A Qualitative study on Therapists' Use of Intrapersonal and Interpersonal Emotion Regulation Strategies During Patient Interactions

Ayana Horton, PhD

College of Health, Medicine, and Life Sciences

Brunel University London

David Holman, PhD

Alliance Manchester Business School

University of Manchester

Gail Hebson, PhD

Department of People and Performance

Manchester Metropolitan University

Acknowledgements

This research was done as part of the first author's doctoral thesis

Horton, A. (2018) Emotion Regulation in Therapeutic Relationships (Unpublished doctoral dissertation or master's thesis). University of Manchester, Manchester, United Kingdom.

No financial support or conflict of interest to acknowledge

Corresponding author:

Ayana Horton PhD, MBA, OTR

T +44(0)1895 268782 | E ayana.horton@brunel.ac.uk

Abstract

Importance

Although therapists' use of emotion regulation strategies may play an important role in building therapeutic relationships, we know little about how therapists use intrapersonal and interpersonal emotion regulation strategies during interactions with patients.

Objective

To understand how therapists use intrapersonal and interpersonal emotion regulation strategies during their interactions with patients.

Design

This qualitative study consisted of two stages of data collection. In the first stage therapists were interviewed regarding how they use emotion regulation strategies during their therapeutic relationships. In the second stage, patient/therapist dyads were observed during treatment sessions and then interviewed at the end of the therapeutic relationship.

Setting

In-patient and out-patient rehabilitation hospitals and clinics in United Kingdom.

Participants

In the first stage 13 occupational therapists and 9 physical therapists participated. In the second stage 14 patient/therapist dyads participated.

Outcome and Measures

A semi-structured interview guide was used to ask therapists how they used emotion regulation strategies during interactions with patients.

Results

Therapists use a wide range of interpersonal and intrapersonal emotion regulation strategies that can be categorised in prominent emotion regulation strategy taxonomies. They used these strategies proactively, in anticipation of emotional events and reactively, in response to

emotional events and their use helps to build and maintain the therapeutic relationship, to protect themselves, to feel better, and to get their jobs done.

Conclusions and Relevance

The ability to regulate one's own emotions and others emotions is an essential part of therapists' work role. Therapists use a wide range of emotion regulation strategies to benefit themselves and their patients.

What This Article Adds

This is the first study to identify the specific intrapersonal and interpersonal emotion regulation strategies used by occupational and physical therapists during patient/therapist interactions. This study makes an important contribution to our understanding of therapists' use of proactive and reactive emotion regulation strategies to build and maintain therapeutic relationships.

Introduction

In allied health professions, the regulation of one's own emotions and the emotions of others is an integral part of one's work role (Miller et al, 2008). Emotion regulation is the goal-directed process of regulating the occurrence, magnitude, or duration of emotional responses (Gross, Sheppes & Urry, 2011). Strategies used to regulate one's own emotional responses are called intrapersonal emotion regulation. Strategies used to regulate other's emotions are called interpersonal emotion regulation (Niven, Totterdell, & Holman, 2009). Emotion regulation may be a particularly useful tool in building therapeutic relationships with patients because a therapists' emotional displays and behaviours help patients understand the professional's thoughts, feelings, and intentions (Van Kleef, 2008) and in this way influence how they understand the quality of the relationship (Niven, Holman & Totterdell, 2012; Methot, Melwani & Rothman, 2017).

The therapeutic relationship is the interpersonal relationship between the therapist and patient (Peplau, 1997). The importance of building positive therapeutic relationships is recognised throughout healthcare professions. Specifically, in the context of occupational therapy, therapeutic success is associated with the quality of the therapeutic relationship (Weiste, 2018). In physical therapy, researchers have found that therapeutic relationships have a significant impact on measures of healthcare quality including clinical outcomes (Hall et al, 2010), patients' adherence to therapist's recommendations (Moore et al, 2020) and patient satisfaction (Beattie et al, 2002). A therapist's interpersonal behaviours, including their use of emotion regulation, can be either a barrier or facilitator to building therapeutic relationships (Morera-Balaguer et al, 2021). Although emotion regulation strategies may play an important role in the therapeutic process and therapeutic relationships, we know little about how therapists use interpersonal emotion regulation strategies during interactions with patients. The aim of this study is therefore to deepen and extend our understanding of how

therapists use interpersonal and intrapersonal emotion regulation strategies during their interactions with patients. This research was conducted as part of the first authors doctoral studies.

Emotion Regulation Strategies

The most prevent taxonomy of intrapersonal emotion regulation strategies is the process model of emotion regulation (Gross, 1998). This model proposes five types of emotion regulation strategies which are distinguished by the point in the emotion-generative process at which they have their primary impact. Antecedent-focused emotion regulation strategies seek to influence emotion before it is generated. Situation selection, situation modification, attentional deployment, and cognitive change or reappraisal are all antecedent-focused emotion regulation strategy families. Response focused emotion regulation strategies seek to influence the emotion after it is generated. Response modulation is the only family of intrapersonal emotion regulation strategies that falls into the response-focused category (Gross, 1998).

