The relationship between a therapist and his or her client has been recognised to be an important determinant of the success or failure of occupational therapy. The purpose of this qualitative study was to explore clients' perceptions of the relationship that they formed with their occupational therapist in the context of rehabilitation. Twenty clients with varied health problems were interviewed.

The analysis of data revealed three main categories, therapist role, power and connection, as pertaining to the characteristics of the client-therapist relationship. From these categories, seven different relationship dimensions were identified and arranged hierarchically. The dimensions were described as concern, direction, fellowship, guidance, coalition, detachment and rejection. Relationships were generally experienced as positive; however, there were also examples of negative and detrimental experiences.

The findings are discussed in relation to the definition of the therapeutic relationship and to client-centred practice. Occupational therapists are encouraged to consider their own attitudes, needs and boundaries when it comes to establishing close connections and to share power with their clients. Furthermore, therapists must explore which form of relationship and participation each client prefers in order to establish an effective collaborative relationship.

Client-Therapist Relationships: Experiences of Occupational Therapy Clients in Rehabilitation

Gudrun Palmadottir

Introduction

The importance of the client-therapist relationship has been recognised from the early days of occupational therapy. The concept has received increased attention during the later years, following the profession's emphasis on client-centred practice (Law and Mills 1998, Canadian Association of Occupational Therapists 2002). Client-centred practice has become a central concept in the philosophy of occupational therapy, as demonstrated clearly in the profession's major practice models (Canadian Association of Occupational Therapists 2002, Kielhofner 2002, American Occupational Therapy Association 2002). Furthermore, recent trends in general health services advocate for patient-centred care and the promotion of patients' involvement as active partners. This philosophy is strongly emphasised as fundamental to the aim and purpose of rehabilitation (Cott 2004, Pellat 2004).

In spite of a varying emphasis on professional competence and personal caring in occupational therapy, the commitment to collaborate with clients is a longstanding one (Peloquin 2003). The client-therapist relationship is believed to be integral to an effective occupational therapy process (Lyons 1994, Wright-St Clair 2001, Kielhofner 2002) and several studies indicate a connection between the quality of this relationship and functional outcome (Hasselkus and Dickie 1994, Norrby and Bellner 1995, Rosa and Hasselkus 1996, Cole and McLean 2003). This connection is also well known among other health care professions, such as physiotherapy (Gyllensten et al 2000, Talvitie and Reunanen 2002), nursing (Bray 2003, Halldórsdóttir 2003) and vocational counselling (Svensson et al 2003). Furthermore, there is considerable scientific support for how humanistic elements, such as compassion, caring, empathy and active listening, enhance the outcome of rehabilitation (Halstead 2001, Thorne et al 2004).

Research studies suggest that clients place a high value on the quality of the client-therapist relationship and tend to be disappointed with therapists who do not relate to them on a personal level (Corring and Cook 1999, McKinnon 2000, Darragh et al 2001, Peloquin 2003). Blank (2004) referred to a body of evidence that identified the relationship between client and therapist as central to the client's experience of occupational therapy. When exploring clients' experiences in rehabilitation, they seem to be less concerned with the rehabilitation content and technical expertise than with the relationship that they formed with their service providers (Darragh et al 2001, Östlund et al

2001). Supportive and empowering relationships have been shown to lead to a positive experience of rehabilitation whereas relationships that do not nurture partnership and equality have a negative effect on that experience (Pellat 2004).

The client-therapist relationship is also an important factor when it comes to how occupational therapists view themselves as competent professionals (Hasselkus and Dickie 1994, Finlay 1997). Rosa and Hasselkus (1996) identified the process of helping as a major cause of job satisfaction for occupational therapists, with positive client-therapist relationships being sources of meaning, self-education and renewal. Alternatively, therapists who did not perceive their relationships as meaningful experienced a feeling of guilt and failure, leading to a decline in their professional function (Rosa and Hasselkus 1996).

In normally occurring relationships, a natural reciprocal rhythm exists. In contrast, professional relationships are necessarily and generously unequal because the therapist is obligated to respond to the needs of the client (Wright-St Clair 2001). Furthermore, the therapist is a knowledgeable expert whereas the client commonly lacks expertise in relation to his or her own disease or disability, which contributes to an uneven distribution of power between client and therapist (Bellner 1999). By tradition, the biomedical model places emphasis on the technical aspect of care and paternalistic decision making, where client compliance with policies, routines and interventions is favoured (Hammell 1998, Lund et al 2001, Cole and McLean 2003). An authoritarian view, where occupational therapists take the authority and make the client a recipient of therapy, has also sometimes been considered to represent a traditional occupational therapy (Mattingly and Fleming 1994).

