

LUND UNIVERSITY

The Tree Theme Method - An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care

Gunnarsson, Birgitta

2008

Link to publication

Citation for published version (APA):
Gunnarsson, B. (2008). *The Tree Theme Method - An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care*. [Doctoral Thesis (compilation), Sustainable occupations and health in a life course perspective]. Birgitta Gunnarsson.

Total number of authors:
1

General rights
Unless other specific re-use rights are stated the following general rights apply:
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.
• Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying the publication in the public portal

Read more about Creative commons licenses: https://creativecommons.org/licenses/

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

LUND UNIVERSITY

PO Box 117
221 00 Lund
+46 46-222 00 00

The Tree Theme Method

An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care

Birgitta Gunnarsson

The Tree Theme Method (TTM), based on creative activities and occupational life storytelling, implies that the client paints trees representing certain periods in their life. The paintings are used as a starting point for the client to tell their life story with focus on everyday occupations (occupational storytelling) and shaping plans for their future (occupational story making). The overall aim was to describe and evaluate the TTM as a method for intervention in outpatient psychiatric occupational therapy. Study I was a case study, including five sessions and a follow-up. The study demonstrated the usefulness of the method for understanding a client's problems and in developing strategies for them to cope with everyday life, and life themes were identified. Study II was a pre-test – post-test study. Nine therapists recruited 35 clients for the TTM. The findings indicated positive significant changes regarding occupational performance and health-related variables. High ratings of the therapeutic relationship were found to be related to the changes observed, and the clients' satisfaction with the TTM was high. Study III investigated clients' experiences of participation in a TTM intervention. Twenty clients were interviewed. In general the clients felt that the TTM helped them to perceive their lives as coherent, and that they became more able to cope with daily life. Furthermore, the intervention and its meaning were closely related to the development of the client-therapist relationship. Study IV examined occupational therapists' experiences of using the TTM. In general, the TTM was experienced as a structured method for starting a process and initiating a therapist-client relationship. The therapists thought that they needed self-knowledge and a therapeutic attitude that motivated the client to take part in the intervention. A good therapeutic relationship was important for initiating a process, leading to new perspectives in everyday life.

LUND UNIVERSITY
Faculty of Medicine

Faculty of Medicine Doctoral
Dissertation Series 2008:120
ISSN 1652-8220
ISBN 978-91-86059-73-6

Birgitta Gunnarsson

The Tree Theme Method

The Tree Theme Method

An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care

Birgitta Gunnarsson



Department of Health Sciences
Division of Occupational Therapy
and Gerontology

THE TREE THEME METHOD

THE TREE THEME METHOD

– An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care

Birgitta Gunnarsson

Akademisk avhandling

som med tillstånd av Medicinska fakulteten vid Lunds universitet för avläggande av doktorsexamen i medicinsk vetenskap kommer att offentligen försvaras i Sal H01, Vårdvetenskapens hus, Baravägen 3, Lund, onsdagen den 10 december 2008, kl. 13.00

Fakultetsopponent:
Professor Synneve Dahlin Ivanoff
Institutionen för neurovetenskap och fysiologi
Sahlgrenska akademin vid Göteborgs universitet, Göteborg



LUND UNIVERSITY
Faculty of Medicine

Lund 2008
Department of Health Sciences, Division of Occupational Therapy and Gerontology
Lund University, Sweden

© 2008 Birgitta Gunnarsson and authors of included articles
Layout & typography: Maria Näslund/Formfaktorn
Printed by Grahns Tryckeri AB, Lund

ISBN 978-91-86059-73-6
ISSN 1652-8220

Organization
LUND UNIVERSITY
Division of Occupational Therapy
and Gerontology,
Department of Health Sciences

Document name
DOCTORAL DISSERTATION

Date of issue
October 29, 2008

Sponsoring organization

Author(s)
Birgitta Gunnarsson

Title and subtitle
THE TREE THEME METHOD
– An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care

Abstract
The Tree Theme Method (TTM), based on occupational therapy, creative activities and life storytelling, implies that the client draws and paints trees representing certain periods in their life. The paintings are used as a starting point for the client to tell their life story with focus on everyday occupations (occupational storytelling) and shaping plans for their future (occupational story making). The intervention comprises of five sessions. The overall aim was to describe and evaluate the TTM as a method for intervention in outpatient psychiatric occupational therapy. Study I was a case study, including five sessions and a follow-up. The study demonstrated the usefulness of the TTM method for understanding a client's problems and in developing strategies for them to cope with everyday life, and important life themes were identified. Study II was a pre-test – post-test study. Nine occupational therapists recruited 35 clients from general outpatient mental health care units, for the TTM. The findings indicated positive significant changes regarding occupational performance and health-related variables. The high ratings of the therapeutic relationship were found to be related to the changes observed, and the clients' satisfaction with the TTM was high. Study III investigated clients' experiences of participation in a TTM intervention. Twenty clients were interviewed. In general the clients felt that the TTM helped them to perceive their lives as coherent, and that they became more able to cope with daily life. Furthermore, the intervention and its meaning were closely related to the development of the client-therapist relationship. Study IV examined occupational therapists' experiences of using the TTM. In general, the TTM was experienced as a structured method for starting a process and initiating a therapist-client relationship. In order for clients to benefit from the TTM, the occupational therapists found it important to balance the therapeutic frames with flexibility. The occupational therapists thought that they needed personal self-knowledge and a therapeutic attitude in order to motivate the client to take part in the intervention. A good therapeutic relationship was important for initiating a dynamic process, leading to new perspectives in everyday life for the client. Future research should address what happens in a long-term perspective and investigate whether frames and techniques need to be adjusted in order to be feasible in clinical contexts.

Key words: Creative activities, evaluation, life storytelling, mental health, occupational therapy, therapeutic relationship.

Classification system and/or index terms (if any):

Supplementary bibliographical information:

Language
English

ISSN and key title: 1652-8220

ISBN 978-91-86059-73-6

Recipient's notes

Number of pages 120

Price

Security classification

Distribution by (name and address)
Christel Leufstadius, Division of Occupational Therapy and Gerontology, Department of Health Sciences, Lund University, Sweden.

I, the undersigned, being the copyright owner of the abstract of the above-mentioned dissertation, hereby grant to all reference sources permission to publish and disseminate the abstract of the above-mentioned dissertation.

Signature  Date October 29, 2008

DOKUMENTDATABLAD enl SIS 61 41 21

Förord

Att kombinera patientarbete inom psykiatrisk vård och att söka kunskap genom studier och utvecklingsarbete har varit viktigt i hela mitt yrkesliv som arbetsterapeut. Därför var det med glädje, som jag tackade ja till halvtidstjänsten som doktorand på FoU-centrum 2003. Doktorandstudierna bygger på mitt arbete som arbetsterapeut, vilket i sin tur har utvecklat mitt sätt att arbeta. Vilken möjlighet, och svårighet, det har varit att genomföra avhandlingsarbetet på en metod som jag tidigare börjat utveckla inom praktiken! Ni är många som jag vill rikta ett varmt TACK till, familj, vänner och arbetskamrater. Ni har visat stort intresse för hur arbetet fortskridit – och har på olika sätt visat att ni bryr er!

TACK alla patienter från Landstinget Kronoberg och Region Skåne, som haft intresset att delta i de olika studierna! Jag vill också tacka arbetsterapeuterna Cecilia Wilsborn, Katarina Eklund, Monica Åkerblom Löwenhielm, Eva Nilsson, Annika Gustafsson, Estrid Lidén, Lilian Agemark, Lotte Svensson och Sara Alexi för att ni deltog i TTM-kursen, genomförde TTM med patienterna och deltog i fokusgrupper. Tack för all uppmuntran jag fått under de här åren!

TACK Mona Eklund, min huvudhandledare. Du har visat tålamod när jag haft svårt att skilja på mina roller som doktorand respektive klinisk arbetsterapeut. Du har en imponerande kunskap, som du generöst har delat med dig av! Du har visat stort engagemang som handledare, uppmuntrat mig och varit ett stöd, steg för steg under avhandlingsarbetets gång. Jag är oerhört tacksam och glad för att du antog utmaningen att bli min handledare!

TACK Jan-Åke Jansson, min biträdande handledare. Du har varit som en ”far och mor” för mig, du har påmint mig om behovet av balans i tillvaron och hjälpt mig att sätta gränser. Jag är också tacksam för allt arbete du lagt ner på bland annat fokusgruppintervjuer och kvalitativa analyser.

TACK Per Nyberg, som har hjälpt mig med statistiska beräkningar! När jag träffar dig ”blir jag fri i tanken”, som när vi en blåsig dag på Vattentorget i Växjö skissade upp hur målade träd skulle kunna användas för livsberättelser.

TACK Kerstin Petersson, för att du så frikostigt delat med dig av dina kunskaper och din livserfarenhet! Du är en god förebild för mig!

TACK Landstinget Kronoberg för sponsring av doktorandtjänsten! För mig är landstinget en kunskapsorganisation, vilket bland annat har visats genom möjligheten att kombinera mitt kliniska arbete med studier, för att kunna sprida den kunskapen. Ett särskilt varmt tack till mina två närmaste chefer, Eva Petterson Lindberg och Jonas Clausson. Ni är båda goda ledare! Ni har på olika sätt uppmuntrat mig att använda mina kunskaper – och trott på min förmåga. Tack också till Gunilla Granat, bibliotekarie inom Vuxenpsykiatriska kliniken – du har varit outtröttlig när det gäller att söka litteratur!

TACK alla kära arbetskamrater inom Vuxenpsykiatriska kliniken, och särskilt alla er på Allmänpsykiatriska mottagningen! Tack för ert intresse för avhandlingsarbetet och för att ni ställt upp när jag har behövt er hjälp.

TACK alla underbara arbetskamrater på FoU-centrum! Ni är alla så generösa med att dela med er av kunskaper och erfarenheter. Hos er finns både allvar och skratt! Tack också till alla er på FoU-Välfärd, och ett särskilt tack till Birgitta Grahn, som uppmuntrade mig att söka doktorandtjänsten!

TACK alla ni som varit mina ”meddoktorander”, för god och varm vänskap och givande diskussioner på forskarkurser, via mail, telefon och möten. En del av er är redan klara, medan andra är på god väg! Ett särskilt stort tack till Christel Leufstadius, Kjerstin Stigmar, Eva Månsson Lexell och Pamela Massoudi!

TACK alla på avdelningen för Arbetsterapi och Gerontologi och i HAV-gruppen! Jag har alltid känt mig välkommen när jag kommit till Lund och träffat er, och upplevt en god gemenskap. Ni har gett mig nya perspektiv! Ett särskilt tack till Gunnel Johansson, som har hjälpt mig med praktiska frågor och Ida Dahlström, som är en underbar vän och en god arbetsterapeut, i ordets bästa bemärkelse.

TACK Förbundet Sveriges Arbetsterapeuter (FSA), Medicinska fakulteten vid Lunds universitet samt Mona Eklund, som förutom Landstinget Kronoberg, på olika sätt bidragit finansiellt till avhandlingsarbetet! Utan er hade det inte varit möjligt!

TACK Helen Shephard och Geoff Dykes för språkgranskning av artiklar och kappa! Jag är också glad över att Maria Näslund gjorde alla avhandlingens texter till en bok och att Hans Runesson fotograferade omslagsbilden av mitt Livsträd, det vill säga lönnen på Nymans.

TACK Sara, min vän och kollega sedan början av 1980-talet. Vi har följts åt genom livet – du är ett viktigt stöd för mig. Jag uppskattar din kunskap, ditt lugn, din värme och humor!

TACK Irene! Du är en underbar och älskad mor och har alltid uppmuntrat mig att läsa vidare! Du har också hjälpt mig i avhandlingsarbetet genom att följa med på resor till Kristianstad och Simrishamn, kontrollerat inmatade data och pysslat om mig!

TACK Linnea och Karl! Det är med värme och kärlek i hjärtat jag tänker på er, det är ni som hjälpt mig att få balans mellan studier och det som är riktigt viktigt i livet. Ni är underbara att vara med! Jag uppskattar våra samtal – om oss själva, studier/arbete, relationer – ja, om Livet självt!

TACK Ingemar, min Älskade! Wiehes sång ”Du är med mig vart jag går, genom månader och år… Du är med mig vart jag far, du är med mig alla dar…” berättar om hur du har följt mig hela vägen under avhandlingsarbetet. Du har lärt mig Endnote, lånat litteratur, uppmuntrat mig i motgång, gett mig rosor i medgång – och hållit mig i handen – varje dag!

Glädje skulle vara att få fortsätta utvecklas som arbetsterapeut och forskare, till nytta för personer med psykisk ohälsa/psykisk sjukdom! Lycka, det är alla nära relationer – och att få uppleva naturens alla skiftningar!

Contents

List of papers 13

Introduction 15

Psychosocial occupational therapy 16
Client centeredness 17

Creativity and creative activities 17
Creativity 17
Creative activities within psychosocial occupational therapy 18
The tree as a symbol 20
The tree theme in clinical settings 21

Occupational life-story telling 23
Life-story telling 23
Occupational storytelling and story making 23

The therapeutic relationship 24

The main features of the Tree Theme Method (TTM) 25
Frames 25
Techniques 26

Approaches to intervention research 29
Evaluation 29
Process research 29
Outcome and process research regarding creative activities 30

Aims 31

Methods 33

Design 33

Participants and context 33
Selection of the participant and the context in Study I 33
Selection of participants and context in Study II 34
Selection of participants and context in Study III 34
Selection of participants and context in Study IV 35

Procedures and data collection 35
The case study (Study I) 35
The intervention study (Study II) 36
The client interviews (Study III) 38
The focus group interviews with occupational therapists (Study IV) 38

Data analysis 39
The case study analysis 39
Qualitative content analysis 39
Statistics 39

Ethical considerations 40

Findings 40

Illustration of the TTM as an intervention 40

Changes in everyday life after a TTM intervention 41

Client experiences of a TTM intervention 42

Occupational therapists' experiences of using the TTM 43

Discussion 44

Discussion of the findings 44
Processes of playing, reflecting and changing perspectives 45
The therapeutic relationship 46
The roles of frames and techniques 47
Requirements on clients and therapists 48

Methodological discussion 48
The qualitative studies (Studies I, III and IV) 49
The quantitative study (Study II) 51

Conclusions and implications 52

Implications for clinical practise and further development of the TTM 53

Implications for research 54

Svensk sammanfattning (Swedish summary) 55

References 58

Papers

Paper I 69

Paper II 83

Paper III 95

Paper IV 107

List of Publications

This thesis is based on the following studies which will be referred to in the text by their Roman numerals:

I. Gunnarsson, A. B., Jansson, J.-A., & Eklund, M. (2006). The Tree Theme Method in psychosocial occupational therapy – a case study. *Scandinavian Journal of Occupational Therapy, 13*, 229–240.

II. Gunnarsson, A. B., & Eklund, M. (2008). The Tree Theme Method as an intervention in Psychosocial Occupational Therapy: client acceptability and outcomes. *Australian Occupational Therapy Journal,* doi:10.1111/j.1440–1630.2008.00738.x.

III. Gunnarsson, A. B., Petersson, K., Leufstadius, C., Jansson, J.-A., & Eklund, M. (2008). *Client perceptions of the Tree Theme Method as an intervention in psychosocial occupational therapy: a journey offering new perspectives.* Manuscript submitted for publication.

IV. Gunnarsson, A. B., Jansson, J.-A., Petersson, K., & Eklund, M. (2008). *Occupational therapists' perception of the Tree Theme Method as an intervention in psychosocial occupational therapy.* Manuscript submitted for publication.

Reprints are made with permission from the publishers; Taylor & Francis regarding Paper I and Blackwell Publishing regarding Paper II.

The Tree Theme Method

– An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care

Birgitta Gunnarsson

Introduction

This thesis is aimed at describing and evaluating the Tree Theme Method (TTM) as a method for intervention in outpatient psychiatric occupational therapy. Besides describing the TTM and how the intervention may be implemented, the focus is on clients' experiences of participation in a TTM intervention and their occupational therapists' perceptions of using the TTM.

The TTM, developed by the author of this thesis as a method for client-centred psychosocial occupational therapy is founded on knowledge gained from occupational therapy (Townsend & Polatajko, 2007; Wilcock, 1998), creative activities (Eklund, 2000; Lloyd & Papas, 1999) and occupational life-story telling (Clark, 1993; Clark, Larsson & Richardson, 1996). Creative activities are often used in psychosocial occupational therapy as tools for intervention (Craik, Chacksfield & Richards, 1998; Griffiths & Corr, 2007), and are documented in textbooks (Atkinson & Wells, 2000; Creek, 2008; Finlay, 2004; Steward, 1996), but up to date little empirical research has been done within the field.

Besides the theoretical frame of reference of the TTM, the method is based on time frames and certain techniques. In addition to the method per se, the TTM intervention also places emphasis on the client-therapist relationship. At present, the TTM is implemented in occupational therapy within psychiatric care in various clinics throughout Sweden. So far it has not been evaluated or studied scientifically. There is a need for developing intervention methods that are holistic and client-centred (Townsend & Polatajko, 2007), and the TTM, with its focus on occupational storytelling and story making, should fulfil these requirements.

Psychosocial occupational therapy

In Sweden, occupational therapists who work with people with a mental illness are typically employed in outpatient mental health care units, inpatient rehabilitation units, psychosis units or day units in community health care settings. In order to meet their clients' needs, they make different kinds of assessments and provide treatments often described in various available text books (Creek & Lougher, 2008; Finlay, 2004), but more seldom examined in studies. Clients in mental health care may suffer from functional problems that affect all areas of their occupational performance (Finlay, 2004) and therapists need to collaborate with their clients and reflect on how the clients' illness may impact on their needs and everyday lives (Hawkes, Johnstone & Yarwood, 2008). Occupational therapy interventions aim at increasing the ability of an individual to cope with their everyday occupations, that is, groups of tasks from everyday life are performed in a context that the individual finds meaningful (Townsend & Polatajko, 2007). Consequently, occupational therapy may focus on clients' self-care, household work, daily work and their leisure activities (Finlay, 2004) and the development of social roles and relations to others (Fieldhouse, 2008).

In Sweden, research with a focus on occupational therapy and mental illness is rather scant, however, some researchers have focused on the area of occupational therapy for, or the everyday occupations of, people with a mental illness. In order to increase knowledge regarding meaningful occupations, some of them have focused on time and occupational engagement among clients with schizophrenia (Bejerholm & Eklund, 2006, 2007) or how clients with persistent mental illness spent their time and how they found meaning in their daily occupations (Leufstadius, Erlandsson, Björkman & Eklund, 2008; Leufstadius, Erlandsson & Eklund, 2006). Ivarsson, Carlsson and Sidenvall (2004), in turn, examined how clients with severe mental disorders perceived their capacity to perform daily occupations.

Several attempts have been made to develop assessments for use in mental health care. Eklund (2004) developed the Satisfaction with Daily Occupations (SDO) as a tool for client evaluation in psychiatric care. Furthermore, Bejerholm, Hansson and Eklund (2006) developed an instrument assessing occupational engagement, and Ivarsson and Carlsson (2002) developed a questionnaire focusing on clients' experiences of occupational performance. In her study, Haglund (2000) found the Occupational Case Analysis and Rating Scale (OCAIRS) to be useful as a screening instrument in general psychiatric care, but she also suggested further research in order to determine how to plan the intervention process, after the assessment. Also Ivarsson *et al.* (2004) suggested that, besides assessment, there is need for structured tools when planning an individual intervention.

Very few studies have focused on interventions, however, Eklund (1996a) investigated treatment processes and the outcome of treatment based on occupational therapy groups in a psychiatric day care unit for clients with long-term mental illness. A related study (Eklund, 1997) showed that the clients perceived the treatment environment, as being a homelike atmosphere, and the interaction in the client group as well as in the relation to the therapist and the therapist's attitude as being important. The clients also found the occupational dimensions, for example the possibility of being occupied and developing new skills, as helpful (Eklund, 1997). Furthermore, Gahnström-Strandqvist, Josephsson and Tham (2004) investigated client-therapist interaction, as perceived by occupational therapists working in psychiatric rehabilitation (such as social working cooperatives and activity centres). They found that various actions were performed by the therapists when

supporting their clients, such as visualizing possible pathways in order for the client to handle a problematic situation and showing the client the turning points they made during the intervention period.

Thus, up to now, the main research focus in Sweden has been on how clients with severe mental illness perceive everyday occupations and on developing instruments to help them. Similar trends are also found internationally (Aubin, Hachey & Mercier, 1999; Goldberg, Britnell & Goldberg, 2002; Krupa & Clark, 2004; Krupa, McLean, Eastabrook, Bonham & Baksh, 2003; Nagle, Valiant Cook & Polatajko, 2002). A review, investigating the evidence of the effectiveness of occupational therapy for, among others, clients with mental illnesses, showed that the knowledge about the efficacy of occupational therapy is still insufficient (Steultjens, Dekker, Bouter, Leemrijse & van den Ende, 2005). In conclusion, there are still knowledge gaps regarding specific methods for occupational therapy interventions and how they may be used with clients in psychiatric care.

Client centeredness

In client-centred practice, as developed by Rogers (1951), the focus is on the client's perspective, and their needs should be the guiding force in the therapy. The client is co-responsible for the intervention process and is the one who decides the goals of the therapy in which the therapist has a non-directive role. However, the therapist's attitude is essential for a client's progress and development. Successful therapy requires a coherent set of therapist attitudes in line with their personality. Such attitudes should express respect, empathy and genuineness, and should be integrated with the therapeutic techniques and methods.

In client-centred occupational therapy the focus of the therapist is on collaboration with the client rather than to be non-directive. The therapist needs to be aware of the client's knowledge, their resources and capacity to make choices in everyday life. It is of significance that the client becomes an active partner in the intervention process: it is in collaboration with their therapist that the client will choose their goals and engage in the intervention process (Townsend & Polatajko, 2007). Therefore, the client's perceptions of an intervention expressed in terms of their level of satisfaction with the treatment should be taken into account. Good intervention outcomes tend to be associated with a high degree of client satisfaction (Eklund & Hansson, 2001).

Creativity and creative activities

Creativity

The word "create" comes from the Latin *creare*, and means to make, bring something into existence, give rise to or produce (Thompson, 1995). To create is to be active and to be able to imagine alternative views of reality (Smith & Carlsson, 1990). The ability to create, creativity, is a biologically based capacity, an ability to bring something into existence (Wilcock, 2006). All humans have more or less capacity to be creative, and an innate capacity and a biological desire to express it (Creek, 2008; Wilcock, 2006). A person's creative ability develops throughout their life span. This ability is not static, and for clients with a mental disease their illness may interfere with their creative ability (Creek, 2008). Hoff and Carlsson (2002), modifying a definition of creativity made by Smith and Carlsson (1990), stated that creativity is "a productive or generative novel way of experiencing reality – including the perceiver's own self" (p. 22). Hoff (2003) divided creativity research into four subject areas; the creative product (which would be useable and original), the creative person, a person who is

flexible, enthusiastic, self-confident and willing to take risks, the creative process, a combination of a rational thinking and an intuitive thinking, a rich inner life and the creative environment, which is defined as openness, liveliness, freedom and playfulness.

Creativity, in terms of concrete creative products (Hoff, 2003), has been practised by humans throughout history (Englund, 2004). To shape and produce various things with one's own hands and create just for the sake of it may give an inner feeling of flow (Csikszentmihalyi, 1990; Persson, 2001). Creative activities, such as painting, sculpturing, dancing and making music (Englund, 2004; Griffiths & Corr, 2007), have also been used in order to achieve magical or healing powers (Englund, 2004). Different rituals have been used to impact on fertility or harvests, and during ancient times engagement in fine arts was used as a form of medical care (Englund, 2004).

A creative person should be intuitive, flexible and a willing to take risks (Hoff, 2003). Wilcock (2006) meant that a creative person makes use of abstract thinking and problem solving and Creek (2008) argued that everyone has the ability to be creative, in such ways as imagining and generating new ideas. According to Hoff (2003), in order for an individual to engage into a creative process both abstract and rational thinking capabilities are required.

Further, the creative process is shaped by the interaction between the individual and their environment (Hoff, 2003). The creative process may be seen as involving four different phases; firstly, in the preparation phase the individual gains knowledge of a problem, followed by the second phase, the incubation phase, where the subconscious works on the problem. In the third phase, the illumination phase, the individual may get an aha-experience and in the fourth and final phase, the verification phase, the individual will test their newly created idea of how to solve a problem (Sahlin, 2001). By using imagination, thinking, and fantasy, one may cope with reality of everyday life (Wilcock, 2006). Fantasy is from a Greek word, which means "make visible". Vygotskij (1930/1995) argued that the difference between fantasy and reality is not distinct, since fantasy brings its material from reality. When making fantasies visible, one tests them and adapts them to reality, but in a creative and not indulgent way. Becoming aware of one's fantasy is a way of achieving knowledge (Björkvold, 1991). Winnicott (1971) meant that the ability to play or use one's creativity is essential for health. He wrote about an intermediate area, the transitional sphere, in which fantasy and reality meet and are expressed through play and creativity.

A creative environment, which is defined in terms of openness and playfulness (Hoff, 2003) make space for an individual to take part in culture and cultural events, which is of importance for social communication (Englund, 2004). People have a need to be creative throughout life which is often expressed in cultural engagement and hobbies, but also in the development of new ideas or products in the work contexts (Eriksson, 1985; Winnicott, 1971). To be creative is closely connected to being alive and to exist. By making use of their creativity a person's identity may be strengthened, and they may become just the person they have the potential to be (Winnicott, 1986).

Creative activities within psychosocial occupational therapy

Creative activities, for example painting or sculpting, are often used in psychosocial occupational therapy (Griffiths & Corr, 2007). Surveys of occupational therapists have shown that more than 80 % of them used creative activities in their work at least once a week (Craik *et al.*, 1998; Griffiths & Corr, 2007). Activities are defined as tasks or actions per-

formed by an individual (Townsend & Polatajko, 2007). Creative activities are here used in the sense of *tasks or actions used in order to generate novel ways of experiencing reality, including the subject's own self, often, but not necessarily, resulting in a product, such as a painting or a poem,* and may be supported by a meaningful context. Creative activities may be seen as the core within occupational therapy (Holder, 2003) and have an impact on human health (Englund, 2004; Reilly, 1962). Methods involving creative activities are found in several textbooks (Atkinson & Wells, 2000; Creek, 2008; Finlay, 2004; Steward, 1996).

A creative activity may be used as an explicit method, that is to say, the purpose of the activity is closely connected with the occupational objective. However, a creative activity is often used as an implicit tool in which the relationship between the doing and the objective is not always obvious, for example when the activity is used to strengthen a specific function, such as endurance or communication (Eklund, 2002). Creative activities used as implicit methods often imply a process aimed at engaging a client in self-exploration, self-discovery and self-help. The purpose is to encourage clients to express their experiences, feelings and thoughts, in order to enhance self-understanding and develop better relations towards others (Atkinson & Wells, 2000; Creek, 2008; Eklund, 2000; Hughes, 1989; Lloyd & Papas, 1999; Thompson & Blair, 1998).

Both assessments and treatments may be based on creative activities (Eklund, 2000; Finlay, 2004; Griffiths, 2008) and the use of creative activities may reveal information about clients that is not achievable by other methods (Edgar, 1999). For assessment purposes, a creative activity may be used in a projective way (Buck & Provancher, 1972; Cramer-Azima, 1982; Fidler & Fidler, 1964; Gillette, 1963; Lerner & Ross, 1977), in order to stimulate a client to get in touch with difficult feelings, by for instance revealing their inner emotions visible on a piece of paper (Finlay, 2004). Creative activities may also be used in a more overt way, as tools to assess clients' occupational performance and cognitive and interpersonal skills (Griffiths, 2008; Griffiths & Corr, 2007). For example, a client's interpersonal skills may be assessed from observing their ability to take part in a group session based on creative activities (Griffiths & Corr, 2007).

As treatment, creative activities may be used for various purposes, such as enhancing intrapersonal skills (e.g. coping with difficult feelings) and facilitating personal growth (e.g. as play promoting pleasure and leisure interests) (Creek, 2008; Griffiths & Corr, 2007) and promoting health by supporting emotional resilience (Creek, 2008). Creative activities may also be used in order to enhance relational skills (e.g. interacting with other people) and to enhance functional performance (e.g. learning new skills and improving concentration and decision making) (Griffiths & Corr, 2007). By using a creative activity as a starting point for progression from non-verbal activity to verbal expression, the client may gain new insights into their everyday life, and thereby develop new strategies for occupational performance (Creek, 2008; Eklund, 2000; Finlay, 2004; Lloyd & Papas, 1999; Thompson & Blair, 1998). Creative activities as treatment media may promote confidence and stimulate the ability to relate to others and to be involved in normal activity (Griffiths, 2008). Interventions based on creative activities can be used to reflect a client's everyday life experiences which in turn can be used as a basis for encouraging changes in their life situation and restoring their competence as an active and independent person (Atkinson & Wells, 2000; Bruce & Borg, 1993; Polkinghorne, 1996).

In creative activities the concepts of *doing, being* and *becoming* are of interest. A synthesis between these concepts makes a person an in-

dividual with an identity of their own (Wilcock, 1998). This is in line with Winnicott (1971), who meant that the individual can find him/herself by doing things and being creative. The reasoning of Wilcock and Winnicott forms a basis for the following scenario: When a client participates in a purposeful creative activity, like painting a picture *(doing)* and reflecting on it afterwards (*being*), the verbal conversation that follows between the client and the occupational therapist can promote a development of the client's self-image (*becoming*) and of how they relate to their environment. Hammell (2004) emphasized the importance of creating meaning in everyday occupations and suggested besides the concepts of doing, being and becoming, an additional concept, *belonging,* which includes the sense of interaction in a social context (Hammell, 2004). In essence, the process with the creative activities (*doing* and *being*) is helpful for supporting a person in *becoming* someone who is able to compose their own life within a certain social context (*belonging*).

The tree as a symbol

The tree is an ancient symbol humans used in different cultures to symbolize themselves and their life situations (Gunnarsson, 1988; Hark, 1986/1995; Morris, 1995; Rankin, 1994). Trees have a long length of life, and tie time and different generations of man together (Gunnarsson, 1988; Hark, 1986/1995; Morris, 1995). Life from birth to death can be symbolized by the development of a tree from a seed to a fully grown tree that eventually withers and dies. A tree can symbolize developments, like physical growth or the mental process of maturity (Gunnarsson, 1992; Jung, 1964; Morris, 1995). The tree mirrors variations in life through its seasonal cycle, for example the bursting open of buds in the spring may express a feeling of hope, vitality or youth, but the shed of leaves may express a feeling of low-spiritedness, resting or old age (Gunnarsson, 1988; Gunnarsson, 1992; Hark, 1986/1995; Morris, 1995). Thus, there might be a relationship between a client's tree image and their life events (Buck, 1948; Rankin, 1994). It is not only the conditions of life which may be symbolized in a tree; its branches can in a concrete, physical shape be seen as human arms, its trunk can be recognised as the human body and the roots as the feet (Gunnarsson, 1988; Hark, 1986/1995). Genealogists use the tree and its branches as a symbol of different generations of the members of a family and it is also common in Sweden to use the name of trees and its parts as family names or parts of them, for example Lind (lime), Lönn (maple), Stam (trunk) or Kvist (twig) (Gunnarsson, 1988).

