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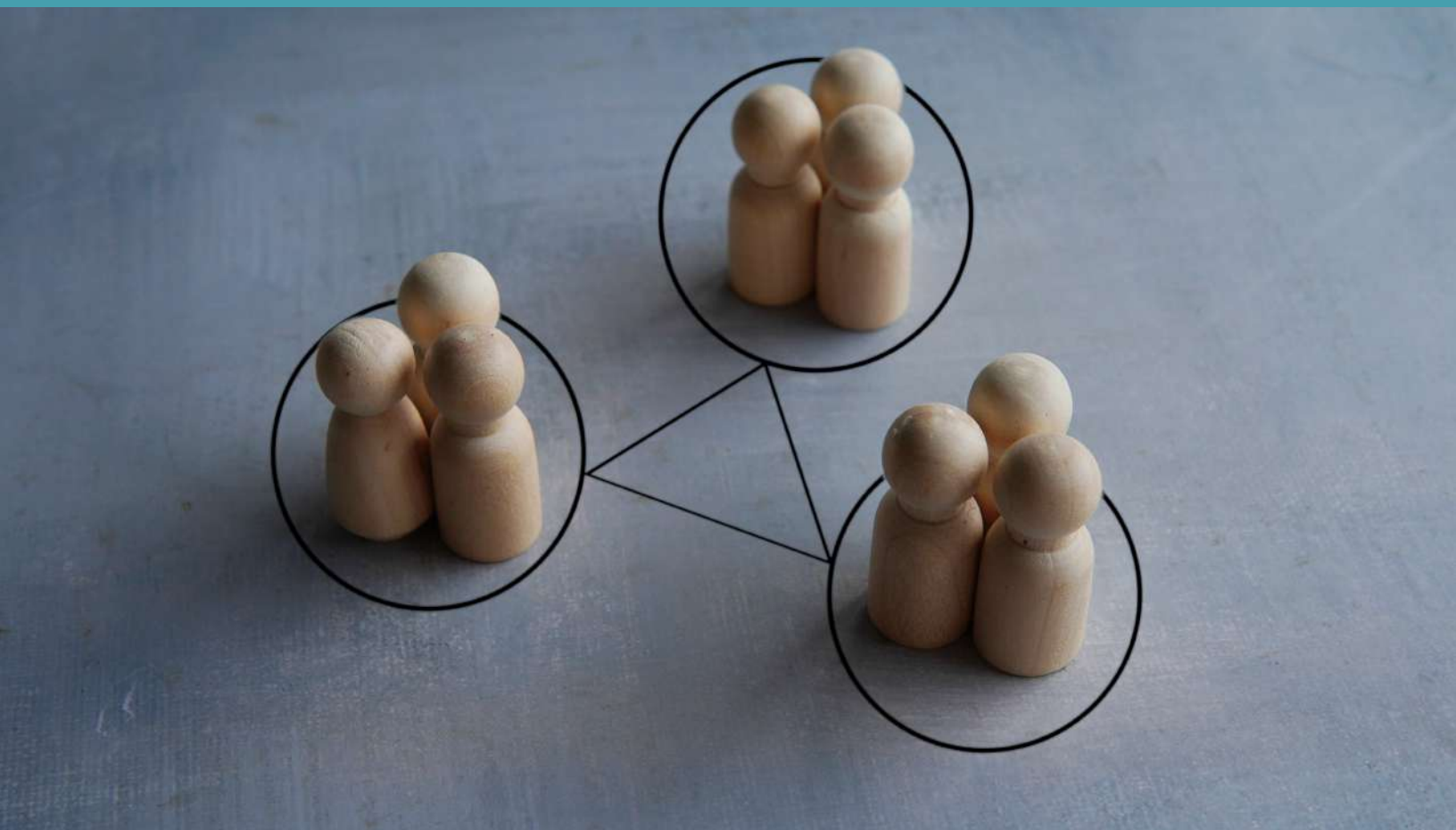
The Intentional Relationship Model



Introduction

Occupational therapists in every practice area will encounter challenging interpersonal events. As providers, we work with populations who cope with chronic disability, sudden injury, mental health exacerbations, and a myriad of other vulnerabilities. Since each person responds to these life events differently, therapists are likely to interact with people who display difficult behaviors, motivational concerns, and other issues as they adjust to their circumstances. Therefore, therapists need to be prepared for any challenging interactions they may encounter while continuing to provide evidence-based, quality care that appropriately serves their clients. This is where the Intentional Relationship Model comes in. This is a practice model that gives OTs guidance in developing and utilizing their interpersonal characteristics to provide client-centered services. Therapists can use three main elements of the Intentional Relationship Model to support client outcomes focused on occupational engagement.

