CHAPTER 4

Knowing Ourselves as Therapists

Introducing the Therapeutic Modes

LEARNING OUTCOMES

4.1 Describe each of the six modes, including their strengths, cautions, and associated phrases, questions, and facial and body language.

4.2 Understand the importance of a clear differentiation between each mode.

4.3 Differentiate between the therapeutic use of a mode and the three circumstances that characterize the suboptimal use of a mode.

4.4 Apply each of the six modes in a simulation or practice situation.

Introduction

Are we obligated to treat clients whose behaviors and attitudes may not be desirable or acceptable to us? To what degree should we try to do so before we decide to refer out? What attitudes and abilities explain the difference between a therapist who can interact successfully with a wide range of clients and one who attempts to do so but has less success with more challenging or disengaged clients? One key consideration in defining interpersonal excellence has been mentioned in the previous chapters; it is the willingness to pursue an empathically based understanding of each client. This allows therapists to accurately identify the critical interpersonal characteristics and events that are likely to complicate the therapeutic relationship. With respect to abilities, the primary means by which therapists may enact an empathic understanding of the client's interpersonal characteristics and events is by adjusting the enactment of his or her interpersonal styles (***therapeutic modes***) to best meet the needs of the client in a given moment.

Initial Self-Assessment

Before continuing, please turn to the end of this chapter and complete the Self-Assessment of Modes, Version III. This assessment is provided for you to begin to gain a greater understanding of the modes you might tend to utilize most frequently in a practice situation, and **it is highly recommended that you complete this assessment before reading any further.** This questionnaire is presented in Exercise 4.1 in the Exercises section. After responding to the questions in the exercise, you should continue reading the chapter. After reading the chapter, it is recommended that you score your responses to Exercise 4.1, complete the Personal Modes Profile, and then complete Exercise 4.2. It is recommended that you **not** score your responses until you have finished reading the chapter.

CASE EXAMPLE 4.1
Margarita's Daughter

Kamisha, an experienced occupational therapist certified in hand therapy, is assigned to work with Margarita Ramos. Ms. Ramos has recovered enough from her injury, described in Chapter 1, that she is now ready to begin working on the passive range of motion in her hand. Kamisha prefers the *Tyromotion Amadeo*® as a central approach for persons with Ms. Ramos' type of injury. The Amadeo® is an interactive technology that uses magnets to guide the hand in ways that increase range of motion. This technology has the capacity to accommodate passive stretching exercises as well as more interactive game work requiring clients to use the muscles in their hands. Kamisha enjoys the Amadeo® because it allows her to record the client's progress and grade the exercises according to the client's self-reported pain tolerance, overall development of range of motion, muscle strength, and control.

For her first appointment, Kamisha encounters Ms. Ramos and her daughter in the waiting room. Kamisha introduces herself, deliberately making eye contact with Ms. Ramos, who remains seated.

Kamisha: "Hello, Ms. Ramos, I am Kamisha, the occupational therapist who will be working with you to strengthen and rehabilitate your hand."

Before her mother can respond, Margarita's daughter rises quickly, towering over Kamisha, and shakes her hand firmly and rapidly, saying,

Dr. Ramos: "Hello, Tamisha (mispronouncing her name), I have learned that you are a certified hand therapist. That's great (wearing an incongruent smile). I'm Dr. Ramos, Margarita's daughter. You can call her Margarita. I will be taking her to her appointments, when I can, and my mom has already signed a HIPAA release allowing me to have access to all information pertinent to her care."

Without thinking twice about it, Kamisha responds:

Kamisha: "I always appreciate it when family members are involved in a client's care (***empathizing mode***). I am very pleased to meet you both. I look forward to our work together" (***encouraging mode***).

Together, the three of them proceed into the upper extremity laboratory. Kamisha begins the session by explaining the role of the occupational therapist and by orienting Margarita to the various exercises and activities that will occupy a good portion of her time during the next several weeks and by asking Margarita if she has any questions about the process. Outside of a concern about costs, which her daughter quickly resolves, Margarita does not have any questions. Kamisha continues the session by asking Margarita several questions about her various roles and daily activities as a spouse, parent, worker, and homemaker. When Margarita occasionally has difficulty expressing herself in English, her daughter speaks spontaneously on her behalf, sometimes embellishing the responses beyond what Margarita actually says. Though Kamisha has an average proficiency in Spanish, she is not very comfortable speaking it, so she allows Dr. Ramos to continue to take charge of the translating.

After several questions, Margarita pauses, and, in Spanish, asks her daughter why Kamisha is asking so many personal questions. According to the IRM, this represents an interpersonal event (***reluctance***). Instead of asking Kamisha the same question, Dr. Ramos abruptly interrupts Kamisha and states that the questions are making her mother uncomfortable (another interpersonal event, ***resistance***). Kamisha apologizes and asks Margarita, directly, if she wants her to stop asking the questions (***collaborating mode***). Margarita responds, again, by wanting to know why Kamisha is asking these questions. Kamisha then explains that her goal is to learn about her daily activities so as to customize the treatment to the greatest extent possible. Margarita looks curious, so Kamisha continues to explain, maintaining eye contact with Margarita (rather than with her daughter):

Kamisha: "The more relevant the treatment activities are to what you actually do in your daily life, the more likely it is that the home exercises I recommend will be more transferrable and successful in the long run" (***instructing mode***).

Although Margarita appears to accept this explanation, her daughter does not. Dr. Ramos makes the following comment and abruptly leaves the room.

Dr. Ramos: "I understand that the chitchat is important for your rapport-building, but my Mom's hand is the real priority, here. I want her to have as much time on the Amadeo® as possible." (speaking to her mother) "Mom, just have me paged when you are ready for your ride home."

Taken aback, Kamisha pauses to collect her thoughts. At this point, Dr. Ramos has left the room, and Kamisha turns to Margarita to say:

Kamisha: "Ms. Ramos, I respect your daughter's desire to ensure that you receive the best care possible ***(empathizing mode)***. Once I fully understand the occupations that are most important to you, I will make sure that you spend time on the Amadeo® and that you receive the high standard of care that I give to all of my clients" (***instructing mode***).

Margarita smiles, with sincerity, and responds:

Margarita: "Sure, I will do my best for you" (Fig. 4.1).

FIGURE 4.1 Kamisha builds rapport with Margarita.

It is becoming clear to Kamisha that Margarita's daughter places a high value on information-seeking and has a high ***need for control*** (a client interpersonal characteristic, in this case, attributable to the client's family member). The case example illustrates how Kamisha effectively used the ***empathizing***, ***encouraging***, ***collaborating***, and ***instructing modes*** to address the interpersonal events that emerged during Margarita's first session.

A ***therapeutic mode*** is a specific way of relating to a client. Six therapeutic modes have been identified in previous work as occurring with a high level of frequency in occupational therapy practice relationships (Taylor, 2008). In this chapter, each of these six modes is described, and examples are provided to illustrate the multiple ways in which the primary modes can be combined and utilized during therapeutic interactions with clients. Practical applications of each mode for specific client characteristics and interpersonal events are discussed. Moreover, the chapter provides a rationale for the importance of the modes to the interpersonal reasoning process within the Intentional Relationship Model (IRM).

Our Interpersonal Behavior

How we relate to others in our day-to-day lives may vary as a function of our current mood state, social and environmental context, and the interpersonal behavior of others. Our interpersonal behavior and way of being in a given social group varies with context. Psychologically adaptive individuals utilize a wide range of natural interpersonal strategies to adapt to the social demands of living (Beck, Freeman, & Davis, 2004). Examples of these strategies are empathy, compassion, hopefulness, altruism, kindness, assertiveness, competitiveness, deference, dominance, passivity, resistance, avoidance, emotionality, restraint, power, aggression, suspiciousness, emotional disengagement, and isolative behavior.

Highly adaptive individuals are able to draw upon these and other strategies in an ever-changing and flexible manner in an attempt to adapt to the social demands of life (Beck et al, 2004). For example, a woman who is otherwise outgoing and gregarious at parties may significantly limit the extent to which she talks and socializes at a funeral if the social atmosphere is such that it requires silence and solemnity.

By contrast, individuals who are not as interpersonally adaptive tend to overutilize a small set of interpersonal strategies in inflexible, maladaptive, or compulsive ways (Beck et al, 2004). For example, an individual whose primary objectives in relating to others involve self-preservation, resource acquisition, and a desire for power concerning others may consistently come across as confident, charming, competitive, and, at times, dominant, even when the situation requires humility and deference.

Although a primary interpersonal style such as this is likely to work well in some competitive work or sporting situations, it does not work well in group situations where people value the sharing of power and other

mutually supportive behaviors. If the previously described individual is unable to demonstrate other characteristics necessary for collaborative activities, such as deference, thoughtfulness, kindness, and empathy, negative consequences are likely to result when these characteristics are needed. For example, an individual with a more fixed style may become emotionally fatigued, may struggle to move into alternative roles within the group, or may even act to interfere with someone else's attempt to move into a position of power. Others in the group may grow fearful or resentful if they are not able to witness this person's humility, vulnerability, or attempts to share and be supportive.

An individual with a greater capacity to draw on a wider range of characteristics is better able to establish appropriate relationships in both social situations. Thus, although our interpersonal behavior is relatively stable, we function best when we utilize interpersonal strategies in a flexible way and adapt to a wide range of individuals in a variety of social situations.

FIGURE 4.2 Kristin Alfredsson Ågren draws on a wide range of modes while working at a community-based daytime activity center in Sweden.

Interpersonal Behavior and Therapeutic Modes

Therapists' interpersonal behaviors are reflected in:

- Their fundamental motivation to serve others
- Their preferred approach to serving
- The values they hold while serving

The way in which therapists interact in their personal lives (outside of therapy) may also be reflected in the specific ways in which they behave and interact with their clients during therapy (i.e., therapeutic modes). Chapter 3 noted that therapeutic communication is optimal when therapists draw on a variety of modes consciously and flexibly. This has several implications. First, therapists should develop an awareness of their natural modes (i.e., the ones that flow from their interpersonal behavior in their daily personal lives). Second, they should develop the self-discipline to use these modes in response to client needs rather than in response to their own internal comfort levels. Third, therapists should be aware of the limits of the modes they use and, in some instances, develop the capacity to use modes beyond those that come naturally (Fig. 4.2).

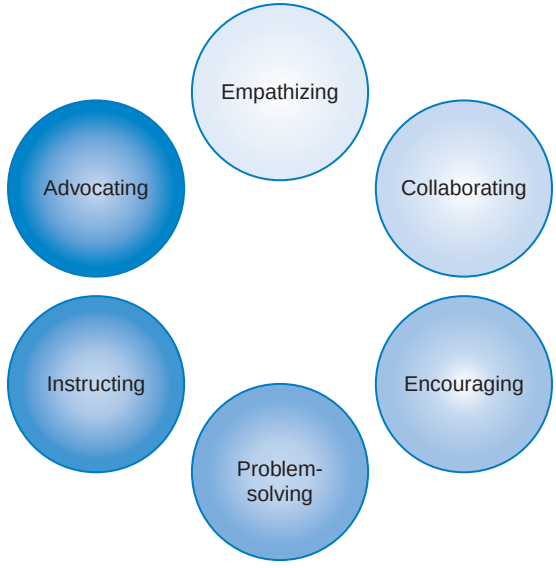


FIGURE 4.3 The six therapeutic modes.

The Six Therapeutic Modes

The six therapeutic modes used most frequently in occupational therapy practice are presented in Figure 4.3.

The idea that a therapist merely needs to select the correct mode to produce a desirable outcome carries an implication that the mode is subject to the interpretation of the client, who is the receiver of that mode. Thus,

the same mode applied to similar situations may produce two opposing reactions in two different clients. A client's reactions are less a function of the mode choice and more a function of the interpersonal characteristics and immediate needs of the client. The case example at the beginning of this chapter illustrates this point with respect to the ***instructing mode.*** When Kamisha explained why she was asking Margarita questions about her daily occupations and roles, Margarita's daughter reacted negatively, whereas Margarita appeared to accept the explanation as being valid. It is important to keep in mind that modes are *perceived*, *relativistic*, *and subjective*. As such, they are best interpreted through the mind's eye of the client. Rather than the mode itself, the client's interpretation and experience of the mode is what determines which mode is most desirable at any given time.

