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Communicate to collaborate: reframing communication to strengthen parent-practitioner collaborative relationships

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COMMUNICATE TO COLLABORATE:

REFRAMING COMMUNICATION TO STRENGTHEN

PARENT-PRACTITIONER COLLABORATIVE RELATIONSHIPS

by

ANA K. BRUSSA

B.H.S.O.T., University of Florida, 1999
MSOT, Boston University, 2002

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Approved by

Academic Mentor _____

Jessica DeMarinis Asiello, OTD, OT, OTR
Lecturer of Occupational Therapy

Academic Advisor _____

Karen Jacobs, Ed.D., OT, OTR, CPE, FAOTA
Associate Dean for Digital Learning & Innovation
Clinical Professor of Occupational Therapy

DEDICATION

For my father who dreamed, strived, and worked for his children to receive higher education and did not live long enough to see this day.

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ANA K. BRUSSA

Boston University, Sargent College of Health and Rehabilitation Sciences, 2021

Major Professor: Jessica DeMarinis Asiello, OTD, OT, OTR, Lecturer of Occupational Therapy

ABSTRACT

Effective communication with the parents of pediatric clients is considered an essential skill and encompasses the verbal exchanging of ideas, listening, and non-verbal communication (Taylor, 2020). Similarly, the therapeutic use of self is integral to the practice of occupational therapy and consists of the conscious enhancement of communication through the use of planned strategies for intentional client-therapist interactions (Taylor et al., 2020). However, many occupational therapy practitioners report communication challenges, such as parent emotional expressions (Andrews et al., 2013) and discussing parent roles and expectations (Kruijsen-Terpstra et al., 2016), and implementing the therapeutic use of self in practice (Bonsaksen et al., 2013). Furthermore, factors such as the limited availability of communication skills training, a limited understanding of how to practice reflection to enhance communication self-awareness (King et al., 2017), and decreased self-efficacy (Coad et al., 2018) hinder the opportunity for practitioners to enhance their communication competencies.

The following chapters discuss the evidence base and guiding theories informing the development of the proposed program, *Communicate to Collaborate. Communicate to*

Collaborate is a communication skills training that aims to strengthen pediatric therapy practitioners' interpersonal communication skills so that how they communicate with families becomes an active, mediating ingredient in their therapy interventions. Through program participation, it is anticipated practitioners will gain greater awareness of both their personal communication approaches and parent's communication preferences and increased self-efficacy in how to communicate intentionally with parents, thus enhancing their therapeutic use of self in practice and improving the quality of family-centered pediatric therapy services.

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LIST OF ABBREVIATIONS

AOTA……American Occupational Therapy Association

ECI……Early Childhood Intervention

IRM……..Intentional Relationship Model

OPC…….Occupational Performance Coaching

OT……..Occupational Therapy

RCT……....Randomized Controlled Trail

SCT…….....Social Cognitive Theory

SFBT……...Solution Focused Brief Therapy

CHAPTER ONE: INTRODUCTION

Background

Communication difficulties are one of the most common causes of conflict in health care, particularly around outcome expectations and disagreements regarding treatment (Coad et al., 2018). Further, the literature notes that communication skills do not improve with experience (Coad et al., 2018; Connolly et al., 2014; Mata et al., 2021). For pediatric healthcare providers, effective communication with the parents and caregivers of pediatric clients is considered an essential skill (Coad et al., 2018) and encompasses not only the verbal exchanging of ideas (King et al., 2012; Taylor, 2020) but also listening (Davis et al., 2013; Davis et al., 2008a; King et al., 2012; Taylor, 2020) and non-verbal communication (Pinto et al., 2012; Roberts & Bucksey, 2007; Taylor, 2020). Additionally, effective communication can help foster a collaborative relationship with the parents and caregivers of pediatric clients (Coad et al., 2018; Feudtner, 2007; King et al., 2015; King et al., 2017).

The Problem

Pediatric therapy practitioners may have difficulty communicating openly and effectively with families. This can result in the misunderstanding of therapy activities (Egilson, 2011), the misunderstanding of the therapist's role, mismatched therapy expectations (Hinojosa et al., 2002; Moll et al., 2018), and misperceptions of how occupational therapy relates to function in the community (Cohn, 2001). Therapist communication style, provision of feedback, and attitude may impede the quality of parent-therapist interactions (An et al., 2019a), parent-therapist collaboration (Bellin, et

al., 2011; Fingerhut et al., 2013; Hanna & Rodger, 2002; Moll, et al., 2018) and parent/caregiver empowerment (Dunst & Dempsey, 2007; An et al., 2019b). Additionally, the communication skills of pediatric therapy practitioners may be taken for granted (King et al., 2017) and have only recently begun to be investigated in the literature (Davis et al., 2008a). Pediatric therapy practitioners looking to strengthen their communication skills frequently find there is limited availability of therapeutic communication skills training (An et al., 2019a; An & Palisano, 2014; King et al., 2017), a limited understanding of how to practice reflection to enhance communication self-awareness (King et al., 2017; Knightbridge, 2019; Shepherd et al., 2014; Taylor, 2020), and decreased self-efficacy (An et al., 2019a; Coad et al., 2018; Connolly et al., 2014; Seko et al., 2021). These contributing factors are further discussed in Chapter Two.

Implications of the Problem

Parent/caregiver-therapist communication difficulties tend to result in less collaboration and in dissatisfaction with rehabilitative therapy services (Moll et al., 2018). For example, while therapy practitioners perceive it as essential to discuss the child's disability, goals, and home exercise program (HEP), they feel less prepared to review support, advocacy, and community resources (Dyke et al., 2006). However, parents/caregivers consistently report the provision of this latter general information as important (Bellin et al., 2011; Dyke et al., 2006; Law et al., 2005), indicating a possible area for communication growth among pediatric rehabilitative therapists. Without intentional therapeutic communication, pediatric therapy practitioners may be omitting what families value in the therapeutic process, resulting in decreased satisfaction and

collaboration while further lending to a misunderstanding of rehabilitative therapy services (Cohn, 2001; LaForme Fiss et al., 2012). The *Occupational Therapy Practice Framework 4th edition* states that the therapeutic use of self is integral to the practice of occupational therapy (OT) (AOTA, 2020). The therapeutic use of self may be defined as the "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, as cited in Taylor et al., 2009, p. 285). When enacting their therapeutic use of self, therapy practitioners consciously enhance communication, collaboration, and partnership within the client-therapist relationship by incorporating planned strategies for client-therapist interactions (Taylor et al., 2011). Without the opportunity to cultivate their interpersonal communication skills, pediatric therapy practitioners may continue to struggle in how to effectively communicate therapy needs, roles, and expectations. Further, pediatric therapy practitioners may continue to feel unprepared to provide emotional support, help parents with advocacy, incorporate opportunities for the whole family, identify family/parent coping needs, and give/receive constructive feedback (Dyke et al., 2006; Fingerhut et al., 2013; Moll et al., 2018).

Proposed Solution

The following chapters will discuss in detail the theories and evidence that support the development of the proposed therapeutic communication skills training, *Communicate to Collaborate*. This evidence-based training, which is informed by the Intentional Relationship Model (IRM) (Taylor, 2020) and Social Cognitive Theory (Bandura, 2001), aims to strengthen the interpersonal communication skills of pediatric

therapy practitioners with the overarching goal of reframing how clinicians communicate with families as an active, mediating ingredient in their therapy interventions. The four-week virtual program incorporates the following learning approaches: educational programming, self-reflective activities, group reflective activities, role-play, and homework tasks. More information about the program content and format can be found in Chapter Three. Through participation in the program, it is anticipated that pediatric therapy practitioners will strengthen their interpersonal base by reporting increased awareness regarding both personal and parent/caregiver communication characteristics, strengths, and preferences, increased ability to self-reflect on communication encounters with parents/caregivers, and increased self-efficacy in managing interpersonal events with parents/caregivers.

CHAPTER TWO: OVERVIEW OF THE THEORY AND EVIDENCE SUPPORTING THE PROJECT

Overview of the Problem

In pediatric therapy, both parents and therapists report valuing open and honest communication and perceive it to be essential for the establishment of a collaborative relationship (King et al., 2017; MacKean et al., 2005; Moll et al., 2018). However, both also report experiencing communication challenges resulting in confusion regarding parent/therapist roles (Kruijsen-Terpstra et al., 2016) and mismatched therapy expectations (Hinojosa et al., 2002; Kruijsen-Terpstra et al., 2016; Moll et al., 2018). Therapists also note difficulties in perceiving and responding to a family's evolving needs (Kruijsen-Terpstra et al., 2014) and anticipating a family's coping (Andrews et al., 2013) and emotional responses (Dyke et al., 2006). Further, pediatric therapy practitioners looking to strengthen their communication skills frequently find there is limited availability of therapeutic communication skills training (An et al., 2019a; An & Palisano, 2014; King et al., 2017), a limited understanding of how to practice reflection to enhance communication self-awareness (King et al., 2017; Knightbridge, 2019; Shepherd et al., 2014), and decreased communication self-efficacy (An et al., 2019a; Coad et al., 2018; Connolly et al., 2014; Seko et al., 2021). These barriers are additionally influenced by time (Davis et al., 2013; Knightbridge, 2019; Seko et al., 2021), workplace philosophy/demands (Knightsbridge, 2019; Seko et al., 2021; Yazdani et al., 2020), and family factors (An & Palisano, 2014; Andrew et al., 2013; Fingerhut et al., 2013) including the parent's preferred communication style and interpersonal characteristics

(Taylor et al., 2009). Given the limited evidence exploring the problem of parent-therapist communication challenges within the rehabilitative therapy fields, this review incorporates works from the medicine and nursing literature. The theoretical lens in examining this problem is social cognitive theory.

Theoretical Lens

Albert Bandura's social cognitive theory (SCT) is a learning theory that views humans as proactive social learners, motivated by forethought, goals, and outcome expectations (Bandura, 2005). It can provide a framework in examining why therapy clinicians may experience difficulties effectively communicating with families, particularly within the constructs of self-regulation and self-efficacy. SCT's key principles include observational learning, self-regulation, and self-efficacy working collectively to enhance human learning (Bandura, 2001; Schunk, 2012).

Observational learning is the process in which people learn both how to perform a behavior through observation and the consequences of that behavior. It is influenced by the model, outcome expectations, motivational factors such as goals and incentives, and self-efficacy beliefs (Bandura, 2001; Bandura, 2005; Schunk, 2012). Therapy practitioners' limited opportunities to participate in communication skills training hinders their access to observational learning. Without partaking in communication training opportunities, therapy clinicians may not have the chance to refine their communication skills through the observation of more effective techniques and hence learn new strategies for effective communication. Self-regulation refers to the human ability to influence and manage personal thoughts, emotions, and actions used to achieve goals (Bandura, 2005;

Schunk, 2012). Self-regulation is also influenced by self-efficacy (Schunk, 2012). A key to self-regulation is the self-evaluation of behavior towards goals through self-reflection (Bandura, 2001; Schunk, 2012). Therefore, SCT would indicate that limited opportunity for therapy practitioners to participate in critical self-reflection regarding their communication skills stunts their ability to monitor their progress and create alternate solutions towards the goal of more effective communication with their clients and families.

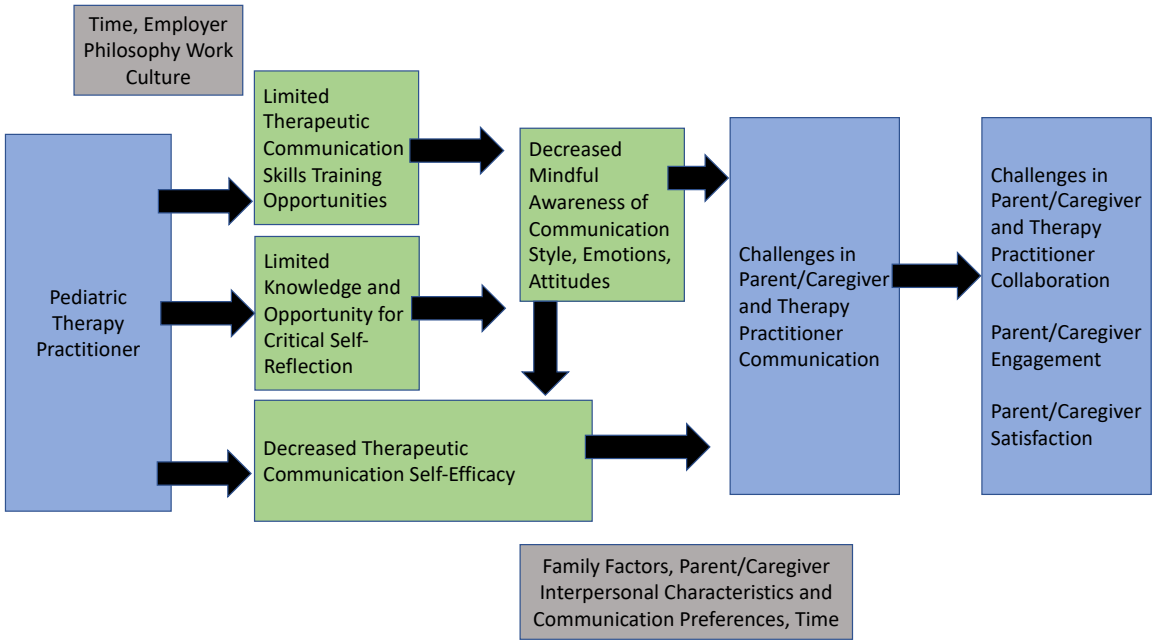
SCT proposes that self-efficacy, or the belief in one's capabilities, is the primary determinant of behavior and influences both the actions people choose and their persistence towards desired outcomes when faced with challenges (Bandura, 2001; Grusec, 1994). Therapy practitioners' self-efficacy or belief in their capabilities to communicate effectively with families may directly influence how in fact they actually communicate with families. The strongest predictor of self-efficacy is past mastery experiences (Schunk, 2012). Therefore, if therapy practitioners have undergone challenging communication encounters with clients and their families without the opportunity to self-reflect on those encounters, then their self-efficacy beliefs regarding communication abilities may be shaken. Additionally, therapy practitioners' sense of self-efficacy related to communication may be strengthened or weakened by family factors, such as parent involvement, parent stress, and parent therapy outcome expectations, parent communication preferences, and parent interpersonal characteristics.

Explanatory Model

Figure 2.1 illustrates a proposed causal pathway leading to challenges in parent-therapy practitioner communication and subsequent difficulties in parent-therapy practitioner collaboration.

Figure 2.1.

Causal Pathway



Note: Casual pathways leading to the problem of parent-therapy practitioner communication challenges.

Limited Educational Opportunities, Critical Self-reflection, and Communication

Limited availability of therapeutic communication skills training has been documented in the literature (An et al., 2019a; Connolly et al., 2014; Davis et al., 2008a; La Forme Fiss et al., 2012; Leonard, 2017). Correspondingly, pediatric therapy practitioners may have limited knowledge and opportunity for critical self-reflection

(Knightbridge, 2019) about their communication encounters. Critical self-reflection allows practitioners to step back, analyze a difficult situation, and problem solve an alternate solution (Hulsman et al., 2009). For example, King et al. (2017) found that self-reflection with individualized coaching facilitated the growth of communication skills among therapists.

Based on this evidence, it can be hypothesized that if pediatric therapy practitioners have limited opportunity to participate in communication skills training then they will have decreased mindful awareness of their communication style, attitude, and emotions. Therapeutic communication skills training may not only enhance communication competencies, but also help uncover previous communication attitudes, beliefs, and knowledge (La Forme Fiss et al., 2012). Further, it can provide an opportunity for pediatric therapy practitioners to build on their current knowledge and skills, identify meaningful areas of growth, and both receive and provide feedback for learning (Adams et al., 2016; Hulsman et al., 2009; King et al, 2017). Similarly, if pediatric therapy practitioners have limited opportunities for critical self-reflection about their communication skills, then they will have decreased awareness of their communication style, emotions, and attitudes. Critical self-reflection through self-assessment can be seen as essential in enhancing knowledge, perspective, and awareness of one's communication style and lead to a new understanding of how we communicate with families (King et al., 2012; King et al., 2015; King et al., 2017; Leonard, 2017; Shepherd et al., 2014; Suter et al., 2009; Yazdani et al., 2020). For example, Yazdani et al. (2020) found that practitioners who completed more self-reflection demonstrated

greater awareness of the multiple aspects within their therapeutic relationships, including their approach and the client's response.

Pediatric therapy practitioners' access to available communication training opportunities and opportunities for critical self-reflection may be moderated by time as well as their work culture or employer philosophy. For example, employers may not invest the time or support in therapy clinicians' professional growth (Fingerhut et al., 2013; Ideishi et al., 2010; Seko et al., 2021; Suter et al., 2009), or may not view communication with families as valued work (Hannah & Rodgers, 2002). Thus, employer philosophy/support may either strengthen or reduce the likelihood of pediatric therapy practitioners having access to communication training opportunities (Espe-Sherwindt, 2008; King et al., 2012; King et al., 2017; Seko et al., 2021). Time constraints have also been reported to decrease the opportunity to partake in communication skills training, to limit participation in self-reflection to assess emotion and perceptions about communication (Davis et al., 2013; Davis et al., 2008b; Seko et al., 2021; Yazdani et al., 2020), to limit progress towards personal communication goals (King et al., 2017), and to restrict quality communication with families (Ideishi et al., 2010).

Self-efficacy and Effective Communication

This explanatory model posits that if pediatric therapists have decreased awareness of their communication style, emotions, and attitudes, then they will have decreased self-efficacy in communication skills. Sundling et al. (2017) found a positive correlation between both communication self-efficacy and mindfulness and communication self-efficacy and empathy. Mindfulness here was defined as an openness

to new situations resulting in alertness and awareness to differences, perspectives, and the present. Further analysis revealed mindfulness to be the only predictor associated with communication self-efficacy (Sundling, 2017). Similarly, Yazdani et al. (2020) found that practitioners who build self-awareness of their communication approach with clients reported increased self-efficacy in their ability to apply new communication modes in practice.

Self-efficacy may influence effective communication (Ammetrop et al., 2007; Parle et al., 1997). Healthcare providers have reported self-efficacy as a major limiting factor in their communication with clients, particularly when faced with difficult topics (Coad et al., 2018) and difficult emotional encounters (Ammetrop et al., 2007). Therefore, it seems logical that if pediatric therapy practitioners have decreased self-efficacy in communication skills, then they will have challenges in parent-therapy practitioner communication. Decreased efficacy associated with communication skills within the healthcare provider may impact the use of conversational behaviors further influencing client openness (Parle et al., 1997), the ability to understand and address client concerns (Connolly et al., 2014), and the ability to respond appropriately to client needs during communication (Coad et al., 2018).

Self-efficacy associated with communication skills may be moderated by time, family factors, and parent communication preferences/interpersonal characteristics. Time constraints have been reported as a barrier to client/family-therapy clinician communication (Davis et al., 2008b; Davis et al., 2013). Additionally, family/client factors such as emotional state (Davis et al., 2013), family dynamics such as denial and

unrealistic therapy expectations (Hinojosa et al., 2002), family follow-through (King et al., 2015), culture (Fingerhut et al., 2013; King et al., 2015), perception of roles (Bellin et al., 2011; Fingerhut et al., 2013), and parent interpersonal characteristics (Taylor et al., 2011) may all influence how efficacious a therapist feels when communicating with families and clients. Therapy practitioners' sense of communication efficacy, as well as a limited opportunity to participate in communication training and limited opportunity for self-reflection, may result in pediatric therapy practitioners experiencing communication difficulties with families. These difficulties may then lead to challenges with parent-therapy practitioner collaboration.

Evaluation of the Evidence

Overall, there is limited evidence investigating the causal factors of parent-therapy clinician communication challenges, and the available evidence varies in methodological rigor. The examination of provider-client/family communication has been largely descriptive, gathered through qualitative semi-structured interviews or focus groups, quantitative surveys and questionnaires, and mixed-method pretest/posttest study designs. Methodological strengths included the reporting of a detailed fidelity protocol (An et al., 2019a; King et al., 2012; La Forme Fiss, 2012), large response rates (Ammentorp et al., 2007; Hulsman et al., 2009; Sundling et al., 2017), or reporting multiple methods of preserving trustworthiness and authenticity (Coad et al., 2018; Davis et al., 2013; King et al., 2015; King et al., 2017; Yazdani et al., 2020). In qualitative research, the preservation of trustworthiness and authenticity through methods such as reflexivity, triangulation, and member checks helps ensure the data collected is accurate

and credible, and that researcher bias has been sufficiently managed (Lysack et al., 2017). Methodological limitations within the literature included low response rates (Bellin et al., 2011; Hinojosa et al., 2002), no report of methods to preserve trustworthiness (Connolly et al., 2014; Robert & Bucksey, 2007; Suter et al., 2009), convenience samples (La Forme Fiss et al., 2012; Sundling et al., 2017), and possible sampling error or bias (Ammentorp, et al., 2007; Davis et al., 2008b; Hinojosa et al., 2002; Robert & Bucksey, 2007; Seko et al., 2021). For example, low response rates resulted in the inability for Coad et al. (2018) to use quantitative data, and in the absence of follow-up quantitative data and limited follow-up qualitative data for Connolly et al. (2014). This can limit the ability to determine the influential relationship between the study variables such as efficacy and communication (Coad et al., 2018) and efficacy, reflection, and communication (Connolly et al., 2014).

Communication Operationalization and Measurement. The operationalization of communication varies in the current literature, limiting the ability to both define the concept of communication and compare results across works. Effective communication within pediatric therapy practice may need to be defined and studied independently of larger constructs such as family-provider collaboration, therapeutic alliance, and family-centered care. This may assist in the development of a more consistent operationalization of effective communication for pediatric therapy providers as the concept of communication varies across contexts (Davis et al., 2008a; King et al., 2012). For example, when exploring perceptions surrounding family-centered care, parents frequently reported the importance of open, clear, and consistent communication with

therapists (La Forme Fiss et al., 2012; Moll et al., 2018). However, what open, clear, and consistent communication means was not explicitly defined as communication was not the focus of the studies leaving this conceptually open to interpretation. Conversely, Ekberg et al. (2018) directly examined family-provider communication and found that families appreciated strategies such as pacing information, checking for understanding, and attending to emotional cues. This begins to explicitly define what open, clear, and consistent communication means within the therapy clinician-family relationship and can lead to concrete effective communication strategies for providers. More research directly exploring the concept of effective communication from both the perspective of the parent/family and that of the provider is needed, particularly when examining barriers towards parent-therapy clinician effective communication for collaboration.

The measurement of communication also varies in the current literature. This may hinder the comparability of results across works as well as the ability to interpret inconsistent results. The majority of studies utilized self-report measures to investigate communication (Ammentorp, 2007; Borghi et al., 2016; Coad et al., 2018; Connolly et al., 2014; Davis et al., 2008b; Davis et al., 2013; Fingerhut et al., 2013; Hinojosa et al., 2002; Hulsman et al., 2009; King et al., 2012; King et al., 2015; King et al., 2017; Shepherd et al., 2014; Sundling et al., 2017; Suter et al., 2009). The use of self-reported data can be a strength as it uses information gathered directly from the source and provides valuable information on how providers currently feel about their communication knowledge, skills, and efficacy. However, depending on the study or the measure, self-reported data may also be biased. Conversely, the behavioral measures of communication

interactions utilized by some studies (An et al., 2019a; Borghi et al., 2016; Robert & Bucksey, 2007) allowed for the objective assessment of different communication aspects such as emotions (Davis et al., 2013), affective behaviors (Roberts & Bucksey, 2007) and how communication behaviors change with experience (Borghi et al., 2016) or throughout the course of therapy intervention (An et al., 2019a). However, these measures also varied across works, making the comparison of inconsistent results difficult. For example, Borghi et al. (2016) found emotions or affective behaviors during communication encounters to decrease with experience, while Roberts & Bucksey (2007) found them to increase with experience. These inconsistencies may point to the need to assess communication from both a self-report and objective observational method. Self-reported data can highlight possible directions to help therapy clinicians grow their communication abilities. For example, providers have reported the benefits of reflection in helping increase their awareness of current listening and communication skills, areas of improvement, and processing of emotional encounters (Davis et al., 2013; King et al. 2017; Shepherd et al., 2014, Suter et al., 2009). However, a combined measure of both self-report and observation of communication skills, emotions, and behaviors may better allow for therapy clinicians to self-reflect on their current skills and monitor their progress towards the outcome of more effective communication (King et al., 2012).

Clinician Characteristics. While many works included various therapy providers, four focused solely on occupational therapists and/or occupational therapy students (Borghi et al., 2016; Davis et al., 2013; Fingerhut et al., 2013; Hinojosa et al., 2002). Demographic information helps determine what practice settings within pediatric

therapy could benefit from further examination and for whom the current data could best be applied. Based on reported demographic information, this explanatory model may best apply to pediatric therapy or overall rehabilitation providers within the ages of 34-54 years (Connolly et al., 2014; Davis et al., 2008b; Ideishi et al., 2010; King et al., 2012; King et al., 2017; La Forme Fiss et al., 2012; Seko et al., 2021; Yazdani et al., 2020) and an average of 10 years or more clinical experience (Davis et al., 2013; Ideishi et al., 2010; King et al., 2012; King et al., 2015; King et al., 2017; La Forme Fiss et al., 2012; Shepherd et al., 2014) who work either at a rehabilitation medical center or a hospital (Bellin et al. 2011; Connolly et al., 2014; Davis et al., 2008; King et al., 2012; King et al., 2015; King et al., 2017; Shepherd et al., 2014; Seko et al., 2021) or in a variety of rehabilitation settings (Borghi et al., 2016; Coad et al., 2018; Fingerhut et al., 2013; Ideishi et al., 2010; La Forme Fiss et al., 2012; Suter et al., 2009; Yazdani et al., 2020). More research is needed to explore effective communication within pediatric therapy including other practice settings such as home health. Additionally, the examination of effective communication across all levels of experience would be beneficial to explore how therapists' communication skills, communication needs, and self-reflection skills evolve over time.

Implications of Evidence for Explanatory Model

The presented evidence establishes a foundation for the exploration of barriers leading to challenges in effective family-therapist communication. Of the mediators presented in the model, communication self-efficacy has received the most evidentiary attention and has been documented to influence provider-client/family communication

skills (Coad et al., 2018; Connolly et al., 2014; Parle et al., 1997). Further research is needed exploring the relationship between provider-client/family communication and self-efficacy and the influence of self-efficacy over time.

Critical self-reflection is also frequently explored as a method of improving communication skills (Adams et al., 2006; Hulsman et al., 2009; Leonard, 2017; Shepherd et al., 2014; King et al., 2017; Yazdani et al., 2020) as it is believed to increase awareness for skill development (Hulsman et al., 2009; Shepherd et al., 2014). However, exactly how critical self-reflection may result in improved effective communication is only beginning to be examined within the therapy field of practice (King et al., 2017; Shepherd et al., 2014; Yazdani et al., 2020). The available evidence appears to suggest that limited opportunity to participate in self-reflection resulting in less awareness of emotions and attitudes regarding communication skills is a plausible pathway to family-therapist communication challenges. Further, how self-reflection and improved mindful awareness of one's communication style is associated with self-efficacy may also be logical, though in need of more investigation (Sundling et al., 2017; Yazdani et al., 2020).

