



# Building rapport in occupational therapy with autistic children: A discourse analytical study

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## 1. Introduction

Autism<sup>1</sup> is a neurodevelopmental condition (American Psychiatric Association [APA], 2022) that occurs in approximately one out of sixty-eight children globally (Maenner et al., 2016; Hurt et al., 2019). Autistic characteristics include difficulties or differences in social communication, and the presence of restricted and repetitive behaviours, including sensory differences (APA, 2022). Therapeutic approaches are commonly used with autistic children, including sensory integration therapy (SIT). SIT is a play-based approach, focusing on the child–occupational therapist (OT) relationship, that uses sensory activities to support autistic children to process and integrate sensory input (Schaaf et al., 2014; Schaaf & Mailloux, 2015).

Establishing rapport is a fundamental aspect to any interaction between health professionals and patients of any age (Duggan et al., 2011; Ross, 2013). Within the OT field, the therapeutic relationship is outlined as a relationship based on trustworthiness and rapport, which has been established between the OT and patient through communication, collaborative work, mutual respect, and empathy displayed by the therapist (Cole & McLean, 2003; Duggan et al., 2011; Hahn-Markowitz & Roitman, 2000; Parham et al., 2011; Tickle-Degnen & Rosenthal, 1990; Werngren-Elgström, 1997). Rapport is hence considered as a dynamic process spanning the therapeutic encounter (Arnold & Boggs, 2010). Developing rapport extends beyond ‘good intentions’, since it is formed by words and actions of all parties involved (Rosenzweig, 1993; Ross, 2013). Fostering a positive relationship with a patient enables the therapist to acquire valuable information that can be used during therapeutic decision-making processes and ongoing therapy sessions (Barnett, 2001). Rapport reaches beyond that, as it promotes

communication, mutual understanding, and collaboration between the interactants involved (Norfolk et al., 2007). It is therefore vital to establish rapport early during the health professional–patient encounter as well as further develop and maintain it over time.

Rapport is a complicated and multidimensional process that is challenging to distil into a set of criteria. Tickle-Degnen and Rosenthal (1990) outlined rapport as a ‘dynamic process’ involving two or more individuals based on three fundamental mechanisms: (1) ‘mutual attentiveness’, (2) ‘positivity’ and (3) ‘coordination’ (p. 268). This model also recognises that rapport might shift over time (Tickle-Degnen & Rosenthal, 1990). Although Tickle-Degnen and Rosenthal (1990) acknowledged that some people are better at rapport-building compared to others, rapport was described as a ‘shared experience’ between all parties involved and subsequently not as a personality attribute (Magnusson et al., 2020). Nevertheless, personality characteristics, such as empathy, sensitivity, attention, warmth, friendliness, humour/light-heartedness, and playfulness, have been positively associated with establishing rapport between adults and children (Saywitz et al., 2015) and particularly in health professional–children encounters (Cepeda & Gotanco, 2016).

Establishing rapport with children might vary in content and duration because each child is different (Magnusson et al., 2020). One of the most common rapport-building strategies involves asking the child open-ended questions about non-hostile topics and/or their personal interests (e.g., hobbies, likes), which establishes initial comfort and familiarity during the interaction (Hershkowitz, 2011; Saywitz et al., 2015). Invitations (e.g., ‘Interesting, tell me more’), statements (e.g., ‘I think this film is amazing’), and open-ended questions to elicit elaboration (e.g., ‘What is your favourite TV show?’) are considered more

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<sup>1</sup> Throughout this paper, we use ‘identity/disability-first’ language (i.e., autistic child) (Kenny et al., 2016; Shakespeare, 2017) to reflect the preferences of the autistic community (e.g., Davidson & Henderson, 2010; Sinclair, 1999).

successful than closed-ended prompts (e.g., yes/no, option-posing) (Boyd & Heritage, 2006; Brown et al., 2013; Magnusson et al., 2020; Saywitz et al., 2015). For example, open-ended prompt utterances to obtain additional elaboration (e.g., ‘You said you like dancing, tell me more about it?’) are associated with lengthier replies from children (Stivers, 2012), as such invitations shift the interactional focus towards the child (Clemente et al., 2012). Thus, these utterances allow children to hold the role of the main speaker, sharing their thoughts and experiences (Boyd & Heritage, 2006; Clemente et al., 2012; Roberts et al., 2004). By fostering a sense of being heard and understood, open-ended prompt utterances are vital to build rapport with children (Bell & Condrén, 2016; Roberts et al., 2004), especially prior to discussion of significant topics or performance of challenging tasks during sessions (Magnusson et al., 2020; Roberts et al., 2004). Closed-ended prompts, such as option-posing (e.g., ‘Do you want the blue or red ball?’) and directive questions requesting elaboration for information mentioned before by the child (e.g., ‘Where are you going to put the dog?’) lead to short replies positioning the adult as the primary speaker as opposed to the child (Boyd & Heritage, 2006; Magnusson et al., 2020; Roberts et al., 2004). The use of directive questions might also exhibit an adult’s discomfort and dissatisfaction with having to deal with a child not collaborating (Gilstrap & Ceci, 2005). However, the use of positive or negative statement tag questions (e.g., ‘You like dancing, don’t you?’, ‘You don’t like volleyball, do you?’) function as mitigation devices aiming to reduce and soften the impact of what was said during conflict or communication breaks (Ali & Salih, 2020). During therapeutic sessions with children, smiling and light-heartedness, prolonged eye contact, posture and verbal mirroring, leaning in and uncrossed arms are also perceived as significant rapport components (Keller et al., 1978; Saywitz et al., 2015). Other strategies, such as social rewarding demonstrating encouragement (e.g., high-five, smiling) and praise (e.g., ‘Well done’, ‘Nice try’), which exhibit approval from the speaker (Brophy, 1981), can create a supportive atmosphere that increases child participation and further improves the child-adult (e.g., therapist, teacher) relationship (Maenner et al., 2016; Ducharme & Harris, 2005; Wiethoff, 2005).

