

THERAPIST PERCEPTIONS ON FORMATION OF THERAPUTIC RELATIONSHIP

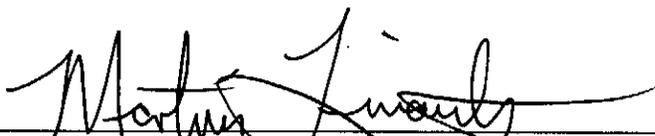
Occupational Therapists' Perceptions of Factors that Influence Therapeutic Relationship with Parents of Children with an Autism Spectrum Disorder

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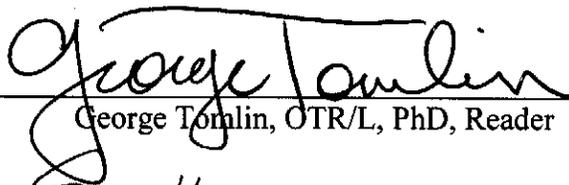
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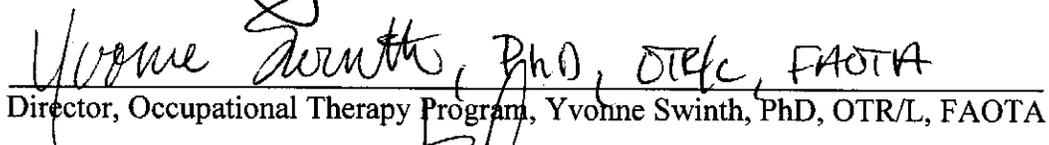
This research, submitted by Erin McCarthy, has been approved and accepted in partial fulfillment of the requirements of the degree of Master of Science in Occupational Therapy from the University of Puget Sound.



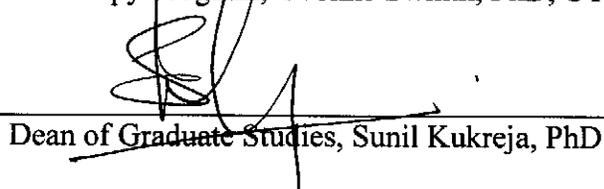
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Abstract

This study had a 3-fold purpose; it attempted to extend Gray's (2001) study to U.S. occupational therapists by investigating how parental "narratives," or reactions to having a child with autism spectrum disorder (ASD), influence occupational therapy intervention, to examine which of the six most commonly used therapeutic modes identified by Taylor (2008) are employed by therapists, as well as to identify ways in which parents and therapists contribute to, or interfere with, the parent-therapist relationship. A survey was mailed to 100 currently practicing occupational therapists in the U.S. Twenty-four returned surveys met the inclusion criteria and were used in this study.

Respondents indicated they felt Gray's assessment of parental "narratives," or reactions to the diagnosis of ASD were *somewhat accurate*, and cited denial as the most common parental reaction not mentioned by Gray. Therapists report they are best at employing the therapeutic modes of collaborating and instructing and needed the most improvement on the advocacy mode. Respondents identified collaboration/communication as ways therapists can *contribute* to parent-therapist relationships, and lack of communication/collaboration as ways they *interfere* with parent-therapist relationships. They identified collaboration/participation as ways parents can *contribute* to the parent-therapist relationship, and doubt in occupational therapists/the occupational therapy process as ways they can *interfere* with the parent-therapist relationship.

Most therapists reported they felt competent in forming a rapport with parents but also indicated their entry-level education did not adequately prepare them to handle this aspect of occupational therapy. There was a statically significant association between the number of years

practicing occupational therapy and the perceived competency level in developing rapport with parents of children with an ASD.

Background

The incidence of autism is rising in the U.S. and worldwide. It is estimated that an average of 1 in 88 children in the United States have an Autism Spectrum Disorder (ASD) (Center for Disease Control [CDC], 2011). Autism spectrum disorder (ASD) is a neurobiological disorder that is characterized predominantly by impairments in social interaction, unconventional behavior, and abnormalities in normal childhood development. Usually present are repetitive and stereotyped patterns of behavior, interests, and activities (American Psychiatric Association, 2000). There are several different specific disorders that fall under the umbrella term of ASD. These diagnostic categories were developed to encompass many disorders that exhibit the same symptoms of autism but do not fit all of the criteria. They are autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) or atypical autism, Asperger syndrome, childhood disintegrative disorder, and Rett's disorder (American Occupational Therapy Association [AOTA], 2009).

Over the years 1997 to 2008 the incidence of autism increased in the U.S. by 13.82% in children ages 3 to 17 (Boyle et al., 2011). The diagnosis is rising not only in the U.S. population; it is becoming more common all over the world. Kim et al. (2011) reported the prevalence of autism in a South Korean community. The authors studied results from the Autism Spectrum Screening Questionnaire given to 55,266 children, ages 7 to 12, to identify children with autism-like characteristics. Previous reports had estimated the prevalence of autism in South Korea as between 0.6 % and 1.8 %. Kim et al. found the overall rate to be 2.64 %.

Parents are the ultimate authority when it comes to their children. No one spends more time with the child or knows the individual needs better than the parent. It is important to respect the parent as the expert on their child (Kuhaneck & Watling, 2010), and thus it is essential to have good therapist-parent rapport. In a survey investigating this rapport, parents of children with cerebral palsy reported positive experiences with collaborative goal setting with their therapist (Wuart, Ray, Darrah, & Magill-Evans, 2010). The experiences described by the parents, however, revealed some disconnect between their preferences and values and the therapists' approaches to intervention. Parents and therapists need to discuss their individual perspectives with each other because the perspectives influence the goals and approaches to intervention (Wuart et al., 2010). To develop effective collaborative partnerships with parents, therapists must strive to understand parents' perspectives, especially when these differ significantly from the therapist's own perspectives (Hanna & Rodger, 2002). Discussions between parents and therapists may help therapists gain a greater understanding of parents' beliefs and values, which may lead to more effective collaboration (Wuart et al., 2010).

It is important for occupational therapists to educate parents about treatments they can continue at home. Numerous studies in the occupational therapy literature have described mothers as one of the biggest assets in therapy. Collaborating with caregivers and educating them about goals and the purpose of therapy is an important part of developing a professional relationship (Olson & Esdaile, 2000). Dullum (2008) found that if therapists explained to parents the reasoning behind the intervention, parents were more likely to complete a home program. It is not only optimal that occupational therapists take a family-centered approach, it is required by law. The Individuals with Disabilities Education Act of 1990 mandated family-centered care for children and families with special health care needs (U.S. Department of Education, 2011).

In a study of families with a child with cerebral palsy, the amount of time therapists spent working with parents and other family members in an outpatient clinical setting was as important as the time they spent working with the child (Hinojosa, Sproat, Mankhetwit, & Anderson, 2002). Hinojosa et al. (2002) concluded that occupational therapists who work with children with disabilities were in a unique position to facilitate family-centered intervention. Parents whose children have disabilities have not always been confident in the role OT played in serving their child. Hinojosa, Anderson and Ranum (1988) examined the role of occupational therapists working with the parents of preschool children with cerebral palsy via a survey. Hinojosa et al. (1988) concluded that, although the majority of occupational therapists believed they were competent in working with parents, they did not believe their basic professional education had adequately prepared them. Researchers concluded that therapists could benefit from training to work collaboratively with parents.