Carrying this point a step further, it is even possible that the same mode applied to similar situations may produce vastly different reactions in the *same* client. For example, when Rigel used the instructing mode to educate Mr. Johnson about the assessment he was using, Mr. Johnson's ***nonverbal cues*** revealed that he was not interested (refer to the case example in Chapter 1). However, when Rigel used the same mode to explain the concept of brain plasticity as justification for why his early engagement in therapy is likely to facilitate functional improvement, Mr. Johnson's body language became more positive. Ultimately, he invites Rigel to return to work with him on the following day.

Because therapists naturally select and use modes that are most consistent with their interpersonal styles in everyday life, the use of therapeutic modes is as diverse and complex as the therapists who use them. All modes have equal potential to enable a functional therapeutic relationship. However, any mode may have a negative effect on a client's attitudes and feelings toward the therapist if used:

- Too frequently or inflexibly
- When the timing is not right for the client
- When the mode is not consistent with the client's interpersonal needs in the moment
- When the mode is not changed so as to be more consistent with the client's interpersonal needs of the moment

In the worst cases, overreliance on a particular mode with a client can result in negative consequences for the therapy process and for the client.

Your ***therapeutic style*** is defined by the primary mode or set of modes that you tend to utilize most often during interactions with clients. It is important to recognize that some therapists' styles reflect the use of one primary mode or set of modes, whereas other therapists incorporate a much wider range of modes into their approach. For this reason, the therapeutic modes are presented in this section in alphabetical order to underscore that no single mode is superior to another. Key points regarding each of the modes and examples of how they are typically enacted are summarized in Table 4.1. The table contains a general description of each mode, examples of phrases a therapist might use when communicating with the mode, examples of questions a therapist might ask when communicating with the mode, recommendations for facial expressions and body language that would be consistent with the mode, and ideas for how a mode might be implemented in practice.

The points describing each mode are guidelines, not rules. They were included to stimulate creative thinking about a wide range of interpersonal behaviors that could potentially converge to form a therapeutic style. As you learn more about each mode, you may begin to form some of your own thoughts and ideas about interpersonal behaviors that you typically utilize that reflect a given mode but are not explicitly described in this section. This type of thinking is encouraged because it promotes critical self-awareness and greater insight into your own unique therapeutic style.

Advocating Mode

The ***advocating mode*** is becoming more prevalent as therapists become aware of and embrace the perspective that disability is a function of environmental barriers rather than client impairments. Therapists using the advocating mode work to ensure that clients have the personal, material, and interpersonal resources they need for maximal participation in productivity, leisure, and all other daily life activities. It includes ensuring that clients have access to housing, transportation, education, equal opportunities for employment, assistive devices, personal assistants, and any other resources pertinent to their independence and well-being. Functioning in the mode of advocate often involves being a facilitator or defender of justice, rather than in the more traditional roles in which the occupational therapist guides, questions, listens, or administers a service (Fig. 4.4).

Table 4.1 **The Six Therapeutic Modes: Descriptions and Practice Application**

Mode	Description	Example Phrases	Example Questions	Face/Body Continuity	Practice Application
Advocating	Providing clients with knowledge about and access to resources, awareness of laws or rights, consciousness-raising, normalization of experience, tends toward roles of facilitator or consultant	"I would like to recommend that you contact an advocacy organization that I know about. . . ." "You may find that you have some common experiences with other parents of children with autism. I know of a group that meets regularly at our clinic. . . ." "Under the Americans With Disabilities Act, you are entitled to request reasonable accommodations at your workplace." "I have worked with a number of clients with [your type of illness or impairment], and what you are going through is normal and shared by others."	Questions assess the client's awareness of disability rights and resources. "Do you know about the equipment or services to which you are entitled?" "Have you inquired about the accessibility of your work or school?" "Do you know whom to contact in order to request reasonable accommodations at work or school?" "Are you aware of your child's rights within the [public] school system?" "Are you interested in talking to other disabled persons?"	Your facial expression should be neutral to serious. Make eye contact with your client. Position your body so that you look like you mean what you are saying.	Encourage the client to be assertive with others about his or her needs and rights. Offer opportunities for a client to have contact with disabled peer role models. Encourage the client to educate himself or herself about his or her entitlements and rights. Utilize your professional capacity to advocate or argue on a client's behalf to obtain a needed resource or outcome. Encourage a client to take legal action, if appropriate. Normalize the client's illness or impairment experience so that the client knows that others have experienced something similar and that it is a part of the range of human experience.

(table continued on page 86)

Table 4.1 **The Six Therapeutic Modes: Descriptions and Practice Application** (continued)

Mode	Description	Example Phrases	Example Questions	Face/Body Continuity	Practice Application
Collaborating	Relinquishing all therapeutic power and control, facilitating the client's independence in thought and behavior, expecting clients to drive your therapeutic reasoning by following their preferences and participation choices, following the client's lead in every way (even if you do not agree with what the client is saying or doing)	"You may choose anything you want." "I would just like to observe you today so that I can learn more about the occupations that are most important to you." "That was my fault. I should not have set the calibration that high. I am sorry and I will not do it again." "Please provide me ongoing feedback about [how you are experiencing therapy/your pain/your fatigue] so that I can adjust things if they are not working." "Please tell me if or how I can better serve you today." "Please help me understand what it is that is most important for you to do today. It can be anything that you choose."	Questions aim to elicit the client's goals and leadership within the therapeutic relationship. "In your opinion, what would be the best use of our time together today?" "What do you think your child needs most from therapy today?" "How am I doing, so far (in terms of meeting your expectations for therapy)?" "Please tell me, what would you want to get out of therapy in the near future? In the distant future?" "What therapy goals would you recommend for yourself?"	Your facial expression should be natural, curious, and unassuming. Maintain a less assertive and more deferential stance or posture. Consider positioning your body adjacent to the client rather than directly in front of the client. Be aware of how your eye contact might be interpreted; use it only in the spirit of listening so as not to be interpreted as being intimidating. Make sure that your arms are open and not crossed in front of your body. If seated, consider sitting without crossing your legs.	Ask the client what he or she needs or wants to get out of therapy. Solicit feedback from the client about the event. Encourage a client to make his or her own decision about the best course of action. Ask the client about how you can improve your approach. Provide a client with a wider range of choices for occupational engagement. Verify with the client that the choices provided are desirable to the client. Ask a client to recommend his or her own goals for therapy. Admit a mistake you made and apologize for it. Consider your own role and responsibility for the interpersonal event that occurred.

Empathizing	Summary statements, mirroring affect, validating negativity, deepening questions that reflect an effort to understand (rather than an implicit therapeutic agenda), not rushing to alter or fix a client's problem, putting a significant amount of time and effort into listening and communicating in ways that increase your understanding of the client's experience, showing tremendous discretion when deciding whether to reveal your spontaneous, heartfelt reactions versus putting your own reactions aside to allow full space for the client's reactions and experience	"Let me stop and summarize what you just told me to make sure I understand. . . . Did I get that right?" "If you feel comfortable talking, I would like to know more about what happened. . . ." "My only goal right now is to listen." "You have a right to be angry." "It makes sense that you would feel that way." "I can believe it." "I am available if you want to talk more about it."	Questions are agenda-free and consist of gentle inquiry and deepening questions. The sole purpose of these questions is to achieve a clearer or more detailed understanding of the client's thoughts, beliefs, emotions, or behaviors. "Are you able to tell me why you are reluctant to do [this]?" "May I ask what about [this] makes you uncomfortable?" "Can you tell me more about [it]?" "What time of day did [this happen]?" "Was anyone with you when [this happened]?" "What were you thinking at that time?"	Your facial expression should be neutral or it should naturally match that of the client's (this is not something that should be forced or play-acted). Maintain eye contact only in the service of listening carefully. Otherwise, minimize your physical presence to the greatest extent possible so that the client feels to be the center of attention. Maintain an open body position (limit crossing of arms and legs). Be conscious of the client's preference for touch; avoid touching the client in place of saying something empathetic or asking deepening questions, which are typically more appropriate and sensitive cross-culturally.	Make summary statements to bear witness to the event and verify your understanding of the client's perspective. Show emotional resonance or share your personal emotional reactions and thoughts about the event. Strive to understand the nature and source of a client's reaction through gentle inquiry. Sit or stand quietly and let time pass in silence. Listen and bear witness silently to your client's experience, giving the client your undivided attention. Articulate or describe a client's emotional response so that he or she knows you see and support it. With caution, and only if invited by the client, reveal something highly similar about yourself or your own life experience (if it is true that you do have a highly similar experience as your client), being careful to acknowledge that your experience was not the same and being open to differences.

(table continued on page 88)

Table 4.1 **The Six Therapeutic Modes: Descriptions and Practice Application** (continued)

Mode	Description	Example Phrases	Example Questions	Face/Body Continuity	Practice Application
Encouraging	Instilling hope, courage, and the will to participate, explore, or perform; praising accomplishments; using positive reinforcement to encourage continued behavior; using cheering, applause, high-fives, compliments, motivational words, humor (only when invited by the client), and engaging in play or other types of joyful expression	"Your range of motion has improved by 25% since you first got here." "You are showing remarkable tenacity." "You can do it! I know you can!" "You are doing great so far! Keep up the excellent work!" "You were able to walk twice as far today as compared with last week." "If you and your child continue practicing, I have every confidence that [your child's skill or behavior] will continue to improve." "The research shows that this approach works more than 80% of the time." "If you complete this [assessment] you may choose whatever you want to do afterward (or next time)."	Questions are not an emphasis of this mode.	Your body language and facial expression should be relaxed and more casual and should match whatever you are communicating within this mode (hope, joy, etc.).	Use humor when invited to do so by the client. Tell a client he or she is doing well during a challenging task. Label a client's strengths. Reassure the client. Remind a client of his or her existing strengths or capacities. Provide a client with hope about the future. Share your confidence in the client. Downgrade an activity or select a no-fail activity to be sure that the client will have an experience with success. Choose a pleasurable, comforting, or mood-enhancing activity. Engage in joyful or entertaining behavior or antics with your client (when invited to do so). Sing to a client. Provide an inspiring or uplifting quote, poem, or story.

Instructing	Directing, informing, guiding, educating, explaining, justifying, providing structure, correcting, redirecting, showing an active and directive style, assuming a teaching stance, making recommendations unapologetically, using gentle or finessed confrontation	"This machine is designed to assess your ability to drive a car safely. Here is what I would like you to do." "I am going to ask you a number of questions that will allow me to learn more about your work environment." "I am concerned that if we do not practice this together here, your functional status may not be at the level where you may go directly home when you leave the hospital." "The rules for the boys' group are as follows." "You may not raise your voice in this clinic. If you need to excuse yourself, there is a room where you can let off some steam." "The sensory room is a place where [your child] can explore and safely expand the limits of [his or her] tolerance for a range of activities, sensations, sounds, and visual stimuli." "I want you to lift your leg about three inches higher so that we can get your sock on."	Questions are rhetorical and agenda-based, where the questions reflect what the client already knows, or should know, but the therapist is using a question instead of telling the client what to do, directly. "Why do you think I am asking you about this?" "What do we do at clean-up time?" "What do we do after we brush our teeth?" "What is the next step after you complete the formatting?" "Where do we put the dishes when we are finished with them?" "Do you think that [behavior] supports a healthy lifestyle?"	Your facial expression should be serious, authoritative, or businesslike. Your body position should convey a sense of confidence and leadership. Be aware of your posture while seated and standing. Your body movements, walking, and actions should be definitive, unapologetic, and confident.	Provide your opinion, advise, or give a recommendation. Assign homework. Provide a client with feedback about how he or she may improve. Describe what is happening to act as a guide. Introduce a limit or boundary and share your rationale. Share with a client how his or her negative behavior affects you or others. Share a different perspective on the event or suggest an alternative viewpoint on the situation. Provide information or education. Provide justification for your approach. Reiterate, find a different way to demonstrate something, or explain yourself more clearly. Educate the client about possible or likely consequences of doing something that would run counter to a therapeutic recommendation.

