

BRIDGING THAT GAP: OCCUPATIONAL THERAPIST EXPERIENCES OF
CLIENT-CENTRED PRACTICE

By

WILLIAM BENNETT MORTENSON

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School
Department of Rehabilitation Science

The University of British Columbia
Vancouver, Canada

Date March 13/02

Abstract

Although client-centred practice has become an essential part of Canadian occupational therapy practice in the last twenty years (Law, 1998; Sumsion & Smyth, 2000), many authors have indicated that therapists do not practice in a client-centred manner (Law, Baptiste & Mills, 1995; Toomey, Nicholson & Carswell, 1995; Hammell, 1998a). Some authors have focused on how therapists are responsible for problems implementing client-centred practice, because they are unwilling to give up power (Sumsion, 1999c; Gage, 1999; Hammell, 1998a; Law, Polatajko, Pollock, McColl, Carswell, & Baptiste, 1994). As power has been identified as an important construct in the literature on client-centred practice, I have conducted an exploratory, qualitative study of occupational therapists' experiences of client-centred practice using standpoint theory and Foucault's work on power to frame the study. Based on a thematic analysis of in-depth ethnographic interviews of nine therapists from acute care and homecare settings three main themes were identified. "Bridging that gap: ideal versus real conceptions of client-centred practice" reveals the tensions that therapists experience between the discourse and practice of occupational therapy. "Related to the service environment: the importance of setting" focuses on how institutional factors shape practice. The final theme "a bit of tension: problems with the client-therapist relationship" describes the client-therapist interaction, which is influenced by discursive and institutional factors. The thesis concludes with a discussion of the theoretical implications, practical applications, limitations and significance of these research findings.

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Lastly, I would like to thank my wife Patricia, who supported me in my decision to return to university, reviewed countless drafts of my thesis, never gave up on me, and still let me go to the mountains.

Dedication

To:

Patricia;

and the nine therapists who shared their experiences with me

Chapter One - Introduction

Initial Research Problem

This research emerged as a result of a four-month period of personal journal writing, during which time I developed a large number of potential theses topics. Despite considerable variation in the nature of these projects, all reflected a common theme that related to my experiences with client-centred occupational therapy. Client-centred occupational therapy has been defined as a collaborative approach between a therapist and his or her client in which client goals are given priority and direct intervention (Sumsion, 1999d).

Since being graduated as an occupational therapist, I have struggled to implement client-centred practice in the settings that I have worked. Over this time my ideas about client-centred practice have evolved; but client-centred practice has remained a challenge for me. For example, I found client-centred practice especially difficult in settings where clients had no input into their goals or interventions and in settings where clients were forced into institutional care because of limited homecare resources that were available.

A review of the literature on client-centred practice revealed much discussion but little research. The discussions frequently blamed therapists for problems in implementing client-centred practice, citing their unwillingness to give up power, while underplaying the role of the institutional environment in shaping client-centred practice. Given the lack of research in this area, I felt that further investigation about therapist experience of client-centred practice was needed that would explore the role of power between clients and therapists and within the institutional settings in which they interacted.

Background to the Study

In the last twenty years client-centred practice has become an important part of occupational therapy practice in many countries around the world (College of Occupational Therapists, 1997; Peloquin, 1997; Mew and Fossey, 1996) and in Canada in particular (Law, 1998). The development of client-centred practice guidelines in Canada began in 1979 (Townsend, Brintnell and Staisey, 1990) and, since that time, has become a core tenet of Canadian occupational therapy.

Despite the history of client-centred practice in occupational therapy in Canada, client-centred practice has only recently been defined as client-therapist partnership that recognises the autonomy of clients, and the need for their input into decision making about occupational needs (Law, Baptiste and Mills, 1995). The amount of therapist input in goal setting is contentious, however. Some authors have advocated that the client should direct therapy with minimal therapist influence, which has been described as client-driven (Gage and Polatajko, 1995). At the heart of this debate is the question of whether therapists should be caring (Peloquin, 1990, 1993a, 1993b; Devereaux, 1984; Lloyd and Maas, 1991; Sachs and Labovitz, 1994) or empowering (Parker, 1999; Northen, Rust, Nelson and Watts, 1995; Townsend, 1999).

There are a variety of client-centred practice process models that have been proposed (e.g., Fearing, Law and Clark, 1997; Gage, 1999; Matheson, 1998; Sumsion, 1999c). Although these models best suit a client who is completely autonomous in decision making, some authors have described how clients with problems with cognition and decision making could be involved in client-centred practice (e.g., Hobson, 1996, 1999a, 1999b; Hammell, 1998a).

Although there has been considerable discussion surrounding the implementation of client-centred practice (e.g., Law, 1998; Sumsion, 1999b; Fearing and Clark, 2000), there has been little research on client-centred practice and even less research on how therapists have experienced it. Most phenomenological research concerned with occupational therapists' lived experience has only indirectly considered their experience with client-centred practice. Although this research reveals elements of client-centred practice exhibited by practitioners, most was conducted prior to the formal adoption of client-centred practice by the professional associations of the therapists studied (e.g., Hasselkus and Dickie, 1990, 1994).

Most research on client-centred practice has tended to hold the therapist responsible for problems implementing client-centred practice such as research on administering the Canadian Occupational Performance Measure (COPM) (Law et al., 1994), a client-centred assessment, or Sumsion and Smyth's (2000) work on therapist barriers to client-centred practice.

Some research has suggested different causes for problems with client-centred practice. Abberley (1995) suggested that occupational therapy's discourse of partnership and holism was a professional rhetoric that benefited the profession rather than the client. The need for therapists to adopt practices that increase professional status has been noted to conflict with attempts to promote an egalitarian therapeutic relationship (Peloquin, 1990; Norby and Bellner, 1995; Bellner, 1999). Other researchers have noted that institutional practices, such as those involved in case conferences (Opie, 1998) have limited client empowerment. Townsend's (1998b) study of community mental health services in the Maritime Provinces using institutional ethnography (Smith, 1987, 1990a,

1990b), revealed many of the hidden institutional barriers to client-empowerment in the settings that she studied.

In sum, discussion about client-centred practice has generally tended to blame the therapist for problems with its implementation, although the client and/or the practice setting have sometimes been implicated. An imbalance in power has been described as an underlying cause of problems with client-centred practice (Gage, 1999) and therapists have been accused of misusing or being unwilling to give up power (Peloquin, 1993; Hammell, 1998a; Gage, 1999; Sumsion, 1999c).

Despite the association between difficulties with client-centred practice and problems in power relationships in the occupational therapy literature, power was rarely defined in these discussions. A literature review on the subject of power revealed that power is a complicated construct and there has been considerable disagreement about how it should be defined. Davis (1993) suggested criteria for an adequate model of power that moved beyond customary definitions of power that focus on power being defined as the objective control that one group or person exerts over another (Labonté, 1996). Davis criteria suggested that power needed to be understood as either negative or positive and allowed individuals to have agency without blaming them for social inequalities.

Based on Davis' criteria I identified two theories that could adequately portray the construct of power: feminist standpoint theory and Foucault's view of power. Standpoint theory recognises that the marginalised position, or standpoint, of those in non-dominant groups provides them with an "epistemic privilege" (Narayan, 1998) in understanding their own lives, the lives of those in dominant positions, and relations between them (Harding, 1998; Smith, 1990). Foucault's view of power is difficult to encapsulate, as his

methodologies changed over time and Foucault was reluctant to explicitly define it. One of Foucault's major contributions to the study of power is the concept of discourse. Discourses are explanations of the world that create "effects of truth" that influence how social reality is understood and experienced (Foucault, 1980). Foucault described how conformity to social norms occurs as individuals "discipline" themselves due to the scrutiny of others (Foucault, 1980). Although this latter notion was seen as overly deterministic, Foucault noted that the use of power always produced resistance (Foucault, 1978) and used the term "governmentality" to refer to the relationship between personal autonomy, discipline and government that existed.

To explore occupational therapy discourse, I reviewed official position statements (e.g., Canadian Association of Occupational Therapists' (CAOT), 1997) and other explorations of occupational therapy values (e.g., Finlay, 1997; Adamson, Sinclair-Legge, Cusick, Nordholm, 1994; Kanny, 1993) and paradigms of occupational therapy knowledge development (Kielhofner, 1997). This examination revealed that occupational therapy discourse had both key features and inconsistencies. Although humanism and client-centred practice were core values, these competed with other values that often stemmed from earlier paradigms, which included professionalism (the therapist as expert), the importance of maximising function and independence, and the idea of holism.

These deliberations about power and discourse suggested that when considering the experiences of occupational therapists power needs to be understood in a way that balances individual agency and contextual institutional factors.

Specific Focus and Guiding Questions

The overall objective of this research was to explore therapist experiences with client-centred practice with the aim of revealing how power in the form of discourse and institutional processes shapes client-centred practice. My guiding questions were:

- 1) How do therapists define client-centred practice?
- 2) How do therapists describe their experience of client-centred practice?
- 3) What do therapists identify as barriers or enabling conditions to client-centred practice?

Methodology

A qualitative methodology was chosen because of the exploratory nature of this research, its focus on the experiences of therapists and because of my interest in revealing how discourse and institutional process shape client-centred practice. Qualitative interviews were used to allow an in-depth exploration of therapist experience, in which responses would not be merely confined to those listed in a survey or questionnaire. To emphasise the role of setting in shaping client-centred practice, therapists from two different physical medicine settings were interviewed: acute care hospitals and community-based homecare. These settings were similar in terms of workload and client-populations, but some research (e.g., Abberley, 1995; Sankar, 1986) had suggested that working within a client's home gave clients more autonomy.

My study was similar to Townsend's (1996; 1998b) institutional ethnography of occupational therapists in mental health in the maritime provinces in its focus on institutional factors and therapist experiences and power, but there were several major differences. Whereas Townsend's study focused on how clients were disempowered by

being objectified, marginally included in the community and offered only limited choices, my study explored therapists' experiences with client-centred practice and the barriers and enabling factors to client-centred practice they identified. My study took place six years after Townsend's research was conducted. Since that time there has been much more critical discussion and research about client-centred practice. The most recent client-centred guidelines, presented in the Canadian Association of Occupational Therapists' (CAOT) *Enabling Occupation: An Occupational Therapy Perspective*, were published in 1997. Since the first Issue of *Occupational Therapy Now* in 1999, Karen Rebeiro's column, *Are You Listening*, has included articles about the difficulties in practising in a client-centred manner (Rebeiro, 2000) and several books have been published on the topic of client-centred practice (Law, 1998; Sumsion, 1999b).

Conceptual Approach

This research on client-centred practice was based upon the models of practice described by the Canadian Association of Occupational Therapists (CAOT) publication *Enabling Occupation: An Occupational Therapy Perspective* (1997). This document included a description of the Canadian Model of Occupational Performance, and described how client-centred practice should be implemented through the Occupational Performance Process Model (OPPM).

Some important definitions contained within this publication include the definition of occupation and occupational therapy. CAOT proposed that:

Occupation refers to groups of activities and tasks of everyday life, named, organised and given value and meaning by individuals and a culture. Occupation is everything that people do to occupy themselves, including looking after

themselves (self-care), enjoying life (leisure) and contributing to the social and economic fabric of their communities (productivity). [p. 34]

CAOT noted that occupation is a basic human need; a determinant of health; a therapeutic medium; a descriptor; a source of meaning, purpose, choice and control, balance and satisfaction; and a means of organising material and space and generating income. CAOT defined occupational therapy as a profession “whose members collaborate with clients [...] in enabling occupation.” [p.182]

Citing Townsend (1996), the *Enabling Occupation* text described how power was organised “by establishing routines, policies, and standards” [p. 11], which included documents and protocols that controlled what therapists could do. To understand how power affects client-centred practice I have used an eclectic mix of standpoint and Foucauldian theory to try and explore how power operates in client/therapist relationships and affects the client-centred practice. These theories of power have assisted me to understand and represent my study participants and their clients in a manner that recognises that they are neither completely autonomous in the decisions they make nor completely dominated by societal or institutional forces beyond their control. This recognition was intended to prevent my research from simply blaming the therapist, client or institution for the problems of implementing client-centred practice and instead elucidate the complex inter-relationship between the three.

Summary of Findings

The interview transcripts of nine occupational therapists, my fieldnotes, personal journal and some supporting institutional documentation, which included occupational therapy data bases, intervention protocols, ethical decision making and risk assessment

guidelines, formed data used in the study. A thematic analysis of these data resulted in the identification of three main themes.

“Bridging that gap: ideal versus real conceptions of client-centred practice” revealed the tensions that therapists experience between their vision of occupational therapy versus their experience in practice. New graduates, in particular, struggle to implement an inconsistent occupational therapy discourse within settings that curtail client choice and limit their involvement in decisions around their care.

The second theme “related to the service environment: the importance of setting” focused on how practice was influenced by institutional operations. Within this theme the organisation of power was evident in the policies, procedures, protocols and budgetary funding of the health care system and within the discourses of various professions. This theme contained two sub-themes: “what the system expectations are” and “resources.” System expectations included the use of care maps, which had pre-established interventions and intervention timelines for clients with a particular diagnosis; the overriding importance of client safety; and the interdisciplinary team as a site of conflict and negotiation of professional discourses. Resources could either act as a barrier or a facilitator to client-centred practice. In areas such as palliative care, where there were increased resources, client-centred practice was facilitated. Limited resources had a serious negative impact on client-centred practice. Client access to desired interventions was curtailed and some clients were placed in institutional settings as a result of homecare funding that limited the amount of assistance available. Most therapists had limited supervision, and although this provided a sense of increased autonomy for many therapists it meant that their initial organisational orientation was often limited and

clinical support was restricted. Priority systems were established to deal with inadequate staffing and time pressures, but these priority systems sometimes conflicted with client priorities.

The third theme “a bit of tension: problems with the client-therapist relationship” explored the client-therapist interaction, which was influenced by discursive and institutional factors and included the sub-themes of “therapists’ difficulties,” “client struggles” and “the continuum of client-centred interactions.” The therapist struggles sub-theme included the difficulty therapists had identifying the client, as their concept of client sometimes needed to be expanded to include family members, and other members of the treatment team, such as physicians. Therapists noted that clients had difficulty with aspects of client-centred practice, because the sudden onset of a disease or disability made goal identification difficult. Therapists noted that clients had problems with goal identification and prioritisation because of cognitive difficulties, language barriers, or personality issues. The continuum of client-therapist interactions ranged from client coercion to client-driven. Some therapists worked on general rather than specific goals that were suited to the institutional setting in which they practised. Despite the considerable pressure put on therapists and client to perform or receive certain interventions, resistance was evident from both therapists and clients.

These themes revealed how occupational therapy intervention was influenced, but not completely determined by either occupational therapy or institutional discourses and practices. The concept of client-centred practice was an important part of occupational therapy discourse, but this discourse was not entirely consistent as it contained elements of previous occupational therapy paradigms that had been based on a biomechanical,

medical approach to treatment. This biomechanical aspect of occupational therapy discourse was in conflict with a client-centred approach, but was supported within institutional settings that emphasised safety, speedy discharge and the expert status of professionals. Institutional practises limited client-choice and goal setting in a variety of ways, which included care maps, priority systems, limited time for interventions, lack of funding for needed equipment and services and coercive care conferences. The reasons for this limitation of client choice seemed to be due to an inter-relationship between the issues of cost reduction, a concern about safety and paternalism, which represent some of the most important underlying institutional ideologies.

Significance of the Research

This research revealed many of the common barriers to client-centred practice that therapists encounter. Understanding the importance of institutional barriers to client-centred practice has powerful practical implications for how client-centred practice should be improved within institutional settings, which would include altering student education, altering current occupational therapy documentation and protocols and advocating for changes to other institutional processes, structures and funding.

From a theoretical perspective this research demonstrated how power was exerted and resisted through discursive and institutional processes. The invisible processes and methods by which power was organised and reproduced, which Smith (1987, 1990a, 1990b) describes as the “relations of ruling” were evident. From a Foucauldian perspective, occupational therapy discourse could be discerned, and conflict between occupational therapy discourse and other health-care professions was evident.

Organisation of the Thesis

The thesis consists of six chapters. Following the introductory chapter, chapter two describes a detailed literature review that describes the importance of client-centred practice in occupational therapy, the history of client-centred practice and its definition, various client-centred practice models and summarises current research and discussion on therapist experience with client-centred practice. Chapter three explains the conceptual framework of this thesis. Conventional views of power are discussed and the criteria for an adequate model of power are presented. Two theories that meet these criteria, standpoint theory and Foucault's theory of power, are detailed and occupational therapy discourse is elucidated. Chapter four describes the research plan and justification, recruitment, participant description, data collection and data analysis. Chapter five presents the data, which includes the three main themes and a variety of sub-themes. Chapter six includes a summary of the findings and a description of the significance of the research, implications for occupational therapy managers, limitations of the research and future research directions.

Chapter Two: Client-Centred Practice Literature Review

The Importance of Client-centred Practice

Client-centred practice has become an integral part of occupational therapy in the last twenty years in many countries around the world. The Canadian Association of Occupational Therapists adopted client-centred practice with its 1983 *Guidelines for the Client-centred Practice of Occupational Therapy* and the American Occupational Therapy Association formally endorsed “client-centred service” in 1995 (Peloquin, 1997). In 1995, the British College of Occupational Therapists integrated client-centred practice in its code of ethics and professional conduct (College of Occupational therapists, 1997). During this time, therapists have grappled with how to incorporate this idea into their practice, as client-centred practice represents a radical shift in the way healthcare is delivered (Law and Mills, 1998).

History of Client-centred Practice

Rogers’ Client-centred Practice in Psychology

The first use of the term client-centred practice was attributed to Carl Rogers (Law and Mills, 1998). Rogers’ notion of client-centred practice represented a form of psychotherapy that used a non-directive approach and focused on the self-described concerns of the client (Rogers, 1951). In psychology, client-centred practice was considered part of a humanistic approach to psychotherapy that represents an alternative to more pessimistic and deterministic behavioural and psychodynamic models (Zimbardo, 1985). Client-centred practice was based on the idea of self-actualisation, that individuals are inherently motivated to constantly strive to achieve their potential (Zimbardo, 1985; Matheson, 1998). One of the basic tenets of Rogers’ client-centred

therapy was that therapists need to have a genuine relationship with their clients, based on unconditional positive regard (Matheson, 1998; Corey, 1990). As the client is viewed as an expert in understanding their reality (Rogers, 1951; Zimbardo, 1986; Law and Mills, 1998), the therapist's role was to facilitate problem solving rather than directing the client (Rogers, 1951).

Client-centred Practice in Canada

In Canada, occupational therapists have been developing client-centred guidelines for twenty years. The development of client-centred standards began in 1979 (Townsend, Brintnell, and Staisey, 1990), as a result of activities that included the development of a national workload system, the creation of standards of occupational therapy practice, the increase in occupational therapy accountability, and the establishment of a task force to develop practice guidelines (Townsend, 1998a; Townsend, Brintnell, and Staisey, 1990). Although client-centred practice was not explicitly defined, the conceptual foundation of the 1983 client-centred practice guidelines was based on the worth of the individual, the holistic view of man [sic], the occupational performance model, the therapeutic use of activity, and a developmental perspective (Department of National Health and Welfare (DNHW) and Canadian Association of Occupational Therapists (CAOT), 1983).

In 1986 intervention guidelines were created that described the five fundamental elements for client-centred intervention as spirituality, motivation, therapeutic relationship, teaching learning process and ethics (DNHW and CAOT, 1986). The recommendations for the development of a client-centred measurement of occupational performance from *Towards Outcome Measures in Occupational Therapy* (DNHW, 1987) were integrated into the Canadian Occupational Performance Measure (COPM) (Law,

Baptiste, McColl, Opzoomer, Polatajko and Pollock, 1990; Pollock, 1993). The COPM was created as an individualised assessment of occupational performance areas defined as important by the client. The COPM involves a five-step process that quantifies clients' identified problems in occupational performance by examining the perceived importance of the activity to clients and their satisfaction with their performance (Law et al., 1990; Pollock, 1993). With the COPM, clients are expected to both identify and prioritise their occupational performance issues.

Townsend (1998a) described how client-centred care was further developed through five "c" initiatives in the 1990s. First, in 1991, *Occupational Therapy Guidelines for Client-Centred Practice* "consolidated" the original 1980's guidelines. Second, the usefulness and uses of the 1980's guidelines were "clarified" with Blain and Townsend's (1993) impact study. In 1993, the third initiative, "concentrating," involved the creation of guidelines for the client-centred practice of occupational therapy in mental health entitled *Occupational Therapy Guidelines for Client Centred Mental Health Practice*. The fourth initiative consisted of "classifying" areas of professional competence in the *Profile of Canadian Occupational Therapy Practice in Canada* (CAOT, 1996). The final step involved "creating" new guidelines for client-centred practice entitled *Enabling Occupation: An Occupational Therapy Perspective* (CAOT, 1997).

Client-centred practice has remained an ongoing area of discussion in occupational therapy. Law (1998) and Sumsion (1999b) published edited books on client-centred practice, and articles on client-centred practice and assessment have appeared in the *Canadian Journal of Occupational Therapy*, *American Journal of Occupational Therapy*, *British Journal of Occupational Therapy*, *Australian Occupational Therapy*

Journal and Physical and Occupational Therapy in Rehabilitation. The first year of the column, Are You Listening, edited by Karen Rebeiro, in *OT NOW*, a CAOT publication, featured articles describing the difficulties implementing client-centred practice in different cultures, in a third party payer system, and in a fee for service system (Rebeiro, 2000).

Despite this discussion of client-centred practice in Canada, Britain, Australia, and the United States, client-centred practice seems less important to the American occupational therapy community. For example, Reed and Sanderson's (2000) *Concepts of Occupational Therapy (4th Ed.)* made no mention of client-centred practice. Although Punwar and Peloquin (2000) in *Occupational Therapy. Principles and Practice (3rd Ed.)* described the occupational therapy process as client-centred, according to their description the client does not appear to identify their own occupational performance issues. A search of the CINHAI database in July 2001 under the search terms "American Journal of Occupational Therapy" and the topic heading "Patient Centred Care" revealed only six articles have included this topic, four of which were published between 1995 and 1997.

Client-centred Practice and Related Definitions in Occupational Therapy and Healthcare Generally

Gage (1995) noted that client-centred practice is one of a number of emerging models of healthcare, which includes client-centred, patient focused, case management and client-driven. Models described as client-centred have generally focused on the client's needs (Gage, 1995), rather than a strict Rogerian definition of client-centred practice. Patient-focused care "appear[ed] to be largely based on a model of

organisational change that focuses activities within an institution specifically on the patient, in order to streamline activities and make them more efficient and less costly” (Gage, 1995). Although models of case management are not homogenous, some models have elements of client-centredness (Gage, 1995). All models of case management are based on the principle of one person interacting with and advocating for the client. In some models the case manager makes most decisions with little input from the client. In client-centred models the client is more active in identifying needs and desired outcomes. Once the outcomes have been identified, the case manager is to seek out solutions and report the risks and benefits of each option, and the client chooses their preferred alternative.

Gage and Polatajko (1995) proposed that the term client-driven was more appropriate than client-centred, as this term better described the role of the client in the therapeutic process. This metaphor suggested that the client is the driver who chooses the destination, while the therapist helps navigate the client to that point. Law and Mills (1998) noted that the meaning of client-driven is closer to Rogers’ client-centred approach than the client-centred approach currently practised within most institutions. Gage (1995) noted, however, “some clients may not be ready or able to be responsible for health decisions” (p. 203).

Despite the semantic differences between client and patient (Peloquin, 1997), Law and Mills (1998) indicated that client-centred and patient-centred approaches were synonymous. Furthermore, family-centred care, involving the collaboration of families and service providers, has been considered consistent with a client-centred approach (Gage, 1995; Law, 1998). Family-involvement in client-centred care increases the

complexity of the therapeutic relationship. Family-centred care can be particularly difficult when different family members express disparate treatment priorities and ideas.

Definitions of Client-centred Practice in Occupational Therapy

Although client-centred practice has been part of occupational therapy practice for the last twenty years, only recently has it been formally defined (Law and Mills, 1998).

Law, Baptiste and Mills (1995) first defined client-centred practice as

an approach to providing occupational therapy, which embraces a philosophy of respect for, and partnership with, people receiving services. Client-centred practice recognises the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure that services are accessible and fit the context in which a client lives. (p. 253)

In *Enabling Occupation* (CAOT, 1997), the definition of client-centred practice was broadened to include institutional clients and was defined as

collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others. Occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients in meeting clients' needs, and otherwise recognise clients' experience and knowledge. (p. 49)

Sumsion (1999d) reported a definition based on a project using the Delphi technique with 63 therapists. The Delphi technique is a multi-stage, consensus building process that

involves multiple rounds of iterative feedback circulated to anonymous participants (Crisp, Pelletier, Duffield, Nagy and Adams, 1999). The resulting draft definition was:

Client-centred occupational therapy is a partnership between the therapist and client. The client's occupational goals are given priority and are at the centre of assessment and treatment. The therapist listens to and respects the client's standards and adapts the intervention to meet the client's needs. The client actively participates in negotiating goals for intervention and is empowered to make decisions through training and education. The therapist and client work together to address the issues presented by a variety of environments to enable the client to fulfil his/her role expectations. (p. 5)

Although these definitions are similar in their emphasis of partnership and client participation in decision making, there is ongoing debate about to what extent therapists should help their clients establish goals. Underlying this debate is whether therapists should be caring for or empowering their clients.

Caring versus Empowerment

Many authors have focused on caring, as a way of describing the best therapeutic relationship (Peloquin, 1990, 1993a, 1993b; Devereaux, 1984; Lloyd and Maas, 1991; Sachs and Labovitz, 1994), but the term has been contentious. In a review of six editions of Willard and Spackman's *Occupational Therapy*, Peloquin (1990) discerned in the profession an evolution from a focus on competence to a focus on the therapeutic relationship and on caring in particular. Based on her review of literature written about occupational therapists by clients, Peloquin (1990) noted that clients see therapists in several roles. The therapist could be seen as either a technician or a helper, providing

nurture and order. If this latter role was carried out to excess, it could be seen as paternalistic. The therapist could also be seen as a covenanter, a relationship equivalent to friendship. Although Peloquin did not discuss client-centred practice, this could be consistent with the last relationship she described.