In the context of autistic children, some rapport-building strategies may be less successful during therapeutic sessions. This is because autistic children might not respond to ‘typical’ social signals in the same way as non-autistic children and might express themselves differently (Mitchell et al., 2021). For example, autistic children might find it difficult to interpret and answer open-ended questions (Vicker, 2002) or maintain eye contact (Kapp et al., 2013). Similarly, autistic children might find small talk and the use of light-heartedness exchanges challenging, as the underlying intention of the message might not be clear or directly relevant to them, leading to literal interpretation or perceiving it as purposeless (Cola et al., 2022; Samson et al., 2013; Samson & Hegenloh, 2010). However, it is important to consider that generally individuals might have diverse perspectives, experiences, and use different interactional styles that can potentially result in difficulties in empathising with a social partner and interactional flow ‘breaks’. Drawing on the ‘double empathy problem’, the interactional mismatch that occurs between autistic and non-autistic individuals may be due to an interactional breakdown of mutual understanding and reciprocity between the individuals who do not share similar experiences with each other (Chown, 2014; Milton, 2012; Mitchell et al., 2021). For example, Crompton, Ropar et al. (2020) and Crompton, Sharp, et al. (2020) suggested that autistic dyads experience smoother communication with fewer communication breaks compared to autistic-nonautistic dyads. Autistic individuals may find neurotypical interactional norms confusing or difficult to navigate, leading to potential misunderstandings and communication breakdowns. Thus, rapport-building between autistic-nonautistic individuals might be more

challenging as the social expectations and interactional styles used might differ. Heasman and Gillespie (2019) explored interactions between two autistic individuals playing video games demonstrating that ‘generous assumptions of common ground’, when comprehended, led to alignment and successful rapport-building events between them. This further suggests that autistic individuals adopt interactional styles substantially more readable by other autistic individuals compared to non-autistic (Milton, 2012; Mitchell et al., 2021). Therefore, health professionals attempting to interact and establish rapport with autistic children through ‘typical channels’ might face challenges because of their different interactional styles (Mitchell et al., 2021).

In healthcare settings, each participant mainly holds a distinct interactional role due to the nature of the interaction. However, they might shift between different roles depending on how the topic of discussion, events and dynamics unfold during the interaction (Cahill & Papageorgiou, 2007; Tates & Meeuwesen, 2001). During therapeutic sessions, it is anticipated that healthcare professionals would principally hold the role of the ‘expert’ due to the nature of the interaction (Parsons, 1952). Holding the ‘expert’ role implies that the individual possesses the relevant knowledge, skills, experience and access to resources essential to understand and address the patient’s need(s) (Cahill & Papageorgiou, 2007; Parsons, 1952), which fundamentally displays power (Freidson, 1970; Greene & Adelman, 2013). The healthcare professional’s interactional style might involve a directive approach following a specific agenda and use of medical jargon (Fisher, 1991; Greene & Adelman, 2013; Mishler, 1984; Roter & Hall, 2006). Respectively, the child is anticipated to primarily hold the dual role of the ‘patient’ (Greene & Adelman, 2013; Korsch et al., 1968) and ‘dependent child’ (Mårtensson & Fägerskiöld, 2008; Tates & Meeuwesen, 2001). Being the patient indicates that they receive or are entitled to receive a therapy (Greene & Adelman, 2013; Korsch et al., 1968), while the role of the dependent child refers to an individual who is a minor relying on their parent(s) (Mårtensson & Fägerskiöld, 2008; Tates & Meeuwesen, 2001). Additionally, the child might also be positioned as a ‘passive participant’ (i. e., ‘nonperson’) (Goffman, 1990; Lambert et al., 2012), due to the healthcare professional’s interactional style and the child’s developmental stage (Coyne & Kirwan, 2012; Davies & Randall, 2015). This positioning may also stem from perceptions of the child’s competence underestimating their ability to contribute meaningfully during the interaction (Coyne, 2006; Coyne & Kirwan, 2012).

Previous research has explored how rapport between neurotypical children and professionals has been established in different medical/healthcare settings (e.g., general practice) and session types (e.g., consultations) (Cahill & Papageorgiou, 2007; Garcia, 2012; Greene & Adelman, 2013; Tates & Meeuwesen, 2001). However, a limited number of studies have considered the interactions between medical/healthcare professionals and children with disabilities (e.g., Dunkerley et al., 1997; Tannen & Wallat, 1987; Tickle-Degnen & Coster, 1995), despite these interactions likely to involve greater disparities of interactional style and power. To date, few studies have focused on interactions between autistic children and healthcare professionals (Garcia, 2012), with none of them focusing on their therapeutic relationship and rapport (Damico & Nelson, 2005; Geils & Knoetze, 2008; Maynard, 2014; Stiegler, 2007; Urano et al., 2011). To address this gap in the literature, this study used the context of SIT sessions to explore autistic child-OT interactions and the ways in which rapport was established.

## 2. Methods

### 2.1. Study design

This study involves a secondary theme-oriented discourse analysis of 50, 1-hour, SIT video-recordings from the Sensory Integration Therapy

in Autism(SenITA) Randomised Controlled Trial (RCT) <sup>2</sup> dataset (Randell et al., 2022). It follows two autistic children throughout their therapeutic journey over 26 weeks, exploring the communication strategies used by OTs to build and maintain rapport. Rather than relying on OT's accounts of SIT sessions, the data can be used to reveal what is or is not said and how it is said. This study does not address SIT's principles, effectiveness, validity, or reliability, as these aspects have previously been investigated (Milosevic et al., 2022; Randell et al., 2022, 2024).

This study is part of a doctoral study led by EG, who has a background in speech and language pathology and special and inclusive education. The researcher's position as a person and professional might have influenced aspects of the study design. For example, the topic selection and research aims and questions, the data collection and interpretation as well as the conclusions drawn (Barry et al., 1999). However, in a conversational model of social positioning, the researcher's own social position was less significant than their professional position in forming the data selection, analysis and presentation. Reflection notes, broader thematic nodes, thorough research plans and reflexive reviews with PhD supervisors (LBH, RM, MBM, CRGJ), as well members of the SenITA RCT (ER, SD) with an extensive expertise in discourse analysis, autism and neurodiversity, occupational therapy, trial design and longitudinal data management, were some of the strategies used to integrate diverse perspectives and prevent bias toward one voice.

## 2.2. Sample strategy and selected case studies

The final SenITA dataset involved a large set of video-recordings ( $n \approx 615$ ) of OT assessment sessions, SIT sessions and re-assessment sessions of 69 participants carried out across several sites. For the purposes of this study, only videos from the 24 SIT sessions were included (Fig. 1). The structure of a typical SIT session included an opening, middle and closing. The session's opening involved initial engagement with the child based on their mood and regulation state. The middle of the session involved warm-up activities aiming to prepare the child for the core SIT activities targeting different sensory-motor factors based on the child's needs and interests. The core SIT activities facilitated the processing and integration of sensory information from the vestibular system (e.g., platform swing, trampoline) or the proprioceptive (e.g., gymnastic rings, skittles) and/or tactile systems (e.g., textured objects/toys) to improve motor skills, self-regulation and social-emotional development. The end involved the session's closing in which the OT prepared the child to transition out of the intervention setting as well as provided the parent debrief and strategies that can be used at home. At the time of sample selection, the SenITA RCT was still actively recruiting participants with 32 having completed the intervention. Thus, we selected our sample from a sub-sample of the SenITA RCT total number of participants.

In this study, the sample strategy and selection did not rely on the number of the RCT participants or video recordings (Parry, 2008; Roberts & Sarangi, 2005). Consequently, the sample was selected based on the number of interaction episodes (i.e., content richness) related to the topic of interest (i.e., rapport). Two case studies were selected (Table 1) to enable in-depth analysis of the interactions, while also enabling some comparison and contrast to be drawn between them (Harrison et al., 2017).