(table continued on page 90)

Table 4.1 **The Six Therapeutic Modes: Descriptions and Practice Application** (continued)

Mode	Description	Example Phrases	Example Questions	Face/Body Continuity	Practice Application
Problem-Solving	Facilitating the client's ability to reason through obstacles, asking Socratic or agenda-driven questions to uncover faulty assumptions or analyze decisions, comparing options for action	"What makes you think that you will not be good at gardening?" "Let's make a list of the strengths of [this approach]. Let's list the weaknesses."	Questions are also agenda-based and strategic, drawing upon the Socratic method in order to clarify, expand, or challenge a client's behaviors or beliefs. "What do you think a friend would say or do?" "What advice would you give to a friend?" "Are there any other possible explanations for [that]?" "Is [this choice] your only alternative?" "How might we verify or disprove what [the teacher] is saying?" "What is the best or worst thing that could happen?" "What might be another way to look at this?"	Your facial expression should be neutral to serious, and your body position should be businesslike and should match the topic of the discussion.	Ask the client questions that will help a client clarify or challenge his or her own thinking about the event. Make a list of options with the client and ask the client to evaluate them with you. Make a list of pros and cons for a given decision that the client is facing. Make a calendar or schedule with the client to enlighten the client about activity patterns or preferred roles. Ask questions to help a client identify alternative solutions.

FIGURE 4.4 Advocating mode. Roland Meisel appears serious and assertive when working to locate the right equipment for a client.

Therapists functioning in the advocating mode are quick to recognize and respond to the physical, social, and occupational barriers that their clients encounter. They are careful not to undermine their clients' autonomy, dignity, sense of personal power, and capacity to judge what is in their own best interest by functioning in an expert role. They are also careful about being misperceived by clients as someone interested in fixing or rehabilitating them. At the same time, therapists functioning as advocates can be ardent and forceful activists and promoters on behalf of their clients when the circumstances require it. Some engage in consciousness-raising with their clients about their legal rights, and some utilize their professional capacity to testify on behalf of a client in a legal situation or to broker access to services or resources to which a client is entitled. Additionally, therapists using this mode will seek opportunities to bring clients together in community with their disabled peers, and also normalize their clients' experiences and impairments as a part of the natural continuum of human experience.

Strengths of the Advocating Mode

The advocating mode is an important one. If occupational therapists did not advocate for their clients, the clients would be on their own to battle insurance companies, agencies that provide public or private aid, landlords, educational systems, employers, and other powerful organizations. Those who function in the advocating mode go out of their way for their clients to provide them with access to vital resources that ensure physical mobility and access, socialization, equal participation, and appropriate work or educational opportunities. Occupational therapists are most often called on to function in the advocating mode when they recognize the advantages of raising a client's awareness of an injustice or when clients are themselves unable to overcome social and economic barriers without additional resources.

Cautions of the Advocating Mode

As with any other mode, the cautions associated with the advocating mode manifest when the mode is overused or misapplied. The strong ideological orientation that often characterizes a therapist in the advocating mode may lead some therapists to overestimate a client's desire; ability; socioeconomic, political, or cultural context; as well as resources for pursuing autonomy and independence. Because clients differ in their experience of disability, they respond differently to advocacy efforts that involve consciousness-raising. For some clients, it may be premature to raise their awareness about injustices that they would rather deny or discover in their own time.

Collaborating Mode

The growing emphasis on client-centered practice in occupational therapy underscores the importance of the ***collaborating mode.*** Therapists functioning in the collaborating mode expect their clients to drive the therapeutic reasoning that underlies the session, to choose their own activities, and to set their own goals for therapy, even if the therapist disagrees with some or all of the client's goals or agenda. Therapists functioning in the collaborating mode also solicit ongoing feedback from their clients about their own performance as therapists and about the therapy process.

Therapists in the collaborating mode believe that clients are more likely to achieve positive outcomes if they take ownership of the therapy process. They tend to view clients as capable of determining what they need from therapy and selecting occupational therapy goals and tasks that address those needs. In this way, they work to promote

CASE EXAMPLE 4.2
The Advocating Mode

Virgil[1] is a man in his late 20s with cerebral palsy and moderate learning disabilities who has lived in an institution for most of his life. The managers of his care team at the institution had built a plan that he would move into independent living within the community with staff support to accommodate him. Before I was referred to work with Virgil, his care team from the institution had already located, set up, and obtained funding for his new housing situation. I was referred to provide Virgil with a bath board to facilitate his bathing in the terraced house that was to become his home.

Virgil had been schooled in the notion that his home was suitable to his needs, and he was thrilled about the possibility of moving into a new home. When I met with him within this new environment, it was immediately evident to me that the housing arrangement was not acceptable. Fundamentally, the way the house was set up did not facilitate Virgil's independence, maximize his dignity, or provide a safe environment for staff to support him.

[1] All client names and geographic information have been changed.

Instead of providing the bath board, I felt it was my duty to inform the managers of Virgil's care team and the organization that was to fund his new housing that I had found the proposed accommodations unacceptable. I provided a report that outlined the safety risks that would have been associated with providing a bath board. The report emphasized other shortfalls in the environmental design of the house and outlined the oversights in the overall care plan for Virgil.

The managers took offense at my report and attempted to remove me from the situation. They insisted that Virgil was no longer in need of occupational therapy services. However, I pursued my agenda and held meetings with the funding organization and the managers to explain the rationale behind my position. Therefore, the funding organization conducted an independent review and later decided to offer Virgil an alternative accommodation. The housing that Virgil was eventually provided enabled him to move freely about the entire home and gain access to the bath, toilet, and other areas in a much safer and more dignified manner.

—Jane Melton

client empowerment, autonomy, independence, and personal choice. When disagreements or other interpersonal difficulties with clients occur, therapists who utilize the collaborating mode encourage clients to use their own judgment. In practice, this mode can be difficult to enact in its purest sense. A therapist must possess the confidence and capacity not only to receive criticism from his or her clients but also to let go of all control and professional authority regarding what is taking place during therapy, if even for a brief period of time. Although most clients for whom this mode is most appropriate make positive decisions on their own behalf, any therapist that has witnessed a client act against his or her own best interest knows how challenging it can be to step aside and watch this occur.

Yet, the power of the collaborating mode lies in the therapist's empathic understanding of the client's need for control in that moment. A therapist using this mode understands that, even though the client made a poor decision in one instance, the confidence that the therapist had in the client to allow that decision to happen may have influenced that client to trust the therapist's judgment and recommendations in the future. Moreover, as explained earlier, the collaborating mode is most appropriate for clients who are educated, informed, and proactive about their care. It is the correct match for a client with a high need to control and drive the goals and outcomes of therapy.

Strengths of the Collaborating Mode

The collaborating mode reflects many of the core values of occupational therapy. Specifically, the field places a strong emphasis on promoting client choice, freedom, and autonomy. Therapists who utilize the collaborating mode demonstrate these values by enabling clients to

CASE EXAMPLE 4.3
The Collaborating Mode

I met Edward, a 17-year-old boy, when he was admitted to the adolescent psychiatric unit for aggression toward staff and peers at his residential placement. At this time his primary diagnoses were conduct disorder, bipolar disorder, and posttraumatic stress disorder. Treatment was initiated with administration of the Adolescent Occupational Self-Assessment, an interview developed for this setting based on the Model of Human Occupation.

During his initial interview, Edward was cooperative but made no eye contact and gave vague answers to the questions asked about his daily routine. He lacked insight into his aggressive behaviors and took no personal responsibility for his actions. He perceived himself as being alone in the world and was anxious to move to independent living where he could come and go as he pleased. Edward had low self-esteem and a poorly defined sense of self. He was motivated to be successful in the role of worker, friend, boyfriend, family member, and student yet consistently experienced failure in all these roles. Edward also reported on the initial assessment interview that he was having some difficulty managing his affect and regulating his feelings.

Edward had a strong interest in origami and experienced a sense of success and pleasure when engaged in this activity. It was the only activity that he wanted to do while on the unit. Because he would not engage in much of anything else, including interacting with his peers during group therapy, I decided not to try to coax him into doing things he disliked. I did not want to become locked in a power dilemma with him by insisting that he engage in therapy tasks or activities with his peers. Instead, I asked him if he would be interested in teaching his peers how to make some simple origami shapes. I asked him to think about it and made it clear that this was not a required assignment but felt that others might find this activity interesting. The next day I approached him in his room, and he stated that he wanted to teach this to others. I explained that we could co-lead an Interest Exploration group that meets every other Wednesday. I asked him what materials he needed, how much time he needed, and any other supports required. I wanted to empower him and encourage him to take a strong leadership role. We talked about how much time he needed to prepare and scheduled a time for us to meet and plan the group structure.

When the day came for group he was nervous about being in front of his peers, so we had a practice session where he role-played with me about what might occur in his role as a leader. We talked about listening when peers had a question and to be patient if some people had difficulty. I helped him empathize with his peers who might not have done this before and needed more support. I also explained to him that I was there to support him and that I was learning as well. If he needed any help, he could just ask. He agreed that I could help let him know when to slow down his teaching or if people were having difficulty hearing his directions (he had a soft voice and sometimes mumbled his words).

During the group meeting, I watched as his face broke into a shy smile when peers would thank him for sharing his skills and told him how much fun they had. Edward, if only for a brief time, had experienced how it felt to be appreciated, respected, and even admired for his abilities. As we processed the group afterward, he shared that he had felt nervous at first but then became more comfortable and asked if we could co-lead another group. I felt that our therapeutic rapport had reached a new level in terms of Edward's willingness to trust me and to allow me to challenge him around developing a more defined sense of self.

—Stephanie McCammon

FIGURE 4.5 Collaborating mode. Clients frustrated by a loss of control may benefit from a therapist's shift into the collaborating mode.

choose activities, have opinions, and participate actively in evaluating the process of therapy and reflecting on their own performance. Use of the collaborating mode is likely to instill confidence in clients because it conveys the idea that the therapist views them as competent in their ability to direct their treatment, choose occupations, and gain greater control in determining the course of their own lives (Fig. 4.5).

Cautions of the Collaborating Mode

The cautions associated with a collaborative style are subtle and involve overreliance on this style or using it nonjudiciously across all types of therapy clients. The collaborating mode may not be received well by clients accustomed to viewing, and who prefer to view, service providers as authority figures or experts. Clients inclined to participate in social or cultural networks with hierarchical role structures and a lack of available and transparent information about health care may not understand the therapy process well enough to know what is best for themselves or may not value independence as the ultimate goal of therapy. Such clients may be looking for structured instruction, advice, resources, and ongoing direction.

Therapists who overvalue the collaborating mode may misunderstand or misperceive less-engaged clients as being passive or even apathetic about their therapy, when these clients are merely behaving according to their own health literacy levels or within their own sociocultural norms. This misperception is likely to be associated with a lack of understanding of the client's narrative, a breakdown in trust, and a lower quality of communication between the client and the therapist. If the therapist does not identify and examine this discrepancy in preferred working styles at a conscious level, she or he may become disappointed in the client or emotionally disengaged.

In some cases, unrestrained or unstructured collaboration may result in diffusion of responsibility or uncertainty regarding who is responsible for which part of the therapy process. Occasionally, it causes confusion about roles in the therapeutic relationship. In addition to these cautions, therapists who overutilize the collaborating mode run the risk of overestimating their client's strengths and capacities, thereby minimizing the client's need for direction. There are times when clients need more directive therapy to feel a sense of psychological security and emotional stability. Asking clients to participate collaboratively before they are ready, or without grading the collaboration, sometimes causes clients to feel confused, lost, insecure, or anxious about the therapy process.

Empathizing Mode

As noted in Chapter 1, there is a strong emphasis on empathy in contemporary discussions of occupational therapy. Use of the ***empathizing mode*** involves the actual enactment of empathetic communication toward the client during therapy. This enactment includes bearing witness to and fully understanding a client's physical, psychological, interpersonal, and emotional experience. This is accomplished through seeking to understand the client by:

- Expressing a general curiosity about the client's state of mind or experience through general questions (e.g., What is on your mind right now? Is there something you do not like about this activity? How are you feeling? Where would you like to begin?). This process is referred to as ***gentle inquiry.***
- Cautiously asking deepening questions that allow the client to elaborate upon a current or past event

(e.g., Can you tell me more about that? When did it happen? What were you thinking at that time? Who was with you?).

- Validating the client's experience and viewpoint, even if it is maladaptive or negative.
- Summarizing one's understanding of the client's experience and asking the client if the summarization accurately reflects that experience (i.e., making ***summary statements***).

