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Client-centered evaluation in American occupational therapy

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CLIENT-CENTERED EVALUATION IN AMERICAN OCCUPATIONAL THERAPY

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CERTIFICATE OF APPROVAL

This is to certify that the Thesis of

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Abstract

Objective: Numerous studies in healthcare literature have suggested that client-centered practice leads to improved client satisfaction, compliance, and functional outcomes. Studies have also identified the importance of the evaluation phase in guiding the therapeutic process. However, few American studies have examined the integration of client-centered concepts in the evaluation phase. This study examines American occupational therapist's perceptions of client-centered care in the evaluation phase.

Method: A survey that looked at definitions, perceptions, appropriateness and use, and supports and barriers of client-centered care was sent to 500 members of the American Occupational Therapy Association (AOTA). The frequencies of participant responses were tallied and statistical analyses were performed to examine the relationship between participant responses and demographic characteristics such as gender and years of experience.

Results: Two hundred and sixty six of the returned surveys met the inclusion criteria, equaling a 53.2% valid response return rate. The majority of participants perceived client-centered care as beneficial, appropriate, and frequently used in the evaluation phase. Significant relationships of little and low levels of strength were found between the definition, perceptions, supports and barriers, and appropriateness and use of client-centered care and the participants' demographic characteristics.

Conclusions: This study demonstrated that American occupational therapists perceive client-centered care as valuable, identify limited barriers to implementation, and utilize concepts regularly in practice. Further research is needed to determine if and how American occupational therapists utilize concepts of client-centered care in practice,

client-perceptions of the incorporation of personal values in practice, and comparisons among occupational therapists in different countries.

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Chapter One: Introduction

Background

According to the *Occupational Therapy Practice Framework*, "occupational therapists and occupational therapy assistants focus on assisting people to engage in daily life activities they find meaningful and purposeful" (American Occupational Therapy Association [AOTA], 2002, p.4). Incorporating client values into evaluation and intervention making the therapeutic process personally meaningful and purposeful, is the essence of client-centered care. Several studies have suggested that client-centered practice has been associated with improved client satisfaction, increased compliance with medical programs, and better functional outcomes (Dunst, Trivette, Boyd, & Brookfield, 1994; Fraser, 1995; Greenfield, Kaplan, & Ware, 1985; Sumison, 1999). The profession of occupational therapy has progressively integrated client-centered views into the practice framework for occupational therapists in the United States, Canada, Britain, and beyond (Hong, Pearce & Withers, 2000).

Theoretical models of practice have also emphasized the integration of a client-centered approach to guide the therapeutic process. The Occupational Performance Model (Canadian Association of Occupational Therapists [CAOT], 1997), Model of Human Occupations (Kielhofner, 2002), Occupational Adaptation Model (Schkade & Shultz, 1992), and the Person-Environment-Occupational Performance Model (Christiansen & Baum, 1997) describe the client as an active participant, rendering constant collaboration between the client and therapist as essential to occupational therapy practice. These theoretical approaches note the importance of identifying client priorities and values in leading to successful outcomes.

Several authors have identified the importance of the evaluation phase in guiding therapeutic process (Fisher & Short-DeGraff, 1993; Dunn, 1998; Stewart et al., 1995). Using a client-centered approach during the evaluation phases involves the client in the decision-making process, encourages autonomy, and allows the client to direct the course of therapy (Hong et al., 2000). Initial assessments are used to establish a baseline of performance and document client change over the course of therapy (AOTA, 2002). Therefore evaluations and re-evaluations are essential for reimbursement and in determining if therapeutic intervention was successful. However, most standardized functional assessments do not address aspects of task performance that are of central importance to the client, and these issues therefore can be disregarded in treatment (Fisher & Short-DeGraff, 1993).

Rationale

Although the importance of client-centered care and the evaluation phase have been researched and emphasized in theory, medical reimbursement systems can often be more influential in guiding practice. Health care spending in the United States is projected to reach $3.1 trillion in 2012, up from $1.4 trillion in 2001, according to a report issued by the Centers for Medicare & Medicaid Services (2002). These increasing costs have a large impact on society and have put pressure on the health care field to achieve faster outcomes to lower expenses. The focus on reimbursement and emphasis on the medical model has shifted occupational therapy to focus less on work, play, and leisure, and more on physical aspects of occupation (Jongbloed & Wendland, 2002). Occupational therapists are therefore torn between their role as client advocates and as health care professionals requiring reimbursement for services. Because assessments have the

potential to guide practice, using a client-centered evaluation could re-emphasize the client priorities in intervention, possibly leading to faster and/or more successful outcomes. This may lead to more satisfied clients, shorter hospital stays, and lower medical bills.

Problem Statement

Although there is an abundance of research demonstrating the significance of using a meaningful, client-centered focus in occupational therapy, as well as identifying the importance of functional assessments and the evaluation process, there is limited discussion of incorporating a meaningful, client-centered approach in the evaluation process.

Purpose

The purpose of this study is to evaluate if and how American occupational therapists incorporate concepts of client-centered care into the evaluation process.

Definition of Terms

Assessment. "Specific tools or instruments that are used during the evaluation process" (AOTA, 1995, pp.1072-1073).

Evaluation. The "process of obtaining and interpreting data necessary for intervention" which ". . . includes planning for and documenting the evaluation process and results" (AOTA, 1995, p.1072).

Occupational performance. "The ability to carry out activities of daily life. Includes activities in the areas of occupation: ADL (Activities of Daily Living), IADL (Instrumental Activities of Daily Living), education, work, play, leisure, and social participation. Occupational performance is the accomplishment of the selected activity or

occupation resulting from the dynamic transaction among the client, the context, and the activity" (AOTA, 2002, p.60).

Purposeful. An occupation that ". . . holds within itself a healing property that will change organic or behavioral impairments" (Trombly, 1995, p. 963).

Meaningful. An ". . . exchange between the therapist and the person to construct the importance of an activity within the context of culture, life experience, disability, and present needs" (Trombly, 1995, p. 968).

Client-centered. Is "an orientation that honors the desires and priorities of clients in designing and implementing interventions" (AOTA, 2002, p. 17), demonstrating ". . . respect for clients" and advocating ". . . with and for clients in meeting their needs and otherwise recognize clients' experience and knowledge" (CAOT, 1997, p.49)

Chapter Two: Review of Literature

Introduction

The concept of client-centered care has been given many different names. In nursing and physiatry, intervention focused on the partnership between client and practitioner is often called patient-centered or patient-focused care. In pediatrics, centering treatment on the child and his or her caregivers is referred to as family-centered care. All of these terms encompass the tenets of client-centered care. Theoretical models have incorporated client-centered care into their core. Research has examined the effectiveness of client-centered practice in multiple health science fields and identified supports and barriers to its implementation. Using a client-centered approach during initial evaluation, which plays an integral role in the therapeutic process, has also been researched. Each of these concepts will be discussed and analyzed in the following literature review.

Defining Client-Centered Care

The purpose of defining client-centered practice in occupational therapy and incorporating it into practice frameworks is to encourage and increase the extent and consistency of therapists' collaborations with their clients for meaningful and effective therapy (Mew & Fossey, 1996). Many different authors have attempted to define client-centered care. These definitions include an ". . . alliance formed between client and therapist to use their combined skills and strengths to work towards client goals related to occupational performance" (Fearing, Law, & Clark, 1997, p.8), and expressing that the client is a ". . . valued human being" (Corring & Cook, 1999, p.78). Most of the literature refers to client-centered care as the active partnership that combines the values and meaningful context of a client's experience with the skill of a therapist to guide the

therapeutic process. Incorporation of this approach in practice includes discovering who the client is, respecting the client's culture and values, facilitating the client in setting goals, providing information to facilitate problem solving, and using professional skills to assist the clients in achieving their personal objectives (Law, Baptiste, & Mills, 1995). To provide a comprehensive picture, a client-centered approach also includes the perspective of the client's family and caregivers (Dunn, 1998).

Professions such as nursing, physiatry, and social work have also defined and incorporated client-centered care into practice (Fraser, 1995; Gage, 1994; Greenfield et al., 1985; Johnson, 1993). Nursing studies have described client-centered care as "a way of teaching and learning" to, and about the client (Vander Henst, 1997, p.97). Physiatry studies have defined the process of client-centered care as developing an ". . . understanding of the illness" through an ". . . understanding of the patient" (Levenstein, McCracken, McWhinney, Stewart, & Brown, 1986, p.24), viewing "patients as partners" (Speechly, 1992, p.22).

The client-centered approach has only recently been explicitly defined and incorporated in the American Practice Framework which defines the profession and guides evaluation, intervention, and outcomes (AOTA, 2002). This definition emphasizes therapists ". . . honoring the desires and priorities of clients" (AOTA, 2002, p.54). The Canadian framework has revolved around a client-centered model since its beginning, defining client-centered practice as an approach where occupational therapists ". . . demonstrate respect for clients, involve them indecision making, advocate with and for client in meeting their needs and otherwise recognize clients' experience and knowledge" (CAOT, 1997, p.49). The British Code of Ethics and Professional Conduct (College of

Occupational Therapists [COT], 2000) also emphasizes the importance of providing client-centered services that reflect the client's personal values. This includes occupational therapists being sensitive to ". . . cultural and lifestyle diversity and provide services which reflect and value these," incorporating the ". . . feelings of the clients and caregivers," and ". . . promoting the autonomy of the individual"(COT, 2000, p.5).

Throughout the expanse of definitions for client-centered care, four major themes evolve. The first theme involves a client-partnership or client-collaboration. In this approach, described by Fearing et al. (1997), the client and therapist bring their expertise together and become equal partners in the therapeutic process. In the second theme of a client-driven or client-inspired approach, therapists are encouraged to take their clients' perspectives into account throughout the therapeutic process, but make decisions independently. This perspective of client-centered care, in which the client inspires intervention, but the therapist uses his or her professional expertise to design the intervention plan, is seen in the definitions of the American Occupational Therapy Association (2002) and Law et al. (1995). The third theme is the client-empowerment approach. In this definition, apparent in the Canadian Association of Occupational Therapists (1997) definition of client-centered care, the therapist's primary role is to advocate with and for his or her clients in meeting their needs. In the final theme, a client-directed approach, the client is seen as having the greatest power and is seen as competent to make and even override decisions of other professionals. In the client-directed definition described by Greenfield et al. (1985) and Sumison & Smyth (2000), the client is the director of care throughout all stages of the therapeutic process.

Although multiple authors and frameworks have defined the role of client-centered care, little research has examined practicing therapist's perceived definition of client-centered care in practice. One study found that British occupational therapists cited collaboration between client and therapist, respecting the client's perspectives/rights, and joint goal-setting and decision-making as being most important to the definition of client-centered care (Sumison, 2000). Although British occupational therapists were surveyed to provide a definition of client-centered care in occupational therapy (Sumison, 2000), no survey of American occupational therapists perceived definition of client-centered care has been compiled.

Client-Centered Care in Practice

Client-centered care which uses engagement in personally meaningful and purposeful occupation throughout the therapeutic process, is integral to the practice of occupational therapy. Using a client-centered approach involves occupational therapists directly asking clients about occupational performance issues that are important to the client such as self-care and leisure performance (Fearing, Clark, & Stanton, 1998). The occupational therapist reflects on the given information, chooses whether or not to administer more in-depth assessments, and links the client to other appropriate contacts (Fearing, et al., 1998). To facilitate client involvement in the therapeutic process, both the client and therapist identify client strengths as well as community, environmental, and caregiver resources. With this information, the therapist and client can negotiate realistic targeted outcomes related to occupational performance (Sumison, 1999). Throughout implementation of a client-centered approach in practice, occupational therapists share information with their clients and ensure their clients have the necessary information to

make informed decisions. The occupational therapist encourages the client to be active in the problem solving process by comparing current performance and targeted outcomes, reviewing the intervention process, and making necessary changes (Fearing, et al., 1998).

Theoretical Models and Client-Centered Occupational Therapy

Theoretical models propose concepts to guide intervention and research in the field. Each theory seeks to generate concepts, test these phenomena, and to develop associated strategies, tools, and techniques for practice (Kielhofner, 2002). A theoretical model in occupational therapy provides an explanation of the organization and function of people and occupation, conceptualizes what happens when problems arise, and provides theoretical explanations of how therapy enables people to engage in occupations that are meaningful, satisfying, and supportive (Kielhofner, 2002). Leading scholars in occupational therapy have developed theories of practice that emphasize the importance of a client-centered approach. Major models within occupational therapy including the Model of Human Occupations, Canadian Occupational Performance Model, Person-Environment-Occupational Performance Model, and the Occupational Adaptation Model, define an important role for the client in this process. Although the profession has diverse models of practice with differing viewpoints, they share a common foundation in engagement in occupations that are personally meaningful and purposeful to the client, the core of client-centered care (Nelson, 1997). The following section will review the major tenets of these models and how they incorporate client-centered principles.

Model of Human Occupations. The Model of Human Occupations (MOHO) uses a client-centered approach to explain how occupation is motivated, patterned and performed. Humans are conceptualized as a dynamic system composed of three

interrelated components: volition, habituation, and performance capacity. Volition focuses on the personal motivation for occupation, habituation refers to establishing occupation performance into patterns or routines, and performance capacity addresses the physical and mental abilities that underlie skilled occupation (Kielhofner, 2002). According to MOHO, one cannot fully understand occupation without recognizing all three components (Kielhofner, 2002). Volition consists of personal causation or belief in personal skills and effectiveness in society, interests, and values that affect a person's activity and occupational choice. Therefore as people develop, change, gain new opportunities, and lose old interests they will change the activities and occupations in which they engage. MOHO is recognized as a client-centered model because it views the client as a unique individual whose characteristics establish the foundation and type of therapeutic goals and strategies (Kielhofner, 2002). It regards the client's actions, thoughts, and feelings as the central mechanism of change (Kielhofner, 2002). MOHO focuses on understanding the client's values, interest, sense of capacity and efficacy, roles, habits, and performance within the environment. A therapist who knows the importance of understanding and supporting a client's perspectives and experience can generate an individualized, client-centered intervention plan.

Canadian Occupational Performance Model. The Canadian Occupational Performance Model (CAOT, 1997) describes the relationship between a person, his or her environments and occupations, and the process by which occupational therapists can enable optimal occupational performance. In this model, spirituality, the innate essence of self, is a central construct. Therefore therapists are expected to collaborate with the client to determine what occupations are meaningful to the client, as well as the physical,

mental, and social capabilities of the client in his or her environment. Hence, client values are an integral part of the occupational therapy process. In the first stage of the therapeutic process the client and therapist identify, validate and prioritize occupational performance problems. In collaboration with the client, the therapist then selects intervention approaches to use to identify performance components and environmental conditions contributing to identified occupational performance problems. The client and therapist then identify strengths and resources, choose targeted outcomes, and develop a plan to achieve them. When the plan is implemented, the client and therapist together evaluate the occupational performance outcomes. Overall, the Canadian Occupational Performance Model uses a client-centered model to plan and implement treatment (CAOT, 1997).

Person-Environment-Occupational Performance Model. The Person-Environment-Occupational Performance Model (Christiansen & Baum, 1997) also has a client-centered foundation. According to the model, a client's occupational performance cannot be separated from client-centered and contextual elements. Therapeutic intervention is driven by the partnership between the client and therapist. The client's self image, determined from competency, self-concept and motivation guides the overall plan of care. This approach requires the therapist to collaborate with the client to determine the activities, tasks, and roles that are important to the client and also to determine the client's intrinsic, extrinsic, and environmental factors that support or inhibit occupational performance (1997).

Occupational Adaptation Model. The Occupational Adaptation Model (Schultz & Schkade, 1992) also contains many client-centered assumptions. In this model, the

client's occupational roles guide therapeutic intervention. A client's expectations of his or her roles are first established. The therapist's knowledge of the client's expectations, abilities, and limitations is then used to design an intervention program to meet these goals (Schultz & Schkade, 1992). This approach assumes that the most effective means to reach the client's goal is to develop the client's capacity for adaptation. Therefore, this model views occupation as enabling change to increase the internal adaptation process that is central to recovery. It is therefore important for the therapist to collaborate with the client to determine the internal resources of the client, establish activities that are meaningful to the client, and determine the relative mastery of the client in their daily occupations (Schkade & Schultz, 1992).

Importance of the Evaluation Process

According to the *Occupational Therapy Practice Framework,* "The evaluation process sets the stage for all that follows" (AOTA, 2002, p.19), and is divided into two segments - the occupational profile and analysis of occupational performance. The occupational profile is the first step in the evaluation process and is designed to gain an understanding of the client's past experience, patterns of daily living, values, interests, and desired outcomes (AOTA, 2002). This specifically involves determining areas of occupation that are successful and areas that are causing problems or risks, contexts that support or inhibit engagement in desired occupations, the client's life experiences, values, previous patterns of engagement in occupations, and the client's priorities and targeted outcomes (AOTA, 2002). The next step, analysis of occupational performance includes identifying the client's assets, facilitators, and barriers in daily life. This involves synthesizing information from the occupational profile; observing client performance in desired

occupations; selecting, administrating, and interpreting specific assessment tools; developing and refining hypotheses of the client's strengths and weakness in performance; creating goals; and developing an intervention approach (AOTA, 2002).

Overall, the evaluation is an ongoing process of obtaining and interpreting data from the client and is the point at which the collaborative partnership between client and therapist begins. This is essential to occupational therapists in determining and guiding the intervention strategies and course of action (Dunn, 1998; Stewart et al., 1995). Assessments are the specific tools or instruments that are used to gather information during the evaluation process (AOTA, 2002). Due to the fact that initial assessments identify specific areas of occupational dysfunction, they often guide the rest of the intervention process.

According to Dunn (1998), the relevance of the occupation to the client is the most important element of designing a measurement strategy. She stated that although many measurement strategies are technically correct, they may give information that is irrelevant to the client's daily needs and wants. An example of this is testing a client who is currently having difficulty with cooking tasks. A therapist may first decide to assess the client's memory and sequencing skills with a standardized assessment. The client may have difficulty finding the relevance between the assessment tasks and cooking when the testing is in isolation from the desired performance. A more client-centered approach would allow the therapist to listen to the barriers the client is encountering during cooking or observe the client cooking. Then as memory and sequencing were discussed between the client and therapist, the relationship would be evident to both (Dunn, 1998).

Several articles written in the early nineties emphasize the need to develop functional, client-centered assessments in occupational therapy. Pollock and McColl (1998) questioned the appropriateness of professionals assigning performance scores to clients in traditional assessments. They suggested that therapists cannot decide which performance issues have the biggest impact on their client's life, and stressed that a more client-centered approach would actively involve the client in the assessment process thereby delineating areas for intervention. Fisher and De-Graff (1993) described how assessments are especially important in occupational therapy due to emphasis on one's ability to function in daily occupations. They also stated that assessments must reflect the philosophical basis of occupational therapy, as well as incorporate the client's desires, needs, and the context in which they perform daily occupations. The authors suggested that evaluations should be dynamic and stress a top-down approach in which observation of client performance leads to the identification of limitations that impact functional performance. Trombly (1993) also emphasized the need for occupational therapists to start with a top-down assessment that determines the client's competency and occupations the client finds to be meaningful. Although these approaches are being encouraged by American authors, a limited number of American assessments that stress a client-centered approach are available. The client-centered assessments that have been developed such as the Occupational Self Assessment (Kielhofner & Forsyth, 2001) and the Canadian Occupational Performance Measure (Law et al., 1994) are not widely used in American occupational therapy practice.

Efficacy of Client-Centered Care

Although client-centered practice is globally supported by occupational therapists (AOTA, 2002; CAOT, 1991; COT, 2000) and viewed as integral in the evaluation phase, it is important to determine if incorporating these values leads to improved quality of care and outcomes. Research from multiple disciplines has found that providing elements of client-centered care leads to adherence to intervention recommendations, increased client satisfaction, and improved functional outcomes. These areas will be discussed in the following section.

Adherence to health recommendations. Studies have shown that providing respectful and supportive services, tenets of client-centered care, leads to improved adherence to health service programs (Greenfield et al., 1985; Hall, Roter & Katz, 1988; Wasserman, Inui, Barriatua, Carter, & Lippencott, 1984). Stewart et al. (1995) found that clients who were encouraged to express their feelings by their physicians were more likely to be compliant than those who did not express their feelings. From their review of the literature, King, King, & Rosenbaum (1994) found evidence that providing service that respects a client's personal values and beliefs is significantly associated with increased compliance to therapeutic recommendations.

Client satisfaction. An individualized approach, where the client's values guide the intervention, has been shown to improve overall satisfaction (Law et al., 1994). Collaboration between the therapist and client along with the therapist advocating for the client's needs, has also been demonstrated to increase satisfaction with service (Greenfield et al., 1985). Dunst et al. (1994) found that using an empowerment model in pediartrics, which encourages parent involvement and decision making, leads to an

increased sense of control and satisfaction for parents. Similarly, King et al. (1994) found that respectful treatment, an open exchange of information, and other practices that foster a partnership between the client and therapist, are also significantly associated with increased client satisfaction. From a review of five studies on the discharge planning process, Abramson (1990) found that the client's level of control during intervention is significantly related to his or her satisfaction with the intervention and the discharge process.

Improved functional outcomes. Research has also suggested that focus on functional independence using client-centered care increases functional performance and leads to a more desirable discharge. Clients with diabetes who were given an intensive client education program on how to read their medical charts and ask pertinent information, were reported to have better functional outcomes (Greenfield et al., 1985). Development of a partnership between the therapist and client has been demonstrated to increase client participation and client self-efficacy, leading to improved function (Dunst et al., 1994; Greenfield et al., 1985). Similarly, an individualized approach in which the client's values guide the intervention, has been shown to improve occupational performance outcomes (Law et al., 1994; Landefield, Palmer, Kresvic, Fortinsky, & Kowal, 1995).

Supports and Barriers to Client-Centered Care

Several supports and barriers to implementing client-centered care have been identified in the literature. The knowledge of client-centered care, time available to spend with clients, level of agreement among clients and therapists, differences of gender and culture, reimbursement, demands of different facility types, and availability of client-centered assessment tools. These concepts will be reviewed in the following section.

