

**Differences and similarities in therapeutic
mode use between occupational therapists and
occupational therapy students in Norway**

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Abstract

Background: The Intentional Relationship Model (IRM) is a new model of the therapeutic relationship in occupational therapy practice. Two previous studies have been concerned with therapist communication style, or “mode” use, but to date no group comparisons have been reported.

Aims: To explore differences between occupational therapists and occupational therapy students with regard to their preferences for therapeutic mode use.

Methods: The study had a cross-sectional design, and convenience samples consisting of occupational therapists ($n = 109$) and of second-year occupational therapy students ($n = 96$) were recruited. The *Self-Assessment of Modes Questionnaire* was the main data collection tool. Group differences were analyzed with independent t -tests.

Results: The therapists showed stronger preference for the collaborative and the empathizing modes than the students did. The students showed stronger preference for the advocating and the instructing modes, compared to the therapists.

Conclusion and significance: There may be systematic differences between students’ and therapists’ preferred modes. Some of the modes may be viewed as requiring more experience, such as the collaborating and empathizing modes, whereas other modes may be related to more recent rehabilitation ideologies, such as the advocating mode. These factors may contribute to explain some of the observed group differences.

Keywords: Intentional Relationship Model, Norwegian Self-Assessment of Modes Questionnaire, therapeutic relationship

Introduction

Psychotherapy research confirms the importance of well-functioning and meaningful therapeutic relationships (1-6). Some argue that the therapeutic relationship can account for up to 20 % of the therapeutic outcome variance (3). A positive therapist-client relationship may be of great importance also for occupational therapy outcomes, as suggested by many researchers in the field (7-10), and the means by which to establish such positive relationships is therefore worthy of further investigation. According to occupational therapy research, one could claim that the quality of the relationship affects treatment outcomes and can facilitate the therapeutic process in a way that encourages the patient's collaboration and satisfaction (11). Despite an acknowledgment of the importance of the therapeutic relationship in occupational therapy, there is a need for more knowledge about how to establish, develop and benefit from a good relationship with clients.

The Intentional Relationship Model (IRM) (12) is a model of the therapeutic relationship and the therapeutic use of self in occupational therapy practice. IRM describes the relationship between therapist and client in the context of the occupational therapy process. The therapeutic relationship is seen as a way to promote occupational engagement and positive therapy outcomes. Given its exclusive focus on the relational aspects of therapy, IRM complements existing occupational therapy models. It includes four central elements: the client, the therapist, the interpersonal events during the therapy process, and the occupation. Particular emphasis is placed on the therapist's mode of interaction with the client. The model proposes that therapists have a tendency to use some modes of interaction more than others, and that those most frequently used are the ones most compatible with the therapist's personality. However, 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. Through careful monitoring of their

self during interactions, the therapist may improve the quality of therapeutic encounters.

Similarly, students can improve the quality of their practice by becoming aware of the different modes and the possibilities for mode change during therapeutic encounters. One can argue that focusing on therapeutic style and developing capacity to use different modes according to the client's needs, helps the students develop more confidence in the therapist role.

The model includes six different therapeutic modes, and suggests that the modes most frequently used constitute the therapist's therapeutic style (12). The therapeutic modes are described as multiple ways of relating to a client. The advocating mode describes the therapist functioning as a catalyst for the provision of 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 well-being. The therapist functions as a facilitator so the client can overcome occupational barriers. In the collaborative mode, the therapist includes the client in all aspects of the therapeutic process, strongly supporting the value of client-centered practice. The therapist promotes client empowerment, autonomy, independence and personal choice and encourage the client to take ownership of the therapy process. The empathizing mode is about making every effort to understand fully the client's experiences, and the therapist is supportive and attentive to the client's feelings. In this mode it is important to pay particular attention to a client's emotional experiences and adjust the therapeutic response accordingly. The empathizing mode includes careful listening and observing, and taking the time to accept and validate painful emotions. The encouraging mode requires the therapist to behave in an applauding manner to the client's performance. In this mode, the therapist encourages and supports the client's initiative. Strategies like making compliments, applauding and cheering on in a creative and sensitive manner are often used to strengthen the client's desire to participate in occupations.

In the instructing mode, the therapist assumes a teacher-like role and educates the client so that he or she can address the issues considered important to occupational participation. A structured and directive communicative approach, with frequent demonstrations and instructions, is key to this mode. The last mode, problem-solving, describes addressing the client's occupational problems constructively using logical reasoning and analysis. The therapist uses strategic questioning, structured guidelines or other logical approaches to enable the client to consider alternative perspectives and solutions.

