**Factors associated with therapeutic approaches among**

**Norwegian occupational therapists: An exploratory study**

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**ABSTRACT**

According to the Intentional Relationship Model, the use of therapeutic approaches tailored to individual clients’ needs is essential for building therapeutic relationships. This study investigated factors associated with occupational therapists’ preferred therapeutic approaches**.** One hundred eight occupational therapists were recruited as a convenience sample, and the data were analyzed with linear regressions. Mental health as the field of practice was associated with a stronger preference for use of empathy. More job satisfaction was associated with stronger preference for the instructing mode. Empathy appears to be more commonly used in mental health practice, whereas instructing may be linked with job satisfaction.

**KEYWORDS** Intentional Relationship Model, therapeutic relationship, therapeutic modes, occupational therapy, Norwegian Self-Assessment of Modes Questionnaire

**Introduction**

The Intentional Relationship Model (IRM) (Taylor, 2008) is a relatively new model in occupational therapy. It describes the therapeutic relationship between therapist and client in the context of the occupational therapy process. A helpful therapeutic relationship is considered important for promoting occupational engagement and positive therapy outcomes. From observing a large number of expert occupational therapists performing in practice, Taylor (2008) conceptualized six distinct approaches to relating to clients, and labelled these approaches as “therapeutic modes”. According to the model, therapists have a tendency to use some modes more than others, and those used most frequently are the ones most compatible with the therapist’s personality. Thus, the intentional use of therapeutic modes is central to the model – this means that the therapist should make every effort to shape his or her interaction with the client in the way that will best serve the client’s interests. By continuous and judicious self-monitoring during interactions, the therapist may improve the quality of treatment.

Six different therapeutic modes are included in the IRM, and the modes used most frequently constitute the therapist’s therapeutic profile (Taylor, 2008). The therapeutic modes or approaches are multiple ways of relating to a client. The *advocating mode* describes the occupational therapist functioning as a catalyst for securing resources and beneficial rights on behalf of the client. For example, it may include ensuring that the client has access to housing, education, equal rights for employment and any other resources to secure independent living and increased quality of life. The therapist works as a facilitator so the client can overcome occupational obstacles. In the *collaborative mode*, the therapist includes the client in every part of the therapeutic process, strongly supporting the value of client-centered practice. The occupational therapist strongly supports client empowerment, autonomy, independence and personal choice and encourage**s** the client to lead the therapy process. The *empathizing mode* includes making every effort to fully understand the client’s experiences and feelings, being particularly attentive to painful emotions. The empathizing mode includes careful listening and observing, and taking the time to accept and validate the client’s description of everyday struggles.

The *encouraging mode* requires strategies like making compliments, applauding and cheering on the client. The occupational therapist encourages and supports the client’s initiative, in a way that strengthens the desire to participate in occupations. The *instructing mode* requires a structured and directive communicative approach, with frequent demonstrations and instructions. The occupational therapist is seen as an instructor, educating the client and addressing the issues considered important to occupational participation. Lastly, the *problem-solving mode* focuses on logical reasoning and analysis. The therapist uses strategic questioning, structured guidelines and other logical approaches to enable the client to consider alternative perspectives and solutions regarding occupational problems.

Research using the IRM model as a theoretical framework is increasing. Taylor and coworkers’ survey (Taylor, Lee & Kielhofner, 2011) included 563 practicing occupational therapists in the United States and examined their preferred modes of interacting with clients. The researchers found that the encouraging mode was the most preferred and the empathizing mode was the least preferred among the therapists. This was explained by referring to the encouraging mode as a frequent starting point for occupational therapists. In order to encourage clients to participate in activities, this mode was often the natural way to begin. The use of other modes increased during therapy. The empathizing mode was seen as more challenging, as it requires a tolerance for negative emotions and difficult client circumstances. It is also possible that therapists traditionally have been less trained to use this mode. Only 9% of the 563 study participants reported seeing clients with psychiatric disorders.

