CHAPTER 3

A Model of the Intentional Relationship

LEARNING OUTCOMES

3.1 Understand why and how the focus of the occupational therapy relationship is on the client's interpersonal characteristics.

3.2 Explain the role of each of the four central concepts in the Intentional Relationship Model (IRM).

3.3 Articulate how the inevitable interpersonal events and the client's interpersonal characteristics interact to mutually influence one another within the therapeutic relationship.

3.4 Decide which of the six therapist interpersonal modes may be communicated depending on a client's interpersonal characteristics and the inevitable events of therapy.

3.5 Describe how the interpersonal reasoning process allows the therapist to respond to a client's interpersonal characteristics and to the inevitable events of therapy.

3.6 Define the 12 underlying principles of the IRM.

Introduction

The ***Intentional Relationship Model (IRM)*** guides occupational therapy practice by defining therapeutic use of self and thereby outlining an interpersonal reasoning process that therapists may apply when interacting with their clients. Each component of this model describes practical skills that may be applied during actual practice situations. The concepts and skills that comprise the IRM have been empirically validated and tested and are explained in greater detail in subsequent chapters. This chapter provides an overview of the IRM so that readers understand how each of the components relate to one another within the very real, dynamic interaction that characterizes the art and practice of occupational therapy.

Building on what we learned in Chapter 1, ***therapeutic use of self*** calls for a dynamic (i.e., ever-changing), personal, and subjective investment in the client during which the therapist makes moment-to-moment decisions about how to initiate and respond to the client's interpersonal characteristics and reactions to the inevitable events of therapy using six distinct communication approaches. This process of using one's therapeutic self is best summarized as ***interpersonal reasoning;*** it is a highly personal, individualized, subjective decision-making process that is grounded in the disciplined application of a set of concepts aimed

at meeting the client's interpersonal needs. Some may believe that the process is driven by one's emotional reactions to clients and an innate or nurtured intuitive capacity (i.e., reliance on one's "heart"). A smaller set of others perceive the process as largely rational and grounded in the disciplined application of a set of interpersonal guidelines.

Irrespective of such viewpoints, the IRM argues that therapeutic use of self is, in large part, a product of the extent to which one approaches practice intentionally, being ever-vigilant toward keeping one's personal reactions to a client in perspective and, instead, focusing one's attention on the client's reactions to us and to the therapy process. Therapeutic use of self involves prioritizing one's attempts to cultivate an empathic understanding of one's client and applying a knowledge base and interpersonal skill set thoughtfully to common interpersonal events, such as when a client is not engaging in therapy appropriately. Accordingly, therapeutic use of self is an occupational therapy skill that must be developed, reinforced, monitored, and refined. One's personal and emotional reactions to clients must be overseen by and balanced with a rational and self-disciplined application of almost selfless empathy toward the client.

This chapter presents the IRM, a conceptual practice model that operationalizes the processes involved in therapeutic use of self. The rationale, conceptual background, and underlying principles of this model are presented. The model explains how components of the client-therapist relationship interact and are enacted in the face of everyday challenges to that relationship. Finally, this chapter presents a set of core principles that guide the implementation of this model.

CASE EXAMPLE 3.1
Rigel Returns to Meet Mr. Johnson

As we learned in Chapter 1, Mr. Johnson became depressed and withdrawn following a stroke. One of Mr. Johnson's most prominent interpersonal characteristics is his ***communication style,*** which tends to be guarded and reluctant. His first interaction with Rigel resulted in an ***interpersonal event cascade*** (i.e., more than one inevitable interpersonal event occurring in succession during a single session). This was because of a series of missed opportunities in not responding to Mr. Johnson's interpersonal characteristics and to the interpersonal events using the appropriate modes. As you may recall, Rigel decides to end the therapy session early and return another day.

After a long evening of contemplation, Rigel returns to work with Mr. Johnson the following morning. This time, he applies interpersonal reasoning by reflecting upon Mr. Johnson's most striking interpersonal characteristic, his communication style. Knowing that Mr. Johnson uses few words and largely communicates nonverbally, Rigel decides he will not engage with him in a way that would require him to speak a great deal. Also knowing that the interpersonal event of ***resistance*** had happened the day before, Rigel decided that he would need to be exceptionally careful about always communicating within one of the six therapeutic modes. Instead of beginning the session with small talk, he decided to begin the session by using the ***empathizing mode.***

Instead of asserting any type of agenda for therapy that day, Rigel enters the room and simply greets Mr. Johnson by saying:

Rigel: "Remember me?"

Mr. Johnson simply looks up to acknowledge Rigel. Rigel sits down at a bit of a distance, not facing Mr. Johnson. Rigel draws upon the empathizing mode by orienting his body at an angle toward Mr. Johnson in a nonthreatening way that would not imply any expectations or demands. After a few moments pass, Rigel uses the empathizing mode by making the following summary statement, which opened a door for continued communication with Mr. Johnson.

Rigel (using the empathizing mode): "I was really fumbling around trying to offer something therapeutic for you yesterday. I knew that I was heading in the wrong direction, so I thought I would come back again, today, just to acknowledge this."

Mr. Johnson makes an ***intimate self-disclosure:*** "It was not your fault."

Rigel continues with the empathizing mode: "That is generous of you to say. I know I already gave you the lecture, yesterday, about what an occupational therapist does, and I covered some of the

ways I might be able to serve you. Today, we can begin wherever we want."

Mr. Johnson says nothing and gives Rigel a curious glance.

Rigel then enacts the ***collaborating mode:*** "If you don't mind, I'd like to just spend our time together observing you as you go about your day. You can do or not do anything you want."

Mr. Johnson responds: "Nothing we do will make a difference."

Rigel then shifts to the empathizing mode: "I want to understand why you believe this."

(Silence and a ***nonverbal cue*** from Mr. Johnson, who looks down and away from Rigel.)

Rigel continues in the empathizing mode: "I just want to get to know you and learn about anything that you might be thinking or anything that is important to you."

The session continues as Rigel observes Mr. Johnson pull out his smartphone and thumb through what appear to be photos of family and friends. After several moments pass, Rigel continues with the empathizing mode and observes:

"I see that you are looking at photos."

Mr. Johnson makes a second intimate self-disclosure:

"I will be useless to these people now."

Rigel responds by asking a deepening question in a spirit of gentle inquiry (consistent with the empathizing mode): "How were you of use to them before the stroke?"

Mr. Johnson: "I was kind of a handyman. A jack of all trades. People relied on me a lot on the reservation, and I did things even when I wasn't paid."

Rigel (empathizing mode): "Thank you for sharing that with me. It sounds like you are concerned that you may not be able to do the handyman jobs that you used to do, and, therefore, that you will not be useful to those that you care about."

Mr. Johnson: "That's pretty much it. No amount of therapy can give that back to me."

Rigel (empathizing mode): "Having lost so much of your ability to control your muscles and your balance, it makes sense that you would think that your abilities will never improve." (shifting to the ***advocating mode***) "I have worked with a lot of people, and most people whose strokes are so new feel this way."

Mr. Johnson remains silent but gazes at Rigel.

Rigel (shifting to ***instructing mode***): "Mr. Johnson, I cannot tell you how much body function you are going to recover. That is a highly individual outcome that varies from person to person. What I can tell you is that working with me toward some concrete goals, beginning now, during these early days after your stroke, will allow you to gain more function than if you do not participate in therapy."

Mr. Johnson nods affirmatively and responds with an invitation: "You can call me Bart."

Rigel (continuing with the instructing mode): "Now that I know a little bit about what you were doing before your stroke, I would recommend that we work on activities and exercises that will serve as the building blocks toward eventually being able to engage in some handyman work again in the future. The future may seem like a long way away, but we need to get started soon in order to maximize the effects of our work. When we work together, I will be sure to explain how each thing that we are doing would build toward being able to complete handyman work one day."

Mr. Johnson continues to listen but does not respond. His face reveals a blunted affect (an ***interpersonal characteristic***). Therefore, Rigel has difficulty reading his expression.

Rigel: "Are you willing to try with me?"

Mr. Johnson: "The doctor told me that recovery is mainly a function of time . . . that it is a waiting game."

Rigel (asks a rhetorical question consistent with the instructing mode): "Did the doctor not explain how therapy can speed the process of recovery?"

Mr. Johnson: "No."

Rigel (instructing mode): "The healing process of the human brain occurs both inside and outside of the body. The brain is not a static organ. It changes and can heal itself, to some degree, depending on whether and how much we exercise it. What a person does while he is healing and how he interacts with the people and objects within his environment can make a big difference—not only in the speed with which he recovers function but also in the extent to which he recovers function."

Mr. Johnson: "OK. I'm tired now."

Rigel (instructing mode): "Yes, and we are out of time. I look forward to continuing our work tomorrow."

Explaining the Therapeutic Relationship: Need for a Conceptual Practice Model

As noted in Chapter 1, there has been discussion of the therapeutic use of self throughout occupational therapy's history. Although numerous recommendations have been made regarding the requisite training, characteristics, feelings, and behaviors necessary for effective interpersonal practice in occupational therapy, until the IRM, these recommendations had not been integrated into a coherent explanation. Moreover, there are few details about how the therapeutic relationship should be approached and managed in light of the field's central focus on the client's engagement in occupation. Educators, supervisors, students, and staff may benefit from a vocabulary with which to discuss and describe the interpersonal phenomena that have an ongoing impact on everyday practice.

The central question that a conceptualization of the therapeutic relationship in occupational therapy must answer is: How can one's therapeutic use of self be utilized specifically to promote occupational engagement and promote positive therapy outcomes?

The IRM is intended as a conceptual practice model (Kielhofner, 2008). It was developed to explain the therapeutic use of self in occupational therapy and how that relationship can facilitate or hinder a client's occupational engagement. The model is designed to guide interpersonal reasoning for addressing dilemmas and challenges to the therapeutic relationship that arise in everyday practice. Finally, the model illustrates how best to develop relationships that embrace the fundamental values and ethics of occupational therapy practice.