Olson and Esdaile (2000) highlighted the importance of striving to understand parents' expectations for therapy and their perception of what is occurring in therapy, and as a result of therapy. Parents' perceptions may serve as a powerful indicator of whether therapy has had an impact on aspects of the child's life considered important by the parents (Cohn, 2001a.). It is also important to consider the parents' mental health when trying to provide occupational therapy for their child with an ASD. Kuhaneck, Burroughs, Wright, Lemanczyk, and Darragh (2010) found that coping mechanisms used by parents can significantly reduce their stress levels. Because time spent with primary care physicians is limited, occupational therapists usually are the ones disseminating information about effective coping strategies, to the extent parents are seeking them out. Occupational therapists' unique holistic approach to therapy and wide base of

knowledge make them ideal for the education of parents who are coping with a child with ASD (Kuhaneck et al., 2010).

Occupational therapists' role is to evaluate, intervene and assess outcomes through measurable data collection (Tomchek & Case-Smith, 2009). Occupational therapy has been able to provide valuable interventions to serve children with an ASD and their efficacy is supported by research (Case-Smith & Arbesman, 2008). The AOTA approved interventions commonly utilized by occupational therapists can be divided into 5 basic subgroups; (1) Sensory integration and sensory based interventions, (2) relationship-based interventions, (3) educational programs, (4) social skills interventions, and (5) behavioral interventions (Kuhaneck & Watling, 2010, p. 701). These interventions are essential in providing effective occupational therapy, but they are only one aspect of the occupational therapists' responsibilities. Successful occupational therapy is built on treating each client as an individual, learning his or her specific needs, then tailoring the intervention to best suit those needs. To understand clients' needs, a therapeutic relationship must be formed.

Taylor (2008), discussed how occupational therapists can engage in therapeutic use of self. She described six commonly used therapeutic modes (ways of relating to a client), in occupational therapy. They are advocacy, collaboration, empathy, encouragement, instruction and problem solving. When employing the advocacy mode, therapists ensure clients have adequate resources to maximize daily functioning and quality of life. Therapists who collaborate with clients make joint decisions and involve them in every aspect of therapy. With Empathizing, therapists strive to understand the client's interpersonal needs and perspective. When utilizing the encouraging mode, therapists become a client's "cheerleader," give clients positive feedback, and celebrate accomplishments. When therapists instruct clients, they are teaching and training

them in specific task and giving a clear rationale for the content of therapy. The last of the six therapeutic modes is problem solving. When implementing this mode, therapists use reason and logic and are solution-oriented (Taylor, 2008, pp. 61-81). When building the therapeutic relationship, the therapist must first identify his or her own strengths and areas for improvement in practicing each therapeutic mode, then begin to identify what the family's needs are. Last, the therapist must take these two factors into consideration and choose an approach that will develop rapport and facilitate the parent-therapist relationship to increase the likelihood of optimal treatment outcomes.

Taylor (2008) described two types of interpersonal characteristics, situational and enduring. Situational characteristics change with the circumstances; enduring interpersonal characteristics remain relatively consistent across time and circumstance (Taylor, 2008, pp. 100-101). When parents learn their child is diagnosed with an ASD, they may display situational interpersonal characteristics and react in a way that is inconsistent with the way they normally interact. This abnormal state of mind may force an individual to use strategies to cope with this sudden life change. It is important for therapists to be aware of this and understand that the emotions, behaviors, and reactions the individual is displaying may be unusual. It is important for occupational therapists to understand how clients and families cope with grief and loss so that the approach to treatment can be altered to fit each client's individual needs.

Gray (2001) conducted a study in an Australian treatment facility that specialized in the treatment of children and families affected by ASD. He found that parents dealt with the diagnosis of ASD in one of three ways: accommodation, resistance, or transcendence. Families that employed accommodation as their coping mechanism accepted the diagnosis and traditional medical model approach to treatment. The resistance and transcendence groups rejected the

facility's model of coping with the diagnosis, which included going through the steps of the grief process and accepting the idea that their child will never be "normal," whereas the accommodation group accepted the model taught by the facility. Families that embraced resistance as their method of coping rejected the facility's model of grief and acceptance. Instead they chose to empower themselves through advocacy and activism. Rejecting the idea that they were powerless to change the reality of their situation gave them a sense of purpose and hope. The third group of families, which Gray labeled the "transcendence" group, chose to reject the facility's claims that they are normal families affected by an abnormal set of circumstances. These families believed there was a divine reason they were dealt the circumstances they were. Their child's condition was meant to be; a higher power was at work and to question it would be futile. These families embraced religion as a way to cope with the difficult plight of their child's behavioral issues by deriving a higher purpose in it or deeper meaning from it. The extent to which Gray's findings are transferable to the U.S. is unknown.

Therefore, the purpose of this study was to investigate (1) how parental "narratives" or reactions to having a child with ASD influence occupational therapy intervention, (2) the extent to which each therapeutic mode is employed by occupational therapists when working with families who have a child with ASD, and (3) the ways in which parents and therapists contribute to, or interfere with, the parent-therapist relationship.

Method

Research Design

Survey research is a method of inquiry done to systematically gather information that can be used to draw conclusions about the sample being studied and then generalize those findings to the greater population from which the sample was drawn (Kielhofner, 2006). Information is

gathered through self-report, usually by sending out mailed questionnaires to a sample of the population of interest. Some of the advantages of this method are (a) it is relatively inexpensive, (b) it is convenient for the respondent, and (c) the respondent can remain anonymous. A disadvantage of obtaining data through questionnaires is that the response rate may be low and the intent of the questions may be unclear or misunderstood. A 50 % return rate is considered good (Kielhofner, 2006). Thus, 100 surveys were mailed for the current study in hopes of receiving about 50 responses. Because respondents can remain anonymous, the survey method is ideal to elicit candid and honest replies.

Participants

The population of interest is occupational therapists with at least one year of experience working with children with an ASD and their families. The accessible population consists of occupational therapists working with children with an ASD who are members of AOTA and who belong to the pediatrics special interest section. The inclusion criterion was that the occupational therapist must have provided services for children with a diagnosed ASD and their families within the past year.

Instrument

A survey was created for this study due to the lack of an established questionnaire. The reliability and validity of this survey are unknown. The survey consisted of four sections (see Appendix). The format of the close-ended questions was multiple choice, Likert scale rating, short answer questions, and check all that apply. The first section focused on demographic information of the therapist, number of years in practice, number of years in pediatrics, and an estimate of the approximate number of families of children with autism they have worked with in their career, in the past year, and in what setting they are currently practicing.