So far, little research has been conducted using the IRM model as the theoretical framework, and only two previous studies have been concerned with mode use specifically. Taylor and coworkers' survey (13) 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. Bonsaksen's small scale survey (14) of 31 occupational therapy students in Norway found that the most preferred mode was problem-solving and the least preferred mode was advocating.

According to IRM theory (12), preferences for therapeutic modes would be strongly related to personality and to the therapist's familiar ways of behaving in relationships to others. As a supplement to this, one might assume that preferred modes of interaction are also contingent upon factors like age, maturity, and relational experience. If this view is relevant, one might be able to detect systematic differences in mode preferences between groups differing in these respects. As per definition, students as a group can be considered as having little experience, whereas occupational therapists as a group can be considered as having more experience. None of the cited studies (13, 14), however, compared students and therapists, and the lack of group comparisons in the existing literature provides a rationale for the present study.

Aim of the study

The present study aims to explore differences between occupational therapists and occupational therapy students with regard to their preferences for therapeutic mode use.

Method**Design, sample and data collection**

The study had a cross-sectional design and the data were collected in the autumn of 2015. The data collection took place at the universities in Trondheim and Oslo. Two convenience subsamples were recruited: one consisting of occupational therapists practicing in the Oslo and Trondheim areas, and one consisting of second-year occupational therapy students enrolled in the occupational therapy education programs. The therapist sample was mainly recruited among participants at professional meetings in nearby hospitals and municipalities, whereas others were approached individually. Some of the participants had experience as fieldwork supervisors for occupational therapy students, but no data was collected about how many this applied to. The student sample was recruited among students participating in IRM seminars, which is part of the curriculum at the universities. The student group in Trondheim had completed one period of six weeks practice fieldwork prior to the study, whereas the student group in Oslo had no fieldwork practice beforehand. The therapists and students were introduced to the IRM prior to the data collection. However, as far as we know, participants had little or no prior knowledge about the different therapeutic modes described in the model. The data were collected by self-report questionnaires, consisting of the Norwegian Self-Assessment of Modes Questionnaire (N-SAMQ) and basic sociodemographic information (age and sex).

Measurement

The *Self-Assessment of Modes Questionnaire* (SAMQ) was designed to help therapists identify the mode(s) of relating to clients that are comfortable for them, and to identify the types of modes that are not (12, 15). There are no published records of psychometric properties related to the assessment. The Norwegian version of the assessment that was used in this study, the N-SAMQ, was developed and its content validated by a formal procedure of forward and back translation using several translators, review by the developer (Taylor), and a pilot study with therapists in the target group (16). The N-SAMQ is comprised of 19 short clinical vignettes (16, 17). A set of six different therapist responses are listed to each of these vignettes, all of which representing plausible therapeutic actions. The respondent is instructed to indicate the one (and only one) of the six 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) and multiplying by 100.

Data analysis

The completed questionnaires were registered electronically. Prior to analysis, 10 % of the dataset was checked against the completed questionnaires for correctness; i.e., we assessed the correspondence between a proportion of the completed N-SAMQ forms and the data as transferred onto the electronic data file. One dataset error was detected and corrected, and we found this minimal level of error satisfactory to proceed with the analysis. Two hundred and seventeen persons gave their consent to participate in the study and completed the questionnaires, including 113 occupational therapists and 104 occupational therapy students. For this study, four therapists (3.5%) and eight students (7.7 %) were excluded from the sample due to missing or inadequate responses on one or more variables. The IBM SPSS

software was used in the statistical analyses (18). Descriptive analyses using means (M) and standard deviations (SD) were performed to assess the participants' relative preference for each of the therapeutic modes. Differences between therapists and students were analyzed with independent t -test on continuous variables, and with the Chi-Square statistic on categorical variables. The level of statistical significance was set at $p < 0.05$, and effect sizes are reported as Cohen's d (19).

Ethics

The study was conducted according to ethical guidelines for research (20). The researchers informed the participants 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 individuals' participation, and conversely, no disadvantages were related to non-participation. The students completed the questionnaires directly following the IRM seminar, whereas the therapists completed them at a time and a place of their own convenience. The study received approval from the Norwegian Data Protection Official for Research (project number 43954).