FIGURE 3.1 Client-therapist relationship in traditional psychotherapy.

Conceptual Background for the Model: How Therapeutic Use of Self in Occupational Therapy Differs From Psychotherapy

Many of the concepts for the IRM have their origins in theory underlying psychotherapy. However, as introduced in Chapter 1, the IRM recognizes a fundamental difference between occupational therapy and psychotherapy. Figure 3.1 portrays the traditional psychotherapy process. As it shows, interpersonal relating between client and therapist is the central focus. Moreover, interpersonal communication is typically the only activity that occurs during psychotherapy.

In occupational therapy, particularly when conducted outside of mental health settings, the client-therapist relationship should not pretend to emulate the intensity, duration, and complexity of a psychotherapy relationship. The central focus of psychotherapy is symptom reduction and psychological change. The central focus of occupational therapy is occupational engagement. The unique role that the therapeutic relationship plays in occupational therapy is diagrammed in Figure 3.2.

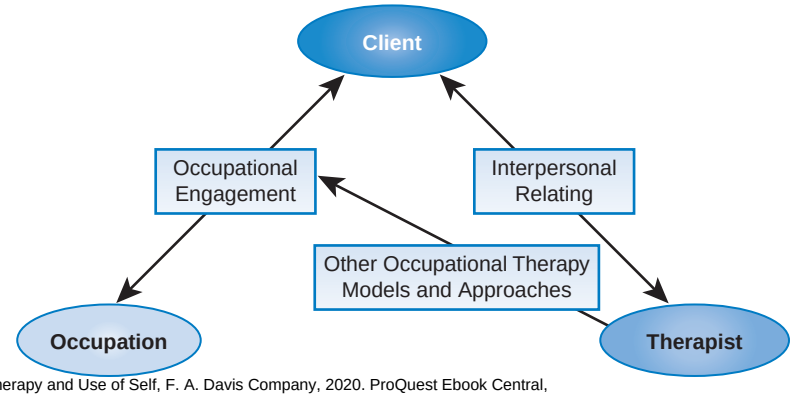

FIGURE 3.2 Unique relationship between client, therapist, and occupation in occupational therapy.

As shown, the occupational therapist employs several therapeutic strategies, usually rooted in existing models of practice, to facilitate the client's engagement in occupation. Depending on the occupational needs, capacities, and diagnosis of the client, any number of occupational therapy practice models might be employed alone or in combination to promote occupational engagement. However, this main task of promoting occupational engagement through employing the specific methods and strategies of occupational therapy does not exist in isolation of a larger process of relating that occurs between client and therapist.

The IRM explains the relationship between client and therapist that is part of the overall process of occupational therapy. Accordingly, the model is intended to complement existing occupational therapy conceptual practice models rather than to replace any single model. It explains the detailed and overarching aspects of the client-therapist relationship, an aspect of occupational therapy not addressed by other practice models in as much detail or as the sole focus. Figure 3.3 shows how the intentional relationship is designed to supplement the use of other occupational therapy conceptual practice models. As shown, the IRM should complement the usual concepts and strategies of occupational therapy that are directly aimed at facilitating occupational engagement.

The model's utility for occupational therapy lies in addressing the otherwise unarticulated aspects of the interpersonal relationship that occur during the therapy process and that influence both occupational engagement and therapy outcomes. If a therapist utilized only this model, the essential work of occupational therapy would not occur. Instead, the model was designed to fill a gap in our practical knowledge about how to manage the interpersonal aspects of therapy, particularly the more challenging ones. This model should complement the field's existing methods and models by making the process of establishing a successful relationship with clients easier, clearer, and more straightforward. The next section defines the elements of this model and provides an explanation of how the elements interact to optimize the circumstances for a successful client-therapist relationship in occupational therapy.

Elements of the Intentional Relationship Model

The IRM views the therapeutic relationship as being comprised of four central elements.

1. The client's interpersonal characteristics
2. The inevitable interpersonal events that occur during therapy
3. The therapist's use of self (i.e., mode use, interpersonal skill base, and ability to apply interpersonal reasoning)
4. Occupational engagement, which is viewed as the mechanism of change

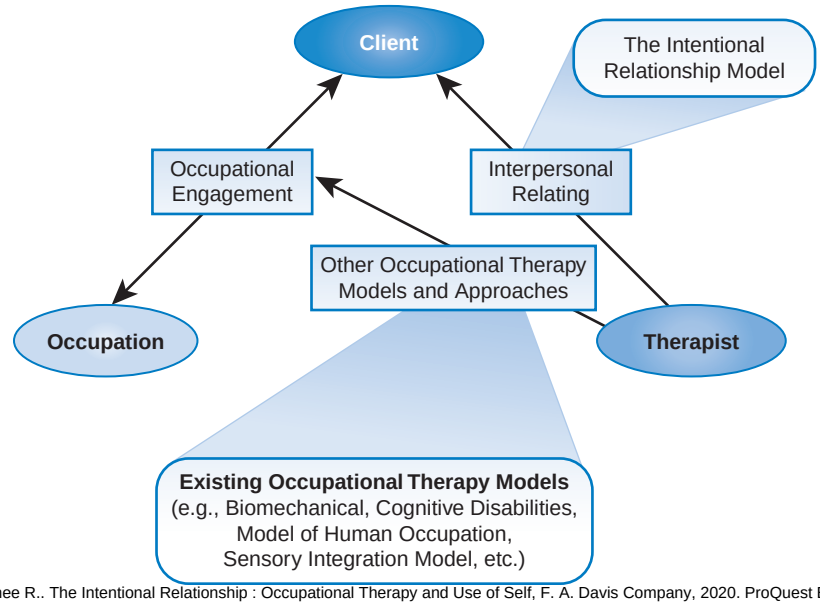

FIGURE 3.3 Intentional relationship model as a complement to existing occupational therapy models.

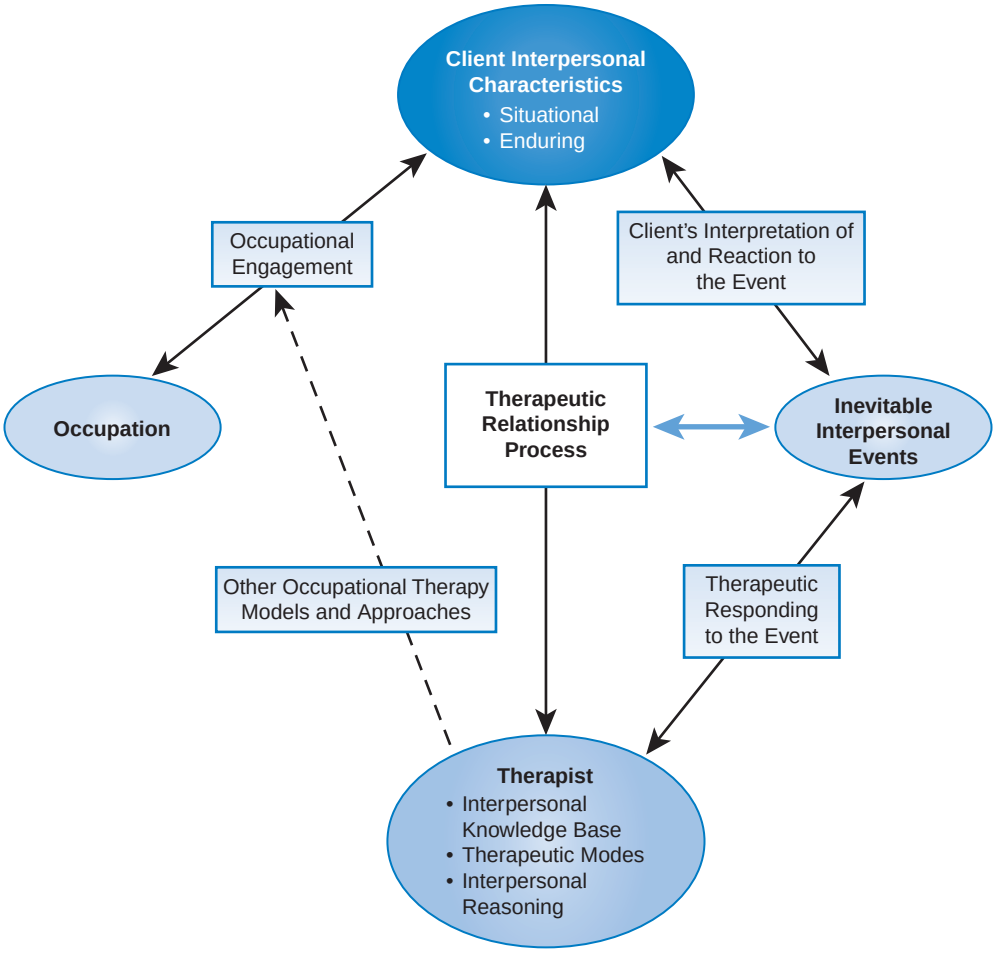

FIGURE 3.4 Model of the intentional relationship in occupational therapy.

A summary diagram of the model is presented in Figure 3.4. The model explains the requirements for a productive client-therapist relationship. It incorporates guidelines for responding to each client's unique interpersonal characteristics and to the interpersonal events that commonly occur during therapy. The relevant aspects of each element of the model and their relations with one another are described in the section that follows.

The Client's Interpersonal Characteristics

According to the IRM, achieving an empathic understanding of the client is the focal point of effective use of self in occupational therapy. It is the therapist's responsibility (rather than the client's) to develop a working and predictable communication with the client and to respond appropriately when interpersonal events occur. To develop this relationship and respond appropriately to the client, a therapist must work to understand the client from an interpersonal perspective. This involves getting to know the client as an interpersonal being. The IRM calls for us to understand the most salient interpersonal characteristics of our clients as they present themselves during occupational therapy.