Site A involved interactions between a nine-year-old autistic girl (Cleo) and her female OT (Sofia). During the therapeutic session, the mother was always present observing the sessions. Cleo had fluent speech and her Sensory Processing Measure (SPM) score indicated at least moderate sensory difficulties (Parham et al., 2007). During SIT sessions, Cleo's behaviour indicated potential special interests in wild

animals and cats. Sometimes she moved around the therapy room during challenging tasks. The OT was very experienced in delivering SIT sessions and was one of the two OTs who mostly delivered SIT sessions during the SenITA RCT. The therapy room had the biggest dimensions of all settings, enabling the OT to have all resources and equipment in the room or available in a locked cupboard.

Site B involved interactions between an eight-year-old autistic boy (Julius) and his female OT (Selene). In some cases, the mother was present in the therapy or observation room. Julius has fluent speech and his SPM score indicates definite sensory difficulties (Parham et al., 2007). During SIT sessions, Julius' behaviour indicated potential special interests in Star Wars, while his hobby was martial arts. Julius moved around the room a lot and had frequent breaks between tasks, especially challenging ones. The OT was experienced in delivering SIT sessions and one of the OTs who mostly delivered SIT sessions. The therapy room was half the size of the site A and had an additional observation room, which was used by the mother to observe the sessions. The door between these rooms was open or closed depending on the interaction, thus when the door state changed (i.e., open, semi-open, closed) it was also mentioned in the transcript. The material and resources used during each session were stored in both the therapy and observation room.

## Ethical approval

Ethical approval for the SenITA RCT and the SIT video-recordings for this study was granted by the Wales Research Ethics Committee 3 (Randell et al., 2019, 2022). Appropriate informed consent was obtained for all participants.

## 2.3. Data collection and management

All the SIT sessions were video recorded, collected, and uploaded by the OTs delivering the sessions to a secure server at the Centre for Trials Research, with participants' names and clinical sites coded to ensure confidentiality. All procedures for data storage, processing, and management adhered to the General Data Protection Regulation 2016 (Randell et al., 2019, 2022).

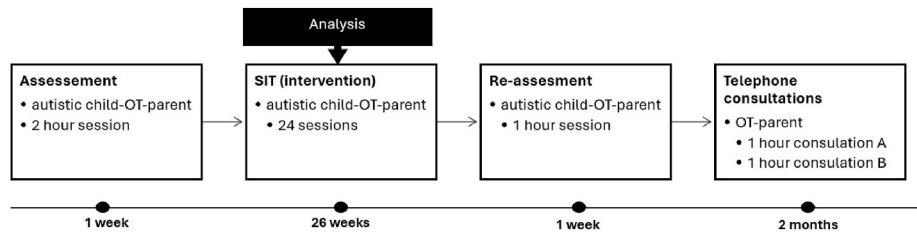
## 2.4. Theme-oriented discourse analysis

A theme-oriented discourse analysis (DA) was used to identify and capture how participants interacted and built rapport during different SIT activities within each session throughout the therapeutic journey. Theme-oriented DA was specifically designed to explore talk in medical and healthcare encounters (Roberts & Sarangi, 2005). It involves the exploration of 'analytic themes' drawn principally from sociolinguistic concepts, revealing how meaning is negotiated within an interaction, and 'focal themes' enabling the researcher to focus on the lens of the research study (Roberts & Sarangi, 2005).

Three different analysis stages were followed: (a) repeated video viewing to identify and select interactional segments (i.e., distinct parts of an interaction where participants engage in meaningful exchanges related to the focal theme), (b) extract preparation for theme-oriented DA (i.e., transcription and conventions – Appendix A.), and (c) repetitive transcript reading based on sociological and cultural concepts of the focal theme. Then, theme-oriented DA was applied to the selected extracts of the two case-studies. The analysis was performed by EG, while LBH, RM, MBM, and CRGJ provided methodological guidance and reflective discussions.

In this study, rapport constitutes the focal theme. The notion of rapport, in the context of child therapeutic encounters, involves a dynamic co-constructed process between all participants involved based on communication, synergy, trust, and mutual understanding (Beebe & Lachmann, 2015; Piaget, 1955; Saywitz et al., 2015). This is a significant element that explores what occurs during the participants' interactions,

<sup>2</sup> The SenITA RCT examined the clinical and cost effectiveness of SIT sessions compared to usual care for autistic children with sensory processing difficulties. Although the sessions took place in an NHS setting, the research was conducted within a clinical trials unit Segrott et al. (2024).



**Fig. 1.** SenITA RCT session timeline  
*Note.* This figure provides the SenITA RCT session timeline followed for each participant.

**Table 1**  
Selected Participants.

Child <sup>a</sup>	Gender	Age	Occupational therapist	Parent attending session	Site <sup>b</sup>
Cleo	Female	9 years and 10 months	Sofia	Mother and/or Father	A
Julius	Male	8 years and 1 month	Selene	Mot <sup>b</sup> er	B

*Note.* This table provides the two selected participants’ characteristics.  
<sup>a</sup> Pseudonyms are used within the original extracts for confidentiality purposes.  
<sup>b</sup> Sessions conducted in two different clinical locations.

influencing the autistic child-OT relationship. Using strategies of building and maintaining rapport in child therapeutic settings, the child and the OT can co-construct new outlooks to foster their relationships throughout the therapeutic journey. A wide range of analytical devices were used in the selected examples, with a focus on the relational aspects of the two case studies: (1) humour and laughter (Dziegielewski et al., 2003; Savage et al., 2017), (2) reformulations/repairs (Cuenca & Bach, 2007; Gülich & Kotschi, 1995), (3) linguistic mirroring/alignment (Giles, 1973; Szczepek-Reed, 2020), (4) hedging and mitigation (Ali & Salih, 2020; Antaki, 1994), and (5) personal narrative (De Fina & Johnstone, 2018; Schank, 2000).

3. Results

The analysis was focused on rapport-building examples from two case studies involving autistic child-OT interactions during SIT sessions. Sometimes the parent(s) were also present in the room observing and/or participating in the session. The extracts selected were from the beginning, middle, and end of the SIT sessions, either during and/or between different activities.

The selected extracts involved three episodes of speaking about personal interests and showing preference for items, and two episodes where the OT creates a child-led atmosphere via directiveness, non-directiveness and social rewarding.

3.1. Talking about personal interests and showing preference to specific items

We explored how discussing non-hostile topics (e.g., personal interests and likes) could serve as an opportunity to establish rapport with the child, while also obtaining valuable information for use in future sessions, encouraging child participation and maintaining rapport. We found that the OTs discovered the child’s preferred items and interests by fostering an attentive approach that allowed space for the child to open and lead the discussion topic and/or activity. The attentive approach was demonstrated in different ways across the sessions. We also noted that the OTs exhibited approval and agreement with the child’s preferences, which appeared to facilitate the child in freely expressing themselves. This appeared to enable the OT to bond and

connect with the child (and sometimes the parent) beyond the therapeutic lens, forming an open and friendly atmosphere that enabled a stronger relationship.