Mosey (1981) described the art of therapy as the capacity to establish rapport, to empathise and to guide others to know and make use of their potential as participants in the community of others or, worded differently, the capacity to engage in a therapeutic relationship with clients. A therapeutic relationship constitutes the non-technical, interpersonal aspect of health care, based on the core values of altruism, equality, freedom, justice, dignity, truth and prudence (Peloquin 2003). The literature emphasises four key characteristics of interactions that occur in a therapeutic relationship: collaboration, communication, empathy and understanding (Norrby and Bellner 1995, Bellner 1999, Peloquin 2003). Cole and McLean (2003, p44) have defined the therapeutic relationship as 'a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect'. However, there is often a breach between rhetoric and everyday practice and relationships between professionals and clients may not always be satisfactory, especially when seen from the client's point of view (Lyons 1994, Talvitie and Reunanen 2002).

The purpose of this study was to explore clients' perceptions of the relationship that they formed with their occupational therapist in the context of rehabilitation. The study is a further analysis of existing data, which were gathered for a more extensive exploration of clients' perceptions of occupational therapy in rehabilitation (Palmadottir 2003). The results from the first analysis indicated that the client-therapist relationship was one of the aspects influencing a client's perception of occupational therapy outcome. It was therefore decided to explore this subject in more depth and to do a further analysis on the parts of the original interviews that were related to the relationship between therapist and client. The study was approved by the Icelandic National Bioethics Committee and the Privacy and Data Protection Authority in Iceland.

Method

The study was qualitative in nature, where unstructured interviews were used to develop a detailed description of the construct of a client-therapist relationship. The focus was on the experience of adult clients that had received occupational therapy as a part of the service provided during their stay at rehabilitation institutions in Iceland.

Participants

Twenty adults, 10 women and 10 men, participated in the study. Following the principles of theoretical sampling (Strauss and Corbin 1998), both men and women of different ages and with a variety of health problems were included. Three rehabilitation institutions were involved and the number of participants from each institution, demographics and health problems reflected to a large extent the population that received occupational therapy within that setting.

The participants' ages ranged from 21 to 70 years, with the majority being between 31 and 60 years old. Experience with occupational therapy ranged in duration from 6 weeks up to 17 months, with 3 or 4 months being most common. There was a considerable variation in the participants' health problems, but these were defined by the participants themselves. Among men, neurological problems were the most common, whereas the women most often described a combination of musculoskeletal and psychological problems. Acquired cerebral dysfunction and mental health imbalance were other health conditions that were identified.

Access to potential participants was obtained through occupational therapists working at the rehabilitation institutions. These therapists identified discharged clients that they believed would be able to participate in an interview and had received at least eight individual occupational therapy sessions. These inclusion criteria were identified for the purposes of the original study.

The first contact with each prospective participant was made by his or her former therapist, who obtained the client's permission to put his or her name and telephone number on a participant list. The researcher received the

list from the occupational therapy director at each institution and, therefore, did not know which therapist had treated which client. When meeting the participant, the researcher explained the study in detail and assured him or her that a strict confidentiality was going to be maintained. After that, the participant was asked to sign an informed consent form.

Data collection

The data were collected through open, unstructured interviews, which aimed at obtaining descriptions of the participants' lived experience. Half of the participants had experienced more than one period of rehabilitation and occupational therapy, but the main focus of the interview was on the most recent experience. Each participant was interviewed once, with the length of the interview being from 30 minutes to over an hour. All interviews took place in the participants' own homes. An effort was made to make the interview look like a conversation that was controlled equally by both the parties involved (Kvale 1996).

During the discussion, the participant was asked to describe the relationship that he or she had with his or her occupational therapist and then the researcher would expand on that description with open-ended questions, such as:

- How much time did you spend with your therapist?
- What happened between you two during that time?
- What was your therapist's role in the tasks that you two were working on together?
- How were decisions made?
- How much choice did you have in what happened during therapy?
- How was information given to you?
- To what extent did you trust and rely on your therapist?
- What did you like or dislike about your therapist and how was your relationship with him or her compared with what you had with other professionals?