The second section is based on the findings of Taylor (2008). Respondents were asked to indicate how often they employed each therapeutic mode in practice when interacting with families of children with an ASD. The third section asked respondents about their perception of the values and beliefs parents bring to therapy. The three parental narratives or reactions Gray reported in his research were stated and respondents were asked if they agreed or disagreed with his assessment. They were also asked if certain parental responses assisted or interfered with therapy. The final section asked therapists to rate their competency in developing relationships with parents, as well as how parents and therapists can better collaborate to establish a successful therapeutic relationship. The last page of the survey invited respondents to elaborate on any of the above questions or make any comments they wished to.

Procedure

Approval from the university Institutional Review Board was received. The survey was reviewed by a research advisor so as to remove biased and leading questions, and to improve clarity. Pilot testing was conducted with two university faculty members with experience as occupational therapists working with children and families affected by ASD. Modifications to the questionnaire were made based on feedback from the piloters.

Names and mailing addresses of occupational therapy practitioners were obtained from AOTA. One hundred members were sampled systematically from the occupational therapy member population in the pediatric special interest section. Each envelope was addressed with a mailing label and sent first class. The mailing packet included a cover letter explaining the purpose of the study, a copy of the survey and a postage paid, pre-addressed return envelope for the completed survey. The return envelopes were coded with a three-digit number from 001 to 100. This was done to identify the first wave respondents so that a second wave of surveys could

be sent to those who did not respond to the initial mailing. Thus, 100 surveys were sent with an expected response rate of 50%, which would yield 50 surveys. An additional mailing was sent after two weeks to those therapists who did not respond to the first mailing.

Data Analysis

Upon return of the survey, data were entered into the Statistical Package for the Social Sciences. The second mailing yielded only seven additional responses. Of those seven, only three met the inclusion criteria. Therefore, first wave and second wave responses were pooled for all analysis. Descriptive statistics for frequency and pattern of response were recorded as appropriate for each item. Associations between pairs of demographic and response variables were explored using chi-square. Short answer questions were recorded and grouped into thematic categories according to similarity of answers, and frequency of response was noted.

Results

Response Rate

Data were collected between April and May 2013. A total of 100 surveys were mailed to occupational therapists who were members of AOTA and the pediatric special interest section. The survey recipients returned a total of 35 surveys. Eleven respondents (31%) did not meet the inclusion criteria of having worked with at least one family who has a child with an ASD in the past year and therefore did not complete the survey. That left a new sample size of 89, of which 24 met inclusion criteria and completed the survey. The adjusted response rate was 24 (26.9%).

Demographics of Respondents

Thirteen respondents (54.2%) reported their entry-level occupational therapy degree was a master's level. The most common highest level of degree attained was a master's degree, (15,

or 62.5%). One respondent (4.2%), obtained a doctoral degree in occupational therapy (OTD). The four quadrants of the U.S. were all represented, with the highest rate of response from the South with 8 (33.3%) followed by the Midwest with 6 (25%), the Northeast with 6 (25%) and the West with 4 (16.7%). Nine respondents (37.5%) had been practicing occupational therapy for over fifteen years. Nineteen of twenty-four therapists (79.2%) reported practicing occupational therapy for more than 5 years. Eleven respondents (45%) reported they had worked with over 100 families of children with an ASD in their career and only one respondent (4.2%) indicated working with between two and ten families. In the past year, 8 therapists (33%) reported they had contact with a range of 11 to 25 families, while an additional 8 (33%) reported working with between 26 and 100 families in the past year. Ten respondents (41.7%) reported they work with two to three families of children with an ASD per week. Only one respondent (4.2%) reported working with over 20 families per week. Respondents were given a choice of eight pediatric treatment settings and asked to check all settings they were currently practicing in. Fifteen people (62%) reported currently working in an outpatient clinic. More information on the rate of reported employment in various treatment settings can be found in Table 1.

Reactions to the Diagnosis of ASD

According to Gray (2001), there are three basic types of parental “narratives” or reactions to the diagnosis of an ASD in their child that characterize their perspective on the condition. The first reaction is acceptance of the professionally based ideologies of adjustment and adaptation, which will be referred to as *accommodation*. The second reaction is one of resistance, where the parent becomes an advocate for the child and asserts him or herself in the political arena, which will be referred to as *resistance*. The final reaction is one of transcendence, where the parent

believes the child's suffering is God's will and must be accepted as such, which will be referred to as *transcendence* (Gray, 2001, p. 1256).

Respondents were asked to rate to what extent they felt the parental reactions of *accommodation*, *resistance* and *transcendence* assisted in therapy, using *very helpful*, *helpful*, *neutral*, *unhelpful* and *very unhelpful* as descriptors. Therapists most frequently reported *accommodation* as being helpful $n = 9$ (45 %), with the only answers selected being *neutral*, *helpful* and *very helpful*. The parental reaction of *resistance* was most frequently rated as both *neutral* $n = 9$ (45 %) and *helpful* $n = 9$ (45 %). Of the two remaining respondents, one reported it as *unhelpful* and the other as *very helpful*. *Transcendence* was rated using all descriptors from *very helpful* to *very unhelpful*, with the majority of respondents using *neutral* and *helpful* $n = 16$ (84 %) to describe the extent to which they feel *transcendence* assists in therapy.

Respondents were then asked to rate to what extent they felt the parental reactions of *accommodation*, *resistance* and *transcendence* interfered in therapy using *not at all interfering*, *interfering*, and *very interfering* as descriptors. Of the 20 respondents who completed this section all reported the parental reaction of *accommodation* as *not at all interfering*. Thirteen respondents (65%) reported the parental reaction of *resistance* as being *not at all interfering* and seven people (35%) indicated it is *interfering*. Fourteen respondents (74%) reported the parental reaction of *transcendence* as being *not at all interfering*; Six respondents (26%) report it is *interfering*.

Three respondents did not fill out questions asking them to select the degree to which Gray's three parental reactions or narratives assist or interfere in therapy. One respondent wrote, "I do not quite understand what Gray is exactly saying and I am declining to answer these questions." Another respondent wrote, "[Gray's descriptions] are too simplistic, the reactions

are more varied with multiple components.” Another simply placed a question mark next to the items.

Respondents were asked if they believed Gray’s assessment is *very accurate*, *somewhat accurate*, *somewhat inaccurate*, and *very inaccurate*. Twenty people responded to this question. Of these, 16 (66%) selected *somewhat accurate*, three people (12%) selected *very accurate* and 1 person (4%) selected *very inaccurate* in response to Gray’s appraisal of parental reactions. The one respondent who felt Gray’s assessment was very inaccurate elaborated on the reasoning behind the rating. He wrote, “The descriptions are not ‘real world’ reactions parents have.” This respondent was also the only one to cite he/she felt he/she is best at employing the therapeutic mode of advocacy. This respondent also reported working in the most settings (five of the seven listed).

Respondents were asked if there are other parental reactions to the diagnosis of an ASD and were given the opportunity to write a response in the form of a short answer. Nineteen respondents (95%) reported there are other parental reactions to the diagnosis of an ASD in their child. A total of 19 statements were made and these were gathered and divided into five thematic sub-categories. Therapists reported the most often observed parental reaction not stated by Gray (2001) was denial, (42%; $n = 8$). See Table 3 for other reactions reported.