Parent-therapy practitioner effective communication when addressed directly can provide information that may improve therapy practitioner communication skills, parent-therapist collaboration, and client outcomes (An et al., 2019a; King et al., 2017; Seko et al., 2021). Although diverse study methodologies assist in the identification of effective communication barriers, the results obtained are limited by the inconsistent operationalization and measurement of communication across works. A consistent definition and psychometrically sound measure are needed to build a strong research

base. Researchers within the field of pediatric therapy have begun to directly examine therapist communication, conceptualize effective communication for therapy practice, and establish a communication measure for pediatric rehabilitation clinicians (Davis et al., 2013; King et al., 2012; King et al., 2017). This explanatory model proposes to further explore the influences of limited communication training opportunities and limited opportunity for critical self-reflection as well as a decreased sense of self-efficacy in communication capabilities as barriers to family-therapist communication. The improvement of family-therapist communication is proposed to result in improved family-therapist collaboration and therefore improve pediatric occupational therapy outcomes.

Overview of Interventions

Evidence examining therapeutic communication skills training is beginning to emerge within the pediatric rehabilitation literature. However, this topic has undergone extensive research within the medical and nursing fields of practice. Therefore, this review of communication skills training interventions will first explore the findings within the medicine and nursing evidence. Then, the evidence within the field of rehabilitative therapy will be discussed. Finally, overall clinician characteristics and recommendations will be presented.

Medicine and Nursing Communication Skills Training Evidence

The communication skills training evidence within the fields of medicine and nursing is vast. Additionally, the related nature of health care provision between medicine, nursing, and rehabilitative therapy may allow for beneficial aspects of

communication skills training to be applied to rehabilitative therapy practitioners. For this review, works were included if the practice setting was pediatrics, focused on working professionals, utilized reflection and/or live experiential learning, examined training effect on self-efficacy, or provided information regarding a particular component of skills training such as ideal clinical characteristics or methods of training. Works were excluded if the target participants were students or used simulation as their primary intervention.

Within the fields of medicine and nursing, communication skills interventions have been shown to have a moderate effect on clinician communication skills (Kodjebacheva et al., 2016; Oliveira et al., 2015) and a moderate effect on nurses' self-efficacy (Ardakani et al., 2019). This is important as the medical and nursing literature suggests that communication skills cannot improve with experience alone (Coad et al., 2018; Connolly et al. 2014; Mata et al., 2021), and therefore, require intervention. Additionally, there is some evidence implying communication training interventions are more effective if they draw from a specific theoretical framework, such as patient-centered care theory (Parry, 2008). This may be secondary to the benefits of having theory frame an intervention to guide the development and delivery towards intended outcomes (Wolf, 2015). Further, participation in communication skills training has been found to have a small but significant effect on patient satisfaction regarding pain management, disability, and care in medical rehabilitative settings (Oliveira et al., 2015). In pediatric primary care, parents' perceptions of care quality were noted to improve amongst clinicians who had undergone communication skills training though this did not

reach a level of significance (Ammentorp et al., 2009).

Communication Skills Training and Self-efficacy

Among the studies reviewed, the works specifically examining the effects of communication skills training on clinician communication self-efficacy reported a significant increase in self-efficacy immediately after training (Ammentorp et al., 2007; Connolly et al., 2014; Doyle et al., 2011; Norgaard et al., 2012), and several reported increased self-efficacy up to six months post-training (Ammentorp et al., 2007; Norgaard et al., 2011). Correspondingly, communication skills training has been found to increase participant self-efficacy through experiential learning (Mata et al., 2021). Further, Ammentorp et al. (2007) found that participation in a communication training group was the only factor significantly predictive of clinician self-efficacy in communication. However, most of the evidence utilized self-reported data, which may not always result in behavioral change. Doyle et al. (2011) included a behavioral assessment in addition to self-report. Here, higher observations of communication behavioral change in the intervention group was reported, though the change did not reach statistical significance (Doyle et al., 2011). Three other works also documented improved feelings of communication competence, confidence, and efficacy among participants after communication skills training (Bowles et al., 2001; Coad et al., 2018; Fryer-Edwards et al., 2006). However, this data was obtained qualitatively.

Five of the studies investigating the effect of communication skills training on participant self-efficacy drew from specific theoretical frameworks such as SCT (Ammentorp et al., 2007; Connolly et al. 2014; Norgaard et al., 2012), Solution Focused

Brief Therapy (SBFT) (Bowles et al., 2001), or common ground method (Doyle et al., 2011). All of these interventions also included both experiential and didactic learning. This is particularly important for the interventions framed within SCT. In this theory, mental and motor practice are proposed to build mastery experiences. This is considered essential for the development of self-efficacy (Bandura, 2001).

Communication Skills Training and Reflection

Although reflection is hypothesized to strengthen communication skills through increased self-awareness, the evidence examining reflection as the primary training method is limited and mostly qualitative. In the medical and nursing literature reviewed, participants of communication skills training in which reflection was a primary component reported valuing the opportunity to reflect on communication skills and the use of reflection to improve practice (Coad et al., 2018). Participants also reported learning from peers through group reflection in a manner that prompted immediate use of skills in practice (Rollnick et al., 2002). This may be secondary to these interventions taking on a strength-based, learner centered approach (Fryer-Edwards et al., 2006; Rollnick et al., 2002) as well as combining didactic with experiential learning (Coad et al., 2018; Fryer-Edwards et al., 2006; Rollnick et al., 2002). For example, in one of the works reviewed, facilitators observed participants' communication during live simulations, provided opportunity for guided group reflection on the experience, and then allowed participants to modify their communication strategies enhancing immediate application of learned skills (Fryer-Edwards et al., 2006).

Evaluation of the Evidence

Among the medical and nursing works reviewed, the majority were set in primary care - two in general practice (Ammentorp et al., 2007; Doyle et al., 2011) and three in pediatrics (Ammentorp et al., 2009; Kodjebacheva et al., 2016; Rollnick et al., 2002). Other clinical areas examined included general oncology (DeVries et al., 2014; Fryer-Edwards et al., 2006), pediatric oncology (Coad et al., 2018), and rehabilitative medicine (Oliveira et al., 2015; Parry, 2008). The remaining works represented a variety of clinical settings (Ardakani et al., 2019; Bowles et al., 2001; Connolly et al., 2014; Mata et al., 2021; Norgaard et al., 2012).

Specific content detailing communication skills training is limited as most studies describe the intervention in general terms (Fryer-Edwards et al., 2006; Parry, 2008). For example, one study stated the skills training included the instruction of techniques from the theory in which it was based, but did not detail how these techniques were instructed (Bowles et al., 2001). Although this indicates the intervention examined was based on previously examined theory, it does not inform the reader on what actually occurred during the training sessions.

Intervention Components. When examining intervention components, the literature reports modest to moderate improvement in clinician communication skills such as interpersonal skills, interview skills, and communication self-efficacy during emotional encounters when using a combination of lectures, seminars, role-playing, and/or educational materials (Ardakani et al., 2019; Kodjebacheva et al., 2016; Mata et al., 2021). The incorporation of experiential learning in addition to didactic learning is

important, as lectures and pamphlets alone have been found to be ineffective (Ardakani et al., 2019; Parry, 2008). Mata et al. (2021) reported the use of various teaching strategies within a training intervention to improve self-efficacy through active learning. Across the medical and nursing works reviewed, all interventions included a combination of didactic and experiential learning. For example, the skills training investigated by Doyle et al. (2011) incorporated didactic learning, role playing, and reflection. Another skills training utilized a variety of experiences including reflection, reflective questioning, live simulation, and group problem-solving to improve participants' communication skills in addition to didactic learning (Fryer-Edwards et al., 2006). Role-playing was the most commonly utilized experiential learning technique (Connolly et al., 2014; Doyle et al., 2011; Norgaard et al., 2012). Other studies incorporated reflection (Coad et al., 2018; Doyle et al., 2011; Fryer-Edwards et al., 2006; Rollnick et al., 2002), live simulations (Fryer-Edwards et al., 2006; Rollnick et al., 2002), group discussions/contextual problem-solving (Fryer-Edwards et al., 2006; Rollnick et al., 2002), and debriefing (Fryer-Edwards et al., 2006) to enhance the didactic learning of communication skills.

Intervention Dosing. Variation in dosing has made it difficult to discern an optimal length and frequency for communication skills training (Parry, 2008). The communication skills interventions reviewed ranged from one to four sessions lasting anywhere between forty-five minutes to eight hours per session. About half of the interventions held sessions every two to four weeks (Ammentorp et al., 2007; Ammentorp et al., 2009; Bowles et al., 2001; Doyle et al., 2011; Norgaard et al., 2012), while others held one day sessions (Coad et al., 2018; Connolly et al., 2014) or weekly

consecutive sessions (Fryer-Edwards et al., 2006; Rollnick et al., 2002). Studies also varied in details surrounding who facilitated the interventions. For example, Norgaard et al. (2012) reported facilitators represented each discipline of the participant sample. In this work, each facilitator underwent forty hours of training over five days from a certified communication trainer (Norgaard et al., 2012). Other works reported facilitators were physicians or nurses trained in the specific intervention provided such as OncTalk (Fryer-Edwards et al., 2006), Solution Focused Brief Training (SFBT) (Bowles et al., 2001), or a program offered by the Danish Medical Association (Ammentorp et al., 2007; Ammentorp et al., 2009). Finally, two studies did not detail facilitator training indicating facilitators were experienced in running workshops (Rollnick et al., 2002) or a professional educator involved in program development (Doyle et al. 2011).

Methodological Quality. The medicine and nursing communication skills training literature is of overall fair methodological quality (Ardakani et al., 2019; DeVries et al., 2014; Mata et al., 2021; Oliveira et al., 2015; Parry, 2008). About half of the studies based their intervention on theory or available evidence (Ammentorp et al., 2007; Ammentorp et al., 2009; Bowles et al., 2001; Connolly et al., 2014; Doyle et al., 2011; Norgaard et al., 2012). This is a methodological strength. The use of theory helps guide the intervention development, delivery, and design, improves the clinical applicability of the intervention, and informs how progress towards intended outcomes is measured (Wolf, 2015). For example, the communication skills training examined by Bowles et al. (2001) used SFBT as its theoretical framework. Therefore, the intervention included techniques based in SFBT such as asking the miracle question and helping clients derive

solutions consistent with their preferred future (Bowles et al., 2001). Ammentorp et al. (2007) investigated a well-studied intervention based in SCT. Hence, the study examined its impact on communication self-efficacy, the primary determinant of behavior in social cognitive learning theory (Ammentorp et al., 2007; Bandura, 2001).

Almost half of the works reviewed documented their fidelity training (Ammentorp et al., 2009; Bowles et al., 2001; Doyle et al., 2011; Norgaard et al., 2012). This strength ensures the reader that measures were applied to enhance consistent administration of the intervention throughout the study and increase each study's internal validity. Other methodological strengths rigorous research designs such five systematic reviews (DeVries et al., 2014; Kodjebacheva et al., 2016; Mata et al., 2021; Oliveira et al., 2015; Parry et al., 2008), one meta-analysis (Ardakani et al., 2019), and three randomized controlled trial (RCT) study design (Ammentorp et al., 2007; Ammentorp et al., 2009; Doyle et al., 2011). The systematic reviews and meta-analysis each examined specific content areas. For example, Ardakani et al. (2019) examined effects of communication skills training on nursing self-efficacy. The systematic reviews investigated topics such as clinical characteristics influencing the impact communication skills training and client outcomes (DeVries et al., 2014) and effective communication intervention strategies to improve client, parent, and provider communication (Kodjebacheva et al., 2016). Large response rates was another reported methodological strength (Ammentorp et al., 2007; Ammentorp et al., 2009; Norgaard et al., 2012).

Attrition was a methodological limitation reported in approximately half of the studies reviewed (Ammentorp et al., 2009; Bowles et al., 2001; Coad et al., 2018;

Connolly et al., 2014; Norgaard et al., 2012). In two cases, attrition limited the ability to obtain the intended qualitative (Connolly et al., 2014) or quantitative data (Coad et al., 2018), and therefore, weakened the studies' ability to fully assess intended outcomes. About half the studies also reported challenges related to their outcome measures (Ammentorp et al., 2007; Bowles et al., 2001; Coad et al., 2018; Connolly et al., 2014; Norgaard et al., 2012). For example, Ammentorp et al. (2007) did not blind study participants. This may have resulted in bias when completing the self-report measures utilized to assess outcomes. Additionally, several studies either developed (Bowles et al., 2001) or adapted measures (Coad et al., 2018; Connolly et al., 2014; Norgaard et al., 2012). This resulted in psychometric difficulties such as the use of an unvalidated measure (Coad et al., 2018) and lack of established internal consistency (Bowles et al., 2001). About one third of works reported the methodological limitation of a small sample size (Ammentorp et al., 2007; Ammentorp et al., 2009; Bowles et al., 2001). Although the studies within the medical and nursing literature consist of higher-rigor research such as RCTs, the wide heterogeneity of designs and inconsistency among measures makes it difficult to determine conclusions on the overall effectiveness of communication skills training when systematically reviewing the literature (DeVries et al., 2014; Kodjebacheva et al., 2016; Parry, 2008).

Rehabilitative Therapy Evidence on Communication Interventions

The current evidence within the rehabilitative therapy fields primarily focuses on communication interventions such as occupational performance coaching (OPC) (Graham et al., 2009), solution-focused coaching - pediatrics (SFC-peds) (Baldwin et al.,

2013), the collaborative intervention process (An & Palisano, 2014) and the intentional relationship model (IRM) (Taylor, 2020). OPC and SFC-peds are family-centered interventions that utilize reflective questioning so clients may feel empowered to problem solve solutions to contextual participation barriers (Baldwin et al., 2013; Graham et al., 2009). OPC is considered to be a specialized health coaching drawing from the coach's knowledge regarding occupation, development, and disability (Graham et al., 2009). SFC-peds, on the other hand, emphasizes language, the client-therapist alliance, and the reframing of problems to possibilities (Baldwin et al., 2013). It is influenced by SFBT, and therefore, more psychosocially based (Baldwin et al. 2013). Both the collaborative intervention process and IRM are mediational practice models, meaning these models are implemented to enhance the delivery of other interventions by improving the client-therapist communicative relationship (An & Palisano, 2014; Taylor, 2020). The collaborative intervention process delineates concrete collaborative strategies rehabilitative therapy clinicians may enact during the process's four phases of therapy (An & Palisano, 2014). These strategies are meant to improve practitioner communication with pediatric clients and their parents. This model draws from the family-centered care and SFBT frameworks (An & Palisano, 2014). IRM aims to increase understanding of how the therapeutic use of self can influence the client-therapist relationship and client participation in therapy (Taylor, 2020). This model emphasizes the use of interpersonal reasoning for intentional communication. The IRM delineates modes of communication therapy practitioners can draw from to navigate everyday interpersonal conflicts and strengthen the client-therapist relationship (Taylor, 2020). Most of the

rehabilitative therapy literature reviewed examines the influence of these interventions on pediatric therapy outcomes (Graham et al., 2013), therapy provider communication styles and behaviors (King et al., 2020; Schwellnus et al., 2019; Taylor et al. 2009; Taylor et al. 2011; Wong et al., 2020; Seko et al., 2020; Seko et al., 2021; Yazdani et al., 2020), and parent-therapist interactions (An et al., 2019a; McKnight, 2016).

Of the communication interventions explored, coaching has undergone the most investigation. Kemp and Turnbull (2014) synthesized the evidence related to coaching in early childhood intervention (ECI). Although coaching was defined inconsistently across works, both indirect and direct coaching twenty to ninety minutes a week appeared to not only improve child developmental outcomes but also parent perceived capabilities, concluding that it is a feasible approach in the ECI therapy setting (Kemp & Turnbull, 2014). Graham et al. (2013) reported similar results when utilizing OPC with mothers of school-aged children in the outpatient setting. Further, therapy practitioners trained in SFC-peds reported feeling empowered in the use of a common language and framework to facilitate the implementation of client-centered care and client-therapist collaboration (Seko et al., 2020; Seko et al. 2021) and increased confidence in building a therapeutic relationship (Seko et al., 2021).

Evidence examining the IRM has explored the modes of communication most utilized by therapy practitioners. Wong et al. (2020) found that OT practitioners in the United States reported the frequent use of instructing, encouraging, and empathizing modes of communication. Interestingly, while therapists reported using the empathizing mode most, clients reported most frequently experiencing the instructing mode. This may

indicate the importance of examining how a practitioner's communication is perceived by others (Wong et al., 2020). Additionally, when a sample of OT clinicians were surveyed regarding the therapeutic use of self, findings suggested that more training in the therapeutic use of self and therapeutic communication may increase clinician awareness of how to identify and respond to interpersonal conflicts, increase awareness of how clinician communication impacts others, and increase confidence during service delivery (Taylor et al. 2009).

Rehabilitative Therapy and Communication Skills Training

The evidence examining the training of therapy practitioners to practice the above interventions and the impact of training is limited but emerging. In preparation for an RCT, King et al. (2017) completed a pilot study examining the feasibility and effectiveness of a listening skills training for pediatric therapy clinicians using SFC-peds. Seko et al. (2020) and Seko et al. (2021) explored a similar training's impact on clinicians' knowledge, confidence, and practice. Correspondingly, Schwellnus et al. (2019) compiled therapists' perceived impact of using SFC-peds among those experienced in the approach. Additionally, An et al. (2019a) completed an RCT exploring the effects of the collaborative intervention process on parent-therapist interactions during therapy. A similar study examined the influence of a coaching approach on the frequency and typology of speech acts between parents and therapy practitioners (McKnight et al., 2016). Similarly, Yazdani et al. (2020) examined the reflections of practitioners who had undergone an IRM based training and its impact on their therapeutic communication. The authors all reported positive outcomes in favor of the

communication intervention training in regards to improved awareness of communication and listening skills (King et al., 2017; Schwellnus et al., 2019; Seko et al., 2020; Yazdani et al., 2020), confidence (Seko et al., 2020; Seko et al., 2021; Yazdani et al., 2020), and parent-therapist interactions (An et al., 2019a). Early findings also indicate that rehabilitative therapy clinicians who are strong communicators and utilize reflection may implicitly tailor their approach to meet client needs (King et al., 2020; McKnight et al., 2016; Schwellnus et al., 2019; Taylor et al., 2011; Yazdani et al., 2020). For example, McKnight et al. (2016) found that therapy clinicians tailored coaching to meet the learning needs of the parent, but tailored therapy to meet the needs of the child. This may suggest the equal importance of meeting both parent and child needs to facilitate change, and the importance of reflecting on the language utilized to empower parents during therapy (McKnight et al., 2016).

Communication Skills Training, Self-Efficacy, and Reflection. None of the works within rehabilitative therapy directly explored the influence of communication skills training on self-efficacy. However, Seko et al. (2020) did include questions about participants' confidence with SFC-peds in their post training surveys. Here, increased confidence using SFC-peds over time was reported with a statistically significant increase noted six months post training. A later qualitative investigation also found clinicians reported increased confidence in the cultivation of therapeutic relationships when using SFC-peds (Seko et al., 2021). Although An et al. (2019a) did not directly measure confidence, this study assessed therapy practitioners' confidence in their ability to carry out communication strategies as part of their fidelity training. The protocol required

therapists to achieve a certain level of confidence in the techniques prior to the study (An et al., 2019a). Additionally, the authors proposed confidence may have influenced the decrease in observed parent-therapist interactions during the actual therapy intervention. This may indicate that parents and/or therapists feel less confident communicating during this time of the therapy process (An et al., 2019a).

Within the rehabilitative literature, reflection is also hypothesized to strengthen communication skills through increased self-awareness. King et al. (2017) utilized both individual and group reflection as intervention key ingredients. After the training, participants reported a wider perspective and increased self-awareness of communication skills. Participants also reported that learning from the reflective experiences of others encouraged the immediate use of skills in daily practice (King et al. 2017). In addition to self-reported progress, King et al. (2017) also found significant improvement in listening skills as measured by a peer observation scale indicating a behavioral change. Further, when later examining the relational dialogue between the intervention coach and study participants, King et al. (2020) discovered that longer pauses/silences in communication were indicative of participant purposive reflection. These pauses were frequently prompted by relational strategies such as supportive reflective and critical thinking, noticing and exploring ideas about behavior, and stimulating to move an idea forward. Through the use of these relational strategies, coaches were able to encourage participants' reflection to increase their self-awareness and strengthen their communication skills (King et al., 2017; King et al., 2020). Yazdani et al. (2020) also examined the reflections of practitioners after an IRM based training. Here, findings

revealed that practitioners who participated in a greater number of reflections demonstrated greater skill at applying the IRM techniques in practice (Yazdani et al., 2020).

Similarities and Differences. Most of the research reviewed directly examining communication skills interventions is based in SFC-peds. In one skills training, pediatric therapy clinicians, all who were reported to be experienced communicators, participated in four training sessions each approximately sixty minutes long (King et al., 2017). Sessions one and three consisted of video simulations, group discussions regarding listening skills, and group debriefing each facilitated by experienced debriefers. The second and fourth sessions included individualized coaching focusing on skill application, goals, and reflection (King et al., 2017). The coaching sessions were facilitated by a member of the research team with extensive SFC-peds experience (King et al. 2017). Similarly, Seko et al. (2020) investigated a mandatory two day, twelve hour training based on SFC-peds which consisted of didactic learning, role play, simulations, and group discussions. Participants also had access to optional modules and training videos after the formal training was completed (Seko et al., 2020). While An et al. (2019a) did not directly examine their communication skills training, the work did document the training therapy practitioners underwent for study participation. Here, therapy practitioners participated in two sessions, two to three weeks apart, for a total of six hours. The first session included the provision of the training manual, didactic instruction on strategies, and video simulations (An et al., 2019a). The second session consisted of reviewing challenge areas and role playing. In this study, the author

facilitated the training (An et al., 2019a). The training examined by Yazdani et al. (2020) was a four day eight hour IRM workshop. Each workshop incorporated lectures, case discussions, and the sharing of practice experiences to reinforce teachings (Yazdani et al., 2020).

Evaluation of the Rehabilitative Therapy Evidence

The rehabilitative therapy evidence reviewed was largely descriptive or qualitative and of overall good methodological quality. Three studies utilized experimental or quasi-experimental designs. These works either investigated a communication skills training (King et al., 2017; Seko et al., 2020) or the effects of using a communication approach on parent-therapist interactions (An et al., 2019; McKnight, 2016) and therapy outcomes (Graham et al., 2013). Given the descriptive nature of the studies, most utilized self-report measures. However, studies examining the communication skills training and or the impact of a training on interactions also incorporated observational measures of communication and/or communication behavior (An et al., 2019a; King et al., 2017; King et al., 2020; McKnight et al., 2016). This is beneficial because it affords the examination of whether skills training transferred to behavioral change. For example, one work reported improved use of SFC-peds techniques in practice using a self-report survey (Seko et al., 2020). Therefore, results may indicate an over or under estimation of actual use of skills in practice (Seko et al., 2020). An et al. (2019a), on the other hand, utilized an observational behavioral matrix that allowed for the observation of strategies implemented to foster parent-therapist interactions.

About half of the studies documented efforts to achieve fidelity (An et al., 2019a; Graham et al., 2013; King et al., 2017; King et al., 2020; McKnight et al., 2016). By qualitative comparison, about a third of the works explicitly stated efforts to preserve trustworthiness through data triangulation (King et al., 2017; King et al., 2020; Schwellnus et al., 2019; Yazdani et al. 2020). These efforts are methodological strengths as they enhance each study's internal validity. The most common methodological limitation reported was small sample sizes. This was noted in about two thirds of the works (An et al., 2019a; King et al., 2017; King et al., 2020; McKnight et al., 2016; Schwellnus et al., 2019; Wong et al., 2020; Yazdani et al., 2020). Another limitation reported included challenges with outcome measures. A third of the works indicated that the measures utilized needed further examination of their psychometric properties (Graham et al., 2013; Taylor et al., 2009; Taylor et al. 2011). For example, Graham et al. (2013) reported low internal consistency when the measure was applied to their sample indicating the results should be interpreted with caution. Seko et al. (2020) reported high attrition as only fifty percent of the sample responded to all post training surveys. Yazdani et al. (2020) also reported that only four of the forty four participants completed all four workshops.

Clinician Characteristics and Communication Skills Training Across All Works

Clinician characteristics found to positively influence communication skills and patient outcomes include having participated in communication training, demonstrating an external locus of control, being empathetic, using a socio-emotional approach, and participating in shared decision making (DeVries et al., 2014). Additionally, there is

some evidence to suggest that communication skills training may have a positive effect if participants are open to change and are practicing professionals versus students (Parry, 2008). Across works reviewed, participants were primarily female health professionals such as doctors, nurses, occupational therapists, and physical therapists from a variety of practice settings with an average range of 3.5 - 21.6 years of experience. Norgaard et al.'s (2012) intervention was the only one that was mandatory, all other participants were volunteers.

Conclusion and Recommendations

Based on the works reviewed, communication skills training benefits in delivery and design when it draws from a specific theoretical framework and/or is based on past communication skills evidence. All of the studies reviewed incorporated a combination of didactic and experiential learning. This is important as lectures and pamphlets alone have been found to be less effective (Ardakani, 2019; Mata et al., 2021; Parry, 2008). Most interventions included experiential learning components using simulation and/or role-playing, which can be both costly and labor-intensive (Parry, 2008). The optimal length of training requires more investigation as the evidence does not yet provide clear guidance (Mata et al., 2021; Parry, 2008). However, based on the works reviewed, most skills training took place over several sessions with time between sessions for practice of content. Mata et al. (2021) reported that time between sessions is beneficial as it allows for reflection and the processing of content.

Examination of the evidence suggests there may be some inherent differences in how rehabilitative therapy practitioners and medical providers approach communication

and the client relationship. For example, the medical literature indicates that communication skills may not improve with experience alone (Coad et al., 2018; Connolly et al., 2014; Mata et al., 2021), and training tends to focus on interviewing skills, interpersonal skills, and self-efficacy. This may be secondary to the nature of the communication needed to navigate care within the more problem-oriented medical model. However, the medical community is becoming increasingly aware of the importance of reflection and how practitioner awareness of communication style, preference, and expression can influence communication and client outcomes (DeVries et al., 2014). The emerging rehabilitative therapy literature, however, indicates that therapy clinicians' communication styles and approaches may evolve with experience (Wong et al., 2020). Further, therapy communication training emphasizes reflection and listening (King et al., 2017). Reflection is considered essential, as improved self-awareness may not only help providers identify and respond to interpersonal communication conflicts during care, but also increase confidence. This may in turn foster more personal growth and improved communication within the therapeutic relationship (Taylor et al. 2009; Yazdani et al., 2020). Additionally, though not reported in the medical works, effective communicators within the rehabilitative therapy field have been noted to implicitly tailor their approaches to best meet client needs (King et al., 2020; McKnight et al., 2016; Taylor et al., 2011). Therefore, rehabilitative therapy practitioners may be drawing from a different interpersonal base than medical providers. Specific to occupational therapy, this may be secondary to the field's close relationship with mental health, the use of a more holistic, solution-focused approach in which psychosocial factors are considered, and the

recognition of how the social and situational context may influence the therapeutic process and relationship.