Knowledge of client-centered care. Limited knowledge of client-centered care and its implementation in practice is a frequently cited barrier of using a client-centered approach (Fraser, 1995; Levenstein et al., 1986). Research has shown that therapists' insufficient knowledge of incorporating client-centered care into the evaluation and intervention process makes them reluctant to use a client-centered approach (Stewart et al., 1989; Toomey, Nicholson, & Carswell, 1995). The literature has also suggested that therapists may be unwilling to take the risks associated with adopting a new approach (Vander Henst, 1997). Therapists who have been trained recently may be more familiar with current methods of practice, such as the client-centered approach, and more likely to integrate concepts of client-centered care into practice (Toomey et al., 1995). Similarly, the literature has also suggested that therapists with more education and training in fields of occupational therapy have greater opportunities to gain knowledge of client-centered care, and may be more likely to incorporate it in practice (Frazer, 1995; Levenstein et al., 1986; Sumison & Smyth, 2000).

Treatment time. Many health practitioners feel they do not have enough time to practice client-centered care. Even though using a client-centered approach has also been found to save a client from needing to return for more in-depth assessments (Stewart et al., 1995), Daly (1993) found that insufficient time to spend with patients was the most frequently cited barrier to client-centered care. Doctors and nurses have reported that time pressures mean they cannot listen or give as much time to each client as they would like (Ersser, 1996; Ku, 1993; McCracken, Stewart, Brown, & McWhinney, 1983). This time pressure can inhibit therapists from sufficiently learning about their clients before setting their therapeutic goals (Corring & Cook, 1999; Kramer, 1997). Facilities without

strict time constraints and increased client treatment durations have been suggested to facilitate the client-therapist relationship and therefore support a client-centered model of practice (McGilton, 2002).

Agreement between client and therapist. Another barrier to client-centered practice includes therapist and client disagreement about the goals for intervention (Clark, Scott, & Krupa, 1993). These differences in goals create a problem for designing intervention and inhibit utilization of client-centered care (Law et al., 1995). If a therapist does not incorporate a client's personal goals, the client may not understand the purpose or meaning of the intervention and be unmotivated to participate in therapy. This can exemplify the client's lack of personal control and decrease client satisfaction (Greenfield et al., 1985). Research has shown that occupational therapists may have trouble determining a client's ability to participate in the therapeutic process and feel the client may choose unsafe or inappropriate goals (Hobson, 1996; Law et al, 1995). Jaffe and Kipper (1982), Schroeder and Bloom (1979), and Wanigaratne and Barker (1995) found that some therapists feel that clients preferred to be told what their problems are. Therapists may also have difficulty facilitating the client's goal identification and find it easier to simply make decisions for them (Sumison, 1993; Sumison & Smyth, 2000). Rebeiro (2000) also found that clients in a hospital-based mental health program described their experiences as less client-centered care than their therapists.

Gender and culture. Differences of gender and culture have also been cited as barriers to client-centered care. Studies have shown that women tend to be more concerned with interpersonal aspects of relationships than men (Hall & Roter, 1998; Valentine, 2001). Law and Britten (1995) found that female practitioners are inclined to be more client-

centered than male practitioners, while another study found that although female practitioners tended to their clients emotional and psychosocial needs, they did not receive higher client satisfaction ratings than males (Hall & Roter, 1998). Although some research suggests that differences in culture and gender between the client and therapist inhibit client-centered practice, others have found this to be the least cited barrier to client-centered practice by therapists (Fraser, 1995; Sumison, 2000).

Reimbursement systems. In the United States, reimbursement systems have traditionally been based on the medical model. This has been hypothesized to make a client-centered approach more difficult to implement in the United States than in countries that practice socialized medicine, such as Canada and Britain (VanLeit, 1995). In the United States, measurable and objective descriptions of functional change needed for reimbursement do not require obtaining the client's meanings and purposes in occupation (Jongbloed & Wendland, 2002). Due to the fact that these are not required or encouraged by health care organizations, they are not often incorporated in treatment (Fisher & Short-DeGraff, 1993). Studies have further shown that a client's health insurance can influence treatment recommendations, resulting in therapists choosing an intervention approach that the client's insurance will cover (Lysack & Neufield, 2003). Third-party payers therefore can influence the client-centeredness of the therapeutic process.

Facility type and dedication to the medical model. Demands of different facilities can support or impede the implementation of client-centered care. A facility's dedication to the medical model has been shown to inhibit client-centered practice (Crowe, 1994; Johnson, 1993). Similarly, a facility's level of commitment to client-centered practice

through its mission statement and policies, management style, specific requirements for documentation, involvement of therapists in organizational changes, general support of team, and practical strategies for implementation of client-centered care have all been linked to the therapist's use of a client-centered approach in practice (Wilkins, Pollock, Rochon, & Law, 2001). The literature has suggested that the acute care environment creates a challenge for implementing client-centered care due to the medical fragility of the clientele (Gage, 1994). Similarly, the literature has also suggested that due to increased length of stay, long-term care facilities support the relationship of residents and care providers, facilitating client-centered care (McGilton, 2002).

Choosing client-centered assessments. It has been suggested that therapists may use an assessment learned in school, that is popular or commonly accepted, or is required by an institution rather than an assessment that is the best measure of their clients' priorities and performance (Dunn, 1998). Assessments can have cultural, gender, or even examiner biases that may affect their usefulness and appropriateness with certain groups, which may deter therapists from administering them (Dunn, 1998). The small number of assessments identified as client-centered in the literature have limited or conflicting reports of reliability, validity, and clinical utility (Donnelly & Carswell, 2002). Suggested barriers to incorporating the few client-centered assessments available to occupational therapists include the complexity of learning new assessments, overwhelming workloads, difficulty in scoring, and lack of availability and practice in facilities (Toomey et al., 1995). The most researched of these client-centered assessments is the Canadian Occupational Performance Measure (COPM) (Law, Baptiste, Carswell-Opzoomer, McColl, Polatajko, & Pollock, 1991), a semi-structured interview used to assess a client's

perception of performance. Although, research has shown that incorporating the COPM into the existing occupational therapy evaluation process not only increased client-centeredness but also increased accuracy in outcome prediction (Simmons, Crepeau, & White, 2000), few American occupational therapists use this measure (Law et al., 1991).

Conclusion

Meaningful and purposeful occupation is the basis of occupational therapy and the basis of client-centered care. Research has shown that incorporating tenets of client-centered care leads to benefits for both the client and the therapist. The literature has also shown the importance of the initial evaluation in guiding the therapeutic process. Although the term *client-centered care* has received attention in the national occupational therapy literature, no articles have examined American therapists' definition of client-centered care, perceptions of client-centered care, or supports or barriers to its implementation. Similarly, there is limited discussion of the incorporation of client-centered care into the evaluation process, its appropriateness, and its frequency of use in occupational therapy.

Chapter Three: Methods and Procedures

Introduction

The purpose of this study was to survey American occupational therapists about their perceptions of client-centered care. The following chapter outlines the selection method, measurement instrument, design, and limitations, delimitations, and assumptions of this study.

Hypothesis/Research Questions

This study addressed the following research questions:

1. How do American occupational therapists define client-centered care?
2. How do American occupational therapists perceive client-centered care and the evaluation phase?
3. Do American occupational therapists incorporate client values into the evaluation process?
4. What do American occupational therapists perceive as supports/barriers to client-centered care and its incorporation into the evaluation process?

Subjects and Selection Method

A randomized list of five hundred members was purchased from the American Occupational Therapy Association (AOTA), which included the names and addresses of practicing occupational therapists who currently work with an adult population. Inclusion criteria for this study included practicing therapists that have a bachelors, masters, or doctoral degree in occupational therapy, are currently working in the United States with clients 18 years of age and older, and who answered a minimum of 75% of survey questions.

Operationalization of Concepts Into Variables

American occupational therapist. American occupational therapist refers to licensed and practicing occupational therapists currently working in the United States. The tear-off cover sheet that accompanied each survey indicated that participants must be occupational therapists currently living and practicing in the United States in order to contribute to the study.

Demographic data. Demographic data refers to statistics of a certain population. Participants were asked to indicate gender by checking *male or female (*question 1*)*. Age (question 2) and clinical experience in occupational therapy (question 3) were measured in years through indication on the measurement instrument. Participants indicated education level by checking their highest level of degree obtained (question 4), specialty certification by checking the appropriate certification received (question 5), primary place of employment by checking facility type (question 6), and average duration of clients' occupational therapy treatment in primary place of employment by checking a designated time frame (question 7). Therapists were also asked to numerically identify the average number of clients they see in a day (question 8).

Definition of client-centered care. A definition of client-centered care refers to a statement of meaning explaining the extent to which a client's personal values and ideas are incorporated into occupational therapy evaluation, intervention, and outcomes. In question nine, participants chose the most appropriate description by ranking four definitions (one equaling *most appropriate* to four equaling *least appropriate*) that were focused on key constructs of client-centered care based on current literature (see Table 1).

Perceptions of client-centered care. Perception of client-centered care refers to general value, importance and usefulness that occupational therapists assign to client-centered care. Participants used a six point Likert scale (one equaling *strongly disagree* to six equaling *strongly agree*) to rank value statements of key concepts of client-centered care derived from the literature.

Perceptions of the evaluation phase. Perception of client-centered care refers to general value, importance and usefulness that occupational therapists assign to the evaluation phase of the therapeutic process. Participants used a six point Likert scale (one equaling *strongly disagree* to six equaling *strongly agree*) to rank value statements of key concepts of client-centered care derived from the literature.

Client satisfaction. Client satisfaction refers to the therapist's understanding of the client's sense of accomplishment during occupational therapy treatment. Participants used a six point Likert scale (one equaling *strongly disagree* to six equaling *strongly agree*) to rank statements regarding the effect of client-centered care on client satisfaction based on the literature.

Client outcomes. Client outcomes refer to the therapist's understanding of the client's end result following intervention. This includes changes in physical, mental, and socio-emotional health. This was measured by participants using a six point Likert scale (one equaling *strongly disagree* to six equaling *strongly agree*) to rank statements on the effect of client-centered care on client outcomes based on the literature.

Incorporation of client values in evaluation. This incorporation refers to how the occupational therapist includes the client's priorities and concerns in the evaluation phase. In survey question eleven, a-f focus on the occupational profile, while g-l focus on

analysis of occupational performance in the evaluation phase (see Table 1). Participants used a four point Likert scale to rank the appropriateness (one equaling *very appropriate* to four equaling *very inappropriate*) and frequency (one equaling *frequently* to four equaling *never*) of client values in key constructs of the evaluation process as identified in the *Occupational Therapy Practice Framework* (American Occupational Therapy Association, 2002).

Appropriateness for occupational therapy. Appropriateness refers to the occupational therapist's feelings toward the suitability of an action for use in the evaluation phase. This was measured using a four point Likert scale (one equaling *very appropriate* to four equaling *very inappropriate*) to indicate the appropriateness for use in occupational therapy evaluation.

Frequency of use. Frequency of use refers to how often an American occupational therapist uses a method in the evaluation stage of treatment. This was measured using a four point Likert scale (one equaling *frequently* to four equaling *never*) to indicate the participant's frequency of use during evaluation.

Supports of client-centered care. Supports refer to physical or intangible items that aid or encourage client-centered practice. Participants used a six point Likert scale (one equaling *strongly disagree* to six equaling *strongly agree*) to rank supports of client-centered care identified in the literature.

Barriers of client-centered care. Barriers refer to any condition that makes it difficult to incorporate or to utilize client-centered practice. Participants used a six point Likert scale (one equaling *strongly disagree* to six equaling *strongly agree*) to rank inhibitors of client-centered care identified in the literature.

Measurement Instrument

The research used a non-experimental survey design in the format of a quantitative, postal questionnaire. The tear-off cover sheet also invited participants to include individual comments. The survey was designed to be easily read and filled out by occupational therapists, taking approximately 25 minutes to complete.

The primary investigator designed the survey based on peer-reviewed research articles that investigated the definition of client-centered care, efficacy in practice, appropriateness and use in the evaluation phase, and supports and barriers to its implementation. Each survey question addressed key constructs of client-centered evaluation identified in the literature (see Table 1). The survey was piloted by six occupational therapists that currently work with an adult population to provide face validity of all test items to be included in the final survey. They were asked to complete the survey as it existed, suggest what other items should be added, and discuss aspects of the survey that might be changed. Sequencing and wording of some items were changed based on the pilot test feedback. Reliability and construct validity were not established and are beyond the scope of this Master's thesis.

Design for Gathering, Analyzing, and Interpreting Data

Via mail, participants received a tear-off cover page that explained the purpose of the study as well as possible harm or benefits (see Appendix B), a two-paged, double-sided survey (see Appendix C) and a pre-addressed stamped envelope. The participants were informed that by returning the survey, they would be demonstrating informed consent. To increase response rate, a reminder letter was sent to therapists who had not replied in two weeks (see Appendix D). Those who had not responded to the survey in the following

two weeks, four weeks from the initial mailing, were sent a second copy of the packet (see Appendix E).

A numeric coding system was developed to ensure all participant responses remained anonymous. Each participant was randomly assigned a code number that was placed on the pre-addressed stamped envelope. A research assistant documented all envelope codes, opened these envelopes, and gave the surveys to the researcher. The research assistant used the coding information to track participants who had and had not returned the survey. This coding system was unavailable to the researcher and was destroyed by the research assistant at the end of the study.

The *Statistical Package for Social Sciences, Version II for Windows* (SPSS) computer program was used to perform statistical calculations. The level of significance chosen for this study was $p < .05$. Correlation results were interpreted using the follow levels to identify the strength of relationships.

.00-.25: little if any

.26-.49: low

.50-.69: moderate

.70-.89: high

.90-1.00: very high

(Munro, 2001)

To answer the first research question and determine how American occupational therapists define client-centered care, frequencies were calculated on the ranked definitions of client-centered care. The association between definition rank and the participants' demographic data was evaluated using Kendall's Tau-b for age, years of

experience, average number of clients seen daily, highest level of education, and average duration of client treatment. The association between definition rank and the participants' primary place of employment was evaluated using the Kruskal-Wallis analysis for variance test. The Mann-Whitney U test was performed when a significant difference was found between groups from the analysis of variance. The Mann-Whitney U Test was also used to identify differences of definition rank between male and female participants and participants with and without specialty certification gender.

To answer the second research question and determine how American occupational therapists perceive client-centered care, frequencies were tallied to summarize perception items in question ten. The association between the perceptions of client-centered care and the participants' demographic data was evaluated using the Pearson product-moment correlation for numerical demographic data (age, years of experience, average number of clients seen daily), Kendall's Tau-b for ordinal demographic data (highest level of education, average duration of client treatment), and a one-way ANOVA for nominal demographic data (primary place of employment). A post hoc test using Bonferroni's method was performed when a significant difference was found between groups for the ANOVA. Independent t-tests were also used to identify differences between male and female participants and participants with and without specialty certification.

To answer the third research question and determine how American occupational therapists incorporate client values into the evaluation process, frequencies were tallied to summarize question eleven. The association between utilization of client-centered care in evaluation and the participants' demographic data was tested using Pearson product-moment correlation for numerical demographic data (age, years of experience, average

number of clients seen daily), Kendall's Tau-b for ordinal demographic data (highest level of education, average duration of client treatment), and a one-way ANOVA for nominal demographic data (primary place of employment). A post hoc test using Bonferroni's method was performed when a significant difference was found between groups for the ANOVA. Independent t-tests were also used to identify differences between male and female participants and participants with and without specialty certification.

To answer the fourth research question and determine what American occupational therapists perceive as supports and barriers to client-centered care, frequencies were tallied to summarize items in question ten. The association between supports and barriers of client-centered care and the participants' demographic data was tested using Pearson product-moment correlation for numerical demographic data (age, years of experience, average number of clients seen daily), Kendall's Tau-b for ordinal demographic data (highest level of education, average duration of client treatment), and a one-way ANOVA for nominal demographic data (primary place of employment). A post hoc test using Bonferroni's method was performed when a significant difference was found between groups for the ANOVA. Independent t-tests were also used to identify differences between male and female participants and participants with and without specialty certification gender.

Limitations, Delimitations, and Assumptions

A limitation of this study includes the sampling of participants from current AOTA members, which may affect external validity. Due to the fact that AOTA members are part of a professional organization and receive peer reviewed journals and other readings

on specific topics in occupational therapy, they may have a greater knowledge of client-centered care than the average American occupational therapist. Voluntary group membership may also reflect increased interest and professional commitment.

The measure assessed the participants' opinions and perceived utilization of client-centered care, not actual use. Although the anonymity of a postal questionnaire has been suggested to enhance therapists' honest reflections on issues which some may find personal and challenging (Sumison, 2000), responses may not reflect clinical use and incorporation of client-centered concepts in therapy. The survey was developed by the researcher and piloted among a small number of occupational therapists. Other weaknesses include:

1. *Reactivity*: Respondents tend to give socially desirable responses that make them look good or seem to be what the researcher is looking for. Participants may feel that they should use a client-centered approach in the evaluation and treatment phase of therapy, and therefore inflate the usage of client-centered methods in their responses.

2. Non-response rate: The responses of occupational therapists that did not participate in survey will not be included in results. These may be therapists who do not have sufficient knowledge in client-centered practice, the evaluation procedure, or who do not value the process. Therapists who are familiar with, interested in, and frequently use a client-centered approach may have been more likely to respond, skewing the data and making it difficult to accurately determine the range of knowledge and use of client- centered concepts in American occupational therapy.

3. *Measurement error*: Surveys can have systematic biases and/or loaded questions. The survey tool assumes that the participant already has a representative definition of client-

centered care, which is the basis for answering all other questions. If participants have an inaccurate definition of client-centered care, their responses may misrepresent their actual practice. Also, the Likert Scale for question ten and eleven are reversed. In question ten, one equals *strongly disagree* and six equals *strongly agree*, whereas in question eleven, one equals *very appropriate* and four equals *very inappropriate*. This reversed scale could have inverted participant responses.

This study confined itself to examining the perceptions of American occupational therapists that currently practice with an adult population only. Perceptions of the appropriateness and usage of client-centered care was investigated in the evaluation phase only. It is assumed that there is validated interest by the public, that the population is literate, biases are accounted for, the sample reports accurate information, and that the measure is valid. Confounding variables that could have affected the results include the participant's familiarity and knowledge of client-centered care, their interest in the subject, and honesty.

Chapter Four: Results

Introduction

A total of 296 surveys were returned. Two hundred and sixty six surveys met the inclusion criteria, equaling a 53.2% valid response return rate. This chapter reports the demographic summary of the survey participants and the statistical findings for the definition of client centered-care, appropriateness and use of client-centered care in evaluation, and supports and barriers of client-centered care.

Demographic summary of participants

The participants in this study were an average of 43.7 years of age ($N = 262$, $SD = 9.32$) with a range of 25 to 72 years. Years of experience in occupational therapy ranged from 1.5 to 50 years, with a mean of 16.6 years ($N = 263$, $SD = 9.11$). Participants saw an average of 8.6 clients a day ($N = 246$, $SD = 5.66$) with a range of 0 to 45 persons. The majority of participants ($N = 265$, 88.7%) identified themselves as female, and 11.3% of survey participants identified as male.

The majority of the participants ($N = 264$, 62.5%) were trained at a bachelors level in occupational therapy, followed by an entry-level Masters in occupational therapy (17.8%), a Masters in a subject other than occupational therapy (12.1%), and a post-professional Masters in occupational therapy (6.1%). A small number of participants reported a Doctorate in occupational therapy or a Doctorate in a subject other than occupational therapy (1.6%). Thirty-eight percent of survey participants reported having specialty certification ($N = 266$). The participants primarily worked in an outpatient rehabilitation setting ($N = 255$, 24.7%), followed by an inpatient rehabilitation setting (17.3%), skilled nursing facility (14.1%), other (12.2%), home health (11.4%), acute care

(7.1%), mental health (5.9%), academic (3.5%), and community-based (3.9%). The greatest number of participants saw their clients for an average of 1-3 months ($N = 257$, 48.2%), followed by under one month (31.1%), over 3 months (13.2%), and under one week (7.4%).

Definition of Client-Centered Care

As shown in Table 2, the greatest number of participants ranked the client-partnership/collaboration definition as the most appropriate for use in occupational therapy ($n = 124$, 48.2%), and the client-directed definition as the least appropriate ($n = 156$, 61.2%).

As shown in Table 3, no significant difference in definition rank was found among male and female participants. Also, no significant difference in definition rank was found between participants with and without specialty certification (see Table 4).

As shown in Table 5, analysis revealed a significant inverse relationship of little strength between age and rank of the client-partnership/collaboration definition ($\tau = -.134$, $p = .007$) and a significant positive relationship of little strength between age and rank of the client-empowerment definition ($\tau = .101$, $p = .036$). As seen in Table 6, a significant inverse relationship of little strength was found between years of experience and rank of the client-partnership/collaboration definition ($\tau = -.121$, $p = .014$) and a significant positive relationship of little strength was found between years of experience and rank of the client-empowerment definition ($\tau = .141$, $p = .003$).

No significant relationship was found between definition rank and average number of clients seen daily (see Table 7). Similarly, no significant relationship was found between definition rank and highest level of education (see Table 8). As shown in Table 9,

analysis revealed a significant positive relationship of little strength between duration of client treatment and rank of the client-directed definition ($\tau = .118$, $p = .040$).

As shown in Table 10, an analysis of variance test showed a significant interaction between rank of the client-partnership/collaboration definition and primary place of employment ($\chi^2 = 17.810$, $p = .023$). The Mann-Whitney U test revealed that participants primarily employed in mental health settings ranked the client-partnership/collaboration definition as less appropriate than participants employed in home health ($U = 101.000$, $p = .009$), inpatient rehabilitation ($U = 185.000$, $p = .020$), outpatient rehabilitation ($U = 226.000$, $p = .003$), and *other* ($U = 132.000$, $p = .032$). Participants primarily employed in outpatient rehabilitation facilities ranked the client-partnership/collaboration definition as more appropriate than participants employed in skilled nursing ($U = 793.500$, $p = .021$) and acute care settings ($U = 393.000$, $p = .042$).