According to the process model of emotion regulation (Gross, 1998), situation selection are strategies used to ensure that one will be in a situation that promotes the desired emotions. Situation modification are strategies used to change a situation for the purpose of promoting desired emotions. Attentional deployment refers to focusing one's attention as a way to influence one's emotions. Cognitive change refers to modifying how one thinks about a situation for the purpose of promoting the desired emotions. Lastly, response modulation refers to strategies used to directly influence the experiential, behavioural, or physiological aspects of one's emotional response.

Using Gross's (1998) classification of intrapersonal emotion regulation strategies as a template, Williams (2007) identified four types of interpersonal emotion regulation strategies;

118 altering the situation, altering attention, altering the cognitive meaning of a situation and
119 modulating the emotional response. Altering the situation involves changing or modifying
120 the situation for the purpose of influencing a target's emotions. Altering attention are
121 strategies used to influence a target's emotions by attempting to divert their attention.
122 Altering the cognitive meaning of a situation are strategies used to influence a targets
123 emotions by helping them think differently about an issue or situation. Modulating the
124 emotional response are strategies used to change how the target experiences or expresses
125 emotion (Williams, 2007).

126 Most research on intrapersonal emotion regulation in healthcare identify the broad
127 categories of intrapersonal emotion regulation strategies described by Gross (1998) that
128 healthcare professionals use rather than the specific strategies that they use (e.g., Mann &
129 Cowburn, 2005; Zammuner & Galli, 2005; Martinez-Inigo & Totterdell, 2016). There are,
130 however, some studies that identify the specific strategies that professionals use. For
131 example, healthcare professionals may use digging deep within oneself, identifying
132 communication barriers, and seeking support (Foster & Sayers, 2012). Smith and Kleinman
133 (1989) identified strategies that healthcare workers use to emotionally distance themselves in
134 order to deal with undesired emotions. For example, they found that healthcare workers at
135 times use derogatory humour to de-humanise their patients and focusing on medical aspects
136 to avoiding dealing with the psychosocial aspects of the patient. Another example is a study
137 by Hammonds and Cadge (2014) that found that healthcare professionals use intrapersonal
138 emotion regulation strategies such as getting social support from family, venting to
139 colleagues, calling in to work to check on patients and participating in distracting activities
140 (Hammonds & Cadge, 2014).

141 Research on interpersonal emotion regulation at work is sparse, particularly in healthcare
142 settings. This small subset of research has mostly focused on how the use of interpersonal

emotion regulation is associated with personal resources and affective experiences (eg., Martinez-Inigo, Mercado& Totterdell, 2015; Martinez-Inigo, Bermejo-Pablos, & Totterdell, 2018). However, there is research on healthcare professionals' responses to patients' emotions which, although not specifically talking about emotion regulation, shines light on the interpersonal emotion regulation strategies that healthcare professionals use. These studies found that healthcare professionals may use strategies that fit into Williams' (2007) categories of interpersonal emotion regulation including humour (Bolton, 2000) (an altering the situation or altering attention strategy), acknowledging patient's emotions, (an altering the emotional response strategy), providing information (an altering the situation or altering the meaning strategy), and using empathetic responses (an altering the emotional response strategy) (Finset, 2012; Mjaaland, Finset, Jensen & Gulbrandsen, 2011).

An important gap in this area of research is there are no studies on intrapersonal emotion regulation in occupational therapy and only one in physical therapy by Foster and Sayers, (2012). Also, there is a lack of studies on interpersonal emotion regulation in occupational or physical therapy. Since the use emotion regulation strategies is context-dependent (Gross, 2015; Dixon-Gordon, Bernecker & Christensen, 2015) meaning different strategies may be appropriate or inappropriate in different contextual situations, emotion regulation may be used differently in different professional contexts. For this reason, it is important to understand emotion regulation use in the specific context of occupational and physical therapy. To address this knowledge gap, semi-structured interviews and unstructured, nonparticipant observation were used to understand how therapists use emotion regulation strategies during interactions with patients.

Method

Study design and procedure

This is an exploratory qualitative study using a constructivist epistemology, meaning that the knowledge sought is perspectival (King & Brooks, 2017) and it was approved by the local institutional review board. This research was conducted in two stages. In the first stage, semi-structured interviews were used with patients and therapists. They were asked to tell the story of a therapeutic relationship that they recently experienced or are currently experiencing and in doing so, highlight emotional events that occurred, the resulting emotions, and the emotion regulation strategies they used to address those emotions. The first stage of data collection informed the second stage by developing a fine-tuned thematic template and interview schedule, both of which were used in the second stage of data collection. Also, since semi-structured interviews are comparatively less time consuming and less intrusive than observation, one of the methods used in the second stage of data collection, the first stage of data collection enabled the researchers to quickly access participants perceptions and access a wide range of therapeutic specialties that may not be appropriate for observational data collection due to ethical reasons.