The IRM asks us to strive to know our clients' interpersonal characteristics and behaviors within 14 categories. The most critical aspect of understanding our clients as interpersonal beings involves a therapist's recognition of characteristics that make it more challenging to communicate and relate with the client. Table 3.1 includes the

Table 3.1 **The 14 Categories of Interpersonal Characteristics**

Interpersonal Characteristic	Example
Communication style	A hyperverbal client talks so much that the therapist feels that there is no room for a response.
Tone of voice	An authoritative client speaks in a low and tense tone of voice, clipping her words.
Body language	A client folds his arms and casts his eyes downward.
Facial/postural expression (affect)	A client's lips are pursed and her shoulders are tight when she recollects a conflict that occurred with her daughter just before the accident.
Response to change and challenge	Each time he is presented with something new, a client admits that he is not sure he will be able to perform the task.
Level of trust	A client watches the therapist with a cautious expression and occasionally appears uncomfortable with certain personal hygiene activities, questioning the purpose of engaging in these activities.
Need for control	A client appears unconcerned about therapy, does not have any goals, and passively complies with all instructions.
Approach to asserting needs	A client is cold and would be more comfortable if she had her sweater, which she left in another room. She shivers through the rest of the session because she does not want to impose on or interrupt the therapist.
Predisposition to giving feedback	A client drops hints about what he would rather be doing but cannot come out and suggest to the therapist that they do something different.
Response to feedback	A client has been disruptive and disrespectful toward others during a group therapy session. When the therapist informs the client of how she is experiencing the client's behavior, the client bursts into tears and abruptly leaves the room.
Response to human diversity	A client comments to the therapist that he looks very young and, despite the therapist having introduced himself as "Dr. Yamamoto," the client asks him when he will be graduating and to whom he is reporting.
Orientation toward relating	A client does not respond to the therapist's attempts to break the ice with small talk and, instead, asks the therapist about the treatment agenda and expected outcomes.
Preference for touch	A therapist innocently places a hand on a client's shoulder in an attempt to reassure her during a cooking task. The client immediately recoils from the therapist's touch.
Interpersonal reciprocity	At the beginning of the session, a client asks the therapist how her day is going, and at the end of the session, the client reminds the therapist of how instrumental she has been during the rehabilitation process.

14 categories of interpersonal characteristics. Each category may be a product of the situation (i.e., situational) or a more stable interpersonal style (enduing). Each characteristic is accompanied by an example of what would indicate a need for closer attention from the therapist.

Our understanding of each of these characteristics should not be approached from a strengths versus liabilities perspective; the IRM is not interested in stigmatizing or pathologizing clients. Instead, the IRM calls for us to understand the interpersonal characteristics of our clients that may be most salient in terms of facilitating or interfering with the client's ability to do one or both of the following:

- Effectively communicate and relate to the therapist
- Engage in whatever occupation is the focus of therapy

According to the IRM, each of these 14 interpersonal characteristics may also be understood along two dimensions:

- Situational
- Enduring

PRACTICAL APPLICATION 3.1

Mr. Johnson (described in Chapter 1 and also featured in the case example earlier in this chapter) offers one example of a person exhibiting several situational interpersonal characteristics. Before his stroke, he was described as an outgoing and sociable person who enjoyed his work and achieved a sense of value from helping family and friends in his spare time. Following his stroke, he exhibited a flat and occasionally angry ***affect,*** and his communication style was guarded and reluctant. These interpersonal characteristics are new and unusual for him and may be attributable to any number of changes that have taken place since the stroke. These might include the neurophysiological effects of the stroke itself, a sense of loss associated with functional decline and impairment, and a sense of lowered self-efficacy or even shame.

Situational Interpersonal Characteristics

When one or more of the 14 client interpersonal characteristics referenced in the preceding paragraph is described as ***situational,*** it means that the characteristic is generally inconsistent with how a client typically and consistently behaves when interacting with others. Instead, a situational characteristic reflects a client's acute behavior or reaction to a specific situation. Situational characteristics that interfere with communication or occupational engagement are most likely to reveal themselves when the client is facing a situation where some immediate aspect of the impairment or the environment is experienced as painful, frustrating, or stressful. Impairments, particularly when they are new or when there is a medical crisis or exacerbation in severity that disrupts one's usual routines or relationships, often cause people to experience stress. Therapists are encouraged to assume, on some level, that a client's impairment situation or the client's interaction with an unaccommodating or difficult environment causes the client to be more vulnerable to experiencing a variety of reactions, many of which may be perceived as negative or at least atypical for that individual.

Feelings of loss are common among newly disabled individuals, and they may manifest in terms of sadness, irritability, anxiety, insecurity, or anger. A health provider's interpersonal behavior, if perceived as insensitive, judgmental, or uncaring, may also serve as a source of stress and cause the client to interact in a manner that is generally inconsistent with his or her usual way of relating. It is important for new therapists to recognize that these and other acute emotional reactions are normative. In fact, they are "givens" in many health-care situations. They may bear no reflection on the client's character. However, they do have the potential to play out within the therapy relationship, and the way in which a therapist chooses to respond to them is often vital to the future of that relationship (Fig. 3.5).

Enduring Interpersonal Characteristics

By contrast, ***enduring characteristics*** are more stable and consistent aspects of the client's interpersonal behavior. Unlike a situational characteristic, enduring characteristics are not necessarily related to the situation of acquiring an impairment, an acute reaction during a brief moment of distress, or to problems in the environment, such as the lack of appropriate accommodations. Instead,

FIGURE 3.5 The client is the focal point.

PRACTICAL APPLICATION 3.2

As explained in Chapter 1, one of Vera's most salient interpersonal characteristics is her high need for control. Vera attempts to direct the therapy session from the moment she meets Erika. She asks Erika numerous questions testing her expertise in the area of cancer and insists on talking about cancer treatment and rehabilitation. Moreover, she occasionally confronts Erika when she does not hear an opinion that aligns with her own. A second characteristic is Vera's hyperverbal communication style. This characteristic presents itself in Vera's constant talking during her interaction with Erika. A third characteristic is Vera's capacity for trust. She is equivocal about Erika's credibility and capacity to serve as her occupational therapist. This drives her to behave in an almost interrogational manner. Although we only have a single interaction during which to ascertain whether these characteristics are situational or enduring, we do know from Chapter 1 that Vera has also been described by her friends as being driven, skeptical, a talker, and strong minded. These characteristics may serve Vera in most contexts, but they have emerged as being problematic for both Vera and Erika during their initial meeting.

enduring characteristics are more deeply rooted, typically emerge repeatedly through time, and comprise an interpersonal profile that is idiosyncratic to the client.

Because they coexist in each client, situational and enduring characteristics are mutually informative. Behavior that reflects one's acute emotional reaction to a stressful event may temporarily attenuate, alter, or intensify one's interpersonal behavior in what are usually more stable categories. For example, a client who normally responds to a challenging situation adaptively may become irritated when the therapist recommends a more challenging activity if, earlier in that day, the client underwent a painful biopsy and then discovered she did not have enough money to cover the insurance copay fees upon leaving the physician's office. Irrespective of whether an interpersonal characteristic is situational or enduring, characteristics that are more challenging to work with make it difficult for clients to engage in occupations as planned. The rationale for distinguishing the two categories of interpersonal characteristics is to help inform therapists' understanding of the client in stressful and nonstressful situations so therapeutic responses can be appropriately tailored and modulated. Both situational and enduring client characteristics and how to assess them are described in more detail in Chapter 5.

Interpersonal Events of Therapy

An ***interpersonal event*** is a naturally occurring communication, reaction, process, task, or general circumstance that occurs during therapy and that has the potential to detract from or strengthen the therapeutic relationship. The therapist's ability to recognize the interpersonal event when it occurs and respond therapeutically determines

- Whether additional interpersonal events will follow, possibly prompting an interpersonal event cascade
- The effect that the event, and its resolution (or nonresolution), will have on the overall relationship with the client

The IRM describes 12 types of interpersonal events that will inevitably occur during therapy, depending on the client, the therapist, and the therapeutic context. Table 3.2 presents the different event categories (along with examples of what would require the therapist's closer attention).

PRACTICAL APPLICATION 3.3

In the case example at the beginning of this chapter, the many nonverbal cues evident during the interaction between Mr. Johnson and Rigel were significant moments during Mr. Johnson's communication and may be interpreted as interpersonal events. Additionally, when Mr. Johnson mentioned to Rigel that it wasn't his fault that their interaction the day before was not productive, another interpersonal event occurred: an intimate self-disclosure. Mr. Johnson admitted to Rigel that he was responsible for the interaction having gone poorly.

During therapy, interpersonal events such as these may be precipitated by the following circumstances.

- A client's interpersonal characteristics or reactions to something inside or outside of the therapeutic context
- The therapist's behavior (e.g., the therapist makes a suggestion or asks a question that the client perceives as intrusive or emotionally difficult)

These examples are only a few of the myriad possible interpersonal events that occur during the course of occupational therapy (Fig. 3.6).

When interpersonal events of therapy occur, their interpretation is a product of the client's unique set of

Table 3.2 **Interpersonal Events That May Occur During Therapy**

Event	Example
Expression of strong emotion	An elderly client begins crying during transfer training or a child client runs up to the therapist and hugs her in the midst of sensory motor activity.
Intimate self-disclosures	A client reveals something personally significant.
Power dilemmas	A client insists on a goal that the therapist believes is not attainable, or the therapist recommends a goal that the client rejects.
Nonverbal cues	A client communicates something significant through body language.
Verbal innuendos	A client makes a general statement about "how young all of the health-care staff seem these days." The therapist happened to look very young, and the client may have been insinuating that the therapist was one among all of the "young health-care staff."
Crisis points	Something critical occurs in the client's personal life or something about the client's health status changes, and it has an effect on the client's ability to engage in therapy.
Resistance and reluctance	A client is unwilling to engage in therapy.
Boundary testing	The client invites the therapist to attend her wedding.
Empathic breaks	The client is offended by a seemingly innocent comment made by the therapist.
Emotionally charged therapy tasks and situations	A client is embarrassed because of losing bladder control or becomes frustrated or fearful in the midst of an activity.
Limitations of therapy	A client needs a piece of equipment that is unavailable within the therapeutic environment.
Contextual inconsistencies	The location of the therapy session changes.

