, and had an active role in data generation, analysis, and the theory that was produced (Bryant, 2017; Charmaz, 2014). It has been argued that when researchers have first-hand experience within a context, nuances that would otherwise have been missed may be noticed and participants' perceptions may be better understood, thus increasing the integrity of data interpretation (Barker et al., 2010; Garratt, 2018). Furthermore, researchers with experience in the research area and connections to the community can inspire a sense of trust and relationship, enhancing their ability to probe more deeply when required and adopt an insider's role to encourage participants to disclose more (Blodgett et al., 2005; Coupal, 2005; Milne & Oberle, 2005). I found participants related to me as an occupational therapist and a parent, with most participants (parents and therapists) interested in knowing about my professional background and how I came to undertake this research. Many also asked about my own children. However, entering research as a practitioner raised challenges of navigating a fine line between interpreting data and imposing preconceptions and assumptions, and balancing

keeping an open mind and identifying concepts of theoretical significance (Birks & Mills, 2015; Charmaz, 2014; Garratt, 2018). Thus, it was important to examine how my preconceptions may shape the analysis, rather than attempt to erase them as in earlier versions of grounded theory (Charmaz, 2014, 2017a).

Reflexivity

Constructivist grounded theorists take a reflective stance towards the research process and product to enhance rigour and remain grounded throughout the research process (Birks & Mills, 2015; Charmaz, 2014). Reflexivity was a key strategy I used to scrutinise my position, experiences, decisions, nascent analysis, interpretations, and instrumental role during this study (Charmaz, 2014; Hall & Callery, 2001; Lincoln et al., 2011; Savin-Baden & Major, 2013). Initially, as part of gaining what Charmaz (2017b) termed 'methodological self-consciousness', and prior to commencing the research, I recorded and transcribed a presuppositions interview with one of my supervisors. The purpose was to explicate my prior knowledge, experience, and taken for granted assumptions, and their potential influence on this study (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014). For example, I had assumed parents were predominantly going to be learning from the therapist and underestimated how mutual the learning was throughout the process. I created a table of my assumptions and their potential influence to reflect on during the research process and check I was not forcing these ideas on the data.

To further engage in reflexivity, during data generation and analysis I wrote memos and kept a reflective journal (Bryant, 2017; Charmaz, 2014). Regular monthly discussions with my supervisors were recorded as they provided an additional opportunity to reflect on research decisions and analysis. My supervisors encouraged me to explain the logic of my analysis and findings to ensure data supported my interpretations and that I was not imposing my own preconceived ideas upon the data and categories. Throughout the study I also actively participated in a monthly university-based peer-support grounded theory group with academics and postgraduate peers. This provided another valuable opportunity to reflect on the research process and theory as it was constructed, test ideas, and justify choices.

Theoretical Sensitivity

Prior experience and knowledge of the field can prove helpful in guiding and sensitising researchers as theory generation is dependent on theoretical sensitivity to concepts evident in the data (Birks & Mills, 2015; Charmaz, 2014). As I become immersed in the data and considered multiple perspectives, made comparisons, questioned the data, and built on ideas, I further developed my theoretical sensitivity and ability to recognise and extract elements from the data which had relevance for developing theory. This assisted in understanding and defining phenomena and relationships between them in abstract terms (Charmaz, 2014; Kelle, 2007). These abstractions became sensitising concepts which prompted further thought and tentative

ideas to pursue, influenced what I noticed, the leads I followed, and questions I asked in subsequent interviews as the theory was constructed (Blumer, 1969; Charmaz, 2014; Hoare et al., 2012). Theoretical sensitivity also turned unexpected moments during an interview or data analysis into an opportunity for theoretical development (Charmaz, 2014). Further, Bryant (2017, 2021) argued that theoretical sensitivity should be accompanied by 'methodological sensitivity'—researchers' aptitude in selecting, combining, and employing methods in the research situation to foster theory construction. Methodological sensitivity is evident in this research where I added the observational element when data analysis and theoretical sampling indicated the need for it.

Ethics Approval

Ethical approval for this research was granted by Auckland University of Technology Ethics Committee (AUTEC) on 13 May 2015 (Number: 15/111) (Appendix A). Modifications were made to the ethics approval and research methods several times, including modifying recruitment strategies and the addition of an observational element (Appendix B), change of title and extending the approval timeframe (Appendix C), change to inclusion criteria and recruitment protocol (Appendix D), and addition of photographs of learning resources provided to parents as data (Appendix E). As the locality where recruitment of the majority of participants took place, a Waikato DHB Approval of Research was applied for and granted on 16 June 2015 (Reference: RD015018) (Appendix F), and subsequently updated for the observational element and amendment to recruitment protocol in September 2016 via email, and for the addition of photos of learning resources in April 2018 via email, as that was all that was required for the DHB to update their record. As part of the DHB approval, an application for cultural approval of this research project was submitted for consideration by the DHB's Te Puna Oranga Māori Consultation Research Review Committee, who subsequently endorsed the study (Appendix G). Ethical approval from the Health and Disability Ethics Committee (HDEC) was not sought because although a child would be involved in the filming of therapy sessions, the focus of the study was the learning and relationship between parent and therapist, and the parent was not a direct consumer or client of the health services concerned. Additionally, I was not accessing any health information.

Ethical Considerations

I prioritised respect for, and protection of, participants throughout the research process. Participation in the study was voluntary and I engaged with participants at their convenience. To minimise potential coercion, I did not directly approach potential parent participants. Instead, paediatric occupational therapists acted as intermediaries to identify and approach potential parent participants from their caseloads. Additionally, parents known to me through my clinical work were specifically excluded from the study to protect the therapeutic relationship. Although

some occupational therapist participants were known to me, I did not have any authority over them, so issues of institutional power did not arise. To give potential participants autonomy and enable them to make an informed choice to participate in the study, verbal information, a flyer (Appendix H) and written information sheet (parent information sheet, Appendix I; and therapist information sheet, Appendix J)[2] were provided. The information sheets covered the aim, investigators involved, their rights as participants, the risks and relevant safeguards, the benefits, and to whom complaints or questions should be directed (Ramcharan, 2010). As data were generated through face-to-face in-depth interviews (except for two phone interviews) and filming of routine therapy sessions where I was present, the participants became known to me. I aimed to establish relationships based on trust, honesty, and respect. Although participants had the opportunity to have a support person with them, none did. As most interviews and all therapy sessions took place in private homes where I had not visited before, a Researcher Safety Protocol was developed for my protection, although the risk was deemed low (Appendix K).

To protect privacy and ensure participants' identities remained confidential, as far as possible, participants selected or were given a pseudonym, as were other therapists or family members mentioned in the data. For the filmed therapy sessions, although it was not possible to prevent both therapist and parent participants from knowing they were both in the study, in reporting the findings their data were not linked. Any stories, practices, and details of an identifying nature were altered or excluded from reporting. Audio recordings of interviews and films were transcribed verbatim, and a confidentiality agreement was signed by the transcriptionist employed (Appendix L). To ensure strict containment of information and privacy, all records of an identifying nature and data were kept in password accessed computer files or a locked filing cabinet, and will be kept for six years according to AUTEC policy, after which time they will be deleted or destroyed.

Ethical obligations to participants continued throughout the study, and beyond. Undertaking constructivist grounded theory research commits the researcher to a relationship of reciprocity with the participants (Mills et al., 2006). As a gesture of reciprocity to acknowledge participants' contribution to the research by sharing their time and knowledge, a koha (Māori word for gift or offering), an unexpected small gift of appreciation ($25 store voucher), was presented after the initial interview, and to both participants at therapy sessions filmed (Jones et al., 2006; McClintock et al., 2012). I also took a gift of home baking to some parents when interviewing at their home. On conclusion of this study each participant will receive a summary of the findings and will continue to be generally acknowledged as a group for their participation and partnership in the study in any reports.

[2] Due to several minor amendments to recruitment and data generation methods during the research there were several versions of the research flyer and information sheets as they were altered to reflect these changes. The final and most comprehensive version of the flyer and information sheets which include all the changes are in the appendices.

Cultural Considerations

In Aotearoa New Zealand, researchers are required to integrate and demonstrate responsiveness to Tiriti o Waitangi in their research design and conduct as part of their ethics application (National Ethics Advisory Committee, 2019; Wyeth et al., 2010). The Te Ara Tika framework addresses Māori ethical issues and draws on tikanga Māori (Māori protocols and practices) to encourage positive outcomes for Māori from research (Hudson et al., 2010). The framework incorporates four tikanga based principles (tikanga reflects values, beliefs, and the way Māori view the world): whakapapa (purpose and relationships); tika (research design); manaakitanga (cultural and social responsibility); and mana (justice and equity) (Came, 2013; Hudson et al., 2010). Consideration is needed as to how Te Ara Tika expectations of ethical research are upheld to ensure all research in Aotearoa New Zealand is relevant to and includes Māori (Came, 2013; Hudson et al., 2010).

Consultation is a key component in development of research involving Māori participants in Aotearoa New Zealand (Wyeth et al., 2010). As a pākehā (non-Māori New Zealander), I recognised that I needed cultural support during this study to adhere to the tikanga principles and optimise Māori participation. Through ongoing collaboration and consultation with Te Puna Oranga (Māori Health Service), Waikato DHB, I received invaluable guidance on cultural issues through all stages of the research—at the outset when doing my ethics application, during recruitment when recruiting parents, during analysis when checking the theory, and when writing the Discussion Chapter 10, to check my interpretations, understanding, and claims. For example, strategies suggested by Te Puna Oranga were implemented when recruiting parents to maximise the opportunity for Māori to participate in the study, in an attempt to ensure the research would be acceptable, accountable, and relevant to Māori and to make it easy and safe for Māori to shape, contribute to and take part (Wyeth et al., 2010). Consultation and strategies used as a result of cultural consultation are discussed in the 'Recruitment' and 'Checking the theory' section of this chapter, and in Chapter 10 Discussion.

Research Process

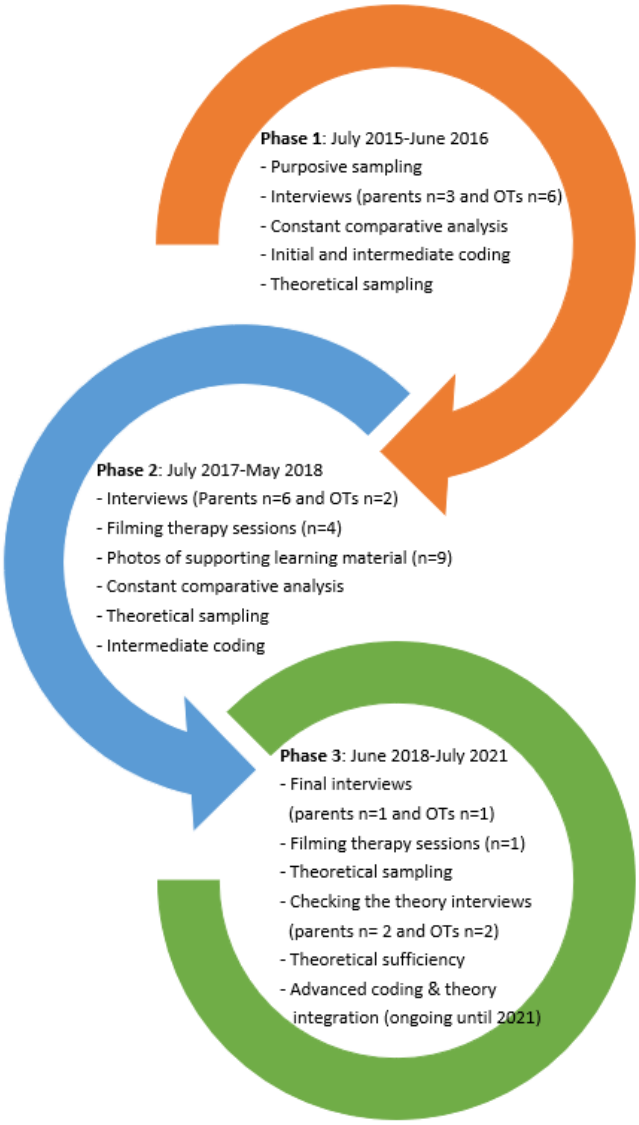
The key constructivist grounded theory methods were introduced in the previous chapter and the implementation of these methods are explained in this section. First, to clarify the research process undertaken, I introduce constant comparative analysis and outline the three phases of data generation and analysis in this study. Second, the process of recruitment and data generation is explained. I outline participant recruitment including sampling rationale and strategies, the recruitment process, and introduce the participants. The use of multiple data sources in this study is discussed. Next, I explain the process of data generation process, and data management and analysis strategies used for each of the data sources—interview, filming therapy sessions, and photos of learning resources. Finally, I explain the process, stages, and methods used for data analysis and theory construction.

Constant Comparative Analysis

Constant comparative analysis is an iterative, recursive process used in grounded theory 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 (Birks & Mills, 2015; Charmaz, 2014; Kenny & Fourie, 2015; Strauss & Corbin, 1998). 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 expatiate the categories with theoretical sampling (Charmaz, 2014; Charmaz & Thornberg, 2020). Figure 4.1 illustrates how data generation and analysis were undertaken across three overlapping phases in this study. Although data generation and analysis processes are articulated separately for clarity, they should be considered in conjunction with each other as data generation was interwoven with data analysis throughout the research process.

Figure 4.1

Phases of data generation and analysis



Recruitment and Data Generation

In line with social constructivist understandings of knowledge generation, participants and myself, as researcher, were acknowledged as co-constructors of both data and the resultant grounded theory (Charmaz, 2014; Ward, Hoare, et al., 2015). Data were not viewed as gathered, discovered, or collected; rather, intentionally generated (or co-constructed) by directly engaging with participants for the purpose of theory construction (Birks & Mills, 2015; Charmaz, 2014; Mills et al., 2006).

As suggested by Charmaz (2014), data generation methods and sources were guided by my research questions so that data were relevant and useful for theory construction. Charmaz advised altering your research question "when you discover that other questions have greater significance in the field" (p. 26). My initial research question was: 'What are the factors influencing parents' learning from paediatric occupational therapists, from the perspectives of parents and therapists?' However, after the first few interviews it became apparent that to understand the influences on learning, I needed to understand what the process of learning was. Additionally, it was clear that the learning was not limited to parent's learning from therapists, but a two-way process. Consequently, I revised my research question and guiding questions for the study became:

- What is the process of learning between parents and paediatric occupational therapists?
- What are the influences on that process and their consequences?

Sampling Rationale and Strategy

In grounded theory, sampling is aimed at data generation to construct a theory. It involves both purposive and theoretical sampling, with an emphasis on generating quality data, not quantity (Bowen, 2008; Charmaz, 2014).

Purposive Sampling

Purposive sampling was undertaken by deliberately selecting participants who could best illuminate the research topic and represent the area under study, as appropriate for qualitative research (Birks & Mills, 2015; Bowen, 2008; Charmaz, 2014; Creswell, 2007; Morse, 2007; Savin-Baden & Major, 2013). Accordingly, parents of preschool age children requiring occupational therapy to support their development, and occupational therapists working with this client group were sought as study participants. It was reasoned that parents of preschool children would be well placed to generate information about the process of learning, because learning would have begun relatively recently, and due to the amount and progression of learning typically occurring close to the time of their child's diagnosis. In line with the pragmatist precept of knowledge being judged in terms of its usefulness and applicability, purposive sampling also contributed to ensuring the theory constructed was likely to be relevant

and useful (Bryant, 2017). Convenience sampling was used with participants selected based on availability and geographical proximity due to time and budget restrictions (Bryant, 2017; Morse, 2007).

Theoretical Sampling

After development of preliminary categories, theoretical sampling guided the remainder of my sampling process. Theoretical sampling is a pivotal grounded theory strategy and was used with the purpose of generating further data, enabling checking, qualifying, following up on leads, and deriving information to fill out properties and explicate categories as the grounded theory was constructed (Charmaz, 2014; Savin-Baden & Major, 2013). Theoretical sampling also addressed gaps identified within and between developing categories and ensured validation of the findings against the context as the theory was constructed, thereby keeping the theory grounded in the data (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014; Strauss & Corbin, 1998). Using a more directed approach, theoretical sampling guided avenues of sampling that could yield the greatest theoretical return, including the participants sought and data generated, until the theory was integrated and theoretical sufficiency reached (Charmaz, 2014; Mason, 2010). Examples of how theoretical sampling was undertaken in this study are outlined in the 'Stages of analysis and theory construction' section of this chapter.

Participant Recruitment

The recruitment strategy outlined in this section was similar whether driven by purposive or theoretical sampling, and for different data sources. Parent and occupational therapist participants were recruited for interview or filming of therapy sessions from paediatric services providing long-term ongoing occupational therapy intervention for pre-school aged children (this included developmental disorders, syndromes, acquired injuries, and other conditions requiring ongoing therapy intervention). Four services covering two large Aotearoa New Zealand cities and surrounding districts were represented (including a charity-run early intervention service and two large DHB paediatric services—services including two VNT and child development services, and an outpatient (burns/plastics) clinic). To protect the identity of participants, specific service names and locations are not disclosed.

Inclusion and Exclusion Criteria

Inclusion criteria were initially for parents (mothers, fathers, caregivers) of pre-school children needing occupational therapy intervention requiring daily parental input at home and who had received intervention for at least three months. However, in line with theoretical sampling, as early data analysis indicated that learning was pivotal from the first therapy interaction, the timeframe of having received therapy for at least three months was removed and the ethics approval amended (Appendix D) to generate data from within the early period prior to three months. As mentioned, parents known to me through my personal clinical work were

excluded. All parents who expressed interest in participating were included, except one who was not comfortable proceeding after discussing what involvement entailed when I made first contact. The inclusion criterion for occupational therapists was that they worked with pre-school aged children. All therapists who expressed interest in participating were included.

Recruitment Process

Multiple strategies were used to alert potential parent participants to the study. A therapist intermediary approached and informed potential parent participants about the study verbally, offering them a research flyer or research information sheet if they expressed interest. Initially parents were required to make first contact with me, which proved a barrier, even with a free phone number for ease of contact. The recruitment strategy was subsequently modified, and ethical approval amended (Appendix B) so that intermediary therapists could pass parents' contact details to me (with their consent) to make first contact, making it less onerous on potential parent participants. This change was also supported by Te Puna Oranga as a strategy to increase potential for Māori participation in the study. Occupational therapist participants were recruited via my professional networks by approaching therapists I already knew from work or professional events. A snowball recruitment strategy was also employed, where participants were provided with a flyer to share if they identified someone else who may be interested in participating when asked at the end of the interview (Bryant, 2017; Savin-Baden & Major, 2013). However, this strategy did not knowingly result in any participants.

Once interest from potential participants was established, I made phone or email contact to check they met the inclusion criteria for the study, discuss what participation involved, answer any questions, and send the relevant parent or therapist participant information sheet (if they did not already have it). I allowed a one-week cooling off period to consider participation before making contact again to answer any further questions, confirm participation or a decision not to proceed, and to arrange a time and place for an interview or filming their next routine therapy session at their convenience (in liaison with all concerned, led by the intermediary therapist for filming). There were several opportunities for participants to withdraw prior to participation including when I (or an intermediary therapist when filming therapy sessions) confirmed their participation and appointment time the day prior, and again when I arrived to meet them for the first time.

Māori participants were openly sought to engage in this research. Advice was sought from Te Puna Oranga regarding recruitment issues and maximising potential for Māori participation in the study on several occasions. Excluding Māori parents who already knew and trusted me through my clinical work was identified as a barrier to Māori participation in the study at the outset. However, this was necessary to ethically protect the therapeutic relationship with families. A further barrier became apparent where several intermediary therapists assumed that many parents, including most Māori parents, on their caseload would not want to

participate in the study. Some therapists told me that they did want not over burden parents by inviting them to participate in this study. Although it seems they were acting as well-meaning gate keepers, these parents were consequently not given the opportunity to consider participation themselves.

Strategies to overcome these issues were discussed with Te Puna Oranga and implemented, including: asking intermediary therapists to tell to all eligible Māori and non-Māori parents on their caseloads about the study to give them the opportunity to decide if they would like to participate for themselves; reminding therapists that having a Māori voice in research fit the DHB's strategy to radically improve Māori health outcomes and reduce inequalities; and asking therapists to remind potential Māori participants of the benefits to Māori of participating; for example, for culturally appropriate service and improving experiences of accessing health services for future whānau (extended family). On the advice of Te Puna Oranga, ethical approval was amended to allow a cultural support person to make first contact with potential Māori parent participants to assist me connecting with them (Appendix D). This was ultimately not required as after implementing the suggested strategies, three parents who identified as Māori were recruited and each participated in filming a routine therapy session and an interview. Further, the addition of the observational element was beneficial in allowing parents to meet me alongside a trusted therapist they already knew at their routine therapy session, which was identified as particularly important for Māori. Consequently, all parents whose initial contact with me was to film a therapy session subsequently agreed to also participate in an interview.

Informed Consent

Consent forms were completed and signed by participants prior to each interview (Appendix M)[3]. For the filmed therapy sessions, the parent and therapist involved each signed a separate consent form (Appendix N). Parents also signed a consent form for their child (and any siblings present) to be in the film (Appendix O). As a child would be in the film, a specific child information sheet and assent form (Appendix P) was developed, but as all parents agreed their child was too young to complete this themselves it was not used. Participants kept a copy of their signed form. Additional verbal consent was obtained at second interviews and captured on the audio recording.

Participants and Their Participation in the Study

This section introduces participants and outlines their participation in the study. In total 23 semi-structured intensive interviews were undertaken, and five routine therapy sessions were

[3] There were two versions of the interview consent form. Due to the addition of photographs of learning resources as a data source, minor amendments to accommodate this change were made. The second and most comprehensive version of the interview consent form which includes this change is in the appendices.

filmed for observational data with 19 participants (parents n=11 and occupational therapists n=8). Four participants (parents n=2 and occupational therapists n=2) participated in a second interview once the theory was taking form to check resonance of the theory (discussed in 'Checking the theory' section). Initial interviews were between 40 and 84 minutes duration (average 65 minutes), with second interviews generally shorter (average length 37 minutes) (see Tables 4.1 and 4.2). The therapy sessions filmed were between 53 and 72 minutes (average 65 minutes) in duration. Separate parent (Appendix Q) and therapist (Appendix R) demographic forms were completed by each participant (see Table 4.1 for parents and Table 4.2 for therapists).

The parents had been working with an occupational therapist to support their child's development for 11 months on average and were mainly visited by the occupational therapist at home. Most parents self-identified as New Zealand European, and three identified as Māori. Eleven parents (mothers n=10 and fathers n=1) of pre-school aged children receiving ongoing therapy intervention participated in 12 interviews. Six of these parents were also filmed during their child's routine therapy session (five therapy sessions). Both the mother and father participated in one therapy session and had a joint interview a week later. Nine photographs of learning resources were also taken at three parent interviews.

Table 4.1

Parent participants' demographics and their participation in the study

Participants		Relation-ship to Child Having Therapy	Time in Therapy Service for Child (Months)	Location of Therapy	Frequency of Therapy Sessions	Interview 1 (Mins)	Interview 2 (Mins)	Filmed Therapy Session	Photos Taken of Learning Resources (N)
1	Lisa	Mother	6	Centre	Weekly	51	-	-	-
2	Sarah	Mother	21	Centre	Weekly	66	31	-	-
3	Louise	Mother	12	Home	Monthly	72	-	-	-
4	Tara*	Mother	6	Home	Fortnightly	40	-	Yes	-
5	Vandella*	Mother	6	Home	3 weekly	69	42	Yes	1
6	Toni	Mother	20	Home/ hospital (outpatient)	6 weekly	42	-	-	-
7	Polly	Mother	22	Home	Monthly	48	-	-	-
8	Samantha*^	Mother	4	Home	3 weekly	83	-	Yes	5
9	David*^	Father	4	Home	3 weekly	83	-	Yes	-
10	Dolly*	Mother	2	Home	Fortnightly	64	-	Yes	3
11	Anika*	Mother	20	Home	Monthly	84	-	Yes	-

Key: #Names are pseudonyms to protect the identity of participants. *Participant in interview and filming therapy session.
^ Joint with both parents participating in interview and filming therapy session (counted once in tally in text). Mins = minutes.
N = number. Information is correct at first contact with participant when demographic information was collected.

The occupational therapists had an average of 20.5 years clinical experience, with an average of 14 years' experience specifically working with children and families. The majority worked for a DHB. Most identified as New Zealand European, two as European, and one as Asian. All therapists were female, and half were parents themselves. Eight occupational therapists working with pre-school aged children participated in 11 interviews. I returned to one therapist for a brief second interview (15 minutes) a week after her initial interview to seek further information after reviewing the interview transcript. Three of the therapists also

participated in filming five therapy sessions (two of the therapists were filmed twice with different parents).

Table 4.2

Therapist participants' demographics and their participation in the study

Participants		Years of Practice as OT	Experience Working with Children and Families (Years)	Employer	Interview 1 (Mins)	Interview 2 (Mins)	Filmed Therapy Session 1	Filmed Therapy Session 2 (with different parent)
1	Annie	13	5	DHB	75	-	-	-
2	Jayne	33	33	Com Org	61	-	-	-
3	Michelle	36	14	DHB	58	51		-
4	Marisa*	8	6	DHB	67	15	Yes	-
5	Kerry	10	9	DHB	73	-	-	-
6	Nicole**	3	Less than 1	DHB	73	44	Yes	Yes
7	Caroline	36	25	Com Org	68	-	-	-
8	Laura**	25	20	DHB	73	-	Yes	Yes

Key: #Names are pseudonyms to protect the identity of participants. *Participant in interview and filming therapy session. **therapist involved in filming two sessions each with different parents. OT = Occupational therapist; DHB = local District Health Board; Com Org = Community organisation; Mins = minutes. Information is correct at first contact with participant when demographic information was collected.

Generating, Managing, and Analysing Data From Multiple Sources

In constructivist grounded theory, generating rich data is central to constructing strong grounded theories and multiple data sources can be used to generate sufficient data to gain a full picture of the topic (Birks & Mills, 2015; Charmaz, 2014; Mills et al., 2006). Moreover, using data triangulation, by combining diverse sources of data, can make the theory constructed more comprehensive as consideration is given to the studied area in different ways and from multiple perspectives (Flick, 2019; Glaser & Strauss, 1967). In line with pragmatism, and the emergent process of constructivist grounded theory, my data generation was designed to inform emerging analysis and theory construction (Charmaz, 2014). Thus, during analysis, emergent understandings and gaps in the data prompted me to revise my data generating methods and sources to provide fresh theoretical understandings and direction as part of theoretical sampling (Birks & Mills, 2015; Charmaz, 2014).

I had initially planned to generate data by interviewing participants about their experiences. Although the emergent analysis of early interviews indicated a complex and dynamic learning process, it was difficult to draw out details about aspects of learning process, such as strategies used, sequencing, and how parents and therapists influenced and responded to each other to support learning. Participants may not have been aware or able to articulate subtleties within or underlying their actions and interactions (Corbin & Strauss, 2015). Therapists often use subconscious, tacit, and taken for granted 'professional craft knowledge' to make skilled judgements and responses in their clinical work. Such knowledge can be perceived as obvious, everyday knowledge, and may not have been articulated during interviews (Gamble et al., 2001). Further, assuming mutual understanding with participants, without probing further, may have been a limitation of being an occupational therapist myself. These gaps directed me to

source additional data elements to generate data about learning encounters as they occurred in context. Consequently, in conjunction with interviewing, routine therapy sessions were filmed as an observational element, and photographs of learning resources given to parents were taken. These were added in the second half of the study (after nine interviews; Parent n=3 and therapist n=6) when tentative categories were already identified and analysis was underway in view of the overall theory (Konecki, 2011; Mey & Dietrich, 2016). Ethics approval (Appendix B), participant flyer, and information sheets were amended accordingly.

Of note, although observations provided an opportunity to confirm whether verbal self-reports of participants' experiences from interviews aligned with what was happening in action (Mulhall, 2003; Savin-Baden & Major, 2013), this aspect was not a priority in this study. I considered both accounts as valid and representing different perspectives on the data (Mulhall, 2003). Further, in line with the pragmatist underpinnings of this study, the goal was construction of a theory judged in terms of usefulness rather than absolute truthfulness, so any inaccuracies were perceived to be inconsequential (Bryant, 2017). As such, the additional data sources (particularly observations) enhanced theory construction by adding a greater depth of understanding and a fuller picture of the process of learning.

Interviews: Data Generation, Data Management, and Analytic Strategy

Intensive semi-structured interviews are commonly used to generate data in grounded theory studies. My interviews involved a flexible 'directed conversation', which allowed in-depth exploration of participants' first-hand experience with the research topic, and the meanings they assigned to their experiences (Birks et al., 2007; Charmaz, 2014; Lofland et al., 2006). The collaborative elements of co-construction of data in constructivist grounded theory fostered an egalitarian exchange and balanced hearing participants' stories in full, while pursuing theory construction (Charmaz, 2014).

In total, 23 semi-structured interviews were undertaken with 19 participants. The location and timing of interviews were selected by participants. Most were face-to-face and took place in homes (parents n=10; OT n=3), workplaces (OT n=7), and a café (OT n=1). One interview was a joint interview with both parents participating. Two parent interviews were telephone interviews by mutual agreement to mitigate logistical issues (geographical location and an unforeseen circumstance restricting my travel on the day). In-depth telephone interviews have been used in other grounded theory studies (Armentrout, 2007; Brown, 2006; Chetpakdeechit et al., 2009; Duggleby et al., 2010; Penz & Duggleby, 2011; Ward, Gott, et al., 2015). The telephone interviews were shorter than the face-to-face interviews. I personally found the absence of context, informal social interaction, and visual cues gained in face-to-face settings a disadvantage. However, similar to the results of a study by Ward, Gott, et al. (2015) on participant views of telephone interview in grounded theory, when invited to comment about their experience both participants were positive. They were comfortable using the phone and felt

they disclosed more, certainly not less, than if I had been physically present. One parent also appreciated the convenience and not worrying about having a tidy house. Thus, the use of telephone interviews did not seemingly impact on the quality of data generated.

In interviews, I adopted the role of an interested learner, thereby viewing participants as the experts on their lives and experiences (Charmaz, 2014). It was made clear that participants did not need to answer a question if they did not wish and could terminate the interview at any time. A flexible interview guide was used as a prompt to encourage free flowing conversation around open-ended questions and reflection on the learning experiences of participants (Charmaz, 2014). As my skill as an interviewer developed, and emergent analysis and theoretical sampling progressed, the interview guide changed accordingly for each interview. I relied on it less during the actual interview and used it more as a tool for preparing for the interviews (example of therapist interview guide, Appendix S; and parent interview guide, Appendix T). To be guided by the priorities of participants, interviews began with a broad open-ended question. For instance, I asked parents, "Can you tell me about your family and your child, and how occupational therapy has been involved?" For therapists, I asked, "Can you tell me about your work and the children and families you work with?" After the first few interviews, I learnt to follow the broad question with a question to guide participants to talk about their experiences of learning. For example, asking parents, "What have you learnt from your child's occupational therapist (OT) so far? What kinds of things have you needed to learn?" And, asking therapists, "What do parents learn from you? What do you set out to teach parents?" To explore further, I encouraged participants to engage in deeper reflection on specific experiences they talked about, such as asking therapists, "Can you think of a specific time recently where you've taught a mum that? [pause] Can you tell me about that time?" And, asking parents, "Can you just think of a recent time where you've actually done that with the therapist that you could tell me about?" To conclude interviews, I checked participants had shared as much as they wanted by asking, "Is there anything else I should have asked you?" and "Is there anything else you'd like to add?" (Charmaz, 2014; Conlon et al., 2013).

As the study progressed, the open-ended, participant-centred nature of earlier interviews shifted towards conversation about theoretical categories. While remaining open to new leads, interviews focused on understanding the complexities around key processes in the data to aid theory construction. Guided by theoretical sampling, I took an increasingly active role and asked more directed questions, as I sought focused data to develop, elaborate, refine, and test categories and fill conceptual gaps; and, for some, followed up on things I had observed from filming therapy sessions (Charmaz, 2014; Conlon et al., 2013; Timonen et al., 2018). For example, to check and further develop the **Establishing relationship** category in a later interview, I asked about the impact of the parent's relationship with the therapist on learning:

> Researcher: Other parents have talked to me about how the relationship they have with their therapist has been important, in terms of how they learn from them and even just working with them. What do you think about how the relationship that you have with the OT impacts on things?
>
> Polly (Parent): *I think it impacts on a lot. I mean the therapist was amazing. She was very easy to talk to, very helpful. Nothing was too much problem, you know! So, I knew if I had any concerns, or anything, I could ask her. Yeah. It was never a sort of a matey, matey; buddy, buddy—let's go down to a pub afterwards—you know. It was always professional, but it was a nice, friendly, and relaxed.*

All interviews were audio recorded and transcribed verbatim. Field notes were also made to capture my immediate thoughts and observations after the interview as memory aids (Charmaz, 2014; Lofland et al., 2006). Transcripts were checked against the recordings for accuracy. To manage the data for analysis, transcripts were inserted into a wide column in a table in a Microsoft Word document with two narrower columns used for coding and comments, with additional comment boxes used for notes (see example of interview data and coding set up Appendix U).

Interview transcripts captured rich detail in the data including participants' statements, the tone and tempo of conversation, pauses, and the form and flow of questions and responses (Charmaz, 2014). Charmaz (2014) encouraged caution when interpreting participants' implicit meaning. Reviewing transcripts enabled me to see times when I assumed a taken for granted meaning and allowed me to reflect on my interviewing skills to make changes (Charmaz, 2014). For instance, I became aware that during early interviews I was often not clarifying, but assuming I knew participants meaning when they said, "you know". Subsequently, I started to follow up on potential, taken-for-granted meanings by asking clarifying question to elicit further information, such as, "How was that for you?" I also used prompts, such as a word participants said during the interview. For example, I checked my understanding and encouraged a therapist to elaborate further on what she meant when she said 'direct'.

> Researcher: When you think about the needs of parents, in terms of what they need to learn from you, how does it change from early on to when you're down the track?
>
> Kerry (OT): *When they grasp the concept, their needs are a lot less down the track. Because they understand what they're doing and it's basically just a catch up, 'How's everything going? You <u>direct</u> me as to what's happening'.*
>
> Researcher: So, the parent <u>directs</u> you?
>
> Kerry (OT): *The parent, yeah. Like I try and get the parent to <u>direct</u> me, like only on occasions where it's appropriate. But I try and give that parent control, per se.*

Filming Routine Therapy Sessions: Data Generation, Data Management, and Analytic Strategy

In grounded theory, observations can help explain what is happening in complex social situations and provide fresh theoretical insight and direction for theory construction (Charmaz, 2014; Griffiths, 2013; Mulhall, 2003; Nilsson, 2012). In this study, the addition of the

observational element by filming (and audio-recording) parents and therapists in routine therapy sessions provided broader and nuanced contextual information about the participants' learning within a natural environment. Filming captured occupations being engaged in, environmental influences, subtleties, sequences, processes, actions, interactions, and responses which I could not obtain through interviews. The information obtained by filming would have been impossible to adequately capture or would have gone un-noticed if only using audio recording or field notes of observations (Griffiths, 2013; Mey & Dietrich, 2016; Mulhall, 2003; Nilsson, 2012; Timonen et al., 2018).

In total, five therapy sessions with six parents and three therapist participants were filmed and audio-recorded. Two of the therapists were filmed twice while working with different parents, in part as theoretical sampling, to explore how therapists adapted and tailored their approach to partnering with and working with different families and to test tentative theoretical concepts and categories (e.g., partnering in learning, reconnecting, and responding). Five of the six parent participants agreed to be interviewed a week later when discreetly invited to do so at the end of the therapy session (one parent had been interviewed prior to the therapy session, but I returned to her later for a second interview when checking the theory). I had already interviewed two of the therapist participants before filming, although I returned to one of them later for a second interview to check the theory. The third therapist was interviewed after filming her in two different therapy sessions.

Each of the routine therapy sessions involving an occupational therapist, parent, and child were filmed in homes, specifically lounge rooms—the location of their usual session in all cases. A small camera with a wide-angle lens (GoPro Hero 6) was set up on a tripod and positioned to capture the whole scene of the therapy session. An audio recorder was also used for transcription and back up purposes. I altered my approach after filming the first session—when arriving with the therapist and gaining consent proved disruptive to the natural flow of the session. I also missed filming the early interactions at the beginning of the session, where the participants re-connected and learned what had transpired since their last interaction. To minimise disruption, for subsequent sessions I arrived independently 15-20 minutes early to meet the parent, complete the consent process, and set up to begin filming as the therapist arrived at the door (therapists were informed of this and their consent was established in advance when confirming the appointment). Filming concluded when it was clear the session was finished, and I informed participants I was turning the camera and audio-recorder off. Field notes were made during the session and immediately after leaving as memory aids to analysis and subsequent data generation (Altheide & Schneider, 2013; Charmaz, 2014; Lofland et al., 2006). I noted initial observations, timing of points of interest, and points to address in the subsequent interviews, such as reconnecting after their time apart, therapists' use of Māori language, and therapist and parent working together to refine a hands-on technique.

During filming I was conscious of my potential influence on the therapy sessions and data generated. Participants were given the option of me leaving once the camera was set up if they preferred, but all participants were happy for me to remain. There was potential that my presence may have had an effect on participants' altering their typical performance when observed (Mulhall, 2003; Savin-Baden & Major, 2013). However, it has been suggested that after the initial stage of entering the field, most participants do not maintain radically different behaviour from normal and recording devices are quickly incorporated into routine activities (Laurier & Philo, 2012; Mulhall, 2003). Further, when the researcher's presence and influence is minimal during observations, participants are less likely to alter or conceal their behaviour (Morse, 2007). Therefore, I took the role of a passive observer while filming, aiming for the least amount of intrusion (Nilsson, 2012). Despite this intent, there were times where I moved the camera and other times where the parent, therapist, and child interacted with me briefly.

Although other grounded theory studies have used observations (Adolph et al., 2012; Carrier et al., 2012; Eyles et al., 2009; Hoare et al., 2013), few have used filming (Griffiths, 2013; Nilsson, 2012). There is a paucity of literature guiding managing and analysing filmed data in grounded theory. Consequently, I developed my own method. To manage the observational data, dialogue (from the audio recorder) was transcribed verbatim, and transcripts were checked against the film for accuracy. Dialogue was colour coded to clearly see the direction of conversations—OT to Parent (grey); OT to Child (blue); Parent to OT (black); Parent to Child (navy). I noted details on the transcript such as shifts in direction of conversations, gestures, body movements, gaze, laughter, use of objects and the environment, and the responses of those involved to support learning, thereby making it like a script. Transcripts were inserted into a wide column in a table in a Microsoft Word document, with two narrower columns for coding and notes.

Filming therapy sessions was introduced after three parent and six therapist interviews, at a stage when I was sensitised to data, had already constructed tentative theoretical categories, and the theory was starting to form. Therefore, analysis was guided by the research questions and theoretical sampling rather than exhaustive documentation of the field, following the grounded theory principles of remaining open to new ideas, probing for clarification, and to follow emerging theoretical hunches (Mey & Dietrich, 2016; Schubert, 2012; Timonen et al., 2018). Informed by earlier interviews, I developed an observation guide (Appendix V) to assist analysis of, and to sensitise myself to, the observational data (Eyles et al., 2009; Nilsson, 2012). The content of the therapy intervention and the child's therapeutic progression were not analysed. When analysing observational data, comparing incident with incident can reveal critical activity sequences, social patterns and processes, which are key concern in grounded theory (Charmaz, 2014; Nilsson, 2012). Therefore, transcripts were 'chunked' by starting a new row in the table when each incident, or the issue of focus, shifted. The reason for the shift was

noted for each new 'chunk'; for example, who or what prompted the shift and why. Iterative analysis was undertaken by viewing the film, while simultaneously chunking and coding the data, and comparing with interview data. I commented on links with related interviews and inserted screenshots in the notes column, to illustrate the dialogue and enhance my memory and analysis (see example of film data and coding set up from two films in Appendix W).

Gaps identified in the data and concepts were checked and further explored with theoretical sampling in subsequent interviews (Charmaz, 2014). For example, observing parents' and therapists' body movements, and the use of non-verbal communication and gestures, when teaching, refining, and clarifying learning, led to further questions and exploration about embodied learning (Arntzen, 2017; Griffiths, 2013; Kinsella, 2018; Nilsson, 2012). Through analysis of the observational data, I also noticed oscillating attention between those present at the therapy session and oscillation between tending relationship and refining learning (action and doing) as they responded to each other. This alerted me to multiple layers of learning happening simultaneously, and rapid shifts between learning (e.g., seeking specific information), responding and tending the relationship. Further theoretical sampling strengthened the theoretical category of **Partnering in learning** and subcategory **Getting on the same page again**, and supported the main concept of the theory, **Responsive learning**.

I was conscious that with observational data researchers have greater autonomy with what they observe, analyse, and interpret compared to interviews where participants have a greater role in leading the direction of questions and discussion (Mulhall, 2003; Savin-Baden & Major, 2013). Therefore, for rigour, it was important to be aware of my own subjectivity when analysing the data (Charmaz, 2014). To manage this, I used my reflective journal, memoing, discussions with my supervisors, and checked interpretations with participants in later interviews. An advantage of filming therapy sessions was the mutual point of reference and shared context for discussions with participants during the subsequent interviews, where I was able to ask participants about aspects of the therapy session and interactions observed and check my interpretations. For example,

> Researcher: You mentioned that she [OT] writes things down sometimes.
>
> Dolly (Parent): *Yes.*
>
> Researcher: And I noticed when I was here last week she offered to, but you didn't need it?
>
> Dolly (Parent): *Yeah, yeah. I think she's really good at writing it down. But to actually sit down and find the time to actually process what she's written down—that's why I was saying to her, 'Even if we can just spend the first 10 minutes of our session doing a recap of what we did the week before, I would find that probably a little bit more helpful than having it written down on a piece of paper'.*

Photographs of Learning Resources: Data Generation, Data Management, and Analytic Strategy

During the interviews and observations, parents and therapists talked about supporting learning resources which therapists gave or sent to parents to use between visits. Halfway through the study a parent invited me to take a photo of her handwritten home programme. This prompted inclusion of photos of learning resources as data, as it was useful to see the information parents were given, how content was carried forward between encounters, and how parents used it. The ethics approval, information sheet, and the consent form were amended accordingly (Appendix E). I returned to amend that parent's consent to include photos with the new consent form.

Photos were only taken of documents offered, using my mobile phone, and immediately shown to the parent for their approval (captured on the audio recording). After the appointment, I transferred the photo to the computer for storage and analysis and deleted the photo from my phone. Photos were edited to exclude identifying information including names, dates, and organisation details. In total, nine photographs were taken at three parent interviews—five were session summaries with instructions on what to do between sessions handwritten by the therapist; three were photocopied handouts given to the parent (two of which had handwritten notes and arrows drawn by the therapist, and the other an unaltered photocopy); and one was tailored instructions for positioning a child, made by the therapist on a computer using two photos of the child (from behind with no face shown) and arrows highlighting specific aspects. To preserve anonymity, the photos are not shown or linked to specific parents in reporting.

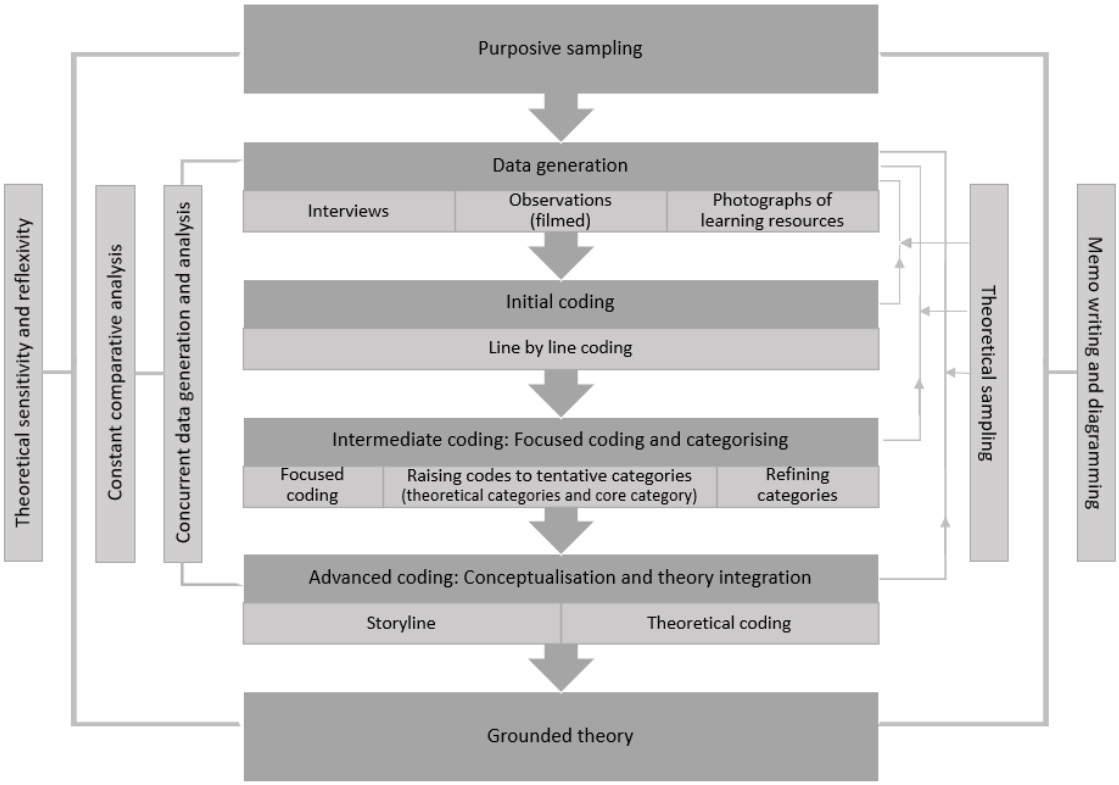
Because the photographs were taken during the interview, I was also able to ask participants directly about the usefulness of the material to their learning and the meaning it held for them. I encouraged participants to lead the interpretation as a form of 'photo elicitation' while we focused on the document in the process of taking a photo (Riley & Manias, 2004). Essentially the photos were a visual record of an extant document given to parents to convey information to support learning. As such, they were analysed as documents with analysis focused on content and how it was conveyed (Charmaz, 2014; Savin-Baden & Major, 2013). I coded a printout of each image, while comparing it with what the parent said during the interview, and against other data, theoretical categories, and the theory as a whole (Charmaz, 2014; Konecki, 2011). Although these data were useful in developing and adding depth to the theoretical category of **Partnering in learning**, and subcategories of **Tailoring learning** and **Getting on the same page again**, and property of 'Responding with media: Individualising learning resources', capturing these documents earlier in the study may have added more value and depth to the theory. These results are incorporated in the results in Chapter 8, **Partnering in learning: Getting on the same page again**.

Methods and Stages of Analysis and Theory Construction

In this section I outline the methods and stages of coding and analysis I used to construct and integrate the theory. Although I have separated the stages of coding for explanation, with constant comparative analysis and the iterative nature of grounded theory I moved back and forth between stages, which often overlapped and occurred simultaneously. This contributed to sensitivity to theoretical possibilities as I concurrently generated and analysed data (Birks & Mills, 2015; Charmaz, 2014; Thornberg & Charmaz, 2014). The grounded theory methods and the stages of coding used for data analysis are outlined in Figure 4.2. While, I could have used computer software and explored the use of NVivo for managing and coding my data, I chose a manual approach to coding and analysis. I used tables and Word documents for coding and memoing, as mentioned, as I found a hands-on approach and the system I used kept me close to the data and was working well for me.

Figure 4.2

My data generation and analysis process



My data generation and analysis process (Birks & Mills, 2015; Charmaz, 2014; Chun Tie et al., 2019). Figure adapted from "Grounded theory research: A design framework for novice researchers", by Y. Chun Tie, M. Birks and K. Francis, 2019, Sage Open Medicine, 7, p. 3 (https://doi.org/10.1177/2050312118822927). CC BY-NC.

Coding

Coding is key to grounded theory analysis and was a crucial link between generating data and constructing a theory to explain the data (Charmaz, 2014). Codes are "a word or short phrase that symbolically assign a summative, salient, essence-capturing … attribute to a portion

of language-based or visual data" (Saldana, 2013, p. 3). Codes reflecting participants' concerns or actions were constructed by naming fragments of data during data analysis (Charmaz, 2014). In line with the suggestion by Charmaz (2008b, 2014), I mostly coded using gerunds—noun forms of verbs ending with 'ing'—to capture and maintain focus on actions and process in the data, such as 'connecting', 'holding back', 'refining', and 'getting it'. I also used 'in vivo' codes which kept language grounded in participants' voices by using their words, such as 'hooking' (Charmaz, 2014). Charmaz (2014) advised being attentive to language when coding, as, in line with symbolic interactionism, in vivo codes serve as symbolic markers of participants' speech, meanings, and actions. Crucially, codes at all stages must earn their way into analysis and should fit the data rather than forcing data to fit the code (Glaser, 1978; Thornberg & Charmaz, 2014). Therefore, all codes were tentative and open to modification and refinement during constant comparative analysis. Coding was inductive and emergent and gave me insights into further data to generate and leads to pursue in subsequent theoretical sampling (Charmaz, 2008b, 2014; Strübing, 2007; Ward et al., 2016).

Stages of Coding

In constructivist grounded theory, Charmaz (2014) outlined initial coding and focused coding as two main stages of the coding process. She also proposed using theoretical coding, when indicated, to clarify and sharpen analysis. However, as shown in Figure 4.2, to explain the coding and analytical stages used in my study, I adopted the terms initial, intermediate, and advanced coding as outlined by Birks and Mills (2015). These terms incorporate Charmaz's coding stages, and clearly outline what was involved in each stage of analysis and theory construction. Initial, intermediate (including focused coding and categorising), and advanced coding (including conceptualising and theoretical coding) also correlate with proposed low-, medium- and high- level conceptual abstraction that occurs as analysis and theory construction progress to an integrated theory (Birks & Mills, 2015; Bryant, 2017). Figure 4.3 represents the coding stages guiding construction of my theory, **Responsive learning: Learning from and with each other**. In the subsequent sections, I explain the coding stages I used.

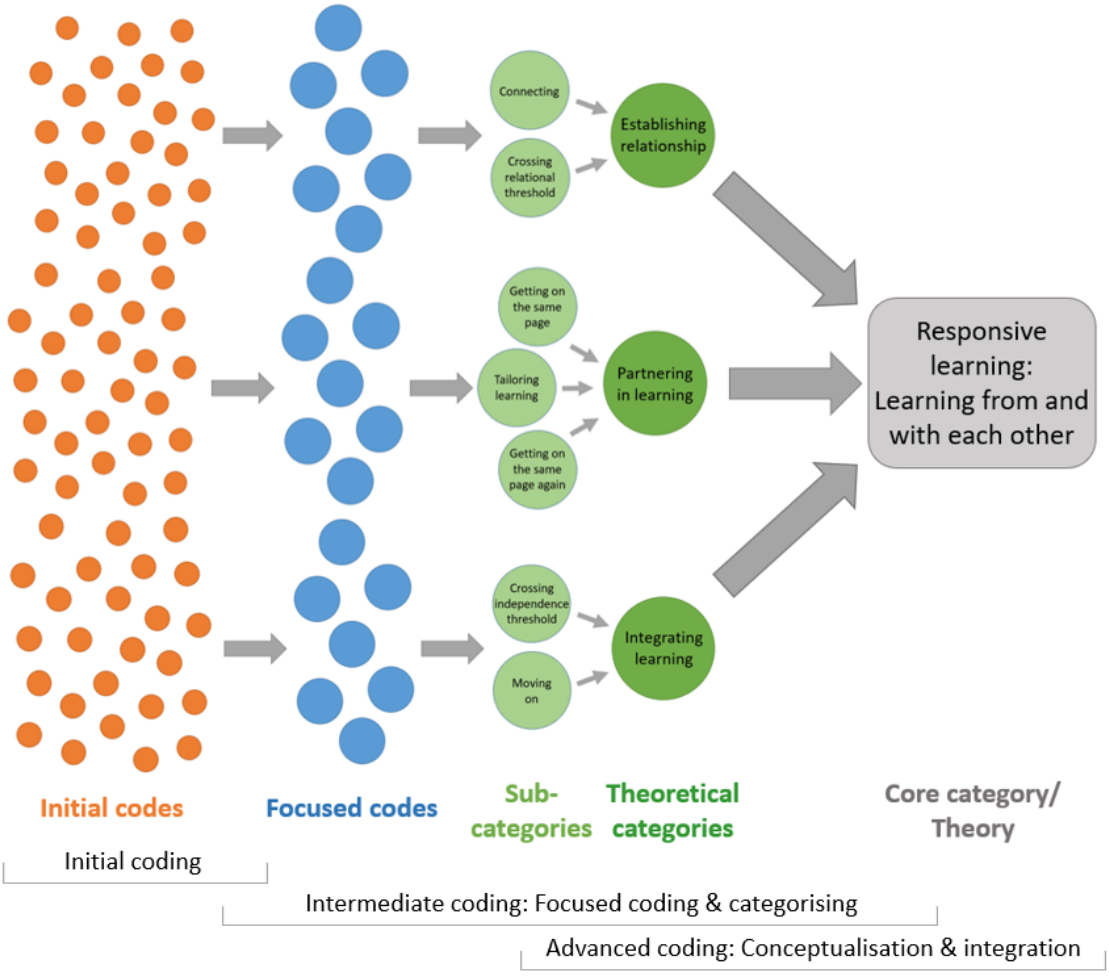
Initial Coding

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 and study fragments of data for their analytic import (Charmaz, 2014). The initial codes were derived inductively and were concise, spontaneous, and interpretive (Thornberg & Charmaz, 2014). The emphasis was on staying close to the data, moving quickly, focusing on action and process, and comparing data with data. Initial coding also provided preliminary ideas and theoretical directions to pursue with theoretical sampling in further data generation and analysis (Belgrave & Seide, 2019; Birks & Mills, 2015; Bryant & Charmaz, 2007; Charmaz, 2014). Line-by-line coding

became redundant as I gained a sense of conceptual control over the data, and shifted to focused coding (Birks & Mills, 2015).

Figure 4.3

Theory construction: Developing theoretical categories and theory



Intermediate Coding: Focused Coding and Categorising

The intermediate stage of analysis encompassed focused coding, constructing tentative categories, and conceptual development of the theory (Birks & Mills, 2015; Charmaz, 2014).

Focused coding

Focused coding involved a higher level of abstraction and conceptualisation than initial coding. It integrated key aspects of the lower level codes, while building on and enhancing their overall explanatory power (Belgrave & Seide, 2019; Bryant, 2017; Charmaz, 2014). A plethora of initial codes were subsumed into focused codes, or new focused codes were constructed to account for the data. The most salient initial codes with more theoretical centrality, direction, and reach were developed into a smaller number of more focused, conceptual codes. Focused coding also put codes to the test with large batches of data and prompted me to re-examine data, check my pre-conceptions, and seek further data guided by theoretical sampling. As ideas started taking hold, I also used incident-by-incident coding to compare similar data and

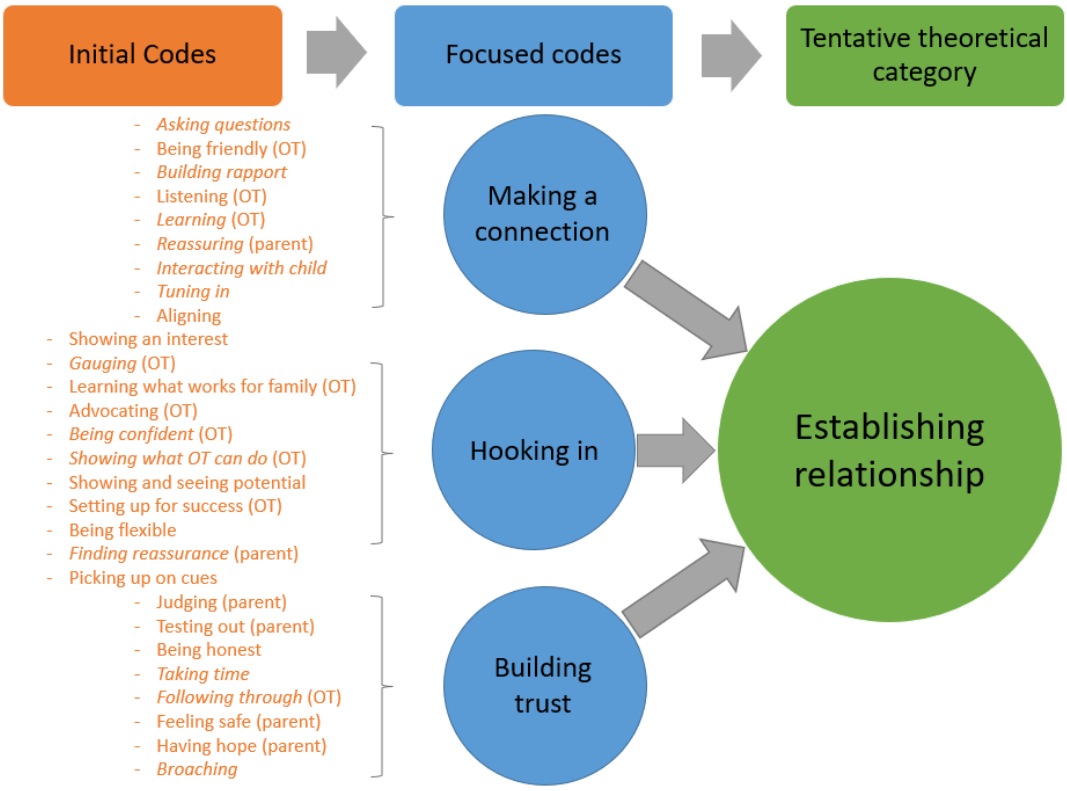
conceptualisations, which aided discovery of patterns and contrasts, particularly when analysing the observational data (Bryant, 2017; Charmaz, 2014).