Section 1: Background

References: 1

The Intentional Relationship Model (IRM) was developed by Dr. Renee Taylor in 2008. In keeping with the field of occupational therapy, the IRM hinges on demands and tasks. However, instead of patient-centered demands, this model outlines the demands and tasks placed on a therapist for building rapport and maintaining a strong patient-provider relationship. These responsibilities are considered equally as important as the technical skills and expertise of a therapist. One of the key ways therapists carry out the IRM is through therapeutic use of self, which is defined as therapists thoughtfully using various facets of their

personality, strengths, communication abilities, and insights throughout each encounter with patients.

Therapists should understand that the ultimate goal of the Intentional Relationship Model is occupational engagement, as all of their efforts should be focused on prompting clients to participate and progress in a therapeutic sense. The IRM is not a fixed concept, as therapists must engage in interpersonal reasoning on an ongoing basis to determine what parts of themselves are the most appropriate and useful for the current situation.

In addition to therapeutic use of self, there are several other key concepts within the IRM. These include occupation itself, a client's interpersonal characteristics (which we will discuss in greater detail in the next section), and unavoidable interpersonal events. The interplay between these concepts is what Dr. Taylor calls the therapeutic relationship process.

There are ten main principles that therapists using the IRM should be aware of. These include:

- A therapist should strive to use their head before their heart
- The client is mainly what determines whether a therapeutic relationship will be successful or not
- Therapists must continually foster their interpersonal knowledge in order to properly use the IRM
- Therapists cannot effectively implement IRM unless they have strong foundations in ethics and values associated with the OT profession
- Cultural competency is central to practice using the IRM
    - In the time since the IRM has been developed, cultural humility has taken the place of cultural competence as the more accepted skill.

Therapists should make note of this and understand how (if at all) this change affects the IRM.

- Interpersonal focusing is a large component of the IRM, but it must be balanced with activity focusing
- Self-discipline is fundamental to a therapist's interpersonal function and effective therapeutic use of self
- Therapeutic use of self also extends to intentional use of self, and critical self-awareness is key to implementing intentional use of self
- Therapists must exercise mindful empathy to truly know clients and their experiences
- Due to the dynamic nature of the OT profession, any number of therapeutic modes may be appropriately implemented with clients as long as therapists remain flexible and apply them properly

In addition to the main IRM principles, therapists should be aware of the interpersonal characteristics set forth by the IRM. There are 14 types of characteristics that any given client may demonstrate, each of which impacts the therapeutic relationship. These characteristics include:

- Preference for touch
    - Each client has varying degrees of comfort with touch. Their personal experiences and background also lead them to interpret touch in different ways. This can particularly impact the provision of manual therapies such as soft tissue massage and joint mobilization.
- Interpersonal reciprocity

    - This details the client's capacity for giving and sharing with their therapist. In order for therapy to be effective, clients must be open about their experiences, strengths, and weaknesses.

- Response to diversity within people
    - Each person responds differently to other people and their personal backgrounds. This sense of openness impacts the therapy process, especially if therapy is conducted in a group setting or the client's therapist is different from them.

- Response to feedback
    - Feedback is integral to the therapy process and indicates a client's openness to change. Clients may or may not be comfortable with constructive and positive feedback, which impacts their ability to grow.

- Orientation toward relating
    - Clients tend to come into therapy with a certain expectation for how their relationship with their therapist will be. This may impact their ability to interact openly or demonstrate restraint and inhibition.

- Stance on giving feedback
    - Similar to receiving therapist feedback, clients may or may not feel comfortable giving their therapist feedback. This may impact their ability to verbalize pain or fatigue to their therapist, and can stem from cultural or religious views.

- Desire for control

    - Clients may try to assume control over the way therapy sessions are conducted. While therapy is meant to be a collaborative process, clients may not get the most out of therapy if they do this too much or without therapist consent.