Townsend (1998b) was critical of the tendency in occupational therapy to focus on disempowering “care” rather than on empowerment. Townsend (1998b) noted that care was defined as “suffering of the mind, grief” (Webster’s 9th, 1983, p. 207) or alternatively “painstaking or watchful attention,” and “charge, supervision” (Webster’s 9th, 1983, p. 207). The idea of care tends to reinforce the differential power relationship that already interferes with collaboration (Townsend, 1998b). Rochon and Baptiste (1998) noted the conflict between the “call to” help others and the Kantian right of self-determination. As Freire (1970) explained

Any situation in which ‘a’ objectively exploits ‘b’ or hinders [b]’s pursuit of self-affirmation as a responsible person is one of oppression. Such a situation in itself constitutes violence, even when sweetened by false generosity. (p. 40)

Recently, perhaps in recognition of this idea, some authors have emphasised the collaborative nature of therapeutic relationship (Rosa and Hasselkus, 1996; Peloquin, 1997; Townsend, 1998a; Baum, 1998).

Many authors have made a direct connection between client-centred care and empowerment (Parker, 1999; Northen, Rust, Nelson and Watts, 1995; Townsend, 1999). “Empowerment is a participatory process of learning to critique and transform individual feelings, thoughts and actions, as well as the organisation of society, so that power and resources can be shared equitably” (Townsend, 1998b, p. 13). Townsend (1998b) noted

that client-centred practice reflects a commitment to equity and democracy: “in other words, client-centred practice brings power into view and transforms power relations” (p. 63). Client-centred practice is “enabling occupational therapists and clients to advocate for relationships that are mutually empowering” (p. 63). This is in keeping with Pollock and McColl’s suggestion that client-centred practice allows the possibility of growth for the therapist who is no longer the expert/teacher (Pollock and McColl, 1998, p. 94).

Empowerment is itself a problematic term. As Townsend (1998b) noted, attempts at empowerment need to avoid supporting the Western idea of individualism that assumes that everyone is relatively homogeneous in terms of what they want and how they think. One of the key questions associated with the idea of empowerment is whether or not it is possible to empower someone else or whether this action reifies the already existing power differential that exists (Lather, 1991; Tom, 1996).

The idea of empowerment also seems at odds with Mattingly’s (1991a, 1991b, 1994, and 1998) idea of therapeutic emplotment and the idea of enabling as defined in *Enabling Occupation* (CAOT, 1997). Based on data collected for a large American study of occupational therapist’s clinical reasoning, Mattingly (1991a, 1991b, 1994, and 1998) noted that therapists attempt to ‘emplot’ their clients in a positively oriented ‘prospective treatment story’ that is based on the client’s illness experience rather than their biomedical problem. This co-constructed narrative (Ochs, 1997) involved negotiation, rather than complete autonomy on the part of the client. Similarly, enabling was defined as

processes of facilitating, guiding, coaching, educating, prompting, listening, reflecting, encouraging, or otherwise collaborating with people so that

individuals, groups, agencies, or organisations have the means and opportunity to participate in shaping their own lives. (CAOT, 1997, p. 50)

These viewpoints represent different understandings of the fundamental nature of the collaborative relationship in client-centred practice and indicate the possibility of conflicting understandings of client-centred practice for therapists within the profession.

Client-centred Practice Process

Recently many authors have described the ideal process of client-centred practice (Fearing, Law and Clark, 1997; Stanton, Thompson-Franson, Kramer, 1997; Gage, 1999; Matheson, 1998, Sumsion, 1999a). These process models defined for therapists the ideal therapeutic relationship. Most of the process models were based on the notion of an autonomous individual (e.g., Matheson, 1998; Gage, 1999; Fearing, Law and Clark, 1997). Stanton, Thompson-Franson and Kramer (1997); however, in discussing the application of the Occupational Performance Process Model. Fearing *et al.* (1997) noted that

Clients are encouraged to take an active role as partners in the Occupational Performance Process; however, it is recognised that clients' values and beliefs, difficulty in making their needs or wishes known, or other factors may influence the extent to which this choice is exercised. (p. 59)

This caveat begins to acknowledge the diverse backgrounds and abilities of the clients with whom occupational therapists work.

Nevertheless, several authors described how a client-centred practice could include special populations where there are problems with cognition and decision making. Hobson, (1996, 1999a, 1999b) has detailed how a client-centred approach could

be used with elderly and cognitively impaired populations. Hammell (1998a) described Ozer's (1988) process to elicit maximal client-participation based on the client's ability to make decisions. First, therapists were to ask in general terms what were the client's goals. If unsuccessful, Ozer (1988) suggested adopting a multiple-choice strategy or, failing that, asking closed yes/no questions. In his view, clients should always be offered maximal choice; and at no point was "no choice" advocated.

On the other hand, others have noted that some clients from non-Western cultures may not wish to be responsible for identifying and prioritising therapeutic goals (Sumsion, 1999c; Iwama, 1999). As client-centred practice is based on Western norms, values and beliefs, Iwama found that "client-centredness reflect[ed] a cultural pattern very much out of social context in Japan" (Iwama, 1999, p. 6). In client-centred practice, a focus on egalitarian therapeutic relationships was at odds with the Japanese idea that hierarchical relationships create harmony and order.

The Client, Service, Society Model (CAOT, 1997, as adapted from Stanton, 1996) described how the client-therapist interaction works within a context of the service environment that occurs within the broader context of society. Elements in organising and delivering client-centred service within this model included plan services, market services, manage services, educate, access and participate in research and evaluate services.

Therapist Experience with Client-Centred Practice

Although some research has been performed on therapist experience in general, no research has exclusively considered the therapist's experience with client-centred practice. Many authors have discussed the problems associated with client-centred

practice focusing on the perceived lack of client involvement in the therapeutic process. Power has appeared as an important construct in this discussion. In the context of client-centred practice Law, Baptiste and Mills (1995) defined power “as a process by which therapist and client achieve what neither could achieve alone” (p. 225). One of the most frequent explanations of the problems associated with client-centred practice, however, is that therapists lack either the ability or desire to share power with their clients (Law *et al.* 1994; Sumsion, 1999c; Hammell, 1998a; Gage, 1999). Client *resistance* to client-centred practice has also been noted as a potential barrier to client-centred practice (DNHW, 1986).

Despite some authors’ optimism about the transition to client-centred practice (Woodside, 1991), researchers have frequently demonstrated the problems therapists have when applying client-centred approaches. Some research has suggested possible explanations for these difficulties of client-centred practice.

Research Describing Problems with Client-centred Practice

Therapists have frequently been noted to limit client involvement in problem identification. Northen, Rust, Nelson, Watts (1995) audiotaped 30 therapists during an initial evaluation, interviewed the therapists and reviewed their documentation. Although the researchers did not use a standardised instrument in their quantitative evaluation, they found that only 37% of therapists tried to elicit the client’s concerns and that no therapists asked clients to establish a priority of concern. Law *et al.* (1994), describing the results of pilot testing of the Canadian Occupational Performance Measure, noted that some therapists were uncomfortable with the client identifying problems for intervention. In a single case study, Mew and Fossey (1996) described the problems a therapist

encountered attempting to implement a client-centred approach in an initial assessment using the Canadian Occupational Performance Measure. Although this study was weakened by the fact that the therapist was inexperienced with the COPM, the therapist demonstrated difficulties in addressing the problems identified by her client.

Other studies have demonstrated more wide spread problems with the therapeutic relationship and alluded to potential problems with client-centred practice. For example, based on analysis of two interviews collected for her 1997 master's thesis, Rebeiro (2000) described how the establishment of a collaborative partnership was hampered by the therapist's tendency to prescribe activity, limit client choice and focus on the illness rather than the individual.

Although not directly concerned with client-centred practice, Hasselkus and Dickie (1990, 1994) explored the lived experience of doing occupational therapy. They asked therapists to describe satisfying and dissatisfying experiences with practice. They identified the most important aspects of therapy for therapists as *change*, which was related to the client outcome, *community*, which involved stories of interpersonal harmony or discord, and *craft*, which included the skills and experience of doing therapy. In a further analysis of the subset of the stories describing community, Rosa and Hasselkus (1996) noted the importance of "connecting" for therapists that involved "helping" and "working together." Problems with client-centred practice were noted when Rosa and Hasselkus (1996) reported that "the therapists in our study did not always agree with patients about what the problems were or what to do about them. These experiences were troubling for the therapists and were associated with feelings of guilt,

rejection, and failure” (p. 257). Disagreement about goals has been noted as a potential barrier to client-centred practice (Sumsion and Smith, 2000).

Tryssenaar’s (1999) case study of the lived experience of a new occupational therapy graduate in Ontario explored the therapist’s attempts to deal with the disillusionment associated with the reality of her first position as a therapist. In trying to overcome some of her negative experiences, the author reported “Maggie (the new graduate) ground[ed] herself in client-centred practice and turn[ed] toward the future,” (Tryssenaar, 1999), p. 110). Although Maggie identified her clients as a source of inspiration and learning (Tryssenaar, 1999), her experience with client-centred practice was not well documented.

In a study by Clark, Corcoran, and Gitlin (1995) therapists were observed treating one of two clients on two different occasions, usually the first and second treatment session. A thematic analysis indicated that there was a therapeutic interaction continuum that ranged from caring, partnering, and informing to directing. More caregiver involvement was noted during interactions labelled caring and partnering and less involvement was noted in informing and directing interactions. Directing was particularly prevalent during the intervention phase of the therapeutic process, while informing was noted in highest frequency in the evaluation stage. According to Clark, Corcoran, and Gitlin (1995) these results indicate that most interactions occurred within a biomedical model of treatment.

Research Exploring Reasons for Problems with Client-centred Practice

Some studies have identified the therapist as the primary barrier to client-centred practice. Sumsion and Smyth (2000) described the barriers to client-centred practice

identified by therapists, based on a questionnaire in which therapists had to rank sixteen therapist barriers that the researchers had drawn from the literature. The three highest ranked therapist barriers to client-centred practice involved problems therapists had accepting and supporting client goals, particularly when these differed from their own. Interestingly, Sumsion and Smyth (2000) included factors such as “therapist is short of time,” “therapist is under financial pressure,” “therapist’s level of stress is high” and “intervention is dominated by the medical model,” as therapist rather than institutional barriers to client-centred practice. The focus of this study on therapist barriers tended to downplay the importance of institutional barriers and client difficulties with client-centred practice.

The problem of holism. Based on data collected in interviews of sixteen occupational therapists, Abberley (1995) argued that occupational therapy’s discourse of partnership and holism serves the profession rather than the client. Abberley argued that, while this ideology helped to differentiate occupational therapy from other health professions, the holism occupational therapy practitioners espoused perpetuated an individual rather than social model of disability. Although functional improvement and client satisfaction were described by therapists as the basis of their definition of successful occupational therapy, the clients were expected to adopt the therapist’s view of reality to form the basis for their sense of satisfaction. In Abberley’s view, success in therapy was attributed to the therapist, while failure was the responsibility of the client.

Finlay (2001) was less pessimistic about occupational therapist’s values of holism, humanism and client-centred practice. Finlay’s phenomenological study involved in depth interviews of nine therapists and participant observation of an additional three.

The major themes she identified from her data were “occupational therapists valuing holism,” “working out what holism means in practice” and “the tensions of applying holism in practice.” Her research revealed that although all therapists valued holism, which often blended with notions of client-centred practice, institutional factors often constrained therapist’s ability to practice holistically. She noted that, for some of her participants, holism seemed like a professional rhetoric that they used to emphasise the value of occupational therapy services and distinguish it from other professions. She noted, however, that this idea of holism was frequently challenged by the reductionistic settings in which they worked. She speculated “that the extent to which therapists are reductionistic or holistic is not so much a philosophical choice as a strategic one. That therapists *consciously* make this choice would seem, however, to be open to question.” (Finlay, 2001, p. 274, author’s italics). This idea could probably be extended to include the value of client-centred practice.

Although holism was included as part of the conceptual foundation of client-centred practice in the 1983 *Guidelines for the Client-centred Practice of Occupational Therapy* (DNHW and CAOT, 1983), this ideology may conflict with the ideology of client-centred practice. In describing how the principles of holism should affect practice, McColl (1994) noted that occupational therapists should not “participate in analysis at the levels of the nervous system, the organ system, the tissues or the cells” (p.75). This idea of holism has been described as a “need to treat the whole client.” This imperative may run counter to client-centred practice, however, if the client only wants a reductionistic treatment. Egen and Dubouloz (2000) noted that therapist’s use of global, non client-centred assessments of client function can lead to the identification/ construction of

problems that are not recognised by the client. For example, a client who has assistance to complete some activities of daily living to conserve energy or because of personal preference would have decreased scores on the Barthel or Functional Independence Measure (FIM). If these scores are used to determine the need for intervention, this client may be instructed in techniques to improve his or her independence in activities of daily living, contrary to his or her wishes. Perhaps if holism was defined as “a willingness to treat the whole person” it would be more congruent with client-centred practice.

The problem of professionalism. Some authors have noted a conflict between professionalism and an egalitarian therapeutic relationship. Peloquin (1990) noted that the early attempts to professionalise occupational therapy focused on competence and tended to de-emphasise the importance of the client-therapist relationship. In a study of therapists’ perceptions of therapeutic relationships, Norby and Bellner (1995) described a potential problem with finding a balance between a desire for “becoming professionalised and their belief in egalitarian patient-therapist relationships” (p. 41). Similarly, Hasselkus and Dickie (1990) noted that therapists had a strong desire to be valued by their clients *and* by other professionals. Bellner (1999) concluded that the use of the medical profession as a prototype for achieving increased professional status may encourage therapists to adopt increased objectivity and interpersonal distance from their clients (Bellner, 1999). This observation is in keeping with a phenomenological study involving Australian occupational therapy students in psychiatric fieldwork placements (Lyons, 1997) which revealed that these students experienced conflicting expectations about client involvement and social distance. They perceived that adopting professional behaviour involved “a) keeping personal feelings in check, b) maintaining a social

distance, c) establishing control, and d) offering *expert* help to remedy perceived deficiencies” (p. 687). Many of these ideas, particularly the idea of establishing control, are opposed to the principles of client-centred practice, as they have been traditionally been described.

Institutional/systemic problems. Some authors have also considered some of the institutional barriers involved in client-centred practice. Opie (1998) studied attempts of multidisciplinary teams (which included occupational therapists) in New Zealand to empower service users and families. Having analysed 45 team meetings and 10 family meetings in three different sites, Opie (1998) found that the procedures and processes in place

positioned the user as subordinate, marginal, and passive in contrast to the active and knowledgeable team members, as recipients of information about different therapeutic processes but not as significant sources of knowledge and information to be exchanged with the team (p. 197).

In explaining these findings, Opie (1998) noted that there were no guidelines governing the meeting and that there was no forum, even for the professionals, to discuss problems with the process.

Townsend’s (1998b) institutional ethnography of community occupational therapy mental health services in the Maritime Provinces provided insight into how client-centred practice/ client-empowerment was prevented within institutional settings. Townsend (1998b) described six different and overlapping processes whereby care giving was promoted over empowerment by therapists and through institutional policies. First, participants were objectified when they were identified as patients and categories of

medical diagnosis. During diagnosis, everyday activities clients participated in were transformed into evidence of pathology. Second, the focus on individual, medically categorised patients downplayed the role of societal factors and discouraged clients from working collaboratively to overcome systemic barriers. Third, collaboration was limited as clients were only allowed to make decisions within narrow, predetermined boundaries. Clients could make decisions about themselves and immediate surroundings, but only professionals could make decisions about philosophy, time, space and other structural elements. Thus “decision making [was] both a skill and highly contextual negotiation over the division of power” (Townsend, 1998b, p. 68). Fourth, clients were made to participate in activities that simulate real life. Although supposedly transitional, these activities often did not lead to non-simulated experiences. Fifth, risk taking was limited because official institutional policies were based on the theory of risk management that actually tends to oppose risk taking behaviours, “curtail[ing] the impetus to face challenges” (Townsend, 1998b, p. 125). Professionals, not clients, were therefore responsible for managing risk. Sixth, clients of mental health services were often marginalised in the community (substandard housing, inadequate nutrition) and given sheltered employment or social recreation. Many clients were not allowed to work, because this would jeopardise their eligibility for special assistance.

Wilkins, Pollock, Rochon and Law (2001) explored the difficulties of doing client-centred practice based on the findings of three qualitative studies that revealed challenges at the level of the system, at the level of therapist and at the level of the client. The first study examined what thirteen service providers from seven children’s rehabilitation centres perceived as the implementation issues of family-centred practice.

The second study looked at the impact the adoption of the COPM had on therapist practice at an occupational therapy agency providing community based service. The third study investigated the process of initiating the COPM in a large, older adult, residential care setting. Collating the results from these three studies, the authors noted that at the system level, organisational support for Client-Centred Practice was required, a participatory management style was preferred, and that lack of time, lack of resources and inhibitory policies represented considerable barriers. At the level of the therapist, some therapists reported that client-centred practice was something that they have always done, but some of those interviewed at the children's hospitals indicated that the attitude that client-centred practice was already present might limit change and improvement in client-centred practice. Challenges at the client level involve problems that therapists had identifying clients, the assumption in client-centred practice of an autonomous client and the problems that clients have participating equally in the therapeutic relationship.

Although Wilkins et al. purported to explore the difficulties of implementing client-centred practice, their paper has a number of limitations. The research studies that they drew upon were not conducted to answer their research question. In the first study, discussion about implementation of family centred/client-centred practice was at a theoretical level, while the latter two studies focused on the implementation of the COPM. Although the COPM is a client-centred assessment, issues around the implementation of the COPM are not synonymous with issues of implementing client-centred practice.

Only one piece of research has found occupational therapists practising within a client-centred framework. In a study of twelve occupational therapists in community

mental health in Britain, Meeson (1998) found that, for clients in their own homes, interventions were chosen on the basis of utility and client-centred values. Meeson (1998) noted that this was contrary to the expectation that therapists were to select an intervention based on the inherent properties of the activity. This points to the difficult balance that therapists need to negotiate between presenting themselves as experts in occupation and as equal partners in an egalitarian therapeutic relationship.

Client-centred Practice Beyond Occupational Therapy

Occupational therapists are not alone in struggles with client-centred practice. Based on his study of physicians involved in a patient-centred adolescent diabetic clinic, Silverman (1993) questioned if this approach has resulted in increased client autonomy. He concluded that, whereas doctor-centred care represented overt social control, patient-centred practice “appear[ed] to reinstate new and, perhaps more subtle strategies of power” (p. 237) and encouraged patients to internalise the medical model in a manner similar to that described by Foucault (1980). This finding indicates that other professionals have difficulties implementing client-centred practice and also points to the subtle ways in which client-centred practice can support traditional power relations.

Non-Research Based Discussion about Client-Centred Practice

Discussion about client-centred practice has tended to focus on the problems associated with client-centred practice. Most authors have included mention of both client and institutional barriers to client-centred practice, but have tended to focus on how practitioners have failed to practice in client-centred ways. As in the research-based literature power has been identified as an important dimension of client-centred practice.

Problems with clients. Clients have been implicated in difficulties with client-centred practice. Many authors have noted that many clients' cognitive abilities limit their ability to make the choices necessary in client-centred care (Toomey, Nicholson and Carswell, 1995; Pollock, McColl, Carswell, 1999; Law, 1998; Sumsion, 1999c). Decision-making may also be hampered by past experience as passive participants within the biomedical model (DNHW, 1986), lack of education about client-centred practice (Sumsion, 1999d), and a cultural background that does not emphasise individual autonomy (Sumsion, 1999c). Clients with new physical disabilities may find a synergistic, client-centred, relationship difficult to engage in, as they might not feel that they have enough knowledge about their condition to make decisions (Gage, 1999). Crabtree and Lyon (1997) noted that there was a strong "predisposition towards a power imbalance in the therapeutic relationship," (p. 58) as patients often seek help from experts. The *Intervention Guidelines for the Client-centred practice of Occupational therapy* (DNHW, 1986) explained "the client may unconsciously gain so much from the present situation that any attempt to foster a mature relationship leading to change is doomed to meet with strong resistance" (p. 19). Similarly, Sumsion (1999c) noted that client barriers might include not wanting to, or being unable to take power.

Some clients, however, have advocated for more egalitarian therapeutic relationships. Self-described consumers/survivors of the mental health system in Sudbury, Ontario reported that good client-centred practice feels like a situation where "no one party holds power," (p.12) and involves the absence of a struggle for power (Biby et al., 1999).

Institutional problems. Some authors have described the difficulties and issues surrounding client-centred practice that are not related to therapist or the client. Marrins (1994) described the difficulty in identifying the client when dealing with children and their families. Stoch (1999) questioned whether third party payers should be considered clients. Pollock and McColl (1998) noted that time issues may prevent the therapist from using client-centred assessments and that there was often a difficulty with contextual fit: “client-centred therapy is difficult to practice in a system dominated and structured by the biomedical model” (Pollock and McColl, 1998, p. 102). Carson (1999) describes how the adoption of clinical pathways may restrict client-centred practice. A clinical pathway is

A diagnosis specific, multidisciplinary, generic documentation system serving as the client’s treatment plan. The pathway consists of several phases with each phase having a target completion date and multidisciplinary goals. [p. 6]

Although Carson (1999) stated that the interdisciplinary goals may be deemed ‘not applicable,’ the pathways do not try to address client identified goals and so clinical pathways seem to seem to violate the principles of client-centred-practice.

Problems with therapists. Generally, the literature on client-centred practice has detailed a litany of problems that therapists have with client-centred practice. Many authors noted that therapists have failed to integrate a client-centred approach into their practice (Sumsion, 1993; Law et al., 1994; Blain and Townsend, 1993; Rebeiro, 2000); and although some had “refocused” their practice, other therapists renamed their approach without changing it (Gage and Polatajko, 1995, p. 116). Therapists depersonalise those they work with, rather than envisioning their clients as individuals capable of participating in the therapeutic relationship (Peloquin, 1993a; Coring and

Cook, 1999). Therapists focus on their own narrowly defined goals that are often in conflict with those of their client (Hammell, 1998a). Therapists tend to take the credit for their client's accomplishments, while blaming them for treatment failure (Bibyck et al., 1999), and labelling them as "uncooperative" rather than exploring how therapist or institutional problems interfered with intervention (Law, Baptiste and Mills, 1995; Hammell, 1998a). Hammell (1998a) noted that therapists were seen as "universally pessimistic" in regard to exploration of opportunities and risk-taking for people with high-level spinal chord injuries.

Stern, Restall and Ripat (2000) developed an interesting measure that evaluates the process of client-centred practice, entitled the Client-Centred Process Evaluation. Although only content validity has been addressed by these authors and no reliability studies have been reported, the Client-Centred Process Evaluation includes both a client and clinician questionnaire that includes questions about the therapeutic process and the context, or environment, within which these interactions takes place. This evaluation might be a useful tool in future research, once reliability studies are completed.

Some authors have attempted to provide an explanation of the problems with client-centred practice, which are frequently based on a construct of power. Gage (1999) described the existence of a power imbalance in the therapeutic relationship created by differences in knowledge, social position and/ or charisma. Peloquin (1993) noted that the caring relationship was frequently undermined by the therapist's misuse of power. Wilkins et al. (2001) noted that issues around power are an important part of challenges at the therapist and client level, but the construct of power was underdeveloped in their discussion. Although several authors have suggested that problems arise as a result of

differing values and beliefs between clients and therapists (Sumsion, 1999c; Law, Baptiste, and Mills, 1995), other authors have noted that therapist's inability or lack of desire to give up/share power with their clients is the primary barrier to client-centred practice (Law et al., 1994; Hammell, 1998a; Gage, 1999). Given this problem, Hammell (1998a) suggested that a realignment of power was necessary and Sumsion (1999c) proposed that therapists be instructed about power relations.

These suggestions indicate that an understanding of power is essential in understanding the dynamics involved in a client-centred therapeutic relationship, but this discussion is underdeveloped in the literature on client-centred practice. To comprehend the relationship between power and therapists' experiences with client-centred practice, the next chapter describes how power has been theorised and how this discussion informs my study.

Chapter Three: A Conceptual Framework: Discourses on Power

This chapter discusses various understandings of the construct of power.

Traditional views of power are described and two theories of power applicable to this research are explored: standpoint theory and Foucault's analysis of power, which is focused on the concept of discourse. The chapter concludes with a description of occupational therapy discourse and its implications for this research.

Although power has been identified as an important aspect of client-centred practice, it is a very complicated construct and despite considerable debate there is little agreement about how it should be defined (Davis, 1993). Some authors, however, have suggested the criteria of an adequate model of power (Davis, 1993) that moves beyond customary definitions of power.

The Requirements of an Adequate Model of Power

Power has traditionally been understood as the objective control that one group or person exerts on another, which has been described as "power over" (Labonté, 1996; Starhawk, 1987) and this notion of power forms the basis of liberal and Marxist political theories (Gatens, 1992). According to liberal political theory, the state exercises power for the benefit of its subjects, while Marxist theory holds that the power of the state is used to maintain the domination of the ruling class over the proletariat (Gatens, 1992). In Marxist theory, the state is thought to exercise power through either repressive (police, prisons, military etc.) or ideological apparatuses (schools, churches, media, etc.). In liberal theory, women are to be empowered by allowing them equal access to the public sphere (Tong, 1998).

Both liberal and Marxist theories of power have been criticised for a variety of reasons. Both theories are problematic as they focus primarily on economics and neglect gender (Gatens, 1992). As women do not represent a class, Marxism has difficulty explaining the operation of power in their lives (Gatens, 1992). Liberal theories of power, which advocate for equal access to the public sphere are based on male norms of individuality (Gatens, 1992). Gatens (1992) asserted that both these theories are based on the dualism of biology/ideology, which ignores how “gender is a material effect of the way power takes hold of the body rather than an ideological effect of the way power ‘conditions’ the mind” (p. 127). As these theories consider only oppressive use of power over, individual agency is undermined and resistance precluded (Davis, 1993).

Based on her experience in exploring power in gender relationships in medical encounters, Davis (1993) described three inherent problems in applying top-down theories of power, focusing on “power over” to empirical analysis: (a) these theories make it difficult to consider power in intimate and friendly relationships; (b) “relegate [...the individual] to the position of “cultural dupe,” that passive and unenlightened victim of circumstances beyond their control” (Davis, 1993, p. 260); and (c) understanding all relationships as power over may foster political nihilism.

Davis (1993) described the requirements of an adequate model to understand power in gender relations. (a) Power needs to be seen in all parts and levels of the social milieu. (b) Power needs to be understood as a complex phenomena that may be positive or oppressive and, most importantly, (c) “reinstates [the individual] to the position of agent without falling into the concomitant stance of blaming them for social inequalities” (Davis, 1993, p. 261).