In the second stage, unstructured, non-participant observation of patient/therapist dyads during their interactions and semi-structured participant verification interviews, with each dyadic partner individually at the end of the relationship were used to understand participants perceptions of how they used emotion regulation strategies during interactions. Unstructured observation was used because it is an ideal way to collect rich data on behaviour and interpersonal interaction under the most natural circumstances (Mulhall, 2003; Kelley, 2002) and it enables the researchers to get an insider's perspective (Salmon, 2015). The first author observed each dyad during their treatment sessions, from the first session when they initially met, to the last when the patient was discharged from therapy services. Therefore, the number of treatment sessions observed varied for each dyad but ranged from 2 to 9 sessions. The observation was done in person, with the observer seated in the clinic within hearing distance

to the dyad being observed, and an audio recorder was used to record dialog. The observer was specifically looking to observe events that may cause emotion and how each dyadic partner responded to those events. The data collected through observation was not analysed and was only used to inform the participant verification interview schedule.

The purpose of the participant verification interview was to verify the researcher's impressions of emotional events, resulting emotions, and emotion regulation strategies used from her observations with the participant's point of view. The basis of the interviews at the end of the therapeutic relationships was the interview schedule from the first stage of data collection, however, for each dyad, the interview schedule was heavily augmented with questions and prompts informed by the data collected through observation. In this way the researcher could ask informed questions about interactional dynamics that occurred during the therapeutic relationship and verify her understanding with the participants perceptions. For example, if through observation of dyadic interactions, it appeared that a particular emotion regulation strategy was used, the researcher would ask both dyadic partners about it during the interview. The second stage built upon the first stage of data collection by using methodological triangulation and including dyadic partners within therapeutic relationships. Interviews and dialog during treatment sessions were audio recorded and transcribed. All data collection was conducted by the first author, who is an occupational therapist with extensive experience working within therapeutic relationships.

A number of strategies were used to ensure the trustworthiness of this research. Methodological triangulation was used to cross verify the data collected. Pilot studies were used to fine-tune the data collection process. Member checking was used to ensure that the researcher's understanding was in line with the participants understanding. A reflective journal was also used to record assumptions, actions, and rationale for those actions.

Participants, recruitment, and contexts

Participants were recruited using purposive sampling from three hospitals and one clinic in the United Kingdom. In the first stage, nine physiotherapists and 13 occupational therapists participated. There were 19 female therapists and three male therapists. The therapists ranged in age from their 20's to their 60's. They worked in various specialty areas, such as musculoskeletal, accident and emergency, and neurology. They ranged in years of experience from 1 years to 35 years.

In the second stage 14 dyads were recruited for the main study. They were recruited from hand therapy clinics in London. The therapists ranged in ages from their 20's to their 40's and had between two and 20 years of experience. Three of the therapists were physical therapists, and the remaining five were occupational therapists. Seven of the therapists were female and one was male. The people who participated in the first stage of data collection did not participate in the second stage of data collection and vice versa.

Data Analysis

The data were analysed using template analysis as described by King (2004a) and NVivo 10 software package. The data analysis began with the formulation of an initial template which consisted of codes based on prior research. Relevant sections of each transcript were coded using King's (2004 a & b) description of the process as a guide. As thematic codes emerged from the data, the researcher incorporated them into the template. In this way, the researcher adds, deletes, and fine-tunes the thematic codes on the template until it is an accurate representation of the themes emanating from the data (King, 2004 a & b).

The data were collected and analysed simultaneously and data analysis was done in repetitive cycles. Each cycle of data collection and analysis benefited from an increasingly more fine-tuned template and the researchers' increasing level of familiarity with the data. Since the data from both stages of data collection focused on understanding therapists' use of

emotion regulation strategies, they are reported together. Only the data relevant to therapists' use of emotion regulation strategies is reported in this paper.

Findings

The findings show that therapists use a wide range of intrapersonal and interpersonal emotion regulation strategies when interacting with patients. They use these strategies both proactively, meaning in anticipation of emotion, and reactively, meaning in response to emotion.

How Therapists Use Intrapersonal Emotion Regulation in Response to Negative Emotion

Therapists described using all categories of intrapersonal emotion regulation strategies described in Gross's (1998) process model of emotion regulation to regulate their own negative emotions (see table 1). Situation selection is choosing to engage or not engage in situations to promote desired emotions and avoid undesired emotions (Gross, 1998). The main way that situation selection was used by therapists within therapeutic relationships was by avoiding interacting with patients that provoke negative emotions. Therapists may do this by exchanging patients with another therapist or therapy student.

> "Me and the physios split them up, and she'll go one day, and I'll go another. And we've got a student, so we send the student the other day. So, it spreads the load a little bit."
>
> (S1P-1-T) Occupational Therapist, 6 years' experience, age range – 20s

Situation modification strategies are used to change a situation to experience desired emotions (Gross, 1998). Therapists used situation modification strategies to steer their interactions in a way to avoid negative emotions. Often this involved efforts to prepare oneself practically and emotionally. For example, one therapist explained how she prepared

herself prior to working with a patient to avoid feeling the anxiety and embarrassment associated with appearing nervous or incompetent.