Therapists who utilize the empathizing mode put a significant amount of time and effort into striving to understand a client's interpersonal needs and perspective as accurately as possible. They are able to notice and respond to the nuances in clients' affect and behavior, and they pay particular attention to clients' emotional experiences during therapy. Generally, they listen carefully, are watchful of what their clients communicate, and adjust their approach accordingly (Fig. 4.6).

To ensure that they see things from the perspective of the client, therapists utilizing the empathizing mode will periodically summarize what a client has said or make other nonverbal attempts to reflect their understanding of what the client is communicating. This strategy leads a client to either affirm the therapist's accuracy or reassert or reexplain his or her perspective. This process of careful listening and observing inevitably leads to a richer understanding of what is being communicated. During occupational therapy sessions that involve activity, empathizing requires a brief period of intermission from the "doing" aspects of therapy so that the therapist can process and convey an understanding of what a client has communicated.

Therapists utilizing the empathizing mode take the time to accept and validate clients' difficult problems and painful emotions. They do not rush to intervene, solve, or ameliorate them. Instead, they work slowly and cautiously, emphasizing an accurate reflection of the client's perspective and relying on his or her continual striving toward understanding to resolve rifts, obstacles, and conflicts that occur during therapy.

Strengths of the Empathizing Mode

Empathy is vital to a functional and trusting therapeutic relationship (Kohut, 1984). Witnessing, validating, actively listening to, and understanding clients' experiences in the absence of judgment facilitates emotional healing and enables clients to organize their thinking independently and gain perspective on their difficulties. Empathizing with clients provides a model for them to learn to empathize with themselves and to self-reflect and gain insight into their emotional reactions and behaviors (Fig. 4.7).

In addition to these strengths, empathy is fundamental to the resolution of conflicts, rifts, and misunderstandings that occur during therapy. Because therapists who utilize the empathizing mode tend to be patient and understanding of negativity when it occurs, they are able to work more effectively with interpersonally challenging clients.

FIGURE 4.6 Empathizing mode. Jane Melton pauses from the usual activities of therapy in an attempt to understand a client's perspective.

CASE EXAMPLE 4.4
The Empathizing Mode

Gretta is an 80-year-old woman who has had many life experiences, including an enduring and loving relationship with her husband. Four months before I met her, she experienced a severe stroke. Following her stroke and within weeks of beginning outpatient occupational therapy, her beloved husband died. Gretta had been depending on caretaking from her children and in-home attendants. She was referred to outpatient therapy to increase mobilization and participation in activities of daily living and independent activities of daily living.

Immediately, I recognized that Gretta was in a period of intense mourning. I could see that this woman was searching for a human connection. She wanted to grieve and talk about her loss. At that time she was less interested in pursuing occupational therapy goals that would address her functional limitations. I knew I would have to wait to begin work on activities of daily living and, instead, focus on what she wanted to talk about: her husband, what he meant to her, how difficult it was to live in his absence, her thoughts about not wanting to burden her children. . . . I was very conscious about when to talk and when not to talk. . . . I made sure she knew that I had heard what she said and that I understood all of the difficulties she was facing. . . . I also made sure she knew that her thoughts and feelings made sense to me and that I accepted them and honored their importance. For weeks we talked about her current situation, the limitations her stroke caused, how she reacted to it, and how her family reacted. In time, we worked together to create a family situation that would make it easier for everyone to cope with the recent death. I was careful not to mention our discussions or disclose her private thoughts and feelings to her family members. A feeling of mutual trust developed between the two of us. We worked together to manage her stroke and her grieving. Therefore, we also made progress toward the original goals of the therapy.

Gretta taught me the importance of having empathy. For her, it was important that I showed an interest in her grieving and that she could tell a person outside her family about her problems and worries. Because Gretta allowed me to support her through empathy, we both saw the improvements in her emotional condition during therapy.

—Anne Reuter

FIGURE 4.7 By sharing a laugh with her client, Anne Reuter reflects her client's value for humor and conveys that she understands the irony of a story he just told.

Empathizing tends to disarm clients who are reluctant, resistant, critical, or otherwise negativistic in therapy. When therapists utilize empathy, clients are likely to feel responded to, cared about, and respected. They are more likely to achieve open, honest communication with clients. This typically increases trust and results in a more stable therapeutic relationship.

Cautions of the Empathizing Mode

It would seem that a therapist could never empathize too much with clients. However, the empathizing mode is no different than the other modes in that its overuse or misuse can cause difficulty. For some clients, overemphasis on the empathizing mode can place emotions too much in the foreground of therapy. Some clients may not be ready to see or hear their thoughts, behaviors, or emotions reflected back to them. Instead, they may feel more stable and comfortable focusing on activity and other practical behavioral aspects of occupational therapy. Similarly, if a therapist relies too heavily on empathy, the pacing of treatment is slow, and some of the fundamental tasks of therapy may be delayed or left unaccomplished. For clients who are not yet ready to engage in occupational therapy, this slower pace may be necessary and appropriate. However, therapists who rely too heavily on the empathizing mode may project their own needs for empathy onto the client. Therefore, they may misread the client's actual level of need for empathy. Therapists who show their own emotional reactions to what the clients are saying or that probe too much for emotional expression from the client are perceived by some clients as overinvolved or psychologically intrusive. These clients may respond by recoiling from what they perceive as too much intimacy or emotional intensity.

Even when a client invites or appears comfortable with the empathizing mode, overutilizing it can overprotect clients. Listening and validating may occur at the expense of questioning or challenging clients to engage in occupation when they are ready. Overreliance on empathy may encourage an inappropriate level of dependence in more vulnerable or isolated clients. In addition, there is a risk that some clients may become confused about the goals of therapy and about the role of the occupational therapist in his or her treatment. In the absence of appropriate boundaries (e.g., time limits, delineation of the limits of the professional relationship) some clients begin to perceive the occupational therapist as a friend and become disappointed, rejected, or abandoned when the therapist does not behave accordingly in other domains. Other risks associated with overreliance on the empathizing mode include the possibility of overidentification with clients, emotional overinvolvement, guilt concerning the limitations of what a therapist can actually do for clients, and resulting feelings of burnout.

Encouraging Mode

The ***encouraging mode*** is one in which a therapist works to instill clients with hope, courage, and the will to explore or perform a given activity. Therapists who use the encouraging mode frequently use such strategies as compliments, applause, and cheering when a client has accomplished something or when otherwise appropriate. They may negotiate with a client or incentivize a behavior, particularly if it is developmentally or functionally appropriate and the client responds well to positive reinforcement. They may rejoice and celebrate with clients when they are successful.

Some therapists use such strategies as entertaining gestures or antics, singing or dancing, and demonstrations of involvement to improve their clients' mood, distract them from anxiety or reluctance, and improve their desire to participate in occupations. When invited by a client, therapists may also engage in humor by making jokes or funny remarks. A client will invite a therapist to use humor by initiating it with a joke, humorous gesture, or funny remark. At that point, a therapist may feel comfortable picking up on the client's lead. Generally, therapists who utilize the encouraging mode attempt any clever or creative twist on activity to generate or help sustain a client's interest in occupational engagement.

Strengths of the Encouraging Mode

There are several strengths associated with functioning in the encouraging mode. Therapists who prefer this mode tend to be open and generous in their emotional expression. They project a great deal of positive energy, and they are particularly skilled at conveying their optimism and hope to their clients. They are willing to celebrate and be joyful with their clients. Some therapists functioning in this mode are viewed as playful by their clients, and this playful attitude may be particularly effective with children and other kinds of clients who respond primarily to emotional forms of engagement. Therapists functioning in the

CASE EXAMPLE 4.5
The Encouraging Mode

Rachel was a 4-year-old girl who was referred for treatment of selective mutism. She would speak only at home with her mother and father. I decided that the framework of a playgroup of peers her own age would be the optimal medium to increase her desire to speak with others. During the months of treatment, I told her that she would only be accepted into the playgroup on the condition that she would *not* speak in the group. I told her she would be allowed to make animal noises and other sounds but that talking was prohibited. I saw by the stars in her eyes that she liked the idea.

Along with sensory integration techniques, I tied up a big sheet that divided the treatment room into two halves. Among other things, I produced dramatic plays that featured the children in the playgroup as actors. The stage became an enticing place for all the children in the playgroup to show their talents while acting out different scenarios. At first, Rachel would smile and draw during the plays. Slowly, she began to make animal sounds. I showed greater appreciation of her performances when they included characters that made sounds.

After a short time, Rachel decided that sounds did not adequately convey what she wanted to express, and she began to say words. I would respond dramatically by making a fuss and contending that speaking words was not in keeping with the group's rules. Soon, her peers sensed her disappointment about not being permitted to say words. They began to support her by trying to convince me to change the rules so that Rachel could speak during the plays. As a group, we then decided that the new rule for the group would be that everyone, including Rachel, had to use words to communicate. Rachel agreed to this plan and through time, she began to speak more fluently in full sentences. She made significant progress at school, too.

I chose to be dramatic and demonstrative in the groups so that the playgroup was infused with high emotional valence and Rachel could easily read my feelings toward her. Through my affect I conveyed that I believed in her, was excited about her participation in the group at any level, and was willing to vigorously support her and meet her at the level at which she wanted to begin work (not speaking). At the same time, I made it clear to her (and to her peers) that I took the group, and its rules, very seriously. Through my emotional tone and enthusiasm, the playgroup became a big deal for Rachel and her peers.

Initially, I deliberately ignored the importance of Rachel's speech to her participation in the playgroup so that its emotional and social desirability would become self-apparent through time. Quickly it became clear to Rachel that, without speech, she was limited in the extent and level at which she could interact with her peers to create plays. In addition, speech became desirable to Rachel because its meaning was transformed from an anxiety-provoking activity that others demanded from her into an enticing and taboo behavior in which only she was forbidden to participate. In addition to this particular approach to use of self, the fact that she enjoyed creating plays was motivating for Rachel. Peer pressure from her new similar-aged friends also served as a powerful lever for her full participation in the group.

—Michele Shapiro

encouraging mode may be particularly capable of reaching clients with more severe developmental and cognitive impairments because they may use forms of communication that convey emotional energy and have multisensory components. Some therapists functioning in the encouraging mode are also skilled at using incentives to elicit participation. Because of their ability to convey their belief in a client's potential for success, these therapists may be more likely than other therapists to elicit participation from clients who are otherwise anxious, demoralized, or reluctant to participate in therapy (Fig. 4.8).

Cautions of the Encouraging Mode

Although there are few cautions associated with providing clients with encouragement, if the encouraging mode is overused, clients may become desensitized to its use

FIGURE 4.8 Encouraging mode. Belinda Anderson enjoys a song and a dance with a client.

through time. Some clients grow to expect the therapist to bolster them to such an extent that they have difficulty developing a sense of intrinsic motivation independently of the therapist.

In some circumstances, use of the encouraging mode with the wrong type of client carries a risk of being misinterpreted. Some clients are in an emotional state that does not allow them to hear or internalize compliments, a hopeful scenario, or comments about their strengths and capacities. Certain clients may undervalue or interpret a therapist's efforts to introduce hope, humor, play, or games into the relationship as being insulting, belittling, foolish, or manipulative. For example, a therapist once relayed a story in which she attempted to conduct a therapy group for adults with substance abuse problems that focused on ways to increase positive energy and hope. She began the session with an inspirational poem, and her ideas were quickly rejected by the group members.

Instructing Mode

Therapists who utilize the ***instructing mode*** emphasize education of clients in therapy and assume a teaching style in their interactions with clients. Therapists who use the instructing mode are skilled at providing clients with (appropriately) detailed descriptions of the objectives and tasks of therapy, providing a clear rationale for the content of therapy, training clients in the performance of specific occupational therapy activities, and providing feedback to clients about the therapy process. They can speak clearly and confidently about any aspect of the therapy process and excel at being structured, active, and directive.

They provide their clients with information, direction, recommendations, and, in some circumstances, advice. When functioning in the instructing mode, therapists utilize instructional statements and mini-lectures, role-modeling and demonstrations, statements that convey feedback to the client, and rhetorical questions as the primary form of therapy communication. Therapists functioning in the instructing mode are unafraid to state their professional opinions, set limits, provide feedback, or disagree with clients. When certain clients or circumstances make it necessary, these therapists are skilled at gentle or finessed approaches to confrontation in order to introduce the need for change. Therapists functioning in this mode may approach disagreements with clients by reexplaining their own point of view, providing more of a rationale for their perspective, explaining consequences of a poor decision, or educating clients further about the value of their approach.