Although Davis' work is concerned with gender relations in doctor-patient encounters, it is relevant for my research on client-centred practice. Although therapists have a similar expert position in relationship to their clients as physicians, their interactions with their clients can not be understood as "power over". The predominantly female composition of the profession and relative position in the healthcare hierarchy means that their agency and that of their client's need to be considered within the complexity of the system in which they work. Davis' criteria offer a more nuanced account of power that can consider not only institutional influences but also how the professional knowledge base affects and shapes therapists and their interactions with clients.

Theories that Meet Davis' Criteria

Two theories of power seem to meet Davis (1993) criteria. Davis (1993) herself, suggested that standpoint theory may meet her criteria of an adequate model of power. Other authors have advocated for the use Foucault's theory of power (Lather, 1991; Sawicki, 1991; Petersen and Bunton, 1997), as Foucault's later work assumes a subject that is "neither entirely autonomous nor enslaved, neither the originator of the discourses and practices that constitute its experiences nor determined by them" (Sawicki, 1991, p. 104). Foucault's work is particularly applicable for my research as it reveals how power and knowledge are linked in what he described as "discourse" (Foucault, 1980), which shapes occupational therapists and occupational therapy practice. Although some might argue that these theories are incompatible, standpoint theory and Foucault's later work are based on an understanding that all knowledge is situated or contextual.

Standpoint Theory

Standpoint theory, developed by numerous feminist authors (Smith, 1987, 1990a, 1990b; Hartsock, 1990, 1998; Harding, 1998), uses the experiences of marginalised people to understand their lives, the lives of those in dominant groups around them, and the structural and symbolic relationships between them (Harding, 1998). Their marginalised position or standpoint provides the opportunity for oppressed people, particularly women, to contrast their personal experience with the masculine and abstract conceptual understanding of how the world should work (Smith, 1990). Harding (1998) noted that

starting thought – theorising – from women’s lives decreases the partiality and distortion in our images of nature and social relations. It creates knowledge—not just opinion—that is socially situated. It is still partial in both senses of the word – interested and incomplete; but it is less distorting than thought originating in the agendas and perspectives of the lives of dominant group men. (p. 100)

The focus in standpoint theory on the experiences of women gives marginalised women an “epistemic privilege,” as they are experts about their own experiences; but this does not necessarily give them insight into the causes of their oppression (Narayan, 1998). Explanations of oppression, therefore, need to be carefully considered as they may represent the “common sense” ideology of the dominant group (Harding, 1998).

Although standpoint theory has its origins in Marxist materialism (Hartsock, 1998; Harding, 1998) it does not assume that all marginalised people have the same experience, as Marx assumed of the proletariat (Harding, 1998). Standpoint theory recognises that the lives of marginalised people are multiple and at times conflicting

(Harding, 1998). For example, although Euroamerican women may be discriminated against because of their gender, they may also benefit from societal practices that oppress women of colour.

Standpoint theory represents an alternative to the notion of objectivity, which is based on the idea that researchers, in spite of their interests and biases, can be completely separated from the phenomena they study. Grosz (1988) noted that

feminist theory is neither subjective nor objective, neither relativist nor absolutist: it occupies the *middle ground* excluded by oppositional categories [...]

Absolutism and relativism both ignore the concrete functioning of power relations and the necessity of occupying a position..." (p. 100, her italics).

Standpoint theory thus acknowledges, as have many feminist authors (Ramazanoglu, 1993; Lather, 1991; Harding, 1998; Smith, 1998), that a rejection of positivism and a focus on phenomenological approaches does not mean the end of knowledge.

Institutional ethnography, based on standpoint theory (Smith, 1998; Hartsock, 1990, 1998; Harding, 1998), is a methodology developed by Dorothy Smith (1987, 1990a, 1990b) that exposes the "relations of ruling," which are the invisible processes and methods within social institutions that reproduce and maintain the organisation of power. Institutional ethnography begins with a standpoint *in* the everyday world, and then focuses on the tensions or "bifurcations of consciousness" between how the world is supposed to function and how it is actually experienced. Institutional ethnography exposes the relations of ruling that involve many imperceptible operations and practices which, although they seem anonymous and objective, are actually ideological (Smith, 1987).

Although a feminist perspective usually helps reveal the simultaneous oppressions that women experience because of gender and other factors, it is useful in research on occupational therapy for several reasons. Ninety-four percent of members of CAOT are female (CAOT, 1999); and, as women, they will occupy a subject position that gives them insight into relations of ruling that govern occupational therapy practice. Although these therapists generally occupy a privileged position over those they treat, a feminist perspective is useful in understanding how occupational therapists' autonomy, like that of nurses (Hart and Bond, 1995), may be limited due to the patriarchal nature of the healthcare system, which is dominated by the medical profession. This understanding is important in my study, as it emphasises the importance of the organisation of the healthcare system in influencing therapists' actions.

Although standpoint theory is very important in understanding how institutional and organisation policies and procedures influence occupational therapy practice, occupational therapists have their own professional ideology that informs therapists' thinking. Foucault's perspective on power allows for an exploration of how this ideology, or what Foucault describes as discourse, influences therapists and their interactions.

Foucault's View of Power

Foucault's view of power is difficult to summarise because of the different methodologies he used over time and because of his reluctance to explicitly define the concept (Darier, 1999). Foucault's first, 'archaeological,' approach focused on the analysis of discourse (Freundlieb, 1994). Although Conley and O'Barr (1990) noted that "discourse is widely used to refer to a stream of scholarly consideration, usually written, of the issues of concern to a particular field of inquiry" [p. 2], for Foucault (1980)

discourses are explanations that although neither true nor false, create “effects of truth” that influence how the world is understood. Miller (1997) noted that

Foucault uses the term *discourse* to analyse diverse configurations of assumptions, categories, logics, and modes of articulation. The configurations provide persons with coherent interpretative frameworks and discursive practices for constructing different social realities within which particular kinds of people reside, relationships prevail and opportunities are likely to emerge. [p. 32]

Although Freundlieb (1994) was critical of Foucault’s theory of discourse, because it does not allow self-determination, Darier (1999) noted that Foucault’s main point during this period “was that knowledge is relative to the historical context from which it emerges” (p. 10). This idea is reminiscent of Haraway’s (1989) notion of “situated knowledge,” in which our understanding of reality is understood as partial rather than universal.

Foucault’s genealogical method responds to the criticisms of his archaeological approach by considering both discursive and non-discursive (social) practices and the power relations that occur within them (Darier, 1999). For as Miller (1997) described:

we enter into discourses as we go about the practical activities of our lives. The discourses are conditions of possibility that provide us with resources for constructing a limited array of social realities, and make other possibilities less available to us. [p. 33]

Rarely is only one discourse available in a social setting (Miller, 1997). For example, in Western society legal, moral, mediative and therapeutic discourses are available for responding to and understanding interpersonal and inter-group conflict

(Miller, 1997). In healthcare services, experience can be understood and structured within a variety of professional and non-professional discourses that involve different assumptions, categories, logics and claims. Although occupational therapists have their own discourse of occupational therapy, other discourses they might access, need to respond within, or be governed by include, but are not limited to, the traditional biomedical discourse, legal discourse and rights discourse. For example, Finlay (2001), in her study of holism in occupational therapy, suggested therapists in her study “seemed to understand holism and enact it in different, sometimes contradictory, ways” (p.24) as a result of absorbing different (often reductionistic) discourses during their years of practice. This relationship between discourse, action and power was a fundamental concern of Foucault.

Despite his interest in power in his genealogical period, Foucault resisted defining it specifically to prevent it from becoming “an essentialist, empiricist category” (Darier, 1999, p. 16). Instead, Foucault viewed power as “as a relationship, which was localised, dispersed and typically disguised through the social system, operating at a micro, local and covert level through sets of specific practices.” (p. xi) Power is seen as “permanent, repetitious, and self-repetitious. It is not a thing acquired but rather exists in its exercise. Moreover, power relations are not separate from other relations but are contained within them” (Foucault, 1980, p. 97). Foucault (1980) used Bentham’s notion of a Panopticon, a circular prison where all prisoners have the potential to be observed at all times, as a metaphor to describe how the clinical gaze of those in authority causes those observed to “discipline” themselves. Disciplinary practices based on the “micro-physics of power”

(Foucault, 1980, p. 28) [...] “produces subjected and practised bodies, ‘docile’ bodies” (Foucault, 1980, p. 138).

Although some authors have described this disciplinary practice as overly deterministic (Lupton, 1997), Foucault noted that power is always associated with resistance; for “where there is power, there is resistance; and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power” (Foucault, 1978, p. 95). For Foucault, power tended to be productive rather than repressive and is constituted through competing discourses (Foucault, 1980). Given his conceptualisation of power, Foucault’s concern was

to locate the forms of power, the channels it takes and the discourses it permeates in order to reach the most tenuous and individual modes of behaviour, the paths that give it access to the rare or scarcely perceivable forms of desire, how it permeates and controls everyday pleasure – all this entailing effects that may be those of refusal, blockage, and invalidation, but also incitement and intensification: in short, the “polymorphous techniques of power.” (1978, pp. 11-12)

For Foucault, knowledge and power, which he labelled power/knowledge, were inextricably linked in that knowledge was a basis for power (Foucault, 1980; Turner, 1997; Fox, 1997). Governmentality is a term Foucault (1991) used to describe the interconnected relationship between sovereignty, discipline and government. Fox (1997) noted that “governmentality seems to offer such a degree of autonomy to the individual it effectively shifts the balance from Foucault’s earlier determinism concerning the ‘rules’ which determine which practices become discursive, to a relatively autonomous

subjectivity” (p. 43). Although many authors have supported Foucault, responses have been varied.

Some feminists have embraced Foucault’s theoretical work. For some Foucault’s philosophy attempts to deal with

the theoretical tensions that result when one acknowledges that we are both victims and agents within systems of domination, that our discourses can extend relations of domination at the same time that they are critical of them, and that any emancipatory theory bears the traces of its origins in specific historical relations of power/knowledge. (Sawicki, 1991, p. 10)

Foucault’s theory of power helps “to emphasise the less spectacular and more insidious forms of power” (Gatens, 1992, p. 127). For Gatens (1992), Bordo (1989) and Bartky (1997), a feminist appropriation of Foucault helps explain how the micro-political operations of power produce socially appropriate bodies.

Some feminists oppose the use of Foucault’s theory of power because it either downplays or ignores issues of oppression due to race, gender, sexual orientation and ability (Ramazanoglu, 1993; Brodribb, 1992; Hartsock, 1990, 1998). Ramazanoglu, (1993) stated that Foucault’s analysis of power ignores the “hidden and institutionalised power relations” (p. 9) that represent systemic political problems. Sawicki (1991) noted, however, that Foucault does not deny domination but avoids universal generalisations because of his concerns about theoretical overreach.

One must [...] conduct an *ascending* analysis of power starting, that is, from its infinitesimal mechanisms, which each have their own history, their own trajectory, their own tactics, and then see how these mechanisms of power have

been—and continue to be—invested, colonised, utilised, involuted, displaced, extended, etc, by even more general mechanisms and by forms of global domination. It is not that global domination extends itself right to the base in a plurality or repercussions... (Foucault, 1980, p. 99.)

Despite these criticisms, some authors have described the advantages of a post-modern view of power.

The Benefits of Post-modern Views of Power

Lather (1991), described how post-modernism generally (and Foucault in particular) could be helpful in understanding the role of power in critical and emancipatory research.

What postmodernism adds to this long-standing debate [about the role of intellectuals in social change] is its focus on how power works via exhibition, observation, classification. To make something available for discussion makes it an object. This suspicion of the intellectual who both objectifies and speaks for others inveighs us to develop a kind of self-reflexivity that will enable us to look closely at our own practice in terms of how we contribute to dominance in spite of our liberatory intentions. Within this self-reflective context, the central question becomes: what would a sociological project look like that is not a technology of regulation and surveillance? (p. 14)

Lather (1991) refuted criticisms that post-modernism fostered “nihilism, relativism and political irresponsibility” (p. 37). The concern about relativism is based on a dichotomy of absolutism and relativism, while reality lies in between (Lather, 1991). Although postmodernism has been accused of “the death of the subject” what died was a “unified,

monolithic, reified, essentialised subject capable of fully conscious rational action, a subject assumed in most liberal and emancipatory discourse” (Lather, 1991, p. 121). One of the benefits of postmodernism is that “hegemonic forms of academic discourse are thoroughly challenged, including those at play in our intendedly counter-hegemonic work” (Lather, 1991, p. 39).

In standpoint and Foucauldian theory, power must be contextualised to be understood. Likewise, although the discourse of occupational therapy can have a disciplinary effect on therapists and clients, it must be understood from within the settings in which occupational therapists practice in which multiple and at times competing alternative discourses exist.

Occupational Therapy Discourse

Although neither completely congruent nor unambiguous, an occupational therapy discourse exists in which some ideas and interpretations are favoured over others; and experience is mediated and understood. This occupational therapy discourse is similar to the discourse of law described by Merry (1990)

Like other discourses, law is limiting in that it asserts some meanings and silences others. [...] Its ambiguities, inconsistencies, and contradictions provide multiple opportunities for interpretation and contest. [p.9]

Occupational therapy discourse includes all of the components of discourse described by Miller (1997), including assumptions, categories, logics and modes of articulation.

Many occupational therapy documents reveal the logics and modes of articulation of Canadian occupational therapy discourse. Fearing (1993) described how client-centred clinical reasoning should be documented. Fearing and Clark (1997) described the

occupational therapy process in their Occupational Performance Process model (OPPM). The Canadian Model of Occupational performance (1997) explained “the dynamic interdependence between person, environment and occupation” (p.33). Similarly, the Person-Environment-Occupational Model is intended to help therapists analyse occupational performance, develop interventions and communicate about occupational therapy practice (Law, Cooper, Strong, Stewart, Rigby, and Letts, 1996).

Kielhofner (1997) described the evolution of many of the assumptions of occupational therapy discourse with his description of the development of occupational therapy knowledge. He described this development in terms of paradigm, which is a map or guide that tells researchers what is important to study, what procedures can be used and what theories or explanations are allowed (Kuhn, 1970). Kuhn (1970) proposed that science does not evolve gradually toward a closer approximation of the truth, but rather involves socially constructed non-contiguous paradigm shifts. Kuhn’s definition of paradigm is similar to Foucault’s concept of ‘discourse.’ Abberley (1995) used the term ideology to describe occupational therapy discourse because this emphasises how these ideas are used to sustain unequal social relationships between therapists and their clients. He noted, however, that discourse and ideology are closely related, as “all discourse is intrinsically ideological” (p. 222).

According to Kielhofner (1997), occupational therapy paradigm development began before the profession was established, with the moral treatment “preparadigm,” which was based on the idea that society has an obligation to help those with mental illness re-engage in normal life patterns. This led to a paradigm that focused on the

importance of occupation, but also held “a belief in the essential worth of individuals and in their right to humane care” (Kielhofner, 1997, p. 37).

As Rogers’ client-centred approach was being developed in psychotherapy, rehabilitation was moving towards the medical model (Law and Mills, 1998). In the 1950s as a result of occupational therapy being considered unscientific, occupational therapy adopted a mechanistic paradigm in which therapeutic media became the focus of analysis and treatment; and the client was conceived of as a passive entity (Kielhofner, 1997). In this paradigm, after a rehabilitation diagnosis was made, a specified intervention followed, based on a pre-established protocol (Law and Mills, 1998).

In the 1960s, according to Kielhofner (1997), Reilly began another paradigm shift, towards a yet unnamed paradigm, by focusing on occupational behaviour and proposing an occupational therapy curriculum that “interrupt[s] the medical model” (Reilly, 1969, p. 299). Many authors have described additional societal factors that have precipitated this change. Law and Mills (1998) noted that this change has occurred in the last two-decades as consumers demand more participation and control over rehabilitation practices. Baum (1998) indicated that this change is part of a changing healthcare paradigm shift. In the United States, Northen, Rust, Nelson, and Watts (1995) described some of the factors that have led to an increasing focus on the client. These include increasing emphasis on individual rights, leading to the concept of informed consent and the patient bill of rights. The overlapping ideals of consumerism, empowerment, patient autonomy, self-care, and locus of control (Northen, Rust, Nelson, and Watts, 1995) have all contributed to what might be summarised as client-centred practice.

Changes in occupational therapy discourse are noted as occupational therapy shifted between paradigms. These shifts have included movement from a paradigm that was focused on occupation to the adoption of a reductionistic, mechanistic paradigm in the 1950s (Kielhofner, 1997; Reed, 1984). This paradigm yielded to a paradigm focused on occupational performance in the 1960s. Over the last twenty years, client-centredness seems to be emerging as a basic tenant of a new paradigm in Canada and in many other countries (Law, 1998).

Statements about occupational therapy values and philosophies reveal many of the assumptions of occupational therapy discourse. Canadian occupational therapists' values have been made explicit in CAOT's (1997) *Enabling Occupation: an Occupational Therapy Perspective*, in which Canadian occupational therapy values and beliefs about occupation, people, the environment, health and client-centred practice are described. Finlay (2001) asserted that occupational therapy core philosophical values are humanism, holism, and client-centredness. A survey of 387 occupational therapists in Australia found that holism, client-centred interaction and client responsibility were valued over biomedical approaches (Adamson, Sinclair-Legge, Cusick and Nordholm, 1994). Canadian occupational therapist's beliefs and values (CAOT, 1997) align fairly well with the core values described by Finlay (2001). A task force of the American Association of Occupational Therapy reviewed official documents and identified seven core values of American occupational therapists, which included altruism, equality, freedom, justice, dignity, and truth (Kanny, 1993). These attitudes do not seem universal to all therapists, as Hocking, Whiteford, and Henare (1995) noted that these ideas "reflect the predominantly positivist orientation of Western society." [p. 175] They noted that

“holding *truth* and *justice* as values begs the questions “Whose truth? and “Whose justice?” [p.175] Hocking, Whiteford and Henare suggested that these values be modified and broadened to acknowledge the existence of multiple realities rather than a monolithic Western one.

Although client-centredness is an important part of current occupational therapy discourse in Canada, this idea is challenged by ideas that have supported previous paradigms. Within a mechanistic paradigm therapists are expected to identify problems and carry out prescribed interventions. Within this framework therapists are considered experts, and it is assumed that all clients should increase their independence and improve function. These ideas are reflected in the 1986 Representative Assembly of the American Occupational Therapy Association definition of occupational therapy as

therapeutic use of self-care, work and play activities to *increase independent function*, enhance development, and prevent disability [that] may include adaptation of task or environment to achieve *maximal independence* and to improve quality of life (AOTA, 1986).” (Italics added)

Although client-centred practice involves clients identifying and prioritising occupational performance issues and allows clients to have goals that decrease their independence, many therapists consider enhancing function to be their primary goal (Turner, 1997). Given these problems associated with the term independence, the American Occupational Therapy Association (AOTA) (1995) has advocated for a broadening of the concept to acknowledge that individuals may become independent through a variety of ways which may include hiring assistance. Likewise, Whiteford and Wilcock (2000) noted that independence is often a “therapist centred, predominantly Western cultural construction.”

(p. 331) and the concept of independence needed to be broadened to reflect ideas from non-Western cultures.

Within the context of client-centred practice, it is recognised that there must be a balance between allowing reasonable risk taking and preventing harm. CAOT (1997) stated that therapists may facilitate risk taking, however:

If client's goals appear to be unsafe or place people at risk for injury or illness, occupational therapists need to exercise legal and ethical responsibilities for identifying potential harm if clients decide to engage in clearly dangerous or socially irresponsible actions. Enabling clients to make choices does not remove occupational therapists responsibility to for alerting them to the dangers and guiding them as safely as possible. [pp. 54-55]

Safety and reasonable risk taking, thus, seem to be part of occupational therapy discourse.

Based on their four-year ethnographic study of 14 therapists in a 900-bed acute care hospital in the United States, Mattingly and Fleming (1994) described how occupational therapy is a profession that fluctuates between a biomedical and phenomenological concern for clients. The former they described as "biomedical discourse" (p. 14). Mattingly and Fleming noted "there are good reasons why therapists are trained in the language and tools of biomedicine [...] but the limitations of biomedicine are clear to practising therapists [...] and they inevitably find themselves addressing concerns that are not strictly biomedical." Occupational therapists use a phenomenological perspective to understand client's illness experience. In describing some of the implications of occupational therapists clinical reasoning process, Mattingly and Fleming noted that occupational therapists' patients are included in the decision

making process, treatment is individualised, and clients are offered choices rather than having decisions made by the therapist. These ideas are in keeping with the principles of client-centred practice. There is an uneasy relationship between biomedical and phenomenological discourses, and conflict may result when clients and therapists do not share the same perspective.

In summary, occupational therapy discourse has several key features and inconsistencies. Humanism and client-centred practice represent the foundations of occupational practice. As noted in chapters two and three, however, this discourse is not monolithic, and there is ongoing debate about a variety of issues. These topics include questions about: (a) the proper extent of caring versus empowerment in the therapeutic relationship; (b) whether or not professionalism (the therapist as expert) interferes with a collaborative therapeutic process; (c) the importance of the therapist's role in improving function and maximising independence versus practising client-centred practice; and (d) whether the idea of holism serves the profession or the client. My attempt to understand how the complex discourse of occupational therapy mediates therapists' experience with client-centred practice has several implications for this research.

Power, Discourse and My Research on Client-centred Practice

These discussions about power and discourse emphasise the need to understand power for clients and therapists in a way that balances individual agency and contextual institutional factors, which has certain methodological implications. Based upon my reading of standpoint theory I have chosen to focus on the experiences of occupational therapists. Although I have carefully considered their explanations of the causes of their experiences, I have also focused on institutional practices in an attempt to reveal the

“relations of ruling” described by Smith (1990a). Based on Foucault’s theory of power, I have attempted to identify how therapists work with a notion of client-centred practice as a core concept within occupational therapy discourse and, tried to understand how therapists “discipline themselves.” For example, therapists may try to enact client-centred practice in settings in which this kind of intervention may conflict with other institutional practices and processes.

I hope that contextualising the therapist’s experience by carefully considering the institutional practices and discourses that influence how client-centred therapy is practised will help prevent this research from becoming what Lather (1991) described as an instrument of surveillance. This is important because “the hegemony of autonomous individualism forces a self-conscious [on the part of the researcher] theorising of data – especially “bad data” [information that reflects negatively on the research participants] – well beyond the consciousness expressed by most [...] informants” (Fine and Weis, 1996, p. 258). Thus, even if therapists indicate that they are not practising in a client-centred manner and perhaps blame themselves for this failure, it is important to consider additional factors that might contribute to this problem. My desire to explore power and discourse and my concern about the need to contextualise therapist experience informed my choice of methodology, which is described in the following chapter.

Chapter Four: Methodology

Research Plan and Justification

The exploratory nature of this research and its focus on institutional and discursive practices dictated the use of a qualitative methodology in the study. This methodology is particularly appropriate for my research on client-centred practice as it is capable of “generating new research questions by exposing inconsistencies in – or limits to – current knowledge and theories” (Hammell and Carpenter, 2000, p. 11). In this way it may be helpful in evaluating theoretical frameworks (Shepard, Jensen, Schmoll, Hack, and Gwyer, 1993), such as client-centred practice.

Quantitative and qualitative methodologies have distinct epistemological bases and assumptions (Domholdt, 1993, Jongbloed, 2000). The positivistic, quantitative paradigm holds that the world can be studied objectively, based on the assumption that a single reality exists “out there” and that it can be reliably measured by researchers using the same “yardstick” (Argyris, Putnam and Smith, 1987, as cited by Woodill, Renwick, Brown and Raphael, 1994). Qualitative research, particularly since the mid 1980s (Hammersley and Atkinson, 1995), assumes the existence of multiple, constructed realities, which means “participants attach meaning to events that occur within their lives and that this meaning is an inseparable component of the events themselves” (Domholdt, 1993, p. 126). Thus exploring meaning is an important part of qualitative research (Bogdan and Bilken, 1982; Domholdt, 1993) and qualitative research is concerned with “the ways different people make sense out of their lives” (Bogdan and Bilken, 1982, p. 32). Whereas quantitative researchers assume research can be value free (Raphael, 1996; Domholdt, 1993), it has been questioned whether even basic science research can be free

from influence from the researchers (Kuhn, 1970). Qualitative researchers acknowledge that the values of the researcher influence what questions are asked, how constructs are defined, and how results are analyzed (Domholdt, 1993). Therefore, qualitative research is not simply concerned with the results of the research but also focuses on the research process (Bogdan and Bilken, 1982). To examine the research process, special attention is given to the context of observations and interviews, which includes consideration of the impact of the researcher that Hammersley and Atkinson (1995) describe as reflexivity. Reflexivity involves the researcher attending to his or her role within the research, recognizing that “we are part of the social world we study” (Hammersley and Atkinson, p. 21). Thus, although the researcher has been considered the key tool in qualitative research (Bogdan and Bilken, 1982), he or she becomes “the research instrument *par excellence*” (Hammersley and Atkinson, 1995) when the researcher reflexively considers his or her role in the research process. With this acknowledgement the qualitative research process becomes a dynamic rather than static process in which data collection and analysis occurs simultaneously and the research design maybe modified to explore emerging patterns and new themes (Carpenter, 1991; Hammersley and Atkinson, 1995).

Research Design

Although there are a wide variety of qualitative approaches (Marshall and Rossman, 1989), my concern with therapist experience necessitated the use of in-depth ethnographic interviews as my data collection technique. The “ethnographic interview is concerned with discovering the meaning of actions and events to people whose lives we seek to understand (Spradley, 1979)” (cited in Wendland and Hammell, 2000, p. 100). Beer (1997) notes it is “the subjectivity of the qualitative interview, its being influenced

by and affecting both interviewer and respondent, that makes discovery possible in qualitative research” [p. 110]. When successful, this interview can reveal, rather than obscure, differences in worldview (Beer, 1997).

A semi-structured interview format (Bernard, 1994; Stanton, 2000) was selected to focus the interviews on the topic of client-centred practice, while still allowing participants to express their concerns in an order that flows. To focus the interview, an interview guide of a list of questions and topics to be covered was developed based on themes emerging from the literature and from my interest in power and institutional processes. This was further modified following analysis of the pilot interviews. Rather than rigidly follow the interview guide, I attempted to allow the discussion to flow naturally to obtain ‘thick,’ descriptive narrative from my subject participants (Hammersley and Atkinson, 1995).

Participant Selection:

To study the experiences of therapists who had been educated in client-centred practice during their university education, I intended to recruit participants who were Canadian educated and were graduated since 1986, when the *Intervention Guidelines for the Client-centred Practice of Occupational Therapy* (DNHW and CAOT) were published. I decided to recruit therapists primarily from the Vancouver area to limit some of the contextual variability, given that Virginia Fearing, professional practice leader for occupational therapy in the Vancouver Hospital and Health Sciences Centre (VHHSC) cluster, and Jo Clark, clinical co-ordinator for occupational therapy at the University of British Columbia site have been influential in encouraging client-centred practice in Vancouver. Fearing and Clark are strong advocates of client-centred practice who

created the Occupational Performance Process Model (Fearing, Law and Clark, 1997) and co-edited a book on implementing client-centred practice (Fearing and Clark, 2000).

