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Client-Centered Practice: Views from Occupational Therapists and their Clients

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Client-Centered Practice:
Views from Occupational Therapists and their Clients

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Abstract

The purpose of this study was to comparatively analyze the perceptual involvement of clients and occupational therapists in the shared decision-making process in healthcare facilities in the United States. This study also investigated whether there is a difference in perception in the shared decision-making process in different adult/geriatric healthcare facilities.

Participants (11 occupational therapists, 30 clients) in adult/geriatric healthcare facilities were each engaged in a semi-structured interview to determine their perceptions of client-centered practice, specifically in relation to the goal setting process. Descriptive statistics were used to analyze the item data. In addition, one-way analysis of variance was computed to identify perceptual differences of opinions in clients and therapists among the four facility variables from where the participants originated from, i.e., longterm care/rehabilitation, hospital outpatient, hospital inpatient, nursing homes.

The occupational therapists in this study indicated use of the principles of client-centered practice in their delivery of occupational therapy services. Their clients however, had displayed mixed perceptions about their role as an active participant in client-centered practice and all responded negative to being aware of the approach. Perceptual differences did appear between the therapists and their clients in relation to the use of client-centered practice, as their responses to similar questions varied. Lastly, facility type significantly influenced clients' knowledge of certain aspects of their treatment in four areas.

Results suggest that a perceptual gap exists between occupational therapists and their clients in relation to their stated use of and participation in client-centered practice. In light of the results, development of a systematic strategy by therapists to elicit the roles that their clients desire to play in the therapeutic process may be an effective intervention to ensure that therapists and their clients are able to fulfill their roles in client-centered practice.

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CERTIFICATE OF APPROVAL

This is to certify that the Thesis of

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Submitted in partial fulfillment of the requirements for the degree of
Master of Science in the Department of Occupational Therapy, School of Health Sciences and Human Performance at Ithaca College has been approved.

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Chapter 1: Introduction

Background

Client-centered practice has been a focus in the healthcare literature across various disciplines such as medicine, nursing, occupational therapy, and physical therapy for nearly a quarter century. The essence of client-centered practice is the healthcare provider being mindful of the fact that the client is the center of therapy. This recognition may be demonstrated through their actions of maximally involving the client in decision-making throughout the treatment process. In order for occupational therapists to demonstrate application of client-centered practice, they must act as a a) listener (O'Neill, 2001; Payton & Nelson, 1996), b) educator (Rogers, 1951; Sumsion, 1999; Toomey, Nicholson, & Carswell, 1995; World Health Organization (WHO), 1979), c) facilitator (Meyer, 1977), and d) enabler (Burnard & Morrison, 1991; Diasio, 1971; Townsend, 1997). In conjunction with the roles of an occupational therapist, the expectation is that the client will be an active participant in the therapeutic process (Gage, 1994; Rogers, 1951; Willard & Spackman, 1947; WHO, 1979). In order to demonstrate their active participation, clients are expected to identify occupations that are meaningful and purposeful to them, participate in the goal setting and treatment planning processes, and demonstrate a desire and motivation to engage in their occupational therapy treatment sessions.

Involving clients in decision-making and educating them about their role as an active participant are standards required by healthcare accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (1992) and the Commission on Accreditation of Rehabilitation Facilities (CARF) (1989), as well as

professional health care associations such as the American Occupational Therapy Association (AOTA) (1998), and the American Physical Therapy Association (APTA)(1985). Therefore, it is essential that occupational therapists enable their clients by providing them with the opportunity to be active participants.

The client-centered approach is predominantly praised throughout various healthcare disciplines. It has been recognized in everyday practice for being related to increased client satisfaction (Ben-Sira, 1976; Calnan, Katsouyiannopoulos, Ovcharov, Prokhorskas, Ramic, & Williams, 1994; Doyle & Ware, 1977; Wasserman, Inui, Barriatua, Carter, & Lippincott, 1984), improved functional outcomes (Gates, 1991; Neistadt, 1987; Starfield, Wray, Hess, Gross, Birk, & De'Lugoff,1981), increased client compliance and adherence to treatment programs (Lowes, 1998; Partridge, 1997; Payton, Nelson, & Ozer, 1990), and decreased client length of stay (Avis, 1994).

Research thus far related to client-centered practice has indicated that therapists are not maximally involving their clients in the goal setting process (Baker, Marshak, Rice, & Zimmerman, 2001; Northern, Rust, Nelson, & Watts, 1995). This is despite the requirements by accrediting organizations and professional healthcare associations and numerous studies highlighting the approach's effectiveness in contributing to positive client results. A possible cause for occupational therapists not maximally utilizing client-centered practice may be due to the numerous barriers that healthcare professionals have discussed that limit their ability to implement the approach on a daily basis. Barriers that occupational therapists may face include: a vagueness of how to apply the approach (Corring & Cook, 1999; Sumsion & Smyth, 2000; Wilkins et al., 2001), occupational therapists who are practicing in environments that are dominated by the medical model

(Sumsion & Smyth, 2000), lack of time to involve clients (Nelson & Payton, 1991; Wilkins et al., 2001), and clients' lack of demand to participate (Swee Hong, Pearce, & Withers, 2000). In light of the indication that there is a vagueness of how to apply the approach, Sumsion (1999) cited that if occupational therapists received education, training, and the opportunity to practice implementing client-centered practice, their vagueness of the approach may decrease. Use of client-centered interviews and assessments such as the Canadian Occupational Performance Measure(COPM) (Fearing & Clark, 2000; Neistadt, 1995; Wressle, Eeg-Olofsson, Marcusson, & Henriksson, 2002) were also cited as methods to decrease vagueness of client-centered practice and facilitate use of the approach.

As occupational therapists are concerned with individuals' abilities to actively engage in daily occupations which they identify to be meaningful to them (Law, 1998), it is logical that they would need to actively engage the individual whom they are treating during the treatment planning and goal setting processes. Therefore, by understanding the principles of client-centered practice and implementing the approach, occupational therapists will be prepared to effectively treat their clients and be in compliance with professional standards.

At the present, use of client-centered practice during the goal setting process, therapists and their clients' perceptions of the approach, positive outcomes related to and barriers faced when implementing a client-centered approach have been discussed and analyzed in various healthcare disciplines and settings. No studies, however, have comparatively analyzed clients' and their occupational therapists' perceptions of client-centered practice across a variety of settings. The present study proposes to study the

extent to which a client-centered approach is used in the goal setting and treatment planning processes, and to gain insight into occupational therapists' and clients' perceptions of the client-centered approach across a variety of adult/geriatric healthcare settings such as hospitals, nursing homes, and long-term care/rehab facilities.

Problem Statement

Educating clients about their role to participate in goal setting and treatment planning, and facilitating their involvement to do so, are requirements established by the AOTA (1998), JCAHO (1992) and CARF (1989). Indirectly, those requirements detail the main components of client-centered practice. The client-centered approach has received much praise in the healthcare literature. In addition, use of the approach is related to a number of positive treatment outcomes. It is important that client-centered practice be utilized in order for clients and occupational therapists to reap the benefits that use of the approach has been documented to elicit. There is limited research addressing across a variety of adult/geriatric healthcare settings, the extent of occupational therapists use of the client-centered approach in goal setting and treatment planning or perceptions of the client-centered approach from the viewpoints of occupational therapists and their clients.

Rationale of the Study

Occupational therapists are recognized for their unique, holistic approach to working with individuals. Enabling individuals to achieve maximum functional independence at performing their activities of daily living, work, and/or leisure occupations is the role of an occupational therapist. Implementing client-centered practice is an ideal method that occupational therapists can utilize to involve their clients in their care and fulfill their role in the healthcare domain.

Understanding whether client-centered practice is used by occupational therapists across a variety of healthcare settings is of great concern. Understanding occupational therapists' and their clients' perspectives of the approach is also of great concern because they may provide insight into factors that may facilitate use of the approach or present barriers to using the approach on a day-to-day basis. Gaining an understanding of this knowledge will assist therapists to develop strategies for implementing the approach more effectively, thereby improving the outcomes of occupational therapy treatment.

Definition of Terms

Client-centered practice: An approach to the delivery of occupational therapy services. It involves ongoing communication between the client and therapist so that the client is truly the center of therapy and involved in the decision-making process throughout the entire treatment process.

Goal setting: The act of stating one's desires for the future.

Meaningful occupation: Anything that a person engages in based on their feelings of motivation and desire to do so.

Perceptions: An individual's ideas or opinions about a particular issue.

Treatment Planning: Making decisions about what will take place during occupational therapy.

Purpose of the Study

This study will investigate across a range of adult/geriatric healthcare facilities in Ithaca, New York and the surrounding area, the extent to which client-centered practice is used in the treatment planning and goal setting process. This study will also investigate occupational therapists' and their clients' perceptions of client-centered practice. The expectation is that these findings will provide further insight into the implications of utilizing the client-centered approach on a day-to-day basis.

Chapter 2: Literature Review

Introduction

The roots of occupational therapy are grounded in the concept of holism. Holism is a unique concept that takes a much more broad perspective than the traditional medical model that is used in many healthcare facilities. For a length of time in the profession of occupational therapy's history, the medical model had a strong influence, and it still does to this day in some settings. However, due to the holistic nature of occupational therapy being concerned with a broader picture of the individuals who receive services, it is vital that clients be involved in all aspects of the therapeutic process and that a shared decision-making process is utilized by the occupational therapist.

Client-centered practice is an approach taken to the delivery of services. The underlying theme in the approach is that the client is the focus of treatment. Clients' values and desires need to be identified and included in treatment plans and goals in order to allow for the most desirable outcomes of treatment. Thus, in client-centered practice, clients need to act as active participants and make their concerns known to their therapist. In turn, occupational therapists need to act as listeners, educators, facilitators, and enablers. Based on the client-centered practice literature to date, application of client-centered practice to the everyday delivery of occupational therapy services is logical as a result of the numerous outcomes that use of the approach has been documented in to facilitate. In addition, numerous strategies are cited in the literature as methods that therapists may use to apply the principles of client-centered practice to their delivery of services. In the literature there are also, however, numerous barriers cited that occupational therapists face in their attempts to implement the approach on a day-to-day

basis. All of these issues will be addressed in detail so that a greater understanding of client-centered practice in occupational therapy will be realized.

Roots of Occupational Therapy

The roots of occupational therapy are grounded in the concept of engaging clients in meaningful and purposeful occupations as treatment to positively alter deficits in occupational performance (Willard & Spackman, 1947). Engaging a client in an occupation which is not meaningful or lacks the potential to elicit purpose is not considered to be a therapeutic intervention (Nelson, 1994), thus borders on lacking a fundamental concept of occupational therapy in its truest sense. In order to identify what is meaningful and purposeful to a client, first and foremost, listening to the rich information that the client has to provide (O'Neill, 2001; Payton & Nelson, 1996), will provide insight into their values. This may be appropriately followed by engaging the client in a discussion that involves open communication, collaboration, and respect (Tickle-Degnen, 1998; Townsend, 1997). In essence, it is the partnership between the client and therapist working together to achieve the client's goals that is the fundamental nature of occupational therapy (Willard & Spackman, 1947).

Medical Model Versus Holistic Practice

Occupational therapists are recognized for their unique means of intervention. As opposed to the traditional medical model, in which the body is reduced into separate parts, occupational therapists view individuals in the context of how their disease or disability affects their ability to perform activities of daily living (ADLs), work, and/or leisure occupations. Holism or holistic practice is the view of looking at an individual in terms of their whole being, and in various contexts, as opposed to a collection of physical

systems acting independently. It is taking a holistic approach to treatment that markedly separates the health discipline of occupational therapy from other medical model approaches and medical disciplines. Finlay (2001) discussed the difference between the holistic approach and the medical model approach by explaining that occupational therapists value clients' perception of their problem, seek their participation in treatment, and take a client-centered approach; whereas in medicine, specific diagnoses and objective findings are the determinants of the approach that will be taken. Comparing the two models, Neistadt (1995) explained that collaborating with the client while setting goals and planning treatment sessions results in better client outcomes as compared to using the traditional medical model approach.

Consider the uses of the traditional medical model approach versus the holistic approach in, for example, a client diagnosed with a cerebrovascular accident. Utilizing the traditional medical model approach, the occupational therapist may seek to identify pathological problems based on a functional assessment, addressing issues such as muscle strength, range of motion, and endurance. Under a holistic approach, the occupational therapist would listen to and speak with the client to identify what meaningful occupations the individual is having difficulty performing, perform a functional assessment to identify possible causes of difficulties stated by the client, and then focus treatment around those problem areas. Henbest and Fehrsen (1992) explain that taking a client-centered approach requires a shift in thinking from the traditional medical model approach to an approach that involves listening to and caring for a client and their problems.

Shift Between the Medical Model and Holistic Practice

Despite the profession of occupational therapy's unique conception in the early twentieth century, its focus shifted in the early 1930's due to a strong medical model influence. The shift to a medical model oriented approach altered the position of control and decision making between the client and therapist. Whereas previously control was held jointly between the client and therapist, the shift to a medical model oriented approach altered the position of control and decision making between the two (Rebeiro, 2000). The result was that control over decision making was held by the therapist. Reliance on formal knowledge was expected of occupational therapists under the dominance of the medical model. As a result, therapists gave little consideration as to the therapeutic benefit of the occupations that they were having their clients engage in (Christiansen & Baum, 1997; Rebeiro, 2000). Often times, for example, the general goal for clients was for them to achieve the medical model's components of function: range of motion, muscle strength, and release from disturbed thought processes (Christiansen & Baum, 1997). In fact, reimbursement for occupational therapy from the mid 1960's to the mid 1980's in the United States was directly related to a therapist's documentation of those components of function (Christiansen & Baum, 1997).

The shift to treating clients with a medical model approach as opposed to the former holistic approach proved to have both positive and negative consequences for the field of occupational therapy. Occupational therapists' shift to the medical model approach heightened outside interests and gained respect for the field of occupational therapy as a profession. The shift also, however, served to distance the field of occupational therapy from its roots and its non-traditional, unique style of intervention.

Reform in the 1970's by client movements such as the Independent Living Movement and the Patient's Bill of Rights, once again shifted the delivery of healthcare services. The Patient's Bill of Rights, developed by the American Hospital Association (1972) recognized three main themes. First, it recognized the innate rights that clients hold. Second, it recognized that an informed client who understands their illness tends to be at ease and more compliant with their treatment program. Last, the Patient's Bill of Rights recognized that a client who is informed and able to participate in the decision-making process is more likely to be satisfied with the outcomes of their treatment. Within the realm of the Patient's Bill of Rights, the hospital had a responsibility to its clients to: a) take the clients individuality into consideration, b) keep the client informed in terms that they can understand, c) respect the clients rights, and d) act reasonably in response to a clients request (Countryman & Gekas, 1980).

The argument that clients have a right to information about their healthcare as well as the right to participate in the decision making process was also strongly advocated for by the founders of the Independent Living Movement. The Independent Living Movement (DeJong, 1979), a healthcare reform plan, stressed the importance of client choice, self-direction, and individual dignity. The Independent Living Movement advocated that clients be involved in planning, directing, and implementing their care (Smith, Smith, King, Frieden, & Richards, 1993).

In addition to reform being led by client movements in the 1970's, in the latter part of that decade, prominent writers in the field of occupational therapy expressed their concern over the profession's shift toward the medical model approach (Christiansen & Baum, 1997). In 1977, Philip Shannon wrote an article entitled, *The Derailment of*

Occupational Therapy. Shannon (1977) believed that occupational therapists were drifting away from their traditional holistic approach as a result of the profession of occupational therapy's unity with the medical model, and adoption of the reductionistic philosophy. Shannon (1977) explained that in employing the reductionistic philosophy, man was no longer viewed as unique and able to influence the state of his health through the use of his hands, but rather an object to be acted upon and controlled.

As concern for the delivery of services in a non-holistic manner continued to rise, healthcare professionals were continuously being confronted with the challenge to reassess their focus and shift back to a more holistic, client-centered approach (Rebeiro, 2000). In response to all the concern expressed in the late 1970's about the direction in which occupational therapy practice was heading, The Canadian Association of Occupational Therapists (CAOT) responded in the early 1980's by creating a document titled, *Guidelines for the Client-Centered Practice of Occupational Therapy*. Although the document does not define what client-centered practice is, it does discuss the basis for implementing a client-centered approach. Numerous times throughout the document, reference is given to the client as being the focal point of care. Likewise, the client-centered roles of the occupational therapist are outlined as being to facilitate the client to engage in meaningful occupations and to create a therapeutic relationship.

Documented Requirements for a Client-Centered Approach

Due to the field of occupational therapy's conceptualization within the concepts of engaging clients in meaningful occupations and its unique holistic approach to treatment, it is a practical requirement that occupational therapists involve their clients in treatment planning and goal setting. The AOTA (1998) stated, "Occupational therapy

personnel shall collaborate with service recipients or their surrogate(s) in determining goals and priorities throughout the intervention process" (p. 3). A core value of occupational therapy practice is the concept of freedom, "which allows the individual to exercise choice and to demonstrate independence, initiative, and self-direction" (AOTA, 1998, p. 7).