FIGURE 3.6 Kathryn Loukas and a client pause to discuss a difficult circumstance during therapy.

interpersonal characteristics and reactions in the moment. Sometimes the event has a significant effect on the client, whereas at other times a client is unaffected or minimally affected. When such events occur, it is important that the therapist be aware that the event has occurred and take responsibility for responding appropriately. The therapist should not overreact or underreact to the event. Instead, the therapist should watch for any cues from the client and listen to anything that the client may say about the event that could prompt a certain type of response from the therapist.

Interpersonal events are:

- Inevitable during the course of therapy
- Ripe with both threat and opportunity

Interpersonal events are part of the constant give and take that occurs during a therapy process. They are distinguished from other events or processes in that they are charged with the potential for an emotional response either when they occur or later upon reflection. Consequently, if they are ignored or responded to less than optimally, these events can threaten both the therapeutic relationship and the client's occupational engagement. When optimally responded to, the events can provide opportunities for positive client learning or change and for solidifying the therapeutic relationship. Chapter 2 presented a series of therapists' stories about particularly challenging moments of therapy. Each was an example of a significant interpersonal event. Chapter 6 describes and gives examples of interpersonal events that have been found from our observations to occur with a high level of frequency in occupational therapy. Because they are unavoidable in any therapeutic interaction, one of the primary tasks of a therapist practicing according to the IRM is to respond to these inevitable events in a way that leads to repair and strengthening of the therapeutic relationship.

The Therapist's Use of Self

Within the IRM, the therapist is responsible for making every reasonable effort to make the relationship work through effective communication and interaction with the client. This requires a tremendous amount of self-discipline and empathy, particularly when clients are not at their best. Specifically, the therapist is responsible for bringing three main interpersonal capacities into the relationship.

- An interpersonal skill base
- Therapeutic modes (or interpersonal styles)
- Capacity for interpersonal reasoning

This section provides a brief description of each of these interpersonal capacities. The first capacity involves development and application of a wide-ranging interpersonal skill base.

PRACTICAL APPLICATION 3.4

Let's revisit an example from the suboptimal interaction between the occupational therapist, Erika, and her client, Vera, presented in Chapter 1. As you may recall, several interpersonal events occurred during that interaction, in rapid succession. According to the IRM, this is referred to as an interpersonal event cascade.

The first interpersonal event was ***boundary testing.*** Vera asks Erika numerous questions to test her credibility, including whether she has had *personal experience* with breast cancer. This was followed by an intimate self-disclosure on the part of the therapist, when Erika revealed to Vera that her grandmother had pancreatic cancer. This disclosure was impulsive and not well planned. Instead, it represented a reactionary attempt on Erika's part to prove to Vera her legitimacy as a cancer expert. Instead of quelling the situation, the disclosure prompted a nonverbal cue, followed by a ***power dilemma*** that ended poorly with an ***empathic break.***

Boundary Testing

Clients will certainly ask personal questions of their therapists, but they are not necessarily entitled to know the answers. Asking about a therapist's health history, for example, is confidential information. By doing this, Vera put Erika in an awkward position, leaving her with a few choices to respond—some therapeutic and others suboptimal.

Therapeutic Responses

One example of a therapeutic response involves making an educated guess, or a construal that gives words to Vera's troublesome behavior that includes pausing and sharing with Vera how she is experiencing the questioning. Erika might say, "Vera, you have a lot of questions for me. I am wondering if you have concerns about whether I have enough knowledge and experience to understand your unique experience with cancer." Another therapeutic response that does not involve interpreting Vera's behavior may involve answering all Vera's questions about cancer except for her personal question. If Vera persists, Erika could set a limit, such as:

"Vera, I appreciate that you would like to know about me and about any personal experience I have had with cancer. As a rule, I do not disclose this kind of personal information to the people I work with because I feel that the focus of my work should be on understanding your unique experience, rather than trying to relate any experience I or a loved one may have had to your experience."

One may ask why Erika's refusal to answer Vera's question could be more therapeutic than what she actually did, which was to disclose her grandmother's experience with pancreatic cancer. The reason that withholding this information would have been more therapeutic than disclosing it lies in three of the underlying principles of the IRM: Principle 2: Interpersonal Self-Discipline Is Fundamental to Effective Use of Self, Principle 3: It Is Necessary to Keep Head Before Heart, and Principle 4: Mindful Empathy Is Required to Know Your Client. These and the other 10 underlying principles of IRM are discussed in further detail at the end of this chapter.

Suboptimal Response

In the actual interaction, Erika engaged in another interpersonal event, an intimate self-disclosure, by responding to Vera's question with a brief personal disclosure that her grandmother had pancreatic cancer. This response was suboptimal for two reasons. First, from Vera's perspective it did not add to her credibility as someone with expertise in cancer. Erika's brief mention that her grandmother had pancreatic cancer really did not do justice to the hours she spent caring for and spending time with her grandmother as she was receiving treatment and also during her period of palliative care. Erika did not have the opportunity to share the range of painful emotions she experienced during her grandmother's cancer experience, nor did she have the chance to explain the ways in which she gained extensive knowledge about cancer, cancer treatments, and cancer rehabilitation. Importantly, Erika did not have the chance to explain how the experience of caring for her grandmother and sharing in her cancer experience strengthened her character and gave her a new perspective about living as well as dying.

At the same time, sharing all this information would have taken time out of the therapy session

and would have taken the focus off of Vera and her unique experience of cancer. Therefore, the best responses would have been those described as therapeutic in the preceding paragraphs.

Nonverbal Cue

An interpersonal event that took place following Erika's disclosure involved a nonverbal cue. Rather than saying something compassionate or empathetic, Vera was not satisfied with Erika's disclosure and, instead, stared blankly.

Therapeutic Response

At this point one example of a therapeutic response might have involved asking about the nonverbal cue. Knowing that one of Vera's central interpersonal characteristics involves a ***high need for control,*** Erika might have said, "I am wondering if my responses are not hitting the mark for you? I am wondering if there is anything else I can do to help understand your experience and to show you how I might be able to support your rehabilitation?" By venturing an interpretation of Vera's blank look and asking a question such as this, Erika would have reasserted her central goal, which was to understand Vera's cancer experience. Additionally, it would have allowed Erika to maintain an appropriate (and, in this case, necessary) leadership role within the therapeutic relationship, limiting the extent to which Vera could continue her excessive questioning.

Suboptimal Response

Erika either did not recognize Vera's blank stare as a nonverbal cue or chose not to respond to it. This allowed Vera to continue to challenge Erika's credibility and assume a more dominant position within the interaction. In many cases, it is desirable when our clients take charge within the therapeutic relationship. Participation and independence are among the core values of our profession. However, there are situations in which a client may assert dominance during an interaction in a way that is uncomfortable, condescending, or overly assertive. The interaction between Vera and Erika is one such circumstance.

Power Dilemma

Unabated, Vera continues questioning and confronting Erika whenever she feels that she is avoiding a question or does not have the correct answers about cancer treatment and rehabilitation. Erika tries to avoid openly arguing with Vera, but she now feels as if she is trapped within an uncomfortable interaction. The undercurrent to Vera's behavior is that she is angry and unhappy about the fact that her breast cancer and all the requisite treatments have interrupted her life and functioning. Because she has always felt in control of her own destiny and now feels out of control, Vera is having difficulty not lashing out at others around her.

Therapeutic Response

At this point, Erika should attempt to stop the negative dynamic in order to avoid the occurrence of additional interpersonal events and the possible deterioration of a new relationship with her client. To do this, she might say something such as, "I am getting the feeling that my responses to your questions are not aligning with your experience. I am wondering if there is anything else I can do to help understand your experience and better support your experience here?"

Suboptimal Response

Erika thought she was being as kind and empathetic as possible with Vera by actively ignoring her overly assertive questions and provocative comments. Instead, Vera experienced Erika's behaviors as dismissive, and her passivity only stoked Vera's need for control and dominance.

Empathic Break

Having been pushed to the limits of her patience, Erika communicated an empathic break by introducing a research article touting the virtues of chemotherapy to Vera. She missed or ignored the fact that Vera did not respond and only learned that Vera did not appreciate the therapy session when her supervisor informed her that Vera had requested to work with a different therapist.

In summary, Erika missed several opportunities to interrupt the interpersonal event cascade that developed with Vera. Had she learned and practiced the skills and concepts of the IRM, she might have approached the interaction with a greater level of intentionality and a more therapeutic approach to developing an empathetic understanding of her client.

Interpersonal Skill Base

The therapist's ***interpersonal skill base*** comprises a continuum of skills that are judiciously applied by the therapist to build a functional working relationship with the client. The perspective of the model is that, depending on the unique experiences, knowledge, and innate capacities of the therapist, some of these skills come naturally whereas others require significant effort and practice to develop.

These interpersonal skills are summarized in terms of nine categories.

- Therapeutic communication
- Interviewing skills and strategic questioning
- Establishing productive relationships with clients
- Working effectively with spouses, partners, families, social systems, and groups
- Working effectively with supervisors, employers, and other professionals
- Understanding and managing difficult interpersonal behavior
- Resolving empathic breaks and conflicts
- Professional behavior, including maintaining appropriate interpersonal boundaries, values, and ethics
- Therapist self-care and professional development

The first category, therapeutic communication, involves activities such as verbal and nonverbal communication skills, therapeutic listening, assertiveness, providing clients with direction and feedback, and seeking and responding to client feedback. Interviewing skills comprise another skill set that involves being watchful and intentional about the way in which one approaches the process of asking a client questions. Strategic questioning is a specific approach to questioning born out of cognitive psychology (e.g., Beck, 1995). It involves asking questions in a way that guides the respondent to think more broadly or differently. Establishing relationships with clients includes rapport building, matching your therapeutic style to the interpersonal demands of the client, managing a client's strong emotion, judicious use of touch, understanding the roles of spiritual and religious diversity in occupational therapy, and cultural sensitivity.