As it has been noted that professionals have reduced power when clients are seen in their own homes (Abberley, 1995; Sankar, 1986) and that therapy in the home may be more client-centred (Meeson, 1998), I intended to interview five therapists who worked with clients in their own residences and five therapists who worked with clients in an institutional setting. Such interviews from different physical medicine settings could highlight institutional factors shaping or conditioning practice. To help focus on the treatment setting, I hoped to interview therapists in institutional settings whose work was similar to that of homecare therapists. As homecare therapists frequently see their clients on one or two occasions only, and have caseloads that need to be prioritised, this work is similar to that of therapists working in acute care hospitals. I therefore planned to interview five therapists who work in acute care hospitals in physical medicine and a similar number of homecare therapists.

Research Process

Recruitment:

I began recruiting following ethical approval from the University of British Columbia Behavioural Ethics Board. I found it relatively easy to recruit therapists working in acute care, and ended up with more therapists volunteering for my study than I could accommodate. Recruitment of therapists working in homecare proved more difficult; and despite a six-month period of recruitment, only four homecare therapists participated in the study. The ease of recruitment in acute care might be attributed to the occupational therapists' familiarity with me in the acute care setting and to the large

number of acute care therapists working in the Vancouver area. The difficulty in attracting homecare therapists into the study may have been caused by a fewer number of available homecare therapists, lack of familiarity with me and organisational change that was occurring at the Vancouver/ Richmond Board of Health at this time. Rather than attempting to include another therapist working with clients in their home from private practice, I elected to include only therapists working in homecare to strengthen institutional comparisons.

I invited therapists to participate in a study of client-centred practice through posters/ notices, which were faxed and mailed electronically to occupational therapy departments and individuals in the Vancouver area. Two therapists, one from acute care and one from homecare who were previously aware of my thesis research, expressed an interest in participating in the study; and their interviews were used as pilot interviews. Ultimately these pilot interviews were included in the study. Subsequently, a total of 14 therapists volunteered for the study, but seven were excluded because they did not meet the inclusion criteria. Potential participants who met the inclusion criteria and who wanted more information about the study were also provided with letters of intent. Of the seven remaining therapists eventually included in the study, two therapists from acute care hospitals responded to the advertisements. Two acute care therapists were recruited by a therapist who had already been interviewed who provided letters of intent [See Appendix A] to colleagues she thought would be interested in participating in the study. This approach has been described as snowballing (Hammell, 1998a, 2000; Carpenter and Hammell, 2000). In homecare the Rehabilitation Consultant and/or another therapist familiar with the study offered therapists the possibility of participating in the study at

their joint meeting occupational therapy meeting on two different occasions. Despite the efforts of two homecare therapists who invited colleagues to participate in the study, only three homecare therapists, in addition to the initial homecare pilot interviewee, participated in the study.

Description of Participants

The final study included five therapists working in acute care settings and four therapists working in homecare settings. All therapists were female, were Canadian educated and had received their education within the last ten years. Five therapists had been practising between three and five years, two therapists for between one and two years, one therapist for between six and eight years and one therapist for between nine and ten years. All of the therapists were native English speakers and all but one was of European heritage. Six of the therapists had worked in more than one setting; these included physical medicine, mental health and private practice settings. All therapists worked in Vancouver, except two homecare therapists who worked in the Lower Mainland. The names below, in Table 1, are pseudonyms, which were assigned either by the participant or myself. Years of practice are given in ranges to help maintain the anonymity of participants.

Table 1: Study Participants

Name	Number of Years of Practice	Current Area of Practice
Hannah	10+	Acute Care
Sarah	3-5	Acute Care
Emily	1-2	Acute Care
Rebecca	1-2	Acute Care
Ruth	3-5	Acute Care
Donna	3-5	Homecare
Lisa	6-9	Homecare
June	3-5	Homecare
Robin	3-5	Homecare

Data Collection and Analysis

Participants were interviewed within the setting of their choosing. Four of those interviewed chose to be interviewed in their own homes, while the others elected to be interviewed at their work site or at the university. Interviews took between one and two hours, averaging one and one half-hours. They were audiotaped and transcribed verbatim.

I began each interview by introducing myself and getting informed consent from participants [see Appendix B] and disclosing that my interest in this topic arose from problems with client-centred practice identified in the literature and from the difficulties I had encountered implementing client-centred practice. I hoped this admission would facilitate disclosure on the part of the participants, who I feared would consider the interview an instrument of surveillance in a Foucauldian sense. Initially the interview guide consisted of the following questions/topics areas.

Interview Guide:

Where do you work? (Which hospital/ company or board of health?)

With whom do you work in terms of clients and co-workers?

How would you describe a typical day?

How is your schedule determined?

How are you supervised?

What is expected of you in the performance of your duties?

Could you describe some instances with clients where you think therapy has been particularly successful?

To what would you attribute this success?

What are some examples where therapy has been difficult?

To what would you attribute these difficulties?

How representative are these experiences of your daily practice?

How would you define client-centred practice?

Can you give me some examples when you feel you have been able to practice in a client-centred manner?

Is there anything that I have missed?

Over the course of the interviews I added additional questions, specifically about how clients were referred, how they were assessed and how clients were prioritised to help reveal more about occupational therapy practices that influenced client-centred practice. These additional questions helped reveal how clients were involved in decision making and problem identification and how certain issues were prioritised above others.

Data Analysis

During many of the interviews, I recorded some scratch notes (Sanjek, 1990), a mnemonic word or phrase to help trigger my memory. Based on either these scratch notes or my immediate recollections, I recorded information on the context in which the interview occurred and my personal reflections on each interview, which formed the basis of my fieldnotes (Hammersley and Atkinson, 1995). Some relevant documents, such as assessment guidelines, risk taking assessments and guidelines for ethical decision making were collected during the study; and a personal journal was maintained during the course of the research. The personal journal not only describes how the research was being conducted but also my thoughts and feelings about the research process

(Hammersley and Atkinson, 1995). All of these sources provided data for analysis in this study.

All interviews were transcribed for analysis and the transcripts reviewed while listening to the audiotape to ensure their accuracy. I attempted and was largely successful at transcribing the interviews as they were completed, to allow for ongoing reflexive monitoring of the research process. This entailed the recording of analytic notes or memos that questioned “*what* one knows, *how* such knowledge has been acquired, the *degree of certainty* of such knowledge and what further lines of inquiry are implied” (Hammersley and Atkinson, 1995, p. 192). These analytic memos were recorded in the margins of the interview transcripts and in the fieldnotes. These reflections formed the basis of my fieldwork journal (Hammersley and Atkinson, 1995). In this journal, I attempted to include the items suggested for recording fieldnotes described by Carpenter and Hammell (2000) based on Morse and Field (1995). These content areas include items such as interview date and time, location, description of environment, content of the interview, non-verbal behaviour, impressions, technological problems, impact of the researcher and analysis.

The interviews were analysed based on Hammersley and Atkinson (1995)’s process of qualitative analysis. Completed interviews were analysed and emerging themes, which evolved over the course of the research, were identified. Once the interview process was complete, physical sorting was used, whereby multiple copies of the data are created and placed in the relevant category envelopes. Categories for coding were developed by reviewing the data and analytic memos, and from participant created or observer identified analytic concepts. As analysis progressed, these themes were

organised analytically to develop a conceptual understanding of therapists' experience with client-centred practice. Initially I identified sixty categories/ codes. While coding, these categories were expanded to eighty, which were then collapsed to 43 categories during ongoing analysis. As more interviews were conducted, I tried to explore themes that emerged in earlier interviews. Central categories were identified, clarified and explored. During this process categories with similar topics were amalgamated, and categories without supporting quotes or which included non-participant categories such as wheelchairs and scooters were deleted. The title of all of each of these categories was derived from the most representative quote from the data in each envelope. After carefully considering the relationship between the remaining 43 codes three major themes were identified. These themes represent a typology, which Hammersley and Atkinson (1995) define as a common pattern that could be applied to data from other situations.

Although I considered using a qualitative computer research program such as ATLAS or NUD*IST to facilitate further coding and indexing (Lewis, 1997), I continued to perform physical sorting throughout the project to help prevent the categories from becoming frozen due to a reluctance to re-code (Hammersley and Atkinson, 1995). An additional benefit of sorting manually was that it helped keep me 'in the data' because I needed to constantly refer back to the interview transcripts and category envelopes.

Authenticity and Plausibility of the Research

There are a variety of ways to evaluate qualitative research that have been suggested (e.g., Guba, 1981; Bhavnani, 1993; Atkinson, 1990). Krefting (1991) notes that qualitative research is too often evaluated with the same criteria as quantitative research. Her suggestion, however, to use Guba's (1981) model of evaluating research, in which

quantitative criteria such as internal/ external validity, reliability, and objectivity are matched with the qualitative criteria of credibility, transferability, dependability, and confirmability seems to replicate the tendency to evaluate qualitative and quantitative research similarly. Based on the work of Atkinson (1990), Carpenter and Hammell (2000) recommend that qualitative research be evaluated under the criteria of authenticity and plausibility. “*Authenticity* suggest[s] qualities such as genuine, authoritative; something that is, in fact, [...] reliable, trustworthy and of established credibility” (Carpenter and Hammell, p. 109). Authenticity demands that the researcher present their biographical and philosophical positioning and how this has impacted the research process. Plausibility indicates that the conclusions of the study are supported by the data.

Bhavnani (1993) proposed three principles, reinscription, micropolitics and difference, which should form the basis of a feminist inquiry based on Haraway’s (1989) description of the features of feminist objectivity. These principles suggest that the research should a) not represent the study participants as they are normally represented in society, as this replicates dominant power relations; b) the researcher must attend to the micropolitical processes that occur during the research; and c) address how the different subject positions that he or she and his or her study participants occupy affect the research.

Position is often indicated by dimensions of social differentiation such as gender, class, race, sexuality and religion (Hammell and Carpenter, 2000), but it also includes worldview and theoretical positioning (Hammell, 1998b). My demographic positioning as a young, able-bodied, white, male, middle class researcher has been described as a

“privileged” *position* (McIntosh, 1995), which allows and encourages me to be blind to issues involving sex, gender, race, ethnicity, class, ability and age.

Although understanding the personal position of the researcher is important in qualitative research, addressing difference and the micropolitics of the research is not a matter of merely *noting* the positions of the researcher and researched or matching the researcher to the researched (Bhavnani, 1993). Both matching and noting strategies can falsely imply that inequalities between the researcher and researched have been addressed (Bhavnani, 1993). In my research, I am matched with my subject participants in many ways and in some respects could be likened to a “native” anthropologist (Narayan, 1993), as I am an “insider” doing research on a group of which I am a member. Narayan (1993) points out; however, the idea of a native researcher denies the complexity of individual identity. In terms of *noting*, are many similarities and differences between the study participants I interviewed and myself that would be obscured by simple dichotomous labels. Some of the similarities included that we are occupational therapists living in the lower mainland of British Columbia. As occupational therapists, we differ in terms of where we studied, when we graduated, our understanding of client-centred practice, and our level of education. All the study participants were women. Some differed from me in areas that I was aware of in terms of ethnocultural background, and some may have differed in ways that I was not aware in terms of sexuality and religion.

My position of insider tended to vary depending on the setting in which the participant worked. I felt more of an insider interviewing therapists working in acute-care settings, as I have primarily worked in acute care hospitals since graduating in 1991. When interviewing therapists working in homecare, I needed to ask a lot more questions

about how occupational therapy services were organised and struggled to understand how the various long-term care programs were related.

My chosen philosophical and political positioning also effected the research process. Although Hammersley and Atkinson (1995) noted

we do not believe that reflexivity implies that research is necessarily political, or that it should be political, in the sense of serving particular political causes or practical ends. For us, the primary goal of research is, and must remain, the production of knowledge [p.17],

the political nature of any research needs to be carefully considered (Morris, 1992). My concern with finding a compromise between an idealist and realist worldview and ethical concerns about my research involving women influenced my decision to approach this research from a critical/feminist perspective.

Attending to the micropolitics of the research was also achieved through peer examination, allowing study participants to review and edit their own transcripts, and member checking (Carpenter and Hammell, 2000). Peer examination involves “discussing the research process and findings with impartial colleagues who have experience with qualitative methods” (Krefting, 1991, p. 219). A qualitative research group, which met monthly and included students and staff at the University of British Columbia involved in qualitative research, was a forum to discuss my research. I also discussed my research with my thesis advisor and other university faculty. My thesis supervisor, for example, in reviewing my initial categories noted that I had tended to focus on barriers to client-centred practice; and she encouraged me to also examine the data for things that facilitated client-centred practice. All study participants were offered

the opportunity to review and edit their own transcripts, so that material that the subjects did not want included in the analysis could be deleted. Although three subjects requested to review their transcripts, no changes were requested. As part of member checking, all participants were asked if they would be interested in reviewing my tentative results; and five participants expressed interest in doing so. Two therapists provided feedback on the five-page summary of themes that I provided. The first therapist discussed how most of the themes resonated with her. The second therapist provided feedback in writing. She only made comments on things she disagreed with or felt needed clarification. As her comments focused on some of the interpretations that I made, her feedback has been incorporated into chapter five and six, where I tried to address some of her concerns about clarity and present some of her alternative interpretations along with my own (e.g., Borland, 1991).

Bhavnani (1993) notes that “men interviewing women [...] is a replication of the most frequently encountered power imbalances in research studies” (p. 102). Reflexivity is therefore an integral part of qualitative research (Dyck, Lynam, and Anderson, 1995) necessary for understanding the micropolitics of the research. The pilot interviews used to develop the interview guide served as opportunities to improve my reflexivity. My thesis supervisor reviewed the transcripts from these interviews to provide feedback and to improve my reflexivity. My personal journal further enhanced my self-reflection and my analytic memos were useful as an additional reflective strategy (Carpenter, 1999).

My personal journal revealed how my role as researcher shaped the research and how I tried to attend to this effect. Although I had been concerned about the problems of men interviewing women as described by Bhavnani (1993), I did not feel that my gender

impacted greatly on the interviews conducted. Therapists did not seem uncomfortable speaking with me and seldom did their conversation seem constrained. In one instance a study participant felt comfortable enough to take control of the interview and asked me how I would define client-centred practice. Participants were able to correct me when, with reflective listening, my restatement of what they had said did not match their intent.

Although I generally tried to ask non-directive questions, my thesis supervisor noted that sometimes I asked leading questions in my pilot interviews. In later interviews I tried to attend to how I asked my questions; and, though not entirely successful, I did become more aware of when my questions were leading. Part of my insider perspective meant that I had strong opinions on some topics participants discussed. For example, in my experience, care maps, in which interventions and intervention timelines were pre-determined without client input, seemed incompatible with client-centred practice. I therefore had difficulty understanding how one of my participants reported that she felt that she had been able to be client-centred in this setting, and I certainly communicated this to the participant. Later discussion revealed that this sense of client-centredness was relative to another setting, in which she felt treatment was even more pre-determined.

Although I initially disagreed with one therapist's belief that intervention/ education sometimes needed to precede client identification of problems, her discussion also caused me to reconsider how I conceptualised client-centred practice in acute care. Through my journal, I also recognised the need to be cautious when attempting to explain participants' statements and reported actions. Although sometimes I disagreed with how some therapists envisioned client-centred practice, reflecting on my journal made me be cautious about theorising around the causes of these differences. This is particularly

important due to potential misunderstandings on a communicative level, the fact that there are multiple ways of thinking about client-centred practice, and the fact that institutional discourse and practices may shape participants' understandings. I was familiar with some participants due to my work at VHHSC, which may have impacted the interview process. Those interviews, on the whole, tended to be more informal and involve more dialogue between the participant and myself.

In this research, I have attempted to adhere to the Bhavnani's (1993) and Atkinson's (1990) criteria for qualitative research. Ultimately, however, it is the reader who must decide how authentic and plausible my findings are.

Chapter Five: Presentation of the Data

The Balance between Plausibility and Anonymity

This chapter describes how I have understood therapists' experience with client-centred practice based on the interviews I have conducted. In presenting these data, I have had to be cognisant of my own power to select what information I present. Although feminist researchers (e.g., Reinharz, 1992) have tried to develop methods of preventing the voice of the participant from being dominated by that of the researcher, ultimately, the voice of the researcher will be loudest (Hammell, 1998b).

One of the conundrums of qualitative research is the need to balance participants' anonymity with the reader's need for information to establish plausibility of the study findings (French, 1993). Although Krefting (1991) notes "it is critical that researchers provide dense background information about the informants and the research context and setting to allow others to assess how transferable the findings are" [p. 220], the anonymity of the participants must be preserved. In presenting this research I have tried to obscure the identity of therapists by 1) selecting quotes that do not identify the speaker or the setting and 2) altering incidental details about the setting or clients that would identify participants. Sometimes to protect the identity of the participant, the speaker was described as "therapist," particularly when the participant was relating information from another setting they had been or were currently employed. It is interesting to note that most of the therapists performed similar editing on the stories they told me. They frequently referred to clients as "Mr. So and So" or "a lady" or "Mrs. Jones." Only rarely would a therapist mention a client's first name and this seemed frequently accidental, as the therapist would usually correct herself afterward. Thus, most stories in this research

have been intentionally altered twice to obscure the identity of the participant and others mentioned. This is important, as the relatively small number of therapists would otherwise make participants easy to identify. Where material cited does not indicate the therapists setting, (AC) follows the names of participants working in acute care and (HC) follows the names of therapists working in homecare.

The material in quotation marks represents exact quotations from therapists participating in the study. Square brackets “[]” were used to indicate when words were altered to improve clarity or words were omitted. A slash “/” was used to indicate when participants interrupted themselves, usually to perform self-corrections in their speech.

My analysis identified three main themes and five sub-themes. “Bridging that gap: ideal versus real conceptions of client-centred practice” is about tensions that therapists experience between the discourse and practice of occupational therapy. “Related to the service environment: the importance of setting” focuses on how institutional factors shape practice and includes two sub-themes: 1) “what the system expectations are,” which focuses on how client-centred practice is affected by institutional processes and practices and 2) “resources”, which describes how resources available to therapists and clients effect client-centred practice. The final theme “a bit of tension: problems with the client-therapist relationship” describes the therapists’ interpretations of client-therapist interaction. This theme includes the sub-themes of “therapists’ difficulties,” “client struggles”, and “the continuum of client-therapist interactions.” After each main theme is presented, the data are compared and contrasted with relevant theoretical material from chapters two and three. Quotations presented were selected as “apt” illustrations (Hammersley and Atkinson, 1995) of the themes generated

from the data. The themes are intended to be understood as interdependent rather than hierarchical. Although discursive and institutional practices have a great deal of influence on the client-therapist interaction, they do not completely determine it. Therapists and clients may also change discourse and practice through their actions.

Bridging that Gap: Ideal versus Real Conceptions of Client-Centred Practice

“What you [learn] and what you do is different and it’s bridging that gap that’s raised a lot of questions for me.” [Hannah (AC)]

All therapists participating in the study identified a discrepancy between their imagined ideal of practice and the working reality that they daily encounter. For Ruth (AC):

I mean, you know, you go through school. I don’t know. I just had such a different view, of what I was supposed to be doing and what I am doing. And I find it really frustrating actually like I really don’t feel I am doing practice the way I should be or want to or what OT can be and all that stuff. I don’t think I’m there.

B: So you feel sort of that practice is very different than the theory that you learned in school.

R: Yeah. Very much so. I mean you try and put it into practice the best you can. I certainly don’t / it’s not as ideal as I thought it would be. Like I / my expectation was that you know you could practice within the medical model and still be client-centred and I - I now know that that’s not what happens. Uh, you’re fighting the system too much to be client-centred.

This disjuncture was especially evident in terms of client-centred practice.

I find it's been very challenging for me and because I've graduated not too long ago for me client-centred practice is sort of basic to everything I've learned in school and then to graduate and then come and work in a hospital setting, in an acute care setting [...] has been a challenge, because how often, how is a swallowing assessment, you know, how can you make that client-centred?

[Rebecca (AC)]

For Lisa (HC) clinical experiences radically altered her approach to goal setting.

I had this big image [when I graduated] of being very client-centred and doing the COPM, you know, and having these wonderful goal setting sessions and client-centred goals and um people working on their goals as you thought they would etc. and now, well its also in the confines of your work. But now, you know, when we were in school we learned to do goals. I find a lot of client-centredness has to do with goal setting. What goals they set. We worked on these exact, very specific, broken down, little goalsy goalsies. You know the little, this week we'll do this and this week we'll do that and this/ well, to tell you truth it doesn't work in the community and no I have had very few clients who have been able to do that without a lot of assistance. So I don't have the time to do that anymore.

These 'tensions' raise questions about therapists' theoretical ideal and how this conflicts with their everyday experiences.

Client-centredness was an important consideration of all the therapists in the study: "OT is one of the professions that really bring client-centredness to the forefront of their practice" (Rebecca (AC)). Emily (AC) noted that client-centred practice was a "philosophy that's really strongly talked about in [the] department" and when introducing

the topic of the interview Lisa (HC) exclaimed, “[Occupational therapists] all say they’re doing it!” This remark indicated the rhetorical nature of client-centred practice in occupational therapy.

Despite the implications of Lisa’s remark, all of the therapists in the study described difficulties in maintaining a client-centred practice, although these problems varied considerably between therapists. Robin (HC) noted that “it’s very easy to forget to be client-centred sometimes,” Ruth (AC) stated “You know in my general practice I don’t think I’m very client-centred,” and Donna (HC) questioned “how client-centred we are.” All of these therapists described their discomfort with the gap between their intended versus actual practice.

Therapists did not dichotomise their practice as either client-centred or not client-centred, but tended to describe it along a continuum of client-centredness in comparison to other settings they have worked. One therapist, who had worked in private practice noted: “Yeah I mean it looks like a struggle, it looks like a struggle anyway, but its definitely more [client-centred than private practice].” Sarah (AC), who was most positive about the client-centred nature of her practice, noted, in terms of her work place, “it’s more client-centred than anyplace I’ve ever worked.”

Definitions of Client-Centred Practice

For participants in the study the complexity of the current occupational therapy discourse was evident in the variety of definitions of client-centred practice. Participant definitions of client-centred practice varied, especially in terms of the level of client involvement. For Ruth (AC) client-centred practice was “taking the person’s wants and needs into consideration when you’re developing goals and treatment plans.” In this

definition, the client has input, but it seems that the therapist is responsible for formulating goals. This definition demonstrated less collaboration and emphasis on client autonomy than the definitions described in Chapter 2, but interestingly did describe how goals and treatment plans were developed in the area that Ruth (AC) worked. For Lisa (HC), client-centred practice involved asking

Generally what/ where do you want to be, what do you want to be able to do. I'm the professional helping you break that down. So then I step in there. And I'll say "These are different components I can teach you this. I can teach you this strategy. You can get this equipment..."

With this approach the therapist solicited the client's general goals and then the therapist indicated what relevant services she could offer. Other therapists emphasised the need for collaboration in developing treatment goals. Hannah (AC) defined client-centred practice as

I would see client-centredness as ideally as being the clients who directs um their care or their occupational care. It's the clients who articulates what their goals are and what priorities they have and what they want to work on. Um, and it's the therapist's role to help the clients I mean ultimately achieve that goal. If they can and if they can't, if it's an unrealistic goal. It's the therapist's role to help them break it down, into achievable steps.

Hannah's idea of breaking down a client's goal is reminiscent of Ozer's (1988) suggestion of graded goal setting. The majority of definitions were in keeping with the range of definitions of occupational therapy described in chapter 2, ranging from an emphasis on collaboration to focus on client autonomy in goal setting.

One definition of client-centred practice was similar to that of client-driven therapy: “client-centred is about talking about you know a respectful way of practising where the client has autonomy and is directing therapy” [Emily (AC)]. Some therapists seemed to feel constrained by this idea of client-centred practice. In describing her discomfort with how some clients demanded that she provide them with a “scooters” (power mobility device), Donna (HC) noted “but we’re being client-centred because we’re doing what the client wants,” a sentiment which is keeping with client-driven therapy. There is an issue here about conflating what the client “wants” with client-centred occupational goals.

Therapists’ definitions of client-centred practice reflected the range of official definitions of client-centred practice described in chapter two. Six of the nine therapists’ definitions were similar to that described by Sumsion (1999) in which “the client actively participates in negotiating goals for intervention and is empowered to make decisions...” [p. 5]. This definition focuses on client autonomy in decision making. Three of the other therapists emphasised more of a collaborative approach to client-centred practice, which echoed that described in *Enabling Occupation: An Occupational Therapy Perspective* (1997). As two of the five therapists from acute care and one of the four therapists from homecare emphasised collaboration, it is difficult to infer any differences in definition between settings.

Discourse about the Process of Client-Centred Practice

Although the definitions of client-centred do not explicitly describe how client-centred practice should be implemented, the COPM (Law et al. 1994) and OPPM have been influential in demonstrating how client-centred practice should be operationalised.

As noted in chapter two, with the COPM, therapists are expected to help the clients identify specific occupational performance issues, and the clients were expected to prioritise them. Step one of the OPPM involves the naming validation and prioritisation of occupational performance issues. Thus, a client-centred occupational goal would not be “To get a scooter” as this goal does not describe any occupational/ activity issues. Occupation issues that might associated with a desire to get a scooter could include “inability to get groceries or perform banking.” Similarly, “To be discharged home” would not be a client-centred occupational goal as this goal is too broad and does not describe what occupational issues might be preventing discharge home. Within the measure and the model there is an expectation that once these goals have been identified that they would be prioritised and the most important goals selected for intervention.

Although none of the therapists used the COPM, my questions about goal identification and prioritisation often caused therapists to reflect about the client-centredness of their practice, indicating how these ideas form part of occupational therapy discourse.

In explaining why the COPM was not used most therapists reported that it was too difficult for clients to use: “[It’s] a really tough assessment to grasp” [Rebecca (AC)].

Emily (AC) described:

We don’t use the COPM on the unit and part of the reason is that um, it was felt that people would have a hard time identifying their own issues with the kind of population that we had just because you’re there in hospital, you’ve just had an injury. You haven’t had a chance to try it out, to go home and say, “Oh, gee, you know I can’t actually put on my socks.”

In describing the problems of administering the COPM with clients with dementia Hannah (AC) noted another explanation for the lack of use of the COPM.