3.1.1. Allowing and encouraging the child to share her personal interests: animation, legendary creatures and animals – setting A, session 1

This example (Table 2) was from the child’s first therapeutic session. We demonstrated how the child opened a conversation about her personal interests. Here the child was primarily sharing their own interests but notably asked the OT if they share the same interests, which enabled the OT to build the conversation by offering personal information in the first therapeutic session. This potentially reflected the child’s need to connect with the OT during a ‘fixed’ situation in which they had to set up the equipment for the next SIT activity. This consequently resulted into a successful transition to the next activity involving sitting on a scooter-board at the soft play ramp.

Throughout this interaction, the participants were aligned as they collaboratively set up the equipment for the next activity and discussed their likes and personal interests. This led to a smooth transition to the next therapeutic activity. In line 1102, the OT directed the child how to set up the equipment and then the child attempted to introduce new information (lines 1104–1105), potentially displaying openness to connect with the OT. This was a successful attempt to create a positive interaction between interlocutors and enough space for both to bond and build rapport, as demonstrated in the next lines. In this extract, the turn-takes between lines 1106 to 1111 facilitated the interactional flow, bridging the gaps between the two activities that could have led to communication breakdowns, while also creating an opportunity for rapport development. They continued to co-expand the discussion topic as the activity progresses. The OT adopted an attentive approach by displaying agreement and openness. They allowed space for the child to initiate the discussion about personal interests (lines 1111; 1114; 1117–1118) and offer their personal experience (lines 1117–1118). Allowing and encouraging the child to expand a chosen topic, could contribute to the relationship growing beyond the therapeutic frame. This example demonstrated how participants made the most of the time between tasks as an opportunity not only to share information about their interests, which can be used to increase future child participation, but also to build a stronger therapeutic relationship.

3.1.2. Expanding the discussion about the child’s favourite TV series: Paddington Bear and Bagpuss - setting A, session 3

This example (Table 3) showed how the OT learned more about the child’s personal interests with the mother’s help during a task-oriented activity. The OT expanded the discussion about the child’s favourite TV series, while also sharing a personal preference that potentially enabled participants to bond. Although this interaction might look simple, it contributed towards participants’ rapport building and overall relationship. This interaction occurred after a challenging and intensive activity for the child, who laid on their stomach on a scooter-board navigating through an obstacle course several times. In the current activity, the child approached the activity area unprompted, climbed on the platform swing and took position signalling the start of the next therapeutic activity (lines 879–880).



**Table 2**

Animation, legendary creatures and animals – Setting A, session 1.

1101 CHI:	((drags with both hands a soft play ramp towards OT))
1102 OT:	Right, put that there ((touches soft play ramp with
1103	hand))
1104 CHI:	((lifts scooter-board)) Guess what DVD <u>I</u> 've got and it's
1105	() actually! ((places scooter-board on top of soft play
1106	ramp))
1107 OT:	What's that? ((surprised softer tone)) ((leans towards
1108	CHI))
1109 CHI:	((whispers in OT's ear while hiding her mouth with an
1110	open hand))
1111 OT:	O:h cool ((softer tone)) (.) I love that!
1112	(1.5)
1113 CHI:	Do you like (my little) po:ny?
1114 OT:	I do!=I (.) love all of these! ((loud camera clicking))
1115 CHI:	What about <u>unicorns</u> ? ((climbs over foam ramp and sits on
1116	the top of scooter-board))
1117 OT:	Yes!=I like those as well (.) I always wanted a <u>pony</u> when
1118	I was a little girl!=So, (you are) gonna go do:wn <u>here</u> .
1119	((points towards the end of soft play ramp))
1120 CHI:	((scoots over the end of soft play ramp))
1121 OT:	Very <u>well</u> ! ((picks up scooter-board and places it on top
1122	of soft play ramp))
1123 CHI:	((returns to start line and sits on top of scooter-board))

In lines 882 and 883, the child initiated the conversation that built up a discussion about Paddington Bear, potentially to adding a more interesting layer to the SIT activity. However, the OT did not initially follow the talk direction (lines 884, 887) that the child attempted to introduce, despite the attempts in lines 882 and 885 leading to a long gap (1.8; line 888). In line 890, the mother mirrored the OT by repeating the OT's question in line 887, prompting the child to answer, while also displaying alignment with the OT. Building on the mother's turn, the OT then continued with a reformulated follow-up question (line 891) directed to the child aiming to repair the communication failure/error (Golinkoff, 1985; Sacks et al., 1974) in line 888. Between lines 892 and 895, the communication failure was not yet repaired, as the child continued the narrative about Paddington, while the OT attempted to repair the break by: (1) repeating the child's statement conveyed as a question (line 893) (Cuenca & Bach, 2007) and, (2) seeking help directly from the parent via an open-ended question (line 895), to understand what the child referred to. The mother's reply towards the OT's request for clarifications (line 896) functioned as a repair mechanism allowing the interaction to flow, while also shielding the child-OT talk from future communication breaks.

The mother's contribution enabled the OT to catch-up with the discussion topic (line 897) and the child to continue adding more Paddington bear characters to the narrative, while also performing the activity (line 898-897). The OT then further commented on the child's narrative (line 899), sharing amusement that displayed alignment. In line 901, the OT produced a positive tag question to further emphasise interest and alignment, while also potentially ascertaining that the communication break was repaired. Between lines 902 and 904, the mother further clarified why the child mentioned Paddington Bear, displaying her 'good parenting' face (Assarsson & Aarsand, 2011; Goffman, 1990; Lareau, 2011), while also potentially attempting to preserve their synergy. This further allowed the adults to speak about

the TV programme (lines 905, 906) and subsequently encouraged the child to engage in the conversation (line 907), initiating a discussion where all three interactants displayed alignment. Between lines 905 and 918, the OT further built on the animations topic and introduced a different children's television series, enabling not only all parties to lighten the mood, and express themselves, but also building rapport within the therapeutic session's boundaries.

Allowing and expanding the discussion of personal interests, such as a film or TV programme, might function as a mechanism to relax and/or shift the child's focus to a more friendly topic beyond the therapeutic lens, repair communication breaks, and preserve rapport. This also enabled the child to freely express themselves within the therapeutic environment, while also building their relationship with the OT. Additionally, the OT and parent had the opportunity to interact and build rapport with each other without shifting the focus from the child and the therapeutic goals.

### 3.1.3. Using Child's preferred item during the therapeutic session: lightsabres and Star Wars – setting B, session 1

In this example (Table 4), we demonstrated how the child showed preference towards lightsabres and how the OT used them within the therapeutic activity. The child sequentially completed four different tasks, aiming to improve overall balance and motor skills: (a) jumping on a mini trampoline while catching and throwing a mini foam ball, (b) moving to a mini scooter-board ramp, (c) riding the scooter-board and (d) returning to the start to repeat tasks. The parent was also present during the session, observing from the observation room.