Categorising

Focused codes demonstrating analytical strength and theoretical reach were then elevated to tentative theoretical categories with higher levels of abstraction (Bryant, 2017; Charmaz, 2014). Tentative categories were constructed by grouping related codes as conceptual patterns were identified, while continuing with close engagement with the data (Birks & Mills, 2015; Bryant, 2017). Figure 4.4 illustrates an example of the coding process that took place to arrive at the tentative theoretical category, **Establishing Relationship**.

Figure 4.4

Example of early coding process (October 2016)



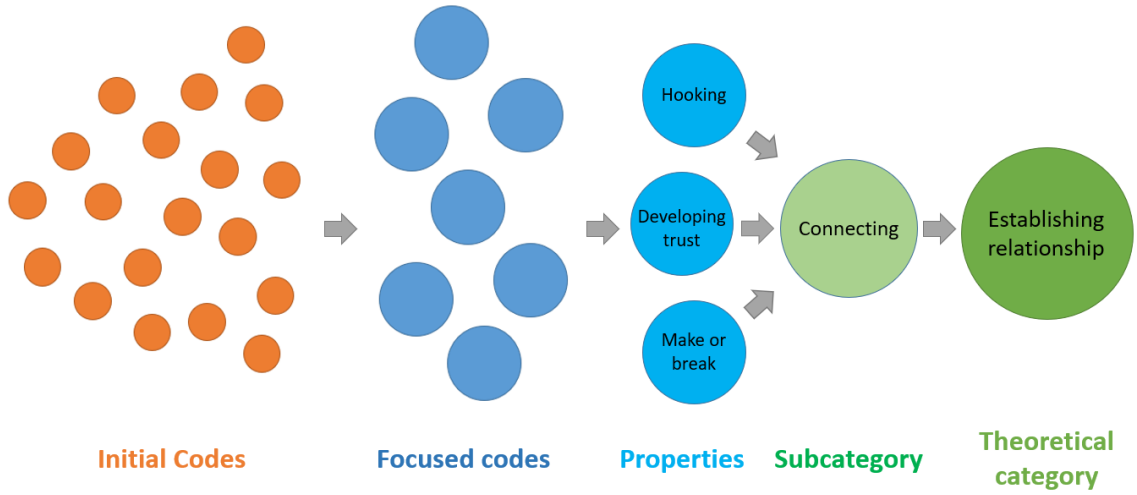
Codes in italics represent overlapping codes from analysis of more than one of the interviews, as the data have been compared.

In this example, theory development involved grouping together initial codes such as, 'asking questions', 'being friendly', and 'tuning in' under the focused code 'making a connection'. As the focused code 'making a connection' was further explored, developed, abstracted, and compared with other tentative focused codes such as 'hooking in' and 'building trust', the initially tentative theoretical category of **Establishing relationship** was constructed, which accounted for these more significant codes at a higher conceptual level. With further analysis and testing, the focused code 'making a connection' became **Connecting** as it was elevated to one of two subcategories, along with the second subcategory of **Crossing the**

relational threshold, under the later confirmed theoretical category of **Establishing relationship**. The renamed focused codes 'hooking' and 'developing trust', along with 'make or break' added later, were subsumed under **Connecting** and became explanatory properties, as detailed in Figure 4.5. Connecting was an important time of learning about each other, needed to establish a relationship.

Figure 4.5

Theoretical category Establishing relationship, subcategory Connecting, and properties



Theoretical categories were multi-dimensional and consisted of subcategories, which collectively explained a broader concept. A key purpose of intermediate coding was linking or integrating theoretical categories by comparing codes to categories, and categories with other categories, while identifying and questioning the relationship and links between these medium-level concepts (Birks & Mills, 2015; Charmaz, 2014). 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 operate under. Tentative hypotheses accounting for the data were tested, and then refined or discarded with further theoretical sampling. In these ways, both deductive and abductive reasoning were used to reach the most plausible explanation of the data (Birks & Mills, 2015; Charmaz, 2008b, 2014; Kennedy & Thornberg, 2018; Strübing, 2007; Ward et al., 2016).

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** (Charmaz, 2014). An abstract core category was constructed as the most significant code, relating to and accounting for more data than the other categories by subsuming the higher-level categories and explicating the properties and connections between them (Charmaz, 2014; Charmaz & Thornberg, 2020). My core category, and the title of my grounded theory, became **Responsive learning: Learning from and with each other** (see Figure 4.3, p. 82).

Advanced Coding: Conceptualisation and Theory Integration

Although theoretical integration began with intermediate coding, advanced coding procedures, including use of storyline (narrative presentation of the theory) and theoretical coding, served to integrate the grounded theory at a high conceptual level and enhance its explanatory power (Birks & Mills, 2015; Birks et al., 2009; Charmaz, 2014).

Storyline

Birks and Mills (2015, 2019) advocated using storyline as a technique to move beyond description, aid theoretical integration, and as way of refining or 'rendering' and presenting a grounded theory. Storyline has been increasingly used in recent grounded theory studies (Birks et al., 2009; Chun Tie et al., 2018; Edwards et al., 2018; Ralph et al., 2017). Although Charmaz does not mention storyline, I appreciated the value it added to make my grounded theory tangible and therefore adopted it as an advanced analytical technique (Birks & Mills, 2019; Dey, 2007). Writing the storyline involved a process of weaving the data, fragmented during earlier coding, back together to integrate it into a coherent theory as a way of making sense of the theory and clearly explaining the story evident in the data (Birks & Mills, 2015). Guided by Birks and Mills (2015, 2019) I initially stepped away from the data to tell the story of the analysis, before refining it iteratively using comparative analysis at a higher conceptual level by moving between data, memos, and writing the storyline. Finally, I evidenced the storyline with data to illustrate abstract concepts, support analytical arguments, and ground the storyline in the data (Birks & Mills, 2019). The storyline produced was a conceptually abstract explanation of the theory, explicating the relationship between categories and concepts which make up the theory (Birks & Mills, 2015). The storyline is presented as Chapter 5 to introduce my theory of **Responsive learning: Learning from and with each other**, the grounded theory constructed in this study.

Theoretical coding

Theoretical coding supported theory integration and enhanced the explanatory power of the theory (Birks & Mills, 2015). Once the grounded theory was constructed, theoretical coding contributed to expanding the depth, breadth, and reach of the theory by situating the new grounded theory in a broader context and body of knowledge. Theoretical codes were drawn from extant theory and literature and used to explain, discuss, and substantiate the theory, and further elucidate the categories, concepts, and properties and relationships between them (Birks & Mills, 2015, 2019; Bryant, 2017; Charmaz, 2014; Glaser & Strauss, 1967). Charmaz (2014) argued that theoretical coding was not always necessary. When used, she recommended that theoretical codes not be forced. Rather, consistent with the pragmatist underpinning and emergent processes of constructivist grounded theory, to be relevant, work, and fit the data and categories within the theory, theoretical codes should be indicated by earlier analysis (Birks & Mills, 2015; Charmaz, 2014; Glaser, 1978; Thornberg & Charmaz, 2014). Applying the work of

others to the grounded theory augmented, supported, and validated existing theories and, in turn, explained and reinforced the value of my theory in a reciprocal process with the shared aim of expanding the extant knowledge base (Birks & Mills, 2015; Glaser, 2005). For example, I used the hui process (Lacey et al., 2011) as a theoretical code as there was homogeneity with concepts in my grounded theory, and it assisted with the explanation of my theory and vice versa. The findings of theoretical coding are incorporated in Chapter 10 Discussion, where I discuss my theory in the context of what is already known.

Memo Writing

Memos were written frequently, spontaneously, and continuously throughout the research process as a tool for recording thoughts, reflections, processes, ideas, questions, analytical insights, and as an audit trail for decisions made in relation to all aspects of the research (Birks & Mills, 2015; Charmaz, 2014; Glaser, 2013). The accumulation of memos has been described as an investment of "intellectual capital in the project bank" (Clarke et al., 2018, p. 107; Glaser, 2013). My memos were handwritten (in a notebook or scribbled notes stuck in later), typed into comment boxes, linked to relevant parts of the transcripts while coding, or mostly typed into a Microsoft Word document. They were a record of my thinking and showed progression of thought as the theory was constructed (Birks & Mills, 2015; Charmaz, 2014). My memos became more focused when I had constructed tentative categories and were kept open to build on as analysis progressed (Charmaz, 2014). Each memo was dated, given a title, and organised in a file with like memos under tentative category headings. Writing memos enabled me to probe data; make comparisons; and gain awareness of links between data, codes, and categories, contributing to keeping the research grounded in the data. My memos prompted new thinking and directions to pursue for theoretical sampling. They also facilitated reflexivity by helping me question my own preconceptions, and potential influence on my interpretations and analysis (Birks & Mills, 2015; Charmaz, 2014; Kenny & Fourie, 2015; Strauss & Corbin, 1998). Revisiting, sorting, and reorganising my memos often resulted in writing more memos to aid in theory construction and contributed to theory integration (Birks & Mills, 2015; Charmaz, 2014). Examples of two memos are in Appendix X.

Diagramming

Diagramming, memoing, and theoretical sampling are interrelated processes recognised as part of the pragmatist influence of abductive reasoning. Collectively, they lead to creative leaps in interpretation, and a deeper understanding of concepts and data (Charmaz, 2014; Crilly et al., 2016; Kennedy & Thornberg, 2018; Richardson & Kramer, 2006; Strübing, 2007). Diagramming formed an intrinsic part of my data analysis and theory construction process. It was an iterative process of visual thinking, or 'graphic ideation' (Crilly et al., 2016). Diagramming helped me reflect on process and action in data, and provided a way to explore,

test, organise, refine and integrate conceptualisations while constructing the theory (Birks & Mills, 2015; Charmaz, 2014; Corbin & Strauss, 2015; Crilly et al., 2016; Glaser, 1978). Diagramming also helped me move the theory beyond description to conceptualisation while experimenting with different visual solutions with various degrees of abstraction (Buckley & Waring, 2013). This led to further theoretical sampling to refine categories, resulting in more sophisticated and refined diagrams as the study progressed (Charmaz, 2014; Crilly et al., 2016). Some of my diagrams were done manually (on paper), but most were done in Microsoft PowerPoint. All diagrams were dated, printed, and stored chronologically in a folder to show progression of analysis and theory development. An example of the progression of my diagrams is in Appendix Y. I also used my diagrams as a 'graphic communication' tool to convey and present ideas and interpretations as a common frame of reference from which discussions with my supervisors and other colleagues took place (Buckley & Waring, 2013; Charmaz, 2014; Crilly et al., 2016).

Using Theoretical Sampling

Theoretical sampling involved intentionally returning to the field to seek additional data sources or generate more data to follow leads or fill gaps, and check and refine the categories, when directed to during analysis (Birks & Mills, 2015; Charmaz, 2014). It provided a way of managing the emergent analysis and kept the developing theory grounded in the data (Charmaz, 2008b, 2014). As mentioned in other parts of the thesis, I used theoretical sampling in several ways.

Theoretical sampling of data. During data analysis I used theoretical sampling to follow lead, fill gaps, test ideas and concepts, and develop and substantiate categories by reviewing existing data or deliberately seeking specific information during interviews as theory construction progressed (Charmaz, 2014). For example, when early data pointed towards the value of relationship for learning between parents and therapists, to check and refine this idea I asked specific questions about how participants felt their relationship influenced learning during subsequent interviews (see table in Appendix Z outlining three examples of emerging concepts identified for theoretical sampling in the early stages of data analysis). At other times, I spontaneously used theoretical sampling to explore areas of theoretical interest that emerged during interviews (Charmaz, 2014). For example, when a therapist talked about a parent being reluctant to try doing something in front of her, it prompted me to think about the idea of parent performance anxiety which several parents had talked about. As a result, I asked the therapist more about this to encourage her to elaborate.

Theoretical sampling using additional data sources. As outlined in the 'Recruitment and data generation' section of this chapter, the addition of filming therapy sessions to generate observational data and taking photographs of learning resources came in

response to gaps in understanding about the learning process. These gaps were filled by using these additional data sources, in conjunction with interviews, to construct a comprehensive theory.

Theoretical sampling for specific participants. To gain diversity of perspectives on learning experiences, I used theoretical sampling several times to deliberately recruit participants who could add variation or depth to theory construction and from different contexts than earlier participants (Charmaz, 2014). For example, I sought to recruit a hospital based occupational therapist, therapists with a range of experience, male in addition to female parents, and Māori parents.

Theoretical sampling of literature. Theoretical sampling to further analyse and substantiate categories by reviewing literature relevant to emergent aspects in the data formed part of my ongoing literature review (see Chapter 2 Literature review) (Birks & Mills, 2015; Charmaz, 2014; Thornberg & Dunne, 2019). For instance, during interviews, parents and therapists talked about practical hands-on learning to support, position, or move a child, and during observations of therapy sessions used their body to show each other what they meant. When it came up during data analysis, I reviewed literature on embodied learning in health practice to confirm, understand, and explain what I was seeing (Arntzen, 2017; Kinsella, 2018; Knowles et al., 2015; Loftus, 2015). Consequently, 'embodied learning' became a sensitising concept for subsequent data analysis (Charmaz, 2014) and contributed to substantiating the category **Partnering in learning** and subcategory **Tailoring learning**.

Checking the Theory

The common practice of member checking in qualitative research to ensure findings provide an accurate representation of individual participants' experiences is a largely redundant source of verification within grounded theory where methods including constant comparative analysis and theoretical sampling enable key concepts to be tested with participants and elaborated on as the theory is being constructed and refined (Birks & Mills, 2015; Bryant, 2017; Charmaz, 2014). Furthermore, as grounded theory aims for conceptual theorisation of a process in relation to a substantive area of enquiry rather than description, and emphasises generalisation and abstracting away from individuals, accuracy becomes less relevant (Birks & Mills, 2015; Buckley & Waring, 2013). Instead, from a pragmatist perspective, it is important that theories are considered in terms of their usefulness in practice, rather than representing an absolute truth (Bryant, 2017; Bryant & Charmaz, 2007; Charmaz, 2014; Dewey, 1938a). Therefore, in line with Charmaz's (2014) criteria for evaluating grounded theory, and the pragmatist underpinnings of this study, rather than 'member checking', the fit, resonance, and usefulness of the constructed theory was checked with selected participants and knowledgeable health professionals towards the end stage of data analysis and theory construction (Bryant,

2017; Charmaz, 2014). These discussions gave useful insights into how the theory was interpreted by others (Buckley & Waring, 2013; Crilly et al., 2016).

Guided by considerations of geographical convenience and breadth of participant representation (including both early and later participants from different services), two parents (Sarah and Vandella) and two therapists (Michelle and Nicole) were invited to participate in a second interview to discuss and provide feedback on the theory. The interviews were audio recorded (with permission), transcribed verbatim, and used as further data for analysis. Feedback was also sought from the last therapist participant during the second half of her interview, when I shared the theory with her. I used a diagram of the theory as a common focus to explain the theory, and as a form of 'graphic elicitation' to encourage discussion and the participants' comments (Buckley & Waring, 2013; Crilly et al., 2016). As suggested by Charmaz (2014), I asked these participants whether the theory resonated and about its fit with their experiences. To counter the risk of being constrained to the content of the theory, it was presented as a work-in-progress subject to further evaluation and revisions (Crilly et al., 2016). At my invitation some participants wrote on the diagram while we talked, indicating points of resonance, whilst I also noted points. The discussions were dynamic, with participants often interacting with and animating the theory diagram by pointing to areas and using gestures to convey flow, relationships, and points of resonance. Suggestions were made and used to improve representations. As a gesture of reciprocity, acknowledging participants' contribution to co-construction of data and the theory, I shared some of their interview quotes or how the observation of their therapy session had informed aspects of the theory and influenced theory construction (Charmaz, 2014; Mills et al., 2006).

In a similar fashion, the theory was also presented to a range of health professionals (an occupational therapy service manager and the university grounded theory group comprised of PhD students and academics representing multiple heath disciplines), followed by discussion on resonance of the theory and fit in their context (Bryant, 2017). Specific feedback was also sought regarding the usefulness and relevance of the theory to Māori and those working with Māori in the health context, and the alignment of Māori concepts and terminology with the theory during two meetings with four different representatives from Te Puna Oranga, including a Māori research advisor and Kaumātua (respected Māori elder/advisor)[4]. They suggested the theory had potential to help health practitioners better engage with Māori. Consultation with Māori also contributed to interpretation of data and theoretical coding, with key concepts of the theory aligning with tikanga Māori (Māori cultural practices). The outcome of this consultation is presented in the 'Resonance of theory concepts with tikanga Māori concepts and practices' section of the Discussion, Chapter 10.

[4] I was requested to refer to Te Puna Oranga collectively, not individuals by name in reporting.

The general response from all discussions confirmed resonance and fit of the theory with diverse experiences and across health disciplines. The language of the theory was readily adopted and used during discussions, such as **connecting**, **getting on the same page**, and **tailoring learning**. The discussions also prompted further theoretical sampling in later interviews and refinements to the theory. For example, the original language, 'getting *back* on the same page' describing the return arrows, was perceived by some people as negative, implying lack of progress, moving backwards, or starting over (particularly highlighted as not appropriate for Māori). Consequently, the language used to represent the cyclical nature of **partnering in learning** was changed to 'getting on the same page *again*' to reflect the concept of building on prior learning more accurately. The overall direction of the process was changed from horizontal to an upward trajectory to reflect progress and building on prior learning as a result of the discussions. Further, the subcategory of **crossing the relational threshold** was strengthened when discussions confirmed that once the relational threshold is crossed there was minimal risk of the relationship breaking. Although parents and therapists still reconnect frequently in a process of **getting on the same page again** they almost never return to the foremost initial **connecting** phase. This is outlined further in results Chapter 6, **Establishing relationship**.

Theoretical Sufficiency

Because grounded theory is emergent, the concept of 'theoretical sufficiency' can be used as a guiding principle for determining sample size and when sufficient data have been generated for theory construction (Charmaz, 2014; Mason, 2010; Stern, 2007). Although the concept of 'theoretical saturation' is used by many grounded theorists (Birks & Mills, 2015; Corbin & Strauss, 2008, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1990), others have described the concept as problematic and "a logical fallacy" (Low, 2019, p. 131) as there always can be new theoretical insights as long as data continue to be collected (Nelson, 2016). Charmaz (2014) also questioned the legitimacy of claims of saturation, pointing to Dey (1999), who argued that "theoretical sufficiency" (p. 257) was a better fit in grounded theory studies. I adopted this notion and theoretical sufficiency was considered reached when new data and analysis did not add to the theoretical explanation of categories, subcategories, and the theory (Charmaz, 2014). Further, Low (2019) proposed analysing the grounded theory as a practical way to confirm 'pragmatic saturation' has been reached. Analysis of the grounded theory constructed during this study is presented in the Discussion, Chapter 10.

Reporting the Theory: Use of Quotes

Consistent with the co-construction of this grounded theory with participants, their voices are represented throughout the reporting of the findings (Charmaz, 2014). When explaining the theory in the following results chapters, to stay close to the data I keep

participant voices prominent. In reporting I refer to occupational therapist/s as ‘therapist/s’, or ‘OT/s’. Throughout the thesis when a participant is quoted the quote is in italics, followed by their pseudonym, participant type (Parent or OT), and at times the data source as follows:

- **Interview data**: e.g., *quote* (Tara, Parent) or *quote* (Annie, OT).
- **Checking the theory interview (CTI)**: e.g., *quote* (Sarah, CTI, Parent) or *quote* (Michelle, CTI, OT).
- **Film data—dialogue between participants**: e.g., *quote* (Film 5) or (OT to Parent: Film 4). Film dialogue quoted is colour coded according to who is communicating with who as follows:
    - OT to Parent (grey)
    - OT to Child (blue)
    - Parent to OT (black)
    - Parent to Child (navy)
- **Film data—individual participant quotes**: e.g., *quote* (Film 1) or *quote* (Film 3).
- **My voice**: To illustrate points, I have occasionally included my voice as researcher, and interview questions (non-italics) in quotes, e.g., Researcher: Question.

Quotes are used verbatim, with some minimal editing for intelligibility. Words or small phrases such as ‘you know’, ‘um’, or ‘like’, which do not detract from the inherent meaning in a quote have been removed. To provide clarity, at times [square brackets] have been added to participant quotes. Where the quote is a sentence or just a few words, it is included in the body of work as part of a sentence; otherwise most quotes are offset regardless of size for clarity. In some parts of the learning process, where the therapists are more active, their voices come to the fore, and in other places where the parents are more involved or feature more, their voices are more prominent. At times in reporting, I use one participant’s account or example to capture the essence of multiple perspectives to give a clear account of an aspect of the theory.

Summary

This chapter has outlined the research methods used in this study for data generation, data analysis, and theory construction. In line with constructivist principles, I positioned myself as researcher within the study and as co-constructor of data along with participants. Ethical considerations were introduced. Data generation strategies and methods were discussed, and methods and stages of data analysis and theory construction were outlined. As part of ensuring credibility, and originality of this study, I have articulated decisions and developments made during emergent data generation and analysis processes and provided multiple examples.

In the following chapters the research findings are presented. In Chapter 5, the theory of **Responsive learning: Learning from and with each other** is introduced. The following four results chapters, 6-9, explicate each of the theoretical categories and their subcategories which

comprise the theory: **Establishing relationship**, **Partnering in learning**, and **Integrating learning**.

Chapter 5 The Theory of Responsive Learning: Learning From and With Each Other

The questions guiding this research were: 1) What is the process of learning between parents and occupational therapists who work with children? and 2) What are the influences on this process and their consequences? Answers to these questions are explicated in the ensuing theory that I have called: **Responsive learning: Learning from and with each other**. The theory has three theoretical categories: **Establishing relationship**, **Partnering in learning**, and **Integrating learning**. In this chapter I introduce the overall theory as a storyline. In the subsequent four chapters I provide a detailed account of the three theoretical categories and their respective subcategories and properties, as outlined in Table 5.1. Through the remaining chapters, the core category (and title of my theory), theoretical categories, and subcategories are highlighted in bold.

Table 5.1

Outline of the findings chapters

Chapter	Content
Chapter 5	Core category: **Responsive learning: Learning from and with each other** Overview of the theory, the three theoretical categories and their subcategories, and relating and doing properties.
Chapter 6	Theoretical category: **Establishing relationship** Subcategories: • **Connecting** Properties: Hooking; Developing trust; Make or break. • **Crossing the relational threshold** Properties: Seeing a shift; Trusting implicitly; Reluctance to go back.
Chapters 7 & 8	Theoretical category: **Partnering in learning** Chapter 7: Subcategories: • **Getting on the same page** Properties: Finding common ground; Building working knowledge. • **Tailoring learning** Properties: Using teaching and learning strategies; Supporting learning in everyday contexts. Chapter 8: Subcategory: • **Getting on the same page again** Properties: Responding relationally: Reconnecting and tending the relationship; Responding while doing: Refining and extending learning; Responding with media: Individualising learning resources.
Chapter 9	Theoretical category: **Integrating Learning** Subcategories: • **Crossing the independence threshold** Properties: Seeing change; Adapting; Sharing learning with others. • **Moving on** Properties: Repeating the process; Ending well.

To provide an overview of the theory of **Responsive learning: Learning from and with each other**, a diagrammatic representation (Figure 5.1) is presented, followed by an outline of each of the three theoretical categories and their subcategories.

Introducing the Theory of Responsive Learning: Learning From and With Each Other

The theory of **Responsive learning: Learning from and with each other** was constructed during data analysis as the core category linking all the categories (Charmaz, 2014; Charmaz & Thornberg, 2020). It is a dynamic learning theory explicating how, throughout the therapeutic process, parents and therapists are continually **learning from and with each other—**exchanging information and responding to each other, while partnering to support the child. Key findings are that the **responsive learning** process is bidirectional and deeply relational.

> *We're learning together, 'You* [parent] *know your child. I know some things. Let's put it together'.* (Caroline, OT)

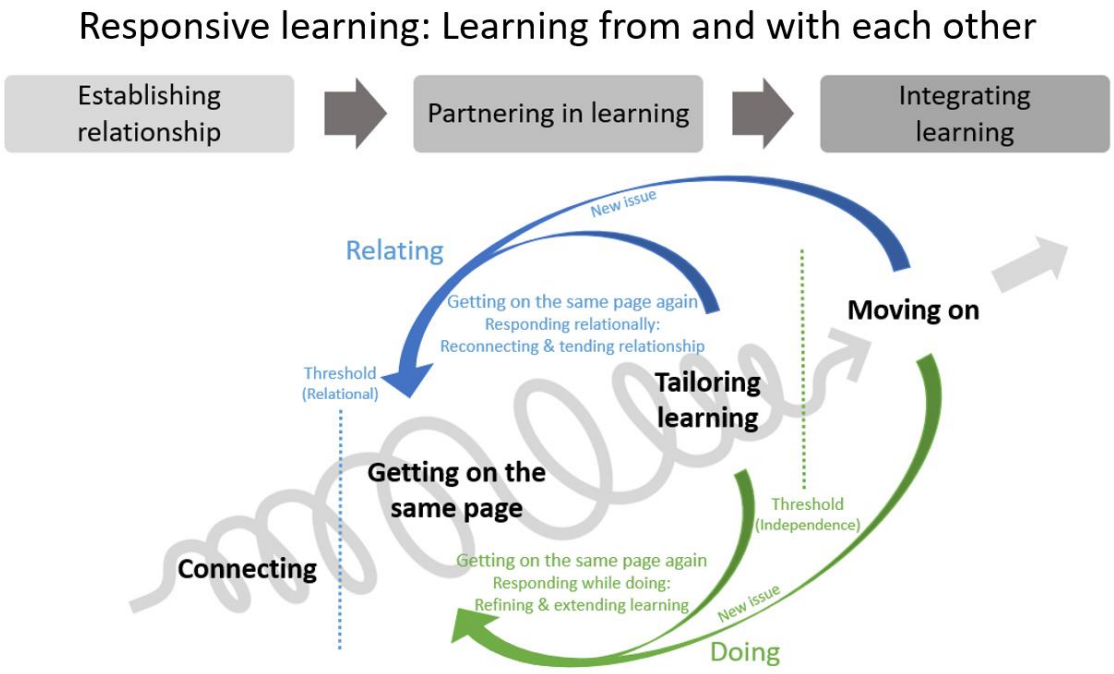
Establishing a relationship is essential for **partnering in learning** and engaging in therapy. The process of **responsive learning** is in constant flux and ever changing, for both parents and therapists, as their needs and situations shift. Parents and therapists respond to each other as they learn to continually refine and build on learnings. Ongoing connection and partnership are key to mutual learning, for moving forward in the therapy process, and, ultimately, **integrating learnings** into everyday life.

Explanation of the Diagrammatic Representation

To aid understanding, Figure 5.1 outlines key elements of the learning process as it moves from left to right. The three theoretical categories comprising the theory are: **Establishing relationship**, **Partnering in learning**, and **Integrating learning**. Although the categories are intricately connected and overlapping, with continuity as each lead into the next, they have been separated out for explanatory purposes. Within the theory there are two thresholds (represented by the vertical dotted lines)**—**a **relational threshold** (blue) and an **independence threshold** (green)—which parents and therapists cross as they move to the next stage of the process.

Figure 5.1

Diagrammatic representation of the theory of Responsive learning: Learning from and with each other



The theoretical process is progressive but not linear. Some elements are cyclical (visually represented by the upper blue and lower green arrows), where the process is recursive as parent and therapist respond to each other to tend the relationship and build on prior learning by frequently **getting on the same page again**. The spiral running through the model illustrates a pathway of learning with continual momentum. It represents the dynamic nature of the learning theory, with learning occurring between parent and therapist, each responding to, and learning from, the other—because "*it's not a one-way street*" (Vandella, CTI, Parent). The beginning of the spiral represents the point of **connecting** in a new relationship at the outset of the therapeutic process. It builds as they respond to and **learn from and with each other**, all whilst tending their relationship. It then narrows again as the therapist's input becomes less as the parent learns, adapts, takes over, and **integrates learning** into everyday life. There is a sense of building on prior learning and experiences with the upwards trajectory of the spiral. When the therapist is no longer needed to support the learning needs of the parent, there is the outward point (**Moving on** arrow) of discharge or moving on to another service more suited to the needs of the parent and their child.

The spiral also depicts moment-by-moment movement (or 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. Relating and doing are key properties in the theory. They are dual intertwined dynamic processes, separated diagrammatically for clarity of explanation. Both are apparent across all three theoretical categories. Parents and therapists learn how to relate to each other and how to tend their relationship, alongside learning how to do things that support

engagement with each other, and the child's development throughout the learning process. However, initially there is more emphasis on the relating aspects when establishing a new therapeutic relationship, depicted in the upper section of the diagram. Doing, the lower section of the diagram, becomes more prominent further into the process after the **relational threshold** is traversed and the relationship firmly established.

As parents and therapists engage in the process of **Responsive learning**, unresolved learning or therapy issues are revisited and refined or new issues addressed to progress learning, through a process of **getting on the same page again**. Both parent and therapist frequently **get on the same page again** relationally by responding to each other, reconnecting, and tending their relationship (upper blue arrows). Similarly, they also **get on the same page again** by responding to and refining the doing of therapy delivery (lower green arrows). This reflects the recursive and responsive nature of the learning process in order to build on learning and move forward.

The theory is flexible and can be viewed at macro (therapy process overview), meso (per therapy session), and micro (individual issue) levels. In most cases, parents and therapists address several different issues simultaneously. Consequently, there may be several learning processes active concurrently, each addressing a different issue. Therefore, at any one point in time, a parent and therapist may be at different places in the learning process with each issue.

> *If we can master one thing, that's great. But there's probably usually always about four or five things that I try and work on throughout the three weeks in between visits. If something's done that's fine and if it's not, we just keep rolling it over.* (Vandella, Parent)

Each process is unique to the individual parent, occupational therapist, and child triad.

Establishing Relationship

Establishing relationship is the first theoretical category and is crucial to ongoing learning. There are two subcategories: **Connecting** and **Crossing the relational threshold**. **Establishing relationship** involves taking time for **connecting** as the parent and therapist start to learn about each other, and how they can work together and establish a foundation for building a trusting relationship. This is a necessary step towards **crossing the relational threshold** which enables them to move forward with therapy. Failure to establish a relationship leads to disengagement and failure of therapy delivery.

Connecting

Connecting is where the parent (and child) and therapist are developing trust and a foundation for their relationship. They are learning about each other and how to work together, aligning and engaging with each other, tuning into each other and getting to know each other as they work towards **getting on the same page** about the therapeutic process on which they will

embark. In this time, therapists start to learn about the child, family context, and parent's concerns as they work to build rapport with parents and establish that they are trustworthy. Parents are learning about what the occupational therapist does and how they can help their child, while deciding if they can trust the therapist and are willing to move forward with therapy.

Both engage in 'hooking' strategies to draw each other into a relationship and therapy. For example, therapists showed parents what they (the therapist) could get their child to do and demonstrated their competence and ability to assist with reaching the child's potential.

> *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.* (Jayne, OT)

Similarly, parents also engaged in a hooking process, enticing therapists by being friendly and making efforts to cement the therapeutic alliance. As each parent-child-therapist triad is unique, the 'hook' needs to be tailored uniquely to them. Parents learning their child was comfortable with the therapist and seeing what the therapist could achieve with their child instilled confidence in them and influenced their trust in the therapist and willingness to proceed with therapy by **crossing the relational threshold**. Where connection was not made, the threshold was not crossed and what could potentially be achieved with therapy curtailed—at times, a make-or-break situation.

Crossing the Relational Threshold

The theory recognises a **relational threshold** positioned between the **Establishing relationship** and **Partnering in learning** theoretical categories of the theory. The key **connecting** strategies of hooking and developing trust culminated in parents and therapists **partnering in learning** with commitment to enter therapy together. All interactions preceding this juncture culminated in determining whether the parent and therapist successfully crossed the **relational threshold**. **Crossing the relational threshold**, for both parents and therapists, was experienced as feeling more comfortable with each other. For example, therapists noted seeing a shift in a parent being more relaxed after a point, thereby knowing they were 'in' as a partner in therapy.

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

The consequences of **crossing the relational threshold** are characterised in parents by increased engagement in therapy, having an inherent bond with their therapist, trusting the therapist implicitly, and an extreme reluctance to go back to engage with another therapist. As the relationship becomes more secure, there is also less risk that the relationship will break down. As a triad relationship of parent, child, and therapist, the child's comfort with the therapist was influential in the parent **crossing the relational threshold**. Parents' perspectives

were interconnected with their child, and they felt reassured if their child was accepting of the therapist, and vice versa.

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

Partnering in Learning

The second theoretical category of the theory, **Partnering in learning**, involves doing and learning together**.** This is the stage where the 'doing' of therapy happens in a recurring cycle between the three subcategories of **getting on the same page**, **tailoring learning**, and **getting on the same page again** (upper blue and lower green arrows for the relating and doing components respectively). In the observations of therapy sessions, this cycle was observed to occur frequently. Sometimes, the partnering had a relating focus, as therapists and parents reconnected and tended their relationship. At other times, there was a focus on doing, as the parent and therapist concentrated on refining a task or aspect of therapy delivery. A key tenet of this aspect of the theory is recognition that both parent and therapist alike are **learning from and with each other**.

> *They'll* [OT] *say, 'Oh I found this idea, what do you think about this?' And then I'll say, 'Oh look I got a plate, this might be helpful for you'. And so, they take that idea. We always swap ideas, and we get ideas for toys or for things to be doing. So yeah, it's very much a team effort and learning from each other.* (Vandella, Parent)

Getting on the Same Page

Getting on the same page involves two key properties of learning—finding common ground and building working knowledge. These learnings, for both parents and therapists, are ongoing, revisited, refined, and built on over time as progress is made and needs change.

Finding common ground is more relationally focused and is about establishing and re-establishing mutual understanding around therapy expectations, goals, and their relationship. It includes learning about how they are going to work together and where they 'stand' with each other. 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)

Building working knowledge is integral to successful therapy delivery. This knowledge is needed in order to work together and make the most of therapy time. Parents need to learn about things like what they can expect from occupational therapy, expectations of them as a parent, information about their child's condition, how to navigate the health system, interventions available to benefit their child, and how to integrate these into their everyday life. Most therapists also recognise the need to learn about what parents already know, so they can "*build on*" and "*complement*" (Jayne, OT) their prior knowledge and experiences. To work

effectively with families and tailor services and interventions to their needs, therapists also need to learn about the child and family unit—including how they function, their priorities, the language they use, how best to engage with and work with them—because each family is different. One therapist explained,

> *I've learnt that what works for one family is not going to work for the next family, and your skill is actually finding out* [or learning] *how you can best work with a family and child. The one down the road is not the same as the one before.* (Michelle, OT)

Building working knowledge involves building and refining mutual working knowledge as parents and therapists continue to learn what to do and how to do things together.

Tailoring Learning

Tailoring learning involves parents and therapists responding to each other and to meet the learning needs in the moment. Intentional teaching and learning strategies are used as information, knowledge, and hands-on therapy skills are being shared, including explaining, demonstrating, modelling, embodied experience, trying out, and practising. Parents often learn in response to watching the therapist work with their child, giving them ideas of both what to do and how they could teach their child.

> *It's the way she shows Jake which teaches me what to do. Putting her hand over Jake's hand and showing him how to do it teaches me that I can teach him in that way too.* (Lisa, Parent)

Thus, both the parent and the child are learning together. Strategies used to support learning include incorporating learning and therapy into everyday routines and contexts to make life easier, as they are doing things together and responding to what is happening and to each other. Concurrently, parents and therapists scan for concerns and opportunities to shape actions in response, while attending to the responses of others—parent or therapist cues, child's interaction, what is working, and what is not—then adjusting and **tailoring learning** in response.

Getting on the Same Page Again

During interactions, parents and therapists are frequently **getting on the same page again** as therapy progresses. With ongoing discussion, disclosure, and refinement, they respond to each other and the changing learning needs. **Responding** oscillates between a focus on relating (upper blue arrows) and tending the relationship, and refining learning through doing (lower green arrows) to **get on the same page again**. Both parents and therapists are active partners in **responding** to each other and the presenting situation as they learn to read and respond to each other's cues. **Getting on the same page again** encompasses relating and doing aspects concurrently. For instance, when parents struggled to grasp an aspect of the therapy, therapists took time to tend the relationship by being positive and pointing out progress, while

encouraging persistence or suggesting an alternative way to do things. Additionally, learning resources and media were used to support learning and involved **Getting on the same page again** both literally and figuratively.

Getting on the Same Page Again by Responding Relationally: Reconnecting and Tending the Relationship (Upper Blue Arrows)

The relating aspect of **getting on the same page again** involves both the parent and therapist responding and taking time to nurture, tend, maintain, and invest in their relationship on an ongoing basis. They use strategies including being encouraging, accepting, positive, and optimistic. There are other times when both parents and therapists intentionally withhold information so as not to offend or upset the other, to maintain their relationship.

At the beginning of each session there is generally a time of **getting on the same page again** by reconnecting and catching up with each other, checking in, learning about what has transpired between visits, and what they may need to work on while together again. Taking time to reconnect allows for tending (or investing in) the relationship as they settle in to work together and to attend to each other, before moving forward with the therapy session. This is often a social chit-chat time, becoming comfortable with each other again, while establishing common ground again for mutual expectations for the session together. Where therapy is home-based, parents also make efforts to welcome the therapist into their home; for example, by tidying up or vacuuming before the therapist comes.

During the therapy session there are times when the parent or therapist needs to revisit and clarify expectations, or to address new issue as needs change, **by getting on the same page again**. For example, therapists tend the relationship by taking a gentle, cautious approach when broaching a difficult subject or situation, or asking the parent to do something uncomfortable, in order to help elicit parent engagement and readiness to move forward together. Therapists often take time and care to prepare parents for what is coming up, so they can learn what to expect in advance.

> *You tend to talk about that* [difficult] *concept a little bit before you actually bring that in.* (Michelle, OT)

Similarly, therapy sessions finish by **getting on the same page again**, highlighting positive aspects and pointing out the child's progress, thereby leaving the session on a mutually positive note.

Getting on the Same Page Again by Responding While Doing: Refining and Extending Learning (Lower Green Arrows)

Getting on the same page again from a doing perspective is about responding to the need and cues of each other to build on working knowledge and extend learning, such as when something needs to be clarified, refined, re-explained, reframed, or demonstrated again. Sometimes they **get on the same page again** to revisit an aspect of therapy where there has

been a misunderstanding, or it is difficult for the parent to master a hands-on skill. At other times, questions or cues from either the parent or therapist prompt a response of refining what they are doing by providing more information, clarification, further demonstration, and practice; or shifting their focus to a specific concern to meet a presenting learning need.

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

For example, when parents struggled, therapists responded by reframing instructions or information in a different way or used analogies to support and extend learning.

Therapy sessions frequently concluded by **getting on the same page again** as they summarised the session and ongoing plan, parting with mutual expectations of what they each will do between sessions. Therapists often leave individualised learning resources with parents. This is commonly a hand-written summary and home programme, or photocopied material tailored to the parent and child, including tasks to work on independently with their child between sessions. Parents use these resources in different ways, including to share their learning with their spouse or to prompt their memory.

> *Then they leave me with homework to do, which I find really good, because things fly out of my head like there's no tomorrow. It reminds me that I do need to be doing those things.* (Vandella, Parent)

One therapist viewed giving the parent a home programme as representing "*passing on responsibility*" (Laura, OT) to the parent after the session to **get on the same page again** with shared expectations of the parent continuing with therapy for their child between visits.

Integrating Learning

Integrating learning is the third theoretical category in the theory. There are two subcategories: **Crossing the independence threshold** and **Moving on**.

Crossing the Independence Threshold

There is a point at which the **independence threshold** is crossed; where knowledge, understanding, or a skill has been gained or mastered. Therapists and parents see change, parents **move on** to other things, and adapt therapy to the needs of their child and family life independent of therapist support. For instance, parents reach a point where they have 'got it', or something has 'clicked' and makes sense. Often therapists also notice a shift in the parent's confidence or that the parent is **moving on** to something else independently of them, and they no longer need help with that issue.

> *When parents show you what they're doing, then they've obviously got it and you can see that they've been doing it by what their child's doing. Or they've gone on and done something else too.* (Caroline, OT)

This signals to the therapist that parents are ready to **move on** to address something new or extend their learning. Parents adapt and apply what they have learnt to other situations and **integrate learnings** into everyday life routines. Parents also become more able to assert themselves and identify their specific needs, taking more of a lead in the direction of the therapy for their child. One parent described,

> *We're at the point where the OT asks me, 'What do I want to work on?' I said, 'What I want to focus on is strengthening her* [child] *muscle tone and helping with her left side a bit more—she's not so much using that hand'.* (Anika, Parent)

Many parents share their learning with other family members. Therapists also share their learning and experiences of working with different families with their colleagues, using these to improve their practice when working with other families in the future.

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

Moving On

The learning process is cyclical as together they repeat the process and **get on the same page again** (upper blue and lower green arrows), building on or extending prior learning, to move forward with the next stage, or to start working on a new issue. They re-enter the **partnering in learning** cycle and **tailoring learning** in response to new issues and changing learning needs arising, as the child grows and as they continue to move forward with therapy for the child. Generally, parents' initial learning needs include wanting reassurance they are accessing the right service, with someone who can help them manage their child's health needs. Over time, learning needs become more specific, such as wanting to learn how to teach their child to go down the playground slide without their foot becoming stuck. **Moving on** to extend learning may occur naturally or be prompted by parents asking, for example, "*How would I progress this? What should he do next? What's the next problem-solving thing he should try to do?*" (Lisa, Parent), when their child has mastered an activity. At times, the parent and child no longer need the therapist, and the child is discharged or referred on to another service (grey **Moving on** arrow). Tending relationship and supporting learning continues to influence ending well when therapy concludes.

Summary

This chapter has introduced the theory of **Responsive learning: Learning from and with each other**, the first of five chapters presenting results of this research. The theory is comprised of three theoretical categories: **Establishing relationship**, **Partnering in learning**, and **Integrating learning**. The theory of **Responsive learning: Learning from and with each other** was presented diagrammatically and an explanation for the diagram given. An overview of each of the three theoretical categories and their subcategories was outlined.

Key findings reflected through the theory are firstly, that learning is bidirectional. **Responsive learning** acknowledges the expertise of both client and therapist, that they teach and learn from each other, and that learning needs are always situational and in flux. Secondly, the learning process between parents and therapists is deeply relational. Establishing a relationship is crucial to proceeding with engaging in therapy. Ongoing connection and partnership are shown to be key for mutual learning, moving forward with therapy, and integrating learning into everyday life. To provide relevant interventions, both the parent and therapist need to connect and be willing to learn about each other and how to work together in partnership, and to respond to each other on an ongoing basis.

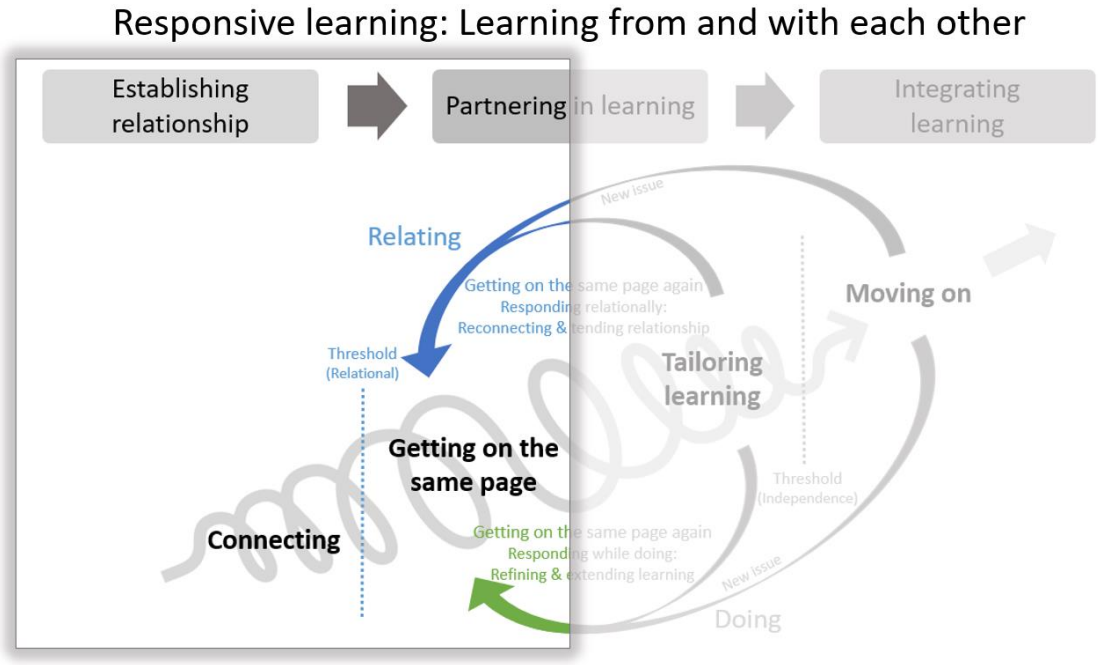
The three theoretical categories, their subcategories and properties are discussed in greater detail in the following four findings chapters.

Chapter 6 Establishing Relationship

This chapter and the next three explain each of the three theoretical categories comprising the theory of **Responsive learning: Learning from and with each other**. Throughout the results chapters, variations and conditions influencing the process of **learning** are intertwined through the chapter and I provide examples from participants to ground the category in the data. This chapter explains the first theoretical category of **Establishing relationship** (Figure 6.1).

Figure 6.1

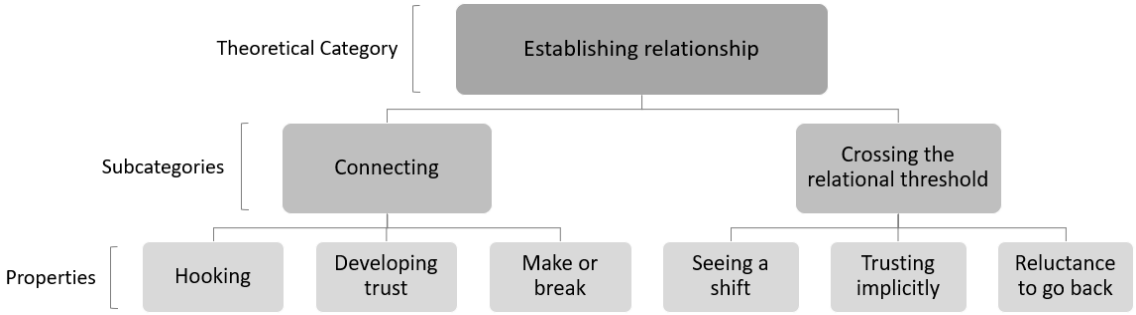
Establishing relationship theoretical category: Connecting and Crossing the relational threshold



In this chapter, I begin by introducing the theoretical category **Establishing relationship**, with its subcategories: **Connecting** and **Crossing the relational threshold**. Properties of **Connecting** (Hooking, Developing trust, and Make or break) and **Crossing the relational threshold** (Seeing a shift, Trusting implicitly, and Reluctance to go back) are outlined. The process of **Establishing a relationship** is an essential precursor to learning and therapy delivery and requires an investment of time and effort. The consequence of successfully **connecting** is that parents and therapists **cross the relational threshold**, indicating that a relationship has been established as they progress into **Partnering in learning** and the 'doing' of therapy with the mutual goal of supporting the child's development. 'Relating' is a dynamic property apparent across all three theoretical categories, as parents and therapists continued investing in maintaining their relationship throughout the learning process. An outline of the theoretical category of **Establishing relationship** and its subcategories and properties covered in this chapter is presented in Figure 6.2.

Figure 6.2

Establishing relationship, subcategories, and properties



Investing in Establishing a Relationship

Investing time and effort in **connecting** in order to **establish a relationship** between parents and therapists was crucial, as it influenced all subsequent interactions, learning, and parents' engagement in ongoing therapy. **Establishing a relationship** involves a complex three-way interaction between therapist, parent, and child, with each learning about, and how to respond to, each other. The common purpose of supporting the child's development is what introduced the parent and therapist to each other in the first place and was the reason why they invested time and effort in **establishing a relationship**. Recognising this common purpose, and the help available from the therapist, influenced parents' willingness to **connect** with the therapist.

> *What makes me more open to people at the moment is if it's involving Gracie* [child], *because obviously they're there for the same reason I need them to be there. So, it makes it a little bit easier for us to get that connection, because they're doing as much as they can to help my daughter.* (Dolly, Parent)

Although therapists acknowledged that "*the child is my patient*" (Marisa, OT), they commonly viewed that their service was for the family "*as a unit, rather than just their child*" (Nicole, OT).

> *We are both focussing on the wellbeing of the child.… You want to meet the child's needs, but you also want to meet the parents' needs.… Then, I think, connecting becomes easier.* (Nicole, CTI, OT)

Consequently, it was important for therapists to connect with both the child and the parent in order to meet both their needs, as they were inherently connected.

Therapists recognised that, in most instances, they were establishing a long-term relationship with parents and that there were negative consequences of not **connecting**.

> *You have to try and build a relationship with these families. You're going to be working with them highly likely long-term. If it doesn't go well from day one, then you're in very deep waters from the very beginning.* (Nicole, OT)

Therefore, investing time and effort in securing a relationship with parents was important to future learning and success of the therapy they provided for the child, because "*If we don't have a good relationship, then they're* [parents] *not going to want to learn from me*" (Marisa, OT). Parents also appreciated that they would be working with the therapist over an extended period and recognised the therapist as a conduit to the support they and their child needed. They were motivated to establish a relationship and learn things to help their child.

> *You want to connect with them* [OT] *because you want that knowledge, you want to help your baby…. It is really nice to have those relationships because you feel like you're not alone. And in this journey, you feel like you're alone a lot of the time.* (Vandella, CTI, Parent)

Parents experienced in working with different therapists recognised the imperative to secure and then keep a therapist they felt comfortable working with. When considering entering a relationship with a new therapist, Sarah (Parent) explained,

> *We don't ever have a choice of just being done* [with therapy]*… With a really high needs child, we're going to have OTs in our life forever. I might not think they're all brilliant, but I'm going to pick the best out of that bunch. To make that work* [I sometimes] *go, 'Oh for goodness sake, Sarah, just bite your tongue and let them. … That annoys me, but I'll deal with it'.* (Sarah CTI, Parent)

Like other parents, knowing the relationship would be necessary and long-term made it worth investing in and safeguarding by consciously refraining from doing anything Sarah thought would potentially jeopardise it. This highlights the importance parents place on establishing a sound relationship with therapists. However, the early stage of the relationship between parent and therapist is tenuous and both make efforts in initially **connecting** in order to **cross the relational threshold** to proceed with therapy and learning**.**

External factors constrain the ability of therapists to connect and invest in **establishing relationship**. Therapists were acutely aware of institutional pressures influencing delivery of services with funding restrictions, limited number of available sessions, outcome measures to meet, and contractual obligations. These confines added pressure for therapists to engage in the 'doing' of therapy quickly, with limited time for **connecting** to **establish a relationship** with parents first. Experiencing conflict between service delivery pressure "*to get their* [employer's] *outcomes*" (Michelle, CTI, OT), and meeting family's needs led some therapists to question, "*Who is it for?*" (Annie, OT). Michelle (CTI, OT) felt conflict between time she wanted to spend on **connecting** and the pressures of meeting institutional obligations, because "*We have to rationalise our time, our caseloads and how much time we spend. It's very pressurised*". Like other therapists, she appreciated that as each family is unique, it is difficult to predict how long **connecting** with different parents would take. When checking the theory with Michelle (OT), she reflected,

> *We can't actually say how long* [**connecting**] *takes. So, it's very individual…. So, how do we balance the disability and our therapy time frame when we've got a limited*

> *session time, when we haven't even* [crossed the **relational threshold**]*? If you don't start* [with **connecting**] *you don't get the carry through, you don't get the knowledge, skill, attitude unless you work through this.* (Michelle, CTI, OT)

She concluded that the time invested in **connecting** was essential for successful engagement in therapy and for achieving service outcomes and therefore, **connecting** and **establishing a relationship** "*needs to be acknowledged and supported*" (Michelle, CTI, OT) by employers.

Connecting: Learning About Each Other and How to Work Together

The process of **connecting** is a key part of **establishing a relationship** and the foundation for an ongoing partnership. **Connecting** encompassed building rapport and tuning into each other, which involved parents and therapists learning about each other, what to expect from each other, and how they might work together to help the child. Specifically, therapists learn about the parent and child, the family context and concerns, and how to 'read' and respond to them, their cues and needs with the intent of establishing rapport and drawing them into relationship and therapy.

> *I've got to take a cue from parents that I don't overdo it. You've got to go gently with their child…. You take a few cues, 'Here, back to mum, have a little time with mum'. And then we'll see if we get the child handed back. I'm reading parents—their anxiety, what they're looking like or if they're hovering around.* (Michelle, OT)

Parents needed to learn about both what (the therapy/organisation/service) and who (the therapist) they were **connecting** with, and what to expect from them and from therapy for their child, especially when they were new to engaging with therapy services. Accordingly, therapists commonly spent time explaining their role and what their service offered, as well as sharing information about themselves. Polly (Parent) appreciated learning about the therapist and how she could help in their initial interaction, which contributed to being drawn into a relationship. She explained,

> *She* [OT] *told me a bit about herself and what her role was, which was important, because … you've got absolutely no idea and then all of a sudden, your home is being invaded by all these different people you know, two, three times a month. It's like, 'Whoa'. So, it was nice that she came in and explained everything and what her role would be and how she can help.* (Polly, Parent)

An investment of time and effort was required from both parent and therapist to connect before a relationship could be established and they were able to move forward with therapy. Recognising the inherent parent-child bond, to draw parents into a relationship and to engage in therapy for their child, therapists needed to connect with both the parent and child. Consequently, some therapists initially focused efforts on **connecting** and developing a rapport with the child, to draw the parent in to a relationship.

> *I need buy-in from the child… I am going to have to have rapport with them and the child has to trust me…. I think it is really important for the parent* [to see the child

> happy with me]. *If I could see my child happy and comfortable with another person, then that in itself would make coming to the trust and rapport easier*. (Kerry, OT)

To the same end, other therapists focused efforts towards encouraging parental engagement in early interactions to access the child. Marisa (OT) explained,

> *If the parent is not happy and not engaged, the child is not going to get anything out of my time. So even though I want to progress the child, parents being engaged is often more of a priority for me than doing my therapy with the child, because* [otherwise] *I feel like I'm not accessing the child.*

Making an initial connection was influenced by the parent learning how the therapist interacted with both them and their child and was often contingent on how receptive their child was to the therapist. Some parents monitored their child's response to the therapist as they were influenced initially by their child's response to, and comfort with the therapist. For Lisa (Parent),

> *It's important to see them* [OT] *interacting with the child well. If Jake* [child] *trusts them and is happy to be around them it makes a big difference*.

Conversely, other parents recognised the influence they had on shaping their child's response to the therapist. When they were comfortable with the therapist, so was their child.

> *Going into situations like that I'm terribly nervous and I probably put on a bit of bravado. So, it's quite important for me to feel at ease, that someone* [OT] *makes us feel at ease, because then Rosie* [child] *does if we are*. (Sarah, Parent)

Therefore, therapists intentionally invested time and effort in **connecting** with both the parent and child in order to establish what was often a long-term relationship with the parent.

As each parent-therapist entity is unique, the time and intensity of effort required to connect varied. Some parents felt they "*instantly connected*" (Vandella, Parent). Others quickly felt comfortable with the therapist. For Polly (Parent), "*After that first session with her, I felt at ease with her* [OT]". However, some parents appreciated the therapist not rushing but investing time in **connecting** by learning about and getting to know their family unit and how to work with them before attempting to do any therapy.

> *It took quite a few weeks before she* [OT] *started doing hands-on stuff. A lot of it before then was getting to know the dynamics of us and seeing how we worked.* (Sarah, Parent)

Therapists taking time to connect and learn about the "dynamics" of the family was a useful investment for **establishing a relationship** and future engagement in therapy. For therapists, learning and responding to the situation, parent, and child cues, and being willing to change their approach was important for successfully **connecting**. Annie (OT) described how, "*You change the way that you interact with different people. You are constantly reflecting on how things went*".