Therapist response to the beliefs parents bring to therapy. Respondents were asked to rate how often they adjusted the way they interact with families based on their attitudes or beliefs about the diagnosis of ASD, using *never*, *sometimes frequently*, and *always* as descriptors. Eleven people (48%) indicated they *sometimes* alter the way they interact with parents based on their beliefs about ASD, while 10 people (43%) do so *frequently*. No respondent indicated they *never* adjust the way they interact with families based on their beliefs about ASD. Respondents

were also asked if they adjust therapeutic goals based on the family's attitudes or beliefs about the diagnosis of ASD. Fourteen respondents (66%) indicated they *sometimes* adjust therapeutic goals based on family's beliefs; 4 respondents (17%) selected *never*.

Respondents were asked to rate how often they experienced a change in parent attitudes, communication styles, or personalities after their child received the diagnosis of autism, using the rating scale of *never*, *sometimes frequently*, and *always*. Of the 21 respondents, twelve (57%) reported they frequently see a change in parents post-diagnosis and no respondents checked *never*. Three respondents chose to skip this question. A reason cited in the margin of the survey was, "the diagnosis always came first for me," indicating they had no experience with a child or family pre-diagnosis.

Therapeutic Modes

Therapists reported they often utilized therapeutic modes promulgated by Taylor. These six modes are advocating, collaborating, empathizing, encouraging, instructing and problem solving. Respondents were asked to rate how often they employed each mode, rating the frequency as *never*, *rarely*, *occasionally*, *frequently* or *always* (see Table 2). Nineteen respondents (79%) reported of the six therapeutic modes, they *always* employ encouragement when dealing with families of children with an ASD. The mode that was cited with the lowest frequency as *always* being used during therapy was advocacy, with 10 respondents (41.7%) reporting they *always* advocate for families of children with an ASD. When working with families of children with ASD, respondents indicated they feel they are best at collaborating, $n = 7$ (29.2%) and instructing, $n = 7$ (29.2%). Therapists reported needing the most improvement in advocacy for their client, $n = 9$ (54%).

Competency in Formation of the Therapist-Parent Relationship

Respondents were asked to rate their perceived competency level in developing a parent-therapist relationship with a family who has a child with an ASD. Therapists reported high perceived competency rates on a scale of 1 (the least) to 10 (the most) ($M = 8.8$, $SD = 1.2$) with the modal response being 10 (41%). There is a statistically significant association between number of years practicing occupational therapy and perceived competency in developing rapport with parents of children with ASD ($\chi^2 (1, N = 24) = 8.061$, $p = .005$). Respondents who have been practicing occupational therapy over ten years rated their perceived competency in developing a parent-therapist relationship higher than those who have been practicing for less than ten years.

Respondents were asked to rate the extent to which their entry-level professional education prepared them to develop rapport with parents of children with an ASD using the same scale. Respondents rated their educational preparation lower than their current competency rates ($M = 5.4$, $SD = 2.4$), with a most frequently occurring response level of “7” ($n = 7$; 29%). A chi-squared test of independence was done comparing entry-level degree and the extent to which respondents felt their entry-level education has prepared them to develop a rapport with parents. For these comparisons based on entry-level degree, entry-level master’s degrees, post-professional masters degree, doctoral degree, masters in education degree were grouped together as one variable level while a bachelor’s degree was the other variable level. There were no statistically significant associations ($\chi^2 (1, N = 24) = .974$, $p = .324$).

Respondents were asked to report to what extent they felt continuing education prepared them to develop a parent-therapist rapport. Therapists most frequently rated the level that continuing education prepared them as “8,” $n = 6$ (25%), with $M = 6.8$ ($SD = 2.3$).

Supports and Barriers to the Therapeutic Relationship

Respondents were asked to list three ways *families* can *contribute* to a successful parent-therapist relationship when treating their child with an ASD. The total number of responses was 66 short answers divided into four groups, with all respondents who completed this section responding with three answers. Responses were grouped by combining synonymous terms or themes. The most common responses were collaboration/participation (e.g., “being present during occasional treatment sessions”) and communication/honesty (e.g., “being honest about behaviors and problems”). The second most common responses were follow the home program (e.g., “carrying therapeutic principles/techniques over at home”) and “other” (e.g., “be patient,” “be realistic about expectations,” “acceptance of the purpose of occupational therapy,” “attend parent groups”). See Table 4 for further information.

Respondents were also asked to list three ways that *families* might *interfere* with a successful parent-therapist relationship. A total of 63 short answers were compiled and divided into six thematic groups. The most common factor that interferes with a successful parent-therapist relationship is parental doubt in the occupational therapist or the occupational therapy process (e.g., “constantly second guessing treatment”). The second most common response was denial about their child’s condition (e.g., “resistance to discussing long-term implications”). The third most cited responses were a lack of follow through with the home program (e.g., “no follow through with strategies”) and “other” (e.g., “showing no initiative,” “becoming oppositional or overbearing,” “overprotective,” “enable child, don’t promote increased independence,” “inappropriate expectations of child or therapist”). See Table 4 for more information.

Respondents were asked to list three ways *occupational therapists* can *contribute* to the formation of a successful parent-therapist relationship. Sixty-six total responses were divided into four groups. The majority of respondents cited collaboration/communication (e.g.,

“listening and understanding parents concerns and being willing to adjust the plan accordingly”). The second most common response was being informed and knowledgeable (e.g., “present thorough baseline data”). See Table 5 for further information.

The last of four short answer questions asked respondents to cite ways *occupational therapists* can *interfere* with the formation of a successful parent-therapist relationship. A total of 64 responses were gathered, divided into four categories. Respondents cited a lack of communication/collaboration (e.g., not collaborating with family to provide treatment consistent with family values and goals”) as interfering with a successful parent-therapist relationship. The second most common responses cited was narrow-mindedness/arrogance (e.g., “not being open-minded about various strategies”). See Table 5 for further information.

Respondents were given the opportunity to provide any further comments about the topics of this survey. Ten respondents (42%) wrote comments in this section. One respondent suggested future research should focus on stress levels or feelings of the parent, “both of which are so critical.” Another wrote, “Discerning between parent personalities and parental reactions to autism can be difficult. Communication and treatments based on the parent/family reaction should be the emphasis.” More than one therapist commented on the importance of the parent-therapist relationship, writing, “...This is a great topic and one that needs broader research. Parent-therapist relationships are integral to the progress for the child with ASD.” Another remarked,

Having been in early intervention for 10 years prior to my current school based position (for 7 years); I can't stress enough the importance of educating parents about autism. What a difference when parents carry over techniques and strategies. [It is] so key to help parents deal with the child in the community at an early age rather than avoiding it and then hoping for improved performance in the community years later... the family is key to effective therapy!