Bonsaksen’s (2013) survey of 31 occupational therapy students in Norway found that the most preferred mode was problem-solving and the least preferred mode was advocating. In Carstensen and Bonsaksen’s study (2016), comparing occupational therapists and occupational therapy students, the most commonly used therapeutic mode among participants in both groups was the problem-solving mode. The study showed that the advocating and instructing modes were used more frequently among the students, while the collaborative and empathizing modes were used more frequently among the occupational therapists. In view of these findings, the collaborative and empathizing modes were referred to as approaches often requiring more experience

Yasdani, Carstensen and Bonsaksen (2016) examined occupational therapy students in more detail, looking for associations between background or study context variables and the students’ therapeutic approaches. Among the students, the problem-solving mode was used most frequently, while the encouraging mode came second. In addition, it was found that being female and studying at the university in Trondheim (as opposed to the university in Oslo) were related to having a stronger preference for the collaborating mode (Yazdani et al., 2016). Otherwise, no associations between background or study context variables and mode preferences were detected, and the statistical models explained relatively small proportions of the variance in the data (between 3.2 % for the encouraging mode and 14.9 % for the collaborating mode).

In light of these findings in the student sample, it is interesting to explore the possibility of associating occupational therapists’ mode use with a set of background and context variables. According to the IRM, mode preferences are likely to be congruent with personality (Taylor, 2008). As demonstrated by the previous comparison between occupational therapists and students, however, (Carstensen & Bonsaksen, 2016), there seems to be systematic variation between groups with regards to their length of education and experience. In turn, this indicates that the level of education and experience may be associated with mode use among occupational therapists.

In Taylor and coworkers’ previous study from the USA, it was found that mode use in general was more frequently used among therapists who reported dealing with challenging behavior among their clients. Challenging behavior referred to clients who had problems with trusting or valuing occupational therapy, and who resisted advice, feedback or suggestions. It also included clients who were emotionally disengaged, and clients who expressed difficult emotions. Occupational therapists who encountered such situations more often reported higher levels of therapeutic mode use (Taylor et al., 2011). As challenging behavior may be encountered more frequently by occupational therapists working in mental health settings, there is reason to examine whether occupational therapists are inclined to use some of the modes, based on their field of practice. Moreover, in the context of a recent study showing high levels of job satisfaction among Norwegian occupational therapists (Opseth, Carstensen, & Bonsaksen, 2017), we wanted to explore whether occupational therapists’ job satisfaction was associated with their use of therapeutic modes.

***Aim of the study***

The present study investigated factors associated with occupational therapists’ approaches and preferences for the six therapeutic modes.

**Method**

***Design, sample and data collection***

The study had a cross-sectional design and the data were collected in the autumn of 2015. The sample of occupational therapists practicing in the Oslo and Trondheim areas were recruited by convenience, mainly among participants at professional meetings in the nearby hospitals and municipalities, and among therapists who had taken on the role of fieldwork supervisor for students at the regional universities. The data were collected by self-report questionnaires, consisting of the Norwegian Self-Assessment of Modes Questionnaire (N-SAMQ) (Bonsaksen, Kvarsnes, Eirum, Torgrimsen, & Hussain, 2015, 2016), and included some requests for additional sociodemographic information.

***Measures***

The *Self-Assessment of Modes Questionnaire* was designed to help therapists identify the mode(s) of relating to clients that are comfortable to them, as well as to identify the modes that are not (Taylor, 2008; Taylor et al., 2013). The Norwegian version of the assessment includes 19 short clinical vignettes. A set of six different therapist responses are linked to each of these vignettes, all of which represent plausible therapeutic actions. The respondent is instructed to indicate one (and only one) of the six suggested responses that he or she feels most comfortable with in the given situation. Each response option represents one of the therapeutic modes. A percentage score for each of the modes is calculated by adding the number of responses that belong to each mode, and then dividing the resulting figure by 19 (the number of vignettes**).**  The score is then multiplied by 100.

*Sociodemographic information* sought included age in years, sex (1 = male, 2 = female), years of higher education, years of experience as an occupational therapist, and field of practice (physical health = 1, mental health [alone or in combination with physical health] = 2).

Job satisfaction was assessed with the question: “In general, how good do you feel about your job and your job assignments?” Response alternatives were very bad (1), bad (2), about average (3), good (4), and very good (5).

***Data analysis***

Prior to analysis, 10 % of the data set was checked against the completed questionnaires for correctness. We assessed the correspondence between a proportion of the completed N-SAMQ forms and the data as transferred onto the electronic data file.No error was detected. One hundred and thirteen persons gave their consent to participate in the study and then completed the questionnaires. For this study, five persons were excluded from the sample because of missing or inadequate responses on one or more variables.