Strengths of the Instructing Mode

The instructing mode is one of the fundamental modes required for the competent conduct of occupational therapy. Without some degree of structure, transfer of knowledge, provision of feedback, and overall leadership, occupational therapy would be something other than what it is.

Therapists who utilize this mode tend to be excellent teachers and clear communicators. They empower and inspire their clients by sharing information, noting accomplishments, providing constructive feedback, and training their clients to utilize the tools required for adaptation and participation. They convey caring and hope through their investment in a client's performance and in the positive outcomes of therapy. Therapists who function in the instructing mode tend to be highly organized and systematic in their approach to therapy. They inject a lot of intellectual energy and creativity into the therapy process.

Cautions of the Instructing Mode

As with any of the other modes, cautions emerge when therapists overutilize or inappropriately and indiscriminately apply the instructing mode with clients. Because the instructing mode usually involves focusing on outcomes more than process, some therapists functioning in

CASE EXAMPLE 4.6
The Instructing Mode

Kay is a 26-year-old woman who was severely injured in a skiing accident. She is paralyzed because of a spinal cord injury. Because she also had a hip fracture caused by the accident, her hospital stay was prolonged. I saw her as an inpatient for a period of 4 months. She is a naturally positive, strong, motivated, internally driven person. She had a creative outlook on occupational therapy and approached her goals in a systematic and self-disciplined manner.

Because Kay was so self-motivated, most of the time I found myself functioning in the collaborating mode when we planned therapy goals and activities. However, there were many times during Kay's therapy when I felt she was asking me to function in the instructing mode. These were times when Kay requested that I teach her specific skills related to activities of daily living. It was common that Kay would begin our sessions by anticipating that she would need to learn a certain skill, such as handling glasses in a restaurant or learning how to cut her own food.

Another responsibility included in my role as instructor was to bear witness to Kay's self-monitoring of her own performance. To do this, we put a piece of paper on the wall that listed her functional accomplishments for each day of therapy. Our systematic daily monitoring of her progress made it feel as if she was in school. I believe this was developmentally familiar to her and it gave her a sense of consistency and control. At first, her accomplishments were small. We would write, "I moved my little finger today" or "I rolled to the side by myself." Soon her accomplishments progressed to: "I ate today without Kim dropping any food." By the time Kay left the hospital the wall was covered with documentation of her accomplishments.

—Kim Eberhardt

this mode may overinvest and thus react more negatively when they cannot get clients to do what they want them to do. Alternatively, they may tend to overinstruct their clients to prevent them from experiencing failure in therapy. These behaviors can undermine clients' confidence, choice, and autonomy.

Occasionally, clients who are sensitive to these issues may misunderstand or misinterpret therapists' behavior in the instructing mode as being parental, authoritarian, dominant, controlling, or demanding. Therapists who overutilize this mode may feel obligated to help all clients address their difficulties and may miss the point at which clients want them to simply listen and validate them. Therefore, they are occasionally at risk for getting locked into arguments and power struggles with sensitive or vulnerable clients or parents who require a more empathic approach.

Problem-Solving Mode

Individuals who favor the ***problem-solving mode*** rely heavily on using reason and logic in their relationships with clients. Therapists functioning in the problem-solving mode generally approach the interpersonal aspects of therapy by using strategic questions, many of which are derived from the Socratic method of inquiry.[1] The key to understanding the types of questions that are asked in this mode is that the questions are agenda-driven. Therapists functioning in the problem-solving mode focus on clarifying and probing the client's beliefs about an issue for three central purposes: (1) to guide the client to think about and approach a problem or challenge in a more adaptive way, (2) to free the client from thoughts and beliefs that inhibit his or her ability to engage in the other aspects of occupational therapy, or (3) simply to help a client clarify their own thinking about an issue. Specifically, these types of questions are aimed at enabling a client to see a wider range of options, consequences, or dimensions of an issue. Therapists often pose these kinds of questions so clients may refine or expand their thinking about an issue or consider alternative perspectives. Therapists in this mode may also lead clients to list pros and cons, or strengths and weaknesses of a given decision or approach. They may,

[1] The Socratic method of questioning is a structured approach to asking a client questions. In the case of the IRM, the questions are designed to test or challenge a client's thinking about a situation to enable the client to think more clearly, rationally, or adaptively.

CASE EXAMPLE 4.7
The Problem-Solving Mode

Madam Bouchard is a 47-year-old woman with schizoaffective disorder. She was admitted to the inpatient unit after a police officer arrested her for driving on the wrong side of traffic on a highway at 5:00 in the morning. She was brought to the hospital because she seemed lost and confused about the incident.

At the beginning of therapy, Madam Bouchard was hypersensitive about the sounds, expressions, and movements made by me and the other therapists on her care team. She would often misinterpret the intentions behind very benign and meaningless body movements as being judgmental, menacing, or threatening. When participating in activities, she fixated on environmental stimuli and on my nonverbal reactions to her rather than concentrating on the activity itself. She often expressed a fear that staff (including me) would keep her in the hospital indefinitely and that we intended to physically harm her. (I discovered that these fears stemmed from an abusive relationship with her husband, and I initiated a social work intervention to address the situation.)

One of the many goals of individual therapy sessions with Madam Bouchard involved reducing her interpersonal anxiety, hypersensitivity, and misinterpretations of nonverbal behaviors during interactions. I arranged a series of structured craft activities with specific steps that would lead to replication of a real-life object (e.g., weaving a basket, painting watercolor according to a model, making a drinking cup out of clay according to a model). These activities allowed Madam Bouchard to orient to reality and center her thinking in the present moment. To address her interpersonal anxieties, I also engaged in other types of craft activities alongside her. I selected my activities based on their potential to force me to move and be physically active during our sessions.

The fact we worked beside each other on a separate activity gave ample opportunity for Madam Bouchard to interpret my gestures and reactions. Once she was emotionally stable and centered in her activity, I would initiate a medium level of physical activity in the room related to completing my craft. Then I would invite her to share her perception of a specific recent situation in which I moved in her presence. If her perception was correct, I would affirm its accuracy.

If her perception was incorrect and not based in reality, I used strategic questions to inquire about the basic point of reference that prompted her to arrive at her conclusion. If my questioning did not lead her to recognize that the reality of our here-and-now interaction was different from her internal thoughts and worries, I invited Madam Bouchard to engage in hypothesis testing. I would introduce a set of alternative hypotheses for interpreting my movements and nonverbal reactions during the session. Together, we analyzed each possibility using a problem-solving approach. To make our analysis concrete, I wrote the options down on paper or on a dry-erase board. The objective of this problem-solving exercise was to introduce the possibility of doubt into her misperceptions and to broaden her viewpoint regarding the myriad possible motives behind another person's actions.

This process allowed Madam Bouchard to verbally express and describe her perceptions without fear of judgment. It also allowed her to practice utilizing reasoning as a means of testing the accuracy of her interpretations of other people's social behaviors. Over time, she naturally used problem-solving as a means of coping with her worries and fears concerning her relationships with others.

—René Bélanger

FIGURE 4.9 Problem-solving mode. René Bélanger and his client analyze the past and consider choices for the future.

for example, facilitate their clients to better manage and clarify their time, priorities, and plan for the future by listing plans and activities on a calendar and comparing them practically and ideologically. To resolve interpersonal difficulties with clients, therapists functioning in the problem-solving mode are likely to structure the dialogue and outline guidelines for the negotiation of differences.

Strengths of the Problem-Solving Mode

By asking questions, co-creating lists, and enabling clients to think differently about problems or obstacles, therapists interact with their clients on a more cognitive and intellectual level. Thus, this mode is most appropriate for clients (young or old) who are able to engage verbally, and in a reciprocally cerebral way, with the therapist. Clients uncomfortable with a more emotion-focused approach to the therapeutic relationship may feel more at ease with the structure, predictability, and intellectualism (in the case of more advanced dialogue) conveyed by therapists using the problem-solving mode (Fig. 4.9).

Cautions of the Problem-Solving Mode

As with other modes, it is impossible for the problem-solving mode to work with all clients in all situations. When therapists function in the problem-solving mode, some are vulnerable to overutilize agenda-focused questioning without paying enough attention to other interpersonal needs that the client may bring to the relationship. Some may find a therapist's adoption of such questions reassuring or enlightening, whereas others may interpret the therapist's behavior as too strategic or even manipulative. Therapists who overutilize the problem-solving mode may be less comfortable with approaches that require more emotionally intense levels of interaction and communication. Additionally, as stated earlier, not all clients will be able or inclined to engage in a reciprocal verbal exchange of this nature with their therapists.

Modes in Perspective

The six therapeutic modes described in this chapter are based on frequently observed interpersonal behaviors that occur in occupational therapy. Although examples of how each of these modes is used in practice are provided, there is no single "typical" manner in which a therapist might enact a mode or a set of modes when working with a client. For example, as noted in Table 4.1, a mode may be delivered with a statement, a question, or, in some cases, nonverbally. It is important to remember that, with the exception of the advocating mode and the problem-solving mode, the four other modes may be delivered nonverbally or verbally. For example, the empathizing mode may be enacted by sitting with a client silently until the client feels ready to talk. The instructing mode may be conveyed by wearing a serious expression and extending a hand to greet a client rather than indulging the client's ongoing attempts to embrace.

Similar to all forms of communication, the intensity with which each mode is enacted may (and should) change according to the client's interpersonal characteristics and the therapeutic context. For example, the encouraging mode may be communicated to a client in a quiet and subtle manner when a client smiles slightly and quietly states: "When I walked by your room this morning, I saw that you were sitting up. It looked like you were practicing your finger exercises." It may be enacted with the same client in a more obvious manner when the therapist wears a big smile and, with an enthusiastic tone of voice, states more loudly: "You made that toilet transfer on your very first try!"

Mode Shifting

According to the IRM, ***mode shifting*** (i.e., shifting from one of the six modes to another of the six modes) is desirable. It is the central part of the interpersonal reasoning process; blended and incongruent mode use, which will be covered in the next section, is not. Thus far, the modes have been discussed and illustrated in isolation of each other. However, there are countless possibilities for ways in which it is optimal for a therapist to switch modes in specific sequences. Modes may and should be used

interchangeably, provided they do not become confused (i.e., ***mixed***) with one another during a single communication point. As introduced in Chapter 3, to be most therapeutic a mode must be used purely, without confusion with another mode. Pure use of modes communicates a single message, and it ensures that the therapist is taking responsibility for his or her chosen means of communicating within a given moment.

For example, when a therapist functioning in the collaborative mode during the time a client is engaging in a familiar task notes that a client appears to need more structure and guidance when engaging in an unfamiliar task, this observation would naturally prompt a shift from the collaborating mode to the instructing mode. In this case, the therapist may cease turning to the client for input and may, instead, make a statement such as: "Would you like me to provide you with some guidance for this task?" Assuming that the client wishes for this guidance, the therapist would then begin to provide clear instruction, making suggestions along the way and providing constructive feedback, where necessary.

Mode Mismatch, Mixed and Incongruent Mode Use

There are three circumstances that characterize ***suboptimal mode use:*** a mode mismatch, mixed mode use, and incongruent mode use. A mode mismatch occurs when a therapist communicates within a mode that does not meet the client's interpersonal needs or is inconsistent with the client's interpersonal characteristics or any interpersonal events that happen to be occurring in that moment. In Chapter 1, when the topic of chemotherapy came up between Erika and her client Vera, Erika presented a research article about recent advances in chemotherapy while smiling to illustrate her point. In this instance, Erika's attempt to use the ***instructing mode*** of communication should be considered a mode mismatch. As a mode mismatch, her attempt failed for two reasons. First, the instructing mode would not be the first mode that the IRM would recommend for a client whose predominant interpersonal characteristic involves a high need for control. Clients that need to be in control do not always appreciate receiving unsolicited information. Second, the interpersonal event that occurred between Vera and Erika, a ***power dilemma***, also characterizes a situation where the therapist's use of the instructing mode should typically be avoided. Vera and Erika were debating or arguing with a client about a given topic (Erika supporting the use of chemotherapy versus Vera not supporting the use of chemotherapy). In this circumstance, Erika providing information to justify her opposing position was not appreciated by Vera. Although Vera did not share her reaction directly with Erika at the time, she later requested to be assigned to a different therapist.