The interviews were taped and transcribed, together with any observations made by the researcher during the visit. No health records were consulted.

Data analysis

To carry out the analysis for this study, the researcher made use of the extensive coding scheme developed when analysing the complete data set collected for the original study (Palmadottir 2003). For that analysis, all data were transferred into ATLAS.TI, a computer programme designed for coding and keeping track of qualitative data. The code labels and their definitions were reviewed and the ones that had something to do with therapist-client interactions and relationships were picked out. The programme made it possible to collect in one large file all the quotations belonging to these codes, while still keeping track of which participant the quotation came from.

The analysis was guided by the work process developed by Strauss and Corbin (1998) in their discussion of grounded theory. This work process is recommended by Bogdan and Biklen (1998) as appropriate for a descriptive analysis as well. First, an open coding was performed on the transcribed interviews in the new data file, with codes emerging from the transcribed text. The codes were sorted and modified to form three main categories: therapist role, power and connection. The category 'therapist role' included all descriptions of the therapist's behaviour and attitudes when interacting with the client. The 'power' category illustrated the client's input and his or her sense of control and influence on the process. The 'connection' category described the client's feeling of closeness and trust towards the therapist and the degree to which the client saw the relationship as equal, with reciprocity of give and take.

The second step of the analysis was to perform an axial coding in order to delineate the different properties and the scope of each category separately (Strauss and Corbin 1998). Finally, using tables and matrices, the three categories were linked together to form seven different relationship dimensions, resulting in a holistic picture of the main construct: the client-therapist relationship. To enhance the credibility of the findings, the analytical process described above and the reasoning behind the categories and relationship dimensions were discussed with experienced colleagues, who provided some useful critique and feedback.

Findings

In general, the participants expressed a great deal of satisfaction with the relationship that they had formed with their primary occupational therapist. Some participants felt that their relationship had been special and of higher quality than what they were seeing going on around them between other clients and therapists. Many participants reported that this relationship was different from what they had had with other professionals during the rehabilitation period. The main difference was the informality of the interaction, which resulted in a close, trusting relationship. Extended and frequent contact on an individual basis was also commonly reported as an explanation of why the participants formed a closer relationship with occupational therapists and physiotherapists than with other health professionals.

The relationships between clients and occupational therapists were found to exist as seven different dimensions. The dimensions were named and defined by the category 'therapist role' and arranged in a hierarchical order, based on the intensity or strength of the two categories 'power' and 'connection'. Most participants experienced more than one relationship dimension, with one usually being dominant. A caring attitude on behalf of the therapist was necessary for a relationship to be experienced as positive. This aspect was mentioned by most participants. A caring attitude meant paying attention to the person's feelings and showing interest in his or her life situation:

> Yes, interest in me as a person and that I feel good and that they want to do their best so the patient not only gets better but also feels good where he is now … it is extremely important being talked to as a human being and when they are teaching you something physically that this is done with a bit of affection and warmth.

Of the seven dimensions, five were described in positive terms. These were given the following descriptors: concern, direction, fellowship, guidance and coalition. One dimension, rejection, was experienced as negative and one, detachment, was described as neither positive nor negative.

Each of the five positive dimensions is discussed and then the remaining two are described. When reporting findings, the pronoun 'he' is used when referring to the clients, both men and women, and the pronoun 'she' when referring to the occupational therapists, who in this study were all women.

Concern

Three participants, all women, discussed their client-therapist relationship exclusively in terms of the dimension labelled concern. These women described their therapists as being warm, considerate and attentive to their needs. The women did not have any expectations or put any special demands on the therapist, but nevertheless she was there, offering them constant support. The therapist was in charge of all the main decisions and it seemed that her main goal was to provide her clients with a feeling of safety, wellness and encouragement without pushing them in any way. The participants saw themselves as dependent and passive recipients of good care. They trusted their therapist completely and expressed a deep sense of thankfulness to her:

> I liked her very much and she did everything she could do for me. I would say that occupational therapists do everything they can to help people … they help with activities and so on … they made a plate so I could slide into bed.

Direction

At a directive level, the therapist was seen as the definitive leader who made most of the decisions, while the client acted in a rather passive way. Five participants, all men, experienced their relationship mainly within this dimension. Compared with the concern dimension, the therapist was more demanding towards the client in terms of active participation. Most commonly, she would decide or at least suggest what activities the client would perform during therapy sessions. However, the client was given the opportunity to oppose, and most commonly the therapist also urged him to participate in the decision making which he was not always ready to do:

> It is often when you have not worked for a long time then you need a push and then it is better that you are assigned a job instead of choosing it yourself.