- Degree of trust
    - Building trust is a gradual process that occurs on an ongoing basis, but some people have difficulty trusting others. If clients demonstrate this difficulty, they may not honor what their therapist says.
- Approach to asserting needs
    - Clients should be able to express their priorities, needs, and wants from therapy in order to make it a truly collaborative process. If they aren't able to do this, they may not get their needs met.
- Response to challenge or change
    - Clients may or may not be able to adapt to their circumstances or environment. This can make achieving their goals and relying on others (if even for a short time) more difficult.
- Facial expression
    - Non-verbal communication methods can relay a client's emotions as well as their response to therapy.
- Body language
    - The posture and amount of movement someone displays helps convey their emotions.
- Tone of voice

    - This adds context to someone's emotions and the words they say.
- Communication style
    - The language (spoken or signed, formal or informal) that someone uses also speaks to their background.

Therapeutic modes are the last main component of the IRM that therapists should understand. There are six modes, each of which is essential to the therapy process. While therapists may favor certain modes over others based on their personality styles and methods of communication, they must remember that such modes are used to meet a client's needs therefore they should mesh well with a client's interpersonal style. Therefore, therapists should be comfortable using each of these modes at any time:

1. **Problem-solving:** This mode requires therapists to use logic and reason first and foremost to guide their interactions with clients.
2. **Encouraging:** Therapists using this mode will instill courage, hope, exploration, and participation in chosen activities.
3. **Empathizing:** This mode warrants therapists recognize and grasp the extent of a client's experience, including interpersonal, psychological, and physical difficulties.
4. **Collaborating:** When using this mode, therapists must work in tandem with their clients to make joint decisions, reason together, and set expectations for the therapy plan of care.
5. **Advocating:** Therapists who take on the advocating mode must understand the barriers many people with disabilities and illnesses experience, then help them overcome any social, physical, and environmental obstacles that may affect their participation.

6. **Instructing:** This mode involves teaching clients about various aspects of their illness and ways to overcome them.

Section 1 Personal Reflection

Do any of the IRM principles align with other OT models, frameworks, and frames of reference that you know of? If so, which ones?

Section 1 Key Words

Activity focusing - When therapists implement strategies to manage a patient's responses to inevitable interpersonal events in order to improve task participation

Interpersonal focusing - When therapists implement strategies to manage task participation in order to address a patient's responses to inevitable interpersonal events

Therapeutic relationship process - The treatment-related dynamic, which consists of the therapist, the interpersonal characteristics of the client, and the influence of inevitable interpersonal events

Therapeutic use of self - The act of a therapist using various aspects of themselves (strengths, experiences, personality, etc.) when working with patients

Section 2: The Intentional Relationship & OT Practice

References: 2, 3, 4, 5, 6, 7, 8

One of the main ways the Intentional Relationship Model assists occupational therapists' work is through social factors. Therapists use a client's social

environment to enhance their occupational engagement, which assists them in making positive progress toward their goals.

The Intentional Relationship Model highlights the ongoing relationship between a client, a given occupation (ideally, one that is identified by the client as a priority), their therapist, and a host of interpersonal events that stand to impact that dynamic. If you recall some theoretical approaches that make up the foundations of OT, you will see many similarities.

- **MOHO**: The Model of Human Occupation (MOHO) explores the ways in which people find motivation for certain occupations, the way they engage in those occupations, and how their environment affects their motivation and occupational performance.
- **PEO Model**: The Person-Environment-Occupation (PEO) Model acknowledges that occupational performance is built from the ongoing dynamic between the self (person), environment, and occupation. The person is made up of various components, including sensory skills, personality, health, cognition, culture, roles, identities, and physical performance abilities. Environment spans institutions, social settings, and physical/cultural/socioeconomic contexts. Occupations refer to any tasks someone participates in that give them a sense of fulfillment and allow them to express or maintain themselves (such as basic self-care skills).
- **EHP**: The Ecology of Human Performance (EHP) is a framework that guides therapists in addressing the main constructs of occupational therapy: context, task, person, performance, and interventions. Each of these aspects is continually impacted by the others.

While it is not directly mentioned in the Occupational Therapy Practice Framework, this overarching document makes mention of many concepts that can

be effectively addressed using the IRM. For example, the act of completing an occupational profile with a client is very dependent on building strong rapport, which is a process that aligns closely with the IRM. This model also allows therapists to more effectively communicate with and educate their clients. Patient education is an essential (and often understated) part of the therapy process that is linked to better health outcomes, so therapists can use the IRM among other tools to encourage this.