> "… prepared myself before going in…. You know how you kind of psych yourself up. You really think through what your treatment plan's going to be, think through what you're going to say just in case the family comes and it's the whole deep breath, in you go."
>
> (1-8-T) Physiotherapist, 13 years' experience, age range – 30s

In preparing for the session, she modified the situation from one where she could have been ill-prepared, to one where she appears competent. In the quote the therapist mentions that she "psyches" herself up. This can be understood as providing evidence that she is simultaneously using cognitive reappraisal, strategies used to modify how one appraises a situation in order to facilitate the desired emotions (Gross, 1998), to prepare for the treatment session.

Other therapists also described using cognitive reappraisal to protect themselves, to maintain their professionalism, to be able to get their job done, and to feel better. They tended to use cognitive reappraisal to not take personal a patient's or their family's negative behaviours towards them or to remind themselves of the limits of their remit. One therapist described how she used cognitive reappraisal to cope with the despair she felt when one of her patients died one week after he was discharged home by thinking about the positive aspects of the situation.

> "I felt… he's gone to rest; the suffering has gone… he's had good care… the best that we could offer… and so that gives me that satisfaction."
>
> (1-14-T) Occupational Therapist, 35 years' experience, age range – 60s

Therapists also used cognitive reappraisal to give themselves permission to feel negative emotions albeit in a controlled way.

"…actually, sometimes unfortunately, like, you can only do what you can do. And so, you have to sometimes, it sounds bad, but be at peace with that."

(1-7-T) Physiotherapist, 3 years' experience, age range – 20s

Attentional deployment strategies are those that attempt to direct or redirect one's attention to influence one's own emotional experience (Gross, 1998). One of the primary ways that therapists used attentional deployment is by ignoring negative emotional events, such as patient's display of anger or irritation directed towards them.

"I guess I just blocked it out after I knew that I couldn't change the outcome…"

(1-13-T) Physiotherapist, 4 years' experience, age range – 20s

Over time they may become acclimated to the common affective events that provoke negative emotion and consequently these emotional events may decrease in their emotional significance.

"Certain frustrations now bounce off my back because I can't influence them… What's the point in worrying about things I can't influence? …"

(S1P-1-T) Occupational Therapist, 6 years' experience, age range – 20s

This statement can be understood as an example of a therapists using attentional deployment and cognitive reappraisal at the same time. The therapist described the need to let frustrations bounce off her back. This is an indication of the therapist using attentional deployment. When the therapist questions the point of worrying about things she cannot influence, this is an indication of her using cognitive reappraisal.

Response-focused strategies are efforts focused on influencing the experiential, physiological, or behavioural, components of an emotional response (Gross, 1998). Examples of therapists use of such strategies include hiding their frustration, holding back tears, and taking a deep breath to try to manage anxiety.

"…it's keeping that professional face and then going away to the bathroom and having a good cry. So yes, the emotions do come out but hopefully not in front of a patient."

(1-17-T) Physical Therapist, 13 years' experience, age range - 20

"So, if I'd got really angry with them, that wouldn't have achieved anything. So, I was internally frustrated. But I didn't let that out."

(1-1-T) Occupational Therapist, 7 years' experience, age range – 30s

Hochschild (1983) called these strategies surface acting. Therapists used these strategies to maintain one's professional composure and to deescalate tense situations. In addition to using intrapersonal emotion regulation strategies before and during the encounter, therapists also use these strategies after the encounter. For example, after the encounter, therapists may use strategies like venting, "switching off", crying, seeking support, eating, and exercising to address residual emotions.

"I said to my manager that I went over backwards to help this family and this is what I get you know."

(1-14-T) Occupational Therapist, age range – 60s

"…If I'm feeling a bit rotten then I'll have a big bag of crisps. And that works. And that does work at work as well. It's been a bad day – shall we go out for lunch? It's quite a common thing in our office."

(S1P-1-T) Occupational Therapist, 6 years' experience, age range – 20s

"… I exercise because of work, I think, more than anything else and probably at times have a glass of wine.

(S1P-6-T) Occupational Therapist, 3 years' experience, age range – 30s

Situation selection and modification are proactive (or antecedent-focused) intrapersonal emotion regulation strategies because they are enacted prior to the experience of emotion.

Attentional deployment, cognitive reappraisal, and response modulation are reactive (or response-focused) intrapersonal emotion regulation strategies because they are used after the experience of emotion.

How Therapists Use Interpersonal Emotion Regulation Strategies

Therapists reported that regulating their patients' emotions is an essential part of their job. In fact, at times regulating their patients' emotions took priority over therapeutic interventions because the patients' emotions influenced their ability to take part in therapy.

