The Intentional Relationship Model
– Use of the therapeutic relationship in occupational therapy practice

By Tore Bonsaksen , Knut Vøllestad and Renee R. Taylor

Abstract

Introduction: The occupational therapy profession has a long tradition for highlighting the role of the client-therapist relationship for the outcomes of occupational therapy. Despite its perceived value and significance among practicing therapists, a consistent theoretical framework for addressing the therapeutic relationship in occupational therapy practice was not published until 2008.

Aim: This article introduces the Intentional Relationship Model, a model which conceptualizes the relational aspects of importance to occupational therapy practice.

Outline of the model: Particular emphasis is placed on describing the therapist's tasks and demands for establishing and sustaining a productive relationship with the client. These demands concern the learning and utilizing of a range of interpersonal skills, the flexible and self-reflective use of six therapeutic modes, and the process of reasoning about the interpersonal events of therapy and how these can be appropriately addressed.

Discussion and implications: In the future, the concepts and the practical usefulness of the model will have to be addressed in research, education, and clinical occupational therapy practice.

Keywords: the intentional relationship model, therapeutic relationship, use of self, occupational therapy.

Key message: The Intentional Relationship Model directs attention to the interpersonal aspects of the occupational therapy process. The ultimate goal of IRM is to help therapists improve their relationships with clients and help them provide their assistance to clients more effectively. In practice situations, the occupational therapist should decide on a therapeutic style – or therapeutic mode – based on reasoning about the client's interpersonal style and the events of therapy.
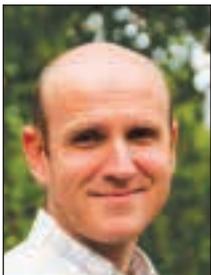
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Worldwide, occupational therapy practice is concerned with supporting clients in their efforts to perform the everyday life occupations that are important to them (American Occupational Therapy Association, 2002; College of Occupational Therapists, 2010; Crepeau, Cohn, & Schell, 2003; Kolsrud, Laberg, & Ness, 2011). By doing this, occupational therapists contribute to clients' participation in life – and to the related experiences of health and wellbeing (Crepeau et al., 2003; Kielhofner, 2009). A vast amount of publications points to a general agreement within the profession that success in promoting client participation in occupations partly relies on the quality of the relationship between the client and the therapist (Allison & Strong, 1994; Cole & McLean, 2003; Eklund & Hallberg, 2001; Palmadottir, 2006; Peloquin, 2003; Peloquin, 1990). Without a basis in a positive and nurturing relationship with the client, otherwise well-intended and thoroughly designed treatment interventions may be compromised.

In line with this view of the therapeutic relationship as an important precondition for productive occupational therapy interventions, there is a longstanding professional tradition for emphasizing the client-therapist relationship as one important aspect of the occupational therapy process (Taylor, 2008). Empirically, a recent survey in the USA with 568 participants confirmed that occupational therapists place a high value on the therapeutic relationship – more than 90 percent believed their relationship with the client affected the client's occupational engagement, and more than 80 percent believed their use of self in the client-therapist relationship was the most important skill in their occupational therapy practice (Taylor, Lee, Kielhofner, & Ketkar, 2009). As a paradox, however, only about half of the respondents felt that they had received sufficient training in the therapeutic use of self during their basic occupational therapy education. Moreover, less than a third felt that there was sufficient knowledge about the therapeutic use of self in
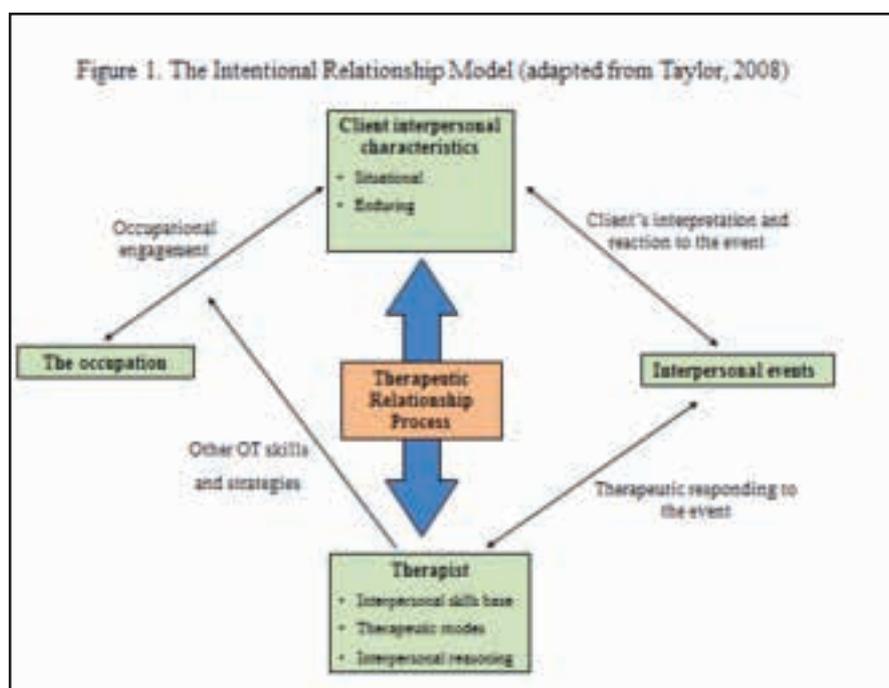

