

**Occupational Therapy Client-Centred Practice:
A Deeper Sense of Collaboration in Client-Centredness**

by

Heather Joan Hermanson
B.Sc., University of Alberta, 1987
M.A., University of Victoria, 1996

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of

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ABSTRACT

This study addressed two questions: (a) how do the various discourses that are at work in everyday practice of occupational therapists inhibit or enhance a collaborative therapist-client therapeutic relationship and (b) what are the ways of strategizing a more client-centred collaborative approach in the midst of the tensions and disjunctures of everyday clinical practice? These questions were addressed by analyzing narratives from the everyday practice of occupational therapy. These narratives were constructed from my own practice in order to provide an insider's view from the clinician's perspective, a view that is missing from the extensive literature on client-centred practice in occupational therapy. Guided by an emancipatory interest, the study focused primarily on the tensions between dominant health care discourses that position the therapist as expert and a collaborative, egalitarian therapeutic relationship, which I called "participatory consciousness" after Heshusius (1994).

The methodology of critical reflexivity had two parts. The first was the assemblage and interpretations of a collage for the purpose of critically examining my values, beliefs and theoretical predispositions; and the second was the critical reading and rereading of

the practice narratives using as analytical tools the concepts of discourse and of occupational therapy clinical reasoning. Discourse refers to ways of thinking, feeling and acting that constitute social and cultural reality. Clinical reasoning refers to how clinicians think in the midst of practice and was the key to identifying how the clinician consciously and/or unconsciously negotiated or resisted the discourses shaping the clinician-client relationship.

The study demonstrated what was entailed in the move to participatory consciousness and offered recommendations to the profession for supporting therapists to move toward a deeper sense of collaboration within client-centred practice.

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Dedications

To the memory of Jim, Kate and Ray.

Introduction

Occupational Therapy Client-Centred Practice: Competing Discourses

Occupational therapists are often caught in a web of opposing discourses, each having a particular set of values, beliefs and assumptions. Recognizing and believing in the value of the profession's client-centred approach, occupational therapists often try to implement client-centredness while adhering unawares to the culture of the dominant health care discourse that places them at the centre of the therapeutic process. They thus find themselves caught in the midst of two opposing discourses. Their response typically is to foreground the requirements of the dominant discourse as if they were being observed and evaluated for professional competence and to practice client-centredness in the shadows. Mattingly and Fleming (1994) encountered this phenomenon in their research on occupational therapy clinical reasoning and labeled the two competing discourses of occupational therapists as *chart talk* (p. 60) and *underground practice* (p.4). In the discourse of *underground practice* therapists value the importance of the client's illness experience and life story. However, the dominant culture with its power structures and dynamics make it difficult, if not impossible, to make this phenomenological aspect of practice explicit. Instead, they privilege *chart talk*. In *chart talk* occupational therapists present only the medical facts and rarely, if ever, discuss the client's perspective of the illness experience. They use the discourse of the dominant culture. Being enmeshed in these dual discourses results in tension and frustration, as well as numerous challenges.

Multiple competing discourses that impinge on a client-centred approach have been highlighted in a number of occupational therapy research articles. Toomey, Nicholson

and Carswell (1995) identified possibilities as to why occupational therapists do not utilize a client-centred approach. Some occupational therapists find the power of the dominant culture too great a challenge to resist and simply comply with it. Others convince themselves that the dominant discourse is the most appropriate response to clients. These occupational therapists may assume that the client's goals and their own are the same when, in fact, they are not. Or they may disagree with clients on the importance of various clinical issues, the result being incongruence between their goals for clients and clients' goals for themselves. For example, occupational therapists may be embedded in the dominant health care discourse and centre their goals for clients' treatment on the illness while clients may be situated in a phenomenological discourse and derive their intervention goals from their experience of illness and how this directly impacts their everyday life in the community. In this situation the occupational therapists are enacting the dominant health care discourse where the professional is considered the expert. Thus, the occupational therapists do not actively nor fully involve the client in the decision making process. The effect is to perpetuate the privilege of occupational therapists to direct treatment and to thwart clients' prerogatives to be involved in the decision-making and problem solving around treatment direction. Sumsion and Smyth (2000) described this situation as a conflict between upholding the autonomy of the individual (client-centred discourse) and doing what the professional considers is good or right for the person (dominant health care discourse). They noted that "this ethical dilemma of trying to simultaneously presume autonomy and beneficence may result in therapists wishing to support the client's autonomy, while fearing that the clients will choose unsafe or inappropriate goals" (p. 18). In all these cases the invisible structures of