The tree is a universal symbol used in different religions, myths and legends (Gunnarsson, 1988; Gunnarsson, 1992; Hark, 1986/1995; Morris, 1995; Tillhagen, 1995). Legends all over the world connect motherliness with the Earth, but also with a tree. Some of these myths tell that the human being is created from a tree and in other cases that man was brought up by a tree (Hark, 1986/1995). Not only human beings but also the gods are supposed to be created from various trees. In Greek mythology Attis was believed to spring from the pine tree and Apollo from the oak tree (Danielsson, 2002; Hark, 1986/1995; Morris, 1995) and in Egyptian mythology Osiris was believed to have been created from the cedar tree (Hark, 1986/1995; Morris, 1995). In Nordic mythology, the Cosmic World Tree Yggdrasil (an ash) is seen as the centre of the world (Danielsson, 2002; Gunnarsson, 1988; Hark, 1986/1995; Tillhagen, 1995), but the Cosmic World Tree is also seen in several other cultures, for example in China and India, as well as in Greek and Egyptian mythology (Gunnarsson, 1992; Hark, 1986/1995; Tillhagen, 1995). With its crown and roots the Cosmic World Tree ties heaven and earth together (Gunnarsson, 1988; Gunnarsson, 1992; Hark, 1986/1995; Tillha-

gen, 1995). According to Nordic mythology, the first human beings, Ask and Embla, were created out of Yggdrasil (Gunnarsson, 1988; Hark, 1986/1995; Morris, 1995; Tillhagen, 1995). Gradually, Yggdrasil was destroyed, but the myth tells that the earth was created from its fragments (Gunnarsson, 1988; Tillhagen, 1995). The Nordic maypole is a symbol of the world tree (Gunnarsson, 1988), and this symbol also exists in several other countries and cultures (Tillhagen, 1995).

The Christian Bible mentions both real trees and mythological trees as symbols. The Old Testament tells of the Garden of Eden, with the Tree of Knowledge at the centre, symbolizing the knowledge of good and evil (Gunnarsson, 1988; Gunnarsson, 1992; Hark, 1986/1995; Morris, 1995; Tillhagen, 1995). The Tree of Knowledge bore forbidden fruit, which Eve was enticed to taste by the Serpent. The casting out of Adam and Eve from paradise was a fact and the contact between human beings and God was broken (Gunnarsson, 1988; Gunnarsson, 1992; Tillhagen, 1995). The Tree of Knowledge can be seen as a metaphor for questions of vital importance on which the human being needs to reflect (Gunnarsson, 1992). The crucifix in the New Testament is also a Tree of Life; the death of Jesus on the cross was to bring life to mankind (Gunnarsson, 1992; Hark, 1986/1995). Hinduism, Islam and Jewry talk about an upside down tree, the inverted tree. The roots start to grow just below the throne of God, and from there the tree grows downwards towards the creation, and through the tree God exists in the whole of creation (Hark, 1986/1995).

In several cultures humans believe that a tree has a soul of its own and that the destinies of trees and a mankind go together. In Swedish folklore it was common to plant a 'Tree of Life' upon the birth of a child. The Tree of Life grew and aged with the child, and therefore it was important to take care of the tree. In a Swedish farmyard a Tree of Life, referred to as a 'Care Tree', was often planted, that is to say a tree especially planted to take care of and protect the inhabitants. From this special tree came a vitality that was transferred to the farm and its occupants. The myth says that the Tree of Care has its roots in the Cosmic World Tree. A Tree of Care is often a broadleaf deciduous tree, such as a lime or a maple, but it is distinguished from other trees through its placement in the centre of the yard close to the house. People thought there was a gnome in the Tree of Care, and possibly the idea of the Tree of Care derives from an ancient term meaning Tree of Gnomes. It was of vital importance to care for the trunk and its branches so that the tree and the gnome living in the tree would then watch over the farm and its occupants (Ewald, 1983; Gunnarsson, 1988; Tillhagen, 1995).

The 'Tree of Death' is another tree found in mythology (Gunnarsson, 1988; Hark, 1986/1995; Tillhagen, 1995). Sooner or later even the most verdant tree loses its strength and dies (Gunnarsson, 1988). In the Nordic myths, Odin, who had to suffer nine days and nights among the branches of Yggdrasil, became the god for those who were hanged. All sacrifices to Odin were performed by hanging (Gunnarsson, 1988; Hark, 1986/1995). The Tree of Death could cure a person; a branch from a tree, from which a man had been hanged, was considered to have a healing effect (Ewald, 1983; Gunnarsson, 1988). Large trees, with a strange appearance, were thought to have magical powers, and one resembling a certain part of the body was believed to have the power to cure that part of the body (Danielsson, 2002; Ewald, 1983; Gunnarsson, 1988; Tillhagen, 1995).

The tree theme in clinical settings

Thus, the tree is a common theme which humans have used as a symbol of themselves. Most people believe they can draw a tree.

According to Kellogg (1970), one of the first motifs a child draws is a tree. The tree has been applied as a theme in assessments as well as treatment methods in different clinical contexts, especially within mental health and child care (Buck, 1948; Cohen, Mills & Kwapien Kijak, 1994; Corboz & Gnos, 1980; Hark, 1986/1995; Jung, 1964; Koch, 1952).

At the end of the 1920s Koch (1952) formed a test, named the 'Tree Test', in which the tree was seen as a symbol for the ego. Koch devised the test with the purpose of guiding young people towards suitable professional jobs. The Tree Test asks the person to draw two trees in which the different parts of the tree should give an indication of their personality and maturity. The first tree is supposed to symbolize a superficial picture of the person and the other tree is seen as the deeper structures of the personality. Corboz and Gnos (1980) further developed Koch's Tree Test and asked children to draw 'three trees'. One of the trees was to symbolize the child, and the other two represent persons of importance for the child. Mostly the children draw themselves and their parents, but they may also draw two other people, for example a teacher or a friend. The drawings of the trees are meant to give an idea of how the child relates to other people.

Buck (1948) developed the 'House-Tree-Person-test', as a projective test. The test subject is asked to paint a picture of a house, a tree and a person on a sheet paper. The tree is seen as a symbol of the person. The house symbolizes their home and the person their relations to other people. There is a manual for the analysis available to psychologists. The analysis of the pictures and contents give an idea about the test subject's personality and maturity as well as their interactions with their environment.

In the 'Diagnostic Drawing Series' (DDS) the tree is one of the themes. Cohen *et al.* (1994) developed the DDS as a clinical tool in order to assess people in mental health care. On three occasions, the client draws pictures which are seen as expressions of the individual who has created them. First, the client is asked to freely draw something of their own choice, using one sheet of paper and various kinds of crayons and water colours. The second theme is to draw a picture of a tree, representing the client's personality. In the final session, the client is asked to draw a picture of how they are feeling, which is supposed to give an indication of the client's ability to express him/herself at an emotional level.

For intervention purposes, Högberg (1996) made use of the tree theme in two steps. Firstly, the client is asked to fold a sheet of paper, and then to paint a tree on the left hand side of the paper. The next step is, that by taking part in a symbol drama (a psychodynamic oriented therapeutic method, in which the client imagines their internal pictures), the client imagines another tree, which they then paint on the paper's right hand. The tree pictures are seen as symbols of the client, expressing their personality and identity. The identity of the client is additionally reflected when they write a story about their two trees, in which the trees communicate with each other. From his work with clients' dreams, Hark (1986/1995) formulated the idea that the tree has three different symbolic dimensions. The crown is about the conscious personality or the possibility to express oneself, while the trunk is about the feeling of one's body or vitality and the roots are associated with how grounded the person is in life's existence. Hark also meant that not only dreams about trees, but also real or depicted trees, for example a picture of a tree hanging on a waiting room wall, may arouse emotions in clients.

As shown above, the tree as a theme has been used in different clinical contexts, and by the use of the tree theme the client may both concretely and symbolically tell something about him/herself. By changing be-

tween talking about the tree as a symbol of him/herself and the tree as a tree, respectively, the client has the possibility to confront the emotions brought about by the symbolism of the tree or to deny them and relate to the tree simply as a tree.

Occupational life-story telling

Life-story telling

One way in which people can reflect on how they compose their lives is by creating narratives. This approach can give important knowledge about just how people form their lives (Atkinson, 1998; Bateson, 1990; Bruner, 1990). According to dictionaries, narrative means a spoken or written story of connected events, or a process of telling a story (Thompson, 1995). Narratives in terms of storytelling, that is to *tell* stories, are an activity in which the story-teller interprets and connects different periods from the past, the present and the future (Atkinson, 1998; Hydén, 1997b; Mattingly, 1998). Narratives in terms of life stories, that is, the *stories*, are expected to have a beginning, middle, and an end, which are meaningfully interweaved. Telling a life story not only produces a story, it is also a way of describing and explaining to oneself and others why one acts in a specific way in a specific situation. By creating a life story, people define themselves and who they want to be, as well as their relating experiences from their environment. It is a way of making life experiences meaningful (Atkinson, 1998; Hydén, 1997a, 1997b; Riessman, 1993). A life story can be presented in the form of facts, metaphors, or an expressive creativity (Atkinson, 1998; Polkinghorne, 1996). The point is not whether the storyteller brings out the truth about different events, but rather that they through the narrative, interprets their experiences of reality (Riessman, 1993).

Each client consulting mental health care has something to tell about emotional pain that limits them achieving a desirable life (Hydén, 1997b; Hydén, 1997c). Mattingly recognized two varieties of therapeutic modes when talking with clients: chart talk and storytelling. Chart talk means that the therapist focuses on the pathology such as symptoms, impairments, assessment goals and treatment strategies. Storytelling focuses on the client's experiences of their disability and its impact on everyday life (Mattingly, 1991). By using a narrative approach, the therapist may show the client a possibility to reinterpret earlier experiences and reconstruct their life story. The client gets an opportunity to interweave the split ends of time and connect and reconstruct various events and time periods so that coherence is established (Hydén, 1997b; Hydén, 1997c). When therapists meet clients for assessment or treatment they take part in their clients' life stories through the narratives mediated by the client. By telling their life story, the client's personal identity may be strengthened, but only if they feel confirmed in their dialogue with the therapist (Crafoord, 1994).

Occupational storytelling and story making

Polkinghorne (1996) pointed out that during rehabilitation, an individual may go through identity changes into engaging in therapeutic interventions and by adopting new occupational strategies, the client may modify their view of themselves (Polkinghorne, 1996). There are several narrative methods that are useful when focusing on a client's everyday occupations, for example case histories (narratives with focus on clinical problems such found in a client's daily life), life-charts (linear diagrammes indicating key events throughout a client's course of life), life histories (narratives of a client's life from birth to the present time) and life stories (narratives in which the client is telling a story about some parts of their life) (Frank, 1996).

In the occupational therapy context, a narrative approach may result in occupational life stories, which is when a person talks about their life with a focus on everyday occupations. Life stories have been used as a method for qualitative research from an occupational perspective in order to understand the meaning to client's of their occupations in everyday life (Alsaker & Josephsson, 2003; Heuchemer & Josephsson, 2006) as well as how occupations in everyday life change over time (Eklund, Rottpeter & Vikström, 2003; Jonsson, Josephsson & Kielhofner, 2000, 2001). A narrative approach has also been useful when evaluating what an intervention in psychosocial occupational therapy or the therapeutic interaction means (Eklund *et al.*, 2003; Gahnström-Strandqvist *et al.*, 2004; Price-Lackey & Cashman, 1996). Life stories are useful for occupational therapists because, in a life course perspective, they reveal knowledge about performed occupations, the meaning attached to everyday life experiences (Persson, 2001; Wicks & Whiteford, 2003) and interactions with others (Wicks & Whiteford, 2003).

Life stories may also be used in intervention methods. A life story interview can serve as a tool for gaining knowledge of a client's general capacity to handle their daily life (Kielhofner *et al.*, 2008; Mallinson, Kielhofner & Mattingly, 1996; Spencer, Krefting & Mattingly, 1993). Storytelling may also be used as a treatment tool, encouraging a client to tell their life story, in the past and at present, in order to create images of the client's possible future life (Mattingly, 1991; Mattingly, 1998; Mattingly & Fleming, 1994) and to act towards creating those possibilities (Mattingly, 1991). Clark (1993) developed a method for treatment by using occupational life stories, including occupational storytelling and occupational story making, in which the client and therapist collaborate. In her work with Penny Richardson, Clark demonstrated how the client Penny, who had survived a stroke, connected her former occupational life with her evolving new life, recovered and became an actor in her own life. Story making is related to Mattingly's (1991) prospective treatment story, in which the therapist encourages and guides the client to imagine and act towards a desirable future.

The therapeutic relationship

Research in psychotherapy has revealed that, regardless of the therapeutic orientation, the therapeutic relationship might be as important as the specific therapy techniques to clients' progress. Various so-called common factors, such as expectations, therapeutic attitudes and the client–therapist relationship, have been explored and shown to be important for the outcomes of interventions (Lambert & Barley, 2002). The therapeutic relationship comprises of the interaction between the client and the therapist, and according to Stenlund (2002) the therapeutic relationship includes the working alliance and collaboration between client and therapist. The therapeutic relationship is of crucial importance in various types of therapeutic contexts. Significant associations have been found between the therapeutic relationship and the outcome in psychotherapy (Hewett & Coffey, 2005; Howgego, Yellowlees, Owen, Meldrum & Dark, 2003; Luborsky *et al.*, 1999), in general psychiatric care (de Roten *et al.*, 2004; Johansson, 2006) and occupational therapy (Davis, 2007; Eklund, 1996b). Two explanations have been proposed regarding how the relationship works: one is that the therapeutic relationship in itself is effective, and the other that the therapeutic relationship facilitates the specific intervention (Eklund, 1996b; Johansson, 2006). Moreover, the therapeutic relationship, as experienced by clients, has shown to be related to client satisfaction (de Roten *et al.*, 2004).

As mentioned above, also the outcomes of occupational therapy have shown to be relat-

ed to clients and therapists perceptions of the quality of the relationship (Cole & McLean, 2003; Davis, 2007; Eklund, 1996b; Palmadottir, 2003). The importance of the therapeutic relationship, and its presumed influence on a client's progress, has also been noted in different textbooks (Kielhofner, 2008; Mattingly & Fleming, 1994; Taylor, 2008; Townsend & Polatajko, 2007). The occupational therapist needs to attend to their own attitude and to promote a relationship with their clients based on communication, empathy, understanding and collaboration (Cole & McLean, 2003; Palmadottir, 2006). Mattingly and Fleming (1994) meant that collaboration, to do something together with the client, is a way of helping to remove them from dependence on others to being an actor in their own life. The occupational therapist needs to interpret what the client wants and modify the interventions in relation to the client's needs and possibilities. Thus, the role of the therapeutic relationship needs to be considered in all contexts of occupational therapy practice and research.

The main features of the Tree Theme Method (TTM)

The TTM is based on certain frames and techniques, which will be described further. The purpose with the TTM is to stimulate life-story telling from an occupational perspective (including both painting pictures of trees and verbally telling one's life story) and intends to be a means of enabling positive changes in daily life.

Frames

Theoretical frames

As previously mentioned, the TTM is developed in a client-centred psychosocial occupational therapy context. The TTM is a method where the creative activity, of painting pictures of trees, that represent oneself at certain periods during one's life, is combined with narrative methods. The TTM is based on knowledge accrued from occupational therapy (Townsend & Polatajko, 2007; Wilcock, 2006), creative activities (Creek, 2008; Eklund, 2000; Lloyd & Papas, 1999), the symbolism of a tree (Buck, 1948; Gunnarsson, 1988; Hark, 1986/1995; Koch, 1952) and narrative methods, including occupational storytelling (i.e. telling one's life story) and occupational story making (i.e. shaping plans for one's future), in order to initiate a process of change in one's everyday life (Clark, 1993; Clark *et al.*, 1996). The painting and storytelling correspond to the concepts *doing* and *being* (Hammell, 2004; Wilcock, 1998). The TTM provides prerequisites for a process of change *(becoming),* while considering individual resources and limitations in physical, mental, socio-cultural, and spiritual aspects of life (Townsend & Polatajko, 2007). Finally, the TTM involves the concept of *belonging*, as the verbal and non-verbal storytelling/story making gives a picture of the client in their own social context (Hammell, 2004).

Tree themes

The method implies that the client is requested to paint pictures of trees with certain specific variations. During the first out of five sessions the client is asked to paint a tree symbolising their present life situation. In the second session they paint a picture of a tree representing their childhood. In the third session they paint a tree depicting their teenage, in the fourth a tree depicting adulthood and in the last session a tree representing their future.

Time frames

The method is also based on time frames in terms of the number of sessions and the length of each session. The five TTM sessions are individual and held approximately once a week, and the course of a TTM intervention runs for between six and nine weeks.

Each session lasts about 1½ hours, apart from the fifth and final session which takes about two hours. The distribution between non-verbal and verbal occupational storytelling may vary with respect to the client's needs and wishes, but there has to be enough time for both parts. A suggestion is to allocate 20 minutes of each session for painting pictures and the rest for verbal storytelling and story making.

Techniques

The TTM is based on certain techniques: progressive relaxation exercises, occupational storytelling and occupational story making (including both picture painting and verbally telling one's life story), a reflective dialogue, and finally, tasks to be carried out outside the sessions. In addition to the method per se, the TTM intervention also places emphasis on the client-therapist relationship.

Progressive relaxation

The four first TTM sessions start with a modified progressive relaxation exercise (Jacobson, 1934, 1938), which means alternating between contracting and relaxing various muscle groups, one at a time, starting with the lower extremities and progressing through the whole body. At the end of the progressive relaxation exercise, the theme is presented, and the client is asked by the therapist "to paint a picture of a tree representing your present life (alternatively childhood, adolescence, adulthood). When you draw the tree consider how a tree with roots, trunk, and crown can symbolize your personality, everyday occupations, interests, and relations to others in your life as it is at present (in childhood/adolescence/adulthood). The focus should be on your resources as well as on your limitations". The fifth session is organised somewhat differently (see below) and includes no relaxation exercise.

Non-verbal occupational storytelling

The next part of the TTM is the painting of pictures of trees, which is the non-verbal part of the occupational storytelling. The materials used are sheets of paper, watercolours and oil crayons. The client is requested to paint a picture of a tree representing their life at present life (childhood/adolescence/adulthood) while working in silence, which helps to enhance the possibility for them to be in touch with their thoughts, feelings and needs. The occupational therapist remains in the room, silent, but should be aware of how the process of painting a picture is progressing. When the painting is finished it is hung on the wall and then the client and the occupational therapist sit down on chairs next to one another, in front of the painting and begin a dialogue around the tree painting.

In the fifth and final session, the focus is on occupational story making and shaping the future. The client and the occupational therapist start with a reflective dialogue based on the tree paintings and the verbal storytelling from the previous sessions. Then the client is encouraged to paint a picture of a tree symbolising the future and express their own expectations for the future, finishing off with the verbal part of occupational story making.

Verbal occupational storytelling

The non-verbal expression of painting a picture of a tree initiates a process of reflection and of interaction between the client and the occupational therapist. The paintings are used as tools for the verbal occupational storytelling and story making, where the whole course of the client's life is included. Starting from the picture, the client is encouraged to tell their life story. The occupational storytelling may contain the client's personality, activities, interests and relations to other people, and the focus is on the expression of abilities

as well as limitations, and how these shape and influence the client's everyday life.

In all of the sessions, as part of the technique and to further encourage verbal occupational storytelling and to help the client see things from more than one perspective, the tree painting is literally rotated and viewed from four different angles.

Tasks

During the course of the TTM intervention, in order to enhance changes in the client's everyday life, the occupational therapist and the client decide on tasks to be carried out for dealing with the client's everyday life between the sessions. Along with the conversation about the tree painting, that is to say, during the verbal occupational storytelling the direction for the task is determined. The aim here is to start a process that will lead the client to becoming more able to cope with their life situation. A task can target concrete everyday occupations, such as having the courage to call a friend or to go by bus to the city. Another kind of task may be to try a new attitude between the sessions, such as having a more confident attitude when approaching someone. The client is encouraged to find suitable strategies, and at the beginning of the following session the task will be followed up. Then the reflection concerns as to what works and what does not, and what strategy the client should choose the next time.

Tools for the occupational therapist

As preparation for using the TTM intervention, the occupational therapist needs education about the frames and techniques of the TTM. The training comprises theoretical knowledge about client-centred occupational therapy, creative activity and occupational life storytelling and story making, as well as practical experience from painting the different tree themes and from acting as a therapist (Gunnarsson, 2001).

The interaction between the client and the occupational therapist is of importance in client-centred occupational therapy practice, and the therapist needs to be aware that they are the most important tool for forming a good therapeutic relationship. The occupational therapist should also be aware of the client's resources and capacity to make choices in everyday life (Townsend & Polatajko, 2007). In the TTM, the focus is on the client's abilities and limitations, as well as on how these influence the client's daily life. The therapist is supposed to encourage the client's driving forces for engaging in the intervention and making choices regarding future goals. While the client is painting the tree pictures, and during the verbal storytelling, the occupational therapist's main target is to try to understand the client's life perspective. Finally, in interaction and collaboration with the client, and starting from the client's needs and desires, the occupational therapist may encourage the client to revise the way they act or reason in everyday life.

As a structure for the professional conversation, Clark's Grounded Theory on the Techniques of Occupational Storytelling and Occupational Story Making is useful (Clark *et al.*, 1996) (Table 1). These techniques cover three main areas, which develop through interplay. At the beginning, the focus is on finding a *Communal Horizon of Understanding,* based on

1) collaboration,
2) building empathy,
3) inclusion of the ordinary,
4) listening actively and
5) reflecting.

Gradually, the other areas come into focus. The second area is *Stimulating Occupational Storytelling*, which means 1) encouraging the client to tell stories about their occupations in their past and present life situations and 2) supporting the client in putting the story

Table 1.
Structure for professional conversation, Clark's Grounded Theory on the Techniques of Occupational Storytelling and Occupational Story Making (modified after Clark, *et al.*, 1996, p. 376).

Finding a Communal Horizon of Understanding	1) Collaborate	2) Build a relation including empathy	3) Include the ordinary	4) Listen actively	5) Be reflective
Occupational Storytelling	1) Encourage to tell stories	2) Make an analysis and synthesis (in relation to time and values)			
Occupational Story Making	1) Coach, encourage, offer occupational strategies and confirm progress	2) Evoke insight	3) Broaden view of activities in everyday life	4) Reconstruct self-image	5) Recover to cultural coherence

into a context by making a reflecting analysis and synthesis of daily occupations in relation to time as well as values. The third area is *Occupational Story Making*, where the occupational therapist uses special techniques to support the client in forming possibilities for the future. Such techniques are

1) occupational coaching (i.e. giving encouragement, offering occupational strategies and confirming progress),
2) evoking insight into limitations and possible solutions,
3) broadening views of activities in everyday life,
4) reconstructing one's self-image and
5) recovering one's position in a cultural coherence (Clark *et al.*, 1996).

In order to facilitate the verbal conversation after the picture painting session, guidelines (Alexi & Gunnarsson, 1995) for the interview, inspired by Hark (1986/1995) and Koch (1952), are used as support for the occupational therapist. The guidelines focus on different aspects of the roots of a tree (are there any roots, what do they look like and how do they grow?), the trunk (is it straight or bent, thin or thick, knotty or crooked?), the crown (in what direction do the branches grow, has the crown thin or thick branches, buds, leaves or fruit?) and the tree as a whole (for example colours, movement, rigidity, proportions and vitality). The focus is further on the environment of the tree (intimacy and distance, are there other trees close by, how is the local environment shaped?). The guidelines for the verbal occupational storytelling serve as a means for putting questions to the client intended to stimulate story telling and are not used for interpreting the picture.

During the last session, in the process of occupational story making, a review of the tree paintings is made. This concentrates on similarities and differences between the paintings, the positive and negative life cir-

cumstances that are reflected in the paintings and the story telling, and any identified, acknowledged or neglected personal or environmental abilities and limitations. An important aspect in this review is to focus on possible changes for the future.

Approaches to intervention research

Implementation means "a specified set of activities designed to put into practice an activity or programme of known dimensions" (Fixsen, Naoom, Blase, Friedman & Wallace, 2005, p.5). Before implementing a new method for intervention, that can be useful in clinical practice, different steps have to be performed: from having an idea, to planning and preparation, the method can then be implemented for the purpose of everyday use (Guldbrandsson, 2008). However, before the implementation process can start, research is necessary and there is need to explore and evaluate the method in different ways.

Evaluation

Evaluation research may be undertaken in order to generate knowledge of an intervention or to improve it. Evaluation does not only mean to focus on treatment effects, but also to a high degree on estimating the quality of the work performed (Vedung, 1998), for example the quality of care. According to Vedung (1998), evaluation is retrospective and aims at assessing the past for guidance for the future, and has to be carried out carefully and systematically. Vedung recommends the use of a combination of several perspectives when evaluating a programme or intervention, since a single perspective only gives partial answers to the research questions. Possible perspectives may focus on the clients' wishes and expectations or the professionals' experiences concerning the value and quality of an intervention. These perspectives are usually found through interviews or observations. There are three questions which have to be answered when carrying out an evaluation;

1) *the question about the intervention* (how to describe the intervention; is the intervention a tool in order to achieve something specific or has the intervention a value of its own?),
2) *the question concerning assessment* (what measures should be used to assess the results, and what should be regarded as success or failure?). And, finally
3) *the question concerning utilisation* (how will the evaluation be used?) (Vedung, 1998).

Governmental reports have emphasised the need for research and evaluation in order to describe and improve methods intended for the care and support of people with mental illness (SBU, 1992; SOU, 2006). These reports also state that evidence based methods, useful in mental health care, are imperative (SOU, 2006). Therefore research on evaluation and implementation of interventions is urgent. According to SBU (1992), there ought to be a stronger emphasis on the following areas: care for people with drug addiction, rehabilitation for people with a persistent mental illness, mental illness among people outside the specialised mental health care service, the value of sub specialised mental health care (including various outcomes such as client satisfaction, decrease of psychiatric symptoms and well-being), maintenance of psychiatric medication, and psychotherapy (including various therapeutic methods). Besides these areas, one report argued that the focus on research and evaluation also has to be on, for example, housing and support in everyday life, psychiatric disability and cognitive devices, work and daily activities and the mental health of young people (SOU, 2006). In line with these recommendations and identified knowledge gaps, descriptions and evalu-

ations of methods used in psychosocial occupational therapy are imperative for generating knowledge that could be used to develop the best possible occupational therapy interventions for clients.

Process research

According to the dictionary a process deals with a course of actions, procedures or changes, which are intended to bring about a result (Thompson, 1995; Wordreference.com, 2008). Process evaluation is a type of qualified evaluation, where both the realisation of the planned intervention and clients' and professionals' participation are evaluated. The purpose is to correct and improve the intervention. When an intervention is evaluated without a control group it is not possible to evaluate the effects. However, an alternative is to study the intervention in its natural environment, proceeding from reality just as it exists and not from experimental conditions. In such a case, the participants may constitute their own controls, which gives a pre-test – post-test design (Vedung, 1998), and changes between the pre-test and post-test measurements may be investigated for their relationship to different aspects of interest, such as the therapeutic relationship.

Other process aspects that may be measured are the therapists' modes and the clients' behaviour, the therapists' and their clients' perceptions, interpersonal concerns and the way in which things are done. Process aspects may also concern what happens in the treatment sessions, for example the therapist's interpretations or the client's new insights. Outcome, in turn, refers to any changes resulting from the treatment, for example decreased symptoms. The distinction between process and outcome is not always obvious, and a process aspect, such as gaining insight, may also be the goal of the treatment. Thus, when evaluating interventions, both process aspects and outcomes in terms of changes or effects are of interest, and the ideal is when process and outcome research are linked (Hill & Lambert, 2004).

Outcome and process research regarding creative activities

A review by Elliott, Greenberg and Lietaer (2004) emphasized the importance of outcome research concerning experiential psychotherapies. Experiential psychotherapies are seen as part of the tradition of humanistic psychology, such as client-centred therapy, psychodrama and emotion-focused expressive therapies. The review showed positive outcomes, in terms of effectiveness of experiential therapy, in the areas of depression, anxiety disorders, and trauma and relationship problems. Also the importance of process aspects, such as emotions and empathy, have been demonstrated and shown in correlations between process and outcome factors.

Some studies have employed quantitative methods when studying creative activities, for example Körlin, Nybäck and Goldberg (2000) and Saunders and Saunders (2000), who used pre-test – post-test designs for examining structured creative arts programmes. Findings in a group of adults with various psychiatric diagnoses indicated significant improvements after treatment in several health-related factors, such as improved sense of coherence and a reduction in mental problems (Körlin *et al.*, 2000). In a study of children with different psychosocial problems, the authors found that a greater number of sessions had a significant positive impact on the rating of the therapeutic alliance (Saunders & Saunders, 2000). In an intervention study, women with breast cancer were randomized to participate in art therapy or to a control group, as a complement to radiotherapy. The results of those, who had participated in the individual art therapy, rated their coping resources higher than the control group (Öster *et al.*, 2006). In a related study, based on the same

participants, the results showed an improved quality of life in the intervention group compared with the control group (Svensk *et al.*, in press).

Creative activities have also been explored by qualitative methodology. Another study among the women with breast cancer showed that, the art therapy helped them legitimise their experiences, which in turn strengthened their ability to protect their own boundaries and interpret their needs (Öster, Magnusson, Engberg Thyme, Lindh & Åström, 2007). A case study performed by Steinhardt (1995) illustrated the impact of working with creative activities with a boy with borderline psychosis. After three years the boy managed to relate to his peers and was able to enter a normal school environment.

The studies found that involving creative activities within occupational therapy has been based on qualitative methodology, focusing on clients' perceptions of an intervention (Henare, Hocking & Smythe, 2003; Mee & Sumsion, 2001; Patrick & Winship, 1994; Reynolds, 2003; Reynolds & Prior, 2003). Results so far support the use of creative activities as a meaningful modality in occupational therapy for self-expression, for providing a sense of meaning, promoting a positive self-image, increasing control and learning how to cope with daily life.

Regarding occupational therapists' views about the value of creative activities, Schmid (2004) found that expressive art may be a therapeutic tool facilitating creative thinking. Not only occupational therapists' views on creative activities, but also their perceptions of the therapeutic relationship are of interest. An investigation carried out in different clinical settings indicated that the therapists found a good relationship to be of importance for the outcome of the occupational therapy (Cole & McLean, 2003). Various studies investigating occupational therapists' perceptions of factors influencing the interaction in treatment have shown that the interaction itself, that is to say, how things were done, seemed to be more important than the content, that is to say, what was done (Adamson, Sinclair-Legge, Cusik & Nordholm, 1994). Similar results have been found also in a physiotherapy context (Lundvik Gyllensten, Gard, Salford & Ekdahl, 1999).

Descriptions and evaluations of methods based on creative activities are important in order to inform occupational therapy practitioners and broaden the occupational therapy base. However, research in this area is very scant, despite the fact that this type of intervention is common in psychosocial occupational therapy (Craik *et al.*, 1998; Griffiths & Corr, 2007). Therefore, there is a need for further scientific study on creative therapies, focusing on outcomes in terms of process as well as on its effectiveness.

Aims

The overall aim of the thesis was to describe and evaluate the TTM as a method for intervention in outpatient psychiatric occupational therapy.

Specific aims were:

Study I: To describe how the TTM intervention may be implemented, illustrated by a clinical case, and to examine how a client perceived the intervention process, including a long-term view. A further aim was to sum up into life themes the client's life story resulting from the occupational storytelling and occupational story making.

Study II: To investigate any correlations between the therapeutic relationship, client satisfaction and changes in everyday occupations and health-related factors among clients going through the TTM intervention. The following research questions formed the point of departure for the study:

1) How did clients and occupational therapists perceive the therapeutic alliance?

Table 2.
Overview of design, participants and methodology of the thesis.