Aside from the client-centered approach being advocated by the AOTA, health care accrediting organizations and regulatory bodies also recommend therapists to adopt its use in their day-to-day delivery of care. The requirement for collaboration set by the JCAHO (1992) in its physical rehabilitation standards for hospitals included, "the client and family participate as appropriate in the development and implementation of the treatment plan"(p. 180).

Similarly, the CARF (1989) stated, "There should be full discussion of how the individual is to participate in goal setting and program planning, unless contraindicated by circumstances unique to the individual, (p. 30); the goals of the person being served and the family when appropriate should be elicited and considered in program planning, (p. 31); lastly, assure that the person served or personal representative is involved on an ongoing basis in discussion of plans, goals, status, etc." (p.32).

History of Client-Centered Practice

The concept of involving clients in their own care is referred to as client-centered practice, or taking a client-centered approach to treatment. Client-centered practice evolved from the concept of client-centered counseling which holds philosophical ties with the existential movement (Burnard, 1995; Sartre, 1956). Generally, the existential movement asserted that individuals make life decisions only for themselves, not choosing

or deciding for another. Carl Rogers (1939) had a similar concept, however, with less assertive undertones. Rogers (1939) used the term client-centered counseling to guide his approach. Rogers (1939) believed that because people were essentially good, if given the opportunity, they would intuitively make the right decisions (Burnard, 1995). Due to Rogers' (1939) belief that humans are innately good, he argued that there should be a therapeutic relationship between the client and therapist. In the therapeutic relationship the client should be allowed to make their own decisions and facilitate their own growth. Simultaneously, the therapist should remain objective and maintain an adequate degree of sympathy, interest, respect, and understanding not only of the client but also himself. Thus, Rogers (1939) challenged therapists to create relationships with their clients that provide the client with some degree of freedom to solve their own problems so that in turn they will be able to develop themselves.

Due to the dominance of the medical model at the time that Rogers submitted his proposals for this concept, his ideas were often misunderstood and the approach was applied incorrectly (Falardeau & Durand, 2002). Client-centered counseling was misinterpreted as being a concept that called for a role reversal between the client and the therapist. Thus, the misunderstood role of the therapist was to be completely passive and to support their client in all their decisions, and the misunderstood role of the client was that they were expected to maintain a directive position and hold the majority of the power in the therapeutic relationship. Rogers noted this misuse of the concept in 1965. He re-explained client-centered counseling and clearly stressed communication and interaction between the client and therapist to be of major importance, as opposed to the client assuming a directive approach.

Rogers' final explanation of client-centered counseling is most clearly linked with the current term, client-centered practice. Client-centered practice focuses intensely on communication and active collaboration between the therapist and client to identify problem areas that are hindering a client's occupational performance, make decisions, and set goals. It is important to make clear, however, that client-centered practice is not exactly "what" the therapist does with the client, but rather "how" they do it with the client (Law, 1998).

Definition of Client-Centered Practice

There are many different phrases that refer to the client-centered concept. Phrases such as, client-centered practice (Corring & Cook, 1999; Hebert, Thibeault, Landry, Boisvenu, & Laporte, 2000) client-centered occupational therapy (Law, 1998), client-centered approach (Falardeau & Durand, 2002), patient-centered approach (Henbest & Fehrsen, 1992, and Rogers, 1939), client-driven (Gage1994), client-focused (Law, 1998), client-centered care (Corring & Cook, 1999; Law, 1998; Lowes, 1998) client-centered counseling (Burnard, 1995; Burnard & Morrison, 1991; Rogers, 1939; Rogers, 1951) and client-centered service delivery (Commission on Practice Task Force, 1995) are some examples. With regards to this paper, the phrase client-centered practice will be used.

Law, Baptiste, and Mills (1995) suggested the first formal definition of client-centered practice in occupational therapy. They defined it as, "an approach to service which embraces a philosophy of respect for, and partnership with, people receiving services" (p. 253). The approach acknowledges clients' autonomy, and the necessity for facilitating client choice in the decision-making process about occupational needs, specific to the clients' life context (Law et al., 1995).

The Commission on Practice Task Force (1995) developed a concept paper entitled, *Service Delivery in Occupational Therapy*. The Task Force stressed the point that client-centered care involves use of a collaborative approach, as a means to determine priorities, set goals, and identify occupations that the client deems meaningful. Client-centered practice may be used in order to demonstrate to the client that they are respected and that their values are an important component of treatment (Commission on Practice Task Force, 1995). Similarly, in Canada, the guidelines for client-centered practice of occupational therapy define client-centered practice as, "collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others. Occupational therapists demonstrate respect for clients, involve clients in decision-making, advocate with and for clients in meeting clients' needs, and otherwise recognize clients' experience and knowledge" (CAOT, 1997, p. 49).

In client-centered practice, both the client and the therapist play active roles in the decision-making, goal setting, and treatment planning processes. This is demonstrated by ongoing collaboration between the client and therapist in order to identify problem areas of occupational performance, followed by the client and therapist discussing what the focus of treatment will be in order to ensure desired treatment outcomes. Under the approach, clients seek the assistance and support of their therapists to help them achieve their goals (Law, 1998). The therapist creates an environment of understanding, trust, and acceptance for the client, to facilitate their pursuit toward their goals (Law, 1998). In effect, client-centered occupational therapy promotes interaction, discussion, respect, and active involvement of the client in decision-making (Law, 1998).

Sumsion (2000) used nine focused groups consisting of sixty-seven occupational therapists to gain information about what they felt were the most important components of client-centered practice that should be utilized in its definition. The resulting definition, "Client-centered occupational therapy is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfill his or her occupational roles in a variety of environments" (p. 308). The client negotiates their goals in terms of priority. The therapist listens to and respects the client's values, modifies interventions to reflect the client's needs and acts as an enabler to ensure the client makes informed decisions. Upon their completion of applying and assessing the client-centered approach in a non-Western setting, Henbest and Fehrsen (1992) defined client-centered practice as an approach that the practitioner can take to guide their relationship with their client in an attempt to understand their client's thoughts, feelings, and expectations, along with their symptoms.

In summary of what the aforementioned authors defined client-centered practice to be, overlapping themes arose. Combining all of the themes, a great picture of client-centered practice may be constructed. Beginning with the outer layer, visualize an environment created by the therapist that radiates respect and acceptance to the client. This is built as the client's values, experiences, and personal choice are elicited, and autonomy respected. In the center of client-centered practice, the therapist listens to the client, and not only hears what the client is saying, but understands the necessity for incorporating the client's narrative into his/her treatment. The therapist, collaborating with their client in order to involve them in decision-making, identifying occupations which are meaningful, determining the client's priorities, and setting treatment goals

based on the client's narrative, may demonstrate the therapists' listening to the client. After the values of the client are attained, the therapist may be prepared to create an enabling and therapeutic treatment environment that empowers the client to achieve their goals.

Criticisms of Client-Centered Practice

Not all of the literature on client-centered practice supports the notion that clients playing an active role in their healthcare will produce the most favorable outcomes. Burnard (1995) explained that the approach ignores the commonalities that many people share. The client-centered approach nulls similar problems and feelings that individuals face, Burnard (1995) discussed, as he interpreted Rogers' explanation of client-centered to mean that only the individual is able to make up their own mind and problem solve as an independent. Thus, Burnard (1995) believed that because persons are expected to act as unique individuals under the client-centered approach, advice and suggestions should not be provided because what the "unique individual" is experiencing is unique to him and has never before been experienced in exactly the same way by anyone else. Burnard (1995) argued, that literally this concept of uniqueness may be true, however, people do encounter similar experiences in their routine lives, which if openly discussed may provide individuals with suggestions or options that they can sort through and incorporate into their lives. I feel it is important to keep in mind, however, that in Burnard's (1995) interpretation of Rogers' theory, he discussed Rogers' initial explanation of client-centered, which too many individuals misinterpreted. Rollo May (1982) was another critic of Carl Rogers. In an open letter to Carl Rogers, May's (1982) initial point of argument against Rogers was his belief that humans are innately good and thus when

given the opportunity, will inherently make the right decisions. The principle of humans' innate goodness was a foundation for Rogers' client-centered counseling, thus, client-centered practice. Similar to Rogers' belief of humans, in May's (1982) opinion, he too believes that humans can be conceptualized as an "organized bundle of potentialities" driven by an urge to affirm, assert and perpetuate one's self (p. 11). However, May (1982) further goes on to explain that that concept is too optimistic because as well as people are good, they are also evil and partially destructive, not only to themselves, but also society. He believes that if a person's potential to affirm and assert him/her self is not integrated into their personality, then the destructive side will evolve, and thus the constructive and creative potentials weakened. Thus in terms of the client-centered approach, some individuals are in fact not essentially good and require additional guidance and support to make appropriate decisions in order to ensure their individual and society's safety.

Occupational Therapist and Client Roles in Client-Centered Practice

Once there is a clear understanding of client-centered practice, it is logical next to formalize the roles of occupational therapists and their clients. A review of the literature above summarized occupational therapists roles in client-centered practice as a) therapists should actively listen to the rich information their clients provide (O'Neill, 2001; Payton & Nelson,1996), b) therapists should educate their clients about their role to participate, (Rogers, 1951; Sumsion, 1999; Toomey et al., 1995; WHO,1979) c) therapists should facilitate their client's involvement in the treatment planning and goal setting processes (Meyer, 1977), and d) therapists should enable their client to engage in their occupational therapy treatment sessions by providing a therapeutic environment that will

facilitate their involvement (Burnard & Morrison, 1991; Diasio, 1971; and Townsend, 1997).

Occupational Therapis'ts Role: Listener

What distinguishes client-centered practice from other approaches to treatment is that under client-centered practice, the client is the focal point and, therefore, greatly involved in their care. Although it may seem basic, a significant method to demonstrate the centrality of the client in the approach is simply to listen to what he has to say. O'Neill (2001) explained that clients are the experts on receiving care, and thus it is vital to listen to what they have to say and work with their experiences. Listening to the client will facilitate him to participate in the treatment planning and goal setting processes. Payton (1990) explained that the therapist's role is to make every effort to assist the client in taking control of his own healthcare by providing him with the opportunity to verbalize his concerns. Listening to what the client has to say is the ideal way to allow this. Likewise, Payton and Nelson (1996) explained that listening to the input that the client has to offer is important to elicit and incorporate, not only for diagnostic purposes, but also because it is rich information that can be useful in creating an individualized treatment plan.

Occupational Therapist's Role: Educator

After the client has had the opportunity to raise any important issues and make his concerns known, it is important that he is educated about client-centered practice and what is expected of him in the approach. Sumsion (1999) discussed the role of the therapist as being an "educator" and discussing with the client what their role is and what will be expected of them in the client-centered approach. Toomey et al. (1995) suggested

that if facilitating the client's participation in their care is a goal, then the therapist must act as a teacher and collaborator, and discuss with their client, their role as an active participant. Rogers (1951) and WHO (1979) emphasized that educating clients facilitates their problem solving and ensures that they will have the knowledge and ability to contribute to the development of their healthcare plan.

Baker et al. (2001) conducted a study and examined whether physical therapists seek client participation in goal setting. They discussed that therapists were providing basic client education; however, items that demanded greater interaction with the clients were less frequently used. Therefore, they concluded that therapists may avoid certain aspects of client education, such as those that require more involvement, perhaps as a result of feeling uncomfortable or poorly prepared. Therapists should keep in mind, however, that clients who lack information tend to feel disempowered, which serves to hinder them from taking an active role throughout the course of their treatment (Wilkins et al., 2001).

Occupational Therapist's Role: Facilitator

After the client has been educated about his role in client-centered practice, it is vital that the occupational therapist follow through and facilitate their client's involvement. Adolph Meyer (1977) discussed the necessity for occupational therapists to act as facilitators and encouragers. The role of an occupational therapist is to give opportunities to clients and facilitate their active involvement, problem solving, and creative abilities, throughout the therapeutic process (Meyer, 1977). In facilitating their client's involvement, occupational therapists are encouraging their client to take an active role.

Occupational Therapist's Role: Enabler

In order to close the circuit on the roles of an occupational therapist in client-centered practice, the concept of the therapist acting as an enabler is necessary to add. Acting as an enabler, the therapist creates a therapeutic environment in which the client can better himself. Diasio (1971), Burnard and Morrison (1991), and Townsend (1997) used the phrase enabler to describe the therapist role. " Enabling refers to processes of facilitating, guiding, coaching, educating, prompting, listening, reflecting, encouraging, or otherwise collaborating with people so that individuals, groups, agencies or organizations have the means and opportunity to participate in shaping their own lives" (Townsend, 1997, p. 50). Burnard and Morrison (1991) explained that therapists need to act as enablers in order to facilitate their client's ability to problem solve and empower them to work through their issues. As an enabler, the therapist incorporates all of the rich information that their client had to offer, in combination with their own personal knowledge of the principles of occupational therapy. Thus, with this information, the therapist is prepared to create an environment that is meaningful, purposeful and motivating to their client so that he will feel empowered and able to achieve maximum functional independence.

Client's Role: Active Participant

Equally important to the role of the occupational therapist in client-centered practice is the role of the client. The role of the client in the client-centered approach compliments the role of the therapist. The main role of the client is to actively participate. Gage (1994), Rogers (1951), Willard and Spackman (1947), and WHO (1979),

recognized the need for clients to play an active role in their own healthcare and to take a portion of the control over the planning and decision-making processes.

Being mindful of the detail and richness in what they expressed to their therapist was also discussed as being a major role of the client in the client-centered care approach by Tickle-Degnen (1998). Tickle-Degnen (1998) explained that communication is a necessary component in the client-centered approach for both clients and therapists. Clients need to engage in it and verbalize to their therapist information about their history, values, present status, and future goals.

In order to fulfill the client role in the client-centered approach, the literature stresses the necessity for clients to play an active role in their own healthcare. Few studies, however, provide insight into clients' perceptions of playing an active role in their treatment or what their perspectives are of client-centered practice.

Strategies to Implement Client-Centered Practice

Education, Training, and Practice

Limited strategies are discussed in the literature pertaining to methods that occupational therapists can use to facilitate use of the client-centered approach. First and foremost, Sumsion (1999) explained that in order to ensure the use of a client-centered approach by occupational therapists, education, training, and the opportunity for occupational therapists to practice implementing the approach needs to occur. Wilkins et al. (2001) suggested that different healthcare facilities collaborate with each other to formulate everyday, practical strategies to implement and increase use of the client-centered practice on an everyday basis. In effect, a conglomeration of effective strategies to implement client-centered practice could serve to provide a pool of options to

therapists, thus allowing them to test out different strategies and incorporate what is most beneficial for their setting. Weiss (1986) discussed a unique strategy to ensure the implementation of client-centered practice. What Weiss (1986) discussed was the effectiveness of establishing a contract between the client and health professional that reflects their mutual agreement on decisions as a means to ensure professionals' use of and clients' participation in client-centered practice.

Use of Interview and Assessments

More formal methods for implementing client-centered practice have also been discussed in the literature. Methods indicated include, a) interviews (Fearing & Clark, 2000; Neistadt, 1995), b) interest checklists or a schedule of activity patterns (Neistadt, 1995), c) Occupational Performance History Interview (OPHI) (Fearing & Clark, 2000; Neistadt, 1995), d) COPM (Fearing & Clark, 2000; Neistadt, 1995; Wressle et al., 2002;), e) Occupational Self Assessment (OSA) (Fearing & Clark, 2000), and f) Goal Attainment Scaling (GAS) (Neistadt, 1995). The Patient Participation System (PPS) is also a useful tool that provides the client with the opportunity to actively collaborate with the therapist (Nelson & Payton, 1991).

Based on my knowledge of the above mentioned assessments and tools to assist occupational therapists in the implementation of a client-centered approach, the COPM is a solid measure to do so. From the initiation of the measure, the clients' input is actively sought and their input forms the basis for what areas the client feels need improvement. Thus, the clients' active involvement is facilitated, their dominant role in client-centered practice. In addition, use of the COPM by occupational therapists also allows them to fulfill their roles in client-centered practice in that therapists will need to utilize listening,

educating, facilitating, and enabling skills in order to guide their clients' completion of the measure.

Wressle, et al. (2002) evaluated the use of the COPM and its effect on clients' perception of having active involvement in rehabilitation. Wressle et al. (2002) concluded that there was a significant difference between the control group (those not assessed with the COPM) and the experimental group (those who were assessed with the COPM) in areas related to the clients' perception that treatment goals were identified, ability to recall goals, feeling that they were active participants in the goal formulation process, and perception that they were able to manage after completed rehabilitation. Thus the results indicated that use of the COPM encourages active client participation in the therapeutic process, clients' main role in client-centered practice. Wressle et al. (2002) conducted a similar study evaluating occupational therapists' perceptions of the clinical utility of the COPM. The results indicated that use of the COPM ensures the implementation of client-centered practice by occupational therapists and enhances occupational therapists' ability to communicate with other members on their healthcare team in a client-centered manner (Wressle et al., 2002).

Outcomes of Implementing a Client-Centered Approach

Use of a client-centered approach in the practice of occupational therapy can produce many positive results. In summarizing what the literature from researchers in the healthcare field identified as being the most common outcomes of implementing a client-centered approach, increased client satisfaction, improved functional outcomes, increased client compliance and adherence to treatment programs, and decreased length of stay were indicated.