Perceptions of Client-Centered Care and the Evaluation Phase

As shown in Table 11, almost all of the participants agreed or strongly agreed with the statement "good occupational therapy should be client-centered" ($N = 264$, 93.9%). When asked if "using a client-centered approach saves a client from having to return for more in-depth assessments," 32.4% agreed or strongly agreed and 32% somewhat agreed ($N = 253$). The greatest number of participants agreed or strongly agreed with the statement "initial evaluations guide the rest of the intervention process" ($N = 262$, 47.7%), while 36% somewhat agreed. Almost all of the participants agreed or strongly agreed with the statement "it is important to create a partnership with my clients" ($N = 265$, 96.9%). About half of the participants agreed or strongly agreed with the statement "I perform client-centered evaluations" ($N = 260$, 49.6%), while 36.9% somewhat agreed. The

majority of the participants agreed or strongly agreed with the statement "client input is essential to the evaluation process" ($N = 266$, 94.4%). About half of the participants agreed or strongly agreed with the statement "I would like to perform evaluations that are more client-centered" ($N = 254$, 46.5%), while 33.1% somewhat agreed.

As seen in Table 11, almost all of the participants agreed or strongly agreed with the statement "a partnership between client and therapist increases client participation and self-efficacy" ($N = 266$, 91.7%), and "identifying the values and priorities of the client should be part of the evaluation process" ($N = 265$, 93.6%). More than half of the participants agreed or strongly agreed with the statement "I would like to know more about the client-centered approach" ($N = 258$, 55.9%) while 28.4% somewhat agreed. The majority of participants agreed or strongly agreed with the statement "client-centered care leads to improved client satisfaction and improved outcomes" ($N = 261$, 84.3%), and "I want to use a client-centered approach" ($N = 258$, 76%). See Table 11 for further details.

No significant differences in perceptions of client-centered care were found between male and female participants (see Table 12). No significant differences in perceptions of client-centered care were found among participants with and without specialty certification (see Table 13). Similarly, no significant relationships were found between perceptions of client-centered care and age of participants (see Table 14).

As shown in Table 15, analysis revealed a significant inverse relationship of little strength between years of experience and agreement with the statement "client input is essential to the evaluation process" ($r = -.134$, $p = .030$), and "identifying the values and priorities of the client should be part of the evaluation process" ($r = -.155$, $p = .012$). As

shown in Table 16, a significant positive relationship of little strength was found between average number of clients seen daily and agreement with the statement, "initial evaluations guide the rest of the intervention process" ($r = .143, p = .025$). A significant inverse relationship of little strength was found between years of experience and agreement with the statement, "I want to use a client-centered approach" ($r = -.134, p = .038$).

As shown in Table 17, analysis revealed a significant inverse relationship of little strength between highest level of education and agreement with the statement "using a client-centered approach saves a client from having to return for more in-depth assessments" ($\tau = -.132, p = .020$), and "I would like to know more about the client-centered approach" ($\tau = -.124, p = .028$). As shown in Table 18, a significant inverse relationship of little strength was revealed between average duration of client treatment in primary place of employment and agreement with the statement "using a client-centered approach saves my clients from having to return for more in-depth assessments" ($\tau = -.108, p = .048$).

As shown in Table 19, an analysis of variance showed a significant interaction between primary place of employment and agreement with the statement "I would like to perform evaluations that are more client-centered" $F(8, 234) = 2.477, p = .013$. Post hoc analysis using Bonferroni's method revealed no significant differences between groups, though a .060 level of significance was found between participants primarily employed in skilled nursing facilities, reporting a higher rate of agreement ($M = 4.69, SD = 1.183$), and participants primarily employed in community-based settings, reporting a lower rate

of agreement ($M = 3.4$, $SD = 1.350$). No other significant interactions were found between perceptions of client-centered care and primary place of employment.

Appropriateness and Use of Client-Centered Care in Evaluation

The majority of participants reported that it was very appropriate for a client to "establish current concerns in daily activities and occupation" ($N = 266$, 78.2%) and 83.6% reported using this method frequently in occupational therapy evaluation ($N = 265$). The majority also reported it was very appropriate for clients to "pinpoint areas of occupation that are successful and areas that are causing problems or risks" ($N = 265$, 66%) and 62% reported using this method frequently ($N = 263$). The majority of participants reported it was appropriate for a client to "determine contexts that support and inhibit engagement in occupations" ($N = 257$, 52.5%) and 33.5% reported it was very appropriate. The greatest number of participants reported sometimes using this method in occupational therapy evaluation ($N = 256$, 48%) while 27.3% reported using it frequently. The majority felt it was very appropriate for a client to "pick personal values and interests" ($N = 266$, 66.5%), and 66.7% reporting using it frequently ($N = 264$). The majority also felt it was very appropriate for clients to "establish their previous pattern of engagement in occupations" ($N = 257$, 52.9%) and 52.5% reported using this method frequently ($N = 257$). Most of the participants reported that it is very appropriate for a client to "choose priorities and targeted outcomes" ($N = 264$, 51.1%), and 45.2% reported using this method frequently, while 43% reported using it sometimes ($N = 263$). The majority felt it was very appropriate for a therapist to "observe a client's performance in desired occupations" ($N = 265$, 67.5%), and 60.2% reported using this method frequently ($N = 264$). The majority of the participants reported that it is very appropriate for a

therapist to "assess areas that the client identifies as important" ($N = 264$, 70.1%), and 71.6% reporting using this method frequently ($N = 261$). The greatest number of participants reported that it was appropriate for a client to "determine supports and barriers to performance" ($N = 262$, 46.2%), while 37.8% reported it was very appropriate. The greatest number of participants reported sometimes using this method in occupational therapy evaluation ($N = 260$, 44.2%), while 35.4% reported using it frequently. The greatest number of participants felt it was appropriate for a client to "establish strengths and weaknesses in performance" ($N = 263$, 48.3%) while 38% reported it was very appropriate. The greatest number of participants reported sometimes using this method ($N = 262$, 45.4%), while 33.6 % reported using it frequently. The majority felt that it is very appropriate for a client to "select goals with the therapist" ($N = 266$, 69.5%), and 67.7% reporting using it frequently ($N = 263$). Half of the participants felt it was appropriate for clients to "collaborate with therapist in choosing the intervention approach" ($N = 266$, 50%), and 38.7% reported it was very appropriate. The largest percentage of participants reported sometimes using this method in occupational therapy evaluation ($N = 265$, 48.7%), while 31.3% reported using it frequently. See Table 20 for further details.

As shown in Table 21, no significant differences were found concerning level of appropriateness and use of client-centered care in evaluation between male and female participants. As shown in Table 22, the statement "client determines the contexts that support and inhibit engagement in occupations" was seen as more appropriate for occupational therapy evaluation by participants with specialty certification ($M = 1.72$, $SD = .721$) than participants without specialty certification ($M = 1.91$, $SD = .753$), $t(255) =$

2.032; $p = .043$. No other significant differences in incorporation of client-centered concepts into the evaluation process were found between participants with and without specialty certification.

As shown in Table 23, analysis revealed a significant positive relationship of little strength between age and inappropriate ratings of the statements "client establishes current concerns in daily activities and occupation" ($r = .165, p = .007$), "client pinpoints areas of occupation that are successful and areas that are causing problems or risks" ($r = .169, p = .006$), "client picks personal values and interests" ($r = .181, p = .003$), "client chooses priorities and targeted outcomes" ($r = .213, p = .001$), "therapist observes client performance in desired occupations" ($r = .176, p = .004$), "client determines supports and barriers to performance" ($r = .135, p = .030$), "client establishes strengths and weaknesses in performance" ($r = .161, p = .009$), and "client collaborates with therapist in choosing the intervention approach" ($r = .169, p = .006$). Therefore, the older the participant was the more likely they were to rank these statements as inappropriate. A significant inverse relationship of little strength was revealed between age and decreased use of "client selects goals with the therapist" ($r = -.159, p = .001$). Therefore as participant age increased, frequency of use also increased. A significant positive relationship of low strength was found between age and inappropriate rating of the statement "client determines the contexts that support and inhibit engagement in occupations" ($r = .269, p = .000$). Therefore, as participant age increased, level of appropriateness for occupational therapy evaluation decreased.

As shown in Table 24, a significant positive relationship of little strength was revealed between years of experience and inappropriate ratings of the statements "client

establishes concerns in daily activities and occupation" ($r = .228, p = .000$), "client pinpoints areas of occupation that are successful and areas that are causing problems or risks" ($r = .221, p = .000$), "client picks personal values and interests" ($r = .197, p = .001$), "client establishes previous pattern of engagement in occupations" ($r = .162, p = .010$), "therapist observes client performance in desired occupations" ($r = .208, p = .001$), "therapist assesses areas that the client identifies as important" ($r = .180, p = .004$), "client determines supports and barriers to performance" ($r = .221, p = .000$), "client establishes strengths and weaknesses in performance" ($r = .187, p = .002$), "client selects goals with therapist" ($r = .189, p = .002$), and "client collaborates with therapist in choosing the intervention approach" ($r = .216, p = .000$). Therefore, the more experience a participant had, the more likely they were to rank these statements as inappropriate. A significant positive relationship of low strength was found between years of experience and inappropriate rating of the statements "client determines the contexts that support and inhibit engagement in occupations" ($r = .278, p = .000$) and "client chooses priorities and targeted outcomes" ($r = .308, p = .000$). Therefore the more experience a participant had, the more likely they were to rank these statements as inappropriate in occupational therapy evaluation. A significant positive relationship of little strength was revealed between years of experience and decreased use of "client chooses priorities and targeted outcomes" ($r = .166, p = .007$). Therefore, as years of experience increased, frequency of use in occupational therapy evaluation decreased.

As shown in Table 25, a significant positive relationship of little strength was found between average number of clients seen daily and decreased use of "therapist assesses areas that the client identifies as important" ($r = .184, p = .004$). Therefore as average

number of clients increased, frequency of use decreased. As shown in Table 26, a significant inverse relationship of little strength was found between highest level of education and frequency of "client chooses priorities and targeted outcomes" ($\tau = -.122, p = .038$) and "client determines supports and barriers to performance" ($\tau = -.128, p = .028$). Therefore, as highest level of education increased, frequency of use in occupational therapy evaluation also increased. As shown in Table 27, a significant positive relationship of little strength was revealed between average duration of client treatment and inappropriate rating of the statement "client establishes previous pattern of engagement in occupations" ($\tau = .130, p = .025$), "client determines supports and barriers to performance" ($\tau = .134, p = .017$), "client establishes strengths and weaknesses in performance" ($\tau = .120, p = .033$), and decreased use of "client determines supports and barriers to performance" ($\tau = .153, p = .006$). Therefore the longer the participants' average duration of client treatment was, the less likely they were to rate these statements as appropriate and the less likely they were to use these concepts in occupational therapy evaluation.

As shown in Table 28, an analysis of variance showed a significant interaction between primary place of employment and the frequency of use of "therapist observes client performance in desired occupations" $F(8, 244) = 2.776, p = .006$ and "therapist assesses areas that the client identifies as important" $F(8, 242) = 2.220, p = .027$. Post hoc analysis using Bonferroni's method indicated that participants employed in home health report observing client performance in desired occupations more frequently ($M = 1.29$, $SD = .659$) than participants employed in mental health ($M = 2.13$, $SD = .915$). Post hoc analysis using Bonferroni's method also indicated that participants employed in skilled

nursing facilities report assessing areas that the client identifies as important more frequently ($M = 1.17$, $SD = .378$) than participants employed in mental health ($M = 1.80$, $SD = .561$).

Supports and Barriers to Client-Centered Care

As shown in Table 29, over half of the participants ($N = 264$, 68.9%) agreed or strongly agreed with the statement "I am familiar with client-centered care." Most of the participants ($N = 266$, 79.9%) strongly disagreed or disagreed with the statement "clients and I often do not agree on therapeutic goals." The greatest percentage somewhat agreed with the statement "I would like to spend more time with each client during the evaluation phase" ($N = 264$, 29.5%), while 42.1% agreed or strongly agreed. The majority agreed or strongly agreed with the statements "my primary place of employment encourages that I obtain clients' values and priorities during evaluation" ($N = 261$, 67.8%), "I find it difficult to separate personal and professional values from client values" ($N = 266$, 72.9%), and "I use assessments that are required by my facility" ($N = 261$, 54.7%).

The greatest percentage of participants somewhat agreed with the statement "clients prefer me to tell them what their problems are" ($N = 260$, 28.1%), while 34.3% disagreed or strongly disagreed. The majority of participants disagreed or strongly disagreed with the statement "using a client-centered approach gives too much power to the client" ($N = 260$, 74.6%). The largest percentage of participants somewhat agreed with the statement "I learned about client-centered care in my occupational therapy curriculum" ($N = 262$, 22.5%), while 42.4% of the participants disagreed or strongly disagreed. The largest percentage of clients somewhat agreed with the statement "I learned about client-centered

care from continuing education workshops" ($N = 262$, 25.6%), while 46.2% disagreed or strongly disagreed.

The majority disagreed or strongly disagreed with the statement "practicing client-centered care involves paying less attention to my clients' medical diagnosis" ($N = 260$, 51.5%). The largest percentage of participants disagreed with the statement "the medical model makes it difficult to incorporate concepts of client-centered care" ($N = 257$, 26.6%), while 23.3% somewhat disagreed and 26.1% somewhat agreed. Over half of the participants disagreed or strongly disagreed with the statement "I do not have enough time to obtain client values and priorities during the evaluation" ($N = 266$, 54.1%), and "I find it difficult to assess a client's ability to choose their own goals" ($N = 265$, 51.3%). The majority of participants disagreed or strongly disagreed with the statement "I use the Canadian Occupational Performance Measure (COPM) in evaluation" ($N = 248$, 85.1%).

The greatest percentage of participants somewhat agreed with the statement "the medical models guides my occupational therapy practice" ($N = 262$, 37.4%), while 24% disagreed or strongly disagreed. The largest percentage somewhat agreed with the statement "few assessments are client-centered" ($N = 254$, 30.7%), while 29.2% disagreed or strongly disagreed. The largest percentage of participants somewhat agreed with the statement "reimbursement guides my goal selection for treatment" ($N = 260$, 27.7%), while 45.4% disagreed or strongly disagreed.

The majority of participants disagreed or strongly disagreed with the statement "I find it difficult to use client-centered care with clients of different genders or cultures" ($N = 261$, 67.4%). Sixty one percent agreed or strongly agreed with the statement "my primary place of employment supports client-centered care" ($N = 259$). The greatest percentage of

participants somewhat agreed with the statement "I find it easier to make treatment decision for my clients" ($N = 262$, 31.3%), while 27.9% disagreed or strongly disagreed. The greatest percentage of participants somewhat agreed with the statement "my clients are reluctant to assume responsibility for their own care" ($N = 263$, 39.9%), while 22.8% somewhat disagreed. See Table 29 for further details.

As shown in Table 30, male participants more strongly agreed with the statement "few assessments are client-centered" ($M = 3.73$, $SD = 1.413$) than female participants ($M = 3.26$, $SD = 1.216$), $t(251) = 1.980$; $p = .049$. Female participants more strongly agreed with the statement "my primary place of employment supports client-centered care" ($M = 4.67$, $SD = 1.090$) than male participants ($M = 4.14$, $SD = 1.356$), $t(256) = -2.398$; $p = .017$. Male participants more strongly agreed with the statement "I find it easier to make treatment decisions for my clients" ($M = 3.90$, $SD = 1.322$) than female participants ($M = 3.29$, $SD = 1.198$), $t(259) = 2.574$; $p = .011$. Female participants more strongly agreed with the statement "my clients are reluctant to assume responsibility for their own care" ($M = 3.56$, $SD = 1.111$) than male participants ($M = 3.03$, $SD = 1.299$), $t(260) = -2.416$; $p = .016$. As shown in Table 31, participants with specialty certification more strongly agreed with the statement "the medical model guides my occupational therapy practice" ($M = 3.74$, $SD = 1.332$) than participants without specialty certification. ($M = 3.40$, $SD = 1.169$), $t(260) = -2.163$; $p = .031$).

As shown in Table 32, analysis revealed a significant inverse relationship of low strength between age and agreement with the statement "I learned about client-centered care in my occupational therapy curriculum" ($r = -.349$, $p = .000$). A significant inverse relationship of little strength was revealed between age and agreement with the statement

"few assessments are client-centered" (r = -.131 , p = .038). As shown in Table 33, a significant positive relationship of little strength was found between years of experience and agreement with the statement "I find it difficult to separate my personal and professional values from client values" (r = .131, p = .034). A significant inverse relationship of little strength was revealed between years of experience and agreement with the statement "I use the Canadian Occupational Performance Measure (COPM) in evaluation" (r = -.131, p = .040). Also shown in Table 33, a significant inverse relationship of low strength was revealed between years of experience and agreement with the statement "I learned about client-centered care in my occupational therapy curriculum" (r = -.465, p = .000). No significant relationships were found between average number of clients seen in a day and supports/barriers of client-centered care (see Table 34).

As shown in Table 35, a significant positive relationship of little strength was found between highest level of education and agreement with the statement "I am familiar with client-centered care" (τ = .161, p = .005) and "I learned about client-centered care in my occupational therapy curriculum" (τ = .182, p = .001). A significant inverse relationship of little strength was found between highest level of education and agreement with the statement "the medical model guides my occupational therapy practice" (τ = -.113, p = .042) and "I find it easier to make treatment decisions for my clients" (τ = -.127, p = .022). As shown in Table 36, a significant inverse relationship of little strength was found between average duration of client treatment and agreement with the statement "I would like to spend more time with each client during the evaluation phase" (τ = -.141, p = .008), and "I use assessments that are required by my facility" (τ = -.193, p = .000).

As shown in Table 37, an analysis of variance showed a significant interaction between primary place of employment and the statements "I would like to spend more time with each client during the evaluation phase" $F(8, 244) = 2.645$, $p = .008$, "I use assessments that are required by my facility" $F(8, 241) = 2.646$, $p = .008$, "I use the Canadian Occupational Performance Measure (COPM) in evaluation" $F(8, 228) = 5.340$, $p = .000$, and "the medical model guides my occupational therapy practice" $F(8, 242) = 3.904$, $p = .000$. Post hoc analysis using Bonferroni's method indicated that participants employed in skilled nursing facilities had a significantly higher level of agreement with the statement "I would like to spend more time with each client during the evaluation phase" ($M = 4.55$, $SD = 1.422$) than participants in community based settings ($M = 2.90$, $SD = 1.287$). Participants employed in inpatient rehabilitation settings had a higher level of agreement with the statement "I use assessments that are required by my facility" ($M = 4.70$, $SD = 1.245$) than participants who reported *other* ($M = 3.29$, $SD = 1.883$). Participants primarily employed in academic settings had a higher level of agreement with the statement "I use the Canadian Occupational Performance Measure (COPM) in evaluation" ($M = 4.13$, $SD = 1.246$), than participants in any other employment group. Participants employed in acute care had a higher level of agreement with the statement "The medical model guides my occupational therapy practice" ($M = 4.35$, $SD = .786$), than participants employed in mental health ($M = 2.67$, $SD = 1.113$), and outpatient rehabilitation ($M = 3.95$, $SD = 1.069$).

Chapter 5: Discussion

Introduction

This study investigated American occupational therapists' perceptions of the definition of client-centered care, efficacy in practice, appropriateness and use in the evaluation phase, and supports and barriers to its implementation. The respondents were primarily female, had a bachelor's degree in occupational therapy, worked in an outpatient rehabilitation setting, and were members of the AOTA, all of which limit the generalizability of this study. The following chapter will answer the four main research questions by comparing and contrasting the findings of this study with peer-reviewed literature regarding client-centered care and its incorporation in the evaluation phase.

How do American occupational therapists define client-centered care?

The majority of participants in this study ranked the definition that emphasized a client-partnership and collaboration, consistent with the definition of client-centered care produced by Fearing et al. (1997), as most appropriate for use in occupational therapy (see Table 2). The definition that emphasized client-empowerment, consistent with reports of the CAOT (1997), was ranked as second most appropriate for use in occupational therapy (see Table 2). The client-driven or client-inspired approach seen in the definitions by the AOTA (2002) and Law et al. (1995), and the client-directed approach described by Greenfield et al. (1985) and Sumison & Smyth (2000), were seen as least appropriate (see Table 2). Therefore, American occupational therapists in this study reported it was most appropriate to define client-centered care as a collaboration that exists between client and therapist when determining priorities and targeted

outcomes that empower the client to engage in occupation and recognize the client's experience and knowledge.

Gender, specialty certification, level of education, and number of clients seen daily. No significant differences in definition rank were found between male and female participants in this study (see Table 3) which contrasts with the research findings of Law & Britten (1995) and Valentine (2001). This may be related to the small number of male therapists that participated in this study. No significant differences in definition rank were found between participants with and without specialty certification or with varying levels of education (see Table 4) in contrast to the findings of Frazer (1995), Levenstein et al. (1986), and Sumison & Smyth (2000) who found that therapists with more education and training in fields of occupational therapy have greater opportunities to gain knowledge of client-centered care. Similarly in this study, no significant relationships were found between definition rank and average client caseload (see Table 7) although this was expected based on previous literature (Corring & Cook, 1999; Daly, 1993; Kramer, 1997; Ku, 1993). Therefore, gender, specialty certification, highest level of education, and average number of clients seen daily did not affect American occupational therapists perceived definition of client-centered care in this study.

Age and years of experience. In this study, American occupational therapists' perceived definition of client-centered care was affected by age and years of experience. Older participants ranked the client-partnership/collaboration definition as more appropriate and the client-empowerment definition as less appropriate than younger participants in this study (see Table 5) in contrast to the findings of Toomey et al. (1995). Also in this study, participants with greater years of experience ranked the client-directed

and the client-partnership/collaboration definition as more appropriate and the client-empowerment definition as less appropriate than less experienced participants (see Table 6) consistent with the findings of Frazer (1995), Levenstein et al. (1986), and Sumison & Smyth (2000). Therapists with more experience in occupational therapy may therefore have greater opportunities to gain knowledge of the partnership between client and therapist that is fostered in client-centered care

Duration of occupational therapy treatment. In this study, American occupational therapists' perceived definition of client-centered care was also affected by the average duration of occupational therapy treatment. Although the definition that emphasized a client-directed approach was ranked as least appropriate overall in this study, participants who saw clients for shorter periods of time ranked the definition as more appropriate than participants who saw clients for longer periods of time (see Table 9) in contrast to the research of Corring & Cook (1999), Kramer (1997), and McCracken et al. (1983). It can be hypothesized that therapists who treat clients for shorter periods of time may feel it is more crucial for their clients to direct care because less time is available to design and implement an intervention plan. The difference between the results of this study and findings in the literature may be related to these past studies being conducted outside the United States under different health care models (Corring & Cook, 1999) and in health care fields other than occupational therapy (Kramer, 1997; McCracken et al., 1983).