Because really I would have to do it sometimes with the family and then, yeah, what they're going to articulate is not going to necessarily go with what the rest of the team wants or sees or what the system needs and then you've got this dilemma [because the client will be discharged regardless of the client's goals]

In this case finding out clients' goals revealed issues that had to be ignored to meet the needs of the healthcare institution.

Although the COPM is a textual representation of the client-centred aspect of occupational therapy discourse, therapists used "home-grown" or therapist/ occupational therapy created client assessments. Although some therapists reported unfamiliarity with the COPM, many had access to it, but did not use it. Robin (HC) noted "we never go out on an initial [assessment with] a family and do the COPM even [though] we have a big bunch of those in the office." These facility-based assessments, copies of which I obtained for the study, although they all included a small section on client goals at the end, focused primarily on the client's functional status currently and prior to admission. Although this focus on function is not in keeping with client-centred practice principles, it was in keeping with institutional discourse that will be described in the next theme. Instead of completing the COPM, six therapists described part of their job involved global assessment of function. Emily (AC) observed: "They really kind of relied on my functional assessments to know what kind of things to put into place in the community and whether or not they were going to need to go to placement." Thus function was part of institutional discourse for therapists.

When I asked Ruth (AC) about whether clients prioritised their goals with her she re-evaluated the nature of her practice.

They sort of leave it up to us to tell them all the things they need [...], but I've always thought we were client-centred.

B: It sounds like you're thinking that that

R: Yeah

B: The fact that you're not prioritising/ getting them to prioritise is not client-centred.

R: I'm starting to think that...

Although she debated whether this meant her practice was less client-centred, and she eventually decided that it was unlikely that her clients could prioritise issues, her self-doubt indicates the importance of these ideas in occupational therapy discourse.

In terms of language use, although Townsend (1998b) reported that all of the therapists in her study referred to those they treated as "patients", or as a diagnosis, rather than an individual, in their discussion and charting, the results of my study were mixed. Although I did not look at actual charting, during the interviews all of the homecare therapists and one hospital based therapist [Emily (AC)] consistently talked about those they treated as clients, rather than patients throughout the interviews. Three therapists from hospital settings used the terms patient and client interchangeably and one hospital therapists consistently referred to those she treated as patients. Two of the hospital-based therapists who described their clients with both terms noted that in their work the term patient was used exclusively:

“...I think a lot of my people are patients. I don’t treat them as clients. Whereas when I was in [another setting] you know I did call them clients.” [Ruth (AC)] “Patient” therefore seems to be the preferred terminology in hospital settings, and seems to reflect a more paternalistic attitude towards individuals receiving treatment and interventions within hospital settings. Despite the variability in terminology, none of the therapists referred to their clients by their medical diagnosis during the interviews (e.g., “the fractured hip in room 234” or “the demented”). This difference to Townsend’s study may represent a change in linguistic practice, although it may also reflect my use of interview, rather than ethnography, as a methodology in the study.

Other Core Concepts of Occupational Therapy Discourse

Client-centred practice was only part of occupational therapy discourse, which also included ideas about the importance of client independence and function and the need to consider clients holistically. The significance of function was indicated by June (HC), who described her dilemma of whether or not she should provide a scooter for one of her clients:

Like for the person who might lose more physical mobility once they have a scooter um and yet as an OT you kind of want to make sure that or try and make sure that they are as functional as possible.

Holism was another important philosophical consideration for therapists, which Sarah (AC) emphasised by describing “OT’s view of treating the person from [...] a holistic point of view.”

Supporting reasonable risk taking was an important part of occupational therapy discourse for therapists in the study. In describing her risk assessment of a woman with dementia Hannah (AC) noted:

She chose to live at risk and we assessed the risk and said, “yes, it’s a reasonable risk for the other people that are around her.” In that she lived in a concrete building, you know and had a good apartment manager.

In this example, the therapist Hannah was able to facilitate return to the community despite her client’s problems with cognition. Safety was an important part of decision making around reasonable risk. In describing a client who refused safety suggestions and equipment Donna (HC) related: “we’ll [...] do whatever we can, you know, to keep him safe within the parameters that he has set for us.” Safety, reasonable risk taking and client-centred practice seem to have an interdependent relationship within occupational therapy discourse as Donna later described:

If I see it as real safety concern, and they’re not interested at all. [...] I’ll probably still pursue it, because I’m concerned about their safety, well that’s not entirely being client-centred because it’s/ it’s not their perception of what their need is um, but on the o/ so I know that I’m not being client-centred and I guess I justify that by saying, “I’m really uncomfortable leaving someone in their home knowing that, they’re at great risk for a fall to injure themselves, because they refused to move the scatter rug.” You know, something simple like that.

This safety component of occupational therapy discourse has a counterpart within the institutional discourses that therapists negotiate within their practice, as will be seen in the next section describing the discourses within the healthcare system.

Summary of Bridging that Gap: Ideal versus Real Conceptions of Client-centred Practice

The theme of “Bridging that Gap: ideal versus real conceptions of client-centred practice” revealed the tensions that therapists experience when putting their ideals about client-centredness into practice. There was a tension between the client-centred portion of occupational therapy discourse and other aspects of occupational therapy discourse and aspects of institutional discourse, which will be described within the next theme. This conflict can be considered from both a Foucauldian and standpoint theory perspective. From a Foucauldian point of view this tension can be described as a conflict between discourses that are found within acute care and homecare settings. From a standpoint theory perspective, this tension can be seen as what Smith (1990a) describes as “bifurcation of consciousness” in which individuals recognise a disjunction between the abstracted conceptual mode of understanding the world and their everyday experience of it. In this case, therapists recognised a gap between their conceptual understanding of client-centred therapy compared with its actual practice. Although Lisa’s comment, “they all say they’re doing it!” indicated, the rhetorical nature of client-centred practice as suggested by Abberley (1995), therapists seemed committed to this part of occupational therapy discourse. All therapists struggled to implement client-centred practice in the settings where they worked, and described their setting along a continuum of client-centred practice.

Therapists’ definitions of client-centred practice reflected those found in the literature. It was interesting to note how Ruth’s definition, which was more therapist directed, mirrored the setting in which she practised. This may indicate the powerful effect that institutional discourse has on individual therapists. None of the therapists

regularly used the COPM, a standardised Canadian client-centred assessment, and instead performed more global assessments of client-function, which supported the importance of function in occupational therapy discourse (AOTA, 1986). Although client-centredness was one of the most important parts of occupational therapy discourse, other aspects, described in the literature such as safety (Townsend, 1998a), holism (Finlay, 2001) and independence (AOTA, 1995) were other important considerations for therapists.

Related to the Service Environment: the Importance of Service Setting

The second theme describes the importance that therapists ascribed to the service environment in shaping their practice. This theme was divided into two subthemes of 1) system expectations about occupational therapist involvement and 2) lack of resources (“we don’t have enough resources”).

All of the therapists described the impact of the institutional setting on their ability to be client-centred. Emily (AC) indicated “the biggest [barriers to client-centred practice] were related to the service environment.” The importance of setting in either enabling or limiting client-centred practice was highlighted by the debate of whether occupational therapists should be in acute care service environments because of difficulty of doing client-centred practice there: “There’s a lot controversy out there in the OT world too as to whether OTs should be in acute care or not” [Hannah (AC)]. Hannah also noted

I think as an OT with/ our theory is sometimes/ we learn from the ideal and the ideal is that we sit down with someone and they can tell me exactly what they need and that’s what you go and work on. But that ideal does not/ the theory does

not take into considerations the system and the system has a huge impact on turning that theory into practice.

In explaining why some therapists did not practice in a client-centred manner Emily (AC) noted that although these therapists may have had client-centred intentions, “maybe they’ve been so bombarded with constraints of the system that they’ve kind of just gradually let a [...] less client-centred way of assessing creep into what they’re doing.” Four of the therapists reported that they had changed settings or wished to find a new job so that they could practice in a more client-centred manner or as Ruth (AC) described, “I almost feel I need to change settings.”

“System Expectations” about Occupational Therapist Involvement

Therapists attempted to enact this inconsistent occupational therapy discourse in settings in which there were multiple and at times contradictory demands mediated through a variety of competing discourses. To understand the importance of institutional discourses in relationship to occupational therapy discourse it was necessary to explore the autonomy of therapists.

Therapist autonomy. Four of the therapists reported “we have a lot of autonomy” or as Robin (HC) reported “I can go out and do whatever I want[...] out in the community.” This apparent autonomy seemed to be limited in scope, however, which was confirmed by Emily (AC) when she provided feedback on the tentative summary of findings that I shared with her. She noted that although therapists had a lot of discretion about when they scheduled clients and to some extent the interventions they performed, “I’ve got two things driving me [...], what the system’s expectations are versus what the client might want from me.” Rebecca (AC) noted that in her setting system expectations

took precedence over those of the client: “I’m still trying to get on to the sub-acute goals before I can move on to the client goals, which is too bad.” Given the importance of system expectations client-centred practice was difficult when the client goals and system goals conflicted: “when the client factors fall in with [...] what the system/ meets the system requirements or needs then it’s easier to be client-centred. Um, other times I think it’s hard” [Hannah (AC)]. In this example, client-centred practice seemed incidental rather than intentional.

Competing discourses within the healthcare system. Other disciplines within healthcare settings had their own discourses, which sometimes competed with occupational therapy discourse. These discourses, like occupational therapy discourse, were shaped by the institutional settings in which they are enacted. Although these discourses vary between professions and are not completely uniform, there are many commonalities between these other professional discourses, particularly regarding safety and risk management. Given these similarities and the limited scope of this study, which explored occupational therapy discourse, rather than the discourses of other professions, I have described these other discourses as institutional discourses.

Referrals, which may be formal or informal, are textual representations of discourses, through which the expectations on therapists in hospitals and homecare are made explicit. Referrals exhibited variability: “sometimes they’re vague and sometimes they’re specific.” [Donna (HC)] Other healthcare providers, such as nursing, physicians, and physiotherapists, usually made referrals for occupational therapy. None of the hospital-based therapists described any client self-referrals, while in the community self-

referral was the exception rather than the rule. Vague referrals often invoked a discourse of client safety:

Something more on the vague spectrum would be somebody who [...] is still in hospital and we're not really sure whether or not they're going to manage in the community and so they ask for a pre-discharge assessment or a day of discharge [assessment]. [Donna (HC)]

With specific referrals people other than the client frequently identified issues and problems:

Then there are other referrals that are very much more specific. [...]

You know, "individual needs a bath stool because the home maker is having difficulty getting them in and out of the tub." That's very specific. A lot of wheelchair, uh, referrals: "needs manual wheelchair because they can't walk to their G.P.'s office anymore or family is unable to transport them there" [Donna (HC)].

In some settings, clinical or critical pathways prescribed therapists' interventions and intervention timelines. For Emily (AC):

What's supposed to be guiding my practice on that ward was clinical pathways [...]. Basically anyone who's had this procedure, you're supposed to see them on day three and teach them ABC kind of thing [and then on day five...].

She later described: "I felt kind of constrained to be fulfilling the [...] bureaucracy or the facility I was in and checking off the little boxes that they wanted checked off and stuff like that." Thus there was a question about whether she could freely identify any of the pre-determined goals as "not applicable." Four of the five hospital-based therapists

interviewed have ‘blanket referrals,’ which meant they did not need a physician’s order to treat clients on their units. Despite these blanket referrals, these therapists received a variety of formal and informal requests for client intervention. As Emily (AC) noted, despite the blanket referrals system on her unit that she would still receive written referrals: “if the [doctor or the] head nurse or somebody thought they needed to be seen by OT they would fill out [a referral] and say [...] ‘ADL assessment’ or something.”

The importance of discharge. System expectations were similar in both homecare and acute care settings, although client discharge into the community appears to be the primary expectation of most acute care hospitals, which, is understandable in light of the funding limitations, force hospitals into “diversion.” At the Vancouver Hospital, facilities went on “critical one” and “critical two” when no more patients could be admitted.

Critical one described when all beds were occupied and critical two was used to indicate when all beds were occupied and people were waiting for a hospital bed, frequently in a hallway. When a facility was at critical one or two, efforts were made to discharge all possible clients from the facility. If a facility was unable to accept new clients, they were “diverted” to other facilities and could even be transported outside the province. The over-riding importance of discharge was described by seven of the therapists in the study: “as soon as they’re medically stable basically we ship them off home” [Ruth (AC)].

Discharge from acute care was an important issue for both acute care and homecare therapists, as clients with greater acuteness of illness on discharge required increased homecare intervention. Sarah (AC) described

When I went to work on the inpatient unit I found so much of it, you weren’t asking the person what they wanted to work on, basically it was like, ‘how can we

get this person out of here? and 'what do they need to do to be discharged' and you know it wasn't really taking into consideration what the person wanted. The goal was to get them out and how could you get them out sort of thing.

Hannah (AC) observed:

"I think acute [is] very focused on discharge planning and I would say I approach most of my clients with that in mind. That I'm here to co-ordinate their discharge and get them ready to be discharged [...] In some ways that's the philosophy of acute-care, you know you get them in there and you get them better and you get them out."

Three of the acute care therapists described how they felt they were responsible for creating a successful discharge:

Quite frankly, you know, it gets to a point where your patients going to go out, whether you have provided the equipment or not and when it comes to that, my thought is that I had better have provided the equipment because otherwise they're going to probably be back in and then whose fault is that going to be or who's responsible? [Hannah]

Or as Ruth (AC) described:

For instance if you didn't assess for med. compliance or medication management and a person goes home without a proper medication plan or follow-up through homecare nursing or whatever then they end up back in hospital and that's poor discharge planning and so it's my responsibility to make sure that all that is done.

Some therapists reported that the treatment team overlooked their concerns about discharge. Emily (AC) noted that on some units she had worked on "what I did often

seemed like a drop in the bucket” in that sometimes her assessments didn’t seem to impact the client’s care or discharge plans. So despite her expert knowledge about client function she had limited power on the treatment team.

The discourse of safety: “you’re just trying to keep them safe”[Ruth (AC)]. In both homecare and acute care, some risk taking was allowed, but safety was a major concern and was discussed by all therapists participating in the study. As safety is an important part of occupational therapy and institutional discourse (as expressed through referrals), safety issues were extremely important in shaping therapist practice. All therapists stressed the importance of safety issues. When I asked Lisa (HC) what her referrals were usually like, she initially responded with only two words: “safety issues.” In describing how referrals that she received identified different goals than those of her clients June (HC) observed:

Sometimes when you get to the home, people are identifying things that are completely different from what the referrals was for and at that point I have to decide [...] *which thing is more important based on safety*. But um if the person, say, is identifying they want a scooter and um but they can’t even make a meal for themselves I am kind of weighing it as to how we can sort of blend the two together somehow so we’re addressing the concern that they have in addition to potential concerns that I might have based on, you know, the *potential risks of doing various things*. [italics added]

June (HC)’s comments demonstrated how therapists needed to balance institutional/professional expectations and client goals. The potential conflict between

client's goals and therapists perceptions of safety were exemplified by Rebecca (AC)'s comments:

Well often times, if a person really wants to go home and they're failing at home and they don't have the insight into the fact that they're not doing all that well, um, and their goal is to get home and we're deeming them unsafe, I don't find that very/ it's not/ it's not client-centred at all.

The over-riding importance of safety limited prioritisation of goals. Rather than having the client prioritise goals Donna (HC) noted that therapists:

Usually just kind of jump in and go with what they think is probably putting the client most at risk. Uh and / again that goes back to what I was saying before that we do a lot of crisis intervention and a lot of just putting out fires and so you tend to say, "you know, okay, what is it that we need to do here to make it safe?" and then go and do it...

Although safety was an important consideration most therapists described how some risk taking was allowed. Answering my question about whether a client's cognitive problems impacted their ability to make decisions, Sarah (AC) responded:

S: Um I don't know how much it impacts their ability to decide if they want to work on something or participate in something necessarily. Um. I mean again you know I might think they need to work on something and they don't have insight or don't think they need to, but then again its sort of that conflict of well, if you don't think that someone safe, you know sometimes I don't think someone's safe at home like around the kitchen or anything like that, but they say no, I don't have any problems with that, I'm not doing your assessment then you know and you

think well, you have no insight into the fact that you might have any problems, but again you can't necessarily force someone to do something if they don't want to do it right?

B: Yeah.

S: And I've also found that on my unit that like there's lots of people I've thought, "You can not manage at home" but you know, who are we to say that they can't go home if that's where they want to be and they're competent, you know, who are we to say you know they can't live their life like they want to live right? The way they want to live it so.

In this example, Sarah (AC) had concerns about client safety but indicated willingness for them to live at risk as long as they were competent to make decisions.

Therapists in homecare had a risk-assessment tool (Altman and Cho, 2002) that I was able to obtain. The tool listed a variety of "risk factors," which included personal and external factors such as functional status, mental status, and health status, risk taking behaviours, social conditions and environmental conditions. The client, the care giver and the healthcare provider were each expected to identify the level of risk on a three point scale that ranges from 0=no risk, 1=tolerable risk and 2=intolerable risk, and provide comment on strengths and personal supports for each risk factor. Intolerable risk elements included:

A change in the person that impairs his or her ability to protect himself/herself or others from harm, evidence of current decline/severe change in condition, the severity of the anticipated harm, the high probability that decline/severe change

will occur, the imposition of risks on others, and the inability to choose to be at risk.”

The document states that if “*If consensus in not reached about client risk this should be identified*” [italics in original]; and, at this point, Vancouver homecare therapists could use Health Board’s ethical decision making framework (Altman and Cho, 2002).

This framework, which was based on the bioethical principles, of autonomy, non-maleficence and beneficence, described a five-phase process to assist in ethical decision making. The framework was designed to facilitate “*weak paternalism*,” in which interference only occurs if the client is “encumbered” by a condition which may affect their decision-making. Weak paternalism was described as “*the desired approach in health care*” [p.4, italics in original]. Despite the assertion that this ethical decision making tool could be used for “day to day professional problem solving” [p.1], the two Vancouver homecare therapists, although familiar with the document, often did not use it or the risk assessment tool in practice. Donna used the decision making protocol in:

One particular case we were working with. The client was living with um her son and the son was very verbally threatening and very intimidating and she wasn’t um/ it was implied that this was threatening to her and that potential he was taking money and she was on oxygen and he was smoking in the apartment which meant they could have blown the whole thing sky high, um, but, it, it um, [...] didn’t identify [her son’s behaviours as a problem] [...]

Donna later noted, however, that the decision making protocol:

Made it really client-centred, in that it gave us some guidelines around um, how can we then dialogue with the client and what things can we do as a professional

in order to assess the risk with the client and determine what it is that will happen
um and what the client is willing to have happen. They may choose to stay in that
risky um, situation and/ and we unless they're being abused and we call it abuse
under the guardianship laws, we can't force anyone to do anything or to change
their environment.

In this case this text seemed to reflect a discourse of client-centred practice within the
confines of reasonable risk taking, but this case seems atypical when compared with most
of the situations described by therapists.

Frequently no formal process was used in healthcare settings to explore risk and
make ethical decisions. In describing her intervention with a woman who was having
difficulty walking, one therapist observed:

T: A little woman. Ninety/ Eighty-two years old who really really does not want
to give up walking. Does not, you know, she's walking with a walker. She's an
accident waiting to happen. She falls a lot. She fell and broke her wrist and things
like that. So we had a care/ we had a family care conference and talked about the
option of a wheelchair. So that afternoon she was really upset. She asked me to
come outside and we talked outside and about "giving up her legs" [...]

B: Yeah/ Yeah. It's interesting. How/ How do you think about that in terms of
being client-centred. How does that work with that idea?

T: Umm (3) There was a lot of pressure externally and stuff that she needs/ she
can't walk/ she can't walk/ she can't walk.

B: Uh hmm

T: But then the physiotherapist who's the one who gets to assess safety in walking and transfers was involved and we actually went in there together to watch her around the room and the physio decided and wrote in her things that she must be supervised. She also has an element of dementia so that throws a wrench in it. Like the uh judgement aspect of it. Um so it felt really bad. That's one of the reasons why that after the care conference/ it came up there/ and basically we were talking about the walking and wheelchair and I said well we could get someone in to show her a wheelchair. That's all I said. And you could just see her face go down like she was depressed and that's why later I took the opportunity to talk to her and tried to lay our her/ and said these are your options and said, "Yes, you can keep walking with this walker. Unfortunately, it means that somebody has to come with you, because that's what the physio / I mean you could go alone. You have every right to go alone, because we're a minimum restraint policy place. So, but you don't want to fall and break your leg?" Telling her some of the pro's and cons. We understand you want to be/ so it felt like I was really/ we/ we as the team, the physio and myself and nursing were imposing on her that she had to have a wheelchair. So it felt really awful. But the fact/ you know/ I said, "But you can try it and you can tell us what you think." You're willing to try. Yes. So when you bring it in and she got to see it and try it and got to make her opinion about it/ it felt definitely a bit better.

B: Yeah so in a sense you sort of changed her/ You modified her g-goals in a way.
And

T: Looked at/ We talked at/ I helped talk to her about/ try not to influence, but let her know that ind/ you know/ the word independence can actually mean a lot of different things and she's got to find what it means to her. And if getting to the dining table on her own is independent, it doesn't matter whether she is using a walker or a wheelchair. If she's in a wheelchair, she can do it alone. If she's in walker she has to wait for someone. So it was around perception. But you still feel like you're implying/ you're/ you're impressing your opinion on someone else.

B: And what if she'd gone the other way.

T: We would have let her. We would have let her.

This example demonstrates how these informal processes can put considerable pressure put on client around safety issues, and how therapists and client can be uncomfortable with this undue influence.

Given the importance of safety, it is not surprising that five of the therapists described how they and others working with clients were expected to monitor clients and identify unsafe behaviours. Ruth (AC) and Hannah (AC) reported collecting collateral information about their clients to either prove or disprove what they said. Donna (HC) reported:

We rely on [home-makers] to give us information on how someone's managing, because often by just going in and spending a half-hour or hour with a client you don't get the best sense of day to day, are they really managing? Or are they just saying to you "yeah, everything's fine"? "Oh no, I don't have any problems with that dear." You know, etc., etc. and then the truth behind this is that they're really living marginally, and at risk, and sometimes the home-maker is the one that's

able to sort of talk to us afterwards and say, “well no, there’s a problem with medications.”

Some clients were aware of therapist’s role in monitoring their safety and

Are very afraid that your going to come in and say, “You can’t live here anymore, you’re going to live in a facility.” And so they might tell you “everything’s okay [...]” But that’s because they’re afraid of that. [Donna (HC)].

In discussing liability issues around power mobility prescription Donna remarked: “Well what if somebody does injure themselves? Could it come back on me?” Therapists will sometimes involve the interdisciplinary team in treatment decisions to share responsibility:

It becomes really hard to take the responsibility for risky behaviours [...] and so you tend to involve the team and then the responsibility isn’t on you as an individual [...] it becomes a team issue and you work on it as a team. [Donna]

The interdisciplinary teams therefore had a great deal of influence on client goal attainment and therapist practice.

Interdisciplinary teams. Therapists in the study worked on interdisciplinary teams that had a significant impact on how they practised as these teams represented the primary means by which professional discourses were communicated and reinforced.

Interdisciplinary teams in hospitals were composed of a large number of people, which could include the physician, social worker, physiotherapist, pastoral care worker, the head nurse, homecare liaison nurse, music therapist, clinical nurse specialist, nursing, recreational therapy and the speech language pathologist. These teams represented arenas of negotiation in which some professional discourses had supremacy over others. The

community teams tended to be smaller and frequently included a physiotherapist, a nurse, a case manager and sometimes a speech language pathologist. The case manager was often a nurse or social worker and “one of their big tasks [was] to organise and oversee all the home-making services” [Donna (HC)]. Case managers also co-ordinated clients admission to the facilities, respite beds and admission to rehabilitation programs.

Five therapists reported feeling supported by the teams they worked on: “the units are very good actually, um I have a lot of support” [Ruth (AC)] and “our rehab team [is] always very supportive and quite close and we certainly help each other out a lot” [Donna (HC)]. Some tension was evident, however, and six of the study participants reported conflicts in their teams. In describing her team in Homecare, Robin (HC) noted “the team is so small you can step on toes that way and there’s a little bit of tension right now on the team.” On her current unit, Emily (AC) noted that although doctors made a lot of decisions around patient care and discharge,

I can’t say that I ever saw a doctor. [laughs] Maybe once or twice. They didn’t come to rounds and um, I very seldom saw them at all. Um, so I hardly even conceptualised them as part of the interdisciplinary team.

Thus in her setting, physicians seemed to have a greater amount of power in decision making than other disciplines.

Conflict in the interdisciplinary team sometimes stemmed from issues around scope of practice, which is defined as the duties that each profession is expected to carry out. In homecare, Donna (HC) noted that “people get a little territorial when someone [other than an occupational therapist] will put in that piece of equipment.” Such boundaries represent conflict between professions’ areas of expert knowledge. Hannah

(AC) observed that all disciplines have difficulty considering looking beyond their own specific areas of interest: "I think we all get our blinkers at times." For Donna (HC) boundary issues sometimes limited services that her clients could receive:

Everybody's got these [boundaries] / you know, the homemakers can only do this and they can't do that and everybody's sort of got their boundaries in which they need to work and sometimes you get so caught up with bumping into everyone's boundaries that what gets missed is that the client is really in need of something and it would, it would be quite simple to solve, but no one's willing to sort of step beyond their boundary.

Some therapists were frustrated by the limitations of these barriers.

In considering crossing one of these boundaries Donna (HC) commented: " 'Oh well, maybe I could just bring them/ bring them something by or drop by the food bank,' but then you're creating a dependency so that's/ that's/ that's not really appropriate either so it's hard." Given this concern about creating dependency, when Donna provided cardboard boxes for a client who requested them, she noted: "So again it was very client-centred. And very client-driven. Of course, is that stretching the boundaries of OT?" She also noted there was a reluctance to make a "transfer of responsibility" in which a homemaker is trained to carry out specific occupational therapy interventions.

When there was conflict on the team some therapists would try to resist team decisions, but this process seemed difficult. Rebecca (AC) described her attempt to go against the wishes of the treatment team as follows:

Well if I'm the only person on a team who thinks that a person should go home and everyone else is saying this person shouldn't go home I usually cave to the

pressure, you know and so again and even if a person wanted to go home and if everyone else thinks that you know they're not going to make it then I would usually cave [in] to that.

In client-centred practice, it seems that therapists sometimes need to advocate for their clients' goals.

Several therapists in acute care settings reported that they felt there was an expectation that they intervene with clients, even if the clients were unable or unwilling to come up with goals they wanted to work on.