Study	Design	Participants	Data collection	Data analysis
Study I	Qualitative design; Case study methodology	1 female client	Paintings and audio taped narratives on 5 occasions and a 3-year follow-up comprising of 3 occasions	Case record, qualitative single case analysis according to Merriam (1988)
Study II	Prospective quantitative design; combined quasi-experimental pre-test – post-test and correlational study	35 clients (29 female and 6 male)	Questionnaires; COPM, SDO, SOC, Mastery, SCL-90-R, HAq-II and CSQ	Spearman's rank order correlation, Wilcoxon's signed rank test, Logistic regression analysis (backward method, likelihood ratio)
Study III	Qualitative design; individual interviews	20 clients (18 female and 2 male)	Individual interviews, each on one occasion comprising about 1 hour, audio taped and transcribed verbatim	Qualitative content analysis according to Burnard (1991)
Study IV	Qualitative design; Focus group methodology	9 female occupational therapists	Focus groups interviews, two groups who met twice between 2-4 hours, audio taped and transcribed verbatim	Qualitative content analysis according to Burnard (1991)

2) What changes were observed based on comparisons of measurements made before and after the intervention, concerning everyday occupations and health-related factors?
3) How were perceptions of the therapeutic alliance related to any changes observed?
4) How did the clients rate their satisfaction with going through the TTM and which variables, in terms of changes regarding everyday occupations, health-related factors and the initial therapeutic alliance, could be used to predict client satisfaction?

Study III: To examine clients' perceptions of participation in a TTM intervention, including the therapeutic relationship with the occupational therapist.

Study IV: To examine occupational therapists' perceptions of using the TTM intervention, including the therapeutic relationship with their clients.

Methods

An overview of the designs, participants and methodologies used in Studies I–IV is given in Table 2.

Design

This thesis constitutes a continuum of research based on four studies starting with an exploratory study in the shape of a longitudinal case study in order to exemplify the TTM (Study I), followed by a study on a group level, based on quantitative research methodologies (Study II), and moving back to qualitative research, where clients' experiences from the TTM (Study III) and occupational therapists' perceptions of using the TTM (Study IV) were examined.

The design of Study I was based on case study methodology (Merriam, 1988), which was applied in order to exemplify the TTM. Case studies are appropriate when making an analysis of a specific phenomenon in order to generate theoretical arguments. It is applicable when seeking a holistic perspective and an understanding of complex processes (Yin, 1989) and can contribute to the knowledge base of occupational therapy practice (Legault & Rebeiro, 2001). Case studies are also useful in exploring communication patterns between the client and the therapist (DePoy & Gitlin, 1998) and applicable for the purpose of researching alternative therapies (Lukoff, Edwards & Miller, 1998).

The design used in Study II was a prospective clinical study with a combined quasi-experimental pre-test–post-test and correlational design (Brink & Wood, 1998; Kazdin, 2003). A quasi-experimental design is useful for evaluating and investigating the "real world", that is, studying an intervention in its natural caring setting makes it clinically relevant (Maas, Buckwalter, Reed & Pringle Specht, 1998; Vedung, 1998). The idea with a correlational design is to study the pattern of relationships between selected variables. Such descriptive designs are useful in new fields of research, where there is still not enough knowledge to set up any hypotheses (Wood & Brink, 1998).

The design of Study III was qualitative, which is a suitable design for research in client-centred occupational therapy (Hammell, 2001) and when the researcher wants to increase their knowledge about client's own views and experiences, in order to understand and make sense of everyday life (Burnard, 1991; Burnard, 1995; Taylor & Bogdan, 1998). In this case individual interviews were used. Finally, a qualitative design with focus group methodology was used in Study IV. Focus groups are interviews in which the interaction and discussions between the participants are of importance. The researcher wants to gain increased knowledge through the discussions between the participants, and to get

a broader understanding of a selected subject (Kitzinger, 1994; Krueger & Casey, 2000), in this case a newly developed intervention. Focus groups generally have between six and twelve participants, but according to Dahlin Ivanoff (2002) small groups have shown to be dynamic and she recommends a maximum of six participants in each group.

Participants and context

Selection of the participant and the context in Study I

The single participant in Study I was chosen among clients from a psychiatric outpatient clinic in southern Sweden. Two criteria had to be fulfilled; the person should be newly admitted to the clinic and be able to reflect on the course of their life. The client who was asked and accepted to participate was a woman, aged 30 years, who was seeking help for anxiety and depression and was given the diagnosis of panic disorder, without agoraphobia but with secondary depression, according to DSM-IV (APA, 1994). The client was married and had a family. She lived in a village and had a blue-collar job. Normally, she was an active person, but now she had turned passive. The client was anxious, suffered from sleeplessness and was afraid of being alone. The psychiatric outpatient clinic had offered her sleeping pills, antidepressants and focused therapy using the TTM.

Selection of participants and context in Study II

The participants in Study II were clients at four general outpatient mental health care units in southern Sweden. The selected client's ages ranged between 18 and 65 years and further selection criteria were; a diagnosis of personality disorders, affective syndromes, anxiety/obsession syndromes or eating disorders according to ICD-10 (WHO, 1993) and the need for occupational therapy as assessed by the psychiatric team. Moreover, the client should not be well-known to the occupational therapist, which meant that the client should not have been in contact with the particular therapist giving them the TTM intervention on more than three previous occasions. Criteria for exclusion were language limitations or cognitive disorders, since the study was largely built on self-rating instruments. The clients were consecutively recruited from the participating units.

Power calculations indicated that 35 clients were needed to reveal an effect size of 0.5 on the chosen outcome variables with 80% power at $p < 0.05$ (Altman, 1991). Forty clients were invited to participate and 36 agreed, giving a participation rate of 90%. All 36 clients chose to complete the intervention study. However, one client, a man, was excluded from the study during the course of the intervention because a cognitive dysfunction was detected. Thus, the final sample consisted of the required 35 participants. The inclusion criteria for participation resulted in a heterogeneous group of participants, representing common diagnoses and age groups of clients in general outpatient mental health care. The clients' ages ranged from 18 to 60 years (mean age = 37, median age = 36). Twenty clients were diagnosed with anxiety/obsession syndromes, ten with affective syndromes, four with personality disorders, and one with an eating disorder. At the time of the TTM intervention, 14 of the clients were engaged in work or education and 10 in work rehabilitation or community-based activity centres. The remaining 11 clients had no organised regular daily occupation at all. The gender distribution was skewed, as 29 of the 35 clients were women.

Selection of participants and context in Study III

The clients in Study III were recruited from the same four outpatient units as above. They

were consecutively recruited after having participated in Study II. Inclusion criteria were an age of 18–65 years, diagnoses of personality disorders, affective syndromes, anxiety/obsession syndromes or eating disorders according to ICD-10 (WHO, 1993), being an outpatient, and having been assessed as having the need for occupational therapy. Twenty-seven strategically selected clients were asked to participate, and 22 gave their informed consent. The first two interviews, with a woman and a man, were considered as pilot interviews and the results were not used in the final analysis as they lacked in depth and quality. Thus, the final sample consisted of 20 clients. The informants' mean age was 37 years (range 18–60 years). Three clients were diagnosed with personality disorders, four with affective syndromes, twelve with anxiety/obsession syndromes, and one with an eating disorder. At the time of the interview, eight of the informants were engaged in work or education and four were participating in work rehabilitation or attending community-based activity centres. The remaining eight informants had no organised, regular daily occupation. The participants consisted of two men and 18 women.

Selection of participants and context in Study IV

In Study IV, all occupational therapists who had previously participated as therapists in Study II were recruited and interviewed. The criteria for participation were: being a qualified occupational therapist, working in general outpatient mental health care units in Sweden, and having taken part in a 30-hour TTM course (Gunnarsson, 2001), comprising of theoretical knowledge and practical experience of picture painting and occupational storytelling/story making. Nine occupational therapists were asked to participate in the study, and all of them gave their informed consent. The occupational therapists were all women, and the mean age was 53 years. They had an average of 22 years experience of occupational therapy practice. Besides the TTM course, six of them had undergone additional training in creative activities. Seven of them had additional psychotherapy training, either psycho-dynamically or cognitive-behaviourally oriented.

Procedures and data collection

The case study (Study I)

In Study I, the data was collected longitudinally over two periods, an intervention period and a follow up three years later. The communication between the occupational therapist and the client was tape-recorded in all of the sessions. The first period of data collection consisted of five sessions based on the TTM. Starting from every tree painting the client's life story was built up with a focus on occupation. In order to facilitate the conversation the occupational therapist used the guidelines by Alexi and Gunnarsson (1995) and the occupational storytelling information (Clark, 1993; Clark *et al.*, 1996). In the final session, there was an active reflecting on the trees painted earlier as a starting point for a dialogue between the client and the occupational therapist. After reflecting, the client painted a picture of her future tree, where the focus was on occupational story making (Clark, 1993; Clark *et al.*, 1996), and finding more adaptive strategies for the future. In between the first period of data collection and the follow-up three years later there were some clinical contacts between the occupational therapist and the client, documented in the clinical record, which constituted another data source for the study. The follow-up sessions three years later consisted of one interview and two TTM sessions. The interview was thematic and was related to the client's experiences from the process three years ear-

lier and she was asked whether the TTM had influenced her approach to everyday life in the long term. Interview themes used were, "life situation before the first TTM sessions", "what about painting and story telling", "memories from each of the trees she painted and the life story starting from these trees", "the TTM as a beginning for further reflections" and "her life situation now after going through the sessions". Then the data collection continued with two tree theme sessions carried out according to the TTM, the first theme being the client's present life situation and the second a perspective of her future. Afterwards the client was asked to compare the former future tree she had drawn with the new one. The last session concluded with a short interview about the client's reflections on participating in the TTM in this second series of sessions.

The intervention study (Study II)

Training

As a preparation for Study II, a group of ten occupational therapists, who were working with psychosocial occupational therapy in outpatient psychiatric care and had agreed to provide the intervention for their clients, were trained on five occasions, in all for 30 hours, by the author of this thesis. The training comprised theoretical knowledge about the value of occupation, creative activity and occupational life storytelling, as well as practical experience of painting the different tree themes and acting as therapists, as described by Gunnarsson (2001). One of the therapists changed workplace before the start of the study, but the remaining nine occupational therapists recruited clients for the study. The occupational therapist, on one to three occasions, assessed by a clinical interview if the intervention with the TTM was appropriate. If so, the client was asked to take part in the study according to consecutive sampling. The principle of informed consent was applied.

Instruments

The instruments in Study II were chosen in order to measure the therapeutic alliance, different aspects of daily occupations and health-related factors and client satisfaction.

Everyday occupations

The Canadian Occupational Performance Measure (COPM) (Law *et al.*, 1998) is a semi-structured interview reflecting clients' self-perceived occupational performance and satisfaction with their performance. The COPM focuses on three areas: self-care, productivity and leisure. The client is asked to identify problematic tasks and everyday occupations and then rate their actual performance and their satisfaction with the performance of the targeted tasks and everyday occupations. The self-ratings are made on a ten-point numeric Likert scale (Streiner & Norman, 2003), ranging from 1, 'Not important at all', to 10, 'Extremely important'. The COPM has been shown to have satisfactory test-retest reliability, sensitivity to change (Law *et al.*, 1998) and construct and criterion validity (McColl, Paterson, Davies, Doubt & Law, 2000). The Swedish version (Swedish Association of Occupational Therapists, 1999), has been found to have high responsiveness to change (Wressle, Samuelsson & Henriksson, 1999) and good clinical utility (Wressle, Marcusson & Henriksson, 2002).

The Satisfaction with Daily Occupations (SDO) (Eklund, 2004) is a measure of perceived satisfaction with everyday occupations. Unlike the COPM, it uses predefined items. It has nine items distributed over four domains: work, leisure, domestic tasks and self-care. The SDO contains an activity level score and a satisfaction score. It is administered as a combined interview and self-rating. First the client answers 'Yes/No' to whether or not they presently perform the occupation. The number of affirmative answers constitutes the activity level score, with a maximum possible score of nine. The client then rates their

satisfaction on a seven-point numeric Likert scale, from 1, 'Worst possible' to 7, 'Best possible'. The SDO satisfaction score has been shown to have satisfactory internal consistency (Eklund, 2004; Eklund & Gunnarsson, 2007; Eklund & Sandqvist, 2006) and acceptable construct validity (Eklund, 2004). Good test–retest reliability has been demonstrated for the satisfaction score as well as for the activity level (Eklund & Gunnarsson, 2007) and the SDO has shown to have good content validity and to be sensitive to change following an occupational therapy intervention (Eklund & Gunnarsson, in press).

Health-related factors

The Sense of Coherence (SOC) measure (Antonovsky, 1987a; Antonovsky, 1987b) is a self-rating scale and reflects the client's perception of the world and their personal environment as a whole. The sense of coherence indicates how well an individual manages stress and remains healthy, and the concept includes three dimensions: comprehensibility, manageability and meaningfulness. In line with Antonovsky's intention the three dimensions were not separated but the sense of coherence was treated as a composite construct. The short version, a 13-item questionnaire, was used. The respondents rated the statements on a seven-point numeric Likert scale, from 1, 'Very often', to 7, 'Very seldom or never'. Eriksson and Lindström (2005) found the face validity of the SOC scale acceptable, the content validity to be moderate and the criterion validity as varying from weak to good. For the 13-item questionnaire they found satisfactory test–retest reliability and high internal consistency.

The Mastery Scale (Pearlin, Menaghan, Lieberman & Mullan, 1981) is a 7-item, self-rating of self-mastery, the sense of being in control and mastering situations and experiences which influence one's own life. The respondents rate the statements on a four-point categorical Likert scale (Streiner & Norman, 2003), from 1, 'Completely agree', to 4, 'Don't agree at all'. The measure has been shown to have good internal consistency and good construct validity (Marshall & Lang, 1990).

The Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1992) is a self-rating scale composed of 90 items rated according to a 5-step categorical Likert scale. It measures psychological problems and symptoms of psychopathology. The scoring is from 0 to 4, where 4 indicates the greatest problem severity. The checklist is divided into nine symptom scales: somatisation, obsession-compulsion, interpersonal sensibility, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. Several indexes have been suggested. In this study, the Global Symptom Index (GSI) was calculated. The SCL-90-R is a frequently used measure and has shown very good reliability and good validity (Derogatis, 1992; Fridell, Cesarec, Johansson & Thorsen Malling, 2002).

The therapeutic relationship

The Revised Helping Alliance Questionnaire (HAq-II) (Luborsky *et al.*, 1996) measures the strength of the alliance between the client and the therapist by means of 19 items, rated on a six-point categorical Likert scale, from 1, 'Strongly disagree', to 6, 'Strongly agree'. There is both a client version and a therapist version, and the client and the therapist independently rate the helping alliance. HAq-II has shown satisfactory internal consistency and test–retest reliability (Luborsky *et al.*, 1996), and good convergent validity with other alliance measures (Hatcher & Barends, 1996; Luborsky *et al.*, 1996).

Client satisfaction

The Client Satisfaction Questionnaire (CSQ) (Larsen, Attkisson, Hargreaves & Nguyen, 1979) contains eight questions concerning the client's satisfaction with the intervention. The self-rating is made on a four-point categorical Likert scale, where 1 and 2

indicate less satisfaction, 3 indicates good satisfaction, and 4 the highest satisfaction. The CSQ has been shown to have satisfactory internal consistency (Larsen *et al.*, 1979; Nguyen, Attkisson & Stegner, 1983) and construct validity (Nguyen *et al.*, 1983). De Wilde and Hendriks (2005) found the concurrent validity to be high, and suggested the CSQ as a good measure for the assessment of general satisfaction in mental health care. Three data sets based on the Swedish version, including clients with mental health disorders, have shown satisfactory internal consistency (Cronbach's alpha 0.85–0.93) (personal communication, Lars Hansson, October 2006).

Procedure

In Study II, pre-test and post-test data concerning the clients were collected over a 21-month period ending in January 2006. The data collection took place at the respective psychiatric outpatient unit. Just before the TTM intervention started, the pre-test was performed, and the author of this thesis met the client and administered the questionnaires COPM, SDO, SOC, Mastery and SCL-90-R. Following this the TTM intervention took place. The five sessions were spread over a period of six to nine weeks. The HAq-II was administered to the clients and the therapists after the second and the final TTM session. Post-test data were collected in accordance with the pre-test data, and the author of this thesis administered the instruments to the client soon after the last session of the intervention, with the addition of the CSQ.

The client interviews (Study III)

In Study III, thematic interviews were formed as dialogues between the interviewer and the interviewee (Kvale, 1996). In line with Mishler (1986), the interviewer encouraged the informant/client to narrate their thoughts, feelings and perceptions of the TTM intervention, and to describe the relationship with the therapist. A thematic interview guide was used, starting with:

> Could you tell me about your experiences of the TTM intervention, including what you think about the therapeutic relationship and your perception of the relationship between you and your occupational therapist?

From this opening question a dialogue developed in which the interviewer encouraged the client to give a detailed narrative. The interviews in Study III were performed at the psychiatric outpatient clinic at which the client had gone through the TTM intervention between two and four months earlier. Each interview took place on one occasion and lasted about an hour. The interviews were tape-recorded and transcribed verbatim. Most of the interviews were performed by the author of this thesis. The rest of the interviews were conducted by a co-researcher in order to minimise the risk of allegiance.

The focus group interviews with occupational therapists (Study IV)

The interviews in Study IV were formed as focus group discussions (Kitzinger, 1994; Krueger & Casey, 2000). Before starting, the informant occupational therapists were introduced to the procedure. Two moderators met both focus groups. One moderator was a psychologist/researcher, and the other was an occupational therapist/research assistant. Both of them had previous experience of leading group interviews, but neither of them had any experience of using the TTM. The moderators encouraged the informant therapists to describe their experiences of using the TTM. A prepared guide was followed covering the various themes of the intervention including the progressive relaxation exercise, occupational storytelling/story making (painting and verbal life-storytelling) and the therapeutic relationship. The informant

therapists were encouraged to talk as freely as possible. The moderators tried to stimulate the interaction and deepen the discussion between the informant therapists by further questions. Two focus groups were formed, consisting of four and five informants, respectively. Each group met twice, with a two-week interval. On the first occasion, the interview lasted for four hours for both focus groups, including a one-hour lunch break. The interview on the second occasion took two hours. The interviews took place at two mental health care units. All sessions were audio taped and transcribed verbatim.

Data analysis

The case study analysis

The tape-recordings from each session were transcribed in whole before the next-coming session took place. Using this procedure, the transcribing becomes part of an interpreting process and analysis (Kvale, 1996; Merriam, 1988). The data analysis included two parts. First a case record (Merriam, 1988), with a narrative structure and description of the intervention process was developed. The second part of the analysis proceeded from this case record and implied identifying themes in the client's life story (Merriam, 1988).

The information from the first period of data collection was integrated and analysed together with the follow-up data. The audiotapes were first listened through and then transcribed by the author of this thesis. The data was then listened to and read through again. An experienced occupational therapist made a peer review of the process of analysis from the raw data to the final result and verified the trustworthiness of the procedure. The final results were eventually formulated in a discussion between the author of this thesis and the peer researcher. A life story telling should be treated as a coherent whole (Polkinghorne, 1995), which was a leading principle for the analysis. The analysis focused on the process of the client and life themes of importance to her, before, during and after the intervention and at the follow-up. The focus was on the experiences of the storyteller and not on external validity (Atkinson, 1998).

Qualitative content analysis

Qualitative content analysis according to Burnard (1991) was used in Study III and Study IV. The various steps of the analysis were carried out as an iterative process by the authors involved. A naive reading was performed with the intention of not only making the researchers conscious and open, but also to strengthen the analysis process. Initially, codes were identified close to the text. Different categories were freely generated and gradually collapsed into broader categories. The analysis continued until consensus was reached concerning the categories and sub-categories. All Burnard's suggested 14 steps, except step 11, which states that "selected informants should be asked to check the data", were performed. When validating the analysis the pre-understanding should be taken into consideration (Elliott, Fischer & Rennie, 1999). The researchers involved represented a broad area of experience. Two of those who conducted the analysis in Study III were also interviewers (BG and CL), while the others were a nurse/researcher, experienced in qualitative methods (KP) and a psychologist/researcher (JAJ). Finally, the senior author (ME), an occupational therapist and experienced researcher, checked all the steps of the analysis to verify the validity of the analysis and identify any possible problems associated with allegiance (Burnard, 1991). In Study IV, one of those carrying out the analysis, and also was one of the moderators (JAJ), one was the nurse/researcher (KP), and the third was the author of this thesis (BG). In order to verify the validity of the analysis the senior author (ME) finally checked all the steps of the analysis, starting

by reading two original focus group interviews and following the naive and more elaborate steps of the analysis. At this stage, further refinement of the categories was made.

Statistics

As all the variables in Study II were assessed on an ordinal scale, only non-parametric methods were used. The initial therapeutic alliance, as perceived by the clients and the therapists, and client satisfaction were correlated (Spearman's rank order correlation) with change scores regarding the occupational and health-related variables. For the evaluation of any differences between measurements made before and after the intervention, Wilcoxon's signed rank test was used. Finally, multiple logistic regression analysis (backward method, likelihood ratio) was performed with CSQ as the dependent variable and the initial HAq-II and change scores concerning COPM, SDO, SOC, Mastery and SCL-90-R as independent variables. The independent variables were all dichotomized. The goodness-of-fit of the model was tested with the Hosmer-Lemeshow test (Hosmer & Lemeshow, 1989). The regression analysis was performed in four stages since the small number of participants did not allow for too many independent variables in the same analysis. The first stage was comprised of the occupational variables, the second the health-related factors, the third the therapeutic alliance, and the fourth stage included those independent variables that had been shown to be statistically significantly related to client satisfaction in the previous stages. The SPSS (Statistical Package for Social Sciences) version 13.0 was used for all analyses.

Ethical considerations

The Research Ethics Committee of Lund University approved all of the studies (LU 319-01, LU 803-03, LU 804-03, LU 805-03). The ethical considerations have proceeded from the principles of the Swedish Research Council (2003). All participants received verbal and written information of the aims and procedures of the studies as well as a description of what their participation would mean. Following this they gave their informed consent to participate with the right to terminate their participation at any time. Concerning confidentiality, the participants' anonymity and integrity was guaranteed. One ethical aspect considered is the possibility that the interview situation might arouse difficult feelings and experiences which in turn might cause suffering. In connection with each data collection the client respondents were informed regarding the possibility to receive support at their usual outpatient mental health care units if required. Generally, however, the participants were positive towards telling their experiences, and they found it meaningful and important to contribute to the development of an intervention.

Findings

Illustration of the TTM as an intervention

This particular case description provided an example of how the TTM can be used and of the development a client may undergo. This case was followed up three years later in order to gain further knowledge about the process.

The client's nonverbal and verbal story, from childhood to midlife, started with her present life situation. She felt gloomy and could not manage to take care of her family; this was symbolized by her painting a brown birch with hanging branches. The client did not feel stable which was illustrated by the weak roots of the tree she drew. The second session was about the client's childhood which she perceived as pleasant and illustrated this

by painting a birch tree with green leaves. She was a playful child and her only problem was shyness when trying new activities. During the third session the client told a non-verbal and verbal story about her adolescence. She told how she felt gloomy which was symbolized by a brown birch tree she had painted. She did not view herself as being capable of studying, so she began to work at a factory. The fourth session focused on her adulthood. The client's mother-in-law had got cancer some years earlier which evoked her anxiety, which was illustrated by the thin branches of the tree. The client then had to support her family, which was illustrated by some thicker branches. Then at the fifth and final session the story making started focused on the future. The client expected both good and bad events in the future, but in the final session she saw herself as an actor in her own life. This was illustrated by knots she painted on the tree trunk. At the follow-up three years later, a recapitulation of the previous intervention was made, and the memories of the former tree paintings served as a help for her reflections. The client found it helpful to paint trees and to tell her life story together with the therapist who she thought was an active listener, and thereby enabled her to express her emotions.

She remembered the different trees she had painted, apart from the first brown birch, as being similar to each other and in that respect as forming a whole. At the follow-up session, she again painted her present life situation. The client now felt stronger and had people close to her who knew what mental illness is about which was symbolized by her painting a strong oak with long roots, a stable trunk and branches with green leaves. She finally painted her current expectations for the future. She felt hopeful and wanted to be an active woman with grandchildren. She let a brown oak with a bird's nest and a swing hanging from a branch, symbolize that type of life.

Four life themes were identified which formed the client's course through life; "being shy", "being close to the family", "being afraid that the worst thing will happen", and finally, "the feeling of being alienated". As revealed by the woman's story the TTM appeared to be a suitable intervention. At the end of the intervention period she had regained her active role at home as well as at her work place, and at the follow-up session she attributed this positive development partly to her participation in the TTM.

Changes in everyday life after a TTM intervention

Study II showed that a good initial therapeutic alliance was experienced by both clients and occupational therapists. Regarding the occupational therapists' ratings of the therapeutic alliance there was a statistically significant increase between the pre-test and the post-test measurements ($p=.031$), but not regarding the clients' ratings ($p=.134$). Statistically significant differences between the two measurement points were also found concerning the measurement of everyday occupations. There was an increase from pre-test to post-test regarding both activity level and satisfaction according to the SDO, and improvements were also found for COPM performance and COPM satisfaction. The result concerning the health-related factors sense of coherence, self-mastery and psychiatric symptoms also indicated positive changes (Table 3).

A good initial therapeutic alliance, as perceived by both occupational therapists and clients, was correlated to increased changes regarding occupational performance and self-mastery. According to the therapists' ratings, a good initial therapeutic alliance was correlated to an increased sense of coherence and a decreased level of psychiatric symptoms. High therapist ratings of the therapeutic alliance were also related to high client satisfaction.

The clients' median rating of their satis-

Table 3.
Changes observed between measurements made before and after the TTM intervention.

Outcome variable	Before the intervention Median (IQR)	After the intervention Median (IQR)	p-value
COPM			
Performance	3.2 (2.0)	4.6 (2.4)	.001
Satisfaction	2.0 (2.2)	4.6 (3.4)	.001
SDO			
Activity level	5.0 (1.0)	5.0 (2.0)	.001
Satisfaction	47.0 (12.0)	50.0 (11.0)	.008
SOC	47.0 (15.0)	48.0 (13.0)	.011
Mastery	18.0 (6.0)	19.0 (5.0)	.006
SCL-90-R GSI	77.0 (21.0)	68.0 (26.0)	.001

Figures in bold indicate IQR (interquartile range), the difference between the 25th and 75th percentiles, that is, containing the central 50% of the observations. COPM, Canadian Occupational Performance Measure; SDO, Satisfaction with Daily Occupations, SOC, Sense of Coherence measure, SCL-90-R, Symptom Checklist-90-R; GSI, Global Symptom Index.

faction with the intervention was high. Multivariate analyses showed that, regarding everyday occupations, the factor of most importance for belonging to the group reporting a higher level of client satisfaction was a positive change in COPM performance. Concerning the health-related factors, those who improved more regarding sense of coherence were more likely to belong to the more satisfied group. The analysis also indicated that those participants for which the therapists' initial ratings were high also belonged to the high ratings group regarding client satisfaction. The final analysis, combining the previous ones by including all significant factors found in the preceding analyses, showed that those for whom the therapists gave a high rating regarding the therapeutic alliance ruled out all other variables in explaining the client satisfaction with the TTM. Viewed against how the clients and the therapists perceived the therapeutic alliance, the clients' ratings of the occupational and health-related variables and the clients' ratings of their satisfaction with going through the TTM, the intervention method seemed to function well in psychosocial occupational therapy.

Client experiences of a TTM intervention

Various perceptions were expressed in the clients' narratives regarding the painting, verbal storytelling/story making and the therapeutic relationship. Six principal categories were derived from the data:

"From a feeling of performance demands to becoming focused and expressive". From a situation of feeling diverted due to stress and thinking of various aspects of everyday life when entering the session, the informants became relaxed and focused. Performance de-

mands gradually became less and the TTM became enjoyable which paved the way for creating the paintings more freely. The informants mastered their situation step by step in a more conscious and reflective way. However, sometimes, painting the trees became more of a productive activity than a tool for a helping dialogue.

"Expressing oneself and one's life situation led to an awakening of memories and feelings". The informants found relief in painting and the possibility to express feelings, experiences and memories. Life patterns could be recognized in the paintings and the fact that the therapist encouraged the client to look at the pictures from various perspectives led to "aha experiences".

"New perspectives of self-image, everyday life and relations to others". There were indications that the TTM did not lead to any process of change, but usually the intervention initiated a process of forming life goals. The informants' self-images gradually changed towards a better self-esteem. They could relate to others and at the same time be more independent. Participation in the sessions resulted in a more active everyday life. The TTM was a starting point for the clients to consider possible changes in daily life but also to initiate action to master the situation.

"Story making led to shaping and reconstructing one's life story". The TTM helped the clients to shape structure, to be aware of various life patterns and to see life as a whole. The story making was perceived as a healing process, useful in everyday life.

"Interaction was of importance when reconstructing one's life story". In order to become involved in a process of change, mutual respect, trust and openness were perceived as necessary between the therapist and the client. To accomplish a successful treatment process, the clients perceived that the client and the therapist have to share the responsibility for the intervention.

"The attitude of the occupational therapist was of importance for the development of a therapeutic relationship". The therapist's attitude and capacity for maintaining the therapeutic framework was of importance in initiating the process of painting and creating one's occupational life story. Mostly, the therapist was seen as being engaged, competent and empathic. However, there were also signs that it could happen that when the therapist made an interpretation it could be perceived by the client as being a rebuke. Further, it was seen as non-therapeutic when the therapist felt more like a friend than a therapist to the client.

In general, the clients seemed to assimilate the TTM intervention well, regarding both the non-verbal and the verbal occupational storytelling and occupational story making, and their perceptions of the therapeutic relationship were mostly positive. The frames and techniques of the intervention and the therapeutic relationship seemed to be closely intertwined in the process of opening new perspectives in everyday life.

Occupational therapists' experiences of using the TTM

The investigation of the occupational therapists' experiences of using the TTM intervention, revealed five categories, each comprising sub-categories:

"Balancing therapeutic frames" included two sub-categories; "shaping a beginning and a definite end of the process" and "following the TTM technique closely or with flexibility". In general, the number of sessions was found to be satisfactory as was the shaping of a beginning and a definite end of the process. The TTM was experienced as being structured, the progressive relaxation was seen as helping the client to be focused, and the paintings were helpful in deepening the client's verbal occupational storytelling. Rotating the painting for alternative perspectives and offering tasks were perceived as useful

in starting the process of coping with everyday life.

"Therapists' requirements of life experiences and expert knowledge" was comprised of three sub-categories; "using life experiences", "developing expert knowledge" and "therapeutic attitude". The therapist's self-knowledge was regarded as being valuable when reacting to a client's narrative, because the TTM was perceived to evoke strong emotions in both parties. The greater the experience gained from using the TTM the more flexibly the therapist used the instructions. The therapist noted that they needed sufficient education and supervision in the TTM in order to help them use it in a flexible way. Accommodating a client's needs placed demands on the therapist's flexibility and ability to change between an active and a more reflective attitude.

"Client requirements of motivation and ability". In order to benefit from the interventions some requirements were placed on the clients. These were reflected in three sub-categories; "motivation for exploring and changing perspectives", "ability to symbolize" and "learning by doing". The client needed to have some interest in revealing their own story and to have enough courage to try new strategies for change in everyday life. The TTM was perceived as useful to most clients, but those who had difficulties in symbolizing generally needed more concrete instructions. The therapists thought that the clients gradually learned how to paint pictures and tell their stories more freely.

"Developing a therapeutic relationship" involved three sub-categories; "readiness for client centeredness", "working to establish a relationship" and "bringing the relationship to an end". The TTM was perceived as a client-centred method, with its focus on the client's storytelling. This focus could result in a good therapeutic relationship and for this to happen the first encounter was regarded as being of crucial importance. Concluding the relationship at the end of the intervention was of concern to the therapist, and there were cases when the therapist noticed signs of separation anxiety among clients. When strong emotions were evoked, the therapist could be frustrated because the TTM only encompassed five sessions.