> "…Even though I was going to see her as a physio, we didn't necessarily do any physio sessions. It was more talk and let her deal with her emotions. And then next time we come and do the physio session."
>
> (1-8-T) Physical Therapist, 13 years' experience, age range – 30s

Therapists described using a wide range of strategies that can be categorised according to Williams' (2007) interpersonal emotion management framework (see table 2). Altering the situation involves modifying or changing the situation to influence the emotional impact on the target (Williams, 2007). Therapists used this type of strategy proactively, that is in anticipation of emotion rather than in response to emotion, to avoid negative emotions. For example, therapists stated that at times they tell their patients they may not achieve full recovery as a tactic to manage the patient's expectations and avoid patients having negative emotions if they subsequently do not fully recover.

> "I think it is important to manage patients' expectations so they can be more realistic regarding what they think they will get out of therapy."
>
> (1-1-T) Occupational Therapist, 7 years' experience, age range - 30s

One therapist discussed how up front she tells her patients that certain decisions are not up to her, even though that is not true, as a way to avoid patient anger if she did not make the decision that the patient would prefer.

"It just makes it easier for me, they (patients) because I don't want to deal with that (referring to patients' anger)."

(1-3-T) Occupational Therapist, 2 years' experience, age range - 20s

Altering attention are strategies used to divert the targets attention to influence their emotions (Williams, 2007). Therapists used small talk to take patients minds off of from taxing or painful therapy. They redirected their patient's attention away from negative emotion causing stimuli, such as their uncertain future functional status or a decline in the patient's status. One therapist explained that while she allows her patients to express their worries, she tries to prevent them from ruminating on their worries by refocusing the patient on the task at hand.

"If they're (the patient) tearful, I listen. I'll be respectful and understanding but then I'll move on. 'That's okay, that's that, so how can me move on?'"

(S1P-8-T) Occupational Therapist, 6 years' experience, age range – 40s

Similarly, another therapist explained how she used the therapy as an attention altering strategy.

"I just reassured him and said these things happen. And try not to focus on it and be too hard on yourself because lots of people have been in the same situation. And those sorts of things. So, and then just focusing on the getting him up and doing more active things to take his mind off it and feel like he is achieving."

(1-9-T) Physical Therapist, 8 years' experience, age range – 30s

This is an example of a therapist using two types of interpersonal emotion regulation strategies at the same time. When the therapists told the patient that many people have been in the same situation, the therapist was also trying to help the patient to understand that he is not alone. This strategy can be categorised as altering the cognitive meaning of a situation,

which is helping the target think about an issue differently to change the emotional consequences. Altering the cognitive meaning of a situation strategies are often used when patients are feeling sad about their lack of functional independence as a way to help the patients to see "the bright side of things". Another example of therapists' use of this strategy is a therapist encouraging patients to think about incremental improvements instead of how far they are from their rehabilitation goals.

Modulating the emotional response involves actions used to change the targets current experience or expression of emotion (Williams, 2007). In general, therapists believed that patients had the right to feel negative emotions. For this reason, they did not try to encourage patients to suppress negative emotions unless the emotions were particularly intense and directed at the therapist. One therapist described how she attempted to regulate her patient's emotional expressions by setting and enforcing boundaries on which emotional expressions are appropriate and which are not appropriate. Patients' emotional expressions that fall outside of those boundaries drew undesirable consequences.

> "… I think a large part of it was building boundaries and then letting him (the patient) know where the boundaries lie in terms of what he could and couldn't do (talking about the patient's emotional expression) ... So, you're saying, I'm not going to accept it. If you're going to shout, then I'll come back when you've calmed down."
>
> (1-9-T) Physical Therapist, 8 years' experience, age range – 30s

Altering the situation is a proactive interpersonal emotion regulation strategy in that it is enacted in anticipation of other's emotion. Altering attention, altering meaning, and modulating the emotional response are reactive interpersonal emotion regulation strategies in that they are used in response to other's emotion.

Discussion

This is the first study to identify the specific intrapersonal and interpersonal emotion regulation strategies used by occupational and physical therapists in response to negative emotions stemming from emotional events that occur during patient/therapist interactions. Similar to previous studies, this study found that therapists may use more than one emotion regulation strategy at once (e.g., Aldao & Nolen-Hoeksema, 2013). Also, like other studies, this study found that the use of intrapersonal emotion regulation may start before the patient/therapist interactions and continue long after the precipitating emotional event to regulate residual emotions (e.g., Wiese, Heidemeier, Burk & Freund, 2017).

This study makes an important contribution to our understanding of therapists, proactive and reactive use emotion regulation strategies. Proactive emotion regulation refers to strategies used to address expected emotions. Reactive emotion regulation refers to strategies used to address experienced emotions. This distinction is important because research has demonstrated that proactive strategies tend to be more effective than reactive strategies (Webb, Miles, Sheeran, P. (2012). While previous studies have asserted that people use intrapersonal emotion regulation strategies proactively and reactively (e.g., Gross, 1998; Hayward & Tuckey, 2011), research on more proactive intrapersonal emotion regulation strategies (e.g., situation modification and situation selection) have been studied less often than more reactive intrapersonal emotion regulation strategies (e.g., attentional deployment cognitive change, and response modulation) (Webb, Miles, & Sheeran, 2012). In addition, studies on interpersonal emotion regulation research, do not tend to draw a distinction between strategies used proactively and reactively (e.g., Tamminen & Crocker, 2013; Niven, Totterdell & Holman, 2009). Therefore, this is one of the first studies to demonstrate the proactive use of interpersonal emotion regulation.