If I'm truly client-centred you know and that's what they need right now, I'm going to not provide OT, because you know they're not coming up with anything that I can help them with. [...] But then you go away and the rest of the team is saying, why aren't you seeing this person? And you know you could say, "well, because they're not identifying any functional issues right now" and they're saying "you know she can't get on or off the commode, I'm having difficulty with that you know, if we were to be able to do this blah, blah, blah." So that's working against where the patient's at. [Emily (AC)]

Thus, therapists reported feeling pressured to work with clients who had no self identified problems they wished to work on.

Five therapists identified there was an attitude in healthcare institutions that "the healthcare professional knows best" [Ruth (AC)]. Rebecca (AC) observed

When you come to a unit where people have been practising for a long time that are set in a certain way of practising that, "I know what's best and I'm going to tell you what's best."

Some therapists felt they were expected to assume the role of expert in identifying their client's needs: "they really do look to us as the expert" [Robin (HC)].

Examples of non-client-centred practice. Hospitals, in particular, seemed to be sites of non-client-centred practice and four of the acute care therapists report instances where clients had little input into treatment decisions. Rebecca (AC) noted:

I think [goals] are set by the healthcare professionals. You know, the goal is discharging that patient to [a] facility. Well maybe that person's goal is to go home, but sometimes that would just be pushed to the way side, um because it's not seen as being a reasonable goal.

One therapist described a case where a client was discharged to a nursing home without his knowledge.

He's going to have to go to a nursing home and he doesn't want to and um and this choice has been put to him in a way that he's going to accept it. Like he's not being told I guess, "you're going to a nursing home and that's the end of it." So he's being told he's being transferred to another hospital and he's going to be discharged from there, which is true. He is going to be going to another hospital, but we know from that other hospital he is going to go to a nursing home. So they're kind of hiding the truth from him right now.

In terms of swallowing assessments Lisa (HC) noted:

You go to the unit and you do your swallowing assessment. You go tell the doctor what you think, which is usually NPO [*non per os*] and the doctor says NPO, but the person isn't really given a choice, I mean they can start sneaking stuff, but it's not an active choice.

Rebecca (AC) described her frustration with clients who are discharged into facilities that they had not chosen. The family was very upset and told Rebecca.

We [don't] want her going there. We don't like that facility. Nobody asked us.

They told us that was where she was going and we were given no choice and on and on and it was really hard for me because it was like "can you help us?"

Healthcare providers seemed to have concerns about family decisions regarding feeding tubes:

In extended care they're looking to implement some kind of decision tree, so that the hospital or the physician or the treatment team can sit down and make the decision to withdraw the tube, even if that was against what the family wanted.

[name omitted to protect anonymity]

These guidelines do not appear to have been formally adopted. A draft document of the guidelines noted that although a tube feed could be used as a:

way to preserve meaningful life. It can also be used to preserve mere biological existence [...] these guidelines are designed to help distinguish between the appropriate and inappropriate use of tube feeding. The advice given applies to decisions about both initiating and continuing tube feeding.

Although the previous ethical decision making process seemed to promote client-centred practice, this proposed guideline indicates how bioethical principles may also be used as a basis to limit client-centred practice.

Resources

All therapists identified lack of resources as a barrier to client-centred practice. Most programs have limited funding for equipment. When asked about her funding for

equipment one therapist replied, “I don’t have any funding for any equipment. I have a budget of zero.” Equipment problems transcended healthcare institutions and involved government policies. Emily (AC) noted that “it’s a whole other kind of social issue, those little old ladies with no money and there’s no government funding for equipment in this province. Some therapists in hospital described the physical environment as a barrier, with limited areas to work with clients, a lack of privacy for client assessments and resources to facilitate goals that are not directly related to discharge. Although many clients wanted to return home, unless the client has a palliative diagnosis, “you’d be hard pressed to get homecare in everyday.” [Sarah (AC)] In describing her frustration with meeting clients’ goals of discharge home, Rebecca (AC) observed:

I think that more people should have the option to go home. I mean how are we supposed to meet people’s goals if they want to go home and they have no family to support them? If that’s their one goal in life, they want to go home and die [?]. We can’t do anything about it. So we’re really just um/ the system is a barrier to client-centred practice with us saying, “No! You have to go to a facility.” And they’re going to spend the last five years of their lives unhappy...

Some clients in hospitals and homecare had very limited incomes. Equipment was very difficult to get for these clients: “where do you find equipment for these people? Um, you know the Red Cross is so maxed out that/ there’s a seven or eight month waiting list period for manual chairs, let alone a scooter or six weeks for a bath stool” [Donna (HC)]. Therapists sometimes encountered problems with long-term care services and housing that did not meet their client’s needs.

We're finding that more as our population ages the folks downtown are ageing as well and are having more /more physical problems and that/ and facilities that will accommodate someone who has a mental/ long standing chronic mental health illness that also has a physical disability and may be street entrenched. Where do you go with them? You know, there's/ there's no where really. So/ so that's a tough part of you know, we don't always directly deal with housing, but we deal with the consequences of it, but/ like the fellow I was talking with the 30 stairs and it's really hard to meet his needs when we can't really get him in and out of the building safely or down the hall for that matter to use the toilet.

Limited resources, therefore, had a great deal of influence on the interventions that therapists could provide.

Donna (HC) described an interesting example of resources as a barrier to client-centred practice in which a ministry client was using his scooter as a mode of long distance transportation. This use of the scooter led to the need for many costly repairs.

Initially Donna (HC) blamed the client for abusing his/her scooter:

Well the client also happens to be abusing the scooter and is using it as transportation and then goes from Vancouver to Burnaby and back, takes it much further than its been explained to this client over and over and over again, has a scooter that's not even a year old, its been provided by the ministry and there's usually a five to seven year replacement period. So its not even a year old. The batteries have been replaced seven times, the manufacturer is now refusing to replace any batteries, the battery/ there's a / they break down, we've had this long discussion around proper use, and the choices that they're making.

Later, however, she noted how the restrictions on the client scooter use are prejudicial against those with limited incomes.

And that's for someone who's going to be funded by the ministry. You take another person who has their own finances. Well they don't need us, they don't need us to say yes or no you can't have this piece of equipment or you're not eligible. They can just go out and buy it themselves and use it as / they can misuse it as much as they want and so then there's that inequality as well, but it makes being client-centred really, really difficult.

Given the limited funding to those on social assistance the client's use of the scooter seems like a creative solution to his transportation needs.

Resource barriers subtly shaped client-centred practice. In homecare, adult clients without families were seen preferentially over clients with families as it was assumed that families would take responsibility for their relatives. This policy was supported by Donna (HC), because of the discomfort she felt "when you see some people that really need the services that can't get them and you know they're living marginally." Despite this support, Donna was concerned with the demands placed on clients with families:

Maybe we're being really um, sort of prejudiced towards that person who does have family, where somebody who doesn't have family will get all this services so is that fair? But there's a lot of inequality and I think that/ that's um that's/ that's a frustration.

For clients who received ministry funding for a scooter Donna noted:

When you're talking about a piece of equipment that could cost you upward of eight or nine thousand dollars, um I suppose we do feel a little bit like the police

squad where you're sort of thinking, 'Okay, yeah, [...] you might want it, but do you really need it?'

In this way, clients with ministry funding received different interventions from clients who could afford to purchase their scooters independently.

A therapist from one setting described how the limited number of occupational therapy staff meant that "we don't have OT's on all the units. We cover maybe two-thirds of the hospital, so [...] the rest of the patients who need OT go on a waitlist and they get seen as caseloads permit, which often means they don't get seen."

In homecare, home making services such as cleaning and meal preparation were limited to clients with a personal care need: "the person has to have a personal care need in order to initiate homemaking. They can then do all those other things as well. Um, but there has to be a personal care need." Donna (HC) was uncomfortable with this situation:

That's difficult for us because some people really can't shop by phone, they don't have any family or friends that can do it and their mobility is really not adequate for them to go into the community. So again it's one of those things. Its/you know you/ and can they afford meals on wheels, which also costs money, so its, its sort of a there's this policy, but how does it fit with actual/ our philosophies as OTs and I don't know that that fit is always the best.

In responding to my question about how she deals with this discomfort, Donna described how she might alter her findings to allow clients to have the resources they require.

Ben: So what do you do with that tension or that um, problem? You try and work around it?

D: You problem solve basically. [...] You have to find some way of enabling that person to/ to be able to/ I guess often what we'll see will happen, we'll find that we can probably justify that someone, if they're not able to get out of the house to do their grocery shopping, then probably their mobility isn't that good so you stretch those rules a little bit and you say, "well a stand by assist, for bathing is appropriate to keep this person safe, and decrease the risk of falls, therefore we can get them some homemaking." Um. And again that's totally a personal choice. Some people will/ are willing to do that, other people are not.

In this way some therapists choose to resist institutional discourses that compete with client-centred practice.

Robin (HC) describes an incident in which she felt she "really came away from client-centred practice." In this example Robin (HC) describes trying to give a client a folding frame chair, although the family wanted a different wheelchair. Her inclination to provide a folding frame chair was encouraged by government policy, because that was "what I'm used to getting every client out there" because it was fully funded by the system. Although she subsequently blamed herself because she "didn't really listen to the family," the fact that only basic equipment is fully funded shapes to some extent what equipment therapists normally offer.

Time

All participants identified time constraints as a major barrier to client-centred practice: "I just don't have the time." [Lisa (HC)] There are time constraints imposed by high rates of client-discharge, limited numbers of therapists and heavy caseloads. Many hospital therapists noted that there is a lot of uncertainty about the time of client

discharge: “you know a person could be in there for a week, I could have them for four weeks, I just never know how long I’m going to have a person, when they arrive on the unit.” [Ruth (AC)] Similarly, although Hannah (AC) would like to spend more time with clients, building up rapport and exploring their goals, she noted:

You don’t necessarily get three or four hours to sit and explore over a couple of days what that would be. You have forty-five minutes to go in there and do your assessment and on to the next [...] cause they might only be in hospital for three days. They might be in hospital for two weeks, but you don’t know.

For Rebecca (AC):

I would love to be able to get to sit down with each person that came in and get to know them well um, talk to them, more than I’m able to make time for that. And I try to make time for that, but something else always comes up that’s more urgent, like a discharge, a new admission, a broken wheelchair, safety concerns, things like that that are more urgent to a lot of team members...

On many in-patient units there was only limited warning about when clients were going to be discharged: “I usually get 24 hours notice that they’re going, so it can be quite rushed at the end.” [Emily (AC)] Despite these workload problems Donna (HC) seemed almost hesitant to identify time constraints as a barrier to client-centred practice:

D: “I don’t know if you would call work load a barrier.”

Ben: It sounds to me like you were saying that you/

D: It certainly makes it really difficult and the pressure to go, go, go. To see more people and to you know, be expedient, about it, is um that to me if I had more time I hope I would stop and spend a bit more time with the person...”

Very few therapy departments have vacation relief or sick time relief included in their budgets: “The workload was fine when all the therapists were there. When anybody went on vacation it was kind of insane, because we don’t have any funding for vacation relief so you have to pick up extra caseload from the therapist that was gone.” [Emily (AC)]
Lack of vacation relief added to therapist stress and workload.

Time pressures ultimately affected therapist performance and some therapists blamed themselves for these mistakes:

Ruth (AC): I find that with the short time span and with many people getting discharged all at once. I find it can be quite chaotic and so I have to be very conscious about making sure that everything is done just so. So that everything runs smoothly and sometimes I do mess up with things just cause it’s moving fast.

Ben: And how does that make you feel?

Ruth (AC): Crappy

In this instance Ruth (AC) blamed herself for institutional problems that resulted from a lack of resources.

Time pressures affected how occupational therapy services are delivered and perceived: “I think OT’s gotten a bit watered down in the sense that we have so many people we need to see um. We always have caseloads far beyond what they should be. We don’t do proper follow-up and then you’re doing it as quick as you can.” [Donna (HC)] Many therapists noted that these time pressures interfere with their ability to develop rapport with their clients. Those who had worked in other settings often contrasted those experiences with those they had in acute care and homecare:

Compared to other places I've worked, like I worked in an extended care for a while and I found that very different as far as client-centredness went. And the time had a lot to do with it. My clients weren't going away; I could develop rapport over/ over a period of time and I could build up trust, to find out what it really was that that person wanted to work on, um. And not just what other people think. [Therapist not identified to maintain anonymity]

Therefore, when time pressures were reduced, clients and therapists were able to develop greater rapport.

The priority system. Due to the importance of system demands on therapists and because of workload and resource problems for homecare and acute care occupational therapy services, "the priority system [was] very essential." [June (HC)] With the priority system in acute care:

Basically you assign a number to each um, person based on their priority and the priority would have to do with um something to do with whether or not they are going to be discharged soon and whether or not um, they have sort of things on the care pathway that was like imminent and they had to be seen. Um, things like that and then / and if they're going to be there longer they get dropped down further on the list of whether or not you're going see them, so basically someone who's already had all their sort of acute things seen to and they're just kind of waiting around on placement would be at the very bottom of the list. [Emily (AC)]

In acute care settings, this meant that waiting placement patients were frequently ignored:

People at the top of the [priority system] are always there. There's always a pile of them to see so if I manage to do that with someone and they've moved down the list and if you're waiting for placement, then I'll probably never get to them. To do anything else with them. [Emily (AC)]

In homecare, there were multiple levels of prioritisation:

In terms of the prioritisation, um the referrals that we get are screened by the intake nurse for the most part and she usually is able to assign kind of criteria based on um priority 1, 2, 3 and 4. One being the highest priority. Things like if a person is at high risk living at home with no supports at all. [...] There's also a screening process that the therapists use to prioritise um, how urgent a person needs to be seen. [June (HC)]

Therapists therefore considered client goals in relationship to the existing priority system.

In homecare health units went "on closure" or "screening" when caseloads were too high. In the former situation, no new referrals were accepted; and, in the latter, only high priority referrals are considered: "screening means that we do still have new referrals that are coming in. And they just have to be of a really high priority. When we're on closure it means we do not accept any new referrals." [Donna (HC)] At the time of these interviews many homecare health units had been on closure for an extended period of time and many clients did not receive timely service:

Donna: We [have] had referrals that had been sitting over three months.

B: Wow.

D: And that's/ I mean that. We could get into a lot of trouble because in number four, which is our lowest priority we're supposed to see them within four weeks.

So that's really bad. You know and that's not something they like people to know, because its/ its obviously it's a really bad reflection on the service we're providing, but that is a reality, um, so and then, then when we're on closure, again it gets reviewed at least weekly. And once we come off closure, there's usually a stack of files that have been waiting and have slowly accumulated.

These workload pressures severely impacted service delivery and therapists' satisfaction:

When you look at the heart of what OT is and what intervention is meant to be/ we don't do a lot of that/ we don't/ we'll farm it out to someone else or you know, kind of do a cursory thing and then off you go, because you've got thirty files that are waiting for you. You're on closure and you're not letting anyone else into the system. But then you've got all these internal referrals that are coming in because they're already on someone else's caseload within the system we have take them on, so you know, everyone complains that they don't have enough time. [Donna (HC)]

Ultimately, time constraints and resource barriers impacted the quality of the client-therapist interaction.

Limited Orientation and Support

Four of the therapists in acute care noted that they have either little or no orientation, while new therapists in homecare tended to have a week of orientation. When I asked Rebecca (AC) about what kind of orientation she received to her position, she answered simply, "none." Ruth (AC) noted that "coming into the job without orientation [was] a huge barrier for me."

Client-centred practice was a skill that needed to be supported. Although Rebecca (AC) noted that “there is good support [...] at the hospital for client-centred practice,” Eight of the therapists indicated that they have limited support and supervision. Emily (AC) noted, “you’re sort of on your own in terms of making clinical decisions” and as a result, “I was [...] kind of up in the air about whether or not um, it was okay what I was doing.” Ruth (AC) and Rebecca (AC) reported that they would have wanted more supervision, as new graduates stating: “particularly for new grads, I feel like you just get sort of plunked into things and it’s either sink or swim, and I think that’s a bit challenging for people” [Ruth (AC)]. Donna (HC) described that she was “supervised at a very, very, very distant um, place” and Lisa (HC) considered herself “pretty much sole charge.” This lack of support curtailed therapists’ development of skills in client-centred practice.

Institutional Facilitators to Client-Centred Practice

Client-centred practice was facilitated in settings that were well resourced, relatively few time limitations and little in the way of discharge pressures. One therapist noted that patients in palliative care “get a lot more resources and access to services.”

Later she described how on:

The palliative care unit the focus is on [...] how does the person want to be spending their time, [...] and if they really want to go home and that means they need twenty-four hours support we try and get twenty-four hour support in there for them. So it’s much more client-centred, than elsewhere and people stay on our unit way longer than they would ever stay on an in patient unit. Because, you know, if they don’t feel they can manage, you know then we’re not going to ship

them out. It's that whole idea of you know this their end/ this is the end of their life and treating/ I guess/ people with respect/ in that/ in that time of their life. Homecare services and resources for palliative care clients were superior compared with services for non-palliative clients. Near the end of life, clients were able to have twenty-four hour homecare and therapists through the program supplied equipment readily.

Summary of Related to the Service Environment: the Importance of Service Setting

This theme emphasised the importance of setting in determining client-centred practice. Although therapists reported a high degree of autonomy, their independence seems be limited. This perception on the part of therapists is reminiscent of Marx's idea of "false consciousness;" however; this may have represented different understandings of what autonomy meant. When Emily later discussed this idea with the writer, she was quite articulate about the limits of her autonomy.

Other professional discourses, which I described as institutional discourse, had a dramatic impact on therapist practice. Most referrals, formal and informal, came from other professionals and the interdisciplinary team represented a site of discursive conflict. Within the institutional setting the importance of discharge was often a source of tension for therapists from a standpoint theory perspective. Therapists were aware that clients were frequently discharged into the community before either the client or the therapist felt they were ready. Clients with a high level of medical need discharged into the community put additional strain on homecare therapists.

The safety discourse as an important component of institutional and occupational therapy discourse had a cumulative effect, which limited reasonable risk taking and prioritisation of goals. Although therapists working in homecare had access to the Ethical

Decision Making Framework, generally therapists in acute care and homecare relied on informal processes to deal with concerns they had about client judgement regarding safety issues. Given the importance of the safety discourse, therapists were expected to monitor their client's safety. Some clients were aware of this surveillance and fearful of the consequences of therapist judgement. This overt power had the potential to intimidate clients and prevent them from disclosing occupational performance issues.

Although many therapists reported feeling supported on the teams where they worked, tension was noted between interdisciplinary team members, which frequently included boundary issues regarding scope of practice. Therapists felt a strong expectation on their interdisciplinary teams to work with clients regardless of whether or not they identified any occupational performance issues. Emily's description of what other staff would say if she did not perform interventions on these clients is similar to Foucault's notion of disciplining in which the individual internalises the expectations of those who observe them.

Although there were incidents of non-client-centred practice in both settings, acute care seemed to have more frequent and more serious incidents of non-client-centred practice. This distinction could result from the increased control or power over that healthcare workers in hospital settings had over their clients.

The resource barrier to client-centred practice can best be understood through standpoint theory as these funding issues revealed the relations of ruling that strongly affected client-centred practice. Although these resources barriers included limited funding and lack of equipment, lack of therapist support, they also included time constraints and limited therapist orientation. Therapists often felt a bifurcation of

consciousness when a lack of resources limited their client's goal attainment. A lack of resources could severely impact the quality of life of therapist's clients and in some cases precipitated admission to institutional care. Donna's example of the client who wanted a scooter is a good example of one of Smith's (1987) disjunctures. Donna understood and supported the policies of homecare regarding proper scooter use yet was also disturbed by how this system ultimately discriminated against clients with limited incomes. Rather than blaming the system, Robin blamed herself for her initial failure to provide the wheelchair her client's family wanted, which is an example of what Fine and Weis (1996) described as the "hegemony of autonomous individualism" in which problems are seen as individual rather than systemic. Donna's description of the therapist who falsified her judgement about a client's mobility so that she could get homemaking services indicates that therapist's actions were not completely curtailed by institutional factors and therapist resistance is possible. As a result of time pressures, a priority system was essential for therapists in homecare and acute care. This priority system, however, was in conflict with allowing client goal prioritisation, an essential part of a client-centred process, which created another tension for therapists. Lack of therapist support and limited orientation sometimes hampered client-centred practice.

When these barriers were removed, however, as in the case of palliative care, client-centred practice was facilitated. This finding emphasises the importance of institutional factors in influencing client-centred care.

A Bit of Tension: Problems with the Client-Therapist Relationship

The client-therapist interaction, which was influenced by the occupational therapy discourse and enacted within barrier laden institutional settings, exhibited "a bit of

tension.” This theme included the sub-themes of “therapists’ difficulties,” “client struggles”, and “the continuum of client-therapist interactions.”

Therapists’ Difficulties

In addition to institutional barriers which impacted client-centred practice, therapists struggled to identify “so who [is] your client,” which was complicated by incidents of client-family conflict. All of the study participants described some difficulty identifying the client. Robin (HC) noted that identifying the client has “probably been the most challenging part of my job” as a new graduate. For Donna (HC) “the client is the individual that the referral came for, but the client also includes to me all the care givers,” which may include homemakers as well as family members.” Hannah (AC) noted that

I often find that my client is actually the family, especially if the person is quite demented. Then you’re truly treating the unit not just one person and you can’t just say, “well this is what this person wants,” but you have to look at the system that they’re in [...] and that might be the family.

Later she revealed

There are times when I have honestly sat down and thought [...] maybe the doctor that I’m working for [...] is my client because I end up doing the things that they ask for [...] but I think, you know, perhaps I wouldn’t do if they didn’t ask me. So sometimes I think I’m making them happy by doing certain self-care [assessments] or whatever that I don’t think as an OT needs to be done.

The complexity of defining the client seemed to lead to confusion about goals.

June (HC) described the need to balance a variety of concerns:

I sort of look at what the person is telling me that they think is happening and sort of looking at the reason for the referral [...]. Sometimes [...] when you get to the home, people are identifying things that are completely different from what the referral was for.

In describing her intervention with a “daughter whose got some care giver burden from looking after mom and you know mom doesn’t want a home maker” Hannah (AC) asked:

How do you get the homemaker in there because we know that’s going to keep the mom at home longer because the daughter’s not going to fall apart or burn out or get sick herself. And if she gets sick then there’s nobody to look after her mom, right? So you want to try and avoid that situation. So sometimes it’s presenting it that way to the patient and sometimes it’s um you know it’s putting the service in anyway. Sometimes it’s contracting, that is what has to happen if you’re going to go home, and that doesn’t always feel that client-centred either.

In this case, the mother and daughter together were the client, and therapist needed to negotiate a way of meeting the best interest of both. Generally, when the idea of client was expanded to include families and caregivers, family/caregiver conflict increased the difficulty of client-centred practice.

Client-family/caregiver conflict. Six of the study participants identified instances of client-family/care-giver conflict, which made subsequent goal identification challenging.

Sarah (AC) described how

We just had a woman whose sons were adamant that she should be doing more stuff, like she should be getting up more, [and] we should be getting her

participating in more things to build up her strength, but she just wouldn't get up and do anything.

In working with a client who wanted to be fed rather than feed himself Robin (HC) reported she was told by one care giver: “ ‘You're the therapist, he's supposed to be independent.’ ” A daughter of one of Donna (HC)'s clients identified that her mother was too anxious to use her scooter independently in the community and so she'd made a referral to homecare.

The idea was after she came out of the hospital a community OT would work with her to increase her comfort level so that she would get out on her own. And that was something that the daughter identified, well in speaking with the client and her friend [the client] was like, “there's no problem!”

Emily (AC) described the difficulty in dealing with a family during a conference for an elderly woman who had some cognitive deficits:

[The family] were really, really worried about her, they didn't want her to live alone. They wanted her to go for placement. Yeah, so as a team we were kind of talking / we were kind of almost advocating for her that she's / she still need to make her own choice as well as assuring them if she did make that choice she wasn't going to be totally alone.

Not all family-client interactions were negative, however, but fell along a continuum described under the final sub theme of the “continuum of client therapist interactions”

Client Struggles

Two therapists commented that clients had difficulty with client-centred practice because they had a “lack of knowledge about what OT is and what OT can address.”

Donna (HC) described the confusion clients demonstrated when she introduced herself as an occupational therapist. She reported that clients would ask “What kind of therapist? Are you a nurse?” to which she would respond, “Oh no, I’m not a nurse.” A client might then state, “Oh you’re the physiotherapist,” and Donna would respond, “No, I’m not the physiotherapist.” This confusion on the part of clients sometimes limited client-centred practice as the client only identified goals that they thought were relevant to the professional with whom they were working.

Several acute care occupational therapists noted that clients with acute illnesses were not “very good at knowing what they need.” They indicated clients had difficulty identifying issues because of barriers, such as lack of knowledge and problems with cognition. Emily (AC) observed, “I don’t think that it’s client-centred to just have someone say, ‘I have no problems.’ And then go, ‘Okay, fine.’ Unless you’ve given them a chance to see you know, kind of become informed about everything.” As suggested in the previous theme, context and timing of intervention were important factors that limited client identification of occupational problems. It seemed that a client experiencing normal role expectations within their home environment would more readily identify issues.

Some clients had difficulties with certain aspects of client-centred practice. Donna (HC) noted,

There are some people that no matter how client-centred you’re trying to be they may not have the skills to identify their own needs, [...] for whatever reason. It could be [...] significant speech difficulties and communication difficulties, they can’t actually state them, or it may just be that they’re unassertive.

Life changes brought about by acute illness or the onset of a chronic disability made problem identification difficult for some clients. Hannah (AC) observed: "I don't think a lot of times people in acute care are very good at/ the patients in acute care are very good at knowing what they need at that time, because they're so overwhelmed by so many different things." Ruth (AC) identified "sometimes [my clients] are so sick they can't even think about doing any occupations they'd like to do." Goal identification therefore required a certain amount of readiness, which some clients with acute illnesses lacked. In the case of serious illness, the thought of future occupations could be inappropriate.

Many therapists reported difficulties with client-centred practice when clients had dementia. In describing the difficulties she had with a client with dementia Lisa (HC) noted "she also has an element of dementia so that throws a wrench in it [...] goal settings out the window. Several study participants described attempting to work with clients with dementia to various degrees of success. With one elderly woman with dementia and some additional conditions Hannah (AC) described how she was able to return her to independent living "because even through her cognitive difficulties you could tell that was her value [to be discharged home]." When clients are completely aphasic or very cognitively impaired, therapists usually rely on family members for goals and information; but this was not always satisfactory for therapists. Rebecca (AC) noted in these cases, "I certainly would talk to the family and try to get a sense of what family feels is important and what they thought that person thought was important in their past. But for the here and now it's very hard." Family members asked to identify goals may experience similar difficulties as those newly diagnosed with disabilities.