Figure 1. The Intentional Relationship Model.

the profession as a whole. These findings advocate for a consistent conceptual framework, addressing the relational aspects of the occupational therapy process, to be introduced.

This theoretical article introduces the recently developed model of the therapeutic relationship in occupational therapy, the Intentional Relationship Model (Taylor, 2008), and aims to clarify its key concepts. Underscoring the clinical utility of the model, particular attention will be given to outlining the tasks and demands of the occupational therapist in the process of establishing and sustaining productive relationships with clients. In conclusion, possible directions for the future application of the model are addressed.

The Intentional Relationship Model

The Intentional Relationship Model (IRM), introduced by Taylor in 2008, is the first theoretical outline of the therapeutic relationship in occupational therapy practice (Taylor, 2008). It is not directly concerned with the profession's primary focus of supporting the client's occupational engagement, but explains the relationship between the client and the therapist as one potential precondition for the client's engagement in the occupational therapy process.

There are several goals related to the use of this model: First, therapists should use it as a tool for self-reflection to be able to shape and develop their relationship with clients intentionally. Second, the model is designed to increase therapists' awareness of their own contributions to the relationship with the client, including an awareness of their preferred «modes» of relating to the client. Third, therapists should use their knowledge of therapeutic modes in order to expand their repertoire of modes – and in order to use each of them flexibly, according to clients' needs. The ultimate goal of IRM is to help therapists improve their relationships with clients, as this can help them provide their assistance to clients more effectively.

According to the IRM, there are four variables of importance to the occupational therapy process (Taylor, 2008). These are the client; the interpersonal events occurring within the client-therapist relationship; the therapist and his or her way of responding to the interpersonal events; and the client's occupation. We will address each of these variables in the following, and Figure 1 shows the proposed relationships between them.

The client

The client's contributions to the therapeutic relationship particularly rela-

tes to his or her interpersonal characteristics. Interpersonal characteristics are emotions, behaviors, and reactions that occur in interactions between the client and the therapist. The client's interpersonal characteristics at any given time should be viewed as determined by a combination of the client's underlying personality traits (enduring characteristics) and important aspects of the client's current circumstances (situational characteristics) (Taylor, 2008).

Enduring characteristics: For a large part, a person's personality constitutes the person's stable and consistent ways of perceiving and relating to other people. Each person has an idiosyncratic interpersonal profile, which involves a habitual style of communication, a certain capacity for trust, and a certain need for control. In addition, the person's personality involves a general orientation to relating to others and a usual way of responding to change, challenge and frustration (Taylor, 2008).

Situational characteristics: Occupational therapists should hesitate to explain the client's ways of responding to the therapy or to the therapist with reference to the client's personality. Clients in need of therapy may have strong personal reasons to act and respond in ways that are inconsistent with their underlying personality. Such reasons may include new or exacerbating illness, symptoms, or impairments – in fact, these are typically the situations that cause the stress that often leads the person into therapy in the first place. Stressful situations give rise to acute emotional reactions that are specific to the situation, and not to the person. In such situations, the stress that the person experiences may attenuate, change, or intensify his or her typical pattern of response. The therapist's interpretation of the client's responses as anchored in enduring personality traits and/or in the stressful situation at hand helps inform the therapist in understanding the client and guides clinical reasoning towards tailoring an appropriate response (Taylor, 2008).

In addition, the client's relations-

hip with the therapist can itself be experienced as a source of stress. For example, if the therapist comes across to the client as insensitive or uncaring, this may cause the client to interact and relate in ways that he or she would not normally do. How these problems are addressed and resolved during the therapy is important for the client-therapist relationship as well as for the client's outcomes from occupational therapy.

Interpersonal events

An interpersonal event consists of 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» (Taylor, 2008, p. 49). In turn, interpersonal events may strongly influence the client's motivation, goal-orientation, and occupational engagement.