Occasionally, an investment of more effort and time was required when **connecting** was difficult. Some therapists encountered parents who were "*very reserved*" (Michelle CTI, OT),

"*just sitting there stony faced*" (Laura, OT), or "*parents texting, not showing interest in the session, and they'll disappear on me*" (Michelle, OT), which challenged their ability to connect. Annie (OT) shared a time when she struggled to connect and questioned if they would even proceed with therapy,

> *Relationship and rapport with the family has taken a really long time to establish and until we got there, not a lot really happened…. In the earlier times, meeting mum would be really flat, and it was really hard. I'd think, 'Oh, do they even want us involved?'*

However, by investing more time and effort to show an interest in the child, help the parents learn how occupational therapy could help their child, and that she was committed to helping them, the relationship changed. Annie (OT) explained,

> *When they could see that we were there for him* [child] *and he was having fun, and we'd come along and be really prepared for sessions, they could see that we were invested, we wanted to be there and could talk about the things that we could offer him and how that might look. It just took a bit of time to get there.*

At times, therapists also invested concerted effort to connect with the child as a means to connect with the parent, because "*It's also dependent on the children. Some children are just observers, and you have to really work hard to really engage the children*" (Laura, OT). For instance, when engaging with a child was challenging, Laura (OT) responded with persistence, visiting frequently and learning more about the family and how to best engage with their child.

> *If a child is not engaging much, I would possibly go visit more often…. And then I talk to the families about, 'You know your child best. What makes her move? What is she happy with?*

Therapists also understood that there were sometimes other unique factors that made therapy not a priority for families and therefore **connecting** difficult, such as "*the timing is not right for that parent, there's lots of other things going on socially, other stressors*" (Michelle, OT). Therapists lacking empathy with family stresses had potential to impede making a positive initial connection. For instance, Samantha (Parent) felt the therapist had neglected to appreciate the stresses in her life as they started working together, impacting them **connecting**. She reflected on how things could have been done differently.

> *Just spending those first few weeks not overlooking the importance of building that relationship and that connection. I don't think Jenny* [OT] *really understood or took the time to appreciate what my life was really looking like at the time of our first connection … she didn't really incorporate that into our times together.* (Samantha, Parent)

Although they came to establish a functional relationship over time, seeing evidence of the therapist investing effort and time to learn and understand the issues impacting her life could have encouraged successful **connecting** sooner. However, Samantha acknowledged that the onus was not just on therapists, but also on parents in **connecting**, *"It is important as a parent to actually take the time to get to know your therapist as well—it doesn't need to all be on the*

therapist to initiate that". This highlights that for both parents and therapists investing effort to learn about each other and how to work together is crucial to **connecting** and establishing a functional therapy relationship.

When encountering resistance from parents, some therapists enlisted additional support to help parents learn of the potential benefits of therapy. For example, when a parent initially refused to work with Michelle (OT), she recognised that their previous experience working with other clinicians influenced the struggle to connect. Consequently, enlisting the support of the family's general practitioner (GP) was a catalyst to connecting with the parent.

> *I had one* [parent] *who downright refused, so I went back to the GP who had a word to the family about what was actually needed. The GP had a word with them* [parent], *then I got back in after that.* (Michelle, OT)

Similarly, there were times when parents enlisted additional support when struggling to connect with a therapist. For example, Anika (Parent) enlisted support from a familiar healthcare nurse for early visits with the therapist, when she was sensitive to the tone of the therapist's communication and found the therapist's perspective on her child's potential conflicted with her own.

> *We're aware that Neve* [child] *can't do a lot of things, but we're also trying to help her do those things.* [The OT] *was just straightforward saying, 'She can't do this or might never be able to do this'. It's offensive…. My feelings were that you don't ever say, 'never'. I'm always persistent. I want her to do these things. My status is she will get there one day. The healthcare nurse was great, always helped me with the sessions with the OT and would say, 'She'll* [child] *get there one day'…. Now, she's* [OT] *good.* (Anika, Parent)

Anika's investment in the relationship with the therapist aligned with her investment in her child. With persistence, their connection improved, they found common ground with expectations, and their relationship developed into a positive one as they continued to learn to understand each other, how to work together and respond to each other.

The consequence of successful **connecting** enabled **establishing a relationship** between the parent and therapist, which was essential for ongoing learning and moving forward to engage in therapy for the child. However, **connecting** was a make-or-break situation, and not always guaranteed. Sometimes a connection was not made, a relationship not established, and progression to engaging in therapy together not achieved. Therapists recognised that without **connecting** and an understanding of each other they collectively "*can't get the max out of* [therapy]" (Michelle, OT). In the following section I explain the three properties identified as intrinsic to the process of **connecting**; 'hooking' to draw each other into a relationship and engage in therapy, 'developing trust' between each other, and the 'make or break' nature of connecting. When achieved, these strategies led to **establishing a relationship**.

Hooking

The process of hooking was evident as the parent and therapist were **connecting** and served to draw each other into therapeutic partnership. Hooking was an intentional strategy, used mostly by therapists to gain parents' buy-in by presenting themselves and their interventions in the best possible light, thus demonstrating their competence as a caring, skilled, and trustworthy therapist. On occasion, parents also used hooking strategies to connect with the therapist and encourage their relationship. The consequence of successful hooking was **crossing the relational threshold** with a commitment to work together in partnership; in a way hooking together. At this point, being 'hooked' was characterised by trust, acceptance, commitment, buy-in, and non-return. However, the relationship was at risk of breaking and forward progress potentially jeopardised when parents were not hooked. In this section, I first present the 'relational' strategies used by therapists and parents to hook each other in, showing how they often mirrored each other, followed by the 'doing' aspects of hooking.

Hooking into Relationship: Feeling Comfortable with Each Other

The hooking strategies therapists used to draw parents into a relationship often reflected the needs of parents, such as providing reassurance, listening, showing an interest in the child, respecting parents as experts on their child, and being friendly to help parents feel at ease during initial encounters. Hooking strategies therapists used also included building parents' confidence in their own abilities.

> *I come from a more personal perspective, so maybe chatting a little bit and making them* [parent] *feel that what they're doing is good. And being really positive and really strengthening their belief in their parenting skills.* (Marisa, OT)

This approach met some parents' initial need for "*reassurance*" and learning from the therapist that they were already "*doing the right things and on the right track*" (Toni, Parent) to help their child. Other parents, like Lisa (Parent), needed the therapist to validate her concerns, and to learn that she was in the right place, with someone who could actually help her, before being hooked and comfortable to proceed with the therapist:

> *I wanted them to agree there wasn't something right, so I needed them to validate my fears … and to say, 'We can help, you're in the right place', that this was their area, this is what they do every day.*

Therapists were aware of parents' need to have their concerns validated, which aligned with their own need to learn about parents' key concerns.

> *You need to listen to the parents, not bombard them with information. You need to find out what the key concerns are, and then just listen, be involved, take a real interest, and spend time and understand their child. And that seems to lead on to that relationship and what you can work on.* (Michelle, OT)

Thus, taking time to listen and learn from parents was a relational hooking strategy, whereby therapists learned from parents about their concerns and priorities for their child. In response,

parents appreciated therapists showing an interest and listening to them. Feeling that they had been "*heard and taken seriously*" (Dolly, Parent) by the therapist, influenced parents being drawn into relationship and consequently engaging in therapy.

> *I think the most important part is just listening. Because at the end of the day it's your child. You know your child better than everybody else.… Just being heard is a very important thing when you've got something going on with your kid.* (Dolly, Parent)

Intentionally showing an interest in the parent and child was a hooking strategy commonly used by therapists to demonstrate they cared and to encourage parents to feel comfortable with them.

> *You have to show the parent that you really are interested and want the best for them. You really want to show them how to understand and develop these skills for their child because you know life's going to be better. I really want to make a difference.* (Jayne, OT)

For most therapists, it was important from the outset to show parents that they wanted to work in partnership with them to help their child. In using this strategy as part of the hooking process, Caroline (OT) was cautious to establish that she respected the parent's expertise on their child, while also helping parents learn that they could work and learn together:

> *Letting parents know that it's their child and I don't know more than they do. That you know your child best, but we can work together, and let's maybe tweak a few things.*

Therapist recognition of parental expertise immediately positioned the therapist as a learner, acknowledging that they needed to learn from and with the parent. Parents appreciated a cautious approach from the therapist and the interest they showed in learning about the family which also helped make parents comfortable.

> *I think just the fact that she* [OT] *came in, she was friendly, she sat down, she talked. She asked me questions. She didn't start barking out orders. She wanted to know about Ryan* [child], *where we were at and how I was feeling. She just made me feel really nice and comfortable.* (Polly, Parent)

For some parents, being hooked into a relationship with the therapist was rapid and dependent on parents' first impressions of a therapist's interpersonal skills. Some parents were clear in the characteristics they wanted in a therapist and swiftly judged if they could work together or not. For example, Sarah (Parent) explained,

> *It's usually that first visit you can tell whether it's going to work or not. Well for us that's what it's like anyway.… So, someone's* [OT] *got to be confident and competent, but gentle at the same time. And a bit of a sense of humour, so things aren't too overly serious. It's just trying to make you feel at ease, because all the other stuff can come later.… You can have the most knowledgeable person in the world but if they have no people skills and they don't make you feel at ease you're not going to take it on board.*

Thus, for some parents (and their child), feeling at ease with the therapist was an immediate hook. For other parents, the process of being hooked into a relationship with the therapist was

more protracted before they were "*hooked*" and committed to proceeding with partnering in therapy.

> *I had to get used to her* [OT]. *Like, after the first visit I wasn't really hooked but it didn't take long after that. I got to really like her and appreciate her.… Now I really see the value of it. That she's great*. **(**Louise, Parent)

Parents also used hooking strategies when **connecting** with therapists to encourage the therapist into a relationship with them and continued using similar strategies to remain hooked as their relationship progressed. Parents wanted to feel comfortable with the therapist, and likewise generally wanted the therapist to feel comfortable with them too.

> *I just want them* [OT] *to feel comfortable with my situation and know my story. If they tell me bits about them that's cool, but they meet lots of people where I only meet them!… So long as I feel comfortable with them.* (Toni, Parent)

Tara (Parent) was motivated to ensure the therapist was happy and comfortable in her home, because she felt it made the doing of therapy smoother:

> *I like to make Nicole* [OT] *feel comfortable in my home, so she is alright. As long as she's comfortable, then it will be alright. As long as she's happy with where we're going that's alright, it makes the job a bit easier.*

It was also important for Vandella (Parent) that the therapist felt comfortable in her home, and "*enjoys coming here too*". She explained, "*I very much want to welcome them* [OT] *in.… You do put a lot of time into the social or the connecting aspect*" (Vandella, CTI, Parent).

In addition to the positive actions undertaken by therapists and parents to hook each other into relationship, both might also intentionally withhold information in order to preserve harmony and not jeopardise the developing relationship. For example, when starting to learn about parents, regardless of her own perspective, Caroline (OT) was cautious to "*listen to them* [parents]*, hear and acknowledge what they're saying, even if I don't totally agree*". Therapists were also aware that parents sometimes held back information from them and did not always tell them the whole truth, potentially "*because they're so polite, they don't want to* [reveal everything]" (Michelle, CTI, OT). Parents acknowledged that sharing information with the therapist was "*a very personal thing*" (Sarah, CTI, Parent). However, parents holding back information impacted the therapist's ability to learn about the family and their needs, and some therapists viewed this as a shortcoming in **connecting** with the parent.

> *Where there is an aspect that the family are holding back from you, if they're not teaching you something in return, I always feel that that deeper level of connection hasn't happened.* (Nicole, CTI, OT)

For parents and therapists to become successfully hooked, the 'relating' hooking strategies that have been described were intertwined with hooking strategies concerning the 'doing' of therapy, which are described in the next section.

Hooking into Doing Therapy: Projecting and Instilling Confidence

To hook parents into doing therapy, therapists used strategies to demonstrate they could connect with the child, how they could help the child, and that therapy would be both manageable and worthwhile. For Michelle (OT), hooking parents in to doing therapy involved them seeing that their child was "*having a little fun*" and "*enjoying*" themselves with the therapist, because "*parents seem to really respond if their child's happy*". She showed parents that she wanted them to be involved and to work together by inviting parents to join her and the child playing, "*Hey, come and join me, let's try this together and let's work on this*". Learning that undertaking therapy for their child would not be overwhelming, but manageable in their daily life also hooked parents in to engaging in therapy. Michelle (OT) explained,

> *Parents seem to really like you getting hands-on, playing and really showing that you're really interested in their child. Bringing in different ideas, different toys, or just using what they have in their home and parents often just think, 'Oh, okay, it doesn't have to be that I'm doing 50 million different things, I actually just have to try this, do this, and it just be part of the everyday routine'.*

Through this hooking process, while learning about the child and parent, therapists impressed parents by demonstrating their skilfulness and practical application of knowledge. In doing so, therapists projected their competence, which gave parents grounds to place their confidence in the therapist and their ability to help their child. For example, therapists used hooking strategies to offer parents a glimpse of their child behaving differently, showing parents what their child could to do when they engaged with the therapist, like "*get the child on board and extend their play*" (Jayne, OT). Achieving success, such as revealing new play skills when the therapist worked with their child, also helped parents learn what doing therapy may entail and achieve, giving parents insights into their child's potential with therapy support. However, it is important to "*make sure you get the right hook*" (Jayne, OT) for both the parents and the child.

> *You just hook them in with something that makes sense to them.… You offer them* [parents] *something, or their child leaves or behaves here in a way that they think, 'Oh wow, that's amazing'. It's that confidence, 'I know what to do'. If you get success, you'll become more confident. So, if you can get that hook for the child, that hook for the parent, and they try it and it works.* (Jayne, OT)

The process of therapists hooking in parents using their skilfulness instilled parents' confidence in the therapist, and gave parents confidence that time spent on therapy would be worthwhile and effective in helping their child.

Having colleagues or other parents endorse a therapist's competence to deliver effective therapy and to know what to do also influenced hooking in parents. For instance, Kerry (OT) shared how parents who were initially resistant gained confidence in her and became hooked when they learned that her knowledge, experience, and guidance was respected and sought when her nursing colleagues asked her in front of them, "*What do we do here? What do you*

reckon, Kerry?" She explained, "*That's when you get quick rapport and quick buy-in because they're* [parents] *like, 'I'm getting the best treatment*"*.* Endorsement from colleagues contributed to hooking these parents in to proceeding with therapy with confidence, reassured that she was competent, and they would receive quality treatment when working with her. Some parents were hooked when they learned about their therapist's competence through other parents' experiences and endorsement of the therapist. For example, Louise (Parent) explained,

> *Local people who have Alex* [OT] *are like, 'Oh, their children love her!' Being well thought of, knowing that it's worthwhile and that she's doing a good job, that gets you to buy-in to it and do what she recommends.… I think I can have confidence* [when they are] *able to recommend her like that.… It makes me realise how lucky we are with Alex.*

Learning that she had a well-regarded therapist was reassuring and instrumental in influencing Louise's confidence to trust the therapist, motivation to work with the therapist, and her buy-in to partnering in therapy for her child.

Developing Trust

Concurrently with hooking, developing trust between parent and therapist was intrinsic to the process of **connecting** and **establishing a relationship**, and integral to learning and working in partnership to provide therapy to the child.

> *Trust and relationship go together, and you're not going to have learning if you don't have either of those. So, it's really important to work on those two things because … they're* [parents] *going to learn more if relationship and trust are there.* (Marissa, OT)

Parents and therapists need to learn about each other in order to trust each other and establish a relationship. For Nicole (OT), trust was also crucial for a establishing a strong relationship.

> *The relationship between client and therapist becomes fuller with trust and equality. They* [parents] *share more and then that way you can help them be prepared for the future. Any relationship is strengthened on trust, and if you've got trust that relationship is going to be strong. If you don't, then you've probably just got an acquaintanceship, not quite a relationship.… If you don't build trust with the family, they will never be able to share what their concerns and fears are to a deeper level.*

For therapists to learn, they needed to gain parents' trust so that parents would share personal details with them and have confidence in the therapist's ability to help their child and buy in to proceeding with a therapy partnership.

Although both parents and therapists acknowledged the importance of trusting each other, learning to trust required effort and was not necessarily immediate. Marisa (OT) noticed that it takes some parents "*a while to warm up, but they're a lot more engaged in the therapy programme if they trust you*". However, once trust was established progression to **crossing the relational threshold** and entering therapy in partnership followed soon after. Trust often became deeper as time and the relationship progressed, with many parents coming to have implicit trust in the therapist they worked with (discussed in '**Crossing the relational**

threshold' section). Trust was built dually on the integrity of the parent-therapist relationship ('Trusting each other') and the acceptance of the professional credibility of the therapist to deliver therapy outcomes ('Trusting the therapist as a professional') which are discussed in this section.

Trusting Each Other: Learning to Trust, Trusting to Learn

Trusting is essential for learning from each other. Likewise, learning about each other contributed to developing trust. Like other parents, Toni (Parent) became more comfortable with the therapist as they got to know each other over time; she explained,

> *As I get to know them* [OT] *I just get that warm feeling, trust… I lose the wall…. I feel more comfortable with her the more that I've dealt with her.*

Learning they could trust the therapist helped put parents at ease and feel safe with the therapist. Trusting consequently became a catalyst for sharing more, which in turn helped therapists learn. However, therapists did not take parents' trust for granted and realised they had to work at gaining parents' trust. Both parents and therapists felt listening was fundamental in building trust and for therapists to learn about parents and their needs. Knowing they had been heard, such as when therapists recalled earlier conversations, and "*remembered things that I've told her* [OT] *… like she's actually really been listening*" (Sarah, Parent), was significant for parents to feel safe sharing things and trusting the therapist. Like other therapists, Marisa (OT) appreciated the close nature of a therapy partnership, and the significance of parents trusting them with personal information and privilege of being trusted:

> *We work so tightly with these families. It is actually a real privilege. And they* [parents] *do tell us lots of things, and many of the mothers start crying. I think they wouldn't do that if they didn't trust us. And you do have to work at that.*

Trusting was reciprocal, "*definitely a mutual thing*" (Marisa, OT) as parents and therapists needed to trust each other to learn.

> *It's a two-way thing, definitely. I've got to trust that they're* [parents] *doing what I'm asking them to do, and they've got to trust that I know enough to be providing them with a service.* (Kerry, OT)

Parents needed to trust the therapist knew what they were doing and that they could learn from them, and therapists needed to trust that parents would implement learned therapy at home.

> *She* [OT] *has to trust that we're doing our bit, that we're providing opportunities, and doing the activities, and stimulating Sophia* [child]. (Louise, Parent)

Simultaneously, therapists also needed to trust that parents were sharing honestly with them so they could learn what was needed and how to tailor learning and therapy to meet parents' needs. This included relying on parents being honest in accounts about progress between therapy sessions, both positive and negative.

> *I'm very much aware that parents know their children better than I do seeing them once a week, so I really rely on them for giving me really honest feedback about what works, what doesn't, and how the child's feeling.* (Caroline, OT)

Therapists consciously demonstrated their reliability and honesty to help parents learn they were trustworthy. For example, Marisa (OT) would "*follow up on things*", and Nicole (OT) visited when a child was in hospital to help parents learn that "*they can rely on me*". Learning the therapist could be relied on, was honest, and would do as they said, was pivotal for parents and influenced their trust in the therapist. This was particularly important for Sarah (Parent), and she judged trustworthiness quickly when meeting a therapist. She felt she could trust the therapist who said, "*Actually, I don't know but I'll get back to you*" when they could not immediately answer her questions. She explained,

> *I don't like it when people try to make things up or ramble or there's no follow through.… What I like about Helen* [OT] *is she always does what she says she's going to do, which is quite important for us. So, when she says, 'I'm going to do this', she actually does do it and will follow through. Whereas lots of times people will say it, but they actually don't.*

For Lisa (Parent), the therapist's honesty with difficult issues, to not just "*say what I want to hear, probably makes me trust her more*". Furthermore, being transparent and honest was another way therapists intentionally gained parents' trust. Nicole (OT) explained her approach,

> *The way I built trust was I was transparent about what I was going to do, 'This is what I'm going to do and because these are the concerns, this is why I'm going to do what I'm going to do'. Explaining my clinical reasoning behind everything I'm doing.*

In a bid for transparency and to help parents learn what to expect of the therapist and therapy, Nicole intentionally set up clear expectations, so there were no surprises for parents.

Future learning was impacted when trust was not established in the relationship. As they progressed with therapy, when parents did not fully share information with therapists, it added frustration and hindered the learning therapists needed to tailor parents' learning opportunities and the therapy to meet their needs.

> *Why is it not working for the family? How are the family doing it? They* [parents] *need to teach me what they're doing. Why isn't it working for them? And what don't they like about it? Because if they don't show me those things, I assume that it's all going well… If they don't share some of these things with you, open up, then, you've essentially failed, because what you've set up may not be working for them.* (Nicole CTI, OT)

Ultimately, a failure to establish mutual trust risked jeopardising the child's progress. When parents lacked trust in the therapist, such as when therapists appeared to lack confidence, were "*airy fairy*" (Sarah, Parent) or uncertain with what they were saying, some parents did not want to proceed with that therapist, and consequently did not cross the **relational threshold**.

Trusting the Therapist as a Professional

Most parents chose, or convinced themselves, to trust the therapist initially because of their professional status. For example, Tara (Parent) trusted the therapist "*because that was her job … I just let her do what she needs to do*". Choosing to trust the therapist as a professional involved parents accepting that the therapist was going to be involved in their life and was there to help their child. Toni (Parent) explained,

> *I trust them* [OT] *fully completely. To start off with I put my trust in* [the OT] *because … they're here to do what they're trained to do. They know what they're doing. I'm not trained in it, I'm just a mum.… I've accepted that they're coming and that they're going to be part of my son's life.… I've just gone with that they help me and try to take on board what they tell me.*

Wanting to learn things to help their child was also a strong motivator for parents to consciously choose to trust the therapist. Dolly (Parent) explained,

> *If you don't trust them* [OT] *then they might as well not be here really. You've got to trust in what they're telling you and asking you to do. It comes back to obviously we're both here to help Gracie* [child] *achieve what needs to be achieved. So, that trust came pretty quickly and naturally. And I guess you've got to be open to it, otherwise you're not going to take anything in and you're not going to help your child in the long run.*

Willingness to trust the therapist extended to some parents continuing to trust the therapist and continuing to engage in therapy, even when based on assumption and experiencing doubt.

> *You assume that it's all for the best and also that what she's doing is worthwhile and also that it's enough. Because with the early intervention you think, 'Should you be doing more? Are we doing enough?' It seems to be natural play. You wonder, 'Are you actually doing anything?' I just trust that she is doing the best.* (Louise, Parent)

Thus, developing trust in the therapist also led parents to choose, or convince themselves, to trust that doing the therapy would be worthwhile.

Make or Break

The early relationship was often tentative and there was an inherent sense of 'make or break' in the process of forming a relationship, where parents were either 'all in' or 'all out' with the therapist, and subsequent therapy. The fragility in the early stages of **connecting** was most apparent in the instances where connection, and therefore relationship, failed to establish. Several parents shared times when **connecting** with the therapist was unsuccessful and, consequently, the **relational threshold** was not crossed and therapy did not commence. Conversely, there was less risk that the relationship would break and jeopardise therapy and learning once the relationship was established and the **relational threshold** was crossed, when there was generally no going back, and parents did not want to start over with another therapist (discussed in **Crossing relational threshold** section on Reluctance to go back).

For example, Sarah (Parent) was offended by what a therapist said at their first meeting and refused to see that therapist again. The relationship broke before it had a chance to establish, and consequently, her child had no therapy intervention for a time.

> *It actually came down to one comment… and that stuck to me. I couldn't believe that she* [OT] *would say that. So that just put us off immensely. We won't deal with her. She came to our house once and then we knew.… That one comment was enough for me.* (Sarah, Parent)

Sarah (Parent) contrasted this negative experience with her current positive experience of working with a therapist whom she is comfortable with:

> *It comes down to, I guess, different relationships, where with the first one I didn't feel comfortable… Whereas, with Helen* [OT]*, I've got that relationship where I would say to her, 'I don't like that, I don't feel okay with that'.*

Once they were over the **relational threshold** and the relationship established, comments that might be 'make or break' earlier in the relationship were overlooked, without damaging the relationship. When asked how it would be if the current therapist said what the first therapist did now, Sarah replied, "*I wouldn't immediately go, 'That's it I'm never working with you again'*". Thus, as the relationship matured and the parameters of the relationship were established, there was greater tolerance for what was said and for disagreement, with significantly less risk that the relationship would break. As they became increasingly comfortable with each other, parents gained confidence to speak their mind, which further provided therapists with ongoing opportunities to learn how to best promote the parent's learning.

Parents who had worked with different therapists over time had learned from their experiences what they wanted and needed from the therapist. This influenced the judgements they made when approaching working with a new therapist. For instance, Sarah (CTI, Parent) needed a therapist willing "*to give opinions*" and "*strong enough*" to say, "*Sarah, you're being ridiculous, this is short sighted, … this is what's worked with others*". In this instance, the 'make or break' issue was not whether the therapist had "*years of experience*"; rather, that she "*says things how it is*". Conversely, when Sarah spoke to another therapist, she "*could tell straight away that this wasn't going to work with that one* [OT] … *and thought, 'No, it's going to be useless'*", choosing quickly to not proceed with that therapist. She explained,

> *I could tell because she* [OT] *was really uncertain with things she was saying.… It's brutal, but I've learned my lesson. Also, because now we're dealing with thousands of dollars because we're dealing with things like bathroom modifications and $28,000 vans. So, for me it's quite clear cut. It's massive trust.* (Sarah, CTI, Parent)

It was a 'make or break' situation, with much at stake and significant financial implications. In contrast, Sarah sought out a different therapist. She was hooked by "*the second person* [OT] *I spoke to and by the time she left I felt like I had* [connected]" (Sarah, CTI, Parent), and was all in.

Another indicator of the importance of the relationship between parents and therapists came to light when observing a parent joining a therapy session with his spouse and child for the first time. He felt inadequately acknowledged and not included and, consequently, felt disconnected and left out from their child's session, preventing a meaningful connection being made with the therapist. When asked about it at a subsequent interview, he explained,

> *To be there but not be interacted with much, I was like, 'Oh, so it's cool that I'm here, but I didn't really feel part of it'…. It would have been nice to actually be semi-included, or to let me speak, or even just the OT to just acknowledge me a bit more.* (David, Parent)

This sense of exclusion occurred even with both his spouse and the therapist attempting to draw him in, and involve him in the session, so he could learn what they were doing. Despite these attempts, he remained on the edge and disengaged throughout the session. This highlights the importance of **connecting** well right from the outset in order to move forward together, and the added complexity of **connecting** when another person comes into an existing therapy relationship (e.g., with the parent who was not primarily involved in their child's therapy).

Therapists recognised the 'make or break' nature of establishing a relationship with parents. There were times where therapists accepted **connecting** with a parent or child was not possible. Laura (OT) explained,

> *I've come to accept that that's what it is. And not everybody has to like me. And, for some kids I might just be too scary because my voice is too loud.… Or, 'No, she's the scary lady that always makes me do stuff that I don't like doing'.*

Therapists were acutely aware that not **connecting** and **establishing a relationship** impacted on their ability to provide optimal therapy for the child. For instance, when Marisa (OT) felt she had not connected with a parent it was "*very unsatisfying because something was missing in your work, and you know that what you discussed is not going to happen*". She shared an example where lack of connection directly implicated the service provided.

> *I didn't feel very welcome in the home … even though the parents let me in. It was difficult for me to suggest things because* [they were not] *really wanting to learn that much. I just didn't do as much as I would have done in other circumstance* [and made] *my visits less frequent. The benefit isn't there if the parents don't want to learn from me.… and they're not going to carry on.… So then basically the service they're receiving is actually less.* (Marisa, OT)

Similarly, when Michelle (OT) sensed the parent was not comfortable with her, it impaired her self-confidence and the therapy provided:

> *Unless I have that relationship starting with a family, they don't get the real me… If parents aren't comfortable with me you can tell, and it does set a barrier for me. They don't get the spontaneous, they don't get the real, because I'm thinking, 'Oh gosh, what am I doing here, what am I doing next?' And it's not a free-flowing session.*

At such times, therapists often "*worked on it and* [found] *it has come right*". However, on rare occasions, "*rapport doesn't build, and we change therapists*" (Michelle, OT), in hope that the

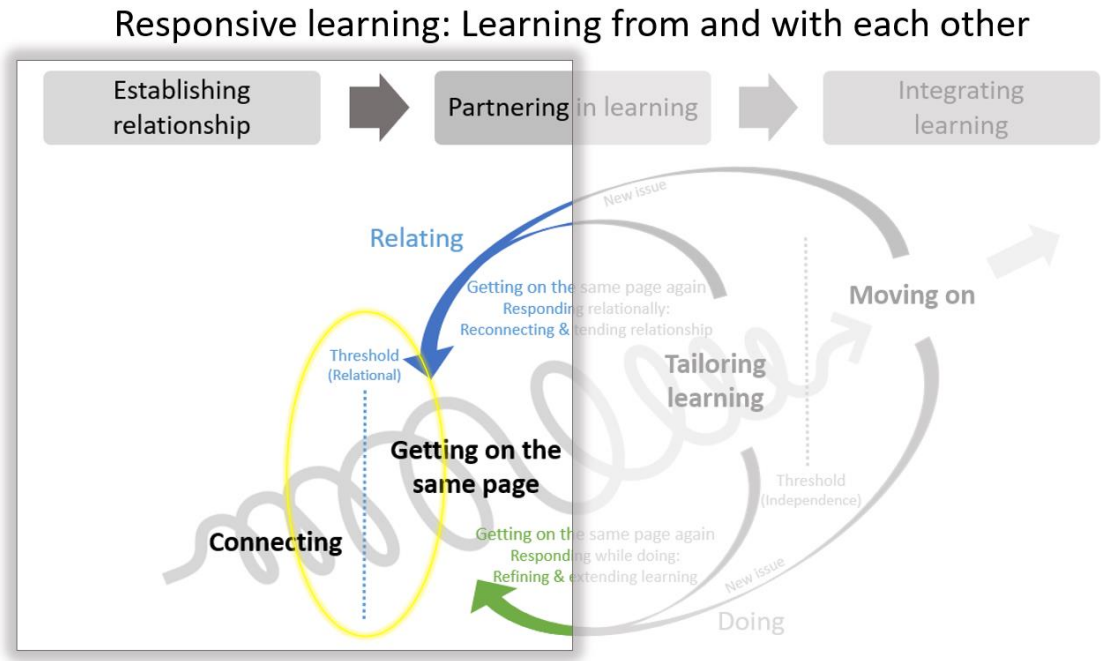
parent may connect more successfully with another therapist to achieve therapy support for the child. Thus, even with the best of intentions, **connecting** was not always successful, and consequently **crossing the relationship threshold** and proceeding with therapy not always guaranteed.

Crossing the Relational Threshold: Moving Forward in Partnership

There is a **relational threshold** between **establishing relationship** and **partnering in learning** (see Figure 6.3). **Crossing the relational threshold** was the culmination of investing in **establishing a relationship** through **connecting**, hooking, and developing trust. Indicators that the threshold had been crossed and they were progressing to **partnering in learning** included seeing a shift in the relationship, an increasing sense of ease with each other, a sense of partnership, parents' apparent buy-in and increased engagement in therapy, implicit trust in the therapist, and parents' reluctance to start the **connecting** process over again with another therapist.

Figure 6.3

Highlighting Crossing the relational threshold



Although **crossing the relational threshold** was not a given, with some not reaching that point, once across the **relational threshold** the risk that the relationship between parent and therapist would break was minimised.

Crossing the relational threshold was not stated by participants as an overt aim of **establishing relationship**, but it was clear in the data that there was a point where both parent and therapist had connected and were committed to proceeding with therapy for the child in partnership, even if the exact point of transition was not identified. In most instances, **crossing**

the relational threshold was more akin to a transition from one state to another rather than a flick of a switch. **Crossing the relational threshold** was not a destination in itself; rather, represented progression to a deeper level of connection between parent and therapist, and the beginning of **partnering in learning** to engaging in the 'doing' of therapy proper.

> *You have to pass that* [relational] *threshold to get to that responsive teaching.… From there onwards it's where the deeper level connection, that bond develops*. (Nicole, CTI, OT)

On occasions the point of **crossing the relational threshold** was identified. For example, having made a concerted effort to invest time to connect with and hook the parent into therapy, Kerry (OT) recognised the point at which something "*switched*", and a parent crossed the **relational threshold**:

> *Making effort, introducing myself, and taking time. Going in daily, being jovial and answering questions.… It took a lot of consecutive days going in, and then when it switched was when I was advocating for her* [parent]*.… that's when I got the rapport.… And it was at that point where we kind of got that switch because mum was like, 'Oh, she is here for us'.… She could see that I had listened and had taken what she was saying under my hat and trying to make something work for her.*

For this parent, learning and accepting that the therapist was working for their good was pivotal for the threshold transition and parent buy-in to partner in therapy.

The time taken and process of reaching the point of **crossing the relational threshold** was unique to each parent-therapist duo. Realising the significance if the threshold was not crossed, Nicole (CTI, OT) explained, "*If you don't get past that* [relational] *threshold point, you kind of remain stuck*". Nicole shared an example, where differencing perspectives of the parent and herself had potential to hinder progress to crossing the threshold:

> *I've had a parent who initially very reserved and resistant to having me on board.… It took us a very long time to get to being on the same page because they had very different views and understandings of what therapy looked like, and what normal or typical development of a child looks like, in comparison to what we thought that it would be in this situation.*

When crossing the threshold was difficult, persistence, further learning, and finding some common ground to start **getting on the same page** with understandings was needed to move forward together. For instance, when working with families from different cultures Michelle (OT) invested time and effort to learn about their culture, which proved crucial to understanding these families, how to approach working with them, and ultimately progress across the **relational threshold** to work together and meet their needs.

> *Cultural support workers have been so handy to actually help me understand. I was trying to work out how to bath a child, and I found out in their culture they don't actually sit in the bath, they shower. So, there was a fundamental shift that I needed to understand before I could get on the same page. The parents were too reserved to tell me.* (Michelle, CTI, OT)

Seeing a Shift in Relationship and Parent Participation in Therapy

Regardless of timing, after **crossing the relational threshold** both parents and therapists generally noticed "*there's a shift in the relationship*" (Laura, OT) and their interactions in terms of ease and comfort with each other and parents' increased participation in therapy. Therapists "*could see changes*" where parents were "*more relaxed*" (Caroline, OT) with them and "*warmed up a little bit and asked me more questions*" (Marisa, OT) after the **relational threshold** was crossed. Laura (OT) also noticed "*a shift in the relationship with the children, in terms of they'll recognise you or they're happy to engage*". Likewise, parents noticed that they felt more at ease with the therapist after a point. Some parents related the transition to both the time spent working together and their appraisal of the therapist's commitment and trustworthiness. Reaching that point provided a firm basis for receiving the therapist in their life and moving forward to partner together in therapy.

> *It makes it more comfortable her* [OT] *being here because you can feel that she is dedicated, and she's motivated to help you to help your child. I guess comes back to the trust and obviously working together.* (Dolly, Parent)

Like other parents, Sarah (Parent) recognised that her relationship with the therapist shifted and developed from a formal didactic situation of being given what she needed to learn and do to a relaxed and open relationship where she was very comfortable to share any concerns.

> *Slowly our relationship has evolved from where we used to go and just get a list of things to do. Whereas now, I will go to her* [OT], *and I will say, 'Man, I've had a terrible week actually, and this has happened'. I'll probably tell her things that aren't even related to the OT stuff or related to Rosie's* [child] *development. But then she can give us advice back from that.*

Therapists also became more comfortable when communicating with parents, as they both became more familiar and relaxed with each other. Sarah (Parent) further reflected,

> *We've got that kind of relationship where we're quite open and honest. She'll* [OT] *say, 'Stop, Sarah, shhh, just let Rosie* [child] *do it' when I need to … and we'll have a laugh. That's what I like and probably need in someone.*

After **crossing the relational threshold**, other parents described realising a sense of purpose and belonging and felt valued as an equal member in the partnership with the therapist. Lisa (Parent) explained,

> *She* [OT] *makes me feel like I'm a partner in it, as opposed to she's the therapist and I'm just a parent…. She makes me feel like it's an equal partnership in teaching Jake* [child], *as opposed to, I have to go there and listen to everything she says. She makes me feel like I'm the most important person to teach Jake…. She asks me a lot about what I think, where I think he needs help or where I think he's not progressing as much. So, I guess that makes me feel I do have a say in it.*

The therapist's acknowledgement of her relationship with and intimate knowledge of her child gave Lisa confidence in proceeding to work with that therapist and confidence in herself that they were working together towards a common goal of supporting the child.

Once across the **relational threshold**, parents generally became more actively involved in therapy sessions, evident to therapists by parents' actions, their enthusiasm, and, for example, "*that they jump straight into it and they really want to get on with the session*" (Nicole, OT). Annie (OT) learnt parents had crossed the **relational threshold** and were on-board when they were responsive to her, showed an interest, and began to initiate what they wanted to work on and take ownership of their time together:

> *I think we got there because when I contacted the family, they'd get back to me immediately. They're like, 'Yes, we'd love you to come out on that day'. Or ask, 'What kind of things are we focussing on this time?' And they'd be telling* me [what they wanted to focus on].

Parents leading the direction of therapy was a key sign they were across the relationship threshold, and on-board with proceeding with therapy.

Developing a Professional Friendship

Some parent-therapist relationships transitioned into a sense of increasing closeness after **crossing the relationship threshold** and as time progressed. Many parents developed a deep appreciation for their child's therapist who they had come to know and appreciate over time as they worked closely together.

> *They* [OT] *were just awesome. They were like a lifeline in the early days. I just really appreciated when they came to visit and any question they didn't mind answering, whether it was small or seemed trivial or not. But yeah, the relationship is really important. It does help because it almost makes you feel like they get what you're going through even though they may not have that hands-on experience, at least maybe they've been with other families that have and they can offer advice. But you do trust them. You form that bond, and they are your constant people that come through and help. So yeah, it has been really good. I appreciate that.* (Vandella, Parent)

Relationships sometimes developed beyond mere acquaintances and started to take on qualities similar to a friendship, such as "*it's quite a friendly kind of chatting relationship*" (Sarah, Parent). Several parents expressed affection for their therapist, with several likening their relationship to developing a friendship of sorts, where "*we've actually become friends*" (Sarah, CTI, OT). Vandella (CTI, Parent) explained that "*you invite them* [OT] *into your home where it's a personal space and you become friends with them*".

At times, regular contact and intimacy with parents inevitably resulted in a form of friendship with some parents for therapists because "*You actually become so much a part of their lives*" (Marisa, OT). Caroline (OT) had learned that an advantage of a friendship-type relationship was that it was easier to broach potentially difficult issues with parents:

> *We see children and their parents every week and you build up quite a friendship with parents, so you can kind of talk to them rather than a therapist to parent way, it can become a lot friendlier than that. So, it's easier to broach subjects I think sometimes that could be quite difficult.*

It was not entirely surprising that learning about each other, revealing and dealing with personal issues, regular close contact, and engaging with each other for a shared cause of helping the child would result in growing familiarity with each other, and consequently contribute to the depth of relationship between parent and therapist. However, most therapists and parents were conscious and cautious that there were professional boundaries to maintain. Michelle (OT) found that preserving the boundary involved learning what parents expected of her as the therapist and then tactfully managing that by helping them learn what the boundaries may be:

> *There are professional boundaries with families too. Some parents want you to be a friend. They want you to come to the christening on Sunday, those sorts of things…. Sometimes you have to be really aware of how they're seeing you and what happens in their culture. Coming into their home, it can be that the next thing you're invited to something that's, 'Oh, we don't actually* [do that]*'. That's our boundary.*

Parents also generally recognised that while their relationship with a therapist might share many characteristics of a friendship, there were defined limits.

> *We're just the clients and they're the therapist. You kind of do get to a certain friend level. Yeah. Not that I would go and friend them on Facebook or anything like that. But I do feel very comfortable with them and tell them personal things about the rest of our family if I have to.* (Toni, Parent)

This closeness and reliance on the therapist contributed to a strong reluctance to begin a relationship with another therapist, and motivation to tend the ongoing relationship as they moved forward to **partner in learning** and therapy.

Trusting Implicitly

Once across the **relational threshold,** many parents implicitly trust the therapist. This was characterised by an unwavering confidence in the therapist and their recommendations. When checking the theory with Sarah (CTI, Parent), she agreed,

> *I won't listen to someone if I just think they're a bit of an idiot. I will just kind of block off. Whereas once that's happened* [**crossing the relational threshold**] *I'll do anything they say. So, I'm like that with OTs now, where I said to this lady today after only half an hour, 'You tell me what to do, because I trust you'.*

Similarly, when Lisa (parent) learned the therapist was competent, and had the knowledge and qualities required to help her child, she felt safe with them, was hooked, and trusted the therapist implicitly:

> *She's* [OT] *so calm and has so much experience, I just inherently trust her for obviously those personal qualities that she has. And she talks about things scientifically as well, so she'll back things up with books. But also, I know that a bit of it is a bit of an art and a science, and I just think she's really good in that way as well.*

Other parents also trusted the therapist unreservedly, confirming "*I just let her* [OT] *do what she needs to do*" (Tara, Parent), and rather than seeking information elsewhere, "*I take Alex's* [OT] *word on it*" (Louise, Parent).

Showing the extent of implicit trust in the therapist, some parents were even willing to persevere with an intervention in the absence of evidence of progress. For example, Samantha (Parent) was not unique in being prepared to "*just keep trying*" and doing what the therapist suggested, "*even if it's not really working*". Despite her misgivings and her efforts apparently having no effect, implicitly trusting the therapist's suggestions, she held onto hope and trusted that continuing to try doing the therapy would make a difference to help her child, regardless.

Reluctance to go Back

The significance of **crossing the relational threshold** was perhaps most apparent in that parents preferred continuity with the same therapist. Parents were unanimous in not wanting to be jettisoned back to the early **connecting** phase with a new therapist—even if only temporarily. They did not want to change therapists, and often preferred waiting rather than seeing a fill-in therapist if their regular therapist was unavailable.

> *I think that* [relationship] *is the most important. I don't think I would want to go somewhere that I had to change therapists all the time.* (Lisa, Parent)

Rationale for this reluctance were based on both the investment and emotional effort required to connect with a new therapist; and the implications of a new therapist needing to learn where their child was at with treatment and what had already been done to get there. Thus, there was dual relational and therapeutic context to loyalty with the current therapist. Of note, suggestive of the degree of connection, parents always called the therapist they had **established a relationship** with by name, for example "*Helen*". But the therapist with whom no relationship had been forged was never referred to by name, rather as "*another one*" (Lisa, Parent), "*somebody else*" (Polly, Parent), "*that woman*" (Tara, Parent), "*that one*" or "*the first one*" (Sarah, Parent).

Reflecting the deep relational connection between parent and therapist, parents had strong reactions to potentially losing the therapist they had come to know and trust, or when contemplating seeing a fill-in therapist. Dolly (Parent) likened it to abandonment, capturing the magnitude of contemplating starting again with another therapist:

> *You'd feel like they were abandoning you if you lost your therapist. It would actually feel quite personal. They come into your house every second week, and they touch your child, interact with your child so it would be quite sad. If somebody else came along I'd be like, 'I don't know you! Don't touch my baby!'*

Parents also questioned if it would be worth the effort to connect with a fill-in therapist if their therapist was only away for a short time, as the therapist would have so much to learn about them.

> *It seems hard work to get that person* [a new therapist] *up to speed again. You've got to go through that whole longer connection phase at the beginning and then you think, 'Oh if it's only for a short time, do I want to? Do I want to invest in that connection, because I'm not going to be seeing them maybe again?'* (Vandella, CTI, Parent)

The sense of ease and familiarity with each other, where privileges included learning personal information and working closely with a child was earned and could not be easily or flippantly transferred to another therapist. Without a sense of connection, the interaction would be more effortful and, perhaps, less reassuring.

Reluctance to engage with a different therapist often stemmed from parents' concern that a new therapist would not know them and their child, or what they had been working on for therapy. Consequently, new therapeutic input may not be as effective. The regular therapist had built up knowledge of the parent and child, and knew what had been going on with the therapy intervention and "*where you're at as well*" (Dolly, Parent). Lisa (Parent) recounted an uncomfortable experience she had working with a fill-in therapist:

> *She* [the new therapist] *made me feel like I wasn't doing the right things or enough. I think it's just because she didn't know us, so she didn't know what we were like or what we'd been doing… And she didn't take the time to find out and just assumed, which was hard to take when you're like, 'I don't think I could fit anymore into my day'…. What she was saying was probably all correct, but I guess when you're with a therapist all the time, she* [regular OT] *knows what you know. So essentially the new OT was reinforcing something that I felt I already knew. So, it's like, 'Well, do you have to tell me again? I already know'.*

The new therapist not taking time to learn about her situation influenced Lisa's reluctance to engage and reinforced her loyalty to her regular therapist. Other parents perceived working with another therapist as a potential stumbling block.

> *You'd have to start all over again explaining to them* [another OT] *the situation—what's happening with Gracie* [child]*, what's not happening with Gracie. Having to start all over again would be really big. Like, at the moment I feel like we're doing something, 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.* (Dolly, Parent)

In particular, the regular therapist knew what they had and were working on, what had worked and not worked, and the path of progress thus far. Therefore, starting again with another therapist was not appealing.

Irrespective of the effort required to engage with a new therapist, a few parents recognised the potential learning benefit from working with a different therapist who might bring a fresh skill set or point of view. However, working with another therapist was generally only acceptable for a short time and certainly not at the expense of their regular therapist. For instance, Dolly (Parent) explained,

> *It might not be so bad, I guess. Different people have a different perspective. They* [another therapist] *might bring different skills or different ways of teaching you how to do stuff, so I guess I'd be comfortable with that short-term, but definitely not long-term!*

However, the potential value of fresh input was not shared by most parents. Polly (Parent) viewed "*a one off*" appointment as riskier than progressing with what she was already doing with her regular therapist, commenting "*I think I'd rather pass on that appointment. They might*

be on a different page. They might have different ideas to what we're going with". Parents appreciated that their regular therapist had learned about them and the intricacies of their lives, and consequently knew them and how best to work with them.

> *She* [OT] *knows Rosie* [child]. *When we walk in, she can remember exactly where she's at and what she's come on from, rather than having to go and read. It's interesting, because one time when she* [OT] *was sick and we've had to work with other people, you suddenly realise the huge difference when they don't know you.* (Sarah, Parent)

On rare occasions, even after the **relational threshold** was crossed, there were limits to what a relationship could endure, and parents did go back to start over with another therapist. Some points of learning were too confronting for even a strong relationship to survive. For example, new issues arising as the child developed and grew were at times difficult for the therapist to address. Caroline (OT) gave an account of a time where she noticed something about a child, sought advice from her clinical colleagues, and felt it was important to address with the parents.

> *We talked to them* [parents] *and told them what we were thinking, and they actually left.… But professionally we felt we needed to be honest with them and we felt it would give them more understanding of what was happening for their child as well. I have no regrets about sharing it with them. It's unfortunate that they weren't ready to hear it or weren't ready to accept that about their child.*

A consequence of addressing an issue the parents were not ready to learn, in this case, was the therapy partnership breaking down and the parents seeking therapy elsewhere.

Summary

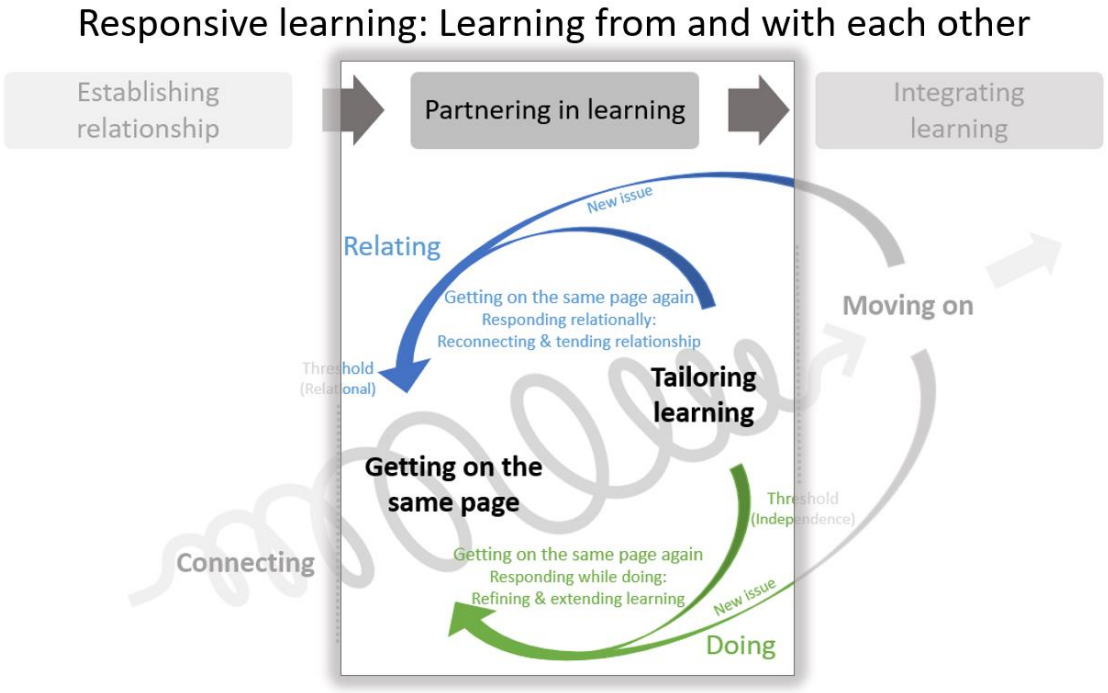
This chapter presented **Establishing relationship**, the first of the three theoretical categories within the theory of **Responsive learning**. The two subcategories, **Connecting** and **Crossing the relational threshold**, and their respective properties, were explicated with supporting data. While establishing a relationship, parents and therapists learn about each other and how they might work together as they are **connecting. Connecting** is a precursor to **crossing the relational threshold** and **partnering in learning** to engage in therapy to support the child's development. Chapter 7, continues the findings discussion, focusing on the second theoretical category of **Partnering in learning**.

Chapter 7 Partnering in Learning: Getting on the Same Page and Tailoring Learning

In the previous chapter, **Establishing relationship**, the initial phase and first theoretical category in the theory of **Responsive learning: Learning from and with each other** was presented. The second theoretical category of **Partnering in learning** (Figure 7.1) involves cycling between the three subcategories: **Getting on the same page**, **Tailoring learning**, and **Getting on the same page again**, as parents and therapists continue to **learn from and with each other** as they work together towards **Integrating learning** (the third theoretical category) in everyday family life. **Partnering in learning** involves responsive teaching and learning, as the parent and therapist partner in 'doing' therapy together. As the learning process cycles through the subcategories, and parents and therapists respond to each other and the situation, the focus of interactions and learning oscillates between relating and tending the relationship, and the practical doing of therapy to maintain forward momentum with therapy and building on prior learning. The consequence of parents and therapists **Partnering in learning** is continual and responsive **tailoring of learning** to meet the needs of each involved.

Figure 7.1

Partnering in learning theoretical category: The cyclical process of Getting on the same page, Tailoring learning and Getting on the same page again



As the theoretical category of **Partnering in learning** contains multiple key components and is presented across two chapters. In this chapter, I explain the first two subcategories: **Getting on the same page** and **Tailoring learning**, which lay the foundation for **Partnering in learning**. **Getting on the same page** (with properties, Finding common ground

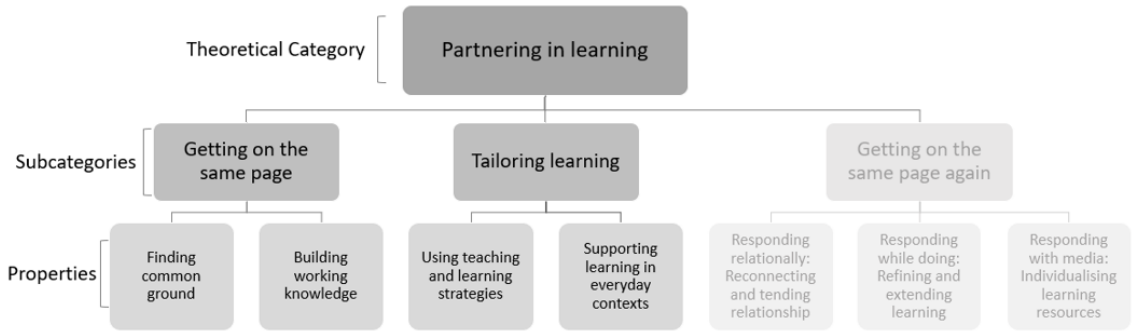
and Building working knowledge) is about why and what parents and therapists learn. **Tailoring learning** (with properties, Using teaching and learning strategies; and Supporting learning in everyday contexts) addresses how they learn. These processes establish the process of working together in partnership in the earlier stages of the relationship.

In Chapter 8, I present the third subcategory **Getting on the same page again (**depicted with the upper blue and lower green arrows, Figure 7.1), where the relating and doing aspects of the ongoing therapeutic alliance are separated out. **Getting on the same page again** (with properties, Responding relationally: Reconnecting and tending relationship, Responding while doing: Refining and extending learning, and Responding with media: Individualising learning resources) is fundamental to the theory of **Responsive learning** as a whole. **Getting on the same page again** is about further refining and extending learning, while simultaneously tending their relationship, to ensure learning and therapy is continually tailored and meeting people's needs. These aspects of the theory are significant in demonstrating the responsive, iterative and cyclical nature of the learning process as parents and therapists strive to move forward with therapy and maintain the relationship over time

Although presented as separate stages in the theory, as previously acknowledged, there is continuity and overlap between each of the categories. An outline of the theoretical category of **Partnering in learning** and the first two subcategories (and properties) covered in this chapter is presented in Figure 7.2.

Figure 7.2

Outline of theoretical category Partnering in leaning, subcategories, and properties



Subcategories Getting on the same page and Tailoring learning covered in this chapter are highlighted.

Partnering in Learning to Meet Learning Needs

The reason for parents and therapists **partnering in learning** was a diagnosis or a long-term medical condition for a child that involved "*a very big learning process for families*" (Marisa, OT). Parents needed to become cognisant of their situation and the need for services that they had not anticipated for their child and family, because "*we've never dealt with a special needs child before*" (Toni, Parent) and "*I didn't know what I was supposed to do*" (Anika, Parent). Parents' learning needs and readiness to learn changed as they adjusted to their

child's condition. Initially, before learning about therapeutic input, parents' general learning needs were about their child's health condition and the implications for the future. Therapists helped parents learn about their child's condition and learned what parents were ready for by, "*how many questions they ask, or things they say, how much they understand*" (Marisa, OT), and the way parents responded to them. Marisa (OT) explained,

> [Parents often] *had a lot of questions and wanted a lot of information.… We follow them* [parents] *through that whole, 'What's wrong with my child? Is it going to go away?' to 'it's not going away'. And obviously the learning is different within those time frames.*

Support from the therapist, as well as information and learning, helped some parents adjust and work through a grieving process of coming to terms with their child's condition.

> *They* [OT] *give you information which you need, and they help you, … won't judge you and are there to support you.… It kind of fills your tank up a little bit and it keeps you busy too.* (Vandella, Parent)

For parents, learning about the implications of their child's condition was key foundational working knowledge and a precursor to learning practical skills of supporting the child's development and participation in family life. Therapists played a key role in helping parents learn about their child's challenges and what they meant for the family, including how to work with their child and to focus on what they and their child could do. Like other therapists, Nicole (OT) focused on "*empowering parents, and at the same time helping them learn that they can do something to support their children, that they don't need to feel useless*". A positive approach and encouragement from therapists helped parents learn and see a way of moving forward and a future for their child. This contributed to parents' confidence in themselves to help their child. Lisa (Parent) explained,

> *She* [OT] *has helped me to relax about the whole situation! She's taught me to celebrate the things that he* [child] *does do and that he's still got a lot of learning to go, and it doesn't all have to happen really quickly. She's helped me deal with things … by just focussing on what I can do rather than what I can't.… They never say he's going to be perfect, they never say he's going to be fine, but they reinforce they're your kid, you love them anyway and we'll do what we can to get the most out of them.*

Getting on the Same Page

Getting on the same page is about why and what parents and therapists are learning. As parents and therapists **cross the relational threshold** and enter the **Partnering in learning** phase of the theory, learning continues as they start **getting on the same page**.

> *Now I'm more into it, we're working together and I'm here to learn how to do these things to help Sophia* [child]*. We're in partnership.* (Louise, Parent)

To partner in learning, parents and therapists need to **get on the same page** to establish mutual expectations and meet learning needs. Within the subcategory of **getting on the same page** there are two key properties. The first, 'Finding common ground' is more relationship focused, based on learning about each other and establishing common understandings and expectations

of each other, of working together, and of the therapy service. The second, 'Building working knowledge' has a more practical focus on learning to work together and the 'doing', or execution, of therapy. Both require the parent and therapist to **learn from and with each other**, in order to work in partnership.