Primary place of employment. American occupational therapists' primary place of employment also influenced their perceived definition of client-centered care in this study. Participants primarily employed in mental health settings ranked the client-partnership/collaboration definition as less appropriate than participants employed in

home health, inpatient rehabilitation, outpatient rehabilitation, and *other* in this study (see Table 10). No previous research has explored this question. Participants employed in mental health facilities may feel their clients do not have the emotional or cognitive capacity to effectively collaborate with the therapist in designing and implementing an intervention plan. As noted, participants primarily employed in outpatient rehabilitation facilities ranked the client-partnership/collaboration definition as more appropriate than participants employed in skilled nursing and acute care settings in this study (see Table 10). Therapists employed in outpatient facilities therefore may place greater focus on collaborating with clients because they may not see their clients on a daily basis and are pressured to provide therapy that is most applicable to the lives of their clients at home and work. Therefore, the therapists' clientele and pace of their employment setting may influence the way therapists view client-centered care.

How do American occupational therapists perceive client-centered care and the evaluation phase?

The outstanding majority of participants in this study reported that good occupational therapy should be client-centered and that identifying client values is essential to the evaluation process. However, only about half of the participants felt they perform client-centered evaluations (see Table 11). This contradicts the literature findings of Clark et al. (1993) and Sumison (1993) who found that therapists who feel that occupational therapy should be client-centered and that it is important to create a partnership with their client are more likely to incorporate its concepts into practice. In this study, the majority of participants also reported they would like to know more about a client-centered approach and reported wanting to use a client-centered approach, but only half reported wanting to

perform evaluations that are more client-centered (see Table 11). No previous research has explored the relationship between therapists' knowledge of client-centered care and their use of client-centered evaluations. Due to the limited amount of client-centered assessment tools (Dunn, 1998; Hong et al., 2000), American occupational therapists may not want to perform client-centered evaluations because they are unaware of or unfamiliar with the tools available and perceive it as too time consuming. Participants may have also reported using a client-centered approach because they feel it is socially expected.

In this study, the greatest percentage of participants felt that client-centered evaluations lead to improved participation, self-efficacy, satisfaction, and outcomes (see Table 11), which is consistent with the findings of Stewart et al. (1989). Most of the participants in this study viewed client input as essential to the evaluation process (see Table 11). Although the research suggests that using a client-centered approach saves a client from having to return for more in-depth assessments (McCracken et al., 1983), only one third of the participants in this study agreed with this statement (see Table 11). Half of the participants in this study felt that initial evaluations guide the intervention process (see Table 11). The literature suggests that therapists who feel the initial evaluation guides the intervention process and view client input as essential, are more likely to use a client-centered approach (Hong et al., 2000; Sumison, 2000). Therefore, American occupational therapists that feel that initial evaluations influence treatment and discharge and are familiar with the benefits of using client-centered assessments may be more likely to implement a client-centered approach in the evaluation phase.

Gender, specialty certification, and age. In this study, no significant differences in perceptions of client-centered care and the evaluation phase were found between male and female participants (see Table 12) which contrasts with the findings of Law & Britten (1995). As in the first research question, this may be associated with the small representation of male therapists in this study. Likewise there were no differences in perceptions about client-centered care between participants with and without specialty certification. Although age has been associated with incorporation of client-centered care (Toomey et al., 1995), no significant relationships were found between age and perceptions of client-centered care and evaluation phase in this study (see Table 14). Therefore, the gender, specialty certification, and age of American occupational therapists in this study did not effect the perception of client-centered care or the evaluation phase.

Years of experience. In this study, American occupational therapists' perception of client-centered care and the evaluation phase was affected by years of experience. Participants in this study with greater years of experience felt that client input is less essential and that identifying the values and priorities of the client is less important to the evaluation process than participants with fewer years of experience (see Table 15). Although this supports the findings of Toomey et al. (1995), it contrasts with research of Frazer (1995), Levenstein et al. (1986), and Sumison & Smyth (2000). This also contradicts the findings of the first research question in this study that established that participants with greater years of experience felt it was more appropriate to collaborate with the client when determining priorities and creating goals than less experienced participants (see Table 6). Therefore the more experienced participants' definition of

client-centered care appears to have no to little affect on their perceived value, importance, and usefulness of client-centered care in practice. It can be hypothesized that therapists with more experience have less recent training, were never formally educated in a client-centered approach, and are more likely to make assumptions about how their clients' impairments will impact their life.

Level of education. In this study, American occupational therapists' highest level of education also affected perceptions of client-centered care and the evaluation phase. Participants in this study with less formal education felt a client-centered approach saves a client from having to return for more in-depth assessments more so than participants with higher levels of education (see Table 17). Similarly, participants in this study with less formal education reported wanting to know more about the client-centered approach than participants with higher levels of education (see Table 17) which is consistent with the findings of Frazer (1995), Levenstein et al. (1986), and Sumison & Smyth (2000). Therefore in this study, American occupational therapists with higher levels of formal education value client-centered assessments and learning about the client-centered approach more than therapists with less formal education.

Duration of occupational therapy treatment and number of clients seen daily. In this study, American occupational therapists' perception of client-centered care and the evaluation phase was also affected by average duration of occupational therapy treatment and average number of clients seen daily. Participants in this study who saw clients for shorter periods of time felt that using a client-centered approach saves a client from having to return for more in-depth assessments more so than participants with longer durations of client treatment (see Table 18). Although this contrasts with the findings of

Kramer (1997) and McCracken et al. (1983), these findings are consistent with research that found practitioners with shorter client treatment durations place greater importance on their clients' priorities during the initial evaluation (Corring & Cook, 1999; McCracken et al., 1983). Similarly, participants in this study who saw a greater average daily number of clients were less likely to want to use a client-centered approach and felt that initial evaluations guide the rest of the intervention process more than participants who saw fewer clients daily (see Table 16) which is consistent with the literature (Corring & Cook, 1999; Daly, 1993; Ersser, 1996; Kramer, 1997; Ku, 1993). As found by Daly (1993) and Kramer (1997), these participants may feel they do not want or are unable to use a client-centered approach because there is insufficient time to foster a partnership between the client and therapist.

Primary place of employment. American occupational therapists' perception of client-centered care and the evaluation phase was also influenced by their primary place of employment in this study. Participants in this study primarily employed in skilled nursing facilities reported wanting to perform evaluations that are more client-centered than participants in community-based settings (see Table 19) as did therapists' in McGilton's (2002) study. Therefore, American occupational therapists working in skilled nursing facilities may see performing client-centered evaluations as a greater priority than therapists working in other settings. However, the finding that participants employed in skilled nursing facilities, who typically have more time to spend with their clients, perform client-centered evaluation does not correlate with the finding that shorter treatment durations promote use of client-centered care in this study. This discrepancy

may be due to the limited representation of participants in this study employed in community-based settings and treating clients for less than one month.

Do American occupational therapists incorporate client values into the evaluation process?

Overall, American occupational therapists in this study reported that client involvement in all stages of the occupational profile and analysis of occupational performance was appropriate (see Table 20). American occupational therapists in this study also reported frequently involving their clients in all stages of the occupational profile and analysis of occupational performance (see Table 20). Although the American Occupational Therapy Association (2002) stresses client involvement throughout the evaluation phase, previous research has not explored this relationship.

Gender. In this study, no significant differences in reported incorporation of client-centered concepts into the evaluation process were found between male and female participants (see Table 21) even though research has shown that women are inclined to be more client-centered (Hall & Roter, 1998; Law & Britten, 1995). Therefore, the gender of American occupational therapists in this study did not affect the reported appropriateness and frequency of incorporation of client values in the evaluation phase.

Age and years of experience. In this study, American occupational therapists' reported incorporation of client values in the evaluation phase was influenced by age and years of experience. Older and more experienced participants in this study felt it was less appropriate for a client to establish current concerns in daily activities and occupation, to pinpoint areas of occupation that are successful and areas that are causing problems or risks, pick personal values and interests, choose priorities and targeted outcomes,

determine supports and barriers to performance, establish strengths and weaknesses in performance, collaborate with the therapist in choosing the intervention approach, determine the contexts that support and inhibit engagement in occupations, and for the therapist to observe client performance in desired occupations than younger participants (see Table 23). More experienced therapists also felt it was less appropriate for clients to establish the previous pattern of engagement in occupations and select goals, and were less likely to asses areas that the client identifies as important. This supports the literature of Toomey et al. (1995) and may be related to the influence of older participants' training in the medical model. Older participants in this study, but not those who were more experienced, also reported having their clients select goals more frequently than younger participants (see Table 23) which contrasts with the findings of Toomey et al. (1995). Therefore, younger, less experienced participants in this study may focus more on the collaboration between client and therapist during evaluation, while older therapists rely more on their expert opinion for evaluation, but then have clients choose their own goals. In general, these results support the findings of Toomey et al. (1995) and lend support to the literature that suggests more recently trained therapists are more likely to use client-centered approach (Crowe, 1994; Johnson, 1993; Law et al., 1995).

Specialty certification and level of education. American occupational therapists' specialty certification and highest level of education also influenced incorporation of client values in the evaluation phase in this study. Participants in this study with specialty certification felt it was more appropriate for a client to determine contexts that support and inhibit engagement in occupations than participants without specialty certification (see Table 22). Similarly, participants in this study with a higher level of education had

their clients choose priorities and targeted outcomes and determine supports and barriers to performance more frequently than participants with less formal education (see Table 26). These results support findings in the literature by Frazer (1995), Levenstein et al. (1986), and Sumison & Smyth (2000) which suggest that therapists with more education and training in fields of occupational therapy have greater opportunities to gain knowledge of client-centered care, and may be more likely to incorporate concepts in practice.

Primary place of employment. In this study, American occupational therapists' incorporation of client values in the evaluation phase was also affected by primary place of employment. Participants in this study employed in skilled nursing facilities report evaluating areas that the client identifies as important more frequently than participants employed in mental health (see Table 28) which supports the findings of McGilton (2002). Participants in this study employed in home health report observing client performance in desired occupations more frequently than participants employed in mental health (see Table 28). This result supports the findings of Gage (1994) and the finding of the first research question that participants employed in home health found the client-partnership/collaboration definition more appropriate than participants employed in mental health settings. Other factors may also be involved in these findings such as client's cognitive and behavioral status and how appropriate client choice is felt to be by the therapist in different treatment settings.

Duration of occupational therapy treatment and number of clients seen daily. The average number of clients seen daily by American occupational therapists in this study influenced incorporation of client values in the evaluation phase. As in the second

research question in this study, participants who saw a greater average number of clients daily reported assessing areas that the client identifies as important less frequently than participants who saw fewer clients (see Table 25) which is consistent with the research findings of Ersser (1996), Ku (1993), and McCracken et al. (1983). Therefore, participants in this study with greater daily caseloads may have less time to devote to each individual client during their treatment sessions.

In this study, American occupational therapists' incorporation of client values in the evaluation phase was also affected by average duration of occupational therapy treatment. Participants with longer durations of client treatment reported it was less appropriate for a client to establish previous pattern of engagement in occupations, determine supports and barriers to performance, and establish strengths and weaknesses in performance than participants with shorter durations of client treatment which is consistent with the findings of the second research question. Similarly in this study, participants with longer durations of client treatment reported that their clients determine supports and barriers to performance less frequently than participants with shorter durations of client treatment (see Table 27). This contrasts with the research findings of Ersser (1996), Ku (1993), and McCracken, Stewart, Brown, & McWhinney (1983). This also contrasts with the results of the second research question in this study that found therapists working in skilled nursing facilities appeared to value and use client-centered care in a setting that would presumably involve longer treatment durations. It may be that participants in this study with longer treatment durations treat clients with more significant impairments with less potential for change and feel it is less appropriate for clients to return to their previous functional status and determine supports and barriers to previous level of performance.

What do American occupational therapists perceive as supports/barriers to client-centered care and its incorporation into the evaluation process?

Multiple barriers to client-centered care were found in this study. About half of the participants in this study reported that they had not learned about client-centered care in their occupational therapy curriculum or in continuing education workshops (see Table 29). Since the majority of the participants in this study also reported they were familiar with client-centered care (see Table 29) it can be assumed that they acquired this familiarity though informal means. According to the findings of Frazer (1995), Levenstein et al. (1986), and Stewart et al. (1989), the participants in this study who have limited formal knowledge of client-centered care may have difficulty implementing client-centered concepts into practice.

About half of the participants in this study reported that their clients are reluctant to assume responsibility for their own care (see Table 29), which is consistent with the findings of Law et al. (1995). About half of the participants in this study reported that clients prefer the therapist to tell them what their problems are (see Table 29), which is consistent with the research of Jaffe & Kipper (1982), Schroeder & Bloom (1979), and Wanigrante & Barker (1995). About half of the participants in this study reported that it was easier to make treatment decision for their clients (see Table 29), which is consistent with the findings of Sumison (1993). Therefore, although the majority of participants in this study report valuing and using a client-centered approach in practice (see Table 11), they report the client themselves as being the most significant barrier.

Primary place of employment. The majority of participants in this study felt that their primary place of employment supports client-centered care and encourages obtaining

client values and priorities during evaluation (see Table 29), which is consistent with the findings of Stewart et al. (1989) and Wilkins et al. (2001). Over half of the participants in this study felt that reimbursement did not guide their goal selection for treatment (see Table 29), which also contrasts with research of Lysack & Neufeld (2003) and McColl et al. (1997). However, the outstanding majority of the participants in this study reported working in treatment settings where reimbursement is necessary for therapist compensation and is a significant issue (see p. 32).

The majority of participants in this study reported using assessments required by their facility (see Table 29). However, the literature has suggested that if a therapist uses assessments required by a facility, they may not be evaluating what the client directly needs or wants (Dunn, 1998). Therefore participants in this study may not be aware of what constitutes a client-centered assessment or how to evaluate the client-centeredness of an evaluation tool. Half of the participants in this study reported that few assessments are client-centered (see Table 29), which is consistent with the literature (Dunn, 1998; Hong et al., 2000). The majority of participants in this study reported that they did not use the Canadian Occupational Performance Measure (COPM) in evaluation (see Table 29), shown to foster a client-centered evaluation (Donnelly & Carswell, 2002; Mew & Fossey, 1996; Simmons et al., 2000; Toomey et al., 1995).

Although the majority of participants in this study reported having enough time to obtain client values and priorities during the evaluation phase, the majority of the participants also reported they would like to spend more time with each client during the evaluation phase (see Table 29). This is consistent with findings of Corring & Cook (1999), Daly (1993), Kramer (1997), and McCracken et al. (1983). Over half of the

participants in this study also felt that the medical model guided their occupational therapy practice but reported this did not make it difficult to incorporate concepts of client-centered care (see Table 29), which contrasts with the findings of Crowe (1994), Johnson (1993), and Law et al. (1995).

Specific settings appeared to influence the participants' views. Participants in this study employed in skilled nursing facilities reported wanting to spend more time with each client during the evaluation phase than participants in community-based settings (see Table 37), although this contrasts with the findings of McGilton (2002). Participants in this study primarily employed in skilled nursing facilities also reported evaluating areas that the client identifies as important more frequently than participants employed in mental health (see Table 28) and therefore may want increased time in the evaluation phase to explore these areas. The relationship between participants primarily employed in skilled nursing facilities and increased value and use of client-centered care was also found in the second and third research question. Participants in this study employed in inpatient rehabilitation settings reporting using assessments required by their facility more often than participants who reported they were employed in *other* settings (see Table 37). Although this relationship has not been established in previous research, this is consistent with literature that shows evaluation requirements vary in different treatment settings (Dunn, 1998; Stewart et al., 1989). Participants in this study who were primarily employed in academic settings reported using the Canadian Occupation Performance Measure (COPM) in evaluation more often than participants in any other employment group (see Table 37), which is consistent with the research of Frazer (1995) and Sumison & Smyth (2002). Occupational therapists employed in academic settings may have

greater opportunities to learn about current issues in occupational therapy literature, such as the client-centered assessments available. In this study, more participants employed in acute care felt that the medical model guides their occupational therapy practice than participants employed in mental health and outpatient rehabilitation (see Table 37), which is consistent with the findings of Gage (1994). Therefore, occupational therapists employed in an acute care environment may more closely adhere to the medical model due to the medical fragility of the clientele.

Client issues. Multiple supports to client-centered care were also found in the literature. Although the literature has shown that a major barrier to client-centered practice is disagreement between the therapist and client about the goals for intervention (Clark et al., 1993; Law et al., 1995), the vast majority of participants in this study disagreed (see Table 29). The majority of the participants in this study reported that it is not difficult to separate personal and professional values from client values (see Table 29) which contrasts with the findings of Law et al. (1995). Although multiple studies have found that practitioners report that using a client-centered approach gives too much power to the client (Hobson, 1996; Law et al., 1995; Vander Henst, 1997), the majority of participants in this study disagreed (see Table 29). The majority of participants in this study reported that practicing client-centered care did not involve paying less attention to their clients' medical diagnosis (see Table 29), which contrasts with the findings of Stewart et al. (1989). The findings of this study may also reflect social change that is moving from a more medically focused model of practice to a more preventative and client-centered model (Jongbloed & Wendland, 2002).

Most of the participants in this study reported it was not difficult to use client-centered care with clients of different gender or culture (see Table 29). Although this contrasts with the findings of Frazer (1995), this is consistent with the findings of Sumison (2000). The majority of the participants in this study did not feel it was difficult to assess their clients' ability to choose their own goals and by assumption choose to involve or not involve them in the goal setting process (see Table 29) although this contrasts with previous research (Hobson, 1996; Law et al., 1995). These results may also reflect why participants in this study employed in mental health facilities, where client judgment and insight may be impaired, report evaluating areas that the client identifies as important less frequently than participants employed in home health (see Table 28).

Gender. In this study, American occupational therapists' perceptions of supports/barriers to client-centered care and its incorporation into the evaluation process was influenced by gender. Male participants in this study reported that it is easier to make treatment decisions for their clients as compared to female participants (see Table 30) which supports the findings of Law & Britten (1995) and Valentine (2001). However, more female participants in this study felt that their clients are reluctant to assume responsibility for their own care than male participants (see Table 30) which contradicts this research. Also in this study, male participants felt fewer client-centered assessments are available than did female participants (see Table 30). Similarly, more female participants in this study felt that their primary place of employment supported client-centered care than male participants (see Table 30). No previous researchers addressed either of these two questions and the results of this study suggest that gender perceptions may need to be further explored in the future.

Age and years of experience. In this study, American occupational therapists' perceptions of supports/barriers to client-centered care and its incorporation into the evaluation process was also affected by age. Younger participants reported learning about client-centered care in their occupational therapy curriculum more so than older participants (see Table 32) and younger participants in this study also felt that fewer assessments are client-centered (see Table 32). The link between age and familiarity with client-centered care has been established (Toomey et al., 1995) and it is logical to expect that younger participants would also be more familiar with the amount of client-centered assessments available. This also supports the findings of the second and third research question which found that therapists with less years of experience valued and used a client-centered approach more frequently than therapists with more experience. It can be hypothesized that occupational therapists with less experience have more recent training, are more familiar with using a client-centered approach in practice, and therefore perceive fewer barriers to its implementation.

American occupational therapists' years of experience also influenced the perceptions of supports/barriers to client-centered care and its incorporation into the evaluation process in this study. Participants in this study with greater years of experience found it more difficult to separate personal and professional values from client values, were less likely to use the Canadian Occupation Performance Measure (COPM) in evaluation, and reported learning less about client-centered care in their occupational therapy curriculum than clients with fewer years of experience (see Table 33). Although this contradicts the research of Frazer (1995), Levenstein et al., (1986), and Sumison & Smyth, (2000) these findings support the findings of Toomey et al. (1995).

Specialty certification and level of education. In this study, American occupational therapists' perception of supports/barriers to client-centered care and its incorporation into the evaluation process was also affected by highest level of education. Participants in this study with higher levels of education reported being more familiar with client-centered care and also reported learning about client-centered care in their occupational therapy curriculum more often than clients with less formal education (see Table 35), which is consistent with the literature (Frazer, 1995; Levenstein et al., 1986; Sumison & Smyth, 2000). Similarly, participants in this study with less formal education reported finding it easier to make treatment decisions for their clients than participants with higher levels of education (see Table 35) which is also consistent with the research findings of Sumison & Smyth (2000). In this study, participants with less formal education reported that the medical model guides their occupational therapy practice more so than participants with higher levels of education (see Table 35). It may be that therapists with less formal education place greater focus on medically based coursework rather than theoretical coursework often learned in advanced training.

Similarly, participants in this study with specialty certification reported that the medical model guides their occupational therapy practice more so than participants without specialty certification (see Table 31). This may be due to the fact that specialty certification often heavily revolves around a medical basis of anatomy and physiology, such as certified hand therapy and neurorehabilitation, and participants in this study with specialty certification may be more likely follow a medical model in practice.

Duration of occupational therapy treatment and number of clients seen daily. In this study, American occupational therapists' perceptions of supports/barriers to client-

centered care and its incorporation into the evaluation process was influenced by average duration of client treatment. Participants with a shorter average duration of client treatment reported wanting to spend more time with each client during the evaluation phase and use assessments that are required by their facility less often than therapists with a longer average duration of client treatment (see Table 36) which is consistent with the findings of Kramer (1997) and McCracken et al. (1983). These results are consistent with third research question which also found a relationship between shorter client treatment time and increased use of client-centered approaches.