In line 189, the child grabbed two lightsabres and moved towards the OT, who was between the mini scooter-board ramp and trampoline. The OT then took the opportunity to interact with child by producing an open-ended question (line 191) and immediately latching 'Sabres?' offering the answer, seeking confirmation that was then accomplished

**Table 3**  
**Paddington Bear and Bagpuss – Setting A, session 3.**

879	CHI:	((climbs on platform swing, stands upright, opens arms and
880		holds swing ropes with hands))
881	OT:	((goes behind child))
882	CHI:	This is (.) (my bed at my house) (.) THIS IS (.) MY BED.
883		((moves back and forth on swing using arms))
884	OT:	°Right,° °Okay.° ((pushes the swing forward))
885	CHI:	At aunt Lucy's ((Paddington bear's aunt)) house! ((moves back
886		and forth on swing))
887	OT:	Do you want a blanket then?
888		(1.8)
889	CHI:	((moves back and forth on swing))
890	PAR:	Cleo, Do you want me to get the blanket?
891	OT:	Are you going to sleep?
892	CHI:	() on the ground. ((moves back and forth on swing))
893	OT:	On the ground? ((surprised voice))
894	CHI:	Yeah! ((laughs)) ()
895	OT:	What's that?
896	PAR:	Paddington.
897	OT:	O:h, I see. ((pushes swing forward))
898	CHI:	With Mr Brown and Mrs Br[own!] ((moves back and forth on
899		swing))
900	OT:	[And ] >both together< Wo:w!
901	CHI:	And the others. ((moves back and forth on swing))
902	OT:	You like >Paddington bear< then, (Don't you?)
903	PAR:	Yeah we just- there's a <u>new</u> film Paddington two has come out,
904		so we've watched (.) Paddington one and now we're watching
905		Paddington <u>Two</u> .
906	OT:	Yeah (.) I used to remember the <u>TV</u> programme.
907	PAR:	Yeah, Yeah, I know.
908	CHI:	I KNOW IT! ((moves back and forth on swing))
909	OT:	Have you got the old one?=I've got [(.) I bought things like]
910	CHI:	[I've seen the old thing ]
911	OT:	<u>Bagpuss</u> ((70s British children's TV series)).
912	CHI:	I LIKE BAGPUSS! ((moves back and forth on swing))
913	OT:	You like Bagpuss?=Ye:ah I <u>love</u> that. ((pushes swing forward))
914	CHI:	We:: ((moves back and forth on swing using))
915	PAR:	Yeah, it's my favourite thing, Bagpuss!
916	CHI:	We:: ((moves back and forth on swing using))
917	PAR:	Showing our age now Sofia! ((laughs))
918	OT:	Oh, I know! [(laughs)]
919	PAR:	[(laughs)]

with the child humming (line 192). This open-ended question could have been more successful if the OT had not immediately provided the answer and had allowed time for a response. Consequently, the OT attempted to further expand the lightsabre topic, possibly to encourage child engagement as the child seemed to enjoy playing with them. First, the OT requested ' = Can I have a sabre?' displaying interest towards the captivating items for the child, potentially to build rapport. She then latched two inverted interrogative questions (Heritage, 2008, 2010) (lines 193–194) displaying not only proposition, but also seeking child confirmation. This possibly demonstrated the OT's need to connect and

gather additional information about the child's interests to further develop their relationship. However, the child did not reply, resulting into a long gap (line 195), left one of the lightsabres in the original spot, and continued playing with the other lightsabre (line 196).

The OT then attempted to repair the communication failure/error (Golinkoff, 1985; Sacks et al., 1974) by forming a simpler and shorter question (line 197), but the child was still focused on playing alone and did not reply. Consequently, the OT attempted to repair and further bridged the 'break' by going closer to the child and asking, 'Can I have one?' showing availability to play with the child and their preferred

**Table 4**  
Lightsabres and Star Wars – Setting B, session 1.

189	CHI:	((grabs two lightsabres placed next to mini scooter-board ramp
190		and moves towards OT))
191	OT:	O:h What are <u>they</u> ?=Sabres?
192	CHI:	H:m. ((crosses above his head the two sabres))
193	OT:	>Okay.<=Can I have a sabre?=Are (.) they sabres, (.) Like in
194		(.) light sabres?=Like in (.) Star Wars?
195		(2.7)
196	CHI:	((leaves one lightsabre next to mini scooter-board ramp))
197	OT:	Do you reckon?
198	CHI:	((swishes, moves around room and plays with one lightsabre))
199	OT:	Can <u>I</u> have one? ((goes closer to the child))
200	CHI:	No:
201	OT:	NO?=NO?
202	CHI:	E:w. E:w. ((swishes and plays with lightsabres in front of
203		observation window))
204	OT:	O:h Careful!=On the trampoline, if you're going to do <u>that</u> (.)
205		and (.) I'm going to see if you can- ((1.8))
206	CHI:	((swishes, plays with lightsabre and goes to trampoline))
207	OT:	I'm going to see if (.) you can (.) <u>bat</u> something away
208		((searches for object))
209	CHI:	Yes! ((excited) ((jumps on trampoline while holding
210		lightsabre))
211	OT:	Could you bat this away? ((holds a foam ball)) =With your
212		sabre?
213	CHI:	Okay.((continues jumping))
214	OT:	Shall we have a go? ((excited))
215	CHI:	Yes! ((continues jumping))
216	OT:	((throws ball towards CHI))
217	CHI:	((hits ball with lightsabre while jumping))
218	OT:	((picks ball)) Again?
219	CHI:	Yes! ((continues jumping))

items. The child replied negatively (line 200), which was unexpected for the OT who repeated the child's turn twice 'NO? = NO?' with louder voice than usual. This further confirmed that the communication break was not yet repaired, since the child continued playing alone with the item in front of the observation window. In the following lines (204–205), the OT successfully recovered the breakdown by incorporating the lightsabres within the therapeutic activity. The child returned to the activity start (i.e., mini trampoline) and jumped, while holding the lightsabre (line 206). The OT then attempted to incorporate an additional item in combination with the lightsabres by first informing the child (line 207–208) and the child, excited, agreed. The OT then invited the child to bat a medium foam ball with the lightsabre (line 211–212) leading to a confirmation from the child (line 213). In line 214, the OT requested 'Shall we have a go?', demonstrating intention to integrate the item within the therapeutic activity while also inviting the child to decide (i.e., child-led), thus the use of 'shall'. Switching from 'you-talk' (line 211) to 'we-talk' (line 214), enabled the OT to foster rapport with the child as the use of 'we' implied synergy, connecting the OT's intentions to the child's, sharing a mutual understanding. They then proceeded with the activity which was collaboratively repeated until the next activity.

In this example, we demonstrated how the child showed preference towards an item (lightsabres) which was available in the room. We also

showed how the OT attempted to connect and repair the 'communication break' caused by the lightsabres, which shifted the child's focus away from the session. The break was repaired by using: (a) simpler and shorter questions, (b) offers, (c) proposals (d) words displaying partnership (i.e., 'we'), as well as, (e) integrating the item within the therapeutic activity. This enabled the OT not only to bridge the 'break' between them, but also build rapport and develop their relationship.