Increased Client Satisfaction

Numerous studies in the medical field have concluded that clients who were treated with a client-centered approach report heightened degrees of satisfaction with the care they receive (Ben-Sira, 1976; Doyle & Ware, 1977; Wasserman et al., 1984; Calnan et al., 1994). Those studies, involving surveys or closed questionnaires, generally asked the subjects for their perception of the care they received, their perception of their practitioner, and the relationship that they had with them. Increased satisfaction was indicated by those clients based on their positive responses related to the amount of encouragement they received, the practitioner's interest in their personal problems, the doctor-client relationship that was established, the amount of information they were given, the communication style of their practitioner, and the amount of time spent in the consultation.

Wressle et al.'s (2002) evaluation of the client-centered instrument, the COPM, and its effect on clients' perceptions of their involvement in the rehabilitation process indicated use of the COPM increased clients' satisfaction with their rehabilitation. The clients who were evaluated with the COPM noted the perceptions that their treatment goals had been identified, that they were actively involved in the goal setting process, and that they were more prepared to manage themselves after termination of their rehabilitation.

Improved Functional Outcomes

Likewise, practicing with a client-centered approach has been documented to improve functional outcomes. In a physical therapy practice setting, the benefits of clients participating in their goal setting, as indicated by Baker et al. (2001), included greater achievement of their goals, increased satisfaction and gains in function, and better

adherence to treatment programs. In a medical practice setting, the influence of client-practitioner agreement on goals was assessed in terms of improvement at a follow up visit. Starfield et al. (1981) reported that when there was a mutual agreement between the practitioner and the client pertaining to what problem areas to focus on, at follow up, clients were more likely to indicate that their problems had been resolved.

Payton et al. (1990) developed the PPS, as an instrument to be utilized by therapists as a means to facilitate client participation in program planning. The background of their method arose from their understanding that clients who are motivated to achieve their goals and are passionate about them, often times achieve them, thereby increasing the effectiveness and efficiency of treatment. Similarly, Gates (1991) explained that having a correct match between the client and their goals increases progress and functional outcomes.

Further support for improved functional outcomes as a result of using the client-centered approach was noted by Neistadt (1987). In the development of an independent living services occupational therapy program for adults with developmental disabilities, clients were encouraged to take an active role in planning their sessions. During the first year of the program, clients made gains in their problem solving skills and initiation. Furthermore, because of the clients' learned assertiveness, they increased their independence, as well as their social interactions.

In long-term care settings, clients who collaborated with their occupational therapist to set their treatment goals made both statistically and clinically significant gains in their abilities, as opposed to previously when they had reached a plateau in treatment when the goals were dictated by the therapist (Neistadt, 1987; Neistadt, 1995;

Neistadt & Marques 1984). Upon a discussion of application of the medical model versus a client-driven model in longterm care facilities, Duncan-Myers and Huebner (2000), Langer and Rodin (1976), and Rodin and Langer (1977) suggested that residents that were given responsibility and choice, indicating use of a client-centered approach, had more positive outcomes, such as increased activity level and alertness, elevated mood, and increased involvement in activities and socialization.

Decreased Length of Stay

Gates (1991) and Avis (1994) identified that utilizing the client-centered approach can shorten the clients' length of stay as a result of improved functional outcomes.

Increased Adherence to and Compliance with Treatment Programs

Greenfield, Kaplan, and Ware (1985), developed an intervention to increase client participation in their care, based on their understanding that an uninformed, passive client is less able to understand their treatment plans and adhere to them in their daily routine. The results of their intervention, in which clients were helped to read their medical records, coached to ask questions and negotiate medical decisions, in comparison to a control group that received a standard educational session, indicated that the intervention group had increased interaction, fewer limitations, increased functional ability, increased satisfaction with care, and a greater preference for being actively involved in the decision-making process. Similarly, Lowes (1998) and Partrigde (1997) explained that adherence to and compliance with treatment plans is more likely to occur when a client participates in creating their treatment plan, is respected, and is encouraged to take responsibility for their own health.

Barriers Faced by Therapists in Client-Centered Practice

In contrast, numerous difficulties of practicing with a client-centered approach have also been argued throughout the healthcare literature. Practicing in a client-centered manner is challenging, not only because of time and resource pressures caused by the United States healthcare system, but also because how exactly to apply the client-centered approach in everyday practice remains vague (Law, 1998). Sumsion and Smyth (2000) sent out sixty questionnaires to occupational therapists practicing in the United Kingdom as means to identify barriers that therapists face in their attempts to implement client-centered practice. After assessment and ranking, the most noted barriers included: "the therapist and client have different goals, the therapist's values and beliefs prevent them from accepting the client's goals, the therapist is uncomfortable letting the client choose their own goals, and their intervention is dominated by the medical model" (p. 19).

The absence of a clear definition of client-centered practice (Corring & Cook, 1999; Sumsion & Smyth, 2000; Wilkins et al., 2001), how to adopt the philosophy (Corring & Cook, 1999; Sumsion & Smyth, 2000; Wilkins et al., 2001), therapists' lack of self-confidence in their knowledge of the client-centered approach, (Fraser, 1995; Law et al.,1995; Levenstein, McCracken, McWhinney, Stewart, & Brown, 1986; Sumsion, 1999), lack of resources (Lane, 2000; Sumsion, 1999; Wilkins et al., 2001), the perception that client-centered practice is too much of a change from current practice approaches, (Gage, 1994; Stewart & Harvey 1990; Sumsion, 1999; Toomey et al., 1995; Wilkins et al., 2001), the perception that client-centered practice is too demanding of a client, (Sumsion, 1999; Wilkins et al., 2001), managerial initiatives (Lane, 2000), and lack of use of the client-centered approach by all healthcare team members due to their

paternalistic tendencies (Gage,1994, Wilkins et al., 2001) were all cited as being barriers to implementing client-centered practice on a day-to-day basis.

Sumsion (1999) explained that if other healthcare team members do not follow a client-centered approach, it may be difficult for the occupational therapist to completely fulfill the client's desires without the support of team members. Not only will this barrier cause frustration for the therapist, but also for the client. In a discussion on how to deal with conflicting goals between the team and client, Gage (1994) explained that team members need to accept the reality of the goal that the client sets, because without an understanding of where the client is coming from, the team will be unable to help the client develop an alternative and more appropriate plan.

Barriers to implementing client-centered practice are very real for occupational therapists working in nursing homes, as a result of the typical medical model orientation. In the nursing home setting, some procedures may encourage "depersonalization, loss of identity, and development of docile behavior that may be detrimental to a resident's quality of life" (Duncan-Myers & Huebner 2000, p. 505; Agbayewa, Ong, & Wilden 1990; Gueldner, Clayton, Schroeder, Butler, Ray, & Ray 1992; Lachman, Spiro, & Ziff 1994). Duncan-Myers and Huebner (2000) explained that despite the medical model dominating nursing home facilities, occupational therapists can embed choice in treatment and daily tasks as a method to implement the principles of client-centered practice, thereby increasing a client's sense of self-control. Results from a study on client empowerment in a nursing home setting revealed that the elderly participants tended to respond more positively to less passive and more empowering environments (Oluwafemi Agbayewa, Ong, & Wilden 1990). Therefore, by implementing client-centered practice,

therapists empower their clients to play an active role in the planning process of their own healthcare, thus facilitating their maximum functional independence in occupations that they identify to be meaningful.

Lack of Time

Lack of time (Nelson & Payton, 1991; Wilkins et al., 2001), and stress caused by large caseloads (Finlay, 2001; Sumsion, 1999) have both been indicated as major barriers to implementing client-centered practice. Many therapists believe that seeking client input into setting goals and discussing treatment sessions will increase the demands on the therapist, causing time to be taken away from direct treatment (Wilkins et al., 2001). However, Henbest and Fehrsen (1992) and Baker et al. (2001) concluded that consultations that were directed with a client-centered approach, where client participation was elicited, were not shown to take significantly longer than those that were not client-centered. "Lack of time cannot be legitimately offered as an excuse for not conducting client-centered consultations"(Henbest & Fehrsen, 1992, p. 316).

Clients' Lack of Demand to Participate

In addition, lack of client participation and demand to play an active role in their health care can also create barriers for effective use of the client-centered approach. Swee Hong et al. (2000) explained that some clients prefer to take a passive role and would rather have their occupational therapist tell them where their problem areas are, while also some clients may have a difficult time identifying occupational performance problems and require much more assistance. Avis (1994) discussed how clients' lack of demand for involvement in their own care creates added difficulty for implementing approach. Unfortunately, many clients feel that for each ailment there is a prescription to

be given or a recipe to follow that will lead to a cure. The expectation that a cure must be prescribed creates a barrier to clients and may serve to prevent them from taking an active role in improving their health via participating in the goal setting and treatment planning processes. Meyer (1977) explained that clients and their families have the expectation that along with a disease, in order to heal from it, there is a set program of treatment, medicine, or at least some change of climate that can be prescribed. Machan Andamo (1984) suggested a unique argument for some clients' lack of participation based on the unnaturalness and structure of hospital settings. He explained that the perceived norm for clients in most hospital settings is to hand over all of their personal control and responsibilities and be healed, thus taking on the sick role. "To expect this patient to participate in a conceptual learning experience would be confusing and unfair. Hospitalized patients expect to be acted upon, to provide direct services to these patients is not wrong. On the other hand, to expect every therapist to be able to maximally function in this setting is unrealistic" (p. 81).

Barriers Faced by Therapists in Client-Centered Practice in Goal Setting

In terms of barriers faced by therapists while using a client-centered approach for goal setting, Payton et al. (1990) explained that in some cases, there may be incongruence between the goals set by the therapist and the goals of the client, thus, lessening therapists' desire to involve their clients. However, in a study assessing hemiplegic clients' ability to participate in the goal setting process, Bohannon et al. (1988) identified that the hemiplegic clients were able to indicate their desired goals for rehabilitation, which were primarily functional, after being asked, "What are your goals, what do you hope to accomplish while you are here?" (p. 181).

Additional barriers faced by therapists in relation to using a client-centered approach during goal setting include: clients may state goals deemed unsafe or that entail unnecessary risk (Law et al., 1995; Sumsion, 1999), the client may select unrealistic goals (Sumsion 1999) and the therapist may have a definite value or belief clash with the client's desired goals (Sumsion 1999).

Wade (1998) and Playford, Dawson, Limbert, Smith, Ward, and Wells (2000) defined goal setting as the process of agreeing on a desirable and achievable future state. The definition includes the term "agreeing" which makes it clear that goals are defined after the therapist and client collaborate and discuss possible outcomes. This definition highlights a key component of what the client-centered approach is all about: discussion so that a desirable end state to treatment can be agreed upon and achieved. If goals are set unilaterally, by the therapist for the client with no discussion, misunderstanding and incompliance technically should not be unexpected. In defense of goals being set unilaterally, Playford et al. (2000) argued that writing meaningful goals that are relevant to the client at all levels, especially contextually, may take weeks or longer to identify as they require an intense knowledge about the client. This can be difficult as some clients are seen by their occupational therapist for some time only two or three treatment sessions due to the nature of our healthcare system.

To remedy that issue, Playford et al. (2000) furthermore discussed that for clients who will spend only a short period of time in the hospital and then return home to independence, in order to increase their participation in the goal setting process, offering them a list of pre-set goals and then giving them the opportunity to select which goals they desire to achieve can serve as a client-centered approach to goal setting.

Barriers Faced by Clients in Client-Centered Practice

Clients also face several barriers that may hinder their ability to fulfill their role in client-centered practice. Barriers that they face typically have to do with the fixed structure and lack of flexibility within many healthcare settings. Duncan-Myers and Huebner (2000) explained that institutional settings, often following a custodial approach to care, typically leave little time open for an individual to make their own decisions. Routines often direct where, when, and how clients will spend their waking hours in the setting (Duncan-Myers & Huebner, 2000). Likewise, established routines in the healthcare system may hinder a client's attempts to display involvement or control over their care as it may run them the risk of being viewed as non-compliant or disruptive (Wilkins et al., 2001). This stereotype of viewing actively involved clients as being disruptive serves to present many barriers to not only therapists in their attempts to implement a client-centered approach to care but also clients who are trying to take control of their health.

In addition to barriers originating from the inflexibility of their healthcare setting, additional barriers clients face that may impede their ability to partake in client-centered practice include: a lack of awareness of client-centered practice and a clear understanding of what their role is within the approach (Law, 1998; Sumsion, 1999), both of which may arise due to inadequate communication between the client and healthcare professional (Avis, 1994). Lastly, Sumsion (1999) discussed how intimidation by the healthcare team and a fear of what will happen if they voice an opinion that differs from their therapist, and cultural issues which may keep the client from playing an active role in their healthcare or providing input into how they feel their care should progress can all act as barriers that a client may face in client-centered practice.

Overall, the literature describes lack of education and understanding of client-centered practice, poor communication between the client and therapist, and rigidity of the healthcare system as being major barriers that clients face in the client-centered approach.

Summary

The most logical way to lessen the barriers that occupational therapists and their clients face in client-centered practice is to go to the source of the problem. Both therapists and clients communicate lack of a clear understanding of client-centered practice and the knowledge of how to effectively participate in their roles as being major barriers that they face under the approach. Based on the requirement that a client-centered approach be utilized by occupational therapists in their delivery of services, it is necessary that the barriers they face be dealt with so that therapists are able to fulfill their requirements entirely. One of the most effective ways to deal with therapists' barriers is to identify their current use of and perceptions of client-centered practice. Second, it is necessary to identify their clients' understanding and perceptions of client-centered practice, so that any issues they raise may be dealt with so that therapists will be more able to utilize the approach. The purpose of this study is an attempt to narrow the gap in research and identify clients' and occupational therapists' perceptual involvement in client-centered practice in a variety of adult/geriatric healthcare settings.

Chapter 3: Methodology

Research Questions

Three questions asked by the study were:
1. Is client-centered practice being used in a variety of healthcare facilities?
2. Do occupational therapists and their clients perceive their use of and participation in client-centered practice differently?
3. Does facility type influence occupational therapists and their clients' perceptions of their use of and participation in client-centered practice?

Participants and Selection Method

Forty-one (30 clients currently receiving occupational therapy and 11 registered occupational therapists (OTR)) individuals were recruited for the study according to their geographic convenience to the researcher and the basis of their availability to participate within the timeframe of the study. Inclusion criteria for clients (21 females and 9 males) were (a) currently receiving occupational therapy for one day or more in either a hospital (30% inpatient and 30% outpatient), longterm care/rehabilitation facility (26.7%), or nursing home (13.3%); (b) 18 years of age or older (M= 70.63); (c) deemed by their occupational therapist to be cognitively intact, able to engage in a 10-15 minute semi-structured interview and provide accurate information about their occupational therapy treatment and their current goals, and (d) informed consent (as approved by the Ithaca College Human Subjects Review Board). Their primary diagnoses varied widely, with the four most common being hand injury, hip replacement, stroke, and a fall. All of occupational therapists (8 females and 3 males) were registered, and practiced in either: a hospital (45.5% inpatient, 9.1% outpatient, and 9.1% inpatient and outpatient), longterm care/rehabilitation facility (18.2%), or nursing home facility (9.1%). Eight therapists held bachelor's degrees and three held master's degrees. Their years of practice ranged from

four months to twenty years (M=10). The occupational therapists and their clients were kept blind to the study's specific purpose, but they were informed that the goal setting process was being studied.

Instrument

Forty semi-structured interview questions, twenty for therapists and twenty for their clients, were developed for this study to determine the extent to which client-centered practice was utilized. Interview questions for clients were directed to a) obtain demographic information, b) to identify the extent to the clients were satisfied with and benefited from occupational therapy, c) to elicit what the clients perceived their occupational therapy goals to be, d) to find out the degree to which the clients participated in setting their goals, and whether or not they identified participating in setting their goals to be important, and e) to identify their awareness of client-centered practice. In the similar format, the therapists were interviewed to a) obtain demographic information, b) elicit a response on how they determined client goals, c) obtain the background for why they used that method, c) understand how important the therapists felt it was to involve clients in setting their goals, d) find out whether or not they educated their clients about their role to participate in setting goals and how much they encouraged the clients to participate in goal setting, e) find out whether or not their clients actually participated in setting their goals, f) find out whether the therapists discussed treatment options with their clients, and g) elicit responses on the extent to which client-centered practice appeals to them. The therapists were also asked to identify barriers, or facilitators, if any, they faced in implementing client-centered practice.

Validity and Reliability of the Instrument

A group of three experienced occupational therapists, each with a doctoral degree, examined the instrument for face and content validity by analyzing and critiquing the questions. Based on their feedback, questions were refined and restructured for clarity and to produce only two levels of results (nominal and rating scale). A Cronbach's alpha was utilized to analyze the internal consistency of the pilot data on questions related to clients' perceptions of their occupational therapy goals and the goal setting process. An alpha of .75 was found for these questions, leading to the acceptance of the questions as a reliable composite instrument.