Because many clients have spouses or partners, caregivers, family members, or other individuals with whom they have regular contact, understanding and working with families, social systems, and groups is an essential aspect of occupational therapy practice. It includes using the guiding principles of IRM in combination with prominent systems theories to gain the collaboration of partners, parents, other family, and friends to serve the goals of therapy. It also involves understanding the structure, process, and interpersonal dynamics of group therapy.

Another fundamental skill involves knowing how to work collaboratively with supervisors, employers, and other professionals. It involves knowing how to communicate with other professionals about clients both in the presence and in the absence of those clients. Additionally, it requires understanding the power dynamics and value systems that underlie supervisor and student, as well as employer and employee, relationships. Understanding and managing clients' difficult behavior is another category of necessary interpersonal skills required in many practice situations. It involves knowing how to respond effectively to behaviors that involve manipulation, excessive dependence, symptom focusing, resistance, emotional disengagement, denial, difficulty with rapport and trust, and hostility. Responding effectively helps limit the extent to which this behavior disrupts the goals and processes of therapy.

Knowing how to resolve conflicts and empathic breaks (or rifts in understanding between client and therapist) is another fundamental skill set that can salvage a failing relationship or repair minor threats to an otherwise functional relationship. Professional behavior and ethics encompass knowledge of how your own values are consistent or inconsistent with the occupational therapy core values, ethical behavior and decision-making, behavioral self-awareness around clients, being reliable and dependable, upholding confidentiality, and setting and managing professional boundaries. Therapist self-care incorporates knowing and managing your own emotional reactions to clients and being accountable to those reactions, a general capacity for self-reflection, an ability to manage your personal life and seek support when necessary, and the capacity to maintain perspective regarding client outcomes. More information about all these skills, which comprise a therapist's interpersonal skill base, is provided in Chapters 8 through 16 (Fig. 3.7).

Therapeutic Mode Use

The second interpersonal capacity that a therapist brings to the client-therapist relationship is her or his primary therapeutic mode or modes. A ***therapeutic mode*** is a specific way of relating to a client. The IRM identifies six therapeutic modes: advocating, collaborating, empathizing,

FIGURE 3.7 Therapists such as Jane Melton assume responsibility for developing a wide range of interpersonal skills to be used in therapy.

encouraging, instructing, and problem-solving. Therapists naturally use therapeutic modes that are consistent with their fundamental interpersonal characteristics. For example, a therapist who tends to be more of a listener than a talker in everyday life and believes in the importance of understanding another person's perspective before making a suggestion would likely utilize empathizing as a primary therapeutic mode in therapy. Therapists vary widely in terms of the range and flexibility with which they use modes in relating to clients. Some therapists relate to clients in one or two primary ways, whereas others draw upon multiple therapeutic modes depending on the interpersonal characteristics of the client and the situation at hand.

One of the goals in using the IRM is to become increasingly comfortable utilizing any of six of the modes flexibly and interchangeably depending on the client's needs. A therapeutic mode or set of modes define the therapist's general interpersonal style when interacting with a client. Therapists able to utilize all six of the modes flexibly and comfortably and to match those modes to the client and the situation are described as having a multimodal interpersonal style.

According to the IRM, a therapist's choice and application of a particular therapeutic mode or set of modes should depend largely on the enduring interpersonal characteristics of the client. In addition, certain events or interpersonal events in therapy may call for a mode shift. A ***mode shift*** is a conscious change in one's way of relating to a client. Mode shifts are frequently required in response to interpersonal events in therapy. For example, if a client perceives a therapist's attempts at problem-solving to be insensitive or off the mark, a therapist would be wise to switch from the problem-solving mode to an empathizing mode so he or she can better understand the client's reaction and the root of the dilemma. An interpersonal reasoning process, described in the paragraph that follows, can be utilized to guide the therapist in deciding when a mode shift might be required and determining which alternative mode to select. Because the interpersonal aspects of occupational therapy practice are complex and require a therapist to have a highly adaptive therapeutic persona, the IRM recommends that therapists learn to draw upon all six of the therapeutic modes in a flexible manner according to the interpersonal needs of each client and the unique demands of each clinical situation (Fig. 3.8).

In addition to the practical application seen in the case example, a brief synopsis of each mode and examples

FIGURE 3.8 Multimodal therapists such as Michele Shapiro are able to answer a variety of interpersonal demands in therapy.

of how Jane Melton (from Chapter 2) used each mode in practice are presented in Table 3.3. According to the IRM, the six modes are a central aspect of the therapist's skill set, and they are defined and elaborated on in more detail in Chapter 4.

Interpersonal Reasoning

The third therapist interpersonal competence involves the capacity to engage in an interpersonal reasoning process when an interpersonal dilemma presents itself in therapy. Interpersonal reasoning is a stepwise process by which a therapist decides what to say, do, or express in reaction to the occurrence of an interpersonal dilemma in therapy. It includes developing a mental vigilance toward the interpersonal aspects of therapy in anticipation that a dilemma might occur and a means of reviewing and evaluating options for responding. A full description of the steps of interpersonal reasoning and examples of its application in practice are provided in Chapter 7.

PRACTICAL APPLICATION 3.5

In the case example at the beginning of this chapter, Rigel uses four of the six modes effectively to resolve the earlier rift with Mr. Johnson that occurred in Chapter 1. He begins the session by remaining in the empathizing mode for a long period of time. He orients his body toward the client in a way that is not threatening, admits that he was not very useful to the client in the previous session, and openly tells the client on multiple occasions that he wants to better understand why he thinks and feels the way that he does. Additionally, Rigel shifts briefly into the collaborating mode early in the session when he suggests to Mr. Johnson that he will observe him doing "anything he wants." There is also a brief moment in which Rigel shifts to the advocating mode in order to normalize Mr. Johnson's feelings of demoralization and doubt. After a substantial amount of time is spent asking Mr. Johnson deepening questions and summarizing his understanding, Rigel shifts into the instructing mode in order to educate Mr. Johnson about the effects of neurorehabilitation efforts on stroke recovery.

In summary, Rigel used interpersonal reasoning to make multiple mode shifts during the interaction that effectively promoted a more truthful and trusting communication with Mr. Johnson.

Desired Occupation

As noted earlier, occupational therapy is unique in that the crux of the therapy process is the client's occupational engagement. The ***desired occupation*** is the task or activity the therapist and client have selected for therapy. Desired occupations may include a wide range of tasks and activities, such as dressing oneself, driving, shopping, gross motor play, participating in a goal-setting group, completing a craft activity, or engaging in a simulated or modified work task. The selection of the occupation and support for occupational engagement is primarily informed by other occupational therapy conceptual practice models such as the Biomechanical Model, the Sensory Integration Model, or the Model of Human Occupation (Kielhofner, 2008).

The primary function of IRM is to enable the therapist to manage the interpersonal dynamic between the client and the therapist that also occurs as part of the therapy process. This interpersonal dynamic influences the occupational engagement and also serves as an arena in which the emotional

Table 3.3 **Brief Definitions of Therapeutic Modes and Practice Examples From Jane Melton**

Mode	Definition	Example
Advocating	Ensuring that the client's rights are enforced and resources are secured. May require the therapist to serve as a mediator, facilitator, negotiator, enforcer, or other type of advocate with external persons and agencies.	Lobbying to secure adequate resources for the provision of ongoing support and environmental adaptation. This enabled a man with learning disabilities to participate safely in self-care and domestic activities in his own home environment.
Collaborating	Expecting the client to be an active and equal participant in therapy. Ensuring choice, freedom, and autonomy to the greatest extent possible.	Facilitating a man to set his own recovery-oriented occupational goals after undergoing an inpatient detoxification program for alcohol misuse.
Empathizing	Ongoing striving to understand the client's thoughts, feelings, and behaviors while suspending any judgment. Ensuring that the client verifies and experiences the therapist's understanding as truthful and validating.	Taking care to summarize and acknowledge the occupational requests and sensitivities of a woman experiencing psychotic symptoms. This approach enabled her to reclaim her values of being a vegan and being very environmentally conscious throughout her therapeutic recovery experience.
Encouraging	Seizing the opportunity to instill hope in a client. Celebrating a client's thinking or behavior through positive reinforcement. Conveying an attitude of joyfulness, playfulness, and confidence.	Spontaneously responding to a woman attending an occupational therapy group session who, inspired by some background music, started to dance. Therapeutic connection was enhanced by this small gesture to join with her joy of the activity.
Instructing	Carefully structuring therapy activities and being explicit with clients about the plan, sequence, and events of therapy. Providing clear instruction and feedback about performance. Setting limits on a client's requests or behavior.	Enabling a withdrawn woman with little belief in her own abilities to undertake self-care activities. This was achieved by talking the woman through the task, all the while verbally reinforcing the correct approach to the task, if required.
Problem-solving	Facilitating pragmatic thinking and solving dilemmas by outlining choices, posing strategic questions, and providing opportunities for comparative or analytical thinking.	Analyzing options for a young man with Asperger syndrome to undertake the activities of value to him that also supported his well-being. This involved analyzing pros and cons of different activities and negotiating with his family, who were concerned about his extraordinary choices of some occupations and his neglect of others.

reactions that stem from or influence occupational engagement can be positively managed. Thus, according to the IRM, the therapeutic relationship has two functions.

- A support to occupational engagement
- A place where the emotions and coping process associated with the client's impairment and its implications for occupational participation can be addressed

Relationships Within the Model

According to the IRM, the client and therapist relationship can be viewed at two levels or scales.

- The usual therapeutic relationship process that consists of the ongoing rapport and patterns of interaction between the client and therapist. This relationship is enduring, and it occurs outside of any unusual circumstances or stressors (macro level).
- The therapeutic relationship process that is influenced by interpersonal events of therapy or the stressors or highlights that have the potential to challenge or enrich the relationship depending on how they are responded to and resolved (micro level).