Discussion

This study attempted to extend Gray's (2001) research to the U.S. therapist population by investigating how parental "narratives" or reactions to having a child with ASD influence occupational therapy intervention. A secondary aim was to examine the extent to which each therapeutic mode described by Taylor (2008) is employed by occupational therapists when working with families who have a child with ASD. Last, it attempted to gain insight into the ways in which parents and therapists contribute to, or interfere with, the parent-therapist relationship.

Parental "Narratives," or Reactions to a Diagnosis of ASD

Gray's (2001) research identified three basic types of parental "narratives" or reactions to the diagnosis of an ASD: *accommodation*, *resistance* and *transcendence*. The majority of respondents agreed his assessment is *somewhat accurate*, but many also noted his three narratives are too simplistic or are not mutually exclusive, meaning an individual may experience more than one reaction simultaneously. Although therapists may have sensed the parental reactions that Gray described, they also felt there are more reactions than the three identified in his research. Therapists perceived that parental reactions do not fit into one category. Many times parental reactions are diverse, and parents may go through various stages of emotions and reactions. One respondent reported seeing parents "go through stages of grief, with some staying in the denial phase for a long time." Another respondent stated,

...I have seen so many parental reactions to the ASD diagnosis. So many parents come to therapy with anger, hostility, even with an "I don't know why we're here" attitude from receiving the diagnosis for their child. That makes for a rough start of a therapist-parent relationship; however, more times than not, I have seen that denial and anger eventually turn into thanks and appreciation.

The sole respondent who felt Gray's descriptions of parental "narratives" or reactions to the diagnosis of ASD in their child were *very inaccurate*, also reported working in the most treatment settings (outpatient clinic, hospital, rehabilitation center, child's home, and outpatient clinic specializing in hippotherapy). This person's exposure to a variety of practice settings may have provided the opportunity to see a greater diversity of parental reactions, and therefore select the rating of *very inaccurate*.

More than half of the respondents reported they frequently saw a change in parents' attitudes, and communication styles, or personalities after their child received the diagnosis of autism. This suggests parents may act in this time of change in a way that is inconsistent with the way they normally behave. Taylor (2008) described this abnormal behavior as a situational change. During this adjustment period parents may temporarily react and cope in ways unlike their typical manner.

Literature describes receiving a diagnosis such as autism in a loved one as being similar to experiencing a death. Many families go through a grief process where they mourn the loss of the future they anticipated for their child. Kubler-Ross (1969) originally described the five stages of grief as (1) denial, (2) anger, (3) bargaining, (4) depression, and (5) acceptance.

Respondents identified five reactions to the diagnosis of ASD that were not identified by Gray: denial, despair/guilt, increased knowledge, acceptance, and "other." Three of the five reactions noted by respondents in the present study are the same as the grief cycle. Those three are: denial, despair/guilt (similar to depression) and acceptance. This suggests that some parents' reactions do indeed align with Kubler-Ross' grief process.

All but one respondent indicated they believe there are more parental reactions than the three articulated by Gray. A factor that may have contributed to substantial disagreement is the

time at which Gray interviewed the majority of families: Most families were interviewed about their child at least four years after the initial diagnosis, allowing them enough time to transition beyond denial.

Another factor that may influence therapist perceptions about parental reactions to autism is the child's level of impairment. Gray interviewed families with children whose impairment level ranged from moderate to severe. Respondents in the present study may see a range of impairments in their practice, from high-functioning children with Asperger syndrome who can function more independently, to severely impaired children with intellectual disabilities who may be totally dependent. Because Gray interviewed families who had a child on the more involved side of the autistic spectrum, he may have dealt with parents who were forced to acknowledge their child's deficits and confront them as opposed to staying in denial. Another parental reaction cited by respondents in the current study is one of acceptance of their child's condition, framing their perspective on their child's condition as something that makes them unique. These therapists could be referring to parents who have children with high functioning autism and can lead a relatively typical life.

The results of the current study suggest respondents agree that the parental "narratives" characterized by Gray (2001) exist, but they do not cover the full scope of reactions to the diagnosis of ASD. The majority of the respondents agreed there are many other ways families deal with this diagnosis. Therapists in the U.S. believe, in addition to Gray's narratives, that families go through the stages of grief, such as denial, despair or acceptance, try alternative therapies (e.g., "gluten free diets" "heavy metal removal"), or increase their knowledge about the condition.

Therapeutic Modes

The majority (83%) of therapists reported that they had adjusted therapeutic goals based on the family's beliefs about ASD. Therapists should be aware of the influences a family's beliefs have on therapy and ensure they are still providing the most effective therapeutic intervention by selecting what is most beneficial for both child and family. This may create a dilemma for a treating therapist. On the one hand, the therapist needs to consider what the client wants (in this case, the client is both the parents and child with an ASD); on the other hand, they need to provide comprehensive treatment for the child with an ASD.

The results of the present study suggest respondents, at one time or another, employed all of Taylor's therapeutic modes of interaction when dealing with families of children with an ASD; no respondents reported *never* using any of the six therapeutic modes (see Table 5). The evidence from this study corroborates the assertion made by Taylor that the six therapeutic modes identified by Taylor (2008) are often used in occupational therapy practice.

Therapists must be aware that overuse or underuse of any therapeutic mode can influence the therapeutic relationship negatively. In this study, therapists cited high levels of confidence and competency in employing collaboration and instruction as therapeutic modes. Taylor (2008) cautions that over-implementation of the collaborating mode may cause some clients, who view therapists as authority figures, to interpret the therapist's stance as passiveness or indifference. Parents may be seeking guidance rather than the give and take relationship that develops during collaboration (p. 75). When instructing, therapists must recognize that over-application of this mode can result in the perception that the parent lacks control of, or autonomy over, the therapeutic process (Taylor, 2008, p. 81).

Therapists cited advocacy as the therapeutic mode they needed the most improvement on. This mode is important to the occupational therapy process because it may be difficult for

families to advocate for themselves immediately post-diagnosis when they are experiencing a variety of emotions. A diagnosis of ASD is a stressful life event and parents may not have knowledge or awareness of their child's rights to receive services, of community resources or other crucial adjuncts to therapy (Taylor, 2008, p. 73).

Therapists should recognize parents' need for guidance and information at this time and assist them in the advocacy process to ensure access to resources that may contribute to better outcomes. If occupational therapists feel they need improvement in this area, steps should be taken in order to gain competency. Advocating for clients can be as simple as being aware of resources and legislation that pertain to people with disabilities. To further develop advocacy skills, therapists should consider getting involved in state and local government, AOTA, or other organizations that support the rights of children with disabilities.

When asked to rate to what extent respondents felt the parental reactions of *accommodation*, *resistance* and *transcendence* assisted in therapy, using *very helpful*, *helpful*, *neutral*, *unhelpful* and *very unhelpful* as descriptors, the majority of respondents wrote these reactions were helpful. No respondents reported that *accommodation* was unhelpful or very unhelpful. It is logical that therapist would rate accommodation positively because when parents are employing this reaction, they adopt the medical model point-of-view and cooperate with the therapist's recommendations. Most therapists felt the reaction of *resistance* was *very helpful*, *helpful* or *neutral*, with only one therapist selecting *unhelpful*. This reaction is one of advocacy and assertiveness. Therapists may have had a positive reaction to this because they believe parental advocacy and involvement are important. *Transcendence* was the only reaction to which a respondent reported they believed it was *very unhelpful*. This therapist may have responded negatively towards this reaction because a parent taking this stance may not take action to

improve their child's quality of life. Therapists have likely seen children make improvements in function and greatly increase their quality of life. They may feel that by not acknowledging the benefits of therapeutic intervention, the parents are doing the child a disservice.