Procedure

The primary researcher was in regular contact with the therapists to determine the most convenient times to conduct the interviews. This was based on scheduling and availability of appropriate clients to be interviewed. Once schedules were arranged, the clients and therapists were formally recruited by the primary researcher. Prior to any interviewing, each participant signed an informed consent form. The interviews took place within the facilities which the occupational therapists were employed and the clients were treated, each at a private location of their choice. All interviews were conducted on a one on one basis either with the clients or with the therapists. In one case, a client's wife was present as she was highly involved in her husband's care. After the interviews with the clients, their actual occupational therapy goals were recorded from the client's chart with the permission of the appropriate authority. No specific order was assigned whether clients or occupational therapists would be interviewed first, rather it was determined by availability. The length of the interviews lasted between 15 and 20 minutes. No incentives were given for participation.

Data Analysis

Interviews from all 41 interviewees (11 therapists and 30 clients) formed the database of this study. Data were coded and analyzed using the Statistical Package for the Social Sciences, Version 11.5. Descriptive statistics were used to analyze and report the data. One-way analysis of variance (ANOVA) with an alpha level of .05 was performed with facility as independent variables (longterm care/rehab, nursing home, inpatient hospital, and outpatient hospital) and responses as dependent variables to determine whether the responses of clients as well as therapists varied significantly on the basis of their facilities. Tukey's HSD post hoc analyses were also performed simultaneously in the SPSS to determine the pair-wise comparison in case of significant results.

References

American Hospital Association (1972). A patient's bill of rights. Chicago, AHA, catalog no. 2415.

American Occupational Therapy Association. (1990). Resolution 631-90. Proactive positioning of occupational therapy for long-term care delivery system. Rockville, MD: Author. Cited in: Born B. & Metzler CA. (1994). Position Paper: Occupational Therapy and Long-Term Services and Supports. American Journal of Occupational Therapy, 48(11): 1035-1036.

American Occupational Therapy Association. (1998). Reference guide to the occupational therapy code of ethics: AOTA commission on standards and ethics. The American Occupational Therapy Association, Inc. Bethesda.

American Physical Therapy Association. (1985). Standards for physical therapy services and physical therapy practitioners. Alexandria, VA: American Physical Therapy Association.

Anderson, R.M., Funnell, M.M., Barr, P.A., Dedrick, R.F., Davis, W.K. (1991). Learning to empower patients. Diabetes Care, 14(7):584-590.

Avis, M. (1994). Choice cuts: An exploratory study of patients' views about participation in decision-making in a day surgery unit. International Journal of Nursing Studies, 31(3): 289-298.

Baker, S.M., Marshak, H.H., Rice, G.T., Zimmerman, G.J. (2001). Patient participation in physical therapy goal setting. Physical Therapy, 81(5): 1118-1126.

Baum, C.M. (1980). 1980 Eleanor Clarke Slagle Lecture: Occupational therapists put care in the health system. American Journal of Occupational Therapy, 34(8): 505-516.

Ben-Sira, Z. (1976). The function of the professional's affective behavior in client satisfaction: a revised approach to social interaction theory. Journal of Health and Social Behavior, 17:3-11.

Bogardus, S.T., Bradley, E.H., Williams, C.S., Maciejewski, P.K., vanDoorn, C, & Inouye, S.K. (2001). Goals for the care of frail older adults: Do caregivers and clinicians agree? The American Journal of Medicine, 110: 97-102.

Bohannon, R.W., Williams Andrews, A., & Smith, M.B. (1988). Rehabilitation goals of patients with hemiplegia. International Journal of Rehabilitation Research, 11(2): 181-183.

Burnard, P. (1995). Implications of client-centered counseling for nursing practice. Nursing Times, 91: 35-37.

Burnard, P., & Morrison, P. (1991). Client-centered counseling: A study of nurses' attitudes. Nurse Education Today, 11: 104-109.

Calnan, M., Katsouyiannopoulos, V., Ovcharov, V.K., Prokhorskas, R., Ramic, H, & Williams, S. (1994). Major determinants of consumer satisfaction with primary care in different health systems. Family Practice, 11(4):468-478.

Canadian Association of Occupational Therapists & Department of National Health and Welfare. (1983). Guidelines for the client-centered practice of occupational therapy. Ottawa, ON: Department of National Health and Welfare.

Christiansen, C. & Baum, C. (Eds.). (1997). Occupational therapy: Enabling function and well-being, 2nd Edition. SLACK Incorporated, Thorofare.

Commission on Accreditation of Rehabilitation Facilities. (1989). Standards manual for organizations serving people with disabilities. Commission on Accreditation of Rehabilitation Facilities, Tucson.

Commission on Practice Task Force: Kanny, E.M., Cada, E.A., Dufresne, G., Gurka, T., Bell, P.F., Hertfelder, S.D. (1995). Concept paper: service delivery in occupational therapy. American Journal of Occupational Therapy, 49(10): 1029-1031.

Corring, D., & Cook, J. (1999). Client-centred care means that I am a valued human being. Canadian Journal of Occupational Therapy, 66(2): 71-82.

Cott, C., & Finch, E. (1991). Goal-setting in physical therapy practice. Physiotherapy Canada, 43 (1): 19-22.

Countryman, K.M., & Gekas, A.B. (1980). Development and implementation of a palient's bill of rights in hospitals. American Hospital Association, Chicago.

DeJong, G. (October 1979). Independent living: From social movement to analytic paradigm. Archives of Physical Medicine and Rehabiliation, 60.

Diasio, K. (1971). Occupational therapy- a historical perspective: The modern era- 1960-1970. American Journal of Occupational Therapy, 25(5): 237-242.

Doyle, B.J., & Ware, J.E., Jr., PhD. (1977). Physician conduct and other factors that affect consumer satisfaction with medical care. Journal of Medical Education, 52:793-801.

Duncan-Myers, A.M., & Huebner, R.A. (2000). Relationship between choice and quality of life among residents in long-term-care facilities. American Journal of Occupational Therapy, 54(5): 504-508.

Executive Board of the World Health Organization. (1979). Formulating strategies for for all by the year 2000. World Health Organization, Geneva.

Falardeau, M., & Durand, M.J. (2002 June). Negotiation-centered versus client-centered: Which approach should be used? Canadian Journal of Occupational Therapy, p. 135-142.

Fearing, V.G., & Clark, J. (Eds.). (2000). Individuals in context: A practical guide to client-centered practice. SLACK Incorporated, Thorofare.

Finlay, L. (2001). Holism in occupational therapy: elusive fiction and ambivalent struggle. American Journal of Occupational Therapy, 55(3):268-276.

Gage, M. (1994). The patient-driven interdisciplinary care plan. Journal of Nursing Administration, 24(4): 26-35.

Gates, A. (1991). Patient goal setting as a method for program improvement/development in partial hospitalization programs. International Journal of Partial Hospitalization, 7(2): 129-136.

Greenfield, S., Kaplan, S., & Ware, J.E. (1985). Expanding patient involvement in care: Effects on patient outcomes. Annals of Internal Medicine, 102:520-528.

Henbest, R.J., & Fehrsen, G.S. (1992). Patient-centredness: Is it applicable outside the west? Its measurement and effect on outcomes. Family Practice, 9(3): 311-317.

James, K., & Biley, F. (1989). Patient Participation. Nursing Standard, 3(18):32.

Joint Commission on Accreditation of Healthcare Organizations. (1992). The 1993 joint commission accreditation manual for hospitals: Volume I. Standards. Chicago: Author.

Lane, L. (2000). Client-Centered practice: is it Compatible with Early Discharge Hospital-at-Home Policies. British Journal of Occupational Therapy, 63(7):310-315.

Langer, E.J., & Rodin, J. (1976). The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. Journal of Personality and Social Psychology, 34(2):191-198.

Law, M. (Ed.). (1998). Client-centered occupational therapy. SLACK Incorporated, Thorofare.

Law, M., Baptiste, S., & Mills, J. (1995). Client-centered practice: What does it mean and does it make a difference? Canadian Journal of Occupational Therapy, 62, 250-257.

Levine, R.E. (1984). The cultural aspects of home care delivery. American Journal of Occupational Therapy, 38(11): 734-738.

Lowes, R. (1998). Patient-centered care for better patient adherence. Family Practice Management. Retrieved on 07/23/2002 from: http://www.aafp.org/fpm/980300fm/client.html

Machan Andamo, E. (Ed.). (1984). Guide to program evaluation for physical therapy and occupational therapy services. New York: the Haworth Press.

May, R. (1982). The problem of evil: An open letter to Carl Rogers. Journal of Humanistic Psychology, 22(3): 10-21.

Mendoza, N. (March-April 1969). The role of an occupational therapist in a home setting. American Journal of Occupational Therapy, 141-144.

Meyer, A. (1977). The philosophy of occupational therapy. American Journal of Occupational Therapy, 31(10): 639-642. Reprinted from the Archives of Occupational Therapy, Volume 1, pages 1-10, 1922.

Neistadt, M.E. (1987). An occupational therapy program for adults with developmental disabilities. American Journal of Occupational Therapy, 41(7): 433-438.

Neistadt, M.E. (1995). Methods of assessing clients' priorities: A survey of adult physical dysfunction settings. American Journal of Occupational Therapy, 49(5):428-436.

Neistadt, M.E. & Marques, K. (1984). An independent living skills training program. American Journal of Occupational Therapy, 38: 671-676.

Nelson, C.E., & Payton, O.D. (1991). A system for involving patients in program planning. American Journal of Occupational Therapy, 45(8): 753-755.

Nelson, C.E., & Payton, O.D. (1997).The planning process in occupational therapy: Perceptions of adults. American Journal of Occupational Therapy, 51(7):576-583.

Nelson, D.L. (1994). AOTA self-study series the practice of the future: Putting occupation back Into therapy: Occupational form, occupational performance, and therapeutic occupation. The American Occupational Therapy Association, Inc., Rockville, MD.

Northern, J.G., Rust, D.M., Nelson, C.E, & Watts, J.H. (1995). Involvement of adult rehabilitation patients in setting occupational therapy goals. American Journal of Occupational Therapy, 49(3):214-220.

Oluwafemi Agbayewa, M., Ong, A., & Wilden B. (1990). Chapter 11: Empowering long term care facility residents using a resident staff group approach. Mental Health in the Nursing Home. The Haworth Press, Inc. p. 191-201.

O'Neill, S. (Feb 2001). Why ask patients what they think? Professional Nurse Supplement, 16(5):S2.

Ord, B. (1990). Care plan sharing. Nursing Times, 86(30): 40-41.

Partridge, Dr.C. (1997). Editorial- The patient as decision maker. Physiotherapy Research International, 2(4): iv-vi.

Payton, O.D., & Nelson, C.E. (1996). A preliminary study of patients' perceptions of certain aspects of their physical therapy experience. Physiotherapy Theory and Practice, 12:27-38.

Payton, O.D., Nelson, C.E., & Ozer, M.N. (1990). Patient participation in program planning: A manual for therapists. F.A. Davis Company, Philadelphia.

Playford, E.D., Dawson, L., Limbert, V., Smith, M., Ward, C.D., & Wells, R. (2000). Goal-setting in rehabilitation: Report of a workshop to explore professionals' perceptions of goal-setting. Clinical Rehabilitation, 14: 491-496.

Randall, K.E., & McEwen, I.R. (2000). Writing patient-centered functional goals. Physical Therapy, 80(12): 1197-1203.

Rebeiro, K.L. (2000). Client perspectives on occupational therapy practice: Are we truly client centered? Canadian Journal of Occupational Therapy, 67(1)7-14.

Rodin, J., & Langer, E.J. (1977). Long-term effects of a control-relevant intervention with the institutional aged. Journal of Personality and Social Psychology, 35(12): 897-902.

Rogers, C.R. (1939). Clinical treatment of the problem child. The Riverside Press, Cambridge.

Rost, K. (1989). The influence of patient participation on satisfaction and compliance. The Diabetes Educator, 15(2): 139-143.

Sartre, J.P. (1956). Being and nothingness. New York: Philosophical Library.

Shannon, P. D. (1977). The derailment of occupational therapy. American Journal of Occupational Therapy, 31(4):229-234.

Smith., Q, Smith, L.W., King, K., Frieden. L., & Richards, L. (1993). Health care reform, independent living and people with disabilities: A report on the national study group on the implications of health care reform for Americans with disabilities and chronic health conditions. Independent Living Research Utilization, Houston.

Starfield, B., Wray, C., Hess, K., Gross, R., Birk, P.S., & D'Lugoff, B.C. (1981). The influence of patient-practitioner agreement on outcome of care. American Journal Of Public Health, 71(2):127-132.

Strecher, V.J., Seijts, G.H., Kok, G.J., Latham, G.P., Glasgow, R., Devellis, B., Meertens, R.M., Bulger, D,W. (1995). Goal setting as a strategy for health behavior change. Health Education Quarterly, 22(2):190-200.

Sumsion, T. (Ed.). (1999). Client-centered practice in occupational therapy: A guide to implementation. Harcourt Brace and Company Limited, Edinburgh.

Sumsion, T. (2000). A revised occupational therapy definition of client centered practice. British Journal of Occupational Therapy, 63(7):304-309.

Sumsion, T., & Smyth, G. (2000). Barriers to client-centeredness and their resolution. Canadian Journal of Occupational Therapy, 67(1):15-21.

Swee Hong, C., Pearce, S., & Withers, R.A. (2000). Occupational therapy assessments: How client-centered can they be? British Journal of Occupational Therapy, 63(7): 316-318.

Tickle-Degnen, L. (1998). Communicating with clients about treatment outcomes: The use of meta-analytic evidence in collaborative treatment planning. American Journal of Occupational Therapy, 52(7): 526-530.

Toomey, M., Nicholson, D., Carswell, A. (1995). The clinical utility of the Canadian occupational performance measure. Canadian Journal of Occupational Therapy, 62(5):242-249.

Townsend, E. (Ed.). (1997). Enabling occupation: An occupational therapy perspective. Ottawa, ON: CAOT Publications.

Wasserman, R.C., Inui, T.S., Barriatua, B.S., Carter, W.B., & Lippincott, B.A. (1984). Pediatric clinicians' support for parents makes a difference: An outcome-based analysis of clinician-parent interaction. Pediatrics, 74(6):1047-1053.

Weiss, S.J. (1986). Consensual norms regarding patient involvement. Social Science and Medicine, 22(4): 489-496.

Wilkins, S., Pollock, N., Rochon, S., & Law, M. (2001). Implementing client-centered practice: Why is it so difficult to do? Canadian Journal of Occupational Therapy, 68(2): 70-79.

Willard, H.S. & Spackman, C.S. (Eds.) (1947). Principles of occupational therapy. J.B. Lippincott Company, Philadelphia.

Wressle, E., Eeg-Olofsson, A.M., Marcusson, J., & Henriksson, C. (2002). Improved client participation in the rehabilitation process using a client centered goal formulation structure. Journal of Rehabilitation Medicine, 34: 5-11.

Wressle, E., Marcusson, J., & Henriksson, C. (February, 2002). Clinical utility of the Canadian occupational performance measure-Swedish version. Canadian Journal of Occupational Therapy, p. 40-48.

Chapter 4: Manuscript

Title: Client-Centered Practice: Views from Occupational Therapists and their Clients

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Abstract

OBJECTIVE. The purpose of this study was to comparatively analyze the perceptual involvement of clients and occupational therapists in the shared decision-making process in healthcare facilities in the United States. This study also investigated whether there is a difference in perception in the shared decision-making process in different adult/geriatric healthcare facilities.

METHOD. Participants (11 occupational therapists, 30 clients) in adult/geriatric healthcare facilities were each engaged in a semi-structured interview to determine their perceptions of client-centered practice, specifically in relation to the goal setting process. Descriptive statistics were used to analyze the item data. In addition, one-way analysis of variance was computed to identify perceptual differences of opinions in clients and therapists among the four facility variables from where the participants originated from, i.e., longterm care/rehabilitation, hospital outpatient, hospital inpatient, nursing homes.

RESULTS. The occupational therapists in this study indicated use of the principles of client-centered practice in their delivery of occupational therapy services. Their clients however, had displayed mixed perceptions about their role as an active participant in client-centered practice and all responded negative to being aware of the approach. Perceptual differences did appear between the therapists and their clients in relation to the use of client-centered practice, as their responses to similar questions varied. Lastly, facility type significantly influenced clients' knowledge of certain aspects of their treatment in four areas.

CONCLUSION. Results suggest that a perceptual gap exists between occupational therapists and their clients in relation to their stated use of and participation in client-centered practice. In light of the results, development of a systematic strategy by therapists to elicit the roles that their clients desire to play in the therapeutic process may be an effective intervention to ensure that therapists and their clients are able to fulfill their roles in client-centered practice.