The need to establish rapport. The need to establish rapport was identified by all participants. For Donna (HC), “Developing rapport is really key, spending time and talking to people and getting to know them and eventually teasing out [their goals].” Language barriers and personality affected the development of a therapeutic relationship. Ruth (AC) described one client “who yells at me every time I see him. Well it’s hard to be client-centred with someone like that because you can’t really have a normal conversation with them.” Sarah (AC) described a client with severe pressure areas who refused intervention. “Every time I go to talk to him he’s like ‘Get out of my face!’ and like yelling at me [...] I can’t establish any sort of rapport there/ let alone do anything with him.” Sarah (AC) described a client whose anxiety made it difficult for him to engage in client-centred practice.

Client’s financial resources also influenced client-centred practice. Ruth (AC) noted that “economic status is definitely a barrier to being client-centred. [...] People who don’t have much money are often trying to figure out how you can discharge them without the supports that they probably need. In describing how differences in funding affect therapists attempts at client-centred practice Donna (HC) noted low income clients have restricted access to equipment, while wealthier clients did not encounter this problem.

Donna noted that it’s difficult to be client-centred with “really heavily drug involved people. “It’s really hard to track them down. [...] They don’t have a phone, the hotel manager isn’t very helpful and so how many times do you go back to try and see someone or yell through the door they’re busy, or they’re sleeping.” Donna described the difficulties of working with clients in the inner city:

It's really tough in a lot of people burn out, a lot of people don't like it, people, you know there are some people that would never, ever want to work with the um clients down there. 'Cause they are difficult and you do put up with a lot you know. You/ you're putting yourself at risk sometimes in the areas that you're in and um you see a lot of really unpleasant things, sometimes clients can be really rough around the edges, which means that they can be quite verbally inappropriate.

These factors often affected the ability of therapists to develop rapport with their clients.

The Continuum of Client-Therapist Interactions

Therapist descriptions of client-therapist interactions in goal setting demonstrated considerable variation. Therapists influenced the issues that a client identifies by giving opinion, providing client education and, in some circumstances, through coercion.

Sometimes therapists helped formulate client's goals into occupational performance issues. Lisa (HC) described one client whose goal was to "get [...] on long-term disability," which was not a task that Lisa could perform. Although she did perform some cognitive testing with this client, which could be used to determine if she was eligible for long term disability by the doctor, Lisa struggled to have the client identify any occupational performance issues. After many attempts Lisa was eventually able to get the client to identify issues such as returning to work, taking care of pets and cleaning the house as occupational issues, which she was able to help the client work on. June (HC) described the process she used to identify the occupational performance issues of a client whose goal was to own a scooter.

If they say they want a scooter and you ask them, ‘what things are you doing that you would not be doing now that you would use the scooter for?’ They might list things like I want to go to the bank [etc.] and all those things are all functional things that they want to be able to achieve and a scooter’s only one possible solution to function issues that they’re having.

Emily (AC) described how she would use functional assessments to help clients understand their functional limitations following hip surgery.

I usually found it was useful to do the assessment even though I probably knew what they could do/ like I could pretty much tell someone’s not going to be able to step over the side of the tub when they’re not weight bearing, but um, the person usually didn’t quite realise that. Because they’ve always been doing that and so I discuss with them what they were going to doing at home it’s just like, “oh yeah, I’ll just take a bath or shower like I always do yeah and the hip’s not going to bother me, I can manage okay. And I’d say okay, “Let’s just make sure you know just for peace of mind and we’ve got a tub here, we’ll go down and try it and so it was more for their information than mine, cause I would already know they probably couldn’t do it.” And then they would try and they’d go, “Oh wow.” And then they’d be really surprised. This happens a lot that “Oh gee, I actually have a little bit more trouble than I thought I did.”

In this case, there was an interesting reversal of client-centred care. Rather than starting with goal setting and moving to further assessment, Emily’s assessment would facilitate issue identification. Although her client’s goal was to get a scooter, June (HC) was able

to try and address this client's underlying occupational performance issues when she found he "wasn't appropriate for a scooter" by:

Presenting alternatives. Like if he wanted the scooter to be able to go banking or something you can offer other things, like other alternative banking methods, like you can phone in or things like that.

Rebecca (AC) noted "a lot of people. Their goal is to walk, so if that's not possible you know I try to work with getting them to move the [wheel]chair and they realise they can still get from A to B, but they don't really need to walk." In this way clients who wished to be independent walking were shown how they might still be independent with mobility, through the use of a wheelchair. When asked to describe this process of having clients adopt the goal of mobilising versus walking Rebecca noted:

You are meeting the goal of mobilising, it's just not, their intended way, but did they know all the options?

B: U hmm

R: They just think getting up and moving and walking is the way to get there, but maybe they didn't know there was another option of moving in their chair, so you're really opening up. You're providing them with suggestions and

B: Yeah.

R: ...And see how they take it and if they said no, really just want to be able to walk then I might try and pursue it a little bit still and try and show them, well look this is/ you know/ let's get your feet down and try and move them, but if their really adamant than/ but I've never come up to that [...] Yeah so it's just a different way to meet that goal.

In describing the process of problem identification Donna (HC) noted

They may just identify it as something that gives them a bit of trouble, but then your/ you sort of take the next step and go, “would you like to try and work on that, could you know, should we try and find some ways that [...] can be easier for you. So they’re still identifying it to a certain extent as a trouble spot, but not necessarily as something they want to work on and you have to bring it to that level.

Sometimes clients identified very general goals and therapists needed to work with them to identify more specific goals. With a client whose goal was “to be healthy” Lisa (HC) noted

I [...] accept the general goal, and I help them/kind of re-direct that a little bit, and then explain to them how I think/ what I have to personally offer. Like “as an OT I can offer to teach you some strategies to make doing your laundry a bit easier. Or perhaps make cooking a little bit easier for you. Does that interest you?” [Describing the client’s response]: “Well, yeah.”

But she didn’t ask me that in the first place.

These examples of goal identification seem to fit within the context of client-centred practice, in which client goal identification is facilitated.

Working on general goals. Three of the therapists identified how they work primarily with general goals without necessarily getting them to identify occupational performance issues. Hannah (AC) noted “usually the client’s goals are broad enough that it’s like, ‘I want to go home.’ So then, we made it/met it by going home, but we didn’t necessarily break down that goal into what they want to be able to do when they go home or those

kind of things.” Ruth (AC) reported that often “the over all goal is to get someone home.” Sometimes therapists identified needs and asked clients if these might be goals for them, but Donna (HC) questioned how client-centred this process was. “You’re being client-centred when the client is identifying their needs, but um, if I’m identifying a need and they’re agreeing with it although it wasn’t something they themselves identified is that still client-centred?”

As she later stated,

I run the risk of [...] coercion or kind of bulldozing over the client if I’m the one who’s constantly saying, ‘you need this and this and these are your / you know, these are your problems that I think you’re having.’ So [...] it’s a fine line with um, allowing someone to identify their goals, but then there are some people that no matter how client-centred you’re trying to be they may not have the skills to identify their own needs.

Working on general goals violated the ideas behind the COPM and OPPM. These general goals, however, fit in well with the institutional expectation of speedy discharge.

Coercion. Sometimes client-therapist interactions displayed a coercive element.

Clients with competency issues, such as dementia presented a challenge to therapists and treatment team. In describing clients whose competence is questionable, Rebecca (AC) stated

The team has quite a bit of power that way. Usually what happens if a person really wants to go home [is] we usually give them one shot. And then they usually get readmitted and then even if they want to go back again we don’t let them out

next time. So they kind of get a one tenuous discharge [laughs] and then [...] we kind of cut them off [...] and sort of do a little arm twisting into placement.

With a client who was unsafe walking and refused to use a walker, June (HC) was able to provide him “a shopping cart with a seat,” which was actually a wheeled walker. When Robin (HC) had safety concerns about a how a family was coping with a dependent family member she noted “so I can tell [them about other interventions] and say there’s other options. Hopefully [they’ll] come to me one day, because that is a concern for me. I can just express concerns [...] but it’s not my issues, if it’s not the family’s issue.” Robin (HC) tried not to overwhelm families by identifying too many issues. “I always make sure that I’m not just um telling them all this other stuff that they should be doing, because I’m an OT and I’ve identified these things that they should be doing.” Rebecca (AC) was very concerned with pressuring families around issues of wheelchair seating.

I find when I’m asking families to fork over money for wheelchairs and I’m very, uncomfortable. I don’t like being in that position. Feeling like I’m selling a chair and I know and I try to offer them as many options as can, you know, from the low-range to the high end chairs, because you know I have a bit of bias as to what chair they should buy. And often/ I don’t pry I don’t ask about the financial situation, because I just, you know, I’ll say whatever you think is appropriate and you can go and talk to other family members about it and see / what they/ you know, I’ll certainly, give them the pros and cons of all chairs, this ones not as expensive, but, certainly it’s going to be a bit heavier and little harder for you to push, but you know, if you’re just trying to, if your son’s going to be the only one

pushing it then maybe that will work, but I really have a hard time asking people to buy wheelchairs, a really hard time.

As she summarised: "It bothers me that I'm asking them to spend this kind of money for something that's a basic need for a family member."

Sometimes clients had limited input into the decision making process. The treatment team Ruth (AC) worked on developed a patient care plan,

Which is basically an agreement we come to as a whole team um to try and get the patient to meet the goals that are set for discharge, basically. And I have to admit these aren't patient centred ones, they're more discharge planning ones that the team has made, ah, so even though the patient's goal may be to get home, they haven't made the goal they are going to sit up for three times a day or whatever to increase their sitting tolerance. The team has come up with that and it's usually presented to the person after, but it's just sort of a way of getting the nurses involved, physio involved, OT involved, and they're all thinking about the same thing, and that gets put on a piece of paper and then uh, basically one person comes to the patient after rounds and sort of reviews the patient care plan and it gets posted over the bed [laughs] so that's when the patient gets involved with the goals after that.

B: I hear you laughing. Why are you laughing?

R: Cause um, I don't think it's very client-centred/ well it's not client-centred, you know, but so. I mean I think it's client-centred in that it uh/ we always try and you know with your initial assessment try and get an idea of a patient's goals then, uh but certainly the intermediary goals sometimes aren't what the patient

wants to do. A lot of times they'd rather lie in bed or something or getting them up for physio twice a day, making them walk to the dining room, you know just sort of being a sergeant major. I don't think that is necessarily what they want to do.

Rebecca (AC) noted that for some families "it's really important for the family to have that person [who is in a vegetative state] maintained on a feeding tube." She commented "that there is sometimes pressure from the team to [...] have that G-tube removed or not to be put in there in the first place." In such instances culture seemed to play a role in the decision making process for families.

A lot of the Cantonese speaking or Asian cultures and for them/ I've even talked to one of the families and providing food/ and food by mouth is very, very important to them um, withdrawing food is, you know, is terrible, like they just/ they can't/ they can't fathom that idea so even if someone's got a feeding tube they're still wanting to feed them orally.

Some therapists were therefore complicit in institutional practices that did not always seem client-centred.

Lack of prioritisation. Although prioritisation of client-goals is an important part of the COPM and OPPM, five of the therapists noted that there was a lack of client prioritisation of goals ("I know I don't stop and ask all the time what it is they want me to address first" [Donna (HC)]) and only one therapist described having the clients prioritise them. Working with clients with a care map Emily (AC) noted clients didn't prioritise goals, "because the things all pretty much had to be covered before they could be discharged. I have them/ they had the opportunity to tell me when they wanted to do

something, you know, but it was kind of all done as a package.” When asked if clients could prioritise their own goals on the unit where she worked, Rebecca (AC) responded “No! No. No. A lot of times it’s what the staff have time for, and what the staff feel is a priority.” Donna (HC) observed: “I don’t know how many therapists actually stop and say, ‘well what do you want me to address first with you?’ They’ll usually just kind of jump in and/ and go with what they think is putting the client most at risk.” Institutional prioritisation therefore seems to take precedence over client prioritisation.

Although some clients prioritised their goals, sometimes therapists needed to work on less important goals to facilitate discharge. Hannah (AC) noted that sometimes a client with a new diagnosis might identify goals that aren’t appropriate for acute care. She asked:

So is that okay then to step in and say, “okay that’s your primary goal, but we need to be working on some other things to help you get better or to help you cope or whatever?” Um, And is that being client-centred or not? I don’t know, if you’re validating what their primary concern is and then saying, “okay then maybe your six, seventh, or eighth priority is self-care and you know what, we’re going to start down there.” Um, I don’t know. It’s hard.

Clients and therapists did not always agree on therapeutic goals as Hannah (AC) notes, “It’s hard I guess as a therapist to be client-centred when we disagree with the decisions or what the client states that [their] goals might be.” Lisa (HC) expanded on this idea in describing a conflict about bathtub safety.

Usually, well, that’s fine if they’re willing to accept services. And sometimes they’ll say, and its that old dilemma, sometimes they’ll say, “Well, you know, I

have a hard time getting in and out of the bathtub and I've slipped a few times, but you know I really want to get down into the water and that's your whole OT thing: "Oh, you know, well that's not very safe," and "oh, come on, you should be sitting on a bath board, or what ever" and that's when I find, you know, that's one of those situations that are a little bit difficult, you know, my idea on what they should be working on versus how they feel they should be doing or what they want to work on etc. A bit of that tension sometimes before/between what you think you should be working on and what they want to be working on so, that's usually how it goes.

In reflecting on her client who eventually accepted the "shopping cart with a seat" rather than a walker, June (HC) noted "he didn't want any adaptive aids at all and essentially he didn't want help from anybody." In describing how clients with cognitive problems impact their ability to make decisions Sarah (AC) stated:

I mean again you know I might think they need to work on something and they don't have insight or don't think they need to, but then again its sort of that conflict of well, if you don't think that someone's safe, you know sometimes I don't think someone's safe at home like around the kitchen or anything like that, but they say no, I don't have any problems with that, I'm not doing your assessment then you know and you think well, you have no insight into the fact that you might have any problems, but again you can't necessarily force someone to do something if they don't want to do it right?

Lack of client insight therefore created a dilemma for therapists attempting to practice in a client-centred manner. The tension Sarah (AC) describes is similar to that described by

Smith (1987) in that Sarah (AC) is caught between a desire to help her clients in a manner in which they would like to be helped and a professional and institutional need to keep them safe.

Client resistance. Although many clients went along with professional recommendations, some clients reacted with resistance: “they’ll just flat out refuse.”

Donna (HC) described how some clients did not follow her recommendations.

So you say to someone, “I think um, what might be best for you is/is to start using a walker and let’s / let’s try that.” And then they’ll flat out refuse. I’ve had that too. “No, I’m not gonna try” And I said, “Let’s try/ ay/ that’s part of the assessment. I just need to see you with the walker and a manual wheelchair.” “There’s no way I’m trying either of those. Period. So you can’t even do your assessment and they’re like, “I want (in this case) a Go-cart you know, and that’s / that’s what I want.” And/ and / he wouldn’t talk about anything else, it was like, unless I was bringing that go-cart, forget it. You know, you can just go on your way.

In another case Donna described how a client’s family did not accept her judgement regarding a client’s scooter safety.

You [can] have family that are really upset and/ and will call and you know, yell at the staff for this or that. Or again, it was around power mobility and one of my colleagues took someone out on two separate occasions because they were unsafe and it was really obvious sort of unsafe: judgement, behaviours and sort of even lack of control, physical control um, and explained very clearly to the client and to the family her concerns and she wasn’t comfortable going through the process

of requesting power mobility um, you know and that the daughter just went up one side of her and down the other on the phone and demanded to speak to the manager and um, you know and was sort of saying “What are your qualifications anyway?” and things that are/ that you know/ that’s a really hard to take when you’re just trying to keep that client safe and here you are being sort of berated.

Rebecca (AC) described how a client refused to comply with an intervention that she had been ordered to carry out by a doctor.

One physician was convinced that if this gentleman had a / it was an AFO, an ankle foot orthotic, and um, then he would be able to stand and walk better. Which is fine, you know, we tried it out and the client hated the splint. He/ he complained about wearing it, it itched, he didn’t like it, he didn’t think it helped and the physician came back and after a couple months and approached me and thought it was doing really well, but he wanted me to get a better one, “can you get him a better AFO,” right. So, well you know I don’t think/ well an AFO is an AFO and I don’t think the client really you know is too keen on having this thing and he doesn’t really like it and we discussed it and the physician was quite adamant that he wear it and that this will improve him to the level where he will be able to walk again with the walker independently having this AFO. So there was a bit of a conflict because he’s writing that in his doctor’s orders and so since he’s sort of the one who knows everything according to a lot of the staff. He’s in that position of authority. They kept, well there’s this order and you’ve got to get this/ this thing done, and so there you’re not I mean at all working with client-centred practice. The client really did not have a lot of cognitive impairment and

was able to say, "I don't want this and this is why and it's not been helping." And I think in that case he knew a lot better than the physician or myself what was best for him and what he wanted, you, know. But he was able to say, "look, I'm not going to get better, I'm happy. I can get around in my wheelchair no problem, I'm quick. Put me in a walker. It takes me a long time to get to A to B, you know." So, that was just. That was the way it was, so I didn't get him a new AFO, because it doesn't exist, there's no such thing as a better AFO and I just left him with his old one and said, "Well, this is what the doctor recommends, but if you're feeling it's not what you're wanting to do, you know, it's up to your discretion." I don't think he wears it very much.

Emily (AC) recalled one client who was very resistant when she was asked to provide him with some dressing and bathing equipment.

So as I came on to the ward the head nurse said, "So and so needs to have ABC. This has to be done because he's leaving. This needs to be done now." So I had this kind of sense of uh what I was doing was based on her saying this has to be done rather than on the client asking for it. So and I sort of felt kind of pressured and I you know grabbed up all of my long handled reachers and everything else and rushed in there and started talking to the guy about this and that and the other thing and he just freaked out [laughs] and he was like, "I don't want to hear about any long handled reachers and I don't want your..." So he started ranting about all the things he was really frustrated with in the hospital/

Eventually, by finding out what the client wanted, Emily (AC) was able to work with the client.

So at that point I realised okay I am not being client-centred coming and telling a guy he needs this and that and the other thing and it's obviously upsetting him and it's just repeating the whole experience that he's had with being told that he needs this and he needs the other thing. So I took a complete / I did a complete switcharoo and um I kind of / 'cause he was sitting on the bed and I was standing, and so I just changed my whole body language and I kind of squatted and knelt down at the bed side. I was lower than him I put away my equipment so I wasn't you know kind of waving it in his face [laughs] and I just kind of listened to him and validated what he was saying. And then I just asked him what he wanted. And he said, "I want to go home and that's all I want."

Thus although therapists are often attributed power over their clients, some client resistance was evident.

Factors that Facilitate Client-Centred Practice

Client-centred practice was facilitated with some clients because of personal factors, which included wealth, good insight and assertiveness. Donna (HC) noted, "a client that's really assertive is more likely to identify their needs with greater ease than someone that's perhaps not as assertive." Or as she also noted, "we're pretty good at being client-centred when somebody really says, "no, I don't want to do this." June (HC) described a client who made it easy to be client-centred given his assertiveness and awareness of occupational therapy, "Basically when I got there this person said I have four things I want to talk to you about." She explained his assertiveness saying, "I think he was knowledgeable enough about what was available in relation to what the OT role is that he had a fairly clear idea of what he could benefit from." Lisa (HC) described how

clients who are younger, with more goals “tend to be the ones that [...] that are really more effective in goal setting.”

Although it was noted earlier that client-family conflict could lead to problems with client-centred practice, some families, however, facilitated client-centred care. Robin (HC) described how family members supported the decision of her client to be fed by care staff. Ruth (AC) noted that “families can be quite helpful in being client-centred in that they can often bring things that are meaningful for the person” to the hospital. Hannah (AC) described one client, who the team felt very concerned about her ability to manage in the community given her diagnosis of dementia and other concurrent medical problems, but “she was just determined that she was going to live independently. This client “with lots of help and lots of persistence on the part of the community” was able to return home for a year before she eventually entered a nursing home. Some persistent clients seemed able to achieve their goals despite considerable obstacles.

Summary of Client-Therapist Interactions

Therapists had similar problems identifying their clients as those described in the study by Wilkins, Pollock, Rochon and Law (2001). Hannah’s comment that perhaps the doctor was her client indicated the strength of the medical discourse within healthcare settings and acute care hospitals in particular. Therapists in the study identified similar problems with clients as have been identified in the literature. These included problems with cognition (Toomey, Nicholson and Carswell, 1995; Pollock, McColl, Carswell, 1999; Law, 1998; Sumsion, 1999c), lack of education about client-centred practice (Sumsion, 1999d), and acuity of a disease or disability (Gage, 1999). Many of these factors interfered with the ability of therapists to develop rapport.

A continuum of client-therapists interactions was noted between therapists and clients similar to that identified by Clark, Corcoran, and Gitlin (1995). Some of the more directive interactions could be understood based on Ozer's (1988) process to elicit maximal client-participation in which clients were involved in increasingly structured methods of goal identification. Emily suggested that, rather than using an assessment like the COPM, a more functional assessment could be used to help the client identify potential goals. While this suggestion might work in theory, in Emily's practice the functional assessment and intervention were collapsed together. This makes it questionable whether or not therapists would be able to complete a functional assessment and still only work on goals or problems that the client identified versus problems that therapists observed. Many therapists reported working on general goals. Although this tendency violated ideas about client-centred practice process in the COPM and OPPM, it fit in well in the institutional contexts in which they worked. General goals like "to be discharged" meshed well with institutional goals about speedy discharge and allowed therapists latitude in their interventions. Sometimes therapists identified coercive aspects within their practice, which frequently represented bifurcations of consciousness for them. For example, Rebecca described her discomfort with trying to get families to pay for expensive wheelchairs that she felt should be paid for through the health-care system. Sometimes therapists were part of institutional processes that limited client goal setting, such as the patient care plan development process on Ruth's team or the Feeding Tube Guidelines that Rebecca described. As noted earlier, therapists, as a result of time constraints and their own prioritisation systems, tended not to have clients prioritise goals.

Clients were not completely powerless within their interactions with therapists within the acute care and homecare settings. Resistance, like that suggested by Foucault, was evident in several examples. In the case of Rebecca's client who did not want an ankle foot orthosis, although she was ordered by the doctor to provide this intervention, she supported her client's resistance to the doctor's treatment.

Client-centred practice was improved by personal factors that included client wealth, insight and assertiveness. When families supported one another, or community support was available, client goals could be facilitated.

Chapter Six: Discussion and Conclusions

Summary of Findings

This research demonstrates how power is exercised in homecare and acute care settings through occupational therapy and institutional discourses and practices, and within client-therapist interactions. Understanding power relations helps comprehend problems in applying and defining client-centred practice. Power in these settings represented a complex phenomenon. Although therapists had the power to influence, in some instances, other professionals and, more frequently, their clients, therapists' actions were frequently affected by other professional discourses and clients who resisted therapist interventions. In exploring power in institutional settings, many of the barriers and facilitators to client-centred therapy were revealed.

Although therapists in two different settings were interviewed, the themes that emerged were found in interviews with all therapists. The commonality of these themes reflects the similarities between these settings, which exhibit subtle rather than radical differences. In both settings, therapists experienced time pressures and lack of resources. Both settings had implemented priority systems to deal with these workload demands. Therapists tended to receive referrals from other professionals in both areas, although hospitals had additional referral mechanisms that included blanket referrals and clinical pathways. In both settings, therapists worked on interdisciplinary teams, which had considerable influence on therapists. Teams within hospitals tended to be larger. Although therapists in hospitals tended to do more frequent interventions, therapists in both settings often worked in a consultative capacity in which their interventions were limited and their role was to help other members of the treatment team. Therapists in both

areas used similar discourses, and identified similar definitions of client-centred practice. Ultimately, although both settings demonstrated instances of client and non-client-centred practice, acute care settings seemed less client-centred and the most extreme cases of non-client-centred practice were found there. Although it is difficult to identify causes for this difference, one possible explanation might be the difference in autonomy that clients have within their own homes compared to hospital settings. Although clients have the same legal rights in terms of informed decision making in both settings, in hospitals treatment teams can exert much more influence over clients “within their care” and a more paternalistic way of treating clients tends to predominate.

The overarching theme “bridging that gap: ideal versus real conceptions of client-centred practice” explored the disjuncture that therapists experience between how they envisioned practice when they studied occupational therapy and the reality of everyday practice. In university, occupational therapy students are inculcated with occupational therapy discourse, which represents the ideals of the occupational therapy profession. As new graduates, however, therapists experienced tension, because they were unable to practice in the manner dictated by occupational therapy discourse and therefore needed to bridge that gap between the ideal and real. This situation was made more difficult because occupational therapy discourse is not a monolithic ideology. Although client-centred practice is an important part of occupational therapy discourse, there is discord within occupational therapy discourse as it incorporates other ideas that sometimes do not facilitate client-centred practice. Occupational therapy discourse for therapists in the study also included elements such as holism, independence and safety, which are constructs that are well documented in current occupational therapy literature, as noted in

chapter two. In examining how participants defined client-centred practice, their definitions reflected the same definitions found in the literature. Some focused more on autonomy and others focused on collaboration in goal selection. More of the hospital therapists described client-centred practice in terms of collaboration, but the small numbers in the study mean that conclusions must remain cautious. Despite the importance of COPM as a textual representation of the client-centred aspect of occupational therapy discourse, none of the therapists in the study used the COPM. There were many reasons for this omission, which included the acute illness of clients in acute care that made goal identification difficult and lack of insight on the part of some clients. Another explanation suggested by one therapist, however, was that the COPM might reveal issues that did not coincide with institutional limitations regarding resources or the overarching importance of discharge.

Rather than using the COPM, all therapists used global assessment forms that assessed client function as a basis of determining potential problems. Although many of these forms included a section about client-goals, these assessments could also encourage the identification of non-client-centred problems. Hannah (AC), in providing her feedback on my initial findings, emphasised that these assessments could help identify occupational problems; she noted that sometimes these assessments were performed to serve the needs of other professionals on the treatment team. These forms, as textual representation of discourse, emphasised the importance of function in occupational therapy discourse.