"A dynamic with several processes". The data revealed a dynamic with several intertwined processes, interacting with each other, and three sub-categories were identified; "the process of playing", "the process of reflection" and "the process of changing perspectives". Often instantly, the intervention evoked a process of playing in the client and the occupational therapists found the paintings helpful in both initiating and deepening a client's storytelling. The painting of a tree started a process of reflection and served as a starting point for an exploratory conversation between the therapist and the client. The occupational therapists perceived that this playful reflection made the client view their everyday life from a new angle. The TTM was seen as helpful to the client in breaking out of old patterns and as facilitating the client to find how to cope with everyday life. The future tree was seen as important and as a turning point to the clients' in order to reconstruct their own future lives.

In general, the TTM appeared to function well in psychosocial occupational therapy. The TTM was experienced as a structured method for starting a process and initiating a therapist-client relationship. In order for a client to benefit from the TTM the occupational therapists needed to balance the therapeutic frames with flexibility. The occupational therapist should have self-knowledge and a therapeutic attitude so as to motivate the client to take part in the intervention. Developing a therapeutic relationship was of importance in order to initiate a dynamic process that could stimulate the client in finding new perspectives in everyday life.

Discussion

Discussion of the findings

This thesis constitutes the first stages of a description and evaluation of the TTM, a new method for intervention in outpatient psychiatric care, based on creative activities and occupational storytelling/story making. According to the findings in Studies I–IV the TTM intervention appeared to function well in general psychiatric care, from both the clients' and their occupational therapists' point of view. The evaluation was, as recommended by Vedung (1998), composed by various perspectives combining clients' and occupational therapists' views and different research methodologies. Vedung raised a few issues that are important when carrying out an evaluation, namely to describe, assess and reflect the utility of an intervention. The first steps in addressing these issues have been taken by describing the TTM intervention and how the intervention may be implemented (Study I), focusing on changes that could be observed based on comparisons of measurements made before and after the intervention (Study II) and taking part in clients' (Study III) and occupational therapists' (Study IV) experiences of participation in the TTM, including their perceptions of the therapeutic relationship.

This thesis may also be framed as a process–outcome study, since it focused on processes, that took place both within the client and in terms of the client–therapist relationship, and how such processes were linked with development and change among the clients. The TTM was perceived as being dynamic, with a simultaneously ongoing process of *playing*, *reflecting* and *changing perspectives* (Study IV). Moreover, the *therapeutic relationship* showed to be important when studied in connection with different methodologies and from different perspectives (Studies II–IV). However, there is need for further reflection on how the *frames* and different *techniques* of the TTM may have served as a starting point for such processes, that aim to help the client cope with and act in everyday life, as well as how different *requirements place upon the clients and the occupational therapists* may have influenced those processes. This result discussion will concentrate on these issues.

Processes of playing, reflecting and changing perspectives

Both the clients (Study III) and occupational therapists (Study IV) in this thesis perceived the TTM as helpful in symbolizing and verbalising a client's life story. The occupational therapists meant that the TTM started a process of play and self-expression (Study IV). Sometimes picture painting was perceived as pure pleasure (Study III), initiating only little reflection, but the intervention seemed to be meaningful anyway. This is in line with Thompson and Blair (1998), who argued that a creative activity and its process may be curative in themselves. The ability to play is essential to an individual (Winnicott, 1971), and through play and creativity, such as painting picture of a tree, an intermediate area may be created where fantasy may be used for coping with everyday life.

The TTM initiated a process of expressing oneself and one's life situation which evoked both unpleasant and pleasurable feelings and memories (Studies I and III). The clients in Studies I and III meant that while they were involved in a process of playing they also took part in a reflective dialogue with their therapists and imagined possible new perspectives in everyday life. This is in line with Hoff (2003), who argued that a creative process takes place in interaction within an individual, and between them and the environment.

The TTM, with its focus on painting pictures of trees from various periods of life, is aimed at stimulating the client to reflect on themselves in their present and former life

situation and imagine a future life. In Study I, it seemed that the pictures of the trees became like the building blocks of a timeline, not only reflecting special events but also the person's "whole life", from childhood to the present day. In only a short period of time, the results from Studies I and II indicated positive changes over the intervention period concerning everyday occupations and health-related factors. These changes might be related to the process of changing perspectives (Study IV), an assumption that is strengthened by the fact that the clients in Study III perceived the intervention as helpful in becoming aware of various life patterns and gaining new perspectives about themselves and their ability to handle everyday life. Further indications of a process of changing perspectives were that the occupational therapists perceived the TTM as useful to the clients in helping them to break out of old patterns (Study IV).

The processes of playing, reflecting and changing perspectives resemble the concepts of doing, being, becoming (Hammell, 2004; Wilcock, 1998) and belonging (Hammell, 2004). When a client paints (doing), tells their story and reflects (being), their sense of identity may be stronger, and they regain their roles at home and at work (belonging) and comes to look upon themselves as capable of composing their own life (becoming). Creating a life story, by both painting and using words, highlighted the client's abilities and revealed their limitations, and seemed to lead to self-understanding and an increased ability to handle everyday life (Studies I, III and IV). This is in line with Lagerkrantz (1998), who expressed the importance of doing things through creative activities, "What I hear, I forget – what I see, I remember – but what I do, I understand" (p. 99).

The therapeutic relationship

The early therapeutic relationship was in Study II, related to changes in various respects, as was also reported by other researchers (Johansson, 2006; Lambert & Barley, 2002). Both the clients' and the therapists' ratings of the initial therapeutic alliance were associated with improvements regarding everyday occupations and self-mastery. In addition, the therapists' initial ratings of the therapeutic alliance were correlated with an increased sense of coherence and a decrease in psychiatric symptoms. Thus, the therapists' perceptions of the initial therapeutic alliance appear to have influenced the intervention, and may have been important for the clients' improvement. Eklund (1996b) obtained similar results when examining clients at a psychiatric day care unit, where the treatment programme was based on creative activities.

The findings revealed that both clients and therapists perceived the therapeutic attitude as being important. The clients in Study III found the therapist's attitude and capacity for maintaining the therapeutic framework to be of importance for initiating the process of painting and creating one's occupational life story. This is in line with Lambert and Barley (2002), who argued that the therapeutic relationship which includes empathy, warmth, acceptance and encouragement, is the most important so-called common factor for the outcome of psychotherapy. However, also in line with some previous studies (Littauer, Sexton & Wynn, 2005; Palmadottir, 2006), there were some negative perceptions of the therapist by clients, such as, that the therapist acted as if she was superior, and gave neither positive nor negative signs, that the therapist felt more like a friend than a therapist. When encouraging the client to become engaged in an intervention, the therapist must have a good knowledge of the therapeutic relationship and of how supportive and encouraging, and sometimes confronting, attitudes should be balanced. According to the occupational therapists' perceptions (Study IV), the therapist should be engaged in, focused on and confirm the client.

Client satisfaction after having gone through the TTM intervention was related to the therapists' ratings of the therapeutic alliance and improvements in COPM performance and sense of coherence (Study II). These results support suggestions by Björkman and Hansson (2001) that client satisfaction is connected with both the outcome of psychiatric interventions and the process of intervention. McKinnon (2000) found, that in client-centred occupational therapy, the quality of the interaction between therapist and client was of great importance for client satisfaction. This is in line with the results from Study II, where high ratings of the therapeutic relationship were correlated with a high level of client satisfaction. However, it is hard to explain why the therapists' rating of the therapeutic alliance was found to be the most important factor for client satisfaction. It appears that the therapists' belief in a helping alliance led to better client satisfaction. Possibly, the therapists' attitudes influenced both the intervention per se, and the clients' tendency to perceive the therapy as helpful. In any case, the results indicate that the TTM, as used in Study II, was highly dependent on the input from the occupational therapist.

The roles of frames and techniques

On the basis of existing literature, the term 'creative activities' was used in this thesis in the sense of *tasks or actions used in order to generate novel ways of experiencing reality, including the subject's own self, often, but not necessarily, resulting in a product, such as a painting or a poem*. It was also stated that creative activities may be supported by a meaningful context. This way of viewing creative activities seems to be applicable to the TTM. The fact that the intervention was perceived as structured (Study IV), with limited time frames and techniques may appear to be contrary to creativity, but within this structure there was a possibility for being creative.

Variations may be found when comparing client perceptions (Study III) with therapist perceptions (Study IV) of the TTM frames. While the clients (Study III) reflected on the frames as a help in getting focused and express thoughts and emotions, the occupational therapists (Study IV) reflected on how to maintain a balance between strictly following the therapeutic frames and adjusting them to their clients' needs. The frames served as a safety net in supporting a client's recovery. This is in line with Atkinson and Wells (2000), who reported that using therapeutic frames dynamically could establish a feeling of psychological safety, in turn promoting clients to take part in a creative activity. However, there might also be a risk involved using the frames flexibly, and the therapist must not modify the frames in such a way that the original intention with the intervention gets lost. The main recommendation is to follow the frames, but occasionally improvise if that can help the client understand the intention with the TTM better or evoke their motivation, such as the case where when one of the therapists asked a very young client to make another tree painting depicting her teenage instead of an adult tree. For the remaining parts of the intervention the therapist adhered strictly to the frames, thus providing a good example of a flexible use of the frames.

Atkinson (1998) saw photos and other forms of memorabilia as being helpful when recalling important events and experiences of one's life and, according to Studies I, III and IV, the tree paintings seemed to function that way in the TTM. This, in turn strengthens the idea that the tree may symbolize a person and their living situation, throughout their life course (Gunnarsson, 1988; Hark, 1986/1995). According to the results from Studies I and III, it mostly appeared to be easy for the clients to associate their life situation with different trees, and the occupa-

tional therapists (Study IV) perceived the tree paintings as helpful in deepening the client's verbal occupational storytelling and occupational story making. The verbal dialogue and the subsequent self-reflections led to a feeling of becoming someone, and provided inspiration for how the client should behave in their daily life in relation to others.

The fact that the TTM intervention gave a possibility for the client to tell their whole life story during a limited time period was expressed by both the clients' (Studies I and III) and therapists (Study IV) as being helpful in seeing life as a whole, which in turn became a healing process (Study III). In Study II, the clients' sense of coherence was found to be increased after the TTM intervention, which was surprising as most studies have found the sense of coherence to be stable over time (Eriksson & Lindström, 2005). Possibly, the TTM intervention, with its limited time frames and a focus on reflecting life as a whole may have promoted a sense of coherence.

Storytelling and story making were also part of the frames and techniques of the TTM. In a case study, Larson (1996) identified important life themes, that also constituted turning points in a woman's life. A similar process was found in Study I. It was possible to both identify important turning points and reflect on their influences on the client's everyday life. This is further in line with Polkinghorne (1995), who suggested that shaping a narrative can be helpful when making shifts in life, and with Wicks and Whiteford (2003), who stated that life stories are useful in occupational therapy in order to describe and explain a person's activities within different contexts, and that storytelling may bring meaning to one's occupational experiences. Another technique of the TTM, that is, to rotate the tree picture and view things from different angles might have facilitated the clients in Studies I and III to discover turning points and possible changes in everyday life.

Requirements on clients and therapists

Life experiences leading to self-knowledge, but also expert knowledge, were regarded as necessary for therapists intending to use the TTM (Study IV). Similarly, Nordholm, Adamson and Heard (1994) stated that several years of practice were needed to become a master clinician. All the informants in Study IV were experienced occupational therapists, but not all were experienced in using the TTM. However, while using the TTM, some of them advanced from being a novice on the subject to becoming competent in the technique. The more experience they had from using the TTM, the more flexibly the therapists used the therapeutic frames in order to accommodate their clients' needs. This is in line with Benner (1984), who found that a novice relies on guidelines, while an expert is able to integrate the guidelines into a specific context and act accordingly. Moreover, further education and supervision related to the use of the TTM were experienced as being helpful in professional development. This is in line with Gaitskell and Morley (2008), who stated that supportive and challenging supervision is essential when building up knowledge and skills.

The occupational therapists in Study IV also expressed that they had requirements towards their clients for making use of the TTM intervention. They thought the clients needed to have motivation to make changes in their everyday life and the ability to symbolize. Further, the occupational therapists meant that an ability to symbolize is also related to the processes of playing, reflecting and changing perspectives. Imagery capacity was shown by Körlin *et al.* (2000) to be of importance for well-being, and the authors stated that it is possible to train the ability to symbolize. According to the occupational therapists in Study IV, the clients gradually learned how to participate in the TTM sessions.

Methodological discussion

When developing a new intervention method, there is need for research in order to successively refine it. According to Kazdin (2003), a diversity of methods are required when studying clinical applications, such as when exploring and evaluating the TTM. This thesis used designs based on both qualitative methodology (Studies I, III and IV) and quantitative methodology (Study II), on a single case level (Study I) as well as on a group level (Studies II–IV). This thesis was also studied from different perspectives, as recommended by Vedung (1998), and included views from both clients and therapists. A logical continuum of research was pursued, starting with case study methodology, followed by quantitative research with a quasi-experimental design, and qualitative research based on individual interviews and focus groups discussions.

The distinction between outcomes in terms of process and effectiveness are not always obvious (Hill & Lambert, 2004). However, this thesis did not aim to investigate any of the effects of the TTM. The focus was on process aspects in order to gain knowledge of different courses of actions and procedures (Thompson, 1995; Wordreference.com, 2008) and what happens in a type of intervention (Hill & Lambert, 2004) such as the TTM. Vedung (1998) stated that it is useful to study an intervention in a naturalistic setting, proceeding from reality just as it exists, and in this thesis this was seen as a suitable way of starting a process evaluation of the TTM. The focus was further to investigate the therapists' and clients' experiences of taking part in the intervention (Hill & Lambert, 2004; Vedung, 1998), their perceptions of the therapeutic relationship (Hill & Lambert, 2004) and how the ratings of the therapeutic relationship correlated with any changes in everyday occupations and health-related factors.

The qualitative studies (Studies I, III and IV)

The validity (Burnard, 1991), or trustworthiness, in terms of credibility, dependability and transferability (Polit, Beck & Hungler, 2001) should be estimated in a qualitative study. Credibility refers to how well the data and the analysis deal with the truth of the data and the focus of the study, while dependability refers to the data's stability over time and its context. Transferability refers to the extent to which the findings can be transferred to other contexts (Polit *et al.*, 2001).

The credibility was strengthened by the detailed descriptions of the procedures for data collection and analysis given in the method sections (Studies I, III and IV). Credibility may also be strengthened in terms of triangulation (Polit *et al.*, 2001), which was used in several ways in this thesis. Multiple perspectives were caught by approaching both clients and occupational therapists and by purposefully selecting participants representing a large variation on, for example, experience, age, diagnosis and gender. Thereby, data source triangulation was accomplished. Moreover, the use of different designs and methodologies added to the variety in the perspectives and constituted a method triangulation. Credibility may also be related to how well the findings, for example categories and sub-categories, cover the data, and in Studies I, III and IV all the researchers performed their analysis independently and following the analysis they discussed the findings among themselves until consensus was reached (investigator triangulation).

Stimulating multiple opinions among the informant therapists strengthened the credibility, that is to say, that the data revealed the informant therapists various views of reality. The sample in Study IV was small with only two focus groups, one containing four and the other five informant therapists. However,

Dahlin Ivanoff (2002) recommended small groups which may help to promote a dynamic interaction, and in Study IV indeed, all the informant therapists participated actively. All the informant therapists had met previously on the TTM course. However, some therapists were less experienced in using the TTM which may have reduced the richness of the data produced. However, on the other hand, it may also have increased the richness of some of the data due to various levels of expert-knowledge and degrees of experience the therapists had gained from using the TTM. This fact was mirrored in the results (Study IV). According to Krueger and Casey (2000), if the informants are closely connected with each other this could have a negative impact on the discussion because their common pre-understanding might lead to certain matters not being commented on. Forming two focus groups, that also met twice, was a way of increasing the variation between and within the groups and, thus, the richness of the data.

The researcher credibility, including the pre-understanding in the data collection and the agreement into the data analysis (Polit *et al.*, 2001), may also deserve some attention. Researcher credibility may be related to problems of dependency and allegiance, and the loyalty of the researcher or their attachment to the therapy method, both of which tend to influence the results of evaluation studies (Luborsky *et al.*, 1999). In Study I, the client attended a unit where the author of this thesis, who was the one who developed the TTM was also the occupational therapist. This may have influenced the result picture in a positive direction and constitutes a weakness in the research design. Being an occupational therapist concerned with the recovery of the client, and simultaneously being a researcher, collecting data regarding the TTM and the intervention process that evolved, inferred double roles for the author of this thesis. Therefore, in the subsequent studies, these two perspectives were separated (Studies II–IV), and several other occupational therapists and their clients, as well as other interviewers, were included. By using two interviewers in Study III, it was possible to check for any allegiance problems concerning the author of this thesis. The senior author (ME) checked transcripts from two different interviews one performed by the author of this thesis and one by the co-researcher, but did not detect any differences in how the conversations, in the two interviews, developed between the interviewer and the informant.

In order to further reflect the researcher credibility and minimize the dependency, the author of this thesis, who led the course with the occupational therapists, refrained from participating in the focus groups. The interviews were performed by two moderators with no experience with the TTM, but each with a long experience as group leaders. The moderators researchers were convinced that all the informant therapists were engaged and participated, however, in one of the groups the informant therapists shared many of the reflections, while in the other group they had more polarized opinions. However, these variations and contrasts were positive in order to reach a deeper knowledge. The moderators told the informant therapists about the importance of being honest and to tell of positive as well as bad experiences, and explained that such information is important when developing a new intervention.

In addition, the researcher credibility should be reflected regarding the analysis process (Polit *et al.*, 2001). According to Burnard (1996), there is no need for complete agreement between the experts during the analysis process, but the discussion should lead to consensus. In Studies I, III and IV, the researchers continued to discuss the findings of the interviews until consensus was reached. This may be seen as a way of strengthening both the credibility and dependability. Furthermore, the researchers' pre-understanding may influence the interpretation of statements (El-

liott *et al.*, 1999). In this thesis, the researchers had various types of pre-understanding when making their analyses, as described in the methods section. The informants were known to some of the researchers, from the interviews performed (Studies I, III and IV), which resulted in one type of understanding when reading the transcripts, while some researchers had no preconceptions based on personal knowledge of the informants. Although the research team represented several perspectives when starting the analysis process, consensus could be reached.

The dependability of the data may be related to how stable and consistent the data is, regardless of, for example, the temporal or geographical context (Polit *et al.*, 2001). To strengthen the dependability (Studies I, III and IV) the transcripts were read through and compared several times by the author of this thesis, and an experienced occupational therapist (Study I) and co-researchers (Studies III and IV), respectively and they constructed independent preliminary analyses of the interviews before the process of reaching consensus started. The whole procedure in each of Studies I, III and IV was then checked by an experienced researcher. In Study I the dependability was further strengthened by interviewing the client at the follow-up regarding her perceptions from the TTM intervention and its impact in her daily life. The focus groups (Study IV) met twice, and the fact that the second round of discussion did not lead to any new or deviant content strengthens the dependability of the study. Further, the dependability in Study IV was strengthened by the use of the same moderators from the research group in both focus groups. Another way of ensuring dependability was to give an audit trail concerning how the data analyses were performed (Studies III and IV).

The transferability of the findings from this thesis must be seen as low. The TTM was exemplified by a clinical case (Study I) and Lukoff *et al.* (1998) meant that the case study methodology is suitable when exploring and describing phenomena that are organized in coherence. However, this case should be used as an illustration of how a TTM intervention may be implemented and cannot be transferred to other clients or settings. Further, the clients of Study III did not represent the desired variation, and most of them were women. Further, the sampling procedure was built on Study II and was not quite transparent. However, it is important to bear mind that, the intention when using qualitative methods is not that the findings should be transferred. Rather, according to Polit *et al.* (2001) it is the reader's decision whether findings of a qualitative study can be transferred to another context or not.

The quantitative study (Study II)

In a quantitative study the validity in terms of internal and external validity should be estimated. The internal validity deals with the possibility of arriving at well-founded conclusions regarding the variables studied. The external validity deals with the extent to which the results can be generalised to other people and contexts (Kazdin, 2003; Polit *et al.*, 2001). Study II was a quasi-experimental study, combining a correlational and pre-test – post-test design, which is useful for clinical studies and for testing less well-tried intervention methods that may be applicable in practice (Kazdin, 2003).

The occupational therapists were informed, during their training, about the criteria for inclusion and they were the ones who recruited the clients. However, there might have been some unknown selection bias as the researchers did not know which clients the occupational therapists chose to ask or not to ask to participate. In order to ensure that the conditions were the same for all clients all data were collected by the author of this thesis. When assessing new interventions in clinical settings it is of importance to use val-

id and reliable instruments (Jerosch-Herold, 2005). The instruments used in Study II were chosen with the aim of measuring changes in the therapeutic relationship in relation to different aspects of daily occupation and health-related factors, as well as to client satisfaction. Most instruments have been tested in their Swedish versions and have shown satisfactory to good psychometric properties. It might have been a weakness that, especially, the HAq had not been validated in its Swedish version, but it was used as it is a frequently used questionnaire in various studies.

If the focus of the study would have been on the effects of the TTM, the fact that there was no control group would have been a weakness. However, the purpose of Study II was not to measure the effects of an intervention, but to examine process aspects, like the therapeutic alliance and client satisfaction in relation to changes in everyday occupations and different aspects of health-related factors. Therefore, the pre-test – post-test design used ought to be appropriate. According to Vedung (1998), a pre-test – post-test study in combination with correlational analyses is a suitable way of checking the utility of, for example, an intervention.

In studies aiming at detecting changes between two measurement points, power calculations have to be performed (Kazdin, 2003). In order to obtain a sample size that would reduce the risk of Type-II errors, 35 subjects were required to reveal an effect size of 0.5 on the chosen outcome variables with 80 % power at $p< 0.05$. Although one client was excluded from Study II because of cognitive difficulties, the required number of 35 client participants still remained.

There were no missing data in the questionnaires, and after the data had been entered into a data base the accurateness of this procedure was ascertained by an independent assistant. The variables were on nominal and ordinal levels, thus only non-parametric methods were applied for the statistical analysis. In the multiple logistic regression analysis with client satisfaction as the dependent variable, the confidence intervals were wide. Although significant odds ratios were obtained, the wide confidence intervals, besides a fairly small sample size, indicate a lack of precision in the estimates. Hence, there is a need for studies based on a larger number of clients, possibly complemented with additional instruments, such as an assessment of social interaction in further evaluation of the TTM. Moreover, since the main focus was on process aspects, in terms of how the changes were related to the therapeutic relationship and client satisfaction, and no control group was used, it is not possible to determine whether the changes found were due the TTM or other factors.

The participating clients were consecutively recruited to the study by their occupational therapist, and there was no possibility for the researchers to exert control over the recruiting. In order to strengthen the external validity, the occupational therapists were trained to use the TTM intervention and were informed about the criteria for inclusion. There was a fairly broad distribution regarding age, diagnosis and main occupations among the clients. However, despite the fact that the included participants seemed to be typical of clients visiting general psychiatric outpatient units in Sweden, the sample size was too small and gender skewed for the findings to be generalised to other settings. According to Blennow (2004), some mental and behavioural disorders are more common among women, such as affective disorders, anxiety/obsessive disorders, and eating disorders, and 31 of the clients had these diagnoses. Still, the gender distribution was more skew than expected, indicating that the findings cannot be generalised to men.

Conclusions and implications

This thesis followed a logical continuum; a case study of the TTM demonstrated the usefulness of the method in understanding a client's problems and in developing new strategies for coping with everyday life. A subsequent study examined changes on a group level. The findings indicated consistently positive significant changes regarding health-related variables and occupational performance. High ratings of the therapeutic relationship were found to be related to the changes observed, and the clients' satisfaction with the TTM was found to be high. A third study explored the clients' perceptions of taking part in a TTM intervention. In general, the clients felt that it helped them to perceive their lives as coherent, and that they became more able to cope with daily life. Furthermore, the intervention and its meaning to the client was closely related to the development of the relationship between client and therapist. Finally, the occupational therapists' experiences of using the TTM were examined in terms of how they perceived the method per se and their relationship with the client. In general, the TTM was experienced as being a structured method for starting a process and initiating a therapist-client relationship. In order for a client to benefit from the TTM, it was found to be important to balance the therapeutic frames with flexibility. The most important conclusions from this thesis are as follows:

- The TTM intervention appeared to function well in general psychiatric care, from both the clients' and their occupational therapists' point of view.
- The fact that the intervention is structured, with limited time frames and techniques may appear to counteract creativity, but within this structure it was possible to be creative.
- The various tree themes appeared to function as a tool for self-exploration, self-discovery and self-help, enhanced by the expression of emotions and thoughts concerning everyday life and relations to others.
- The various tree themes worked as a starting point for encouraging the client's verbal occupational storytelling and occupational story making.
- The TTM intervention was perceived by the clients and their therapists as helpful when telling and making their life story and in seeing life coherently.
- The concepts of doing, being, belonging and becoming were applicable in the TTM intervention.
- In their interaction with the occupational therapist, the clients could identify turning points and possible changes in their everyday life.
- The way the occupational therapists perceived the therapeutic relationship seemed to be important for the clients' improvement.
- The therapeutic attitude, self-knowledge and expert-knowledge seemed to be important prerequisites for the therapists when using the TTM intervention.

Implications for clinical practise and further development of the TTM

This thesis has provided knowledge about the TTM as a method for psychosocial occupational therapy and shed light on how it may be used in general outpatient psychiatric care. The findings also gave indications regarding possible further development of the TTM:

- The TTM may be used flexibly and the occupational therapist should consider when there is need for following the different techniques strictly or when it is suitable to adjust them according to the individual client's needs.

- Rotating the tree picture to accomplish different perspectives is a usable technique for encouraging a client to identify turning points in life and make use of them.
- The occupational therapists that used the TTM needed to have expert knowledge regarding the TTM, including training and supervision, but also self-knowledge. Thus, the most suitable therapists are those who after their basic training as an occupational therapist both have experience from going through therapy themselves and are trained to use the TTM.
- When developing a therapeutic relationship, the occupational therapist needs to be client-centred and to collaborate with the client. The therapist should be an active listener in order to gain an understanding of the client and their storytelling. Further, the therapist should bring the relationship to an end in a cautious manner.
- A possible adjustment of the TTM would be to identify vital life themes, which emerged in the results of Study I as being important. Life themes might be useful to sum up and organise the therapeutic process as part of the occupational story making, and this could be included as a supplement to the TTM guidelines.

Implications for research

So far, the TTM appears to be a promising intervention, as investigated in the context of clients in general outpatient psychiatric care. However, in order to further evaluate the various processes of the TTM, there is need for research that addresses what happens in a long-term perspective. Future research should also address whether the TTM frames and techniques need to be adjusted. Possible variations in frames and techniques, such as the number of sessions and variations in themes should be studied in order to identify what are the crucial building blocks of the TTM. Furthermore, the effects of the intervention ought to be studied. A suitable research design would be that one group, receiving intervention, takes parts in the TTM and a second one, a control group, is offered verbal short-time therapy or occupational therapy according to normal practice.

Moreover, in this thesis the TTM was aimed to be used for clients with mental illness visiting general outpatient psychiatric care, but it should also be studied with other target groups in mind. It is possible that clients with more severe mental illnesses, as well as clients with other types of persistent illnesses, for example chronic pain, might also benefit from the TTM intervention. Thus, much work remains to be done in order to evaluate the usefulness and effects of the TTM and to develop the intervention further.

Svensk sammanfattning (Swedish summary)

Att utveckla och utvärdera behandlingsmetoder inom psykiatrisk vård är en angelägen uppgift. Författaren av denna avhandling har som kliniskt verksam arbetsterapeut påbörjat arbetet med att utveckla en metod för bedömning och behandling. Metoden benämns Trädtemat, på engelska the Tree Theme Method (TTM). Målet för arbetsterapeutisk behandling är att öka patientens förmåga att ta hand om sin egen person samt att klara vardagliga aktiviteter och relationer till andra. Forskning avseende utvärderingar (processsåväl som utfallsaspekter) av behandlingsformer inom psykiatrisk arbetsterapi har tyvärr utförts i mycket begränsad utsträckning, men är ett angeläget forskningsområde.

Skapande aktiviteter, som till exempel att måla en bild, används inom psykiatrisk arbetsterapi. Med skapande aktiviteter avses i denna avhandling *verksamheter som används för att generera nya sätt att uppleva verkligheten, och även individens inre liv, och som ofta, men inte nödvändigtvis, resulterar i en produkt såsom en bild eller ett poem*. En skapande aktivitet bör äga rum i ett meningsfullt sammanhang. Den kan användas explicit, där målet med aktiviteten har ett tydligt samband med slutmålet. Den kan också användas implicit, där slutmålet inte är så tydligt, exempelvis för att stärka självförtroendet. Målet med en skapande aktivitet är att individen ska uppmuntras att uttrycka erfarenheter, känslor och tankar, för att på så sätt få ökad självförståelse om sin livssituation och utveckla sina relationer till andra människor. Inom skapande aktiviteter är dimensionerna görandet (doing), varandet (being), tillhörigheten (belonging) och blivandet (becoming) av intresse, då de beskriver olika slags meningsupplevelser som aktiviteter kan ge upphov till.

TTM är klientcentrerad, vilket innebär ett aktivt samarbete mellan arbetsterapeut och patient. Trädet som symbol används i metoden, som bygger på att med hjälp av skapande aktiviteter skapa en livsberättelse med fokus på vardagslivets aktiviteter (occupational storytelling) samt att skapa en vision av framtida möjligheter och mål (occupational story making). TTM genomförs under en avgränsad tidsperiod (6–9 veckor). En session består av avspänningsövning, icke-verbal livsberättelse, i form av att måla ett träd, samt verbal livsberättelse, vilken sker i en reflekterande dialog med arbetsterapeuten. TTM innebär att en patient vid fem olika tillfällen målar symboliska träd och använder dem som utgångspunkt för att berätta sin livshistoria. Vid första sessionen målas ett träd som symboliserar den aktuella livssituationen. Vid andra tillfället målas ett barndomsträd, sedan ett tonårsträd och därefter ett vuxenträd. Vid sista tillfället målas ett träd som symboliserar framtiden. Avsikten är att patienten ska få nya perspektiv och hitta nya strategier för att förbättra sin livssituation. I TTM ingår också att identifiera olika hemuppgifter, som patienten tränar på mellan sessionerna. I interventionen använder arbetsterapeuten ett klientcentrerat förhållningssätt samt en särskild struktur för att uppmuntra patienten till livsberättelse i ett aktivitetsperspektiv. En checklista finns tillgänglig som hjälp för att ställa frågor i samband med skapandet av livsberättelsen.

Det övergripande syftet med avhandlingen var att beskriva och utvärdera TTM som metod för intervention. Det första delarbetet var en fallstudie, som sträckte sig över en behandlingsperiod och inkluderade en uppföljning tre år senare. Studien beskrev TTM som metod och utgjorde ett exempel på en patients behandlingsprocess och upplevda resultat. Patienten var en 30-årig kvinna med ångest- och depressionsproblematik. Studien beskrev hur de olika teman som uppkom i TTM kunde relateras till för patienten vitala livsteman, och

hur olika hemuppgifter kunde stärka patientens utveckling mot en mer stabil mental hälsa. I denna studie utgjorde författaren själv den behandlande arbetsterapeuten, och detta metodproblem diskuteras i studien.