No significant relationships were found between average number of clients seen in a day and supports/barriers of client-centered care in this study (see Table 34) which contrasts with findings in the literature (Ersser, 1996; Ku, 1993; McCracken et al., 1983). Therefore, the average number of clients seen daily by American occupational therapists in this study did not affect their perception of supports/barriers to client-centered care and incorporation into the evaluation phase.

In summary, American occupational therapists in this study are aware of client-centered care and have a desire to use it. The definition of choice focuses on a client-partnership/collaboration, advocating with and for the client in all stages of the therapeutic process. Time constraints in specific settings, higher levels of experience, older age of therapists, less formal education and in some instances lack of specialty certification were factors that were most related to decreased reported use of client-centered care. Few barriers to implementation of client-centered care during evaluation were identified which included lack of formal education of client-centered care, the clients reluctance to assume responsibility for their care, clients preference to be told

what their problems are, easier to make treatment decisions for clients, and using assessments required by the facility.

Chapter 6: Summary, Conclusions, and Recommendations

Overall, American occupational therapists who participated in this study viewed client-centered care as a collaborative partnership between client and therapist throughout evaluation, treatment, and discharge. The participants reported tenets of client-centered care as valuable in practice, supported on multiple levels, having limited barriers, and appropriate and frequently used in the evaluation phase. In this study, parts of the evaluation phase that were reported as less appropriate for client involvement and less frequently involving the client included the client determining contexts that support and inhibit engagement in occupations, the client determining supports and barriers to performance, the client establishing strengths and weaknesses in performance, and the client collaborating with the therapist in choosing the intervention approach. However, this study would need to be completed with a larger sample of occupational therapists to generalize results. These findings can guide further research to investigate clinical usage of client-centered care, comparing and contrasting views of American occupational therapists with their clients, international occupational therapists, and other health disciplines, and help organizations and facilities to better define and implement a client-centered model of practice.

Most of the research analyzed in the literature review and the discussion section described studies on client-centered care from the last three decades, conducted outside the United States, and/or in health fields other than occupational therapy. Due to rapidly changing health care models, emphasis on cost effectiveness, and reimbursement, studies from only a few years ago may not accurately reflect how client-centered care is currently implemented in the evaluation phase. Similarly, differences in health care systems

between countries may not make research from Canada, Australia, and Britain applicable to occupational therapy within the United States. Also, the challenges of client-centered care faced in nursing, social work, and physiatry are potentially quite different from the experiences of occupational therapists. All of these points may account for the many discrepancies found between the literature and the findings of this study. However this makes up to date research about client-centered care evaluations in the United States even more crucial.

This study solely examined occupational therapists' perceptions of client-centered care, its supports and barriers, and appropriateness and frequency of use in the evaluation phase. Similarly, the majority of research examining the utilization of client-centered care in practice is based on therapists' reports. As past research has shown, practitioners' perceived utilization of client-centered care might differ from actual clinical use of client-centered care (Clark, Scott, & Krupa, 1993). To gain greater insight into the incorporation of client-centered care into practice, future research can measure occupational therapists' perceptions of use and compare to actual client involvement in the evaluation phase.

Past research has similarly shown that practitioners' perceptions of the client-centeredness of evaluation and treatment can differ from their clients' perspectives (Clark, Scott, & Krupa, 1993). Although a qualitative study comparing therapist and client perceptions of the usage of client-centered care has been completed in Canada (Rebeiro, 2000), no published research to date examining this relationship has been conducted in the United States. Therefore, it is important for future research to qualitatively and quantitatively contrast and compare American occupational therapists'

and clients' feelings toward the usage of client-centered care in the evaluation and treatment process.

Although studies have shown the effectiveness of client-centered care in the domain of occupational therapy (Law et al., 1995), few have been conducted in the United States. Due to differing healthcare models and reimbursement systems, it is difficult to transfer and apply these findings in the United States. While this study exclusively examined the perceptions of the American occupational therapists, future research could contrast and compare these findings to occupational therapists practicing around the world. Similarly, no research has examined the usage of client-centered care among other health science professions such as physical therapy and speech language pathology. This information could potentially assist health care practitioners to understand and adopt a more client-centered model of practice.

Future studies can use this information to examine how professional organizations and healthcare facilities can incorporate and adopt a more client-centered model of practice. Understanding how to increase supports and decrease barriers to client-centered care can assist in creating guidelines for client-centered practice during each stage of therapeutic intervention. With support from the facility, these guidelines can provide practitioners with a concrete means to improve client involvement, increasing the use of client-centered care. Past research has shown that client-centered care can lead to increased client satisfaction and decreased costs (Dunst et al., 1994; Greenfield et al., 1985; Stewart et al., 1989). Therefore a client-centered model built into an organization's structure could not only improve client care, but also benefit administrative and general operations.

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Appendix A

ALL-COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH
COVER PAGE

Investigators: Lauren Roth, OTS

Department: Occupational Therapy

Telephone: (607) 272-1678 (917) 881-2325
(Campus) (Home)

Project Title: Client-centered evaluation in American occupational therapy

Abstract: (Limit to space provided)

According to the *Occupational Therapy Practice Framework*, "occupational therapists and occupational therapy assistants focus on assisting people to engage in daily life activities they find meaningful and purposeful" (2002, p.4). Incorporating client values into evaluation and intervention, making the therapeutic process personally meaningful and purposeful, is the essence of client-centered care. Several studies have suggested that client-centered practice has been associated with improved client outcomes, such as satisfaction and compliance (Sumison, 1999). Occupational therapy has progressively integrated client-centered views into framework for practicing occupational therapists in the United States, Canada, Britain, and beyond (Hong, Pearce & Withers, 2000).

Theoretical models of practice have also emphasized the integration of occupations and client-centeredness to guide the treatment process such as the Occupational Performance Model, Model of Human Occupations, Occupational Adaptation Model, and the Person-Environment-Occupational Performance Model. Although the importance of the client-centered model has been incorporated into theory, medical reimbursement systems can often be more influential in guiding practice. The emphasis on the medical model had shifted occupational therapy to focus less on work, play, and leisure, and more on physical aspects of occupation (Jongbloed & Wendland, 2002). Many studies have shown the effectiveness of client-centered occupational intervention with multiple populations. Because assessments have the potential to guide practice, using a client-centered evaluation could re-emphasize the client priorities in intervention, possibly leading to faster and/or more successful outcomes.

Initial assessments are used to establish a baseline of performance and document client change over the course of therapy. Therefore they are essential for reimbursement and in determining if therapeutic intervention was successful. Using a client-centered approach in assessments involves the client in the decision-making process, encourages autonomy, and lets them direct the course of therapy (Hong, Pearce, & Withers, 2000). However, most standardized functional assessments do not address aspects of task performance that are of central importance to the client, and these issues therefore tend to be disregarded in treatment (Fisher, 1993). Although there is an abundance of research demonstrating the significance of using a meaningful, client-centered focus in occupational therapy, as well identifying the importance of functional assessments, there is limited discussion of incorporating meaningful, client-centered activity into assessments.

Purpose: The purpose of this study is to evaluate how American occupational therapists incorporate concepts of client-centered care into the evaluation process.

Proposed Date of Implementation: Commencing Oct. 1st, 2003 for one year

Lauren Roth, Sue Leicht, & Marilyn Kane
Print or type name of principle investigator and faculty advisor

Signature (use blue ink) Principle Investigator and Faculty advisor

ALL-COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH
CHECKLIST

Project Title: Client-centered evaluation in American occupational therapy

Investigator(s): Lauren Roth, OTS

Investigator Use	HSR Use Only	Items for Checklist
X		1. General Information
X		2. Related experience of investigator(s)
X		3. Benefits of the study
X		4. Description of subjects
X		5. Description of subject participation
X		6. Description of ethical issues/risks of participation
X		7. Description of recruitment of subjects
X		8. Description of how anonymity/confidentiality will be maintained
N/A		9. Debriefing statement
N/A		10. Compensatory follow-up
N/A		11. Appendix A – Recruitment Statement
X		12. Appendix B – Informed Consent Form (or tear-off cover page for anonymous paper and pen/pencil surveys)
X		13. Appendix C – Survey Instrument
X		14. Appendix D – Reminder letter
N/A		15. Appendix E – Glossary to questionnaires, etc.

Items 1-8, 11, and 12 must be addressed and included in the proposal. Items 9, 10, and 13-15 should also be checked if they are appropriate – indicate "NA" if not appropriate. This should be the second page of the proposal.

1. **General Information About the Study**
   a) **Funding:** There are no external sources of funding for this project. The Ithaca College Occupational Therapy Department and graduate student will meet all costs.
   b) **Location:** The surveys will be sent from Ithaca College and will be completed by individual subjects at their desired location. Data analysis will occur at the Ithaca College Occupational Therapy Department.
   c) **Time Period:** Commencement of the study will take place in October 2003 and continue for one full year.
   d) **Expected Outcomes:** The results of this research will be used to complete a graduate-level thesis. The results may also be presented at a professional conference and eventually published in a professional journal.

2. **Related Experience of the Researcher**

As a graduate occupational therapy student, Lauren Roth has completed coursework in statistics and research design. She was granted the Dana Student Internship in the summer of 2002, mentored by occupational therapy faculty member Carole Dennis in her ongoing research surrounding clinical reasoning development in undergraduate students. Lauren coded data for confidentiality, completed article searches, and performed statistical analyses. She has recently completed a Level II 12-week fieldwork in a sub-acute adult facility.

Marilyn Kane is an assistant professor in the occupational therapy department. She has been an occupational therapist for approximately 30 years. She has been involved in assessment tool and program development (Functional Needs Assessment for Chronic Psychiatric Patients), and the associated analysis of the tool/program effectiveness with that population. She has successfully supervised four graduate student theses and one group research course (six graduate students). She is currently conducting research (with assistant professor Susan Leicht of Ithaca College) on using the Dynavision 2000 to improve occupational performance in post-CVA clients. She is also conducting research (with assistant professor Donna Twardowski) on the effectiveness of using a disability simulation learning experience with occupational therapy students to change attitudes towards individuals with disabilities.

Sue Leicht has been an occupational therapist for 21 years with experience and a Specialty Certification in Neurological Rehabilitation. She has also undertaken several extensive advanced-training courses related to the evaluation and treatment of clients with Cerebral Vascular Accident (CVA)/Stroke. As part of both her undergraduate and graduate studies she has taken several courses in statistics and research design. As a faculty member in occupational therapy she teaches in both the clinical courses related to stroke at both the undergraduate and graduate level and research methods courses. Sue has also been involved in several research projects including the investigation of Reflex Sympathetic Dystrophy in CVA patients and Clinical Reasoning of Occupational Therapists. She is currently conducting research (with assistant professor Marilyn Kane of Ithaca College) on using the Dynavision 2000 to improve occupational performance in post-CVA clients. Sue has conducted other group research projects: one looking at the Hand Function of Children with an experienced and award winning researcher from

Cornell University, the other looking at the relationship of motor return after CVA and functional performance. She is also writing a doctoral research proposal for her doctoral studies at the University of Queensland in the area of upper extremity return after a CVA, evidenced-based practice, and clinical reasoning.

3. **Benefits of the Study**
There will be no direct benefits of this study to the individual participants. The study will provide information about how American occupational therapists perceive client-centered care. It is expected that the results from this research will emphasize the importance of incorporating client values within the evaluation stage. It will also identify supports and barriers to client-centered evaluation.

4. **Description of the Participants**
   a) **Number of participants recruited:**
   At least 300 participants will be surveyed from the American Occupational Therapy Association for this study.
   b) **Characteristics:**
   Although no specific age range is specified for this study, all participants must be practicing therapists that have a bachelors, masters, or doctoral degree in occupational therapy. They must currently work with clients 18 years of age and older.

5. **Description of participation**
Via mail, participants will receive a tear-off informed consent form that explains the purpose of the study as well as possible harm or benefits (see Appendix B), a two-paged, double-sided survey (see Appendix C) and a pre-addressed stamped envelope. The participants will also be informed that by returning the survey, they will be demonstrating informed consent. The survey will be filled out by each individual participant, which will take approximately twenty minutes. The participant will mail the survey back to Ithaca College using the pre-addressed stamped envelope. Please note that the survey tool will be piloted by 5-10 occupational therapists in the community and on faculty at Ithaca College for expert review and may undergo minor changes.

6. **Ethical Issues**
   a) **Risks of participation:**
   There is minimal risk of participation. Participants may be uncomfortable answering some of the questions and can choose to not answer these questions and/or not return the survey.
   b) **Informed consent:**
   Informed consent is assumed by the participant returning the survey (Appendix B).

7. **Recruitment of Participants**
   a) **Recruitment Procedures:**
   A randomized member list will be purchased from the American Occupational Therapy Association that includes the name and addresses of practicing occupational therapists who currently work with an adult population. A tear-off informed consent form (Appendix B), a copy of the survey (Appendix C), and a pre-addressed stamped

envelope that displays the participant's randomized code number, will be sent to each participant requesting their involvement in the study.
The following methodologies will be used to increase response rate: Two weeks later, a reminder letter will be sent to the participants who have not yet returned the survey (Appendix D). Those who have not responded to the survey in the following two weeks will be sent another copy of the survey. A coding system will be used to track participant surveys that have been returned (see 8 for details).

b) Inducement to Participate:

No inducement to participate will be provided in the study.

8. Confidentiality/Anonymity of Responses

A numeric coding system will be developed to ensure the all participant surveys responses remain anonymous. Each participant will be randomly assigned a code number linked to his or her mailing address. Each participant's code number will be placed on the pre-addressed stamped envelope, not on the individual survey. A research assistant in the occupational therapy department will document all envelope codes, open these envelopes, and give the unmarked surveys to the researcher. The research assistant will use the coding information to track participants who have and have not returned the survey. This coding system will not be available to the researcher and will be destroyed by the research assistant at the end of the study.

9. Debriefing

Participants will not be deceived as part of this study, so there will be no structured debriefing. Participants will be able to contact the researcher by phone or e-mail at any time during or after the study about the procedures or to obtain a copy of the results of the study.

10. Compensatory Follow-Up

No structured follow-up plan is needed or offered for this study.

Appendix B

October 22, 2003

Dear fellow occupational therapist,

My name is Lauren Roth and I am a graduate student in Occupational Therapy at Ithaca College in Ithaca, New York. As part of my graduate thesis, I am conducting a research study investigating how American occupational therapists incorporate concepts of client-centered care into the evaluation process. Client-centered care has received a lot of attention in the OT literature during the past decade. I hope that this study will reveal how these concepts are used in your practice. You have been randomly selected from current AOTA members to take part in this survey. All participants in this study are practicing occupational therapists that have a bachelors, masters, or doctoral degree in occupational therapy and currently work with clients 18 years of age and older.

The survey will ask you questions on your thoughts and opinions in several different issues pertaining to client-centered care and how it relates to the evaluation phase in occupational therapy. The survey should take approximately 25 minutes for you to fill out and return. A pre-paid envelope has been included for your convenience. If at anytime a question causes you to feel uncomfortable, you may choose to not answer it. All of your answers will remain anonymous throughout the data analysis.

Your prompt completion and return of this survey is essential to this study. Sending the completed survey back will imply your informed consent to participate. If you have any questions or concerns regarding this study, please contact me at (607) 272-1678 or e-mail at lroth1@ithaca.edu. I will be extremely grateful if you take the time to complete this survey adding any comments you feel necessary. Thank you for your time and energy.

Sincerely,

Lauren Roth, OTS
Ithaca College

11. Please circle the number in each row that most closely reflects your views about the appropriateness of each method and how often you use each method in occupational therapy evaluation using the scales below:

	Appropriateness for OT evaluation **1 – Very Appropriate** **2 – Appropriate** **3 – Inappropriate** **4 – Very Inappropriate**				I use this method in OT evaluation **1 – Frequently** **2 – Sometimes** **3 – Rarely** **4 – Never**			
a. Client establishes current concerns in daily activities and occupation	1	2	3	4	1	2	3	4
b. Client pinpoints areas of occupation that are successful and areas causing problems or risks	1	2	3	4	1	2	3	4
c. Client determines the contexts that support and inhibit engagement in occupations	1	2	3	4	1	2	3	4
d. Client identifies personal values and interests	1	2	3	4	1	2	3	4
e. Client establishes previous pattern of engagement in occupations	1	2	3	4	1	2	3	4
f. Client chooses priorities and targeted outcomes	1	2	3	4	1	2	3	4
g. Therapist observes client performance in desired occupations	1	2	3	4	1	2	3	4
h. Therapist assesses areas that the client identifies as important	1	2	3	4	1	2	3	4
i. Client determines supports and barriers to performance	1	2	3	4	1	2	3	4
j. Client establishes strengths and weaknesses in performance	1	2	3	4	1	2	3	4
k. Client selects goals with therapist	1	2	3	4	1	2	3	4
l. Client collaborates with therapist in choosing the intervention approach	1	2	3	4	1	2	3	4

Thank you for your participation. Please mail this survey back using the pre-addressed envelope at your earliest convenience.

Client-centered Evaluation in American Occupational Therapy

Please place a check mark on the appropriate line or fill in the blank.

1. Gender: ☐ Male ☐ Female
2. Age: _____
3. Years of clinical experience in occupational therapy: _____
4. Highest level of education:
   - ☐ Associates
   - ☐ Bachelors (OT)
   - ☐ Masters (entry-level OT)
   - ☐ Masters (post-professional OT)
   - ☐ Masters (other)
   - ☐ Doctorate (OT)
   - ☐ Doctorate (other)
5. Specialty Certification:
   - ☐ Pediatric
   - ☐ Neurorehabilitation
   - ☐ Geriatric
   - ☐ Other (please specify)_____
6. Primary place of employment:
   - ☐ Home Health
   - ☐ Inpatient Rehabilitation
   - ☐ Outpatient Rehabilitation
   - ☐ Mental Health
   - ☐ Skilled Nursing
   - ☐ Community-based
   - ☐ Acute Care
   - ☐ Academic
   - ☐ Other (please specify)_____
7. Average duration of clients' occupational therapy treatment in primary place of employment:
   - ☐ Under 1 week
   - ☐ Under 1 month
   - ☐ 1-3 months
   - ☐ Over 3 months
8. Average number of clients you see in a day: _____
9. Rank the following definitions of client-centered care in order of appropriateness for use in occupational therapy with #1 being the most appropriate and #4 being the least appropriate:

__ An orientation that takes into account the desires of clients when designing and implementing intervention

__ A collaboration that exists between client and therapist when determining priorities and creating goals that address the desired targeted outcomes

__ A treatment method in which the client is the director of care and executes power over decisions through all stages of therapeutic intervention

__ A relationship that empowers the client to engage in occupation by recognizing the client's experience and knowledge, with the therapist advocating with and for clients in meeting their needs

10. Please circle the number in each row that most closely reflects your views using the scale below:

1 – Strongly Disagree **4 – Agree Somewhat**
2 – Disagree **5 – Agree**
3 – Disagree Somewhat **6 – Strongly Agree**

1. I am familiar with client-centered care	1	2	3	4	5	6
2. Good occupational therapy should be client-centered	1	2	3	4	5	6
3. Clients and I often do not agree on therapeutic goals	1	2	3	4	5	6
4. I would like to spend more time with each client during the evaluation phase	1	2	3	4	5	6
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	1	2	3	4	5	6
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	1	2	3	4	5	6
7. I find it difficult to separate my personal and professional values from client values	1	2	3	4	5	6
8. I use assessments that are required by my facility	1	2	3	4	5	6
9. Clients prefer me to tell them what their problems are	1	2	3	4	5	6
10. Using a client-centered approach gives too much power to the client	1	2	3	4	5	6
11. I learned about client-centered care in my occupational therapy curriculum	1	2	3	4	5	6
12. Initial evaluations guide the rest of the intervention process	1	2	3	4	5	6
13. It is important to create a partnership with my clients	1	2	3	4	5	6
14. I learned about client-centered care in continuing education workshops	1	2	3	4	5	6
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	1	2	3	4	5	6

16. The medical model makes it difficult to incorporate concepts of client-centered care	1	2	3	4	5	6
17. I do not have enough time to obtain client values and priorities during evaluation	1	2	3	4	5	6
18. I perform client-centered evaluations	1	2	3	4	5	6
19. I find it difficult to assess a client's ability to choose their own goals	1	2	3	4	5	6
20. Client input is essential to the evaluation process	1	2	3	4	5	6
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	1	2	3	4	5	6
22. The medical model guides my occupational therapy practice	1	2	3	4	5	6
23. Few assessments are client-centered	1	2	3	4	5	6
24. I would like to perform evaluations that are more client-centered	1	2	3	4	5	6
25. A partnership between client and therapist increases client participation and self-efficacy	1	2	3	4	5	6
26. Reimbursement guides my goal selection for treatment	1	2	3	4	5	6
27. I find it difficult to use client-centered care with clients of different genders or cultures	1	2	3	4	5	6
28. My primary place of employment supports client-centered care	1	2	3	4	5	6
29. I find it easier to make treatment decisions for my clients	1	2	3	4	5	6
30. Identifying the values and priorities of the client should be a part of the evaluation process	1	2	3	4	5	6
31. I would like to know more about the client-centered approach	1	2	3	4	5	6
32. Client-centered care leads to improved client satisfaction and improved outcomes	1	2	3	4	5	6
33. My clients are reluctant to assume responsibility for their own care	1	2	3	4	5	6
34. I want to use a client-centered approach	1	2	3	4	5	6

Appendix D

November 20, 2003

Dear fellow occupational therapist,

My name is Lauren Roth and I am a graduate student in Occupational Therapy at Ithaca College in Ithaca, New York. As part of my graduate thesis, I am conducting a research study investigating how American occupational therapists incorporate concepts of client-centered care into the evaluation process. About two weeks ago, I sent you a questionnaire about client-centered evaluation in American occupational therapy. Your name was randomly selected from current AOTA members to take part in this survey. All participants in this study are practicing occupational therapists that have a bachelors, masters, or doctoral degree in occupational therapy and currently work with clients 18 years of age and older.

If you have already returned the questionnaire, please accept my sincere thanks. If not, please do so at your convenience. Because it was sent to only a small number of occupational therapists, your answers are necessary to accurately represent the opinions and experiences of occupational therapists. The survey should take approximately 25 minutes for you to fill out and return. A pre-paid envelope has been included for your convenience. If at anytime a question causes you to feel uncomfortable, you may choose to not answer it. All of your answers will remain anonymous throughout the data analysis.