Planning communication skills training for rehabilitative therapy practitioners may need to shift from the training models found in the medical and nursing literature. When considering an educational opportunity to strengthen therapy clinicians' communication skills, it should draw from a theoretical framework such as the IRM, reflective practice, and/or social cognitive theory to help guide the training. Additionally, it should have a reflection component and perhaps use reflection as its specific focus. There is evidence to suggest that rehabilitative therapy practitioners value reflection to improve clinical practice, but feel that they do not have time for reflection and may not know how to incorporate reflection into their work (Knightbridge, 2019). Further, rehabilitative therapists have reported frequently thinking about their clients during non-work hours. This includes worrying about their client's progress and reviewing frustrating encounters (Taylor et al., 2009). This extra thinking can be considered unstructured reflection. Therapeutic communication skills training with a reflective component may provide an opportunity for therapy clinicians to structure their thoughts surrounding a clinical situation and use communication to problem solve alternate solutions. Examples of therapy conflicts or difficult encounters through clinical scenarios or videos may be utilized within the educational opportunity to facilitate the problem-solving process. The goal would be to reframe communication with clients and families as an active ingredient in the therapeutic process. By boosting self-awareness of personal communication style, preferences, attitudes, and feelings, therapy practitioners may then

enhance their ability to identify their clients' and families' communication preferences, explicitly tailor their communication approach to best meet clients' and families' evolving needs, and strengthen their therapeutic relationships.

CHAPTER THREE: DESCRIPTION OF THE PROGRAM

Program Purpose

Communicate to Collaborate is a communication skills training that reframes communication as an active ingredient in therapeutic intervention so that pediatric practitioners may foster positive therapeutic relationships with parents and resolve everyday therapy conflicts by communicating with intention. The program's underlying premise is that if therapy practitioners can develop their communication self-awareness, then they will feel more efficacious in their communication skills. If they feel more efficacious in their communication skills, then practitioners will communicate with intention when interacting with parents during therapy sessions and therapy interpersonal conflicts. If therapy practitioners can communicate with intention, then the collaborative relationship with parents will improve. If the collaborative relationship improves, then parents will be more engaged in the therapeutic intervention and more satisfied with their services.

Program Delivery

Communicate to Collaborate consists of four modules, each approximately two hours long. Each module will have a specific focus. Current topics include "Getting to Know Yourself"; "Getting to Know Your Client"; "Intervention Approaches and Techniques"; and "How to Communicate with Intention and Resolve Therapy Interpersonal Conflicts". There will be one week between modules. During this time, participants will complete homework activities to help facilitate the transfer of learning into practice. A course Padlet with both module-related content and supplementary

resources will be available for participants to review at their own pace. Participants will register as cohorts to promote familiarity for group sharing and reflection. Due to the COVID-19 pandemic, the workshops will be synchronous and virtual using the Zoom platform. Once the program can be delivered face-to-face, it will take place at a planned location such as a conference room or therapy clinic. At that time, the program's structure may shift to accommodate in-person learning.

Basis of the Program

According to the family-centered care literature, pediatric therapy clinicians may have difficulty communicating with parents particularly when reviewing parent-therapist roles (Kruijsen-Terpstra et al., 2016), discussing therapy expectations (Hinojosa et al., 2002; Kruijsen-Terpstra et al., 2016), and navigating emotional encounters (Dyke et al., 2006; Andrews et al., 2013).). Despite these challenges, there are limited available educational opportunities for therapy practitioners looking to improve their communication skills (King et al., 2017). Communication skills training is an emerging topic in the pediatric rehabilitation literature (King et al., 2017). Early evidence suggests that communication skills training increases clinicians' self-awareness of their communication approach, thus strengthening their communication skills (King et al., 2017; King et al., 2020). Further, participants report the ability to immediately use learned skills in practice (King et al., 2017), resulting in increased parent-therapist interactions (An et al., 2019a). This program plans to provide pediatric therapy clinicians with an educational opportunity that incorporates critical self-reflection so they can enhance their communication self-awareness. Additionally, proposed homework

activities will afford practitioners the opportunity to include these skills in their therapy practice.

Communicate to Collaborate draws from social cognitive theory (SCT) (Bandura, 2001) and the Intentional Relationship Model (IRM) (Taylor, 2020). SCT is a learning theory that highlights humans as agentic, social learners influenced by their self-efficacy, outcome expectations, observations, and self-regulation (Bandura, 2001; Schunk, 2012). Self-efficacy is the belief in one's own capabilities. It is considered by SCT to be the primary determinant of whether learned knowledge is transferred into behavioral change (Grusec, 1994). A person's self-efficacy may be formulated by their interpretation of actual performances, observed performances, social or verbal feedback, and physiological/emotional factors (Bandura, 1977; Schunk, 2012). Actual performances of a learned task are considered reliable indicators of a person's capabilities and the strongest predictor of their self-efficacy beliefs. Successful performances are believed to increase self-efficacy and failures to lower it (Schunk, 2012). *Communicate to Collaborate* aims to improve therapy practitioner communication self-efficacy through reflection, discussion, and practice. Practice with mindful feedback will be completed through role-playing and group reflective tasks as well as homework activities. The hope is to foster successful performance in a safe environment and then relate that performance to work experience through the homework tasks.

The IRM is a mediational model that aims to increase understanding of how the therapeutic use of self can influence the client-therapist relationship and client participation in therapy (Taylor, 2020). It emphasizes the use of interpersonal reasoning

for intentional communication through the therapeutic use of self. The IRM delineates modes of communication clinicians can draw from to navigate everyday therapy interpersonal conflicts and strengthen the client-therapist relationship (Taylor, 2020). The *Occupational Therapy Practice Framework 4th edition* states that the therapeutic use of self is integral to the practice of occupational therapy (OT) (AOTA, 2020). The therapeutic use of self may be defined as the "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, as cited in Taylor et al., 2009, p. 285). When enacting their therapeutic use of self, therapy clinicians consciously enhance communication, collaboration, and partnership within the client-therapist relationship by incorporating planned strategies for client-therapist interactions (Taylor et al., 2011). However, when a large sample of occupational therapists (OT) in the United States was surveyed, 90% felt that their relationship with the client influenced the client's engagement in occupational therapy (Bonsaksen et al., 2013). Additionally, 80% reported that the most important skill in their practice was their therapeutic use of self within the client relationship (Bonsaksen et al., 2013). Yet, only half of the respondents felt sufficiently trained in how to implement the therapeutic use of self in practice, and less than a third felt they had sufficient knowledge regarding the therapeutic use of self in practice (Bonsaksen et al., 2013). Moreover, it was noted that training in the therapeutic use of self and therapeutic communication may help OT practitioners better identify and respond to interpersonal difficulties with clients (Taylor et al., 2009). *Communicate to Collaborate* aims to fill this gap by increasing participants' knowledge of the IRM practice model, as well as other communication

approaches. Participants will cultivate their mindful empathy, critical self-reflection skills, and interpersonal competency through self and group reflective activities, discussions, and homework assignments.

Program Activities

Each training module will cover a specific communication topic. The aim is to provide knowledge and use reflection to enhance the practitioner's interpersonal reasoning and communication awareness. The first module, "Getting to Know Yourself", will begin with participant introductions and a spiral journaling activity. This spiral journaling activity will help participants reflect on their current communication strengths and weaknesses and identify a goal or intention to achieve by the end of the training. Next, participants will engage in a presentation reviewing the Intentional Relationship Model (IRM) (Taylor, 2020), basic communication skills, and modes of communication as defined by the IRM (Taylor, 2020). Within the presentation, there will be an opportunity to participate in an empathetic listening activity with a partner. Group reflection will occur during this activity. It will be completed in small group breakout rooms with a large group general share of the experience. Participants will then complete a *Self-Assessment of Modes* (Taylor, 2013) and reflect on the findings. They will be free to share any findings with the group. After this module, participants will be provided with a homework assignment. This will include completing a daily communication self-reflection sheet after one therapy session and a daily empathetic listening checklist adapted from Taylor (2020) with a partner.

The second module, "Getting to Know Your Client", will follow a similar format.

First, participants will review any new thoughts, learning, successes, or challenges that may have arisen during the homework activities. Then, participants will engage in a presentation reviewing client interpersonal characteristics, strategies to assist in the building of an intentional relationship, mode matches, mode versatility, and identifying client suboptimal responses. Within the presentation, participants will complete a breakout room reflection discussion covering their experiences with common client characteristics, how their preferred communication modes may facilitate communication and meet client needs, and how modes not frequently utilized can be considered in a similar situation. This will provide them with the opportunity to reflect as a group. Homework will consist of completing a client reflection sheet which will include asking one client a day for feedback regarding therapy and therapy needs. The participant will then reflect on the findings. A client reflection sheet outlining this activity will be provided.

"Intervention Approaches and Techniques", the third module, will begin with reviewing any relevant findings from the homework. A presentation will then review communication approaches in addition to the IRM that are available for therapeutic use. These approaches include the coaching models (Baldwin et al., 2013; Graham et al., 2009; Rush & Sheldon, 2020) and the collaborative intervention model (An & Palisano, 2014). Participants will review how the IRM can enhance these approaches. Therapeutic strategies to optimize communication will also be reviewed. These will include the *Canadian Occupational Performance Measure* (COPM) (Law et al., 2019), *Goal Attainment Scaling* (GAS) (King et al., 1999), and visualizing a preferred future (An &

Palisano, 2014; De Jong & Miller, 1995). Additionally, strategic questioning as a technique will be discussed. Two reflective breakouts will occur in this module. The first breakout discussion will divide participants into small groups. Here, they will reflect on a complicated parent-therapist relationship they have experienced. Then, they will think about approaches reviewed and reflect on which approaches they feel would have enhanced their ability to communicate within this complicated relationship. They will also think about which approaches they feel would match their interpersonal characteristics for use in practice. The groups will share their thoughts and discuss these challenges together. The second breakout room activity will afford the opportunity to practice strategic questioning. The participants will be divided into groups of two or three. They will then choose from one of the types of strategic questioning and practice using role play. The person being questioned and the third person observer (if present) will provide constructive feedback. The homework assignment will consist of completing a strategic questioning activity to promote the intentional practice of the technique.

Similarly, the final module, “How to Communicate with Intention and Resolve Therapy Interpersonal Conflicts”, will begin with a review of the homework and the sharing of any new insights. A presentation will follow reviewing common therapy interpersonal conflicts and empathetic breaks. Participants will discuss the six steps of the interpersonal reasoning process (Taylor, 2020) to manage emotional intensity and resolve interpersonal conflicts. Clinical case scenarios will then be presented. Participants will collaboratively resolve the conflicts presented in each case using the knowledge learned throughout the course. More detailed information regarding the educational content,

activities, discussions, and presentation of each module is available in Appendix C.

Program Personnel

The author will initially deliver the program. An additional clinician/facilitator will be incorporated to support instruction as needed. This clinician/facilitator will also assist in the process of identifying and gathering funds for overhead costs and identifying partnerships in education (i.e. continuing education companies/organizations). Other personnel include a data collector/manager to oversee data collection and analysis and a social media marketer to facilitate program promotion and participant recruitment.

Intended Audience and Recruitment

The intended audience for *Communicate to Collaborate* is pediatric therapy practitioners. Indirectly, the program may also benefit pediatric clients, parents of pediatric clients, and owners of pediatric clinics and home care agencies. Since the target audience is pediatric therapy practitioners, participants can be recruited using social media blasts, such as pediatric therapy Facebook groups, and posting on the AOTA CommunOT forum. Recruitment may also occur by contacting and marketing the program to local pediatric therapy agencies and clinics.

Desired Program Outcomes

The primary outcomes are for participants to gain greater self-awareness of both their personal communication approaches and client communication characteristics/preferences, to gain knowledge and skill of how they can incorporate critical self-reflection on their communication interactions in practice, and to gain increased self-efficacy in how to communicate intentionally with parent clients. The

grounding of communication interactions in the IRM is hypothesized to help clinicians to remain objective, particularly during difficult encounters so clinicians can identify communication challenges, explore their underlying triggers, cope, and respond in a manner that strengthens the parent-therapist relationship (Popova et al., 2020).

Potential Barriers and Challenges

Table 3.1 outlines potential barriers and challenges the proposed program may face and how these barriers and challenges might be addressed.

Table 3.1

Potential Barriers/Challenges and How They Might Be Addressed

Potential Barrier/Challenges	**How it is Addressed**
Attendance	● Advertise in practice area forums such as OTCommun, social media blasts on Facebook groups and Instagram, OT Practice and equivalent publications for other pediatric therapies; ● Target pediatric agencies/clinics - suggest they offer the course as part of client relations training to improve client satisfaction.
Interactive participation during virtual program presentation	● Incorporate interactive exercises that carry into the virtual forum. ● Use breakout rooms for activities such as role-playing and smaller group reflection.
Generalization of skills learned into practice	● Encourage the completion of homework activities by beginning each session with a reflection/discussion on how the homework activity may have/have not been possible to complete and whether it enhanced learning. ● Allow participants to share perspectives and feedback and refine homework tasks as needed to meet participant needs. ● Provide the option to receive course highlights every few weeks as a refresher for key content.
Participation of	● Highlight the IRM - the model is forgiving in the sense

practitioners less interested in improving interpersonal communication/motivation to improve communication skills	that it emphasizes the interpersonal challenges are bound to happen to everyone, it fosters reflection for continual improvement and learning - no "wrong" way, but what may be the "best" way for a practitioner to meet the client's interpersonal needs. ● Promote the program to be included as part of mandated staff training for agencies/clinics.
Funding/Materials	● Apply for grants. ● Have either individual participants and/or individual agencies/clinics pay for themselves and/or staff to complete the program.
Transition to in-person presentation	● The transition from four 2-hour modules to two 4-hour modules, one week apart to maximize continued attendance. ● Consider adjusting homework tasks for this new program format. ● Continue to offer a virtual alternative

Note. This table outlines potential program barriers/challenges and how they may be addressed.

Summary

Communicate to Collaborate is a communication skills training program designed to enhance pediatric practitioners' interpersonal communication skills so they can build stronger relationships with their clients and families. Upon course completion, participating practitioners will be able to demonstrate increased awareness of their and their clients' communication preferences. They will also demonstrate the ability to reflect on their communication approaches and responses in practice to then actively modify their communication to best meet clients' needs. Further, participating practitioners will demonstrate increased self-efficacy in their interpersonal communication skills as well as in their ability to identify and then respond to therapy-related interpersonal conflicts. The program is based on the IRM, a mediational model emphasizing the intentional use of

communication to both build relationships and navigate interpersonal conflict. *Communicate to Collaborate* affords participants the opportunity to strengthen their therapeutic use of self to then implement it in practice.

CHAPTER FOUR: PROGRAM EVALUATION

Program Scenario

Communicate to Collaborate aims to provide a consultative communication skills training opportunity for pediatric therapy practitioners working within the home care, early childhood intervention (ECI), and outpatient rehabilitative therapy clinics. The program is designed as a virtual group four-week training course consisting of two hour weekly synchronous modules. This delivery structure may change if the program transitions to an in-person educational opportunity. Participants will have access to asynchronous supplementary material and resources through a course Padlet. The synchronous modules will incorporate didactic instruction, individual self-reflective activities, group reflective discussions, role play, and practice activities to enhance content learning. The author will initially deliver the program. As the program grows, an additional facilitator will be recruited. This facilitator will be a pediatric occupational therapist with knowledge of the IRM and strong interpersonal skills. Program results will be used to educate pediatric therapy clinicians on the benefits of growing their interpersonal base and to grow the evidence base surrounding therapeutic communication, the therapeutic use of self, and parent-therapist collaboration. Past participants, future participants, continuing education providers, the American Occupational Therapy Association (AOTA), pediatric clinic or agency owners, parent advocacy agencies, and researchers aligned with the program's theoretical framework may be interested in the program evaluation findings.

Vision for the Program Evaluation Research

In the short term, program evaluation research will focus on formative information. The primary goal will be to obtain information on program structure, process, content, instruction, and activities. Modifications can then be made to best meet the program's intended outcomes and also meet participants' needs and expectations. Data regarding the program's influence on variables such as communication skills, communication self-efficacy, reflection, and perceived parent-therapist interactions will also be examined using a pretest/posttest design. This examination will be used to guide future research. In the long term, program evaluation will continue to gather formative information through the course evaluation. However, the program's influence on variables such as communication skills, communication self-efficacy, reflection, and perceived parent-therapist interactions would be more formally examined. Summative information will also be gathered using a pre/post-test design to determine if correlations between program participation and the variables of interest exist.

Engagement of Stakeholders

The primary stakeholders for this program are pediatric therapy practitioners including occupational therapists (OT), physical therapists (PT), and speech-language pathologists (SLP) in the United States (U.S.) who work with children and families within the home, hospital, and clinic settings.. When this program was presented to therapy clinicians at the virtual IRM Unconference in October of 2020, it received positive feedback from presentation attendees (Brussa, 2020). At that time, an occupational therapist offered to be available for feedback and conferencing.

Additionally, pediatric speech therapy, physical therapy, and occupational therapy colleagues, as well as a pediatric home care agency owner, have been identified as individuals who may partake in the formative evaluation process. The therapy practitioners may be most interested in the feasibility to attend the program and the value the program content would bring to their practice. The pediatric agency owner may also be interested in how participation in the program may improve therapy delivery and parent satisfaction. When the program is ready to be piloted, these stakeholders may aid in recruitment of participants. The author will ensure the engagement of these stakeholders by directly addressing and implementing suggestions that would positively impact program development and delivery.

A professor-researcher at a university has been identified as a possible stakeholder. This individual directly studies the use and application of therapeutic communication and the client-therapist relationship. Initial emails have been exchanged. This individual would provide essential guidance on the use of theoretically aligned measures and research. The program's potential to add to the therapeutic communication evidence base may ensure this individual's continued engagement. A parent advocacy group has also been identified as a potential stakeholder. The author has volunteered and worked with this group in the past. The parent advocacy group would help gather the parent's perspective to guide program content. The outcomes of *Communicate to Collaborate* align with the parent advocacy group's mission of parental education and empowerment as improved practitioner communication skills may enhance the parents' engagement in therapy services. This outcome may motivate the parent advocacy group's

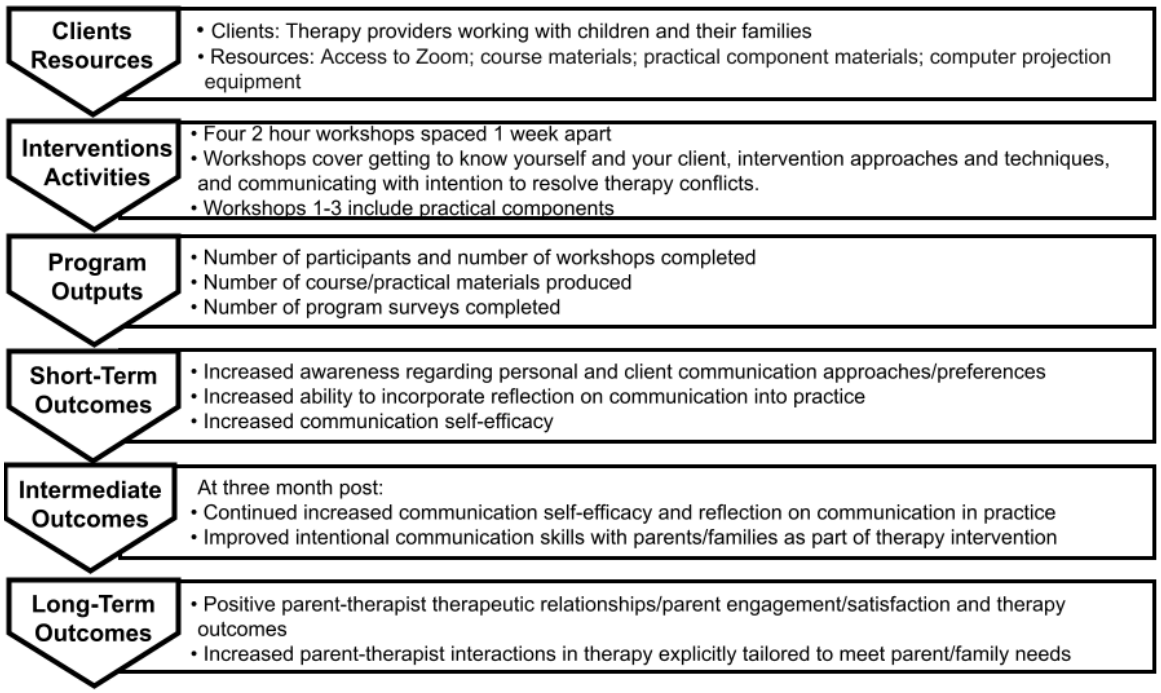
continued engagement. AOTA and other continuing education providers have also been identified as possible stakeholders and funding sources. These organizations will be contacted after the program has been implemented and shown to positively address intended outcomes. This ensures the presentation of a well-developed program worthy of their investment. The program's potential as a continuing education course that will further knowledge in a unique content area may prompt these stakeholders' engagement.

Simplified Logic Model for Use with Stakeholders

The simple logic model for *Communicate to Collaborate* is displayed in Figure 1. Projected program clients and resources include pediatric therapy practitioners, course materials, and access to the Zoom platform. Proposed interventions, such as the nature and content of the workshops, program outputs, such as the number of course materials needed, and short-term, intermediate, and long-term outcomes are also presented. The short-term outcomes represent the variables of interest during the formative evaluation. The intermediate and long-term outcomes represent the summative variables of interest after program implementation.

Figure 4.1.

Simplified Logic Model for Communicate to Collaborate



Note. This figure shows the expected program inputs and outputs, plus short-term, intermediate, and long-term outcomes. Short-term outcomes will be measured during the initial program launch.

Preliminary Exploration and Confirmatory Process

As previously mentioned, pediatric therapy practitioners, a pediatric home care agency owner, an academic professor researcher, a parent advocacy organization and AOTA/continuing education providers have been identified as stakeholders for this program. As the exploration and confirmatory process proceeds, some stakeholders will participate in group meetings while others will meet individually with the author. This will help facilitate the tailoring of meeting content and goals to best fit each stakeholder's role and needs. The author plans to meet with the pediatric practitioners and pediatric

home care agency owner together. Separate meetings will be scheduled with the academic professor/researcher, the parent advocacy organization, and AOTA/continuing education providers as needed throughout the program evaluation process. All meetings at this time will be virtual over the Zoom platform. The number of meetings per stakeholder group may vary.

During the meeting with the pediatric practitioners and home care agency owner, a brief overview of the evidence and need for *Communicate to Collaborate* will be presented. Program structure, content, activities as well as intended outcomes will be reviewed. The program logic model will be used to help frame the discussion. Since this group represents the target participant audience, their insight on course activities, feasibility of course attendance, and the applicability of course content to practice will be invaluable. Program evaluation discussions with this stakeholder group will focus on the formative evaluation. This stakeholder group can contribute to the formation of the post-course evaluation survey and follow-up survey. This will help keep the survey simple, yet informative. Additionally, this group can serve as a brainstorming and sounding board for open ended survey questions to help ensure questions are clear, easy to understand and elicit answers that will inform program outcomes. The author would verbally acknowledge appreciation of their participation and incorporate their feedback and suggestions in program modifications.

During meetings with the academic professor/researcher, the course's alignment with the underlying theoretical construct, possible program evaluation methods, and evaluation outcome measures will be discussed. The author would present how the

program may contribute to the limited evidence base surrounding therapeutic communication in pediatric therapy. The formative investigation may also be reviewed. Further discussions may include the intermediate and the long-term summative research designs. Other meetings may examine how to best operationalize vaguer constructs, how to best measure variables of interest/program outcomes, and how to analyze the data. The author would verbally acknowledge appreciation for this stakeholder's involvement and any research work worthy of publication would include this stakeholder as an author.

During meetings with the parent advocacy group, a general summary of the parent perception family-centered care literature, an overview of the program, and how the program may benefit parents of children receiving therapy services would be presented. The goal would be to meet with a sample of parents whose children receive pediatric therapy and gain the parents' perspectives on parent-therapist communication. This will help guide program content particularly for the workshop titled "Communication Skills - Getting to Know Your Client". Parent narratives regarding interpersonal conflicts may be gathered for use during the course to help provide participants with the parent's point of view. This stakeholder group may not be initially interested in the program evaluation. However, the author can provide general information to help connect their contributions to program outcomes. The author would verbally acknowledge appreciation for participation and incorporate program modification based on feedback.

Meetings with possible funding agencies such as continuing education providers and AOTA will be scheduled after the program is more well-developed and has undergone a formative evaluation. During these meetings, an overview of the evidence

justifying the need for the program, preliminary program evaluation results, and how the program can contribute to the knowledge and skills of practicing therapy practitioners will be presented. The author will seek out information regarding what continuing education providers look for in courses and availability of grants during program content development.

Program Evaluation Research Questions by Stakeholder Group

Table 4.1 outlines the types of research questions stakeholders may want answered by the program evaluation research. Some questions may be explored in the piloting phase, while others may be examined after the program has been launched and more summative information is to be gathered.

Table 4.1

Types of Research Questions by Stakeholder Group

Stakeholder or Stakeholder Group	**Types of Program Evaluation Research Questions**
Author, as a researcher	***Qualitative***: ● Was the program content and structure presented in a manner that promotes attendance, participation, and use of skills learned in practice? ● Did the "homework" activities contribute to the program experience and to the transfer of learning into practice? ***Quantitative***: ● Will participants report increased communication self-awareness and awareness of client communication preferences? ● Will participants report increased communication self-efficacy? ● Will participants report increased use of communication strategies/skills to meet client communication needs and resolve interpersonal conflicts?

Pediatric therapy practitioners and Pediatric Agency/Clinic Owners	***Qualitative***: ● Was the course easy to access and navigate? ● Was the synchronous course schedule easy to attend? Was the asynchronous material helpful? ● Was the content relevant to your practice? ● Was the content paced in a way that made it easy to learn? ● Did the "homework" activities add value to the program skills learned? ● What was liked best/least about the course? ● Was the instructor easy to understand, approachable, knowledgeable? ● Is there anything that should be changed or added to the course content? ● How has the course influenced your practice? ● Did course participants demonstrate improved client service provision/communication with parents? ● Would the cost of the course allow for it to be sponsored for staff? (pediatric clinic/agency owners) ***Quantitative***: ● Did participants gain knowledge and skills related to program goals and objectives? ● Did participants learn more about themselves as communicators? Learn more strategies to know their clients as communicators? ● Did participants learn to use reflection to improve communication skills and alter approach? ● Did participants report increased efficacy in communication with intention and resolving everyday therapy interpersonal conflicts?
Academic Professor/Researcher	***Qualitative***: ● Does the course content align with the theoretical framework? ● Are the outcomes being reliably measured given their operational definitions? ● Will the program increase awareness of developments in the study of therapeutic communication? ***Quantitative***: ● Will the research data show that the intervention led to the desired change in the dependent variables of interest?
Parent Advocacy Group/Parents	***Qualitative***: ● Does the presentation of the parent perspective enhance the program experience and promote changes in practice?