Finding Common Ground

To find common ground, parents and therapists learn about each other and the therapy service while establishing shared understanding and mutual expectations of each other and the therapy. Parents appreciated learning where each other "*stands*" (Tara, Parent) by "*having common ground where she* [OT] *knew what I was saying or knew what was going on*" (Vandella, Parent).

Learning What to Expect of Each Other

Learning about each other helped parents and therapists understand and find common ground regarding what to expect of each other. Therapists recognised the "*privilege*" (Marisa, OT) of parents sharing personal information with them and often reciprocated by sharing snippets about themselves so parents could also learn something about them. For instance, "*to set the scene*" for expectations, Nicole (OT) voluntarily shared about her limited experience as a therapist with parents.

> *Because they're sharing so much about themselves, I share a little about me, and I say, 'I don't have kids and I have got limited experience in paediatrics'. I try and lay it out in front of them so that they feel that the communication can be honest and that my inexperience isn't something that I'm worried about or I'm trying to hide.*

For Nicole, being transparent helped establish an expectation of honest communication and trust with parents, while reassuring parents that even if she could not answer their questions, they could still expect her to help them, and "*find out for you, and I can get you that information*".

Reciprocity in divulging personal information and common experiences served to strengthen the relationship, demonstrate mutual understanding, and enhance the perceived expertise of the therapist. Several therapists gave examples of openly sharing with parents if they had children or not. Michelle (OT) only shared personal information with parents if asked, but by doing so felt parents learned she could relate to them in some way:

> *I don't talk about me and my life, this is their session. Sometimes parents want to know if I've got kids, so I tell them briefly, 'Yes, I've got adult children'. And they seem to be happy, 'Oh yeah, she does know something about it, she's had kids'…. Some parents are not interested at all, others definitely want to know, and they feel perhaps assured that I've been through the sleepless nights somewhere along the way myself.*

Even learning a little about the therapist was valued by parents to see "*they're a whole person, as well there to do their job*" (Vandella, Parent). Learning the therapist had common experiences as a parent was particularly reassuring.

> *Even just knowing maybe if they* [OT] *have kids, they will get some things.… They understand maybe a little bit about what you're going through, … another little layer of understanding.* (Vandella, Parent)

Therapists trusting parents by divulging personal information also contributed to developing trust and equalising the relationship by helping parents feeling valued in the partnership.

> *I've divulged heaps and last week for the first time she* [OT] [shared about her daughter]*.… That was really nice because I've always wondered. And, it has changed it. I trust her even more now because she divulged a little bit about her. Not unprofessionally, but enough that it made me feel special, because you're sharing so much with them.* (Sarah, Parent)

Therapists accepted that "*every family is different*" and "*you've got to pick up every family where they're at*" (Laura, OT). Therefore, learning about parents' perspectives, ideas, philosophies, and preferences helped therapists understand them as individuals and to find common ground to work effectively together.

> *Some parents have interesting ideas about things, and you don't quite know how to take it, or what to think of the situation. Later on, you just understand their perspective better and you understand their whole family routines and how everything works—how the family approaches things.* (Marisa, OT)

For example, Louise (Parent) "*once read that you shouldn't tickle children.… So now therapists who turn up and tickles her* [child], *that kind of jars with me*". Louise suggested therapists should "t*ake a cue from the parents*" regarding things they should not do. Other parents held strong personal philosophies regarding children including, "*not to put your babies in positions that they can't already put themselves into or out of*" (Dolly, Parent); and "*not forcing children to do things that they're not quite ready to do…because as far as I'm concerned, they need to learn those skills themselves*" (Polly, Parent). Parents appreciated when therapists made efforts to learn about, respect, and accommodate their perspectives as they worked together. Polly (Parent) explained,

> *The therapist said to me at the start, 'Take what you need from what we do, but if there's anything that you're not comfortable with then just don't do it'.… Our OT was very accommodating with how I feel about children. She understood how I feel about them. So, she'd incorporated that into her therapy.*

Parents and therapists need to find common ground regarding expectations of where they stand with each another and how they work together as partners in learning and therapy. There was consensus among parents and therapists that parents were the experts on their child, because "*At the end of the day, it's your child. You know your child better than everybody else*" (Dolly, Parent). Therapists particularly worked at supporting parents to learn that within the relationship they both had expertise, they could learn from each other, and they would work in partnership.

> *The parent's the expert on their child and the therapist is the expert on development … and you've got to work together and work out how you best benefit that individual child.* (Laura, OT)

While therapists contributed their clinical knowledge, experience, and expertise to the relationship, to "*empower*" parents, and "*open up the platform for two-way learning*", Nicole (OT) intentionally set up the expectation with parents that "*because you're the expert on your child, you can teach me some skills and vice versa*". Parents also recognised they were not only learning from each other but were learning together. For example, Dolly (Parent) appreciated the therapist's expertise regarding child development, but when it came to specific knowledge regarding her child's condition, "*I don't expect her [OT] to know that sort of stuff. It's all a learning curve for both of us really*".

Like other therapists, Caroline (OT) was careful to lay out her expectation to help parents learn that they were working together in partnership, by explaining "*How it works here in that we work alongside each other…. we can work together, and … I give them permission to lead*". To partner with parents, therapists needed to learn about parents' needs, wants, and expectations of working together. For example, some parents expected the therapist to be "*confident, because otherwise you can bulldoze over them* [OT] *if you have a little bit of information yourself*" (Sarah, Parent), and "*blunt…. to tell me how it is, what to do, and how we will work towards fixing it*" (Sarah, CTI, Parent). Laura (OT) relied on her experience to gauge parents' expectations and how to work with different families because "*with one family it might be more prescriptive … saying, 'this is what you need to do'*". To work collaboratively, therapists also needed to learn what they could realistically expect of parents by seeing "*how they react in doing that*" (Marisa, OT); "*if you* [parent] *can do this, … what's realistic*" (Michelle, OT), and "*have I pushed them too far?*" (Laura, OT). However, there were times parents held misplaced expectations about therapist capabilities with "*magic hands*", "*curing the child*", or as a specialist who "*should be doing it all*" (Marisa, OT) without parent input.

Learning What to Expect of Therapy and the Service

To find common ground with expectations, parents needed to learn what to expect for their child in the future, and what they could realistically expect from engaging in therapy and the service to be "*forewarned or forearmed about the picture that their child paints and what things will benefit this child going on*" (Caroline, OT). However, therapists "*don't have a crystal ball*" (Sarah, Parent) and were cautious about predicting "*what that child's going to be like*" (Nicole, OT). Rather, to establish mutual expectations, therapists helped parents learn what to expect of therapy by being honest and realistic about what therapy could achieve when parents asked questions like, "*Will my child walk and talk?*" (Caroline, OT). Some therapists drew on research and resources such as The Gross Motor Function Classification System

(GMFCS)[5] to provide credibility when addressing parents' concerns and expectations about their child's potential to walk.

> *When the GMFCS levels came in it was like—oh my gosh, yes, I do have permission to say to the parents, 'I know it would be really lovely if your child would walk but actually what we know is that's not going to be the case for your child because this is where he's at and this is what research says'.* (Laura, OT)

However, most therapists balanced being realistic with being positive to gently help parents understand what to expect for their child, while reassuring them of the benefits of therapy, making "*it seem not such a scary, unknown thing*" (Lisa, Parent). Learning that there was potential for improvement, "*lots of good things to build on*" (Caroline, OT) with therapy "*that he will do things at his own time*" (Vandella, Parent) and "*it's not going to be like this forever*" (Dolly, Parent) contributed to parents having hope and forming positive and realistic expectations of the future, which aligned with those of the therapist.

As many parents had never worked with therapists before, learning what was expected of them as parents and how therapy services operated helped parents form realistic expectations of the service and what could be provided. At times, parents' initial expectations of what therapy would involve differed from the reality of doing therapy. For example, "*There haven't been a lot of exercises…. It's not as involved as I thought it was going to be*" (Louise, Parent). To align parents' expectations with the service and to "*make the most of* [the service]" (Annie, OT), therapists helped parents learn about supports available, service constraints, accessing "*various therapy services you could use*" (Louise, Parent), and "*that they can ask for certain things*" (Annie, OT). Some therapists intentionally laid out what parents could expect at the beginning, "*realistically giving them very honest time frames, 'This is how long the referral process takes and this is why it takes so long'*" (Nicole, OT). Offering parents options that aligned with how the service could be provided was another way parents learned what to expect. For example, "*We could do a fortnightly session, or we could do monthly. What might work best for you?*" (Annie, OT). Explaining when therapy would end at the outset, such as "*once the child starts walking that's it, the end of her* [OT] *time with us*" (Polly, Parent), helped parents learn the reality of what was to come, so it was not a surprise later. Learning about the service delivery and what to expect contributed to parents building working knowledge to use as they proceeded to learn to navigate health services for their child.

Building Working Knowledge

The second property of **Getting on the same page** is Building working knowledge. Building working knowledge has a more practical focus on parents and therapists learning together to gain knowledge and skills to communicate and partner effectively to support the

[5] The GMFCS levels are used to describe, classify, and predict future function for children with Cerebral Palsy (Rosenbaum et al., 2008).

child's development. Therapists learn things about how the family unit functions, the parents' leaning needs and how they can meet these. Meanwhile, parents learn more about managing their child's condition and skills needed to support their child.

Learning to Communicate With Each Other

Learning about each other's (and the child's) verbal language and non-verbal cues was key working knowledge for both therapists and parents in order to communicate, understand, convey meaning, respond to each other, and partner effectively. Nicole (OT) noted that "*every family uses different language*". To minimise potential for confusion, therapists often made efforts to "*learn their* [parents] *language*" and "*once you understand what they mean you tend to use their language*" (Nicole, OT). For some therapists, using the family's language, included following the parent's lead to incorporate te reo Māori words in interactions.

> *She'll* [OT] *often get our books out to turn pages, so she'll see that a lot of our books are in te reo. So, she knows that we do incorporate some of the Māori language into our interactions with Niko* [child]*. … I always say, 'ka pai'* [good]*. She has said something like that.* (Samantha, Parent)

This was observed when filming the therapy sessions where a therapist instructed a child to "*E tū* [stand up]" (Film 5), and another therapist repeatedly praised the child by saying "*Oh yay!! Ka pai* [while clapping hands]" (Film 3), as the parent had done earlier.

However, miscommunication or incorrect pronunciation when working together had potential to adversely affect the relationship and consequently subsequent learning. For example, correct name pronunciation was important to Samantha (Parent) and her whānau. However, the therapist continually mispronounced her child's name and, as some time had passed, she was uncomfortable correcting it.

> *She* [OT] *never asked and pronounces it slightly wrong. For ages she didn't call him* [child] *by any name, and only more recently has she been sort of stepping out and calling him his name but it's* [not quite right].

Had the therapist learnt to pronounce the child's name correctly from the outset it may have enhanced their ability to work together more openly and comfortably.

Parents learned "*a whole new vocabulary from therapists*" (Polly, Parent) including biomechanical, medical, and specific therapy language relating to their child's health condition. Parents confidently used specific therapy terminology during their interviews with me when explaining things related to their child's therapy interventions, including: "*hypotonia, the low muscle tone*"; "*core muscles*" (Polly, Parent); "*core strength*" (Vandella, Parent), and "*body awareness*" (Sarah, Parent). To explain, reinforce, and extend parents' understanding of concepts and terminology, and to "*empower parents to use early intervention language*" (Jayne, OT), therapists labelled what they were doing while working with the parent and child.

> *'Hand over hand' would be another technique we might use, particularly for eating. We label techniques to the parents so they would know what it's about. So, we might say the words 'engagement' and 'joint attention', and gently start to introduce those concepts so that they get a fuller picture.* (Jayne, OT)

Other therapists were wary of over-reliance on medical or professional language "*because we don't want to turn parents off by being medical about things*" (Caroline, OT). Instead, Caroline (OT) preferred to "*describe what it is we're seeing*" by putting what was being experienced into every-day words for parents, to support their learning. However, learning medical language was bidirectional. Therapists also learned from parents' use of terminology derived from previous medical encounters.

> *Some parents come in with all that* [medical] *language, plus some and it's like, 'Well could you explain it to me?'…. Or, 'Oh, you'll have to tell me what that is'…. I've found it's much better to ask the question and actually find out, rather than thinking you know it and you're off on a tangent somewhere.* (Caroline (OT)

Therefore, learning from each other contributed to parents and therapists having a common understanding of the meaning of terminology to build working knowledge as they **got on the same page**.

Communicating and expressing meaning between therapist, parent, and child was not limited to words, but included body movements, gestures, and vocalisations. Consequently, to build working knowledge to work together effectively, therapists were also learning to read the parents' and child's "*cues*" (Nicole and Michelle, OTs). For example, Caroline (OT) relied on parents' guidance to learn the meaning of non-verbal cues, including how far to push a child's engagement in therapy, particularly as they are still getting to know each other.

> *I'm not so good at reading their signs if I don't know them so well. Sometimes if the little one's crying and I think that they're probably okay, but I will check, 'Is it okay?' Parents have said, 'No I think that may be enough, they look tired'. Which is a nice way of saying, 'Look, just stop'.*

Parents helped therapists learn to understand a child's "*body language*" or to communicate with a child "*in her* [child's] *own language*" (Anika, Parent). For example, during a therapy session the therapist elicited the parents' 'translation' of what their child's vocalisations meant.

> [Child making noises reaching up and passing discs to OT]
> OT to Child: *Can I have those? What do you want me to do?*
> [Child making noises]
> Parent to OT: *I think she wants you to show her how to do that.*
> OT to Child: *Okay. Shall we do it together? Ready. Two. One in this hand.*
> (Film 5)

After learning what the child's vocalisation meant, the therapist responded accordingly by showing the child what to do and consequently proceeding to do the activity together. Parents' verbal and non-verbal responses also influence how and when therapists offer information and interventions, such as showing hesitancy.

> *I'm judging how she's* [parent] *responding to what I'm discussing with her.… If she looks unsure or hesitant, that's when I tend to offer it again.… I have gotten to a stage where I can read her cues a bit better.* (Nicole, OT)

Learning to read and understand each other's cues was thus a key aspect of building working knowledge that therapists and parents used to respond to each other.

Learning What Parents Need and How They Want to Learn

To help build parents' working knowledge, therapists needed to learn what parents already knew, what they needed and wanted to know, and how they preferred to learn. Learning what parents already knew was useful for therapists to help fill gaps in parents' understanding and to build on prior learning. Therapists also learned from parents' existing knowledge, highlighting the importance of learning what they already know.

> *Sometimes you've got to find out, to give the person respect, 'What do you know already?' And, 'How would you like me to build on that with what I know to complement what you know?' It's very important not assuming people know or assuming people don't know about their child's condition. Because sometimes they know more than us. They know all the insides out and upsides downs.* (Jayne, OT)

Some parents were clear on what they needed and wanted to learn from a therapist to build on what they already knew.

> *I knew how to do stuff with Jake* [child] *physically, but I didn't know how to play. I didn't know how to teach him how to think and how to progress his learning. All I could do was teach him to sit, to crawl, to walk. So it was that whole other side that I had no idea about. They've* [OT] *had to teach me.* (Lisa, Parent)

When the therapist learnt what she needed, Lisa (Parent) found it helpful that she could "*focus on the stuff I don't know, so it makes it a lot more specific to me … and it makes it a lot easier in teaching him* [child]". Parents built working knowledge best when they were invested in what they were learning and understood why it was beneficial. For Anika (Parent), knowing the "*whys are always good*". When Samantha (Parent) learned and understood *why* something was important it influenced her motivation to do it.

> *The less motivated part of me would be like, 'Oh he'll* [child] *be fine, he'll just figure it out'. But then we'd talk about it, because I need to know the why and if it's important enough for me then I'll do it.… She* [OT] *would talk about why it was important and the sort of flow on effects it would have with the brain development. I found that really helpful.*

To help parents learn, therapists needed to have a sense of the way they preferred to learn. Sarah (Parent) was aware of her own learning style and preferences and felt "*really lucky that she's* [OT] *tapped into the way we learn*".

> *I'm kinetic and I would much rather watch something than read it.… That's probably why Helen* [OT] *always shows me by doing it too. Sometimes she's given me books and then she'll say, 'So, did you read that?' And I'll say, 'Hmm, no'. So, she's gauged the way I learn—most of it is just by copying and talking about it. I learn by watching.*

To meet parents' learning needs Sarah felt therapists should take time to learn by, for example, simply asking parents, "*Would you prefer something written down or would you prefer I show you?*". As parents' learning needs changed frequently, depending on the situation at hand, therapists often asked parents what would be helpful for them or "*what is going to click with you?*" (Jayne, OT).

> *Parents might take a photo of stuff … and this week might want this and next week don't. You just ask them* [parents]*, 'Look, do you want me to write that down? Yes, no?'* (Jayne, OT)

Learning About What Works for the Family

To build knowledge to work in partnership and gain understanding about how to work with parents, therapists needed to learn about the child and family unit. Parents and therapists both acknowledged that it is important for therapists to learn what does and does not work for the family.

> *She'll* [OT] *show us what to do and say, 'Try it at home, come back and tell me if it worked or not, if you saw any differences'. And, then if it did that's great and if it doesn't then we'll do something else'.* (Sarah, Parent)

Open and honest communication was essential for therapists to learn what was realistic and when things did not work for parents, so they could make changes and adjust strategies to better meet the family's needs and to make therapy achievable, successful, and worthwhile. Some parents directly informed therapists "*why something's not going to work*" (Anika, Parent) in the moment during the session. At other times, therapists learned from the response of the parent or child. For instance, Toni (Parent) explained that the therapist "*had to learn to be flexible around me*" and *"learned to understand when things were not going to work—if Massey* [child] *was packing it in then she couldn't do her full session because he's done*". Like other therapists, when Marisa (OT) learned something was not working, she questioned, "*Why it's not working and what you can change about it?*" Learning what did or did not work for parents also helped therapists build practical working knowledge which they could use when working with other families.

> *The families will teach you, 'Oh this doesn't work and that doesn't work'. So, from them I learn a lot about different things they've tried and the different things that have worked, which is great because it's another suggestion, it's another skill that we can put in our belt that we can utilise with other people*. (Nicole, OT)

Learning about the family included therapists learning about their priorities, home environment, everyday routines, including "*how they* [the family] *work as a unit*" (Nicole, OT), "*their understanding of the situation, how they're coping, and strategies they use*", and "*what works*" (Marisa, OT). Caroline (OT) explained.

> *What do I learn from parents? To be careful about what I expect them to do, realistically. I learn about their child, how they react to things or what they like, what they don't like.*

It was also crucial for therapists to learn what was important to the family in relation to their child as this sometimes differed from therapy priorities.

> *You may assess that the child has fine motor problems, but does that actually matter to the family? Maybe other things have to be addressed first.… They're not going to focus on putting beads onto a string if those other things aren't addressed yet.* (Marisa, OT)

Learning about the home environment was essential for supporting parents to incorporate therapy into their everyday life. It was important to learn what was achievable and appropriate for each family's environment and cultural needs.

> *They're* [parents] *not going to do it if it doesn't fit or doesn't work in the environment. For example, an Indian family, I'm not going to give them a highchair because they sit and eat on the floor.* (Marisa, OT)

Some therapists preferred visiting families in their home, to learn first-hand about how the family functioned in their environment and their routines to realistically meet their needs.

> *I prefer the home in a lot of ways because I get a sense of the family more—what's going on, what's important, how they* [parents] *can fit things into their day. Because they can come to me and I can say, 'Here's 10 things to carry on with'. And you go to the home and think, 'Oh, my gosh, what's going on here? You cannot do all this in this environment'.* (Michelle, OT)

Learning about the family routines was how therapists made optimal use of face-to-face therapy times, such as planning sessions around a child's sleep times and incorporating therapy into existing routines so it was less onerous on parents.

> *Knowing what a typical day looks like for a family and how much time they've got and where things might fit in. We can kind of build that into what they're doing already so that it isn't additional time.* (Annie, OT)

Learning to Support and Teach Their Child

Therapists helped parents build working knowledge and skills to support their child's development so that they could, in turn, teach their child themselves. Therapists often used play to guide parents to learn to support and extend their child's development. Caroline explained,

> *How to just relax and play and how to feed in language; how to do that in a playful way.… How to position children for play, … the importance of being well positioned so that children can use their hands or use their eyes.… Looking at why children are reacting why they are, what in the environment we could change, or what's different at home that makes it different at home*. (Caroline, OT)

Occasionally, therapists helped parents learn and understand how their well-meaning attempts to support their child may hinder their progress.

> *There are families that mollycoddle their kids and hold them and support them, where you then have to talk about, 'So, if you* [parent] *want them* [child] *to progress, look this is what you're doing', With walking.… If Mum is doing the balancing by holding you* [child] *by your arms, you're not learning to control your hips*. (Laura, OT)

Some parents needed to learn about, and how to use, aids and equipment such as chairs, hoists, or standing frames to support their child's positioning, care, play and participation in family life. Michelle (OT) explained that "*there are little tricks*" that parents can learn to make using equipment easier. Parents also learned from therapists' endorsement if a piece of equipment was worthwhile for their child, gaining reassurance of their value and "*makes me use them more*" (Louise, Parent). However, it was important for therapists to learn about parents' use of equipment and any issues they may have to be able to respond and change something if it was not working, as persisting when things did not work was wasteful to time, effort, and resources. Therefore, therapists checked equipment was effectively meeting their child's needs by asking parents.

> *How's it been going? How often do you use it? Have you found it useful or is it just a waste of space? Is it just a piece of equipment that is of no use? Because there's no point in having that'.* (Caroline, OT)

As parents gained working knowledge, they wanted to learn specific things to teach their child themselves. For example, Sarah (Parent) described how she asked the therapist what to do so she could learn how to teach her child to be independent going down a playground slide:

> *Rosie* [child] *often gets her feet trapped when she'll go to sit down. And so, the therapist taught us how to tap and gradually get the foot to come around so that she's aware that she has to bring her own foot around, as opposed to I just used to scoop it around and give her a push down the slide. And it's me teaching Rosie how to do it herself rather than me just bulldozing and doing it for Rosie.*

This learning shifted the person guiding the child's learning experience from the therapist to the parent.

Filtering Information

Therapists often helped parents learn and build working knowledge about their child's situation by filtering information they gained from other sources, such as health professionals, other parents, and the internet. Some therapists acted as translators to help parents understand information learned from other health professionals. For example, Michelle (OT) would "*join in*" with a child's specialist appointment, "*so I can actually hear what they're* [parents] *being told, so I can then discuss it with them*" later. Toni (Parent) found support from other parents on the internet, "*I get support, I get help… all the blogger mums are a lot like me*". The internet was a common source of information and support for parents, including Google, Facebook groups, webpages on specific conditions, and blogs. Seeking out information from these sources was parents' natural response to wanting to learn more and understand what they were facing when coming to terms with their child's diagnosis.

> *Straight away we went to Google mode, which can be bad and can be good.… I think just for my own reassurance and when you're faced with something that you don't know*

> *about. I just had to information grab, I had to just try and process it all, and that was my way of kind of grieving, but also dealing with it all.* (Vandella, Parent)

Vandella (Parent) explained how she "*did a bit of filtering*" by discussing things she read with the therapist, "*and they* [OT] *would correct me if I was wrong*". Parents often asked therapists for help to make sense of information they found, for example, "*I* [Parent] *Googled this, does it mean this or that? What does it mean for our future?*" (Marisa, OT).

Although at times useful, parents' "*Googling*" (Kerry, OT) to source information was a point of contention for both therapists and parents. Therapists sometimes found it unhelpful and problematic because "*there's a point where you* [parents] *can be doing too much and … there's no research to back it up*" (Kerry, OT), and "*sometimes there's just some really weird wacky things that are out there*" (Caroline, OT). Often, information parents found on the internet was from other countries and not relevant for working with children in the Aotearoa New Zealand context. Consequently, therapists helped parents filter and apply the information to their context to learn what was relevant to them.

> *Obviously, they're* [parents] *out there looking for things so it's—how do we bring it back to try and answer what they're looking for, or what's available, what support group is available here, or what piece of equipment might be that equivalent?* (Caroline, OT)

Parents also found problems when using search engines as a source of information, as often the information they found was difficult to deal with. Dolly (Parent) shared her experience,

> *I have learned very early on not to Google stuff about her* [child]*, because it always brings up the negative and the worst-case scenario of things. So, I'm better not to do any of that … because I think you need to be looking at the positive.*

For similar reasons, and like other parents, Toni (Parent) "*stopped reading things*" and decided to "*take it as it comes*", relying primarily on the therapist for relevant information.

Tailoring Learning

This section outlines **Tailoring learning**, the second subcategory of **Partnering in learning**. **Tailoring learning** is about 'doing' therapy while learning together. A key part of **tailoring learning** is therapists individualising learning to each parent. Parents valued this process, with some finding it "*a lot more helpful than reading a book or looking it up because … she* [OT] *can teach me directly and tailor it to where Jake's* [child] *at*" (Lisa, Parent). Conversely, parents were not impressed to think that "*other mums that go through my same therapist* [might be] *all doing the same thing at the same time. I would hope that she individualises to us all*" (Toni, Parent). The overlapping properties of **tailoring learning** focus on how parents and therapists learn what to do and how to do it by 'Using teaching and learning strategies' and 'Supporting learning in everyday contexts' to ensure sustainability of the therapy in the context of family life. These properties are presented in this section.

Using Teaching and Learning Strategies

Therapists and parents both used a range of teaching and learning strategies when working with each other including asking and answering questions, explaining, modelling, demonstrating, watching, teaching "*tricks*" (Louise, Parent and Michelle, OT), "*showing parents with their child what they need to be doing, why the child can't do this, and how we can try and improve that*" (Michelle, OT), doing, embodied experience, and practising. Therapists recognised that, "*you've got to have a range of strategies up your sleeve*" (Jayne, OT) to adapt and tailor to individual parents and situations. Evident during the observed therapy sessions, parents also adopted similar strategies to help the therapist learn, for example, what had transpired in their absence or how parents were struggling to implement a technique they were learning.

Questioning

Parents and therapists asking and answering questions was a way of tailoring learning specific information and alerting the other person to immediate learning needs.

> *It's evolving, our questions and talking together. Every week they've* [parent] *noticed something with their child that's improved or they're thinking more about what's actually happening, so they'll have a question next week, 'What's going to happen next?', or 'What else can we do? How do we continue that?* (Michelle, OT)

Through questions they learned how to respond; information and actions were introduced, revisited, extended, and refined. When tailoring learning for parents, therapists were often guided by parent questions.

> [Parents] *have a lot of questions, so it does lead on to discussion about what actually is happening. So, I'm taking a lead from them, but actually trying to elaborate. … I can talk about what I'm seeing and what I think is happening; where I'm coming from, and how we can work together.* (Michelle, OT)

Questions were used in different ways. During therapy sessions, therapists often asked specific questions to learn about what child usually did, to fill in gaps in their knowledge, and build an accurate picture of the child's typical actions. For example,

> OT to Parent: *How does he like to read books, or just look at pictures?*
> Parent to OT: *He'll read them and grab a book and pull the picture out.*
> OT: *Does he tend to turn the pages?*
> Parent: *Yeah, he'll turn like three and then rip.*
> (Film 2)

Clarifying questions aided learning by shedding light on the information needed in a given moment, revealed gaps in understanding and where further information was needed. For example, during a therapy session when attempting what the therapist had just demonstrated, the parent's question to clarify what the therapist had done prompted the therapist to respond by going over an action again and tailoring provision of further information to help the parent understand how to do the task herself.

OT to Parent: *Yeah, good work. Can you, you're doing the movement. Can you see the difference between how I did it and you did it? Yeah.*
Parent to OT: *Were you just moving your leg?*
OT: *I was just moving my leg and that made her tilt.* [moving leg to demonstrate] *But I think it's possibly because you're holding her fairly high up.* [putting hands on her own hips and then shifting them higher on her torso to demonstrate]
Parent: *Okay*
(Film 4)

Responding to questions helped parents understand the task, learn to notice subtleties, and how to adjust what they were doing themselves. Therapists would also ask questions such as, "*Right, any questions on your end?*" (OT to Parent: Film 1) to make sure more information was not needed before moving on to another issue. Several times during therapy sessions, a parent's question, directly or indirectly, helped the therapist learn how to proceed. Questions such as, "*Are you getting tired?*" (Parent to Child: Film 1) or "*Is it cup of tea time?*" (Parent to Child: Film 5) indicating the parent or child were ready to move on, prompted the therapist to move on to something else or finish up the session.

Breaking Things Down

To help parents (and child) learn what to do in manageable chunks, therapists broke tasks down into smaller steps or graded activities. For example,

> *The thing that I'm teaching parents is, 'Okay, you want your child to walk, this is where they are, what steps do they need to get there?' Let's start with the first step. This is what they need to learn, and this is the next step to get there'.* (Laura, OT)

In this way, parents learned what was involved to help their child progress. Breaking tasks down made learning easier and less overwhelming for parents. It also motivated parents' engagement in doing therapy as it "*made it achievable for them* [Parents], *so they feel like they can do it and want to do it*" (Marisa, OT). Doing so, parents in turn learned "*how they can grade*" (Nicole, OT) activities themselves to make them accessible and achievable for the child's participation in everyday family life.

Several therapists attributed their occupational therapy training and skills in breaking tasks down into smaller achievable steps as useful for helping parents to incrementally learn skills they needed to support their child. For example, Laura (OT) recognised that, "*I'm teaching* [parents] *a different perspective of looking at things … because part of the OT process is breaking things down into steps*". Likewise, Jayne (OT) acknowledged her occupational therapy skills were "*an advantage*" in adapting to the needs of the parent concerned, and breaking tasks down into achievable steps.

> *You might have to pitch things in a different way, simplify it, take longer, or you might break it down into parts. So that's where it's good being an OT because you can think, 'Well, we can't get all of that, we'll start with this and keep working step by step'.*

Tell, Show, Do: Explaining, Demonstrating, and Doing

Several therapists and parents described a similar sequence of teaching strategies when helping parents learn, involving a "*tell, show, do*" (Kerry, OT) cycle of explaining, demonstrating, and then inviting the parent to try doing. Caroline (OT) shared an example of applying this process when helping a parent learn to support their child to stand. Having explained, Caroline then "*modelled it and they* [Parents] *had a trial*":

> *I got mum to put him* [child] *on the step and sit him there. We talked about what it would look like, … then I modelled and showed her where to put hands for moving from there to standing and then she had a try. Mum had a go and Dad was there, so he had a go too. We talked about the next bits and where to position hands, and they had a trial.*

The 'tell-show-do' process was apparent when parents described learning from therapists. Toni (Parent) shared an example of how the therapist helped her to learn how to encourage her son to stand by first explaining what to do, then "*showing me just how to place where his feet and then I've done it and she's* [OT] *helped me realign his feet*". Common to these scenarios was that the parent and therapist were both involved in the repetition of telling, showing, and doing as parents and therapists continually responded to each other and the task at hand to clarify, reinforce, or refine what they were doing as they progressed towards the "*next bits*" (Caroline, OT).

Explaining and pointing things out

Explaining and pointing things out contributed to parents leaning about their child's challenges, to appreciate intricacies of their child's movement, and recognise subtle differences in what they and the therapist were seeing and doing. Parents also learned what to notice, and how to do a task themselves to make a difference for the child. When approaching working on a therapy task, therapists would often "*explain it as much as I can initially*" (Nicole, OT), including explaining to the parent exactly "*what it means and what that could mean for the child's functioning*" (Marisa, OT), and "*explaining what it will do to help*" (Anika, Parent). For example, Marisa (OT) verbalised what she was doing and pointed out what she was noticing when assessing a child to help parents learn how to support their child,

> *It really helped for me to analyse the movements out loud, so she* [parent] *understands what exactly it is we're looking for. Saying, 'Okay, compare what he's* [child] *doing here to what he's doing there. We want this to be that way'. And then she could actually see the difference rather than just, 'Oh, she's not using the hand'.*

Pointing things out was frequently observed in therapy sessions when therapists were helping parents learn specific details of a task such as crawling.

> OT to Parent: *I'm looking for that weight, both arms extended.* [holding arms our straight in front of her]. *Taking weight so that eventually she'll want to crawl forward. What I saw today was she needed lots of support at the trunk.*
> (Film 5)

Pointing things out helped equip parents with insights and knowledge about how to respond to encourage their child's progress and independence with activities. Sarah (Parent) appreciated the therapist "*teaching as we're going along*" as they engaged in activities together. For example, the therapist would stop, "*look up at me and say, 'Now this is where we should be pausing and waiting for this', or with her body awareness, 'tap on her foot'*". Pointing out also helped parents learn to notice and recognise things their child was doing well and to see progress from the perspective of the therapist. Laura (OT) explained,

> *I could see progress, but I can see why she* [parent] *can't see progress. It's the subtle qualities. So, when he* [child] *rolls, he is more active. He doesn't roll any more frequently than last time, but he is engaging more, he's tolerating tummy time a little bit longer. So, I can definitely see progress and I pointed that out to her.*

Drawing parents' attention to "*what things are going really well*" was used to motivate them by "*acknowledging the positives and seeing their child as a little one that's going to learn or has got some abilities*" (Caroline, OT).

Demonstrating and modelling

Demonstrating and modelling were teaching and learning strategies both therapists and parents used to enhance explanations. For instance, Annie (OT) explained her approach of "*showing when you talk*" when helping a parent learn about issues with a child's posture:

> *Showing the parent what that looks like on their child so that they can understand, with this child, they've got low tone in their trunk. Showing them what it looks like, and how it might affect that child being able to do something with their hands.*

Therapists often asked parents to show them what they were "*typically doing*" (Caroline, OT) with their child so they could check their understanding of parents' accounts and learn what might be done to enhance that.

> *I sometimes ask the parents to show me what they mean by certain things as well. So, if they say, 'x, y and z is sitting up independently now', I'll always say, 'Oh that's fantastic, could you show me what that looks like?'* (Nicole, OT)

To learn about what the parent needed, Marisa (OT) would observe parents demonstrating how they did things with the child and then ask questions about, "*what it is they can see, or why they think their child is doing this or that?*". In doing this, she gauged parents' understanding to help her learn what to change or where to guide them next.

Parents watched therapists closely as they worked with their child. Parents' learning was enhanced when they could see a visible difference in their child when the therapist demonstrated or modelled what they meant, in conjunction with explanation. For example, when parents were learning how to encourage their infant's head control, Laura (OT) found using a "*simple towel rolled that helps the kids to prop actually makes a visible difference and the parents can see right there and then*" how to achieve the goal of the task. Watching the therapist also helped parents learn how they could change and improve what they were doing,

because "*You think you're doing it the same but you're not, … you're not actually achieving anything*" (Dolly, Parent). Sarah (Parent) explained,

> *Sometimes when she says it, I'll think, 'Oh, but I've been doing that at home'! And then I'll watch her do it and it will be quite different, and I will realise, 'Oh actually I haven't been doing that!'*

Learning by doing

Therapists and parents both recognised the value of parents learning through the experience of doing therapy techniques themselves, particularly when learning physical, hands-on therapy skills. Nicole (OT) explained, "*It's learning the skill to feel confident and that happens through physically doing, physically moving their child's body, physically seeing*". When learning to help her child roll, Vandella (Parent) described how she learned from "*the experience in doing practically…. I kind of had a bit of an idea, but it's not until you're physically doing it a bit more by yourself that you really get it right*". Therapists were also learning as they were doing therapy together, such as what was working and what needed to change to best support parents' learning.

Therefore, often after explaining and demonstrating a technique, therapists invited parents in that moment, "*Do you want to try it?*" (OT to Parent: Film 4) or to "*have a go*" (Louise, Parent) at doing it themselves. Sometimes this was by initially doing it together and "*getting the parent to do part, and me to do part*", with the aim of the parent eventually "*taking over the whole thing*" (Michelle, OT). For Dolly (Parent) to learn she explained that, "*I need to do it after her* [OT] *and then she can fine tune it and say, 'Yes, you're doing that right' or 'you just need to do that'*". Therapists supported parents' learning by guiding and encouraging them as they attempted doing something new, which parents generally appreciated. Capturing the sentiment of other parents, Polly (Parent) explained,

> *The OT always made sure that I tried it while she's [OT] there and* [if I struggled] *she'd help me out…. She wouldn't say, 'No, that's wrong'. But, she'd say, 'If you move your hand up here a little bit, he's* [child] *got more support here'. So really encouraging support.*

The guidance and feedback therapists gave while parents were doing things helped them learn. Parents' learning was further enhanced by practising therapy techniques between therapy visits. Through learning by doing therapy tasks together, and then parents practising between therapy visits, parents gained mastery of the task, and many developed their own strategies and solutions. Marisa (OT) noticed change after a parent had practised what they had been working on between visits.

> *I came back a week later and she's* [parent] *come up with some really good solutions. And now when I say, 'Okay, we want the child to be doing this'. Mum said, 'Oh, we can do it like this'. So, the mum had totally understood the whole concept.*

Parents had mixed feelings about the therapist watching them doing things. Some parents were not fazed by doing things in front of the therapist. For example, Toni (Parent) was comfortable when learning by doing things herself in front of the therapist, "*If I did it wrong, she'd correct me, but she would never make me feel that she was watching over me to make sure I was doing everything like the way she taught me*". Similarly, Lisa (Parent) did not feel 'watched', "*because that would feel like I'm getting a bit of a test and it doesn't feel like that. It just feels like she had a go and then I had a go*". Other parents were self-conscious and found doing something in front of the therapist invoked a sense of performance anxiety. For Dolly (Parent), it was nerve wracking and "*a bit daunting*":

> *It's a bit like being back at school and the teacher's asking you to do something!… The whole reason she* [OT] *comes and shows you these things is so that you can do it when she's not here. So then when you're trying to show her, and she's obviously the professional, it's like, 'Oh, am I doing this right?' It's like cooking for a cook isn't it!*

Performance anxiety was more evident early in the relationship when they were still getting to know each other and, for many parents, working with a therapist was a new learning experience.

> *Early on when there was stuff to do and she'd* [OT] *say, 'Okay, now you do it'. It was like, 'Oh!' It was a new step for me because it was like, 'Oh no, I've got to do it in front of Alex* [OT] *and I've got to do it properly!'* (Louise, Parent)

As time progressed, and with more experience learning and working together, parents generally gained confidence in themselves and consequently became more comfortable doing things in front of, and with, the therapist. Louise (Parent) explained, "*It took time to build up my confidence of doing things and getting into the swing of it—it's a bit more natural now*". However, one parent was hesitant of doing things in front of the therapist to the point of not trying out therapy suggestions during the session or directly exhibiting her learning to the therapist. Tara (Parent) viewed the therapist as the professional and the therapist's role as doing things with her child. She preferred to "*watch and learn*" while the therapist was there and then to try doing things herself after the therapist had left.

> *She* [OT] *always knows that I would do it on my own time. Because if she tells me to do it, I'll say, 'No', because that's her job to do it at the moment, because she's a professional and she knows what to do.* (Tara, Parent)

Instead, Tara found an effective compromise where she would video what her child was doing on her phone to show the therapist at the next visit. This way she could still convey her learning and her child's progress between visits in a way that she was comfortable, while allowing the therapist to learn how things were progressing and lead into the next round of learning.

Therapists were mindful that parents often found doing things in front of them "*nerve wracking*" (Michelle, OT) and that parents sometimes felt "*shy*" (Marisa, OT), "*anxious*" (Michelle, OT), "*self-conscious*" (Caroline, OT) and "*reluctant to have a go with me watching*"

(Laura, OT), or that "*they're doing it wrong*" (Marisa, OT). Most therapists were aware that "*if parents don't feel comfortable, they're not going to do it*" (Laura, OT). Some therapists, like Jayne (OT), were cautious when inviting parents to try doing things and gauged their approach "*depending on how well I knew* [the parent] *and how well engaged they were*". Consequently, therapists made efforts to use strategies to draw parents into a learning moment and make them feel comfortable. For example, Michelle (OT) would "*ease them in gently*" by inviting parents to join her to work together, and Marisa (OT) tried "*very hard to make parents not feel stupid if they're not doing something that I told them to do, or if they haven't understood it*".

Supporting parents to be comfortable to learn by doing involved therapists striking a balance between keeping the parent motivated and parents learning to do the therapy to help their child. Therapists concurred that for parents, "*it can be a bit confronting that you've just got the family to do something that they were really reluctant to do and then you go, 'You're not doing it quite right'*" (Laura, OT). Consequently, therapists' general approach was to be positive and encouraging, then to reiterate the targeted response of the child and highlight the important aspects of the task.

> *I make sure that I try and praise them and say, 'that's really good, this is what we're looking for when I am trying to do this: make sure the feet are in alignment', or whatever it is.* (Laura, OT)

Laura (OT) also tended the relationship and empathised with parents, acknowledging that some of the learning was difficult and encouraged them that with time and practice techniques become more routine,

> *I try and emphasise that handling isn't actually easy and that you do need practice and experience with it. I try and emphasise there is no real right or wrong.*

Embodied Learning

Both parents and therapists used embodied experiences to support learning from each other. This involved using whole body modelling, positioning, and movement of themselves to convey information and establishing mutual understanding, and when learning the feel of a hand-on task. For example, therapists demonstrated what they wanted the child or parent to do with their own body when it would have been difficult to explain with words alone.

> *The OT would get on the floor and then she'd do 'the flop'. She would often demonstrate it with her own body, not just talk about it or show it on Sophia* [child]*—she'd do it herself.* (Louise, Parent)

Embodied learning was often reciprocal. Apparent in the observation of therapy sessions, parents' and therapists' body movements, gestures, actions, and positions often mirrored each other with subtle differences as they demonstrated and refined physical tasks. For instance, in one therapy session a parent used her body to demonstrate while concurrently describing how her child was crawling, when she lacked the words to explain it.

> Parent to OT: *He's* [child] *… been getting right up on his feet, I don't know what you'd call it, but he's crawling around like this.* [Parent shifting from sitting on floor to getting up into crawling position on hands and knees and then on stretched arms and legs to demonstrate walking forward on hands and feet]
> OT to Parent: *Well, we call it bear, well this is bear standing* [OT moving from sitting on floor to demonstrating in same position parent just did] *and then when they crawl it's bear crawling,* [OT crawling forward in that position, as parent did, then sitting back on floor] *which is normal.*
> (Film 3)

The therapist learned what the parent wanted to know and as the therapist explained terms around positioning using her own similar embodiment to demonstrate it; the parent thereby gained the understanding she sought. They continued mirroring each other's body positioning and movements as they refined their understanding, clarifying and extending learning.

Similarly, parents and therapists often used mirroring hand gestures as they animated while talking to reinforce angles, actions, and movements. For example, during a therapy session, the reciprocal gestures of parent and therapist supported their learning about the angles when positioning a child for feeding.

> OT to Parent: *How are you feeding him? Are you holding him when you're feeding him?* [gesturing with arms at different levels like holding baby in arms position, moving arms up and down]
> Parent to OT: *It varies because I lie him down to get him set up and he's slightly elevated* [gesturing with right arm elbow significantly higher than hand] *and then sometimes I'll pick him up and feed him and other times he will just be lying on an angle* [gesturing with right arm elbow only slightly higher than hand, then lowering].
> OT: *I wonder whether it's positioning, if he's slouching a little bit or if he's quite well elevated?* [Moving her body to sit up straight, then exaggerating slouching to sitting very straight with shoulders back again]
> Parent: *Not inclined as much is maybe why it could be?* [Gesturing incline with left arm, moving right hand on angle above left arm].
> (Film 2)

Mirroring gestures helped both the parent and therapist to clarify their understanding of each other; for the therapist to learn what had been tried and what she could suggest, and for the parent to consider alternatives to support her child's feeding.

Embodied learning also involved supporting parents to learn the feel of a task, such as how to handle, position, and move their child; to feel the difference between various body positions; or force or pressure needed to facilitate or support movements. For example, "*you've got to push him slowly, so he felt the movement*" (Tara, Parent), and "*How much you actually push or help them* [child] *to roll, versus just a slight movement to sort of encourage them to do it themselves*" (Dolly, Parent). Louise (Parent) was surprised to learn how much pressure she needed to use to facilitate her child's movement; "*You really did have to quite bend her* [child], *you really had to apply a bit of pressure—I remember having to do more bending that you naturally would*". To help parents learn the feel of an action, therapists would also demonstrate the movement on the parent themselves as a way of "*showing them what that feels like*" (Annie,

OT). Marisa (OT) explained, "*I'll put my hands on top of their* [parents] *hands so they can feel it or I ask if I can do it on them, so they know how much pressure I use*". To further refine parents' learning, therapists used their hands to guide parents to make subtle positioning changes when handling their child. Caroline (OT) explained,

> *I help shape her hands around him* [child].… *While she's got him, I might go behind and just do a little bit of changing, repositioning and get mum to support him there to kind of feel what that difference looks like.*

Incorporating Play and Toys in Learning

Learning often occurred in the context of the parent and therapist engaging in the shared occupation of playing with the child. In this way, play was a tool to support learning. For example, Caroline (OT) explained how through modelling how she positioned herself while playing with a child, parents learned strategies they could use to extend the child's attention and engagement in an activity:

> *When you're sharing a game, you might just sit with your arm tucked around the child and say* [to the parent], *'Did you just see he thought about going, but because my hand was there, he thought, actually I might just stay here for a while?' But I also model ways of how to position things to do, and how to position yourself therapeutically to encourage that.*

Parents noticed this too. Samantha (parent) explained how the therapist modelled and explained what she was doing and what to notice while she they were playing with the child together:

> *She* [OT] *would be explaining to me while we're playing, 'I'm looking at how he's getting on with this movement, and can you see how I'm trying to guide him to do this movement?' Explaining as she goes. And then she would say, 'Oh look, do you want to get your hand and try and do the same thing that I'm doing?' That sort of modelling.*

At times, therapists brought their "*bag of tricks*" (Vandella, Parent) including their own toys to encourage learning and play during therapy sessions, with mixed results. For example, Samantha (Parent) tried using a doll the therapist brought to help her learn a technique when her child was "*a bit tired and grizzly and over being manoeuvred*",

> *She* [OT] *would manoeuvre the doll really well, but I wasn't always able to.… Even just watching her do the movement with the doll, I found that more helpful than me using the doll.*

In this instance, the doll proved not to be as effective as just observing the therapist.

Toys were frequently used with the intent of engaging the child in play or supporting parents' learning. For example, the therapist used a toy car to help Lisa (Parent) learn how to teach her child to play more intentionally,

> *She* [OT] *talked to me about positioning so it's easy for him to make eye contact. So, I'd be on the other side of the toy and putting my hand over his to teach him to put it up the top, to show him how to do it a few times first.*

However, therapists did not always get toy selection right and had to learn what would work well for each child and family. Caroline (OT) explained,

> *You know very quickly if you've got the wrong toy. Complete disregard* [gesturing throwing with a sound effect]. *Ah yeah, you know when you've got it wrong! And, you know if a child's really enthusiastic about a toy—You can capture them, extend the time they're playing, and change the challenge.*

Some parents preferred using the child's own toys during therapy sessions. For instance, Anika (Parent) preferred her daughter to play with the same toys that her other children also used.

> *We work on using her* [child's] *own stuff that she can play with all the time, an everyday thing. I like the everyday things to help her development, rather than something that's not normally there and she's the only one that's going to have it.*

Other parents appreciated the novelty and benefit of the therapist's new and unfamiliar toys in gaining their child's attention.

> *The OT brought a different toy, and Gracie* [child] *was really interested in it because she had not seen it before. It's a new thing and not familiar, so that got her attention a little bit more than all our toys.* (Dolly, Parent)

When the therapist brought toys, parents also learnt about the suitability of different toys to help their child progress, and "*ideas about what I can use while she's* [OT] *not here*" (Vandella, Parent). As parents gained insight into the purpose of a specific toy that the therapist selected, some made links with toys they already had at home. During a therapy session, the therapist's toy reminded the parent of a family favourite toy which could be used in a similar way, prompting a learning opportunity.

> Parent to OT: *I've got a toy that I want to show you to check it's okay to be using it. It's one of his brother's old ones and it's a car with noises and acceleration and braking and it's got lots of lights on it. He seems to quite like it, he just can't support himself as much as with this one* [comparing to toy OT brought]. *I don't know whether it's quite appropriate or not. You turn it on and it's all about driving* [turning it on and demonstrating driving with the steering wheel].
> OT: *That's brilliant. And you know what, it's even better in prone because if you just gently get his hands on the horn* [Gesturing with hands] *he's going to want to move it a little bit.*
> Parent: *Oh cool. I could get it a little bit higher, so he's got more room*. [Holding the car toy up higher]
> (Film 2)

The therapist endorsed the toy, reinforcing the parent's observations of its merits, and together they evaluated its suitability. In the process, the parent gained new ideas for using the toy in other ways to further encourage movement.

Supporting Learning in Everyday Contexts

Supporting learning includes ways of encouraging and reinforcing learning to sustain engagement in doing therapy in the context of everyday life. Strategies used to support learning

in everyday contexts included incorporating learning in everyday family life and environments and connecting parents with shared circumstances.

Incorporating Learning into Everyday Life, Routines, and Environments

Involving parents and working with them to incorporate their child's therapy into everyday activities and routines in context was a way therapists supported and encouraged parents' learning, while endeavouring to make doing ongoing therapy less onerous on the parent. Caroline (OT) shared that she had learned from parents, "*not to overload them with stuff; that some of them are doing their best by getting through the day; and be careful about what I expect them to do, realistically*". Often strategies to incorporate learning and therapy into family life were "*not rocket science*" (Jayne, OT), but simple and effective ideas—"*new tricks*" (Louise, parent) and solutions for parents to encourage their child's development and participation in everyday activities. For example, Jayne (OT) encouraged the use of a standing frame in place of a highchair at mealtimes,

> *So, the child would stand up to eat at the table with the family…. It wasn't an added extra…. It became part of the eating routine, which was something they were doing anyway and she's joining in…. There's lots of interactions going—other than her eating, she's doing communication, tactile stuff as well. So, there are big advantages.*

Laura (OT) also taught parents to work towards a therapy goal with minimal effort by slightly modifying what they were already typically doing, such as being intentional with positioning their baby when naturally putting them on the floor.

> *If you remember to put them* [child] *in side-lying every time you put them down, which you do 10, 15 times a day, they will plonk on their back, and they'll have half a roll. If you then start putting them slightly in prone, they'll have to* [work harder]. (Laura, OT)

Parents learning to incorporating therapy into everyday routines was observed in therapy sessions. For instance,

> OT to Parent: *With some of the rolling and some of the stretches, you can always incorporate it into changing time or bath time, if you're supporting him quite well and he's got some toys that he can play with. And same goes for rolling when he's on his tum when he's being changed for nappy.*
> Parent: *Okay, that's a good idea.*
> OT: *That's one way of incorporating it in your day.*
> Parent: *Sort of normal everyday routine. Yeah cool. Okay and then that's not too hard at all. That's pretty doable.*
> (Film 2)

By incorporating a therapy activity into everyday routines, parents were more likely to "*repeat it and stick with it*" (Nicole, OT), thus sustaining engagement in therapy and increasing the therapy dose. However, even with the intent of making life easier for the parent, occasionally therapists experienced resistance from parents when making suggestions, as experienced by Jayne (OT),

> *I said, 'The stretches, you could do it at every nappy change, it would only take you an extra couple of minutes'. And she* [parent] *looked at me and gave me a bit of growling, 'Do you think I've got nothing else to do all day?'*

Although only two therapists mentioned using coaching, it was apparent from descriptions and the observation of therapy sessions that this was a common means of supporting parents to learn and to incorporate therapy into their child's routines. Coaching included "*looking at strengths-based stuff*" (Caroline, OT) when goal setting and getting the parents "*to help you to problem solve*" (Jayne, OT) by asking guiding questions, such as "*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?*" (Jayne, OT). Jayne (OT) noted that expectations of how therapists work had changed over time in the way therapists have "*moved from [doing] therapy on someone to coaching and mentoring*" by working more collaboratively with parents, and "*enabling and encouraging and empowering, and giving parents confidence*". One therapist specifically mentioned using OPC[6] to encourage parents to "*have more ownership of it* [the therapy]", which for her meant "*being open and allowing families to come up with their own solutions*" (Laura, OT). Some therapists found it was a challenge to hold back and let parents lead, and something they were consciously "*learning as a therapist—to be able to let go and actually giving yourself permission to give them* [parents] *that ownership, … that there is not one right answer*" (Laura, OT).

Most parents in the study had home-based therapy with their child. This supported therapists' learning about the reality of the family environment, and supported parents learning how they could use the resources in the home in therapy for their child's development. Therapists often suggested the use of a household furniture or objects to help achieve the therapy goal, such as "*going around corners with chairs and pushing something like a washing basket*", which parents found "*really helpful*" (Samantha, Parent). During therapy sessions, therapists showed parents how to use couches and dining chairs and placing toys on them to extend the child's standing, creeping and progression to walking. For example,

> OT to Parent: *Have you tried putting chairs a little bit of a distance apart and encouraging him to walk in between?*
> Parent: *So, he has longer to go?*
> OT: *Do you mind if I bring in one of those chairs* [pointing to dining chair in the next room] *and put it here?* [pointing next to couch] *I want to see what he does.*
> Parent: *Not at all.* [Parent gets up and goes to get the chair and brings back two, placing them side to side, next to the couch]
> (Film 3)

This act shifted the parents' understanding of their environment and the opportunities in it to viewing items in their environment as teaching aids to help their child progress.

[6] OPC is a form of coaching and goal-oriented approach to support "client engagement in occupational performance and participation in life situations they value". In OPC, "client agency takes precedence in the selection of goals, analysis of situations, decisions about actions to be taken, and evaluation of the success of those actions" (Graham, 2021, p. 1).

Connecting Parents

Engaging with other parents sharing similar challenges was a way for parents to learn from each other, compare experiences, and gain additional support in their everyday context. As a strategy to support parents' learning, some therapists intentionally provided information, connected or were "*linking in*" (Annie, OT) parents with organisations such as the Cerebral Palsy Society, parent groups or other parents in their community who were in similar situations. Sometimes this involved "*offering parents a couple of education evenings*" (Annie, OT) on issues such as autism, feeding issues or school preparation. Parents' positive feedback from such evenings, including parents "*sharing information with other families and that they're not on their own*" (Annie, OT), showed that learning from other parents was valued.

Therapists sometimes offered to link parents directly with each other to their support learning. Parents exhibited variable acceptance of this. Vandella (Parent) explained, "*I don't think I was* [ready] *a couple of months ago, but now it will be interesting to see and learn off other people*". Sarah (Parent) was initially reluctant when the therapist suggested she should meet another parent, "*I'd say, 'Oh yeah, I'll do it', but I wouldn't*". However, she was grateful that the therapist knew her well enough to persist with encouraging her to connect with this other parent, as a supportive friendship resulted,

> *She* [OT] *kept saying, 'Sarah, you are actually going to really like this person.… I think you should really call them'. And now we've become really close, really good friends.*

When the therapist connected Louise (Parent) with another parent in a different area, she learned about equipment she could ask the therapist about which worked better for them.

> *It's been really interesting to hear what she's got, and I've been able to ask Alex* [OT] *for those things.… Like I mentioned the highchair and Alex is like, 'Oh yeah, I can get you a highchair'. We had our own highchair and were managing, but this one's been much better.*

Thus, connecting parents with other parents supported them to learn about others' experiences of a similar situation, services, and other ways they can support their child in real-life contexts.

Summary

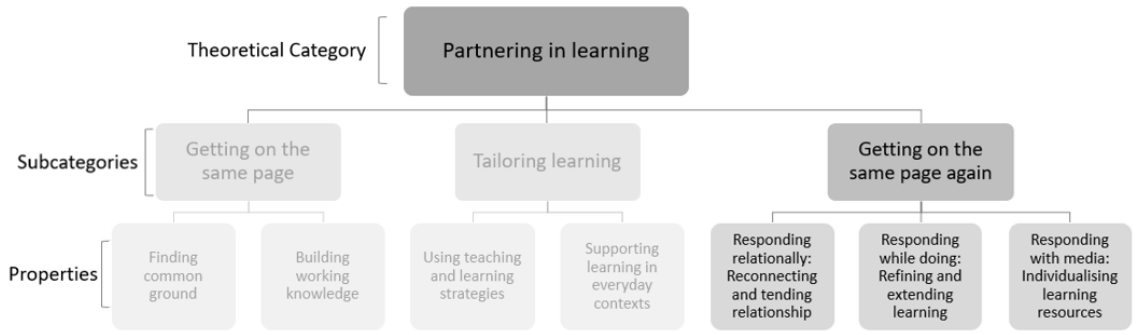
This chapter is the first of two chapters presenting the theoretical category of **Partnering in Learning**. The first two subcategories, **Getting on the same page** and **Tailoring learning** and their properties were explained, as the foundation for **Partnering in learning**. Chapter 8, continues the discussion of the **Partnering in learning** theoretical category, focusing on the third subcategory of **Getting on the same page again**, which is key to the theory of **Responsive learning**, as parents and therapists respond to each other to tend their relationship, build on learning, and move forward with therapy.