Introduction

In occupational therapy practice, the phrase 'client-centered' is being increasingly emphasized (Falardeau & Durand, 2002; Law, Baptiste, & Mills, 1995; Sumsion & Smyth, 2000). In essence, client-centered practice is an approach to treatment in which the client is the focal point around which occupational therapy treatment evolves. In this article, the phrase 'client-centered practice' is used as opposed to the phrase 'client-centered care' (Baptiste, 2003). We believe that the term 'care' inadvertently creates a misconception and hierarchy in which the therapist is the provider of care, and the client is the passive recipient. Both of those roles are opposite of what is expected in client-centered practice. In client-centered practice, the roles of an occupational therapist include a) listener, paying attention to the rich information that their client has to add throughout the course of their occupational therapy treatment (O'Neill, 2001; Payton & Nelson,1996) b) educator, educating their client about their role to participate in the decision-making process, (Toomey, Nicholson, & Carswell, 1995; Rogers, 1939; World Health Organization (WHO), 1979) c) facilitator, facilitating their client's involvement in the treatment planning and goal setting processes (Meyer, 1977), and d) enabler, enabling their client to engage in their occupational therapy treatment sessions by providing a therapeutic environment that will facilitate their involvement in order to attain their goals (Burnard & Morrison, 1991; Diasio, 1971; and Townsend, 1997). Acting as an enabler, an occupational therapist serves to empower his/her clients to achieve maximum functional independence in occupations which the clients identify to be meaningful, be they activities of daily living (ADL), work, or leisure interests, and thus the approach achieves the main goals of occupational therapy. Clients can

participate in client-centered practice by a) actively involving themselves in discussion (Tickle-Degnen, 1998), specifically related to occupations that they identify to be meaningful and purposeful, b) participating in the goal setting and treatment planning processes (Gage, 1994; Willard & Spackman, 1947; WHO, 1979), and c) demonstrating a desire and motivation to engage in their occupational therapy treatment sessions.

The importance of client-centered practice is reflected in the professional standards established by the American Occupational Therapy Association (AOTA) (1998). Accrediting organizations including Commission on Accreditation of Rehabilitation Facilities (CARF) (1989), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (1992) also emphasized the need for client-centered practice. The reasons behind such emphasis on client-centered practice are based on the numerous positive outcomes that are associated with implementation of the approach such as, a) increased client satisfaction (Ben-Sira, 1976; Calnan, Katsouyiannopoulos, Ovcharov, Prokhorskas, Ramic, & Williams, 1994; Doyle & Ware, 1977; Wasserman, Inui, Barriatua, Carter, & Lippincott, 1984) b) increased client adherence to and compliance with treatment programs (Lowes, 1998; Partridge, 1997; Payton, Nelson, & Ozer, 1990) c) decreased length of stay (Avis, 1994), and d) improved functional outcomes(Gates, 1991; Neistadt, 1987; Starfield, Wray, Hess, Gross, Birk, & De'Lugoff,1981). Therefore, it can be assumed that the process of client-centered practice would be centrally positioned in healthcare practice including the practice of occupational therapy.

Client-centered practice was not formally recognized in occupational therapy practice until the early 1980's. The phrase client-centered was first published in a

document created by the Canadian Association of Occupational Therapists (CAOT) 1983 titled, *Guidelines for the Client-Centered Practice of Occupational Therapy.* Although the document does not define what client-centered practice is, it does discuss the basis for implementing a client-centered approach. It was a combination of events throughout the 1970s including, the development of a Patient's Bill of Rights, discussion amongst prominent writers in the field of occupational therapy, and the Independent Living Movement, that facilitated healthcare professionals to understand the necessity for implementing client centered practice. A Patient's Bill of Rights, developed by the American Hospital Association (1972) recognized three main themes, a) clients hold innate rights, b) an informed client who understands their illness tends to be at ease and more compliant with their treatment program, and c) a client who is informed and able to participate in the decision-making process is more likely to be satisfied with the outcomes of their treatment. Thus, A Patient's Bill of Rights called for clients to have the opportunity to be more actively involved in their treatment program based on their innate rights. In 1977, Phillip Shannon, a prominent writer in the field of occupational therapy, wrote of a shift, "derailment", the profession had taken. Shannon (1977) discussed that the field shifted from practicing under the ideals of its holistic roots to being strongly influenced by the medical model, thus demonstrating less concern for clients' engagement in meaningful and purposeful occupations. Shannon called for occupational therapists to shift back to their holistic, client-centered roots. Third, the development of the Independent Living Movement (DeJong, 1979) a healthcare reform plan which stressed the importance of client choice, self direction, and individual dignity added to the combination of events which encouraged the implementation of client-centered

practice. The Independent Living Movement advocated that clients be involved in planning, directing, and implementing their care (Smith, Smith, King, Frieden & Richards, 1993).

Success of client-centered practice depends on two principal components. One is the desire and ability of the clients to take part in the decision-making process and the second is the desire and ability of the therapists to include clients in the decision-making process. As Larsson Lund, Tamm, and Branholm (2001) pointed out, in reality, there might be a perceptual gap between those two components. In that effect, a number of occupational therapy researchers have stressed the need for occupational therapists to actively develop and implement a systematic strategy to involve clients in the goal setting and decision-making processes in the delivery of their services (Larsson Lund & Branholm, 1996; Neistadt, 1995; Nelson & Payton, 1997; Northern et al, 1995).

Thus, in light of the requirement for clients to be educated about their participatory role in the goal setting and treatment planning processes, and to be involved in the decision-making process, it is important to question to what extent, then, is client-centered practice being utilized by occupational therapists in actual practice? In addition, it is also important to question what do clients perceive their role in be in client-centered practice, and do they meet the standard of being an active participant throughout the decision-making process? In their desire to answer the first question, Northern et al. (1995), audiotaped thirty registered occupational therapists practicing in adult physical rehabilitation facilities during an initial evaluation, reviewed their corresponding documentation, and interviewed each occupational therapist. Using a self created patient participation evaluation form (PPEF), the researchers were seeking to identify whether

occupational therapists involved their clients in the goal setting process and if so, what methods they used. The researchers found that the occupational therapists were involving their clients in the goal setting process to some extent. However, such involvement did not follow any systematic strategy. As a result, discrepancies were found in the issues related to a) discussion with clients and their family on the initial and ongoing treatment processes, evaluations, and treatment outcomes, b) clients' concern about the occupational therapy treatment processes, and c) collaboration with clients in establishing treatment goals. Therefore, the researchers concluded that the maximum potential of client-centered practice was not realized throughout the treatment process (Northern et al., 1995). Although Northern et al. (1995) interviewed therapists from 10 different facilities, they did not analyze whether differences in the approach of client- centered practice existed in different facilities. This issue is important to explore as client-centered practice is exceedingly important in long term care and nursing home facilities where residents generally suffer from chronic diseases and the clients need to take control over their health as often times the quality of life is more important over other therapeutic issues (Lund et al., 2001). Furthermore, the clients' perceptions towards client-centered practice was also not taken into account in the study by Northern et al. (1995).

In order to explore the perception of participation of clients and the strategies adopted by different care providers to encourage client participation, Larsson Lund et al. (2001) conducted a study in Sweden. The researchers investigated the issue through semi-structured interviews with hospitalized clients, nurses, and occupational therapists. They observed that the clients' level of participation could be classified into three categories, namely, a) relinquishers (were not interested in participation), b) participants

(participated in decision-making process), and c) occasional participants (participated occasionally in decision-making process). Similarly, the strategies of the professionals to encourage participation could be classified into two categories, namely, a) information providers (those who informed clients about the rehabilitation plan after the professional had created it) and b) rehabilitation practitioners (those who perceived they had an interactive relationship with their clients). The results, therefore, indicated that both professions adopted similar strategy in encouraging client participation. The researchers also identified that the clients' perceptions of their participation was the same, regardless whether the care providers occupational therapists or nurses. The study further stressed the need for identifying systematic strategies to encourage maximum participation from the clients. Similarly, with regard to clients' perceptions of their involvement in the goal setting and treatment planning processes, Nelson and Payton (1997) interviewed fifteen clients receiving occupational therapy in adult physical rehabilitation facilities. The majority of the clients they interviewed indicated that they had participated in planning occupational therapy, however, their participation was considered to be weak by the researchers' analysis. The finding that clients were considered to have weak involvement did not affect, however, the clients' valuation of occupational therapy as 93% of the clients viewed occupational therapy positively, and 60% provided strong supporting evidence. Thus, as the results indicate weak client involvement in the goal setting and treatment planning processes, did not directly effect the clients' valuation of occupational therapy. Similar to the study by Northern et al (1995), this study was limited by the sample of convenience and lack of variability in healthcare settings.

Purpose

The aforementioned studies established three priority issues for further research in occupational therapy under the tenets of client-centered practice. First is to conduct a comparative study on the perceptual involvement of clients and occupational therapists in the shared decision-making process in healthcare facilities in the United States; as to the best of our knowledge there is none. Second is to investigate whether there is a difference in perception in the shared decision-making process in different healthcare facilities. Third is to identify strategies to enhance the desire and ability of both the clients and therapists to engage in client-centered practice. The purpose of the present study was to investigate the first two issues as a preliminary step in this line of research.

Methodology

Participants and Selection Method

Forty-one (30 clients currently receiving occupational therapy and 11 registered occupational therapists (OTR)) individuals were recruited for the study according to their geographic convenience to the researcher and the basis of their availability to participate within the timeframe of the study. Inclusion criteria for clients (21 females and 9 males) were (a) currently receiving occupational therapy for one day or more in either a hospital (30% inpatient and 30% outpatient), longterm care/rehabilitation facility (26.7%), or nursing home (13.3%); (b) 18 years of age or older (M= 70.63); (c) deemed by their occupational therapist to be cognitively intact, able to engage in a 10-15 minute semi-structured interview and provide accurate information about their occupational therapy treatment and their current goals, and (d) informed consent (as approved by the Ithaca College Human Subjects Review Board). Their primary diagnoses varied widely, with the four most common being hand injury, hip replacement, stroke, and a fall. All of

occupational therapists (8 females and 3 males) were registered, and practiced in either: a hospital (45.5% inpatient, 9.1% outpatient, and 9.1% inpatient and outpatient), longterm care/rehabilitation facility (18.2%), or nursing home facility (9.1%). Eight therapists held bachelor's degrees and three held master's degrees. Their years of practice ranged from four months to twenty years (M=10). The occupational therapists and their clients were kept blind to the study's specific purpose, but they were informed that the goal setting process was being studied.

Instrument

Forty semi-structured interview questions, twenty for therapists and twenty for their clients, were developed for this study to determine the extent to which client-centered practice was utilized. Interview questions for clients were directed to a) obtain demographic information, b) to identify the extent to the clients were satisfied with and benefited from occupational therapy, c) to elicit what the clients perceived their occupational therapy goals to be, d) to find out the degree to which the clients participated in setting their goals, and whether or not they identified participating in setting their goals to be important, and e) to identify their awareness of client-centered practice. In the similar format, the therapists were interviewed to a) obtain demographic information, b) elicit a response on how they determined client goals, c) obtain the background for why they used that method, c) understand how important the therapists felt it was to involve clients in setting their goals, d) find out whether or not they educated their clients about their role to participate in setting goals and how much they encouraged the clients to participate in goal setting, e) find out whether or not their clients actually participated in setting their goals, f) find out whether the therapists

discussed treatment options with their clients, and g) elicit responses on the extent to which client-centered practice appeals to them. The therapists were also asked to identify barriers, or facilitators, if any, they faced in implementing client-centered practice.

Validity and Reliability of the Instrument

A group of three experienced occupational therapists, each with a doctoral degree, examined the instrument for face and content validity by analyzing and critiquing the questions. Based on their feedback, questions were refined and restructured for clarity and to produce only two levels of results (nominal and rating scale). A Cronbach's alpha was utilized to analyze the internal consistency of the pilot data on questions related to clients' perceptions of their occupational therapy goals and the goal setting process. An alpha of .75 was found for these questions, leading to the acceptance of the questions as a reliable composite instrument.

Procedure

The primary researcher was in regular contact with the therapists to determine the most convenient times to conduct the interviews. This was based on scheduling and availability of appropriate clients to be interviewed. Once schedules were arranged, the clients and therapists were formally recruited by the primary researcher. Prior to any interviewing, each participant signed an informed consent form. The interviews took place within the facilities which the occupational therapists were employed and the clients were treated, each at a private location of their choice. All interviews were conducted on a one on one basis either with the clients or with the therapists. In one case, a client's wife was present as she was highly involved in her husband's care. After the interviews with the clients, their actual occupational therapy goals were recorded from

the client's chart with the permission of the appropriate authority. No specific order was assigned whether clients or occupational therapists would be interviewed first, rather it was determined by availability. The length of the interviews lasted between 15 and 20 minutes. No incentives were given for participation.

Data Analysis

Interviews from all 41 interviewees (11 therapists and 30 clients) formed the database of this study. Data were coded and analyzed using the Statistical Package for the Social Sciences, Version 11.5. Descriptive statistics were used to analyze and report the data. One-way analysis of variance (ANOVA) with an alpha level of .05 was performed with facility as independent variables (longterm care/rehab, nursing home, inpatient hospital, and outpatient hospital) and responses as dependent variables to determine whether the responses of clients as well as therapists varied significantly on the basis of their facilities. Tukey's HSD post hoc analyses were also performed simultaneously in the SPSS to determine the pair-wise comparison in case of significant results.

Results

Data from the semi-structured interviews produced information in three areas: (a) extent of use of client-centered practice by occupational therapists and the extent of participation in client-centered practice by clients b) is utilized in treatment planning and goal setting; (b) perceptual differences on use of and participation in client-centered practice, and (c) influence of facility type on the perceptions of occupational therapists and their clients in client-centered practice.

Table 1 summarizes the occupational therapists responses to interview questions related to the extent of their use of client-centered practice in their delivery of

occupational therapy services. Overwhelmingly, the therapists responded positively on all the components of the client-centered practice questions. Two out 11 therapists did not educate the clients on participating in the goal setting process. One out 11 therapists was unsure about the importance of client-centered practice and did not discuss goals with their clients as part of their method to set them. Two out 11 therapists were also unsure whether their clients participated in the goal setting process. Additionally, 72.2% of the therapists noted that they encouraged their clients "a lot" to participate in setting their goals and in response to how the client-centered approach appeals to them, 63.6% identified client-centered practice to be "very appealing". Therefore, results indicated that occupational therapists were using a client-centered approach in their delivery of occupational therapy services in the target area.

Extent of Participation in Client-Centered Practice by Clients

Table 2 summarizes the clients' responses to the interview questions related to their perception on the extent of their participation in client-centered practice. Although a major percentage of clients indicated that they benefit from and are satisfied with occupational therapy, only a fraction of the clients assisted in setting their goals. One third of those clients who did not participate in setting their occupational therapy goals reasoned that their therapists addressed all of their concerns, therefore eliminating their need to participate. Interestingly, a large number of clients i.e., altogether 76.9% indicated knowledge of more than half of their actual occupational therapy goals. When clients were asked to rate whether or not it was important to them to participate in setting their goals, however, 60% responded "Yes, very much" whereas 26.7% responded "No" with reasons such as "I'd rather have them tell me what to do"; or "Right now I have too

much"; or "They tell me what to do, that's what they're trained for"; or "I don't know that I need to, they know what they're doing." Lastly, when asked whether they were aware of the phrase client-centered practice or had ever heard of it, all of the clients responded negatively.

Perceptual Differences on Use of and Participation in Client-Centered Practice

A comparison of Table 1 and Table 2 provides insight into the incongruence between occupational therapists and their clients' perceptions on their use of, and participation in, client-centered practice. For example, in response to the question, "Do you talk to your clients about what occupational therapy is and what occupational therapy can do for them?" All the therapist responded "Yes" with one stating, "It's required". However, in response to the similar question to clients, "Did your occupational therapist talk to you about what occupational therapy is and what it can do for you?" about 60% clients responded "Yes" while the rest answered in negative. In another case, 10 of 11 Therapists indicated that they discuss goal options with their clients and 9 of 11 therapists stated that they took suggestions of their clients into account in setting goals. In response to similar questions on the clients' part, a varied picture emerged. Only 13 of 30 clients were able to state all of their goals, 23 of 30 were able to state half or more of their goals, and 6 of 30 were only able to state a quarter or less of their goals.

Influence of Facility Type on Occupational Therapists' and their Clients' Perception of Client-Centered Practice

Within the boundaries of client-centered practice, open communication between clients and their occupational therapists is of utmost importance. Whether the clients knew the therapists by their first name could be an important indicator of open communication between the two. The one-way ANOVA revealed a significant difference

in clients' knowledge of their occupational therapist's name across the four facilities ($F(3,29)= 4.580$, $p= .011$). Post-hoc Tukey's HSD test revealed that clients from both hospital inpatient ($p=.037$) or hospital outpatient ($p=.014$) settings were significantly more aware of the name of their therapists compared to clients from longterm/rehab facilities. Clients from nursing homes showed a trend of greater awareness ($p=.066$) of their therapist's name than the clients from longterm/rehab facilities. There was no indication of post-hoc significant difference between clients from inpatient hospitals, outpatient hospitals, or nursing home facilities, thus indicating that the clients were equally aware of their therapist's name.