When asked to rate if the parental reaction of *accommodation* interfered with therapy all respondents felt that it was *not all interfering*. Close to one-third of respondents felt the parental reaction of *resistance* interferes with therapy. Almost one-fourth of respondents felt the parental reaction of *transcendence* interferes with therapy. It is unknown why a larger number of therapists responded that *resistance* and *transcendence* interfere with therapy, and a smaller number selected *unhelpful* or *very unhelpful* to describe if they felt the parental reactions of *resistance* and *transcendence* assist in therapy.

Supports and Barriers to the Parent-Therapist Relationship

Occupational therapists usually interact with families more often than medical doctors do, and thus, parents often go to therapists with their questions and concerns (Kuhaneck et al., 2010). This makes effective communication especially important for occupational therapists. The results of this study suggest therapist collaboration and communication with parents are essential contributing factors to the development of the successful parent-therapist relationship. Other research also supports the idea that therapists' collaboration and communication with parents is important to occupational therapy intervention (Hinojosa et al., 1988, Hinojosa et al, 2002, Olson & Esdaile, 2000). Respondents cited collaboration as a way parents *and* therapists can assist the therapeutic relationship, and further identified *participation* as the secondary term when expressing how *parents* can contribute to therapy. The secondary term used when describing how *therapists* can contribute to therapy was *communication*. This use of different terminology may be due to an inherent difference in the two roles.

The most frequently cited way therapist *interfere* with the parent-therapist relationship is lack of communication and collaboration. Therapists are professionals who are expected to have a certain level of expertise in their field. If their role as an authority figure is transformed into being the “one who knows it all,” the result may be a lack of communication. The second most frequently cited way therapists can *interfere* with development of the parent-therapist relationship is *narrow-mindedness and arrogance*. A therapist who feels superior to parents will likely not communicate with them and feel “they have more to offer than the parent,” as one respondent noted. If communication does occur with a therapist who is arrogant, as another respondent noted, they may “use too much technical language,” which results in ineffective communication.

Parents may have a variety of emotions about participation in occupational therapy. They did not choose this path for their child and may feel that they lack control or autonomy over choices. Many times they are thrust into a life that includes doctor visits and therapy sessions. Parents may be resentful of this and not participate. The most frequently cited way families *interfere* with the parent-therapist relationship is to have *doubt in the occupational therapist or the occupational therapy process*. Parents may not have confidence in the value of occupational therapy and this may result in a lack of participation as well.

Education and experience. Occupational therapy intervention often takes place in the form of a home program. These recommendations are more likely to be followed if parents understand why follow-through at home is so important (Dullum, 2008). Overall, therapists rated their competency in developing rapport with parents of children with ASD high. This study suggests there is an association between years of experience and a higher perceived competency

rate in developing rapport with parents. Therapists with over 10 years of experience had statistically significantly higher levels of self-perceived competence when working with parents.

Respondents reported their entry-level professional education only moderately prepared them to develop rapport with families of children with ASD, in agreement with Hinojosa et al. (1988). They concluded that therapists could benefit from extra education and practice working collaboratively with parents.

Implications for Occupational Therapy

Overall, therapists reported high levels of competency in developing rapport with parents of children with an ASD. Higher competency was associated with more years of experience in the field. The current entry-level educational curriculum only moderately prepares therapists to build rapport with parents. Novice pediatric occupational therapists may want to consider seeking further education when entering into the workforce, but it is unknown if education will assist therapists in building therapeutic relationships; experience may be the most effective tool in developing competency.

Individuals who wish to seek information on how to develop a successful parent-therapist relationship may consider becoming a mentee of a therapist experienced in interacting with families. Continuing education courses that specifically address the development of a successful parent-therapist relationship may be of help to therapists with less experience. Also, universities may want to consider the addition of an optional session for students who are preparing for fieldwork and wish to practice in a pediatric setting.

Limitations

The ideal population consisted of all occupational therapists in the U.S. who have worked with at least one family with a child with an ASD in the past year. The accessible population was

AOTA members who subscribed to the pediatric special interest section. The results of this study are of unknown generalizability to this cross-section of therapists. The initial mailing of one hundred surveys was relatively small and the response rate modest (26.9%). A greater number of respondents would have increased the power of the study and made it more likely the responses represented the population of interest.

Another limitation was that some respondents did not answer all of the questions. The most common questions left blank addressed Gray's three basic types of "parental narratives" or reactions to the diagnosis of ASD in their child. A number of respondents indicated they would have liked further detail about the "parental narratives" of Gray.

Also, in certain sections that addressed parental reactions and the values and beliefs they bring to therapy, respondents were asked to give their interpretation of the parents' experience of having a child with an ASD. Because this is a secondary source, the results may be less reliable than if parents would have reported their own experience of reacting to their child's diagnosis. Having parents fill out a similar survey would get closer to uncovering an accurate depiction of the lived experiences of parents of children with an ASD and how this influences the parent-therapist relationship.

Future Research

Respondents in this study reported a lack of educational preparation and continuing education in developing the parent-therapist relationship. The current availability of continuing education courses may not be adequate to assist novice therapists in developing the skills and knowledge to promote strong parent-therapist relationships. Research should be done to assess the best method to teach such interpersonal skills in a continuing education class.

Conclusions

This study set out to expand on Gray (2001), and determine the extent to which his findings are applicable to the U.S. A large majority among the responding therapists reported believing that Gray's depiction of the three parental narratives about the diagnosis of autism in their child was *somewhat accurate*. Ninety-five percent, however, responded that there are other parental reactions to the diagnosis of autism, most commonly parental denial.

Occupational therapists should be cognizant of their personal styles of interaction, the needs of the family, and keep open lines of communication in order to facilitate effective therapeutic intervention. One respondent wrote, "Discerning between parent personalities and parental reactions to autism can be difficult. Communication and treatments based on the parent/family reaction should be the emphasis." The effectiveness of treatment based on the parent/family reaction has not been explored in the occupational therapy literature and further research in this area needed.

Parent contributing & interfering factors. Among Taylor's (2008), six most frequently employed therapeutic modes in occupational therapy (advocating, collaborating, empathizing, encouraging, instructing, and problem solving), respondents most frequently reported being best at instructing and collaborating and needing the most improvement with advocacy when working with parents of children with ASD. They reported encouraging and empathizing as *always* being utilized in therapy.

The results of this study indicate that experience in occupational therapy is associated with an increase in perceived feelings of competency in developing a rapport with parents of children with ASD. It also suggests respondent's felt their entry-level education only moderately prepared them to develop the parent-therapist relationship. This finding supports Hinojosa et al. (1988). Therapists most frequently indicated collaboration/communication as a way therapists

can contribute to the formation of a parent-therapist relationship and collaboration/participation as a way parents can contribute to the parent-therapist relationship.