As different persons respond to different things in different ways, the kinds of interpersonal events that may have an impact during the course of occupational therapy defies definition. One typical example, however, can relate to the client and the therapist having a disagreement over appropriate goals for therapy. These are issues that need to be resolved in order to make therapy work. Another example concerns the client's overt expression of grief or anger during a therapy session. The occupational therapist needs to respond appropriately to such emotionally challenging events.

The IRM emphasizes that interpersonal events are, by their nature, unavoidable. Moreover, the therapist should not try to ignore them when they occur, but rather deal with them. Interpersonal events are what happen between persons who interact, and who do so in ways that stimulate, or even call for, an emotional reaction. The emotional reaction may surface at the time when the interaction takes place, or later upon reflection. As interpersonal events are charged with emotion, they should not go unnoticed. Ignoring them, or responding to them inappropriately, may threaten the therapeutic relationship. Con-

versely, appropriate responding to emotionally charged events can solidify the relationship and provide opportunities for the client's learning or change (Taylor, 2008).

The therapist

The intentional use of the therapeutic relationship includes the therapist's consideration of appropriate responses to the interpersonal events occurring in therapy. To accomplish this, the therapist should preferably be able to draw from a large base of interpersonal skills. According to the IRM, interpersonal skills are summarized in nine categories. Some of these skills develop naturally as the person develops, whereas others require considerable training to develop and maintain (Taylor, 2008). The nine interpersonal skills are summarized in Table 1.

The interpersonal skill base: Therapeutic communication skills allow the occupational therapist to establish a relationship with the client characterized by caring and understanding. Therapeutic communication skills involve verbal and non-verbal communication skills, therapeutic listening, assertiveness, and being able to give feedback to the client and respond to feedback from the client. Interviewing skills and skills related to strategic questioning are important in order to gain sufficient information about the client. Establishing relationships is necessary for building and maintaining rapport with clients.

Similarly important is the therapist's knowledge about the impact of families, social systems, and groups relevant for the client's current situation, is he or she to be able to work effectively with these groups. Other important stakeholders in clinical collaboration can be supervisors, employers, and other professionals, and the occupational therapist would benefit from learning to cooperate effectively with them. In direct therapy with a client, difficult interpersonal behaviors may occur, and effective occupational therapists are able to understand and manage such behaviors and their consequences. One reason for experiencing difficulties in

the relationship with the client can be the occurrence of an empathic break or a conflict between the client and the therapist, and skills in mending such ruptures in the therapeutic relationship is a fundamental interpersonal skill.

The occupational therapist should be able to uphold and practice professional behavior, including the adherence to professional ethics and values. Finally, the model proposes that one therapist skill is related to caring for oneself and caring for his or her professional development.

Therapeutic modes: A therapeutic mode is a specific way of relating to a client. For therapists, the most frequently used mode or modes tend to be consistent with the therapist's personality. Therefore, the therapist's favorite mode defines his or her interpersonal style in relationship to clients. Performing therapy is most comfortable when relating in a way that is familiar; relating in more unfamiliar ways demands a high level of therapist self-knowledge in addition to a willingness to change. The goals of the IRM include both of these aspects. Developing as a therapist involves being able to use the therapeutic modes based on the client's personality and current needs, as opposed to the therapist's personal preference (Taylor, 2008). Each mode has its inherent strengths and weaknesses, and they should therefore be used flexibly and with good timing. The IRM identifies six distinct therapeutic modes, and an overview is provided in Table 1.

The *advocating* mode often relates to an understanding of disability emphasizing the environmental barriers to occupational participation. Using this mode of relating, the therapist will seek to ensure that the client is provided with access to the various types of resources they need in order to participate in desired occupations. For example, imagine Daniel, a client with chronic mental illness who has just started a supportive employment program. He is stressed by the new situation and tells the therapist that he has started hearing more voices. He has also told the psy-

Interpersonal skills	Therapeutic modes	Interpersonal reasoning
Therapeutic communication	Advocating	Anticipate
Interviewing skills and strategic questioning	Collaborating	Identify and cope
Establishing relationships with clients	Empathizing	Determine if a mode shift is required
Families, social systems, and groups	Encouraging	Choose a response mode or mode sequence
Working effectively with supervisors, employers, and other professionals	Instructing	Draw upon any relevant interpersonal skills associated with the modes
Understanding and managing difficult interpersonal behavior	Problem-solving	Gather feedback
Empathic breaks and conflicts		
Professional behavior, values, and ethics		
Therapist self-care and professional development		

Table 1. Interpersonal skills, therapeutic modes, and steps in the interpersonal reasoning process

chiatrist about this, and the psychiatrist has increased Daniel's medication. The situation makes him worry that he may lose his job if the supervisor finds out about his increased symptoms. A response to this client within the advocating mode can be to point out to him that he has certain rights to have the workplace accommodated to his needs. Also, the therapist can remind him about the possibility of negotiating the problem with the supervisor if he feels this will be necessary.