Funding source/AOTA /Continuing Education Provider	***Qualitative***: ● Are the long-term goals of the project realistic and achievable? Are they easy to understand? ● Will the project increase awareness of developments in the field of therapeutic communication? ● Do participants report favorable course evaluations to justify the cost? ***Quantitative***: ● Does participation in the course improve participant use of reflection, improved therapeutic communication with parent clients, and improve self-efficacy resulting in communication behavioral change?

Note. This table outlines questions as they might be asked by users of the program evaluation data that could be answered by the study accompanying launch of *Communicate to Collaborate*.

Research Design

Communicate to Collaborate will undergo both formative and summative evaluations. The research designs are presented in the subsequent sections. The plan is to pilot the program to gather preliminary formative data. The summative evaluation will occur after the program has been formally launched.

Formative Research Design

The formative evaluation design will be a pretest-posttest one group design with follow-up four to six weeks later. The study will utilize a post-program survey and follow up survey to collect descriptive and qualitative data as well as formal outcome measures. Any outcome data gathered at this time will have a formative purpose. The primary goal of the post-program survey is to gather information related to how the program is structured, how it runs, what participants liked best, what they liked least, and what

modifications may be needed. It will also gather descriptive information related to demographics such as age and years of experience and qualitative data regarding variables of interest such as reflection, communication skills, and communication self-efficacy. Correspondingly, the follow-up survey will explore whether the program has lasting influence on the variables of interest, on the application of course content in practice, and on participants' perceptions of their interactions with parents.

Preliminary outcome measures investigating communication self-efficacy, reflection, and communication skills will also be administered. The primary goal here is to examine if the program as designed is influencing the intended outcome variables. Additionally, the use of formal measures in this phase will determine if the selected measures adequately assess the variables as operationalized and if the measures can be feasibly completed by the program participants. The information from this formative evaluation will not only guide program content and design modification, but also determine if the variables of interest and/or outcome measures need to be adjusted or further examined in future research.

Summative Research Design

After the program has been formally launched, program research will shift to a more summative design. This study will be a replication of the pilot study except follow-up in this design will occur at three months. Although formative information will still be gathered using a standard post-course evaluation survey, the research's main purpose will be to investigate if participation in the program consistently influences outcomes as intended across a larger sample of participants. The same outcome measures, if

determined to be accurate and feasible during the pilot, will be utilized to determine any variable changes. Demographic information will also be collected. Pending the results of this one group design, a longer-term summative research goal will be to replicate the study again using a comparison group.

Methods

Since the proposed studies involve human participants, are methodologically driven, and may contribute to pediatric therapy practice, Institutional Review Board (IRB) approval will be obtained prior to the data collection. The author will complete the required human subject participation training and IRB application process. Additionally, to maintain confidentiality, participants will be assigned a corresponding code. A spreadsheet connecting participants to their codes will be kept in a separate and secure location. Once IRB approval has been obtained and consent forms drafted, the author will delineate a script explaining the study, consent, and confidentiality to participants.

Formative/Qualitative Data Collection Methods

The pilot study will have a small sample of six to eight participants. Inclusion criteria may include employment as a pediatric therapy clinician with at least one year of practice experience and access to virtual learning/internet. Exclusion criteria may include being a student practitioner having not yet graduated from an accredited program and working in a practice area other than pediatrics. Participants can be recruited using social media blasts, posting on the AOTA CommunOT forum, and contacting local pediatric therapy agencies.

Communicate to Collaborate is currently set up as a virtual program. Therefore, survey data collection will also occur over electronic platforms such as SurveyMonkey and/or Google Survey. The post-course survey will occur immediately upon course completion. The follow up survey will be sent to participants' email addresses at the four-week mark and again within the fifth- and sixth-week post course if they have not yet responded. Both surveys will contain closed ended questions using an ordinal scale and open-ended questions for qualitative information. Example survey questions include "Did you find the content relevant to your current practice?"; "Since completing the course, how do you feel your interactions with parents have changed?" To optimize credibility of qualitative responses, data will be triangulated using independent peer review. Demographic statistics will guide the transferability of the results, and reflexivity will be completed to reduce bias during data analysis.

The formal outcome measures being considered for the program evaluation include the *Effective Listening and Interactive Communication Scale* (ELICS) (King et al., 2012), the *Self-Efficacy for Therapeutic Use of Self Questionnaire* (Fan et al., 2020; Hussain et al., 2018), and the *Reflective Practice Questionnaire* (RPQ) (Priddis & Rogers, 2017). The ELICS is a reliable and valid self-report measure pediatric practitioners can use to assess their evolving listening and communication skills (King et al., 2012). Similarly, the *Therapeutic Use of Self Questionnaire* is an IRM-inspired self-report measure that allows practitioners to assess their self-efficacy in communication mode use, identifying interpersonal characteristics, and managing interpersonal conflicts (Fan et al., 2020). Lastly, the RPQ is a reliable self-report tool designed to facilitate the

understanding of reflection engagement in practice (Priddis & Rogers, 2017). These measures will be administered electronically. If they are not available electronically, then paper/pencil copies will be provided through the mail. During the formative evaluation phase, participants will complete these measures prior to and immediately after program participation.

Methods for Formative/Qualitative Data Management and Analysis

Survey ordinal data will be analyzed using the descriptive methods available through survey providers such as SurveyMonkey and/or Google Survey. An enumerative approach, such as content analysis, may be best suited to code survey qualitative data from open-ended questions. SurveyMonkey does offer a service that will analyze this data. Pending cost, this may be considered. If the content analysis is to be completed manually, hotjar.com offers a step by step tutorial (Grenier, 2018). As it will be beneficial to have the data coded by someone other than the course facilitator, colleagues with research experience may be recruited for assistance. Data from the outcome measures will be entered into a computer program for analysis. Given its wide use and familiarity with researchers, SPSS will be the software proposed for analysis. Analysis using a paired t-test will be considered as this is a one group study design examining changes within the same individual. Further, the measures being considered collect interval data and therefore, lend themselves to parametric statistical analysis. Outcome data analysis will aim to explore if there is a relationship between program participation and improved communication skills, increased self-efficacy, and increased reflection on intentional communication. All data will be stored on a secure cloud for backup.

Summative/Quantitative Data Collection Methods

The summative research design will be a replication of the formative pilot design except follow up will occur at three months post program completion. Therefore, participant recruitment, sample inclusion and exclusion criteria, and the mode of survey and measure administration will remain the same. A statistical power analysis will be conducted to determine the optimal sample size for the determined level of confidence. Depending on the desired sample size, it may be necessary for participants to partake in the program over several cohorts. Therefore, a fidelity protocol outlining program administration will be developed and followed to maintain program consistency across cohorts being studied. The independent variable is participation in *Communicate to Collaborate*. The dependent variables include communication skills, communication self-efficacy, and communicating with intention operationalized through reflecting on communication. The same outcome measures from the pilot study will be utilized. However, in this design, participants will complete the measures prior to participating in the program, immediately after the program, and three months post program completion. The results of this intermediate study will guide the decisions for future summative research plans examining long-term outcomes.

Methods for Summative/Quantitative Data Management and Analysis

Data from the outcome measures will be entered into SPSS for analysis. As this is a replication of the pilot study, analysis using a paired t-test will again be considered. However, if differences across cohorts are discovered, further examination of the data using an analysis of variance may be necessary. Descriptive statistics will be completed

to rule out any possible covariates of significance within the sample such as age, discipline, or years of experience. In this study, data analysis will aim to determine if any relationships discovered during the pilot between program participation and improved communication skills, increased self-efficacy, and increased reflection on intentional communication consistently exist across a larger sample of participants. All data will be stored to a secure cloud for backup.

Disseminating the Findings of Program Evaluation Research

After the summative evaluation phase has concluded, the dissemination of evaluation findings will begin. Stakeholders most interested in evaluation results may include the academic researcher, pediatric therapy agency owners, and AOTA and other continuing education providers. The message for the academic researcher will focus on how the program evaluation findings help build the evidence base in the area of therapeutic communication, and how the program may support future research in this area. This information can be relayed through an email using a "killer" paragraph focusing on major findings and their contribution to this area of study. Similar to an abstract, a "killer" paragraph is a compelling, concise, and stand-alone summary of the program evaluation research that focuses on major findings (Grob, 2015). The email will include an attachment to a ten-page report. A ten-page report not only communicates major evaluation findings, a summary of the program, and the program's purpose, but it also relays information regarding methodology and interpretations of the findings (Grob, 2015). The academic researcher may be interested in this additional information. A technical report will also be available in case more comprehensive information regarding

methodology and data analysis is requested. An academic power writing style using American Psychological Association (APA) formatting will guide the content of both the ten-page and technical reports. Both reports will be available as PDFs, and any graphics of major findings will be designed using universally printer friendly color schematics.

Although pediatric therapy agency owners, AOTA, and other continuing education providers may all offer the program as a form of education for therapists, their messaging when communicating findings will differ. Pediatric therapy agency owners may provide the program as a form of staff training. However, they will likely be interested in how participation in the program improves business as well as staff development. Therefore, messaging will include major findings alongside qualitative information from the post-course surveys. This will express how participants feel about their communication with parents after course participation as well as quantitative results. A two-page executive summary report will be used to convey evaluation findings to pediatric therapy agency owners. This report is a persuasive document that summarizes major evaluation findings, the purpose of the program, and a program summary (Grob, 2015). Depending on the findings, how program participation influences customer service and subsequently patient satisfaction can be discussed to persuade agency owners to invest in the program. This information will most likely be delivered electronically through an email, a post on a pediatric therapy business owners forum, or within a pediatric therapy practice newsletter. A “killer” paragraph may be utilized to attract interest. A link to access the executive summary will follow the “killer” paragraph. This link will lead to a web posting that it is visually pleasing and emphasizes major findings

by incorporating headings, bold typeface, and a maximum of two compatible font styles. A power writing style will again be incorporated to relay findings and highlight this stakeholder group's message.

AOTA and other continuing education providers will be interested in how the program enhances pediatric therapy clinicians' knowledge and skills for practice. Therefore, their message will highlight the progress participants made towards the intended outcomes, and how this progress improves practice within the area of therapeutic communication and therapeutic use of self. Similar to the pediatric agency owners, an executive summary will be used to express this message and persuade the provision of the program within their continuing education curriculum. When reaching out to AOTA and other continuing education providers, it will be important to establish contact with the appropriate personnel. Once this has been established, an email may be sent using a "killer" paragraph to attract interest. The executive summary will be included as an attachment or a link to either a PDF or a web posting. The same writing style and visual formatting applied for the pediatric therapy agency owners will be adopted here.

Conclusion

This chapter outlines the proposed program evaluation research plan for *Communicate to Collaborate*. Within this plan, a description of the program's overall design and causal pathway is presented. Information regarding stakeholder groups, meetings with stakeholders, and their particular interests is also reviewed. Additionally, the evaluation research plan delineates the proposed formative and summative research designs, purpose, and methodologies. Finally, an overview of the dissemination of

program evaluation findings for several audiences is discussed.

CHAPTER FIVE: FUNDING PLAN

Program Summary

Communicate to Collaborate is a communication skills training program that reframes communication as an active, intentional ingredient in therapeutic intervention. When communicating with intention, pediatric practitioners can foster positive therapeutic relationships with parents and use communication to resolve everyday therapy conflicts. The program aims to increase pediatric therapy practitioners' communication self-awareness, communication reflection, and communication self-efficacy. This is achieved through education, self-reflective and group reflective tasks, role play, and practical activities. Program topics are based on important aspects of improving interpersonal communication skills identified within the evidence reviewed and the IRM practice model. Program teaching topics include: getting to know yourself as a communicator, getting to know your client as a communicator, communication approaches, interventions and strategies, and how to use communication to resolve everyday therapy conflicts.

Program Implementation

During the first two years of the program, *Communicate to Collaborate* will be undergoing piloting. Throughout the first year, the program's structure, synchronous content, and asynchronous content will be finalized. The program will initially be piloted virtually, as this was the design in response to the COVID-19 pandemic. Based on participant feedback and program evaluation results, any necessary program modifications will be made. Since experiential learning is considered an essential

component of communication skills training (Ardakani et al., 2019; Mata et al., 2021; Parry, 2008), the program will be piloted in person during the second year. This will determine if virtual versus in-person programming are equally effective and well-received by participants. Once the program has been piloted and evaluation results have been obtained, the author will apply for approval as an American Occupational Therapy Association (AOTA) continuing education provider. The program will then be available as a consultation service and continuing education opportunity for pediatric rehabilitation hospitals, pediatric home health agencies, and pediatric outpatient clinics. This chapter will review available resources, budget description, and potential funding sources associated with the development and implementation of *Communicate to Collaborate* during its first two years.

Available Resources

The author has a supportive employer who is not only available to advise as a business owner and pediatric clinician but also allows the author to use employee resources such as her work Zoom account for program purposes. The employer has also offered to help pilot the program. Additionally, the author has a friend who has a Master's degree in Communications with an emphasis on program implementation. This friend has offered to provide program implementation guidance and assistance as her availability allows. The author's sister is the Chief Marketing Officer of a family-owned business. She can serve as a resource during the development of promotional materials. Finally, there is an occupational therapy program located within the author's community and may afford the opportunity for occupational therapy students to volunteer and assist

with survey data collection and analysis.

Budget Description

An anticipated budget was created under the presumption that *Communicate to Collaborate* will run two times per year for the first two years. During the first year, the program will be conducted virtually. It would then run as an in-person program during the second year. The program will have approximately six to eight participants each cycle. Table 5.1 delineates the estimated cost and description of each budget item.

Table 5.1

Budget Item Description and Estimated Cost

Budget Item	Description	Estimated Expense Year 1	Estimated Expense Year 2
Zoom Pro Account	Zoom is the platform for the virtual program. A Zoom Pro account costs $149.99. While piloting the program, the author will be able to utilize the Zoom Pro account available through her employer. Therefore, the cost will be $0 (Zoom, n.d.).	$0	$0
Padlet Pro Account	A Padlet Pro account is priced at $96/year. During the first two years, the program will use the free version of Padlet, upgrading to the Pro account if needed at a later time. The estimated cost will be $0 (Padlet, n.d.).	$0	$0
Microsoft Package (Word, PowerPoint, Excel)	A Microsoft package will be needed for course materials, course presentation, and data management. This is priced at $69.99. The author already has access to Microsoft, however, it is likely the package will need to be renewed during Year 2 (Microsoft, n.d.).	$0	$69.99
Facilitator's Salary	The program, including a facilitator's manual, has been created during the author's doctoral education. Therefore, there is no additional cost here. The office hour rate for	$960.00	$960.00

	an OT training new hires at a home health agency is approximately $30/hour. This is a reasonable rate for also conducting training at other agencies and clinics. The program is estimated to run for eight hours total. An additional eight hours may be added to compensate for preparation time and any necessary modifications. If the program is to run twice a year for the first two years, the facilitator's compensation would be a total of $960/year.		
Marketing Brochures	Brochures to market the program pilot will be created using available online templates such as Google, Canva, or Microsoft. Brochures will be shared on virtual forums like OT Facebook groups and AOTA Commun General Forum and will also be emailed to local pediatric home health agencies and clinics.	$0	$0
Facility Rental	For the in-person program, a facility rental in Austin, TX will be needed. Various spaces available for ten to sixteen people are priced at approximately $50-$75/hour with the majority of spaces including WiFi, tables, chairs, screen, monitor, and coffee. Therefore for each in-person cycle, the estimated cost would be $900 (Peerspace, n.d.).	$0	$1800.00
Paper Course Booklets	Paper copies of the presentation, course activities, and practical homework tasks will be provided during the in-person program. Per Office Depot, the cost of each booklet would be $0.96/booklet. To create booklets for each cycle of six to eight participants and two extras to have on hand, the approximate expense will be $9.60. Virtual copies will be available on the course Padlet during virtual programming (Office Depot, n.d.).	$0	$20.00
Program Evaluation Materials	Outcome assessments are available online. The author will create the course evaluation survey. Surveys and assessments will be administered and analyzed using a free	$0	$8.00

	online survey system such as Google forms. A small number of paper versions will be administered during the in-person program in case there is difficulty accessing the online option. Per Office Depot, copies are priced at $0.50/copy. If four paper versions of the survey and assessments are to be made available, then the total cost would be approximately $8.00 (Office Depot, n.d.).		
Refreshments	Refreshments for the in-person course will include snack items, water, and coffee. These may be obtained in bulk at Costco using the membership the author already owns. A maximum budget of $25 will be set for each in-person program.	$0	$50.00
IT equipment	The author already owns a Mac laptop computer and has access to WiFi as these are necessary for her employment. For the in-person pilot, the author may need to purchase a Mac projector connector which can be found at Walmart for $10.99. Many of the facilities for rent listed on peerspace.com include access to WiFi, monitors, and projectors.	$0	$10.99
AOTA Provider Application	Sometime within the first two years, the author plans to apply to become an AOTA provider of continuing education. The application has a one-time cost of $350 (AOTA, 2020b).	$0	$350.00
Dissemination Activities	Year one estimates expenses of $563.00 for attendance and travel to the AOTA conference for a short course presentation. Year two estimates expenses of $132.00 for the creation and maintenance of the program website.	$563.00	$132.00
Total Costs		$1,523.00	$3,400.98

Note. Delineation of budget items, budget item description, and estimated cost for years one and two of the program.

Potential Funding Sources

The estimated expense of fully implementing *Communicate to Collaborate* for both year one and year two is $4,923.98. For successful implementation, it will be necessary to obtain outside financial support. Several potential funding sources have been identified, including grants and an Angel Investor. Table 5.2 describes these potential funding sources. Any obtained funding will assist in the financial support of program materials, equipment, and personnel.

Table 5.2

Description of Potential Funding Sources

Potential Funding Source	Source Description
Texas Occupational Therapy Foundation (TOTF)	TOTF supports and promotes research to improve clinical practice and raise public awareness of OT. The foundation specifically supports programs developed by OT practitioners in Texas. The maximum amount awarded is $5,000. (TOTA, n.d.).
American Occupational Therapy Foundation (AOTF)	AOTF's Intervention Research Grants fund the development of new programs/ideas and the generation of their preliminary data. The purpose is to support the gathering of preliminary information to lay down the groundwork for larger studies of proven concepts. A maximum of $50,000 may be obtained (AOTF, n.d.).
Graduate Women In Science (GWIS) National Fellowship Program	This program supports research by women in the social and natural sciences. Grants are awarded for up to a 12 month period. A maximum of $10,000 can be requested and used towards equipment and research publications (Graduate Women in Science, n.d.).
Beam	Beam is an Austin-based non-profit Angel Network that supports women entrepreneurs during the early and most critical stages of building their business. They have since expanded to other Texas communities. They help provide opportunities to access early capital, connect recipients to potential investors and/or mentors, and educate them on how to scale their business efficiently. They also host a series of Fundraising Essentials to help women prepare for the application process (Beam, n.d.).

The Awesome Foundation	The Awesome Foundation supports a wide variety of projects and initiatives considered to be "awesome" by area chapters. Awesome is a relative term, therefore, the foundation funds a range of arts, technology, community development projects, and more. Past projects supported by the Austin and San Antonio chapters include S.T.R.I.V.E. with Women's Storybook Project, Giving Austin Labor Support, and Innerally: Building Resiliency from the Inside Out. The foundation gives $1,000 no-strings-attached grants to the projects they support (theawesomefoundation, n.d.).
Texas Council for Developmental Disabilities (TCDD)	TCDD provides 35 to 45 grants to organizations working in Texas whose projects support the goals and mission of the TCDD. Projects include the Developmental Disabilities Project Fellow which aims to increase the number of people with the knowledge and skills to support life participation in people with developmental disabilities and the Current Leadership Challenge at Texas State University which supports a development leadership training for individuals who run organizations benefiting people with intellectual developmental disabilities (TCDD, n.d.).
Partnerships with local pediatric agencies and clinics	A collaboration with local pediatric agencies or clinics may allow for the program to be implemented in their setting in exchange for the costs of materials, refreshments, and physical space.

Note. Description of potential funding sources including grants, fellowships, and investors.

Conclusion

Communicate to Collaborate is a communications skills training program aimed at strengthening pediatric therapy practitioners' interpersonal communication so they can build stronger collaborative relationships with parent clients. The first two years will focus on piloting the program; Year one will pilot the virtual program, while year two will pilot the program in-person. Therefore, no revenue will be generated from its initial implementation. Several funding sources, such as grants, investors, and partnerships, have been identified to cover the costs of implementing the program during the first two

years. Through the acquisition of these funds, financial support can be obtained to support the program pilot.

CHAPTER SIX: DISSEMINATION PLAN

Proposed Program Description

A practitioner's self-awareness of their communication style, provision of feedback, and attitude can influence the quality of parent-therapist interactions (An et al., 2019a) and parent/caregiver empowerment (Dunst & Dempsey, 2007; An et al., 2019b). In turn, this can influence a child's outcomes and overall satisfaction with therapy services. Early evidence from the pediatric rehabilitation evidence-based literature suggests that participation in communication skills training increases clinicians' self-awareness of their communication approach, thus strengthening their communication skills (King et al., 2017; King et al., 2020). *Communicate to Collaborate* is a communication skills training program that aims to increase pediatric therapy clinicians' communication self-awareness, communication reflection, and communication self-efficacy by reframing communication as an active, intentional ingredient in therapeutic intervention. This is achieved through didactic education, self-reflective and group reflective tasks, role play, and practical activities. This chapter outlines the dissemination plan for *Communicate to Collaborate* following the program's pilot phase and formative evaluation. The plan described next reviews dissemination goals, target audiences, key messages, activities, budget, and evaluation.

Dissemination Goals

Assuming the program's pilot implementation and formative evaluation yield positive results, the following goals for dissemination have been established:

- Long-term goal: Dissemination of program results to the primary and secondary

audiences will lead to an increase in knowledge on how intentional communication and interpersonal reasoning can be applied to improve the quality of parent-clinician interactions and inform the resolution of day-to-day complicated therapy situations.

- Long-term goal: Dissemination of program results to the primary and secondary audience will lead to the program being considered a valuable evidence-based educational opportunity for pediatric rehabilitation therapy providers.
- Short-term goal: Dissemination of program results to the primary audience of pediatric clinicians will lead to an increase in knowledge on how reflection habits can inform the tailoring of communication during therapy to meet individual client needs.
- Short-term goal: Dissemination of program results to the primary and secondary audiences will facilitate understanding of how the use of a uniform communication approach among pediatric therapy teams can enhance interdisciplinary collaboration and client satisfaction.

Target Audiences

Communicate to Collaborate aims to provide a consultative communication skills training opportunity for pediatric therapy practitioners working within the home care, early childhood intervention (ECI), and outpatient rehabilitative therapy clinics. Therefore, the primary audience for this dissemination plan is pediatric therapy practitioners including occupational therapists (OT), physical therapists (PT), and speech-language pathologists (SLP) in the United States (U.S.) who work with children and

families within the home, hospital, and clinic settings. The dissemination of results to this audience can influence how practitioners working with children and families use communication to build strong relationships and facilitate therapy outcomes.

The secondary audience is owners and directors of home health agencies, ECI agencies, therapy clinics, and hospitals within the U.S. the service pediatric clients and their families. By targeting these individuals, *Communicate to Collaborate* program results will spread to a larger audience, including clinicians outside of the pediatric setting. The dissemination of results to this secondary audience can influence how others in rehabilitation think about communication, specifically how changing the communication approach influences collaborative interdisciplinary interactions, parent-practitioner interactions, therapy outcomes, and client satisfaction.

Key Messages

Pediatric Therapy Clinicians

- Following participation in *Communicate to Collaborate*, pediatric therapy clinicians report improved communication self-awareness, knowledge of strategies to identify communication preferences and needs of clients, and use reflection to inform communication. Clinicians' confidence in how to apply an interpersonal reasoning process to navigate complicated day-to-day therapy situations without compromising the parent-clinician relationship was also reported.
- Pediatric therapy clinicians play a key role in the education and support of parents during their child's therapy intervention. Through the application of the

communication knowledge, skills, and strategies acquired during program participation, clinicians improve the quality of their interactions with parents by tailoring their communication to meet the needs of the parent during therapeutic intervention. This approach can increase parent and child engagement throughout the therapy process.

- Through participation in *Communicate to Collaborate*, clinicians reported feeling more confident when enacting their therapeutic use of self. Clinicians enact their therapeutic use of self when they intentionally plan the use of their personality, observations and strategies to enhance their communication with clients (Taylor et al., 2011). This approach can increase parent/child participation, increase positive therapy outcomes, and improve parent/child satisfaction.

Pediatric Therapy Agency/Clinic Owners or Directors

- Leadership within an agency or clinic sets the cultural and emotional working climate for employees. A climate that welcomes reflection on individual communication strengths and growth areas, client communication preferences and needs, and difficult communication therapy sessions would demonstrate support for clinicians to grow in their communication skills and build communication self-efficacy. *Communicate to Collaborate* provides a framework to build and reinforce this reflective practice.
- Evidenced-based research supports that pediatric therapy teams trained in a common communication approach report increased collaboration regarding client care (Seko et al., 2021; Seko et al., 2020). *Communicate to Collaborate* can help

establish interdisciplinary uniformity in how to approach, discuss and navigate complicated parent-clinician encounters and relationships. This may lead to the positive resolution of interpersonal parent-clinician misunderstandings and improve child therapy services and outcomes.

- The style and quality of clinician communication with parents can influence parent collaboration and satisfaction (Moll et al., 2018). Additionally, up to 90% of OTs surveyed reported feeling that therapist-client relationships influenced client engagement in therapy (Bonsaksen et al., 2013). A workforce supported in the building of positive collaborative relationships with parents of clients can enhance child therapy outcomes, improve satisfaction with services received, and possibly yield more client referrals.

Sources/Messengers

Primary Audience: Pediatric Rehabilitative Clinicians Working with Children and Families in the U.S.

- Sonrisas Therapies Pediatric Therapy Practitioners: The author is currently is discussing with Tsambika Bakiris, the owner and founder of Sonrisas Therapies regarding plans to pilot the program. Once the program has been piloted and evaluation results received, participants' testimonials will be utilized to disseminate its perceived benefits.
- American Occupational Therapy Association (AOTA) Children and Youth Special Interest Section (SIS): The AOTA is the primary professional association promoting the advancement in the practice and study of OT (AOTA, n.d.). The

Children and Youth SIS may be interested in program information and evaluation results. Their *Occupational Therapy's Distinct Value* resource articulates the importance of parent-practitioner collaboration and the vital role parent involvement plays in OT services (AOTA, 2016). This aligns with *Communicate to Collaborate*'s purpose, learning objectives, and outcomes. Later in the dissemination efforts, the American Physical Therapy Association and the American Speech-Language-Hearing Association will be incorporated into the dissemination plan.