Your prompt completion and return of this survey is essential to this study. Sending the completed survey back will imply your informed consent to participate. If you have any questions or concerns regarding this study, please contact me at (607) 272-1678 or e-mail at lroth1@ithaca.edu. I will be extremely grateful if you take the time to complete this survey adding any comments you feel necessary. Thank you for your time and energy.

Sincerely,

Lauren Roth, OTS
Ithaca College

Table 1

Survey question specifications

Number	Rationale	Reference
1	Research has shown that women tend to put greater focus on their client's emotional and psychological needs, naturally leading to client-centered practice.	Hall & Roter, 1998; Law & Britten, 1995; Valentine, 2001
2&3	Therapists who have more recently been trained may be more familiar with current methods of practice, such as the client-centered approach.	Toomey et al., 1995
4&5	Therapists with more education and training in fields of occupational therapy have greater opportunities to gain knowledge of client-centered care, and may be more likely to incorporate it in practice.	Frazer, 1995; Levenstein et al., 1986; Sumison & Smyth, 2000
6	Certain facilities have been shown to foster more client-centered environments.	Gage, 1994; Sumison & Smyth, 2000; Wilkins et al, 2001
7 & 8	Research has shown that shorter client treatment time inhibits the client-therapist relationship, impeding on client-centered practice.	Kramer, 1997; McCracken et al., 1983

Number	Rationale	Reference
8	The number of clients a therapist sees in a day has been shown to affect incorporation of client-centered care.	Corring & Cook, 1999; Daly, 1993; Ersser, 1996; Kramer, 1997; Ku, 1993
9-1	Client-driven/inspired – Therapist takes client perspectives into account though the therapeutic process, but makes decisions independently.	AOTA, 2002; Law, Baptiste, et al., 1995
9-2	Client-partnership/collaboration - Client and therapist bring their expertise together and become equal partners in the therapeutic process	Fearing et al., 1997
9-3	Client-directed – Client is seen as having the greatest power and is able to make and even override decisions of other professionals	Greenfield, et al., 1985; Sumison & Smyth, 2000
9-4	Client-empowerment – Therapist primary role is to advocate with and for their client in meeting their needs.	Canadian Association of Occupational Therapists, 1997
10-1	Support/barrier: Research has shown that a barrier to client-centered care is a general lack of knowledge in concepts of client-centeredness.	Frazer, 1995; Levenstein et al., 1986
10-2	Perception: If a therapist feels that occupational therapy should be client-centered, they are more likely to incorporate its concepts.	Sumison, 1993

Number	Rationale	Reference
10-3	Support/barrier: Disagreement between the therapist and the client on goals for intervention is a noted barrier to client-centered care.	Clark et al., 1993; Sumison & Smyth, 2000
10-4	Support/barrier: Insufficient time to spend with each client has been cited by therapists as a major barrier to client-centered care in the evaluation phase.	Corring & Cook, 1999; Daly, 1993; Kramer, 1997; McCracken et al., 1983
10-5	Perception: Research suggests that using client-centered approach saves a client from having to return for more in-depth assessments.	Levenstein, 1986
10-6	Support/barrier: Encouragement from employment facilities has been noted to increase client-centered practice in the evaluation phase.	Stewart et al., 1989
10-7	Support/barrier: Research has shown that therapists may find it difficult to separate personal and professional values from client values.	Law, Baptiste, et al., 1995
10-8	Support/barrier: The literature has suggested that if a therapist uses assessments required by a facility, they may not be evaluating what the client directly needs or wants.	Dunn, 1998

Number	Rationale	Reference
10-9	Support/barrier: Research has shown that therapists feel that some clients prefer to be told what their problems are	Jaffe & Kipper, 1982; Schroeder & Bloom, 1979; Wanigrante & Barker, 1995
10-10	Support/barrier: A noted barrier to client-centered care is therapist feeling it gives too much power to the client.	Hobson, 1996; Law, Baptiste, et al., 1995; Vander Henst, 1997
10-11	Support/barrier: Knowledge of client-centered care, gained from coursework in school, is a noted support of client-centered practice.	Stewart et al., 1989
10-12	Perception: The literature suggests that therapists who feel the initial evaluation guides the intervention process, are more likely to incorporate client values.	Hong et al., 2000
10-13	Perception: Research suggests that therapists who think it is important to create a partnership with their client, are more likely to use client-centered practice.	Clark et al., 1993
10-14	Support/barrier: Knowledge of client-centered care gained from continuing education, is a noted support of client-centered practice.	Stewart et al., 1989

Number	Rationale	Reference
10-14	Support/barrier: Knowledge of client-centered care gained from continuing education, is a noted support of client-centered practice.	Stewart et al., 1989
10-15	Support/barrier: The literature has shown that therapists may feel client-centered clinicians attend to the client's agenda because they do not know enough about the disease.	Stewart et al., 1989
10-16	Support/barrier: Dominance of medical model has been shown to impede on use of client-centered practice.	Crowe, 1994; Johnson, 1993; Law, Baptiste, et. al, 1995
10-17	Support/barrier: Insufficient time to spend with each client may inhibit a therapist from obtaining the client's values and priorities in the evaluation phase.	Corring & Cook, 1999; Daly, 1993; Kramer, 1997; McCracken et al., 1983
10-18	Perception: Research has not suggested whether therapists feel they perform client-centered evaluations.	
10-19	Support/barrier: The literature has suggested that therapists find it difficult to determine how capable clients are to participate in client-centered care.	Hobson, 1996

Number	Rationale	Reference
10-20	Perception: Research proposes that if a therapist feels that client input is essential to the evaluation process, they are more likely to use a client-centered approach.	Sumison, 2000
10-21	Support/barrier: The Canadian Occupational Performance Measure (COPM) was designed using a client-centered approach and has been shown to foster a client-centered evaluation.	Donnelly & Carswell, 2002; Mew & Fossey, 1996; Simmons et al., 2000; Toomey, et al., 1995;
10-22	Support/barrier: Dominance of medical model has been shown to have greater influence on practice than concepts of client-centered care.	Crowe, 1994; Johnson, 1993; Law, Baptiste, et al., 1995
10-23	Support/barrier: Occupational therapy literature has noted that a limited number of assessments use a client-centered approach.	Dunn, 1998; Hong et al., 2000
10-24	Perception: Research has not confirmed whether therapists want to perform client-centered evaluations.	
10-25	Perception: Literature has suggested that client-centered care leads to increased client participation and self-efficacy.	Stewart et al., 1989

Number	Rationale	Reference
10-26	Support/barrier: Research has shown that when reimbursement guides goals selection, practitioners are less likely to practice client-centered care.	Lysack & Neufeld, 2003; McColl & Pollock, 2000
10-27	Support/barrier: Differences in culture and gender among therapists and their clients have been suggested to inhibit client centered care practice.	Frazer, 1995; Sumison & Smyth, 2000
10-28	Support/barrier: Support of a client-centered approach by employment facilities has been shown to increase use of client-centered concepts in practice.	Stewart at al., 1989; Wilkins et al., 2001
10-29	Support/barrier: Research has shown that some therapists feel it is easier to make decisions for their clients, discouraging use of client-centered concepts.	Sumison, 1993
10-30	Perception: Identifying the values and priorities of the client during the evaluation process is a basic tenet of client-centered care.	AOTA, 2002; Hong et al., 2000
10-31	Perception: The literature has not identified whether therapists would like to increase their knowledge of client-centered care	

Number	Rationale	Reference
10-32	Perception: Research suggests client-centered practice results in increased client satisfaction and compliance, reduction of concern, symptom reduction, and improved outcomes.	Stewart et al., 1989
10-33	Support/barrier: The literature suggests therapists feel clients are reluctant to assume responsibility for their care, inhibiting a client-centered approach.	Law, Baptiste, et al., 1995
10-34	Perception: Research has not confirmed whether therapists want to use a client-centered approach in practice.	
11-a	a-f: Stages of the occupational profile Identifying the "client's current concerns relative to engaging in occupations and in daily life activities."	AOTA, 2002, p.21
11-b.	Identifying "what areas of occupation are successful, and what areas are causing problems or risks."	AOTA, 2002, p.22
11-c	Identifying "what contexts support engagement in desired occupations, and what contexts are inhibiting engagement."	AOTA, 2002, p.22

Number	Rationale	Reference
11-d	Identifying the "client's occupational history" including "life experiences, values, interests..."	AOTA, 2002, p.22
11-e	Identifying the "client's occupational history" including "previous patterns of engagement in occupations and in daily life activities, and the meanings associated with them."	AOTA, 2002, p.22
11-f	Identifying the "client's priorities and desired targeted outcomes."	AOTA, 2002, p.22
11-g	g-l: Stages of analysis of occupational performance "Observe the client's performance in desired occupations and activities, noting effectiveness of the performance skills and performance patterns"	AOTA, 2002, p.24
11-h	"Select assessments, as needed, to identify and measure more specifically context or contexts, activity demands, and client factors that may influence performance skills and performance patterns."	AOTA, 2002, p.24
11-i	"Interpret the data to identify what supports performance and what hinders performance."	AOTA, 2002, p.24

Number	Rationale	Reference
11-j	"Develop and refine hypotheses about the client's occupational performance strengths and weaknesses."	AOTA, 2002, p.24
11-k	"Create goals in collaboration with the client that address the desired targeted outcomes."	AOTA, 2002, p.24
11-l	"Delineate potential intervention approach or approaches based on best practice and evidence"	AOTA, 2002, p.24

Table 2

Frequencies of definition rank of client-centered care

Definition	Rank	1	2	3	4
Client-driven/inspired	n	43	64	84	65
	%	16.8	25.0	32.8	25.4
Client-partnership/collaboration	n	124	88	37	8
	%	48.2	34.3	14.4	3.1
Client-directed	n	12	21	66	156
	%	4.7	8.2	25.9	61.2
Client-empowerment	n	92	79	66	22
	%	35.5	30.5	25.5	8.5

Note. 1 = Most Appropriate; 4 = Least Appropriate

Table 3

The difference between male and female participants' definition rank of client-centered care

Definition	Mean Rank		*U*	*z*	*p*
	Male	Female			
Client-driven/inspired	117.67	129.22	2799.000	-.799	.424
Client-partnership/collaboration	148.33	126.16	2556.000	-1.602	.109
Client-directed	145.94	125.31	2566.500	-1.592	.111
Client-empowerment	123.95	130.18	3064.500	-.437	.662

Note. $*p < .05$.

Table 4

The difference between participants with and without specialty certification in definition rank of client-centered care

Definition	Mean Rank		*U*	*z*	*p*
	Without	With			
Client-driven/inspired	130.89	124.71	7396.500	-.675	.500
Client-partnership/collaboration	127.86	130.79	7670.500	-.336	.737
Client-directed	133.42	119.45	6876.000	-1.698	.089
Client-empowerment	128.05	133.10	7640.500	-.553	.580

Table 5

The relationship between age and definition rank of client-centered care

Definition	*n*	tau-b	*p*
Client-driven/inspired	252	-.073	.129
Client-partnership/collaboration	253	-.134**	.007
Client-directed	251	.063	.207
Client-empowerment	255	.101*	.036

Note. $*p < .05$. $**p < .01$.

Table 6

The relationship between years of experience in occupational therapy and definition rank of client-centered care

Definition	*n*	tau-b	*p*
Client-driven/inspired	253	-.087	.071
Client-partnership/collaboration	254	-.121*	.014
Client-directed	252	.063	.212
Client-empowerment	256	.141**	.003

Note. *$p < .05$. **$p < .01$.

Table 7

The relationship between average number of clients seen daily and definition rank of client-centered care

Definition	*n*	tau-b	*p*
Client-driven/inspired	237	-.025	.620
Client-partnership/collaboration	238	-.060	.247
Client-directed	236	.041	.429
Client-empowerment	239	.052	.300

Table 8

The relationship between highest level of education and definition rank of client-centered care

Definition	*n*	tau-b	*p*
Client-driven/inspired	254	.051	.370
Client-partnership/collaboration	255	.042	.477
Client-directed	253	-.009	.882
Client-empowerment	257	-.067	.244

Table 9

The relationship between average duration of client occupational therapy treatment in primary place of employment and definition rank of client-centered care

Definition	*n*	tau-b	*p*
Client-driven/inspired	247	-.099	.071
Client-partnership/collaboration	248	.074	.187
Client-directed	246	.118*	.040
Client-empowerment	250	-.024	.662

Note. $*p < .05$.

Table 10

The relationship between primary place of employment and definition rank of client-centered care

Definition	Employment	*n*	Mean rank	χ^2	*p*
Client-driven/inspired	Home Health	27	120.15	3.218	.920
	Inpatient	42	133.17		
	Outpatient	60	120.48		
	Mental Health	14	134.04		
	Skilled Nursing	35	110.49		
	Community	9	131.72		
	Acute	18	123.50		
	Academic	9	136.61		
	Other	31	118.95		
Client-directed	Home Health	27	109.96	17.810*	.023
	Inpatient	43	113.94		
	Outpatient	61	105.05		
	Mental Health	14	164.32		
	Skilled Nursing	35	137.84		
	Community	9	151.11		
	Acute	18	139.44		
	Academic	9	146.33		
	Other	30	126.42		

Definition	Employment	*n*	Mean rank	χ^2	*p*
Client-empowerment	Home Health	27	129.89	10.545	.229
	Inpatient	42	106.38		
	Outpatient	60	130.66		
	Mental Health	14	122.18		
	Skilled Nursing	35	123.87		
	Community	9	75.33		
	Acute	18	128.08		
	Academic	9	134.50		
	Other	30	127.85		
Client-partnership/collaboration	Home Health	28	148.48	11.576	.171
	Inpatient	42	127.44		
	Outpatient	61	130.23		
	Mental Health	14	84.64		
	Skilled Nursing	36	112.21		
	Community	10	120.85		
	Acute	18	118.44		
	Academic	9	100.06		
	Other	30	131.88		

Note. *$p < .05$.

Table 11

Frequencies of perceptions of client-centered care

Perceptions	Rank	1	2	3	4	5	6
2. Good occupational therapy	n	1	0	1	14	112	136
should be client-centered	%	.4	0	.4	5.3	42.4	51.5
5. Using a client-centered approach	n	8	34	48	81	71	11
saves my clients from having to	%	3.2	13.4	19.0	32.0	28.1	4.3
return for more in-depth							
assessments							
12. Initial evaluations guide the rest	n	2	17	24	95	90	36
of the intervention process	%	.8	6.4	9.1	36.0	34.1	13.6
13. It is important to create a	n	0	0	1	7	78	179
partnership with my clients	%	0	0	.4	2.6	29.4	67.5
18. I perform client-centered	n	8	9	18	96	99	30
evaluations	%	3.1	3.5	6.9	36.9	38.1	11.5
20. Client input is essential to the	n	1	1	3	10	85	166
evaluation process	%	.4	.4	1.1	3.8	32.0	62.4
24. I would like to perform	n	4	20	28	84	86	32
evaluations that are more client-	%	1.6	7.9	11.0	33.1	33.9	12.6
centered							
25. A partnership between client	n	0	0	1	21	107	137
and therapist increases client	%	0	0	.4	7.9	40.2	51.5
participation and self-efficacy							

Perceptions	Rank	1	2	3	4	5	6
30. Identifying the values and	n	0	0	2	15	103	145
priorities of the client should be a	%	0	0	.8	5.7	38.9	54.7
part of the evaluation process							
31. I would like to know more	n	7	12	22	74	92	54
about the client-centered approach	%	2.7	4.6	8.4	28.4	35.2	20.7
32. Client-centered care leads to	n	0	0	6	35	113	107
improved client satisfaction and	%	0	0	2.3	13.4	43.3	41.0
improved outcomes							
34. I want to use a client-centered	n	1	3	2	56	121	75
approach	%	.4	1.2	.8	21.7	46.9	29.1

Note. 1 = Strongly disagree; 2 = Disagree; 3 = Disagree Somewhat; 4 = Agree Somewhat; 5 = Agree; 6 = Strongly Agree.

Table 12

The difference between male and female participants' perceptions of client-centered care

Perceptions	Mean		*t*	*df*	*p*
	Male	Female			
2. Good occupational therapy should be client-centered	5.24	5.46	-1.667	261	.097
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	3.93	3.80	.559	250	.576
12. Initial evaluations guide the rest of the intervention process	4.28	4.38	-.509	261	.611
13. It is important to create a partnership with my clients	5.55	5.65	-.910	262	.364
18. I perform client-centered evaluations	4.21	4.40	-.918	257	.359
20. Client input is essential to the evaluation process	5.57	5.54	.219	263	.827
24. I would like to perform evaluations that are more client-centered	4.10	4.30	-.889	251	.375
25. A partnership between client and therapist increases client participation and self-efficacy	5.33	5.44	-.861	263	.390

Perceptions	Mean		*t*	*df*	*p*
	Male	Female			
30. Identifying the values and priorities of the client should be a part of the evaluation process	5.50	5.47	.206	262	.837
31. I would like to know more about the client-centered approach	4.53	4.51	.106	258	.916
32. Client-centered care leads to improved client satisfaction and improved outcomes	5.14	5.24	-.691	258	.490
34. I want to use a client-centered approach	4.83	5.04	-1.237	255	.217

Table 13

The relationship between participants with and without specialty certification and perceptions of client-centered care

Perceptions	Mean		*t*	*df*	*p*
	Without	With			
2. Good occupational therapy should be client-centered	5.41	5.49	-.954	262	.341
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	3.83	3.78	.321	251	.749
12. Initial evaluations guide the rest of the intervention process	4.33	4.45	-.879	262	.380
13. It is important to create a partnership with my clients	5.63	5.66	-.423	263	.673
18. I perform client-centered evaluations	4.33	4.46	-.927	258	.355
20. Client input is essential to the evaluation process	5.49	5.61	-1.360	264	.175
24. I would like to perform evaluations that are more client-centered	4.34	4.17	1.099	196.362	.273
25. A partnership between client and therapist increases client participation and self-efficacy	5.43	5.43	.055	264	.956

Perceptions	Mean		*t*	*df*	*p*
	Without	With			
30. Identifying the values and priorities of the client should be a part of the evaluation process	5.48	5.48	.004	263	.996
31. I would like to know more about the client-centered approach	4.51	4.51	-.004	259	.996
32. Client-centered care leads to improved client satisfaction and improved outcomes	5.21	5.26	-.540	259	.590
34. I want to use a client-centered approach	4.97	5.07	-.951	256	.342

Table 14

The relationship between age and perceptions of client-centered care

Perceptions	*n*	*r*	*p*
2. Good occupational therapy should be client-centered	260	-.030	.626
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	249	-.054	.398
12. Initial evaluations guide the rest of the intervention process	260	.091	.143
13. It is important to create a partnership with my clients	261	-.044	.480
18. I perform client-centered evaluations	256	.007	.913
20. Client input is essential to the evaluation process	262	-.071	.254
24. I would like to perform evaluations that are more client-centered	251	.026	.686
25. A partnership between client and therapist increases client participation and self-efficacy	262	.004	.949
30. Identifying the values and priorities of the client should be a part of the evaluation process	261	-.091	141
31. I would like to know more about the client-centered approach	258	.015	.806
32. Client-centered care leads to improved client satisfaction and improved outcomes	257	.035	.575
34. I want to use a client-centered approach	255	.052	.407

Table 15

The relationship between years of experience in occupational therapy and perceptions of client-centered care

Perceptions	*n*	*r*	*p*
2. Good occupational therapy should be client-centered	261	-.061	.325
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	250	-.060	.346
12. Initial evaluations guide the rest of the intervention process	261	082	.188
13. It is important to create a partnership with my clients	262	-.071	.251
18. I perform client-centered evaluations	257	-.084	.182
20. Client input is essential to the evaluation process	263	-.134*	.030
24. I would like to perform evaluations that are more client-centered	252	.000	.995
25. A partnership between client and therapist increases client participation and self-efficacy	263	-.117	.058
30. Identifying the values and priorities of the client should be a part of the evaluation process	262	-.155*	.012
31. I would like to know more about the client-centered approach	258	-.068	.277
32. Client-centered care leads to improved client satisfaction and improved outcomes	258	-.084	.179

Perceptions	*n*	*r*	*p*
34. I want to use a client-centered approach	255	-.006	.930

Note. $*p < .05$.

Table 16

The relationship between average number of clients seen daily and perceptions of client-centered care

Perceptions	*n*	*r*	*p*
2. Good occupational therapy should be client-centered	244	-.007	.910
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	233	-.027	.681
12. Initial evaluations guide the rest of the intervention process	244	.143*	.025
13. It is important to create a partnership with my clients	245	.008	.903
18. I perform client-centered evaluations	240	-.124	.056
20. Client input is essential to the evaluation process	246	-.087	.173
24. I would like to perform evaluations that are more client-centered	236	.040	.542
25. A partnership between client and therapist increases client participation and self-efficacy	246	.034	.591
30. Identifying the values and priorities of the client should be a part of the evaluation process	245	-.011	.858
31. I would like to know more about the client-centered approach	243	-.095	.142
32. Client-centered care leads to improved client satisfaction and improved outcomes	241	-.102	.114

Perceptions	*n*	*r*	*p*
34. I want to use a client-centered approach	239	-.134*	.038

Note. *$p < .05$.