The lack of focus on proactive use of interpersonal and intrapersonal emotion regulation strategies is surprising given the fact that expected emotions have a direct impact on self-

regulatory behaviour, whereas experienced emotions have an indirect impact on self-regulatory behaviour (Brown & McConnell, 2011; Baumeister, Vohs, DeWall & Zhang, 2007). In other words, expected emotions may explain and guide emotion regulation behaviour more than experienced emotion. To fully understand emotion regulation behaviour, more research is needed on proactive interpersonal and intrapersonal emotion regulation.

Implications for Occupational Therapy Practice

Therapists use emotion regulation during their interactions with patients to build/maintain the therapeutic relationship, protect their own emotional wellbeing, present themselves as competent and professional, and to facilitate the therapeutic process. The multifaceted application of this skill highlights the importance of therapists developing their emotion regulation ability and has the following implications:

- Occupational and physical therapy employers and educational programs can provide training to help therapists and students improve their ability to use interpersonal and intrapersonal emotion regulation during their interactions with patients.
- Researchers can focus more on the emotional aspects of the therapeutic relationship to better understand relationship development, maintenance, and breakdown.
- After emotional events, occupational and physical therapists can reflect upon their use of emotion regulation strategies and associated outcomes to begin to understand how they can best regulate emotions during interactions with patients.

Limitations

As with all studies, there are limitations that must be acknowledged. While semi-structured interviews are a useful way to access participants perceptions, the information

gained may be limited by participants' memory, understanding of the topic, or their willingness to disclose information. The use of observation combined with participant verification interviews in the second stage of data collection mitigated some of these limitations since we could ask questions base on our observations that might compensate for any deficits in their understanding or jog their memory. However, using observation introduced additional limitations since participants may act differently when being observed. Also, the very nature of some emotion regulation strategies makes them difficult to observe. However, through observation we could develop an understanding of the context and emotional events that enabled us to ask informed questions about emotion regulation during the participant verification interviews. Finally, as with all qualitative research, the generalisation of the results is limited to the specific context in which the research was conducted.

Conclusion

This research focused on how occupational therapists and physical therapists use emotion regulation strategies during interactions with patients. Therapists use a wide range of intrapersonal and interpersonal emotion regulation strategies before, during, and after interacting with patients, oftentimes using more than one strategy at once. This research makes an important contribution to our understanding of emotion regulatory processes in naturalistic rehabilitation contexts.

References

Aldao, A., & Nolen-Hoeksema, S. (2013). One versus many: Capturing the use of multiple emotion regulation strategies in response to an emotion-eliciting stimulus. *Cognition and Emotion*, 27, 753-760. https://doi:10.1080/02699931.2012.739998

Baumeister, R. F., Vohs, K. D., DeWall, C. N., & Zhang, L. (2007). How emotion shapes behavior: Feedback, anticipation, and reflection, rather than direct causation. *Personality and Social Psychology Review*, 11, 167-203. https://doi:10.1177/1088868307301033

Beattie, P. F., Pinto, M. B., Nelson, M. K., & Nelson, R. (2002). Patient satisfaction with outpatient physical therapy: Instrument validation. *Physical Therapy*, 82, 557-565.

Bolton, S. C. (2000). Who cares? offering emotion work as a gift in the nursing labour process. *Journal of Advanced Nursing*, 32, 580-586. https://doi:10.1046/j.1365-2648.2000.01516.x

Brown, C. M., & McConnell, A. R. (2011). Discrepancy-based and anticipated emotions in behavioral self-regulation. *Emotion*, 11, 1091-1095.

Dixon-Gordon, K., Bernecker, S. L., & Christensen, K. (2015). Recent innovations in the field of interpersonal emotion regulation. *Current Opinion in Psychology*, 3, 36-42.

Finset, A. (2012). "I am worried, doctor!" emotions in the doctor-patient relationship. *Patient Education and Counseling*, 88, 359-363. https://doi:10.1016/j.pec.2012.06.022

Foster, C., & Sayers, J. (2012). Exploring physiotherapists' emotion work in private practice. *New Zealand Journal of Physiotherapy*, 40, 17-23.