What sets the IRM apart from other models is the addition of various therapist-focused components, such as therapeutic use of self, therapeutic modes, and interactive communication styles. The IRM also gives a name to one of many difficult situations therapists may experience with patients: empathic breaks. According to the IRM, these breaks occur if a therapist fails to properly communicate with their client in a way that allows for a strong therapeutic relationship.

IRM Research

Research has looked at the use of the IRM within occupational therapy practice. Some experts have aimed to explore the effects of this model on patient care. However, more studies have focused on which modes were most commonly integrated into practice.

A somewhat dated study looking at IRM modes found that the instructing mode was most frequently utilized, though there may have been cultural differences in providers that led to this being the case. Another dated study looked at what aspects of the IRM both occupational therapists and occupational therapy students used. Results showed that practicing therapists predominantly took advantage of the empathizing and collaborating modes while students utilized instructing and advocating modes. Researchers suggest this may be due to the

assumption that empathy and collaboration are more learned skills that come along with practical experience. Since advocating often aligns strongly with theoretical foundations and ideologies taught in OT academic curricula, these may have come more naturally to students.

A dated study conducted by the creator of the IRM also explored what modes therapists used most often, though it included a wide range of therapists across all practice areas. Taylor found that encouraging and collaborating modes were used the most often, followed by problem-solving, instructing, and empathizing. Results showed no trends among therapists working with certain populations, which shows how person-centered the decision to use various modes is. Interestingly enough, Taylor also found that therapists who worked with patients that often displayed strong emotions and difficult behaviors more commonly used all modes during the care process. Providers who encountered difficult behaviors (at any frequency) more often reported use of the problem-solving and instructing modes. OTs who worked with patients who had depression also endorsed use of the problem-solving mode along with collaborating and emphasizing. Therapists also most commonly used the problem-solving mode with anxious patients. While the efficacy of these approaches has not been tested, it speaks volumes that so many therapists chose the problem-solving mode to address a range of difficult behaviors. With so many therapists reporting high comfort levels with problem solving, it reflects well upon OT's role as experts in task analysis.

Another dated study showed similar diversity in therapeutic modes used by Norwegian occupational therapy students. This group's most preferred mode was problem-solving and the study also found that female students were more likely to utilize a collaborative approach compared to male students. Researchers emphasized the importance of therapists (and therapy students) being comfortable with the mode(s) they select, as this leads to the best outcomes.

It is important to note studies that look at preferential modes within students are likely to reflect the structure of the OT program itself. There is likely to be some degree of bias based on what modes are used most by the professors and fieldwork educators as well as those that make the most sense based on learning opportunities presented and program content. These studies all show that therapists may unintentionally favor some modes over others. While this is partly due to a provider's personality and demonstration of therapeutic use of self, it is not necessarily best practice. Research such as this is a good reminder that therapists should become comfortable with all modes in order to remain flexible and use what is best for the patient.

Popova et al. (2022) measured provider use of the IRM within early intervention with included providers being occupational therapists, physical therapists, speech-language pathologists, and developmental therapists. Results showed that therapists more often chose family-centered practices rather than sharing information (both general and therapy-specific). Despite favoring this form of rapport building ahead of disseminating information, therapists tended to use the instructing, encouraging, and empathizing modes most often. These practices also led to improvements in outcomes such as provider and parenting self-efficacy, process of care, and communication between providers and parents. While these results present an opportunity for providers to expand their skillset in problem-solving, collaborating, and other modes, this study also shows the benefits of IRM-style communication and family-centered care in this setting.

Kwan et al. (2025) looked at the use of the IRM within an adjacent field: behavioral science. These researchers used the metaphor "1000 cups of coffee" to describe just how time intensive the process of building trust with clients and partners can be. These investigators also went as far to say that therapeutic development and the application of joint interventions stands to be ineffective or become irrelevant without the incorporation of models such as the IRM. Kwan et

al. suggested that embedding the IRM into practice is one of the best ways to ensure it is used properly. In order to best do this within the OT profession, academic programs should ensure students have sufficient opportunities dedicated to exploring their character traits, strengths, and preferences. This can assist with later IRM training that involves using one's personality to help navigate various (often difficult) clinical scenarios.

Bernhard et al. (2024) explored a modification of the IRM called the Intentional and Attuned Therapeutic Relationship Model, which helps providers develop the aforementioned bond with children who have autism spectrum disorder and their parents or caregivers. As the name suggests, this model is based on the IRM and the concept of attunement. This neurodiversity-affirming practice strongly utilizes the collaborative mode of IRM while affirming a child's strengths and addressing skills such as emotion regulation and sensory processing. Therefore, therapists should strengthen their ability to use this mode when working with children who have neurodevelopmental concerns while still remaining flexible to incorporate other modes as needed.