The one-way ANOVA revealed a significant difference in clients' knowledge of their occupational therapy goals across the facilities ($F(3,29)=7.699$, $p=.001$). Post-hoc Tukey's HSD test revealed that clients from both nursing homes ($p=.003$) and outpatient hospitals ($p=.002$) were significantly more aware of their occupational therapy goals than clients from longterm/rehab facilities. Clients from inpatient hospitals showed a trend of more awareness ($p=.058$) of their occupational therapy goals than the clients from longterm/rehab facilities. No post-hoc significance was indicated between clients from inpatient hospitals, outpatient hospitals, or nursing home facilities, thus indicating they were equally aware of their occupational therapy goals.

Lastly, the one-way ANOVA revealed a significant difference across the facilities exists in the assistance that clients provide in setting their occupational therapy goals ($F(3,29)=4.993$, $p=.007$). Post-hoc Tukey's HSD test indicated that clients in the outpatient hospitals assisted significantly more in setting their treatment goals than clients

either in nursing homes (p=.012) or in inpatient hospitals (p=.026). Other post-hoc Tukey's HSD comparisons were insignificant.

Additionally, no significant differences were indicated among the clients' receipt of information about the role of occupational therapy, clients' perception of their benefit from occupational therapy, clients' extent of satisfaction with occupational therapy, or clients' belief of their importance to participate in the goal setting process.

Similarly, no significant difference was indicated between the responses of occupational therapists across different facilities with one-way ANOVA indicating that the therapists responded similarly on all questions.

Discussion

Extent to Which Client-Centered Practice is Utilized: Occupational therapists versus Clients

The essence of client-centered practice is the healthcare provider being mindful of the fact that the client is the center of practice. Understanding of this concept may be demonstrated by providers' actions of maximally involving their clients throughout the entire treatment process (Sumsion, 1999). Findings of the present study indicate that the occupational therapists involved their clients in discussions on goal setting and treatment planning across all facilities. This statement is supported as the majority of occupational therapists indicated that a) they discuss goal options with their clients as a method to set them, b) feel it is very important to involve their clients in the goal setting process, c) educate their clients about the clients' role to participate in the goal setting process, d) encourage their clients "A lot" to participate in setting their goals, e) discuss treatment options with their clients, and f) achieve client participation in setting their goals. This finding is similar to that of Northern, et al. (1995) where they found in physical

rehabilitation settings, occupational therapists working with adults did involve their clients in the goal setting process to some extent. Therefore, the present study indicates that the occupational therapists fulfilled one criterion of client-centered practice by educating their clients, as envisioned by Sumsion (1999).

Although occupational therapists participating in this study indicated their desires of application of the principles of client-centered practice, they also indicated numerous barriers to the approach. These barriers of implementation of client-centered practice include: a) clients with decreased cognition, b) clients who may have no desire to contribute to setting their goals and expect their therapist to do so for them, c) facility productivity may decrease, d) not every client is able to verbalize their concerns, e) the difficulty of practicing in an environment where the client's personal goals may not be the focus of treatment on the healthcare teams agenda, and f) some clients are indifferent and unmotivated to be independent. In addition, a number of other studies also indicated numerous barriers that occupational therapists explained to have faced in their attempts to implement client- centered practice on a daily basis. Barriers that occupational therapists may face include, a vagueness of how to apply the approach (Corring & Cook, 1999; Sumsion & Smyth, 2000; Wilkins et al., 2001), occupational therapists who are practicing in environments that are dominated by the medical model (Sumsion & Smyth, 2000), lack of time to involve clients (Nelson & Payton, 1991; Wilkins et al., 2001), and clients' lack of demand to participate (Swee Hong, Pearce & Withers, 2000).

Extent to Which Clients Participate in Client-Centered Practice

Gage (1994), Rogers (1939), Willard and Spackman (1947), and WHO (1979), recognized the need for clients to play an active role in their own healthcare and to take a

portion of the control over the planning and decision making processes. The results of this study indicate that there was an equal split in the clients' participation in setting their goals. Half of the clients participated in 50% or more and half participated in 50% or less in assisting with setting their goals. This kind of split was also evident in clients' rating of the importance of them participating in setting their goals, as more than half (60%) stated it was very important to participate, 13.3% stated it was somewhat important, and a large number (26.7%) stated it was not at all important. The heterogeneous grouping of clients is also similar to the finding of Larsson Lund et al. (2001) where they found that the clients can be grouped as participants, occasional participants, and relinquishers on the basis of clients' perception of participation. However, despite some clients' lack of desire to participate in the goal setting process, their knowledge of their occupational therapy goals was not neglected as half of the clients were aware of all of their treatment goals. Likewise, a large percentage of clients (66.7%) rated they were fully satisfied with occupational therapy. Thus, it can be assumed that these high rates of client satisfaction with occupational therapy treatment occurred as a result of a client-centered practice approach being utilized by the occupational therapists. This assumption is consistent with studies conducted by a number of other researchers (Ben-Sira, 1976; Doyle & Ware, 1977; Wasserman et al., 1984; Calnan et al., 1994).

In addition to clients' participation in client-centered practice, their perceptions of the approach also appeared to vary due to confounding factors such as the clients' varying age and gender. Northern et al. (1995) indicated that a clients' age may effect their participation in the goal setting process. According to their study, those who participated more in the goal setting process averaged to be 30 years younger than

patients who participated less. The authors did not address this issue further, however, due to unequal weight given to some of the items. The results of this study indicated that age did play a factor in participation, as younger clients did participate more in the goal setting process as compared to older participants, who participated the least. However, gender may also be a factor effecting participation in the goal setting process as the group who participated significantly more in the goal setting process, the hospital outpatient clients, were not only younger, but also the majority were male.

Perceptual Differences on the Extent of Use of Client-Centered Practice

The results identify that a perceptual gap exists between occupational therapists and their clients in relation to their stated use of and participation in client-centered practice. This is because of inconsistency in occupational therapists' and their clients' responses to similar questions. For example, all of the occupational therapists stated that they explained what occupational therapy is to their clients, however, when clients were asked the same question, just over half responded that they had been told what occupational therapy was or what it would be doing for them. When occupational therapists were asked if their clients typically participated in setting their goals, over three quarters of the therapists responded in positive, however, the majority of clients stated little or no active participatory involvement. In addition, while almost all of the occupational therapists indicated the importance of involving their clients in the goal setting process, only just over half of the clients indicated the importance of participating in the goal setting process. Lastly, the majority of occupational therapists viewed client-centered practice as very appealing, while none of the clients had even the slightest awareness of the approach. One of the reasons of such a gap could be that in the present

study, the occupational therapists formed a homogenous group in terms of their perceptions of the goal setting and treatment planning processes, whereas the clients formed a heterogeneous group in terms of their perception of their participation as mentioned earlier. As a result, if a similar strategy is utilized by the therapists to encourage all of the clients, who have such a range of perceptions, to participate in the the goal setting and treatment planning, there is a possibility that a gap in perception between the clients and therapists will result. The results thus point to the fact that therapists should establish a therapeutic environment that facilitates open communication with clients. This should be done in order to identify the level of active participation the clients desire to engage in, in occupational therapy treatment. After this is elicited, therapists will then be able to establish a strategy to encourage their clients' participation in the rehabilitation process, as suggested by Northern et al. (1995).

Furthermore, a gap between clients' actual involvement in the goal setting and treatment planning processes and their perceived involvement, as found by Nelson and Payton (1997) might too add to the perceptual gap found in this study. In their study, Nelson and Payton (1997) interviewed fifteen individuals who had received occupational therapy in adult physical rehabilitation facilities. The results indicated that the majority of clients felt that they were involved in the goal setting, treatment planning, and outcome evaluation processes, however, based on the researchers' analysis, their indication was considered to be weak. In addition the results indicted that despite the clients' weak involvement in the planning processes, they had a high valuation for occupational therapy with strong indicators determined by the researchers' analysis. The issue raised was that the participants in their study predominantly had relatively acute medical conditions. The

researchers cited Thorne (1993) for his stages that individuals with chronic illnesses may face in their relationship with their healthcare providers. Thorne (1993) explained that there are three stages that individuals with a chronic illness may face including: naïve trust, disenchantment, and guarded alliance. Nelson and Payton (1997) reasoned that due to the acuteness of their participants' conditions, they may have been in the stage of naïve trust, and therefore, have a high valuation for occupational therapy. Carrying Thorne's stages over into this study, in which some of the clients interviewed were receiving occupational therapy in longterm care/rehab facilities, nursing homes, and/or outpatient hospital facilities, they may be in the disenchantment or guarded alliance stages and therefore have a lesser degree of valuation for occupational therapy. The results of this study do not support Thorne's stages as indicated in Table 3.

Influence of Facility Type on Client-Centered Practice

Although the results indicated no significant differences existed among the responses of the therapists across the four facility types, general differences did appear to show some trends. Occupational therapists in hospital inpatient facilities tended to show the strongest trend of not utilizing client-centered practice and having the most difficulty in their attempts to do so. For example, the therapists in the hospital inpatient setting consistently deviated from the norm of therapists on questions related to a) discussion about goals, b) level of encouragement to their clients to participate in setting their goals, c) their perception of the importance to involve their clients in the goal setting process, and d) educating their clients about their role to participate in the goal setting process. However, hospital inpatient therapists' responses to questions related to the barriers of utilizing a client-centered approach indicated that their clients do not always participate

in the goal setting process due to their inability to do so. Based on their clients' inability, it is reasonable to assume that hospital inpatient therapists, who consistently work with clients who are unable to participate in the goal setting process, or lack the desire to play an active role in the therapeutic process may utilize client-centered practice on an infrequent basis. Thus, it is logical that therapists practicing in hospital inpatient settings use of client-centered practice would be less than that of other therapists who did not indicate those barriers. Machan Andamo (1984) suggested a unique argument for some clients' lack of participation in their hospital based services based on the unnaturalness of the setting. He explained that the perceived norm for clients in most hospital settings is to hand over all of their personal control and responsibilities and be healed, thus taking on the sick role. Machan Andamo (1984) argued that to expect clients to participate maximally in the experience may be very difficult and therefore, an unfair expectation, thus, to provide a paternalistic style of service to those clients is not wrong. Furthermore, it was explained that to expect therapists to function maximally in the hospital setting may also be very difficult and unrealistic.

In terms of facility type influencing clients' perceptions of client-centered practice, based on the results, facility type was a significant factor on questions related to clients' knowledge of the name of the occupational therapist, knowledge of their occupational therapy goals, and their participation in the goal setting process. Facility type, however, can not be the sole determinant for causing these changes, however, as there were many other confounding factors within the facilities that may have caused the differing perceptions, for example, age, gender, satisfaction with or benefit form occupational therapy, personal value placed on participating in the goal setting process,

or previous exposure to occupational therapy. For example, clients in the nursing home facility were all female and they participated the least in the goal setting process, however, they were the most knowledgeable of their goals and indicated the most satisfaction with and benefit from their occupational therapy treatment. In contrast, the longterm/care rehabilitation facilities had the oldest clients, over eighty-five percentage of the clients indicated it is "very important" to participate in the goal setting process, the clients were knowledgeable of the least percentage of their goals, indicated the least benefit from and satisfaction with occupational therapy, and were least knowledgeable of the name of their occupational therapist. Lastly unique, close to ninety percentage of hospital outpatient clients indicated they participated in the goal setting process, were the youngest, and the majority of them were males.

Limitations

Limitations of this study are the small sample size and the non-probability convenience sample that was used to identify participants. Due to the first factor, the occupational therapists largely formed a homogenous group in their responses, thus limiting the generalizability of the findings. An additional limitation was the unequal distribution of the occupational therapist and clients in their respective facilities, thus some facilities were over or under represented. Lastly, extensive reliability tests were not performed on the semi-structured interview questions. The questions were assumed to be appropriate, however, after being analyzed by a group of experienced occupational therapists, each with a doctoral degree.

Conclusion

A perceptual gap exists between occupational therapists and their clients in relation to their stated use of and participation in client-centered practice. This gap may occur as a result of therapists and clients not fully understanding their roles within the client-centered practice approach. In light of the results, development of a systematic strategy by therapists to elicit the roles that their clients desire to play in the therapeutic process may be an effective intervention to ensure that therapists and their clients are able to fulfill their roles in client-centered practice.

Acknowledgements

We thank all of the occupational therapists and clients who volunteered their time to participate in this study. We also thank the Ithaca College Occupational Therapy department for making this study possible. This study was completed by the first author in partial fulfillment of the requirements for the master of science degree, Ithaca College Department of Occupational Therapy, Ithaca, New York.

Manuscript References

American Hospital Association (1972). A patient's bill of rights. Chicago, AHA, catalog no. 2415.

American Occupational Therapy Association. (1998). Reference guide to the occupational therapy code of ethics: AOTA commission on standards and ethics. The American Occupational Therapy Association, Inc. Bethesda.

Avis, M. (1994). Choice cuts: An exploratory study of patients' views about participation in decision-making in a day surgery unit. International Journal of Nursing Studies, 31(3): 289-298.

Ben-Sira, Z. (1976). The function of the professional's affective behavior in client satisfaction: A revised approach to social interaction theory. Journal of Health and Social Behavior, 17:3-11.

Burnard, P., & Morrison, P. (1991). Client-centred counselling: A study of nurses' attitudes. Nurse Education Today, 11: 104-109.

Calnan, M., Katsouyiannopoulos, V., Ovcharov, V.K., Prokhorskas, R., Ramic, H, & Williams, S. (1994). Major determinants of consumer satisfaction with primary care in different health systems. Family Practice, 11(4):468-478.

Canadian Association of Occupational Therapists & Department of National Health and Welfare. (1983). Guidelines for the client-centered practice of occupational therapy. Ottawa, ON: Department of National Health and Welfare.

Commission on Accreditation of Rehabilitation Facilities. (1989). Standards manual for organizations serving people with disabilities. Commission on Accreditation of Rehabilitation Facilities, Tucson.

Corring, D., & Cook, J. (1999). Client-centred care means that I am a valued human being. Canadian Journal of Occupational Therapy, 66(2): 71-82.

DeJong, G. (October 1979). Independent living: from social movement to analytic paradigm. Archives of Physical Medicine and Rehabiliation, 60.

Diasio, K. (1971). Occupational therapy- a historical perspective: The modern era-1960-1970. American Journal of Occupational Therapy, 25(5): 237-242.

Doyle, B.J., & Ware, J.E., Jr., PhD. (1977). Physician conduct and other factors that affect consumer satisfaction with medical care. Journal of Medical Education, 52:793-801.

Executive Board of the World Health Organization. (1979). Formulating strategies for for all by the year 2000. World Health Organization, Geneva.

Falardeau, M., & Durand, M.J. (2002 June). Negotiation-centered versus client-centered: Which approach should be used? Canadian Journal of Occupational Therapy, p. 135-142.

Gage, M. (1994). The patient driven interdisciplinary care plan. Journal of Nursing Administration, 24(4): 26-35.

Gates, A. (1991). Patient goal setting as a method for program improvement/development in partial hospitalization programs. International Journal of Partial Hospitalization, 7(2): 129-136.

Joint Commission on Accreditation of Healthcare Organizations. (1992). The 1993 joint commission accreditation manual for hospitals: Volume I: Standards. Chicago: Author.

Larsson Lund, M., Tamm, M., & Branholm, I.B. (2001). Patients' perceptions of their participation in rehabilitation planning and professionals' view of their strategies to encourage it. Occupational Therapy International, 8(3): 151-167.

Larsson Lund, M., & Branholm, I.B. (1996). An approach to goal-planning in occupational therapy and rehabilitation. Scandinavian Journal of Occupational Therapy, 3: 14-19.

Law, M., Baptiste, S., & Mills, J. (1995). Client-centered practice: What does it mean and does it make a difference? Canadian Journal of Occupational Therapy, 62, 250-257.

Lowes, R. (1998). Patient-centered care for better patient adherence. Family Practice Management. Retrieved on 07/23/2002 from: http://www.aafp.org/fpm/980300fm/client.html

Machan Andamo, E. (Ed.). (1984). Guide to program evaluation for physical therapy and occupational therapy services. New York: the Haworth Press.

Meyer, A. (1977). The Philosophy of Occupational Therapy. American Journal of Occupational Therapy, 31(10): 639-642. Reprinted from the Archives of Occupational Therapy, Volume 1, pages 1-10, 1922.

Nelson, C.E., & Payton, O.D. (1997).The planning process in occupational therapy: Perceptions of adults. American Journal of Occupational Therapy, 51(7):576-583.

Neistadt, M.E. (1987). An occupational therapy program for adults with developmental disabilities. American Journal of Occupational Therapy, 41(7): 433-438.

Neistadt, M.E. (1995). Methods of assessing clients' priorities: A survey of adult physical dysfunction settings. American Journal of Occupational Therapy, 49(5):428-436.

Northern, J.G., Rust, D.M., Nelson, C.E, & Watts, J.H. (1995). Involvement of adult rehabilitation clients in setting occupational therapy goals. American Journal of Occupational Therapy, 49(3):214-220.

O'Neill, S. (Feb 2001). Why ask patients what they think? Professional Nurse Supplement, 16(5):S2.

Partridge, Dr.C. (1997). Editorial- The patient as decision maker. Physiotherapy Research International, 2(4): iv-vi.