The ***therapeutic relationship*** is a socially defined and personally interpreted interactive process between the therapist and a client. It is socially defined in that the therapist and the client are engaged in an interaction within publicly understood roles. The therapist is recognized as bringing a certain kind of expertise, ethical guidelines, and values into a relationship. The client is recognized as a person receiving service to address a particular need. The relationship is understood to exist for the sole purpose of achieving improvement in the client's situation. These parameters are given and provide an important definition of the relationship. Therapist and client are in a particular relationship that can be differentiated from other kinds of relationships such as friendships. At the same time, this relationship has a personal side. The client and therapist are human beings who encounter each other with the same potential range of thoughts and emotions that occur when any two people interact (Fig. 3.9).

Consequently, the therapist's responsibility is to ensure that

- The appropriate definitions and boundaries of the therapeutic relationship are sustained.
- Positive interpersonal relating, such as trust, mutual respect, and honesty, characterizes the relationship.

FIGURE 3.9 For Belinda Anderson, the relationship is fully human.

Sustaining the therapeutic relationship is an ongoing task that does not focus solely on interpersonal events. The therapeutic relationship process that occurs outside of the interpersonal events is the macro dimension of the interpersonal process of therapy.

Responding to the immediate events that occur during therapy is the micro dimension. Responding to these interpersonal events of therapy requires that the therapist detects the occurrence of an event, reads the client's reaction to the event, and decides on an appropriate way to address the event with the client.

Both the micro and macro scales of therapeutic interaction play a critical role in the overall process of occupational therapy. Moreover, they are interrelated. That is, the nature of the therapeutic relationship has an influence on how the client interprets and how the therapist responds to interpersonal events; and, in turn, interpersonal events and their resolution either enhance or detract from the therapeutic relationship.

In some cases, the two scales of interaction are difficult to differentiate. For example, some therapy relationships last only one or two sessions. In these cases, a therapist must work to respond to a client and to interpersonal events with much more vigilance and self-control because a more stable underlying therapeutic relationship does not yet exist. Moreover, the interpersonal events and their resolution during the therapy sessions are the major determinants of the therapeutic relationship.

In most cases, however, therapy continues during a period of weeks or months, allowing the development of some kind of predictable pattern or usual way of interacting within the therapeutic relationship. That therapeutic relationship is infused and shaped by interpersonal events that occur in the moment-by-moment therapy process. It is also influenced by the characteristics and behaviors the client and therapist bring to the relationship as well as by the circumstances surrounding the relationship. These circumstances include such factors as the nature and unfolding of the client's impairment and the context (e.g., school, rehabilitation setting, home, work) in which the therapy takes place.

It is the therapist's responsibility to manage and continually strive to fortify the therapeutic relationship and to seek optimal resolutions to interpersonal events in therapy. The stability and success of a therapeutic relationship cannot be assumed. Rather, it begins early in treatment with attempts by the therapist to build rapport, followed by other efforts to develop a relationship that meets the client's immediate interpersonal needs and is appropriate in terms of the circumstances of therapy and the demands of the treatment setting. Recognizing and sustaining a successful therapeutic relationship might include such things as:

- Sharing certain interpersonal rituals that facilitate bonding (e.g., paying a visit to a garden or other favorite locale within the client's setting each time before the ending of therapy)
- Witnessing the client enjoying or benefiting from therapy
- Sharing mutual feelings of respect, admiration, or appreciation
- Feeling interested and engaged in the therapy process
- Being open and comfortable digressing during therapy for discussion, venting, or advice-seeking about events in his or her personal life (without interfering with progress toward goals)
- Being able to discuss and overcome the interpersonal events that might otherwise challenge the relationship
- Having a long-standing private joke with a client
- Sharing a certain intensity of eye contact that communicates mutual trust
- Noticing a certain way a client laughs that conveys her appreciation of the therapist

These are only a few examples among myriad factors that might contribute to a successful therapeutic relationship. It is the responsibility of the therapist to be vigilant to explore, identify, and sustain the factors that contribute to a relationship that supports positive therapy outcomes.

This is not to say that the client does not make positive contributions to the therapeutic relationship. In most instances, clients bring important or essential characteristics and behaviors into the relationship. However, the fundamental difference is that it is the therapist who must assume the ultimate responsibility for ensuring that the relationship is positive. By assuming this responsibility, the therapist creates a space in the relationship wherein a client can be vulnerable, distressed, frustrated, or angry without fearing that the relationship will be ruptured. Moreover, this does not mean that the therapist assumes an expert or authoritative stance in the relationship. Rather, it means that the therapist must assume responsibility for the caring within the relationship.

The enduring aspects of the therapeutic relationship are systematically built and fortified because of naturally occurring variables in the relationship (similar interpersonal styles or interpersonal chemistry or other optimal circumstances and timing) and because of the therapist's consistent efforts to build the relationship in the face of the inevitable interpersonal events and challenges that occur. If the therapist's efforts to build a relationship are successful and the client is not particularly sensitive, untrusting, or otherwise vulnerable, the therapeutic relationship becomes stronger through time and is more likely to withstand interpersonal events that would otherwise challenge or strain the relationship.

For any number of reasons, however, the therapeutic relationship may not develop adequately to endure threats caused by the interpersonal events that routinely emerge during therapy. Signs that there is difficulty in the therapeutic relationship may include, but are not limited to:

- Change in affect, attitude, or interpersonal behavior
- Becoming disengaged from therapy
- Appearing or feeling impatient, irritable, or angry
- Experiencing therapy as "boring"
- Questioning the utility of the therapy
- Feeling questioning or criticism is excessive
- Taking therapy "home"
- Dreading or becoming apprehensive about the next appointment

- Having a desire to refer or terminate prematurely
- Developing conflict with the client
- Noticing client's attendance pattern changes or declines

There are several potential reasons that difficulty may emerge within the therapeutic relationship. For example, a client may bring a particular interpersonal history into the treatment relationship that makes it difficult for the therapist to establish rapport in ways that usually work. Conversely, the client may be mistrustful of the therapist because of the circumstances under which he is being seen. For example, a client may have been mandated by an insurance company to receive an evaluation for work potential, and the client perceives that the therapist has tremendous power to influence his life (i.e., whether he continues to receive disability support). Alternatively, a therapist may have a negative reaction to a client because the client reminds the therapist of someone with whom the therapist has had a difficult relationship in the past. General sources of difficulty within the relationship may include, but are not limited to:

- Client brings a difficult interpersonal history into the relationship or has an Axis II diagnosis.
- Circumstances under which client is being seen are threatening or pressured (i.e., an evaluation is being conducted for the purpose of verifying disability to an insurance company).
- There is a poor match between client's and therapist's interpersonal styles.
- There is an inability to overcome challenges caused by differences in culture, values, or worldview.
- Client or therapist reminds the other of someone with whom he or she had a negative experience.
- Client or therapist disappoints or fails to meet expectations.
- Client or therapist inadvertently says or does something that is perceived as injurious, and the situation is not processed and resolved.

These and other obstacles to a more stable enduring relationship with a client are only intensified by inevitable interpersonal events. Examples of events that are likely to further stress an already-vulnerable therapy relationship include such things as a therapist's unanticipated absence for a period of time, a common misunderstanding that occurs between client and therapist, a comment or question that is perceived by the client as insensitive or inappropriate, or an unexpected personal crisis that causes the client to regress or temporarily relinquish treatment goals. Although they are normal and inevitable examples of difficult aspects of therapy, the way in which the therapist responds to them is a powerful mediator of the final outcome.

Irrespective of the extent to which the therapeutic relationship process is stable and strong, the process of therapeutic responding to interpersonal events is essential to good therapy. If a therapist does not respond adequately to interpersonal events or challenges to the relationship, the process of occupational engagement may suffer, and the therapeutic relationship process quickly erodes.

For the duration of the therapy process, the therapist must engage in a process of interpersonal reasoning. Interpersonal reasoning is the process by which a therapist consciously and reflectively monitors both the therapeutic relationship and the interpersonal events of therapy in order to decide on and enact appropriate interpersonal strategies. Chapter 7 discusses the interpersonal reasoning process in detail.

Intentional Relationship Model: 10 Underlying Principles

The IRM defines the most critical components of the client-therapist relationship as it occurs in occupational therapy. In addition to its central elements and mechanisms, 10 fundamental principles underlie the conceptualization of this model (Box 3.1). They are explained in the following sections. Each principle specifies unique assumptions about how the client-therapist relationship is approached. Collectively, the principles should be kept actively in mind anytime the model is applied during an interaction with a client.

Principle 1: Critical Self-Awareness Is Key to the Intentional Use of Self

Developing critical self-awareness involves having a working knowledge of your interpersonal tendencies while interacting with clients of different interpersonal styles and under different conditions and circumstances. These interpersonal tendencies may manifest in one's emotional reactions to others and in one's verbalizations and

BOX 3.1 Underlying Principles of the Intentional Relationship Model

1. Critical self-awareness is key to the intentional use of self.
2. Interpersonal self-discipline is fundamental to effective use of self.
3. It is necessary to keep head before heart.
4. Mindful empathy is required to know your client.
5. Therapists are responsible for expanding their interpersonal knowledge base.
6. Provided that they are purely and flexibly applied, a wide range of therapeutic modes can work and be utilized interchangeably in occupational therapy.
7. The client defines a successful relationship.
8. Activity focusing must be balanced with interpersonal focusing.
9. Application of the model must be informed by core values and ethics.
10. Application of the model requires cultural sensitivity.

nonverbal behavior. Critical self-awareness also requires understanding how your interpersonal reactions and behaviors change, become attenuated, or become amplified in awkward, tense, or stressful situations. Understanding yourself in these highly detailed and variegated ways is not easy to achieve. Nevertheless, this understanding is critical to developing interpersonal skills that are perceived as therapeutic by clients.