The IBM SPSS software version 24 (IBM Corporation, 2016) was used in the statistical analyses. Descriptive analyses using means (*M*) and standard deviations (*SD*) were performed on continuous interval-level variables, and frequencies and percentages were calculated for categorical nominal-level variables. Bivariate associations with mode preferences, which are continuous interval-level variables, were analyzed with Pearson’s correlation coefficient *r.* Then, multivariate regression analyses were performed, using each of the six mode percentage scores as dependent variables. As the mode percentage scores are continuous interval-level data, the analytic strategy was considered appropriate. Age and gender were not included in the multivariate analysis owing to low bivariate correlation coefficients (age) and the predominance of women in the sample (gender). Therefore, independent variables were included in one block consisting of years of higher education, years of experience as occupational therapist, field of practice, and job satisfaction. The level of statistical significance was set at *p* < 0.05, and effect sizes were reported as standardized *β* weights.

***Ethics***

The study was conducted according to ethical guidelines for research (World Medical Association, 2008). The researchers informed the participants appropriately about the aims and procedures of the study, and all participants provided a written consent form. The participant information emphasized that the collected data would be used to analyze preferences for therapeutic modes on an aggregated group level. In addition, it was emphasized that participation in the study was optional. No benefits were related to participation, and conversely, no disadvantages were related to non-participation. The therapists completed the questionnaires at a time and a place of their own choosing, but mainly recruited among participants at professional meetings in nearby hospitals and municipalities, whereas others where approached individually. The questionnaires were stored in a locked cabinet in a locked office, both in Oslo and in Trondheim. The study received approval from the Norwegian Data Protection Official for Research (project number 43954).

**Results**

***Sample characteristics***

The sample characteristics are provided in Table 1. One hundred and eight occupational therapists participated in the study, and a larger proportion (*n* = 61, 56.5 %) of the sample had their practice in the Trondheim area as compared to those who practiced in the Oslo area (*n* = 47, 43.5 %). The participants were 11 (10.2 %) men and 97 (89.8 %) women, with a mean age of 40.8 years (SD = 10.8 years). Of the six therapeutic modes, the problem-solving mode was the most frequently endorsed (*M* = 25.9 %, *SD* = 14.1 %) with the encouraging mode coming second (*M* = 20.2 %, *SD* = 12.4 %).

[TABLE 1 ABOUT HERE]

***Factors associated with therapeutic approaches***

Table 2 shows the results from the bivariate correlation analysis. Having mental health as the field of practice, alone or in combination with physical health, was associated with a higher preference for the empathizing mode. Greater job satisfaction was associated with a lower preference for the collaborating mode, and with a higher preference for the instructing mode.

[TABLE 2 ABOUT HERE]

Table 3 shows how each of the proposed predictor variables were independently associated with the six modes. In general, the models had little predictive power, i.e., the models explained between 2.6 % and 8.6 % of the variance in the outcome variables. Having mental health as the field of practice, alone or in combination with physical health, was independently associated with a higher preference for the empathizing mode. Higher job satisfaction was independently associated with a higher preference for the instructing mode.

[TABLE 3 ABOUT HERE]

**Discussion**

This study investigated factors associated with occupational therapists’ use of therapeutic modes, as described by the IRM. Working in mental health as the field of practice (alone or in combination with physical health) was independently associated with a stronger preference for using the empathizing mode. The empathizing mode may be understood as a complex way of meeting a client’s needs by paying particular attention to his or her feelings (Eklund & Hallberg, 2001; Taylor et al., 2011). In agreement with Eklund and Hallberg (2001), Carstensen and Bonsaksen (2016) found higher levels of empathizing mode use among therapists compared to students, and subsequently argued that the use of the empathizing mode could be seen as an aspect of practice at higher levels of competence. Students may have limited capacity to use empathy actively as a therapeutic mode of practice, and may be limited in terms of their engagement in clinical reasoning about its effects (Mattingly & Fleming, 1994; Unsworth & Baker, 2016; Unsworth, 2001). Logically, experience as an occupational therapist would provide greater confidence in managing a client’s painful emotions, and in validating both expressed and unexpressed feelings. Therefore, it would make sense that the more experienced occupational therapists also showed higher scores on the empathizing mode than did the less experienced ones. This study, however, failed to demonstrate a significant association between years of experience and use of the empathizing mode (see Table 3). As the levels of empathizing mode use were similar between occupational therapists possessing different levels of experience, but has been shown to be higher among occupational therapists in comparison to students (Carstensen & Bonsaksen, 2016), the interpretation may be that even a little clinical experience may add substantially to the level of use of the empathizing mode. Nonetheless, fostering the empathizing mode in students and novice practitioners so that they become comfortable with using it more fluidly in practice appears to be serviceable.