The *collaborating* mode strongly relates to the principles of client-centered practice, with its emphasis on client empowerment. Therapists using this mode will often involve clients in all aspects of therapy, including setting goals for therapy, making decisions about courses of action, and

in reasoning about the therapeutic process. Imagine once more the case of Daniel, who was worried about losing his job if the supervisor found out about him hearing voices. A collaborative therapist response can be to ask the client what he thinks he will need to do to keep his job, and if he can set a goal for himself that will direct his efforts towards staying in it.

The *empathizing* mode concerns the therapist's striving towards fully understanding the client's inner world, including all facets of his experience. Therapists using this mode will listen vigilantly to the client and be 'tuned in' to be able to adjust their approach rapidly and respond carefully to slight changes in the client's affect and behavior. Applied to the case of Daniel, the therapist can use the empathizing mode by acknowledging

the difficulties related to experiencing more symptoms when he has just started in a new job. The therapist can also invite Daniel to tell more about the things that he goes through.

The *encouraging* mode is characterized by the therapist instilling the client with hope and courage, so that the client will pursue with exploring or performing important occupations. The role of a «cheerleader» can be a salient metaphor for this mode, and frequent strategies connected with the mode are complimenting and cheering. The client's successes are celebrated with joy. The therapist can convey an encouraging response to Daniel by reminding him about a time in the recent past when he had a similar increase in symptoms. The problems at that time were temporary, the therapist may remind him – the symptoms eventually faded, and the fact that Daniel managed to get through it back then gives much hope that he will again now.

Therapists using the *instructing* mode often educate their clients about various topics, and may well assume a teacher-like style of communication. Clients are provided with clear instructions about, for example, how to perform a specific task, or about the rationale for the proposed occupational therapy intervention. The style is characterized by an active, directive, and structured way of relating to the client. Applied to Daniel, an instructing mode of relating can be expressed if the therapist chooses to remind him how long the psychiatrist has said it may take for medication to be effective. In addition, the instructing therapist may review with Daniel possible strategies for managing hallucinations on the job.

Finally, the *problem-solving* mode is based on using reason and logic in the therapeutic approach. Reasoning as a way of relating can for example be used when exploring with the client a range of options for action, as well as the potential consequences of these actions. Strategic questioning is often used as a way of structuring the dialogue with the client, and therapists using this mode will often rely on logic also when resolving conflicts

in the relationship. A problem-solving response to Daniel can take the form of asking him whether he can think of any other reasons why he may lose his job – or conversely, why he may keep it. A therapist performing in this mode can also pose further questions in order to help Daniel think more rationally about his current job situation.

Interpersonal reasoning: Interpersonal reasoning is an important task that requires the therapist's attention towards the interpersonal aspects of therapy. The attention is based on the anticipation that problems or dilemmas might occur in the relationship with the client, and that the therapist should be able to review and evaluate alternatives for therapeutic responses to such problems (Taylor, 2008). According to the IRM, the process of interpersonal reasoning is described in six steps. An overview of these steps is provided in Table 1.

First, the therapist should anticipate that the inevitable interpersonal events of therapy may test, challenge, or pose a threat to the therapeutic relationship. Second, when such events occur, they must be accurately identified by the therapist. This often involves labeling the event, either silently to oneself, or aloud to the client in order to seek access to his or her interpretation of what just happened. The therapist must also find ways to cope with the event, in terms of managing his or her own emotional reactions to it, but also in terms of reflecting about what aspects of the client's behavior can lead to non-therapeutic responses – commonly experienced are problems related to client's anger or hostility, excessive criticism or negativism, and controlling and manipulative efforts.

Next, having identified, labeled, and initially coped with the event, the therapist should assess whether or not a shift in therapeutic mode is required. Such a shift in therapeutic approach can often be useful in responding to interpersonal events of therapy that otherwise may have the potential to create ruptures in the therapeutic bond between client and therapist. Mode shifts require a range of

capacities and skills, including the therapist's being knowledgeable about the different modes and their inherent strengths and limitations. The therapist must also be able to identify his or her own mode use in the moment, to reason about which mode(s) can be better suited as a response mode to the situation at hand, and to be able to learn and practice responses that are related to unfamiliar modes.