Chapter 8 Partnering in Learning: Getting on the Same Page Again

The previous chapter presented the first two subcategories of **Partnering in learning**. As previously mentioned, in this chapter, I present the third subcategory, **Getting on the same page again**, and its three properties (Figure 8.1), which emphasise the responsive, iterative and cyclical nature of learning. **Getting on the same page again** is essentially responding and it is the crux of the theory. **Getting on the same page again** involves dynamic interaction between its first two properties of Responding relationally: Reconnecting and tending the relationship, with a focus on relationship, and Responding while Doing: Refining and extending learning, as parents and therapists continued building working knowledge. The third property, Responding with media: Individualising learning resources is an extension of these and comprises of literally and figuratively **getting on the same page again** by using resources, materials, and media to prompt those involved to return and remain on the same page.

Figure 8.1

Outline of theoretical category Partnering in learning, subcategories, and properties

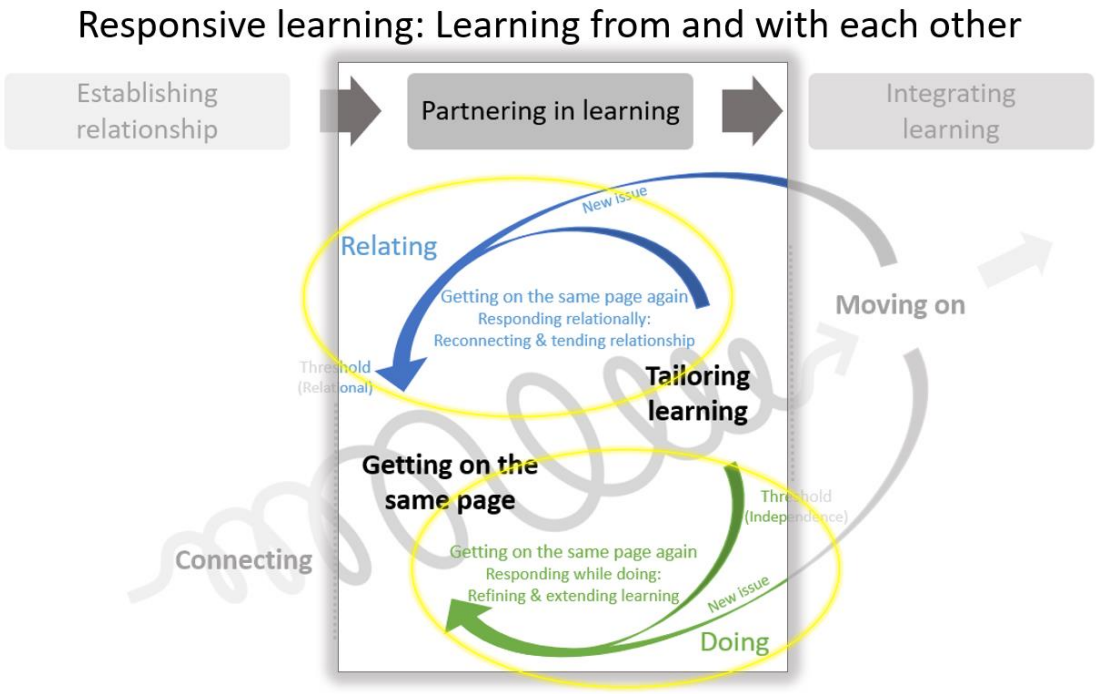


The subcategory **Getting on the same page again** covered in this chapter is highlighted.

The learning process is dynamic and continually cycling between **tailoring learning** and **getting on the same page again.** Key to **getting on the same page again** is the responsiveness of parents and therapists to each other, the situation at hand, and to their constantly changing learning needs, in ways that serve to maintain the relationship, as well as to support and build on learning (shown by the upper blue and lower green arrows, Figure 8.2). As parents accumulate knowledge, experience, and resources to manage their child with increasing autonomy, their learning needs change and they become ready for other learning. When it was apparent parents and therapists had drifted from the same page, they engaged in **getting on the same page again** by finding common ground and building working knowledge again, as described in Chapter 7. The process of **getting on the same page again** was evident throughout their whole interaction and enabled them to build on and extend learning, while also tending their relationship.

Figure 8.2

Getting on the same page again by Responding relationally: Reconnecting and tending relationship (upper blue), and Responding while doing: Refining and extending learning (lower green)



Particularly evident during the observations of therapy sessions was continual oscillation between the relating and doing properties of **getting on the same page again** as parents and therapists responded to each other, depicted by the spiral in the theory model (Figure 8.2). Therapists often combined encouragement (tending relationship) and positive feedback to foster ongoing learning or to prime parents for new learning (and doing). This was exemplified by Laura's (OT) approach of initially telling parents, "*'You're already doing a fantastic job', and after that we did a bit of intervention*". Caroline (OT) recognised relationship and doing as separate things, but that encouraging both was essential for parent learning and engagement in therapy:

> *Acknowledging what they're* [parents] *doing really well and the huge effort that's going into it, but also you* [parent] *obviously come here for some input so this is another little bit you can maybe add to what you're doing.*

Parents generally responded favourably when therapists combined encouragement (relating) with instructions about the next steps (doing).

> *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 that I want to consider them to work on.… And parents are really responsive.* (Nicole, OT)

The focus on relationship and doing of therapy outlined in the respective properties are both independent of each other and yet interdependent. The three properties of **getting on the same**

page again which illustrate the responsive nature of learning are presented separately in the following sections.

Responding Relationally: Reconnecting and Tending Relationship

The ongoing attention and effort parents and therapists gave to maintaining their relationship throughout the learning process highlights the importance of relationship as a basis for ongoing learning. Responding relationally included reconnecting and tending the relationship when it became apparent that the parent and therapist were not on the same page, that they needed to ensure they were on the same page, or to encourage parents' continued engagement in therapy. This included when coming together again after a time away, when starting to address a new issue during the session, and when concluding a therapy session.

Reconnecting

Parents and therapists were **getting on the same page again** at the beginning of therapy sessions as they took time to reconnect relationally by easing in to being together again. This involved being friendly and checking in to catch up with each other after a time apart and find common ground. Usually, reconnecting was facilitated through taking time to engage in an activity or play together with the child, "*before launching into trying some new things*" (Samantha, Parent). Reconnecting and nurturing the relationship and partnership were often precursors to the 'doing' of therapy.

Part of reconnecting was ensuring the therapy session supported parents and prioritised meeting their needs. While reconnecting, the therapist learned what had transpired for the family between visits, where things were at for the parent and child, and how to respond to address the needs during the session. Parents appreciated the care and interest therapists showed by learning about what had been happening for their family when reconnecting and checking in before proceeding with the session.

> *Because there's three weeks or so between sessions, it is quite nice just having a catch up—10 minutes at the start just to sort of touch base as to what's been going on and what's happening in your lives—the whole picture.* (Vandella, Parent)

Therapists often asked parents, "*How's it been going?*" (OT to Parent: Film 3), as they were interested in learning about things that may need prioritising or impact on the doing of therapy. Learning what "*impacted on their week*" (Caroline OT), "*other things going on in their lives*" (Marisa, OT), the parent and child's "*mood of the day*" (Caroline, OT), and the parent's feedback on how therapy suggestions had translated into family routines, helped therapists gauge how to respond to support the parents, more adequately meet their needs, and make the most of the session.

> *I like to talk to parents about whether they've got any burning issues or concerns they really want me to look into.… That gives me a good heads up into what I might need to look out for when I'm doing my visit.* (Nicole, OT)

When reconnecting, the therapist often initiated **getting on the same page again** to find common ground for the purpose and expectations of the visit.

> OT to Parent: *What I thought would be really good for today especially, is just for me to have a look at how he's* [child] *doing developmentally and how he's progressing with some of his skills. So, I'm really happy he is getting into standing and taking some steps.*
> (Film 1)

Getting on the same page again by reconnecting was also evident as therapists and parents both concluded therapy sessions by recapping what had happened during the session, emphasising important aspects, clarifying mutual expectations of what each would do between visits, and making the next appointment time to ensure they were **on the same page** as they parted ways. For example,

> OT to Parent: *We'll just see how we go next month, and I'll talk to my colleagues as well.*
> Parent to OT: *Yeah*
> OT: *And you give me a call if anything comes up.*
> Parent: *Yeah. Right. Otherwise, we'll work on these.* [Picking up and looking at what OT's written down]
> (Film 3)

Tending Relationship

During their interactions, parents and therapists were responding in the moment to tend the relationship to maintain ease, trust, and openness between each other. Tending relationship involved therapists respecting parents as partners in therapy, encouraging and reassuring parents that they were doing well, sharing celebrations of achievements, and being gentle with parents. Although these aspects of tending relationship were largely therapist driven, at times both parents and therapists moderated their responses to each other so as not to offend. Parents made continued efforts to welcome therapists into their home and make them comfortable. For example, Polly (Parent) prepared for sessions by tidying her home and racing "*around with the vacuum cleaner, so the floor was clean before the therapist arrived*", so it was ready for the therapy session to commence. These strategies served to protect their ongoing relationship and maintain engagement of both parent and therapist in learning and doing therapy.

To help parents feel comfortable, respected, and valued in their partnership, Caroline (OT), like other therapists, kept the session informal and intentionally encouraged parents to take the lead:

> *It's lots of reminding parents that it's your child, you're the boss, please tell me if you want me to stop. This is what I'm thinking, and how about we push a little bit further? But tell me if you want me to stop. Giving them permission to be the leaders.*

Therapists also tended the relationship and encouraged parents when needed by empathising with them and acknowledging "*what they're doing, and the situation is really hard, …* [but] *you've got this*" (Marisa, OT). Others adopted a positive and strengths-based focus, highlighting

abilities, to encourage parents to learn the next steps in therapy to build on the parent and child's strengths.

> *We focus on what children are doing well, … identifying what children are able to do and if they can't totally do it independently, what help do you give them to enable them to do the next step. So, strengths-based, rather than this child is not doing … or cannot. And try and keep it, 'Okay, here's the next bit, this is where we're heading.* (Caroline, OT)

Parents appreciated the therapist being "*optimistic and positive*" (Vandella). During therapy sessions therapists frequently **got on the same page again** with parents to encourage them by concluding a challenging interaction on an upbeat, encouraging note and highlighting the child's abilities. This helped the parents' learning and coming to acquiescence of the situation.

> OT to Parent: *But despite that, he's* [child] *doing really well. He loves exploring and he loves feeling toys, listening to them very carefully. So, he's definitely high in all the other senses.*
> Parent: *That's right, yeah. I realised the other day, like I keep on being in that fix it mode you know, want to fix, fix, fix. But I do have to come terms with the fact that maybe one day we can't fix it and we'll just have to get on with life and that will still be great for him but just a different way of learning.*
> OT: *Definitely.*
> (Film 2)

Through reassuring parents, therapists helped tend the relationship. Parents often sought reassurance from therapists by checking what they were doing "*just to make sure I'm doing it right*" (Vandella, Parent) and build their self-confidence in what they were learning to do. Samantha (Parent) explained,

> *I was constantly checking in with Jenny* [OT]*, 'Am I doing the right thing?' I should quit worrying and just start taking a bit of confidence in my ability.… I just sort of built on her knowledge. I didn't really feel like there was a strong power dynamic there, but I appreciate that she was the professional and she had the knowledge, and I didn't.*
> (Samantha, Parent)

Reassurance also involved therapists supporting parents to learn that each child is different, encouraging parents not to give up, and motivating them to persist with therapy, at times when progress was slow. Sarah (Parent) shared her experience of trying to teach her child to wave and point for over a year,

> [Our OT encouraged us] *to keep doing it, not give up. And that's been a big thing is to not give up but to just keep going, keep going. It's that kind of reassurance about that we know that some kids do things differently.… That's been real huge learning for us.*

Therapists saw it as an advantage in the relationship when parents felt comfortable to speak up to say, for example, "*I haven't understood*" (Marisa, OT) or "*Oh, that didn't work*" (Michelle, OT), and to disclose when something was challenging, or they had not followed through with a plan. Learning these things helped therapists consider "*How could you change this, what's going to work with this family?*" (Michelle, OT).

Taking time to respond, pause, acknowledge the learning progress, and celebrate the child and parent's achievements was a way of tending the relationship. Celebrating affirmed that the effort to learn how to do something was worth it, and encouraged continued engagement in therapy and **getting on the same page again** before finding common ground to build on learning and moving on to the next step or something else. Parents were generally excited about their child's progress and wanted to share that with the therapist, "*I can't wait for her to see what Rosie's* [child] *been doing*" (Sarah, Parent). Therapists also recognised the value of acknowledging incremental gains with parents as a learning opportunity to helped shape parents' perspectives on progress and to recognise the significance of small changes. Jayne (OT) explained,

> *So, the child might not have achieved independence, but I can see they've made this step and then we can celebrate, 'Oh, that's great, he's* [child] *going with you to the loo! That's a big step for him'.*

Celebrating was also a way of therapists guiding parent into the next step of learning.

> *A parent would come, and they would say, 'Guess what happened this week? This is so exciting, he's* [child] *doing this now, I didn't think I'd see that!' So, those conversations are really important. And, then you can use the conversation as a springboard to the next step or you might say, 'Let's just stop and celebrate his achievement and then we'll start the next thing'.* (Jayne, OT)

Conversely, there was threat to the relationship when parents and therapists were not **on the same page** regarding celebrations. For example, Samantha (Parent) was disappointed that the therapist focused on the next stage rather than taking time to acknowledge her child's achievements. She explained,

> *Every time she* [OT] *comes we're always looking to the next stage and there's no, 'Wow, he's done so much in the last two weeks!' … I'd just be like, 'Guess what he's doing today?' Because he was picking up a lot of new things with Jenny's* [OT] *intervention. It was like, 'Oh I'm so excited'. I would just say to Jenny, 'Let's celebrate what he's done this week'. She'd be like, 'Let's focus on what we can do next'. She wouldn't say that, but it was always that sort of focus.*

Although this therapist had the opportunity to learn from and respond to Samantha's cues regarding celebrating, her missed opportunity and differing priorities potentially impacted the relationship. Lisa (Parent) agreed, and the advice she would give therapists was:

> *Make sure you celebrate the things they* [child] *do well and give the parents time to enjoy it and be proud of what their kids have done, rather than rushing on to the next thing, because there's always something to learn. But if you've worked so hard to get them to do something then you don't want to be told straight away to go onto the next thing.*

Addressing challenging issues with parents was another time when there was a threat to being on the same page and to the relationship. Therapists responded to tend the relationship, while carefully timing the learning to gently and gradually introduce or broach sensitive or difficult issues. For instance, to maintain relationship, Caroline (OT) held back and waited for a

cue from parents that they were ready to hear about their child's condition before addressing it gently:

> *Sometimes you might get a feeling about a child* [having additional challenges] *before the parents are ready to hear it and I'll will sit on it until an opportunity comes up where they're starting to wonder about things themselves.… She'd been here probably for about a year* [before] *we broached the subject of autism.*

When anticipating a period of adjustment, therapists' way of **getting on the same page again** balanced expectations and information with taking a gentle approach, thus tending the relationship, while "*planting that seed*" (Laura, OT) of what was to come. For instance, adopting a similar approach to other therapists, Michelle (OT) took time to gradually and cautiously introduce a large piece of equipment (hoist) needed to safely transfer a growing child. She had learnt from experiences with other families that having "*an institutional thing in their home*" and "*removing that contact with the child*" could be "*quite confronting*". Therefore, she gently introduced the idea by prompting their thinking and offering solutions, while staying positive to tend their relationship.

> *I said, 'Well gosh, this is getting quite difficult … how on earth are you* [parent] *managing* [lifting your child]*? What's happening with your back?' Or just general discussion, 'How's the lifting going?' And so, then they'll start thinking about it. Then I'll say, 'How about I bring you some information and we can have a look and see what might work?* (Michelle, OT)

Once the hoist was in, she took time with "*introducing the hoist, the sling, the training with using the sling*" and supported the parent by "*going in every week to make sure she* [parent] *was confident using it*" (Michelle, OT).

Tending the relationship sometimes involved holding back, gradually revealing information, or moderating responses to protect the relationship, particularly early in the relationship when it was less secure. Lisa (Parent) appreciated the therapist knowing "*when she shouldn't say something, and how to encourage it in a way that doesn't make anybody feel that they're doing it wrong, or that they're not doing it enough, but here's a way to make it better*". To tend the relationship some parents responded by withholding information that had potential to offend the therapist, even though holding back this information constrained the therapist from learning how to work with the child and potentially impacted how effective the therapy would be. For example, so as not to offend the therapist, when Louise (Parent) realised that the therapist thought her toys motivated the child more than toys available in the house she just went along with it and kept quiet,

> *What I think was funny for a while was that Alex* [OT] *would get her toys out but really what would motivate her* [child] *was her brother's toys to get her moving! Like, 'Oh yes, I'll go over and get that'.… I got the impression she thought that Sophia* [child] *would be more interested in her sparkly toys and her caterpillar seat.* (Louise, Parent)

Other parents also went along with therapists' suggestions in order to not offend, even when they had no intention of following through. Sarah (Parent) explained what happened when the therapist gave her a book to read,

> *I looked at it and I said to my husband, 'I'm not going to read that, that's just ridiculous, it's going to make me more paranoid'. So, I just put it away and I never touched it. I held on to it for three weeks. I took it back and she* [OT] *goes, 'Did you like it?' And I went, 'Ah, bits'. And she said, What bits?' And I said, 'The back'. And she just laughed because then she knew. And, she's never offered another book ever again because it was real obvious I didn't read it.* (Sarah, Parent)

The therapist responded in a way that served maintaining the relationship and supporting the parent's learning. By asking light-hearted questions regarding the book the therapist laughed, understood, and let it go. Through this interaction she learnt how to better tailor learning for Sarah moving forward.

Therapy sessions often ended with the therapist encouraging parents that they (and their child) were doing well. For example, "He's doing really well, and I'm really happy" (OT to Parent: Film 1). Similar to reconnecting at the beginning of the session, both parents and therapists concluded sessions on a friendly, social note as a way of tending the relationship and easing out. For example, "Thank you. What are you up to for the rest of the day?" (Parent to OT: Film 3), and "So, have you got a busy day ahead or manageable?… See how you go. If you don't get everything done that's fine. You're a busy mum of three kids!" (OT to Parent: Film, 2).

Responding While Doing: Refining and Extending Learning

Getting on the same page again by responding from a 'doing' perspective was often prompted by a challenge with the learning or learning needs not being met, and focused on refining and extending learning to move forward with therapy. Refining and extending learning involved using strategies discussed in **tailoring learning** (Chapter 7) by going over, showing, and doing something again; correcting, clarifying, or providing further guidance or more information to build working knowledge and find common ground again to address the next step or a new issue. This may be to clarify interpretations, address misunderstandings, and to tailor learning to fill gaps in knowledge when it was evident the parent and therapist were no longer **on the same page**. This resonated with Vandella (Parent), when checking the theory with her.

> *Several times we've come to this part* [**Tailoring learning**] *and I'm not doing something right with his movements and so we'll come back to this* [**Getting on the same page again**] *and she'll teach me again what the right way of doing the whatever it is. So that's fair, that's true*. (Vandella, CTI, Parent)

Refining Learning

Therapists often asked questions to evaluate parents' understanding of therapy tasks and identify gaps in their learning; and to learn how to respond to revisit, refine, and tailor learning experiences to support ongoing learning and meet parents' changing needs. Refining learning involved a range of strategies including "*tweaking a few things*" (Caroline, OT); providing more information, support, and guidance; reinforcing, reframing, recapping, or "*reiterating it*" (Nicole, OT); and correcting. When a parent struggled with learning, therapists often respond by changing their approach or "*try to approach it in a different way, explaining it better or making it easier for them* [parents], *and … back track to make things a lot simpler … or start from a different angle*" (Marisa, OT).

During therapy sessions, refining learning often involved "*working in with what they're* [parents] *already doing and fine tuning it a bit*" (Laura, OT). For instance, when Marisa (OT) sensed a parent was struggling with stretches she asked him to "*show me how you understand it*" and offered, "*Do you want me to show you again?*" By responding through **getting on the same page again** and checking the parent's understanding, they proceeded to refine the parent's learning by going over it again, practising for the parent to gain confidence, and encouraging him to continue. Marisa explained that even though the parent "*did it well…he felt he was maybe doing it wrong, and he wasn't comfortable. So, I reinforced what he was doing well*". Thus, part of refining learning was also encouraging parents to give them confidence to continue. In one of the observed therapy sessions, a discussion about adapting activities using household items helped refine the parent's learning about how adapting different activities would help the child with walking, while simultaneously checking and confirming her understanding.

> OT to Parent: *Fill a laundry basket with heavy things and encourage him* [child] *to push it walking on his knees, or even crawling.* [Holding arms up demonstrating]
> Parent to OT: *Is that like for strength of his arms or just coordination?*
> OT: *For the core as well because to push and not collapse you've got to recruit your core,* [OT kneeling and demonstrating with her body collapse and bringing her hands to her waist] *and do the whole coordination of moving and pushing as well.*
> Parent: *Yep. And that would be more difficult say than using that which has got wheels on it,* [pointing to trolley walker] *like it will be more challenging for him than the laundry basket?*
> OT: *Well, it will be more challenging for his strength, but probably easier for his balance with the basket because it doesn't roll away and he doesn't have to control it rolling.*
> Parent: *Okay, yep. Sure, that's good.*
> (Film 3)

Therapists used analogies as a way of **getting on the same page again** to refine learning by reframing or explaining a concept or information in a different way in order to help parents gain understanding. Kerry (OT) consciously used analogies to simplify and make concepts easier to understand and more relatable; she explained,

> *I try and use little things so that they* [parents] *can kind of visually see what we're trying to do. I try and relate it to the person and what they'll relate to…. That's how I like to learn myself…. I do a lot of work about the principles and trying to get them to understand why they're doing what they're doing and that's where a lot of the analogies come out—to try and get them to 'click'.*

When Dolly (Parent) struggled to understand what she had been told by doctors, she appreciated the therapist's response of using an analogy of a roadblock to help her understand her daughter's condition and how they could work at overcoming her child's difficulties:

> *She* [OT] *put it to me one day, she said, 'Because she* [child] *has damage on the left side, what we're trying to do it's almost like a roadblock. If you think of a roadblock there is other avenues you can take to get around the roadblock, to get to your destination and that's what we're trying to do now. So, we can't go that way, we'll find another route, rewire, and then get to where we need to be'. I thought that was a really a good way of putting it…. When she explained it like that that was like, 'Oh, well that makes sense to me'. That obviously sits better with me than them saying, 'Oh, she's got brain damage'.*

The analogy helped Dolly make sense of and accept previous information she had found overwhelming and difficult to understand.

As parents learned hands-on skills, they would often **get on the same page again** by revisiting, refining, and recapping instructions to support and extend learning. For example, when parents struggled with learning, Nicole (OT) responded by revisiting and refining her explanation and suggestions to help parents understand the task.

> *I try and explain why it's difficult and why this way is probably the easiest way to do that. … So, I might say, 'Yeah, just try it without bending the knee and see how it feels', and they'll be like, 'Yeah, I can see what you mean'.*

Parents appreciated therapists reiterating information, "*because you're learning something new every second week, you sort of tend to forget the stuff that you've originally started with*" (Dolly, Parent). Recapping was also used to reinforce and support parents' learning about the important aspects of therapy. For instance, to **get on the same page again** at the end of a therapy session, the therapists asked questions to go over what they had done, to check the parents' understanding, and refine her learning about important aspects to focus on.

> OT to Parent: *So, we did lots of activities today. Which of the ones do you think are going to work to continue practicing with Neve* [child]*?*
> Parent to OT: *She likes this one* [holding out shaker]. *Probably that one and the bowl.*
> OT to Parent: *And what are you going to be focussing on when you play with her?*
> Parent: *Mostly her bending her knees properly.*
> OT: *Yeah, yeah, and how can you help her with that?*
> Parent: *Ah, while she's picking up things just to touch her knee and then she bends that one.*
> OT: *Perfect. So, if you see her doing it with straight legs all the time?*
> Parent: *Just touch the back of her knee.*
> OT: *Yeah.*
> (Film 5)

Although this parent had a good understanding of what to do, by **getting on the same page again** at the end of the time they collaborated, the parent chose the activities to focus on and they found common ground with expectations and a plan for between sessions.

As parents were learning hands-on skills for doing therapy with their child, therapists sometimes responded to correct and refine what they were doing; for example, when parents were learning subtle refinements to aspects of a task or their hand placement. During therapy sessions, when the parent was learning to master a hands-on task, such as helping a child develop sitting balance, therapists were frequently observed to correct parents by refining instructions while giving positive reinforcement.

> [Parent now sitting on the couch with child on her knee, ready to try again]
> OT to Parent: *I think you can hold her* [child] *much further down. You can use your fingers to hold her pelvis.*
> [OT demonstrating on herself. Parent shifting her hand to copy OT on child]
> OT to Parent: *Can you get your fingers further down? Yeah, that's right. And get her sitting upright first. She's leaning forward.* [OT leaning forward reflecting child's position and parent shifting her hands on child] *Good work. Yeah. So, the further forward you put her, the more her hips will tilt.*
> (Film 4)

Although corrections were often made in the context of the therapist providing "*really encouraging support*" (Polly, Parent), there were times when parents found being corrected "*a bit frustrating for me, because I'd obviously been doing it that way for a little while and then to* [learn I had it wrong]" (Dolly, Parent). When correcting parents, therapists were conscious of balancing encouragement and offering "*praise*" (Laura and Marisa, OTs) with further instruction. The consequence of correcting performance and refining learning was mutual confidence. Parents became more confident in what they are doing, and for therapists, "*I show them something and we maybe just tweak how they are doing things, but then I also feel confident leaving them to do it*" (Marisa, OT).

Extending Learning

Learning was ongoing, incremental, and cumulative. Parents and therapists respond to each other as learning needs change by **getting on the same page again** which helped keep the therapy progressing and built on and extended prior learning. As parents were building on their own learning, they were also building on their child's learning as the child "*built up a bit of knowledge about what he's* [child] *supposed to do*" (Caroline, OT). Vandella (Parent) explained, "*Some of the stuff is quite repetitive, in very small steps, which is good because it's building on what he* [child] *knows, … it's building on top of what he's learning*". Extending learning often involved parents learning about "*the next steps that we should be doing with him* [child] *to help him get to where he needs to be*" (Toni, Parent). During therapy sessions, extending learning was often by "*having a discussion about what might come next*" (Caroline, OT), which may involve modifying or changing a therapy task to increase the challenge for

progression to the next step. This was evident during the therapy sessions when therapists extended parents' learning on how to grade activities to challenge their child by building on and extending what they had been doing together. For example, "*Because he's rotating and squatting when he's holding onto furniture, the next step, is to move the sofa apart further, it will encourage him to take more steps with holding one hand only on furniture*" (OT to Parent: Film 1). Further, to help parents learn the next step, Laura (OT) described helping parents to learn to extend tasks themselves within activities they were already doing with their child to make learning less arduous on parents:

> *What's the next step? Put their child in sitting and put all their toys next to them so they can reach them. If you* [parent] *can put it slightly out of reach, not too far so that they* [child] *fall over, but slightly out of reach so that they've got to actually put some effort in, you're working on trunk 10 times a day.*

Helping parents in this way also set them up with the knowledge they needed to modify other therapy task themselves when the therapist was not present.

During therapy sessions, a question asked to clarify understanding or seek further information often prompted a response of **getting on the same page again** to extend learning. For example, a parent initiated a change in topic during a natural lull in conversation by asking the therapist a question, indicating her desire to learn more about her child's language development.

> Parent to OT: *So, what would you expect his language to be at this stage?*
> OT to Parent: *I think say you know having a kind of like between 14-15 months, having a few words or sounds that sounds like words he uses as part of. But you know like 'dog', and I know that he does 'ta'.*
> Parent: *Does 'ta', and 'Mum', and 'Dad'.*
> OT: *Obviously a few.*
> (Film 3)

The consequence of the therapist responding to the parent's lead was them **getting on the same page again** by shifting their focus to the new issue and opening a learning opportunity for them both to learn more about the child's language skills. Extending learning also involved use of additional supporting learning resources such as written material, photos, and video to reinforce and encourage ongoing learning and engagement in therapy between visits.

Responding with Media: Individualising Learning Resources

Getting on the same page again to support, reinforce, and extend learning often involved providing tailored learning resources and using other media such as photos and videos as a common point of information or focus in response to individual learning needs. As each therapy session was not isolated, providing learning resources for parents to use at home between visits was a way of therapists maintaining connection and encouraging practicing, building on learning, and continuity with engagement in therapy at home. Parents referred to

such resources as "*homework*" (Vandella, Parent), "*piece of paper*" (Sarah and Toni, Parents), and "*written instructions*" (Samantha, Parent).

Individualised resources and media were also used as a mutual reference point when responding to **get on the same page again** while reconnecting at the beginning of the next session; for example, by therapists checking in on "*how we got on from the last lot of little bits of homework that we've been doing*" (Vandella, Parent) or parents showing the therapist a video so they could learn what they had been doing. However, some therapists were cautious of tending the relationship and avoiding pressuring parents while revisiting the 'homework', "*It's a fine line because you also don't want to make parents feel like they haven't done their homework*" (Laura, OT).

Responding to Individual Needs: Customising Resources

Parents' information needs varied between individuals and often depended on the stage parents were at with their learning. Therapists responded to individual parent's learning needs at the time by providing customised resources. Therapists generally provided parents with more resources to support learning initially—when there was a lot for them to take in and while they were still getting to know each other. Often fewer resources were provided as time went on.

> *Typically, when children first start, I might give them* [parents] *more written stuff to kind of set them up with different bits and pieces.… We talk through the things during the session, then I'll write, at the end of the session. Write it down and get them to check it and see if it makes sense.… So, it's just a bit of a prompt and a few ideas of what we might have done in the session and why we did it, kind of thing.* (Caroline, OT)

As therapists came to know the parent and learned how to work with them, they were better able to respond to customise learning resources to meet parents' specific needs and where they were up to with the therapy. Several parents noticed that the therapist provided written resources less frequently or stopped writing things down as they progressed, changing to giving more verbal recommendations over time. Louise (Parent) commented,

> *It changed to verbal and maybe things weren't as detailed.… Maybe because it's physical, and maybe because you've done it physically you don't need to describe it.*

Thus, it appears that the more the parent learnt and did, the less supporting resources they needed. Other resources were also more welcome at different stages of readiness for learning. For instance, Louise (Parent) reflected on the therapist giving her a photocopied book section to read which she did not ask for,

> *I'm probably happy to take her word for it rather than read up on it. But maybe if I got the book out now, I might be more interested in it now that I've been further on my journey. Possibly I should do that.*

Learning resources took different forms, including handwritten or computer made home programmes or instructions, printed or photocopied information sheets or pamphlets, and photocopied book sections or articles on specific therapy related topics, which therapists

tailored in response to individual parents' needs. Further, therapists often personalised home programmes and photocopied handouts to individual parents by using pictures, doodles, drawings, arrows, and comments to show parents how to do specific therapy interventions, clarify instructions, highlight important aspects, and ensure they were **on the same page again** with understanding a task. For example, Polly (Parent) noted that the therapist "*does little drawings on the things, like when we were trying to get him* [child] *to crawl and kneel—diagrams of how to have him, how to hold him so that he's using those core muscles*", which she found helpful. Although doodles and drawings were intended to reinforce parents' learning and understanding of how to do therapy interventions, Laura (OT) also responded by offering parents verbal explanations as to what her doodles meant, to help them make sense because "*They're not very easy to understand*"; for example, "*I point out, 'This is what this symbolises' and if it's a stick figure around 90/90 sitting, I'll put the angle in and say, 'This means 90 degrees'*".

To customise information and make instructions accessible and intelligible, therapists responded by writing "*in the parent's language*" (Nicole, OT) and ensuring instructions were "*easy and always with things that families have at home*" (Marisa, OT). However, therapists did not always get it right and there were occasions when parents could not understand or read the written material therapists provided. When this occurred, some parents, like Tara (Parent), responded by explaining the difficulty,

> *She* [OT] *will talk to you, tell you what to do, but also write it down, so you understand what she's done and what needs to be done. But half the time I can't read her writing. I told her once, 'You need to stop writing with your flicks and stuff'. She's like, 'Why?' 'Because half the time I can't read your writing!'*

Combining verbal instructions with written material using a combination of telling was important for Tara's understanding. Laura (OT) learnt from an experience of working with a parent whom she discovered was illiterate. She explained, "*I've worked with somebody that said, 'I can't read'. It's like, wow, okay, that's another aspect I need to consider*". That experience prompted her to not assume every parent could read and she consequently responded by using photos if she sensed an issue with parental literacy or, as other therapists often did, asking parents what they wanted to meet their needs better.

Like other therapists, Kerry (OT) used different resources with different parents as she responded to their requests or needs. For instance, she provided relevant journal articles to parents who requested evidence for their child's therapy interventions to help build their understanding and working knowledge, and confidence in her and what they were doing.

> [When parents ask], *'what's the evidence?' I go and photocopy the article.… I'm happy to provide them that information.… For some parents that's what they need. They need concrete evidence; they need to know the ins and outs of what they're doing for their child.* (Kerry, OT)

Other times Kerry used the shared focus of a "*circling key things*" on a pre-made pamphlet while talking to parents support their learning. Caroline (OT) responded to a parent's specific interest in learning about their child's language development by providing them with a relevant information sheet. On a later visit, she saw evidence that this information had helped them learn how to encourage their child's progress.

> *I gave them* [parents] *some information about early language and different stages of communication. And they've taken it away.… I went out today and I could see quite a difference—they're waiting for her* [child] *to respond.* (Caroline, OT)

Nicole (OT) carried a range of learning resources with her to leave with parents, such as "*play skills pictures photocopied from a book*". Like other therapists, she also used "*physiotherapy exercise programmes on the internet*" and tailored pictures or diagrams to the parent's need which she would send by post or email after a visit, as needed.

Some therapists made home programmes on the computer and emailed or sent them to the parents later; for example, Michelle (OT) used "*a computer programme that has things in it so I can actually pick and change little pictures of what I'm wanting them* [parents and child] *to do*". Therapists also occasionally used photos taken of the child or parent doing a therapy task during the session and added written instructions to tailor-make a "*photo programme*" (Michelle, OT). Using familiar photos in a home programme made it relatable for parents. When Dolly (Parent) showed me the learning resources her therapist had provided during the interview, she admitted not using the photocopied handouts with personalised notes but responded to, preferred, and "*looked at*" a tailor-made home programme using her daughter's photos, because "*I think it's more familiar, you're more drawn to it*". Anika (Parent) also preferred home programmes with her child's photos, but more as a keepsake because "*I like all the memories of her*" as she did not take a lot of photos herself.

Although most therapists provided parents with some form of additional learning resource, surprisingly, many did not know what parents did with it, but suggested that "*some parents I know will never look at it again*" (Caroline, OT) or, conversely, "*90% of my parents have them on the fridge*" (Nicole, OT). Several parents liked having written instructions and would put them on the fridge or wall as a motivator and prompt to remind them what to do and "*what I need to be working on*" (Vandella, Parent) and "*reinforce how to do things*" (Lisa, Parent) when the therapist was not there to support them in person. For example, like other parents, Lisa (Parents) would "*Hang it on the wall above his* [child] *changing table, so we look at it every time we change him or bathe him—it keeps me focused on what I should be doing*". Parents also found written information useful for sharing information with others. For instance, Sarah (Parent) found putting information on the fridge a useful way of sharing information with her husband, to help him also learn what to do, as he was not there learning with her during the therapy session:

> *Ideas on games and prompts and what noises to try and start with and ideas of games to do with that…. The paper gets hung on the fridge. As soon as my husband walks in, he sees it up on the fridge and so it's not me nagging saying, 'You should do this'.*

However, other parents filed the papers away or put them in a drawer. Of note, during interviews several parents offered to show me the learning resources they had received but could not find them when they went to look for them. Although many parents valued the learning resources, the idea of having them rather than using them seemed more prominent for some.

The information and learning resources provided symbolised different things to different parents and therapists. For some parents personalised resources held sentimental value and several parents collected and kept all of their child's home programmes like a keepsake "*for when he's* [child] *older*" (Tara, Parent). Other parents valued the supporting learning material provided as a record of "*what's been going on*" and appreciated the idea of "*referring back to them*" (Vandella, Parent) to see progress, as a reminder of how far they had come, "*Oh yeah he couldn't do that and now he can*" (Lisa, Parent). For Sarah (Parent) and her partner, receiving "*a bit of paper*" was a way they judged how well they were doing with therapy,

> *We haven't had a bit of paper for a while, I wonder if that means we're doing well? We can tell if we've made a bit of a jump or not so much of a jump, because then usually we'll get a bit of paper. It's like, 'Let's try these new things'.*

Like other therapists, Laura (OT) viewed such information as an ongoing resource for parents to refer to and revisit for activity ideas if they "*run out of ideas of things to do with your child*" (Laura, OT). For Laura (OT), "*sometimes leaving the home programme also makes me feel like I'm passing on responsibility* [to the parent]*, 'I've done my bit, now it's up to you to do it'*" and to carry on with the therapy between visits. In this way, passing written resources to parents symbolises sharing responsibility with the parent, as they work in partnership, at times together and at times apart, at times one leading and at times the other.

Co-constructing a Home Programme

Significant time spent **getting on the same page again** to conclude a therapy session was observed and described by parents and therapists. During this time, therapists commonly handwrote a home programme or instructions to leave with parents, while simultaneously verbally summarising what was covered during the session, highlighting progress, discussing important aspects, and giving recommendations and instructions of what to do between visits. For example, Anika (Parent) explained,

> *We'll talk about it and she'll* [OT] *write it at the same time. Like each thing that we're going to focus on, she'll talk with me about it and explain what it will do to help.*

What therapists captured was also in response to parent cues and questions, gaps in understanding and skill mastery, and changing learning needs. During this time, some parents

responded by clarifying and checking their own understanding of what to do, which, in turn, influenced what the therapist wrote. For example,

> Parent to OT: *So, in summary, I've just got to keep on trucking working on the roll, rolling over thing. Keep working on the arms* [gesturing raising arms]. *Visual sort of stimulation* [pointing to eyes]. *Oh, and sound, to make him turn. And, just make that tummy time a bit more consistent. So, keep going a bit more.* [OT nodding]
> (Film 2)

In this manner, responding to each other and capturing information to support, clarify, reinforce, and extend learning was a collaborative process and co-construction between parent and therapists of literally and figuratively **getting on the same page again**. It was also a way of re-establishing shared understanding and expectations of the plan moving forward, and what each would do between visits. The process of writing and providing this handwritten information also gave the therapist the opportunity to respond to the parent by affirming and reassuring them that they were doing enough, and for both the parent and therapist to confirm that they were on **the same page again** with mutual understanding of expectations as they finished up their time together.

> OT to Parent: *On that* [handwritten sheet of paper] *I've just got all the things we've just talked about. You talked about his sleep, you talked about feeding and his surgery. I've seen him do quite a lot of squatting, taking steps between furniture, playing with blocks really well. Finding objects when they're hidden. And the next part is increasing gap to furniture, to encourage him to take bigger steps. When he gets into bear standing* [OT demonstrating with her body position, both hands on hips as she tilts her hips], *like I said last time, just give his hips a bit of a tilt forward* [gesturing with hands]. *And lucky last thing is probably hand over hand for blocks. You're doing well!*
> (Film 1)

Generally, both parents and therapists kept a copy of written learning resources provided as a mutual point of reference they could both revisit. Some therapists used a feedback template with carbon paper when handwriting notes and instructions to make a duplicate so the parent and therapist could both have an instant copy. Therapists often kept a copy in their clinical records and used it as a prompt when writing clinical notes. However, therapists were aware that it was important to ensure information provided to support parents' learning was useful and relevant, otherwise it was a waste of time and resource.

> *You have to really think about what's working because if I spend hours on a programme that's going to sit in a drawer, what's the point in that? So, I try to do short, sharp and to the point and they* [parents] *can ask me more about it if they want.*
> (Michelle, OT)

Not all parents wanted handwritten information, because "*Reading it and seeing it are two different things*" (Parent to OT: Film 4). To meet parents' needs, therapists needed to learn from them how to capture and present learning resources in a way that was useful and preferred. Therapists often asked parents, "*'Do you want me to write it down or are you okay with what we talked about?' Some parents like it written down others don't*" (Caroline, Therapist). For

instance, Dolly (Parent) declined the therapist's offer of writing something down for her because she found it hard "*to actually sit down and find the time to actually process what she's written down*". She explained her preference to the therapist, "*If we can just spend the first 10 minutes of our session doing a recap of what we did the week before, I would find that probably a little bit more helpful than having it written down on a piece of paper*" (Dolly, Parent). Consequently, on learning this, the therapist responded to better meet her needs because Dolly was comfortable saying to the therapist, "*This isn't working, can we try this?*"

Using Visual Media to Respond to Learning Needs

Parents and therapists sometimes used visual media such as videos and photos to share information and respond to particular learning needs. Some parents took photos or videos between visits to show the therapist when they reconnected and caught up with what had been happening as they **got on the same page again** at the beginning of the session. This enabled therapists to learn and gain an accurate picture of what the child had been doing when the therapist was not there, to guide them on how to respond, and what to focus on next for therapy.

> *I take lots of videos and I show her* [OT] *videos. Usually, a new video each time. Just something that he's* [child] *been doing, like climbing in and out of cupboards…. And, she can see what he's doing, because he's quite stubborn. So, when she gets here, he doesn't always like doing what she asks him to do. So, I have to video a lot of things to show that he is doing it.* (Toni, Parent)

Other parents took photos on their phone of what their child was doing between visits to show the therapist. Tara (Parent) explained, "*Last time she* [OT] *wanted to see how he got up and how he got down off the couch. So, I showed her* [the photos I took]". After viewing the photos, the therapist responded by saying "*Okay, now I know what I need to work on with him*" (Tara, Parent).

Photos were also used to **get on the same page again** to learn about equipment. For example, Vandella (Parent) used photos to ask therapists about specific equipment, "*I'll take photos and say, 'Oh, I need to go get one of those'*", so the therapist was clear on what she wanted for her child. Therapists also used photos to help parents learn about a piece of equipment, what it looks like, and how it could be used to benefit their child, so they could start planning how to integrate it into their environment before it arrived. For example, during a therapy session the therapist used her phone to show the parent a photo of a chair that she had ordered for the child.

> OT to Parent: *So that's what it looks like.* [Leaning over to show parent photo on her phone] *That's the chair* [pointing to phone screen]*. So, you can see it's like the OJ, but has got a different seat in there and it's from a different place, Tripp Trapp.*
> Parent: *Yeah* [nodding]
> OT: *It comes with a tray. That's where he* [child] *would sit and I'd adjust his feet* [pointing to phone screen].
> Parent: *Okay.*

> OT: *It's really good and it takes into account growth, so as he grows all we'd need to do is keep adjusting it and I think it will just help with his play, his vision and his feeding, so definitely worth it. I'll call you once it arrives.*
> (Film 1)

By showing the photo while discussing the chair, they could **get on the same page again** so the parent could learn what to expect with the chair and how it would work in their house and for their child.

Summary

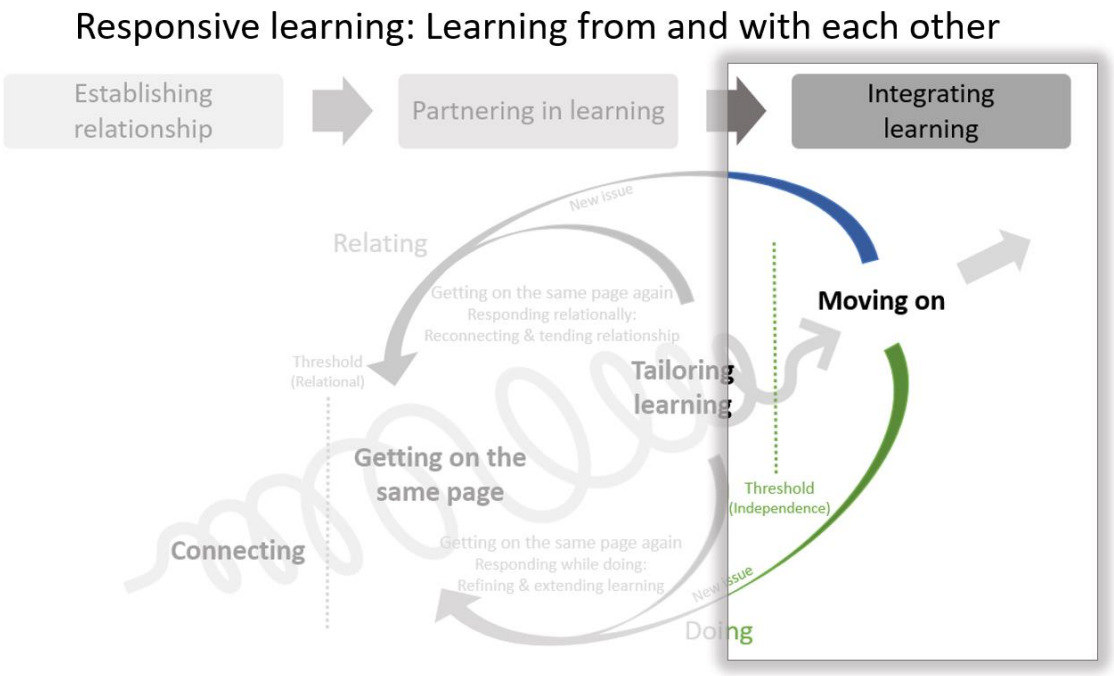
This chapter is the second of two chapters presenting the theoretical category of **Partnering in learning**. In the previous chapter, I outlined the first two subcategories of **Getting on the same page** and **Tailoring learning**. In this chapter I have presented the third subcategory, the responsive and iterative process of **Getting on the same page again** that was integral to meeting changing needs and build on learning, while tending the relationship to progress with therapy. In the next chapter I explain the third theoretical category, **Integrating learning**, the process of parents and therapists integrating learning into families' everyday life.

Chapter 9 Integrating Learning

This chapter is the last of the four findings chapters explaining the theoretical categories comprising the theory of **Responsive learning: Learning from and with each other**. The first two theoretical categories, **Establishing relationship** (Chapter 6) and **Partnering in learning** (Chapters 7 and 8), have been outlined in the previous chapters. This chapter presents the third theoretical category, **Integrating learning**, with its two subcategories **Crossing the independence threshold** and **Moving on** (Figure 9.1).

Figure 9.1

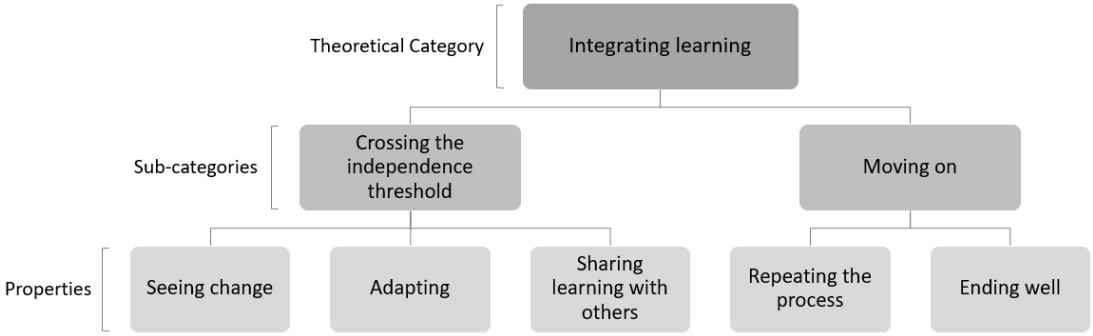
Integrating learning theoretical category: Crossing the independence threshold and Moving on



In this chapter I explain the process in which parents and therapists **integrate learning** into everyday life. The two subcategories are outlined. **Crossing the independence threshold** (including properties Seeing change, Adapting, and Sharing learning with others) sees parents gain greater confidence in themselves and independence from therapist support. **Moving on** (including properties Repeating the process and Ending well) involves ongoing learning and tending relationship as they **move on** to either build on prior learning and address a new issue or **move on** to another service or out of therapy altogether. An outline of the subcategory of **Integrating learning** and its subcategories and properties covered in this chapter is presented in Figure 9.2.

Figure 9.2

Outline of Integrating learning, subcategories, and properties



Progression through **partnering in learning** continues to the point of **crossing the independence threshold** to **move on** to other learning. This was evidenced by **integrating learnings** into family life and routines to support the child, and by therapists integrating their own, ongoing learning within their practice with future parents. Although parents were intentional in their learning, and therapists intentional in helping parents learn, not all learning was explicit. While the majority of learning discussed in prior chapters and the following sections might be considered intentional learning, incidental learning gained from experience of engaging in therapy was also important for parents in adapting to support their child's development. Incidental learnings were acquired concomitantly over time, through exposure and experiences, without being overtly taught or intentionally learned, such as through learning from experience of navigating therapy and the healthcare system.

Integration of intentional learning was generally evidenced by parents seeing their child's progress and demonstration of parents' skill proficiency and increased independence in therapy tasks and management of their child's condition. Commonly, incidental learnings only became apparent upon reflection or in hindsight. As parents gained experience of the therapy service and health system, they incidentally learned and integrated strategies for navigating the health system with newfound patience, confidence, and assertiveness, which added to a sense of acceptance and acquiescence of their situation. Like other parents, Tara (Parent) learned from the therapist "*to be patient*" with her child and when accessing resources or other services such as "*waiting for a pram or an operation*". Learning that helped her to accept progress "*takes time*", even though this went against her nature.

> *You've got to be patient with a child like Micah* [child]. *And I'm not patient! I'm like, 'Hurry up. Take a step'…. It's a waiting game, but it's also about being patient. It takes a lot of time—it's taken him a very, very long, long time to get where he's at now.* (Tara, Parent)

Such learning, and seeing their child's progress (even if slow), contributed to shaping parents' expectations of services and outcomes. Other parents learned incidentally that they needed to be assertive, vocal, and persistent in order navigate the health system, to get answers, and what

they felt their child needed. For instance, Dolly (Parent) learned to persistently "*push*" to feel heard and be taken seriously by health professionals as she was trying to learn about her child's condition.

> *I was like, 'Why is no one taking me seriously? Something's wrong with my child'.… So just pushing, push, push, push, push. Otherwise, you don't get anything, which is really sad. 'Just take me seriously!'… I just hate to think what would have happened if I hadn't pushed.* (Dolly, Parent)

Similarly, Anika (Parent) learned, "*You have to be pushy*" to not be overlooked.

> *That's the main thing I've learned from her* [child] *being sick is just ask. You've got to ask everything. Put yourself out there. If you don't then, you just get forgotten about.… It seems these days you have to ask, or you won't be told. Like people aren't just telling you this can help you. Unless you ask you don't get.* (Anika, Parent)

Consequently, **integrating** incidental **learning** of being assertive equipped parents to advocate for, and access, the help their child and family needed.

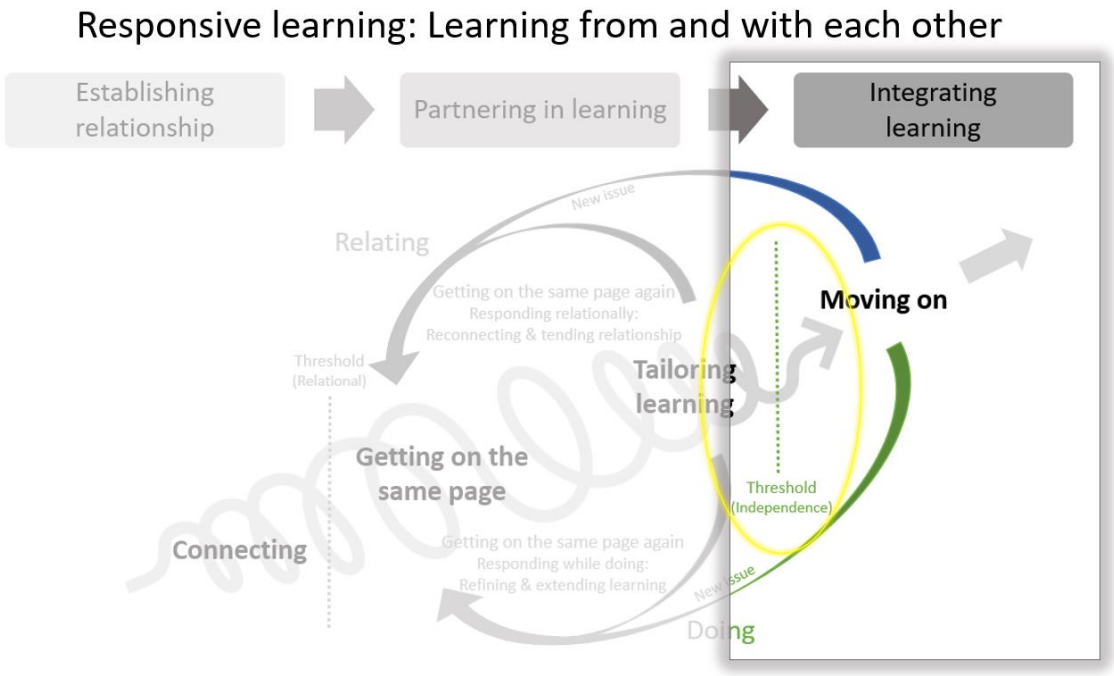
Learnings acquired either intentionally or incidentally were collectively valuable and integrated into aspects of daily life, routines, and interactions with the child and others. In accumulating and integrating intentional and incidental learning, and **crossing the independence threshold**, parents could see changes, adapted, and gained acquiescence with their situation. They also gained confidence in their own abilities to **move on** to build on their learning, deal with future issues and interactions within the health care system, and share their learnings with others with increasing independence from the therapist. In the following sections I present the two subcategories of **Integrating learning**: **Crossing the independence threshold** and **Moving on**.

Crossing the Independence Threshold

The theory identifies a second threshold, bridging **Partnering in learning** and **Integrating learning**. **Crossing the independence threshold** (Figure 9.3) represents a transition in the learning process characterised by parents' mastery—both skilled performance (competence) and understanding the indication for the specific intervention (comprehension)—such that they become confident and autonomous in therapy delivery and supporting their child's needs and sharing their learnings with others. Evidence for a threshold is primarily seen by parents moving from a learner to a master role in a facet of therapy. They simultaneously exhibit understanding, skill, self-confidence, and independence as they integrate what they learn into family life and routines to support their child's needs.

Figure 9.3

Highlighting Crossing the independence threshold



Crossing the independence threshold is not a homogenous process; rather, it is variable depending on the parent-child-therapist triad concerned, the issue being dealt with, and the related complexities of the context. Having **crossed the threshold** may be realised suddenly in situations where a segment of or whole skill or understanding was mastered, such as at a point when parents experienced an "*a-ha*" (Vandella, Parent) moment or realised, "*I've got that*" (Vandella, Parent). In other situations, it may be insidious, where independence was gradually attained over time and evidenced by competence with performance of a skill or a shift in who was driving the therapy focus in a particular situation. This was a transition that therapists worked towards—from parents' reliance on them to parents developing autonomy, no longer dependent on or interdependent with the therapist, thereby rendering the therapist's support redundant.

Depending on the context, the **independence threshold** may be applicable on a 'micro' level (e.g., acquisition of a new skill), a 'meso' level (e.g., gaining independence with a complex therapy task, or finishing a therapy session), or a 'macro' level (e.g., completion of therapy engagement and exit from a therapy service). Parents and therapists recognised points at all levels (task/session/completion of therapy) when parents (and the child) were observed to have changed. Seeing evidence of change when parents crossed the **independence threshold** was a cue for therapists that parents were ready to **move on** to repeat the process and **get on the same page again** to build on learning with the next step, a new issue together, or **move on** entirely with autonomy.

Seeing Change: Accepting and 'Getting It'

Crossing the independence threshold was evident in increased parental confidence and ability, and the progress observed by both parents and therapists. For parents, seeing explicit change or progress in their child was a precursor to acceptance and feeling more comfortable and confident in their situation.

> *The differences are humungous, huge, huge, huge, huge! We wouldn't have achieved that without OT involvement because we just don't think that way.* (Sarah, Parent)

Changes were also seen in parents 'getting it' by gaining understanding and grasping what to do and how to do aspects of their child's therapy. Identifying the learning they had gained and seeing their child's progress resulted in positive reinforcement and motivated them to continue with therapy. Vandella (Parent) explained,

> *It makes you feel better. It makes you feel like you can actually help him* [child] *in some small way, albeit tiny. You think, 'Oh good, I'm making a difference maybe'. You get more confidence, and it does make you feel you're actually helping and doing something positive.*

While parents often saw their child's progress, therapists also saw parents' progress, noting a shift in the actions of the parent and their interactions with their child. For Michelle (OT), this was particularly evident when reconnecting at the beginning of a therapy session.