514 Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review*
515 *of General Psychology*, 2, 271-299. https://doi:10.1037/1089-2680.2.3.271
516
517 Gross, J. J. (2015). The extended process model of emotion regulation: Elaborations,
518 applications, and future directions. *Psychological Inquiry*, 26, 130-137.
519 https://doi:10.1080/1047840X.2015.989751
520
521 Gross, J. J., Sheppes, G., & Urry, H. L. (2011). Cognition and emotion lecture at the 2010
522 SPSP emotion preconference: Emotion generation and emotion regulation: A distinction we
523 should make (carefully). *Cognition and Emotion*, 25, 765-781.
524 https://doi:10.1080/02699931.2011.555753
525
526 Hall, A. M., Ferreira, P. H., Maher, C. G., Latimer, J., & Ferreira, M. L. (2010). The
527 influence of the therapist-patient relationship on treatment outcome in physical rehabilitation:
528 A systematic review. *Physical Therapy*, 90, 1099-1110. https://doi:10.2522/ptj.20090245
529
530 Hammonds, C., & Cadge, W. (2014). Strategies of emotion management: Not just on, but off
531 the job. *Nursing Inquiry*, 21, 162-170. https://doi:10.1111/nin.12035
532
533 Hayward, R. M., & Tuckey, M. R. (2013). Emotional boundary management: A new adaptive
534 approach to emotion regulation at work. In P. L. Perrewé, C. C. Rosen & J. R. B. Halbesleben
535 (Eds.), *The Role of Emotion and Emotion Regulation in Job Stress and Well Being,* 35-74.
536 Bingley, United Kingdom: Emerald Group Publishing.
537 http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=psyh&AN=2014
538 -22593-002&site=ehost-live&scope=site&custid=s1123049

Hochschild, A. (1983). The Managed Heart: Commercialization of Human Feeling. Berkeley: University of California Press.

Kelley, H. H. (2002). *Close Relationships*. Clinton Corners, N.Y: Percheron Press.

King, N. (2004a). Doing template analysis. In G. Symon, & C. Cassell (Eds.), *Qualitative Organizational Research: Core methods and Current Challenges*. Sage Publications.

King, N. (2004b). Using templates in the thematic analysis of text. In C. Cassell, & G. Symon (Eds.), *Essential Guide to Qualitative Methods in Organizational Research*. London: Sage Publications.

King, N., & Brooks, J. (2017). Template analysis for business and management students. London: Sage Publications, Inc.

Mann, S., & Cowburn, J. (2005). Emotional labour and stress within mental health nursing. *Journal of Psychiatric & Mental Health Nursing*, 12, 154-162. https://doi:10.1111/j.1365-2850.2004.00807.x

Martínez-Íñigo, D., Mercado, F., & Totterdell, P. (2015). Using interpersonal affect regulation in simulated healthcare consultations: An experimental investigation of self-control resource depletion. *Frontiers in Psychology*, 29, 1486. https:// doi: 10.3389/fpsyg.2015.01485

564 Martínez-Íñigo, D., & Totterdell, P. (2016). The mediating role of distributive justice
565 perceptions in the relationship between emotion regulation and emotional exhaustion in
566 healthcare workers. *Work & Stress*, 30, 26-45. https://doi:10.1080/02678373.2015.1126768
567
568 Methot, J. R., Melwani, S., & Rothman, N. B. (2017). The space between us: A social-
569 functional emotions view of ambivalent and indifferent workplace relationships. *Journal of*
570 *Management*, 43, 1789-1819. https://doi:10.1177/0149206316685853
571
572 Miller, K., Reeves, S., Zwarenstein, M., Beales, J. D., Kenaszchuk, C., & Conn, L. G. (2008).
573 Nursing emotion work and interprofessional collaboration in general internal medicine wards:
574 A qualitative study. *Journal of Advanced Nursing*, 64, 332-343. https://doi:10.1111/j.1365-
575 2648.2008.04768.x
576
577 Mjaaland, T. A., Finset, A., Jensen, B. F., & Gulbrandsen, P. (2011). Physicians' responses to
578 patients' expressions of negative emotions in hospital consultations: A video-based
579 observational study. *Patient Education & Counseling*, 84, 332-337.
580
581 Moore, A. J., Holden, M. A., Foster, N. E., & Jinks, C. (2020). Therapeutic alliance facilitates
582 adherence to physiotherapy-led exercise and physical activity for older adults with knee pain:
583 A longitudinal qualitative study. *Journal of Physiotherapy*, 66, 45-53.
584 https://doi:10.1016/j.jphys.2019.11.004
585
586 Morera-Balaguer, J., Botella-Rico, J., Catalán-Matamoros, D., Martínez-Segura, O., Leal-
587 Clavel, M., & Rodríguez-Nogueira, Ó. (2021). Patients' experience regarding therapeutic
588 person-centered relationships in physiotherapy services: A qualitative study. *Physiotherapy*

Theory and Practice. 37, 1-11. Philadelphia, Pennsylvania: Taylor & Francis Ltd. https://doi:10.1080/09593985.2019.1603258

Mulhall, A. (2003). In the field: Notes on observation in qualitative research. *Journal of Advanced Nursing*, 41, 306-313. https://doi:10.1046/j.1365-2648.2003.02514.x

Niven, K., Holman, D., & Totterdell, P. (2012). How to win friendship and trust by influencing people's feelings: An investigation of interpersonal affect regulation and the quality of relationships. *Human Relations*, 65, 777-805. https://doi:10.1177/0018726712439909

Niven, K., Totterdell, P., & Holman, D. (2009). A classification of controlled interpersonal affect regulation strategies. *Emotion*, 9, 498-509. https://doi:10.1037/a0015962

Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly*, 10, 162-167.