### 3.2. Creating a child-led atmosphere: directiveness, non-directiveness and social (Verbal and non-verbal) rewarding

In this section, we demonstrated how the use of specific communication strategies (e.g., invitations, social rewarding) can be used by the OTs to foster a positive interaction with children and encourage their participation. When the OTs used both verbal and non-verbal social rewarding (e.g., 'Fantastic!', clapping) (2) non-directive (e.g., invitations), and/or (3) directive requests (e.g., option-posing), they encouraged the child to gain power and make synergistic decisions. This created a collaborative atmosphere, which enabled alignment and rapport development between participants.

### 3.2.1. Allowing 'space' for the child to lead during a target practice (skittles) activity: social rewarding, directiveness and non-directiveness - setting A, session 7

This example (Table 5) uncovered how the OT encouraged the child throughout the activity, using social rewarding, non-directive and/or directive strategies depending on the sub-task that the child was completing. Using these strategies the OT attempted to foster a positive and enjoyable interaction with the child, while also maintaining their rapport. The child had to push the scooter-board to knock down the mini and big foam skittles (target practice activity) aiming to further improve hand-eye coordination and overall balance. This extract captured the child's last two attempts, as the child then requested to knock down the skittles while riding the scooter-board, which was the upcoming (and more advanced) task, based on previous therapeutic sessions.

In line 220, the child pushed the scooter-board and knocked down only the mini foam skittles, which was the first of the two targets. Thus, the OT chose to downplay the outcome by conveying a positive tag question (lines 221–222), potentially to shift the focus from the child's performance and preserve participation. The child then informed the OT about what she will do next and picked up the scooter-board (lines 223–225). This demonstrated that the OT successfully maintained the child's participation, despite not fully achieving the goal of knocking down all the skittles. In line 226 the OT, using two directives, further encouraged the child to 'go on) then (push it) back up!', which the child does whilst also vocally imitating a car horn sound (i.e., 'Be:ep. = Be:ep.'). possibly to make the process more interesting and playful (line 227–228). In line 229, the OT mirrored the child's turn by repeating the car horn sound, displaying alignment towards the child. Between lines 233 and 235, the child pushed the scooter-board to the start of the mini ramp to restart the task, while they further discussed the challenges in succeeding at the task due to the equipment.

In line 237, the child counted to three signalling her attempt, while the OT directed the child to 'Push it h:ard.' (line 238), reminding the child that this activity required strength to successfully knock down the skittles. Indeed, the child pushed the scooter-board with force knocking down all the mini and one of the two big foam skittles and immediately laughed, exhibiting satisfaction with their achievement (lines 239–240). The OT then cheered the child's accomplishment and clapped, which acknowledged the child's effort. This created a friendly and empowering 'space' for the child, who mirrored the OT (line 242) and immediately they both laughed (line 242–243) displaying alignment and a positive relationship. In line 243, the OT continued empowering the child to continue by highlighting the child's successful attempt with a statement. Between lines 242 and 261, the child returned to the activity start and, in collaboration with the OT, reorganised the equipment for the next round. This was another display of alignment. Throughout this process, the OT used follow-up (line 252) and option-posing (line 252–253) questions, allowing space for the child to communicate their preferences (lines 251, 254) and make decisions on the equipment setup (line 248–261). In line 262, the OT returned next to the child, signalling the task start. The child then informed 'I'll do it myself!' and the OT further encouraged them (line 264). The child then slid down and knocked down all the skittles (line 268). The OT immediately leaned towards the child and clapped (line 269), acknowledging the child's effort, while the child laughed (line 270) in another display of happiness. In line 271, the OT also socially rewarded the child 'Well done!', emphasising approval, while also clapping to further enhance praise towards the child's accomplishment. Then, the child loudly commented on the outcome and laughed, projecting happiness and excitement due to their success and approval obtained by the OT (line 272). The OT then also confirmed loudly 'YOU DID!' and then latched another social praise (line 273), displaying alignment and fostering a deeper therapeutic relationship.

In this example, we revealed how the OT used several different strategies throughout the activity: (1) verbal and non-verbal social rewarding (e.g., Well done!, clapping), (2) non-directive (e.g., tag questions and invitations), and (3) directive strategies (e.g., option-

posing requests) depending on the interactional moment. These strategies appeared to support the child in making decisions and in collaboratively lead the session with the OT. As a result, the interaction was underpinned by positive affect and the maintenance of rapport.

### 3.2.2. Encouraging the child to try out a new activity (Gymnastic rings): non-directiveness and social rewarding – setting B, session 7

In this example (Table 6), we demonstrated how the OT used verbal and non-verbal rewarding as well as invitations throughout attempts to: (a) encourage child participation during a new and repetitive activity, (b) praise the child for their effort, and (c) facilitate upcoming sessions requiring the child to perform intermediate and advanced tasks building on this activity. The child hung on to the gymnastic rings, pulling themselves up repeatedly as long as they could, with the aim of developing upper body strength.

In line 1101, the child hung on to the gymnastic rings and the OT instructed the child to notify when they will start their attempt, potentially reminding the child that they had control over the task (line 1102). The child then shared his next moves with the OT (lines 1103–1105) and then released his hands from the gymnastic rings and fell on the mat (lines 1104–1105). The OT then requested 'You want to pull up on those?' (line 1106) inviting the child to carry out the task differently. The child accepted the OT's invitation (line 1107) and immediately hung on to the gymnastic rings and pulled up (line 1109). This attempt was possibly unexpected by the OT, who acted surprised (line 1110), potentially because it was challenging to accomplish this from the first attempt. In line 1112, the mother clapped displaying non-verbal social rewarding that praised the child's effort. The OT then asked the child 'Mate ((laughs)) You are alright? = Are you alright?' possibly to ensure that the child did not hurt during the release, displaying empathy and care. Addressing the child as 'Mate' might be used to improve the child-OT relationship solidarity, since this term suggested 'a sense of companionship' (Leech, 1999). In line 1114, the child returned to the activity start and in the next lines the OT continued to develop their rapport.

Between lines 1115 and 1122, the OT chose to further socially reward the child for the first successful attempt, while also initiating a 'high five' that exhibited synergy and alignment between them, and potentially further deepened rapport. The mother also aligned with them by clapping (line 1120), which might serve as a mechanism to express gratitude and approval. In lines 1121, the OT continued verbally rewarding the child and latched a request for action, putting the child in position of power. The repetition of this request (line 1122) reinforced to the child that he has power to decide about the activity's next step. The session continued with the child successfully completing the task several times.