Delarbete II var en klinisk studie med kvasiexperimentell design, med kombinerad korrelations- och pre-test – post-testdesign. Som förberedelse för delarbetet anordnades en kurs för arbetsterapeuter i att leda TTM. Tio arbetsterapeuter deltog, men en bytte sedan arbete till annat verksamhetsområde än psykiatrin. De resterade nio tillfrågades om att medverka som terapeuter, och samtliga samtyckte. Dessa rekryterade vid sina respektive arbetsplatser sammanlagt 35 konsekutiva patienter som var villiga att delta i TTM. Urvalskriterierna för patienterna var en ålder mellan 18 och 65 år, att ha en psykiatrisk diagnos av typen affektiv sjukdom, ångestsjukdom, ätstörning eller personlighetsstörning, samt att ha behov av arbetsterapi. Sex av studiens patienter var män och 29 var kvinnor. Delarbetet fokuserade på den terapeutiska relationen mellan patient och arbetsterapeut, patienternas tillfredsställelse med att delta i TTM, förändringar i aktivitets- och hälsorelaterade faktorer under behandlingsperioden, samt hur dessa process- och förändringsfaktorer samvarierade. För- och eftermätningar avseende dagliga aktiviteter och olika hälsorelaterade faktorer gjordes via självskattningar. Resultaten visade på goda kvaliteter beträffande den terapeutiska relationen, hög grad av patienttillfredsställelse och positiva förändringar i aktivitetsnivå, förmåga att utföra aktiviteter, tillfredsställelse med aktiviteter, känsla av sammanhang, egenkontroll och upplevda psykiska symptom. Via olika multivariata analyser framkom det att den viktigaste faktorn för patienternas tillfredsställelse med TTM var en hög skattning från terapeutens sida av den terapeutiska relationen.

Delarbete III var en kvalitativ studie, där 20 (2 män och 18 kvinnor) av de patienter som deltog i TTM i delarbete II intervjuades om sina erfarenheter av att ha genomgått TTM och hur de uppfattade relationen till arbetsterapeuten. Intervjuerna genomfördes av författaren samt ytterligare en forskare/arbetsterapeut. Överlag hade patienterna en positiv uppfattning om TTM som de upplevde som utvecklande och stödjande. Med hjälp av en kvalitativ innehållsanalys framkom sex huvudkategorier:

1) ”Från en känsla av prestationskrav till att bli fokuserad och uttrycksfull”,
2) ”Att ge uttryck för den egna livssituationen väckte minnen och känslor”,
3) ”Nya perspektiv på självbild, vardagsliv och relationer till andra”,
4) ”Story-making ledde till rekonstruktion av ens livshistoria”,
5) ”Interaktionen var viktig vid skapandet av livshistorien” och
6) ”Arbetsterapeutens attityd var betydelsefull för hur den terapeutiska relationen utvecklades”.

Det fjärde delarbetet utgjorde en fokusgruppsstudie där de nio arbetsterapeuter som genomförde interventionen i delarbete II deltog. Samtliga arbetsterapeuter var kvinnor. Medelåldern var 53 år och de hade i genomsnitt arbetat som arbetsterapeuter under 22 år. De bildade två grupper, som vardera träffades två tillfällen, tillsammans med två moderatorer. Den ena moderatorn var forskare och psykolog och den andra var arbetsterapeut och projektassistent. Fokus för dessa intervjuer/diskussioner var arbetsterapeuternas erfarenheter av att ha använt sig av TTM. Efter en kvalitativ innehållsanalys av de verbatim utskrivna fokusgruppsdiskussionerna framkom fem huvudkategorier:

1) ”Att balansera de terapeutiska ramarna”,
2) ”Krav på arbetsterapeutens erfarenhet och expertkunskap”,
3) ”Krav på klientens motivation och färdigheter”,

4) ”Utvecklandet av en terapeutisk relation” samt
5) ”En dynamisk process med flera dimensioner”.

Resultaten från delarbetena ger följande implikationer:

- TTM upplevdes som en strukturerad intervention, men ramarna kan användas flexibelt och därför behöver arbetsterapeuten vara uppmärksam på när han/hon ska följa de olika teknikerna, och när han/hon kan anpassa dem efter patientens individuella behov.
- Att vända på bilderna och reflektera över dem från fyra olika vinklar, var en användbar teknik för att identifiera vändpunkter och bli uppmärksam på olika perspektiv och strategier.
- Att identifiera olika livsteman under TTM-sessionerna är ett sätt att förändra och förbättra checklistan. Livsteman skulle kunna vara användbara för att summera och få struktur i patientens icke-verbala och verbala livsberättelse, som en del av att skapa sin framtida aktivitetshistoria.
- Resultaten visade att arbetsterapeuterna som använde TTM utvecklade färdigheter mot en expertkunskap, och för att arbeta mot det målet behöver de utbildning, handledning och självkännedom.
- Vid utvecklandet av en terapeutisk relation, behöver arbetsterapeuten vara klientcentrerad och samarbeta med patienten. Arbetsterapeuten behöver lyssna aktivt för att få en förståelse för patienten och hans/hennes livsberättelse. Vidare behöver arbetsterapeuten vara uppmärksam på att avsluta relationen på ett tillfredsställande sätt.

Denna avhandling utgör en beskrivning och utvärdering avseende TTM, men ytterligare studier är nödvändiga för att undersöka dess betydelse i ett längre tidsperspektiv. Dessutom behöver betydelsen av de ramar och tekniker som utgör TTM, undersökas i syfte att förfina och förbättra interventionen. Även effekter av TTM-interventionen behöver studeras. Ett förslag är att utforma en forskningsdesign med en interventionsgrupp som deltar i TTM och en kontrollgrupp som erbjuds samtalsterapi eller traditionell arbetsterapi vid fem tillfällen. I denna avhandling har TTM riktats till patienter inom allmänpsykiatrisk öppenvård, men bör studeras också i andra grupper. Det är tänkbart att till exempel patienter med en långvarig psykisk sjukdom eller personer med smärtproblematik skulle ha nytta av interventionen, vilket fortsatt forskning får utröna.

References

Adamson, B. J., Sinclair-Legge, G., Cusik, A., & Nordholm, L. (1994). Attitudes, values and orientation to professional practice: a study of Australian occupational therapists. *British Journal of Occupational Therapy, 57*, 476–480.

Alexi, S., & Gunnarsson, B. (1995). *Trädet som bild och livssymbol – i litteratur och psykiatrisk behandling [The tree as a symbol of life in the literature and in mental health care]*. Lund: Vårdhögskolan Lund-Helsingborg, Institutionen för arbetsterapi.

Alsaker, S., & Josephsson, S. (2003). Negotiating occupational identities while living with chronic rheumatic disease. *Scandinavian Journal of Occupational Therapy, 10*, 167–176.

Altman, D. G. (1991). *Practical statistics for medical research*. London: Chapman & Hall.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Antonovsky, A. (1987a). The structure and properties of the sense of coherence scale. *Social Science Medicine, 36*, 725–733.

Antonovsky, A. (1987b). *Unravelling the mystery of health: how people manage stress and stay well*. San Francisco, CA: Jossey-Bass.

Atkinson, K., & Wells, C. (2000). *Creative therapies: a psychodynamic approach within occupational therapy*. London: Stanley Thornes Publishers Ltd.

Atkinson, R. (1998). *The life story interview*. Thousand Oaks, CA: Sage.

Aubin, G., Hachey, R., & Mercier, C. (1999). Meaning of daily activities and subjective quality of life in people with severe mental illness. *Scandinavian Journal of Occupational Therapy, 6*, 53–62.

Bateson, M. C. (1990). *Composing a life.* New York: Penguin.

Bejerholm, U., & Eklund, M. (2006). Engagement in occupations among men and women with schizophrenia. *Occupational Therapy International, 13*, 100–121.

Bejerholm, U., & Eklund, M. (2007). Occupational engagement in persons with schizophrenia: relationships to self-related variables, psychopathology, and quality of life. *American Journal of Occupational Therapy, 61*, 21–32.

Bejerholm, U., Hansson, L., & Eklund, M. (2006). Profiles of occupational engagement in people with schizophrenia (POES): the development of a new instrument based on time-use diaries. *British Journal of Occupational Therapy, 69*, 58–68.

Benner, P. (1984). *From novice to expert. Excellence and power in clinical practice*. London: Addison-Wesley.

Björkman, T., & Hansson, L. (2001). Client satisfaction with case management: a study of 10 pilot services in Sweden. *Journal of Mental Health, 10*, 163–174.

Björkvold, J.-R. (1991). *Den musiska människan [The music orientated human being]*. Stockholm: Runa.

Blennow, I. (2004). Det osynliga könet inom psykiatrin [The invisible gender in mental health care]. In I. B. Hovelius & E. E. Johansson (Eds.), *Kropp och genus i medicinen [Body and gender in medical health service]* (pp. 259–265). Lund: Studentlitteratur.

Brink, P. J., & Wood, M. J. (1998). *Advanced design in nursing research*. Newbury Park: Sage.

Bruce, M. A., & Borg, B. (1993). *Psychosocial occupational therapy. Frames of reference for intervention* (2nd ed.). Thorofare, NJ: Slack Inc.

Bruner, J. (1990). *Acts of meaning*. London: Harvard University Press.

Buck, R., & Provancher, M. (1972). Magazine picture collages as an evaluative technique. *American Journal of Occupational Therapy, 26*, 36–39.

Buck, J. N. (1948). The H-T-P test. *Journal of Clinical Psychology, 4*, 151–159.

Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse Education Today, 11*, 461–466.

Burnard, P. (1995). Interpreting text: an alternative to some current forms of textual analysis in qualitative research. *Social Sciences in Health, 1*, 236–245.

Burnard, P. (1996). Teaching the analysis of textual data: an experiential approach. *Nurse Education Today, 16*, 278–281.

Clark, F. (1993). Occupation embedded in a real life: interweaving occupational science and occupational therapy. *American Journal of Occupational Therapy, 47*, 1067–1078.

Clark, F., Larsson, E. A., & Richardson, P. R. (1996). A grounded theory of techniques for occupational storytelling and occupational story making. In R. Zemke & F. Clark (Eds.), *Occupational science. The evolving discipline* (pp. 373–392). Philadelphia, PA: F.A Davis Company.

Cohen, B. M., Mills, A., & Kwapien Kijak, A. (1994). An introduction to the diagnostic drawing series: a standardized tool for diagnostic and clinical use. *Journal of the American Art Therapy Association, 11*, 105–110.

Cole, M. B., & McLean, V. (2003). Therapeutic relationships re-defined. *Occupational Therapy in Mental Health, 19*, 33–56.

Corboz, R. J., & Gnos, P. U. (1980). Der Dreibaumtest in der Volksschule [The three-trees test in the public school]. *Acta Paedopsychiatrica: International Journal of Child & Adolescent Psychiatry, 46*, 83–92.

Crafoord, C. (1994). *Människan är en berättelse. Tankar om samtalskonst [Man as a narrative. Reflections on the art of conversation]*. Stockholm: Natur och Kultur.

Craik, C., Chacksfield, J., & Richards, G. (1998). A survey of occupational therapy practioners in mental health. *British Journal of Occupational Therapy, 61*, 227–233.

Cramer-Azima, F. (1982). The Azima Battery: an overview. In B. Hemphill (Ed.), *The evaluative process in psychiatric occupational therapy* (pp. 57–61). Thorofare, NJ: Slack Inc.

Creek, J. (2008). Creative activities. In J. Creek & L. Lougher (Eds.), *Occupational therapy and mental health* (4th ed., pp. 333–343). London: Churchill Livingstone.

Creek, J., & Lougher, L. (Eds.). (2008). *Occupational therapy and mental health* (4th ed.). London: Churchill Livingstone.

Csikszentmihalyi, M. (1990). *Flow. The psychology of optimal experience*. New York: Harper & Row.

Dahlin Ivanoff, S. (2002). Focus group discussions as a tool for developing a health education programme for elderly persons with visual impairment. *Scandinavian Journal of Occupational Therapy, 9*, 3–9.

Danielsson, J. (2002). *Träd i marker och myter [Trees on the lands and in mythology]*. Stockholm: Svenska Förlaget.

Davis, J. (2007). Finding value in client resistance. *Occupational Therapy in Mental Health, 23*, 39–54.

de Roten, Y., Fischer, M., Drapeau, M., Beretta, V., Kramer, U., Favre, N., *et al.* (2004). Is one assessment enough? Patterns of helping alliance development and outcome. *Clinical Psychology and Psychotherapy, 11*, 324–331.

de Wilde, E. F., & Hendriks, V. M. (2005). The Client Satisfaction Questionnaire: psychometric properties in a Dutch addict population. *European Addiction Research, 11*, 157–162.

DePoy, E., & Gitlin, L. N. (1998). *Introduction to research. Understanding and applying multiple strategies.* St Louis: Mosby.

Derogatis, L. R. (1992). *SCL-90-R, Administration, scoring & procedures. Manual II.* (2nd ed.). Towson, MD: Clinical Psychometric Research Inc.

Edgar, I. R. (1999). The imagework method in health and social science research. *Qualitative Health Research, 9*, 198–211.

Eklund, M. (1996a). *Occupational group therapy in a psychiatric day care unit for long-term mentally ill patients.* Lund University, Lund.

Eklund, M. (1996b). Working relationship, participation and outcome in a psychiatric day care unit based on occupational therapy. *Scandinavian Journal of Occupational Therapy, 3*, 106–113.

Eklund, M. (1997). Therapeutic factors in occupational group therapy identified by patients discharged from a psychiatric day centre and their significant others. *Occupational Therapy International, 4*, 200–214.

Eklund, M. (2000). Applying object relations theory to psychosocial occupational therapy: empirical and theoretical considerations. *Occupational Therapy in Mental Health, 15*, 1–26.

Eklund, M. (2002). Explicit and implicit methods in psychosocial occupational therapy.

Occupational Therapy in Mental Health, 18, 3–15.

Eklund, M. (2004). Satisfaction with Daily Occupations: a tool for client evaluation in mental health care. *Scandinavian Journal of Occupational Therapy, 11*, 136–142.

Eklund, M., & Gunnarsson, A. B. (2007). Satisfaction with Daily Occupations: construct validity and test-retest reliability of a screening tool for people with mental disorders. *Australian Occupational Therapy Journal, 54*, 59–65.

Eklund, M., & Gunnarsson, A. B. (in press). Content validity, clinical utility, sensitivity to change and discriminant ability of the Swedish Satisfaction with Daily Occupations (SDO) instrument: a screening tool for people with mental disorders. *British Journal of Occupational Therapy*.

Eklund, M., & Hansson, L. (2001). Determinants of satisfaction with community-based psychiatric services: a cross-sectional study among schizophrenia outpatients. *Nordic Journal of Psychiatry, 55*, 413–418.

Eklund, M., Rottpeter, J., & Vikström, F. (2003). The meaning of psychosocial occupational therapy in a life-story perspective. A long-term follow-up of three cases. *Occupational Therapy International, 10*, 185–206.

Eklund, M., & Sandqvist, G. (2006). Psychometric properties of the Satisfaction with Daily Occupations (SDO) instrument and the Manchester Short Assessment of Quality of Life (MANSA) in women with scleroderma and without known illness. *Scandinavian Journal of Occupational Therapy, 13*, 23–30.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215–229.

Elliott, R., Greenberg, L. S., & Lietaer, G. (2004). Research on experiential psychotherapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: John Wiley & Sons, Inc.

Englund, B. (Ed.). (2004). *Skapande och kroppsbaserade komplementära terapier [Creative and body-centred complementary therapies]*. Lund: Studentlitteratur.

Eriksson, E. H. (1985). *Den fullbordade livscykeln [The life cycle completed]*. Lund: Natur och Kultur.

Eriksson, M., & Lindström, B. (2005). Validity of Antonovsky's sense of coherence scale: a systematic review. *Journal of Epidemiology and Community Health, 59*, 460–469.

Ewald, G. (1983). *Svenska vårdträd [Trees as a protective symbol in Swedish folklore]*. Vårgårda: Vårgårda Tryckeri.

Fidler, G., & Fidler, J. (1964). *Occupational therapy: a communication process in psychiatry*. New York: McMillan.

Fieldhouse, J. (2008). Community mental health. In J. Creek & L. Lougher (Eds.), *Occupational therapy and mental health* (pp. 489–512). London: Churchill Livingstone.

Finlay, L. (2004). *The practice of psychosocial occupational therapy* (3rd ed.). Cheltenham: Nelson Thornes Ltd.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: a synthesis of the literature*. Tampa, Florida: University of South Florida, Louise de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Frank, G. (1996). Life histories in occupational therapy clinical practice. *American Journal of Occupational Therapy, 50*, 251–264.

Fridell, M., Cesarec, Z., Johansson, M., & Thorsen Malling, S. (2002). *Svensk normering, standardisering och validering av symtomskalan SCL-90. [A Swedish standardisation and validity check of the symptom scale SCL-90]. Rapport nr 4/2002*. Västervik: Statens Institutionsstyrelse SiS.

Gahnström-Strandqvist, K., Josephsson, S., & Tham, K. (2004). Stories of clients with mental illness: the structure of occupational therapists' interactions. *OTJR: Occupation, Participation and Health, 24*, 134–143.

Gaitskell, S., & Morley, M. (2008). Supervision in occupational therapy: how are we doing? *British Journal of Occupational Therapy, 71*, 119–121.

Gillette, N. (1963). Occupational therapy and mental health. In H. Willard & C. Spack-

man (Eds.), *Occupational therapy* (4th ed., pp. 51–131). Philadelphia, PA: Lippincott.

Goldberg, B., Britnell, E. S., & Goldberg, J. (2002). The relationship between engagement in meaningful activities and quality of life in persons disabled by mental illness. *Occupational Therapy in Mental Health, 18*, 17–44.

Griffiths, S. (2008). The experience of creative activity as a treatment medium. *Journal of Mental Health, 17*, 49–63.

Griffiths, S., & Corr, S. (2007). The use of creative activities with people with mental health problems: a survey of occupational therapists. *British Journal of Occupational Therapy, 70*, 107–114.

Guldbrandsson, K. (2008). *From news to everyday use. The difficult art of implementation: a literature review*. Stockholm: Statens folkhälsoinstitut [Swedish National Institute of Public Health].

Gunnarsson, A. (1988). *Träden och människan [Trees and man]*. Stockholm: Rabén & Sjögren.

Gunnarsson, A. (1992). *Fruktträden och paradiset [The fruit-trees and paradise]*. Sveriges lantbruksuniversitet, Alnarp.

Gunnarsson, B. (2001). *Utbildning i användandet av trädtemat som terapeutisk metod vid psykosocial rehabilitering [Training in the use of the Tree Theme Method as a therapeutic tool in psychosocial rehabilitation]* (FoU-meddelande 2001:1). Växjö: FoU-centrum, Landstinget Kronoberg.

Haglund, L. (2000). Assessments in general psychiatric care. *Occupational Therapy in Mental Health, 15*, 35–47.

Hammell, K. W. (2001). Using qualitative research to inform the client-centred evidence-based practice of occupational therapy. *British Journal of Occupational Therapy, 64*, 228–234.

Hammell, K. W. (2004). Dimensions of meaning in the occupations of daily life. *Canadian Journal of Occupational Therapy, 71*, 296–305.

Hark, H. (1995). *Drömbild träd [Trees in dreams]* (G. Ingestad, Trans.). Solna: Centrum för Jungiansk Psykologi. (Original work published 1986).

Hatcher, R. L., & Barends, A. W. (1996). Patient's view of the alliance in psychotherapy: exploratory factor analysis in three alliance measures. *Journal of Consulting and Clinical Psychology, 64*, 1326–1336.

Hawkes, R., Johnstone, V., & Yarwood, L. (2008). Acute psychiatry. In J. Creek & L. Lougher (Eds.), *Occupational therapy and mental health* (pp. 393–407). London: Churchill Livingstone.

Henare, D., Hocking, C., & Smythe, L. (2003). Chronic pain: gaining understanding through the use of art. *British Journal of Occupational Therapy, 66*, 511–518.

Heuchemer, B., & Josephsson, S. (2006). Leaving homelessness and addiction: narratives of an occupational transition. *Scandinavian Journal of Occupational Therapy, 13*, 160–169.

Hewett, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: literature review. *Journal of Advanced Nursing, 52*, 561–570.

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: John Wiley & Sons, Inc.

Hoff, E. (2003). *The creative world of middle childhood. Creativity, imagination, and self-image from qualitative and quantitative perspectives.* Lund University, Lund.

Hoff, E. V., & Carlsson, I. (2002). Shining lights or lone wolves? Creativity and self-image in primary school children. *Journal of Creative Behavior, 36*, 17–40.

Holder, V. (2003). The use of creative activities within occupational therapy. *British Journal of Occupational Therapy, 64*, 103–105.

Hosmer, D. W., & Lemeshow, S. (1989). *Applied logistic regression*. New York: Wiley.

Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zeeland Journal of Psychiatry, 37*, 169–183.

Hughes, J. (1989). Art in psychosocial occu-

pational therapy: guidelines for use and an art exercise battery. *Australian Occupational Therapy Journal, 36*, 14–23.

Hydén, L.-C. (1997a). De otaliga berättelserna [The innumerable narratives]. In L.-C. Hydén & M. Hydén (Eds.), *Att studera berättelser [Studying narratives]*. Stockholm: Liber.

Hydén, L.-C. (1997b). Illness and narrative. *Sociology of Health and Illness, 19*, 48–69.

Hydén, M. (1997c). Berättelsen i psykoterapins värld [Narratives in the world of psychotherapy]. In L.-C. Hydén & M. Hydén (Eds.), *Att studera berättelser [Studying narratives]*. Stockholm: Liber.

Högberg, Å. (1996). *Att utvecklas med symboler [To develop with symbols]*. Stockholm: Natur och Kultur.

Ivarsson, A.-B., & Carlsson, M. (2002). Development of the experiences of occupational performance questionnaire: validity and reliability in a sample of individuals with severe mental disorders. *Scandinavian Journal of Occupational Therapy, 9*, 184–191.

Ivarsson, A.-B., Carlsson, M., & Sidenvall, B. (2004). Performance of occupations in daily life among individuals with severe mental disorders. *Occupational Therapy in Mental Health, 20*, 33–50.

Jacobson, E. (1934). *You must relax; a practical method of reducing the strains of modern living.* New York: McGraw-Hill.

Jacobson, E. (1938). *Progressive relaxation.* Chicago: University Chicago Press.

Jerosch-Herold, C. (2005). An evidence-based approach to choosing outcome measures: a checklist for the critical appraisal of validity, reliability and responsiveness studies. *British Journal of Occupational Therapy, 68*, 347–353.

Johansson, H. (2006). *Therapeutic alliance in general psychiatric care.* Lund University and Division of Psychiatry, Lund University Hospital, Lund.

Jonsson, H., Josephsson, S., & Kielhofner, G. (2000). Evolving narratives in the course of retirement: a longitudinal study. *American Journal of Occupational Therapy, 54*, 463–470.

Jonsson, H., Josephsson, S., & Kielhofner, G. (2001). Narratives and experience in an occupational transition: a longitudinal study of the retirement process. *American Journal of Occupational Therapy, 55*, 424–432.

Jung, C. G. (1964). *Man and his symbols.* London: Aldus Books.

Kazdin, A. E. (2003). *Research design in clinical psychology.* (4th ed.). Boston: Allyn & Bacon.

Kellogg, R. (1970). *Analyzing children's art*. Paulo Alto, CA: Mayfield Publishing.

Kielhofner, G. (2008). *Model of human occupation: theory and application* (4th ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Kielhofner, G., Forsyth, K., Clay, C., Ekbladh, E., Haglund, L., Hemmingsson, H., *et al.* (2008). Talking with clients: assessments that collect information through interviews. In G. Kielhofner (Ed.), *Model of human occupation: theory and application* (4th ed., pp. 262–287). Baltimore, MD: Lippincott Williams & Wilkins.

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness, 16*, 103–121.

Koch, C. (1952). *The Tree Test. The tree-drawing test as an aid in psychodiagnosis.* Bern: Verlag Hans Huber.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups. A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.

Krupa, T., & Clark, C. (2004). Occupational therapy in the field of mental health: promoting occupational perspectives on health and well-being. *Canadian Journal of Occupational Therapy, 71*, 69–74.

Krupa, T., McLean, H., Eastabrook, S., Bonham, A., & Baksh, L. (2003). Daily time use as a measure of community adjustment for persons served by assertive community treatments teams. *American Journal of Occupational Therapy, 57*, 558–565.

Kvale, S. (1996). *Interviews. An introduction to qualitative research interviewing.* London: Sage.

Körlin, D., Nybäck, H., & Goldberg, F. S. (2000). Creative arts groups in psychiatric care: development and evaluation of a therapeutic alternative. *Nordic Journal of Psychiatry, 54*, 333–340.

Lagerkrantz, A. M. (1998). Bildterapi [Art Therapy]. In T. Theorell (Ed.), *När orden inte räcker till [When words are not enough]* (p. 99). Stockholm: Natur och Kultur.

Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. C. Norcross (Ed.), *Psychotherapy relationships that work. Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: development of a general scale. *Evaluation and Program Planning, 2*, 197–207.

Larson, E. A. (1996). The story of Marcela and Miguel: a narrative analysis of dimensions of adaptation. *American Journal of Occupational Therapy, 50*, 286–298.

Law, M., Baptiste, S., Carswell, A., McColl, M. A., Polatajko, H., & Pollock, N. (1998). *Canadian Occupational Performance Measure* (2nd ed.). Ottawa, ON: CAOT Publications ACE.

Legault, E., & Rebeiro, K. L. (2001). Occupation as means to mental health: a single-case study. *American Journal of Occupational Therapy, 55*, 90–96.

Lerner, C., & Ross, G. (1977). The magazine picture collage: development of an objective scoring system. *American Journal of Occupational Therapy, 31*, 156–161.

Leufstadius, C., Erlandsson, L.-K., Björkman, T., & Eklund, M. (2008). Meaningfulness in daily occupations among individuals with persistent mental illness. *Journal of Occupational Science, 15*, 27–35.

Leufstadius, C., Erlandsson, L.-K., & Eklund, M. (2006). Time use and daily activities in people with persistent mental illness. *Occupational Therapy International, 13*, 123–141.

Littauer, H., Sexton, H., & Wynn, R. (2005). Qualities clients wish for in their therapists. *Scandinavian Journal of Caring Sciences, 19*, 28–31.

Lloyd, C., & Papas, V. (1999). Art as therapy within occupational therapy in mental health settings: a review of the literature. *British Journal of Occupational Therapy, 62*, 31–35.

Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavits, L. M., Frank, A., *et al.* (1996). The revised Helping Alliance Questionnaire (HAq-II). Psychometric properties. *The Journal of Psychotherapy Practice and Research, 5*, 260–271.

Luborsky, L., Diguer, L., Seligman, D. A., Rosenthal, R., Krause, E. D., Johnson, S., *et al.* (1999). The researcher's own therapy allegiances: a "wild card" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice, 6*, 95–106.

Lukoff, D., Edwards, D., & Miller, M. (1998). The case study as a scientific method for researching alternative therapies. *Alternative Therapies Health Medical, 4*, 44–52.

Lundvik Gyllensten, A., Gard, G., Salford, E., & Ekdahl, C. (1999). Interaction between patient and physiotherapist: a qualitative study reflecting the physiotherapist's perspective. *Physiotherapy Research International, 4*, 89–109.

Maas, M. L., Buckwalter, K. C., Reed, D., & Pringle Specht, J. K. (1998). Quasi-experimental designs. In P. J. Brink & M. J. Wood (Eds.), *Advanced design in nursing research.* Newbury Park: Sage.

Mallinson, T., Kielhofner, G., & Mattingly, C. (1996). Metaphor and meaning in a clinical interview. *American Journal of Occupational Therapy, 50*, 338–346.

Marshall, G. N., & Lang, E. L. (1990). Optimism, self-mastery, and symptoms of depression in women professionals. *Journal of Personality and Social Psychology, 59*, 132–139.

Mattingly, C. (1991). The narrative nature of clinical reasoning. *American Journal of Occupational Therapy, 45*, 998–1005.

Mattingly, C. (1998). *Healing dramas and clinical plots. The narrative structure of experience*. Cambridge: Cambridge University press.

Mattingly, C., & Fleming, M. H. (1994). Interactive reasoning. Collaborating with the person. In C. Mattingly & M. H. Fleming (Eds.), *Clinical reasoning. Forms of inquiry in a therapeutic practice*. Philadelphia, PA: F.A. Davis Company.

McColl, M. A., Paterson, M., Davies, D., Doubt, L., & Law, M. (2000). Validity and

community utility of the Canadian Occupational Performance Measure. *Canadian Journal of Occupational Therapy, 67*, 22–30.

McKinnon, A. L. (2000). Client values and satisfaction with occupational therapy. *Scandinavian Journal of Occupational Therapy, 7*, 99–106.

Mee, J., & Sumsion, T. (2001). Mental health clients confirm the motivating power of occupation. *British Journal of Occupational Therapy, 64*, 121–128.

Merriam, S. B. (1988). *Case study research in education.* San Francisco, CA: Jossey- Bass Inc.

Mishler, E. G. (1986). *Research interviewing: context and narrative*. London: Harvard University Press.

Morris, B. M. (1995). The diagnostic drawing series and the tree rating scale: an isomorphic representation of multiple personality disorder, major depression, and schizophrenia populations. *Journal of the American Art Therapy Association, 12*, 118–128.

Nagle, S., Valiant Cook, J., & Polatajko, H. J. (2002). I'm doing as much as I can: occupational choices of persons with a severe and persistent mental illness. *Journal of Occupational Science, 9*, 72–81.

Nguyen, T. D., Attkisson, C. C., & Stegner, B. L. (1983). Assessment of patient satisfaction: development and refinement of a service evaluation questionnaire. *Evaluation Program Planning, 6*, 299–314.

Nordholm, L. A., Adamson, B. J., & Heard, R. (1994). Australian physiotherapists' and occupational therapists' views on professional practice. *Journal of Allied Health, 24*, 267–282.

Palmadottir, G. (2003). Client perspectives on occupational therapy in rehabilitation services. *Scandinavian Journal of Occupational Therapy, 10*, 157–166.

Palmadottir, G. (2006). Client-therapist relationships: experiences of occupational therapy clients in rehabilitation. *British Journal of Occupational Therapy, 69*, 394–401.

Patrick, J., & Winship, G. (1994). Creative therapy and the question of disposal: what happens to created pieces following the session? *British Journal of Occupational Therapy, 57*, 20–22.

Pearlin, L. I., Menaghan, E. G., Lieberman, M. A., & Mullan, J. T. (1981). The stress process. *Journal of Health and Social Behavior, 22*, 337–356.

Persson, D. (2001). *Aspects of meaning in everyday occupations and its relationships to health-related factors.* Lund University, Lund.

Polit, D. F., Beck, C. T., & Hungler, B. P. (2001). *Essentials of nursing research. Methods, appraisal, and utilization* (5th ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education, 8*, 5–23.

Polkinghorne, D. E. (1996). Transformative narratives: from victimic to agentic life plots. *American Journal of Occupational Therapy, 50*, 299–305.

Price-Lackey, P., & Cashman, J. (1996). Jenny's story: Reinventing oneself through occupation and narrative configuration. *American Journal of Occupational Therapy, 50*, 306–314.

Rankin, A. (1994). Tree drawings and trauma indicators: a comparison of past research with current findings from the Diagnostic Drawing Series. *American Art Therapy Association, 11*, 127–130.

Reilly, M. (1962). Occupational therapy can be one of the great ideas of 20th century medicine. *American Journal of Occupational Therapy, xvi*, 1–9.

Reynolds, F. (2003). Reclaiming a positive identity in chronic illness through artistic occupation. *OTJR: Occupation, Participation and Health, 23*, 118–127.

Reynolds, F., & Prior, S. (2003). 'A lifestyle coat-hanger': a phenomenological study of the meanings of artwork for women coping with chronic illness and disability. *Disability and Rehabilitation, 25*, 785–794.

Riessman, C. K. (1993). *Narrative analysis. Qualitative research methods*. London: Sage.

Rogers, C. R. (1951). *Client-centered therapy*. London: Constable & Robinson Ltd.