Table 17

The relationship between highest level of education and perceptions of client-centered care

Perceptions	*n*	tau-b	*p*
2. Good occupational therapy should be client-centered	262	.011	.858
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	252	-.132*	.020
12. Initial evaluations guide the rest of the intervention process	262	.008	.880
13. It is important to create a partnership with my clients	263	.017	.781
18. I perform client-centered evaluations	259	.082	.149
20. Client input is essential to the evaluation process	264	.060	.316
24. I would like to perform evaluations that are more client-centered	253	.038	.502
25. A partnership between client and therapist increases client participation and self-efficacy	264	.010	.871
30. Identifying the values and priorities of the client should be a part of the evaluation process	263	.049	.410
31. I would like to know more about the client-centered approach	259	-.124*	.028
32. Client-centered care leads to improved client satisfaction and improved outcomes	259	.066	.261

Perceptions	*n*	tau-b	*p*
34. I want to use a client-centered approach	257	.074	.206

Note. $*p < .05$

Table 18

The relationship between average duration of client occupational therapy treatment in primary place of employment and perceptions of client-centered care

Perceptions	*n*	tau-b	*p*
2. Good occupational therapy should be client-centered	255	.027	.635
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	244	-.108*	.048
12. Initial evaluations guide the rest of the intervention process	255	-.061	.261
13. It is important to create a partnership with my clients	256	.027	.646
18. I perform client-centered evaluations	251	-.007	.895
20. Client input is essential to the evaluation process	257	-.051	.370
24. I would like to perform evaluations that are more client-centered	245	-.046	.404
25. A partnership between client and therapist increases client participation and self-efficacy	257	-.066	.248
30. Identifying the values and priorities of the client should be a part of the evaluation process	256	-.047	.412
31. I would like to know more about the client-centered approach	253	-.026	.626
32. Client-centered care leads to improved client satisfaction and improved outcomes	252	-.040	.475

Perceptions	*n*	tau-b	*p*
34. I want to use a client-centered approach	249	-.008	.880

Note. $*p < .05$.

Table 19

The relationship between primary place of employment and perceptions of client-centered care

Definition		*SS*	*df*	*MS*	*F*	*p*
2. Good occupational therapy should be client-centered	Between Groups	4.140	8	.517	1.128	.345
	Within Groups	111.900	244	.459		
	Total	116.040	252			
5. Using a client-centered approach saves my clients from having to return for more in-depth assessments	Between Groups	11.770	8	1.471	1.039	.407
	Within Groups	331.350	234	1.416		
	Total	343.119	242			
12. Initial evaluations guide the rest of the intervention process	Between Groups	7.788	8	.974	.816	.589
	Within Groups	291.026	244	1.193		
	Total	298.814	252			
13. It is important to create a partnership with my clients	Between Groups	2.492	8	.311	1.032	.412
	Within Groups	73.906	245	.302		
	Total	76.398	253			
18. I perform client-centered evaluations	Between Groups	7.012	8	.877	.753	.644
	Within Groups	279.253	240	1.164		
	Total	286.265	248	.486		

Definition		*SS*	*df*	*MS*	*F*	*p*
20. Client input is essential to the evaluation process	Between Groups	3.585	8	.448	.937	.466
	Within Groups	117.646	246	.478		
	Total	121.231	254			
24. I would like to perform evaluations that are more client-centered	Between Groups	25.220	8	3.152	2.477*	.013
	Within Groups	297.751	234	1.272		
	Total	322.971	242			
25. A partnership between client and therapist increases client participation and self-efficacy	Between Groups	2.390	8	.299	.683	.706
	Within Groups	107.547	246	.437		
	Total	109.937	254			
30. Identifying the values and priorities of the client should be a part of the evaluation process	Between Groups	2.917	8	.365	.874	.539
	Within Groups	102.189	245	.417		
	Total	105.106	253			
31. I would like to know more about the client-centered approach	Between Groups	7.348	8	.918	.627	.755
	Within Groups	353.008	241	1.465		
	Total	260.356	249			

Definition		*SS*	*df*	*MS*	*F*	*p*
32. Client-centered care leads to improved client satisfaction and improved outcomes	Between Groups	6.616	8	.827	1.436	.182
	Within Groups	138.840	238	.576		
	Total	145.456	246			
34. I want to use a client-centered approach	Between Groups	6.274	8	.784	1.087	.373
	Within Groups	171.710	238	.721		
	Total	177.984	246			

Note. $*p < .05$.

Table 20

Frequencies of appropriateness and use of client-centered care in evaluation

Evaluation		Rank	1	2	3	4
a. Client establishes concerns in	Appropriate	n	208	46	2	10
daily activities and occupation		%	78.2	17.3	.8	3.8
	Frequency	n	222	33	5	5
		%	83.8	12.5	1.9	1.9
b. Client pinpoints areas of	Appropriate	n	175	76	4	10
occupation that are successful and		%	66.0	28.7	1.5	3.8
areas that are causing problems or	Frequency	n	163	81	13	6
risks		%	62.0	30.8	4.9	2.3
c. Client determines the contexts	Appropriate	n	86	135	27	9
that support and inhibit engagement		%	33.5	52.5	10.5	3.5
in occupations	Frequency	n	70	123	53	10
		%	27.3	48.0	20.7	3.9
d. Client picks personal values and	Appropriate	n	177	71	7	11
interests		%	66.5	26.7	2.6	4.1
	Frequency	n	176	73	11	4
		%	66.7	27.7	4.2	1.5
e. Client establishes previous	Appropriate	n	136	105	7	9
pattern of engagement in		%	52.9	40.9	2.7	3.5
occupations	Frequency	n	135	88	26	8
		%	52.5	34.2	10.1	3.1

Evaluation		Rank	1	2	3	4
f. Client chooses priorities and	Appropriate	n	135	108	13	8
targeted outcomes		%	51.1	40.9	4.9	3.0
	Frequency	n	119	113	25	6
		%	45.2	43.0	9.5	2.3
g. Therapist observes client	Appropriate	n	179	70	4	12
performance in desired occupations		%	67.5	26.4	1.5	4.5
	Frequency	n	159	69	26	10
		%	60.2	26.1	9.8	3.8
h. Therapist assesses areas that the	Appropriate	n	185	65	4	10
client identifies as important		%	70.1	24.6	1.5	3.8
	Frequency	n	187	62	8	4
		%	71.6	23.8	3.1	1.5
i. Client determines supports and	Appropriate	n	99	121	32	10
barriers to performance		%	37.8	46.2	12.2	3.8
	Frequency	n	92	115	44	9
		%	35.4	44.2	16.9	3.5
j. Client establishes strengths and	Appropriate	n	100	127	27	9
weaknesses in performance		%	38.0	48.3	10.3	3.4
	Frequency	n	88	119	46	9
		%	33.6	45.4	17.6	3.4

Evaluation		Rank	1	2	3	4
k. Client selects goals with	Appropriate	n	185	70	4	7
therapist		%	69.5	26.3	1.5	2.6
	Frequency	n	178	69	12	4
		%	67.7	26.2	4.6	1.5
l. Client collaborates with therapist	Appropriate	n	103	133	23	7
in choosing the intervention		%	38.7	50.0	8.6	2.6
approach	Frequency	n	83	129	45	8
		%	31.3	48.7	17.0	3.0

Note. Appropriate: 1 = Very Appropriate; 2 = Appropriate; 3 = Inappropriate; 4 = Very Inappropriate. Frequency: 1 = Frequently; 2 = Sometimes; 3 = Rarely; 4 = Never.

Table 21

The difference between male and female participants and appropriateness and use of client-centered care in evaluation

Evaluation		Mean		*t*	*df*	*p*
		Male	Female			
a. Client establishes	Appropriateness	1.30	1.30	-.016	263	.987
concerns in daily activities	Frequency	1.33	1.21	.852	32.360	.401
and occupation						
b. Client pinpoints areas	Appropriateness	1.40	1.44	-.260	262	.795
of occupation that are	Frequency	1.63	1.46	1.048	33.379	.302
successful and areas that						
are causing problems or						
risks						
c. Client determines the	Appropriateness	1.69	1.86	-1.150	254	.251
contexts that support and	Frequency	2.07	2.00	.408	253	.684
inhibit engagement in						
occupations						
d. Client picks personal	Appropriateness	1.37	1.45	-.586	263	.558
values and interests	Frequency	1.50	1.39	.622	32.489	.538
e. Client establishes	Appropriateness	1.66	1.56	.677	254	.499
previous pattern of	Frequency	1.90	1.61	1.863	254	.064
engagement in						
occupations						

Evaluation		Mean		*t*	*df*	*p*
		Male	Female			
f. Client chooses priorities	Appropriateness	1.67	1.59	.560	261	.576
and targeted outcomes	Frequency	1.63	1.70	-.453	260	.651
g. Therapist observes	Appropriateness	1.33	1.44	-.772	262	.441
client performance in	Frequency	1.67	1.56	.536	33.569	.595
desired occupations						
h. Therapist assesses areas	Appropriateness	1.47	1.38	.649	261	.517
that the client identifies as	Frequency	1.30	1.35	-.434	258	.664
important						
i. Client determines	Appropriateness	1.87	1.81	.300	33.375	.766
supports and barriers to	Frequency	2.00	1.87	.834	257	.405
performance						
j. Client establishes	Appropriateness	1.83	1.78	.330	260	.742
strengths and weaknesses	Frequency	2.00	1.90	.666	259	.506
in performance						
k. Client selects goals with	Appropriateness	1.47	1.36	.831	263	.407
therapist	Frequency	1.52	1.39	1.020	260	.308
l. Client collaborates with	Appropriateness	1.60	1.77	-1.217	263	.225
therapist in choosing the	Frequency	1.87	1.92	-.374	262	.708
intervention approach						

Table 22

The difference between participants with and without specialty certification and appropriateness and use of client-centered care in evaluation

Evaluation		Mean		*t*	*df*	*p*
		Without	With			
a. Client establishes	Appropriateness	1.32	1.27	.633	264	.527
concerns in daily	Frequency	1.20	1.25	-.693	263	.489
activities and occupation						
b. Client pinpoints areas	Appropriateness	1.46	1.39	.792	263	.429
of occupation that are	Frequency	1.51	1.42	1.006	261	.315
successful and areas that						
are causing problems or						
risks						
c. Client determines the	Appropriateness	1.91	1.72	2.032*	255	.043
contexts that support and	Frequency	2.06	1.94	1.152	254	.250
inhibit engagement in						
occupations						
d. Client picks personal	Appropriateness	1.47	1.41	.648	264	.518
values and interests	Frequency	1.37	1.46	-1.075	262	.283
e. Client establishes	Appropriateness	1.57	1.57	-.034	255	.973
previous pattern of	Frequency	1.63	1.65	-.134	255	.894
engagement in						
occupations						

Evaluation		Mean		*t*	*df*	*p*
		Male	Female			
f. Client chooses priorities	Appropriateness	1.62	1.57	.499	262	.618
and targeted outcomes	Frequency	1.71	1.65	.713	261	.477
g. Therapist observes	Appropriateness	1.45	1.40	.516	263	.607
client performance in	Frequency	1.53	1.64	-.989	262	.324
desired occupations						
h. Therapist assesses areas	Appropriateness	1.38	1.40	-.177	262	.860
that the client identifies as	Frequency	1.33	1.36	-.384	259	.701
important						
i. Client determines	Appropriateness	1.85	1.78	.684	260	.495
supports and barriers to	Frequency	1.90	1.86	.426	258	.670
performance						
j. Client establishes	Appropriateness	1.80	1.78	.181	261	.856
strengths and weaknesses	Frequency	1.93	1.88	.465	260	.642
in performance						
k. Client selects goals with	Appropriateness	1.39	1.35	.502	264	.616
therapist	Frequency	1.41	1.38	.375	261	.708
l. Client collaborates with	Appropriateness	1.80	1.67	1.394	264	.164
therapist in choosing the	Frequency	1.96	1.84	1.262	263	.208
intervention approach						

Note. $*p < .05$

Table 23

The relationship between age and appropriateness and use of client-centered care in evaluation

Evaluation		*n*	*r*	*p*
a. Client establishes concerns in daily activities and occupation	Appropriateness	262	.165**	.007
	Frequency	261	.031	.619
b. Client pinpoints areas of occupation that are successful and areas that are causing problems or risks	Appropriateness	261	.169**	.006
	Frequency	259	-.061	.331
c. Client determines the contexts that support and inhibit engagement in occupations	Appropriateness	254	.269**	.000
	Frequency	253	.043	.496
d. Client picks personal values and interests	Appropriateness	262	.181**	.003
	Frequency	260	.044	.480
e. Client establishes previous pattern of engagement in occupations	Appropriateness	254	.080	.206
	Frequency	254	.024	.699
f. Client chooses priorities and targeted outcomes	Appropriateness	261	.213**	.001
	Frequency	260	.101	.103
g. Therapist observes client performance in desired occupations	Appropriateness	261	.176**	.004
	Frequency	260	.024	.702
h. Therapist assesses areas that the client identifies as important	Appropriateness	260	.109	.079
	Frequency	257	-.056	.374

Evaluation		*n*	*r*	*p*
i. Client determines supports and	Appropriateness	259	.135*	.030
barriers to performance	Frequency	257	-.009	.885
j. Client establishes strengths and	Appropriateness	259	.161**	.009
weaknesses in performance	Frequency	258	-.081	.194
k. Client selects goals with therapist	Appropriateness	262	.093	.134
	Frequency	259	-.159*	.011
l. Client collaborates with therapist in	Appropriateness	262	.169**	.006
choosing the intervention approach	Frequency	261	-.031	.622

Note. *$p < .05$. **$p < .01$.

Table 24

The relationship between years of experience in occupational therapy and appropriateness and use of client-centered care in evaluation

Evaluation		*n*	*r*	*p*
a. Client establishes concerns in daily activities and occupation	Appropriateness	263	.228**	.000
	Frequency	262	.016	.791
b. Client pinpoints areas of occupation that are successful and areas that are causing problems or risks	Appropriateness	262	.221**	.000
	Frequency	260	.015	.805
c. Client determines the contexts that support and inhibit engagement in occupations	Appropriateness	254	.278**	.000
	Frequency	253	.088	.163
d. Client picks personal values and interests	Appropriateness	263	.197**	.001
	Frequency	261	.062	.320
e. Client establishes previous pattern of engagement in occupations	Appropriateness	254	.162**	.010
	Frequency	254	.085	.178
f. Client chooses priorities and targeted outcomes	Appropriateness	261	.308**	.000
	Frequency	260	.166**	.007
g. Therapist observes client performance in desired occupations	Appropriateness	262	.208**	.001
	Frequency	261	.062	.315
h. Therapist assesses areas that the client identifies as important	Appropriateness	261	.180**	.004
	Frequency	258	-.098	.116

Evaluation		*n*	*r*	*p*
i. Client determines supports and	Appropriateness	259	.221**	.000
barriers to performance	Frequency	257	.061	.330
j. Client establishes strengths and	Appropriateness	260	.187**	.002
weaknesses in performance	Frequency	259	-.024	.702
k. Client selects goals with therapist	Appropriateness	263	.189**	.002
	Frequency	260	-.092	.138
l. Client collaborates with therapist in	Appropriateness	263	.216**	.000
choosing the intervention approach	Frequency	262	.000	.999

Note. *$p < .05$. **$p < .01$.

Table 25

The relationship between average number of clients seen daily and appropriateness and use of client-centered care in evaluation

Evaluation		*n*	*r*	*p*
a. Client establishes concerns in daily activities and occupation	Appropriateness	246	.031	.631
	Frequency	245	.104	.103
b. Client pinpoints areas of occupation that are successful and areas that are causing problems or risks	Appropriateness	245	.014	.829
	Frequency	243	.012	.848
c. Client determines the contexts that support and inhibit engagement in occupations	Appropriateness	238	-.041	.531
	Frequency	237	.039	.552
d. Client picks personal values and interests	Appropriateness	246	-.033	.602
	Frequency	244	.025	.698
e. Client establishes previous pattern of engagement in occupations	Appropriateness	237	-.077	.238
	Frequency	237	-.032	.620
f. Client chooses priorities and targeted outcomes	Appropriateness	244	-.037	.565
	Frequency	243	.096	.134
g. Therapist observes client performance in desired occupations	Appropriateness	245	.027	.677
	Frequency	244	.124	.053
h. Therapist assesses areas that the client identifies as important	Appropriateness	244	.081	.208
	Frequency	241	.184**	.004

Evaluation		*n*	*r*	*p*
i. Client determines supports and	Appropriateness	242	-.060	.349
barriers to performance	Frequency	240	-.039	.553
j. Client establishes strengths and	Appropriateness	243	-.107	.096
weaknesses in performance	Frequency	242	-.066	.305
k. Client selects goals with therapist	Appropriateness	246	-.091	.153
	Frequency	243	-.039	.544
l. Client collaborates with therapist in	Appropriateness	246	-.005	.935
choosing the intervention approach	Frequency	245	.051	.430

Note. $^{*}p < .05$.

Table 26

The relationship between highest level of education and appropriateness and use of client-centered care in evaluation

Evaluation		*n*	tau-b	*p*
a. Client establishes concerns in daily	Appropriateness	264	-.043	.479
activities and occupation	Frequency	263	-.033	.581
b. Client pinpoints areas of	Appropriateness	263	-.061	.311
occupation that are successful and	Frequency	261	.006	.916
areas that are causing problems or risks				
c. Client determines the contexts that	Appropriateness	255	-.061	.304
support and inhibit engagement in	Frequency	254	-.092	.118
occupations				
d. Client picks personal values and	Appropriateness	264	-.023	.698
interests	Frequency	262	-.013	.822
e. Client establishes previous pattern	Appropriateness	256	-.044	.471
of engagement in occupations	Frequency	256	-.088	.138
f. Client chooses priorities and	Appropriateness	262	-.112	.060
targeted outcomes	Frequency	261	-.122*	.038
g. Therapist observes client	Appropriateness	263	-.062	.302
performance in desired occupations	Frequency	262	-.088	.133
h. Therapist assesses areas that the	Appropriateness	262	.015	.804
client identifies as important	Frequency	260	.059	.333

Evaluation		*n*	tau-b	*p*
i. Client determines supports and	Appropriateness	261	-.026	.653
barriers to performance	Frequency	259	-.128*	.028
j. Client establishes strengths and	Appropriateness	262	-.028	.630
weaknesses in performance	Frequency	261	-.049	.397
k. Client selects goals with therapist	Appropriateness	264	-.049	.417
	Frequency	261	-.052	.387
l. Client collaborates with therapist in	Appropriateness	264	-.107	.069
choosing the intervention approach	Frequency	263	-.089	.123

Note. *$p < .05$.

Table 27

The relationship between average duration of client occupational therapy treatment in primary place of employment and appropriateness and use of client-centered care in evaluation

Evaluation		*n*	tau-b	*p*
a. Client establishes concerns in daily activities and occupation	Appropriateness	257	.076	.186
	Frequency	256	-.046	.431
b. Client pinpoints areas of occupation that are successful and areas that are causing problems or risks	Appropriateness	256	.081	.158
	Frequency	254	-.029	.609
c. Client determines the contexts that support and inhibit engagement in occupations	Appropriateness	248	.041	.472
	Frequency	247	.051	.363
d. Client picks personal values and interests	Appropriateness	257	.033	.558
	Frequency	255	.037	.524
e. Client establishes previous pattern of engagement in occupations	Appropriateness	249	.130*	.025
	Frequency	249	.063	.268
f. Client chooses priorities and targeted outcomes	Appropriateness	255	.017	.771
	Frequency	254	.050	.379
g. Therapist observes client performance in desired occupations	Appropriateness	256	.095	.099
	Frequency	255	.049	.382

Evaluation		*n*	tau-b	*p*
h. Therapist assesses areas that the	Appropriateness	255	.025	.667
client identifies as important	Frequency	252	.020	.735
i. Client determines supports and	Appropriateness	253	.134*	.017
barriers to performance	Frequency	251	.153**	.006
j. Client establishes strengths and	Appropriateness	254	.120*	.033
weaknesses in performance	Frequency	253	.078	.163
k. Client selects goals with therapist	Appropriateness	257	.072	.213
	Frequency	254	.023	.688
l. Client collaborates with therapist in	Appropriateness	257	.110	.051
choosing the intervention approach	Frequency	256	.005	.925

Note. $*p < .05$. $**p < .01$.

Table 28

The relationship between primary place of employment and appropriateness and use of client-centered care in evaluation

Evaluation			*SS*	*df*	*MS*	*F*	*p*
a	Appropriate	Between Groups	1.803	8	.225	.542	.824
		Within Groups	102.299	246	.416		
		Total	104.102	254			
	Frequency	Between Groups	2.638	8	.330	1.111	.356
		Within Groups	72.716	245	.297		
		Total	75.354	253			
b	Appropriate	Between Groups	2.220	8	.277	.588	.787
		Within Groups	115.544	245	.472		
		Total	117.764	253			
	Frequency	Between Groups	4.901	8	.613	1.410	.193
		Within Groups	105.618	243	.435		
		Total	110.520	251			
c	Appropriate	Between Groups	6.312	8	.789	1.527	.149
		Within Groups	122.505	237	.517		
		Total	128.817	245			
	Frequency	Between Groups	4.683	8	.585	.971	.460
		Within Groups	142.313	236	.603		
		Total	146.996	244			

Evaluation			*SS*	*df*	*MS*	*F*	*p*
d	Appropriate	Between Groups	2.249	8	.281	.540	.826
		Within Groups	128.159	246	.521		
		Total	130.408	254			
	Frequency	Between Groups	3.839	8	.480	1.161	.323
		Within Groups	100.841	244	.413		
		Total	104.680	252			
e	Appropriate	Between Groups	3.034	8	.379	.792	.610
		Within Groups	113.551	237	.479		
		Total	116.585	245			
	Frequency	Between Groups	6.148	8	.769	1.342	.223
		Within Groups	135.693	237	.573		
		Total	141.841	245			
f	Appropriate	Between Groups	4.472	8	.559	1.113	.355
		Within Groups	122.595	245	.502		
		Total	127.067	253			
	Frequency	Between Groups	6.163	8	.770	1.439	.181
		Within Groups	130.071	243	.535		
		Total	136.234	251			

Evaluation			*SS*	*df*	*MS*	*F*	*p*
g	Appropriate	Between Groups	5.663	8	.708	1.398	.198
		Within Groups	124.101	245	.507		
		Total	129.764	253			
	Frequency	Between Groups	13.695	8	1.712	2.776*	.006
		Within Groups	150.479	244	.617		
		Total	164.174	252			
h	Appropriate	Between Groups	3.893	8	.487	1.066	.388
		Within Groups	111.435	244	.457		
		Total	115.328	252			
	Frequency	Between Groups	6.505	8	.813	2.220*	.027
		Within Groups	88.643	242	.366		
		Total	95.147	250			
i	Appropriate	Between Groups	4.596	8	.575	.959	.469
		Within Groups	144.974	242	.599		
		Total	149.570	250			
	Frequency	Between Groups	2.572	8	.322	.497	.858
		Within Groups	155.315	240	.647		
		Total	157.88	248			

Evaluation			*SS*	*df*	*MS*	*F*	*p*
j	Appropriate	Between Groups	1.506	8	.188	.334	.952
		Within Groups	136.923	243	.563		
		Total	138.429	254			
	Frequency	Between Groups	3.960	8	.495	.785	.616
		Within Groups	152.549	242	.630		
		Total	156.510	250			
k	Appropriate	Between Groups	.978	8	.122	.302	.965
		Within Groups	99.547	246	.405		
		Total	100.525	254			
	Frequency	Between Groups	2.417	8	.844	1.446	.178
		Within Groups	102.770	245	.584		
		Total	105.187	253			
l	Appropriate	Between Groups	4.579	8	.572	1.170	.318
		Within Groups	120.339	246	.489		
		Total	124.918	254			
	Frequency	Between Groups	6.789	8	.844	1.446	.178
		Within Groups	142.983	245	.584		
		Total	149.732	253			

Note. $*p < .05$.