Research from Gagné-Trudel et al. (2023) looked at the most essential themes that arose within the therapeutic relationship when OTs worked with children. Perhaps one of the most prevailing themes was the subjective nature of all therapeutic relationships, since this varies between different therapists, children, and caregivers. Other themes addressed the main aspects of the therapeutic relationship, which researchers identified as communication, power dynamics, and honoring/accepting diversity. Lastly, this study also highlighted the ways in which a therapeutic relationship can instill positive change in children, their caregivers, and the family unit as a whole. In order to honor the different interpretations of the therapeutic relationship, therapists should continually check in with their patients to learn how they feel about the process. This allows OTs to receive feedback that can help improve their rapport in the moment as well as

with future patients. Therapists should also remain culturally competent and practice cultural humility, as failing to do so can negate any positive outcomes resulting from use of the IRM.

Nelson et al. (2025) explored how the use of the IRM and similar approaches assisted OTs in providing mental health treatment while working in acute care settings. This study also utilized a constructivist grounded theory approach, allowing researchers to create four main themes: cultivating therapeutic relationships over time, finding and creating new therapeutic relationships, using healthy communication to assist the therapeutic approach, and the intersection between the professional and personal aspects of administering care. The last theme in particular highlights the essence of the IRM. Therapists must thoughtfully blend their personality and other aspects of themselves with their clinical training in order to provide care. This combination is what makes OT both an art and a science, as success in the field goes far beyond the basic mechanics of evaluation and intervention.

Section 2 Personal Reflection

How can therapists avoid preferential use of certain interpersonal modes?

Section 3: Rapport building and Interviewing with the IRM

References: 9, 10, 11, 12, 13, 14, 15

While the IRM sets forth various concepts, it is important for therapists to translate these into practice-specific skills. Rapport building and interviewing are two of the core skills part of this model. Therapists can use various techniques to build rapport over the course of the plan of care. When it comes to interviewing,

therapists may assume this is isolated to the first visit (the evaluation). While this is when the bulk of patient interviewing takes place, it certainly doesn't end there.

Interviewing patients on an ongoing basis is required to keep the lines of communication open. This serves the purpose of letting therapists know how home exercise programs are going, learning about remaining deficits or symptoms that may be present, understanding if skills are being carried over outside of sessions, and more. Just as with many aspects of the IRM, it can take time and practice for therapists to become comfortable with interviewing and rapport building. However, there are some steps that make the process easier.

Rapport Building

When it comes to rapport building, therapists should be able to convey their competence (and confidence) in handling a patient's problem areas. This should be person-focused, and therapists can demonstrate their abilities by having an open discussion with patients about potential solutions. They may even opt to explain the ways they worked through similar problems with others. In addition, therapists can display their competence by using evidence-based strategies and communicating these methods to their patients as they go along. This builds trust and helps them feel like a greater part of the patient-provider relationship.

Another way to build solid rapport is by creating safe spaces. This goes beyond simply having a welcoming and friendly clinic space, since emotional safe spaces are just as essential. When a therapist proves they are non-judgmental and accepting of anything that comes their way, this paves the way for honest patient disclosure about their struggles, viewpoints, and more. Avoiding making assumptions is another rule that goes hand in hand with being non-judgmental. While they may not be negative in nature, assumptions can still be harmful because they stem from poor communication. Rather than making assumptions

about patients, it's always better to ask patients for clarification and use that as a learning opportunity. In order to properly use the IRM and effectively build rapport, therapists must also remain flexible. This adaptive nature allows therapists to smoothly shift between interpersonal modes as well as be the most responsive to patient needs.

Active listening is an important component of rapport building. Therapists should allow clients to speak freely without interruptions during crucial moments of sharing. In order to demonstrate their active listening skills, providers can respond by paraphrasing what a patient has said. This not only shows they were listening, but prevents any misunderstandings by clarifying aspects of what a patient has said.

When encouraging patients to talk, therapists can ask open-ended questions. This also shows that therapists are interested in subjective responses that build a connection between them. In addition to active listening, mirroring a patient's energy is a non-verbal way of showing interest and participation in the conversation. If therapists focus on matching their patients' energy, this not only demonstrates their presence but also clarifies certain aspects of the patients' communication.