> *At the next visit I'll get a very clear impression, 'Wow, that child's progressed'. The parents tell me what they've been doing.… I can see that they're really hands-on with their child and I can see where the child is, they're all set ready for me. So, there's a lot of little cues.*

Jayne (OT) could see that what parents had been learning started to make sense for them, and "*it all links together*". Like other therapists, as parents started to integrate what they had learnt, she "*might see a difference in how that parent actually speaks to their child … using more describing and questions*" or could "*see it in action*". Jayne explained,

> *Parents take on board different types of language—you see it in their interactions with their child. You see it in their confidence to talk to other parents. You can see that there's that transfer of information and experiences. You're seeing progress and you see in the way they are interacting with their child. They might be doing things like, instead of standing up they might actually be kneeling down with their child face to face, so you see differences in the way they communicate.*

As parents began integrating their learnings, Jayne (OT) also saw a shift in the way parents saw their child's progress and how small gains were seen as positive progress.

> *It might be the kind of description that they* [parents] *give you. One of the nice things is that you might see more positivity and more strengths-based, 'We're still not going to the toilet, but he's* [child] *following me into the toilet now and watching me do wees', for example.*

Accepting: Reaching a place of acquiescence

Integrating learning helped some parents come to terms with and reach a place of acquiescence with their situation and child's challenges. For some parents, **crossing the independence threshold** reflected how learning and support helped them accept their family's situation and that "*some kids do things differently*" (Sarah, Parent). Toni (Parent) explained,

> *We did a lot of reading when we first had him* [child] *and then we stopped reading things and just decided to take it as it comes. She* [OT] *sort of does say, 'Oh, other kids are like this, but they're all so different and some pick it up quicker than others'. So, we've just totally gone with that.… Yeah, sometimes it takes a little bit longer.*

Early on, Sarah (Parent) had wanted her child to be "*normal, like all the other kids, even though it was so stressful for me*". She explained how the therapist's reassurance helped her learn that doing what her child needed, even if it took time and when it was not the same as what other parents were doing, was okay. This acceptance gave her confidence going forward with continued engagement in therapy. Sarah reflected on their progress,

> *It's nice to think about how far we've come.… We never used to go anywhere, we used to hate it.…Whereas now we take her* [child] *places.*

As parents were learning in the context of adapting to a life different from that which they had anticipated, some went through a process of grief.

> *We were grieving for what he* [child] *would probably miss out on.… We were thinking 20 to 30 years ahead about getting a girlfriend, going studying or driving a car, and we were like, actually well he's not going to know any different and that's just our grieving. So, we've got to just pull right back and just literally deal with like day to day, week to week and things will change so much throughout that time, you can't be focussing that far ahead because you don't know what's going to be happening in that time.* (Vandella, Parent)

Through a process of grief and learning, Vandella (Parent) came to accept the implications of her child's condition and to deal with challenges as they happen. Integrating this learning contributed to shaping their expectations for their child's future and that they could achieve "*a new normal for us, and it's okay*" (Vandella, Parent). She explained,

> *You just have to have a new normal, because it changes everything. And look, we're going to have this journey with him* [child] *where we'll have to relearn how to teach him things throughout his life so that's going to be different. And we will need to pull on all that support. And I've always been really grateful that from day dot there's been lots of support around.* (Vandella, Parent)

Learning that their child had potential, would progress, that they could manage their child's situation, and that they had support, was reassuring and helped parents come to a place of acquiescence.

Getting it: Gaining understanding and mastering skills

Crossing the independence threshold was evidenced by parents (or their child) 'getting it' with understanding of why a particular facet of therapy was being done, what should

happen next, and by mastering skill performance. Skill mastery required practice and was associated with increased confidence in performance and greater internalisation of the reason behind the task. For parents, reaching a point of 'getting it' was often the culmination of learning achieved gradually during a process of practising, responding, and refining as parent and therapist partnered in learning. For instance, Vandella (Parent) described her gradual progression from anxiously not knowing what to do to becoming a "*pro*" when learning a strategy from the therapist.

> *I did practice a couple of times with the arms—they were so stiff, and I wasn't sure if I was going to hurt him* [child] *or do it right. So, did that a couple of times with her* [OT] *while she was here. And then I've practiced after bath time and got a little bit better at it. Now I'd say I'm pro, I've got that!*

The time taken for parents to "*get it*" was variable where, "*Some parents 'get it' … and other parents, they're still two, three sessions down the track … and that's just a matter of repeating what you're trying to achieve*" (Laura, OT).

Sometimes there was a sense of a "*switch*" (Marisa, OT) or "*click*" at a defining moment of realisation or skill mastery when parents "*got it*" (Vandella, Parent and Caroline, OT). For example, Dolly (Parent) had been practising what she had learned from the therapist to encourage her daughter's core stability, when it suddenly made sense and she became aware of what she was doing and why, and was ready to **move on**:

> *The other day when she* [OT] *showed me that I had to hold Gracie* [child] *a bit lower I was like, 'Oh okay, that makes more sense'. Because I'm doing all the movement while I've got holding her up here* [demonstrating hands on her waist], *whereas if I was holding her down lower* [demonstrating hands on her hips] *it's more Gracie doing the work.*

Therapists also noted times when they knew parents had 'got it'. For instance, Marisa (OT) noticed a parent had **integrated learning** when she proceeded to contribute to solving problems and extending a task herself. She explained, "*I feel like the parent has made a 'switch'—she's* [parent] *become a lot more proactive*".

As parents and their child learned simultaneously, there was a strong connection between what the parent and child was doing and how they were learning together. As children gained confidence doing things, this influenced the parent's own confidence and independence in doing therapy tasks. For instance, Caroline (OT) recounted a time when she noticed a parent's confidence with a ball activity increased as her child became more confident with it too.

> *Just the way she* [parent] *handles him* [child] *and she has expectations that she will push him a little bit and she knows when it's too much. I can tell that they've been doing it because he's confident on it as opposed to say the week before when he was scared. It was all new, but you can see that he's been on it*. (Caroline, OT)

Parents noted times when learning "*all of a sudden just clicks*" (Toni, Parent) for their child too. Toni (Parent) explained, "She [OT] *can be showing us something for weeks and he* [child] *just doesn't get it, and then all of a sudden, he just gets it*". The child's learning consequently influenced the parent's learning. Vandella (Parent) explained how her son's progress and improvement as they practised a therapy task together was pivotal in her feeling like she had "*got it*". She also gained a "*boost*" in confidence in what she was doing and motivation to keep going knowing that what she was learning was helping her child.

> *The arm thing—I got really good at that. So that was bit of a 'click' thing for me as well.… It took me a few days of practice and then when he* [child] *did it, and we were okay with it, I kind of thought, 'Oh good, I must be doing it right'.… It took a few days, but then I got it.* (Vandella, Parent)

There was a noticeable motivating and reinforcing effect of both the parent and child 'getting it', **crossing the independence threshold**, and **integrating learning**. Samantha (Parent) explained,

> *My main motivator became, as he* [child] *began to do new things, he was getting a lot of joy out of that, he's enjoying learning, discovering the world around him. So that's going to keep pushing me to do this.*

Learning that they could help their child learn and develop, and seeing their child's progress, also served to reinforce the utility of therapy and build parents' confidence to continue learning and engaging in therapy with increasing independence.

> *Parents that have worked with the therapist might have gone through this whole process and they realise, 'Actually, not only have I got it, I think I can help myself'.* (Nicole, CTI, OT)

Parental confidence was potentially reinforced each time they mastered and integrated a strategy or intervention and **crossed the independence threshold**.

Adapting: Owning It and Leading It

Evidence of **crossing the independence threshold** was apparent when learning had been adapted and integrated into family routines. This adaption process was characterised by a progression through various stages of competence as acquisition and integration of knowledge, understanding, and skills progressed. There was often a shift to increasing parental autonomy and personalisation of skilled performance as they **crossed the independence threshold**. Subsequently there was a sense of the parent driving, or 'owning' and, thereafter leading the therapy.

Owning it: Making it their own

Over time, and with experience, parents often came to adapt what they learned from the therapist to make their own iteration that worked better for them and their child. Making it their own involved taking control of the therapy by selecting, adapting, modifying, or using an

approximation of what they had learnt and integrating it to suit their family routines and contexts. Parents were discerning about which aspects of learning they felt were applicable to them and relevant to their child to select and focus on. Toni (Parent) explained,

> *Some things I did when we were trying to get him* [child] *to sit independently and get up, and some things I just could see he wasn't ready to do. So, I just left it and I just wouldn't go over those things*.

Once parents had learned the goal and purpose of a therapy task, they found confidence when implementing it with their child at home. For instance, when Louise (Parent) first started working with the therapist, she was concerned with trying to do whatever the therapist taught her exactly right, "*making sure she* [child] *doesn't roll back, push her there and push her there, making sure she's sitting right on her hips*". However, like other parents, with time and experience she developed confidence to do it her own way. For example, when helping her child stand at the couch Louise found using her hands a better alternative than supporting the child with her body as the therapist had demonstrated. She explained, "*The way Alex* [OT] *does it is she gets in behind her* [child] *and kind of uses her whole legs and pushes her up onto the couch, or you can just use your hands, which I do*". Other parents adapted tasks by using different objects they had at home that worked better for them than what the therapist had suggested. For example, once Dolly (Parent) understood that the goal of a task was to encourage her daughter to use her right hand, she used her daughter's dummy, which elicited a better response towards achieving the therapy goal.

> *She's* [child] *not that keen on toys, so I was using her dummy which was making her a bit frustrated, but it was working. So, I was pushing with that which is obviously helped. You understand the goal behind the action.* (Dolly, Parent)

Therapists noticed parents' increased confidence and how they thrived, or with "*just the right information and she* [parent] *just blossomed, and continued to blossom*" (Jayne, OT), when helping their child as they implemented what they learnt and integrated it in their family's routines without depending on the therapist. Kerry (OT) explained,

> *It was like a little yahoo moment, 'Oh my gosh, she's* [parent] *taken in everything I've said and applied it without me having to'…. So that was like a milestone and that was really cool for her.*

"Yahoo" moments signalled the **independence threshold** had been crossed.

Leading it: Changing roles

After **crossing the independence threshold** there was often a shift in roles within the parent and therapist partnership as to who was leading the direction of therapy, with parents taking an increasingly active role in directing and leading the therapy focus, task, or session. This was evident when parents went ahead to problem solve or get what they wanted and needed to support the child themselves, independently of the therapist. For instance, Laura (OT)

shared a situation where parents came up with their own solution for their child's wheelchair problem:

> *She* [parent] *is so proactive. The other day she said to me, 'I've got a new wheelchair, I've got a tray, but this tray isn't working. Is there something else? Or I'm thinking of getting my husband who's a builder to create a tray with a flap'.*

Laura responded to the parents' lead by offering her support and suggesting alternatives, which led to a solution of getting a bigger tray, while continuing to work in partnership. Other parents also knew what they wanted to learn and took the lead. For example, Anika (Parent) had done extensive research regarding support available for her child and initiated finding out about and accessing them herself. Anika explained,

> *I thought, I'd like to get these things for Neve* [child]*.… I researched what I'd like for her, and this is what I want to apply for.… I researched it all. I made sure I looked through everything … and I make sure I was aware of everything.*

Through Anika sharing what she had learned from her research, the therapist also learned useful information to integrate into her practice to help other families. Anika noted, "*She* [OT] *has told me that she's going to use some of the things that I've told her with other families*".

Therapists noted parents' leading of therapy often increased after they came to a point where they "*are more confident to know what it is their child needs*" (Jayne, OT), when they started, for example, *"telling me, 'Oh, we'd* [Parents] *like to focus on the sleep system', or 'We'd like to focus on switching'— they were owning it*" (Annie, OT). Seeing that their role in supporting parents was changing with parents' increasing autonomy, often cued a response by therapists to "*step back*" (Kerry, OT). For some therapists, stepping back involved extending time between appointments and passing the onus of initiating contact for booking future appointments to parents. Other therapists consciously stepped back to let parents "*have more ownership*" (Laura, OT) of the therapy and "*run with it*" (Kerry, OT) themselves. For instance, Laura (OT) consciously integrated her own "*learning as a therapist to be able to let go and actually giving yourself permission to give them that ownership*" to lead the direction of their child's therapy. Consequently, the role of the therapist shifted, often taking a more passive monitoring role. Reflecting other therapists' accounts, Kerry (OT) explained,

> *When they* [parents] *grasp the concept, their needs are a lot less down the track, because they understand what they're doing and it's basically just a catch up, 'How's everything going? You* [parent] *direct me as to what's happening'.…* [Earlier there is] *lots more hands-on, lots more direction, lots more too-ing and fro-ing with things, and lots more options. Down the track they're like, 'Oh, that's not working again, can we try this?' They give me a bit more direction down the track when they get to a point*.

Sharing Learning with Whānau, Colleagues, and Other Families

As parents and therapists accumulated knowledge, experience, and skills, there were times when they shared their learning with someone else. **Crossing the independence threshold** was apparent when parents shared their learnings with their spouse or extended

whānau (such as in-laws or grandparents) after the therapy session. One father, who had only recently attended a therapy session, and whose wife was primarily working with the therapist, "*appreciated the things that the OT taught my wife, that she then taught me around the positioning, the reaching, trying to get him* [child] *up on his knees, and trying to build that core*" (David, Parent). He particularly appreciated learning "*more of the do's as opposed to the don'ts*" and explained how his wife taught him by demonstrating what she had learned, so he could support their child's development too.

> *She's* [wife] *just told me certain strategies to try with him, as opposed to like unpacking each session.… Early on, when it was around positioning his body, … she gave me visual instructions, which was really good.… Since then, she just tells me, and I don't need visual.* (David, Parent)

When another parent found her attempts to teach her husband what she had learned regarding communicating with their child challenging, she enlisted the therapist to help her.

> *I'd go and say, 'Helen* [OT], *James* [husband] *is like doing these ridiculous signs that aren't anything and it's confusing Rosie* [child]*!'… So then when James is there, she* [OT] *does it in such a lovely gentle way, she'll teach him. And when she teaches him, he comes home and does it 110%. Whereas I'm just being bossy.* (Sarah, Parent)

The therapist responded and supported both parents to share in learning to communicate with their child. In this case, the close relationship between the therapist and parent, and learning to read each other's cues, meant they could work together to help the husband learn too.

Therapists also integrated what they learned from parents and accumulated experiences of working with different families to help other families. They integrated their learnings into their clinical practice by sharing them directly with other parents and improving their approach to benefit other parents. For instance, during a therapy session, the therapist shared what they had learned worked well for one family in order to help another achieve a similar therapy goal.

> OT to Parent: *You know what I've done with one boy to get him to squat? His parents brought a $2 shop whoopee cushion. Do you know the one you sit on, and they make the farting noise? So, we encouraged him to sit on something like that.*
> Parent to OT: *Yeah, she'd* [child] *just keep sitting up and down.*
> (Film 5)

Nicole (OT) appreciated that she also learned about things parents had tried that had not worked. She viewed her culmination of learning as "*building up this book of knowledge*" to help other families. Several therapists also found sharing their experiences with different families and learning from and with their colleagues had influenced and enhanced their practice and approach to supporting parents' learning. This included "*having conversations with colleagues around … how you adapt for different families*" (Annie, OT) and sharing ideas to "*pick up and steal some bits*" (Caroline, OT). Marisa (OT) explained how she integrated such learning to benefit the parents she works with,

I think I'm a lot better at adjusting strategies to the families, breaking things down and make it very easy and achievable for them so they feel like they can do it and want to do it, so it doesn't become too overwhelming.

Moving On

Integrating learning also encompassed the concept of completion and a consequence of **crossing the independence threshold** was **moving on**. When parents had successfully **integrated learning** into family life and no longer required support for a specific issue, **moving on** involved the parent-child-therapist unit re-engaging in the **partnering in learning** phase to **move on** to the next step of a task, or to **move on** to a new issue altogether. This happened frequently by repeating the process to **get on the same page again** to build on and extend learning with a new issue. This is similar to the process discussed in **getting on the same page again** (Chapter 8), where that focus was more about refining and meeting changing learning needs in the moment, instead of **moving on** to learn about a new issue as at this stage.

Alternatively, completion may denote when goals have been achieved, boundaries of the service exhausted, or therapy support are no longer required. In this case, **moving on** meant leaving the therapy partnership altogether, with the child (and family) discharged from the service. Some families may engage with a new service where the learning process will begin anew. Learning and tending the relationship continues to 'end well', to support parents' transition and connecting with another service, or to 'set up well' for potential future relationships and engagement with different therapists and therapy services. At times the relationship even extended beyond the official ending of a therapy partnership.

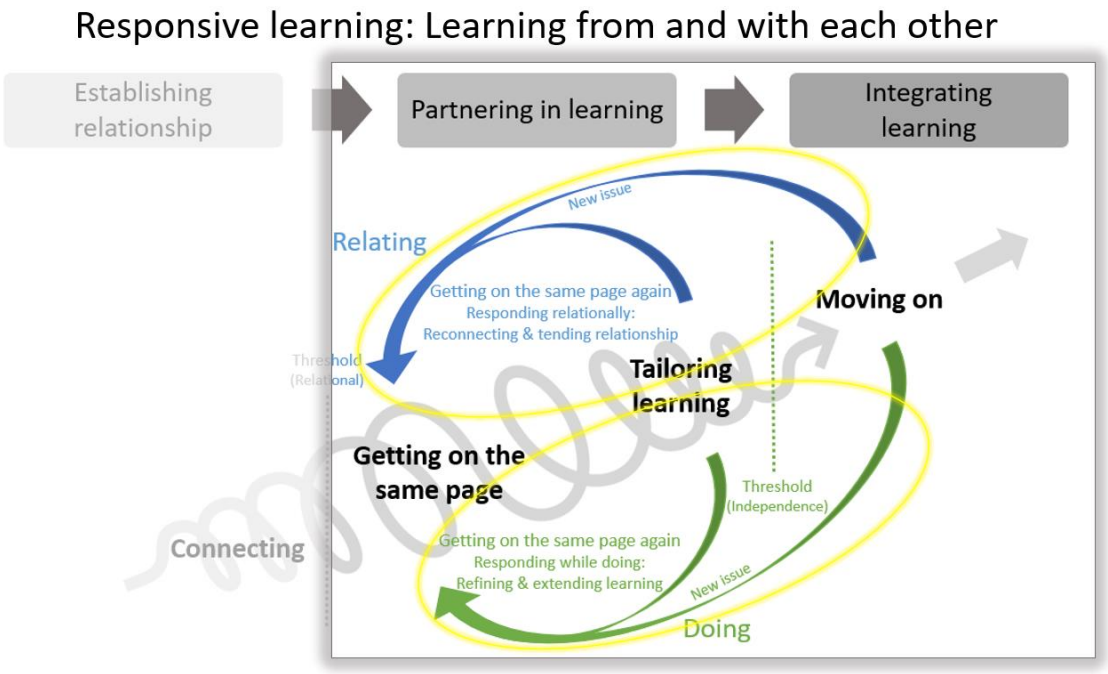
Repeating the Process: Getting on the Same Page Again with a new Issue

In an iterative process, learning led to further learning. A cycle of building on learning was often initiated by repeating the process and returning to **partnering in learning** by **getting on the same page again** to tailor learning to changing needs. This involved either extending or addressing a previously identified issue with a new (or related) therapy goal, extending to the next step, or **moving on** to focus on another issue while maintaining an ongoing emphasis on relating and tending the relationship, as illustrated in Figure 9.4 (upper blue 'relating' and lower green 'doing' arrows).

At times, progression to repeating the process involved "*when you* [achieve] *that goal, you naturally progress the next phase of it*" (Dolly, Parent) and extend the learning. At other times, therapists and parents recognised they had finished addressing something and were ready to move on to a new issue; for example, "*we're at the end of the crawling thing and we can move onto something else*" (Samantha, Parent). Thus, they often **got on the same page again** as new issues arose, and as the child continued to grow, develop, and change.

Figure 9.4

Moving on: Repeating the process to get on the same page again with a new issue



Repeating the process may happen frequently during a therapy session, when either the parent or the therapist is ready to **move on** to **get on the same page again** with a different issue. This was evident in that either the parent or therapist initiated a shift by redirecting the focus and changing the activity or asking a question, signaling they were ready to address a new issue. For example, "And I also heard you ended up in hospital. Is the new Mic-key button[7] in?" (OT to Parent: Film 5). Responding to this cue, typically both would **get on the same page again** to focus on for a period of time. On occasion, where an original issue was important to one of them and it felt incomplete, **moving on** to repeat the process involved redirecting the focus to revisit an issue to extend and build on the earlier learning. This was evident in a therapy session when the therapist drew the parent's attention to an earlier conversation.

> OT to Parent: *One of the things you'd said earlier, you know when he's on his tummy, when his legs are sort of bent. If you put your hands just at his feet and he will push off them to move forward. That's one of the ways you can help him move when he's on his tummy. So, it will just kind of give him the feel of what it's like to move forward.*
> Parent: I can build on that, yeah.
> (Film 2)

This resulted in them **getting on the same page again** and building on learning with that issue. Thus, the cycle continued during the session and therapy interaction.

Learning was continuous and ongoing. As children were constantly growing, developing, and changing over time, their learning needs, and therefore those of their parent in supporting them, were constantly changing.

[7] A Mic-key button is "a low-profile tube that allows children to receive nutrition, fluids, and medicine directly to the stomach" (The Children's Mercy Hospital, 2022).

> *When she* [OT] *started with us he* [child] *was a little baby and now he's walking. So, throughout each stage, pretty much every month she was here and something different was happening for him. So, the goals and things changed each month*. (Polly, Parent)

Initially, parents' learning needs were broad and revolved around their child's general health and accessing relevant support services as they came to terms to their situation. For example, Louise (Parent) explained,

> *What we were worried about the first year, that apparently, she* [child] *was more prone to infection. We were more worried about keeping her healthy. We thought that that was going to be the biggest challenge. And it turned out that she's quite robust. We haven't had to worry too much, so that's awesome*.

Like other parents, as time progressed and Louise (Parent) learned that her child was more resilient than first anticipated, her learning needs changed and became focused on helping her child's development and physical skills, such as, "*at the moment it's stand up on the couch and practise sitting*".

As parents accumulated knowledge, skills, experience, and resources, their learning needs often became more focused and specific. Therapists also needed to continually learn what parents were ready for and needed in order to respond in a way that helped progress the parent and child's learning and development. Therefore, therapists would frequently repeat the process by **getting on the same page again** to address presenting issues and learning needs. Several parents described how their more recent learning needs differed from what they needed to learn when they first started working with the therapist. Generally, the initial focus was on "*physical movement*" (Sarah, Parent) or "*moving the body because everything's so tight and scrunched up when they're so little*" (Vandella, Parent). Over time, learning how to align their child's body extended to a task or focused on activities the child and parents were doing together with a focus on participating in play and family occupations. Samantha (Parent) explained,

> *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*.

Thus, learning needs became directed by participation in occupations.

Therapists noticed parents' learning needs became more specific as they gained experience and resources. Caroline (OT) explained the shift she noticed,

> *Down the track they've* [parents] *got a more definite pathway. They've got a whole lot of ideas that they've worked through and they're more focussed on specifics…. You've had all of those discussions and you've worked through a whole lot of things and focussed and achieved some goals. They get more direction about the future stuff and what they need.*

Caroline (OT) attributed this shift to parents seeing change and progress with their child as they aged and reached new milestones. She shared an example of parents realising that their child

and family needs altered as their child became older and consequently what they needed to work on changed too,

> *When they* [parent] *started it was more about her* [child] *having fun and enjoying life and that's still part of it, but they are looking at school now. 'Okay so, what do we need for that, and can she dress herself and can she open her lunchboxes?' So, more functional kinds of goals … and language is always part of that. They've worked out what they want this little one to be able to say to make their life at home easier. And they're looking at more functional kinds of things, as well as her having fun and enjoying herself. But they realise that she's quite a big little girl, so she's going to have to help as well.* (Caroline, OT)

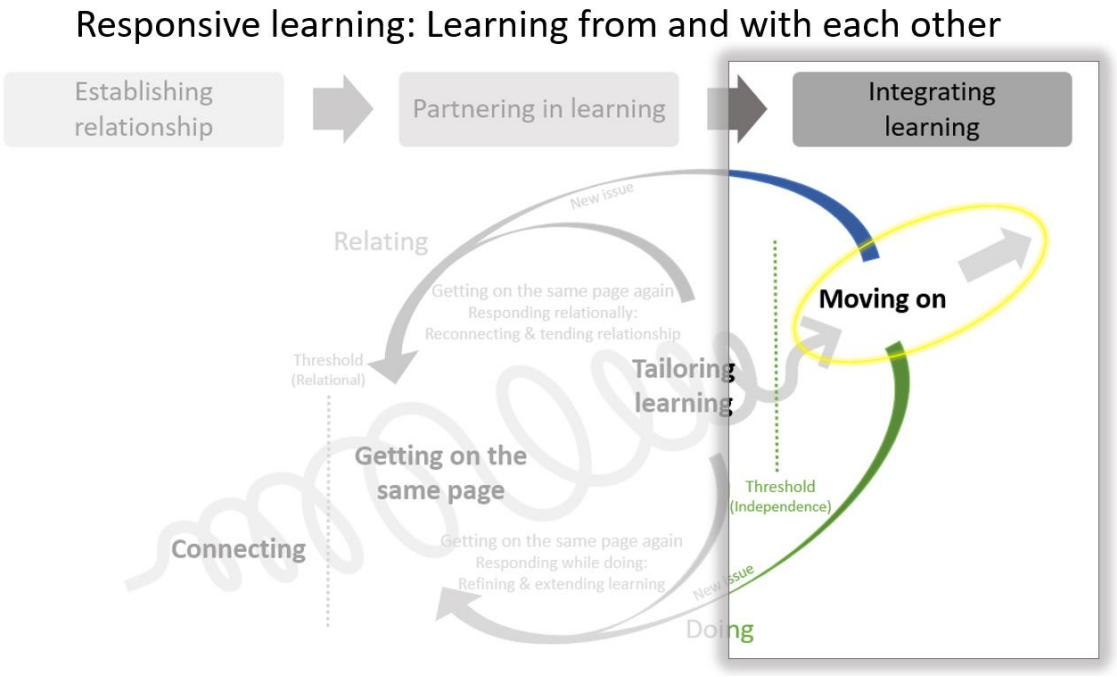
Therefore, as parents **integrated learning** into everyday life and new situations, they also gained awareness of what they needed to learn to **move on** and repeated the process to **get on the same page again**.

Ending Well: Gradually Moving On and Out

Inevitably, the therapy partnership between parent and therapist drew to an end when the objectives of therapy had been adequately met or the boundaries of a service were exhausted and the child transitioned to another service, as represented by the grey arrow in Figure 9.5.

Figure 9.5

Moving on and out



The value parents and therapists placed on their relationship was evident in their mutual efforts to tend the relationship throughout the whole learning process, including ending the relationship positively, with care and consideration. To honour that relationship and how it had supported the learning process, and thus the child's developmental trajectory, it was important for both parties to end it well. Consequently, severing the relationship was approached with reluctance from many parents and some uncertainty at **moving on** without the therapist.

Therapists were also aware of their responsibilities to end well in order to provide a positive starting point for any subsequent therapy relationship. As such, taking time to transition out was an important part of the learning process. For example, Nicole (CTI, OT) found it important to ensure she finished on a positive note; explaining,

> *It's like an entire experience.… If you don't round it up and end on that positive note, it kind of leaves a bitter taste in your mouth.… I found that the end of my relationship is just as important as the start because all of this sets the foundation for another therapist to come on board. So, if I've left a negative taste behind, they're going to have a really hard time connecting or hooking this family in again.*

Some therapists adopted a process of gradually withdrawing as they supported parents to learn that they could manage independently of therapy support, while other therapists supported parents' learning while transitioning to enter a new therapy relationship in a new service.

Learning to manage independently of the therapist: Easing out

Therapists were aware that some parents struggled to **move on** and, as such, consciously made efforts to disconnect. At the end of their time working with parents, therapists wanted the parents to feel "*less dependent on services*" (Marisa, OT). That is, to have learned that they could be "*self-sufficient … and feeling more capable that they can do things themselves*" (Marisa, OT), and could manage without regular therapy input. Nicole (OT) further summed up the sentiment of other therapists,

> *To end it you need to leave the parent feeling like, now I've* [OT] *stepped so far back and you're* [parent] *still managing really well, so there is no cause for concern. I'm* [OT] *not needed anymore.*

This learning strategy aimed to instil confidence in parents so they were capable and equipped to move forward with their learning and to continue to support their child's ongoing development independently.

When initially **getting on the same page** with the therapist, many parents had learned about the criteria for ending therapy with a service, such as when a child walked or reached a certain age. Having this knowledge enabled parents to anticipate and prepare for when therapy involvement would end. As this time approached, therapists continued to tend the relationship as they gradually eased out their involvement with the family. Some therapists applied the strategy of "*grading*" (Nicole, OT) to the process of concluding the relationship and withdrawal of therapy support by gradually extending the time between visits so that parents learned they could manage.

> *A lot of families don't want to let go. They* [parent] *might see their child doing well, but they've had your reassurance for so long they really don't want to see you leave. Grading the discharge process helps the most. So slowly make* [visits] *months rather than weeks.* (Nicole, OT)

Other therapists tailed off the therapy by putting the onus on parents to initiate contact if they felt they needed further therapy support.

> *We're getting to the point now that he's* [child] *started walking and once he walks, she's* [OT] *said that's generally when we sign off. So, we can't be too far away and now it's just if I feel I need her. So, she can read that in me too, that she doesn't need to come and see me, and she knows I'll call her if I need her.* (Toni, Parent)

This process gave the parent experience with managing without the therapist's support, while having a safety net.

However, despite therapists' efforts to ease parents towards their withdrawal, not all parents felt readied and knowledgeable enough and were reluctant or disappointed when therapy came to an end. When this happened for Polly (Parent), she expressed concern as she did not think the need for therapy input was finished,

> *We've finished. It was quite sad you know. She's* [OT] *been really great, such a huge support … even though he's* [child] *walking, he can't walk up or down steps, he's not running or anything like that at the moment. She has said if I need her to come back then just get in touch with her, and she's happy to come and help us out. But it would be quite nice too, if she could have stayed on for that little bit of it.*

Although Polly (Parent) was aware that therapy for her child was coming to an end as he was walking, she found the last session came on her abruptly:

> *At that appointment she* [OT] *told me that would be her last one. So that was quite sad because I wanted to get her a little bunch of flowers or something to say, 'Thank you for everything'. But she said she's not overly good with final sessions…. It would have been nice to have had a little bit more notice…. I mean two and a half years with one family; you get to see that baby grow and develop and you know that you're helping them get there…. I think maybe we could have had a session and she'd have said, 'Okay, the next session is my final session with you'.*

Polly appreciated that the therapist had worked closely with her and her child for several years and contributed to her child's progress and development. Although the therapist's own struggle with concluding their partnership and **moving on** appeared to drive the abrupt end and breached the relationship they had developed, tending the relationship with the therapist was still important to Polly. She wished she had more warning and the opportunity to show her appreciation with a gesture of thanks for the therapist in the way she wanted. Vandella (Parent) also found finishing with a therapist difficult because of the close emotional relationship they had developed and associated it with a sense of loss,

> *You kind of grieve a little bit because you miss that relationship. You've really bonded, and they* [OT] *know so much about you. And I know that for them, maybe you're another patient, but you do kind of really miss them.*

Learning to ease transition to another service

Some paediatric services have age and criteria limitations, so discharge from one therapist does not necessarily mean the end of therapy completely, rather a process of

supporting parents to **move on** and transition to another service, such as a school, for ongoing therapy input for children with long-term therapy needs. As the family were "*getting a whole set of new therapists*" (Nicole, OT) to work with, they would need to connect and establish a relationship with a new therapist and service. Therefore, therapists engaged in a process supporting parents when transitioning the child's therapy care which involved "*liaison with the team that's going to be taking over, being clear, and handing it over*" (Nicole, OT) and helping parents learn about transitioning to school with "*lots of discussions around how to move into school, a discharge plan of making some contact with them in school and doing a school visit and talking to them about. 'What now?* "' (Caroline, OT). Other therapists would assist in transitioning families by going with parents to the next service to help connect them. For example, Sarah (CTI, Parent) explained how the therapist went with her when she was nervous about learning how to relate to new service providers with her child,

> *I was like, 'Oh my god, I'm going to have to go and deal with a whole lot of new people, and they're going to have to learn my sense of humour, which will offend so many people'. I always get very nervous … Helen* [OT] *came with me and she could help ease them into that.*

In this way, the therapist acted as a bridge to pass on the therapeutic relationship and help connect the parent and new therapist before bowing out. To gradually ease out, some therapists checked in once the parents were engaging with the new service with "*phone contacts and maybe a finishing kind of visit*" (Caroline, OT).

The depth of the relationship was such that, in some instances, parents and therapists maintained a relationship beyond discharge. For example, Sarah (CTI, Parent) would "s*till go see Helen* [OT]*, and she's like, 'Sarah, I've discharged you!'… We've discharged from work, but we actually still have a really good friendship*". Although this ongoing connection was apparently driven by the parent, some therapists appreciated learning how families were faring after they had moved on. Caroline (OT) explained, "*Some of them* [parents] *will come back and visit. It is nice. It's kind of nice to see how things have gone*".

Summary

In this chapter, **Integrating learning,** the last of three theoretical categories within the theory of **Responsive learning,** was explained. The subcategories: **Crossing the independence threshold** and **Moving on**, with their respective properties, were explicated with supporting data. As they learnt, parents accumulated understanding, knowledge, and practical skills. **Crossing the independence threshold** was characterised by parents assuming increased confidence, autonomy, and independence with learnings integrated into their family routines to support their child's development. Both parents and therapists sometimes shared what they learned with others. There was often a shift in the partnership with parents increasingly directing therapy to meet their needs and exhibiting less reliance on therapists' support. **Moving**

on to address new issues involved an iterative process of **getting on the same page again** to build on learning. When engagement with a therapist or therapy service came to an end, ending well was important for potential future therapy partnerships as they were **moving on**. At times learning continued to aid the family's transition to connect with a new service.

This chapter concludes the presentation of the research findings. The theory of **Responsive learning: Learning from and with each other** was presented in Chapter 5, along with its three theoretical categories: **Establishing relationship**, **Partnering in learning**, and **Integrating learning** in Chapters 6-9. The final chapter of the thesis discusses the salient points from the findings; evaluates the theory in the context of extant knowledge; and considers the implications for practice, education, and research arising from the study.

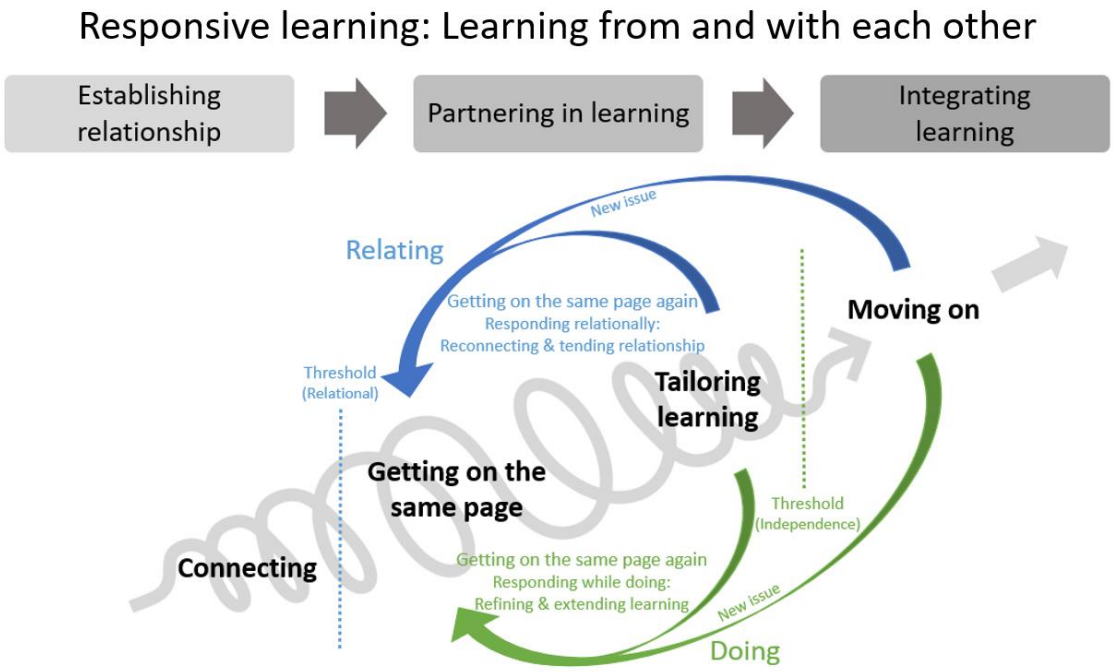
Chapter 10 Discussion

Introduction

This research aimed to provide a theoretical explanation of the process of learning between parents and occupational therapists by answering the questions: 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? Using constructivist grounded theory, a substantive theory of **Responsive learning: Learning from and with each other** has been constructed which addresses that aim and adds new knowledge to the health field (Figure 10.1). Fundamentally, my research proposes that learning between parents and occupational therapists is a complex, dynamic, and two-way process. First, it highlights the importance of bidirectional learning, and that parents and therapists are **learning from and with each other** as they respond to each other and changes in the situation and context through a process of **Responsive learning**. Second, the learning process is deeply relational, where ongoing investment in relationship, connection, and partnership are key for mutual learning, moving forward together, and **integrating learning** into practice and life.

Figure 10.1

The theory of Responsive learning: Learning from and with each other



In this chapter, I situate the theory and salient concepts from the findings in the broader body of knowledge and highlight the contribution of my research to the field. There is limited occupational therapy specific literature aligning with my theory, so broader paediatric rehabilitation, allied health (including physiotherapy and speech language therapy research, at times with occupational therapy representation), and general health research have been

considered. Aspects of my theory align with extant literature in the health fields, but none entertain the described process in its entirety. In line with the multi-phase literature review approach used in this research, literature pertaining to the areas covered in this chapter were targeted around categories and concepts in the theory, as previously discussed in Chapter 2 (Thornberg & Dunne, 2019). The use of extant theory and literature as theoretical codes (such as the hui process, see Chapter 4 Methods) also serves to enhance the explanatory power of the theory and potential for applicability beyond the substantive area of research (Birks & Mills, 2015).

The theory of **Responsive learning: Learning from and with each other** was constructed using data from interviewing and observing parents and occupational therapists working in the context of family-centred care, and photographs of learning resources therapists provided to parents. It emphasises collaboration and partnering and delivers insight and explanation into how those 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. Recent literature has continued to point to learning and developing knowledge as an essential element of family-centred care and empowering parents to participate as collaborative partners with health practitioners in their child's care (Alsem et al., 2017; An & Palisano, 2014; Fordham et al., 2012; Hurtubise & Carpenter, 2017; Kruijsen-Terpstra et al., 2016; Reeder & Morris, 2020), making the findings as relevant now as when the study was initiated.

In the following sections, the two key findings of bidirectional and **responsive learning** and the importance of relationship in learning are initially presented and positioned alongside extant literature. Next, key points distilled from the findings chapters that are considered salient, either for their prominence in the data or relevance for clinical practice and future work, are presented. First, I discuss the findings in the context of occupational therapy practice and then in the context of health practice in Aotearoa New Zealand. Following, I present the implications of this research for clinical practice, education, and further research. I then reflect on the limitations of the study and critique the quality of the research.

Bidirectional and Responsive Learning and Extant Literature

Bidirectional and Reciprocal Learning

Bidirectional and **responsive learning** involving **learning from and with each other** is a key finding of this research. The concept of reciprocal learning by **learning from and with each other** shares similarities with social constructivism and pragmatism (philosophies underpinning this study). For instance, social constructivism acknowledges that knowledge, although individual, it is often constructed between people through shared activity and experience (Dolittle & Camp, 1999). From a pragmatist perspective, John Dewey recognised

reciprocity in learning and theorised about learning through actions, and how individuals and groups work as part of the environment through adaptive process towards the good in their everyday life (Coppola, 2012). Like my theory, Dewey's (1916) focus was relational and, along with participating and sharing in an activity, he identified reciprocity as essential in education, arguing when engaging in "shared activity, the teacher is a learner and the learner, without knowing it, a teacher" (p. 160). Dewey acknowledged the value of collaborative and shared experience for learning, as well as learning as part of engaging in activity. Therapists' learning about clients to guide the direction of therapy has been recognised from the early days of the occupational therapy profession. Dunton (1918) advised "the occupational therapist should make a careful study of the patient in order to know his or her needs and attempt to meet as many as possible through activity" (cited in Bing, 1981, p. 509).

A bidirectional, reciprocal perspective on learning, as demonstrated in my theory, shares consistency with other learning theories; yet, when applied in occupational therapy literature, this focus is at times omitted. For instance, Lev Vygotsky (1978) stressed that learning is a socially mediated process (Schunk, 2008). He emphasised a person-centred collaborative approach to learning based on the interaction and reciprocal relations between people and their environment, and the social mediation of knowledge as co-constructed between two or more people, which aligns with social constructivism (Kolb & Kolb, 2017; Kolb, 2015; Schunk, 2008). However, when applications of Vygotsky's theory are discussed in therapy literature, the emphasis has been on 'scaffolding' the learning experience and progress towards autonomy with facilitated support and instruction by the therapist for supporting the patient to master skills or task performance in a didactic way (Greber & Ziviani, 2010; Greber et al., 2007a; Kaplan, 2010; Schunk, 2008). The importance of a personal relationship, and reciprocal learning by the therapist to skilfully support their clients, as demonstrated in my theory, is not considered as the nuanced process my study reveals it to be.

As discussed in Chapter 2, traditional learning theories described in occupational therapy and paediatric literature related to therapy delivery are often framed as didactic, with unidirectional flow of knowledge from expert/teacher/therapist provider to novice/learner/client recipient, with a hierarchical overlay. Conversely, the theory of **Responsive learning: Learning from and with each other** emphasises the importance of ongoing responsive two-way learning between parents and therapists, and provides an explication of this process, which other studies do not. However, the importance of bidirectionality in the learning process is supported by other research, and parent education has been described as 'bidirectional' where parents and clinicians communicate, exchange information, and respond to what is expressed (Kaiser et al., 1999). More recently, Keiter Humbert et al. (2020a, 2020b) identified parents and therapists were 'learning from one another'. They found relationship supported reciprocal learning and facilitated collaboration to assist practitioners in providing responsive and

individualised intervention with families. Others have also recognised that to create optimal learning experiences, build effective partnerships, and communicate useful and practical information for parents, there needs to be exchange of information and reciprocal learning about each other. As in my theory, therapists need to learn from and about parents to be aware of their existing level of understanding, learning needs, priorities and preferences, and their readiness for information to equip them to care for children with long-term medical conditions (Hurtubise & Carpenter, 2017; Nightingale et al., 2015; Reeder & Morris, 2016, 2020; Woods & Lindeman, 2008). Suggestions for therapists to learn from and about parents include facilitating conversation (An & Palisano, 2014) or, more reliably, asking parents directly (Nightingale et al., 2015). Resonating with my results, Woods et al. (2011) argued that a reciprocal, bidirectional teaching and learning relationship and process, where the family and clinician assume roles as both teacher and learner, is the basis for a truly individualised family-centred approach. Answering questions about the process of learning was not the focus of these studies, as in mine, but learning was an aspect of their findings.

Therapists' learning from parents is often framed as assessment; for example, assessing to identify the child and parents' needs and preferences to optimise therapy delivery and clinical outcomes (Nightingale et al., 2015). Assessment has been described as a learning process for parents and their child, with bidirectional learning between parents and therapists recognised in relation to assessment of a child (O'Connor et al., 2019). Despite support for bidirectional learning from philosophers, learning theory, and research, therapist participants in this study generally did not self-report learning, even as part of assessment or by asking parents specifically about things. In fact, from the data in this study, I was left with an overall impression that therapists were unknowing learners and largely not alert to the significance of their own role as learners. Although therapist learning was apparent during the therapy session observations and what was said indirectly in interviews, when asked what they learn from parents most therapists struggled to answer. In relation to promoting learning, the strategies therapists in this study used appear to align with aspects of the learning theories in occupational therapy textbooks (as outlined in Chapter 2), but none of the participants knowingly drew on any of these theorists. Rather, they appeared to take it as a given that, for example, learning needs to be individualised, responsive to needs and readiness, and is affected by the environment. Elevating therapists from being unknowing learners to knowing, intentional cognisant co-learners (Hurtubise & Carpenter, 2017) when working with families, may make a difference in initial and ongoing partnering with parents, parent engagement, and, potentially, outcomes. Key elements of co-learning previously described by Rutherford (2011) align with my findings, including the concept of "learning with, from, and about each other" and "sharing the roles of expert and novice, teacher, and learner" (p. 353).

Responsive Learning

My theory of **Responsive learning: Learning from and with each other** recognises an ongoing and iterative process of responsiveness as key to the learning process, influenced as the child develops, situations change, and as parent and therapist learning needs fluctuate and change as they progress with therapy. **Responsive learning** was evident in the data where parents and therapists responded and exchanged information or actions to meet the individual learning needs of the other, and through oscillation between a focus on relating and doing as they were frequently **getting on the same page again** to support learning and progression. This resonates with Turpin and Copley's (2018) illustration of an effective interaction between occupational therapist and client as an "interactional dance subtly guided by the occupational therapist" (p. 246) who pays "close attention to their clients" (p. 257). While Turpin and Copley preserve the notion of therapists as "the lead partners" (p. 257) rather than equal partners in reciprocal learning, they similarly emphasise being attentive and responding to each other by engaging in ongoing conversation to understand changing and developing learning needs, tailoring information, recalibrating shared goals, and exchanging purposeful information accordingly (Almasri et al., 2018; Turpin & Copley, 2018).

Responsiveness in my study demonstrated the concepts of 'knowing-in-action' and 'reflecting-in-action' where the 'teacher' spontaneously responds and adapts to learners' reactions, which is aligned to the work of Schön (1983) who related reflection to problem solving (Bradshaw, 2011; Kinsella, 2018; Knowles et al., 2005). The concept of **responsive learning** is also consistent with pragmatism and social constructivism, which assert that through interactions with their environment, people come to know and understand their world and respond to develop practical actions to solve problems to adapt in their constantly changing world (Charmaz, 2014; Cutchin, 2004; Ikiugu & Schultz, 2006; Jeon, 2004; Strübing, 2007). **Responsive learning** can be considered in terms of responding to changing learning needs, transactional learning, and embodied learning, which I will now address.

Responding to Changing Learning Needs: Readiness, Continuity, and Cumulative Learning

My findings on **responsive learning** are supported by Dewey's (1922, 1933, 1938a) philosophy of experience and continuity in learning. For Dewey (1938a), learning was part of a continuous stream of experiences where knowledge and skill learned "in one situation becomes an instrument of understanding and dealing effectively with the situations which follow" (p. 44). Dewey (1933) argued that engaging in occupation also has continuity as "a consecutively ordered activity, in which one step prepares the need for the next one and that one adds to, and carries further in a cumulative way, what has already been done" (p. 219). Through this continuous back-and forth process, individuals readjust their actions to a constantly changing environment (Cutchin, 2004; Östman & Öhman, 2010). Consistent with these propositions, in my study, as understanding and skills accumulated they became integrated automatic

components of family life and professional practice; and, consequently, learning needs changed. In response, new issues or areas for learning were addressed by **getting on same page again** in an ongoing process to continually build on or extend prior learning.

Readiness to learn and meeting changing learning needs is explained by adult learning theory and theoretical perspectives on cumulative learning and continuity in building on learning. Knowles' theory of andragogy, or adult learning, is a constructivist approach to learning (with roots in pragmatist and humanist philosophy) that views new learning as based on previous experiences or understandings which can be used as a resource for further learning (Knowles et al., 2015). Andragogy is learner-centred, in that the teacher has an interactive, coaching and guiding role to tailor learning to meet learner needs. However, learning transactions involve active participation by both teachers and students (Knowles et al., 2005; Neufeld, 2006; Oestmann & Oestmann, 2011). Recently proposed theory reiterated themes of being responsive to learner needs. For example, occupational therapy and health literature refers to Prochaska et al. (2008, 2015) who developed a 'transtheoretical model of intentional change' (TTM) (Flinn & Radomski, 2008; Helfrich, 2014; Hoffmann, 2009; Neufeld, 2006). A central tenet of TTM is that behavioural change is a process occurring over five stages, and clients are at different stages in the process depending on their readiness to change or learn. Meeting individual participant's learning needs in a working partnership requires learning about such needs and responsiveness with relevant information and support to meet those needs.

Similarly, my findings recognise that parents (and therapists) were ready to learn different things at different times, based on their accumulated experiences, knowledge, and skills, and through incorporating a process of continual adjustment to meet changing learning needs. Specifically, the responsive cyclical nature of **getting on the same page again** and the upwards trajectory of the model reflect cumulative learning and building on prior learning. Further alignment with established educational or learning theory is evident in the strategies therapist participants used to support parents to learn. Their actions reflect Kolb's (2015) cycle of experiential learning to promote learners' ability to reflect on their actions and experiences as a means of developing a plan for refinement and action in immediate and future situations (Kemp & Turnbull, 2014; Rush & Shelden, 2011). However, what those prior explanations lack, which was evident in my findings, is recognition of the reciprocal process of teacher becoming learner, as parents also considered what therapists needed to learn, their readiness to learn, and how to coach or guide them to that learning.

A further point of alignment is that parents transitioned from novice to expert (although they did not use that terminology) as they gained increasing independence from the therapist and crossed the **independence threshold** having **integrated learning** in everyday life. This transition is consistent with the Dreyfus Model of Skill Acquisition, which supports learning, skill acquisition and development on a continuum of five levels of proficiency—novice,

advanced beginner, competent, proficient, and expert (Benner, 1982, 1984; Leighton & Johnson-Russell, 2011; Romano, 2009b). Similarly, Hurtubise and Carpenter (2017) found that as parents acquired knowledge and skills, they transitioned from observing, copying, and practising with therapist feedback to taking initiative in modifying or adapting an activity to suit their child's responses. Likewise, parents in my study took ownership and adapted what they had learnt to make their own iteration as they were **integrating learning** into everyday life in the process of **moving on**. Becoming proficient or expert in one aspect of therapy facilitated parents' confidence and learning for subsequent tasks. As in my theory, learning was cumulative and parents described their learning level changing with each new experience, task, or skill (Hurtubise & Carpenter, 2017). In sum, the emphasis my theory of **Responsive learning** places on both therapists and parents being responsive to the other's changing learning needs has good support from educational theory and research findings from the early 1980s to the present. What is new is the finding that parents actively gauge therapists' readiness to learn and strategise to promote their learning.

Transactional Learning

Bidirectional and **responsive learning**, with dynamic exchanges between the parent and therapist, and oscillating between relating and doing, can be linked to a transactional perspective, as represented by the spiral in the diagram depicting my theory (Figure 10.1, p. 194)). Dewey's work, and his combined later work with Arthur Bentley, has influenced understandings about transaction. From a transactional perspective, meanings are co-constructed as a consequence of continuous and dynamic transactions involving people (client and therapist), activity (occupation or intervention), and the context, which are intertwined and reciprocally influence one another (Dewey & Bentley, 1946; Graham & Ziviani, 2021c; King, Chiarello, Ideishi, et al., 2021; King et al., 2018; Lee Bunting, 2016). According to Dewey and Bentley (1946), a consequence of individuals' coordinative processes as they participate in the process of transactions, is that "both parties undergo change" (p. 185).

Transaction is also recognised in occupational therapy practice and paediatric therapy literature, such as in the person-environment-occupation model as a transactional approach to occupational performance (Graham & Ziviani, 2021c; Law et al., 1996; Turpin & Iwama, 2011). Transactional perspectives on occupation have been linked to pragmatism including Dewey's assertions that people learn by coordinating with others, and are part of and not apart from their context (Aldrich & Cutchin, 2012; Cutchin & Dickie, 2012). Learning is an important part of occupation in the transactional perspective and occupations are central to 'functional coordination' and transactions between people and their worlds (Cutchin & Dickie, 2012; Garrison, 2001). King et al. (2018) proposed a conceptual framework of transactional processes for paediatric rehabilitation, describing how "meaningful situated and cumulative experiences lead to capacity development, and adaptation" (p. 1830), as parents learn skills to navigate

services and support their child with the support of health professionals. As in my study, as parents learn the skills they need therapists became part of the context of the child and family in a transactional and interdependent relationship (King et al., 2018). **Establishing relationship** and **partnering in learning** to **learn from and with each other**, as in my theory, explains how such a transactional relationship and learning can be achieved.

Embodied Learning

In the observations of therapy sessions, along with verbal instructions, parents' and therapists' use of body positioning and gesture were examples of **responsive learning**. For example, while engaging in shared activity, both used their bodies to show what the child had or could be doing to demonstrate meaning or instruction and clarify understanding, which helped them learn how to respond to each other to address gaps and extend learning. This observation finds support in concepts of embodied learning and learning in interaction, which were key influences on learning and parent' and therapist' responses to each other (Horton, 2008; Kinsella, 2018). Through participating and responding in bodily performances and gestures, people develop ways of relating to others resulting in co-construction of shared meaning, mutual knowledge, and understanding (Arntzen, 2017; Goldin-Meadow, 2003). In clinical encounters, 'embodied attunement' occurs as clinician and client work in partnership and respond to each other to generate meaning in the moment-by-moment interaction taking place (Loftus, 2015; Svenaeus, 2000). There is a fit of these precepts with the notion of 'finding common ground' where shared understanding is part of **getting on the same page**. As seen in my data, embodied relational understandings between clinician and client can be communicated through interaction and bodily co-ordination of positioning of self, animating abstract qualities such as movement and gesture, facial expression, and learning to read and respond to cues (Arntzen, 2017; Goldin-Meadow, 2003; Kinsella, 2018; McNeill, 1992; Mewburn, 2008, 2009).

A second form of embodied learning was also evident in this study as a key influence to how parents learned hands-on skills or gained 'embodied knowing' to support their child which could only be learned through embodied experiences (Loftus, 2015; Todres, 2007). It involved parents learning to develop a 'feel' for manual therapy skills, such as hand placement and pressure needed to encourage movement, or when positioning a child to encourage play. Therapists also learned from parents' demonstration how to respond to adjust and refine their skills as together they worked hands-on with the child. In the context of learning hands-on clinical skills, Loftus (2015) highlighted the importance of embodied learning experiences as there are times when "it is difficult to articulate further what such a 'feel' is like for those who have never experienced it. There are limits to what our language can allow us to say" (p. 142). Although literature on embodied learning is often directed at training health professionals, the findings in this study suggest that understandings of the embodied learning of clinical skills

could also be applied to other learning situations, including therapists teaching parents, and vice versa.

Relationship and Learning

My theory of **Responsive learning: Learning from and with each other** posits that learning is deeply relational and that the therapist-parent relationship and learning are intertwined. Support for this proposition is found in the work of An and colleagues, who have similarly asserted that relationship and learning are crucial for collaboration between parents and therapists, underpinning the sharing of information, knowledge and skills; parent engagement in therapy; making shared decisions on goals and intervention; building capacity to empower parents to work in partnership; and optimising therapy outcomes (An & Palisano, 2014; An et al., 2016; An et al., 2019). In my theory, **Establishing a relationship** and **Partnering in learning** promote interaction, collaboration, and learning between parent and therapist, which have been previously recognised as key for family engagement and participation in therapy (An & Palisano, 2014; Keiter Humbert et al., 2020a; Novak & Cusick, 2006). The relationship between therapists and clients is important when sharing information to empower and equip clients or parents to engage in a therapeutic partnership in family-centred care, and can also affect outcomes (Turpin & Iwama, 2011). What is less apparent in the literature is that establishing and maintaining a trusting relationship takes time and requires ongoing mutual effort. To my knowledge, the oscillation between tending the relationship and doing therapy has not previously been described, and neither has failure to cross the **relational threshold**. The role of relationship specifically in the context of learning between practitioners and clients is infrequently addressed.

Similar to the structure of my model of **responsive learning** and its emphasis on partnering in learning, An and Palisano (2014) developed a model of family-professional collaboration to give professionals strategies to foster collaborative processes with families. The iterative, cyclical collaborative process they described holds similarities with the **partnering in learning** cycle of my theory, where therapists and parents move on to another concern or goal and repeat the process and **get on the same page again** to address a new issue once they have achieved something. However, the proposed two-way interactions in their model are framed as collaboration between parents and therapists, rather than learning.

In considering the unique contribution the theory of **Responsive learning: Learning from and with each other** makes to knowledge, four topics are considered: the benefits of relationship, relationship and ongoing engagement in therapy, professional friendships and boundaries, and collaborative relationships within a family-centred approach.