Results

Sample characteristics

Ninety-six students and 109 therapists were included in the analysis. Compared to the students, the occupational therapists were older (students mean age = 23 years, therapists mean age = 41 years, $p < 0.001$). There was a larger proportion of females ($p = 0.02$) in the sample: 98 (89.9%) female therapists and 11 (10.1%) male therapists were included. The student group consisted of 75 (78.1%) women and 21 (21.9%) men.

Therapeutic mode preferences

With regard to their therapeutic modes preferences, the therapists showed more preference for the collaborative ($p = 0.03$) and the empathizing modes ($p < 0.01$) than the students. The students, on the other hand, showed more preference for the advocating ($p < 0.001$) and the instructing modes ($p < 0.01$), compared to the therapists. Both groups, however, had strongest preference for the problem-solving mode. The results are provided in Table 1.

[TABLE 1 ABOUT HERE]

Discussion

This study aimed to explore differences between occupational therapists and occupational therapy students with regard to their preferences for the therapeutic modes. Not surprisingly, the therapists were older, but the therapist group also included a larger proportion of females compared to the student group. As there has been an increasing number of males enrolled in occupational therapy education over the last years, this likely accounts for the higher proportion of males in the student group.

With regard to therapeutic mode preferences, the therapists showed more preference for the collaborative and the empathizing modes than the students did. The students, on the other hand, showed more preference for the advocating and the instructing modes compared to the therapists. This means that therapists in this study, compared to the students, were more inclined to include the client in all aspects of the therapy process, in line with the values inherent in client-centered practice. The therapists were also more inclined to be supportive and attentive to the clients' feelings, carefully listening and taking time to validate and accept painful emotions. Awareness of these results may be used as a way of ensuring quality improvement – for therapists in practice as well as for students in education. Therapists who

are skilled in providing, for example, empathizing and collaborating responses may find developing their capacity to communicate within other modes to be one way to grow as a professional therapist (12). Similarly, given the variety of client needs, students need to learn communicating within a variety of therapeutic modes, and need also to be challenged to practice communicating in modes other than their favorite mode (14).

Compared to the therapists, the students had a stronger preference for the advocating and instructing modes, which means they have more focus on an instructive, directive and teacher-like role that educates the clients, and on targeting occupational barriers in the environment and on securing beneficial rights the clients might have. The different patterns of mode preferences in the two groups represent a promising possibility: students and therapists may learn from each other, for example during fieldwork education, as shown also in previous research (21, 22) In this case, therapists can exemplify and demonstrate to students how they can be more empathizing and collaborating during therapeutic encounters. Conversely, students may suggest ways that therapists can incorporate more of the advocating and the instructing modes in their clinical practice.

The detected group differences may be related to different levels of experience, and thus possibly related to different clinical reasoning processes among the participants. According to prominent examples from the clinical reasoning literature (23-26), our choices as therapists – the way we solve clinical problems and make decisions – are influenced by experience. Within this frame of reference, both therapists and students develop and improve their clinical practice as they increase their experience – a journey from novice to expert. According to Unsworth (25), differences in the performances of more and less experienced clinicians are to a large extent owing to their different clinical reasoning skills. Contrasting the two extremes, experts and novices, she outlines five main differences. Experts possess a better knowledge base than novices do, which enables them to compare a current problem to

their recollection of past cases. Experts also use relevant information, and are able to disregard irrelevant information, when making decisions, and they seem to recall critical cues better than novices do. In addition, experts seem to produce a variety of working hypotheses concerning the client's situation. Novices, on the other hand, tend to confirm their initial hypothesis by collecting information that supports it. Experts work faster and seem to have better general problem-solving skills and clinical reasoning skills than novices have.

Although it is unlikely that all participants in the therapist group had reached the expert level, they all had – per definition – more experience than the participating students did. Less experience among the students may have increased the students' preference for the instructing mode, compared to the therapists. Lack of experience may be implicitly expressed in the desire for a specific and instructive way to deal with the many decisions to be made during therapy with a client (24). In comparison, therapists may be more likely to show confidence in empathizing with the client, and also to collaborate with the client – openly, honestly, and on equal footing. Relating in the empathizing mode can be complex and emotionally demanding, as suggested from previous studies (13, 27). It seems logical that therapists, having more clinical experience and more advanced skills than students, may feel better prepared for this type of interaction. Relating in the collaborating mode, the therapist would include the client in all aspects of the therapeutic process, strongly supporting the value of client-centered practice (12). In line with Unsworth (25), one could argue that experience is the key to be able to deal with therapy in this manner. For example, it would involve the ability to generate a variety of assumptions and perspectives, to assess them in open collaboration with the client, and to adjust the therapeutic approach in accordance with the client's expressed perspective. Client-centered practice requires a therapist who encourages, facilitates and coaches the client, rather than one who controls the process in an instructing and directive manner. The goal is that the client should engage in occupations that shape their

lives and hold personal significance. Such a process may take time, and may include setbacks for the client – but it represents empowerment and enabling occupation in a democratic way. Sometimes the therapist needs to sit back and allow this to happen in order to enhance the client's self-efficacy and autonomy. As such, the collaborating mode, as described in the IRM, captures the very essence of client-centered practice.