Payton, O.D., & Nelson, C.E. (1996). A preliminary study of patients' perceptions of certain aspects of their physical therapy experience. Physiotherapy Theory and Practice, 12:27-38

Payton, O.D., Nelson, C.E., & Ozer, M.N. (1990). Patient Participation in Program Planning: A Manual for Therapists. F.A. Davis Company, Philadelphia.

Rogers, C.R. (1939). Clinical treatment of the problem child. The Riverside Press, Cambridge.

Shannon, P. D. (1977). The derailment of occupational therapy. American Journal of Occupational Therapy, 31(4):229-234.

Smith., Q, Smith, L.W., King, K., Frieden. L., & Richards, L. (1993). Health care reform, independent living and people with disabilities: A report on the national study group on the implications of health care reform for americans with disabilities and chronic health conditions. Independent Living Research Utilization, Houston.

Starfield, B., Wray, C., Hess, K., Gross, R., Birk, P.S., & D'Lugoff, B.C. (1981). The influence of patient-practitioner agreement on outcome of care. American Journal of Public Health, 71(2):127-132.

Sumsion, T. (Ed.). (1999). Client-centred practice in occupational therapy: A guide to implementation. Harcourt Brace and Company Limited, Edinburgh.

Sumsion, T., & Smyth, G. (2000). Barriers to client-centredness and their resolution. Canadian Journal of Occupational Therapy, 67(1):15-21.

Swee Hong, C., Pearce, S., & Withers, R.A. (2000). Occupational therapy assessments: How client-centred can they be? British Journal of Occupational Therapy, 63(7): 316-318.

Thorne, S. (1993). Negotiating health care: The social context of chronic illness. Newbury Park, CA: Sage.

Tickle-Degnen, L. (1998). Communicating with clients about treatment outcomes: The use of meta-analytic evidence in collaborative treatment planning. American Journal of Occupational Therapy, 52(7): 526-530.

Toomey, M., Nicholson, D., Carswell, A. (1995). The clinical utility of the Canadian occupational performance measure. Canadian Journal of Occupational Therapy, 62(5):242-249.

Townsend, E. (Ed.). (1997). Enabling occupation: An occupational therapy perspective. Ottawa, ON: CAOT Publications.

Wasserman, R.C., Inui, T.S., Barriatua, B.S., Carter, W.B., & Lippincott, B.A. (1984). Pediatric clinicians' support for parents makes a difference: An outcome-based analysis of clinician-parent interaction. Pediatrics, 74(6):1047-1053.

Wilkins, S., Pollock, N., Rochon, S., & Law, M. (2001). Implementing client-centred practice: Why is it so difficult to do? Canadian Journal of Occupational Therapy, 68(2): 70-79.

Willard, H.S. & Spackman, C.S. (Eds.) (1947). Principles of Occupational Therapy. J.B. Lippincott Company, Philadelphia.

Tables

Table 1: Extent of Use of Client-Centered Practice by Occupational Therapists

Extent of Occupational Therapists' Use of Client-Centered Practice

	Yes		No		Sort Of	
View	n	%	n	%	n	%
Is the role of OT Explained to Client	11	100	-	-	-	-
Is the Goal Being Addressed Discussed	10	90.9	-	-	1	9.1
Is Client Educated About Participating in the Goal Setting Process	9	81.8	2	18.2	-	-
Are Treatment Options Discussed with Clients	10	90.9	-	-	1	9.1
Do Clients Participate in the Goal Setting Process	9	81.8	-	-	2	18.2
Is it Important to Involve Clients in the Goal Setting Process	10	90.9	-	-	1	9.1

Table 2 : Extent of Participation in Client-Centered Practice by Clients

Extent of Client Participation in and Perception of Client-Centered Practice

	100%		99-75%		74-50%		49-25%		24-0%	
Extent of Participation	n	%	n	%	n	%	n	%	n	%
Benefit from OT	19	63.3	5	17.7	3	10	1	3.3	1	3.3
Satisfaction with OT	20	66.7	6	20	3	10	1	3.3	-	-
Knowledge of what percentage of OT Goals	13	43.3	1	3.3	9	30	1	3.3	6	20
Percent Assisted with Goal Setting	7	23.3	3	10.0	5	16.7	-	-	14	46.7
Importance to participate in Goal Setting	18	60	-	-	4	13.3	-	-	8	26.7

Table 3: Benefit from Occupational Therapy

	100%		75-99%		50-74%		25-49%		0-24%		Unsure	
Facility	n	%	n	%	n	%	n	%	n	%	n	%
Longterm Care/Rehab	3	37.5	2	25	2	25	-	-	1	12.5	-	-
Nursing Home	3	75	1	25	-	-	-	-	-	-	-	-
Hospital Inpatient	5	55.6	2	22.2	1	11.1	1	11.1	-	-	-	-
Hospital Outpatient	8	88.9	-	-	-	-	-	-	-	-	1	11.1
Satisfaction with Occupational Therapy												
Longterm Care/Rehab	2	25	4	50	2	25	-	-	-	-	-	-
Nursing Home	4	100	-	-	-	-	-	-	-	-	-	-
Hospital Inpatient	7	77.8	1	11.1	1	11.1	-	-	-	-	-	-
Hospital Outpatient	7	77.8	1	11.1	1	11.1	-	-	-	-	-	-

Human Subjects Review Board Materials

ITHACA

Ithaca College
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Office of the Provost and
Vice President for
Academic Affairs

October 23, 2002

Frances Erway
Department of Occupational Therapy
School of Health Sciences and Human Performance
Ithaca College

Re: ***The Goal Setting Process: Views from Therapists and Their Patients***

The All-College Review Board for Human Subjects Research has received your request for expedited review of the above named proposal. The proposal has been reviewed and the Board authorizes you to begin the study. This approval will remain in effect for a period of one year from the date of authorization.

After you have finished the project, please complete the enclosed Notice-of-Completion Form and return it to my office for our files.

Best wishes for a successful study.

Sincerely,

Garry L. Brodhead

Garry L. Brodhead, Associate Provost
All-College Review Board for Human Subjects Research

/jv

Enclosure

cc: Kinsuk Maitra, Faculty Advisor

All-College Review Board
For
Human Subjects Research

COVER PAGE

Investigators: Frances Erway and Kinsuk K. Maitra

Department: Occupational Therapy

Telephone: Campus: 4-1736 Home: 273-8030

Project Title: Client-Centered Practice: Views from Therapists and Their Clients

Abstract: In occupational therapy treatment, it is vital that the patient or client maximally participates and collaborates with their therapist to establish their occupational therapy treatment goals. Such treatment planning and goal setting is central to the concept of client-centered care. Presently, practicing with a client centered care approach is becoming a requirement set by many health care accrediting agencies and also encouraged by the American Occupational Therapy Association. The purpose of this study is to identify the level of client participation in occupational therapy goal setting, as well as the facilitating factors and barriers of participation. This study is proposing to address this issue with adult and geriatric clients at a variety of local health care facilities such as, hospitals, long term care, home care, and nursing homes. The data will be gathered from occupational therapists and their clients in a focused interview format at their facility or at a place of their choice on two separate occasions. The first occurring immediately following completion of the initial evaluation, and the second, two weeks after the initiation of occupational therapy treatment. Prior to the interview, the participants will sign informed consent forms and the interviews, as well as the initial evaluation will be audiotaped for analysis. Data collected from the interviews and evaluation will be statistically analyzed to determine the extent of client participation.

Proposed date of Implementation: October, 2002

Frances Erway	Kinsuk K. Maitra
Principal Investigator	Faculty Advisor

ALL-COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH

CHECKLIST

Project Title: Client-Centered Practice: Views from Therapists and their Clients

Investigator(s): Frances Erway and Kinsuk Maitra

Investigator Use	HSR Use Only	Items for Checklist
X	X	1. General Information
X	X	2. Related experience of investigator(s)
X	X	3. Benefits of the study
X	X	4. Description of subjects
X	X	5. Description of subject participation
X	X	6. Description of ethical issues/risks of participation
X	X	7. Description of recruitment of subjects
X	X	8. Description of how anonymity/confidentiality will be maintained.
NA	X	9. Debriefing statement
NA	X	10. Compensatory follow-up
X	X	11. Appendix A: Recruitment Statement
X	X	12. Appendix B: Informed Consent Form
NA	X	13. Appendix C: Debriefing Statement
X	X	14. Appendix D: Survey Instruments
NA	X	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.

1. General Information about the Study

a) Funding. The principal investigator, Frances Erway will bear the charges incurred throughout the study. Limited support will also be available from the Occupational Therapy Graduate program.

b) Location. Interview of the participants will be conducted at various locations including hospitals, long-term care facilities, nursing homes, or at a client's home, depending on the suitability and availability of the clients and therapists. Analysis of the results will be done in the occupational therapy research laboratory, CHS 213.

c) Time Period. Tentatively from October 30, 2002 through October 30, 2003.

d) Expected Outcomes. Completion of the study will result in a written thesis, which will fulfill part of the requirements for the Occupational Therapy Master's degree program. Publication in a peer reviewed occupational therapy journal is also anticipated.

2. Related Experience of the Researcher and Faculty Advisor

a) Frances Erway is an occupational therapy graduate student, knowledgeable of the research methods used in occupational therapy. She has past experience working as a research assistant under the supervision of Dr. Kinsuk Maitra, performing tasks such as: recruiting subjects, carrying out experimentation procedures, and analyzing data. Previous coursework in the occupational therapy curriculum as well as her clinical fieldwork experiences have provided her with knowledge in this area of research, practicing client centered care and the goal setting process. Relevant coursework includes those courses in both adult and geriatric practicum and theory, research methods and research seminars. During her most recent adult/geriatric fieldwork at Johns Hopkins Bayview Medical Center, and her past adult/geriatric fieldwork at Cayuga Medical Center, she regularly engaged in communication with registered occupational therapists and clients, and was also exposed to and utilized goal setting procedures daily.

b) Kinsuk K. Maitra is an Assistant Professor and Graduate Program Chair in the Occupational Therapy Department. He has a Ph. D. and Master's degree in Occupational therapy. He has extensive previous research experience in movement studies. He has completed 7 projects with human subjects over the last 10 years.

3. Benefits of the Study

This study will examine occupational therapists use of client participation during the goal setting process, in various adult/geriatric health care settings. As indicated in the abstract, there are very few studies that have addressed the issue of client participation in setting occupational therapy treatment goals in a variety of settings. The present study hopes to generate a set of objective data that will help determine whether or not occupational therapists maximize their clients' involvement in setting occupational therapy treatment goals. The study also aims to identify the facilitating factors or barriers of the implementation of client centered care as advised by the American Occupational Therapy Association.

4. Description of Subjects

a) Number of Subjects. We hope to interview 15-20 occupational therapists and their clients. We anticipate interviewing 5 clients per therapist, therefore, 75-100 clients.

b) Salient characteristics. The therapist population will include Registered and Licensed occupational therapists (OTR/L) practicing in either hospitals, long-term care facilities, home care, or nursing home settings. The population will also consist of clients with various disabilities that include but are not limited to stroke, spinal cord injury, orthopedic problems etc. being treated by the occupational therapists. The client participants must be cognitively intact, as determined by their occupational therapist, and have the ability to understand, verbalize, and answer to the investigators' questions. Every effort will be given to include all forms of diversity in the client population.

5. Description of Subject Participation

The primary investigator will engage participating occupational therapists in focused interviews on 2 separate occassions. The first interview will be conducted within 24 hours after the completion of the initial occupational therapy evaluation. The second follow up interview will occur 2 weeks later. The primary investigator will also engage participating clients in a focused interivew on 2 separate occassions. The first interview will be conducted within 24 hours after the completion of the initial occupational therapy evaluation. The second follow up interview will occur 2 weeks later. The two-week time span will allow us to determine whether treatment has been conducted according to the initial goals and also allow the client to perceive about the treatment process. The interviews for both the clients and the therapist will consist of five questions,(See Appendix D), and last approximately ten minutes each. The timing as to when the interviews will be conducted will be mutally decided upon by the therapist, their client, and the primary investigator. The interviews as well as the initial evaluation will be audio taped. Prior to participation and audio taping both clients and therapists will sign an informed consent form.

6. Ethical Issues-Description

a) Risks of Participation. We do not anticipate any physical or psychological risks to develop in either the clients or therapists after participation in this study. However, following the interview therapists might feel that they are doing a poor job of meeting the standards set by the American Occupational Therapy Association in involving their clients in setting treatment goals. Likewise, the clients might also realize that they have been insufficiently educated about their role as a participator in setting their treatment goals. These psychological risks, although anticipated to be minimal, are necessary and part of the objectives of the study and thus cannot be avoided. To lessen these risks, the investigator will conduct the interviews in a non- threatening, non-judgmental manner. The idea of confidentiality of the data and the results will be reinforced before and after the interview.

b) Informed Consent. A copy of the informed consent form is attached in Appendix B.

7. Recruitment of Subjects

a) Recruitment Procedures. Occupational Therapists and their clients will be recruited, on a volunteer basis, from the area hospitals (Example: Cayuga Medical Center), long-term and nursing care facilities (Example: Lakeside, Long View, Alterra, Kendal etc.), and from Home health care (Example: Visiting nurse service). The primary investigator will contact the occupational therapists via telephone, (See Appendix A). Upon contact, the primary investigator will explain the purpose, research protocol including audiotaping of the interviews and the initial evaluation, risks, and benefits of the study . A recruitment flyer as well as the informed consent forms will also be mailed to the therapists. Consenting therapists will identify clients they feel will be able to partipate in the study and explain the protocol to them (See Appendix A). Followed by this initial information, the primary investigator will visit the clients and explain in detail about the purpose, the protocol including the audio taping, the risks of participation, and the benefits of the study (See Appendix A). The primary investigator will then leave the flyer as well as the informed consent forms with the clients, and request that interested individuals fill out the form and contact either the therapists or the investigator to set up an appointment for further discussion and participation in the study. All therapists and clients will be assured that participation in the study is strictly voluntary and that they can withdraw from the study at anytime without prejudice. In addition, they will be assured that all results will be kept confidential and the participants will not be identified in any papers or presentations that arise from this project. In addition, the clients will be reminded that their decision of whether or not to participate in this study will in no way effect the course of their occupational therapy treatment.

b) Inducement. There will be no inducements for participation in this study.

8. Confidentiality/Anonymity of Responses.

To ensure confidentiality of the participants, they will be given a code number or letter for identification and later analytical referencing. Participant's names will not be used anywhere in the study. Audio taping will occur in this study to ensure that all of the comments that the participant's state will be analyzed. Only the investigators will have access to the audiotapes. The audiotapes will not be put to any "public" use, and they will be destroyed after the study is complete. During data collection and analysis, the codes will be used in place of names. According to the department's policy and procedure, the code key and the audiotapes will be kept in a locked filing cabinet in CHS 208 under the supervision of occupational therapy department's administrative assistant, Lisa Butts.

9. Debriefing.

Since there is no deception in the study, there will be no debriefing.

10. Compensatory Follow-up.
    If the participants report any feelings of psychological stress following their participation in the study, they will be comforted, the idea of confidentiality of results will be reinforced, and they will be explained that such distress is transient. No further compensatory follow-up is anticipated at this time.

References

Baker SM, Marshak HH, Rice GT, & Zimmerman GJ. (2001). Client Participation in Physical Therapy Goal Setting. Physical Therapy, 81(5):1118-1126.

Nelson CE, & Payton OD. (1997). The Planning Process in Occupational Therapy: Perceptions of Adult Rehabilitation Clients. American Journal of Occupational Therapy, 51(7): 576-583.

Northern JG, Rust DM, Nelson CE, & Watts JH. (1995). Involvement of Adult Rehabilitation Clients in Setting Occupational Therapy Goals. American Journal of Occupational Therapy, 49(3): 214-220.

Appendix A. Subjects Recruitment Statement (statements and flyers)

Occupational therapists will be recruited by telephone, via a yellow pages Search by the primary investigator. Clients will be identified by the occupational therapists treating them, and recruited by the primary investigator.

A. Telephone Recruitment Statement-for OTR/L's
The recruiting telephone conversation being delivered to the occupational therapists will go as follows:

Hi! My name is Frances Erway, and I am an occupational therapy graduate student at Ithaca College. I'm calling you today, because I was wondering if you would be interested in participating in my Master's thesis study. What I'm researching is how occupational therapy treatment goals are established in a variety of health care facilities. What I'm planning to do is audiotape the initial evaluation and then separately engage you and 5 of your consenting clients in a focused interview. I will then interview you and those same 5 clients again, 2 weeks after the initiation of occupational therapy treatment. Each interview should only take approximately 10 minutes of your time. I want to assure you that this study will remain completely confidential. You also have the right to withdraw from the study or refuse to answer any of the questions. I do not anticipate there to be any physical or psychological harm to develop following your participation. However, following the interview you may feel that you are doing a poor job of meeting the standards set by the American Occupational Therapy Association in involving your clients in setting treatment goals. These psychological risks, although anticipated to be minimal, are necessary and part of the objectives of the study and thus cannot be avoided. To lessen these risks, I wil conduct the interviews in a non- threatening, non-judgmental manner. I anticipate that your participation as well as the results of this study will both serve to increase awareness of the goal setting processes utilized by occupational therapists and clients in a variety of health care settings. Do you have any questions? Do you feel that this is something that you would be interested in participating in?