the dominant discourse shape the therapist-client relationship (Gage & Polatajko, 1995; Law, Polatajko, Pollock, McCall, Carswell & Baptiste, 1994; Law, Baptiste & Mills, 1995; Sumsion 1993; Sumsion & Smyth 2000; Toomey et al., 1995; Townsend, 1993; Woodside, 1991).

Another set of competing discourses to which occupational therapists are subject revolves around the issue of time. Occupational therapists may opt into the dominant health care discourse even though contrary to their espoused preference for a client-centred discourse because they perceive that to implement a client-centred approach will take more time than they have available. The high caseloads and other pressures of the work environment often validate that they have insufficient time to practice in such a manner. Institutional demands for productivity, efficient and effective use of time, finances and staff resources are the underlying often invisible forces of the dominant discourse that shapes daily practice.

Although the research and professional literature on client-centred practice has identified tensions that arise from what may be called competing discourses, the sources of the discord and the resulting influences on practice have not been explicitly explored or explained. In the studies available to date, researchers have gained information either by interviewing occupational therapists or observing practice settings. They have not been directly involved in the situation being studied nor have they interpreted or analyzed material from personal clinical experiences. Researchers looked in from outside and encapsulated the situation in a limited time frame. Therefore the picture of client-centred practice available in the literature is necessarily drawn only in broad-brush strokes. Although partnership and collaboration between therapists and clients are mentioned,

descriptions are scant. There is no emphasis on establishment of the therapeutic relationship between the occupational therapist and the client. In order for occupational therapists to be in a position to resist the dominant discourses in favor of an approach that is firmly grounded in the principles of client-centredness, a more intimate and detailed picture is needed. I believe it is necessary to illuminate the multiple competing discourses and the consequent tensions encountered in striving to implement a client-centred approach, particularly a collaborative therapist-client therapeutic relationship. To do that, I believe it is necessary to gather data from within that relationship. I am specifically interested in the ways that the face-to-face therapist-client therapeutic relationship is constituted by competing discourses and the possibilities that exist for (re)constructing a collaborative therapeutic relationship within the practice site.

My particular contribution to this process is derived through my unique position of having extensive administrative and clinical experiences as an occupational therapist and thus access to the intricacies of both policy and practice. By examining and analyzing personal clinical narratives from practice there is a special opportunity to excavate disjunctures and relations of power and how these constitute the collaborative therapist-client therapeutic relationship. Being a reflective practitioner who is also the researcher provides a rich insider's view on the data in contrast to a researcher who is looking in on practice from the outside. In addition, I am in a position to show how possibilities of over-coming these tensions, challenges and disjunctures may be negotiated at the practice site.

Researcher Location

My numerous years in a variety of clinical settings and my position as an occupational therapist have provided unique opportunities for me to identify and explore areas of tension in relationships of occupational therapists and their clients and to generate knowledge about these relationships. I bring to this effort, years of experience and an intimate knowledge of the profession as well as the practice of occupational therapy.

In my administrative capacity, I have been actively involved in the development, implementation and review of discipline-specific and organizational policies and procedures that relate to client-centred practice from a managerial perspective. I am concerned about how these policies and procedures shape daily occupational therapy practice. In this role I also had a responsibility to be aware of, understand, implement and manage policies and procedures that met the requirements, mandate and directions of the organization. On the other hand, as a clinician working directly with clients I have had to adhere to, respond to and put into practice the work-related requirements of client-centred practice, the organizational policies and procedures and related government policies. As a professional in the practitioner role, I experienced the opposition between my responsibility to interpret and implement in the clinical environment the organization's requirements and the profession's client-centred practice guidelines and my responsibility to conform to the texts regarding occupational therapy professional competency. This can lead to disjunctures at the practice site that are often invisible to the practicing clinician. Because these latter texts are initiated, implemented and evaluated through the national professional association and the provincial occupational therapy regulatory bodies, they carry a great deal of weight and cannot be ignored. Having extensive experience in both

administrative and clinical portfolios provides significant and unique opportunities to view, at first hand, the colliding forces of policies in and on practice and the multi-contradictories that converge, often unconsciously and unknowingly for the practitioner, at the practice level.