Benefits of Relationship for Learning

Benefits of a positively perceived therapeutic relationship have been documented in paediatric occupational therapy literature (Broggi & Sabatelli, 2010; D'Arrigo et al., 2020; Harrison et al., 2007; Keiter Humbert et al., 2018; Reeder & Morris, 2018). Occupational therapists generally recognise their responsibility in establishing and sustaining a relationship with their clients, supported by frameworks such as the 'intentional relationship model' in occupational therapy and terms such as 'therapeutic use of self', referring to therapists' deliberate efforts to enhance interactions with clients and facilitate occupational engagement (Solman & Clouston, 2016; Taylor, 2019; Taylor et al., 2009). Copley et al. (2008) identified processes used by therapists with adults with neurological symptoms to aid tailored information-giving and to support individualised interventions. These included developing a therapeutic relationship to aid information gathering and developing a collaborative relationship to facilitate clients' active participation in decision making. Similar to my theory, the authors described an iterative or back-and-forth process between negotiating, understanding, and tailoring information further. Although forging a therapeutic relationship is often perceived as therapist driven, in my study there was mutual effort with parents also working to connect and maintain relationships with the therapist. Efforts made by a clients to sustain a positive relationship with clinicians were similarly described in an earlier occupational therapy study by Egan et al. (2010).

The importance of relationship between clinicians, clients, and families is also recognised in wider health literature. Concerning a relational orientation to person-centred care in adult neurorehabilitation, Terry and Kayes (2020) found when relational practice was prioritised and viewed as legitimate rehabilitation work, it led to experiencing a 'real relationship' (not simply a task to be ticked off) with health professionals, client engagement and participation in clinical decision making, and rapid improvement. They found reciprocity in client and clinician sharing information about themselves helped engender trust. This is similar to my findings where parents learning about the therapist as a person, and their competence and reliability, helped with both 'hooking' into relationship and therapy. As with my study, Terry and Kayes highlighted the need for two-way engagement and the patient and clinician relationship to be treated as a priority, thus supporting the reciprocal nature of the relationship central to my theory.

The benefits of relationship to therapists' learning, as elaborated in my theory, have been recognised by others. For example, Gerlach et al. (2016) explored relational approaches to fostering health equality for Indigenous children in Canada. Like my results, they found workers learnt through a deeply relational process of inquiry with reciprocal exchange of information with families, embedded in their experiences of doing things together. As in other studies, they found investing time in building trust and learning from families resulted in gaining a depth of

knowledge about families which was anchored in relationships. Connections were developed and strengthened over time based on shared investment in the therapeutic process (Gerlach et al., 2016; Keiter Humbert et al., 2018). Consequently, coming to know (or learning about) each family benefitted staff by helping them understand how to tailor engagement expectations and strategies to each family (Gerlach & Gignac, 2019). In my learning theory, those ideas are implicit to **establishing relationship**, g**etting on the same page** (finding common ground and building working knowledge), and **tailoring learning** to meet family needs.

Relationship, Learning, and Ongoing Engagement in Therapy

Other therapy studies support my findings regarding the importance of **establishing a relationship** and **partnering in learning** for parent engagement in paediatric therapy. For example, Harrison et al. (2007) proposed that time spent building relationships with families was as useful as time spent on therapy. Reeder and Morris (2018) found fostering a positive and trusting relationship was vital to parental engagement with the information and services provided. Other studies have reported the linkage of developing a therapeutic alliance (D'Arrigo et al., 2017) or knowing (or learning about) clients as unique individuals to cultivating a good relationship to foster engagement (King, Chiarello, Ideishi, et al., 2021; King, Chiarello, Phoenix, et al., 2021). Conversely, lack of responsiveness or inattention to the parent-therapist relationship risks disengagement from therapy (D'Arrigo et al., 2020). Specific overlap with my theory is evident in Phoenix et al.'s (2020a, 2020b) assertions about the importance of the parent-therapist relationship to parents learning—alongside their children and by watching therapists—as indicated by their willingness to share information, ask questions, and raise concerns. Of note, reaching agreement about families' needs and how to move forward with therapy was similarly labelled as "being on the same page" (Phoenix et al., 2020a, p. 2156).

Akin to my **relational threshold**, Keiter Humbert et al. (2018) described 'tipping points' as breakthrough moments within the relationship and therapeutic process, such as clients disclosing personal information. These contributed to strengthening connection between therapist and client, coming to "find common ground" with shared understanding, and provided opportunities for therapists to learn about clients, or "find the key to unlock the client's potential for occupational performance" (Keiter Humbert et al., 2018, p. 6; Rosa & Hasselkus, 2005). Reflecting the mutual learning in my theory, these authors found therapists also experienced 'tipping points', moments of awareness, or realisation of their own learning that brought greater insight about clients and their challenges.

The notion of tending relationship also finds support in previous literature in reports that effective engagement with parents requires therapists to take time and be alert, attuned to, and responsive to parents' needs (D'Arrigo et al., 2020; Terry & Kayes, 2020). Appropriate responses tended the relationship and provided opportunities for learning and change (Bonsaksen et al., 2013). Responses involved therapists using learning strategies including

listening, involving parents in therapy sessions, monitoring and responding to signs of disengagement (King, Chiarello, Ideishi, et al., 2021; King, Chiarello, McLarnon, et al., 2021; King, Chiarello, Phoenix, et al., 2021). Differing from these studies, in my findings the onus was not just on therapists; rather, both parents and therapist were responding to each other and both making efforts relationally. Further, the general focus of these studies was engagement in therapy, not learning; fostering ongoing engagement was primarily therapist driven and, when mentioned, most learning was unidirectional and focused solely on parents' learning.

Professional Friendships, Professional Boundaries

Several parent and therapist participants in this study identified the closeness of their relationship as a friendship of sorts. This finding is not new. Turpin and Copley (2018) suggested, "a therapeutic relationship is a very particular type of friendship. It is not a friendship, although it requires friendliness" (p. 251). That assertion echoes Harrison et al.'s (2007) earlier finding that "an emotionally supportive 'friendship' between therapist and mother" (p. 83), with the therapist being viewed as "a very knowledgeable friend" (p. 94), or even "a family member" (p. 85), supported an effective relationship and mothers' learning. More recently, Phoenix et al. (2020a) found parents who had a strong connection with their service provider and felt like the therapist knew them and their child well, referred to the service provider as "friend", 'buddy", or even "extended family" (p. 2156). Professional friendships have been recognised in wider health literature where close relationships are formed, such as between patients and health care professionals in home-care settings (Lindahl et al., 2011) and between parents and midwifes (Jepsen et al., 2017). It has been suggested that for novice clients, and some novice therapists, the concept of boundaries helps with distinguishing friendly therapeutic relationships from friendships (Austin et al., 2006), with the onus for establishing professional boundaries lying with the therapist (Keiter Humbert et al., 2018; Reeder & Morris, 2018, 2020). In my study, the need for such learning was not apparent; rather, both therapist and parent participants were cautious to maintain professional boundaries.

Learning and Collaborative Relationships Within the Family-Centred Approach

Learning relationships between parents and therapists generally have an inherent power differential and relationship asymmetry, with parents in a position of vulnerability seeking help for their child from a professional with expert knowledge in a position of power (Austin et al., 2006). This presents challenges with enacting family-centred practice, which positions parents as peers and active collaborative partners with therapists in sharing and directing all aspects of their child's care (Goldstein, 2013; Hinojosa et al., 2002; Keiter Humbert et al., 2020a; Rosenbaum et al., 1998). As outlined in Chapter 1, health legislation, codes, and strategies in Aotearoa New Zealand, including Te Tiriti o Waitangi, Code of Ethics for Occupational Therapists (Occupational Therapy Board of New Zealand, 2015a), and Competencies for

Registration and Continuing Practice (Occupational Therapy Board of New Zealand, 2015b) also have a client and family-centred focus. However, these do not account for the investment of time to establish and tend these collaborative relationships, nor the learning required to work in this way.

My theory highlights the need for investing time in **establishing relationship** to engage in learning and therapy, and the importance of tending the relationship and ongoing mutual **responsive learning** to progress with therapy. Others have argued that recognising parents as the expert source of knowledge about their child and acknowledging parents as partners contributes to addressing power imbalances. It also empowers parents to collaborate, problem solve with therapists, and confidently use skills learned in therapy at home (D'Arrigo et al., 2020; Reeder & Morris, 2020). Likewise, my results posit clinician and parent as equal, albeit different, experts, each with knowledge the other must learn to facilitate an effective learning and therapy partnership. My theory encourages greater equality in the parent-therapist relationship and can help health practitioners meet their obligations and enact health initiatives in order to work effectively as collaborative partners with parents, and to support learning to empower them to take up their partnership role and actively manage their child's health needs, as expected in family-centred care (An & Palisano, 2014; Hurtubise & Carpenter, 2017; Reeder & Morris, 2020).

Coincidence with Contemporary Therapy Approaches

There is alignment between the focus on **partnering in learning** in my theory and emergent directions in paediatric therapy practice in Aotearoa New Zealand and internationally. Recent trends in therapy practice have shifted toward collaborative practice approaches involving children and families co-constructing interventions with clinicians and applying change strategies to their real-life situations (An & Palisano, 2014; An et al., 2019; King et al., 2018). Such approaches include use of parent driven home programmes (Ferre et al., 2017; Novak & Berry, 2014; Novak et al., 2020); strengths-based approaches (Dunn, 2017) promoting positive communication, such as the use of F-words (function, family, fitness, fun, friends, and future) as meaningful language to facilitate conversation and interaction with families (Rosenbaum & Gorter, 2012; Soper et al., 2019, 2020); relational models of client change (King, 2017); and various coaching approaches (Baldwin et al., 2013; Dunn et al., 2012; Little et al., 2018). Of note, OPC, based on the work of Aotearoa New Zealand based Fiona Graham (Graham, 2011; Graham & Rodger, 2010; Graham et al., 2014; Graham et al., 2016; Graham & Ziviani, 2021c) has strong resonance with aspects of my theory. For example, OPC recognises **connecting** as a first step (Graham, 2021; Graham & Kessler, 2021), and **tailoring learning,** where practitioners learn about parents' existing knowledge and use teaching and learning strategies which meet parents' needs and abilities (Graham & Rodger, 2010). Similar to **crossing the independence threshold** in my theory, parents in research on OPC report reaching

a ‘turning point’ as a moment of learning transformation with a shift of perspective or insight gained (Graham et al., 2014; Graham & Ziviani, 2021c).

As in my theory, coaching practices related to working with parents incorporate principles of both adult learning and family-centred practices (Baldwin et al., 2013; Friedman et al., 2012; Graham & Ziviani, 2021c; Kemp & Turnbull, 2014). Occupational therapists have argued for thinking about coaching as a process of learning or learning approach, and clients as adult learners (Cox, 2015; Graham & Ziviani, 2021c). Like my theory, coaching is seen to provide experiential learning opportunities and to “focus on collaborative relational processes (e.g., transactional processes of negotiation, co-ownership, and co-construction of plans) as the underlying mechanism of change” (King et al., 2018, p. 1833). Parents are considered autonomous, self-determining adult learners, and therapists are seen as collaborators with parents as a consultant, facilitator, educator, and coach; rather than providers of treatment (Graham & Ziviani, 2021b, 2021c; King et al., 2018). In addition, transformative learning is evident in both coaching approaches (Bruner et al., 1966; Cox, 2015; Foster et al., 2013; Graham & Ziviani, 2021c; Knowles et al., 2005; Neufeld, 2006) and in my theory, such as when a change in thinking, feelings, and actions alters everyday activities, or in the process of manipulating knowledge to make it fit new tasks, as seen when parents **crossed the independence threshold** and **integrated learning** into their everyday life.

A further similarity was in using written home programmes and individualised learning resources to support and reinforce learning. In paediatric therapy literature, home programmes are recognised as an effective mode of therapy delivery to augment direct therapy and as a way of maximising a child’s potential with a focus on increasing the intensity or dose of specific therapy interventions, rather than learning (Ferre et al., 2017; Novak & Berry, 2014; Novak et al., 2020). However, authors acknowledge that to carry out home programmes parents need regular therapist coaching, support, and feedback on their child’s progress; a partnership-based approach; and treatment activities aligned with the needs of the child and family, which parents can change to suit their routine (Chamudot et al., 2018; Ferre et al., 2017; Novak & Berry, 2014). Although tailored handwritten home programmes and learning resources were often provided to parents in my study, they were not apparently aligned to a specific therapy intervention focus. Rather, home programmes were a method of supporting parents’ learning and were co-created through a two-way process involving contributions of both parent and therapist. This bidirectional, co-construction of a forward plan of action is not prevalent in literature where home programmes are predominantly therapist driven.

A further point of difference is that although coaching and other intervention strategies share similar theoretical underpinnings to my theory, with comparable emphasis given to relational and collaborative processes, co-ownership, and co-construction of plans, and promoting learning and client autonomy, mine is not an intervention approach per se, nor

dependent on any one intervention approach. Rather, intervention approaches such as OPC are conceptualised as being embraced by **partnering in learning**, which provides an overarching explication of the process of learning and how learning might occur between parents and therapists. Nonetheless, such intervention approaches lend support to my theory and my research also lends support to them. In providing an integrated explanation of bidirectional, relational learning from initiation of a therapeutic encounter to its conclusion, my theory has a broader scope, including **establishing the relationship** and **crossing the relational threshold** that are foundational to effective therapeutic engagement.

Situating the Research in the Aotearoa New Zealand Context

Enacting Research in Aotearoa New Zealand

In Aotearoa New Zealand, respecting Māori culture and tikanga Māori are a core component of health service provision and health research. Tikanga Māori is about purpose, practices, and protocols found in every aspect of Te Ao Māori (Māori world view) and is underpinned by the high value placed on manaakitanga (hospitality)—connecting, nurturing reciprocal relationships, respecting, and looking after people (Jones et al., 2006; Mead, 2016; Pitama et al., 2014; Tipene-Matua et al., 2009). As a pākehā researcher, I came to this study with rudimentary knowledge of how the principles of Te Tiriti o Waitangi should guide and inform my research. I was naive to Māori practices and cultural issues but wanted to learn in order to give this aspect of the research due respect, and to meet my obligations as a pākehā researcher to Te Ara Tika principles (Hudson et al., 2010). In particular, considering the concept of Article III of the Treaty, ōritetanga (equality), it was important that I conducted research that was acceptable, accountable, and relevant to Māori, and to gain knowledge that in some way may contribute towards improving outcomes and reducing disparities for Māori (Wyeth et al., 2010). Consequently, the issue of Māori representation in the study and recruitment of Māori participants was recognised as essential, as research that is relevant and beneficial for Māori should involve Māori (National Ethics Advisory Committee, 2019; Wyeth et al., 2010).

As described previously in Chapter 4, I was greatly assisted by representatives from Te Puna Oranga (Māori Health Service) at Waikato DHB who provided invaluable insights into conducting research in partnership with, and for the benefit of, Māori. Their input significantly helped inform and nurture this research, specifically with maximising opportunity for Māori participation and recognition of how my key study findings align with Te Ao Māori. Key concepts in my theory find resonance with Māori concepts which I discuss below, followed by reflection on the cultural challenges faced in the process of conducting the study.

Resonance of Theory Concepts with Tikanga Māori Concepts and Practices

My theory describes three theoretical categories in the process of learning that broadly encompass the relational and learning experience of parent and therapist participants, that is

establishing relationship, **partnering in learning**, and **integrating learning**. Post hoc comparisons of my theory with concepts and traditions articulated in the Māori world view coincidentally identify likeness between my theory and tikanga Māori cultural practices. These observations were further informed through consultation with Te Puna Oranga advisors as I became aware of similarities. For instance, the Māori concept of 'ako' (meaning both teaching and learning, or the acquisition of knowledge as well as the imparting of knowledge) in education underpins the learning experience for Māori and is grounded in the principle of reciprocity, acknowledging that new knowledge and understandings can grow out of shared learning experiences (Alton-Lee, 2003; Morrison & Vaioleti, 2011). This shares commonalities with the essence of the theory where parents and therapists **learn from and with each other**, learning together as they work in partnership. Ako validates "reciprocal learning experiences that in turn promulgate shared learning" (Berryman et al, 2002, cited in Education Review Office, 2016, p. 8).

Te Puna Oranga advisors likened much of my findings as reflecting a hui (meeting or coming together) or pōwhiri (typically a welcoming ceremony on a marae or meeting grounds) process. Lacey et al. (2011) described a hui process as a framework to enhance doctor-patient relationship with Māori. The hui process has also been recommended as part of tailoring occupational therapy approaches when working with Māori, such as OPC (Graham & Ziviani, 2021a). Others in health research and service provision have suggested a similar pōwhiri process which, like the hui process, can be considered as instructions for how to conduct an appropriate relationship or interaction (Drury, 2007; McClintock et al., 2012). Pitama et al. (2014) developed an Indigenous Health Framework incorporating the hui process (Lacey et al., 2011) and the Meihana model (Pitama et al., 2007) providing "a clinical framework to assist health practitioners working with Māori patients and whānau to contribute to improved Māori health outcomes" (p. 117) which aimed to translate cultural principles into an approach health practitioners could use in everyday practice. The overarching concept of whakawhanaungatanga (process of establishing meaningful relationships) and strong relational focus is integral to each of these, and to my theory.

The hui process (Lacey et al., 2011) includes four key elements which share similarities with components of my theory. The first two elements—mihi (initial greeting) and whakawhanaungatanga (making a connection)—parallel with the theoretical category **establishing relationship**, and subcategories of **connecting** and **crossing the relational threshold**. The theoretical category **partnering in learning** reflects the third element of kaupapa (attending to the main purpose of the encounter). The fourth element, poroporoaki (concluding the encounter), is represented in **getting on the same page again** at the end of a session, or **integrating learning** and **moving on** from a specific issue or from therapy as a whole.

For Māori, building relationship and making connections before starting to address the purpose of the interaction is critical. Investing time to make a strong connection and establish relationship before **crossing the relational threshold** was fundamental to successful **partnering in learning** and engaging in 'doing' therapy. In congruence with my theory, Jones et al. (2006) highlighted the importance of connecting by taking time to establish relationship in whakawhanaungatanga, stating, "Allowing the time and space to develop these relationships is not an indulgence, an excess, a luxury or an optional extra: it is absolutely fundamental" (p. 70). Mihi (introductions/setting the scene) is a key tikanga element of establishing connection and developing a relationship (or therapeutic alliance) by introducing and sharing information about oneself (and in the case of the therapist their role), and acknowledging the reason for the interaction (Drury, 2007; Lacey et al., 2011; McClintock et al., 2012; Tipene-Matua et al., 2009). Crucially, part of enhancing whakawhanaungatanga and getting to know each other prior to commencing an interaction involves engaging with and learning about each other through reciprocal disclosure of personal information (Graham & Ziviani, 2021a; Pitama et al., 2014).

A central tenet of my theory is that buy-in to and partnering in therapy only comes after a connection is made, relationship has been established, and the **relational threshold** crossed. Thus, achieving connection was a one-off process. When considering **establishing relationship** and **crossing the relational threshold** in the theory, one Te Puna Oranga advisor likened this to the pōwhiri process, explaining,

> *You do it once. You might touch up, you might catch up, you might come into line with each other again, but you'll never go back to that first pōwhiri. So, rather than saying you are going to come back, you want to say that you have to do well at that first interaction, that engagement has to be spot on.*

Thus, for Māori in particular, the **relational threshold** may be a crucial point in the learning process and stronger than for other cultural groups.

Partnering is intrinsic to meaningful interactions in my theory. Maintaining the relationship and therapeutic alliance is key to successful therapy (Drury, 2007). In the theory, once the **relational threshold** is crossed and parents and therapists are **partnering in learning**, the original connection is not revisited. However, the relationship is continually tended throughout the duration of the interaction with **getting on the same page again** relationally, by regularly reconnecting during the learning process and efforts made by both parent and therapist to nurture their relationship. There are similarities with the tikanga Māori concept of manaakitanga including looking after people and treating them with care and respect (Jones et al., 2006; Mead, 2016; Tipene-Matua et al., 2009).

Kaupapa (attending to the main purpose of the encounter) allows for focusing on the presenting issues and concerns, as well as facilitating ongoing whakawhanungatanga or reconnecting (Lacey et al., 2011) as the parent and therapist discuss and address concerns and

the changing situation, as seen in the **partnering in learning** theoretical category. The Māori concept of tika (to be correct, right, fair, accurate and appropriate) relates to the subcategory **tailoring learning** to ensure the service is high quality and responsive to meeting the needs of those involved. Te Puna Oranga advised that it is inadequate doing whakawhanungatanga well, if the service delivery (**tailoring learning**) then falls short. This is particularly relevant for Māori who experience inequalities in accessing and receiving relevant and quality health services (Hopkirk & Wilson, 2014; Jansen et al., 2009; Wyeth et al., 2010). When working with Māori, general knowledge about the value of connection is perhaps emphasised over service delivery. My theory's emphasis on bidirectional learning and responding to what is being learned in the moment contributes to meeting the needs of those involved in order to provide a high-quality service.

Poroporoaki (concluding the encounter) involves farewells and acknowledgments and has also been translated as "leavetaking" (Lacey et al., 2011; Mead, 2016, p. 397; Tipene-Matua et al., 2009). It can include acknowledging the work done, recapping what has happened, discussing what has arisen during the meeting, and parting in peace (Tipene-Matua et al., 2009). In the theory, this is seen when **getting on the same page again** at the end of a session where mutual understanding of what has transpired and been discussed is checked and both parties understand what would come next or be done until they next meet (Lacey et al., 2011). That is, they parted by **getting on the same page again** with mutual understanding and expectations (sometimes with written resources provided to confirm this). When considering **moving on** and concluding the therapy relationship as a whole, the efforts made to part well and end the therapeutic partnership gracefully, for instance by easing out and ensuring ongoing services were linked in, also shares similarities with poroporoaki.

The advantage of formalised processes such as the hui process means that everyone involved is 'on the same page' about what is valued, what is going to happen and where they are up to in the process. My theory of **Responsive learning: Learning from and with each other** appears consistent with, and follows a similar ebb and flow as, the hui process. My theory highlights the importance of establishing and tending relationship when engaging in therapy and other health interactions for all involved, consumers, clinicians, service managers, and policy makers, especially for Māori. It may assist health practitioners to better engage with service users, particularly with Māori. Further development of this would need to be in conjunction with Māori.

Challenges and Opportunities with the Research Process

Consultation is a key component of research involving Māori participants (Tolich, 2002). Accordingly, I had consulted with Te Puna Oranga advisors at all stages of the research—during planning, recruitment, analysis and, at the final stage, checking the fit and relevance of the theory being constructed to Māori. Their guidance and checking my

understanding proved invaluable to developing my own awareness and responsiveness to Māori through the research process. Where possible I implemented advice received; but there were tensions between following consultation advice to design a study that was capable of producing results relevant to Māori and other factors impacting my efforts to genuinely respond to te Tiriti by involvement of Māori in the study (Wyeth et al., 2010). Several challenges were identified that potentially limited Māori participation in this study, as discussed in Chapter 4 Methods. These included excluding parents already known to me through my clinical work, and therapists acting as gatekeepers, particularly with Māori parents.

As discussed in Chapter 4, the ethical reason for excluding parents known to me through my clinical work was to preserve the therapy relationship, which reflected western research ethics. This stance conflicted with a Māori world view, where connection is vital for engagement. As such, it is an historical and persistent consequence of colonisation which has contributed to inequalities in health status between Māori and non-Māori (National Ethics Advisory Committee, 2019). Consultation advice at the outset was that not meeting parents prior to interviewing and excluding those already known to me may be a barrier to Māori participating. This is not surprising considering the importance of the Māori concept of whakawhanaungatanga (making a connection) and establishing a relationship before attending the purposes of an interaction (Jones et al., 2006; Lacey et al., 2011). This is also a common sentiment amongst many non-Māori who would prefer to engage with a known person rather than someone completely unfamiliar. This challenge proved true in that further consultation and change in recruitment strategy was required when parent participants were not forthcoming.

Another identified barrier to Māori participation is encapsulated in the concept of 'pākehā paralysis', where fear of breaching cultural boundaries has resulted in 'paralysis' among pākehā researchers and practitioners, creating challenges to meet obligations under te Tiriti to treat Māori adequately (Drury, 2007; Hotere-Barnes, 2015; Tolich, 2002). This was evident when intermediary therapists, although well-intended in not wanting to overburden parents, unwittingly disabled parents, particularly Māori parents, from making their own choice to participate in this research by not offering information or the opportunity to decide for themselves. Implementing Te Puna Oranga advice of reminding therapists of the importance of people, particularly Māori, having the opportunity to decide for themselves, and benefits of Māori participation in research contributed to overcoming this barrier. I too experienced 'pākehā paralysis' as a researcher (Drury, 2007; Hotere-Barnes, 2015; Tolich, 2002). Lacking confidence and unaware of my own naivety I consciously avoided tikanga practices such as offering a karakia (Māori prayer, incantation, or blessing) with Māori participants because I felt uncomfortable and concerned I may not do it appropriately, despite having a karakia prepared. On reflection, it would have been better to offer, rather than ignore, the karakia. I have since undertaken Tikanga Best Practice training at Waikato DHB to further my understanding of

Māori cultural practices and sought to learn a karakia to be more prepared and confident to offer it in future interactions.

Recommendations

This research has contributed new knowledge by providing a substantive grounded theory, theoretical model, and explication that increases understanding of the process of learning between parents and occupational therapists. Specifically, the research showed that learning is bidirectional and responsive, and learning is deeply relational. Recommendations arising from this research have implications for further research, clinical practice, occupational therapy (and other health professionals), and education.

<u>Further Research</u>

- This study focused on the learning between parents and therapists. Further work focusing on the child-parent-therapist triad of learning would extend the findings.
- Parent participants in this research were engaged in working with a therapist for long-term intervention for their child. The research could be further extended by research into the process of learning in settings where there is short-term therapy involvement.
- Learning was found to be bidirectional. A useful direction for further research would be to determine if there is a difference in creating the therapeutic alliance and family engagement in therapy when therapists were more aware of their own learning trajectory. A further action research study potentially including interviews, observations and focus groups could explore therapists understanding and experiences of using the theory of **Responsive learning: Learning from and with each other** in different clinical contexts in cultivating relationships and enhancing their practice over time.
- Parents in this study were active in cultivating and maintaining relationship with the therapist.
    - Further grounded research using interviews and observations would be useful for capturing, understanding, and explaining specific processes and strategies used in connecting, tending, and maintaining relationships from both clinician and clients in different clinical contexts and with people from different cultural backgrounds, genders, and sociocultural status.
    - Research to find out whether there are circumstances that make parents' or clients' relational work more, or less, prominent would deepen understanding, such as when therapy may be short or long-term; when interactions with service providers are new, irregular and short; or familiar, routine and often (where more learning may have occurred).
- Therapists in this study talked about time and service constraints influencing their ability to connect with parents and invest in establishing relationships. Further research

into constraints parents experience when investing in establishing relationships would be a direction for future research to help therapists navigate the connection process more effectively.

- Future research may involve validation of the theory in the context of practice models that shift the focus of intervention from remediation to directly supporting participation, as these continue to evolve and enter practice. Uptake of these practice models could conceivably alter therapists' and parents' experience of therapy, with families' differing aspirations for their children's participation requiring greater alignment of therapy goals with each family's circumstances.
- With increasing use of telehealth and virtual platforms in place of in-person interactions in health service delivery and education (Camden & Silva, 2021; Kinsella, 2015; Rosenbaum et al., 2021), it would be beneficial to ascertain whether this theory supports partnering, interactions, and outcomes in virtual contexts.
- Further research into embodied learning and the use of gesture in learning, as seen influencing learning in the observations in this study, particularly when balancing use of technology and virtual platforms, whilst maintaining embodied human contact in clinical and education encounters (Loftus, 2015), would extend this work.
- Using the theory of **Responsive learning: Learning from and with each other** in practice may impact outcomes of therapy, but these were not measured in my study. Further mixed methods research is recommended to determine if **responsive learning** would influence clinical outcomes and to consider if time spent establishing and maintaining relationships is justifiable to achieve better outcomes.
- Exploring the transferability of the theory of **Responsive learning: Learning from and with each other** with further research with different client groups in different contexts within and beyond occupational therapy would extend this work. For example, exploring its resonence, relevance and usefulness when working in two-person learning relationships (such as therapist and older child, or therapist and adult), practice areas beyond paediatrics (such as rehabilitation, mental health, and community services), and with different professional groups (such as physiotherapists, speech language therapists, nurses and doctors).
- Further research considering my theory when tailoring learning to Māori would be beneficial in the Aotearoa New Zealand context in conjunction with Māori.
- The combination of interview, observation, and photographs of documents as data sources was pivotal in this study. The addition of observations proved invaluable to revealing insights that were not apparent in interviews, which added depth to the findings and theory construction. Incorporating multiple data sources would be advantageous in future research in this area.

Clinical practice

- Clinicians often feel institutional pressure to quickly engage in therapy and achieve outcomes. **The theory of Responsive learning: Learning from and with each other** supports prioritising and investing time into establishing and maintaining a relationship to effectively engage in learning to gain value from therapy. Successful relationship influences future relationships with other health professionals. Time spent investing in relationships should be encouraged prior to therapy proper commencing.
- As learning is bidirectional and responsive, therapists should be alert to the significance of their role as a learner and intentional about learning, and responding to what they learn, when working with parents.
- This research brings to light the relational work of parents. It would be helpful for students and therapists to appreciate that the clients are also engaged in working to build and maintain the relationship with clinicians. Additional research to inform practice and service delivery might involve educational experiences to alert students and therapists to the relationship work clients do. Interviews or surveys could be used to explore whether they observed what they had learnt in their practice, noticed other things clients were doing to this end, and whether being cognisant of the mutual relational work of clients and clinicians affected their experiences of being a service provider.

Education

- Health care practitioners would benefit from knowledge and understanding about adult learning theory (andragogy) and skills in order to teach, facilitate client/parents' learning, and understand themselves as learners (Nightingale et al., 2015). Incorporating social and adult learning theories and teaching approaches within professional training programmes and continuing professional education would equip therapists to fulfil their roles as resource people and become intentional cognisant co-learners in the therapy partnership and learning process (Hurtubise & Carpenter, 2017).
- Using the theory of **Responsive learning: Learning from and with each other** in academic curricula could support students' learning and development as clinicians to enhance collaborative relationships and practice, and improve service delivery and client participation in therapy. The following aspects may be especially beneficial:
    - **Responsive learning** involves oscillation between a focus on tending and maintaining relationship and building on learning to engage in therapy. Responding to both aspects through a process of **getting on the same page again** is the crux of **responsive learning**, working collaboratively and moving forward with therapy.

    - Alerting students and clinicians to the value of being cognisant on-going and responsive co-learners in their practice and interactions with clients to effectively tailor learning and therapy support to clients.
    - Teaching students that time spent building relationship is useful and productive in order to initiate and progress with therapy. Highlighting to therapists and students that learning and therapy occur in the context of relationship and involves mutual efforts of clients and therapists in establishing, tending, maintaining, transferring, and ending relationships may enhance long-term client engagement in health services.
- Embodied learning was significant in influencing parent and therapist learning in this study. Occupational therapy training involves embodied learning of hands-on skills. Students need to be aware that they will be teaching similar skills to parents or clients to achieve the required therapy at home.
- In the Aotearoa NZ context, links with Māori tikanga and the Hui process would help contextualise **Responsive learning** for students to apply in clinical practice.

Limitations

It is important to acknowledge limitations in this study which potentially impacted on the grounded theory constructed (Birks & Mills, 2015). 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. Considering the child as more than an influence on the learning process between the adults and generating data that directly included the child within the learning process may have produced different results. Several constraints contributed to limiting the child's inclusion in this study including the potential challenge of gaining ethical approval given the age of the children concerned.

Participants were recruited from four services in two large cities (and surrounding districts) in Aotearoa 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 in the research. Further, there were no Māori therapist participants who may have added a different perspective.

Although therapist participants had experienced concluding therapy with parents, most of the parent participants sharing their experiences were within the therapy process and had not experienced concluding therapy with a therapist or **moving on** to other services. Therefore, data were limited by parent participants' experience and data supporting that aspect of the therapy were predominantly from therapists' perspective.

Guided by theoretical sampling, in addition to interviewing parents and therapists, I added filming therapy sessions for observation and later took photos of learning resources provided to parents by therapists as data sources. I may have gained greater depth of understanding in the theory had I incorporated these sources from the outset. As an emerging researcher, I was learning, experimenting, and developing my understanding, research and analytical skills while undertaking the research process. My practical interviewing and observation skills were refined as I gained experience and engaged in reflexivity as the study progressed. Progress was evident in gaining greater depth of data as interviews progressed.

In constructivist grounded theory, researchers acknowledge their role as part of the research process and co-constructor of data and theory with participants in the research (Charmaz, 2014; Charmaz & Bryant, 2010). My roles as researcher, clinician, and parent potentially brought both strengths and limitations to the study. In some cases, these roles meant I could relate to participants and some of their experiences. However, a limitation was my potential influence on the research, and risk of assumed understandings of what participants meant based on being a clinician or parent, and vice versa. These were managed through reflection, memoing, and discussion with my supervisors. I became increasingly alert to times I might have been influencing the data or assuming meaning, which prompted me to ask more and probe deeper to gain participants' meaning. However, another grounded theorist may have constructed a different theory with the same participants.

This PhD was undertaken over an extended time and is reporting data that are several years old. If I were generating data today it may reflect more current participation focused practice initiatives and terminology current in paediatric occupational therapy practice in Aotearoa New Zealand such as OPC (Graham, 2021) and use of F-words for child development (Rosenbaum & Gorter, 2012) which are increasingly prevalent in practice, but not in my data. However, as I was looking at the process of learning, not specific intervention approaches, the essence of the theory in unlikely to be different.

Reflecting on the Quality and Strengths of the Research

This constructivist grounded theory research was undertaken using Charmaz's criteria of credibility, originality, resonance, and usefulness as a quality reference point (Charmaz, 2014; Charmaz & Thornberg, 2020), as outlined in Chapter 3 Methodology. I return to these criteria to evaluate the quality and strengths of the study.

Credibility reflects the logic and conceptual grounding of the study (Birks & Mills, 2015; Charmaz, 2014). To enhance rigour and credibility of the study, care was taken to rigorously plan and develop the study with congruence between the purpose of the research, methodological approach, and grounded theory methods used. The way I applied grounded theory methods strengthens the study rigour and claims I make. I have demonstrated

transparency throughout the thesis with my methodological positioning and decisions regarding grounded theory processes used. I provided examples from data analysis to clarify methodological explanations and links between data, analysis, and conceptual development in the Methodology and Methods chapters (Chapters 3 and 4). Grounded theory methods, such as theoretical sampling, enabled me to check and validate concepts in the theory with participants as the theory was constructed.

Credibility was strengthened through inclusion of diverse participant groups (parents and occupational therapists) and the triangulation of data generation sources (interview, film, and photos). Other paediatric therapy studies predominantly consider a unidirectional perspective. Unique to my study was the perspective of both parents and therapists in the generation of data and construction of the theory.

To ensure the theory remained grounded in the data, participants' voices and experiences are reflected in each aspect of the theory and categories presented in the findings (Chapters 5-9). Reflexivity and self-reflection have been consistently used throughout with the use of a reflective journal, memoing, discussions with my supervisors, and active participation in a monthly university peer-support grounded theory group to scrutinise and critique my decisions, understandings, and interpretations; and maintain awareness of my potential influence and role in the research as the theory was constructed.

Originality refers to the significance of the study and whether the grounded theory offers new insights and extends extant knowledge (Birks & Mills, 2015; Charmaz, 2014). The findings chapters (Chapters 5-9) present this original grounded theory and demonstrate how the theory, concepts and categories, and connections between them, are firmly grounded in the data. The theory has been situated within extant literature and the contributions the study has made to knowledge have been discussed earlier in this chapter. From a pragmatist perspective, all claims to knowledge are instrumental and provisional (Bryant, 2017). Therefore, although useful grounded theories add new knowledge, they also present directions for further research, which have been suggested in the recommendations section.

Resonance and usefulness relates to knowledge development and practical application, the extent to which the substantive research conceptual insights prove useful, and potential scope of the study and extendibility to other settings (Birks & Mills, 2015; Bryant, 2017; Charmaz & Thornberg, 2020). Bryant (2017) argued, "the overarching criteria of good research should be that is makes a difference" (p. 344). As a clinician and researcher, it was important to me that the results had clinical application and usefulness to clinicians and parents, and the wider health context.

Resonance has been considered within the research process through theoretical sampling, and by checking the theory with participants to confirm meaning and fit with them. 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 contexts. Consultation and checking the fit and applicability of the theory for Māori was undertaken with Te Puna Oranga in an effort to ensure relevance to Aotearoa New Zealand context (Chapters 4 and 10).

The theory has also been presented to and discussed with occupational therapists, health professional colleagues, and service managers in various forums. These discussions revealed resonance with the theory and concepts within it, the potential utility of the theory in everyday clinical practice and indicated transferability with application in other situations and contexts such as for informing service improvement projects or in different clinical settings. This feedback aligns with Charmaz's (2014) argument that "grounded theory concepts can travel within and beyond their disciplinary origins" (p. 16) and suggests the relevance, usefulness, and transferability of this theory to the broader therapy and health context.

Conclusion

The aim of this constructivist grounded theory research was to provide a theoretical explication of the process of learning between parents and occupational therapists who work with children. Using grounded theory methods, the theory of **Responsive learning: Learning from and with each other** was constructed.

The occupational therapy profession has historically referred to an eclectic range of learning theories. Moreover, the profession has predominantly framed learning as unidirectional with clients learning from an expert therapist. There has been scant progress in gaining understanding of the process of learning between occupational therapists and their clients. This understanding is an important foundation for effective service delivery. My theory newly addresses the unique needs and nuances of teaching and learning within occupational therapy practice when working with parents of children requiring support with their development. It provides a unique occupational therapy-based explication of teaching and learning within the profession. The theory of **Responsive learning: Learning from and with each other** highlights the bidirectional and responsive nature of learning, and that relationship is key to learning between parents and occupational therapists. While components of my theory align with extent literature, theory and emerging 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**.

This localised substantive grounded theory explaining the learning process between parents and therapists will inform and challenge clinical practice, and enhance the learning experiences of parents, children, and therapists. Understandings gained from this research will

potentially encourage more efficient, equitable, and effective engagement with clients within therapy services. Although the applicability of my theory in contexts beyond that where it was developed is yet to be explored, it has potential to extend beyond the occupational therapy profession to inform the practice of clinicians in a range of health settings. This research holds promise for improving health outcomes through better meeting the needs of service users by prioritising establishment of collaborative relationships, embracing enhanced mutual learning strategies, and responding to learning in clinical practice.

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Appendices

Appendix A: AUTEC Application Approval

AUT UNIVERSITY | AUTEC SECRETARIAT

13 May 2015

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Ethics Application: **15/111 Factors influencing parents' learning from paediatric occupational therapists: Perspectives of parents and therapists.**

Thank you for submitting your application for ethical review. I am pleased to confirm that the Auckland University of Technology Ethics Committee (AUTEC) has approved your ethics application for three years until 11 May 2018.

AUTEC would like to commend you and researcher on the quality of your application.

AUTEC advises that the Information Sheet needs a section on 'How was I identified'.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 11 May 2018;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 11 May 2018 or on completion of the project;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Cait Harvey cait.harvey.nz@gmail.com; Margaret Jones

Auckland University of Technology Ethics Committee
WA505D Level 5 WA Building City Campus
Private Bag 92006 Auckland 1142 Ph: +64-9-921-9999 ext 8316 email ethics@aut.ac.nz

Appendix B: AUTEC Amendment for Revision of Recruitment Protocol and Addition of Observation Component

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

2 June 2016

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re: Ethics Application: **15/111 Factors influencing parents' learning from paediatric occupational therapists: Perspectives of parents and therapists.**

Thank you for your request for approval of amendments to your ethics application.

I have approved minor amendments to your ethics application allowing:

- Revision of recruitment protocol
- Addition of an observation component

NOTE: Inclusion of advice in the Information Sheet that footage will only be used for analysis, and will not be show to any other person would be helpful.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTEC):

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 11 May 2018;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 11 May 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Cait Harvey; Margaret Jones

Appendix C: AUTEC Amendment for Title Change and Extending Timeframe

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

1 June 2017

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re: Ethics Application: **15/111 The process of learning between parents and occupational therapists who work with children: A grounded theory study.**

Thank you for your progress report and request for approval of amendments to your ethics application.

I have approved minor amendments to your ethics application allowing a change of title, change of qualification, alteration of recruitment criteria, and an extension of time to 20 August 2020.

I remind you of the Standard Conditions of Approval.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: cait.harvey.nz@gmail.com; Margaret Jones

Appendix D: AUTEC Amendment for Change to Inclusion Criteria and Recruitment Protocol

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

17 July 2017

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re: Ethics Application: **15/111 The process of learning between parents and occupational therapists who work with children: A grounded theory study.**

Thank you for your request for approval of amendments to your ethics application.

I have approved minor amendments to your ethics application allowing changes to the inclusion criteria and recruitment protocols.

I remind you of the Standard Conditions of Approval.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: cait.harvey.nz@gmail.com; Margaret Jones

Appendix E: AUTEC Amendment for Addition of Photographs of Supporting Learning Material

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

6 December 2017

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re: Ethics Application: **15/111 The process of learning between parents and occupational therapists who work with children: A grounded theory study.**

Thank you for your request for approval of an amendment to your ethics application.

The amendment to the data collection protocols (photographs) is approved.

I remind you of the Standard Conditions of Approval.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: cait.harvey.nz@gmail.com; Margaret Jones

Appendix F: Waikato District Health Board (DHB) Approval of Research

Waikato DHB Approval of Research

RD015018	Factors influencing parents' learning from paediatric occupational therapists: Perspectives of parents and therapists (The Learning Study)

Project Personnel

Principal Investigator:	
Waikato DHB investigators:	Cait Harvey Cait.harvey.nz@gmail.com 021 468 229
Primary contact name and details:	Cait Harvey

Date Submitted:	04/03/2015
Type of Project:	Other
Multisite?	Not a multi-centre project
Department:	Child Development Centre
Service:	Child Health

Project Description:

Start: 11 May 2015
End : 11 May 2017
Sample Size : potentially 5-8 parents

Paediatric occupational therapists work collaboratively with parents to deliver therapy interventions. A key therapy role is to help parents learn about their child's condition, treatment options, and the hands-on skills required to implement therapy at home. This learning can impact parents' decisions regarding their child's treatment, buy-in and commitment to services, and subsequent outcomes of interventions provided.

This qualitative research aims to bring together perspectives of parents and therapists to better understand the process of learning in the parent-therapist collaborative relationship, the factors that influence this process, and their consequences, and to generate a theory with participant data as central. Data will be obtained from interviewing ten to sixteen participants; both parents of pre-school aged children receiving on-going therapy intervention and occupational therapists working with this client group.

The outcomes of this research may assist occupational therapists and other clinicians to better understand the process of learning in the parent-therapist collaborative relationship. It may

challenge clinicians to consider their practice and relationships when working with families, to improve the learning opportunities and the education they provide parents, and justify time spent on parent education and learning. Parents can only benefit from this and ultimately their children, who are the therapists' clients.

The resourcing from Waikato DHB for this study would be minimal- only a moment of clinician time to tell parents about the study, to pass on a flyer to a parent or give them my contact details if a parent is interested in participating in the study, so the parent can contact me of their own volition. I anticipate accessing therapist participants for the study through my own professional networks. Some may be Waikato DHB employees, but I anticipate any meetings with them would be out of normal work hours. I will be recruiting for participants from other organisations as well. I am not wanting to talk to or gather any patient information, just the parents.

Management and Resource Sign-offs

Choose from option 1 or 2 for locality review

This study does not require HDEC review (will get University Ethics review).

Locality Review – *the undersigned agree to the following statements:*

- The study protocol and methodology are ethical and scientifically sound.
- This researcher has identified that this study does not require Health & Disability Ethics Committee (HDEC) review.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Cultural consultations have occurred or will be undertaken as appropriate
- Appropriate confidentiality provisions have been planned for.
- Appropriate arrangements are in place to notify other relevant local health or social care staff about the study, and for making available any extra support that might be required by participants, where relevant.
- Conducting this research will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that the results of the study will be disseminated and where practical and appropriate the findings of the study will be translated into evidence based care.

Queries about this research must be made to the Primary Contact person listed.

Dept/Service/ Org	Role	Name (print clearly)	Signature	Date signed
Child Health	Clinical Unit Leader	Dave Graham		16-5-15
Child Health	Group Manager	Di Peers	DPeers	14/6/2015
Te Puna Oranga	Service Development Manager	Millie Berryman	MBerryman	19-05-15

Clinical Support Services Sign-offs

CROSS OUT/ADD SIGN-OFFS APPLICABLE TO THIS PROJECT

SIGNATORIES DECLARATION: We agree that appropriate resources are available in our service to support this project

Clinical Support Service	Name (print clearly)	Signature	Date signed
~~DHB Pharmacy~~	~~Rajan Ragupathy~~		
~~Laboratory~~	~~Kay Stockman~~		
~~Radiology~~	~~Dr Muthu~~		
~~Medical Records~~	~~Marilyn Hunt~~		

Please return to the Research Office (via Sarah Brodnax, Menzies L9) along with required documents as identified in the checklist for final approval.

Office use only:
Office of the Chief Operating Officer, Waikato DHB

Signature: **Date:** 30/1/2015

Name: Brett Paradine
Interim Chief Operating Officer **Position:**
Waikato DHB

Appendix G: Te Puna Oranga Māori Consultation Research Review Committee Endorsement

29 April 2015
– Cait Harvey

Re: Paediatric Occupational therapists perspective of parents and therapists

Tēnā Koe Cait,

Thank you for submitting the above research proposal to the Waikato DHB Te Puna Oranga Māori Consultation Research Review Committee (TPOMCRRC) for consideration and endorsement. The Committee has reviewed the research and acknowledges our face to face discussion regarding your research.

The Committee and Te Puna Oranga Māori Health service support research that benefits and improves the health of Māori while reducing inequalities of care and access for Māori. There are simple steps that can be made within research to ensure that this occurs, starting with engaging Māori as participants and/or researchers and collecting ethnicity data to improve data collection.

We wish you well with your study and encourage you to continue to consult with Te Puna Oranga Māori Consultation Research Review Committee or TPOMCRRC and to incorporate our recommendations into your study.

Millie Berryman
Pou Whakahaere
Te Puna Oranga-Maori Health Service
Millie.Berryman@waikatodhb.health.nz

Appendix H: Flyer

About the researcher:

Cait Harvey has been working as an occupational therapist with children and their parents for over 20 years, in different clinical settings.
She works part-time at the Waikato DHB Child Development Centre and teaches occupational therapy students in Hamilton.
Cait is also a parent, with 4 children aged between 6 and 13.

Cait is a PhD student at Auckland University of Technology (AUT), and is doing this research for her thesis.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:
Professor Clare Hocking, clare.hocking@aut.ac.nz, 09 921 9162.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC:
Kate O'Connor, ethics@aut.ac.nz, 09 921 9999 ext 6038.

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Approved by Auckland University of Technology Ethics Committee on 17th July 2017, AUTEC Reference number 15/111.

The Learning Study

The process of learning between parents and occupational therapists who work with children

An invitation to consider participating in this research.

What is this research about?

This research is studying the process of learning between parents and occupational therapists, and the factors which influence this learning, from the perspectives of both parents and therapists.

The results may challenge clinicians to consider their practice and relationships when working with families, and to improve the learning opportunities and the education they provide parents.

Who can participate in this research?

Parents of pre-school aged children receiving on-going occupational therapy intervention requiring daily parental input at home are being invited to participate in this study.

Occupational therapists working with this client group are also invited to participate.

What is involved if I participate in this research?

Participating in this research would involve either being interviewed at a time and place that suits you or a routine therapy session with your child's occupational therapist being filmed.

In an interview I am interested in finding out about your experiences, as a parent, of working with and learning from your child's occupational therapist.
Through filming a routine therapy session I'm interested in seeing what may influence learning during therapy sessions.

By participating in this research you will help me generate the data that will be used for analysis in this research.

I will give you a pseudonym (made up name), so no one will be able to identify you in the reporting of the study. Participants will not be told who else is participating in the research, but I may ask you if you know of other parents who might be interested in participating.

Can I change my mind?

Participation is entirely voluntary.
You would be free to withdraw from the research up until one week after the interview or filming of a therapy session, if you change your mind.

How do I find out more about participating in this research?

If you are interested in participating in this research or for more information please leave Cait a message with your contact details at:

Email: thelearningstudy@gmail.com
Phone: 0800 753 276 (0800 7learn)
or Text: 021 653 276

Alternatively, you can ask your child's occupational therapist to pass on your contact details to Cait and she will contact you.

What happens then?

Cait will contact you and answer any questions you might have.
She will send you a more detailed information sheet about the research and what is involved.

She will then give you some time to consider if you want to accept the invitation to participate in this research, before making arrangements with you for an interview, or with you and your child's occupational therapist to film one of your child's routine therapy sessions.

Appendix I: Parent Information Sheet

Participant Information Sheet

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Information for Parents

Date Information Sheet Produced: 12 May 2016

Project Title:

The process of learning between parents and occupational therapists who work with children

An Invitation:

My name is Cait Harvey and I am a PhD student at Auckland University of Technology (AUT). I am conducting research to understand more about the process of learning between parents and occupational therapists who work with children, and the factors which influence this learning. I am interested in understanding the perspectives of both parents and therapists.

I would like to invite you to participate in my research. Participation is entirely voluntary and would involve me either interviewing you at a place of your choice or filming a routine therapy session with your child's occupational therapist. If your child's therapy session is filmed, I may ask you if I can interview you at a later date also. You would be free to withdraw from the research up until one week after the interview or filming of the therapy session, if you change your mind.

Researcher background:

I have been working as an occupational therapist with children and their parents for over 20 years, in different clinical settings. In my role as an occupational therapist, I have always been interested in working collaboratively with parents to achieve the best therapy outcomes for their child. I work part-time at the Waikato DHB Child Development Centre and teach occupational therapy students in Hamilton. I am also a parent, with 4 children aged between 6 and 13.

What is the purpose of this research?

This research aims to assist occupational therapists and other clinicians to better understand the process of learning in the parent-therapist collaborative relationship. It may challenge clinicians to consider their practice and relationships when working with families, and to improve the learning opportunities and the education they provide parents. This research will contribute to the completion of my PhD thesis. The findings from this research may be published in an academic journal or presented at a professional conference.

How was I identified and why am I being invited to participate in this research?

Someone may have told you about this research as they thought you may be interested in participating. You may have seen information about this study and made contact with me to find out more about it, or you may have given your child's occupational therapist your contact details to pass onto me so I could contact you.

Parents of pre-school aged children receiving on-going occupational therapy intervention requiring daily parental input at home are being invited to participate in this study. However, if I am one of your

child's occupational therapists from the Child Development Centre Splinting Clinic, you will not be eligible to participate in the research.

What will happen in this research?

By participating in this study and sharing your experiences with me you will help me generate the data that will be used for analysis in this research, to help understand the factors that influence the process of learning between parents and occupational therapist who work with children, from the perspective of parents.

For an interview: We will arrange a time and place that suits you to meet for an interview. The interview should take approximately 1-1 ½ hours. I would be happy to come to your home if that is most convenient, or I could meet you at another place you may suggest. For most participants only one interview will be required, but in some instances I may ask to return to you for a second short interview or have a telephone call to clarify aspects of the first interview, or to gather more information. You are also very welcome to have someone else with you for the interview, such as a family member or friend.

In the interview I am interested in finding out about your experiences, as a parent, of working with and learning from your child's occupational therapist; how you have learnt about your child's condition, therapy intervention and how to do your child's home programme; and the things you have found helpful and things that could have been done differently. The interview will be audio-taped and transcribed.

I am also going to be interviewing occupational therapists for their perspectives as part of this research.

For filming a therapy session: Your child's occupational therapist will have asked you if you agree for a therapy session to be recorded and asked you for verbal consent to pass on your contact details to me. Your therapist will arrange a routine therapy session in the usual way, at the usual location. I will attend the planned therapy session to answer any questions you may have and to set up the video camera on a tripod in the room prior to the session starting. I will either stay in the session as a passive observer or can leave, if you, your child or your child's therapist prefers. The session will be filmed with a video recorder, and the recording transcribed.

From filming the therapy session, I am interested in seeing the process of learning between you and your child's occupational therapist. I will be focusing on the interaction and learning between you and the occupational therapist. I am also interested in how the context of the therapy influences learning and the influences of your child on communication and learning. I will not be analysing the therapy intervention itself, your child's therapy progress, or judging you or the therapist. In order to protect your child's privacy and modesty, full face shots will be avoided where possible and therapeutic interventions (if any) involving removal of the child's clothing, such as demonstrating exercises to incorporate into nappy changing or bathing, will not be filmed.

You may like to show me, or I may also ask to take a photo of, a home programme or other educational materials that you have been given by the therapist, such as handouts or pamphlets. Identifying information will not be captured in the photo or will be edited out.

At a later time I will ask you to look at a copy of the preliminary findings to check you feel that it is consistent with your experiences.

What are the discomforts and risks?

I don't anticipate any risks to you from participating in this research. However, if you find the interview or filming upsetting, I can provide contact details for local counselling services.

What are the benefits?

You may appreciate the opportunity to share your experiences and the opportunity to contribute to knowledge that will inform therapists and influence the experience of parents in the future.

How will my privacy be protected?

Participants in the research will be given a pseudonym (false name) either by myself or have the option to choose their own, which will be used to protect your identity on all material such as tapes, filmed recordings, transcript and in reporting about the research. Participants will not be told who else is participating in the research, but I may ask you if you know of any other parents who may be interested in participating.

The interview tapes, filmed recordings, photos and transcripts will be confidential to me, the typist (who will sign a confidentiality agreement) and my 2 supervisors from AUT, and will be stored in a locked cabinet, separate from your consent form and contact details. Audio recording, filmed footage and photos will be used for analysis only, and will not be shown to any other person. All of these will be destroyed 6 years after the completion of the research. Any details of an identifying nature will be excluded from publication or adapted to protect the participant's identity.

What are the costs of participating in this research?

The only cost is your time. This includes time for the interview or filming a routine therapy session (about 90 minutes), a possible follow up discussion to clarify any queries that arise (no more than 30 minutes), and giving me feedback on preliminary findings (no more than 30 minutes).

If your therapy session with your child's occupational therapist has been filmed, I may ask you if you would be willing to be interviewed for the study at a later date. If you agree, that would involve an addition interview time (about 90 minutes), a possible follow up discussion to clarify any queries that arise (no more than 30 minutes), and giving me feedback on preliminary findings (no more than 30 minutes). There is no obligation to do this and the focus of the interview would not be on the filmed therapy session specifically, but on your experiences of learning with your child's occupational therapist in general.

If required, some assistance may be provided for reasonable travel and child minding expenses to enable your participation in this research.

What opportunity do I have to consider this invitation?

I appreciate your interest in this research.

For an interview: If you think you would like to participate by being interviewed for this research, I would like to hear from you. Please contact me to leave a message letting me know how I can contact you and how you would prefer to communicate- either by phone, email or text. Alternatively, you can ask your child's occupational therapist to pass on your contact details to me. I will contact you to check you meet the inclusion criteria for the study, to answer any questions you might have and to make sure you have all the information you need.

After that, I will leave you to consider this invitation for a week before getting in touch again to confirm whether you are still interested in participating and to make plans for an interview.

For filming a usual therapy session: If you think you would like to participate by allowing a routine therapy session with your child's occupational therapist to be filming for this research, your child's occupational therapist will have told you about the research and asked for your verbal consent to pass on your contact details to me – either phone, email or text, depending on your preference. Your child's occupational therapist may have given you a copy of this information sheet, or I will send you one. I will leave it for a week to give you time to consider this invitation before contacting you to confirm that you are still interested in participating; to confirm you meet the inclusion criteria for the study; to answer any questions you might have; and to make sure you have all the information you need.

I would be happy to come and visit you at a location of your choice before you agree to an interview or a therapy session to be filmed, if that is what you would like.

How do I agree to participate in this research?

Once an interview time and place that suits us both is arranged, or your child's occupational therapist arranges a routine therapy session which will be filmed, I will send you a copy of the consent form to read. We will go through the consent form and I will ask you to sign it when we meet, before we start the interview or filming. You will keep a copy of the consent form and I will keep a copy.

For filming a therapy session, as your child will be also be part of the filmed session, I will provide you with information to share with your child for their agreement and will also ask you to sign a consent form on their behalf.

Will I receive feedback on the results of this research?

All participants will receive a summary of the findings of this research once it has been completed, if they so wish.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking, clare.hocking@aut.ac.nz, 09 9219162.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz, 09 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Cait Harvey
Doctoral Student
C/- Clare Hocking
Department of Occupational Science and Therapy
Auckland University of Technology
Private Bag 92 006
Auckland 1142
Email: thelearningstudy@gmail.com
Phone: 0800 753276 (0800 7learn)
Text: 021 653276

Project Supervisor Contact Details:

Professor Clare Hocking
Department of Occupational Science and Therapy
Auckland University of Technology
Private Bag 92 006
Auckland 1142
Email: clare.hocking@aut.ac.nz
Phone: 09 9219162

Approved by the Auckland University of Technology Ethics Committee on 6th December 2017, AUTEC Reference number 15/111.