Sahlin, N.-E. (2001). *Kreativitetens filosofi [The philosophy of creativity]*. Nora: Bokförlaget Nya Doxa.

Saunders, E. J., & Saunders, J. A. (2000). Evaluating the effectiveness of art therapy through a quantitative, outcomes-focused study. *Arts in Psychotherapy, 27*, 99–106.

SBU. (1992). *Behov av utvärdering i psykiatrin [The need for evaluation in psychiatric care]*. Stockholm: Statens beredning för utvärdering av medicinsk metodik [The Swedish Council on Technology Assessment in Health Care].

Schmid, T. (2004). Meanings of creativity within occupational therapy practice. *Australian Occupational Therapy Journal, 51*, 80–88.

Smith, G. J. W., & Carlsson, I. M. (1990). *The creative process: a functional model based on empirical studies from early childhood to middle age*. Madison: International Universities Press.

SOU. (2006). *Ambition och ansvar. Nationell strategi för utveckling av samhällets insatser till personer med psykiska sjukdomar och funktionshinder [Ambition and responsibility. A national strategy for the development of society's support for the mentally ill and mentally disabled]* (Slutbetänkande av nationell psykiatrisamordning [The national board of health and welfare] No. 100). Stockholm: Statens Offentliga Utredningar.

Spencer, J., Krefting, L., & Mattingly, C. (1993). Incorporation of ethnographic methods in occupational therapy assessment. *American Journal of Occupational Therapy, 47*, 303–309.

Steinhardt, L. (1995). Longterm creative therapy with a borderline psychotic boy. *American Journal of Art Therapy, 34*, 99–106.

Stenlund, G. (2002). *Psykodynamisk korttidsterapi. En intensivstudie av samspel, förändring och utfall [Psycho-dynamic short-term therapy. An intensive study of interplay, change and results]*. Lund University, Lund.

Steultjens, E. M. J., Dekker, J., Bouter, L. M., Leemrijse, C. J., & van den Ende, C. H. M. (2005). Evidence of the efficacy of occupational therapy in different conditions: an overview of systematic reviews. *Clinical Rehabilitation, 19*, 247–254.

Steward, B. (1996). Creative therapies. In M. Willson (Ed.), *Occupational therapy in short-term psychiatry* (3rd ed. ed., pp. 173–194). Edinburgh: Churchill Livingstone.

Streiner, D. L., & Norman, G. R. (2003). *Health Measurement Scales. A practical guide to their development and use.* (3rd ed.). Oxford: Oxford University Press.

Swedish Association of Occupational Therapists [Förbundet Sveriges Arbetsterapeuter (FSA)]. (1999). *Canadian Occupational Performance Measure Swedish version (Svensk version)*. Stockholm: Förbundet Sveriges Arbetsterapeuter.

Swedish Research Council. (2003). *Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning [Research ethical principles of humanistic – socialscience research]*. Stockholm: Elanders Gotab.

Svensk, A.-C., Öster, I., Engberg Thyme, K., Magnusson, E., Sjödin, M., Eisemann, M., *et al.* (in press). Art therapy improves experienced quality of life among women undergoing treatment for breast cancer: a randomized controlled study. *European Journal of Cancer Care*.

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

Taylor, S. J., & Bogdan, R. (1998). *Introduction to qualitative research methods. A guidebook and resource* (3rd ed.). New York: John Wiley & Sons Inc.

Thompson, D. (Ed.). (1995). *The concise Oxford dictionary* (9th ed.). Oxford: Clarendon Press.

Thompson, M., & Blair, S. E. E. (1998). Creative arts in occupational therapy: ancient history or contemporary practice? *Occupational Therapy International, 5*, 48–64.

Tillhagen, C.-H. (1995). *Skogarna och träden [The forests and the trees]*. Stockholm: Carlssons.

Townsend, E. A., & Polatajko, H. J. (2007). *Enabling occupation II: advancing an occupational therapy vision for health, well-being, & justice through occupation*. Ottawa, Ontario: CAOT Publications ACE.

Vedung, E. (1998). *Utvärdering i politik och förvaltning [Evaluation in politics and public administration]* (2nd ed.). Lund: Studentlitteratur.

WHO. (1993). *The ICD-10 classification of mental and behavioural disorders*. Geneva: World

Health Organization.
Wicks, A., & Whiteford, G. (2003). Value of life stories in occupation-based research. *Australian Occupational Therapy Journal, 50*, 86–91.
Wilcock, A. A. (1998). Reflections on doing, being and becoming. *Canadian Journal of Occupational Therapy, 65*, 248–256.
Wilcock, A. A. (2006). *An occupational perspective of health* (2nd ed.). Thorofare, NJ: Slack Inc.
Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock Publications.
Winnicott, D. W. (1986). *Home is where we start from*. London: W.W. Norton & Company.
Wood, M. J., & Brink, P. J. (1998). Correlational designs. In P. J. Brink & M. J. Wood (Eds.), *Advanced design in nursing research*. Newbury Park: Sage.
Wordreference.com. (2008). *English dictionary*. from http://www.wordreference.com/definition/process.
Wressle, E., Marcusson, J., & Henriksson, C. (2002). Clinical utility of the Canadian Occupational Performance Measure – Swedish version. *Canadian Journal of Occupational Therapy, 69*, 40–48.
Wressle, E., Samuelsson, K., & Henriksson, C. (1999). Responsiveness of the Swedish version of the Canadian Occupational Performance Measure. *Scandinavian Journal of Occupational Therapy, 6*, 84–89.
Vygotskij, L. S. (1995). *Fantasi och kreativitet i barndomen [Fantasy and creativity in childhood]* (K. Öberg, Trans.). Göteborg: Bokförlaget Daidalos. (Original work published 1930).
Yin, R. K. (1989). *Case study research.* Newbury Park: Sage.
Öster, I., Magnusson, E., Engberg Thyme, K., Lindh, J., & Åström, S. (2007). Art therapy for women with breast cancer: the therapeutic consequences of boundary strengthening. *Arts in Psychotherapy, 34*, 277–288.
Öster, I., Svensk, A. C., Magnusson, E., Engberg Thyme, K., Sjödin, M., Åström, S., *et al.* (2006). Art therapy improves coping resources: a randomized, controlled study among women with breast cancer. *Palliative and Supportive Care, 4*, 57–64.

Paper I

Scandinavian Journal of Occupational Therapy. 2006; 13: 229–240

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

The Tree Theme Method in Psychosocial Occupational Therapy: A Case Study

A. BIRGITTA GUNNARSSON[1], JAN-ÅKE JANSSON[2] & MONA EKLUND[1]

[1]*Department of Health Sciences, Division of Occupational Therapy, Lund University, and* [2]*Department of Psychology, Lund University, Lund, Sweden*

Abstract
This study aimed to describe the Tree Theme Method (TTM) as a method for intervention in psychosocial occupational therapy. The TTM is based on theories concerning creative activities and occupational storytelling and story making. In order to exemplify the method a case study of a treatment process with follow up was undertaken. The participant was a female client suffering from anxiety and depression. During an interview the client painted symbolic trees on five different occasions with specific variations of the tree theme: a tree symbolizing her present life, her childhood, adolescence, adulthood, and, finally, a tree representing her future. The trees were used as starting points for the client to tell her life story. The intention was that she would find new strategies for how to change her daily life. Three years later there was a follow up stage where the client painted new trees and told her story. Some life themes were identified. The TTM appears suitable for intervention in psychosocial occupational therapy. In future studies the TTM should be subjected to evaluation research based on several clients in order to develop a deeper understanding of the process and what kind of results changes in the TTM intervention may provide.

Key words: *Creative activities, intervention, mental health*

Introduction

Creative activities, for example painting or sculpture, are often used in psychosocial occupational therapy. The purpose is to stimulate communication by encouraging clients to express experiences, feelings, and thoughts in order to enhance self understanding and develop better relations towards others (1–4). Clients' everyday life experiences as reflected in interventions based on creative activities can be used to change their life situation and restore their competence as active and independent persons (5–7).

In creative activities the concepts of *doing*, *being*, and *becoming* are of interest. A balance between these concepts makes a person an individual with an identity of her or his own (8). When a client participates in creative activities, such as painting a picture (*doing*) and reflecting on it afterwards (*being*), the verbal conversation between the client and the occupational therapist can promote a development of the client's self image (*becoming*) and of how she or he relates to the environment. In essence, the process with creative activities (*doing* and *being*) is helpful for supporting a person in becoming one who is able to compose his or her own life.

One way of reflecting on how people compose their lives is by creating narratives, as life stories render important knowledge about how we form our lives (9–11). A life story intervention is not only telling a story about the past, it is also a way to understand one's actions and how to act. By telling your story and experiences, you define not only yourself and tell others who you are, but also who you want to be, as well as your experiences of your environment. It is a way of making life experiences meaningful (9). A life story can be presented in the form of facts, in metaphors, or as expressive creativity (9,12).

When employing occupational therapy a narrative approach may result in occupational life stories,

Correspondence: Birgitta Gunnarsson, MSc OT Reg, FoU centrum, PO Box 1223, SE 351 88 Växjö, Sweden. Tel: +46470 589078. Fax: +46470 586455. E mail: birgitta.gunnarsson@ltkronoberg.se

(Received 8 November 2005; accepted 20 March 2006)

ISSN 1103-8128 print/ISSN 1651-2014 online © 2006 Taylor & Francis
DOI: 10.1080/11038120600772908

which is when a person talks about his or her life and occupations. Life stories are useful for occupational therapists because this narrative form of information brings out knowledge about occupations performed, the meaning attached to occupations, and any interactions with others, in a life course perspective (13).

Occupational life stories may include storytelling and story making. As a structure for the professional conversation of occupational therapists, Clark's Grounded Theory on the Techniques of Occupational Storytelling and Occupational Story Making is useful. This technique concerns three main areas, which develop through interplay. At the beginning the focus is on finding a *Communal Horizon of Understanding*, based on collaboration and empathy, including small talk, listening actively, and reflecting. Gradually the other areas come into focus. *Stimulating Occupational Storytelling* means encouraging the client to tell her or his story about her/his past and present life situation. The therapist supports the client in putting the story into context by making a reflective analysis and synthesis of daily occupations in relation to time as well as value. The third part is S*tory Making*, where the occupational therapist uses special techniques to support the client in forming possibilities for the future. Such techniques lead to occupational coaching, evoking insight into limitations and possible solutions, broadening views of activities in everyday life, reconstructing one's self image reconstruction, and recovering one's cultural position (14,15). This present study is based on the idea that creative activities like painting a tree may be used for occupational storytelling and story making.

The Tree Theme

A theme used in creative activities is to paint a tree symbolizing oneself. The tree is an old symbol that humans have used in different cultures to symbolize themselves and their present life situation. Trees have a long length of life, which tie time and the different generations together (16,17). The tree demonstrates variations in life through its seasonal cycle. The life of a human from birth to death can be symbolized as the development from a seed to a tree, which first becomes fully grown then later withers and dies. A tree symbolizes many things. For example it can symbolize development, like the physical growth or the mental process of maturity (17,18). Most people have seen a tree and almost everyone believes he or she can draw one. According to Kellogg one of the first motifs a child draws is a tree (19). The tree theme has been applied as an assessment as well as a method for treatment in different clinical contexts (18,20–24).

The tree is a common symbol in art therapy and also for occupational therapists using creative activities. In Gunnarsson (25) the purpose of the Tree Theme is to stimulate storytelling from an occupational perspective. The Tree Theme Method (TTM) is a method whereby the tree theme is combined with a creative activity, painting, and a narrative approach comprising occupational storytelling and story making (14,15). The painting and storytelling correspond to the concepts *doing* and *being*, as described by Wilcock (8). The TTM provides prerequisites for a process of change (*becoming*), which has a focus on individual resources and difficulties in the physical, mental, sociocultural, and spiritual aspects of life (26).

At present the TTM is implemented in occupational therapy within mental health care in different clinics in Sweden. So far it has not been evaluated or studied scientifically. There is a need to develop intervention methods that are holistic and client centred and the TTM, with its focus on occupational storytelling and story making, should fulfil these requirements. Therefore, the main aim of this study was to describe the TTM as a method for intervention in psychosocial occupational therapy, in the shape of a case study of a treatment process with follow up. Specific aims were:

- to describe how the intervention may be implemented, as illustrated by the case;
- to examine how the client perceived the intervention process, including a long term view;
- to sum up the life story resulting from the occupational storytelling and story making into life themes.

Material and method

In order to exemplify the TTM, a case study method (27) was applied. Case studies are appropriate when one wishes to make an analysis of a specific phenomenon, generating theoretical arguments. It is applicable to studies in a holistic perspective, seeking understanding of complex processes (28). Case studies are also useful in exploring communication patterns between the client and the therapist (29) and applicable to researching alternative therapies with the purpose of generating findings in this field (30).

The Participant

This was a longitudinal study comprising one of the first cases where the TTM was used. The participant was chosen among clients whom the first author met through her ordinary work as an occupational

therapist in a psychiatric outpatient clinic. Two criteria had to be fulfilled. The person should be newly accepted at the clinic and be able to reflect on his or her life course. The outpatient who was asked and accepted to participate was a woman seeking help for anxiety and depression, and who was given a diagnosis of panic disorder, without agoraphobia with secondary depression, according to DSM IV (31). The study was approved by a research ethics committee.

The client, here called Maria, was about 30 at the time of the first data collection. She was married and had three children. Maria lived in a village and worked as a blue collar worker. She described her life as being quite ordinary. Her mother in law had died of cancer three years earlier, which had made Maria anxious that something would happen to her children or herself. After a lengthy infection Maria reacted with strong heart palpitations. She thought she was going to die and went immediately to the hospital where she was examined, but the doctors found nothing wrong. After this incident, Maria's mood changed and she lost her sense of meaning. Normally she was a very active person; now she had become passive. She often cried, was anxious, and could not sleep. She was afraid to be alone. At this point she contacted the psychiatric outpatient clinic and was offered sleeping pills, antidepressants, and focused therapy with the TTM amounting to five sessions.

The TTM

The TTM was used as an occupational therapy intervention based on the theories from occupational therapy, life storytelling, and creative activities (including the symbolism of a tree) presented in the introduction.

The method implied that the client was requested to paint trees with certain specific variations for each one. During the first of the five sessions Maria painted a tree symbolizing her present life situation. In the second session she painted a tree representing her childhood. In the third session she painted a teenage tree, in the fourth an adult tree, and in the last session one representing a future tree. The occupational therapist introduced the theme, painting a tree, during a modified progressive relaxation exercise according to Jacobson (32,33), which means alternating between contracting and relaxing various muscle groups, one at a time, starting with the lower extremities and progressing through the whole body. The client was given the question: How can a tree with roots, trunk, and crown symbolize your personality, activities, interests, and relations to others? The focus was on the client's resources as well as on her limitations.

The materials used were sheets of paper, 40×48 cm, watercolours, and oil crayons. Maria was requested to paint in silence, to enhance the possibility for her to get in touch with her thoughts, feelings, and needs. The occupational therapist, i.e. the first author, remained in the room, silent. When the painting was finished it was hung on the wall.

The storytelling (15) then began with the tree as a starting point. By looking at the picture from a distance both mentally as well as physically, Maria was free to talk about the Tree as a tree or to talk about the Tree as herself. The occupational therapist helped with questions and associations in order to stimulate Maria's storytelling as she interpreted and talked about what her picture represented. The purpose of the TTM was to start a process of inner communication, reflection, and also of interaction between the client and the occupational therapist. Maria's current and earlier resources and limitations were identified and discussed. In order to start the process of story making the occupational therapist stimulated her and offered different strategies for her to continue with in her daily life.

The TTM was used as a tool for Maria's storytelling and story making. The structure for the professional conversation was Grounded Theory on the Techniques of Occupational Storytelling and Occupational Story Making, where the whole life course is included (14,15). As support for the occupational therapist, in facilitating the verbal conversation after the painting session, guidelines for the interview (34) inspired by Hark (23) and Koch (24) were used. They focused on different aspects of the roots of a tree (are there any roots, what do they look like, and how do they grow?), the trunk (is it straight or bent, thin or thick, knotty or crooked?), the crown (in what direction do the branches grow, has the crown thin or thick branches, buds, leaves, or fruit?) and the tree as a whole (for example colours, movement, rigidity, proportions, and vitality). It also focused on the environment of the tree (intimacy and distance, are there other trees close by, how is the local environment shaped?). The guidelines for the interview served as a means for putting questions that would stimulate Maria's story telling and were not used for interpreting the picture. During the last session, in order to emphasize the process of story making, a review of the former tree pictures was carried out. This concentrated on similarities and differences between the pictures, the positive and negative aspects that emerged from the pictures and the storytelling, recognized repetitions in the pictures, and identified, acknowledged, and neglected resources and limitations. An

important aspect in this review was to focus on possible changes for the future.

The data collected were of two kinds, the trees painted by Maria and her life story narration, which together formed occupational storytelling and story making (14,15). This implies an effort to create an atmosphere of collaboration between the client and the occupational therapist in order to stimulate the client to tell her story freely. The occupational therapist must take an active listening attitude towards the story in order to get as full an understanding as possible of all its meaning and aspects.

Procedure

Data were collected longitudinally over two periods, an intervention period and a follow up stage three years later.

The first period of data collection consisted of five sessions based on the TTM. Starting from every tree, the client's life story was built up with a focus on occupation. In order to facilitate the conversation the occupational therapist used the guidelines for the interview. Storytelling and reflections on the present situation (*doing* and *being*) were used. In the final session, there was active reflection on the trees painted earlier as a starting point for a dialogue between the client and the occupational therapist. After reflecting, Maria painted her "future" tree, where the focus was on story making and finding more adaptive strategies for the future (*becoming*).

In between the first period of data collection and follow up three years later, there was some clinical contact between the occupational therapist and the client, documented in the clinical record, which constituted another data source for the study.

The follow up sessions three years later consisted of one interview and two TTM sessions. The interview was thematic and was about Maria's experiences from the process three years earlier and whether the TTM had influenced her approach to everyday life in the long term. Interview themes used were, "Maria's life situation before the first TTM sessions", "What about painting and storytelling", "Memories from each of the trees and the life story starting from these trees", "The TTM as a beginning for further reflections" and "The life situation after going through the sessions". The data collection then continued with two tree theme sessions, carried out according to the TTM, the first theme being the present life situation and the second a perspective on her future. Afterwards Maria was stimulated to compare the former "future" tree with the new one. The last session concluded with a short interview regarding Maria's reflections on participating in the TTM in this second series of sessions.

The communication between the occupational therapist and Maria was tape recorded. Immediately after each session the occupational therapist made her own notes on her spontaneous impressions and reflections. Each recording was transcribed in total before the next session, which in Merriam's (27) and Kvale's (35) opinion becomes part of an interpreting process and analysis.

Data analysis

The data analysis included two parts, in order to address the specific aims. First, the aims to describe how the intervention may be implemented and the examination of how the client perceived the intervention process were addressed by means of a case record (27). The second part of the analysis, corresponding to the third specific aim, proceeded from this case record and implied identifying themes in the participant's life story, in order to distinguish the strategies she used to find meaning in life (27).

The case record was composed by summarizing the biographical data, including the periods of therapy, along a timeline. Then the analysis of important life themes was in turn performed in several steps. The audiotapes were first listened to all the way through and then transcribed by the first author. In the second step the data were condensed by the first author and an experienced occupational therapist made a peer review of the process of analysis from the raw data. The third step was to use a holistic approach to find important life themes. This meant going back to the raw data to examine how the themes corresponded to the original statements. Further, by reading the data as a whole several times the first author and the experienced occupational therapist refined the life themes. The final themes were formulated in a discussion between the first author and the peer researcher. Last, the second and third authors read and commented on the statements, and they could confirm the trustworthiness of the procedure. The analysis focused on the process of the client and her important life themes, before, during, and after the intervention and at follow up. Life themes may be seen as patterns influencing one's feelings, thoughts, and actions during one's everyday life. They are not meant to be an exact copy of the historic truth. Rather, the storyteller gives his or her view of life and that story is subjective. The approach is more focused on the experiences of the storyteller than on external validity (9). Furthermore, a life storytelling should be treated as a coherent whole (12). These were leading principles for the analysis of this study.

Results

Period of Intervention

In the first session Maria painted a tree (Figure 1), where the roots, trunk, and crown symbolized her life at that moment. It was a birch, but was coloured brown. The branches were hanging low and had only a few leaves in brown and yellow. Maria said that as she felt sad she painted a withered tree. She had painted the roots so that they were visible above the ground, because she did not feel strong and stable. She could not take care of her family or manage the household or job any longer. The only thing she felt capable of doing was making her own breakfast. She felt gloomy and had no hope of there being any change. The only positive thing she could think of was a walk she had taken the day before and she was therefore encouraged by the occupational therapist to go on taking walks.

One week later, when she came for her next session, Maria said that she had been crying a lot and that during the previous days she had felt empty inside. This time she painted a tree that symbolized her childhood. She painted a birch with a white trunk and green leaves because her childhood had been a pleasant time. She had felt secure within her family and up to her teenage years she described herself as a playful child. Her main problem was that she was shy. She had always been afraid to engage in new activities and make new friends. Maria also talked about her present life. Since the last session she had managed to go shopping, which she had enjoyed. Because of her previous experiences of being shy she had now engaged herself more in her own children, supporting them in trying new activities and meeting new friends.



Figure 1. The tree, symbolizing Maria's life at the present moment.

When Maria came for her third session one week later, she said that she felt better, although she had not slept well. She had tried to participate in family life again. This time the theme focused on her teenage years. She painted a birch, but the roots, the trunk, and the branches were brown. There were a few leaves in green and yellow. She could recognize the same gloominess in this teenage tree as in her first tree painting. She had met her husband at the age of 14. When with him she was not shy, but when they met their friends she was often quiet. When the others got drunk, she felt gloomy, just like now. At that time she did not see herself as being capable of going to college so she began working in the same industry as the rest of her family. Now, at the time of the third tree session, Maria regretted her choice of work. Her fear of new things happening had increased. She had also become more and more afraid that something such as an accident would happen to her or her family. During the past weeks she had tried to think differently by having more positive thoughts.

Two weeks later, at the fourth session, Maria was feeling much stronger and more alert. She was not anxious any more and was sleeping better. Maria said she was more active at home again and that she had more confidence in herself. The occupational therapist encouraged her to go on doing things in her everyday life, such as pottering about doing household chores. She was busy with the household, and she said that the rest of the family had noticed that she was happy again. She had planned to go back to work half time. During this session she painted a tree symbolizing the period in her life as an adult. Maria painted a white birch with roots and a stable trunk. The crown had leaves in varied green colours. Some branches were thin and others were thicker. Maria reflected on this and remembered that when her mother in law got cancer she had been forced to support the rest of the family. At the same time she was pregnant and needed more support than she actually received. She started more often thinking "the worst will happen" and became afraid and anxious. At this session the occupational therapist offered her a strategy "instead of thinking that the worst will happen". She should try to think according to an occupational approach such as "STOP" (Stop, Think, Orientate, and Plan), and use that strategy as a tool for finding new ways of acting.

After a week, at the last appointment, Maria painted a tree symbolizing the future (Figure 2). Before Maria painted this tree, she and the occupational therapist looked back at the previously painted trees. By focusing on her resources as well as on her limitations, Maria, in collaboration with her occupational therapist, had the possibility to reflect on her

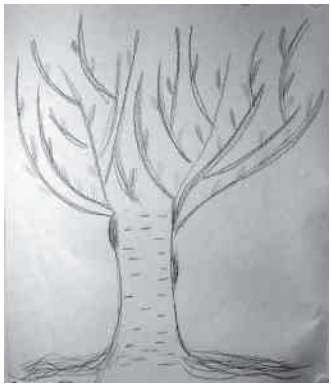


Figure 2. The tree, symbolizing Maria's future.

situation with a view to finding more adaptive strategies for the future. She painted a strong birch with leaves of green and yellow. There were also some knots on the trunk, which symbolized that she had managed to come through this bad experience of anxiety and depression. Now she felt she would manage if "the worst happened", for example a mental or a somatic disease. She expected that both good and bad events in life would happen in the future. Maria was now active as a member of her family and back at work. She felt more ready to make decisions for herself and her family. She decided to work part time until the children have grown up. Maria and her husband had started to allow the children to do more things on their own, like cycling to their friends or making their own snacks. Maria took walks almost every day, a habit that she wanted to continue. Often when she and her husband walked together they talked about practical things, as well as emotions. Maria now had more confidence in herself than at the start of the therapy and it was easier for her to talk about herself and others. However, she was still a bit shy but was willing to make an effort in order to change this behaviour. Maria's story indicated that she had managed to become an actor in her own life.

Maria's Everyday Life between the Period of Intervention with the TTM and Follow up

One month after the fifth TTM session Maria and the occupational therapist, the first author, met for a planned conversation. Maria was pleased and active. She said that she was able to enact in her everyday life the changes she had decided on. Maria now worked part time. She and her husband continued to take walks together now and then. They had also been to a movie and to a restaurant. They both had the ambition to engage themselves in an activity outside their home, once a month. Setting reasonable limits on their children had worked successfully. Maria explained that she could still feel worry, but that she tried to think "This is not dangerous".

Life was going on, with her job, housework, and caring for her family and relatives. After six months she was phasing out the antidepressants. A year later there were some incidents in her family: one of Maria's children got pneumonia and at the same time Maria had several gallstone attacks. She had to be operated and was on the sick list for a month. This resulted in her being sleepless and anxious. She contacted her doctor who ordered antidepressants again, but Maria was ambivalent about this solution. Before deciding to start taking medicine she made contact with her occupational therapist, i.e. the first author. Maria explained about the strong anxiety she felt when there were difficulties in her family and her fear of taking antidepressants again. They talked about the troubles but also how to find strategies to handle them. After visiting the occupational therapist at the clinic three times, Maria again felt more competent, but she was still in need of additional help and she decided to try the medicine. Very soon she once again became an active member in her family and could return to work.

Follow up Three Years Later

Recapitulation of the intervention. Three years after the intervention period Maria and her occupational therapist met again for the purpose of this case study. The follow up started with an interview where Maria talked about her experiences and memories from the TTM three years earlier. Maria found it very helpful to paint trees and to tell her life story. She reminded herself of an ordinary day three years ago, before the therapy started. It was a busy day. She had to take care of her family, her job, and then do the household work. "Everything was just rushing ahead" and there was no time for rest, which Maria saw as one of the causes of her illness. She remembered her earlier anxiety and difficulty in sleeping. She felt afraid, lonely, and alienated from her daily family life. "I had only negative thoughts in my head".

Maria remembered the first meeting with the occupational therapist. At first she thought it was strange to paint trees but she needed help, which she got. She remembered the first tree as being withered. She painted it with short roots because it "could easily fall, at that time". Maria imagined the next trees as being healthier; it seemed that she remembered these trees as forming a whole. Maria thought it was good to use the method of tree painting and storytelling. By drawing a tree with its roots and

leaves in different seasons you can express your feelings and thoughts, Maria said. "The medicine and the conversations with the occupational therapist were good, but it is 'in painting' that one could express oneself and how one felt." Her daily life changed between all the sessions, and she got more active and involved. She became more positive and could enjoy life. She experienced herself three years earlier as being more dependent, shy, and always expecting "the worst" to happen. This had changed in a more positive direction nowadays. The decisions she had made while she painted and talked about her "future" tree were still being acted upon. She had stopped taking sleeping pills, went for walks, had more time with her husband, and went on working part time. She would never forget how bad she had felt but said that it had also given her the experience of working on difficulties.

The TTM at Follow up. Besides the interview there were two new Tree Theme sessions. At the first session Maria again painted a tree symbolizing her current life situation. It was a brown oak with long roots that could partly be seen above the earth. The trunk was stable and there were several branches with leaves in varied green colours. On some branches there were also some leaves in yellow and black, which reminded her that there are bad days at times but that she can handle them nowadays. The roots showed that the tree was stable. Maria meant she now felt stronger and had people close to her who knew what mental illness is about. One of her new strengths was that she no longer thought "the worst will happen". In the mornings she had to hurry, because she was sleepy and would always get up late, but at work she was not agitated. She liked her job, even if it was a bit monotonous. Her workmates were sympathetic and some of them had similar experiences of not feeling well. Nowadays she had the courage to tell her boss when something went wrong, which she did not do three years before; the same was true for parent–teacher meetings. In her spare time she had a lot of housework to do as well as caring for the children. She spent more time on this than her husband did. She also had some time of her own, which she used to listen to music.

At the next session Maria painted a tree symbolizing the future (Figure 3). It was a brown broad leafed tree, like an oak, with long and powerful roots. The trunk was stable with some knots and there were many branches with leaves of different colours. There were also two broken branches and some leaves in yellow and brown. In the crown there was a bird's nest and on one stable branch hung a swing.



Figure 3. Maria's new "future tree", three years later.

Maria described her tree as stable and old and growing in rich earth. The broken branches reminded Maria that more bad days could come if she should live a long life. Such things as illness or death might fall on herself, her family, or her friends. But these things were now not "the worst". "The worst thing" was if her anxiety and depression were to come back. Somehow, she had now learnt more about herself and she did not have to be afraid. In a far away future Maria hoped to have grandchildren. The swing in the painting was a symbol for that. But not yet – now she wanted to engage in different activities with her husband and children. She also stated that a bird's nest and a tree belong together; that is life.

During this second session Maria made a comparison between the "future" tree of three years before and the "future" tree of today. She was surprised, because the former tree was weaker than she remembered. She thought it was a strong tree just as the new one was. In conclusion, Maria thought the intervention based on the TTM had been helpful to her and now served as a basis for her everyday life. Similarly, Maria found the follow up sessions fruitful and felt that they served as an opening for reflecting on both what she still had to change and what was working well in her current life.

Life Themes. Four important life themes formed Maria's course through life. When telling her story of the period in her life from early childhood until adulthood using the TTM intervention Maria had *been shy*. This had led to difficulties in saying "no" and in her expressing her own opinions. She never dared to try new activities when she wanted to. Having gone through the first sessions, and even more so at the follow up sessions, she was more able

to state her own view and set limits to others. She managed to listen to others as well as to talk about her own experiences. She was able to listen to advice but in the end made her own decisions regarding her activities, at home, at work, or at her children's school.

Being *close to the family* was the second life theme. Maria felt safety in the company of her family and relatives but it also led to limitations for her in the form of her not testing her resources at school or at her job, or trying to find new interests. At the time of the follow up, Maria still saw her childhood family as well as her new family as the basis for her safety. But she had begun to reflect on other possibilities. In the future she might go for a new job or start studying. At the follow up, it was noted that Maria and her husband now engaged themselves in more activities outside their home, and Maria looked forward to taking part in them. She revealed that as the children grow older she and her husband will have more time to spend together and she also pointed to some interests that were "only for herself".

The third life theme is *being afraid the worst thing will happen*. Maria's experiences when her mother in law developed cancer produced negative thoughts that something unexpected would happen. She felt anxious each time that she or one of her children became ill. The fear that somebody would die or that she would not be in control of her life situation was always on her mind. At the end of the intervention period Maria had managed to go through a difficult period of anxiety and depression with positive results. To master her situation she learned to adopt the occupational strategy "STOP" (Stop, Think, Orientate, and Plan) and she had continued to use this strategy as a tool for finding new ways of acting. At the time of the follow up, Maria still maintained her self confidence and thought she could manage other difficulties; however, she accepted that there could be some more trying experiences in her future life.

The fourth theme was *the feeling of being alienated*. As a child she did not dare to play with other children as much as she wanted to, even though they did not shut her out. She mostly played with one of her younger relatives. As a teenager she felt depressed when spending her spare time with her husband to be and their friends. Other friends shared different interests in which she was not involved. When as a grown up she developed anxiety and depression she felt alienated from her family – they were healthy but she was not. She did not manage to keep up with the daily chores at home or at work as she had done earlier. At the end of the intervention period Maria regained her active role at home as well as at her workplace. At parent–teacher meetings she now felt that she was just like any of the other parents. At the follow up session she painted a tree showing power and life, which contained "all in life".