The mental health field of practice requires the occupational therapist to develop and nurture the capacity for coping with the clients’ emotions and feelings, and the emotional aspect of occupational therapy may be more salient in mental health practice than in other health care contexts. One could argue that the ability to empathize is an essential therapeutic skill that needs to be practiced by all, regardless of context. On the other hand, the empathizing mode may be particularly challenged, but also nurtured, within mental health contexts. In addition, and across professional disciplines, there is a strong and long-standing tradition that emphasizes empathy in mental health care, as demonstrated in recent literature (e.g., Varvin & Geirdal, 2017) as well as in curricula for mental health education programs (Oslo and Akershus University College of Applied Sciences, 2016). Brown and colleagues (2010) argued that high workloads, personal stressors and pressures to demonstrate treatment efficacy can compromise empathy. This could be the case for occupational therapists working in physical health care in particular. High workloads and pressures toward cost effective treatment may result in a shortage of time, which in turn may undermine the use of the empathizing mode. Simply put, empathy takes time (Irving & Dickson, 2004), whereas instructions can be given rather quickly. Considering all of the above, it seems logical that the empathizing mode was used more frequently among occupational therapists working within mental health (alone or in combination with physical health care) than among those working in physical health care contexts.

Higher job satisfaction was associated with a stronger preference for the instructing mode. In the bivariate analysis, we also found an inverse association between higher job satisfaction and less use of the collaborative mode, but this association was not statistically significant when controlled in the multivariate analysis (see Table 2 and Table 3, respectively). Interacting in the instructive mode provides the therapist with the opportunity to be structured and clear in his or her approach to treatment, and to include frequent demonstrations and instructions (Taylor, 2008). The instructive mode may be viewed as a way to interact with clients and client groups that can provide the occupational therapist with a better overview and more perceived control over the therapy process. In light of this, it appears that occupational therapists who find themselves more in control over the therapeutic situations they engage in, tend to be generally more content with their job and their job assignments. For example, with a structured and pre-planned way to meet the clients, occupational therapists may feel that their workday is one that they can control and manage, and may thereby feel more content with the job. This reasoning is in agreement with research emphasizing the role of control for occupational therapists’ job satisfaction (Scanlan & Still, 2013; Wressle & Samuelsson, 2014), but contradicts the results of a recent study of job satisfaction among Norwegian occupational therapists (Opseth et al., 2017). In the latter study, control was not found to be significantly associated with job satisfaction. In combination, these findings may allow for a more nuanced view of work-related control and its significance. In the therapeutic relationship, in terms of the ability to relate to clients in a structured way (i.e., controlling the treatment situation), the results of the current study showed that clearly controlling the goals, rationale, and procedures of therapy, was related to higher levels of job satisfaction among Norwegian occupational therapists. Control in the wider sense, however, as in being able to control the content and pace of job assignments in general, was not related to their job satisfaction (Opseth et al., 2017).Thus, it seems that micro-level control, as expressed by the occupational therapists preference for using the instructing mode in client-therapist interactions, was more important for their job satisfaction, compared to a more general sense of control over their work situation.

***Strengths and limitations***

The study had a relatively small sample, consisting of 108 occupational therapists, and it was a convenience sample. This will make the results of the study difficult to apply to occupational therapists in general. Participants were, however, recruited from two different cities in Norway. Only a small number of independent variables were included in the regression analysis, and as a result, only small portions of the outcome variance was accounted for. Future studies may include a wider range of variables and assess their relationships to therapeutic mode preferences. We wondered whether there could be systematic organizational differences between the different workplaces in the Trondheim and Oslo area**s**, and that such differences may have influenced the study’s results. However, subsequent analyses showed that the results remained the same, even when controlling for university. The study is also limited because of the not yet psychometrically validated tool for data collection that was employed.

***Conclusion***

In this sample, the empathizing mode was used more frequently among occupational therapists working in mental health than among those working in physical health. The emotional aspect of occupational therapy may be more salient in mental health practice than in other health care contexts. Empathy takes time and one could argue that more time is generally devoted to understanding and managing clients’ painful emotions and expressed feelings in the field of mental health, when compared to other contexts.

Higher job satisfaction was associated with a stronger preference for the instructing mode. The instructive mode may be viewed as a mode of interaction that can provide the occupational therapist with a better overview and more perceived control over the therapy process. Thus, the perceived control and overview provided by using the instructing mode may increase occupational therapists’ general satisfaction with their job**s** and their job assignments.

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