Secondary Audience: Therapy Agency or Clinic Owners or Directors who Service Pediatric Clients and their Families within the U.S.

- Tsambika Bakiris, owner and founder of Sonrisas Therapies Pediatric Home Health Agency, Austin, Texas: Tsambika Bakiris has demonstrated interest in piloting the program at Sonrisas Therapies. Following successful program implementation and positive evaluation results, Ms. Bakiris can provide a positive testimonial regarding the program and its influence on team collaboration. *Communicate to Collaborate*'s purpose, learning objectives, and outcomes align closely with the values and culture of this agency.
- Texas Association of Home Care and Hospice (TAHC&H) Pediatric Forum: TAHC&H is the overseeing organization for home health and hospice agencies across the state of Texas. It advocates on behalf of these agencies to advance practice regarding quality, ethics, and economic viability (TAHC&H, n.d.). TAHC&H has a members' pediatric forum where key representatives from

various pediatric home health and hospice agencies meet to discuss trending topics (T. Bakiris, personal communication, June 14, 2021). The author would be able to gain access to this forum through her employer.

Dissemination Activities

A variety of dissemination activities will be established to relay program information and evaluation results to the primary and secondary audiences. Table 6.1 delineates these activities as well as their priority within the dissemination plan.

Table 6.1

Dissemination Activities

Dissemination Activity	Target Audience	Description	Priority/Timing
Person to Person: American Occupational Therapy Association (AOTA) 2022 conference short course	Primary: Pediatric OTs	The AOTA annual conference hosts a variety of presentations by OT practitioners, including posters, short courses, and larger lectures (AOTA, n.d.). Practitioners who attend the *Communicate to Collaborate* short course will gain knowledge on communication modes, empathetic listening, reflection on personal and client communication characteristics, and guidance on how to reflect through a therapy interpersonal event.	High - Submission deadline for the course proposal is in late June 2021. The presentation would be offered in March of 2022. It is possible, pending timing, that the program will be piloted once prior to this presentation.
Electronic Media: Correspondence with owners and directors of local pediatric	Secondary: Owners or directors of pediatric therapy clinics,	The primary contact information and email for local area clinics, agencies, and ECIs will be gathered. An email will then be sent to each of these centers. The email will include general program information, program	High - Communicate to Collaborate aims to run as a consultative communication skills training service. Therefore, it is imperative to begin

clinics, agencies, and ECIs	agencies, or ECIs	contact information, and a link to a virtual brochure outlining more specific program information, program evaluation results, testimonials from participants, and the benefits of hosting the program. Once the website is operational, a link to the website will be provided. The above links and similar content will also be posted on the TACH&H Connect online community forum.	marketing to local businesses that would benefit from the program to enhance their therapy services and care.
Electronic Media: Creation of a program website	Primary and Secondary: Pediatric clinicians Owners or directors of pediatric therapy clinics, agencies, or ECIs	After program implementation and evaluation, a formal website dedicated to Communicate to Collaborate will be created. The website will a virtual home base for relevant program information including content, learning objectives, cost, available dates, and contact. Program evaluation outcomes and attendee testimonials will also be shared. A link to the website will then be shared across social media channels such as AOTA CommunOT, TACH&H Connect, and pediatric therapist groups on Facebook.	High - A website is essential for the continued operation of Communicate to Collaborate post piloting. As pilot data is analyzed and positive results received, the process for the website creation will be initiated during year two.
Written: Publication in the *Journal of Continuing Education in the Health Professions*	Primary and Secondary: Pediatric clinicians Owners or directors of pediatric therapy clinics,	The *Journal of Continuing Education in the Health Professions* is a peer-reviewed journal that covers multiple aspects of continuing education within the fields of medicine, nursing, and allied health professions. Particular areas of interest include innovative education programs and interventions, education program	Medium - This journal publishes quarterly. It is anticipated that it will take time for program pilot evaluation results to be collected and analyzed as well as for an article to be written per journal requirements. It is

	agencies, or ECIs	development, planning, and assessment, program outcome evaluations, learning-behavioral change, and quality improvement (JCEHP, n.d.).	anticipated a manuscript may be submitted one year after the program pilot ends and data analysis is complete.
Person to Person: Guest speaker at the TAHC&H pediatric forum meeting	Secondary: Owners or directors of pediatric therapy clinics, agencies, or ECIs	TAHC&H pediatric forum meets monthly to discuss trending topics impacting the pediatric home care and hospice agencies in Texas (T. Bakiris, personal communication). A presentation to this group may inform how training in therapeutic communication improves service delivery, team collaboration, and client care.	Medium - After the program pilot has been completed, including data analysis and compilation of results, a short presentation to the members of the TAHC&H pediatric forum can result in more interest in the program.

Note. Delineation of dissemination activities, target audiences, activity description, and priority.

Dissemination Budget

For the dissemination plan to be realized, funding for each activity needs to be considered and incorporated into the overall funding plan for *Communicate to Collaborate*. Table 6.2 outlines the estimated budget for each dissemination activity.

Table 6.2

Dissemination Budget

Dissemination Activity	Description	Estimated Expense Year 1	Estimated Expense Year 2
AOTA Conference 2022 short course presentation	The cost to attend the conference is estimated at $523.00. The conference will be held in San Antonio, TX, an hour and a half drive from the author's home. The estimated cost of gasoline is $20 each way. The author plans to use hotel points to secure lodging for conference dates. The author has already created the program's detailed facilitator's manual, including practical activities as part of Boston University's doctoral program. Therefore, no additional cost is estimated at this time.	$563.00	N/A
Correspondence with owners and directors of local pediatric clinics, agencies, and ECIs	A free program-specific email account will be set up using Gmail. Email brochures will be created using available online templates such as Google, Canva, or Microsoft. Once the website is operational, a link to the website will be sent out as well. Additionally, similar information will be posted on the TAHCH Connect community forum (TAHCH, n.d.). The estimated cost of this dissemination activity is $0.	N/A	$0
Creation of a program website	When examining reviews of free web builders online, Wix appears to have the best reviews and services for the price (Carney, 2021). Creating a website using Wix can cost about $18-$22/month including domain, maintenance, and website (Wix, n.d.). The author anticipates beginning the website creation process six months prior to the full program launch. This is estimated to cost approximately $132.	N/A	$132.00

Written publication in the *Journal of Continuing Education in the Health Professions*	The author plans to initiate the process of writing an article at the end of the program's second-year pilot. The estimated time spent in preparing the article for journal submission during the second year is 10 hours. The author plans to finalize the article when data collection, analysis, and interpretation are complete. The article will most likely be completed and submitted during year 3 - post-pilot. The average office time rate for an OT in home health is approximately $30/hour. Therefore, the estimated expense to cover the author's time is $300. However, the author is willing to volunteer the necessary time. There does not appear to be a cost associated with publication in the *Journal of Continuing Education in the Health Professions* (JCEHP, n.d.).	N/A	$0
Speaker at TAHC&H pediatric forum	It is anticipated that it may take the author 10 hours to create a short presentation for TAHC&H pediatric forum members. The average office time rate for an OT in home health is approximately $30/hour. Therefore, the estimated expense to cover the author's time is $300. However, the author is willing to volunteer the necessary time.	N/A	$0
Total Estimated Expense	The total estimated expense of dissemination for Communicate to Collaborate is $695.00.	$563.00	$132.00

Note. Estimated expenses for dissemination activities during the first two years of program implementation and evaluation.

Evaluation of Dissemination Plan

An evaluation of the dissemination plan will be conducted to determine the success of dissemination activities and if dissemination goals were achieved. Table 6.3 delineates the indicators for success for each dissemination activity. Table 6.4 describes

the methods utilized to determine if goals were successfully achieved.

Table 6.3

Dissemination Activity Evaluation

Dissemination Activity	Indicator of Success
AOTA Conference 2022 short course presentation	Submission of presentation to AOTA by June 28, 2021, and subsequent acceptance. Completion of presentation in March 2022.
Emails to owners and directors of local pediatric clinics, agencies, and ECIs	Generation of a list of local agencies/clinics and contact information three months prior to the end of the pilot phase. Initial emails with dissemination information will be delivered once data analysis is complete and dissemination materials and a website have been created. Subsequent follow-up emails will be delivered as appropriate throughout the rest of the year. After the initial email push, a response from at least two agencies or clinics interested in completing the program at their facility will determine success.
Creation of a program website	Completion of the program website three to six months prior to the end of the pilot. The website will aim to have at least 500 visits per month once formally launched with continued growth in visits over time.
Written publication in the *Journal of Continuing Education in the Health Professions*	Manuscript submission within one year of the program's pilot end and subsequent acceptance.
Guest speaker at TAHC&H pediatric forum.	Short presentation completed within one year of program pilot completion, including data analysis and compilation of results. Contact from at least one agency after the presentation.

Note. Indicators of success for dissemination activity evaluation.

Table 6.4

Dissemination Goals Evaluation

Dissemination Goal	Indicator of Success
Long-term goal: Dissemination of program results to the primary and secondary audiences will lead to an increase in knowledge on how intentional communication and interpersonal reasoning can be applied to improve the quality of parent-practitioner interactions and inform the resolution of day-to-day complicated therapy situations.	● Completion of a review of the evidenced-based literature in the three-year period following publication, presentations, and continued program implementation to track outcomes of communication skills training among pediatric rehabilitative practitioners, including intentional communication, therapeutic use of self, and communication-based interventions. ● Brief online survey among pediatric practitioners distributed through Facebook groups, discipline-specific organizational community threads, and pediatric home health agencies, ECI agencies, and clinics. Although this will not likely be a representative sample, it may inform regarding trends on how practitioners are using/applying intentional communication and the therapeutic use of self, reflection to improve communication, perceived quality of parent-practitioner interactions, and perceived resolution of complicated situations. ● Follow-up correspondence, including a brief survey, TAHC&H pediatric forum members to determine if there are any trend changes in perception regarding intentional communication, interdisciplinary collaboration, and client satisfaction.
Long-term goal: Dissemination of program results to the primary and secondary audience will lead to the program being considered a valuable evidence-based educational opportunity for pediatric rehabilitation therapy practitioners.	● By the end of year three, the program will be scheduled to run at least three times with eight to 10 participants.

Short-term goal: Dissemination of program results to the primary audience of pediatric clinicians will lead to an increase in knowledge on how reflection habits can inform the tailoring of communication during therapy to meet individual client needs.	● OT practitioners who attend the AOTA short course presentation will complete a short survey. This survey will gather information regarding the perceived benefit of the information shared, perceived knowledge gained, perceived usefulness of reflection strategies shared, and perceived confidence in trialing strategies. Although this will likely be a small sample, it may inform on trends regarding the use of intentional communication when working with parents and families.
Short-term goal: Dissemination of program results to the primary and secondary audiences will facilitate understanding of how the use of a uniform communication approach among pediatric therapy teams can enhance interdisciplinary collaboration and client satisfaction.	● Completion of a review of the evidenced-based literature in the three-year period following publication, presentations, and continued program implementation to track trends regarding the influence of communication skills training across rehabilitation therapy teams on interdisciplinary collaboration, therapy outcomes, and client satisfaction. ● Follow-up correspondence with previously contacted pediatric agency and clinic owners or directors to determine if there has been an increase in the intentional use of communication using a uniform approach across team members and its influence on collaboration and client satisfaction. A brief survey will be included.

Note. Indicators of success for dissemination goals.

Conclusion

Communicate to Collaborate is a communication skills training that promotes the intentional use of communication strategies to strengthen the parent-practitioner therapeutic relationship. It focuses on increasing practitioner communication self-awareness, practitioner awareness of parent communication needs, and practitioner self-efficacy through guided group and self-reflection, interactive discussion, and the application of interpersonal reasoning to navigate everyday complicated therapy situations. Following successful program implementation and evaluation, results will be

shared with pediatric clinicians, including OT, PT, ST, and pediatric home health agency owners, pediatric clinic owners, and ECI directors. Dissemination activities include informational emails, a formal website launch, and presentations. Following dissemination, it is expected that practitioners will increase their knowledge on the value that intentional communication brings to therapeutic intervention. Further, it is anticipated practitioners will increase their confidence in the application of the therapeutic use of self to enhance therapy relationships, outcomes, and satisfaction.

CHAPTER 7: CONCLUSION

Both parents and therapists report valuing open and honest communication and perceive it to be essential for the establishment of a collaborative relationship (King et al., 2017; MacKean et al., 2005; Moll et al., 2018). However, both also report experiencing communication challenges specifically regarding parent/therapist roles (Kruijsen-Terpstra et al., 2016) and mismatched therapy expectations (Hinojosa et al., 2002; Kruijsen-Terpstra et al., 2016; Moll et al., 2018). Practitioners also report difficulties in identifying and responding to a family's evolving needs (Kruijsen-Terpstra et al., 2014) and anticipating a family's coping (Andrews et al., 2013) and emotional responses (Dyke et al., 2006). When engaged in the therapeutic process, these communication difficulties can negatively influence the parent-practitioner collaborative relationship (Almasri et al., 2018; Mackean et al., 2005).

Limited availability of communication skills training (An et al., 2019; An & Palisano, 2014; King et al., 2017), limited understanding of how to practice reflection to enhance communication self-awareness (King et al., 2017; Knightbridge, 2019; Shepherd et al., 2014; Taylor, 2020), and decreased self-efficacy (An et al., 2019a; Seko et al., 2021) impact practitioners' ability to enhance their communication competencies (La Forme Fiss et al., 2012). These factors also prevent practitioners from identifying meaningful areas of growth and awareness through self-reflection (King et al, 2017; Shepherd et al., 2014). Similarly, many occupational therapy (OT) practitioners report limited training and limited knowledge regarding the therapeutic use of self (Bonsaksen et al., 2013), even though it is integral to occupational therapy (OT) practice (AOTA,

2020a). The therapeutic use of self can be defined as the "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, as cited in Taylor et al., 2009, p. 285). When enacting their therapeutic use of self, therapy practitioners intentionally plan strategies for client-therapist interactions to enhance communication, collaboration, and partnership within the client-therapist relationship (Taylor et al., 2020). Without the opportunity to cultivate their communication skills, pediatric therapy practitioners may continue to feel unprepared to provide emotional support, help parents with advocacy, identify parent coping needs, and give/receive constructive feedback during sessions (Dyke et al., 2006; Fingerhut et al., 2013; Moll et al., 2018).

The emerging rehabilitative therapy literature reports positive outcomes in favor of the communication intervention training. These outcomes include improved awareness of communication and listening skills (King et al., 2017; Schwellnus et al., 2019; Seko et al., 2020; Yazdani et al., 2020), confidence (Seko et al., 2020; Seko et al., 2021; Yazdani et al., 2020), and parent-therapist interactions (An et al., 2019a). Specifically, reflection within these training has resulted in increased confidence regarding new techniques (Yazdani et al., 2020) and promoted the immediate use of learned skills in practice (King et al., 2017; Yazdani et al., 2020). Further, practitioners who were identified as strong communicators and utilized reflection were noted to implicitly tailor their approach to meet client needs (King et al., 2020; McKnight et al., 2016; Schwellnus et al., 2019; Taylor et al., 2011; Yazdani et al., 2020). Therefore, communication skills training with a reflective component can help practitioners structure their thoughts surrounding a clinical

situation and use communication to problem-solve alternate solutions while preserving the therapeutic relationship.

Communicate to Collaborate, a communication skills training informed by the Intentional Relationship Model (Taylor, 2020) and Social Cognitive Theory (Bandura, 2001), was created based on evidence supporting the use of reflection to improve communication skills as well as communication self-efficacy. The program includes four weekly synchronous virtual workshops and a course Padlet with supplementary material. Workshop topics include: "Getting to know yourself", "Getting to know your client", "Intervention approaches and techniques", and "How to communicate with intention and resolve therapy interpersonal conflicts". Additionally, assigned practical homework activities aim to promote the transfer of course content into practice. *Communicate to Collaborate* will be initially facilitated by the author, a pediatric occupational therapist. A facilitator's manual has been created to optimize the training of future facilitators. Through the use of educational programming, self-reflective activities, group reflective activities, role-play, and reflective homework tasks, practitioners can increase their confidence through practice and learn to ground their communication interactions in the IRM and other complementary communication approaches. This can increase the practitioners' ability to remain objective, particularly during difficult encounters so they can identify communication challenges, explore their underlying triggers, cope, and respond in a manner that strengthens the parent-practitioner relationship (Popova et al., 2020).

The program evaluation will utilize a post-program survey and follow-up survey

to collect descriptive and qualitative data as well as quantitative data regarding program content, structure, and activities. Outcome measures, including the Effective Listening and Interactive Communication Scale (ELICS) (King et al., 2012), the Self-Efficacy for the Therapeutic Use of Self Questionnaire (Fan et al., 2020), and the Reflective Practice Questionnaire (RPQ) (Priddis & Rogers, 2017), will be administered to assess communication skills, communication self-efficacy, and reflection. Dissemination of evaluation results will be distributed to pediatric practitioners and the owners of pediatric home health agencies and clinics as well as early childhood intervention directors. Dissemination activities include a short course at the American Occupational Therapy Association annual conference, creation of a program website, email correspondence, a presentation for the Texas Association of Home Care and Hospice Pediatric Forum, and a publication submission for the *Journal of Continuing Education in the Health Professions*. It is anticipated that through program participation and the sharing of findings, practitioners will use evidence-based strategies to improve their communication awareness and increase their confidence in identifying the communication preferences of others. This will lead to the intentional tailoring of their communication approach to best meet clients' and families' evolving needs, thus enhancing the therapeutic use of self in practice. This will in turn improve the quality of family-centered pediatric therapy intervention resulting in stronger collaborative relationships with parents, improve child therapy outcomes, and increase parent satisfaction with therapy services.

APPENDIX A: Executive Summary

Introduction

For pediatric therapy practitioners, effective communication with the parents and caregivers of pediatric clients is considered an essential skill and encompasses not only the verbal exchanging of ideas (King et al., 2012; Taylor, 2020) but also listening (Davis et al., 2013; King et al., 2012; Taylor, 2020) and non-verbal communication (Pinto et al., 2012; Taylor, 2020). According to the family-centered care evidence-based literature, pediatric therapy practitioners have difficulty communicating with parents, particularly when reviewing parent-therapist roles (Kruijsen-Terpstra et al., 2016), discussing therapy expectations (Hinojosa et al., 2002; Kruijsen-Terpstra et al., 2016), and navigating emotional encounters (Dyke et al., 2006; Andrews et al., 2013). These communication difficulties can negatively influence the parent-practitioner collaborative relationship (Almasri et al., 2018; Mackean et al., 2005).

Correspondingly, the therapeutic use of self is integral to occupational therapy (OT) practice (AOTA, 2020) and may be defined as the "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, as cited in Taylor et al., 2009, p. 285). When enacting their therapeutic use of self, practitioners consciously enhance communication, collaboration, and partnership within the client-therapist relationship by incorporating planned strategies for client-therapist interactions (Taylor et al., 2020). Without the opportunity to cultivate their communication skills, pediatric practitioners may continue to feel unprepared to provide emotional support, help parents with advocacy, identify parent

coping needs, and give/receive constructive feedback during sessions (Dyke et al., 2006; Fingerhut et al., 2013; Moll et al., 2018). Further, without intentional communication, pediatric practitioners may be inadvertently omitting what families value in the therapeutic process, resulting in decreased satisfaction and collaboration while further lending to a misunderstanding of rehabilitative therapy services (Cohn, 2001; LaForme et al., 2012).

Key Findings

Pediatric therapy practitioners looking to strengthen their communication skills frequently find there is limited availability of communication skills training (An et al., 2019a; An & Palisano, 2014; King et al., 2017), a limited understanding of how to practice reflection to enhance communication self-awareness (King et al., 2017; Knightbridge, 2019; Shepherd et al., 2014; Taylor, 2020), and decreased self-efficacy (An et al., 2019a; Seko et al., 2021). These factors not only limit the opportunity for practitioners to enhance their communication competencies (La Forme Fiss et al., 2012) but also to identify meaningful areas of growth and awareness through self-reflection (Shepherd et al., 2014; King et al, 2017). Although rehabilitative practitioners value reflection to improve their clinical practice, many report that employer support (King et al., 2017; Seko et al., 2021), time constraints (Knightbridge, 2019; Yazdani et al., 2020), and knowing how to incorporate reflection into their work as limiting factors (Knightbridge, 2019).

Self-efficacy is also reported as a major limiting factor when communicating with clients, particularly when faced with difficult topics (Coad et al., 2018) and emotional

encounters (Ammentorp et al., 2007). Self-efficacy during communication is further influenced by family/client factors such as emotional state (Davis et al., 2013), family dynamics such as denial and unrealistic therapy expectations (Hinojosa et al., 2002), family follow-through (King et al., 2015), and perception of roles (Bellin et al., 2011; Fingerhut et al., 2013).

According to the emerging evidence-based rehabilitative literature, the positive outcomes of communication skills training include improved awareness of communication and listening skills (King et al., 2017; Seko et al., 2020; Yazdani et al., 2020), increased confidence (Seko et al., 2020; Seko et al., 2021; Yazdani et al., 2020), and increase parent-therapist interactions (An et al., 2019a). Specifically, reflective experiences have been reported to increase confidence in identifying and responding to the relational dynamics within the client-practitioner relationship (Yazdani et al., 2020) and to promote the immediate use of learned skills in practice (King et al., 2017; Yazdani et al., 2020). Therefore, communication skills training with a reflective component can help practitioners structure their thoughts surrounding a clinical situation and use communication to problem-solve alternate solutions while preserving the therapeutic relationship.

Project Overview

Communicate to Collaborate is a communication skills training that aims to strengthen pediatric practitioners' interpersonal communication skills with the overarching goal of reframing how practitioners communicate with families as an active, mediating ingredient in their therapy interventions. Through program participation,

practitioners will gain greater awareness of both their personal communication approaches and their client's communication preferences. In addition, participants will engage in reflection related to communication interactions, thus increasing their self-efficacy in how to communicate intentionally with parents. Evidence-based research also suggests that pediatric therapy teams trained in a common communication approach report increased collaboration regarding client care (Seko et al., 2021; Seko et al., 2020). Therefore, a secondary outcome is to assist in establishing interdisciplinary uniformity in how to approach, discuss and navigate complicated parent-clinician encounters and relationships. This will increase the positive resolution of interpersonal parent-practitioner misunderstandings and improve child therapy services and outcomes.

Guiding Theories

Communicate to Collaborate is informed by the Intentional Relationship Model (IRM) (Taylor, 2020) and Social Cognitive Theory (SCT) (Bandura, 2001). The IRM is a practice model that increases understanding of how the therapeutic use of self can influence the client-therapist relationship and client participation in therapy through the use of interpersonal reasoning and intentional communication (Taylor, 2020). It is meant to enhance the delivery of other therapeutic interventions by improving the client-practitioner communicative relationship. The IRM delineates modes of communication clinicians can draw from to navigate everyday therapy conflicts (Taylor, 2020). Although 80% of surveyed occupational therapists (OTs) reported that the most important skill in their practice was their therapeutic use of self, only half of the respondents felt sufficiently trained in how to implement the therapeutic use of self in practice. Further,

less than a third felt they had sufficient knowledge regarding the therapeutic use of self (Bonsaksen et al., 2013). *Communicate to Collaborate* aims to fill this gap by increasing participants' knowledge on how to ground their communication interactions in the IRM and other complementary communication approaches. In turn, this can increase the practitioners' ability to remain objective, particularly during difficult encounters so they can identify communication challenges, explore their underlying triggers, cope, and respond in a manner that strengthens the parent-practitioner relationship (Popova et al., 2020).

SCT is a learning theory that highlights humans as social learners influenced by their self-efficacy, outcome expectations, observations, and self-regulation (Schunk, 2012). Self-efficacy is the belief in one's own capabilities and can be strengthened by actual performances of a learned task (Schunk, 2012). *Communicate to Collaborate* aims to improve practitioner communication self-efficacy by facilitating successful actual performance in a safe environment and then promote the transfer of performance to work experience through practical homework activities.

Recommendations for Implementation

Communicate to Collaborate is a four-week program that incorporates the following learning approaches: educational programming, self-reflective activities, group reflective activities, role-play, and practical homework tasks. Each week, participants attend a synchronous module workshop. Participants then complete practical activities throughout the week to facilitate the processing of module content and the transfer of learning into practice. A course Padlet with both module-related content and

supplementary resources will be available for participants to review at their own pace. Module topics include: “Getting to Know Yourself”; “Getting to Know Your Client”; “Intervention Approaches and Techniques”; and “How to Communicate with Intention and Resolve Therapy Interpersonal Conflicts”.

Program Evaluation and Dissemination

The program will be evaluated using a pre- and post-test one-group study with follow-up four to six weeks later. The study will utilize a post-program survey and follow-up survey to collect descriptive and qualitative data as well as quantitative data regarding program content, structure, and activities. Outcome measures, including the Effective Listening and Interactive Communication Scale (ELICS) (King et al., 2012), the Self-Efficacy for the Therapeutic Use of Self Questionnaire (Fan et al., 2020), and the Reflective Practice Questionnaire (RPQ) (Priddis & Rogers, 2017), will be administered to assess communication skills, communication self-efficacy, and reflection. The ELICS is a reliable and valid self-report measure pediatric practitioners can use to assess their evolving listening and communication skills (King et al., 2012). Similarly, the Therapeutic Use of Self Questionnaire is an IRM-inspired self-report measure that allows practitioners to assess their self-efficacy in communication mode use, identifying interpersonal characteristics, and managing interpersonal conflicts (Fan et al., 2020). Lastly, the RPQ is a reliable self-report tool designed to facilitate the understanding of reflection engagement in practice (Priddis & Rogers, 2017).

After program implementation and evaluation, dissemination of results to the primary audience of pediatric practitioners, including OTs, physical therapists, and

speech-language therapists, and the secondary audience of pediatric home health agency and clinic owners and early childhood intervention directors will be completed. Dissemination activities include a short course at the American Occupational Therapy Association (AOTA) annual conference, creation of a program website, email correspondence, a presentation for the Texas Association of Home Care and Hospice Pediatric Forum, and a publication in the *Journal of Continuing Education in the Health Professions*.

General Conclusion

Communicate to Collaborate provides an opportunity for pediatric practitioners to strengthen their communication skills so they can intentionally use their communication with clients and families to enhance the therapeutic process. Through educational programming, small group discussions, group and individual reflection, and role play, practitioners can boost awareness of their personal communication style, preferences, and attitudes and how these factors influence their communication with clients and families. Additionally, pediatric therapy practitioners can feel more confident in how to identify the communication preferences of their clients and families and explicitly tailor their communication approach to best meet clients' and families' evolving needs. This can result in stronger collaborative relationships with parents, improve child therapy outcomes, and increase satisfaction with therapy services.