The second circumstance of suboptimal mode use concerns mixing modes. Mixing modes occurs when a therapist is not clear about his or her intended message and conveys two modes simultaneously within a single moment of communication (typically within the same sentence). When one wishes to shift from one mode to another, one should ensure that there is a strong rationale for the mode shift and that the two modes can be easily distinguishable by the type of phrase, action, or question chosen, and by the congruity of one's facial expression and body language. In doing this, the word *but* should not be used to join the modes. The rationale for avoiding the word *but* is that it is a word that conveys contradiction. When joining two ideas, using this word undermines the first idea, and, at the same time, the second idea is not any more convincing (because the first idea remains, undeniably, a part of the sentence). When a therapist intends to empathize with a client and, instead, blends the empathizing mode with the instructing mode, he or she sends a mixed message to the client about his or her true thoughts, feelings, and intentions. For example, a therapist locked in a power struggle with her client regarding the client's alcohol use sends a mixed message by saying in a single breath: "I understand why you want to use alcohol, but I am concerned that, among other things, it will interact with your other medications and exacerbate your balance problems." This can be confusing for clients, and it weakens the intended message or messages. Ultimately, it may weaken the therapist's influence within the relationship and the client's trust in the process.

The third circumstance of suboptimal mode use involves mode incongruence. Incongruent mode use occurs when a therapist shows ***emotional incongruence*** when communicating with a client. Emotional incongruence occurs when a person is communicating one statement verbally and the same person's emotional expression, facial expression, or body language contradicts or does not support what the person is saying. Correspondingly, ***mode incongruence*** occurs when a therapist delivers a mode

Table 4.2 **The Three Circumstances of Suboptimal Mode Use**

Suboptimal Mode Use	Description	Practice Example
Mode Mismatch	A mode is not appropriate for a client's interpersonal characteristics or the interpersonal event.	A therapist uses the empathizing mode when a client is primarily seeking information about the rehabilitation process and would prefer the instructing mode.
Mode Mixing	Two modes are used in the same moment of communication, causing confusion about the therapist's true meaning.	A therapist responds to a client's question about how long the recovery process will take by stating: "I can understand why you would want to know how long this will take, but I cannot tell you because it is different for everyone."
Mode Incongruence	The therapist's facial expression or body language is inconsistent with the mode or interpersonal context.	A therapist offers a client encouragement by stating: "I saw that you were able to cut a circle with those scissors last time" while at the same time looking down and wearing a blank facial expression.

verbally but his or her facial expression or body language is inconsistent with the mode or with the overall interpersonal context of the communication. In Chapter 1, when Erika smiled as she delivered the instructing mode, her smile was a nervous smile, and it was emotionally incongruent. Typically, it is not appropriate to smile during an intense dialogue or argument. Mode incongruence happens frequently, particularly when a therapist is nervous or uncomfortable during an interaction. Table 4.2 presents a synopsis of the three circumstances of suboptimal mode use and additional examples. It is important to note that emotional incongruence, in general, is most likely to occur within the overall context of suboptimal communication; it is not something that occurs exclusively during mode use. This will be covered in more detail in a later chapter.

Mode Shifting: Avoiding Suboptimal Communication

Much more can be accomplished interpersonally if a therapist shifts modes clearly and intentionally by applying interpersonal reasoning. When shifting modes, three powerful techniques may be used to separate the communication of one mode from another. The first involves time. The more time that a therapist can pause, verbally, between the two phrases or sentences that characterize the different modes, the more likely it is that the client will understand that a different approach to communication is being used. The second concerns body language. If appropriate within the therapeutic context, the therapist should move to a different part of the room, change posture, or, if appropriate, shift the therapeutic activity to mark the new idea being communicated. The third involves announcing one's intention to shift modes to the client. Ideally, any two or, if appropriate, all three of these techniques will maximize the likelihood that the mode shift will take place in a way that the client fully understands that a different approach to communication is being used.

In the example about the client with alcoholism, the therapist could have applied any three of these techniques to shift modes cleanly, improving the clarity and intentionality of communication with the client. If the therapist would have used the pausing technique, she would have taken considerable time to listen to and understand the client's perspective on alcohol use, asking a few additional deepening questions to better understand what initiated and is sustaining the addiction, if appropriate. Then, after the therapist received some nonverbal or verbal indication from the client indicating that she has felt fully seen and heard, the therapist would shift into an instructing

mode in an attempt to communicate her perspective of educating the client about her balance. If the therapist also applied the second technique involving body language, she could have walked across the room to sit in a different chair and before shifting into the instructing mode. Applying the third technique, the therapist could have stated: "Now that I have learned a little more about why drinking is important to you, I feel an obligation to switch modes and talk with you about some of the possible consequences of your drinking in terms of your overall functioning."

These and other suggestions for ensuring that each of the modes a therapist selects are received as intended are summarized in the following list:

- Announce the mode shift to the client, if appropriate.
- When shifting, let as much time pass between modes as appropriate. This may involve seconds or minutes, depending upon what is appropriate.
- Shift your body language or the task or activity to earmark your shift in the mode of communication being used.
- Think about what message you believe the client needs to hear at the moment and remain utterly loyal to that message. Apply the same process for the new mode upon shifting.
- Seek justification through interpersonal reasoning for why it is therapeutic for the client to receive the new mode. Is the mode appropriate for the client's interpersonal characteristics and for any interpersonal events of the moment? If you are confident about the appropriateness of the mode, it will be easier to convey that confidence when communicating with the client within the mode.
- Take responsibility for what you say or ask of a client, even if you are communicating in a mode that feels interpersonally risky or outside of your own comfort zone.

Additional examples of ways in which therapists have drawn upon the various therapeutic modes to manage various interpersonal events in practice are included in later chapters.

Therapeutic Style: Using the Modes

As therapists become more experienced, they may begin to notice that they emphasize and draw upon certain modes more often than others when treating clients. Accordingly, they develop a ***therapeutic style,*** or a skill set that incorporates the therapeutic modes they view as being maximally therapeutic for their clients.

For example, Jane Melton describes herself as having a "natural optimistic belief in people" and as drawing upon her determination, patience, and ability to empathize and listen to clients reflectively as well as her honesty, tact, resilience, and gentleness when providing feedback and working with clients. Although Jane utilizes several interpersonal modes and adapts them thoughtfully depending on the unique needs of each client, her self-description indicates that she draws most heavily on her natural hope and optimism, her belief in her clients' capacity for autonomy and independence, her self-discipline as it manifests in the form of patience, her preference for listening and understanding over activity-focusing or rushing into doing, and her overall gentleness of style. To summarize this in terms of mode, empathizing, collaborating, and encouraging are Jane's primary modes of interaction.

However, we saw earlier in this chapter that she also uses the advocating mode to ensure that her clients receive the entitlements they deserve, such as fully accessible housing. Although Jane mostly uses the empathizing, collaborating, and encouraging modes, she maintains and utilizes additional modes as required by the unique demands of any given client or therapeutic situation. As an experienced therapist, Jane possesses a broad repertoire of therapeutic modes.

Broadening One's Repertoire of Modes: A Central Objective of the Intentional Relationship Model

The broader the repertoire of modes a therapist can draw upon to adjust to clients' various interpersonal presentations and demands, the more likely it is that the therapist can function effectively with even the most resistant and interpersonally challenging clients. Because therapists' personalities are relatively stable, it is a natural inclination for them to invoke modes that fall within their "comfort zone." For example, a person who is reserved, quiet, and mostly other-oriented during most social interactions likely feels more comfortable in the empathizing and collaborative modes (i.e., empathizing with and listening to clients, allowing them to take the lead in therapy, and facilitating their independence, autonomy, and choice).

This same therapist may feel less comfortable working with passive clients or those who require a therapist to be more directive, assertive, frank, evaluative, or even appropriately confrontational.

Conversely, a therapist who is extroverted, comfortable asserting her needs in relationships, and self-assured in sharing her knowledge with others may find it relatively easy to be directive, assertive, frank, evaluative, or even confrontational with her clients. This therapist's preferred modes may be the instructing and problem-solving modes. However, a therapist such as this one may unwittingly undermine a client's autonomy and choice; he or she may lack patience, may pace the therapy too quickly, or may be vulnerable to becoming involved in power struggles with clients who behave in resistant or confrontational ways.

Any preferred mode that falls within our comfort zone has a benefit and a downside. Moreover, one's preferred modes do not work for all clients or in all circumstances. To function with as much intentionality in therapeutic relationships as possible, therapists have a responsibility to extend their capacity to function within a wide range of interpersonal modes during therapy. A more extensive repertoire of interpersonal modes allows you to communicate more effectively with a wider range of clients. More specifically, it allows you to respond to clients in ways that more accurately address their interpersonal needs. Accurately identifying each client's preference for therapeutic interaction and responding in ways that meet each client's interpersonal preferences conveys to our clients that we are willing to interact and work with them in their comfort zones rather than in our own.

Adjusting our own responses to the covert or expressed interpersonal needs of each client is possible only if we possess the capacity to exhibit a wide enough range of interpersonal behaviors in therapy. When we draw on ways of interacting that are inconsistent with our values or that we simply have not learned or practiced as often in social situations, we are immediately forced out of our own interpersonal comfort zones. However, the departure from our own comfort zone is sometimes the only means by which it is possible to enter the interpersonal worlds of our clients.

For example, Michele Shapiro works with pediatric clients, some of whom are nonverbal and severely developmentally disabled. With these low-functioning clients, Michele had for many years been accustomed to assuming a structured and goal-directed approach to therapy. Once she broadened her approach to include careful vigilance toward her clients' needs and nondirective strategies, Michele recognized that she was more able to engage a wider range of her clients in therapy. During our interview, Michele disclosed:

> Years ago when I worked with learning disabled kids, I remember sometimes feeling that I must try to "control" the child's behavior. Now I prefer working with a child who has special needs and is out of control. When I do my detective work and decipher the base of the sensory problem, then it makes me feel good. In the past I needed to see things happening to know I was successful—today a child's smile makes me feel that the session was successful.

Locating One's Comfort Zone of Preferred Modes

A central objective of the IRM is to identify one's current "comfort zone" of interpersonal behavior during therapy. As you develop as a therapist, it is similarly important to practice broadening that comfort zone to include increasingly unfamiliar and unutilized interpersonal styles, or modes. The beginning of the chapter asked you to complete the Self-Assessment of Modes Questionnaire, Version III, located in the Exercises section (Exercise 4.1). Now, you should use those responses to fill out the Personal Modes Profile that follows. Doing so will indicate your preferred therapeutic modes and their relative strength. Following this, you should identify less familiar modes that might strengthen your relationships with clients or allow you to practice more successfully with a broader range of client personalities in Exercise 4.2.

Therapeutic Style and Daily Interpersonal Behavior: Striving Toward Integration

The idea of developing a therapeutic style and using modes can be misunderstood as lacking a sense of genuineness. However, this conclusion emanates from a misunderstanding of the role of genuineness in therapy. The genuine therapist is one who sincerely wants and makes an effort to do what is best for the client. Genuineness is not simply being yourself. It is being the best person you can be, given the client's needs.

That said, it is nonetheless important for therapists to strive toward and integrate their therapeutic style and their more innate daily ways of interacting with others. The closer one's everyday interpersonal behavior is to one's therapeutic style, the more likely it is that a therapist feels able to interact therapeutically with clients in ways that feel natural. Thus, although it is important to broaden one's repertoire of therapeutic modes, it is equally important to develop a therapeutic style that feels true and is generally consistent with one's everyday ways of interacting.

To a certain extent, every therapist must practice a degree of interpersonal self-discipline. That is, you must exercise restraint regarding the extent to which you reveal all aspects of your personality to clients. The Occupational Therapy Code of Ethics (American Occupational Therapy Association [AOTA], 2015) and occupational therapy's core values statement (AOTA, 1993) reinforce that it is in the best interest of clients to conduct therapy with prudence and circumspection. This sometimes includes controlling one's interpersonal impulses and always avoiding interactions with clients that may be perceived as exploitive or emotionally harmful. Any experienced therapist knows that at certain moments during therapy practice, particularly with more challenging clients, it takes impulse control and significant restraint to draw only on the aspects of oneself that have the potential to be therapeutic. It is impossible to appreciate all clients equally, and there are moments when we may wish to show clients we find more difficult how we really feel about them, but our values, ethics, and better judgment prevent us from doing this.