In recent years, in light of concepts like enabling occupation (28) and occupational justice (29) one could say that the increased focus on collaboration and democratic client-centered approaches in occupational therapy represents a trend – a trend that may explain the therapists' stronger preference for the collaborating mode, compared to the students. The students may not yet fully appreciate this trend, and may therefore place stronger emphasis on for example the instructing mode, which may be more closely associated with a medical model (expert in relation to help-seeker) approach to therapy (14, 30).

The students' substantially stronger preference for the advocating mode (compared to the therapists) is more difficult to relate to the groups' different levels of experience. Moreover, the finding is in direct contrast to the previous student survey (14), in which the advocating mode was found to be the least preferred mode among the participants. The advocating mode describes the therapist as a catalyst for the provision of resources and beneficial rights on behalf of the client (12). This may be understood as the use of ambient factors – various aspects of the environment – to provide assistance to the client. There has been an increasing focus on health promotion and facilitating environments in current occupational therapy in Norway. Thus, the stronger preference for the advocating mode in the student group may be viewed as reflecting a historical trend in Norwegian occupational therapy education and practice.

The level of experience is an important factor that may influence the preference and use of different therapeutic modes, but it is not the only one. Treatment trends in healthcare,

as well as the more general cultural context at any given time, may play a part. For example, health services with high demands on cost-effectiveness will often require a short treatment period with highly specific treatment plans. Such circumstances may not give much room for the client to control the therapy process himself. Moreover, the therapist working under such conditions may feel pressured towards using problem-solving and instructing modes, rather than empathizing and collaborating modes. Given such circumstances, the therapists' use of modes may to an extent be subordinated the needs of the organization that he or she works for.

Strengths and limitations

The study had an adequate sample size, consisting of ninety-six students and 109 occupational therapists. However, as the recruited sample was one of convenience, the results of the study may be difficult to apply to occupational therapists and occupational therapy students in general. Participants were recruited from two different universities, which may support the generalizability of the results. One may argue that there could be systematic organizational differences between the two universities and between the different workplaces in the Trondheim and Oslo area, and that such differences may have influenced the study's results. The study is limited because of the not yet psychometrically validated tool for data collection that was employed. Thus, the results should be considered tentative and mainly as a starting point for reflection about how one can understand the development of mode preferences in light of the development from student to therapist; from novice to expert.

Conclusion

According to clinical reasoning theory, our choices as therapists are strongly influenced by our level of experience. The collaborative and empathizing modes are complex and emotionally demanding ones, and it seems logical that the therapists feel better prepared for these types of interaction, compared to the students. The students, on the other hand, are less

experienced and may therefore rather seek an instructive way of interacting with clients during therapy. The students' stronger preference for the advocating mode may be a result of the increased focus on health promoting and facilitating environments in current occupational therapy education in Norway.

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Table 1

Therapeutic mode preferences in the study sample consisting of occupational therapists (n = 109) and students (n = 96)

	Students (n = 96)	Therapists (n = 109)	<i>p</i>	Cohen's <i>d</i>
<i>Modes</i>	<i>M (SD)</i>	<i>M (SD)</i>		
Advocating	15.9 (9.4)	9.8 (7.7)	< 0.001	0.71
Collaborating	14.3 (8.6)	17.4 (10.8)	0.03	0.31
Empathizing	10.7 (10.6)	15.5 (14.6)	< 0.01	0.38
Encouraging	21.8 (11.1)	20.6 (12.9)	0.48	0.10
Instructing	14.5 (8.0)	11.1 (8.4)	< 0.01	0.42
Problem-solving	22.8 (11.1)	25.6 (14.2)	0.12	0.22

Note: Statistical test is independent *t*-test for continuous variables. Cohen's effect size *d* >

0.40 is interpreted as moderate and clinically meaningful (19).