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APPENDIX B: Fact Sheet

BOSTON UNIVERSITY

Communicate to Collaborate: Reframing Communication to Strengthen Parent-Practitioner Collaborative Relationships

Ana K. Brussa MS, OTR/L
OTD Candidate

Communicate to Collaborate is a communication skills training for pediatric therapy practitioners that aims to reframe how practitioners communicate with parents and families as an active, mediating ingredient in their therapy interventions.

Background

- Effective communication with the parents and caregivers of pediatric clients consists of the verbal exchanging of ideas, listening, and non-verbal communication.[1]
- Therapeutic use of self is the "planned use of […] personality, insights, perceptions, and judgments as part of the therapeutic process.[1]
- When enacting their therapeutic use of self, therapy practitioners enhance communication by incorporating planned strategies for client-therapist interactions.[1]

Clinical Problem

Pediatric therapy practitioners report difficulty with communication challenges such as parent emotional expressions, anticipating parent coping needs, discussing a family's evolving needs or parent perspective/expectations, and balancing the needs of both the child and parent.

Factors Contributing to the Problem

⇒ Limited availability of communication skills training[2-3]
⇒ Limited knowledge and opportunity to practice self-reflection[3-4]
⇒ Decreased communication self-efficacy[2,5]
⇒ Time, employer philosophy, and family factors including the parent's preferred communication style and interpersonal characteristics[1-2,4]

Communicate to Collaborate - Guiding Theories

Intentional Relationship Model (IRM)[1]

- Examines how the therapeutic use of self influences the therapeutic relationship and client participation. The IRM outlines modes of communication, interpersonal characteristics, and an interpersonal reasoning process practitioners can draw from to navigate everyday therapy conflicts.

Social Cognitive Theory[6]

- Humans are social learners influenced by their self-efficacy: the belief in one's own capability to successfully learn a behavior.

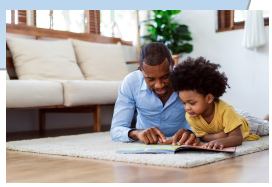
Communicate to Collaborate – Program Outcomes

- Increased knowledge and awareness of one's own communication strengths/areas of growth and parent communication characteristics and preferences.
- Increased engagement in reflection habits regarding one's communication.
- Increased communication self-efficacy, particularly when navigating everyday therapy conflicts.

Program Format
⇒ Small group cohorts
⇒ Four virtual synchronous workshops, one per week
⇒ Course Padlet available for supplemental material

Program Workshop Modules
⇒ Getting to know yourself
⇒ Getting to know your client
⇒ Intervention approaches and techniques
⇒ How to communicate with intention and resolve therapy interpersonal conflicts

Learning Approaches
⇒ Educational programming
⇒ Individual and group reflective activities
⇒ Role play
⇒ Practical homework activities



Impact on Occupational Therapy (OT)

Strengthening the communication skills of pediatric therapy practitioners through knowledge and reflection can:

- Enhance practitioner therapeutic use of self through the intentional tailoring of communication approach to best meet the parent's evolving needs.
- Improve the quality of OT intervention resulting in stronger collaborative relationships with parents, improved child therapy outcomes, and increased parent satisfaction with therapy services.

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APPENDIX C: FACILITATORS MANUAL

Communicate to Collaborate
Facilitator Manual and Educational Content Draft
By: Ana K. Brussa, MS, OTR/L

Program Outline

M1 Module 1: Getting to know yourself

A. Course Objectives
B. Introductory Activities
C. Presentation
D. Reflective Activity/Self-Assessment of Modes
E. Homework

M2 Module 2: Getting to know your client

A. Course Objectives
B. Homework Review/Reflections
C. Presentation
D. Reflective Discussion
E. Homework

M3 Module 3: Intervention approaches and techniques

A. Course Objectives
B. Homework Review/Reflection
C. Presentation
D. Reflective Activity/Discussion
E. Homework

M4 Module 4: How to communicate with intention and resolve therapy interpersonal conflicts

A. Course Objectives
B. Homework Review/Reflection
C. Presentation
D. Reflective Group Problem-Solving - Clinical Case Scenarios

Module 1: Getting to Know Yourself

M1

Objectives

1. Participants will be able to identify key communication skills for effective communication.
2. Participants will demonstrate knowledge of the Intentional Relationship Model (IRM) and how the model mediates communication with clients/parents.
3. Participants will be able to perform an empathetic listening checklist with a peer.
4. Participants will identify their preferred modes of communication as per the IRM.

Materials Needed

- Computer, internet access, zoom application
- Electronic copies of homework assignments, module activities, and informational handouts

Introductory Activities

M1

Introduction

- The instructor and participants will introduce themselves.
- Spiral Journaling activity will be completed.
    - Each participant will have a sheet of paper and a pen/pencil.
    - They will divide the paper into four squares. In the center, they will draw a tight spiral from the center outwards.
    - In the first square, participants will have 2 minutes to complete this statement: To me, effective communication with the parents/families of my clients means -
    - In the second square, participants will have 2 minutes to complete this statement: When communicating with the parents/families of my clients, I am really good at-
    - In the third square, participants will have 2 minutes to complete this statement: When communicating with the parents/families of my clients, I have trouble with-
    - In the fourth square, participants will have 2 minutes to complete this statement: By participating in this course, I hope to learn -

Module 1 Outline

Objectives

- To learn about the IRM and identify how it can strengthen our communication skills during therapy.
- To review any previous knowledge and increase knowledge in basic communication skills
- To identify what are modes of communication as defined by the IRM and reflect on the modes preferred by participants in therapy interactions.
- To discuss and practice the use of empathetic listening in our communication interactions.

Presentation Outline

- What is IRM? (Taylor, 2020)
- Therapeutic Use of Self - What is it? What does it require? (Taylor, 2020)
- Activity:
    - Self-Assessment of Modes (Taylor, 2013)
- Communication Basics (Taylor, 2020)
    - Verbal communication
    - Non-verbal communication
    - Therapeutic/Empathetic listening
- Activity:
    - Empathetic listening with a partner
- Modes of Communication (Bonsaken et al., 2013; Taylor, 2020; Yazdani et al., 2020)
    - Empathizing mode
    - Collaborating mode
    - Encouragement mode
    - Problem - solving mode
    - Instructing mode
    - Advocating mode
- Activity:
    - Self-Assessment of Modes (Taylor, 2013) results and reflection
- Homework review

Module 1: Educational Content for Presentation and/or Padlet M1

What is the Intentional Relationship Model (IRM)? (Taylor, 2020)

- The IRM is a conceptual model that aims to improve communication with our pediatric clients and their parents so that it is open, honest, and trustworthy.
    - It is a mediational model. This means that it aims to improve our communication with parents as we simultaneously implement other interventions so our pediatric clients can achieve their goals and engage in age expected occupations with the support and participation of their parents.
    - The IRM hopes to fill the gap between our practical clinical knowledge and skills and our interpersonal reasoning knowledge and skills so we can build stronger client/parent-therapist relationships.
    - The IRM defines interpersonal reasoning as the individualized decision-making process we use during parent-therapist communication to best meet the client and parent's interpersonal needs.
- The IRM provides a set of concrete communication skills pediatric therapists can use to navigate the client and parent's ever-changing interpersonal characteristics and the emotional, behavioral, interpersonally intense therapy situation.
    - It looks to answer the question: How can we apply our therapeutic use of self to facilitate positive client outcomes for both client and parent through the participation in occupation?
    - Include a picture of the IRM visual conceptual model
- *(If there is time) The IRM has 10 core principles:*
    - *"Critical self-awareness is key to the intentional use of self" (Taylor, 2020, p 70)- we need to be aware of our strengths, areas of growth, how we react under stress, how we communicate verbally, nonverbally, emotionally, and what we mindfully withhold.*
    - *"Interpersonal discipline is fundamental to effective use of self" (Taylor, 2020, p 71)- includes asking for and responding to parent client feedback, anticipating and responding to ongoing communication, having awareness of the type of parent/client/situation that would strain your interpersonal self, avoiding the internalization of interpersonal conflicts - not a measure of how "good" you are*
    - *"It is necessary to keep head before heart" (Taylor, 2020, p 73) - our heart though in the right place may not always end in a positive result. We need to be mindful of our interpersonal communication within our parent client relationships*
    - *"Mindful empathy is required to know your client" (Taylor, 2020, p 73)- this is when we are able to observe and understand our parent client's feelings/reaction from their perspective while remaining objective.*
    - *"Grow your interpersonal base" (Taylor, 2020, p 75)- we must continue to work on our skills as communicators and strengthen our use of self within our client communication and relationships.*

- *"Provided they are used purely and flexibly applied, a wide range of therapeutic modes can work and be utilized interchangeably" (Taylor, 2020, p 75) in therapy* M1
- *"The client defines a successful relationship" (Taylor, 2020, p 76)- we strive to meet the client's needs to mediate their success; their needs may change over time.*
- *"Activity focusing must be balanced with interpersonal focusing" (Taylor, 2020, p 76) - the activity is what we do and the interpersonal is how we feel - when adapting activities for our client's success we should balance that with also addressing how they feel while doing the activity or as a result of the activity*
- *"Application of the model must be informed by core values and ethic" (Taylor, 2020, p 77) - discipline values and ethics*
- *Cultural competence is central to practice*

Therapeutic Use of Self - What is it? What does it require?

- The therapeutic use of self may be defined as the "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, as cited in Taylor et al., 2009, p. 285).
  - When we enact our therapeutic use of self, we consciously enhance how we choose to communicate, collaborate, and partner within the client/parent-therapist relationship. We intentionally incorporate planned strategies for client/parent-therapist interactions (Taylor et al., 2011).
- The therapeutic use of self requires (Taylor, 2020):
  - Physical self-control - our personal hygiene, professional presentation, how neat and safe we keep our therapy environment.
  - Behavioral self-control - facial expressions, body language, use of touch
  - Emotional self-control - our body, facial, vocal reactions during communication
  - Psychological self-control - how we take care of ourselves; prevent burn out/caregiver fatigue
  - Interpersonal self-control - our reactions/responses to client/parent behaviors or emotions during therapy communication
- To enact our therapeutic use of self, we need to increase our communication self-awareness so we can respond to the needs of our clients and their parents with intention.

Self-Assessment of Modes (Taylor, 2013 - used with permission from the author)

- Before we move on, let's participate in an exercise that will help us learn our preferred mode of communication. Please take a moment to complete the following questionnaire. It will not be scored at this time. After we review the information presented in this module, we will score the questionnaire and complete a reflective activity about our responses.

Verbal communication (AHRQ, n.d.; Taylor, 2020)

M1

- This is the use of language that is spoken or signed. What do you feel strengthens verbal communication?
- It is important that we consider the following when communicating verbally with our clients and parents:
    - Our words should be clear and easily understood - this should be perceived by both the client/parent and therapist. It is our responsibility to ask clarifying questions and adjust our communication approach to meet the needs of clients/parents to the best of our abilities.
    - Content should be brief and accurate - consider cultural background, health literacy/education background, language preference, and method of communication preference.
    - Communication should be intentional in regards to both timing of information and amount of information, detail/complexity; We need to be mindful to empower, not to overwhelm our clients and their parents.
    - We should be aware of our emotional modulation during communication - does our tone and/or word choice match the situation? Meet the client/parent's communication needs/preferences?
    - Communicate with confidence, professionalism, and respect. It's OK to say "I don't know/I'm not sure, but I will look into it for our next visit".

Nonverbal communication (Taylor, 2020)

- Communication not based on the spoken word - tone of voice, gestures, facial expression, body language/movements.
    - It is how our clients and their parents experience our communication and it is what they tend to remember after therapy is over.
    - It influences the parent's overall impression of us. We need to be just as intentional with our non-verbal communication as we are with our words.
    - Nonverbal communication norms can vary per cultural background - please consider your client's culture and adjust nonverbal communication accordingly.
- Include pictures of nonverbal expressions for participants to interpret

Therapeutic and empathetic listening (Taylor, 2020)

- This is when we listen and gather information in a way that supports a deeper understanding of the parent's experience and validates their perspective as appropriate, particularly when considering the client's therapy and goals. May require us to listen empathetically.
    - It is important to set our bias/judgment aside so we can understand the parent's interpretation of and reactions to what happens during therapy or what is happening in their life.
- When we listen with empathy, we can use a summary statement to confirm what we gathered from our listening is consistent with what the parent is trying to convey.

    - A summary statement is a brief statement that reflects on the main points being communicated.
    - It is NOT repeating what the parent has said word for word, adding to what the parent has said, trying to figure out what the parent might say next or what they may be feeling.
    - Summary statements take practice to refine and strengthen the skill.
- Common obstacles to listening include:
    - Jumping into the conversation to help the parent finish a thought
    - Planning what you are going to say in a way that distracts from your listening; wandering thoughts
    - Comparing the parent experience to someone else, normalizing the experience, relaying something similar that happened to you
    - Introducing a new topic or giving advice when not asked
    - Judging, analyzing, trying to figure out if what the parent is saying is true

M1

Empathetic listening reflective activity with a partner

- Participants will be paired into groups of 2-3 depending on the number of participants. They will go into a Zoom breakout room. Each person will pick one of the following scenarios (Taylor, 2020):
    - Scenario 1: Ask your partner to tell you about his or her favorite occupation and why it is meaningful and enjoyable.
    - Scenario 2: Ask your partner to tell you about the neighborhood(s) in which he or she spent his or her childhood years.
    - Scenario 3: Ask your partner to tell you about a mentor, teacher, or advisor who influenced his or her life in a positive way.
- The participant telling the story will have about 5-10 min depending on the time and number of participants. The others will listen and then complete an Empathetic Listening Reflection Checklist modified from Taylor (2020). - See homework
- Upon return participants will be invited to share any findings with the larger group.

The IRM Modes of Communication (Taylor, 2020)

- A therapeutic mode of communication is a specific way of communicating with clients and their parents. Your therapeutic style is defined by the mode/modes you use most frequently when interacting with clients/parents.
- The IRM identifies 6 modes of communication most frequently utilized by occupational therapists in practice.
    - Empathizing
    - Collaborating
    - Encouraging
    - Problem-solving
    - Instructing
    - Advocating

- Modes of communication are "perceived, relativistic, and subjective" (pp. 84) - Hence, enacting the same mode in two similar circumstances may result in two different responses across two different parents. M1
- No one mode is better than the other - they all have potential to strengthen the therapeutic relationship. However, we need to be mindful of
    - Not overusing any one mode when interacting with parents
    - Our timing when enacting a specific mode to meet the parent's interpersonal needs
    - Whether the mode we use in that moment matches the parent's needs. If not, then a mode change or approach on our part may be needed so we can meet the interpersonal needs of the parent/client.

Empathizing mode (Bonsaksen et al., 2013; Yazdani et al., 2020)

- Understanding and demonstrating understanding of the parent/client's personal experience; asking deeper questions to promote this understanding
- Seeing the parent/client's world from their perspective in the absence of judgement
- Strengths (Taylor, 2020)
    - Can enhance emotional healing - can provide the parent/client opportunity to self-reflect and gain perspective on their experience
    - May help resolve conflicts and misunderstandings
    - May promote de-escalation of emotional situations or disarm negative/critical parents/client
- Cautions with over use (Taylor, 2020)
    - Can be too emotionally heavy for some resulting their holding back
    - May slow the pace of therapy and draw away from other therapy tasks
    - May result in an isolated parent/client becoming overly reliant or dependent on the clinician

Collaborating mode (Bonsaksen et al., 2013; Yazdani et al., 2020)

- Involves the client in all aspects of therapy such as goal setting, treatment tasks, discharge readiness; therapist intentionally engages client in all therapy processes.
- Emphasizes client empowerment
- Strengths (Taylor, 2020)
    - Promotes client choice - works well with parents who are well-informed and proactive
    - Can build parent confidence through autonomy
    - Can empower parents who need to have more control
- Cautions of overuse (Taylor, 2020)
    - May not work well with parents who view the clinician as the expert
    - May not be understood by parents of cultures who have hierarchical structures

Encouraging mode (Bonsaksen et al., 2013; Yazdani et al., 2020)

- Relays hope; boosts resilience for client/parent exploration and participation.
- Involves cheering the client on during therapy tasks
- Strengths (Taylor, 2020)

    - Projects a positive energy and celebrates effort/success
    - Enhances the playfulness of therapy
    - May work well with clients who are cognitively/developmentally delayed due to its high energy and multi-sensory factors
- Cautions of overuse (Taylor, 2020)
    - Parents/clients may stop responding to the encouragement
    - May delay intrinsic motivation during therapy
    - May be misunderstood as being patronizing or trite by some clients/parents

M1

Problem-solving mode (Bonsaksen et al., 2013; Yazdani et al. 2020)

- Use of strategic questioning to resolve a therapy challenge or conflict
- Use of reason and logic to facilitate a wider perspective
- Strengths (Taylor, 2020)
    - Engages cognition and intellect - may work well for clients/parents who are verbal and analytical and/or uncomfortable with emotions
- Cautions of overuse (Taylor, 2020)
    - May be seen by some as too strategic
    - Reliance on structure and agenda like approach may neglect other interpersonal needs within the parent/client-therapist relationship

Instructing mode (Bonsaksen et al., 2013; Yazdani et al., 2020)

- Provides the client education i.e. therapy objectives and rationale
- Therapist uses a teaching approach and/or style - Teaches the client how to complete a therapy task or how to use equipment
- Provides client/parent with feedback
- Strengths (Taylor, 2020)
    - May promote the transfer of learning
    - May empower parents/clients through the sharing of information, teaching, and constructive feedback
- Cautions of overuse (Taylor, 2020)
    - Focus of mode is on the process - this may result in over instruction or in clinician frustration when the parent/client cannot perform as desired. This may decrease parent/client confidence
    - Can be viewed by some a authoritarian
    - Can result in power struggles with more sensitive or oppositional clients/parents

Advocating mode (Bonsaksen et al., 2013; Yazdani et al., 2020)

- Relates the client's disability to the larger social-environmental context (i.e. support systems, educational support, housing, employment)
- Responds to barriers (physical, social) client experiences preventing participation in occupations
- Provides access or information to resources for increased participation in occupation
- Strengths (Taylor, 2020)

    - Promotes client/parent awareness of occupational and social injustices and provides them with resources to remove contextual barriers and enhance mobility, access, and participation M1
- Cautions of overuse (Taylor, 2020)
    - May overestimate the client/parent's drive for independence or change - client/parent may not be emotionally ready; may need time to discover barriers/injustices on their own.

Strengthening communication (Taylor, 2020)

- Therapeutic communication is strengthened when we can use a variety of modes with mindful intention to meet client/parent interpersonal needs
- We can learn to do this by
    - Increasing our awareness of the modes that we use naturally in communication and learning the limitations of our preferred mode/modes of communication
    - Learning to enact and use modes to meet the needs of the client/parent, not our own
    - Learning to intentionally enact modes we do not typically use when interacting with clients/parents so we can meet their interpersonal needs.

Self-Assessment of modes (Taylor, 2013; Taylor, 2020)

- Let's score the assessment we took earlier.
- After scoring - participants will draw four boxes on a piece of paper.
    - In the first answer - What are your natural modes? Consider the strengths and cautions of this/these modes.
    - In the second - What modes are you less comfortable using? Consider if the strengths of this/these modes balance out the cautions of your preferred modes?
    - In the third - What modes do you feel you can call upon if you needed to? Consider situations where you would use these modes in practice.
    - In the fourth - What modes would you like to learn to use more effectively? Consider available resources to help develop these modes (i.e. mentor/colleague).

Summary slide

- The IRM is a mediational framework model that provides therapists with the interpersonal knowledge and resources to facilitate communication with parents/clients.
- Within the IRM, we need to develop critical self-awareness of our communicative practices including verbal, nonverbal, and listening skills. By increasing our awareness we can become more mindful when communicating with parents and using our therapeutic use of selves.
- The IRM describes 6 modes of communication that we can use during our therapeutic communication to meet parent client interpersonal needs.
- Knowing our preferred mode/modes of communication and those we could grow in using helps us develop the skills to become more effective communicators with parents and in meeting our clients interpersonal needs during therapy.

Homework - week one

- Complete at least one Empathetic Listening Checklist with a partner
- For one client/parent encounter each day, complete a Communication Self-Reflective Assessment

Empathetic Listening Checklist

Adapted from Taylor (2020)

M1

According to the IRM, empathetic listening is a part of the therapist-parent relationship, especially when navigating difficult therapy sessions or discussing emotional therapy topics. It is a skill that requires mindful practice. To complete this activity, select a partner. One person will role play as the client, the other as the therapist. The client will select a scenario from the list and answer the question. The therapist will listen and then offer the client a summary statement. Then, please complete the following checklist and self-reflect on your responses. If you have a third person in your group, this person can serve as an objective observer. For the homework, please complete with a friend, partner, colleague, or family member. You can also use this checklist after client sessions and can compare answers over time to assess your progress.

- Scenario 1: Ask your partner to tell you about his or her favorite pastime and why it is meaningful and enjoyable.
- Scenario 2: Ask your partner to tell you about their favorite childhood memory.
- Scenario 3: Ask your partner to tell you about a favorite book, band, TV show, or movie that impacted them in a meaningful way and why it had that effect.

While listening how do you feel you were able to:		
	Adequate	Needs Work
• Listen without judgement or bias		
• Keep free of distractions		
• Understand your partner's point of view – ask clarifying questions if needed i.e. "What do you mean when you say?"		
• Wait until your partner was finished talking before responding		
• Refrain from planning what to say next		
• Refrain from stopping your partner to give your opinion		
How do you feel your summary statement:		
• Reflected your partner's main points		
• Evaluated and then paraphrased what your partner said (did not repeat back word for word)		
• Refrained from adding to what your partner said		
• Demonstrated your partner's point of view versus yours		

If your initial summary statement did not accurately reflect your partner's experience, how do you feel you were able to:		
• Recognize a clarification was needed		
• Use your partner's feedback to make a new summary statement		
• Provide a new summary statement that your partner felt reflected what they were expressing		
• Focus on your partner's feelings/perspectives (and not yours)		
How do you feel you were able to:		
• Demonstrate a neutral tone or one similar to your partner's		
• Demonstrate that you were listening (nodding, "uh-huh")		
• Remain without judgement		
• Express what you observed about your partner's feelings/behaviors		

Reflecting over your responses…...
What were your personal strengths when listening?
_____
_____

In what areas while listening is their room for growth?_____
_____
_____

What growth area will you mindfully focus on during your next listening encounter?
_____
_____
_____

Communication Self-Reflection Sheet

Adapted from AHRQ (n.d.) and Taylor (2020)

M1

When strengthening our communication with parents of clients, it can be helpful to reflect on the interactions that occurred during our therapy sessions. This self-reflection activity was created to facilitate this process. As part of your homework assignment, please select one parent interaction each day to reflect on. You can continue to use this format to reflect on your therapy interactions after course completion.

Reflect back on your communication interaction. Then respond to the following questions.

	Yes	No	Neutral	NA
My communication was clear, audible, and well-paced for the parent/caregiver/client.				
I greeted the parent/caregiver/client and demonstrated appropriate eye contact.				
My tone of voice was confident.				
My emotions were modulated to the parent/caregiver's or client's needs.				
I used language that was easy for the parent/caregiver or client to understand.				
I was professional and respectful in my word choices.				
I took the time to repeat important aspects of the conversation as needed.				
I provided concrete directions and details.				
I used pictures, graphics, and/or demonstration as needed to meet the parent/caregiver/client's needs.				
I provided the "just right" amount of communication/information.				
I considered the parent/caregiver's and client's culture and altered my approach appropriately.				
I was able to note changes in the parent/caregiver/client's affect, posture, tone of voice.				
I was aware of my own affect, posture, tone of voice.				
I listened empathetically.				

M1

I intentionally used verbal prompts or gestures to encourage communication.				
I asked the parent/caregiver/client if they had any questions.				
I checked that the parent/caregiver/client understood the information provided.				

Looking over your responses….

What did you do well? What interpersonal strengths did you use?

_____
_____
_____
_____

What areas do you feel you can improve?

_____
_____

What communication modes did you intentionally use? Why did you enact this mode?

_____
_____

What may you do differently next time? _____

_____
_____
_____

Module 2: Get to Know Your Client

M2

Objectives:

1. Participants will demonstrate a greater understanding of how client/parent characteristics and culture may influence communication interactions.
2. Participants will demonstrate how to ask and respond to client/parent feedback regarding therapy and communication interactions.

Materials Needed:

- Computer, internet access, zoom application
- Electronic copies of homework assignments, module activities, and informational handouts

Module 2: Outline

M2

Objectives:

1. Participants will be able to identify common enduring and situational client characteristics as well as cultural considerations.
2. Participants will demonstrate how different communication modes can be used intentionally when considering client characteristics.
3. Participants will identify strategies to help build the intentional relationship.
4. Participants will define strategic questioning and when to use it.
5. Participants will demonstrate the ability to ask and then respond to client feedback.

Presentation Outline

- Homework Reflections
    - Participants will be invited to share any thoughts, successes, challenges, or reflections from the previous week's homework assignments. Participants will also have the opportunity to ask questions.
- Client-Centered Therapy Communication (Taylor, 2020)
    - Client interpersonal characteristics - situational vs enduring
    - What to look for - types of interpersonal characteristics
- Communication Modes and Parent Client Interpersonal Characteristics (Taylor, 2020)
- Reflective Discussion - small group
    - Client interpersonal characteristics and our modes of communication - how do they add up?
- Mode Match and Mode Versatility (Taylor, 2020)
- Suboptimal Responses (Taylor, 2020)
- Strategies to Strengthen Communication with Parent Clients
    - Rapport building
    - Impression management
    - Setting an emotional climate
- Client Feedback - It's Important! (Ideishi et al., 2010; Moll et al., 2018)
- Homework Review

Module 2: Educational Content for Presentation and/or Padlet M2

Client-Centered Therapy Communication (Taylor, 2020)

- According to the IRM, it is our job as therapists is to get to know our clients interpersonal characteristics and preferred communication modes.
- A client's interpersonal characteristics are "the emotions, behaviors, and reactions" (Taylor, 2020, p. 122) expressed by the client during therapy communication interactions with the therapist.
    - Interpersonal characteristics can be situational or enduring.

Situational Interpersonal Characteristics (Taylor, 2020)

- These are emotions, behaviors, and/or reactions that are at odds with how the client typically communicates and usually occur under some kind of interpersonal duress.
- These are typically dependent on contextual circumstances. May include:
    - Feelings of sadness, frustration, stress
    - Feeling overwhelmed, shocked, irritable, angry
    - Hypersensitive, emotional, insecure, or negative responses
    - Feelings of stigma, bias, judgement
- Can we think of any circumstances which may trigger situational characteristics in our clients/parents?
    - Pain, employment needs, financial stress, social isolation, feeling misunderstood or under appreciated, need for self-care.

Enduring Interpersonal Characteristics (Taylor, 2020)

- These are the emotions, behaviors, and/or reactions that are typical for the client across contexts, audiences, and time - part of their usual selves.
- Enduring characteristics benefit from our attention and understanding during therapy interactions as they may guide us on how to best communicate with parent clients.
- Our ability to intentionally match our communication mode to the parent client's needs may depend on their enduring characteristics, particularly for those with consistently challenging styles.
- Think of a client/parent past or present that may have had some challenging enduring characteristics. How did this impact your therapeutic relationship? Your ability to carry out therapy with their child?