As therapists develop expertise in the therapeutic use of self, they find that they do not have to work as hard as they did before to exercise this capacity for circumspection and self-restraint. As therapists become more experienced in the use of self, the act of interacting therapeutically comes to feel natural. This sense of naturalness comes from knowing the benefits and limits of one's natural modes and developing comfort utilizing the modes that were not, at first, as easy to use. In addition, therapists often feel they can function more seamlessly with certain types of clients and in settings that match their natural inclinations, using certain modes rather than others. For example, a therapist once shared that she enjoys working with young children because she can freely draw on the encouraging mode without fear of judgment if she happens to overuse the mode with a given client. Similarly, another therapist once told me that she prefers working in physical rehabilitation settings because she enjoys functioning in the role of teacher in that much of her job involves demonstrating certain tasks and instructing clients to relearn important daily living skills.

More experienced therapists often see little difference between their therapeutic styles and the ways they typically behave with friends and family. Even though they may feel more relaxed and spontaneous in their relationships with clients, therapists for whom there is little difference between their therapeutic styles and their everyday interpersonal interactions tend to make fewer interpersonal oversights with their clients; they tend to say and do the appropriate things at the right times. For example, when they provide feedback to a client that might be difficult to hear, it is well timed—consistent with their general way of relating—and presented with great sensitivity and tact. Therapists whose therapeutic style matches their everyday style generally feel they do not have to exercise considerable emotional restraint and extensive tactical thinking during therapy.

Vardit Kindler provides a succinct description of this match. She describes her therapeutic style and her behavior in everyday life as relatively indistinguishable.

> My general style of relating is very informal. I accept everyone as an equal. I look at people's strengths without being overly critical. This is my style of relating both inside and outside therapy.
>
> —Vardit Kindler

Similarly, Carmen-Gloria de las Heras explains:

> I flow easily between the two. I keep my way of being. I am spontaneous and generous. I am firm when I have to be, but I keep my fundamental belief in people. I am myself with clients as I am with everyone else.
>
> —Carmen-Gloria de las Heras

This ability to integrate and see an increasing number of parallels between one's therapeutic style and one's interpersonal style outside of therapy, combined with the ability to draw on a wide repertoire of interpersonal behaviors as appropriate for any given interaction, may be associated with decreased feelings of burnout and frustration. Having a therapeutic style that feels consistent with one's day-to-day personality is referred to as an ***integrated*** use of self.

Assessing Mode Use

To date, nine assessments of mode use based on the IRM have been developed. One of these assessments is featured in this chapter: The Self-Assessment of Modes, Version III. The Self-Assessment of Modes, Version III, consists of nine different clinical scenarios, each portraying a client or caregiver facing a dilemma. Four possible therapeutic responses (i.e., modes) are presented beneath each clinical scenario. Respondents are required to rank-order the responses from one to four based upon the degree to which they agree with the given response. The additional IRM assessments, most of which have been validated or are in the process of being validated, are available at the IRM website: http://irm.ahslabs.uic.edu/.

SUMMARY

The "cautions" section under each of the interpersonal modes reveals one of the hidden secrets of therapeutic use of self—that no therapist is perfect. There is no way to escape the caveats and downsides that go along with any therapeutic mode or set of modes. Additionally, no one is immune from communicating the modes suboptimally from time to time. One key to the intentional use of self is to familiarize oneself with the caveats to each of the modes that are part of one's therapeutic style. The more you develop an ability to draw on as many modes as necessary and appropriate for a given client, the more likely you are to avoid overutilizing one style at the expense of using a more appropriate or more indicated style for that client.

Exercises for Learning and Reflection

1. Please complete Exercises 4.1 to 4.3. Reflect upon your responses.
2. Provide a description of each of the six modes.
3. Why is it important to clearly differentiate between each of the six modes when communicating with a client?
4. Define the three types of suboptimal mode use. Why is it important to differentiate mode use and suboptimal mode use?

Exercise 4.1

Self-Assessment of Modes Questionnaire, Version III

This assessment is designed to allow you to identify whether you have a dominant way or central set of ways of responding to various interpersonal events that arise in therapy. Please do not think too hard about the responses and respond as if you were facing the situations described in real-time practice. All responses represent plausible therapeutic actions, and there are no incorrect responses.

For every scenario, please rank-order *each* of the four response options according to the extent to which you would view the option as being consistent with your predominant (i.e., usual) way of interacting. Please rank the *general idea or feeling you have about the response*, even if the way that the example is worded is not identical to what you would actually say. Your numeric rankings should adhere to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

Please note that you may only assign a number once; please do not assign the same number to more than one response option. It is recognized that your actual response may depend on information that is not available in the case description. The point of this questionnaire is not to ascertain a correct response but to ascertain the one that is most representative of your interpersonal style. Please do not dwell on the options for too long. Instead, choose the response that would be the easiest, most natural, or most typical for you in each situation.

Please see the following example, where, in this case, option "d" is the response most consistent with the respondent's usual way of interacting:

A marathon runner is looking for a relief station to rehydrate but cannot find one. The runner is trying to decide whether to continue running or to rest in order to avoid a state of complete exhaustion. Walking alongside the runner, you are able to have a conversation. Please rank-order the following possible responses.

a. __3_ Assume a clear leadership role by providing the runner with information, structure, guidance, or constructive feedback (e.g., educate the runner on the potential consequences of continuing to run without hydration).

b. __2_ Ask questions or engage in a discussion that leads the runner to think about alternative ways of approaching the situation (e.g., assist the runner in weighing the pros and cons of continuing to run without hydration).

c. __4_ Give the runner total and complete control over the situation (e.g., ask the runner what he or she feels is the best thing to do in this moment).

d. __1_ Normalize the runner's experience or connect the runner with social or physical resources that will enable him or her to have an equal chance of finishing (e.g., let the runner know that dehydration is common among marathoners; if desired, gather information for the runner about the location of the next relief station).

1. You are working with a 92-year-old retired steelworker who has always performed his own handiwork around the house. He is receiving postsurgical therapy for a shoulder injury that he endured after a fall from a stepstool while changing a light bulb in his home. When the client is not in the room, his family members tell you that this is not the first accident that he has had doing handiwork. They add that, recently, he has become more accident-prone while completing tasks that should be done by hired workers. The client's family is concerned about his safety. They feel that he does not listen to them when they ask him to call a hired worker instead of performing household duties on his own. The family reports that the client is otherwise safe when not engaging in household tasks. Please rank-order each response to the family according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Assume a clear leadership role by providing the family with information, structure, guidance, or constructive feedback (e.g., provide the family with information on the type of safety recommendations that you will discuss with the client and reassure them that these recommendations will be included in the client's next session).

b. ___ Give the family total and complete control over the situation (e.g., ask the family what they think they will need from you to better ensure the client's safety at home).

c. ___ Witness, listen to, and show full acceptance of the client's thoughts, feelings, or behavior (e.g., summarize what you have just learned and make a statement that validates their concerns about the client's safety).

d. ___ Ask questions or engage in a discussion that leads the family to think about alternative ways of approaching the situation (e.g., assist the family in weighing the pros and cons of a range of ways that a convincing message about safety might be best communicated to the client).

2. You are working with a 42-year-old engineer specializing in geomechanics. Work has always been one of the most gratifying things in his life. He is receiving occupational therapy following a spinal cord injury. Because of the injury, the client now requires a special form of powered mobility that traverses different types of terrain in order to complete fieldwork assignments. However, neither his employer nor his insurance company is willing to cover the cost of the equipment, arguing that the powered mobility that he currently uses should be adequate. The client tells you that this specialized power mobility is vital to his ability to complete his work. He adds that his current chair frequently gets stuck, limiting his timeliness, efficiency, and overall productivity. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Witness, listen to, and show full acceptance of the client's thoughts, feelings, or behavior (e.g., summarize what you have just learned and make a statement that validates the client's experience).

b. ___ Normalize the client's experience or connect him with social or physical resources that will enable him to have equal access and opportunities (e.g., inform the client that the desired chair represents a reasonable accommodation and connect him with a well-known disability rights organization for assistance).

c. ___ Give the client total and complete control over the situation (e.g., ask him what he feels he needs from you in order to address the situation).

d. ___ Ask questions or engage in a discussion that leads the client to think about alternative ways of approaching the situation (e.g., create a list of options for actions that might be taken to address this situation and analyze the viability of each option with the client).

3. You are working with a 74-year-old homemaker and accountant from a rural community. She has invested her entire life in raising a family while simultaneously operating a successful part-time tax-assistance business from home. Until now, she has been in perfect health and has never experienced any injuries or impairments. Newly referred for rehabilitation and having successfully accomplished all of the activities thus far, she is clearly frustrated and demoralized over the difficulty that she is having making a toilet transfer. After two transfer attempts, she tells you that she knows she cannot do it, and that she is going to end up in a nursing home. She is concerned that she won't be able to return to her home, where she has lived for 30 years. Most individuals with her level of impairment are eventually able to return to independent living and are able to make the transfer. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a ___ Assume a clear leadership role by providing the client with information, structure, guidance, or constructive feedback (e.g., tell her that learning a transfer requires practice and review the steps that you have already taught her thus far).

b. ___ Normalize the client's experience or connect her with social or physical resources that will enable her to have equal access and opportunities (e.g., tell the client that her frustration is normal and that most clients on the unit feel this way when they are first learning the transfer).

c. ___ Witness, listen to, and show full acceptance of the client's thoughts, feelings, or behavior (e.g., ask the client to tell you more about her frustration to get a better understanding of her concerns).

d ___ Provide the client with hope or positive feedback and generally show a positive attitude or emotions (e.g., tell her that you know that she will eventually learn to make the transfer because you have noticed her strength and success with equally difficult tasks).

4. You are working with a studious and well liked 13-year-old client with cerebral palsy you have worked with for the past 2 years. She tells you she is feeling hurt and betrayed by something she overheard one of her friends say to another peer at school today in reference to her disability. Because of the presence of many bullies and a lack of appropriate disciplinary oversight, her school is a socially tough environment for many students. Though she is quite gregarious and popular with most of her peers, this is not the first time that she has been hurt by jokes and disparaging comments by peers and

others in public through the years. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Normalize the client's experience or connect her with social or physical resources that will enable her to have equal access and opportunities (e.g., tell the client about a peer network of other students with disabilities who have also endured bullying and are proud of their identities and of what they have achieved; offer to connect her to other students living in her area).

b. ___ Give the client total and complete control over the situation (e.g., ask the client what she thinks would be most helpful to her at this time).

c. ___ Provide the client with hope or positive feedback and generally show a positive attitude or emotions (e.g., remind the client that she is one of the more popular students in her class; also remind her of all the positive things you know that her other friends say about her on a regular basis).

d. ___ Witness, listen to, and show full acceptance of the client's thoughts, feelings, or behavior (e.g., tell her that she has a right to feel betrayed and ask her to tell you more about the people and circumstances involved).

5. You are working with a 26-year-old, recently divorced truck driver who is recovering from internal injuries and multiple abrasions and fractures to his left hand, arm, and leg. His injuries occurred during a post-divorce party with friends that involved drinking and riding jet skis. In the middle of an uncomfortable icing treatment on his hand, he tells you that none of his friends have visited him in the hospital and that he feels very anxious about how dependent he has become on the hospital staff. He is worried about losing his job, being alone, and how he will get by once he returns to his home. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Provide the client with hope, positive feedback, and generally show a positive attitude or emotions (e.g., point out the client's strengths, highlighting all of his good progress thus far; remind him that as his functioning improves, he will begin to build increasing confidence about returning home and eventually getting back to work).

b. ___ Assume a clear leadership role by providing the client with information, structure, guidance, or constructive feedback (e.g., educate the client about the course of rehabilitation, emphasizing that he will not be discharged from the hospital to outpatient and work rehabilitation until he feels confident about his abilities and is assessed by the treatment team to be ready and safe for such).

c. ___ Ask questions or engage in a discussion that leads the client to think about alternative ways of approaching the situation (e.g., ask the client about the source of his concerns—if it was something someone said or something else that happened since the accident that is causing him to be concerned about his independence).

d. ___ Give the client total and complete control over the situation (e.g., ask the client what he thinks he will need to be able to do before he returns home, and assist him in converting his thoughts into short- and long-term goals for therapy).