In this example, we highlighted the ways in which the OT encouraged the child to try out a new challenging activity for the first time. The use of invitations and offers, as well as verbal (e.g., That was fantastic!) and non-verbal (i.e., high-five) social rewarding, throughout the activity encouraged child participation and created opportunities to bond and deepen rapport. Additionally, the OT set the scene for upcoming sessions in which the child will perform more challenging tasks with the gymnastic rings (e.g., hanging and kicking), enabling further rapport development based on previous rapport events, such as this one, to ensure child participation.

## 4. Discussion

The concept of rapport in healthcare encounters, constitutes a critical feature of the developing positive therapeutic relationship (Norfolk et al., 2007; Ross, 2013). It allows professionals to elicit significant information from their patients, and encourages communication, collaborative work, and alignment between participants. In the current study, we followed two autistic children during their SIT journeys, exploring how rapport was build and how therapeutic relationship were formed



**Table 5**  
Target Practice Activity (Skittles) – Setting A, session 7.

220	CHI:	((pushes scooter-board, knocks down only mini foam skittles))
221	OT:	O:h No, they're not weighty enough to knock those big ones
222		over, Are they?
223	CHI:	I'll start again because (.) it's knocked all of these <u>small</u>
224		ones (.) down.=It (didn't) knock just the big one. ((picks up
225		scooter-board))
226	OT:	Oh, (go on) then (push it) back up!
227	CHI:	Be:ep.=Be:ep. ((pushes scooter-board with hands from opposite
228		side of mini ramp))
229	OT:	Be:ep.=Be:ep.=Beep.=Beep.=Beep.=Beep.= (Keep) <reversing,>
230		(Keep) <reversing.>
231	CHI:	Wo:w, is it just () back. ((pushes scooter-board))
232	OT:	I did.
233	CHI:	Watch, ((pushes scooter-board)) It didn't stay still!
234	OT:	They're quite (sliding) Aren't they?
235	CHI:	PING! ((reaches start of mini ramp))
236	OT:	You have to just do it <u>h:ard</u> .
237	CHI:	(One, two, three,)
238	OT:	Push it h:ard.
239	CHI:	((pushes scooter-board and knocks down one of the two big
240		foam skittles)) ((laughs))
241	OT:	We:y! ((excited)) ((clapping))
242	CHI:	We:y! We:y! ((excited)) [((laughs))]
243	OT:	[((laughs))] You managed one down!
244	CHI:	((goes to start))
245	OT:	Are they having another go? ((sets up big foam skittles))
246	CHI:	No.=Me this time.=I wanna go. ((leaves start of mini ramp))
247	OT:	O:h.
248	CHI:	But with that again! ((picks up scooter-board and returns to
249		the start of mini ramp))
250	OT:	Are you gonna put this one up?
251	CHI:	And the tiny ones ple:ase.=Can I have the tiny ones ple:ase?
252	OT:	The tiny ones as well?=On the (.) top ((index finger
253		pointing)) or (.) on [the-?] ((index finger pointing))
254	CHI:	[On tolp of there! ((shows with open
255		palm))
256	OT:	Yeah, Cos otherwise, (.) you'll just get stuck.=Do you
257		remember last time? ((picks up small foam skittles))
258	CHI:	Yeah. ((waiting on top of scooter-board))
259	OT:	((places mini foam skittles on top of big foam skittles)) It
260		was stuck under the (scooter-board,) (isnt' it?)
261	CHI:	Yeah.
262	OT:	((returns to start next to the child))
263		((inaudible cross talk between PAR1 & PAR2))
264	CHI:	I'll do it myself!
265	OT:	Go on then.
266		((inaudible cross talk and laughing between PAR1 & PAR2))
267	OT:	Go on then!
268	CHI:	((slides down and knocks down all skittles))
269	OT:	O:::H! [((leans towards CHI and claps))]
270	CHI:	[((laughing)) ]
271	OT:	<u>Well done!</u> ((clapping)) =Now it's <u>all</u> down! ((clapping))
272	CHI:	I DID (IT WITH) MY (FEET) ((laughs))
273	OT:	<u>YOU DID!</u> =That was <u>fantastic!</u>

**Table 6**

Gymnastic Rings Activity – Setting B, session 7.

1101 CHI:	((hangs on to gymnastic rings))
1102 OT:	Say when Julius, say When.
1103 CHI:	H:m Look at this!=I wanna do (.) I wanna do one more feet
1104	up.=And then I'm going to this!=Ye::ah! ((releases hands and
1105	falls off on foam mat))
1106 OT:	You want to pull <u>up</u> on those?
1107 CHI:	Kay.
1108 OT:	Okay. Well I-
1109 CHI:	Hu::h ((hangs on to gymnastic rings and pulls up))
1110 OT:	Who:a, Julius.((surprised))
1111 CHI:	((releases hands and falls off on foam mat))
1112 PAR:	((claps))
1113 OT:	Ma::te ((laughs)) You are alright?=Are you alright?
1114 CHI:	((returns to start of activity))
1115 OT:	Who:a, I think that deserves a high five Julius! ((goes closer
1116	to CHI))=High five for that! ((raises her hand about the child's
1117	head-height))
1118 CHI:	((raises his hand and slaps the flat of his palm against the
1119	OT's flat palm))
1120 PAR:	((claps extendedly))
1121 OT:	That was <u>fantastic</u> !=So, Julius (.) what do <u>you</u> wanna do?=What
1122	do you wanna do?
1123 CHI:	((reaches gymnastic rings with hands))
1124 OT:	Cause we've got another pair of these!=I'm going to put them
1125	a bit <u>lower</u> ?=So that you can pull up on them?
1126 CHI:	Ye:ah! ((hangs on to gymnastic rings and moves forward))
1127 OT:	Kay? ((goes to swing storing area))

between each child and their OT. rapport. Using theme-oriented DA, we found that rapport is a dynamic and co-constructed process. The OT's interactional style shifted between directiveness and non-directiveness, using invitations, offers, reformulations, and social rewarding. Additionally, switching from 'you' to 'we' talk was found to create a synergistic environment and further develop rapport between the autistic child and OT. The data suggest that encouraging and allowing autistic children to co-lead therapeutic sessions can increase engagement, alignment, and rapport with OTs.

In the current study, a key finding was that relationships and rapport between OT and autistic child dyads across SIT sessions were not static. Rather, they were a continuously changing and dynamic process (Fairclough, 1989; Saywitz et al., 2015). Our findings also suggested that rapport could be one of the 'ingredients' that gradually shifted the autistic child-OT communication from the perfunctory 'getting to know you better' interaction to a meaningful therapeutic relationship. Throughout these sessions, all participants were synergistically constructing their rapport and relationship during and between different SIT activities, regardless of who initiated the rapport building. Due to their professional identity and responsibilities, and nature of the interactions, the OTs might have initiated rapport more frequently than the children. However, this allowed the children to actively co-participate by aligning with the OT - either verbally or non-verbally. Shifting the focus away from who initiated the rapport building reveals that aligning and working collaboratively fosters a meaningful interplay in interaction. The OTs shifted between directiveness, non-directiveness, and 'you' to 'we' talk styles, while using different communication

strategies (e.g., reformulations, invitation, offers, social rewarding) to build and deepen rapport with the children.