The second theme “related to the service environment: the importance of setting” with the sub-themes of “what the system expectations are” and “resources” described

how professional discourses, other than that of occupational therapy, and lack of resources influenced occupational therapy practice. Although therapists reported having considerable autonomy, this autonomy seemed to be limited in nature to decisions about scheduling and individual interventions. Referrals from other professionals represented discourses that could compete with some aspects of occupational therapy discourse. For example, the importance of the service environment is a good illustration of the Client, Service, Society Model (CAOT, 1997) described in chapter two, as the sub-culture of the service environment has powerful influence on the client-therapist interaction. For some hospital therapists, clinical pathways dictated interventions and timelines, which were based on facility expectations regarding discharge and therapist involvement. The need for speedy discharge as a result of funding limitations within the system put pressure on hospital and homecare therapists and all other institutional staff. Although discharges were made as quickly as possible, these discharges needed to involve minimal client risk as safety was a cornerstone of all professional discourses, which made up institutional discourse.

At the heart of this safety issue was a concern about liability, which was used to prevent clients' attempts at risk taking. Although reasonable risk taking is supported in occupational therapy discourse, this was found difficult in settings where risk management is practised and was source of tension for therapists. The Vancouver Richmond Health Board's risk assessment tool, for example, rather than focusing on specific areas of concern, was an exhaustive assessment, which examined a plethora of risk factors. This tool was designed to identify where there was disagreement among client's, therapist's and caregiver's assessment of risk. Ultimately, this tool identified

areas where professional “expert knowledge” conflicted with client’s knowledge that then necessitated the use of the Health Board’s Ethical Decision Making Framework. In hospital settings this process was not formalised, and in homecare, the Health Board’s Ethical Framework was not commonly used. Although the Ethical Framework seemed as if it might support reasonable risk taking, the use of less formal processes in homecare and acute care may reflect the importance of risk management within institutional discourse, which is more easily practised informally. Given the importance of safety within homecare and acute care, therapists were expected to perform “surveillance” on their clients. Although Hannah (AC), one of the therapists providing feedback on my preliminary findings found this term offensive as she did not consider herself “a spy,” I kept this term as it reflects Foucault’s discussion about power. This expectation to monitor clients created a tension for therapists who were professionally mandated to help client’s work on goals of their choice but were expected to constantly monitor their clients to ensure that these goals were safe or “realistic.” If client behaviours were found unsafe, they could be forced into institutional care.

Interdisciplinary teams were sites of conflict and negotiation of professional discourses. Although many therapists reported feeling supported by the interdisciplinary teams they worked on, conflict was evident. Boundary issues reflected areas in which the expert knowledge of various professions competed for supremacy. Some therapists found it difficult to openly disagree with other members of the treatment team, and several reported feeling compelled to intervene with clients who did not identify any current occupational performance issues. Within these treatment teams, expert professional knowledge was sometimes used to manipulate and coerce clients, especially regarding

decisions around what amount of risk was reasonable and whether clients were able to stay at home.

Resources could represent either barriers or facilitators to client-centred practice. Generally, lack of resources acted as a barrier to client-centred practice and as an incentive for many non-client-centred practices. These practices included limited intervention options, the overwhelming importance of timely discharge, the lack of choice about discharge location, and the forced discharge of clients to institutional settings. Lack of resources limited client-choices in hospital and the community and caused considerable discomfort for therapists. Limited access to mobility devices, for example, left Rebecca (AC) uncomfortable in getting families to purchase wheelchairs that she felt should have been provided through the healthcare system, and Donna (HC) commented that she felt required to police clients regarding the appropriate use and provision of scooters. Many clients were unable to be discharged home due to inadequate homecare funding, which only allowed for a limited number of hours of care per day and allowed home-making services only if there was an accompanying personal care need. Resource problems were even more pronounced for clients with limited income as this prevented them from obtaining beneficial equipment and resources. Limited occupational therapy staffing meant caseloads and work demands were sources of tension for therapists. Resource issues meant that there was limited orientation for many acute care therapists and limited support and supervision for most therapists in the study.

Lack of time was problematic for therapists and clients. Therapists felt uncomfortable with the pressure to see clients quickly. Many clients did not seem to have enough time to come to understand personal changes that occurred because of the onset

of illness or disability and subsequently identify goals. Time pressures necessitated the use of priority systems in homecare and acute care. These systems sometimes made the client's prioritisation of goals superfluous, as therapists were required to intervene with discharge and safety issues, regardless of the client's wishes. The lack of resources led to closure for homecare therapists and created considerable discharge pressures for therapists in hospitals. This lack of time also led to the development of prioritisation systems that made safety concerns (and for hospital therapists, discharge issues) higher priority than other goals the client may value. When resources were available, in settings such as palliative care, client-centred practice was facilitated. Themes about lack of resources and impact of facility expectations on therapists emphasised the importance of institutional factors in influencing client-centred practice.

The final theme "a bit of tension: problems with the client-therapist relationship" exposed the complex power relations that exist within healthcare institutions and between therapists and clients. This included the sub-themes of "therapists' difficulties," "client struggles" and "the continuum of client-centred interactions." Within the first sub-theme, therapists struggled to identify who was their client. Although the client was frequently the person receiving services, it was sometimes expanded to include family members. Some therapists noted that because of the power of other professional discourses, other professionals sometimes became their clients, as they were the ones identifying client issues. Client-family conflict made goal identification more challenging for therapists.

Study participants perceived that clients had difficulties with the therapeutic interaction for a variety of reasons similar to those described by a variety of authors (Toomey, Nicholson and Carswell, 1995; Pollock, McColl, Carswell, 1999; Law, 1998;

Sumsion, 1999c). The sudden onset of disease or disability sometimes made it difficult for clients to be able to generate OPIs as they struggling to understand the impact of these changes on their lives. Some clients with cognitive impairments lacked sufficient insight to identify and prioritise goals. Language barriers and personality issues could also prevent the establishment of rapport between therapist and client, which impaired goal setting for some clients.

The continuum of client-therapists interactions demonstrated considerable variation. Sometimes therapists helped clients formulate their goals into occupational performance issues. For some therapists, functional assessments helped clients identify areas where they were having difficulty performing occupations. In this way clients were encouraged to enter into occupational therapy discourse, which focused on occupation. Sometimes therapists worked on general goals, rather than getting clients to identify specific occupational performance issues. These general goals, which often involved discharge home, gave therapists latitude to work on occupational performance issues that were related to general goals but not specified by clients. Although this conflicted with client-centred practice, it was in keeping with institutional goals regarding timely discharge.

Therapists and other professionals had a great deal of influence over their clients' actions; and in some instances, clients were coerced to accept certain interventions or discharge plans. This was a source of tension for many therapists, as they felt uncomfortable pressuring clients and their families in decision making. This discomfort seemed to emanate from the disjuncture between the humanistic focus in occupational therapy discourse on client-centred practice compared with institutional practices and

discourses, which focused on safety and cost savings. Within the client-therapist interaction, none of the therapists described getting their clients to explicitly prioritise their goals. This omission is not surprising given that the prioritisation systems that were used to deal with lack of temporal and financial resources did not consider client priority.

For many therapists, there was a tension about the demarcation between reasonable versus unreasonable risk taking. Despite the considerable pressure placed on therapists to provide certain interventions and the pressure on clients to accept recommendations by occupational therapists and other team members, resistance by both therapists and clients was evident. Although there were many factors that limited client-centred practice within the therapeutic relationship, client-centred practice was facilitated by determinants such as client wealth, assertiveness, and insight.

Significance of the Research

Theoretical Implications

Although much of the research on client-centred practice focuses on the therapist as a barrier to client-centred practice, my research emphasises how the setting and occupational and institutional discourses shape, but do not completely determine, the client-therapist interaction. The influence of the setting is reminiscent of Townsend's (1998b) institutional ethnography of occupational therapy mental health services in the Maritime Provinces, which revealed how clients were disempowered by institutional policies. In my research, it seemed that therapist and client agency was curtailed but not eliminated by institutional practices, as both client and therapist resistance was evident. Power in this study can be understood in accordance with Foucault's conceptualisation of

power and standpoint theory. In keeping with Foucault's theory occupational and institutional discourses are extremely important influences on therapists' practice.

Although there are similarities in how therapists envision their practice, occupational therapy discourse is not entirely internally consistent. The client-centredness part of occupational therapy discourse is challenged by ideologies that have supported previous paradigms, such as the therapist as expert and the client as a passive recipient of service. These ideas echo the traditional medical model of practice and the mechanistic paradigm of knowledge. Ideas in the occupational therapy discourse about increasing independence and improving function, which fit in with the medical model, are not always client-centred. Some clients may choose to increase their dependence on others so that they have more energy to do activities they enjoy or have more time for preferred occupations. A possible explanation for the importance of function in occupational therapy discourse is the discursive power of this concept. There was considerable pressure to discharge clients as quickly as possible, especially if they were deemed ready for discharge from a medical perspective through physicians' discourse. Discharge could sometimes be delayed, however, if they were deemed unable to *function* at home by an occupational therapist. Although the treatment team sometimes ignored these judgements, in other instances, clients could benefit from additional treatment. These findings were reminiscent of the research of Mattingly and Fleming (1994) who described how therapists work between two discourses: the biomechanical and the phenomenological.

Although Abberley (1995) suggested that occupational therapy's discourse of partnership and holism served the profession rather than the client, the findings of this

study were more ambiguous. There were instances in which client involvement in goal setting was limited; similar to those described by Northen, Rust, Nelson, Watts (1995) and Rebeiro (2000). There were also, however, incidents in which clients were able to achieve their goals and times when therapists needed to strongly advocate on behalf of their clients for this to occur. Therapists were sincere in their beliefs about the importance of client-centred practice, hence their discomfort about “the gap.” Thus, although therapists described the importance of client-centred practice in delineating occupational therapy from other health-care professions, clients also seemed to benefit from this discourse.

There was an uneasy relationship between occupational therapy and many other professional discourses. Although these other discourses are not identical, they have many similarities, especially in regards to concerns about risk; and so I have described these in terms of institutional discourse of which the importance of discharge and the importance of safety are key elements. As safety is part of occupational therapy discourse and institutional discourse, it seems to create a synergistic effect for these therapists, who felt considerable pressure to keep their clients safe. The importance of safety in institutional settings encouraged therapists to practice risk management (the elimination of risk) rather than reasonable risk taking. When considering what Foucault described as disciplinary practices, it seems that non-occupational therapy staff influenced therapists more than other occupational therapists. This need to be valued by other professions, as Norby and Bellner (1995) noted, has the potential to interfere with the therapeutic relationship. The lack of supervision and support for therapists compared to the influence of other professional staff seemed to reinforce institutional discourse over occupational

therapy discourse and encouraged therapists to adopt non-client-centred ways of practice and thinking.

Although it is tempting to explain all power relations in institutional settings as “power over”, power and resistance in this study seem inextricably linked, as Foucault suggested; and client-therapist interactions existed along a continuum, similar to that described by Clark, Corcoran, and Gitlin (1995). Although therapists experience pressure to conform to institutional discourse, many therapists also reported evidence of resistance as in, for example, Donna’s (HC) reporting that the client had a self-care need so he or she could receive homemaking and Rebecca (AC) supporting her client’s decision to not use the ankle foot orthosis the doctor had prescribed. Similarly, although clients frequently seemed to have limited input into treatment decisions, they did not always passively submit to suggested interventions. This lack of “power over” also seemed to apply to physicians, who, although they were frequently thought to be extremely autonomous, encountered pressures from other team members and at times resistance from their clients.

The difference between academic occupational therapy theory and working practice represented what Smith (1987) describes as a ‘bifurcation of consciousness’ or ‘tension’ for many therapists in this study. These disjunctures revealed what Smith describes as the relations of ruling, which, as noted in chapter three, are the invisible processes and methods that maintain the organisation of power. Given the complexity of power relations within these healthcare settings and a variety of institutional factors, therapists experienced many bifurcations of consciousness. Many institutional practices and operations limited client choice and reduced goal-setting options. As these relations

of ruling were diametrically opposed to the principles of client-centred practice, therapists experienced tension between their desire to practice in a client-centred manner and their need to work within these institutional settings. The most overt examples of the limitation of client-choice were a) the clinical pathway in Emily (AC)'s setting in which the interventions and intervention timelines were predetermined and b) the care plans that were developed by the team and presented to the client in Ruth (AC)'s setting. In this case, the team decided what goals the client would be working on and these were then presented to the client. These instances were troubling for both therapists and clients.

The reasons for the institutional discouragement of client choice seemed to be due to an inter-relationship between issues of cost reduction, concern about safety and paternalism. Due to the limited funding for healthcare, some client goals were unable to be met. As Rebecca (AC) commented, although many clients' overall goal is to be discharged home, funding limitations in homecare force some of these clients into institutional care, as they were deemed unable to manage safely on their own. These findings seemed to echo ideas found in the social model of disability (Oliver, 1990). In this model, disability was understood to be caused by social factors, which include environmental barriers and lack of resources. Within this study therapists indicated that clients experienced increased disability, because of lack of community and hospital resources.

Safety was frequently an over-riding concern in homecare and hospitals. This finding was similar to Townsend's (1998b) finding that institutional practices in healthcare facilities were based on the principle of "risk management" in which the

possibility of risk is to be eliminated to prevent legal liability. This liability issue made risk management a monetary necessity for healthcare institutions and professionals.

Although client conferences in hospitals were ostensibly created to increase client input, as Sarah (AC) noted, they often represented arenas where considerable pressure was put on clients, particularly in regard to safety issues. These issues were similar to those noted by Opie (1998) in her study of the process of case conferences described in chapter two.

The issue of paternalism was best exemplified by the proposed Vancouver Hospital guidelines for the use and removal of feeding tubes, described on page 104. This document seemed to indicate that the healthcare provider was the expert (morally and technically) and therefore had the right to make decisions about euthanasia, without consideration for the choices of the client or family. In keeping with the inter-related nature of the issues of decreasing costs, promoting safety and paternalism, sustaining life through the use of feeding tubes has considerable economic impact on the healthcare system.

Although discourses and institutional practices did not completely determine the client-therapist interaction in this study, their influence was considerable. In many instances in this research, these factors seemed to limit client-centred practice, but in some areas client-centred practice was actually facilitated. In settings such as palliative care, where occupational therapy discourse was more compatible with the palliative care philosophy, there were fewer resource issues and client choice and goal setting was actually facilitated.

Individual client factors that facilitated client-centred practice included wealth, assertiveness and good insight, whereas client-centred practice was made more difficult

by poverty, lack of awareness about occupational therapy, aggressiveness and lack of insight. These findings suggest that client-centred practice works best with wealthy, well educated, and insightful individuals. To this extent client-centred practice seems to replicate the power relations commonly found in society, in which individuals, who are poor, less well educated and have cognitive problems have the least power to assert their rights.

In summary, in this research power was, as Foucault suggested, both “localised and dispersed” or as Davis noted “is seen in all parts and levels of the social milieu.” Power was mediated through discourse through a variety of competing discourses through which the truth claims of various disciplines’ expert knowledge were contested. Incorporating ideas about independence and function into occupational therapy discourse increased its power, as discharge could be delayed (if client was deemed unable to function at home) or the discharge location might be altered (to a rehabilitative setting or institutional care). Yet, despite this inclusion, occupational therapy discourse did not seem as persuasive as other professional discourses; and therapists often felt compelled to perform duties they were not comfortable with, although some resistance was noted. There were a variety of mechanisms whereby clients were made to conform to occupational and institutional discourses. Clients were monitored regarding their judgement around safety issues, encouraged to work on goals that were in keeping with facility expectations around discharge, and allowed access to only limited interventions and resources. Conflict was sometimes reported between client and their families, as adult children would attempt to take over decision making in their parents, particularly those with cognitive difficulties. Clients’ resistance was also evident however, as clients

would not always comply with recommendations and sometimes would co-opt the client-centred part of occupational therapy discourse so that they could receive the interventions that they wanted, because as Donna (HC) noted “we’re doing what the client wants.”

Standpoint theory was an essential tool for understanding the effects of institutional processes on therapist behaviours and attempting to explain the ideological underpinnings to hospital and homecare practices. Although it might be tempting to blame Robin for her failure to offer the family the high-end chair that they wanted, I used standpoint theory and Smith’s work on the relations of ruling to consider an alternate explanation that considered how funding limitations altered the interventions that therapists offered. Standpoint theory was also helpful in examining how the priority system affected client-therapist goal identification and attempting to reveal the underlying ideologies that the priority system supported. Looking at the data from standpoint theory sometimes revealed practices through which clients were discriminated against on the basis of socio-economic status, and age.

Practical Applications

This research suggests that occupational therapists need to consider the inconsistent nature of occupational therapy discourse and decide whether client-centred practice should take precedence over ideas such as holism, maximising function, improving independence and ‘the therapist knows best.’ Therapists and occupational therapy students need to be aware of how institutional practices, which vary in different settings, can shape client-centred practice. There needs to be recognition that some clients, either due to cognitive or psychiatric problems, or recent onset of disease or disability may be unable to formulate goals. In these instances, education and/or

increased therapist intervention in goal setting may be required and client-centred practice may need to be envisioned along a continuum rather than dichotomising practice as client-centred or not. Thinking about client-centred practice on a continuum would allow therapists to be less defensive about the client-centred nature of their practice. This would allow therapists to consider methods of improving client-centred practice without feeling threatened. This recognition may allow client-centred practice to be less of a rhetorical aspect of occupational therapy discourse. When attempting to improve client-centred practice, clinicians need to avoid considering themselves, their clients or their institutions in isolation. In effect, the Person Environment Occupational Model (Law, Cooper, Strong, Stewart, Rigby, and Letts, 1996) could be applied to the occupation of occupational therapy. Based on this model, the occupational performance of client-centred practice would be understood as the result of a dynamic interaction between the therapist (and their beliefs), the occupation of occupational therapy (which would include occupational therapy discourse) and the environment (which would include other discourses and institutional processes). As noted in chapter two, the Client-centred Process Evaluation (Stern, Restall and Ripat, 2000) may be useful to improve client-centred practice, as it asks clients and clinicians to reflect on the therapeutic relationship and the environment in which it occurs, although further reliability studies are required for this measure to be fully developed.

Although it is useful for occupational therapy students to learn how client-centred therapy should ideally be conducted, it would be beneficial if they learned about the difficulties encountered in trying to put client-centred therapy into practice. All of these

measures would help therapists better understand and begin to bridge “that gap” between the theory and practice of client-centred therapy.

Implications for Occupational Therapy Managers

The findings of this study indicate how occupational therapy management can facilitate client-centred practice in a twofold manner. One, by supporting therapists in their attempts to adopt and improve client-centred practice and two, to advocate for institutional changes that would alter some of the institutional barriers to client-centred practice. Supporting therapists would include providing adequate orientation to new staff and fostering an environment where issues about client-centred practice can be discussed in way that does not blame therapists. Orientation is essential for therapists to understand what client-centred practice issues are salient in a given setting and feel comfortable in the setting they are in to facilitate change. Occupational therapy management could facilitate review of documentation to ensure that client goals are identified and prioritised by assessment tools used by clinicians.

Advocating for institutional change would involve lobbying for increased client involvement in decision making about institutional policies regarding service provision. Managers could advocate for increased funding and the adoption of fairer processes for client involvement in interdisciplinary rounds and decision-making processes about safety concerns. These changes would attempt to alter institutional discourse to allow for increased risk taking and would help reduce the financial pressures that contribute to many autonomy reducing practices. Ultimately, these changes could help address the power imbalance that exists between healthcare professionals and the clients they treat.

Limitations of the Research

This research represents the data collected from one-time interviews from nine therapists in the lower mainland of British Columbia who volunteered to participate in the study. Given the small number of participants, it would be inappropriate to assume that these therapists' experiences represented the experiences of all therapists in Vancouver, or British Columbia or Canada. As therapists self-selected to participate in the study, this indicated they had some interest in discussing client-centred practice, which was probably reflected in the content of the interviews. In exploring therapists' experiences with client-centred practice, the data collected reflects their perspective, rather than that of their clients or those around them. The predominance of therapists from a European background may have influenced their experiences with client-centred practice, as therapists from minority cultural groups may have felt they had less influence within the multidisciplinary teams in which they worked.

As this study had no longitudinal component, this has probably made the settings discussed seem static. This aspect of the study was highlighted for me by informal discussion with study participants who described positive and negative changes that have occurred in their practice after the interviews. Some therapists described changes that had been made to improve client-centred practice. For example, forms had been altered and client-centred practice had become a focus of professional development. In some cases changes were negative. With changes to homecare delivery and the deletion of the occupational therapy Rehabilitation Consultant position, some concern was expressed about the quality of the orientation process, which had otherwise been superior to that described by most acute care therapists. Although, ultimately, the themes that I identified

have been influenced by own position as an occupational therapist/ researcher and my interest in power as a construct, I hope these findings may resonate with other therapists in Canada and perhaps other countries as well, and may alter how they conceptualise client-centred practice, and its barriers and facilitators.

Future Research Directions

As this research has been exploratory in nature the findings of the study suggest many interesting areas for further investigation. The conflict between occupational therapy and institutional discourse could be further explored through an ethnographic study that would involve hospital and occupational therapy administrators, therapists, their co-workers and clients and their families. This study could examine the client-therapist interactions during treatment sessions and team conferences and explore the textual discourses that are evident in charting, and institutional policies and procedures. In light of the limitations previously described, further research into therapist experiences of client-centred practice could also involve an increased variety of settings, an increased number of participants and the use of tools such as the Client-centred Evaluation Process (Stern, Restall and Ripat, 2000).

Additional studies could involve the exploration of settings, which were reported to exemplify client-centred practice to further explore how it might be facilitated. Studies of how the cultural/linguistic background of the client in relation to the therapist impacts client-centred practice would provide interesting findings. Longitudinal studies of therapists who were attempting to alter their practice (personally and institutionally) to improve client-centred practice would be extremely instructive for others trying to improve the client-centred nature of their practice. The experiences of undergraduate

students who received additional training about overcoming institutional barriers could be compared with other recent graduates as part of a prospective study.

Final Remarks

This research has revealed how power operates within the client-therapist relationship and within the homecare and acute care settings in which study participants practised. Rather than blaming therapists for problems with client-centred practice, this research has shown how occupational therapy discourse and other competing professional discourses impact the client-therapist interaction and how it is further shaped by institutional factors that reveal the relations of ruling. Despite the influence of setting, however, therapists and clients have a degree of self-determination and may resist non-client-centred practices. It is my hope that by understanding how institutional processes and discursive practices affect the client-therapist interaction, occupational therapists, occupational therapy managers and occupational therapy professors will be able to facilitate client-centred practice.

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Appendix A

Letter of Initial Contact

Occupational Therapist: The following is a description of a study being conducted to explore therapists' experiences with client-centred practice. If, after reading this letter, you would like to participate in this study, please contact the co-researcher at the telephone number below.

Title of the Study: Client-centredness in Occupational Therapy: An Exploration of Therapist's Experience

Principal Investigator: Isabel Dyck, Associate Professor, School of Rehabilitation Science, Faculty of Medicine University of British Columbia. Phone number (604) _____.

Co-Investigator: Ben Mortenson, Graduate Student, Faculty of Graduate Studies, University of British Columbia. Phone number (604) _____.

Purpose of the Study:

Although client-centred practice has become an increasingly important part of occupational therapy practice in Canada in the last twenty years, no research has exclusively studied the therapist's experience with this treatment philosophy. Given this lack of research and the difficulties that have been noted in the literature with the

implementation this study intends to explore the therapist's experience with client-centred practice.

Study Procedure and Time Required:

The research will consist of an interview, lasting between 45 minutes and two hours in the location of your choice. With your permission the interview will be recorded on cassette tape. You will be free to end the interview at any time and you may choose not to answer any questions you desire. You will be able to review the content of the interview and edit it if you wish. You will be offered the opportunity to provide feedback on the preliminary analysis of the data. This participation is completely optional and time required would be at your discretion. This additional participation would involve reading a summary of the preliminary findings of the study and providing the researcher with feedback either in person or in written form. If you wish you may receive a copy of the final summary of the findings of this study and may also be informed about the time of the thesis defence. This research is being completed as part of a graduate degree.

Confidentiality

Any information from these interviews will be strictly confidential. In the written transcripts of the interviews your real name or place of work will not be used, your name will be replaced by a name of your choosing, and the names of anyone else that you mention will be treated likewise. No information that could identify you will be used in the reports. All notes and tape recordings will be kept in a locked cabinet and the tapes will be destroyed once the study has been completed. Data will be stored in a computer file that only the co-researcher has access to.

Remuneration/ Compensation

Not applicable

Contact:

If you would like to participate in the study or desire further information, please contact

Ben Mortenson at _____.

Appendix B

Consent Form

Client-centredness in Occupational Therapy: An Exploration of Therapist's Experience

Principal Investigator: Isabel Dyck, Associate Professor, School of Rehabilitation Science, Faculty of Medicine University of British Columbia. Phone number (604) _____.

Co-Investigator: Ben Mortenson, Graduate Student, Faculty of Graduate Studies, University of British Columbia. Phone number (604) _____.

Purpose:

Although client-centred practice has become an increasingly important part of occupational therapy practice in Canada in the last twenty years, no research has exclusively studied the therapist's experience with this treatment philosophy. Given this lack of research and the difficulties that have been noted in the literature with the implementation this study intends to explore the therapist's experience with client-centred practice. This research is being completed as part of the co-investigator's graduate degree.

Study Procedure and Time Required:

The research will consist of an interview, lasting between 45 minutes and two hours in the location of your choice. During the interview you will be asked to describe the setting where you work and discuss experiences that you have had with clients. With your permission the interview will be recorded on cassette tape. You will be free to end the interview at any time and you may choose not to answer any questions you desire.

You will be able to review the content of the interview and edit it if you wish. You will be offered the opportunity to provide feedback on the preliminary analysis of the data. This participation is completely optional and time required would be at your discretion. This additional participation would involve reading a summary of the preliminary findings of the study and providing the researcher with feedback either in person or in written form. If you wish you may receive a copy of the final summary of the findings of this study and may also be informed about the time of the thesis defence.

Confidentiality

Any information from these interviews will be strictly confidential. In the written transcripts of the interviews your real name or place of work will not be used, your name will be replaced by a name of your choosing, and the names of anyone else that you mention will be treated likewise. No information that could identify you will be used in the reports. All notes and tape recordings will be kept in a locked cabinet and the tapes will be destroyed once the study has been completed. Data will be stored in a computer file that only the co-researcher has access to.

Remuneration/ Compensation

Not applicable

Contact:

If you have any concerns or desire further information with respect to the study, you may contact either Isabel Dyck at _____ or Ben Mortenson at _____.

If you have any concerns about your treatment or rights as a research subject, please contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at 822-8598.

Consent:

I understand that my participation in the study is completely voluntary and I may refuse to participate or withdraw from the study at any time without explanation.

I have received a copy of this consent form for my own records.

By signing below, or stating verbal approval on a cassette tape I consent to participate in this study.

Signature of the participant

Date

Signature of witness

Date