Having considered the need for a mode shift, a response mode or a sequence of modes should be chosen and used with the client. In this process, the therapist draws upon any relevant interpersonal skills associated with each of the modes. In addition, the IRM suggests that messages to the client should be framed within the boundary of one therapeutic mode, as more complex, many-faceted messages may lose some of their intended meanings (Taylor, 2008).

As the client defines the quality of the client-therapist relationship, the therapist may want to gather feedback from the client on a regular basis, and particularly following interpersonal events. The therapist may check in with the client about his or her perception of what takes place in therapy, including his or her perceptions of the relationship with the therapist. Following an interpersonal event, the client may well be asked about his or her feelings about it, and similarly about how he or she feels about the therapist's way of managing the event. This will provide the therapist with valuable information concerning how the use of modes is perceived by the client, and will eventually prepare the therapist for subsequent mode shifts based on the feedback.

The occupation

According to the ideology of occupational therapy, the therapeutic mechanisms by which the client achieves or returns to health, mastery, and well-being are related to his or her engagement in valued and important occupations (American Occupational Therapy Association, 2002; College of Occupational Therapists, 2010; Crepeau et al., 2003; Kolsrud et al., 2011). Promoting occupational parti-

cipation is, consequently, at the core of occupational therapy practice (Crepeau et al., 2003; Kielhofner, 2008; Kielhofner, 2009). Occupations may include the performing of a wide range of activities, such as dressing oneself, making a meal, taking the kids to a ball game, or reading a book. The IRM conceives a sound therapeutic relationship as a precondition for the therapist's promotion of occupational engagement in the client (Taylor, 2008). Without a trusting relationship with the occupational therapist, the client will not, or will only reluctantly, become engaged in the occupational therapy process. Given a well-functioning relationship with the therapist, where the client feels safe to explore, practice, and sustain new occupations – or new ways to perform old ones – important change can take place (Kielhofner, 2008).

Future directions

In this article, the key concepts of the Intentional Relationship Model are described. The model is focused on the therapeutic relationship in occupational therapy – that is, the dynamic relationship between client and occupational therapist throughout therapy. The importance of this relationship for the client's process and outcomes from therapy has been highlighted in much of the profession's existing literature (Allison & Strong, 1994; Cole & McLean, 2003; Eklund & Hallberg, 2001; Palmadottir, 2006; Peloquin, 2003; Peloquin, 1990; Taylor et al., 2009). However, the IRM is the first conceptual outline that systematically has addressed the role of the therapeutic relationship in occupational therapy practice.

On a critical note, some may argue that the IRM focus on the therapeutic relationship brings about an attention shift for occupational therapy practice, bringing the attention closer to the focus area of psychotherapy. This is not the intention of the model. Although the IRM purports to be a conceptual model of occupational therapy practice, it reports openly about its limitations. The IRM focuses on the relational aspects of occu-

pational therapy practice, and not on the occupation itself. Although this relational context is considered highly important for the outcomes of occupational therapy – particularly in cases where the client has mental health problems, or other problems that impact the client's relationships to others – the IRM should always be used in conjunction with other conceptual models of occupational therapy practice (Taylor, 2008). It should not be used as the therapist's only tool for clinical reasoning, but as an additional model highlighting the relational aspects of therapy. Other occupation-focused models should always underpin the practice of occupational therapists.

The IRM is a relatively new model of practice. The extent to which it will have an impact on occupational therapy practice depends on several factors. The model's concepts will have to be put into use by occupational therapists in order to verify or question their usefulness for clinical practice. Are these concepts useful to reason with? Can the model help me improve my understanding of real life practice situations? Does it provide me with tools for changing and developing my way of managing relationships with clients? These are questions that need to be addressed from a clinical practice viewpoint. In addition, assessments based on the model will have to be tested in order to ascertain their validity. A process of investigating the psychometric properties of selected IRM assessments at the University of Illinois at Chicago, in collaboration with a number of universities worldwide, is currently progressing.

The further development and dissemination of this model appears to be timely. The recent survey conducted in USA confirmed the high value being placed on the therapeutic relationship by occupational therapists (Taylor et al., 2009). However, about half of the therapists felt they were insufficiently trained during basic education, and a larger proportion felt there was insufficient knowledge available in the profession as a whole about the use of self in occupational therapy practice. This gives reason to

put more energy into researching the role of the therapeutic relationship in occupational therapy practice, and into teaching the therapeutic use of self in basic and advanced occupational therapy education. ❑

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