B. Identification Statement-for clients receiving occupational therapy. Participating occupational therapists will be given this statement to verbally present to their client as a means to identify if that client would be interested in participating in this study.

The identification statement will be delivered as follows:

Good Morning/Afternoon Mr./Mrs....I was recently contacted by Frances Erway, an occupational therapy graduate student at Ithaca College. She contacted me because she is looking for people to participate in her Master's thesis research study. What she is researching is how occupational therapy treatment goals are established in a variety of health care facilities. What she is asking you to do is engage in 2 interviews, 2 weeks apart. The first inteview will be within 24 hours of your initial occupational therapy evaluation and the second will be a follow up interview 2 weeks later. The interviews as well as the initial evaluation will be audiotaped. The interviews consist of 5 questions and will last approximately 10 minutes. Do you think this is something you would be interested in participating in? If you think it is, I will contact Frances Erway so that she will be able to further explain your participation and additional aspects of this study to you.

C. Personal Recruitment Statement-for clients receiving occupational therapy
The recruiting conversation being delivered to the clients by the primary investigator will go as follows:

Hi! My name is Frances Erway, and I am an occupational therapy graduate student at Ithaca College. I'm came to visit you today because I was wondering if you would be interested in participating in my Master's thesis study. What I'm researching is how occupational therapy treatment goals are established in a variety of health care facilities. What I'm planning to do is audiotape your initial occupational therapy evaluation and then immediately following, to engage you in a focused interview. I will then be back in 2 weeks to interview you again. Each interview should only take approximately 10 minutes of your time. I want to assure you that this study will remain completely confidential. I also want to assure you that your of whether or not to participate in this study will in no way effect the course of your occupational therapy treatment. You will have the right to withdraw from the study or refuse to answer any of the questions. I do not anticipate there to be any physical or psychological harm to develop following your participation. You may however realize that you have been insufficiently educated about your role as a participator in setting your treatment goals. These psychological risks, although anticipated to be minimal, are necessary and part of the objectives of the study and thus cannot be avoided. To lessen these risks, I will conduct the interviews in a non- threatening, non-judgmental manner. I anticipate that your participation as well as the results of this study will both serve to increase awareness of the goal setting processes utilized by occupational therapists and clients in a variety of health care settings. Do you have any questions? Do you feel that this is something that you would be interested in participating in?

D. Flyer for the therapists

OTR/L's Wanted to Participate in an Occupational Therapy Research Study on the Goal Setting Process

What you will be asked to do: You will be asked to engage in a maximum of ten focused interviews, which will be audiotaped, with each interview lasting approximately ten minutes. The number of interviews that you engage in is dependent upon your consent and the number of clients you are treating that also consent. The initial occupational therapy evaluation for each of your consenting clients will also be audiotaped.

What we will do: We will record the initial evaluation and your responses to the questions asked during the interview. We will then analyze the information via a statistical measure.

What you will get: The satisfaction of taking part in enhancing the available research, vital towards evidence based practice, in the field of occupational therapy. Your participation will also serve to increase awareness of the occupational therapy goal setting processes utilized in a variety of health care facilities.

Please contact:

Fran Erway
phone: (607) 256-3276
email: franerway@hotmail.com

E. Flyer for the clients

Individuals Receiving Occupational Therapy Services Wanted to Participate in an Occupational Therapy Research Study on the Goal Setting Process

What you will be asked to do: You will be asked to engage in two focused interviews consisting of five questions each. The interviews will be audiotaped and should last approximately 10 minutes each. The first interview will take place following your initial occupational therapy evaluation, and the second will take place two weeks after the start of occupational therapy treatment. You will also be audiotaped during the initial occupational therapy evaluation.

What we will do: We will record the initial evaluation, and your responses to the questions asked during the focused interview. We will then analyze the information via a statistical measure.

What you will get: The satisfaction of enhancing available research in the field of occupational therapy. You will also support increasing the awareness of the occupational therapy goal setting processes utilized in a variety of health care facilities.

Please contact:
Fran Erway
phone: 256-3276
email: franerway@hotmail.com

Appendix B.
INFORMED CONSENT FORM-Form for OTR/L-page 1

The Goal Setting Process: Views from Therapists and Their Clients

Purpose of the Study. The purpose of this study is to identify how occupational therapists and their clients establish their occupational therapy treatment goals in a variety of health care facilities.

Benefits of the Study. Benefits of the study include the satisfaction of taking part in expanding the field of research utilized during occupational therapy practice. Your participation will also increase awareness of both the facilitating factors and barriers faced during the goal setting process.

What You Will Be Asked to Do. You will be asked to engage in a number of focused interviews, each entailing five questions. Each interview will last approximately 10 minutes, and they will be audiotaped. The interviews will be approximately two weeks apart. You will also be audiotaped during the initial evaluation process for each of your consenting clients.

Risks. We do not anticipate any physical or psychological risks of participation. However, following the interview you may feel that you are doing a poor job of meeting the standards set by the American Occupational Therapy Association in involving your clients in setting treatment goals. These psychological risks, although anticipated to be minimal, are necessary and part of the objectives of the study and thus cannot be avoided. To lessen these risks, the interviews will be conducted in a non- threatening, non-judgmental manner.

If You Would Like More Information About the Study.
For any information either before, during, or after the study, please contact:
Frances Erway
email: franerway@hotmail.com
phone: 607-256-3276

Withdraw from the Study. You are free to withdraw from the study at any time, and you may omit answering any questions you feel uncomfortable discussing.

_____
Initial

INFORMED CONSENT FORM-Form for OTR/L-page 2

How the Data will be Maintained in Confidence. Your participation in this study will remain confidential, and you will be assigned a number or letter code for analysis purposes. All data will be held in confidence and responses will be viewed by only Frances Erway and K.K. Maitra. Audiotaping will occur during the focused interviews and during the initial evaluation. Audiotapes will be destroyed after completion of the study. According to the department's policy and procedure, the code key and the audiotapes will be kept in a locked filing cabinet in CHS 208 under the supervision of occupational therapy department's administrative assistant, Lisa Butts.

I have read the above and I understand its contents. I agree to participate in the study. I acknowledge that I am 18 years of age or older.

_____

Print or Type Name

_____

Signature Date

I give my permission to be audio taped.

_____

Print or Type Name

_____

Signature Date

Appendix B.
INFORMED CONSENT FORM- Form for clients-page 1

The Goal Setting Process: Views from Therapists and Their Clients

Purpose of the Study. The purpose of this study is to identify how occupational therapists and their clients establish their occupational therapy treatment goals in a variety of health care facilities.

Benefits of the Study. Benefits of the study include the satisfaction of taking part in expanding the field of research utilized during occupational therapy practice. Your participation will also increase awareness of both the facilitating factors and barriers faced during the goal setting process.

What You Will Be Asked to Do. You will be asked to engage in two focused interviews, each entailing five questions, and lasting approximately 10 minutes each. The interviews will be audio taped. You will also be audiotaped during the initial evaluation occupational therapy evaluation.

Risks. We do not anticipate any physical or psychological risks of participation. You may however realize that you have been insufficiently educated about your role as a participator in setting your treatment goals. These psychological risks, although anticipated to be minimal, are necessary and part of the objectives of the study and thus cannot be avoided. To lessen these risks, the interview will be conducted in a non- threatening, non-judgmental manner.

If You Would Like More Information About the Study.
For any information either before, during, or after the study, please contact:
Frances Erway
email: franerway@hotmail.com
phone: 607-256-3276

Withdraw from the Study. You are free to withdraw from the study at any time, and you may omit answering any questions you feel uncomfortable discussing.

_____
Initial

INFORMED CONSENT FORM- Form for clients-page 2

How the Data will be Maintained in Confidence. Your participation in this study will remain confidential, and you will be assigned a number or letter code for analysis purposes. All data will be held in confidence and responses will be viewed by only Frances Erway and K.K. Maitra. Audiotaping will occur during the focused interviews and during the initial evaluation. Audiotapes will be destroyed after completion of the study. According to the department's policy and procedure, the code key and the audiotapes will be kept in a locked filing cabinet in CHS 208 under the supervision of occupational therapy department's administrative assistant, Lisa Butts.

I have read the above and I understand its contents. I agree to participate in the study. I acknowledge that I am 18 years of age or older.

_____

Print or Type Name

_____

Signature Date

I give my permission to be audio taped.

_____

Print or Type Name

_____

Signature Date

Appendix D.
SEMI-STRUCUTRED INTERVIEW PROTOCOL
Interview Coding System

Identification Number: IDXXX

PATIENT QUESTIONS
Type of Facility

FAC001	LongTerm Care/Rehab.	FAC002	Home Care
FAC003	Nursing Home	FAC003	Hospital

Gender of Client:

GEN001	Male	GEN002	Female

Age of Client: Actual :

AGE01	30-35	AGE02	36-40	AGE03	41-45	AGE04	46-50	AGE00551-55		AGE06	56-60
AGE07	61-65	AGE08	66-70	AGE09	71-75	AGE10	76-80	AGE11	81-85	AGE12	86-90
AGE13	91-95	AGE14	96-100								

How many days they have been receiving occupational therapy?
Ans: (get from chart)

Admitting Diagnosis
Que: Do you know why you are here?
Ans:
(Get from the chart)

DIS001	Stroke	DIS002	Parkinson's	DIS003	Hip Replacement
DIS004	Knee Replacement				
DIS005	Heart Problems	DIS006	Hand Injury	DIS007	Spinal Fusion
DIS008	TBI	DIS009	SCI	DIS010	MS exacerbation
DIS011	Cancer	DIS012	Other		

Past Medical History
Que: Do you have any major medical problems in the past?
Ans:

(get from the chart)

DIS01	Stroke	DIS02	Parkinson's	DIS03	Hip Replacement
DIS04	Knee Replacement			DIS05	Heart Problems
DIS06	Hand Injury	DIS07	Spinal Fusion	DIS08	TBI
DIS09	SCI	DIS10	MS exacerbation	DIS11	Cancer

Past deficits in occupational performance in ADL, Work, Play & Lesisure
Que: Before this most recent health issue, did you have any problems with getting dressed, doing housework, eating, going to work, visiting friends, talking on the phone?
Ans:

(get from the chart)

PDOP01	ADL	PDOP02	Work	PDOP03	Play & leisure

Family Support
Que: How would you describe the support (help, assistance)you get from your family?
Ans:

FAMSUPP01 Economic FAMSUPP02 Moral FAMSUPP03 Mental
FAMSUPP04 Physical FAMSUPP05 I don't get any support

Que: If YES then, Would you say that your support is consistent?
Ans:

FAM01 Yes-Get it all the time (75-100%) FAM02 Yes-Some of the time (50-75%)
FAM03 Rarely (0-50%) FAM04 Not at all

Previous exposure to OT
Que: Have you ever had occupational therapy before now?
Ans:

Pre001 Yes Pre002 No Pre 003 Not Sure (Don't Know)

Knowledge of what OT is, or what it will be doing for them
Que: Did your OT talk to you about what OT is and what it can do for you?
Ans:

DEF001 Yes DEF002 Sort of DEF003 No

Que: Do you know who your OT is, can you name him/her?
Ans:

NAM01 Yes NAM02 No NAM03 Not Sure

Know OT Goals-Initial
Que: Do you know what your goals are or what you want to achieve in occupational therapy?
Ans:

KNOGO01 Yes KNOGO02 No KNOGO03 Sort of

If YES then, Can you tell me what they are?
Ans:

(check chart)
LTG01 Yes 100% LTG02 Yes 75-99% LTG03 Yes 50-74%
LTG04 Yes 25-49% LTG05 Yes 0-24% LTG06 No

How goals were set
Que: Do you know how your goals for OT were set? If Yes then, How?
Ans:

SET0I Client set SET02 Therapist set SET03 Client and therapist set, equally
SET04 Client and therapist set, 25:75 SET05 Client and therapist set, 0:95
SET06 Client and therapist set, 75:25 SET07 Client and therapist set, 95:0

Que: Did you assist your OT in setting of your tx. goals?
Ans:

(check chart)
EFF01 Yes, 100% EFF02 Yes, 75-99% EFF03 Yes, 50-74%
EFF04 Yes, 25-49% EFF05 Yes, 0-24% EFF06 No

Que: If YES then, Do you think your input was taken into account in setting your treatment goals as you see them?
Ans:
(check chart)
ACC01 Yes, Always100% ACC02 Yes, Most of the time 75-99%
ACC03 Yes, Sometimes50-74% ACC04 Yes, Once in a while 25-49%
ACC05 Yes, Not very often 0-24% ACC06 No, not at all.

Que: If NO then, Why didn't you give any suggestions for what you wanted to work on in treatment?

NOSUGG01 I don't know NOSUGG02 I didn't have any
NOSUGG03 The OT addressed all of my concerns NOSUGG04 The OT didn't ask

Aware of their role as a participant in setting their OT goals
Que: Have you ever heard of the phrase 'client/client centered care'?
Ans:
PCC01 Yes PCC02 No PCC03 Sort of

Que: If YES then, can you tell me what it means?
Ans:
Response: Correct Incorrect Somewhat correct

Satisfaction with OT
Que: To what extent are you satisfied with your OT experience thus far?
Ans:

SAT01 100%(very) SAT02 75-99%(pretty satisfied) SAT03 50-74%(kind of)
SAT04 25-49% (a little) SAT05 0-24%(not very) SAT06 None (not at all)

Do you think you benefit from OT?
USE01 Very USE02 For the most part USE03 Sort of
USE04 A little USE05 Not

Do you think that you personally should actively participate in the OT process?
OTPROCES01 Yes, very much OTPROCES02 Yes, somewhat OTPROCES03 No

View of self in general
Would you define yourself as being an extrovert or an introvert?
Ans:
Sel001 Extrovert Sel002 Introvert

THERAPIST QUESTIONS
Gender of Therapist
GTP001 Male GTP002 Female

Highest Degree Earned
DEG01 BS DEG02 MS DEG03 PhD

Therapist years of experience: Actual:
YRS01 25+ YRS02 20-24 YRS03 15-19 YRS04 10-14 YRS05 5-9 YRS06 0-4

Years at current setting: Actual:
CUR01 25+ CUR02 20-24 CUR03 15-19 CUR04 10-14 CUR05 5-9 CUR06 0-4

Decision for setting OT goals
Que: How did you decide what goals to set for your client?
Ans:

INI01 I decided them INI02 Administered a formal Assessment
INI03 Based on just what pt. stated that they wanted to work on
INI04 Discussed with client

Why did you use that method to set the OT goals?
Ans:

?SET01 Facility standard-care map ?SET02 What I always do
?SET03 Felt they were able to contribute ?SET04 Pt. not able to state own
?SET05 Pt. left it up to me ?SET06 It's consistent with client centered care

Did pt. voice desire to contribute to setting goals?
Que: Did your client tell you what they wanted to do in treatment?
Ans:

PTVOICE01 Yes PTVOICE02 No PTVOICE03 Sort of

Que: If yes, or sort of, do you think their suggestions were applicable to be addressed in occupational therapy treatment?
Ans:

CONADD01 Yes CONADD02 No CONADD03 Sort of

Que: If no, or sort of, Why did you think their suggestions were not applicable?
Ans:

NOTAPP01 Their response was not within the realm of OT
NOTAPP02 The facility lacks the resources to carry out their suggestion
NOTAPP03 Not enough time to address their desires

Was pt. educated about the role of OT and how it pertains to them in general?
Que: Did you talk to your client about what OT is and what we do as OT's.
Ans:

OTED01 Yes OTED02 No OTED03 Sort of

Was pt. educated about their role as a participant in setting goals?
Que: Did you talk to your client about participating in setting their treatment goals?
Ans:

EDU01 Yes EDU02 No EDU03 Sort of

Did you elicit their participation in setting goals?
Ans:

EDU01 Yes EDU02 No EDU03 Sort of

Que: If NO, What were the barriers you faced that hindered your ability to elicit their participation?
Ans:

?BAR01 Time ?BAR02 Caseload
?BAR03 Not a standard, not supported by peers
?BAR04 Didn't feel that they would be able to contribute effectively

Que: If YES, did they provide any input?
Ans:

VER01 Yes, Consistently VER02 Yes, Inconsistently
VER03 Yes, but irrelevant to OT VER04 NO

After goals were set, did therapist tell the client what the goals were?
Que: Now that their goals have been set and they've been working on them in treatment, do you think they know what they are?
Ans:

REI01 Yes REI02 Yes, 50% REI03 Yes, 0-1 of the goals REI04 No
REI05 Maybe

Que: How important do you feel it is to involve the client in setting their goals?
Ans:

IMP01 Very IMP02 Pretty important IMP03 Somewhat important
IMP04 Kind of IMP05 Not very

Que: Have you every heard of the phrase, 'client centered care'?
Ans:

CCC01 Yes CCC02 No CCC03 Sort of

Que: If yes, do you ever feel that you can treat with this apporach?
Ans:

?APP01 Yes, consistently ?APP02 Yes, inconsistently ?APP03 No

What factors facilitate use of a client centered approach?

What factors are barriers toward practicing with a client centered approach?