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Appendix

Therapists' perception of parental reactions to the diagnosis of ASD and its influence on the formation of the therapist-parent relationship

Erin McCarthy

The purpose of this study is to investigate factors affecting the therapist-parent relationship in cases of children with autism spectrum disorder.

- 1) Are you a registered and/or licensed occupational therapist who **in the past year** provided services for one or more children with a diagnosed autism spectrum disorder (ASD) and their families?

_____ Yes

_____ No

If you answered "Yes," please continue with question #2. If not, please stop here and return the survey in the prepaid envelope. This will assist the researcher in keeping track of the response rate. Thank you for participating.



PLEASE NOTE: YOU MAY SKIP ANY QUESTIONS YOU DO NOT WISH TO ANSWER AND STILL COMPLETE AND RETURN THE REMAINDER OF THE SURVEY

Section 1: Demographic Information

2) What was your entry-level occupational therapy degree?

_____ BSOT, BAOT, BOT, BSCOT

_____ MOT MSOT, MAOT

_____ OTD, DOT, DrOT

3) What is the highest-level occupational therapy degree you have obtained?

_____ bachelor's

_____ master's entry level

_____ post-professional master's

_____ clinical doctorate (OTD)

_____ other: _____

4) Which region of the country do you currently work in? (*please circle*)

West: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY

South: DE, DC, FL, GA, MD, NC, SC, VA, WV, AL, KY, MS, TN, AR, LA, OK, TX

Midwest: IN, IL, MI, OH, WI, IA, KS, MN, MO, NE, ND, SD

Northeast: CT, ME, MA, NH, RI, VT, NJ, NY, PA

5) How long have you been practicing OT?

- Less than 1 year
- 1- 2 years
- 3- 5 years
- 6- 10 years
- 11-15 years
- More than 15 years

6) Estimate the number of families of children with ASD that you have worked with in your career?

- 1
- 2-10
- 11 – 25
- 26 – 100
- Over 100

7) Estimate the number of families of children with ASD that you have worked with in the past year?

- 1
- 2-10
- 11 – 25
- 26 – 100
- Over 100

8) How many times per week do you have contact with families with a child with ASD to whom you provide occupational therapy service?

- 1
- 2 – 3

- _____ 4 – 10
- _____ 11 – 20
- _____ Over 20

9) Please mark the setting(s) where you are currently working (check all that apply)

- _____ outpatient clinic
- _____ hospital
- _____ school
- _____ rehabilitation center
- _____ child’s home
- _____ early intervention center
- _____ other: _____

Section 2: Therapeutic Modes- how they affect the therapist-parent relationship

Definitions

According to Renee R. Taylor, OTR/L, Ph.D., in her book, *The Intentional Relationship*, therapeutic modes are a specific way of relating to a client. The following are definitions of the six most commonly occurring therapeutic modes utilized in occupational therapy practice:

- **ADVOCATING**- therapists ensure clients have the adequate resources to maximize daily functioning and quality of life
- **COLLABORATING**- therapists make joint decisions with clients and involve them in every aspect of therapy
- **EMPATHIZING**- therapists strive to understand the client’s interpersonal needs and perspective
- **ENCOURAGING**- therapists become a client’s “cheerleader,” give clients positive feedback and celebrate accomplishments
- **INSTRUCTING**- therapists teach and train clients in tasks and give a clear rationale for the content of therapy
- **PROBLEM SOLVING**- therapists use reason and logic in therapy and are very solution-oriented

10) For each therapeutic mode below, please mark how often you employ that mode when dealing with families of children with ASD.

| | | | | | |
|--|-------|--------|--------------|------------|--------|
| | Never | Rarely | Occasionally | Frequently | Always |
|--|-------|--------|--------------|------------|--------|

| | | | | | |
|-----------------|--|--|--|--|--|
| Advocating | | | | | |
| Collaborating | | | | | |
| Empathizing | | | | | |
| Encouraging | | | | | |
| Instructing | | | | | |
| Problem Solving | | | | | |

For questions 11 and 12 please select the one best answer as it applies to you (even if other options apply).

11) In which mode do you feel you are at your best when working with families of children with ASD?

- Advocating
- Collaborating
- Empathizing
- Encouraging
- Instructing
- Problem solving

12) In which mode do you feel you need the most improvement when working with families of children with ASD?

- Advocating
- Collaborating
- Empathizing
- Encouraging
- Instructing
- Problem solving

Section 3: Values and Beliefs Parents Bring to Therapy

13) In your experience, do parents’ attitudes, communication styles, or personalities change after they receive the diagnosis of autism or ASD for their child?

- Never
- Sometimes
- Frequently
- Always

14) Do you adjust the way you interact with families based on their attitudes or beliefs about the diagnosis of ASD?

- Never
- Sometimes

- _____ Frequently
- _____ Always

15) Based on the family’s attitudes or beliefs about the diagnosis of ASD, do you adjust your goals in therapy?

- _____ Never
- _____ Sometimes
- _____ Frequently
- _____ Always

According to Gray (2001), an Australian researcher, there are three basic types of parental “narratives,” or reactions, to the diagnosis of autism (ASD) in their child. They are described as follows:

- a) This narrative approximates the biomedical account of autism and endorses professionally based ideologies of adjustment and adaptation. (Gray, 2001, p. 1256).
- b) This narrative is one of resistance where the parent redefines herself in terms of political activism and personal assertiveness (Gray, 2001, p. 1256).
- c) The last narrative is one of transcendence where the parent draws on religious faith as a way to make sense of the child’s suffering (Gray, 2001, p. 1256).

16) Please estimate the percent of time you see each type of parental reaction to the diagnosis of autism, of all the cases of ASD where you interact with parents.

- _____ a
- _____ b
- _____ c

17) For each of these three parental reactions, to what extent do you feel it *assists* in therapy?

| Very Helpful | Helpful | Neutral | Unhelpful | Very Unhelpful |
|--------------|---------|---------|-----------|----------------|
| a) | | | | |
| b) | | | | |
| c) | | | | |

18) For each of these three parental reactions, to what extent do you feel it *interferes* with therapy?

| Not at All Interfering | Interfering | Very Interfering |
|------------------------|-------------|------------------|
| a) | | |
| b) | | |
| c) | | |

19) Based on your experience, to what extent are these three reactions found by Gray (2001) accurate descriptions of the parental response to the diagnosis of ASD? Circle your response.

- Very Accurate Somewhat Accurate Somewhat Inaccurate Very Inaccurate

20) In your experience, are there other parental reactions to the diagnosis of ASD in their child?