The therapist could either automatically have taken this control or the client had deliberately given it to her. In both instances the clients were satisfied with the arrangement and that satisfaction was based on their genuine trust in the therapist, who they believed both cared for them and knew what would be of most help. One of them said:

> She was so active and had me try out a lot of things. She knew what would be good and what would not … she gave me assignments and asked me to do some exercises.

This relationship was not especially close. However, the participants felt that their therapist was someone that they could always ask for assistance and advice and sometimes they would take the initiative and propose some activities or service to meet their special needs. Commonly, the therapist would take the client's issues forward to other professionals or agencies and act as a spokesperson for him.

Fellowship

The fellowship dimension was characterised by activity from both therapist and client. The client sensed a strong connection and that he was to some extent at an equal level with the therapist and not in a patient role, despite his dependence on her. In fact, some clients kept an informal relationship with their therapist after finishing the rehabilitation period. The participants described their interactions with their therapist as relaxed and natural, based on mutual dignity, involvement and the sharing of personal experiences. However, the therapist was viewed as the one having most influence on how the relationship could develop:

> They approach you as their equal or a friend. They are all so genuine and they are just themselves. They are not trying to be anything else, that is just how they are.

When discussing their therapist, these participants almost exclusively used the description 'good friend', whom they could always turn to with their personal matters. The therapist in a sincere manner would listen attentively, encourage them, provide reassurance and support and foster confidence:

> It was good to know that she was always there and one could always talk to her privately if something was bothering you. She was always positive and it was always good to talk to her … good to be able to say your opinion, knowing that she would not react negatively.

In the fellowship dimension, decisions were made collectively after thorough discussions and input from both client and therapist. The participants pointed out how important it was to have clear goals that they had been actively involved in defining. Five participants described their relationships mainly within this dimension. Furthermore, fellowship was the dimension most commonly experienced in combination with other relationship forms.

Guidance

At the guidance level, the client set the pace and identified therapy goals. Considerable initiative and responsibility

were taken by the client at this level too. The client's values were the leading principle and the therapist would respect the client's choice as long as his safety was not at risk. Most frequently, however, the client would consult with his therapist before taking critical actions related to his future roles:

> I wanted to try this out a month earlier, but they knew better where I was at.

The therapist was seen in the role of an adviser or a guide to aid the client in getting what he wanted from therapy without limiting the client's sense of responsibility and power. Guidance related to both practical matters and emotional conflicts. One participant described how his therapist guided him in how to begin the new life he was facing:

> She taught me something about what is important when going back to the real life … When we were talking she would deal with the important things. She did more than just show me how to put on my socks.

Similar to the fellowship dimension, the client felt a close connection with his therapist. The interaction was relaxed like a friendship and based on feelings of equal worth, dignity and warmth. Three participants perceived the relationship with their therapist to be primarily at this level.

Coalition

Coalition was the highest level, where the relationship was perceived to be of benefit to both the client and the therapist. Client and therapist worked together towards clear goals, solving issues that were of importance to both of them. Tasks were formally distributed between the two and responsibility was shared. The outcome of the therapy process was twofold because, while the client gained increased occupational skills, the therapist gained increased knowledge, competence and experience. This twofold outcome was deliberately identified and mutually agreed upon.

Although this sounds somewhat like a business relationship, it was not the case. The relationship was experienced as close and informal, characterised by a high level of confidence and an awareness of the worth and abilities of both individuals. Only one participant described this level of a relationship as the dominant form:

> This was so much designing for both me and her. We just did most things together … I maybe have something on my mind and she had something on her mind and then we sat down over a cup of coffee and discussed it. We discussed what was possible in life … and when you are discovering things together you will get closer … she learned to value me for what I was and I her for what she was.

Detachment

The detachment dimension was characterised by little contact and a lack of closeness. The therapist did not show much interest in interacting with the client. However, the two women that had their main experience at this level did not consider their relationship directly as being negative and they did not dislike their therapists personally. Nevertheless, the women felt that the therapists were passive and that they had not received from the therapists the information that they needed on the occupational therapy service. One of the women took on a passive role as well and she described how she was left on her own in an activity situation:

> There was no connection other than I just attended the sessions and worked on my project, but if there was something she had in mind then she would of course talk to me.