Table 29

Frequencies of supports and barriers to client-centered care

Supports/Barriers	Rank	1	2	3	4	5	6
1. I am familiar with client-	n	5	6	13	58	117	65
centered care	%	1.9	2.3	4.9	22.0	44.3	24.6
3. Clients and I often do not agree	n	69	143	23	18	9	4
on therapeutic goals	%	25.9	53.8	8.6	6.8	3.4	1.5
4. I would like to spend more time	n	7	38	30	78	68	43
with each client during the	%	2.7	14.4	11.4	29.5	25.8	16.3
evaluation phase							
6. My primary place of	n	5	16	14	49	99	78
employment encourages that I	%	1.9	6.1	5.4	18.8	37.9	29.9
obtain clients' values and priorities							
during evaluation							
7. I find it difficult to separate my	n	77	117	45	16	8	3
personal and professional values	%	28.9	44.0	16.9	6.0	3.0	1.1
from client values							
8. I use assessments that are	n	20	37	14	47	92	51
required by my facility	%	7.7	14.2	5.4	18.0	35.2	19.5
9. Clients prefer me to tell them	n	22	67	50	73	36	12
what their problems are	%	8.5	25.8	19.2	28.1	13.8	4.6

Supports/Barriers	Rank	1	2	3	4	5	6
10. Using a client-centered	n	82	112	44	17	3	2
approach gives too much power to	%	31.5	43.1	16.9	6.5	1.2	.8
the client							
11. I learned about client-centered	n	55	56	21	59	52	19
care in my occupational therapy	%	21.0	21.4	8.0	22.5	19.8	7.3
curriculum							
14. I learned about client-centered	n	61	60	24	67	38	12
care in continuing education	%	23.3	22.9	9.2	25.6	14.5	4.6
workshops							
15. Practicing client-centered care	n	49	85	50	49	18	9
involves paying less attention to	%	18.8	32.7	19.2	18.8	6.9	3.5
my client's medical diagnosis							
16. The medical model makes it	n	22	68	60	67	31	9
difficult to incorporate concepts of	%	8.6	26.5	23.3	26.1	12.1	3.5
client-centered care							
17. I do not have enough time to	n	49	95	47	50	20	5
obtain client values and priorities	%	18.4	35.7	17.7	18.8	7.5	1.9
during evaluation							
19. I find it difficult to assess a	n	36	100	63	49	17	0
client's ability to choose their own	%	13.6	37.7	23.8	18.5	6.4	0
goals							

Supports/Barriers	Rank	1	2	3	4	5	6
21. I use the Canadian Occupation	n	149	62	9	14	5	9
Performance Measure (COPM) in	%	60.1	25.0	3.6	5.6	2.0	3.6
evaluation							
22. The medical model guides my	n	16	47	45	98	47	9
occupational therapy practice	%	6.1	17.9	17.2	37.4	17.9	3.4
23. Few assessments are client-	n	20	54	56	78	41	5
centered	%	7.9	21.3	22.0	30.7	16.1	2.0
26. Reimbursement guides my goal	n	55	63	33	72	28	9
selection for treatment	%	21.2	24.2	12.7	27.7	10.8	3.5
27. I find it difficult to use client-	n	66	110	47	28	7	3
centered care with clients of	%	25.3	42.1	18.0	10.7	2.7	1.1
different genders or cultures							
28. My primary place of	n	4	11	22	64	103	55
employment supports client-	%	1.5	4.2	8.5	24.7	39.8	21.2
centered care							
29. I find it easier to make	n	16	57	59	82	42	6
treatment decisions for my clients	%	6.1	21.8	22.5	31.3	16.0	2.3
33. My clients are reluctant to	n	12	43	60	105	35	8
assume responsibility for their own	%	4.6	16.3	22.8	39.9	13.3	3.0
care							

Note. 1 = Strongly disagree; 2 = Disagree; 3 = Disagree Somewhat; 4 = Agree Somewhat; 5 = Agree; 6 = Strongly Agree.

Table 30

The difference between male and female participants' identification of supports and barriers of client-centered care

Supports and Barriers	Mean		*t*	*df*	*p*
	Male	Female			
1. I am familiar with client-centered care	4.43	4.83	-1.924	261	.055
3. Clients and I often do not agree on therapeutic goals	2.20	2.11	.408	263	.684
4. I would like to spend more time with each client during the evaluation phase	3.70	4.16	-1.775	261	.077
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	4.66	4.75	-.405	258	.686
7. I find it difficult to separate my personal and professional values from client values	2.27	2.12	.712	263	.477
8. I use assessments that are required by my facility	3.93	4.20	-.895	258	.371
9. Clients prefer me to tell them what their problems are	3.47	3.24	.855	257	.393
10. Using a client-centered approach gives too much power to the client	2.24	2.03	.943	33.109	.352
11. I learned about client-centered care in my occupational therapy curriculum	3.03	3.23	-.697	39.196	.490

Supports and Barriers	Mean		*t*	*df*	*p*
	Male	Female			
14. I learned about client-centered care in continuing education workshops	2.79	3.01	-.702	259	.483
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	2.69	2.73	-.138	257	.890
16. The medical model makes it difficult to incorporate concepts of client-centered care	3.34	3.15	.770	254	.442
17. I do not have enough time to obtain client values and priorities during evaluation	2.50	2.69	-.776	263	.438
19. I find it difficult to assess a client's ability to choose their own goals	2.93	2.63	1.386	262	.167
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	I.79	1.75	.146	245	.884
22. The medical model guides my occupational therapy practice	3.83	3.50	1.540	38.418	.132
23. Few assessments are client-centered	3.73	3.26	1.980*	251	.049
26. Reimbursement guides my goal selection for treatment	3.40	2.87	1.888	257	.060
27. I find it difficult to use client-centered care with clients of different genders or cultures	2.48	2.24	1.124	258	.262

Supports and Barriers	Mean		*t*	*df*	*p*
	Male	Female			
28. My primary place of employment supports client-centered care	4.14	4.67	-2.398*	256	.017
29. I find it easier to make treatment decisions for my clients	3.90	3.29	2.574*	259	.011
33. My clients are reluctant to assume responsibility for their own care	3.03	3.56	-2.416*	260	.016

Note. *$p < .05$.

Table 31

The difference between participants with and without specialty certification and supports and barriers of client-centered care

Supports and Barriers	Mean		*t*	*df*	*p*
	Without	With			
1. I am familiar with client-centered care	4.80	4.76	.272	173.47	.786
3. Clients and I often do not agree on therapeutic goals	2.21	1.99	1.598	264	.111
4. I would like to spend more time with each client during the evaluation phase	4.13	4.06	.404	262	.686
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	4.83	4.61	1.418	259	.157
7. I find it difficult to separate my personal and professional values from client values	2.21	2.02	1.385	264	.167
8. I use assessments that are required by my facility	4.17	4.18	-.031	259	.976
9. Clients prefer me to tell them what their problems are	3.24	3.31	-.415	258	.678
10. Using a client-centered approach gives too much power to the client	2.07	2.02	.381	258	.703
11. I learned about client-centered care in my occupational therapy curriculum	3.20	3.21	-.030	260	.976

Supports and Barriers	Mean		*t*	*df*	*p*
	Without	With			
14. I learned about client-centered care in continuing education workshops	2.96	3.03	-.338	260	.735
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	2.72	2.73	-.073	258	.942
16. The medical model makes it difficult to incorporate concepts of client-centered care	3.16	3.18	-.105	255	.917
17. I do not have enough time to obtain client values and priorities during evaluation	2.76	2.51	1.538	264	.125
19. I find it difficult to assess a client's ability to choose their own goals	2.65	2.69	-.329	263	.742
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	1.80	1.69	.664	246	.508
22. The medical model guides my occupational therapy practice	3.40	3.74	-2.163*	260	.031
23. Few assessments are client-centered	3.38	3.22	.933	252	.352
26. Reimbursement guides my goal selection for treatment	2.85	3.06	-1.134	258	.258

Supports and Barriers	Mean		*t*	*df*	*p*
	Without	With			
27. I find it difficult to use client-centered care with clients of different genders or cultures	2.33	2.17	1.133	259	.258
28. My primary place of employment supports client-centered care	4.60	4.61	-.067	257	.946
29. I find it easier to make treatment decisions for my clients	3.40	3.30	.618	177.27	.537
33. My clients are reluctant to assume responsibility for their own care	3.54	3.44	.742	261	.459

Note. $*p < .05$

Table 32

The relationship between age and supports and barriers of client-centered care

Supports and Barriers	*n*	*r*	*p*
1. I am familiar with client-centered care	260	-.038	.537
3. Clients and I often do not agree on therapeutic goals	262	.068	.272
4. I would like to spend more time with each client during the evaluation phase	260	.112	.072
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	258	.030	.629
7. I find it difficult to separate my personal and professional values from client values	262	.114	.065
8. I use assessments that are required by my facility	258	-.012	.844
9. Clients prefer me to tell them what their problems are	256	-.030	.631
10. Using a client-centered approach gives too much power to the client	256	.105	.093
11. I learned about client-centered care in my occupational therapy curriculum	259	-.349**	.000
14. I learned about client-centered care in continuing education workshops	259	.052	.401
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	258	-.004	.949
16. The medical model makes it difficult to incorporate concepts of client-centered care	254	-.031	.618

Supports and Barriers	*n*	*r*	*p*
17. I do not have enough time to obtain client values and priorities during evaluation	262	.071	.251
19. I find it difficult to assess a client's ability to choose their own goals	261	-.055	.376
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	245	-.115	.072
22. The medical model guides my occupational therapy practice	258	-.006	.928
23. Few assessments are client-centered	251	-.131*	.038
26. Reimbursement guides my goal selection for treatment	256	-.078	.211
27. I find it difficult to use client-centered care with clients of different genders or cultures	257	-.081	.193
28. My primary place of employment supports client-centered care	255	.083	.186
29. I find it easier to make treatment decisions for my clients	258	-.033	.600
33. My clients are reluctant to assume responsibility for their own care	260	.059	.340

Note. *$p < .05$. **$p < .01$

Table 33

The relationship between years of experience in occupational therapy and supports and barriers of client-centered care

Supports and Barriers	*n*	*r*	*p*
1. I am familiar with client-centered care	261	-.039	.526
3. Clients and I often do not agree on therapeutic goals	263	.026	.673
4. I would like to spend more time with each client during the evaluation phase	261	.056	.366
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	258	.011	.858
7. I find it difficult to separate my personal and professional values from client values	263	.131*	.034
8. I use assessments that are required by my facility	258	.067	.285
9. Clients prefer me to tell them what their problems are	257	-.031	.622
10. Using a client-centered approach gives too much power to the client	257	.087	.166
11. I learned about client-centered care in my occupational therapy curriculum	259	-.465**	.000
14. I learned about client-centered care in continuing education workshops	259	.068	.278
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	257	.017	.791

Supports and Barriers	*n*	*r*	*p*
16. The medical model makes it difficult to incorporate concepts of client-centered care	254	-.060	.344
17. I do not have enough time to obtain client values and priorities during evaluation	263	.015	.813
19. I find it difficult to assess a client's ability to choose their own goals	262	.026	.680
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	246	-.131*	.040
22. The medical model guides my occupational therapy practice	259	.051	.412
23. Few assessments are client-centered	251	-.082	.193
26. Reimbursement guides my goal selection for treatment	257	.024	.703
27. I find it difficult to use client-centered care with clients of different genders or cultures	258	.026	.677
28. My primary place of employment supports client-centered care	256	-.004	.949
29. I find it easier to make treatment decisions for my clients	259	-.069	.265
33. My clients are reluctant to assume responsibility for their own care	260	.058	.353

Note. *$p < .05$. **$p < .01$.

Table 34

The relationship between average number of clients seen daily and supports and barriers of client-centered care

Supports and Barriers	*n*	*r*	*p*
1. I am familiar with client-centered care	244	-.013	.834
3. Clients and I often do not agree on therapeutic goals	246	.071	.265
4. I would like to spend more time with each client during the evaluation phase	245	.112	.079
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	242	-.087	.178
7. I find it difficult to separate my personal and professional values from client values	246	-.068	.287
8. I use assessments that are required by my facility	242	-.007	.916
9. Clients prefer me to tell them what their problems are	242	.059	.362
10. Using a client-centered approach gives too much power to the client	240	-.022	.733
11. I learned about client-centered care in my occupational therapy curriculum	242	-.029	.653
14. I learned about client-centered care in continuing education workshops	242	.060	.353
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	240	-.041	.523

Supports and Barriers	*n*	*r*	*p*
16. The medical model makes it difficult to incorporate concepts of client-centered care	237	-.082	.209
17. I do not have enough time to obtain client values and priorities during evaluation	246	.108	.091
19. I find it difficult to assess a client's ability to choose their own goals	245	-.057	.376
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	231	-.079	.231
22. The medical model guides my occupational therapy practice	242	.054	.403
23. Few assessments are client-centered	236	.017	.795
26. Reimbursement guides my goal selection for treatment	240	-.123	.057
27. I find it difficult to use client-centered care with clients of different genders or cultures	241	.048	.459
28. My primary place of employment supports client-centered care	240	-.045	.491
29. I find it easier to make treatment decisions for my clients	242	-.101	.118
33. My clients are reluctant to assume responsibility for their own care	243	.048	.456

Table 35

The relationship between highest level of education and supports and barriers of client-centered care

Supports and Barriers	*n*	tau-b	*p*
1. I am familiar with client-centered care	262	.161**	.005
3. Clients and I often do not agree on therapeutic goals	264	.089	.119
4. I would like to spend more time with each client during the evaluation phase	262	.036	.510
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	259	-.012	.829
7. I find it difficult to separate my personal and professional values from client values	264	.004	.937
8. I use assessments that are required by my facility	259	-.056	.316
9. Clients prefer me to tell them what their problems are	258	-.042	.449
10. Using a client-centered approach gives too much power to the client	259	-.065	.261
11. I learned about client-centered care in my occupational therapy curriculum	260	.182**	.001
14. I learned about client-centered care in continuing education workshops	260	-.031	.580
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	259	-.022	.694

Supports and Barriers	*n*	tau-b	*p*
16. The medical model makes it difficult to incorporate concepts of client-centered care	256	-.099	.077
17. I do not have enough time to obtain client values and priorities during evaluation	264	-.053	.337
19. I find it difficult to assess a client's ability to choose their own goals	263	.095	.088
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	246	.035	.561
22. The medical model guides my occupational therapy practice	261	-.113*	.042
23. Few assessments are client-centered	253	.105	.063
26. Reimbursement guides my goal selection for treatment	258	-.079	.154
27. I find it difficult to use client-centered care with clients of different genders or cultures	259	-.030	.598
28. My primary place of employment supports client-centered care	257	.044	.438
29. I find it easier to make treatment decisions for my clients	260	-.127*	.022
33. My clients are reluctant to assume responsibility for their own care	261	.029	.603

Note. *$p < .05$. **$p < .01$.

Table 36

The relationship between average duration of client occupational therapy treatment in primary place of employment and supports and barriers of client-centered care

Supports and Barriers	*n*	tau-b	*p*
1. I am familiar with client-centered care	255	.012	.827
3. Clients and I often do not agree on therapeutic goals	257	-.091	.096
4. I would like to spend more time with each client during the evaluation phase	255	-.141**	.008
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	253	-.048	.373
7. I find it difficult to separate my personal and professional values from client values	257	-.070	.197
8. I use assessments that are required by my facility	253	-.193**	.000
9. Clients prefer me to tell them what their problems are	252	-.024	.655
10. Using a client-centered approach gives too much power to the client	251	-.021	.707
11. I learned about client-centered care in my occupational therapy curriculum	253	-.005	.930
14. I learned about client-centered care in continuing education workshops	253	.032	.539
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	251	-.034	.523

Supports and Barriers	*n*	tau-b	*p*
16. The medical model makes it difficult to incorporate concepts of client-centered care	248	-.006	.916
17. I do not have enough time to obtain client values and priorities during evaluation	257	-.017	.751
19. I find it difficult to assess a client's ability to choose their own goals	256	.032	.550
21. I use the Canadian Occupation Performance Measure (COPM) in evaluation	240	-.025	.668
22. The medical model guides my occupational therapy practice	253	-.015	.773
23. Few assessments are client-centered	246	.011	.836
26. Reimbursement guides my goal selection for treatment	251	-.068	.203
27. I find it difficult to use client-centered care with clients of different genders or cultures	252	-.001	.988
28. My primary place of employment supports client-centered care	251	.028	.605
29. I find it easier to make treatment decisions for my clients	253	-.036	.505
33. My clients are reluctant to assume responsibility for their own care	254	.003	.958

Note. $^{**}p < .01$.

Table 37

The relationship between primary place of employment and supports and barriers of client-centered care

Supports/barriers		*SS*	*df*	*MS*	*F*	*p*
1. I am familiar with client-centered care	Between Groups	12.954	8	1.619	1.455	.174
	Within Groups	271.520	244	1.113		
	Total	284.474	252			
3. Clients and I often do not agree on therapeutic goals	Between Groups	10.189	8	1.274	1.215	.291
	Within Groups	257.952	246	1.049		
	Total	268.141	254			
4. I would like to spend more time with each client during the evaluation phase	Between Groups	36.646	8	4.581	2.645**	.008
	Within Groups	422.610	244	1.732		
	Total	459.257	252			
6. My primary place of employment encourages that I obtain clients' values and priorities during evaluation	Between Groups	18.194	8	2.274	1.551	.141
	Within Groups	353.422	241	1.466		
	Total	371.616	249			

Supports/barriers		*SS*	*df*	*MS*	*F*	*p*
7. I find it difficult to separate my personal and professional values from client values	Between Groups	10.930	8	1.366	1.283	.253
	Within Groups	261.987	246	1.065		
	Total	272.918	254			
8. I use assessments that are required by my facility	Between Groups	48.781	8	6.093	2.646**	.008
	Within Groups	555.475	241	2.305		
	Total	604.256	249			
9. Clients prefer me to tell them what their problems are	Between Groups	18.986	8	2.373	1.389	.202
	Within Groups	410.034	240	1.708		
	Total	429.020	248			
10. Using a client-centered approach gives too much power to the client	Between Groups	7.211	8	.901	.952	.475
	Within Groups	227.303	240	.947		
	Total	234.514	248			
11. I learned about client-centered care in my occupational therapy curriculum	Between Groups	34.613	8	4.327	1.600	.125
	Within Groups	654.319	242	2.704		
	Total	688.932	250			

Supports/barriers		*SS*	*df*	*MS*	*F*	*p*
14. I learned about client-centered care in continuing education workshops	Between Groups	24.895	8	3.112	1.341	.224
	Within Groups	561.623	242	2.321		
	Total	586.518	250			
15. Practicing client-centered care involves paying less attention to my client's medical diagnosis	Between Groups	13.961	8	1.745	.997	.439
	Within Groups	420.072	240	1.750		
	Total	434.032	248			
16. The medical model makes it difficult to incorporate concepts of client-centered care	Between Groups	12.893	8	1.612	1.007	.431
	Within Groups	379.271	237	1.600		
	Total	392.167	245			
17. I do not have enough time to obtain client values and priorities during evaluation	Between Groups	17.850	8	2.231	1.411	.192
	Within Groups	388.958	246	1.581		
	Total	406.808	254			
19. I find it difficult to assess a client's ability to choose their own goals	Between Groups	2.963	6	.370	.294	.968
	Within Groups	308.549	245	1.259		
	Total	311.512	253			

Supports/barriers		*SS*	*df*	*MS*	*F*	*p*
21. I use the Canadian	Between Groups	57.801	8	7.225	5.340**	.000
Occupation	Within Groups	308.511	228	1.353		
Performance Measure	Total	366.312	236			
(COPM) in evaluation						
22. The medical model	Between Groups	44.391	8	5.549	3.904**	.000
guides my	Within Groups	344.000	242	1.421		
occupational therapy	Total	388.390	250			
practice						
23. Few assessments	Between Groups	5.865	8	.733	.464	.881
are client-centered	Within Groups	369.698	234	1.580		
	Total	375.564	242			
26. Reimbursement	Between Groups	29.662	8	3.708	1.824	.073
guides my goal	Within Groups	487.88	240	2.033		
selection for treatment	Total	517.550	248			
27. I find it difficult to	Between Groups	12.982	8	1.623	1.333	.228
use client-centered	Within Groups	293.418	241	1.218		
care with clients of	Total	306.400	249			
different genders or						
cultures						

Supports/barriers			*SS*	*df*	*MS*	*F*
28. My primary place of employment supports client-centered care	Between Groups	11.138	8	1.392	1.147	.333
	Within Groups	290.136	239	1.214		
	Total	301.274	247			
29. I find it easier to make treatment decisions for my clients	Between Groups	15.025	8	1.878	1.297	.246
	Within Groups	350.417	242	1.448		
	Total	365.442	250			
33. My clients are reluctant to assume responsibility for their own care	Between Groups	8.069	8	1.009	.759	.639
	Within Groups	322.927	243	1.329		
	Total	330.996	252			

Note. **$p < .01$.