6. You are working with a 50-year-old retired cook who is a mother and a grandmother. She experienced a traumatic brain injury approximately 3 years ago, and for the past year she has been attending a day center in her community that serves individuals with brain injuries. The client typically loves participating in and sometimes leading a range of activities, including a cooking group that she sometimes leads because of her expertise in this area. Recently, she has not been participating in most of the activities and has had to be encouraged to come into the dining room during mealtimes. Today, she refuses to eat or participate in the cooking group. She states that she believes that the kitchen is not clean enough for eating and cooking. You know that the kitchen is particularly clean. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Assume a clear leadership role by providing the client with information, structure, guidance, or constructive feedback (e.g., explain that the kitchen is cleaned after each use and was just cleaned this morning; offer to clean it with her again).

b. ___ Ask questions or engage in a discussion that leads the client to think about alternative ways of approaching the situation (e.g., ask the client if there is something in particular that is giving her the idea that the kitchen is not clean; invite her to show you where the kitchen is not clean).

c. ___ Witness, listen to, and show full acceptance of the client's thoughts, feelings, or behavior (e.g., tell the client that you want to understand more about her concerns about the kitchen and ask her to explain more about why she does not want to eat or participate in the cooking group).

d. ___ Provide the client with hope or positive feedback and generally show a positive attitude or emotions (e.g., remind the client of how much she usually enjoys the cooking group, and tell her that you, in particular, enjoy eating the food during times when she leads the group).

7. You are working with a 72-year-old farmer who has been working on his family's large acreage since he was very young. He is currently in the middle of a severe gout flare-up. You can see that he is becoming increasingly upset about the situation. The harvest is approaching, and if he misses it, his business will lose a significant amount of money. He is particularly worried about whether he will be able to drive the tractor for as long as the harvest requires. His son and daughter, who would normally be available to help him, are both out of town. He cannot take the type of pain medications that would provide him with rapid relief because of the side effects they have caused, and the gout medication that he takes is effective only if taken during a period of several days. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Provide the client with hope or positive feedback and generally show a positive attitude or emotions (e.g., based on your knowledge of the usual length of his gout flare-ups, remind the client that the attack is very likely to end soon, as it has every other time; encourage him not to lose hope that he will bring the harvest in on time).

b. ___ Ask questions or engage in a discussion that leads the client to think about alternative ways of approaching the situation (e.g., ask the client questions to help him compare different alternatives and plans for how to manage the needs of his business during the flare-up).

c. ___ Normalize the client's experience or connect him with social or physical resources that will enable him to have equal access and opportunities (e.g., work with the client to reach out to an advocacy-based organization whose mission is to help farmers in crisis).

d. ___ Assume a clear leadership role by providing the client with information, structure, guidance, or constructive feedback (e.g., review all of the pain management strategies that you and the client have tried, including modifying his diet and sleep hygiene; remind the client of adaptations that may be used and show him alternative ways to manage the pain during the flare-up).

8. You are working with a 3 ½-year-old boy with speech and fine motor delays and behavioral problems. The child's tantrums are becoming more frequent during therapy, so you decide to address them, involving the child's mother in your plan. The child's mother agrees to this plan, and the approach is beginning to work. When you use this

approach today, however, the child's mother interrupts therapy and reports that she has been feeling uncomfortable with the approach. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Witness, listen to, and show full acceptance of the parent's thoughts, feelings, or behavior (e.g., ask the child's mother to tell you more about her concerns, taking the time to validate her feelings of discomfort).

b. ___ Ask questions or engage in a discussion that leads the parent to think about alternative ways of approaching the situation (e.g., weigh all of the different options for responding to the client's tantrums with his mother; discuss the pros and cons of each option with her).

c. ___ Normalize the parent's experience or connect the parent with social or physical resources that will enable her to have equal access and opportunities (e.g., let the child's mother know that she is not alone and that many parents are uncomfortable with this approach; provide her with contact information for a parent empowerment group that critically evaluates this method and many other different methods for addressing behavioral problems).

d. ___ Give the parent total and complete control over the situation (e.g., inform the child's mother that she is in control of what happens during her son's therapy; ask her if she can think of a way to modify the approach so that she feels more comfortable with it, or if there is another strategy she wants to try instead of this one).

9. You are working with a 10-year-old girl who loves and excels at many sports. She has academic difficulties related to dyslexia and attention deficit-hyperactivity disorder. You have noticed that when anyone gives her an assignment that is slightly more challenging than what she is used to, she reacts immediately by not even looking at it, and instead says she doesn't get it. At the same time, if she discovers an even more challenging assignment on her own, she often completes it without errors. It is clear to you that the client is capable of doing the slightly upgraded assignments that you are recommending, but she gives up before even attempting them. Today is not different than any other day. When you present the client with a slightly more advanced assignment that you know she is capable of completing, she quickly claims she does not understand it. Please rank-order each response according to the following scale:

1 = highly consistent with how I would usually respond

2 = very consistent with how I would usually respond

3 = moderately consistent with how I would usually respond

4 = slightly or not at all consistent with how I would usually respond

a. ___ Assume a clear leadership role by providing the client with information, structure, guidance, or constructive feedback (e.g., give the client feedback that you have noticed that she completes more challenging assignments that she gives herself, but when given assignments by others, she says she does not understand it before she even reads the directions and considers how she might complete it).

b. ___ Normalize the client's experience or connect her with social or physical resources that will enable her to have equal access and opportunities (e.g., tell the client that it is normal for people to say that they can't do something when they are feeling challenged; provide her with self-advocacy language so that she can tell others what she needs when she is given more challenging assignments).

c. ___ Provide the client with hope or positive feedback and generally show a positive attitude or emotions (e.g., remind the client how well she did on a similar assignment the previous week; tell her you know she can do it).

d. ___ Give the client total and complete control over the situation (e.g., invite the client to share what she thinks would be most helpful the next time she is given something new to work on).

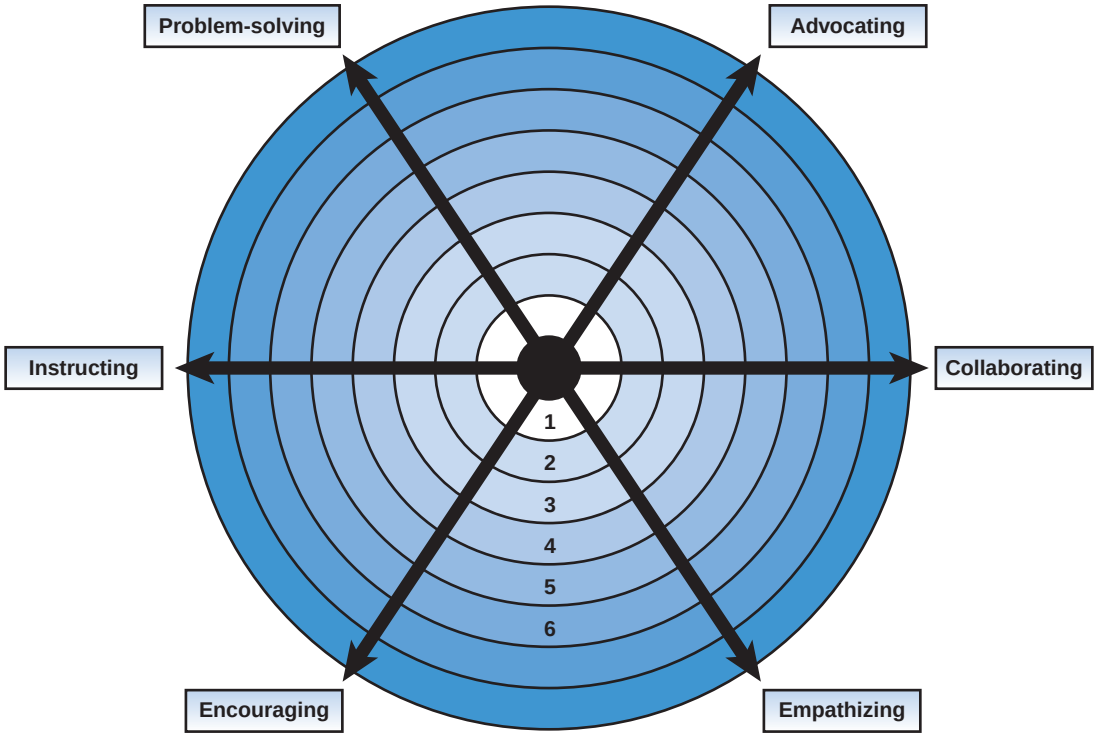
A scoring key and interpretation map for this assessment are presented on the following pages. So that you will have a better understanding of the strengths and limitations of each mode, it is recommended that you read this chapter before scoring your self-assessment.

Scoring for Exercise 4.1: Determining Your Therapeutic Style

To determine your therapeutic style (i.e., the modes you are more or less inclined to use), you should first record your responses to the Self-Assessment of Modes Questionnaire, Version III, on the Modes Scoring Key by circling the response you chose for each question. Then, add up the number of times you chose responses corresponding to each mode and record them at the bottom of each column. The total possible number of responses for each mode is 6. You may calculate your percentage score for each mode by dividing the total number of actual responses for each mode by the total number of response possibilities (6) and then multiplying by 100. The higher your score for each mode, the more comfortable you may feel with using the mode.

You may plot your profile on the Therapeutic Style Form by darkening each area in the arrows that fall inside the concentric circle that corresponds to your mode scores. This will provide a visual representation of the therapeutic style you are most likely to use during therapy.

Visual Map: My Therapeutic Style



Modes Scoring Key

Advocating	Collaborating	Empathizing	Encouraging	Instructing	Problem-Solving
___	1b	1c	___	1a	1d
2b	2c	2a	___	___	2d
3b	___	3c	3d	3a	___
4a	4b	4d	4c	___	___
___	5d	___	5a	5b	5c
___	___	6c	6d	6a	6b
7c	___	___	7a	7d	7b
8c	8d	8a	___	___	8b
9b	9d	___	9c	9a	___
Advocating	Collaborating	Empathizing	Encouraging	Instructing	Problem-Solving
Total:_____/6	Total:_____/6	Total:_____/6	Total:_____/6	Total:_____/6	Total:_____/6
Percent: ___%	Percent: ___%	Percent: ___%	Percent: ___%	Percent: ___%	Percent: ____%

Exercise 4.2

Examining Your Therapeutic Style

The Therapeutic Style Form indicates the relative amount of comfort you have with each mode. In the end, however, you should reflect on and plan your own therapeutic style. A good beginning is to think about:

- Your natural modes and their strengths and cautions
- The modes you want to incorporate into your therapeutic style (including the modes with which you may wish to become more comfortable and proficient)

Your Natural Modes and Their Strengths and Cautions

By examining your Therapeutic Style Form and reflecting on the descriptions of the modes provided in this chapter, you should first decide for yourself the extent to which you are comfortable with each mode. To facilitate this process, you can use the following table to think carefully about the six modes and decide your degree of comfort with each of them.

My natural/preferred mode(s)
Mode(s) I can use when I need to
Mode(s) with which I am less comfortable/less able to use

Next, go back and review Table 4.1, looking at the potential strengths of your preferred mode(s). Each person uses a given mode in different ways, so the actual strengths of your use of a mode depend on how you typically use it. So, reflecting on ***the particular way that you use your preferred mode(s)***, list five key strengths of your therapeutic style.

1. _____
2. _____
3. _____
4. _____
5. _____

Next, examine the cautions of your preferred mode(s) and consider to which of the potential pitfalls of the mode(s) you might be prone. Based on that self-examination, list five key areas of caution for yourself.

1. _____
2. _____
3. _____
4. _____
5. _____

Exercise 4.3

Modes You Want to Incorporate Into Your Therapeutic Style

Now, examine the strengths of the modes that are *not* your preferred modes (either those you listed as "Mode(s) I can use when I need to" or "Mode(s) with which I am less comfortable/less able to use"). Consider whether the strengths of these modes are a good counterbalance to the liabilities of your preferred modes. Based on this consideration, identify the mode(s) you wish to use more naturally and regularly. Record them here.

If the mode(s) you wish to incorporate into your therapeutic style fall in the category of "Mode(s) I can use when I need to," you may wish to make plans for the situations in which you want to practice these modes and monitor your use of them. Record your thoughts here.

If the mode(s) you wish to incorporate into your therapeutic style fall in the category of "Mode(s) with which I am less comfortable/less able to use," you may wish to seek supervision, training, or other kinds of support that would help you develop the ability and comfort with using that mode.

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