- _____ Yes
- _____ No

21) If you answered “Yes” in #20, please describe below other parental reactions to the diagnosis of ASD, *please write the response in the box below:*

Section 4: Therapist-Parent Relationship

For the next three questions, please use a scale from 1 (the least) to 10 (the most):

22) To what extent do you feel competent in developing the parent-therapist relationship with a family who has a child with ASD? _____

23) To what extent do you feel your entry-level professional education adequately prepared you to build rapport with parents of children with ASD? _____

24) To what extent do you feel continuing education has adequately prepared you to build rapport with parents of children with ASD? _____

25) Please list 3 ways *families* can **contribute** to a successful therapist-parent relationship when you are treating their child with ASD.

- 1. _____
- 2. _____
- 3. _____

26) Please list 3 ways that *families* might **interfere** with a successful therapist-parent relationship when you are treating their child with an ASD.

- 1. _____
- 2. _____
- 3. _____

27) Please list 3 ways that *occupational therapists* can **contribute** to a successful therapist-parent relationship when they are treating a child with ASD.

- 1. _____
- 2. _____
- 3. _____

28) Please list 3 ways that *occupational therapists* might **interfere** with a successful therapist-parent relationship when they are treating a child with ASD.

- 1. _____
- 2. _____
- 3. _____

Please provide any further comments you have about the topics of this survey:

THANK YOU!

Please return the survey to:
 Erin McCarthy, OTS
 Occupational Therapy Program
 University of Puget Sound
 1500 N. Warner St. CMB# 1070
 Tacoma, WA 98416

Gray, D. (2001). Accommodation, resistance and transcendence: Three narratives of autism. *Social Sciences and Medicine*, 53, 1247-1257.

Taylor, R. R. (2008). *The intentional relationship: Occupational therapy and use of self*. Philadelphia, PA: F. A. Davis

Table 1
Demographic Information on Survey Respondents (N = 24)

| | Frequency | % |
|--|-----------|------|
| Years working as an occupational therapy practitioner | | |
| < 1 | 0 | 0 |
| 1-2 | 3 | 12.5 |
| 3-5 | 2 | 8.3 |
| 6-10 | 6 | 25.0 |
| 11-15 | 4 | 16.7 |
| > 15 | 9 | 37.5 |
| Highest-level degree obtained | | |
| Master's entry level | 14 | 58.3 |
| Bachelor's | 7 | 29.2 |
| Post-professional master's | 1 | 4.2 |
| Clinical doctorate (OTD) | 1 | 4.2 |

| | | |
|---------------------------------------|----|------|
| Other | 1 | 4.2 |
| Current practice setting ^a | | |
| Outpatient clinic | 15 | 62.5 |
| Child's home | 9 | 37.5 |
| School | 7 | 29.2 |
| Hospital | 5 | 20.8 |
| Other | 3 | 12.5 |
| Rehabilitation center | 2 | 8.3 |
| Early intervention center | 2 | 8.3 |

^a Respondents were asked to "check all that apply."

Table 2

Frequency of Employment of Therapeutic Modes in Occupational Therapy Practice (N = 24)

| Mode | Frequency % | | | | |
|-----------------|-------------|---------|--------------|------------|-----------|
| | Never | Rarely | Occasionally | Frequently | Always |
| Encouraging | 0 (0) | 0 (0) | 0 (0) | 5 (20.8) | 19 (79.2) |
| Empathizing | 0 (0) | 0 (0) | 1 (4.2) | 6 (25.0) | 17 (70.8) |
| Instructing | 0 (0) | 0 (0) | 1 (4.2) | 8 (33.3) | 15 (62.5) |
| Problem Solving | 0 (0) | 0 (0) | 2 (8.3) | 7 (29.2) | 15 (62.5) |
| Collaborating | 0 (0) | 0 (0) | 0 (0) | 12 (50.0) | 11 (45.8) |
| Advocating | 0 (0) | 1 (4.2) | 6 (25.0) | 7 (29.2) | 10 (41.7) |

Table 3

Other Parental Reactions to the Diagnosis of ASD (N = 24)

| | Frequency | % |
|---|-----------|----|
| Denial (e.g., “resistance to the diagnosis and the approach behind intervention”) | 8 | 42 |
| Despair/guilt (e.g., “feel like a failure;” “sadness;” “guilt for not addressing issues sooner”) | 5 | 26 |
| Increase knowledge (e.g., “genetic testing for themselves and other family members;” “set out to find a cure”) | 3 | 15 |
| Acceptance (e.g., “he/she is who he/she is,” “eager to resolve issues and move on”) | 2 | 10 |
| Other (e.g., “alternative therapies, naturopaths,” “Gluten/casein free diets,” “heavy metal removal,” “hyperbaric O ₂ therapy.”) | 1 | 5 |

Table 4

Ways Families Contribute to or Interfere with the Parent-Therapist Relationship (N = 24)

| Contributing Factors | Frequency | % |
|---|-----------|----|
| Collaboration/participation (e.g., “being present during occasional treatment sessions”) | 22 | 33 |
| Communication/honesty (e.g., “being honest about behaviors and problems”) | 22 | 33 |
| Following home program (e.g., “carrying therapeutic principles/techniques over at home”) | 11 | 16 |
| Other (e.g., “be patient,” “be realistic about expectations,” “accept of the purpose of occupational therapy,” “attend parent groups”) | 11 | 16 |
| | | |
| Interfering Factors | | |
| Doubt in occupational therapy/occupational therapy process | | |

| THERAPIST PERCEPTIONS ON FORMATION OF THERAPUTIC RELATIONSHIPS | | 45 |
|---|----|----|
| (e.g., “constantly second guessing treatment”) | 23 | 37 |
| Denial about condition (e.g., “resistance to discussing long-term implications”) | 11 | 17 |
| Other (e.g., “showing no initiative,” “overprotective,” “enable child,” “becoming oppositional,” “inappropriate expectations of child or therapist”) | 10 | 16 |
| Lack of follow through with home program (e.g., “no follow through with strategies”) | 10 | 16 |
| Poor attendance (e.g., “missed treatment sessions”) | 6 | 10 |
| Unsupportive home environment (e.g., “family dynamics overpower treatment”) | 3 | 4 |

Table 5

Ways Occupational Therapists Contribute to or Interfere with the Parent-Therapist Relationship
(N = 24)

| Contributing Factors | Frequency | % |
|--|-----------|----|
| Collaboration/communication (e.g., “involve family in treatment”) | 38 | 58 |
| Informed/knowledgeable (e.g., “Present thorough baseline data,” “know about community resources”) | 11 | 18 |
| Empathic/understanding (e.g., “sensitivity to diagnosis,” “being thoughtful of the mourning process”) | 8 | 12 |
| Other (e.g., “reliability,” “flexibility,” “patience- be non-confrontational”) | 8 | 12 |
| Interfering Factors | | |
| Lack of communication/collaboration (e.g., “closed-door approach | 29 | 45 |

to parental involvement”

Narrow-mindedness/arrogance (e.g., “egos are oversized”) 12 19

Other (e.g., “intolerance,” “addressing issues not important to the family,”
“using too much technical language,” “too many demands too quickly”) 12 19

Therapist incompetence/lack of knowledge
(e.g., “lack of evidenced based treatment approaches”) 11 17