Lastly, the act of giving feedback is another topic that should be broached carefully. While many therapists innately want to give feedback as it is in their nature to help, it is important to do this with proper timing and tact. Therapists should refrain from adding bits of advice to conversation until a patient has either asked for it or otherwise demonstrated they are ready to hear someone else's view on the situation. While most patients are in therapy for assistance or help of various forms, it can injure the therapeutic relationship and negate any rapport built thus far if a provider jumps into giving advice too early.

One study found that focused listening, mutual participation, engaged curiosity, respect for the patient, and self-awareness were some of the most important factors in building rapport between providers and patients. These factors all relayed authenticity and adaptability by creating a connection between the providers' thoughts and actions.

Additional research on rapport building in group settings showed that stability, collaboration, and support were among the best features of the therapeutic relationship. Institutional barriers and fear of rejection tended to negatively affect the bond patients had with their provider. However, this same study discovered that positive relationships shielded patients from these concerns as well as harmful effects such as impersonal interactions and malfeasance.

A dated presentation from occupational therapists found that the bond between patient and provider was more frequently endorsed as critical to treatment outcomes than goal- and task-related items were. These same researchers also found a moderate correlation between participation and the therapeutic relationship, which solidifies the importance of rapport to end results.

Interviewing

Rapport building, strategic questioning, and interviewing are all closely related, as therapists can look at the interviewing process as rich with opportunities to build rapport. Strategic questioning is a more targeted form of interviewing that involves thoughtfully structuring dialogue with a patient to learn about them. This type of interviewing also requires therapists to use logic along the way, in the event any conflicts may arise.

For example, a patient may express being torn between two decisions in their personal life. This may or may not relate to the reason they presented to therapy. If the patient indicates they are looking for the therapist's advice on this topic,

some people may think giving that feedback is the most reasonable response. However, therapists can make this process more meaningful and more effective by using strategic questioning. According to this method, the therapist may instead ask the patient questions that encourage them toward rational thinking in an attempt to make the answer more clear. This builds a patient's independence while letting the patient know that the therapist trusts in their ability to make the right decision. As you can see, the act of strategic questioning serves multiple purposes within the therapeutic relationship.

As we mentioned before, open-ended questions can be used to build rapport by allowing patients to talk more, but they are also an important part of the interview process. Open-ended questions help patients build a greater sense of self-awareness, which helps them in developing logic and reasoning skills. While therapists can certainly play a more hands-on role in helping patients build these skills, open-ended questions allow for patients to reflect and reach the answer more independently. Reflection in and of itself can also be a valuable tool, so this helps therapists encourage patients to meet their goals and teach them various skills along the way.

Section 3 Personal Reflection

What occupational therapy service provision component(s) incorporate (or can incorporate) interviewing? How can a therapist use these opportunities to also build rapport?

Section 3 Key Words

Strategic questioning - A targeted form of interviewing that uses structured dialogue and logic to learn about a patient and smoothly resolve conflicts that may arise in the process

Section 4: Case Study 1

A 62-year-old female presents to an outpatient clinic for an initial evaluation. Front desk staff report she was very demanding over the phone during the scheduling process. She went into detail with them about how she is upset at the doctor for not sending her records to the clinic in a timely manner. The patient got even more upset when the clinic couldn't get her in for the evaluation that week. She also expressed a preference for a male therapist, which the clinic couldn't accommodate. When the front desk staff asked what the main reason for her referral was, she refused to give a clear answer.

Upon arriving for her evaluation, a female OT led the patient to a shared treatment room. The patient scowled and replied, "I guess you're the only choice I have for a therapist, huh?" The OT attempts to get more specific information from the patient about her presenting problem(s). She was more verbose with the therapist than the front desk staff about this topic. The patient listed off over 20 problems, none of which were noted in the medical records the OT received from her doctor. The patient got more and more emotional as she continued to explain these concerns. She eventually started crying and said she wants to reschedule for another day "when she has better control of herself."

1. Is there anything this therapist could have done differently thus far?
2. What interpersonal mode(s) might initially be most effective with this patient?

3. What action steps, if any, should the therapist focus on taking in the early stages of the evaluation?

4. Is it too early for the therapist to assist the patient in narrowing down her list of presenting concerns? Why or why not?

Section 5: Case Study 1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. Is there anything this therapist could have done differently thus far?