What to Look for in Client Interpersonal Characteristics (Taylor, 2020)

- The IRM identifies 14 areas in which personal and client characteristics can vary. We need to consider our own characteristics as well as the parent client's as we get to know our parent clients and determine what these may mean as either enduring or situational characteristics. For each, also consider the context, the parent's medical/psychological/social history, and their behavior/non-verbal cues. These include:

- Communication style: How the client expresses themselves in regards to pace, gestures, and words. M2
- Tone of voice: May reflect their feelings about the interaction.
- Body language: May also reflect comfort/feelings about the interaction.
- Affect: facial expressions; reflect internal thoughts/feelings (meme from Golden girls)
- Response to challenge/change: at one point or another in therapy parents/clients will have difficulty responding to change or a challenge in therapy.
- Trust: many therapy tasks and conversations require at least a minimal level of trust; some trust more easily than others;
- Control needs - consider the extent to which the parent client attempts to control the narrative/therapy activities - do they have a high need or a low need for control? How does this impact your communication?
- Approach to communicating needs - does the parent client ask for assistance when needed? How do they do it? This requires open communication.
- Predisposition to give feedback - Is the parent client comfortable giving you feedback? Do they give excessive feedback? How does this impact your communication?
- Response to feedback - How does the parent client respond to constructive feedback?
- Response to human diversity - How does the parent client view those with difference? How does this view influence your communication?
- Relating preferences in therapy- What is the parent client looking for in a therapist (i.e. preference for emotions/straight to business, humor, chit chat)? What level of connection? Are they able to relay this?
- Preference for touch - Is the client comfortable with touch? How should we as therapists present touch-based interventions to clients? Ask the client their preference; ask for permission before starting.
- Interpersonal reciprocity - What is the parent client's capacity for reciprocating within the relationship? Are they able to share freely their thoughts/feelings and ask about therapist's? It is important in our communication that we match the parent client's level of reciprocity.
- Culture -How does the family's culture influence their communication preferences? Consider the above categories within the context of culture as well as the person's individual interpersonal characteristics.

Client Interpersonal Characteristics Takeaway (Taylor, 2020)

- When working with parent clients, it may be helpful to
  - Identify and understand their client interpersonal characteristics
  - Observe and consider how their interpersonal characteristics influence their reactions to therapeutic communication
  - Be aware of your responses to their reactions

Communication Modes and Client Interpersonal Characteristics (Taylor, 2020) M2

- Remember that in the IRM "the client defines a successful relationship" (Taylor, 2020, p. 141)
- We must try to intentionally use communication modes that match the parent client's level of comfort and needs, especially during times of interpersonal communication conflicts.
- A parent's preferred communication modes may change over time depending on where the parent client is in the therapeutic process.
- We should use communication modes flexibly and mindfully in response to client characteristics and communication conflicts.

Breakout Room - Reflective Discussion (time TBD)

- Participants will be grouped into small breakout groups.
- Discussion guiding questions:
    - How have parent client interpersonal characteristics influenced your communication with parents in your practice? Is there any category of interpersonal characteristics that you find particularly challenging in practice?
    - Consider the IRM modes of communication:
        - Are there any modes you naturally use that facilitate communication given a parent client's interpersonal characteristics? How is this mode/modes helpful? How might using the mode with intention (rather than naturally) strengthen your ability to meet the parent client's communication needs.
        - Consider the modes you enact less frequently. If used with intention, how can one of these modes meet a parent client's needs?

Mode Match and Versatility (Taylor, 2020)

- A mode match is our intentional effort to use a communication mode that best meets the parent client's interpersonal needs that session date or their preferred ways of interacting in therapy.
- When we are intentional in what we say and what we do, specifically when the parent client is experiencing a sensitive situation in therapy, we are demonstrating therapeutic responding.
    - In most cases - go with your gut - your first mode choice is likely to match
    - A mode match can be achieved more easily when you know the parent client and/or get a sense a mode works when communicating with this parent/family.
- However, if a parent client is more complex, is noted to be acting/feeling differently than usual, or if the typical mode loses its effect, then a mode shift, or an intentional change in communication approach, may be needed.
- A mode shift requires mode versatility. Mode versatility is our trial and error approach to determine the best mode for the parent client at that time.

    - We must monitor the parent client's reaction to our attempts and receive their feedback to guide us in figuring out whether the new mode is a match or if another one is needed. M2
    - We must be mindful not to accidentally mix modes (combine two modes together) as this may lead to confusion in communication.
    - Remember - the goal is not perfection as communicative relationships are not perfect. Rather, the goal is mindful intention in our efforts and consideration of client feedback so we can hone in on our abilities to meet their communication needs.
- What may be some client signs that a mode shift is needed?
    - A parent comments wanting to be more independent in carrying out the exercises done in therapy with their child but is having a hard time figuring out when and how to do them - The therapist previously used instructing mode. What alternative mode may work here? (i.e. problem-solving mode)
    - A parent appears overwhelmed when working with the therapist on goals for therapy. They feel their child has too many needs and can't identify a specific goal - the therapist had been using the collaborating mode. What may be an alternative mode to try? (i.e. instructing mode to provide structure/guidance)
    - An involved parent is hesitant to trial a therapy technique. They are nervous they will do it wrong. The therapist has been encouraging the parent to let them know they can do it. The parent is still reluctant. What mode might the therapist try? (i.e. empathizing to help see the client perspective).
- What may be some client signs that we have found a mode match?
    - Relaxed face/body
    - Increased interest in therapy communication/signs of engagement
    - Increased attention to therapy and therapy communications
    - Positive feedback and appreciation

Suboptimal Responses (Taylor, 2020)

- This is when our therapeutic communication is "not experienced as therapeutic by the client" (Taylor, 2020, p. 367).
- May be identified by the parent client's
    - Body shift or withdrawal
    - Eye rolls or looking away
    - Becoming quiet, disengaged or sighing/changing their breathing
- When there is a suboptimal response, it may result in the parent client feeling hurt, confused, frustrated, or sad.
- Suboptimal responses may be subtle and may be signs that a change is needed.

Strategies to Strengthen Communication with Parent Clients (Taylor, 2020) M2

- **Rapport building (Taylor, 2020)**
  - Deliberate small talk and other simple behaviors that help the parent client feel comfortable and help the parent client get to know us as individuals.
  - Should be genuine in manner
  - We need to consider the timing and our attitude as it influences the parent client's opinion of us.
  - What are some examples of rapport building?
    - Eye contact/greeting/ asking "how are you"
    - Clarifying how the parent client would like to be addressed/how their child should be addressed/correct name pronunciation
    - Introducing ourselves in the manner we think the client will best receive it
    - Impersonal chit chat (i.e. traffic, weather)
    - Sharing about yourself as a professional and your therapy approach
- **Impression management (Taylor, 2020)**
  - Considering how we present ourselves (and how this presentation is perceived by parent clients) is part of building an open and trusting communicative relationship.
  - These are the behaviors that let the parent client get to know us as professionals
  - If we are effective in how we manage our impressions, this may help us build rapport faster
  - What are some examples of impression management?
    - Physical appearance
    - Emotional presentation and self-regulation (calm and evaluative vs panicked/rushed/stressed)
    - Confidence projection (do we look capable; are we able to instruct when needed)
    - Open, non judgmental, yet able to establish professional boundaries
    - Ability to project that we like what we do; we take pride in our work
- **Setting an emotional climate (Taylor, 2020)**
  - This is how the parent client experiences our interactions during therapy - it is the feeling that stays with them after our therapy is over and we have left
  - Consider the intensity of our communication approach with parent clients and their child
  - Is it high intensity? What might this look like?
    - Loud voice volume; big animated movements; big forms of expression
    - Cheering/singing
    - Urgency or firmness during times of safety

        - What modes of communication do we think we enact during high intensity climates? (i.e. instruction, encouraging, empathetic)

    - Is it low intensity? What might this look like?
        - Soft voice/neutral tone/limited body movements or gestures
        - More quiet presence
        - What modes of communication do we think we enact during low intensity climates? (i.e. collaborating, advocating, problem solving, empathetic)
    - Notice empathetic mode may be enacted effectively in both high intensity and low intensity climates. This is because it entails us matching our client's emotional intensity.

Parent Client Feedback - It's Important.

- Eliciting and then responding to parent client feedback is essential to our interpersonal self-discipline and also for the strengthening of the client-therapist communicative relationship. Parent clients value open and honest communication (Ideishi et al., 2010; Moll et al., 2018). Affording parents the comfort and safety to express their feelings and feedback about therapy may pave the way for more open and honest communication.
- When asked in an anonymous informal survey by the author, parents reported "open and honest communication" with therapists to mean:
    - "Non judgmental child focused sharing of information with intention of achieving targeted results" "Reasoning behind recommendations and assessment"
    - "That all information bad and good is put on the table so that parents understand the therapeutic goals, what can get better, what might never get better and how the parents can best be prepared to further help and advocate for their child."
    - "Letting me know if my child isn't responding to therapy. Letting me know if my child would benefit from other services or a different provider. Letting me know when the therapist has done all she / he can."
    - "Telling me everything I need to know about my child's therapy and making sure I understand all the information that is communicated to me."
- Examples of situations where communication has worked:
    - "I recently had a conversation with my child's therapist regarding his group sessions and how I felt my son was not benefitting from them. I appreciated how we had an open and honest conversation and the therapist acknowledged and validated my concerns and was able to provide me with solutions. Because of this conversation, I felt we could continue with the group sessions."
    - "When the therapist meets with me separately from my child."
    - "Details after each session on where my child is succeeding, where more work is needed and how we as parents can work with our child at home."

    - "As part of a high conflict parenting situation all therapists have been asked to include both parents in communication which should occur over email. When my co parent intentionally communicates with the therapist and leaves me off, the therapist respects our decree and follows the orders. That is helpful." M2
- Examples of situations where communication has not been effective:
    - "Setting expectations that one thing would happen and doing quite the opposite in therapy. This was feeding therapy with an OT. In the eval: Your child won't have to eat anything he's not ready to eat. I set those expectations with my child. In the first session, which I was observing, "you have to eat this". Trust was irrevocably broken between me and the therapist, and we switched therapists."
    - "When the therapist tried to communicate in a space that was being used by another therapist and child. It was distracting and unprofessional."
    - "No clear goals outlined therefore I didn't know how to measure progress"
    - "My child received therapy at school. I would email the therapist to see how it was going, and she wouldn't respond to my emails. It got to a point that I would copy her classroom teacher to ensure the therapist was receiving my messages."
    - "Not being honest or telling us how we could work with him at home."

Summary Slide

- Parent clients have both enduring and situational interpersonal characteristics. It is important for us to identify them and learn how to respond to them in our communicative relationship. This may require us to change our mode of communication or approach.
- Parent client suboptimal responses may also indicate that a change is needed, while therapeutic responses may indicate that a mode match has been achieved.
- We can strengthen our communicative relationship with parent clients by building rapport, impression management, and setting an emotional climate that meets their/their child's needs.
- Parent client feedback helps us take a pulse on how our approach is meeting the needs of the client and allows for parents to feel safe in expressing their views.

Homework

- This week, select a client visit each day and complete the client reflection sheet. The goal is to further develop our skills in identifying client interpersonal characteristics, adjusting better meet their communicative/interpersonal therapy needs, and becoming more accustomed to asking and then responding to client feedback regarding therapy.

Client Reflection Sheet

M2

When strengthening our communication with parents of clients, it can be helpful to reflect our interactions with parents after the session. Reflecting on the parent's interpersonal characteristics, our ability to identify and respond to these characteristics and our willingness to receive and respond to parent feedback can help promote our ability to do these things during future parent client interactions. This self-reflection activity sheet was created to facilitate this process. As part of your homework assignment, please select one parent/client/family each day to reflect on. You can continue to use this format to reflect on your therapy interactions after course completion.

	Yes	No	Neutral	NA
In my therapy communications with this parent client,				
• I have explained therapy services, what it is, what their child will receive, how/where they will receive it				
• I have established goals in collaboration with parent				
• I have reviewed the goals and the progress towards goals to confirm these are still meaningful to this family.				
• I have checked in with the parent client about therapy activities, approaches, HEP to ensure understanding.				
• I have discussed therapy expectations with parent client				
• I have told the parent client know that I am open to feedback				
• I have asked the parent for feedback regarding therapy services, approaches, activities				
• If I asked for feedback today, I was specific in the kind of feedback I was looking for				
• I remained calm and confident when asking and receiving parent feedback				
• I apologized if appropriate				
• I summarized main points to make sure I understood the feedback the parent was communicating				

M2

• If parent was not pleased with something, I asked the parent client what they would have preferred				
• If appropriate, I discussed the "why" or clinical reasoning behind the task/topic of feedback in a non-defensive way				
• If appropriate, I offered to change approach for next visit				

Adapted from Taylor, 2020

This parent/client's enduring interpersonal characteristics to consider during therapy communication include: _____

_____

_____

How do the client's interpersonal characteristics "click" with mine? How do they not?

_____

_____

_____

This parent/client's preferred mode/modes of communication include:

_____

_____

Modes I used during this session:

_____

What observed parent client responses let you know you are using a mode that meets this parent client's needs (therapeutic responses)? _____

_____

Were any signs of suboptimal responses noted? If so, what did you observe? _____

_____

Were any changes in approach made in response to these suboptimal responses? What were they and were they effective? _____

_____

_____

If changes are needed, what can be tried next session?

Module 3: Intervention approaches and techniques

Objectives:

1. Participants will demonstrate knowledge of communication intervention approaches, in addition to IRM, that can guide their communication with parents.
2. Participants will learn about strategic questioning as a technique to help refine their communication with parents.
3. Participants will demonstrate strategic questioning as part of the homework activity.

Materials Needed:

- Computer, internet access, zoom application
- Electronic copies of homework assignments, module activities, and informational handouts

Module 3 Outline

M3

Objectives

1. Participants will identify coaching models that can be implemented in practice.
2. Participants will define the collaborative intervention process model.
3. Participants will be able to list how the IRM can enhance the use of these models in practice to improve communication with parents.
4. Participants will define techniques such as the Canadian Occupational Performance Measure, Goal Attainment Scaling, Family Activity Matrix, visualizing a preferred future and strategic questioning and list how the IRM can strengthen the use of these techniques in practice.

Presentation Outline

- Homework Reflections
    - Participants will be invited to share any thoughts, successes, challenges, or reflections from the previous week's homework assignments. Participants will also have the opportunity to ask questions.
- Coaching Interventions
    - What is coaching? (Kemp & Turnbull, 2014; Rush & Sheldon, 2020)
    - Occupational Performance Coaching (Graham et al., 2009)
        - What is it? What does the evidence say? (Graham et al., 2013; Graham et al., 2016; Graham et al., 2018)
    - Solution Focused Coaching Pediatrics (Baldwin et al., 2013)
        - What is it? What does the evidence say? (Schwellnus et al., 2019; King et al., 2019)
    - Collaborative Intervention Process (An & Palisano, 2014)
        - What is it?
        - Suggested communication tools
            - Canadian Occupational Performance Measure (Law et al., 2019)
            - Scaling questions (An & Palisano, 2014)/Goal Attainment Scaling (King, 1999)
            - Family Routine and Activity Matrix (An & Palisano 2014)
        - What does the evidence say? (An et al., 2019a; An et al., 2019b)
    - Reflective Discussion - small group
        - Reflection on approaches/intervention and how they align with our communication strengths/needs in practice with parent clients
    - Strategic Questioning (Taylor, 2020)
    - Role Play Practice Activity with Partner - Strategic Questioning
    - Homework Review

Module 3: Education Content for Presentation and/or Padlet M3

Coaching Intervention Models

What is "coaching"? (Kemp & Turnbull, 2014)

- Coaching is a collaborative process during therapy planning and intervention that is characterized by joint interaction, reciprocal feedback, and reflection between parent client and therapist.
- It is the main model implemented within the setting of early intervention (EI)
- Coaching as characterized by Rush & Sheldon (2020) includes 5 steps:
    - Joint planning - collaboratively developing a plan for the meaningful knowledge and skills to be taught/reviewed during therapy sessions
    - Observation - when one person careful watches the other with the outcome being evaluating skills and/or discussing new ideas or strategies
    - Action/practice - when the parent is given the opportunity to try new skills/strategies; when action items on the plan are reviewed and/or added; when the parent practices the skill in the presence of the therapist
    - Reflection - when the parent and therapist together reflect on the action/practice and review what worked, what didn't work, why, and what can be next steps.
    - Feedback - when the therapist provides the parent with feedback, informative and/or affirmative, based on observations and reflection
- Kemp and Turnbell research synthesis of the EI literature found coaching provided 20-90 minutes/week with carryover resulted in improved child development outcomes and increased parent perceptions of their capability. It was also found to be a feasible model in the home setting.
- Outside of early intervention, coaching models are gaining momentum with two prevailing in the literature: Occupational Performance Coaching and Solution Focused Coaching Peds

Occupational Performance Coaching (OPC) (Graham et al., 2009; Graham et al., 2013; Graham et al., 2016)

- OPC is the "process whereby parents are guided in solving problems related to achieving self-identified goals" (Graham et al., 2009, p. 16). Goals can be parent goals in regards to their roles and responsibilities and /or child performance goals.
- Approach is strength based, occupation centered, and family centered. Considers the role of the environment.
- Therapists use specific language, questions, and reflection to help parents identify solutions to contextual barriers impacting performance in daily occupations.
- Three enabling domains:
    - Structured process: the problem solving process therapists engage in with therapists - may include guiding parents to reflect on past successes in similar situations and to consider current influences on performance; devising an action plan - a list of specific actions parents see as doable, relevant, and likely to work.
    - Emotional support: interpersonal strategies used by therapists so parents feel understood and supported - may include verbal and

non-verbal strategies within listening, empathizing, reframing, guiding, and encouraging

    - Information exchange**:** two way conversation led by therapist influenced by observations, context, and knowledge base - may include eliciting what a parent already knows and helping them use their knowledge to help find solutions; Also providing information to help build the parent knowledge gap by providing information on performance context and possible strategies.
- **OPC - What does the evidence say?**
    - Graham et al. (2013) - Found the use of OPC to increase child performance on goals both directly and indirectly addressed during intervention; increased maternal performance on goals directly addressed, but not indirectly addressed; and an increase in parent sense of competence (though with caution due to low internal consistency of measure in sample).
    - Graham et al. (2016) - mothers undergoing OPC as an intervention reported finding the following strategies learned during OPC as beneficial: Beneficial context focused strategies - adjusting their manner before interacting with child, creating distance by ignoring negative behaviors or distancing themselves from child/situation when not coping well with situation, matching the task to the child, adding structure/routine, and teaching strategies such as modeling, demonstration, and visualization. Beneficial child focused strategies: learning collaborative strategies to use with the child to aid performance (i.e. visuals, negotiating) and offering choice.
    - Graham et al. (2018) - A focus group of 12 OTs and PTs was completed to gain their perspectives on using OPC with families. Main findings: Therapists reported the overarching theme of "listening better"; other themes included sharing power, reprioritizing process, and liberating but challenging.

Solution Focused Coaching Peds (SFC-Peds) (Baldwin et al., 2013)

- SFC- peds "reflects a strengths-based, goal-oriented collaboration between client and therapist designed to inform and guide the development of client directed change within natural environments" (Baldwin et al., 2013, p. 473).
- Draws from Solution Focused Brief Therapy
- Has 7 key elements:
    - Setting the stage - it is essential to understand the stage from the client's point of view. The client brings their strengths, resources, experiences, previous knowledge, values, and hopes; therapist brings their clinical experience, professional knowledge and training, work setting, and their own perspective. These set the stage for the therapy stage.
    - Forming the client-therapist relationship - this is the heart of the therapeutic process and a predictor of client satisfaction and perceived successful outcomes. Therapists build the relationship by asking about the

client's preferences, needs, and priorities. It is further built through respect, warmth, and affirmation of strengths.

M3

    - Envisioning a preferred future - this is essential to any solution focused work. By envisioning their preferred future, client and therapist can discuss the client's therapy expectations, hopes, and situational creative thinking
    - Goal discovery - goals are explored through the client's preferred future and are based on the client's focus and priorities within the client's point of view. Clients are empowered to express their goals while therapists guide based on the clinical perspective.
    - Strategy creation - a plan with strategies is created through questions expanding on client's ideas on how goals can be achieved. The plan reflects client choices, readiness, unique situation, and context.
    - Plan confirmation - use of strategic questioning and positive feedback to refine and clarify the plan reinforcing client strengths, resources, and capabilities.
    - Action and reflection cycle - Reflection on client's actions/performance - what went well, what didn't, what can be done differently - highlighting strengths and next steps. Evaluating new actions and discussing future positive changes. Through this cycle the plan is refined as needed.
- For SFC, therapists need:
    - Skills for relationship building
    - Use of coaching skills - connecting, listening, reframing, questioning
    - Skills for facilitating change - recognizing and responding to client readiness for change

SFC - What does the evidence say?

- Schwellnus et al. (2019)
    - Surveyed 6 OTs/PTs who had been using SFC-peds for at least 2 years
    - Therapists reported:
        - Approach facilitated the shift from expert to facilitator, from teller to listener. This took some pressure off themselves and allowed them to find solutions and better respond to client needs because the approach focuses on clients finding their solutions with therapist facilitation.
        - Able to have clearer expectations of their role in therapy.
        - Felt more flexibility to adjust plan and tailor it to meet client changing needs through the understanding of their client's preferred future. Felt it facilitated the establishment of the client-therapist relationship increasing service effectiveness.
        - Approach enhanced client capacity as clients took control and were empowered to find solutions - helps therapist take a strengths based FCC approach
        - Allowed therapists to consider their clients ecological context/everyday environments

        - Challenges: Problem oriented medical model pressures therapists to "do more" - approach may at times look to others like therapists are "doing nothing"; requires a conscious reframing of therapist role (not the expert). M3
- Seko et al. (2021)
    - Interviewed 13 therapy clinicians who had been practicing using SFC-peds for 6 months.
        - Therapists reported increased confidence in their ability to build a therapeutic alliance with clients, increased team cohesion and improved collaborative solution finding.
        - Time constraints, decreased organizational support, and unclear intervention expectations impeded the use of SFC-peds.
- King et al. (2019) https://doi.org/10.1080/01942638.2017.1379457
    - Interviewed 9 sets of family who had undergone therapy using SFC-peds
    - Families reported:
        - Feeling therapy was collaborative and engaging.
        - Helped facilitate improved skill in client as well as community participation
        - Empowerment component helped families report increased confidence and efficacy, autonomy, and broadened perspectives.

Collaborative Intervention Process (An & Palisano, 2014)

- Collaborative intervention process is a mediational model that aims to provide pediatric therapists with concrete strategies and tools to facilitate collaboration with families.
- Model has 4 steps:
    - Mutually agreed upon goals - foundation for therapy planning and decision-making. Conversation that highlights client interests, past experiences, and priorities. For OTs, this is similar to building an occupational profile (see AOTA example).
    - Recommended tools for this phase include:
        - Canadian Occupational Performance Measure (COPM) (Law et al., 2019) - The COPM is a client centered tool administered as a semi-structured interview. Together, the client/family and therapist explore wants, needs, and expectations surrounding self-care, work/school, and leisure/fun. After ranking the most important areas/activities for growth, the family/client then scales the client's current performance and their satisfaction with this performance on a scale from 1 (not able to at all/not at all satisfied) to 10 (able to do without difficulty/very satisfied). An improvement of 2 or more points on the scale at re-evaluation indicates statistically significant improvement. The COPM has undergone much research and is frequently utilized in research. It has good reliability and validity, including when used with a parent proxy.

        - Visualizing a preferred future - from solution-focused brief therapy - helps the client/family look to the immediate future and identify what meaningful change looks after successful intervention. For example, if the goal is brushing teeth independently one could ask "in the next 6 months, what about your child brushing their teeth would have you say - wow therapy has really help my child; knowing your child, what would progress here look like to you?" M3
    - Shared planning - the planning of intervention with the family to ensure the intervention is strength based, uses available resources, and provides information using methods preferred by the family. May also include connecting family to community resources.
    - Recommended tools for this phase include:
        - Scaling questions (An & Palisano, 2014)/Goal Attainment Scaling (GAS) (King et al., 1999). In scaling questions, the therapist takes the scoring from the COPM and considers the family's preferred future. For example, if the family scored the client's performance when brushing teeth as a 2, the therapist would then ask in 3 months, if therapy is going well, what do you see your child's performance being then. If they reply with a 4, the therapist follows up by asking, what would it look like to you for your child to score a 3; what is the difference between a 3 and a 4? Then goals and expectations can be clearly laid out. GAS is a similar process except the goals are scaled according to expected outcome. See supplemental chart /padlet and briefly review with class.
        - Family Routine and Activity Matrix - this is a chart developed by the therapist and family when designing a home exercise program or activities for home carryover. The matrix identifies and defines the activities, outlines times within the client's/family's everyday routine when the activity can be completed, and identifies the roles of those who will be helping the client with the activity. See example.
    - Shared Implementation - During therapy intervention, the therapist facilitates parent/family reflection and guides discussions regarding what between sessions is going well, what is not going well, and what may be some solutions. Modifications to the plan are made as needed.
    - Shared Evaluation - The therapist and family determine if the therapy has been effective and if goals have been met. The COPM and GAS (if used) are repeated. New therapy directions and goals are determined.
- **Collaborative Intervention Process - What does the evidence say?**
    - In an RCT, therapists and parents in the group using the collaborative intervention process demonstrated significantly more positive interactions than those doing typical therapy. However, in both groups, therapists and

parents demonstrated a drop in interactions during Shared Implementation (An et al., 2019a).

M3

    - In an RCT, therapists and parents in the group using the collaborative intervention process reported greater effect in child performance and parent satisfaction with performance on COPM; parents in experimental group reported greater confidence in carrying over therapy activities and working with therapist; therapists in the experimental group perceived giving more instruction to parents and working with parents than the control group (An et al., 2019b).
- **Breakout rooms discussion (time TBD)**
    - Think back on a parent/client relationship that was complicated for you. Reflect on this parent's interpersonal characteristics and your preferred modes. Now that you are aware of communication frameworks to help ground how you approach complicated therapy relationships, reflect
        - Which of these approaches (OPC, SFC-peds, Collaborative Intervention Process, IRM) would be useful to help facilitate these complicated relationships?
        - Would you use just one approach, or a combination of a few? What from each approach do you feel will help strengthen your communication and therapy relationships in similar situations moving forward?
        - Share your thoughts in the breakout room. What common themes, if any, pop up in your discussion?