The difficulty involved in achieving critical self-awareness is illustrated by research findings that therapists are usually not accurate in their self-estimation of the extent to which they convey an attitude of care and empathy toward their clients (Burns & Auerbach, 1996; Orlinsky, 1994). In studies of psychotherapy, empathy was linked to positive outcomes only if it was perceived by the client; therapist self-ratings of empathy were not associated with positive outcomes (Burns & Auerbach, 1996). Because therapists are not always accurate self-estimators of their own interpersonal capacities, merely considering oneself to be a caring and empathic therapist does not offer adequate assurance that an effective interpersonal process has occurred in therapy. Many of us have probably had the opportunity to know someone whose caring behavior toward us was fully spontaneous, sincere, and heartfelt but nevertheless largely missed what we most needed at the time.

Truly effective use of self hinges on ongoing critical awareness of your interpersonal behavior and emotional reactions to clients. This includes a mindfulness concerning:

- What you are communicating verbally (content, choice of words, types of questions asked)
- What you are communicating nonverbally (stance or sitting posture, positioning of arms and legs, angle of torso and head in relation to the client, gestures, extent and pace of body movements)
- What you are communicating emotionally (tone, tenor, and volume of voice; facial expression; extent to which emotion is shown or shared)
- What you are withholding, limiting, or otherwise not communicating and the implications of these kinds of noncommunication for the therapeutic interaction

Principle 2: Interpersonal Self-Discipline Is Fundamental to Effective Use of Self

Achieving critical self-awareness is necessary for effective therapeutic relationships, but it is not sufficient. Therapists must also have the courage to seek and respond to interpersonal feedback from clients in a manner that reflects a dynamic, second-by-second recognition of what the client needs at any given moment. These abilities to anticipate, measure, and respond to the effects of ongoing communications with a client is most succinctly characterized as interpersonal self-discipline. Interpersonal self-discipline is fundamental to the use of self because it allows a therapist to develop stable, predictable relationships with clients. It allows a client to trust that the therapist has the ability to place his or her own interpersonal reactions and expectations aside to best fulfill what the client wishes to take from the relationship.

A critical aspect of interpersonal self-discipline involves acting on your awareness of your reactions to interpersonally challenging clients whose interpersonal behavior does not meet your expectations or tends to be negative. These clients may be particularly emotional, hypersensitive, defensive, demanding, critical, manipulative, difficult to manage, or otherwise vulnerable. Therapists differ among and within themselves regarding:

- What kinds of client behaviors and emotions are experienced as difficult
- The extent to which they feel comfortable managing these different types of difficult interpersonal behaviors

Some therapists find it easier to work with an emotionally sad client than an angry client, whereas the opposite may be true for another therapist. Interpersonal self-discipline involves knowing the types of client and the situations that are most likely to test your interpersonal resolve and emotional perspective. Once you are familiar with your own vulnerabilities, you can more effectively prepare yourself emotionally and psychologically before interacting with these clients. In addition, you can more readily seek support, advice, and guidance from mentors and peers when treating difficult clients.

Collectively, the actions you take toward self-preparation and self-management in the face of interpersonally difficult clients helps ensure that the ways in which you choose to interact with these clients will be optimally therapeutic. This decreases the likelihood that you will unwittingly act out your own negative feelings toward a difficult client. For example, a therapist once shared that she felt less guilty about precipitously changing an appointment with a client in order to meet an out-of-town friend for lunch because the client tended to behave in demanding ways and had recently questioned her approach. Changing an appointment with a client for a nonurgent matter is not a disciplined way of managing one's feelings toward a client. Moreover, changing the appointment with an already-difficult client may lead to increased tension in the relationship. Another example is the extent to which one may make special efforts on behalf of a client. It is generally easier to make these extra efforts for clients whom one likes and sees as investing a great deal in the therapy. However, depriving the difficult client or the client who is not invested in therapy of one's extra effort is not justified ethically.

Table 3.4 contains additional examples of difficult interpersonal behaviors that clients commonly exhibit, typical emotional reactions a therapist might have to such behavior, and undisciplined versus disciplined ways in which therapists can behave in response.

In addition, Exercise 3.1 in the Activities section of this chapter provides a blank copy of this table so that you can furnish your own examples of difficult interpersonal situations, note your own reactions, and judge for yourself what would be a disciplined versus an undisciplined response.

Another important aspect of interpersonal self-discipline is that therapists avoid viewing the relationship as a potential source of self-esteem or as a barometer by which to measure their own interpersonal competence. Regardless of whether a relationship is successful or unsuccessful, the extent to which a therapist can truly control what occurs during a clinical interaction is limited. Therapists must keep their successes and failures in perspective and work to manage their needs to feel connected with, approved of, or celebrated by clients. Investing too much of one's own interests in having a relationship with a client can result in deep feelings of disappointment when a positive connection does not occur. Importantly, more intuitive clients may detect subtle hints toward the therapist's need for connection or approval and may withdraw further because they feel pressured or emotionally suffocated. When clients do not meet a therapist's expectations, some may detect underlying feelings of disappointment or frustration in the therapist. Through time, not keeping therapeutic relationships in perspective can also lead to emotional exhaustion or burnout in therapists.

A final aspect of interpersonal self-discipline in the therapy process involves perspective and responsibility-taking. According to the IRM, it is the therapist's responsibility to manage the more challenging aspects of the relationship and continually strive to fortify the relationship with the client. This aspect of interpersonal self-discipline is particularly relevant to working with more frustrating clients who are interpersonally sensitive, difficult, or otherwise vulnerable. Even if a client misperceives a therapist's good intentions, attempts to break professional boundaries, or becomes upset with the therapist for no apparent reason, it is the therapist's responsibility to respond to the client in a way that is ethical and maximally therapeutic given the client's interpersonal characteristics and the circumstances of therapy. More information about therapeutic responding is provided in Chapter 7.

Table 3.4 **Examples of Disciplined Versus Undisciplined Responses to Interpersonally Difficult Clients**

Client's Behavior	Effect of Client's Behavior	Undisciplined Response	Disciplined Response
Critical of new approach	Feel judged by client	Avoid trying new approaches in the future	Discuss pros and cons before recommending new approach
Emotionally overreactive	Feel emotionally drained	Become less engaged with the client through time	Assist client in verbalizing or describing feelings when they occur
Distant and uninvolved	Feel I am not trying hard enough to build rapport with the client	Try harder to build rapport	Identify possible explanations for client's lack of involvement
Entitled and demanding	Feel anger toward client	Set more limits with this client than with others	Discuss different perceptions about therapy expectations with client
Needy and manipulative	Feel guilty and sorry for client	Respond inconsistently; occasionally do more for this client than for others	Respond consistently within reasonable limits and boundaries

Principle 3: It Is Necessary to Keep Head Before Heart

Responding to clients from the heart—that is, intuitively, spontaneously, and emotionally—should be considered an indulgence and a privilege earned by therapists rather than an entitlement. Responding from the heart must be accompanied by sufficient development of critical self-awareness and interpersonal self-discipline. With sufficient experience and practice, therapists become aware of the various types of positive therapeutic communication of which they are capable. By the same token, therapists become familiar with the many potential ways in which their communication (or lack of communication) has the potential to become nontherapeutic, psychologically risky, ambiguous, or (at worst) emotionally harmful to clients. With sufficient practice, a disciplined and systematic process of therapeutic responding becomes automatic and intuitive. Through time, therapists feel as if they are responding to their clients spontaneously and intuitively, even though each of their more critical communications is accompanied by a sophisticated process of interpersonal reasoning (Fig. 3.10).

According to this principle, it is incorrect to assume that so long as your heart is in the right place you naturally react and behave appropriately in therapy. Instead, it is important to know that each of us has certain tendencies that do not always play out positively for a client simply because we care, have compassion, or can appreciate the client's life story. To be sure, these are all important attitudes for a therapist to sustain, but they are not a replacement for thoughtful self-knowledge and self-discipline.

Principle 4: Mindful Empathy Is Required to Know Your Client

As reviewed in Chapter 1, the centrality and importance of empathy to the client-therapist relationship is supported by several occupational therapy scholars and practitioners. A therapist's capacity for empathy is a prerequisite for a functional client-therapist relationship. However, the IRM differs from prior discussions of empathy in the

FIGURE 3.10 René Bélanger putting head first as a client discusses a significant occupational concern.

FIGURE 3.11 Roland Meisel relies on mindful empathy when striving to understand a client's views about returning to work.

occupational therapy literature in that it treats empathy as a mindful process rather than a predominantly affective one. The concept of mindful empathy was developed based on Heinz Kohut's (1984) underlying theory of self-psychology.

Mindful empathy is an objective mode of observation in which the therapist comes to feel and understand a client's underlying emotions, needs, and motives while at the same time maintaining an objective viewpoint. Kohut labeled the empathic process of accessing a client's internal world "vicarious introspection," and he consistently emphasized the importance of evaluating each client's experiences and behaviors from the client's unique perspective (Gardner, 1991; Kohut, 1984). The idea of mindful empathy, which was influenced by some of these ideas, assumes that the client is the expert on the meanings that he or she attaches to his or her experiences in therapy (Fig. 3.11).

According to the IRM, mindful empathy is fundamental to interpersonal reasoning. It guides both the therapist's response to interpersonal events and the therapist's efforts to sustain the therapeutic relationship. For instance, mindful empathy is necessary to interpret accurately a client's reactions to a given interpersonal event. Achieving an understanding of the client's cognitive interpretation and emotional and behavioral reactions to the event must be accomplished through empathically based listening and questioning. Although the client's interpersonal characteristics are likely to play a role in his or her interpretation and reactions to the event, assumptions about a client's reaction and needs should not be made until the client's reactions have been verified through

reflective listening and an explicit conversation about the event that has occurred. Assumptions should not be based entirely on prior knowledge of the client's interpersonal characteristics. Mindful empathy is an advanced skill in the therapist's interpersonal knowledge base. More information about this skill and examples of how therapists have employed mindful empathy in practice is presented in subsequent chapters of this book.

Principle 5: Grow Your Interpersonal Knowledge Base

Interpersonal communication is as complex as the limits of human understanding. From client to client, communication is as variegated and unique as are the differences between and within individuals, families, social networks, communities, neighborhoods, nations, cultures, geographies, climates, and governments. For these reasons, therapists benefit from knowing as much about human behavior as possible, particularly as it pertains to more commonly occurring events in the client-therapist relationship.