   Since this patient was being somewhat difficult before even beginning the evaluation, the therapist could have taken a little extra time to orient her to the clinic. This patient may have felt more comfortable after receiving a brief tour of the clinic, getting an introduction from the therapist, and being taken to a more private treatment space. The therapist also could have acknowledged the patient's expressed preference for a therapist of a different gender while offering a short explanation as to the reason the clinic wasn't able to accommodate that request. These steps may have started the encounter off on a different note, making the patient feel somewhat more at ease.

2. What interpersonal mode(s) might initially be most effective with this patient?

   Historically, the empathizing mode is a great option for therapists dealing with difficult patients. This mode would assist the therapist in building a rapport with this patient. After taking the steps discussed in the previous

question, the therapist could have incorporated the empathizing mode into the evaluation as she asked the patient to explain what brought her to therapy. This would allow the therapist to understand the full extent of the patient's difficulties, helping the OT evaluate and treat the patient more effectively.

3. What action steps, if any, should the therapist focus on taking in the early stages of the evaluation?

   The therapist should ensure the patient has sufficient time and a safe environment to express her concerns to the therapist. Along with completing the necessary steps of the evaluation, this should be the therapist's main focus since this will likely be the best way to build rapport during such an encounter.

4. Is it too early for the therapist to assist the patient in narrowing down her list of presenting concerns? Why or why not?

   The evaluation period is the time when the therapist learns about what a patient wants to work on and sets goals for their time together. This means they should mutually agree upon goals by the end of the evaluation, so it's not too early to address this. The therapist can use various modes to get this done. For example, the therapist can use the instructing mode to inform the patient of an OT's scope of practice and the ways that scope can assist some of her presenting concerns. The collaborating mode can then be used to translate those concerns into realistic goals and associated timelines. The therapist can also take advantage of the advocating mode to make referrals and recommend resources or other tools the patient can use to address some of the remaining concerns.

Section 6: Case Study 2

A 45-year-old appliance repairman is seen by an OT in the hospital, where he was admitted yesterday after a spinal cord injury. When the OT asked him about the nature of his injury, the patient insisted that it's just a bad muscle spasm from a particularly strenuous job he was working on. The patient said he will work with OT but only for today, because he plans to go home tomorrow and get back to work. However, due to the level of this patient's injury, he is currently incontinent of both bowel and bladder function, cannot walk, and may need to be assessed for a wheelchair before his discharge. He kept mentioning that he was bored because he couldn't find the book his wife brought him and he was having trouble using the TV in his room.

After the OT completes their session, she asks the patient when might be a good time to stop by tomorrow. The patient started yelling at the therapist, "No one around here listens to anything I have to say! I already told you I'm not going to be here tomorrow so you can just forget about seeing me ever again." As the OT walked out of the room, she overheard the patient talking to his nurse through his remote and complaining about the therapist, then asking if they called his wife to pick him up yet.

1. Which of the OT's actions may have negatively impacted their encounter with this patient?
2. What interpersonal mode might have been most appropriate for this therapist to use?
3. What steps could the therapist have taken in an attempt to build rapport with this patient?

Section 7: Case Study 2 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. Which of the OT's actions may have negatively impacted their encounter with this patient?

   It appears that the patient's injury itself was a sensitive subject, so the therapist should have avoided asking about it and referred to his medical records for that information. The therapist also should have avoided asking about scheduling the next visit since the patient was adamant that he'd be going home before then. Due to the nature of the practice setting, the therapist could have asked the unit's nurse if the patient had any other appointments tomorrow and planned a tentative time of day based on that. These two events likely had the biggest negative impact on their rapport.

2. What interpersonal mode might have been most appropriate for this therapist to use?

   Since the patient expressed wanting TV or his book to alleviate his boredom, the therapist could have shifted into advocating mode by helping meet those needs. The therapist could have looked through the patient's room to try and find the book for him or asked other unit staff if they have seen anything up front. The therapist could have tried troubleshooting the TV issues in an attempt to fix it.

3. What steps could the therapist have taken in an attempt to build rapport with this patient?

Building off the therapist's use of the advocating mode in the earlier question, the OT could possibly have worked with the patient to explore what might be wrong with the TV in his room. Due to his occupation, that likely would have been a great way to build rapport. From there, they may have gone into a discussion about the patient's typical work duties and other ways he likes to occupy his time. If the therapist couldn't meet those needs, connecting the patient with someone who could may also have gone a long way in proving her ability and dedication to helping him.

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