Both of our case studies showed that invitation requests and offers from the OT to the autistic child might be less overpowering than directives, as they function as a mechanism to promote child participation, while also safeguarding the child-OT relationship. Aligning with these findings, research has also shown that invitations and offers prompting further elaboration can lead to better and positive interactions with children within therapeutic encounters compared to directive questions requesting further elaboration (Boyd & Heritage, 2006; Brown et al., 2013; Magnusson et al., 2020; Saywitz et al., 2015; Stivers, 2012). However, directiveness might result in shorter replies by the child, creating opportunities for adults to dominate the talk (Gilstrap & Ceci, 2005; Magnusson et al., 2020). Thus, our findings suggest that in the early stages of rapport building, the use of non-directiveness by the OTs might be a better mechanism to build rapport with the children rather than directiveness. However, the use of directiveness might no longer threaten the therapeutic relationship, once rapport has been established previous sessions.

In the current study, it was also observed that both case studies demonstrated the use of verbal and/or non-verbal social rewarding by the OT, and sometimes the parent. Examples included displaying attentiveness and expressing praise when the child succeeded and were seen to lead to positive interactions. We suggest that this would contribute to further deepening rapport and the therapeutic relationship. Our interpretation are supported by research highlighting that social rewarding can be a powerful rapport-building strategy, resulting

in a stronger relationship between adults and children in therapeutic encounters and beyond (Maenner et al., 2016; Wiethoff, 2005). Our findings are also supported by Brophy's (1981) earlier work on social rewarding within the educational context, highlighting that verbal social rewarding in classrooms can indicate the speaker's approval, which can boost the student-educator relationship. In the context of our OT sessions, we found that verbal social rewarding strategies might also encourage children to complete an activity and positively close a session, while also preparing them for similar activities in upcoming sessions. This is particularly relevant to autistic children, who might face challenges transitioning between activities (APA, 2022; Banda et al., 2009). Thus, our case studies revealed that the use of social rewarding by OTs allowed both parties to deepen their rapport and relationship.

As observed in the current study, switching between 'you' to 'we' talk can also foster a synergistic environment and further develop autistic child-OT rapport. Saywitz et al. (2015) has also highlighted that rapport constitutes a 'moment-to-moment interplay' among two and/or more people 'co-regulating' their talk, emotions, roles, and positions (Beebe & Lachmann, 2015; Piaget, 1955). We consider rapport as a continuous and powerful process, requiring all participants involved to synergistically dance the steps and movements of an interactive choreography. This is further supported by both of our case studies, which uncovered that encouraging and allowing space for the children to co-lead during each therapeutic activity, increased their engagement and alignment with the OT throughout each session.

Previous research suggests healthcare professionals seeking to interact and establish rapport with autistic children through 'typical channels' might find this difficult (Mitchell et al., 2021). However, our findings demonstrated that OTs were able to work collaboratively with autistic children towards shared interactional goals. Furthermore, whilst other research has shown that autistic children might find small talk and the use of light-heartedness exchanges challenging (Cola et al., 2022; Samson et al., 2013; Samson & Hegenloh, 2010), our findings show how light-heartedness can be used successfully to gain rapport. This emphasises the need to recognise each autistic children as an individual with individual interactional styles, needs, and interests.

Early medical/healthcare communication studies involving children often positioned them as 'non-person' (Goffman, 1990) and passive participants (Adelman et al., 1987; Aronsson, 1991; Aronsson & Rundström, 1988, 1989) during interactions. In contrast, the current study we found that the autistic children were equal protagonists who 'have voice', and who could contribute to and co-lead the sessions. This is not surprising as SIT is based on a child-led approach, focusing on the therapeutic relationship between participants, while also using play-based sensory activities (Case-Smith et al., 2014), thus positioning the child as an active participant. By including the autistic child as a co-partner within this 'interactive choreography' during each session, this model of OT practice means that participants can build rapport and a strong therapeutic relationship. Therefore, the current study supports that children can hold a much more active and powerful role when interacting with adults than considered in previous research (Hoogsteder et al., 1996; Tates & Meeuwesen, 2001).

We acknowledge both the strengths and limitations within this study with respect to methods used, practical constraints, and study scope. This study captured the therapeutic journey of two autistic children with different behavioural presentations, receiving SIT from two different OTs across two different settings. However, expanding the sample size in future research could provide broader insights into how autistic child-OT interactions unfold during therapy, as well as how parents position themselves within interaction, capturing a broader range of interactional styles and contextual dynamics. Nevertheless, the rich data generated from our longitudinal approach provided a powerful insight into autistic children's journey of rapport building during SIT sessions with their OTs. The findings have potential value to OTs and other healthcare professionals who work with autistic children. We hope the data encourage practitioners to reflect on their practice and explore new

approaches to communication and supporting different interactional styles with autistic children in clinical settings. Future work could integrate our findings into OT training, specifically targeting the development of practitioner interactional styles to build rapport with autistic child during therapy sessions.

Qualitative research is important to enable a detailed understanding of the autistic experience, which can be particularly relevant for professionals who support autistic people (e.g., medical and health professionals) (Bölte, 2014; O'Reilly et al., 2016). In this paper, a theme-oriented DA approach was used to explore autistic child-OT interactions during therapeutic sessions. In contrast to other possible methods, this study involved the analysis of real-life data revealing what was or was not said during autistic child-OT interactions. This research adds another meaningful layer to the complex topic of relationship building and rapport between autistic children and OTs in therapeutic encounters. By focusing on both the autistic child and OT, this study conceptualised all parties involved as equal collaborators working together towards therapeutic goals. Looking beyond the 'powerful' adults (i.e., OT-parent) interactions and positioning autistic children as equal protagonists, rather than passive participants, empowers autistic children and further highlights their contribution towards rapport building and shaping of the therapeutic relationship.

## 5. Conclusions

Shifting between non-directiveness and directiveness and switching from 'you-talk' to 'we-talk' styles through communication strategies, such as invitations, offers, reformulation, and social rewarding, might function as rapport-building mechanisms that support the positive development of autistic child-OT relationship in therapeutic encounters. The examples we included here provide an indication of the importance of encouraging and allowing autistic children space to have power and co-lead between and during activities. Using such strategies has the potential to increase overall participation and alignment with the SIT process.

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## CRedit authorship contribution statement

**Eleni Glarou:** Writing – review & editing, Writing – original draft, Visualization, Validation, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Rachel McNamara:** Writing – review & editing, Supervision, Resources, Conceptualization. **Monica Busse-Morris:** Writing – review & editing, Supervision. **Catherine R.G. Jones:** Writing – review & editing, Supervision. **Elizabeth Randell:** Writing – review & editing, Resources, Data curation. **Sue Delport:** Writing – review & editing, Conceptualization. **Lucy Brookes-Howell:** Writing – review & editing, Supervision, Conceptualization.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ssmqr.2025.100611>.

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