Appendix J: Therapist Information Sheet

Participant Information Sheet

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Information for Therapists

Date Information Sheet Produced: 12 May 2016

Project Title:

The process of learning between parents and occupational therapists who work with children

An Invitation:

My name is Cait Harvey and I am a PhD student at Auckland University of Technology (AUT). I am conducting research to understand more about the process of learning between parents and occupational therapists who work with children, and the factors which influence this learning. I am interested in understanding the perspectives of both parents and therapists.

I would like to invite you to participate in my research. Participation is entirely voluntary and would involve me either interviewing you at a place of your choice or filming a routine therapy session with one of the children on your caseload and their parent. If a therapy session is filmed, I may ask you if I can interview you at a later date also. You would be free to withdraw from the research up until one week after the interview or filming of the therapy session, if you change your mind.

Researcher background:

I have been working as an occupational therapist with children and their parents for over 20 years, in different clinical settings. In my role as an occupational therapist, I have always been interested in working collaboratively with parents to achieve the best therapy outcomes for their child. I work part-time at the Waikato DHB Child Development Centre and teach occupational therapy students in Hamilton. I am also a parent, with 4 children aged between 6 and 13.

What is the purpose of this research?

This research aims to assist occupational therapists and other clinicians to better understand the process of learning in the parent-therapist collaborative relationship. It may challenge clinicians to consider their practice and relationships when working with families, and to improve the learning opportunities and the education they provide parents. This research will contribute to the completion of my PhD thesis. The findings from this research may be published in an academic journal or presented at a professional conference.

How was I identified and why am I being invited to participate in this research?

I may have contacted you directly or someone may have told you about this research as they thought you may be interested in participating, or you may have seen information about this study and made contact with me to find out more about it.

Occupational therapists who work with parents of pre-school aged children receiving on-going occupational therapy intervention requiring daily parental input at home are being invited to participate in this study.

What will happen in this research?

By participating in this study and sharing your experiences with me you will help me generate the data that will be used for analysis in this research, to help understand the factors that influence the process of learning between parents and occupational therapist who work with children, from the perspective of occupational therapists.

For an interview: We will arrange a time and place that suits you to meet for an interview. The interview should take approximately 1-1 ½ hours. I would be happy to come to your workplace or home if that is most convenient, or I could meet you at another place you may suggest. For most participants only one interview will be required, but in some instances I may ask to return to you for a second short interview or have a telephone call to clarify aspects of the first interview, or to gather more information.

In the interview I am interested in finding out about your experiences, as an occupational therapist, of working collaboratively with parents; how you provide education to parents about their child's condition, therapy intervention and teaching hands on therapy skills parents need to implement home programmes; and the things you have found helpful and things that could have been done differently. The interview will be audio-taped and transcribed.

I am also going to be interviewing parents for their perspectives as part of this research.

For filming a therapy session: If you agree to participate in this research by allowing one of your routine therapy sessions to be filmed, I will ask you to talk to parents of pre-school aged children on your caseload about also participating in the research in this way and to give the Participant Information Sheet: Information for Parents or The Learning Study flyer to interested parents. I will also ask you to pass on the parent's contact details and preferred way of communicating to me (phone, email or text), with their verbal consent. I will give parents a week to consider participating in the research before contacting them to confirm their interest in participating in the study; to answer any questions they may have; and ensure they have all the information they need. You will arrange a routine therapy session in the usual way, at the usual location. I will attend the planned therapy session to answer any questions you or the parent may have, and to set up the video camera on a tripod in the room prior to the session starting. I will either stay in the session as a passive observer or can leave, if you, the child, or the parent prefers. The session will be filmed with a video recorder, and the recording transcribed. I will provide the parent with information to read with their child, so those children who are able to understand that a camera and new person will be there can give their assent. I can provide you with copies of this information.

From filming the therapy session, I am interested in seeing the process of learning between you and the parent. I will be focusing on the interaction and learning between you and the parent. I am also interested in how the context of the therapy influences learning and the influences of the child on communication and learning. I will not be analysing the therapy intervention itself, the child's therapy progress, or judging you or the parent.

You may like to show me, or I may also ask to take a photo of, a home programme or other teaching materials that you give parents, such as handouts or pamphlets. Identifying information will not be captured in the photo or will be edited out.

At a later time I will ask you to look at a copy of the preliminary findings to check you feel that it is consistent with your experiences.

What are the discomforts and risks?

I don't anticipate any risks to you from participating in this research. However, if you find the interview or filming upsetting, I can provide contact details for local counselling services.

What are the benefits?

You may appreciate the opportunity to share your experiences and the opportunity to contribute to knowledge that will inform therapists and influence the experience of parents in the future. After the

interview, I will give you a letter of acknowledgement of your participation in this research for your professional portfolio.

How will my privacy be protected?

Participants in the research will be given a pseudonym either by myself or have the option to choose their own, which will be used to protect your identity on all material such as tapes, filmed recordings, transcript and in reporting about the research. Participants will not be told who else is participating in the research but I may ask you if you could recommend other occupational therapists who may be interested in participating in this research.

The interview tapes, filmed recordings, photos and transcripts will be confidential to me, the typist (who will sign a confidentiality agreement) and my 2 supervisors from AUT, and will be stored in a locked cabinet, separate from your consent form and contact details. Audio recordings, filmed footage and photos will be used for analysis only, and will not be shown to any other person. All of these will be destroyed 6 years after the completion of the research. Any details of an identifying nature will be excluded from publication or adapted to protect the participant's identity.

What are the costs of participating in this research?

The only cost is your time. This includes time for the interview or filming a routine therapy session (about 90 minutes), a possible follow up discussion to clarify any queries that arise (no more than 30 minutes), and giving me feedback on preliminary findings (no more than 30 minutes).

For filming a routine therapy session, I would need you to liaise with me and to inform me of when and where the session will take place and anticipate that answering questions, signing consent forms and set up of filming equipment should take no longer than 10 minutes prior to the session.

If a therapy session has been filmed, I may ask you if you would be willing to be interviewed for the study at a later date. If you agree, that would involve an addition interview time (about 90 minutes), a possible follow up discussion to clarify any queries that arise (no more than 30 minutes). There is no obligation to do this and this interview would not be focused on the parent involved in the filming, but on your experiences with all parents in general.

If required, some assistance may be provided for reasonable travel and child minding expenses to enable your participation in this research.

What opportunity do I have to consider this invitation?

I appreciate your interest in this research. If you think you would like to participate in this research either by being interviewed or filmed during a routine therapy session, I would like to hear from you.

Please contact me to leave a message letting me know how I can contact you and how you would prefer to communicate- either by phone, email or text. I will contact you back to check you meet the inclusion criteria for the study, to answer any questions you might have and to make sure you have all the information you need.

After that, I will leave you to consider this invitation for a week before getting in touch again to confirm whether you are still interested in participating and to make plans for an interview or to film a routine therapy session with a pre-school aged child on your caseload and their parent.

I would be happy to come and visit you at a location of your choice before you agree to an interview or a therapy session to be filmed, if that is what you would like.

How do I agree to participate in this research?

Once an interview time and place that suits us both is arranged, or you have arranged a routine therapy session to be filmed with a parent who is also willing to participate in this study, I will send you a copy of the consent form to read. We will go through the consent form and I will ask you to sign it when we meet, before we start the interview or filming. You will keep a copy of the consent form and I will keep a copy. When filming a therapy session, the parent will also be asked to sign their own

copy of the consent form, as well as completing a consent and assent form with their child, for their child's inclusion in the filming.

Will I receive feedback on the results of this research?

All participants will receive a summary of the findings of this research once it has been completed, if they so wish.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking, clare.hocking@aut.ac.nz, 09 9219162.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz, 09 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Cait Harvey
Doctoral Student
C/- Clare Hocking
Department of Occupational Science and Therapy
Auckland University of Technology
Private Bag 92 006
Auckland 1142
Email: thelearningstudy@gmail.com
Phone: 0800 753276 (0800 7learn)
Text: 021 653276

Project Supervisor Contact Details:

Professor Clare Hocking
Department of Occupational Science and Therapy
Auckland University of Technology
Private Bag 92 006
Auckland 1142
Email: clare.hocking@aut.ac.nz
Phone: 09 9219162

Approved by the Auckland University of Technology Ethics Committee on 6th December 2017, AUTEC Reference number 15/111

Appendix K: Researcher Safety Protocol

Researcher Safety Protocol

Project title: The process of learning between parents and occupational therapists who work with children: A grounded theory study

Project Supervisor: Professor Clare Hocking

Researcher: Cait Harvey

- Prior to leaving for an interview, I will give my husband the address of where I am going in a sealed envelope, which will only be opened if necessary or destroyed after the interview.
- On arrival at the venue of an interview I will park my car in a position to exit safely and quickly, if need be.
- I will assess the venue for any visible signs of danger and reschedule the interview if there are any concerns for my safety.
- Before exiting my vehicle, I will text my husband with the following: "Arriving at interview-*time*".
- Once an interview is completed and within 2 hours of the start (once in my vehicle, preparing to leave) I will text my husband with the following: "Leaving interview - *time*".
- If for any reason the second text is not received within the 2 hours by my husband, he will first attempt to text or phone me.
- If contact cannot be made, he will open the envelope with the address and drive to the address to establish my whereabouts.

Project Supervisors Contact Details:

Professor Clare Hocking
clare.hocking@aut.ac.nz, Ph: 09 921 9162

Approved by the Auckland University of Technology Ethics Committee on 1st June 2017, AUTEC Reference number 15/111.

Appendix L: Transcriber Confidentiality Agreement

Transcriber Confidentiality Agreement

Project title: Factors influencing parents' learning from paediatric occupational therapists: Perspectives of parents and therapists.

Project Supervisor: Professor Clare Hocking

Researcher: Cait Harvey

- O I understand that all the material I will be asked to transcribe is confidential.
- O I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- O I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details:

.....

.....

.....

.....

Date: .....

Project Supervisor's Contact Details:

Professor Clare Hocking
clare.hocking@aut.ac.nz, Ph: 09 921 9162

Note: The Transcriber should retain a copy of this form.

Approved by the Auckland University of Technology Ethics Committee on 13th May 2015, AUTEC Reference number 15/111.

Appendix M: Interview Consent Form

Consent Form
For interview

Project title: The process of learning between parents and occupational therapists who work with children: A grounded theory study

Project Supervisor: Clare Hocking

Researcher: Cait Harvey

- O I have read and understood the information provided about this research project in the Information Sheet dated 12 May 2016.
- O I have had an opportunity to ask questions and I am satisfied with the answers I have been given.
- O I understand that notes will be taken during the interview and that the interview will also be audio-taped and transcribed.
- O I understand that taking part in this research is voluntary (my choice), and that I may withdraw myself or any information that I have provided for this project at any time up until one week after the interview, without being disadvantaged in any way.
- O If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- O I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this research.
- O If applicable, I give consent for Cait to take a photo of a home programme or other targeted teaching material e.g. handouts and pamphlets (please tick one): Yes O No O
- O I know whom to contact if I have concerns or questions about the research.
- O I agree to take part in this research.
- O I wish to receive a copy of the report from the research (please tick one): YesO NoO

Participant's signature: .....

Participant's name: .....

Participant's Contact Details:

.....

.....

.....

Date: .....

Note: The Participant should retain a copy of this form.

Approved by the Auckland University of Technology Ethics Committee on 6th December 2017, AUTEC Reference number 15/111.

Appendix N: Film Consent Form

Consent Form

For filming a therapy session
Parent/Caregiver & Therapist

For use in conjunction with appropriate Child Consent and Assent Forms when legal minors (people under 16 years) are participants in the research.

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Project title: The process of learning between parents and occupational therapists who work with children: A grounded theory study

Project Supervisor: Clare Hocking

Researcher: Cait Harvey

- O I have read and understood the information provided about this research project in the Information Sheet dated 12 May 2016
- O I have had an opportunity to ask questions and I am satisfied with the answers I have been given.
- O I understand that the researcher, Cait Harvey, will be present to answer any questions regarding the research prior to the therapy session and to set up the videorecorder on a tripod.
- O I understand that notes may be taken during the session and that the therapy session will also be filmed with a video camera and transcribed.
- O I understand that the focus of filming this therapy session is on the interaction and learning between parent/caregiver and their child's occupational therapist.
- O I give consent for Cait to remain in the session as a passive observer (please tick one):
  Yes O No O
- O I understand that taking part in this research is voluntary (my choice), and that I may withdraw myself or any information that I have provided for this project at any time up until one week after the therapy session is filmed, without being disadvantaged in any way.
- O If I withdraw, I understand that all relevant information including recordings and transcripts, or parts thereof, will be destroyed.
- O I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this research.
- O If applicable, I give consent for Cait to take a photo of a home programme or other targeted teaching material e.g. handouts and pamphlets (please tick one): Yes O No O
- O I know whom to contact if I have concerns or questions about the research.
- O I agree to take part in this research.
- O I wish to receive a copy of the report from the research (please tick one):
  Yes O No O

Participant's signature: .....Date :.....

Participant's name: .....

Participant's Contact Details: .....

.....

Note: The Participant should retain a copy of this form.

Approved by the Auckland University of Technology Ethics Committee on 6th December 2017, AUTEC Reference number 15/111.

Appendix O: Parent/Caregiver Consent Form for Child's Participation for Filming a Therapy Session

Consent Form

For filming a therapy session

Parent/Caregiver consent for their child's participation

For use when legal minors (people under 16 years) are participants in the research.

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Project title: The process of learning between parents and occupational therapists who work with children: A grounded theory study

Project Supervisor: Clare Hocking

Researcher: Cait Harvey

Parent/Caregiver:

- O I have read and understood the information provided about this research project in the Information Sheet dated 12 May 2016.
- O I have had an opportunity to ask questions and I am satisfied with the answers I have been given.
- O I understand that my child's therapy session will be filmed and the transcribed.
- O I understand that the focus of filming this therapy session is on the interaction and learning between myself, as parent/caregiver, and my child's occupational therapist, and that my child will be part of that interaction.
- O I understand that as part of filming this therapy session my child will be included in the filmed recording of the therapy session.
- O I understand that allowing my child to take part in this research is voluntary (my choice), and that I may withdraw my child from this project at any time up until one week after the therapy session is filmed, without being disadvantaged in any way.
- O If I withdraw my child, I understand that all relevant information including recordings and transcripts, or parts thereof, will be destroyed.
- O I understand that my child's participation in this study is confidential and that no material which could identify them will be used in any reports on this research.
- O I know whom to contact if I have concerns or questions about the research.
- O I agree for my child to take part in this research.

Child's name: .....

Parent/caregiver's signature: .....

Parent/caregiver's name: .....

Contact Details:

.....

Date: .....

Note: The Participant should retain a copy of this form.

Approved by the Auckland University of Technology Ethics Committee on 1st June 2017, AUTEC Reference number 15/111.

Appendix P: Child Information Sheet and Assent Form for Children Under 12

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Dr Clare Hocking, chocking@aut.ac.nz , (09) 921 9162.*

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext. 6038.

Approved by the Auckland University of Technology Ethics Committee on 1st June 2017, AUTEC Reference number 15/111

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

The process of learning between parents and occupational therapists who work with children

Information Sheet and Assent Form for children under 12

(Parent/Caregivers please read to your child)

This form will be kept for 6 years

You can colour in this picture.

Hello. My name is Cait Harvey. This is a photo of me:

Can you tell me your name, so I can write it here?

……

I would like to visit you and film one of your times with the occupational therapist (OT). It will be great to meet you and your family. You will know who I am because of my photograph. I will also wear a badge with my name on it.

You won't need to do anything differently from what you would usually do when you see your OT. I want to see how your Mum/ Dad/ Caregiver and your OT learn from each other. You will also be on the film.

It will be just like every other time you have with your OT, only I might be there too. A camera will be in the corner of the room recording a film for me. You probably won't even notice it, but I can show it to you, if you like. I might stay in the room and watch your time with your OT. I might write some notes. The camera will look bit like this:

Image: Clipartpanda.com

If you don't want me to film or stay in the room, that is okay. If you are not sure or worried about it, you can ask your Mum/ Dad/ Caregiver, your OT, or me. You don't need to let me watch and if you don't want me to be there I can go away. If you don't want the camera to film you at any time you can say 'stop' and we can turn the camera off.

When we finish filming your time with your OT, I will look at the film and write a story about it, so that I can tell other people about how we can learn from each other. You can choose a pretend name, so that no one who reads the story will know who you really are.

I need to ask you if you are okay with me filming your time with the OT. Please circle the word 'yes' below if you are happy for the camera to film your time with the OT and 'no' if you don't want to have it there.

I am happy for the camera to film my time with the occupational therapist (circle one):

Yes No

Date: ……

Appendix Q: Parent Demographic Form

Demographic Information Form
Parent Form

Project title: The process of learning between parents and occupational therapists who work with children: A grounded theory study

Project Supervisor: Professor Clare Hocking

Researcher: Cait Harvey

The following information will assist with reporting on the diversity of participants in this study.

About you:

Pseudonym: _____

Age: 16-25 26-35 36-45 46-55 55+ (circle answer)

Ethnicity: NZ European Maori Pacific Island (circle answer)

Other: _____

Are you currently in paid employment? Yes No (circle answer)

If yes, how many hours a week are you employed? _____

Who lives in your household? _____

How many children are in your household? _____

How old are they? _____

What is your relationship to your child seeing an occupational therapist? _____

About your child who is seeing an occupational therapist (OT):

Age of child: _____

Gender of child: male female (circle answer)

Child's diagnosis: _____

How old was your child when they first saw an OT? _____

How often do you see your child's OT?_____

Where do you see your child's OT?_____

Who else helps you with your child's home programme/ care? _____

What other therapies/services does your child receive? _____

Project Supervisor's Contact Details:
Professor Clare Hocking: clare.hocking@aut.ac.nz, 09 921 9162

Approved by the Auckland University of Technology Ethics Committee on 1st June 2017, AUTEC Reference number 15/111.

Appendix R: Therapist Demographic Form

Demographic Information Form
Therapist Form

Project title: The process of learning between parents and occupational therapists who work with children: A grounded theory study

Project Supervisor: Professor Clare Hocking

Researcher: Cait Harvey

The following information will assist with reporting on the diversity of participants in this study.

Pseudonym: _____

Age: 16-25 26-35 36-45 46-55 55+ (circle answer)

Ethnicity: NZ European Maori Pacific Island (circle answer)

Other: _____

Year qualified as an occupational therapist: _____

Qualification/s: _____

Country of training: _____

Years of experience working with children and their families: _____

Current employment: Clinic/centre based (family comes to you) Home based (you go to family home) (circle answer)

Other: _____

Employer: DHB Community organisation Private Practice (circle answer)

Employment: Part-time Full-time (circle answer)

Area of practice: VNT Burns/plastics Child Development Service (circle answer)

Other: _____

Are you a parent? Yes No (circle answer)

If yes, ages of your children: _____

Project Supervisor's Contact Details:
Professor Clare Hocking: clare.hocking@aut.ac.nz, 09 921 9162

Approved by the Auckland University of Technology Ethics Committee on 1st June 2017, AUTEC Reference number 15/111.

Appendix S: Example of Therapist Interview Guide From Preparation for Therapist Interview 6

Working with children and families:

- About your work & the children and families you work with.
- What does a visit look like? Sorts of things do you do during sessions?

In what ways do the parents you work with learn from you?

- **What do parents learn from you? What do you set out to teach parents?** Condition, hands-on skills, metacognitive managing life stuff (**TS**)?
- **Most important things for them to learn.** How do you know what they want and need to learn? **(TS)**
- **What strategies do you find work best for helping parents learn** about their child's condition or treatment interventions? Give me examples? Why do you think they work well?
- A **specific time** when you have helped a parent:
    - **understand more about their child's condition**
    - **shown a parent how to do a specific treatment intervention**
    - **helped them learn about how to manage life**?

  How did you do this? Can you tell me about **what happened**?
- **How is the child involved** in the parent's learning? Interconnected? Learning to teach child? Examples (**TS)**
- **Taking on board/ easy & challenge** - Times like that for any of the parent's you've worked with? What happened?
- **Switching - How do you know when parents understand** or are confident doing things themselves? Evaluating? Is that you learning? (**TS)**
- **Different learning needs at different times** - Do you find parents have e.g., at the beginning and as time progresses? What? Why? Examples. **(TS)**

Providing information/ information sources:

- How do you **provide information** to parents? Why that way? **Tailored? (TS)**
- What do the parents **do with this information**? Teach others?
- In what **other ways** do the parents you work with **get information**?

Context - influence on parent's learning / taking on information? **Timing & location**

Prior experience:

- **Someone or something** that has **influenced/shaped** the way you approach sharing information or skills with parents?
- **Looking back on your time** as an OT, has your **approach to teaching parents changed** over time? What is **different** now, than what you used to do? Are there **some things you do the same way** or differently? **Why**? Example/s?
- A**dvice would you give to a new OT** about how to work with parents and how to teach them about their child's condition and therapy interventions?

Theoretical Sampling- ideas to test out from other interviews

- **Relationship**- impact on learning? Important? Good/ bad examples? **(TS)**
- **Trust**- impact of learning? Important? Building, knowing parent trusts? Mutual? Example **(TS)**
- **What do you learn from parents?** What do you need to/ should you learn from parent? **Does your learning needs change over time** – beginning to down the track?
  Consciously/ subconscious or intentional/consequential learning. **(TS)**
- **Getting on same page:**
    - **Learning about each other and how to work together**
    - **Working knowledge (TS)**
- **Gauging-** Is that learning? When are they? Evaluating parent's learning, knowing to change something? **(TS)**
- **Goal setting-** What do parents need to learn before they can set realistic goals? **(TS)**

Closing

- Are there other things I should have asked you? Is there anything they would like to add? Anything not thought of before but occurred to you in interview?

Thank participant for their time and sharing their experiences with me.

Appendix T: Example of Parent Interview Guide From Preparation for Parent Interview 8

- **About your how OT has been involved with your family/child**. How has it been working with and **learning from** OT?
- **What a typical visit looks like?**
- **How did Dad find it?**

Learning from your child's occupational therapist (OT):

- **What have you learnt from your child's OT so far**?
- **Kinds of things have you needed to learn** - information, how to do things.
- **Changing** needs - Beginning **to now?**
- **OT Teaching you** - **In what ways, how,** said or did something useful?
- **What helped you learn these things?**
- **Learning/ understanding about Condition** - specific time, how, feelings.
- **Learning skill** - specific time, OT shown you **how to do a treatment intervention** that is part of your child's home programme? **How was that for you?**
- **Working and not** – What was **good**, how could it have been **done differently**?
- **OT checking** - Aware **OT checking** you were OK with what she/he was teaching you?
- **Understood.** How did he/she do that? (Got you to practice? Gave feedback?)
- **Taking on board/ easy & challenge** - tell me more, **things that didn't work as well for you? Misunderstanding?**
- **Learning something tricky** or complex? Something they are concerned about?
- **Teach someone else** - E.g., husband, grandparent. What did you do?
- **When the therapist was not there** - needed to carry on? Between visits?
- **Following up with the therapist- seek more information** or feeding back.
- **Switching**- How does OT/parent know when to move on? '**Got it'**? **(TS)**
- What happens at the end? **Moving onto next issue**, leaving something behind?
- **Coming up to being discharged- does she feel finished? How did it come to an end? OT needed/not needed? Aware of OT setting up to finish? Anything else to learn? Tell me about.**
- **Context** – Impact on learning. **Time. Location**.

Receiving information/ information sources:

- **Written material - prepared specially for you** or **pre-published** materials? Home programme- photo?
- **Other places/sources** of useful information? Other people? Other Mums?

Theoretical sampling:

- **OT learning- What does the OT learn from you? Aware they were learning? What should they learn? Your family ways, language? (Same page TS)**
- **Relationship with therapist** - have bearing on learning? What makes difference? What is **important i**n that? What works and what doesn't? **(TS)**
- **Trust - What about trust? Her/ child. (TS)**
- **Setting goals**- Involved? Learning needed to do that. **(TS)**
- **Getting on the same page**-
  - **Learning about each other** and how to work together- learning what OT is, who the OT is.
  - **Working knowledge-** each other's language, expectations etc.

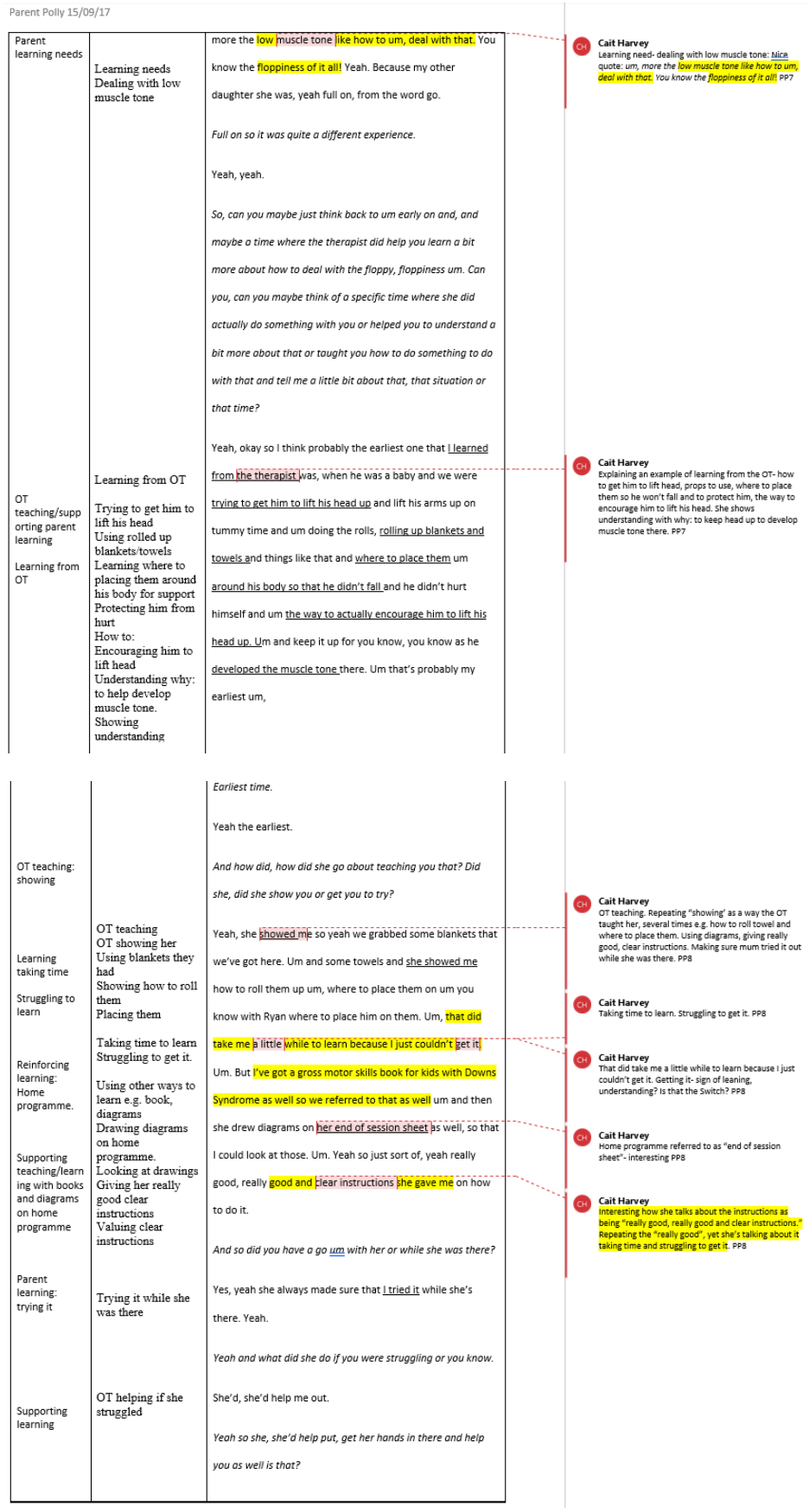
From filming:

- **How did Dad find being there?** What did he learn?
- **Working together** with OT e.g., both helping child to climb on couch
- **OT following lead of Mum and child**- responsive teaching (TS)
- **Use of Māori language during session** e.g., Dad first and then OT did- learning their language
- **OT offering to find out information** from psychologist- has she done before? Heard back?
- **Using what they had in the house** e.g., showing them lining up/placing chairs to encourage child to walk around.
- **Use of Fred the doll**- how? Useful?

Closing:

- **Advice** for the **next OT** & **Advice** for **other parents**
- **Other things** I should have asked you? Anything you would like to add? Anything you thought of during the interview that hadn't before?

Appendix U: Example of Interview Data and Coding Set Up (Parent Interview 7)



Parent Polly 15/09/17

Parent learning needs	Learning needs Dealing with low muscle tone	more the low muscle tone like how to um, deal with that. You know the floppiness of it all! Yeah. Because my other daughter she was, yeah full on, from the word go. *Full on so it was quite a different experience.* Yeah, yeah. *So, can you maybe just think back to um early on and, and maybe a time where the therapist did help you learn a bit more about how to deal with the floppy, floppiness um. Can you, can you maybe think of a specific time where she did actually do something with you or helped you to understand a bit more about that or taught you how to do something to do with that and tell me a little bit about that, that situation or that time?*
OT teaching/supporting parent learning Learning from OT	Learning from OT Trying to get him to lift his head Using rolled up blankets/towels Learning where to placing them around his body for support Protecting him from hurt How to: Encouraging him to lift head Understanding why: to help develop muscle tone. Showing understanding	Yeah, okay so I think probably the earliest one that I learned from the therapist was, when he was a baby and we were trying to get him to lift his head up and lift his arms up on tummy time and um doing the rolls, rolling up blankets and towels and things like that and where to place them um around his body so that he didn't fall and he didn't hurt himself and um the way to actually encourage him to lift his head up. Um and keep it up for you know, you know as he developed the muscle tone there. Um that's probably my earliest um,
OT teaching: showing Learning taking time Struggling to learn Reinforcing learning: Home programme. Supporting teaching/learning with books and diagrams on home programme Parent learning: trying it Supporting learning	OT teaching OT showing her Using blankets they had Showing how to roll them Placing them Taking time to learn Struggling to get it. Using other ways to learn e.g. book, diagrams Drawing diagrams on home programme. Looking at drawings Giving her really good clear instructions Valuing clear instructions Trying it while she was there OT helping if she struggled	*Earliest time.* Yeah the earliest. *And how did, how did she go about teaching you that? Did she, did she show you or get you to try?* Yeah, she showed me so yeah we grabbed some blankets that we've got here. Um and some towels and she showed me how to roll them up um, where to place them on um you know with Ryan where to place him on them. Um, that did take me a little while to learn because I just couldn't get it. Um. But I've got a gross motor skills book for kids with Downs Syndrome as well so we referred to that as well um and then she drew diagrams on her end of session sheet as well, so that I could look at those. Um. Yeah so just sort of, yeah really good, really good and clear instructions she gave me on how to do it. *And so did you have a go um with her or while she was there?* Yes, yeah she always made sure that I tried it while she's there. Yeah. *Yeah and what did she do if you were struggling or you know.* She'd, she'd help me out. *Yeah so she, she'd help put, get her hands in there and help you as well is that?*

Cait Harvey
Learning need- dealing with low muscle tone: Nice quote: *um, more the low muscle tone like how to um, deal with that. You know the floppiness of it all!* PP7

Cait Harvey
Explaining an example of learning from the OT- how to get him to lift head, props to use, where to place them so he won't fall and to protect him, the way to encourage him to lift his head. She shows understanding with why: to keep head up to develop muscle tone there. PP7

Cait Harvey
OT teaching. Repeating "showing' as a way the OT taught her, several times e.g. how to roll towel and where to place them. Using diagrams, giving really good, clear instructions. Making sure mum tried it out while she was there. PP8

Cait Harvey
Taking time to learn. Struggling to get it. PP8

Cait Harvey
That did take me a little while to learn because I just couldn't get it. Getting it- sign of leaning, understanding? Is that the Switch? PP8

Cait Harvey
Home programme referred to as "end of session sheet"- interesting PP8

Cait Harvey
Interesting how she talks about the instructions as being "really good, really good and clear instructions." Repeating the "really good", yet she's talking about it taking time and struggling to get it. PP8

		Yes. Yeah. *Yeah. Um great. And can you think of maybe a more recent time with something that um you've learned from her? That maybe you could tell me a little bit about how she went about showing you or teaching you to do something?*
OT teaching: Suggesting, showing	Helping him crawl Making suggestions Using cardboard boxes to make tunnel Crawling through tunnels Using incentives to motivate Showing Mum body positions. Describing learning process: OT being hands on child. Holding him Placing legs and hands Asking mum to do the same Thinking OT happy she was doing it right Attributing to not hurting him. Thinking it was good that way.	Yeah, I think maybe crawling you know um getting him to crawl. So, he was very much into bear crawling you know on his hands and feet rather than on his hands and knees. So to get him to try and crawl on his hands and knees she um suggested like using cardboard boxes for him to crawl through, getting a tube for him to crawl through um. Yeah making little bend type things, tunnels that he had to crawl through. Yeah and just using incentives at the end of you know, the tunnel to get him to actually come on his hands and knees. Um and the other thing she showed me with that too is also body position. Um you know *How did she* How to. She physically did it to him. Yeah so she would hold him and place his legs in the right place you know his knees in the right place and his hands in the right place, just sort of hold on to him. And then she'd ask me to do the same to him. Um so that I, so that I think really she was happy that I was doing it right and I wasn't going to hurt him um. Yeah. So things like that was good.
OT teaching: being hands on, asking Mum to try		

CH **Cait Harvey**
Giving ideas. Making it fun. Using boxes, making tunnel. Motivating child with incentives.

CH **Cait Harvey**
Giving Mum experience. Trying out after being shown. Learning process: OT handling child, placing legs and hands in right place, asking Mum to do the same to child. PP9

CH **Cait Harvey**
She must have known the OT was happy with her doing it right- could have asked more.

		So did she show you, she showed you where to put your hands and how to help move him.
	Showing her where to place hands	Yes, yeah, yeah. *Yep and where you aware, were you aware of her checking that you were doing it how she wanted you to?*
	OT watching Suggesting moving hand if not in right place Not saying "that's wrong" Explaining why moving hand is better Giving encouraging support.	Yes, yeah. *How, what did she do that made you aware of that?* She was just watching and sort of you know if I wasn't doing it, if I didn't have my hand right she'd suggest putting my hand in the correct place. Like she wouldn't say—no that's wrong. But she'd say you know—if you move your hand up here a little bit he's got more support here, yeah. So yeah really encouraging support. *Really encouraging and supporting you.* Supportive. *Yeah. Supportive.* Yeah. *And um you mentioned that sometimes you found things a little bit tricky to get like um initially.* Oh like the towel rolling up yeah.
Responsive teaching Supporting learning: Giving "encouraging support"		

CH **Cait Harvey**
Giving "encouraging support"- Mum seems to respond well to this. See diagram and memo book for 15.11.17. I think this concept of giving encouraging support is one to think more on. It seems a gentler more respectful approach than "no that's wrong". More empowering because it gives the parent understanding and knowledge to support what they are doing. PP10

Appendix V: Observation Guide

Indicative observation guide:

Interactions:

- Who is talking or interacting and when e.g. parent and child, parent and therapist, therapist and child?
- What verbal interactions occur e.g. conversation, giving instructions?
- What non-verbal interactions occur e.g. gestures, hands on guiding?
- Does the interaction between parent and therapist include the child, and does it change in response to what the child is doing or saying?
- How does the therapist change their approach in response to the interaction or feedback from the parent?
- Who is leading the interaction? How?
- What choices does the parent have during the session?
- What changes the interaction e.g. disruption, frustration, perceived understanding?
- How does the interaction change?
- Where are the parent and therapist looking while they are interacting with each other?
- Does the focus of the therapist shift or remain on the parent and/or child? Why?
- Does the focus of the parent shift or remain on what the therapist and child are doing? Why?
- Does the interaction feel well-paced, or do the parent or therapist seem rushed or preoccupied?
- How does the parent join in? When is the parent joining in? When are they just watching?

Information exchange:

- What kinds of information are the parent and therapist are seeking from each other?
- What kinds of information are the parent and therapist are sharing with each other?
- How are they using this information?
- What terminology is used?
- Do either of them check the other has understood? How?
- What happens if one does not seem to understand what the other is saying?
- Is there hesitancy to ask for or provide information?
- Is there any reference back to previous conversations, reporting what has happened since the last meeting, or summaries of points covered? Who initiates that?
- Are there any changes in the way information is shared because of e.g. interruption, questions, checking understanding?

Teaching strategies used:

- What are the different ways the therapist teaches the parent e.g. conversation, explicit teaching, demonstration, modelling, instructing, coaching, guiding, giving feedback, problem solving, joint interaction with child?
- How is the therapy advice or teaching moderated to fit with information gathered about the family and how it operates?
- How does the therapist explain things to the parent?
- How does the therapist show the parent how to do something?
- How does the therapist check the parent understands or can do what they are teaching them?
- Does the therapist change their approach in response to the parent or child? How?
- How does the parent respond to what the therapist is teaching or showing them e.g. asking questions, wanting to practice, not wanting to participate?

Environment:

- What is the environment like e.g. what space is there to use, where are items situated?
- Are things in the environment are referred to?
- What items are used? What activity is involved?
- Do the parent/therapist/child move around or stay in the same area?
- What resources are used by the parent and therapist in sharing information or showing how to do something?
- How does the therapist or parent change the environment to support learning for the parent or child?

Facilitators:

- What appears to help parent or child participation in the interactions and session?
- What strategies does the therapist use to encourage/ support participation in the session? What are the child and parent's responses to those?
- How does the therapist help the parent understand or learn something?

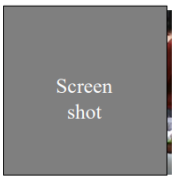
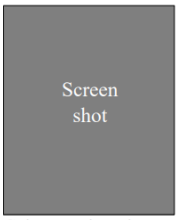
Barriers:

- Is there anything that appears to limit parent or child participation in the session, or interaction between parent and therapist and child?

Appendix W: Examples of Film Transcript and Coding Set Up From Films 4 and 5

Film 4:

Filming 4 – 21 May 2018

M2U00002 0.29.29	*[Mum sitting child on her knee again, holding hips and leaning child forward]* OT: Much, much slower, much, much slower *[gesturing with hand out- slow].* And side to side *[gesturing with hands side to side]* is um probably more challenging. *[Mum moving child side to side and then leaning back]* OT to child: Yeah good work. Whoopsie. OT to Mum: Can I have a go? *[reaching out for child and Mum passing child to OT]* OT to Mum: *[turning child around to sit on knee and face Mum]* So, you put her on your leg. You really want to be doing the tilting with your leg. Mum to OT: Oh okay, using my leg to tilt, okay. OT to Mum: Just, just see how it's just little adjustments that she's using. *[tilting her leg slightly side to side]* Mum: Yeah. OT: And the slower you tilt, the more she's adjusting. Does that make sense? *[showing Mum how much to tilt]* Mum: Yeah. OT to child: *[moving knee and making clicking horsy noises. Child leaning forward]* Where you going? Where you going? *[OT leaning back to straighten child]* Yeah. OT to Mum: So and so the more she's using her trunk, like right now she's got to stabilise herself. Mum: Yeah OT to Mum: I can feel that she's engaging her tummy muscles.	Mum trying again Practicing  Asking permission to have a go  Going over it again. Highlighting important bits Showing mum Asking if Mum sees it Reinforcing Going over again	GOTSPA- doing/action Seeing action cycle **Is responsive teaching= doing and encouraging support= tending relationship?**
M2U00002 0.31.14	OT to child: *[Clicky horsy noises while jigging leg slightly]* OT to Mum: But you have to start feeling comfortable doing it, so you know if, but the further, the higher up Mum to OT: I know that it's littler *[gesturing with hands]* and slower. [OT passing child back to Mum] OT to child: Let's try that again. *[Mum placing child on knee and getting ready to try again]* OT to Mum: So, in terms of how far forward again you've got to feel comfortable. That's not so much the issue, but I think you can hold her much, much further down. *[gesturing]* You can use your fingers to hold the, her pelvis. *[Showing on herself. Mum shifting her hand to copy OT on child]* OT to Mum: Can you get your fingers further down? Yeah, that's right. And get her sitting upright first. She's leaning forward *[OT eaning forward].* *[Mum shifting her hands on child]* Good work yeah. Yeah. *[OT leaning forward and pointing]* So the further forward you put her, the more her hips will tilt. So find a space, *[mum moving child forward on knee]* no, I'm suggesting to put her a little bit further back. The further forward you put her, Mum: Oh okay OT: the more she, her hips are going to tilt forward. *[OT gesturing and pointing to mum's knee]* Mum: Okay.	Highlighting Explaining why Checking in Asking if it makes sense Explaining what's happening **Embodied learning** Telling mum what she feels Giving Mum some hooks OT demonstrating on herself Mum mirroring on child. Mum trying OT correcting Encouraging Instructing Refining	I can see her doing this here oscillating between keeping relationship and doing: Interesting quote from OT interview after this session about refining: *It's such* ***a give and take*** *and sometimes I find that, or on reflection, that can be a bit confronting.* ***You know that you've just got a family to do something that they were really reluctant to and then you go and say to them—you're not doing it quite right****. So I am quite aware of that and* ***I do try in terms of the way that I word it*** *. . . making sure that I try and praise them. At least that's my intention. . . And, being aware of have I pushed them too far?* (15) Embodied learning- demonstrating on herself, pointing.

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Film 5:

Filming 5 – 17 Sept 2018

	OT: You want to sit on my lap? Okay come and sit on my lap. *[child sitting in her lap]* Mum to OT: You just actually have to hold her right hand. OT: That's what I was trying to do. Mum: See because she OT to child: Yay. *[child putting disc in bowl]* Mum to OT: Instead of putting in with her left one she just quickly switched it to the right. OT to child: Here we go. You hold it. You're going to have to work, Neve. Come and get it. *[holding disc so child has to reach]* You can get it. *[Child gets up and walks over to Mum]* Mum to OT: Because it usually does take it awhile but you've got to sometimes sit there for a while, and she'll eventually focus on doing it but it does take her a lot longer. OT to Mum: And that's fine. Mum: For the right hand she'll just quickly pick up but the other one she's got to try a few times. OT to Mum: Yeah. And that's her brains still building those pathways to use her left hand. OT to child: You got it. *[child dropping disc into bowl OT is holding]* You hold on to it. You hold the bowl. Yeah. *[Child taking bowl to Mum]*	Mum telling OT how to do it. Mum pointing out to OT what child is doing Screen shot Mum telling OT what it's usually like OT explaining why	Switch of roles? Mum telling and pointing out to OT. Is this 'Switching' OT oscillating attention between Mum and child See oscillating Memo 15/03/19 GOTSPA with what child is usually like- Mum telling OT how it is. Oscillating focus between Mum and child
	OT to Mum: I'm really happy with how long she's playing with it. OT to child: Here *[child looking at her as she holds disc. Child turns to Mum holding 2 discs joint together]* Mum to child: Can you pull it apart? OT to child: Pull it apart. Mum to child: You do it. See if you can get it apart. *[Mum showing child how to pull it apart]* … [Child making noise]	Parent and OT working together OT-parent-child interacting with task	Co-occupation
GPO22772 0:07:23	OT to Mum: Gosh it must be so hard understanding what she's trying to communicate. Mum: She's getting good though. OT: Is she? Mum: So. Um like she, the other day she, I'm thinking she may be able to be ready for toilet training at some stage soon. But it's um, she's getting good at telling. OT to Mum: How is she telling? Mum: Well she, she's always touching her nappy but she hasn't done anything. OT: Ah ha Mum: So you sort of know. Do you need to go to the toilet? And sure enough she does. OT: Okay, So have you started potty?	**Child noises prompting OT to shift discussion to communication difficulties and toileting** Bringing up toilet training- Mum OT learning/ finding out	**GOTSPA/ partnering** Tailoring, responding, OT oscillating attention between Mum and child

Appendix X: Examples of Two Memos

03/08/2017 Memo on Getting on the same page (GOTSP)

I think that whole second stage of GOTSP and building working knowledge happens in two ways. There's mutual learning of actually getting to know each other and how we are going to work together knowledge, and then there is another level of the working knowledge. Once they're on the same page, building the working knowledge has to do with the problems that they are addressing together. GOTSP is the point you might come back to. You might end up refining learning, but the therapists are talking about when it's not working—so I had to go back and take a different approach to help that parent understand, or we had to go over it in a different way. Maybe it is like getting back on the same page?

Some of the parents have given me stories like—they (OT) kept telling me to do this at home, but it just doesn't work, so we had to go back and say, this just isn't working, so they tried to say, instead of doing that, can you try a different place at home or put markers on your steps so they can see the edge of the step (Sarah, parent). So, the fact that the whole 'getting on the same page' was something that I had missed at first, but now I've looked back, it's totally happening, and I hadn't pulled it out or named it, but now I have it it's actually becoming one of the most crucial areas at the moment. I need to be asking parents and OTs more about that for theoretical sampling.

17/07/2020 Memo on interpretation of data after supervision discussion

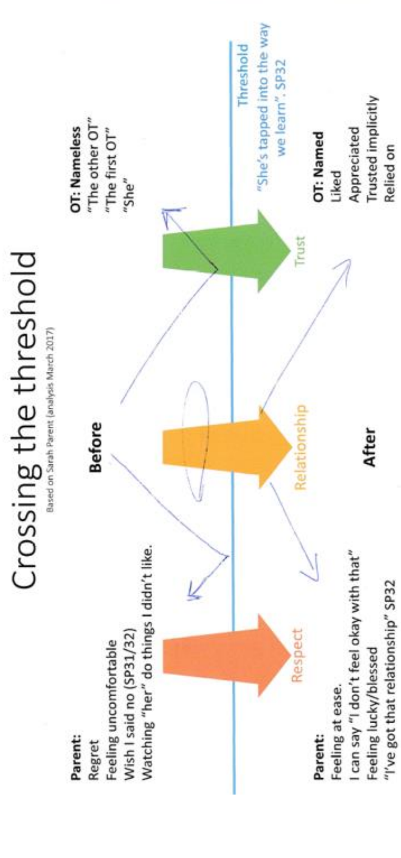
I had some discussion with my supervisors about my concern with times where I may have attributed a motive to participants doing something and the fine line I'm feeling with interpreting the data.

I'm just conscious that I need to be aware of where I could be attributing motives to people and justifying why I have done this. Sometimes the why of what happened is where the interpretation comes in—when asking myself why are they doing that? In answering that, I am sometimes attributing motives to participants that they didn't explicitly tell me. I am interpreting it—that would be because…. For example, one Mum (Sarah) talks about how to make it work with the OT she is going to bite her tongue and something along the lines of—*that annoys me, but I'll just hold my tongue anyway*. So, I attributed the motive of her doing that to not wanting to offend the therapist—she is constantly holding her tongue to keep or tend the relationship. She hasn't explicitly said, "I don't want to offend the therapist", but she did say it was to keep the therapist she liked. I've interpreted something along the line of "in not wanting to offend the therapist, parents would withhold information". When I wrote it, I wondered if I was being too bold with my interpretation? Why did I interpret it as such? Is it because I can image scenarios where I have worked with parents who may have done the same thing? Is it because I've held my tongue to not rock the boat in a relationship myself?

The theory is that the parent and therapist are both doing things to tend the relationship—by not saying the thing you are thinking (parent) and by being encouraging (therapist). So, this example illustrates that it is not just therapists who are working at tending the relationship, but parents too. I think it is a logical and plausible interpretation and explanation and my supervisors (from our discussion) agreed, so I think in this regard my interpretation of this is okay and fits with that aspect of the theory.

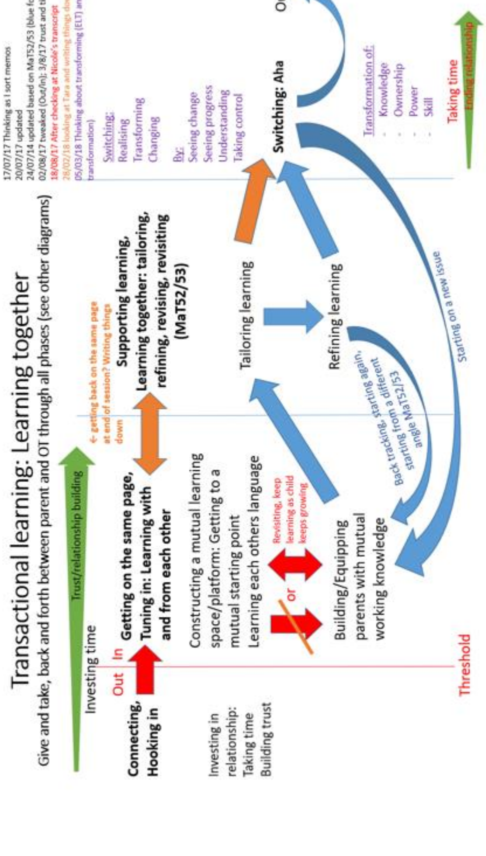
Appendix Y: Examples of Progression of Diagrams

20/03/2017



17/09/2017

05/03/18



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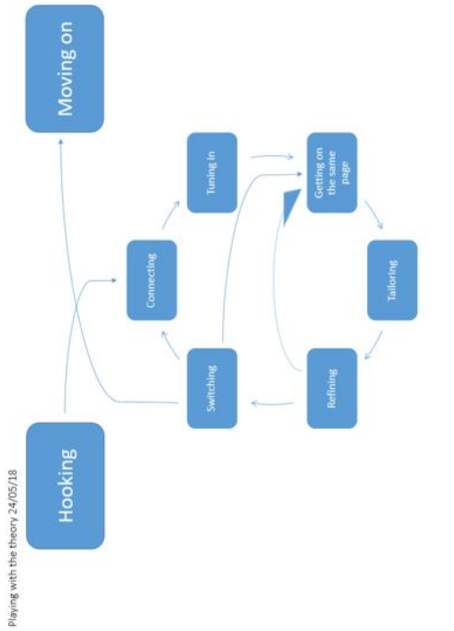

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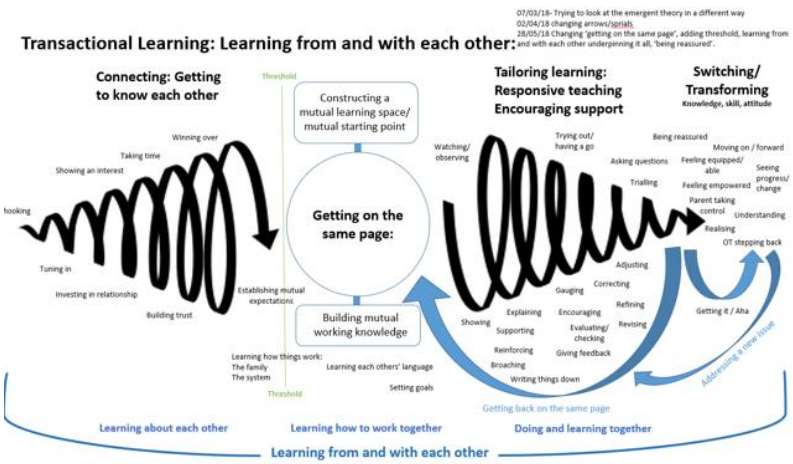

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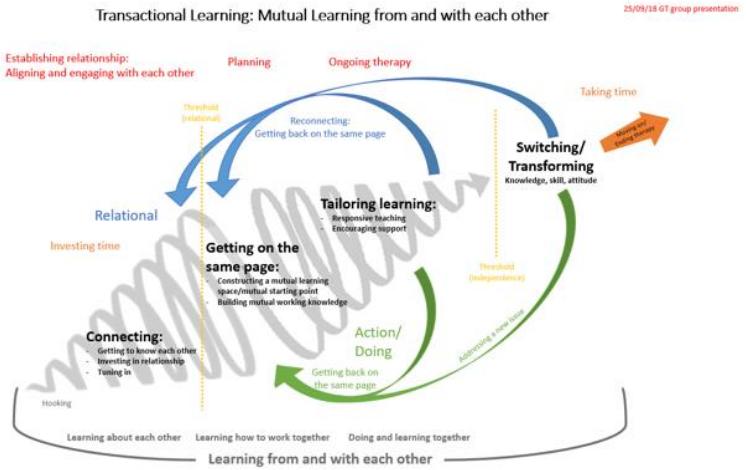
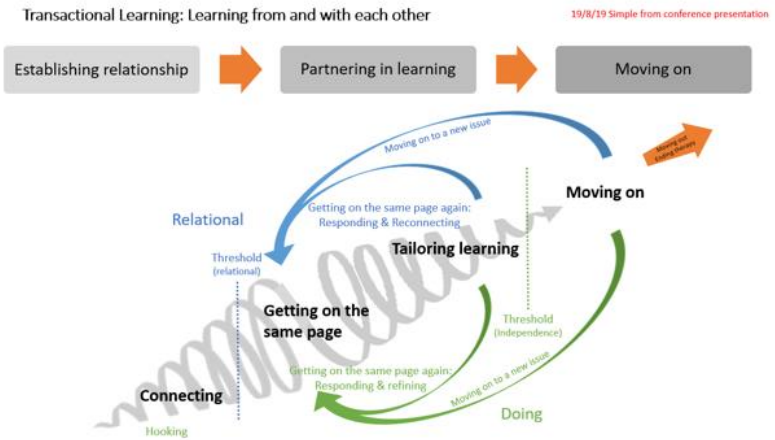
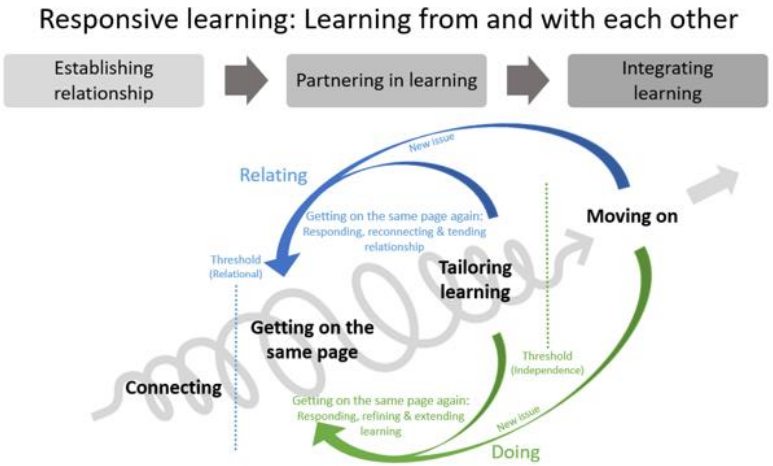


19/08/2019



18/12/2021



Appendix Z: Early Theoretical Sampling Examples

09/02/2017

Emerging (tentative) concept for theoretical sampling	**Make or break: Connecting to learn**	**Changing learning needs over time**	**Therapists are learning too**
Participant quotes which prompted further questions and memo	Negative experience with an OT: "*I think it actually came down to one comment … that stuck to me. … So that just put us off immensely. We won't, yeah, we won't deal with her. She came to our house once and then we knew*." (Sarah (parent), p. 2) Positive experience with current OT: "*We've got that kind of relationship, I think, where we're quite open and honest with that … she'll say, 'stop, Sarah, shhh, just let Rosie (child) do it', when I need to. So, we've got quite a good relationship like that, and we'll have a laugh and that's what I like and that's what I probably need in someone as well."* (Sarah (parent), p. 16)	Early learning need: *'I think I wanted them to agree there wasn't something right, so I needed them to validate my fears in a way, but then I needed them to alleviate my fears!! In the next sentence, to say that we can help, you're in the right place. Just to know that they could help that this was their area, this is what they do every day."* (Lisa (parent), p. 29) Later learning need: *"Yeah, so I might go in and say, 'Jake's learned how to post, how would I progress this? Like, what should he do next?', 'What's the next problem-solving thing he should try to do?'"* (Lisa (parent), p. 32)	Sarah (parent): "*So, she's gauged the way I learn, so most of it is just by copying and talking about it."* (Sarah, p. 22) Jayne (OT): *"What things happen during the day that are tricky?"* (Jayne, p. 2) "*… how in their daily routine can this really busy mum, do this so-called therapy or intervention for the baby with the other little boy"* (Jayne, p. 8) *"Depending on the parent you might be able to go into more detail or less detail about what might be happening for that child at different levels … quite simplistically for some parents and some parents want to know more detail."* (Jayne, p. 10) *"Sometimes you've got to find out, to give the person respect, 'what do you know already? And how would you like me to build on that with what I know to complement what you know?' It's very important, … not assuming people know or that assume people don't know about their child or the child's condition. Because sometimes they know more than us … they know all the insides out and upsides downs."* (Jayne, p.38)
Example of further questions or areas to be addressed in future interviews from my reflective memo journal	Memo Feb 2016- *Ask more about trust- at what point they feel trust e.g., offensive earlier, not later?* *Do OTs see that?*	Memo Jan 2016- *Ask therapists: What difference do therapists see in parent's learning needs at the beginning and as time progresses? (I already ask parents)*	Memo October 2015: *Therapists don't seem to be explicitly learning- they are finding out, gauging, listening, asking. What and how are therapists learning? Ask therapists what, when and how they learn from parents. Ask parents what therapists do or need to learn from them?*