When asked if she could talk to her occupational therapist about her worries, she replied:

> No I did not, because I felt this did not belong to occupational therapy, this is all somehow sorted down you know.

The relationship itself had no specific impact on the client and there was very little encouragement on the behalf of the therapist. However, input from the client's side was allowed. The other participant, well aware of her service needs, got additional attention and more service options at her own request. Involvement in therapy turned out to be dependent on the initiative of the client. Some other participants, although having different experiences themselves, reported seeing a relationship like the one described here around them between other clients and their occupational therapists.

Rejection

The data also contained evidence of a negative and even damaging relationship, with a lack of caring and where basic trust had not been established. Here, the occupational therapist appeared in the role of a superior, looking down on the client and not listening or paying attention to his feelings. None of the participants had this kind of experience with his primary therapist. However, two clients found their relationship with a substitute therapist to be on this level:

> She often spoke to me as I was a little kid. One is of course confused these first weeks and sometimes when I was shaving myself I forgot to turn off the water and then she would say with disdain; well, did we forget something … People that put themselves on a pedestal … maybe she felt her job was so important that she was too good to talk to patients.

Despite this destructive experience, one of the participants reported that because of his own stubbornness he could still learn some skills, whereas the other participant withdrew and stopped showing up for occupational therapy sessions. Two additional participants described a similar experience in their past, with occupational therapists in different service contexts.

As mentioned above, most participants expressed satisfaction with the relationship that they had formed with their occupational therapist and, with a few exceptions, these relationships were meeting the clients' needs. However, some discrepancies were found. For example, one participant described how his therapist put

a great deal of pressure on him to take more action and power, whereas he needed a more directive relationship where most of the power lay with the therapist.

Discussion

In this study, the participants generally reported having a positive relationship with their occupational therapists. Most participants described how their relationship took on different forms, as therapist's role, closeness, reciprocity and power structure varied between situations. Seven relationship dimensions were identified and arranged in a hierarchical order based on these qualities. Different forms and dimensions are commonly reported in studies of client-therapist interactions that have been conducted within different disciplines (Jones et al 1997, Melton 1998, Cipriani et al 1999, Darragh et al 2001, Östlund et al 2001, Halldórsdóttir 2003, Peloquin 2003). Similar to the present study, the therapist's role, the reciprocity of interaction and the distribution of power are the crucial factors that differentiate between forms of relationships.

Of the seven dimensions identified in this study, five were experienced as positive, one as negative, and one as neither positive nor negative. One may wonder if a positive experience of the relationship with a therapist is sufficient for it to be therapeutic. For this discussion, Cole and McLean's (2003, p44) definition is used and the therapeutic relationship defined as 'a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect'.

Positive dimensions

The five positive dimensions – concern, direction, fellowship, guidance and coalition – all seem to fulfil the requirements of a trusting connection, rapport, communication, empathy and respect. The dimensions of fellowship, guidance and coalition also seem to fulfil the requirements of collaboration. In these situations, the client was encouraged by the therapist to take an active role and to share power and responsibility with the therapist. Collaboration is usually defined as a joining of two or more parties in an action where there is mutual respect and exchange and where responsibility is shared throughout the whole process (Cipriani et al 1999). A collaborative partnership between clients and occupational therapists is a fundamental concept in client-centred practice and this is facilitated by a conscious shift of power from therapist to client (Law and Mills 1998, Canadian Association of Occupational Therapists 2002). The shift in power occurs when the client identifies the issues of therapy and participates actively in decisions about intervention focus and outcomes (Hammell 1998).

With this in mind, collaboration was not so clearly found within the concern and direction dimensions. Concern was characterised by therapist listening, understanding and support, while the client was passive and dependent. The same was somewhat true for direction; however, in this dimension the therapist tried harder to involve the client in decision making and demanded more input from him. Despite limited distribution of power, the participants who experienced their relationship mainly in terms of concern or direction described it as satisfying and meeting their needs. Evidence from research in rehabilitation suggests that clients do not necessarily expect to be actively involved in the planning and implementation of therapy. Not all clients are interested in sharing responsibility and some will actually choose to have professionals make decisions for them (Lund et al 2001, Pellat 2004). One may wonder if it is reasonable to expect that all clients wish to be partners in therapy. Perhaps some clients just need to feel valued, understood and cared for, and could not that too be considered therapeutic and client centred? Would it not be legitimate for a therapist to have such a relationship with a client, although it could not be described as a partnership or a collaboration?