Strategic Questioning (Taylor, 2020)

- In IRM, strategic questioning is "asking clients questions in a way that intends to influence their perspective, convey a certain message, or cause them to reflect upon and evaluate their thinking on a given topic" (Taylor, 2020, p. 250).
- These questions subtly challenge clients to think differently.
- Examples:
    - To assist parents in reframing why their child has certain behaviors.
    - To assist parents in developing more realistic therapy expectations.
    - To help parents become aware of alternate ways they can support their child's abilities/participation.
    - To help parents become more aware of what they can or can't control.
- In some situations, these questions can come across as unsupporting. It is very important to consider timing and context when using strategic questioning. These questions are best suited for when parents are not specifically vulnerable at the time. Parents need to be ready for this sort of questioning as it may challenge existing ideas.
- There are 5 types of strategic questions (Taylor, 2020):
    - Origin or source questions - these questions surround the origin or source of a particular topic, thought, belief, or idea.
        - Your client has motor delay of unknown origin. The child is very hypotonic and is having a hard time building the strength and

coordination needed to walk. The parent has just expressed that they believe their child is never going to walk. They are feeling down about the amount of time it is taking for their child to make progress. You feel that the child may walk someday, but it will take them a while to do so and they may need so adaptive equipment. The parent is resigned but not sensitive or vulnerable; you decide to explore the topic further with strategic questioning in hopes that the parent will rethink their conclusion and regain a hopeful outlook. "How did you first get the idea that your child will never be able to walk?" "How does your child's doctor feel about this?" What has led you to believe that the use of a gait trainer or assistive device won't help?"

- Questions that probe evidence - questions that surround the evidence to support/not support a particular topic, thought, belief, or idea
  - A parent has concluded that their child is never going to talk. They have expressed this in therapy. You feel that the child is going to talk. It may take longer than the parent would like and may require the use of assistive technology/augmentative communication. The parent has not wanted to trial augmentative communication in the past. The parent is at a place in the therapeutic relationship where you feel this can be further explored. You decide to use strategic questioning. "What do you already know that supports your idea that your child will never talk?" "Do you believe that is enough evidence?" "Why else might your child have a hard time talking?" "What evidence do you have that says he is not learning how to talk?" "Is there evidence that your child can talk using an assistive device?"
- Questions that probe assumption - questions that surround assumptions made in regards to a particular topic, thought, belief, or idea
  - Your client has self-regulation challenges that result in sensory seeking behaviors. The client is always on the go, has trouble sitting still, and likes to touch people/objects to the point of irritating others. The parent really wants the child to sit at the table for a family meal. The parent has expressed that they are not sure about "this sensory stuff" and assumes their child "is just behaving this way to be bad; to not listen". You decide to use strategic questioning to see if this assumption can be changed. "Let's assume for a moment that your belief that your child is just being bad and not listening is true? What do you feel this says about your child? About you and your family?" "To come to the conclusion that your child will never listen or sit still at the table, what must you assume?" Do you think another parent or a friend would make the same assumption?"

- Questions about viewpoint - questions regarding a specific point of view the parent may have about a topic M3
    - A parent whose child has cerebral palsy would like to continue therapy so their child can eat "more like other kids". The child is able to eat independently with utensils. Since the child's arms are affected by increased muscle tone, the quality of the child's movements results in it "looking different" from others when at the table. You have worked with the family for some time and know this family well. You decide to use strategic questioning to help the parent think of an alternate point of view. "It sounds like you believe your child needs to look like everyone else while she is eating. Why might you have this perspective?" "How might another parent whose child feeds themselves independently but looks different feel?" "How might your friends/family feel?" "How would you reply to a parent who expressed this concern?"
- Questions about consequences - questions to explore the outcomes of choices regarding a topic, thought, belief or idea.
    - You have a feeding client who is an aspiration risk. Although the client did not aspirate on their last MBSS, they demonstrated multiple flash penetrations (incidences where the liquid peeks into the trachea but then pops back down the esophagus). The client is cleared to trial thin liquids using a specific feeding plan. You have worked with the family on accommodating the feeding plan so it is easier to follow and keeps the client at minimal risk for aspiration. The parent has expressed difficulty in consistently following the feeding plan as it is "just easier to let the child drink as they choose". You decide to use strategic questioning to help the parent see the benefit of the feeding plan. "OK, let's say you decide to let the child drink as they choose (not follow the feeding plan), what might be some positive consequences of that decision?" "What might be some negative consequences?" "What may be some short term results of not following the feeding plan?" "What may be some long term results?".

- When working with families, we frequently encounter moments where strategic questioning can help parents come to an alternate perspective. This is a skill that requires practice since it can come across as not supportive.
- **Strategic questioning practice:**
    - Let's take the time to practice strategic questioning. We will break out into pairs. Please refer to the Strategic Questioning Homework sheet and select one of the 5 types of strategic questions to practice. Complete this exercise with your partner. Reflect on strengths/challenges/when to use strategic questioning as a technique. Have some thoughts to share with the group.

- **Homework:**
  - Now that you have had a chance to practice strategic questioning in class, you will have the opportunity to continue your practice at home. At this time, it is recommended that you practice with a partner, friend, family member, or colleague. Aim to practice the remaining types of strategic questions this week.

- **Summary slide**
  - In addition to the IRM, coaching models, such as OPC and SFC-peds, and the collaborative intervention models each have strategies and techniques that can help ground and frame your communication with parents during therapy.
  - While OPC and SFC-peds are interventions that may require additional training, the IRM and collaborative intervention models are designed to work alongside your therapy interventions to strengthen communication and relationships. The aim of this module was to increase your knowledge of these available models for further exploration and use in practice.
  - Strategic questioning is a technique that may be used to help parents reflect and evaluate their thinking and possibly change their perspective on a given thought or topic. Please remember that this technique requires practice. Timing and context should be considered when applying strategic questioning.

Strategic Questioning Homework
(adapted from Taylor, 2020)

M3

This exercise is meant to provide you with practice opportunities for the use of strategic questioning in future practice. Please note that this is a challenging technique and practice is needed before attempting this technique with clients. The goal here is to become more aware of this technique, become comfortable with phrasing and asking strategic questions, developing the intentional use of these questions, and reflecting on its use (and if it is right for you). This homework will incorporate self-reflection and role playing with a partner. Please select a partner, classmate, peer, family member/friend, and/or coworker to partake in this with you. If a third person is available, they may serve as an observer. Please refer to the examples in the module for some direction if needed. Once you are done with the role play, ask your activity partner and observer (if present) for feedback: How did they feel being questioned this way? How did your questioning come across in regards to tone, timing and context?

Questions that probe origin or source

- These questions are meant to probe thoughts/feelings of negativity, doubt, resignation that parents/clients may feel during the therapeutic process.
- Think of a time when a parent shared such feelings with you. What did the parent express?

_____

_____

_____

- What questions could you ask to probe these feelings? (for reflection only)

_____

_____

- Ask your activity partner to think of something they feel doubtful about, or something they feel negatively about. If there is nothing on hand, ask them to remember a time they felt negatively or doubtful about something. Once they have a scenario in mind, ask questions probing about the source of these thoughts/feelings.

Questions that probe evidence

- These questions are meant to help parents examine the evidence they are using to support any feelings/thoughts of worry, insecurity, concern.
- Think of a time when a parent shared such feelings with you. What did the parent express?

_____

_____

_____

- What questions could you ask to probe these feelings? (for reflection only)

- Ask your activity partner to think of something they are worried about or feel insecure about. If there is nothing on hand, ask them to remember a time they felt worried or unsure about something. Once they have a scenario in mind, ask probing questions about the evidence for/against their worry.

Questions that probe assumptions

- These questions are meant to probe thoughts or assumptions parents feel are getting in the way of their child, them, or family achieving their goals.
- Think of a time when a parent shared such feelings with you. What did the parent express?

- What questions could you ask to probe these feelings? (for reflection only)

- Ask your activity partner to think of a goal they are capable of reaching or a skill they are capable of learning that they doubt they will ever achieve/learn. If there is nothing on hand, ask them to remember a time they had a goal or skill they wanted to achieve but doubted they could do it. Once they have a scenario in mind, ask probing questions about their assumptions.

Questions that probe viewpoint

- These questions are meant to probe strong opinions parents may have about their child's abilities/participation/behavior, therapy expectations, therapy goals, and/or interventions.
- Think of a time when a parent shared such opinions with you. What did the parent express?

- What questions could you ask to probe these feelings? (for reflection only)

- Ask your activity partner to express a strong opinion they may have about something meaningful to them. Ask probing questions about this opinion.

Questions that probe consequences

M3

- These questions are meant to help parents examine the relative consequences to upcoming choices in their/their child's life (i.e. therapy/treatment choices, surgery, life choices).
- Think of a time when a parent shared such a circumstance with you. What did the parent express?

_____

_____

_____

- What questions could you ask to probe these situations? (for reflection only)

_____

_____

- Ask your activity partner to share an upcoming choice or a choice they have made in the past. Ask questions that probe the relative consequences of each possible choice.

M4

Module 4: How to Communicate with Intention to Resolve Therapy Interpersonal Conflicts

Objectives:

1. Participants will learn to identify interpersonal events and empathetic breaks
2. Participants will learn about the IRM interpersonal reasoning process for use in practice.
3. Participants will problem-solve clinical scenarios using the interpersonal reasoning process.

Materials Needed:

- Computer, internet access, zoom application
- Electronic copies of homework assignments, module activities, and informational handouts

Module 4 Outline

M4

Objectives:

1. Participants will be able to identify the most common interpersonal conflicts and emotional encounters experienced by therapy clinicians.
2. Participants will be able to define what is an empathetic break.
3. Participants will be able to list the 6 steps of the IRM interpersonal reasoning process.
4. Participants will be able to use group reflection and the IRM interpersonal reasoning process to problem solve a series of clinical scenarios.

Presentation Outline

- Homework Review - participants will share any thoughts or insights from last week's homework activity.
- What is an interpersonal event? (Taylor, 2020)
    - Review the 12 main types of interpersonal events
- The IRM Interpersonal Reasoning Process (Popova et al., 2020; Taylor, 2020)
    - Anticipate
    - Identify and cope
    - Determine of a mode shift is needed
    - Choose a response mode
    - Draw on the interpersonal characteristics associated with that mode
    - Gather feedback
- Group reflective activity
    - Clinical case studies and impromptu popcorn with presented conflict/difficult behavior to collectively reflect and problem-solve solutions

Module 4: Education Content for Presentation and/or Padlet M4

Homework Review

- Review the past week's homework and discuss any new insights, reflections, challenges experienced.

What is an Interpersonal Event? (Popova et al., 2020; Taylor, 2020)

- An interpersonal event is communication, reaction, activity, or circumstance that occurs within the parent-therapist relationship and may elicit an emotional response.
- They are inevitable within the therapeutic process.
- Our response to an interpersonal event may either strengthen or weaken the therapeutic relationship.
- When we are able to identify an interpersonal event, there is a possibility that we will also uncover an underlying interpersonal stressor that may have otherwise gone unnoticed.
- When we are able to mindfully reflect on interpersonal events, we may be strengthening our ability to remain objective and respond to them intentionally.

12 Most Common Interpersonal Events (Taylor, 2020)

- Expression of strong emotion (Taylor, 2020)
    - Level of emotional intensity is beyond what is considered to be the norm.
    - Parents and clients may express big emotions during therapy. The most common expressions of emotion during therapy intervention are expressions of sadness, anger, and anxiety.
    - What can be some indications that a parent is sad? Angry? Anxious?
    - General strategies to consider when experiencing a parent's expression of emotion include:
        - Provide safe space for the emotion and simply witness the expression of emotion.
        - Show emotional resonance or mirror the emotion through your affect or words.
        - Label the emotion being expressed (i.e. "I see that you are upset/frustrated/angry/nervous/sad").
        - Intervene in a manner that is appropriate for the emotional dynamic in the relationship. This may include:
            - Reassuring in a way that does not minimize the experience (i.e. "The beginning of this process is often the most challenging part"; "You have already done so much for your child. This is hard and you will continue to do what you feel is best").
            - Take charge in a supportive way (i.e. "I am here to support you and your family").

        - Suggest participation in meaningful activities that are fulfilling. M4
    - Draw from the communication modes. Depending on the emotional expression, different modes may be helpful?
        - Empathetic mode: Shows the client they are seen/heard. Demonstrates you are considering the emotion from their perspective.
        - Instructing mode: May provide needed structure or guidance to an emotional situation;
        - Collaborating mode: Works with the parent in managing the emotional encounter; Can collaborate on next steps, promote active decision-making and gives the parent a sense of control – how therapy will help.
        - Encouraging: Depending on the emotional expression, this mode can reassure the parent and instill hope.
- Emotionally Charged Tasks/Situations (Taylor, 2020)
    - Situations or activities that result in parent/client expressing emotional reactions such as frustration, humiliation, shame.
    - Often time, these tasks/situations may be related to the tasks/situations within the role of parenting.
    - Examples:
        - Learning a new strategy (i.e. becoming frustrated that their attempt at a behavioral/sensory strategy is not working out like it does in therapy).
        - Trialing a meaningful activity with their child and "failing" (i.e. feeding their baby a bottle for the first time and their baby chokes/sputters/does not eat).
        - Feeling "evaluated" by clinician (i.e. helping a child with neuromuscular issues transition into sitting under the supervision of the clinician).
        - Child is having difficulty in therapy with a task and parent responds to the situation with emotion.
    - What can we do? What modes can we use?
        - Be mindful of the environment/context, newness of the task for the parent (as opposed to the therapist), parent past experiences/feelings and how these may be impacting the current activity/situation.
        - Empathize – see it from their perspective; Slow down and process what is happening.
        - Normalize expressed emotions
        - Reassure the parent and if appropriate discuss anticipated challenges to come.

- Intimate self-disclosure (Taylor, 2020) M4
    - When a person shares private, sensitive disclosures about oneself or a someone else.
    - Example, I once worked with a mother who appeared aloof about the therapy, yet always hung around nearby. I would bring in ideas for a HEP, offer her handouts, and explain what we were doing and why. She gave the impression she was loosely listening. Over time, I noticed that she hung some of the HEP by the daily calendar and mentioned how they had played some of the OT games over the weekend. I responded with encouragement. Soon after, she disclosed "I like listening to the stuff you do. Growing up, I didn't really have anyone around. No one showed me how to be a mom".
    - Helpful responses may be to be supportive, validate the client's experience. What mode(s) may help here?
- Power dilemmas (Taylor, 2020)
    - May appear within the therapy context secondary to parent/client's perception of power within the relationship/context; may be influenced by past experiences with authority
    - Therapist behavior may trigger a power dilemma (i.e. when a therapist holds firm with an oppositional client/parent)
    - A sudden loss of power due to loss of skill or ability (i.e. parent dealing with a child's new diagnosis – may no longer feel like the "expert")
    - Can manifest as resistance, control, confrontation, or passivity.
    - A helpful response is one that allows the client to experience autonomy, negotiation of power issues. What mode(s) may help here?
- Nonverbal cues (Taylor, 2020)
    - Subtle communications that occur without spoken words that if interpreted correctly can provide insight into what the parent/client is thinking or feeling. (i.e. eye contact, facial expressions, postural responses, body position/movement)
    - If interpreted appropriately, the therapist can use these cues to optimize communication, receive feedback, identify possible therapy and/or relationship problems. (i.e. shy client, hiding behind mom, looking away from OT)
- Verbal innuendos (Taylor, 2020)
    - A verbal expression from the parent that is meant to hint at something rather than directly saying it.
        - Examples: "Well that is an interesting feeding technique"; "You are just all over the place today"; "Well that's a daring activity"
    - How should we approach verbal innuendos?
        - Can be situation dependent
        - Ideally – address with problem-solving mode by asking logical questions – "What exactly do you mean by interesting?"; "What

about me is all over the place?"; "How do you feel this activity is daring?"

M4

        - This helps identify what the parent is really thinking/feeling and opens the door for direct communication. Be prepared, the feedback my not always be positive. If not, use interpersonal reasoning to:
            - Consider which mode to respond to the parent's communication. What modes may be helpful here: empathizing, instructing?
            - Sometimes, if the parent is particularly vulnerable it may be best to let it go.
- Crisis points (Taylor, 2020)
    - Life events that are stressful, unexpected, and distracts from a parent's ability to participate in therapy/meaningful occupations.
        - i.e. change in their health or in that of a loved one; death in the family; job loss; change in relationship status
    - When working with parents undergoing a crisis point, we must be mindful of these events and be prepared to respond/alter therapy to meet the parents' needs.
    - Modes here? – empathizing, instructing, collaborating
- Resistance/reluctance (Taylor, 2020)
    - Resistance – when parents/clients refuse to participate in therapy activities/HEP and the underlying resistance may be related to the parent-therapist relationship.
        - Examples: challenging, questioning, confronting therapist; ignoring; avoiding therapy or avoiding direct communication with clinician
        - Why may resistance happen?
            - Stressors outside of therapy coming into play within the therapeutic relationship
            - Parent perception of a forced/not really agreed upon therapy plan
            - Misunderstanding of therapy activities/what is happening in therapy.
    - Reluctance – hesitation to participate in a therapy activity or task. This is typically not related to the parent-therapist relationship and easy for the clinician to understand.
        - Activity is seen as too difficult
        - Activity results in feelings of anxiety, being overwhelmed
- Boundary Testing (Taylor, 2020)
    - Boundaries are important in therapeutic relationships as they help manage clinician expectations and help the relationship stay professional.

M4

- Boundary testing – when parent/client behavior results in clinicians landing in a spot where they may feel being pushed outside of the professional relationship.
  - Examples: Being asked about personal information; inappropriate gifts/comments; contacting clinician outside of work hours; being invited to a personal event or into a business venture.
- Some clients test boundaries by accident – they are just trying to relate to the clinician; others do so purposefully and may require more consistent, firm limit setting.

- Empathetic Breaks (Taylor, 2020)
  - When the client/parent attempts a communication and the clinician either fails to notice it or misunderstands it. Or when the client misinterprets clinician communication as not therapeutic (i.e. hurtful, insensitive, rude).
  - These occur naturally in the therapy process largely secondary to human nature.
  - Examples include:
    - Therapy demands (i.e. task, HEP, sensory diet) seen as overwhelming or impossible to implement
    - Parent-clinician mismatch in therapy expected outcomes
    - Mismatch in parent-clinician communication styles – clinician seen as too direct, too firm, not firm enough, impatient, too loose, too rigid
    - Parent feels not listened to by the clinician
    - Clinician behavior or communication is perceived as unprofessional (i.e. always late; commenting on other family members).
  - If therapist is not aware of empathetic break or parent is not able to directly discuss it, parents may begin to demonstrate behaviors such as not showing up, disengaging, verbal innuendos/comments.
  - What to do?
    - Resolving an empathetic break can be challenging. When thinking about mode to use, the IRM indicates that empathizing mode is the optimal mode when attempting to resolve an empathetic break.
  - Steps to resolving a break:
    - Recognize that a break has occurred.
    - Avoid minimizing it by using humor, distraction, or allowing the parent/client to take the blame i.e. saying “its ok”.
    - Avoid doing or saying something that will deepen the break (i.e. using sarcasm in attempts to minimize).
    - Raise it with the parent/client – acknowledge your actions (i.e. “I realize that I have been running late to our sessions”).
    - Repeat your understanding of the break. (i.e. “When I am late, you feel that your child’s therapy needs and time weren’t as important to me”).

        - Accept responsibility, reassure client, and apologize. (i.e. "You are right, your child's therapy needs and your time are important. I am sorry to being late and will plan out my day better in the future"). M4
- Limitations of Therapy (Taylor, 2020)
    - Service restrictions secondary to cost, time, clinician knowledge/skills, and available resources.
        - Examples:
            - Insurance issues
            - Therapy environment/context ability to fully meet therapy/client needs
            - Available equipment/toys/space for therapy needs.
            - Clinician's skill areas may not best meet client needs
            - Clinician/parent are not a good match.
    - Frustrating for both clinician and parent/family
    - What can we do?
        - Advocate when possible – ask for more visits if appropriate, creatively find access to equipment, provide family with community resources.
        - Directly discuss with parent/family any foreseen limitations and manage any limitations that pop up during therapy.
- Contextual Inconsistencies (Taylor, 2020)
    - These are any changes in the client/parent's interpersonal or physical environment that impact the natural flow of therapy. People vary in their response to these changes with some not minding at all and others being quite thrown off.
    - Examples:
        - Change in people in the environment (i.e. who is present – mom vs dad vs grandparent; new staff/student; number of people in the room)
        - Change in physical environment (i.e. home vs school vs clinic; décor/room layout; sensory changes – lights, sounds, smell)
        - Change in clinician appearance (haircut, clothes, glasses)
    - What to do?
        - Check in with the client/parent – ask how they are doing with the changes.
        - Use observed response/behaviors to help anticipate and minimize response to any future contextual inconsistencies.

Breakout rooms (Time TBD)

- Participants will break out into small groups for a reflective discussion using the following prompts (adapted from Taylor, 2020):
    - Think back to a complicated therapy relationship where you may have been uncomfortable with the parent/client, the client/family's upcoming

visits gave you anxiety, or you had to stop working with a client/family and another clinician had to take over the case. M4
    - Once you have a situation, describe it, label it using the interpersonal events reviewed, and discuss how this impacted therapy/therapy relationship.
    - Think to a client/parent with whom you feel you had a positive relationship/therapy outcome. Describe a situation in which an interpersonal event took place within this relationship, label the event, and discuss the impact did this have on the therapy/relationship.

Interpersonal Cascades (Taylor, 2020)

- Sometimes one interpersonal event can trickle into another and then into another resulting in what the IRM call an interpersonal cascade.
- This can happen in response to clinician action, in response to clinician inaction, or despite clinician's best effort to mediate events.
- If interpersonal events happen frequently with a client/family, then this may indicate a complicated therapy relationship.
- It is important to recognize these events, use the interpersonal reasoning processing, and do our best to focus on repairing any breaks in the relationship.

Interpersonal Events – How Do We Respond? (Popova et al., 2020; Taylor, 2020)

- When we are able to respond to interpersonal events in ways that result in the parent/client feeling understood and supported, we are responding therapeutically.
- When we respond in ways where the parent/client feels unheard, judged, or hurt, we are responding suboptimal.
- Using an interpersonal reasoning process during these events can help us stay objective and build our ability to cope and respond therapeutically and with intention.
- To best utilize the interpersonal reasoning process, it is beneficial to draw from:
    - Our knowledge of our interpersonal strengths and areas of challenge
    - Our knowledge of the parent client's interpersonal characteristics, particularly the characteristics that are likely to result in our suboptimal responding.
    - Our developing mindful awareness of the interpersonal aspects of therapy/therapy tasks in addition to the clinical aspects.

Interpersonal Reasoning Process (Popova et al., 2020; Taylor, 2020)

- Step 1: Anticipate
    - Drawing from past interpersonal events, our interpersonal strengths/challenges, and parent/client interpersonal characteristics, try and anticipate therapy situations, tasks, or conversations that may result in interpersonal stress before they happen.
- Step 2: Identify and Cope
    - When an event happens, take a second before responding.
    - Label the interpersonal event (either to yourself or aloud) and observe the client's reaction – if not clear, what is their perception of the event?

M4

    - Identify the dynamics at play.
    - Cope with the event
        - Take a deep breath
        - Remember, these events happen, they are part of therapy
        - If something we did/said started the interpersonal event, remember that we typically have good intentions and that we alone may not have caused it.
        - Consider that another parent on another day may have had a different reaction.
        - Consider that the parent/client will be ok after the event.
        - Avoid taking the easy way out.
- Step 3: Determine if a mode shift is required
    - What mode are you currently using? How effective is it in an event like this one?
    - Would another mode be more effective?
    - Consider the nature of the event and the client's characteristics.
- Step 4: Choose a response mode or mode sequence
    - (Review the modes here)
    - When choosing a response mode, consider
        - Client preferences
        - How this event may impact the parent/client-therapist relationship
        - Client safety and ethical responsibilities – these take precedence!
        - The balance between interpersonal focus/responding and activity focus/responding – which would benefit the parent/client given their preference/abilities.
- Step 5: Draw on any relevant interpersonal skill associated with that mode(s)
    - Consider your interpersonal strengths/areas of growth using chosen mode
    - This may mean drawing from your
        - Communication skills, professional skills
        - Past experiences managing conflict
        - Knowledge of how the client's characteristics may affect you
        - Ability to read behavior/non-verbal cues
- Step 6: Gather feedback
    - Remain present and observe parent/client response to chosen mode(s)
    - Check in with the parent/client for feedback – this may also help when the child client has an event and the clinician has undergone the process. One may ask the parent for feedback or ask both the parent and child
        - Ask how they feel about the event and the clinician's response
        - Ask if they are comfortable with the response approach used.
        - Ask if there is anything else they would like to discuss.
    - If the parent/client continues to feel unresolved, we can hope to achieve a mutual understanding. See if the parent will share their perspective,

validate their experience, and acknowledge if the response was suboptimal. M4

- Responses to avoid depending on the situation as they are commonly perceived as suboptimal include:
    - Responding defensively
    - Responding in a dominating way (talking over, interrupting, instructing)
    - Responding anxiously
    - Responding with self-disclosure or a comparison client
    - Responding with judgement
    - Responding in a way that minimizes the parent experience, in a casual manner, or humorously.

Clinical Scenarios and Guiding Questions

Guiding Questions for Reflection on Interpersonal Events

M4

When you experience an interpersonal event with a parent or client during a therapy session, it can be helpful to take a moment ant reflect on that event. The IRM interpersonal reasoning process (Taylor, 2020) provides a clear framework for this type of reflection. These guiding questions are meant to support your reflection using the interpersonal reasoning process so that you may determine how to best move forward. You may also use these questions to help you plan for an upcoming discussion or therapy activity you feel can become an interpersonal event. This may be completed individually or with a mentor/colleague(s). As this process becomes more familiar, you may be able to complete it in the moment while navigating through the interpersonal event. Remember, interpersonal events are inevitable and provide us with an opportunity for growth and learning.

Anticipate

- Have you experienced a similar situation in the past? What worked well? What did not?
- What interpersonal/communication strengths can you draw from?
- What interpersonal/communication challenges can get in your way? How are these triggered?
- What do you know about this parent's communication characteristics and preferences? How do these influence your next steps?
- How may you approach this topic or task in the next session?
- How do you feel the parent will receive this approach?

Identify and Cope

- Label the event: What interpersonal event(s) has occurred?
- What dynamics might be in play (i.e. power dynamics, emotional dynamics)?
- Take a deep breath and remember these events happen even with our best intentions.

Determine if a mode shift is required

- What mode were you in when the even occurred?
- How well does this mode work in an event like that one? How well does it work with this parent?

- Is there another mode that might work better for this client; for this situation? M4

Choose a response mode or mode sequence

- Considering the event and this parent, what mode or sequence of modes should you use to respond?

Draw on any relevant interpersonal skill associated with that mode(s)

- What are your strengths and challenges when using the response mode?
- How may your strengths and challenges influence your response?
- Is it best to respond interpersonally or through the activity?

Gather feedback

- Did you ask for feedback? If so, how did the parent respond? Did they feel the event was sufficiently resolved?
- How do you feel about the event's resolution?
- Given the feedback and your consideration, what can be done differently in a similar future event?

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