Salmon, J. (2015). Using observational methods in nursing research. *Nursing Standard*, 29, 36-41. https://doi:10.7748/ns.29.45.36.e8721

Smith, A. C., & Kleinman, S. (1989). Managing emotions in medical school: Students' contacts with the living and the dead. *Social Psychology Quarterly*, 52, 56-69. https://doi:10.2307/2786904

Tamminen, K. A., & Crocker, P. R. E. (2013). 'I control my own emotions for the sake of the team': Emotional self-regulation and interpersonal emotion regulation among female high-performance curlers. *Psychology of Sport and Exercise*, 14, 737-747. https://doi:10.1016/j.psychsport.2013.05.002

Van Kleef, G. (2008). Emotion in conflict and negotiation: Introducing the emotions as social information (EASI) model. In N. M. Ashkanasy, & C. L. Cooper (Eds.), *Research Companion to Emotion in Organizations*. Cheltenham, UK: Edward Elgar.

Webb, T. L., Miles, E., & Sheeran, P. (2012). Dealing with feeling: A meta-analysis of the effectiveness of strategies derived from the process model of emotion regulation. *Psychological Bulletin*, 138, 775-808. https://doi:10.1037/a0027600

Weiste, E. (2018). Relational interaction in occupational therapy: Conversation analysis of positive feedback. *Scandinavian Journal of Occupational Therapy*, 25, 44-51. https://doi:10.1080/11038128.2017.1282040

Wiese, B. S., Heidemeier, H., Burk, C. L., & Freund, A. M. (2017). When work takes over: Emotional labor strategies and daily ruminations about work while at home. *Journal of Personnel Psychology*, 16, 150-154. https://doi:10.1027/1866-5888/a000174

Williams, M. (2007). Building genuine trust through interpersonal emotion management: A threat regulation model of trust and collaboration across boundaries. *The Academy of Management Review*, 32, 595-621. https://doi:10.2307/20159317

Zammuner, V. L., & Galli, C. (2005). The relationship with patients: 'emotional labor' and its correlates in hospital employees. In C. E. Härtel, W. J. Zerbe & N. M. Ashkanasy (Eds.), *Emotion in Organizational Behavior*. (pp. 251-285). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers. http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=psyh&AN=2005-00477-014&site=ehost-live&scope=site&custid=s1123049

Table 1 - Specific intrapersonal emotion regulation strategies therapists used when working with patient to address negative emotions

Category	Specific Strategies
Situation Selection	"… I didn't feel I could work with her and so it's (meaning treatment of the patient) gone to one of my colleagues." (S1P-1-T) Occupational Therapist, 6 years' experience, age range – 20s
Situation Modification	"That's the prep before the visit. So, for me, I don't like to go into a situation cold. I need to have looked at the background, I need to know what kind of illness I'm dealing with, what kind of family dynamics, so I've got some semblance of what I'm about to expect." (S1P-8-T) Occupational Therapist, 6 years' experience, age range – 40s
Cognitive Reappraisal	"I think a lot of the way that I dealt with the situation as it went through was more just not taking it personally. Just recognising that it wasn't a personal attack on me." (1-9-T) Physical Therapist, 8 years' experience, age range – 30s
Attentional Deployment	"So, I just distracted myself I suppose and went from there." (1-12-T) Physical Therapist, 3 years' experience, age range – 30s
Response Modulation	"… because you don't want to come across too sad in front of your patients. So yes, probably hide it I'd say, hide it." (1-11-T) Physical Therapist, 11 years' experience, age range – 30s

650

651

652

653

654 **Table 2 - Specific interpersonal emotion regulation strategies therapists used when**

655 **working with patient to address negative emotions**

656

Category	Specific Strategies
Altering the Situation	"Because she (the patient) obviously said this previous comment about us being a physio-terrorist or something. And I said, well it's the terrorists, here we are! And then it becomes a bit, it doesn't become an elephant in the room. It becomes more of a fun thing you can use and she kind of went with that and it was, it created a bit more positivity I think." (1-11-T) Physical Therapist, 11 years' experience, age range – 30s
Altering the Cognitive Meaning	"…we spoke to him and we said, look we don't do these things… to embarrass you, it's to help you realise as to where you are and to help you improve. So, we tried, we explained to him that it's not about being embarrassed, it's about just realising what you need to do to improve and where you're at now and this is merely just a tool to help you improve. So that he didn't feel humiliated." (1-7-T) Physical Therapist, 3 years' experience, age range – 20s
Altering Attention	"So, for example, if I feel that they're… in like an angry mind-set, I try to joke with them, interact, be playful, talk about their family, talk about pictures. I won't go straight to the assessment. I try to defuse the situation if I sense that." (S1P-8-T) Occupational Therapist, 6 years' experience, age range – 40s
Modulating Emotional Response	"I apologised for having that conversation in front of him if he didn't feel happy with that conversation…" (1-8-T) Physical Therapist, 13 years' experience, age range – 30s

657