The IRM describes skills that are essential to meeting the basic interpersonal demands of practice, such as listening effectively, communicating clearly, overcoming basic conflicts and events, and being reliable and predictable in interactions. The model describes additional skills that are required to achieve a level of communication with a client that responds to his or her interpersonal needs. This continuum of skills is described in detail and accompanied by clinical examples in Chapters 8 through 16.

Principle 6: Provided That They Are Purely and Flexibly Applied, a Wide Range of Therapeutic Modes Can Work and Be Utilized Interchangeably in Occupational Therapy

Individuals who enter the profession of occupational therapy have a side to their personalities that is oriented toward others and desires to support, uplift, empathize with, motivate, advocate for, guide, or otherwise empower people. At the same time, each therapist has a unique combination of interpersonal characteristics that largely derive from his or her temperament, usual interpersonal style with others, and from life experience. These characteristics influence the therapist to have a natural therapeutic mode or modes (i.e., particular ways of relating to a client in a given situation). As already mentioned, the six interpersonal therapeutic modes are the advocating mode, collaborating mode, empathizing mode, encouraging mode, instructing mode, and problem-solving mode. The therapeutic mode or set of modes that characterize a therapist's general approach to interacting with clients is referred to as the therapist's interpersonal style.

An underlying principle of the IRM is that no particular mode or interpersonal style is superior to another. Two therapists with diametrically opposite personalities, who use different combinations of modes, can be equally effective. However, certain interpersonal styles tend to work better with different populations and circumstances. Thus, therapists who are critically self-aware choose areas of practice most suited for their interpersonal style.

More importantly, effective use of self depends on the flexible and appropriate use of modes depending on the client and the situation. A therapist who relies heavily on only one therapeutic mode is effective with a narrower range of circumstances and clients than a therapist who can employ a variety of modes in response to changing interpersonal circumstances. Thus, the IRM recommends that therapists make an ongoing effort to expand their capacity to use different modes as demanded by individual differences between clients and the unique features of specific interpersonal events that may occur during therapy.

When a therapist decides to invoke a particular mode, it is important that the mode is communicated to the client accurately in its pure form. To achieve the pure, accurate use of a mode, it is recommended that the therapist remain within that mode for as long as it takes to communicate and ensure that the client has received the intended interpersonal message (e.g., that the intention for the moment is solely to empathize, solely to instruct, solely to problem-solve, or what have you). If a therapist attempts to blend modes so two interpersonal messages are being communicated simultaneously, it is likely to weaken the intended communication of both modes and to result in the client becoming confused. For example, if a therapist's true intention is to address a client's behavior by using the instructing mode but, instead, begins to question the client about the reasons behind the behavior in a way that conveys disapproval, the therapist is blending the problem-solving mode into the instructing mode.

The result is that the client receives a confused message about the desirability of the behavior (e.g., does the therapist want me to stop the behavior, or might it be okay if I explain to her why I am doing this?). Similarly, if a therapist shifts modes too rapidly it may also lead to confusion or weakening of the communication, depending on the cognitive level and emotional maturity of the particular client. Although the IRM acknowledges the need for therapists occasionally to share mixed feelings with a client and send complex messages to clients that involve many mode shifts, this approach to communication must be done with great circumspection. These and other issues pertinent to shifting modes are discussed in more detail in Chapter 7.

Principle 7: The Client Defines a Successful Relationship

Clients differ widely in terms of what they are seeking from their relationships with health-care professionals. For instance, some clients prefer a relationship that is professional, hierarchical, and relatively distant in which the therapist provides specific instructions, technologies, or resources to assist in the accomplishment of occupational goals and objectives. Other clients desire a relationship that involves a more personalized connection and results in feelings of emotional support as well as tangible occupational outcomes. Still others wish for a collaborative relationship in which mutual planning and problem-solving take place.

What is considered a successful relationship in occupational therapy must be defined by the client rather than the therapist. A successful client-therapist relationship must be based on the achievement of the type of therapeutic relationship the client needs most and is capable of during the time he or she is in therapy. This means that a successful therapeutic relationship is not defined by a feeling of closeness, or connection, unless the client clearly wants it as a feature of the relationship. Although in many circumstances these variables are associated with the client's perception of a successful relationship, for some clients a successful relationship may mean one that involves a certain level of professional distance or some other kind of interaction that is consistent with the client's prior experiences with health-care professionals and cultural expectations.

A corollary to this principle is that clients may change through time in their desires for the therapeutic relationship. The following are some examples. A client who at first desires a more hierarchical and therapist-structured relationship following a traumatic event resulting in impairment may wish for a more collaborative relationship later during the course of therapy. A long-term client seen first as a child may wish to achieve more distance as he or she comes into adolescence. A client who previously insisted on a highly collaborative relationship may, following an exacerbation of an impairment or symptom or during a crisis, need an empathic and supportive relationship. Such changes in a client's desires for the therapeutic relationship may reflect such factors as responses to stress, personal growth, or natural development. They must be respected and accommodated by the therapist.

Principle 8: Activity Focusing Must Be Balanced With Interpersonal Focusing

One way to determine what a client needs from the therapy relationship is by evaluating his or her preference for interpersonal interaction during therapy. Not all clients benefit from the same level of emotional intensity or closeness in the therapeutic relationship. For this reason, interpersonal self-discipline is required on the part of the therapist to ensure that ***activity focusing*** must be well balanced with ***interpersonal focusing*** in occupational therapy.

Activity focusing refers to strategies of responding to interpersonal events that emphasize "doing" issues regarding "feeling" or "relating" issues. Interpersonal focusing refers to strategies that emphasize the latter more so than doing issues. The difference can be illustrated through the following examples. Let us say a client becomes upset, frustrated, or fearful when trying a new activity. Activity focusing would involve modifying the activity or the environment or encouraging a client to try another activity. By contrast, interpersonal focusing would involve addressing the client's emotional reaction to what the therapist is saying or doing. In this instance, it might mean interrupting the activity to discuss the client's emotional reaction to therapy, or it may involve strategic questioning that reveals the client's inner feelings about the activity or to the overall therapy approach (Fig. 3.12).

FIGURE 3.12 Jane Melton is careful to attend to both the activity and interpersonal dimensions of the therapy process.

This balance between activity focusing and interpersonal focusing varies from client to client depending on the client's progress in therapy, expectations from therapy, construal of the relationship, and reactions to the therapist. To accomplish this balance, a large measure of interpersonal reasoning and self-discipline is required. Interpersonal reasoning and self-discipline allow the therapist to keep the client's unique needs in focus to interpret the appropriate balance clearly. If a therapist achieves this balance, he or she does not rely too much on using activities to avoid direct discussion of interpersonal issues or, by contrast, does not overemphasize discussion of interpersonal issues when it is not comfortable for that particular client or appropriate for the situation.

Principle 9: Application of the Model Must Be Informed by Core Values and Ethics

Occupational therapy core values (American Occupational Therapy Association [AOTA], 2015) and ethics (AOTA, 2005) must inform application of the IRM in practice. As each component of the model is covered in subsequent chapters of this book, examples of how occupational therapy core values and ethics inform application of the model are provided. In addition, Chapter 14 overviews the occupational therapy core values and ethics, highlights the importance of the use of self in applying ethical principles, and specifies the numerous associations between ethical principles and the model. Examples of ethical dilemmas from clinical practice and possibilities for resolution are provided.

Principle 10: Cultural Sensitivity Is Central to Practice

Therapeutic use of self must be informed by human diversity. In client-therapist relationships, human diversity is defined by differences in sex, age, race, ethnicity, socioeconomic status, religious views, sexual orientation, disability status, and a wide range of other social and cultural dimensions. Developing cultural sensitivity is fundamental to effective use of self in occupational therapy. For this reason, cultural sensitivity is considered a central skill that must be developed and incorporated into every therapist's interpersonal knowledge base. Chapter 9 summarizes existing knowledge about cultural sensitivity in the field of occupational therapy and provides additional recommendations for professional development in this area.

SUMMARY

A rationale for the need of the IRM was provided, and the primary elements of the model were described. Ten principles underlying the model were also elaborated. Formulation of these principles was influenced by several sources, including information provided by the contributing therapists and direct observations of their behavior in practice, my own training and clinical experience as a psychotherapist, occupational therapy core values and ethics, and general principles derived from the occupational therapy and psychology literature and existing knowledge bases. The remainder of this book describes the IRM as one explanation of what occurs during our relationships with clients. Clinical examples of this model in action that were provided by the 12 featured therapists are incorporated throughout the book to illustrate how the concrete skills and concepts of this model can be utilized in practice.

Exercises for Learning and Reflection

Exercise 3.1

1. Have you ever experienced a client or other person in your life with one or more interpersonal characteristics that posed a challenge within the relationship? Please provide a detailed example, using IRM vocabulary to label the person's interpersonal characteristics.

Client's Behavior	Effect of Client's Behavior	Undisciplined Response	Disciplined Response

2. In a past volunteer or professional capacity, have you ever prompted or witnessed an interpersonal event to have occurred? Describe what happened, including any attempts to resolve the situation.
3. Refer to the case example featuring the client, Mr. Johnson, and Rigel, an occupational therapist, at the beginning of this chapter. In your personal or professional experience, have you ever encountered or observed a similar situation? What do you think about the interaction between Mr. Johnson and Rigel? In what ways was it effective and ineffective? Would you have done anything differently? Why or why not?

4. Which of the 10 underlying principles of IRM did Rigel draw upon during his interaction with Mr. Johnson at the beginning of the chapter? Please explain your answer.
5. Explain what is meant by "keeping head before heart" in IRM terms. Is this relevant to developing an empathic understanding of a client? Explain your answer.
6. Imagine that you are Erika and you have the chance to see Vera for a second session. How would you attempt to repair the rift that occurred in Chapter 1?
7. How does the IRM define therapeutic use of self in occupational therapy?

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