When discussing the concepts of collaboration and power, it should be recognised that there is a difference in roles and an inequality in status between therapists and clients in the health care system. The role of the therapist implies being a knowledgeable professional, whereas the client is a layperson without formal health-related knowledge and, in most instances, is unable to determine the tasks and proper role of the therapist (Bellner 1999). The responsibility of meshing these two different roles to create a collaborative intervention process falls on the therapist (Hammell 1998).

Any collaborative actions related to decision making and the direction of therapy are some of the therapist's main responsibilities as a professional, in addition to the provision of a technically competent service (Bellner 1999). The therapist has to foster the client's self-directedness and responsibility for his own health and quality of life. However, since it is the therapist's obligation to attend to and fulfil the client's needs, she may also feel responsible for the therapy that is provided and its outcome, contradicting the process of transferring responsibility and power to the client. Despite emphasis on client autonomy and client-centredness in current rehabilitation, health care systems are still greatly influenced by the traditional paternalistic biomedical model which rewards client passivity and compliance. Furthermore, the biomedical model's emphasis on the technical aspect of care and on measurable functional outcomes may result in therapists having problems in finding a way to practise their belief in egalitarian relationships and facilitate the participation of their clients.

The form of relationship that develops between therapist and client is an interaction of both therapist's and client's qualities. In the present study, there were instances where two participants had been treated by the same therapist, but had very different experiences in the relationship that developed. Gyllensten et al (2000) proposed that clients may set the initial tone for the relationship process and, once the tone has been interpreted by the therapist, he or she will most likely

assume the role desired by the client. This may well be the case in the present study.

Research also indicates that a relationship is enhanced when the therapist identifies personally with the client in age, gender and stage in life cycle (Hasselkus and Dickie 1994). One might wonder if it was a coincidence that all the participants who reported direction as their dominant relationship dimension were men. Interestingly, of the three women experiencing the dimension of concern, two were considerably older than their respective therapists. In neither case was the relationship especially close or reciprocal.

It may also have to be kept in mind that even the most experienced and skilled therapists enter the client-therapist relationship with personal assumptions, preferences and needs. Their own personal characteristics must be taken into account because they respond to their clients as people and not just as clients with whom an exclusively professional relationship is developed.

Negative dimensions

Special attention must be drawn to the fact that not all the participants in the study had their needs met through the relationship with their therapists. The dimensions of detachment and rejection were characterised by a lack of interest from the therapist's side and even a negative attitude towards and humiliation of the client. These experiences were not common, but some participants reported having observed such relationships between fellow clients and their occupational therapists. Evidence of distant and disqualifying behaviour of therapists exists both in the occupational therapy literature (Bellner 1999, Corring and Cook 1999) and in the writings of other health professionals (Jones et al 1997, Östlund et al 2001, Halldórsdóttir 2003). There is a general consensus on how relationships such as those described previously are likely to result in clients' feelings of fear and impaired self-esteem, which have a negative effect on the healing process (Halstead 2001, Pellat 2004). This was also the experience of the participants in this study.

Conclusion

When considering the findings from this study, it needs to be kept in mind that this was a small selective group since the participants were identified by their own therapists. Without being aware of their bias, the therapists might have had the tendency to select clients with whom they had developed a positive relationship.

Despite these limitations, the study provides some useful insights into client-therapist interaction. Some suggestions can be made for what could make the client-therapist relationship more successful and productive as one of the most important tools in occupational therapy. The therapist's knowledge of her own attitudes to power is crucial and an awareness of how these attitudes are communicated and acted out. Some therapists may have the need to control and for them partnership will be especially challenging. Therapists also need to be aware of the signals clients send in order to establish an effective collaborative process. Clients cannot be considered as a uniform group and therapists have to investigate which form of relationship and participation each client prefers rather than acting on the basis of established routines.

Therapists must be aware of their own professional skills, needs and boundaries when it comes to establishing close connections with their clients. Rapport, mutual trust and respect are not dependent upon the therapist's sharing of personal experiences. Therefore, therapists should not feel inadequate if they do not feel a deep connection with their clients because they can still make a positive difference for them. Occupational therapists, with their emphasis on daily occupations and informal aspects of service, must take advantage of this unique opportunity to develop therapeutic relationships with clients.

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