Discussion

This study showed the potential importance of the TTM as a therapeutic method for clients with mental disorders. People with a mental illness may have difficulties in expressing their problems and in verbalizing their feelings and thoughts. While not feeling well they may become more and more introvert. Wilcock (36) argues that humans have a fundamental need to be occupied and stimulated in order to survive. Being active, using their creative capacity can be advantages for their mental health. Creative activities are often used in implicit occupational therapy (37), with the purpose of stimulating communication and also to increase specific functions. Painting trees and telling one's story while participating in the TTM gives possibilities for the client to acquire new knowledge about him or herself and develop strategies for how to act in specific situations in life. The TTM is an application in clinical practice that looks at the client's life pattern in a holistic perspective which enables the client to look back at her/his progress through life, and which results in what Mattingly (38) has characterized as conditional clinical reasoning. Further, the TTM may be regarded as a client centred method for intervention (26).

In the present study the TTM as a method for telling one's story (9), by using Clark's Grounded Theory on the Techniques of Occupational Storytelling and Occupational Story Making (14,15) in combination with the tree paintings strengthened the identity of the client. By telling her life story, the inner motivation for changing her life seemed to increase the possibility to be an active person and engage in her everyday life. According to Wilcock (8) the process with the TTM (*doing* and *being*) was helpful for the client to *become* someone who is capable of composing her own life.

Maria's process

Atkinson (9) exemplifies photos and even other forms of memorabilia as being helpful when recalling important events and experiences of one's life. When looking at Maria's paintings at the end of the period of intervention, it was easy for her and the occupational therapist to recapitulate what they had talked about in the earlier sessions. The pictures of the trees became like building blocks of a timeline, reflecting not only special events but also "the whole life". At the interview three years later, Maria remembered

her former tree paintings, especially the first withered tree. The other trees she remembered as a whole: they were all birches. When recalling her memories of the trees, she also remembered the storytelling and story making that she had spoken of. When Maria painted (*doing*), reflected (*being*) and told her story, her sense of identity appeared to get stronger and she came to look upon herself as a capable person.

According to Maria's storytelling it seemed to be easy for her to associate her own life situation with different trees. For example, she could let deep roots symbolize a sense of stability, to be stable as a person. The crown symbolized Maria's feelings as they were at that period in life to which the theme alluded; for example, the first painted crown was withered, just like she was when the intervention started. In the final follow-up session, Maria painted a healthy and strong oak as her "future" tree, and Maria imagined herself as being healthy and powerful in the future too.

According to Clark's (15) Grounded Theory on the Techniques of Occupational Storytelling and Story Making, the result of the intervention depends on the therapeutic alliance between the client and the occupational therapist as well as on finding new strategies for the future. A good therapeutic alliance was reached between Maria and the occupational therapist by building a communal horizon of understanding as described by Clark et al. (15); this alliance emerged from the creative activity of painting trees and storytelling. An occupational approach was useful for Maria, for example when the occupational therapist suggested actions like taking walks and working part time, and also gave other types of support promoting a more active everyday life (*doing*) between the sessions. By learning how thoughts and reactions influenced emotions Maria achieved mastery over her life situation. At the follow-up, the decisions she had made three years earlier of how to change her approach to daily life were still guiding her.

Maria's Life Themes

The sessions with painting, storytelling, and reflecting started a process ensuring that in between the sessions Maria would reflect on and try to change her everyday life. By implementing the TTM the turning points in her life story were identified. This is in line with Larson (39) who has identified important life themes as turning points in life. These shifts may bring costs as well as benefits and shape the present and the future of a client (39). By attending the TTM sessions Maria had a possibility to both identify these turning points and reflect on their influence on her present everyday life in negative as well as positive respects. Telling and making her story enabled Maria to see herself as having resources as well as limitations. This strengthened her view of herself as being a capable person, which was helpful for her actual recovery. Polkinghorne (12) suggests that shaping a narrative like storytelling can be helpful towards shifts throughout a person's lifetime, like, for example, changing from being a passive to an active individual.

As Maria's life story was enacted the way she dealt with her life themes changed. From *being shy* Maria had learned to handle emotions and share intimacy and friendships and she worked continuously on reconstructing her image. From the stage of *"only being close to her family"* she had reconstructed her self-image and found new occupational strategies, imagining having another job and developing new interests. By using occupational strategies Maria had achieved mastery over her situation and self-confidence so *the fear that the worst thing will happen* no longer took hold of her. She created a new image as an actor in her own life, finding a useful occupational strategy when she felt anxious. From being *alienated*, Maria became more involved. She had found her place in life. According to Clark et al. (15) Maria had "taken the survivor's cultural place into account" (p. 390). These themes emerged in the data analysis of this study, and were not discussed in these terms during the intervention. In a clinical context life themes are often used to sum up and organize the therapeutic process but not as explicitly as in this case study.

The TTM

Maria had experienced positive changes in her life situation reflected in the storytelling but also visible in the tree pictures. From first having painted birches, at the time of the follow-up Maria now painted oaks. She meant thereby that she had become stronger and could now cope with her daily life and therefore the birches had been superseded by oaks. Thus, there was a correspondence between Maria's verbal story and her "painted" story, suggesting a kind of method triangulation. This, in turn, validates the TTM as a method for gathering narrative data.

A creative activity used in psychosocial occupational therapy may apply to object relations theory (2), and also cognitive theory (40). In this present study the method applied to both because the TTM aims at enhancing self-understanding and developing better interpersonal relations as well as supporting the client to achieve mastery over his or her daily

life. However, the TTM is not restricted to object relations theory or cognitive theory, but may be used with other theories as well. The principal basis for the occupational therapist is the occupational perspective, while the psychological theory serves as related knowledge (41).

There are various guidelines for how to use drawings of trees in therapy. According to Batza Morris (16) the therapist interprets the drawings by recognizing for example the space usage of the sheets of paper, colour usage, the outline of leaves, and root-or-trunk emphasis. Batza Morris argues that used like this the tree theme serves as a diagnostic tool. Contrary to Batza Morris the present study illustrates how the use of guidelines may stimulate a client's storytelling. The guidelines (34) served as a potential for putting adequate questions to the client during the sessions and no therapist interpretation of the pictures was made. This refraining from interpretation may be one of the major characteristics in how occupational therapists use projective methods as compared with psychotherapists.

In the present case study identifying life themes was a way of analysing data and presenting the results. Identifying life themes was not part of the TTM per se but could be included as a supplement to the guidelines previously developed. The occupational therapist may encourage the client to discover and sum up his or her life themes as part of the process of shaping their future everyday life.

Methodological issues and needs for future research

The TTM was exemplified by a case study. Lukoff et al. (30) argued that a case study is appropriate in research on alternative therapies with the purpose of developing increased knowledge in theory and methodology. Data collection for a case study may consist of interviews as well as artwork, where the reliability can be strengthened by detailed description of the procedure and the data collection (30), so that another researcher may repeat the study. According to Kvale (35) the reliability becomes stronger by using active dialogue between the interviewee/teller and the researcher/listener. By listening and making obscurities clear with the use of attentive and open questions by the researcher, the interviewee may reject or confirm the reflections of the researcher. These measures suggested by Lukoff et al. (30) and Kvale (35) were all taken in this study to ensure its trustworthiness.

In the present study the TTM was used as an intervention for assessment and treatment during the intervention period and as a method for data collection at the follow-up. It seems natural that a method developed for storytelling and story-making can be used for both purposes. Moreover, in this study the case was part of a clinical praxis where the first author was also the occupational therapist involved in the intervention. Normally, in clinical practice there is not time enough to tape a conversation, transcribe it, and reflect on it, as was done in the present study. This may have had a positive effect on the result of the intervention but also creates weakness in the research. Being concerned about the recovery of the client as an occupational therapist and simultaneously as a researcher, and further observing and documenting the TTM and the intervention process that evolved, inferred double roles for the first author. In further research into the TTM these two perspectives need to be separated. Further, the first author had a positive allegiance with the method. The allegiance, the loyalty of the therapist, or the attachment to the therapy method probably influences the outcome of the intervention (42). There is need for further evaluation studies involving several other occupational therapists and their clients in order to minimize any effects of allegiance.

Furthermore, the therapeutic alliance has been shown to correlate with the effectiveness of the treatment (43). Therefore, future research on the TTM ought to examine not only other occupational therapists' and clients' experiences of the method but also the therapeutic alliance between the client and the therapist.

There are a few previous long-term follow-up studies of psychosocial occupational therapy research (44–47). This present case study is another follow-up presenting an intervention that appears to have been useful for a client, Maria, in order for her to achieve mastery over her situation and self-confidence. There could be cases where the TTM with five sessions is not enough, e.g. when a client is very deeply depressed. Thus, a study based on the TTM might not have yielded relevant information about such a patient. Moreover, since the client tells her or his life story, the client can choose to deselect problems he or she does not want to talk about, or the occupational therapist does not know, and it is impossible to deal with that problem. Whether this was the case in the present study is impossible to verify, as in all studies based on self-report data, but nothing in the process of therapy and data collection indicated this. However, that the TTM is helpful can only be stated as a hypothesis in this study and needs, in line with Lukoff et al. (30), to be tested by the examination of several cases. Through multiple cases it would be possible to examine other explanations for the outcomes of the intervention and whether results can be generalized.

Conclusions

In conclusion, this study illustrated the TTM as a method for psychosocial occupational therapy. The intervention, painting trees and using these for occupational storytelling and story-making, was useful for identifying the life themes of a client, which is in turn important for understanding her problems and for developing strategies for her to cope with daily life. Using previously developed guidelines (34) and Clark's Grounded Theory on the techniques of occupational storytelling and occupational story-making (15) helped the occupational therapist in assisting the client to tell her life story. This study has generated new research questions pertaining to the TTM, such as the outcomes of and experiences from TTM sessions among a larger number of clients, and the importance of the therapeutic alliance from both client and therapist perspectives.

Acknowledgements

The authors are grateful to Per Nyberg, PhD, for supporting the development of the TTM and to Sara Alexi, OT Reg., for her support during the data analysis. The study was financially supported by Kronoberg County Council and the Swedish Research Council.

References

1. Creek J. Creative activities. In: Creek J, editor. Occupational therapy and mental health, 3rd ed. London: Churchill Livingstone; 2002. p. 265–73.
2. Eklund M. Applying object relations theory to psychosocial occupational therapy: Empirical and theoretical considerations. Occup Ther Ment Health. 2000;15:1–26.
3. Hughes J. Art in psychosocial occupational therapy: Guidelines for use and an art exercise battery. Aust Occup Ther J. 1989;36:14–23.
4. Lloyd C, Papas V. Art as therapy within occupational therapy in mental health settings: A review of the literature. Br J Occup Ther. 1999;62:31–5.
5. Atkinson K, Wells C. Creative therapies: A psychodynamic approach within occupational therapy. London: Stanley Thornes; 2000.
6. Bruce MA, Borg B. Psychosocial occupational therapy: Frames of reference for intervention, 2nd ed. Thorofare, NJ: Slack; 1993.
7. Polkinghorne DE. Transformative narratives: From victims to agentic life plots. Am J Occup Ther. 1996;50:299–305.
8. Wilcock AA. Reflections on doing, being and becoming. Can J Occup Ther. 1998;65:248–56.
9. Atkinson R. The life story interview (qualitative research methods). Thousand Oaks, CA: Sage; 1998.
10. Bateson MC. Composing a life. New York: Penguin; 1990.
11. Bruner J. Acts of meaning. London: Harvard University Press; 1990.
12. Polkinghorne DE. Narrative configuration in qualitative analysis. Int J Qual Studies Educ. 1995;8:5–23.
13. Wicks A, Whiteford G. Value of life stories in occupation-based research. Aust Occup Ther J. 2003;50:86–91.
14. Clark F. Occupation embedded in a real life: Interweaving occupational science and occupational therapy. Am J Occup Ther. 1993;47:1067–78.
15. Clark F, Larsson EA, Richardson PR. A grounded theory of techniques for occupational storytelling and story making. In: Zemke R, Clark F, editors. Occupational science: The evolving discipline. Philadelphia, PA: FA Davis; 1996. p. 373–92.
16. Batza Morris M. The diagnostic drawing series and the tree rating scale: An isomorphic representation of multiple personality disorder, major depression, and schizophrenia populations. J Am Art Ther Assoc. 1995;12:118–28.
17. Gunnarsson A. Träden och människan [Trees and man]. Stockholm: Rabén & Sjögren; 1988.
18. Jung CG. Man and his symbols. London: Aldus Books; 1964.
19. Kellog R. Analyzing children's art. Paulo Alto, CA: Mayfield Publishing; 1970.
20. Buck JN. The H-T—P test. J Clin Psych. 1948;4:151–9.
21. Cohen BM, Mills A, Kwapien Kijak A. An introduction to the diagnostic drawing series: A standardized tool for diagnostic and clinical use. J Am Art Ther Assoc. 1994;11:105–10.
22. Corboz RJ, Gnos PU. The three-trees test in the public school. Acta Paedopsychiat. 1980;46:83–92.
23. Hark H. Träume als Wegweiser. Traumbild Baum. Olten: Walter-Verlag AG; 1986.
24. Koch C. The Tree Test. The tree-drawing test as an aid in psychodiagnosis. Bern: Verlag Hans Huber; 1952.
25. Gunnarsson B. Trädtemat – ett arbetsterapeutiskt redskap för att berätta sin livshistoria [The tree theme – a therapeutic tool for occupational storytelling and story making]. Lund: Institutionen för klinisk neurovetenskap, Lunds Universitet; 1999.
26. Canadian Association of Occupational Therapy. Enabling occupation: An occupational therapy perspective. Ottawa, ON: CAOT Publications ACE; 1997.
27. Merriam SB. Case study research in education. San Francisco, CA: Jossey-Bass; 1988.
28. Yin RK. Case study research. Newbury Park, CA: Sage; 1989.
29. DePoy E, Gitlin LN. Introduction to research. Understanding and applying multiple strategies. St Louis: Mosby; 1998.
30. Lukoff D, Edwards D, Miller M. The case study as a scientific method for researching alternative therapies. Alt Ther Health Med. 1998;4:44–52.
31. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th ed. Washington, DC: American Psychiatric Association; 1994.
32. Jacobson E. You must relax: A practical method of reducing the strains of modern living. New York: McGraw-Hill; 1934.
33. Jacobsen E. Progressive relaxation. Chicago: University Chicago Press; 1938.
34. Alexi S, Gunnarsson B. Trädet som bild och livssymbol – i litteratur och psykiatrisk behandling [The tree as a picture and a symbol of life – in the literature and in mental health care]. Vårdhögskolan Lund–Helsingborg: Institutionen för arbetsterapi; 1995.
35. Kvale S. Interviews. An introduction to qualitative research interviewing. London: Sage; 1996.
36. Wilcock AA. An occupational perspective of health. Thorofare, NJ: Slack; 1998.
37. Eklund M. Explicit and implicit methods in psychosocial occupational therapy. Occup Ther Ment Health. 2002;18:3–15.
38. Mattingly C. The narrative nature of clinical reasoning. Am J Occup Ther. 1991;45:998–1005.

39. Larson EA. The story of Marcela and Miguel: A narrative analysis of dimensions of adaptation. Am J Occup Ther. 1996;50:286–98.
40. Willson M. Cognitive change. In: Willson M, editor. Occupational therapy in short-term psychiatry, 3rd ed. Edinburgh: Churchill Livingstone; 1996. p. 97–110.
41. Kielhofner G. Model of human occupation, 3rd ed. Baltimore: Williams & Wilkins; 2002.
42. Luborsky L, Diguer L, Seligman DA, Rosenthal R, Krause ED, Johnson S, et al. The researcher's own therapy allegiances: A wild card in comparisons of treatment efficacy. Clinl Psychol: Science and Practice. 1999;6:95–106.
43. Norcross JC, editor. Psychotherapy relationships that work: Therapist contributions and responsiveness to patients. New York: Oxford University Press; 2002.
44. Eklund M. Stability in patients receiving psychiatric occupational therapy – a one-year follow-up. Scand J Occup Ther. 1997;4:15–22.
45. Eklund M, Rottpeter J, Vikström F. The meaning of psychosocial occupational therapy. Occup Ther Ment Health. 2002;18:3–15.
46. Sexton H, Fornes G, Kruger MB, Grendahl G, Kolset M. Handicraft or interactional groups: A comparative outcome study of neurotic inpatients. Acta Psychiat Scand. 1990;82: 339–43.
47. Speed J. Behavioral management of conversation disorder: Retrospective study. Arch Phys Med Rehabil. 1996;77:147–54.

Paper II

Australian Occupational Therapy Journal (2008) doi: 10.1111/j.1440-1630.2008.00738.x

Research Article

The Tree Theme Method as an intervention in psychosocial occupational therapy: Client acceptability and outcomes

A. Birgitta Gunnarsson[1,2] and Mona Eklund[2,3]

[1]*Department of Health Sciences, Division of Occupational Therapy, Lund University, Lund, Sweden,* [2]*R&D Centre, Kronoberg County Council, Växjö, Sweden, and* [3]*Department of Health and Society, Malmö University, Malmö, Sweden*

Background/aim: *The Tree Theme Method (TTM) is an intervention in which the client paints trees representing certain periods in his/her life. The intervention comprises five sessions, using trees as a starting point to tell one's life story. This study, which is part of an implementation project, aimed to examine the therapeutic alliance and client satisfaction, in relation to perceptions of everyday occupations and health-related factors, with clients going through a TTM intervention.*

Methods: *Nine occupational therapists recruited 35 clients, at general outpatient mental health care units, for the TTM intervention. Self-rating instruments, targeting therapeutic alliance (HAq-II), different aspects of daily occupations (Canadian Occupational Performance Measure, Satisfaction with Daily Occupations), health-related factors (Sense of Coherence measure, Mastery Scale, Symptom Checklist-90-R) and client satisfaction (Client Satisfaction Questionnaire), were administrated before and after the intervention.*

Results: *A good initial therapeutic alliance, experienced by both therapists and clients, was correlated to increased changes regarding occupational performance and self-mastery. According to the therapists' ratings, a good initial therapeutic alliance was correlated to increased sense of coherence and a decreased level of psychiatric symptoms. The results showed positive significant changes in occupational performance and health-related factors. High ratings of the therapeutic alliance by the therapists were also related to high client satisfaction.*

Conclusions: *The TTM seemed to function well in psychosocial occupational therapy, but there is a need for further implementation studies to deepen our understanding of the treatment process, comprising both technique and formation of the therapeutic alliance.*

KEY WORDS *art therapy, creativeness, mental health, patient satisfaction, therapeutic process.*

Introduction

Descriptions and evaluations of methods for use in psychosocial occupational therapy are important in order to be able to offer the best interventions possible for clients, and for generating knowledge in occupational therapy practice and research. Methods for assessment and treatment in psychosocial occupational therapy are often based on creative activities (Eklund, 2000). Edgar (1999) hypothesised that using creative modalities could increase knowledge of clients in a way that is not achievable by other methods, but this has not been empirically tested to any large extent.

Most studies involving creative activities have been evaluated by qualitative methodology (e.g. Henare, Hocking & Smythe, 2003; Mee & Sumsion, 2001; Patrick & Winship, 1994; Reynolds, 2003; Reynolds & Prior, 2003; Steinhardt, 1995), and results so far support the use of creative activities as a meaningful modality in occupational therapy for self-expression, increasing control and learning how to cope with daily life. A few studies have employed quantitative methods, e.g. Körlin, Nybäck and Goldberg (2000), and Saunders and Saunders (2000), who examined structured creative arts programs for clients using pre-test–post-test designs. Findings in a group consisting of adults with various psychiatric diagnoses indicated significant improvement in several health-related factors after treatment (Körlin *et al.*). Likewise, in a group of children with different psychosocial problems, the authors found that a greater number of sessions had a significant, positive impact on the rating of the therapeutic alliance (Saunders & Saunders). However, research in this area is very scant, despite the fact that this type of intervention is common in psychosocial occupational therapy. Therefore, there is a need for further scientific studies on creative therapies, in order to gain knowledge that may be used to improve treatment programs.

A. Birgitta Gunnarsson MSc; Registered OT. **Mona Eklund** PhD; Registered OT.

Correspondence: Birgitta Gunnarsson, FoU-centrum, PO Box 1223, SE-351 12 Växjö, Sweden.
Email: birgitta.gunnarsson@ltkronoberg.se

Accepted for publication 22 October 2007.

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

The tree, with roots, trunk and crown, is a symbol that humans have applied in different cultures to symbolise themselves and their life situation (Batza Morris, 1995). The tree as a theme has been used in interventions in various clinical contexts (Buck, 1948; Cohen, Mills & Kwapien Kijak, 1994; Corboz & Gnos, 1980; Hark, 1986; Koch, 1952) and has been developed into a method for intervention in psychosocial occupational therapy, namely the Tree Theme Method (TTM) (Gunnarsson, Jansson & Eklund, 2006). The method is client-centred (Canadian Association of Occupational Therapy (CAOT), 1997) and based on knowledge regarding the value of occupation, creative activity and life-storytelling. The creative activity, painting trees representing oneself at certain periods during one's life, is used in combination with a narrative approach (Gunnarsson *et al.*). The narrative includes occupational storytelling, i.e. telling one's life story, but may also include story making, i.e. shaping plans for one's future, in order to initiate a process of change in one's everyday life (Clark, 1993; Clark, Larsson & Richardson, 1996).

Polkinghorne (1996) pointed out the changes in identity that individuals can go through during rehabilitation. By engaging in therapeutic interventions and by adopting new occupational strategies, clients may modify their views of themselves. One course of action for finding new insights and strategies is telling one's life story. The TTM is based on five sessions, during which the client is asked to paint trees representing him or herself. The instructions vary somewhat between the sessions, but on each occasion the painted tree is used as a starting point for storytelling. This initiates a process of reflection and interaction between the client and the occupational therapist. The TTM intervention, combining painting, storytelling and story making (about the past, present and the future), is intended to be a means of enabling changes to be made in one's daily life. In Gunnarsson *et al.* (2006) the TTM was exemplified by a case study reflecting a treatment process and a follow-up 3 years afterwards. The case description provided an example of how the TTM can be used and of the development a client may undergo, shaping new strategies to cope with daily life.

There is a need for further empirical studies of the TTM in order to study how the intervention works. In psychosocial occupational therapy based on a client-centred perspective (CAOT, 1997), interventions aim at increasing the ability of an individual to cope with his/her everyday occupations. Therefore, in connection with the TTM intervention, changes in performance of and satisfaction with daily occupations should be taken into account. Furthermore all interventions in mental care are intended to modify health-related factors, in terms of minimising psychiatric symptoms and increasing the sense of self-mastery and the sense of coherence. Thus, both everyday occupations and health-related factors are of interest when studying an intervention with the TTM.

In addition, various so-called common factors have been shown to be important when studying an intervention (Johansson, 2006). Research on psychotherapy has revealed several common factors that influence the outcome, e.g. extra therapeutic factors, expectations and the client–therapist relationship (Lambert & Barley, 2002). The therapeutic alliance, i.e. the interaction between the client and the therapist, is an important ingredient in general psychiatric care and rehabilitation (Johansson; de Roten *et al.*, 2004), and has also been found to be important in occupational therapy (Eklund, 1996; Palmadottir, 2006). Significant relationships have been found between the therapeutic alliance and outcome in psychotherapy (Hewett & Coffey, 2005; Howgego, Yellowlees, Owen, Meldrum & Dark, 2003; Luborsky *et al.*, 1999) and in general psychiatric care and occupational therapy (Davis, 2007; Eklund; Palmadottir, 2003). Two explanations have been proposed: the therapeutic alliance in itself is effective, and the therapeutic alliance leads to the success of the specific intervention (Eklund; Johansson). Thus, when exploring the TTM in clinical contexts, it would be of interest to examine how the therapeutic alliance is associated with changes regarding everyday occupations and health-related factors upon completion of the intervention.

In client-centred occupational therapy, for example, the TTM, it is of significance that the client becomes an active partner in the intervention process (CAOT, 1997). Therefore, the client's perceptions of the intervention expressed in terms of satisfaction with the treatment or not should be taken into account. Good intervention outcomes have been associated with a high degree of client satisfaction (Eklund & Hansson, 2001). Moreover, the process factor therapeutic alliance, as experienced by clients, has been shown to be related to client satisfaction (de Roten *et al.*, 2004). The question of whether clients will be satisfied with their treatment using the TTM is one that is both clinically justified and theoretically interesting.

Against this background we developed a study, aiming at investigating the TTM when implementing psychosocial occupational therapy. The therapeutic alliance, regarded as a process factor, and client satisfaction among clients going through the TTM intervention were studied, and the main focus was set on any correlations between these aspects and changes in everyday occupations and different aspects of health-related factors. This would generate new information on the application of the TTM in terms of client acceptability–outcome relationships. The following research questions formed the point of departure for the study:

1 How did clients and occupational therapists perceive the therapeutic alliance?
2 What changes were observed, based on comparisons of measurements made before and after the intervention, concerning everyday occupations (occupational performance, occupational satisfaction and activity level) and health-related factors (psychiatric symptoms, sense of coherence and self-mastery)?

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

3 How were perceptions of the therapeutic alliance related to changes observed?
4 How did the clients rate their satisfaction with going through the TTM and which variables, in terms of changes regarding everyday occupations, health-related factors and the initial therapeutic alliance, could be used to predict client satisfaction?

Methods

This was a prospective clinical study with a combined quasi-experimental pre-test–post-test and correlational design (Kazdin, 2003). The Research Ethics Committee of Lund University approved the study.

Subjects

The participants were clients at four general outpatient mental health care units in the south of Sweden. Clients between 18 and 65 years of age, with a diagnosis of personality disorders, affective syndromes, anxiety/obsession syndromes and eating disorders according to International Classification of Diseases-10 (WHO, 1993) who were stable outpatients were included. Clients with a need for occupational therapy were eligible for participation in the study. Moreover, the client should not be well-known to the occupational therapist, i.e. the client should not have been in contact with this particular therapist on more than three previous occasions. Criteria for exclusion were language limitations or cognitive disorders, since the study was largely built on self-rating instruments. The clients were consecutively recruited from the participating units.

Power calculations indicated that 35 clients were needed to reveal an effect size of 0.5 on the chosen outcome variables with 80% power at $P < 0.05$ (Altman, 1991). Forty clients were invited to participate and 36 agreed, that is, a participation rate of 90%. All 36 clients chose to complete the intervention study. However, one client, a man, was excluded during the course of the intervention because a cognitive dysfunction was detected. Thus, the final sample consisted of 35 participants. The inclusion criteria for participation resulted in a heterogeneous group of participants, which included common diagnoses and age groups of clients in general outpatient mental health care units (Table 1). The clients' ages ranged from 18 to 60 years (mean age = 37, median age = 36). At the time of the TTM intervention, 14 of the clients were engaged in work or education and 10 clients were participating in work rehabilitation or in community-based activity centres. The remaining 11 clients had no organised regular daily occupation at all. The sex distribution was skewed, and of the 35 clients 29 were women.

TABLE 1: *Characteristics of the subjects (n = 35)*

Characteristic	
Sex (number of men/women)	6/29
Mean age (range, std)	37 (18–60, 12)
Diagnostic groups:	
Affective disorders (F31–38)	10
Anxiety/obsessive disorders (F40–49)	20
Eating disorders (F50)	1
Personality disorders (F60)	4
Main occupation (number):	
Work/Education	14
Rehabilitation	10
No organised daily occupation	11

The TTM intervention

The TTM intervention, as described by Gunnarsson *et al.* (2006), comprises five sessions, during which the client is asked to paint trees, with some variation in the instructions in each session. The theme is introduced by the occupational therapist, followed by a modified progressive relaxation exercise, developed by Jacobson (1938), where the client is instructed to alternate between contracting and relaxing various muscle groups, one at a time, throughout the whole body. Then the client is asked to paint a tree, based on the following guidelines from the occupational therapist: How can a tree with roots, a trunk and a crown be used to symbolise your personality, activities, interests and relations to others? On the first occasion, the client is asked to paint a tree representing his/her present life situation, then on the following occasions one for childhood, one for adolescence and one for adulthood. The pictures are used as a starting point for the client to tell his/her life story, reflecting on abilities as well as limitations. Finally, at the fifth session, the focus is on occupational story-making and shaping the future, based on the previous tree paintings and storytelling, which are available during the session, and the client is asked to paint a tree symbolising the future. During the whole TTM intervention the occupational therapist stimulates the client to find possible strategies for continuing with everyday life between the sessions, in order to start a process that will enable the client to cope with daily life.

Instruments

The instruments were chosen in order to measure the therapeutic alliance, different aspects of daily occupations and health-related factors and client satisfaction.

Everyday occupations. The Canadian Occupational Performance Measure (COPM) (Law *et al.*, 1998) is a semistructured interview reflecting clients' self-perceived occupational performance and satisfaction with their performance. The COPM focuses on three areas: self-care, productivity and leisure. The client is asked to identify problematic tasks and everyday occupations, and then rate their performance and their satisfaction with the

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

actual performance of the targeted tasks and everyday occupations. The self-ratings are made on a ten-point numerical Likert scale (Streiner & Norman, 2003), ranging from 1, 'Not important at all', to 10, 'Extremely important'. The COPM has been shown to have satisfactory test–retest reliability, sensitivity to change (Law *et al.*) and construct and criterion validity (McColl, Paterson, Davies, Doubt & Law, 2000). The Swedish version (Swedish Association of Occupational Therapists, 1999) has been found to have high responsiveness to change (Wressle, Samuelsson & Henriksson, 1999) and good clinical utility (Wressle, Marcusson & Henriksson, 2002).

The Satisfaction with Daily Occupations (SDO) (Eklund, 2004) is a measure of perceived satisfaction with everyday occupations. Unlike the COPM, it uses predefined items. It has nine items distributed over four domains: work, leisure, domestic tasks and self-care. The SDO contains an activity level score and a satisfaction score. It is administered as a combined interview and self-rating. First the client answers 'Yes/No' to whether he or she presently performs the occupation or not. This results in an activity level score, with a maximum possible score of nine. The client then rates their satisfaction on a seven-point numeric Likert scale, from 1, 'Worst possible' to 7, 'Best possible'. The SDO satisfaction score has been shown to have satisfactory internal consistency (Eklund; Eklund & Gunnarsson, 2007; Eklund & Sandqvist, 2006) and acceptable construct validity (Eklund). Good test–retest reliability has been demonstrated for the satisfaction score as well as for the activity level (Eklund & Gunnarsson).

Health-related factors. The Sense of Coherence (SOC) measure (Antonovsky, 1987a,b) is a self-rating of the 'sense of coherence', which denotes the client's perception of the world and his/her environment as a whole. The sense of coherence indicates how well an individual manages stress and remains healthy, and the concept includes three dimensions: comprehensibility, manageability and meaningfulness. In line with Antonovsky's intention, the three dimensions were not separated in this study, but the sense of coherence was studied as a composite construct. In this study, the short version, 13-item questionnaire, was used. The respondents rated the statements on a seven-point numerical Likert scale, from 1, 'Very often', to 7, 'Very seldom or never'. Eriksson and Lindström (2005) found the face validity of the SOC scale acceptable, the content validity moderate and the criterion validity varying from weak to good. For the 13-item questionnaire they found satisfactory test–retest reliability and high internal consistency.

The Mastery Scale (Pearlin, Menaghan, Lieberman & Mullan, 1981) is a seven-item, self-rating of self-mastery, the sense of being in control and mastering situations and experiences which influence one's own life. The respondents rate the statements on a four-point categorical Likert scale (Streiner & Norman, 2003), from 1, 'Completely agree', to 4, 'Don't agree at all'. The measure has been shown to have good internal consistency and good construct validity was found (Marshall & Lang, 1990).

The Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1992) is a self-rating scale composed of 90 items rated according to a five-step categorical Likert scale. It measures psychological problems and symptoms of psychopathology. The scoring is from 0 to 4, where 4 indicates the greatest problem severity. The checklist is divided into nine symptom scales: somatisation, obsession–compulsion, interpersonal sensibility, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. Several indexes have been suggested. In this study, the Global Symptom Index (GSI) was calculated. The SCL-90-R is a frequently used measure and has shown very good reliability and good validity (Derogatis; Fridell, Cesarec, Johansson & Thorsen Malling, 2002).

The therapeutic relationship. The Revised Helping Alliance Questionnaire (HAq-II) (Luborsky *et al.*, 1996) measures the strength of the alliance between the client and the therapist using a 19-item self-rating scale, using a six-point categorical Likert scale, from 1, 'Strongly disagree', to 6, 'Strongly agree'. There is both a client version and a therapist version. The client and the therapist rate the helping alliance independently of each other. HAq-II has shown satisfactory internal consistency and test–retest reliability (Luborsky *et al.*), and good convergent validity with other alliance measures (Hatcher & Barends, 1996; Luborsky *et al.*).

Client satisfaction. The Client Satisfaction Questionnaire (CSQ) (Larsen, Attkisson, Hargreaves & Nguyen, 1979) contains eight questions concerning the client's satisfaction with the intervention. The self-rating is made on a four-point categorical Likert scale, where 1 and 2 indicate less satisfaction, 3 indicates good satisfaction, and 4 the highest satisfaction. The CSQ has been shown to have satisfactory internal consistency (Larsen *et al.*; Nguyen, Attkisson & Stegner, 1983) and construct validity (Nguyen *et al.*). de Wilde and Hendriks (2005) found the concurrent validity to be high, and suggested the CSQ as a good measure for the assessment of general satisfaction in mental health care. Three datasets based on the Swedish version, including clients with mental health disorders, have shown satisfactory internal consistency (Cronbach's alpha 0.85–0.93) (Lars Hansson, personal communication, October 2006).

All instruments were Swedish translations. Except for the CSQ, they have been validated in Sweden.

Procedure for data collection

In preparation for the study, a group of 10 occupational therapists, who were working with psychosocial occupational therapy in outpatient psychiatric care and had agreed to provide the intervention for their clients, were trained at five occasions, in all for 30 h, by the first

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

author in the TTM intervention. The training comprised theoretical knowledge about the value of occupation, creative activity and occupational life storytelling, as well as practical experience of painting the different tree themes, as described by Gunnarsson *et al*. (2006). One of the therapists changed workplace before the start of the study, but the remaining nine occupational therapists recruited clients for the study. The occupational therapist assessed by a clinical interview, on one to three occasions, if the intervention with the TTM was appropriate. If so, the client was asked to take part in the study according to consecutive sampling. The principle of informed consent was applied.

Pre-test and post-test data were collected concerning the clients over a 21-month period ending in January 2006. Data collection took place at the respective psychiatric outpatient unit. Just before the TTM intervention started, the pretest was performed, and the first author met the client and administered the questionnaires COPM, SDO, SOC, Mastery and SCL-90-R. Then the TTM intervention took place. It consisted of five sessions, as described above, during a period of 5 to 9 weeks. The HAq-II was administered to the clients and the therapists after the second and the final TTM session. Post-test data were collected in accordance with the pretest data, and the first author administered the instruments to the client soon after the last session of the intervention, but with the addition of the CSQ.

Data analysis

The SPSS (version 13.0, SPSS Inc., Chicago, IL, USA) was used for all analyses. As all variables were assessed on an ordinal scale, only non-parametric methods were used. The initial therapeutic alliance, as perceived by the clients and the therapists, and client satisfaction were correlated (Spearman's rank order correlation) with change scores regarding the occupational and health-related variables. For the evaluation of any differences between measurements made before and after the intervention, Wilcoxon's signed rank test was used. Finally, multiple logistic regression analysis (backward method, likelihood ratio) was performed with CSQ as the dependent variable and the initial HAq-II and change scores concerning COPM, SDO, SOC, Mastery and SCL-90-R as independent variables. The independent variables were all dichotomised at the median values, while the CSQ was dichotomised at 24, with those having a lower score forming a subgroup reporting lower satisfaction, and those with a sum of 24 or above a subgroup reporting greater satisfaction with the intervention. The goodness-of-fit of the model was tested with the Hosmer–Lemeshow test (Hosmer & Lemeshow, 1989). The regression analysis was performed in four stages since the small number of participants did not allow for too many independent variables in the same analysis. The first stage comprised the occupational variables, the second the health-related factors, the third the therapeutic alliance, and the fourth stage included those independent variables that had been shown to be statistically significantly related to client satisfaction in the previous stages.

Results

The therapeutic alliance

The rating of the therapeutic alliance could theoretically range between 19 and 114. The clients' median rating of the initial therapeutic alliance was 97 (minimum 62 and maximum 111, interquartile range (IQR) 13) and the therapists' median rating was 82 (minimum 71 and maximum 95, IQR 11). Upon completion of the intervention the clients' rating of the therapeutic alliance was 99 (minimum 59 and maximum 111, IQR 14) and the therapists' rating was 85 (minimum 63 and maximum 96, IQR 11). Regarding the occupational therapists' ratings of the therapeutic alliance there was a statistically significant increase between the two measurements ($P = 0.031$), but not regarding the clients' ratings ($P = 0.134$). For further analyses, the initial rating was used.

Occupational and health-related factors before and after the TTM intervention

Statistically significant differences were found regarding most of the occupational and health-related variables when measured before and after the TTM intervention (Table 2). Concerning the measures of everyday occupations, SDO and COPM, there was an increase from pre-test to post-test regarding both activity level and satisfaction according to the SDO, and improvements were also found for COPM performance and COPM satisfaction.

The result concerning the health-related factors sense of coherence and self-mastery also indicated positive changes. The subscales of the SCL-90-R showed statistically significant improvements regarding obsession–compulsion, interpersonal sensibility, depression, anxiety, phobic anxiety, paranoid ideation, psychoticism and for the GSI. However, no significant changes were found for somatisation or hostility.

The therapeutic alliance in relation to changes in the occupational and health-related variables

The clients' perceptions of the initial therapeutic alliance were associated with changes regarding occupational performance ($r_s = 0.373$; $P = 0.027$) and satisfaction ($r_s = 0.432$; $P = 0.009$) according to the COPM, and with self-mastery ($r_s = 0.370$; $P = 0.029$). The initial therapeutic alliance as perceived by the therapists was significantly correlated with changes concerning the satisfaction score of the COPM ($r_s = 0.380$; $P = 0.024$), self-mastery ($r_s = 0.518$; $P = 0.001$), sense of coherence ($r_s = 0.416$; $P = 0.013$) and psychiatric symptoms in terms of the GSI score ($r_s = 0.337$; $P = 0.048$). No further correlations were found between the SCL-90-R subscales and the initial therapeutic alliance, according to the clients' or the therapists' ratings.

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

TABLE 2: *Changes observed between measurements made before and after the TTM intervention*

Outcome variable	Before the intervention Median (IQR)	After the intervention Median (IQR)	*P*-value
COPM			
Performance	3.2 (2.0)	4.6 (2.4)	**0.001**
Satisfaction	2.0 (2.2)	4.6 (3.4)	**0.001**
SDO			
Activity level	5.0 (1.0)	5.0 (2.0)	**0.001**
Satisfaction score	47.0 (12.0)	50.0 (11.0)	**0.008**
SOC	47.0 (15.0)	48.0 (13.0)	**0.011**
Mastery	18.0 (6.0)	19.0 (5.0)	**0.006**
SCL-90-R symptom scales			
Somatisation	70.0 (28.0)	64.0 (22.0)	0.050
Obsession–compulsion	73.0 (26.0)	68.0 (26.0)	**0.001**
Interpersonal sensibility	72.0 (18.0)	61.0 (15.0)	**0.001**
Depression	72.0 (18.0)	61.0 (24.0)	**0.005**
Anxiety	73.0 (19.0)	69.0 (27.0)	**0.001**
Hostility	51.0 (21.0)	47.0 (16.0)	0.201
Phobic anxiety	73.0 (35.0)	62.0 (27.0)	**0.001**
Paranoid ideation	68.0 (29.0)	60.0 (22.0)	**0.035**
Psychoticism	78.0 (36.0)	61.0 (24.0)	0.001
SCL-90-R indexes			
GSI	77.0 (21.0)	68.0 (26.0)	**0.001**

Figures in bold indicate IQR. The difference between the 25th and 7th percentiles, that is, containing the central 50% of the observations. COPM, Canadian Occupational Performance Measure; GSI, Global Symptom Index; IQR, interquartile range; SCL-90-R, Symptom Checklist-90-R; SDO, Satisfaction with Daily Occupations; SOC, Sense of Coherence measure; TTM, Tree Theme Method.

Factors related to client satisfaction after the TTM intervention

The clients' median rating of their satisfaction with the intervention was 26 (minimum 16 and maximum 31, IQR 5). A high level of client satisfaction was significantly correlated with change according to the COPM satisfaction score ($r_s = 0.352$; $P = 0.038$), self-mastery ($r_s = 0.447$; $P = 0.007$) and sense of coherence ($r_s = 0.417$; $P = 0.013$). Better client satisfaction was also correlated with higher ratings of the therapeutic alliance, both as perceived by the clients ($r_s = 0.448$; $P = 0.007$) and the therapists ($r_s = 0.427$; $P = 0.011$).

Multivariate analyses showed that, regarding everyday occupations, the factor of most importance for belonging to the group reporting higher level of client satisfaction was a positive change in COPM performance (OR = 14.452; 95% CI = 1.784–117.089). Concerning the health-related factors, those who improved more regarding sense of coherence were more likely to belong to the more satisfied group (OR = 7.111, 95% CI = 1.234–40.984). Regarding the therapeutic alliance, the analysis indicated that those participants for which the therapists' initial ratings were high belonged to the high group regarding client satisfaction (OR = 19.125; 95% CI = 2.056–177.921). The fourth stage, which combined the previous ones by including all significant factors found in the preceding analyses, showed that those for whom the therapists gave a high rating regarding the 'therapeutic alliance' were more likely to belong to the high group regarding 'client satisfaction' with the intervention (OR = 15.093; 95% CI = 1.523–149.561). (Hosmer–Lemeshow test: 0.225) Thus, in this final model, the therapists' ratings of the 'therapeutic alliance' ruled out all other variables in explaining the 'client satisfaction' with the TTM.

Discussion

Discussion of the results

The focus of this study was on the process factor therapeutic alliance and on client satisfaction, and how they were related to outcome variables in terms of change scores regarding occupational and health-related factors. Only small changes were found regarding the therapeutic alliance between the second and the fifth session. The ratings of the therapeutic alliance were in general high, according to both the clients and the therapists, but especially the clients' ratings. Presumably, the alliance was already formed when the first assessment was

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

made, which is in line with previous findings (de Roten *et al.*, 2004; Johansson, 2006), indicating that the alliance will be established after three to four sessions.

However, early therapeutic alliance was related to changes in various aspects as has been reported by others, including Johansson (2006). In their reviews of the literature, Lambert and Barley (2002) reported that early therapeutic alliance was correlated with positive changes following psychotherapy. In the present study, both the clients' and the therapists' ratings of the initial therapeutic alliance were associated with improvements regarding everyday occupations (COPM performance and satisfaction and COPM satisfaction, respectively) and self-mastery. In addition, the therapists' initial ratings of the therapeutic alliance were correlated with an increased sense of coherence and decrease in psychiatric symptoms. The therapists' perception of the initial therapeutic alliance may have influenced the intervention, and may have been important for the clients' ability to perceive the intervention as useful. Eklund obtained similar results when examining clients at a psychiatric day care unit, where the treatment programme was based on creative activities. High ratings of the therapeutic alliance were found to be a positive factor, allowing the clients' needs to be met (Eklund, 1996).

The results of this study showed significant changes following intervention with the TTM, as indicated by differences between measurements before and after the intervention concerning both everyday occupations and health-related factors. The changes were in a positive direction in all instruments except the SCL-90-R subscales of somatisation and hostility where no change was found. As this was a study with the main focus on process aspects, and not on effects of the TTM, no control group was used. Thus, it is not possible to determine whether the changes found were because of the TTM or other factors. However, although not revealing the reason why, the results clearly showed that the clients had improved during the TTM intervention.

The changes regarding sense of coherence found in the present study and by Körlin *et al.* (2000) were somewhat surprising as most studies have found the sense of coherence to be stable over time (Antonovsky, 1987a,b; Eriksson & Lindström, 2005). However, a study carried out by Krantz and Östergren (2004) showed that although it is assumed that the sense of coherence is established early in life, and is largely resistant to environmental factors, it is also related to the present life situation, in terms of factors such as social network, work conditions and support, indicating that the sense of coherence is also subject to change. The TTM intervention aims to stimulate the client to examine their whole life and one could speculate that formulating one's story, including future plans, may promote a sense of coherence.

There was a high level of client satisfaction with the intervention. Larsen *et al.* (1979) showed that low client satisfaction was correlated with early intervention drop-out. In the present study there were no drop-outs, which is probably a reflection of the high degree of client satisfaction with the TTM intervention. It is not possible to determine whether the lack of drop-outs was due to the quality of therapeutic alliance, the intervention technique, or both. The fact that the clients knew they were participating in a research study may also have had an influence on their behaviour. Consequently, there is a need for further studies focussing on the clients' perception of the TTM intervention in order to examine the importance of these factors.

Factors indicating greater client satisfaction after having gone through the TTM intervention were the therapists' ratings of the therapeutic alliance, and improvements in COPM performance and the sense of coherence. The confidence intervals were wide, but the odds ratios were still significant. These results support suggestions by Björkman and Hansson (2001) that client satisfaction is of importance both in relation to the outcome of psychiatric interventions and the process of intervention. In the fourth stage of regression analysis, combining the initial therapeutic alliance, the occupational performance variables and the sense of coherence, high ratings of the initial therapeutic alliance by the therapists predicted a higher degree of client satisfaction. McKinnon (2000) found that in client-centred occupational therapy the quality of the interaction between therapist and client was of great importance in client satisfaction. The fact that both clients and therapists rated the alliance as good in the present study supports that finding. However, this cannot explain why the therapists' rating of the therapeutic alliance was found to be the most important factor for client satisfaction. It appears that the therapists' belief in a helping alliance led to better client satisfaction. This, in turn, indicates that the TTM, as used in this study, was highly dependent on the input from the occupational therapist. This raises further questions about the process; about the client, the occupational therapist and the TTM with painting, occupational storytelling and story-making, and how these aspects interact with each other, but these questions will have to be addressed in future studies.

Although the aim of this study was not to examine the effects of the intervention, it is plausible that the TTM contributed to some of the changes found, possibly as the result of a combination with other kinds of ongoing psychiatric treatment. The fact that, in previous studies, associations have been found between good intervention outcome and a high level of client satisfaction (Eklund & Hansson, 2001), combined with the finding of a high level of client satisfaction in the present study, indicates that the TTM was a successful intervention.

Methodological discussion

This study employed a correlational and quasi-experimental design, which is useful for clinical studies and for testing less well-tried methods of intervention

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

that may be applicable in practice. If the focus of the study would have been on the effects of the TTM, it would have been a weakness that there was no control group. However, the purpose of the study was not to measure the effects of an intervention, but to examine a process aspect like the therapeutic alliance, and client satisfaction, in relation to changes in everyday occupations and different aspects of health-related factors.

Participation in the study was based on the client's motivation to participate in the intervention. This is in line with client-centred praxis, but important when interpreting the results. This principle for inclusion also resulted in a somewhat skewed sex distribution. According to Blennow, some mental and behavioural disorders are more common among women, such as affective disorders, anxiety/obsessive disorders, and eating disorders. Thirty-one of the clients had these diagnoses. Other mental disorders are more frequent among men, for example personality disorders (Blennow, 2004). Still, this sex distribution was more skew than expected, indicating that the findings cannot be generalised to men. Otherwise, there were fairly even distributions regarding age and diagnosis.

In the multiple logistic regression analysis with client satisfaction as the dependent variable, the confidence intervals were wide. This may indicate that there was a large variation in the variables and/or a small sample size. Both explanations are applicable to this study, which indicates that there is need for further studies of the TTM intervention in a larger number of clients. Power is usually calculated and reported for a two-group comparison and when studying outcomes in terms of effects. Still, in order to obtain a sample size that would reduce error we made a power calculation, suggesting 35 subjects. Thus, the study only just met the requirements.

Conclusions

This study targeted a group of clients admitted to general outpatient mental health care. Viewed against how the clients and occupational therapists perceived the therapeutic alliance, the clients' ratings of the occupational and health-related variables and the clients' ratings of their satisfaction with going through the TTM, the intervention method seemed to function well in psychosocial occupational therapy. When implementing a new method in psychosocial occupational therapy there is a need to examine the method from various aspects. The study of the implementation of the TTM follows a logical continuum of research, starting with exploratory studies such as qualitative case study (Gunnarsson *et al*., 2006) followed by studies like the present study based on quantitative research methodologies. The findings emphasise the need for further studies to deepen our understanding of the TTM and how to implement it. Qualitative research based on interviews, where the clients' experiences from the TTM technique and the therapeutic alliance are examined, would explain more about the nature of the intervention. As the occupational therapists' ratings in this study seemed to be of great importance, it would also be of interest to further examine the therapists' experiences of using the TTM and how they perceive the alliance.

Acknowledgments

The study was financially supported by the Kronoberg County Council and the Swedish Research Council. We would also like to express our gratitude to the occupational therapists in Kronoberg County Council and Region Skåne, who recruited the participants, and to Dr Per Nyberg who kindly assisted in the statistical analyses.

References

Altman, D. G. (1991). *Practical statistics for medical research*. London: Chapman & Hall.

Antonovsky, A. (1987a). The structure and properties of the sense of coherence scale. *Social Science Medicine*, *36*, 725–733.

Antonovsky, A. (1987b). *Unraveling the mystery of health: How people manage stress and stay well*. San Francisco, CA: Jossey-Bass.

Batza Morris, M. (1995). The diagnostic drawing series and the tree rating scale: An isomorphic representation of multiple personality disorder, major depression, and schizophrenia populations. *Art Therapy: Journal of the American Art Therapy Association*, *12*, 118–128.

Björkman, T. & Hansson, L. (2001). Client satisfaction with case managements: A study of 10 pilot services in Sweden. *Journal of Mental Health*, *10*, 163–174.

Blennow, I. (2004). Det osynliga könet inom psykiatrin [The invisible gender in mental health care.]. In: B. Hovelius & E. E. Johansson (Eds.) *Kropp och genus i medicinen [Body and gender in medical health service.]* (pp. 259–265). Lund, Swenden: Studentlitteratur.

Buck, J. N. (1948). The H-T-P test. *Journal of Clinical Psychology*, *4*, 151–159.

Canadian Association of Occupational Therapy (CAOT) (1997). *Enabling occupation: An occupational therapy perspective*. Ottawa, ON: CAOT Publications ACE.

Clark, F. (1993). Occupation embedded in a real life: Interweaving occupational science and occupational therapy. *American Journal of Occupational Therapy*, *47*, 1067–1078.

Clark, F., Larsson, E. A. & Richardson, P. (1996). A grounded theory of techniques for occupational storytelling and story making. In: R. Zemke & F. Clark (Eds.) *Occupational science. The evolving discipline* (pp. 373–392). Philadelphia, PA: F.A. Davis Company.

Cohen, B. M., Mills, A. & Kwapien Kijak, A. (1994). An introduction to the diagnostic drawing series: A standardized tool for diagnostic and clinical use. *Journal of the American Art Therapy Association*, *11*, 105–110.

Corboz, R. J. & Gnos, P. U. (1980). The three-trees test in the public school. *Acta Paedopsychiatrica: International Journal of Child & Adolescent Psychiatry*, *46*, 83–92.

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

Davis, J. (2007). Finding values in client resistance. *Occupational Therapy in Mental Health*, *23*, 39–54.

Derogatis, L. R. (1992). *SCL-90-R, Administration, scoring and procedures. Manual II* (2nd ed.). Towson, MD: Clinical Psychometric Research, Inc.

Edgar, I. R. (1999). The imagework method in social science and health research. *Qualitative Health Research*, *9*, 198–211.

Eklund, M. (1996). Working relationship, participation and outcome in a psychiatric day care unit based on occupational therapy. *Scandinavian Journal of Occupational Therapy*, *3*, 106–113.

Eklund, M. (2000). Applying object relations theory to psychosocial occupational therapy: Empirical and theoretical considerations. *Occupational Therapy in Mental Health*, *15*, 1–26.

Eklund, M. (2004). Satisfaction with daily occupations: A tool for client evaluation in mental health care. *Scandinavian Journal of Occupational Therapy*, *11*, 136–142.

Eklund, M. & Gunnarsson, A. B. (2007). Satisfaction with daily occupations (SDO): Construct validity and test–retest reliability of a screening tool for people with mental disorders. *Australian Occupational Therapy Journal*, *54*, 59–65.

Eklund, M. & Hansson, L. (2001). Determinants of satisfaction with community-based psychiatric services: A cross-sectional study among schizophrenia outpatient. *Nordic Journal of Psychiatry*, *55*, 413–418.

Eklund, M. & Sandqvist, G. (2006). Psychometric properties of the Satisfaction with Daily Occupations (SDO) instrument and the Manchester Short Assessment of Quality of Life (MANSA) in women with scleroderma and without known illness. *Scandinavian Journal of Occupational Therapy*, *13*, 23–30.

Eriksson, M. & Lindström, B. (2005). Validity of Antonovsky's sense of coherence scale: A systematic review. *Journal of Epidemiological Community Health*, *59*, 460–469.

Fridell, M., Cesarec, Z., Johansson, M. & Thorsen Malling, S. (2002). Svensk normering, standardisering och validering av symtomskalan SCL-90. [A Swedish standardization and validity check of SCL-90]. *Rapport nr 4/2002*. Västervik, Sweden: Statens institutionsstyrelse SiS.

Gunnarsson, A. B., Jansson, J.-A. & Eklund, M. (2006). The Tree Theme Method in psychosocial occupational therapy – A case study. *Scandinavian Journal of Occupational Therapy*, *13*, 229–240.

Hark, H. (1986). *Träume als Wegweiser. Traumbild Baum*. Olten, Switzerland: Walter-Verlag AG.

Hatcher, R. L. & Barends, A. W. (1996). Patient's view of the alliance in psychotherapy: Exploring factor analysis in three alliance measures. *Journal of Consulting and Clinical Psychology*, *64*, 1326–1336.

Henare, D., Hocking, C. & Smythe, L. (2003). Chronic pain: Gaining understanding through the use of art. *British Journal of Occupational Therapy*, *66*, 511–518.

Hewett, J. & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of Advanced Nursing*, *52*, 561–570.

Hosmer, D. W. & Lemeshow, S. (1989). *Applied logistic regression*. New York: Wiley.

Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L. & Dark, F. (2003). The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zeland Journal of Psychiatry*, *37*, 169–183.

Jacobson, E. (1938). *Progressive relaxation*. Chicago, IL: University Chicago Press.

Johansson, H. (2006). *Therapeutic alliance in general psychiatric care*. Lund, Sweden: Department of Psychology, Lund University and Division of Psychiatry, Lund University Hospital.

Kazdin, A. E. (2003). *Research design in clinical psychology*. Boston, MA: Allyn & Bacon.

Koch, C. (1952). *The Tree Test. The tree-drawing test as an aid in psychodiagnosis*. Bern, Switzerland: Verlag Hans Huber.

Körlin, D., Nybäck, H. & Goldberg, F. S. (2000). Creative arts groups in psychiatric care: Development and evaluation of a therapeutic alternative. *Nordic Journal of Psychiatry*, *54*, 333–340.

Krantz, G. & Östergren, P. O. (2004). Does it make sense in a coherent way? Determinants of sense of coherence in Swedish women 40–50 years of age. *International Journal of Behavioral Medicine*, *11*, 18–26.

Lambert, M. J. & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In: J. C. Norcross (Ed.) *Psychotherapy relationships that work. Therapist contributions and responsiveness to patients* (pp. 17–32). New York: Oxford University Press.

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A. & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, *2*, 197–207.

Law, M., Baptiste, S., Carswell, A., McColl, M. A., Polatajko, H. & Pollock, N. (1998). *Canadian occupational performance measure* (2nd ed., Rev.). Ottawa, ON: CAOT Publications ACE.

Luborsky, L., Barber, J. P., Siqueland, L. *et al*. (1996). The revised helping alliance questionnaire (Haq-II). Psychometric properties. *Journal of Psychotherapy Practice and Research*, *5*, 260–271.

Luborsky, L., Diguer, L., Seligman, D. A. *et al*. (1999). The researcher's own therapy allegiances: A 'wild card' in comparisons of treatment efficacy. *American Psychological Association*, *6*, 95–106.

Marshall, G. N. & Lang, E. L. (1990). Optimism, self-mastery, and symptoms of depression in women professionals. *Journal of Personality Social Psychology*, *59*, 132–139.

McColl, M. A., Paterson, M., Davies, D., Doubt, L. & Law, M. (2000). Validity and community utility of the Canadian Occupational Performance Measure. *Canadian Journal of Occupational Therapy*, *67*, 22–30.

McKinnon, A. L. (2000). Client values and satisfaction with occupational therapy. *Scandinavian Journal of Occupational Therapy*, *7*, 99–106.

Mee, J. & Sumsion, T. (2001). Mental health clients confirm the motivation power of occupation. *British Journal of Occupational Therapy*, *64*, 121–128.

Nguyen, T. D., Attkisson, C. C. & Stegner, B.-L. (1983). Assessment of patient satisfaction: Development and refinement of a service evaluation questionnaire. *Evaluation and Program Planning*, *6*, 299–314.

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

Palmadottir, G. (2003). Client perspectives on occupational therapy in rehabilitation services. *Scandinavian Journal of Occupational Therapy*, *10*, 394–401.

Palmadottir, G. (2006). Client-therapist relationships: Experiences of occupational therapy clients in rehabilitation. *British Journal of Occupational Therapy*, *69*, 121–128.

Patrick, J. & Winship, G. (1994). Creative therapy and the question of disposal: What happens to created pieces following the session? *British Journal of Occupational Therapy*, *57*, 20–22.

Pearlin, L. I., Menaghan, E. G., Lieberman, M. A. & Mullan, J. T. (1981). The stress process. *Journal of Health Social Behavior*, *22*, 337–356.

Polkinghorne, D. E. (1996). Transformative narratives: From victims to agentic life plots. *American Journal of Occupational Therapy*, *50*, 299–305.

Reynolds, F. (2003). Reclaiming a positive identity in chronic illness through artistic occupation. *Occupation, Participation and Health*, *23*, 118–127.

Reynolds, F. & Prior, S. (2003). 'A lifestyle coat-hanger': A phenomenological study of the meanings of artwork for women coping with chronic illness and disability. *Disability and Rehabilitation*, *25*, 785–794.

de Roten, Y., Fischer, M., Drapeau, M. *et al*. (2004). Is one assessment enough? Patterns of helping alliance development and outcome. *Clinical Psychology and Psychotherapy*, *11*, 324–331.

Saunders, E. J. & Saunders, J. A. (2000). Evaluation the effectiveness of art therapy through a quantitative, outcomes-focused study. *Arts in Psychotherapy*, *27* (2), 99–106.

Steinhardt, L. (1995). Longterm creative therapy with a borderline psychotic boy. *American Journal of Art Therapy*, *34*, 43–49.

Streiner, D. L. & Norman, G. R. (2003). *Health measurement scales. A practical guide to their development and use* (3rd ed.). Oxford: Oxford University Press.

Swedish Association of Occupational Therapists [Förbundet Sveriges Arbetsterapeuter (FSA)] (1999). *Canadian occupational performance measure* (Svensk version). Stockholm, Sweden: Förbundet Sveriges Arbetsterapeuter.

World Health Organization (1993). *The ICD-10 classification of mental and behavioural disorders*. Geneva, Switzerland: World Health Organization.

de Wilde, E. F. & Hendriks, V. M. (2005). The client satisfaction questionnaire: Psychometric properties in a Dutch addict population. *European Addiction Research*, *11*, 157–162.

Wressle, E., Samuelsson, K. & Henriksson, C. (1999). Responsiveness of the Swedish version of the Canadian Occupational Performance Measure. *Scandinavian Journal of Occupational Therapy*, *6*, 84–89.

Wressle, E., Marcusson, J. & Henriksson, C. (2002). Clinical utility of the Canadian Occupational Performance Measure – Swedish version. *Canadian Journal of Occupational Therapy*, *69*, 40–48.

© 2008 The Authors
Journal compilation © 2008 Australian Association of Occupational Therapists

Paper III

Paper IV

Dissertations from the Division of Occupational Therapy, Department of Health Sciences, Lund University, Sweden

1. Persson, D. (2001). *Aspects of Meaning in Everyday Occupations and its Relationship to Health-related Factors.* ISBN 91-974281-0-8.

2. Carlsson, G. (2002). *Catching the Bus in Old Age. Methodological Aspects of Accessibility Assessments in Public Transport*. ISBN 91-974281-1-6.

3. Dychawy-Rosner, I. (2003). *Daily Activities among Persons with Developmental Disabilities. Assessment, Staff Experiences and Caring Dynamics*. ISBN 91-974281-2-4.

4. Nygren, C. (2003). *The Complexity of Geriatric Rehabilitation. A One-year Follow-up of Client, Caregiver, and Administration Perceptions*. ISBN 91-974281-3-2.

5. Erlandsson, L-K. (2003). *101 Women's Patterns of Daily Occupations. Characteristics and Relationships to Health and Well-being*. ISBN 91-974281-4-0.

6. Fänge, A. (2004). *Strategies for Evaluation of Housing Adaptations – Accessibility, Usability, and ADL Dependence*. ISBN 91-974281-5-9.

7. Sandqvist, G. (2004*). Hand Function, Everyday Occupations and Wellbeing in Individuals with Systemic Sclerosis*. ISBN 91-974281-6-7.

8. Brandt, Å. (2005). *Outcomes of Rollator and Powered Wheelchair Interventions –User Satisfaction and Participation*. ISBN 91-974281-7-5.

9. Werngren-Elgström, M. (2006). *Deaf Sign Language Users – Prevalence and Aspects of Quality of Life in Old Age*. ISBN 91-85481-74-2.

10. Haak, M. (2006). *Participation and Independence in Old Age - Aspects of Home and Neighbourhood Environments.* ISBN 91-85559-56-3.

11. Bejerholm, U. (2007). *Occupational Perspectives on Health in People with Schizophrenia –-- Time Use, Occupational Engagement and Instrument Development.* ISBN 91-85559-89-X.

12. Nilsson, L. (2007). *Driving to Learn. The process of Growing Consciousness of Tool Use – A Grounded Theory of De-plateauing.* ISBN 91-85559-11-4.

13. Leufstadius, C. (2008). *Spending my time – Time use and meaningfulness in daily occupations as perceived by people with persistent mental illness.* ISBN 978-91-86059-18-7

14. Löfqvist, C. (2008). *Mobility devices in everydy life among very old Europeans: Aspects of use and changes over time.* ISBN 978-91-86059-45-3.

15. Gunnarsson, B. (2008). *The Tree Theme Method - An Occupational Therapy Intervention Applied in Outpatient Psychiatric Care.* ISBN 978-91-86059-73-6.

Distribution:
Division of Occupational Therapy and Gerontology, Faculty of Medicine
Box 157, S-221 00 Lund, Sweden
www.arb.lu.se