My many years of active involvement in provincial and national professional associations offer an important and key view to my research study. Through this professional participation I am familiar with the organization's policies and ethics and knowledgeable about the Canadian client-centred practice guidelines and their importance to professional practice issues. Thus, I am privy to the intimacies of policy as well as practice.

The insider perspective presents challenges as well as opportunities. Having worked in large organizations and being active in professional associations I am a member with knowledge, experience and specific discourses that have shared language, beliefs, values and ways of working (Campbell & Gregor, 2002). As an insider researcher I have an advantage in that I am familiar with the discourses and their nuances. However, as a researcher I also have to be mindful of the effects of these discourses that I may take for granted.

My dual role as a researcher and clinician calls for attention to "the tension between standing apart and being fully involved" (Gordimer, cited in Atwood, 2002, p. 29). This position creates a detachment that offers a space and freedom for further exploration while I remain embedded in the practice setting as researcher and clinician. As the clinician I strategize ways to negotiate and create a collaborative therapist-client therapeutic relationship. As a researcher I unravel the tensions produced by this effort and

thereby expose the disjunctures in the discursive power relations that constitute the collaborative therapist-client therapeutic relationship. I believe that as a clinician-researcher I bring a particular awareness and specific knowledge that gives me a unique position and enriches my research study of how multiple discourses and the power relations they produce affect the collaborative therapist-client therapeutic relationship.

Situating My Research Interest

Occupational therapy has been my clinical practice for over three decades. I have worked in diverse practice areas including acute pediatric, adult and geriatric psychiatry; acute physical medicine; pediatric rehabilitation and long-term care. In these clinical settings I have been employed as a practitioner, a director of services, a coordinator of clinical fieldwork placements for provincial, national and international rehabilitation students and an occupational therapy clinical specialist.

Throughout my career there has been a common thread weaving through these practice areas, namely my interest in the therapeutic relationship between the clinician and the client. My interest has not always been visible or explicit even to me. However, the profession's introduction of client-centred practice drew my attention to the importance of the client-therapist relationship to the value I ascribe to it. I was excited by the evolution of client-centredness and the emphasis by the profession on collaboration, partnership, enablement and occupation but disappointed at the lack of direct attention given to making the collaborative therapeutic partnership between the therapist and the client more explicit. I believe that the therapeutic client-therapist relationship is the core foundation or the heart and soul of a client-centred approach to practice, particularly a

collaborative one, and that this entails the client's active participation in all aspects of his or her recovery process.

In working directly with clients and in mentoring staff and students striving to employ a client-centred approach I became aware of and interested in not only the relationship in a collaborative partnership but also the tensions and difficulties embedded in developing and implementing a client-centred enabling approach. Occupational therapists may be interested in developing a client-centred approach to their practice and some may even work in an institution where implementing a client-centred approach is supported and respected. However, the discourses of the dominant culture and the social systems they spawn may subordinate this approach.

I am answering the call to further explore the tensions, illuminate the sources of the disjunctures and show how they influence occupational therapists endeavoring to establish a collaborative client-centred therapeutic relationship within a client-centred enabling approach to practice.

Research Questions and Purpose of the Study

This research study addresses two questions.

1. How do the various competing discourses that are at work in the everyday practice of occupational therapists inhibit or enhance a collaborative therapist-client relationship?
2. What are ways of strategizing a more client-centred collaborative approach in the midst of the tensions and disjunctures of everyday clinical practice?

The purpose in addressing these questions is to illuminate the competing discourses at work in the everyday practice of occupational therapists. The object is to reveal their effect on therapist-client interactions and particularly the collaborative therapist-client therapeutic relationship, and to document ways of strategizing in the midst of the tensions and disjunctures of everyday clinical practice. The focus of analysis is three narratives from the everyday practice of an occupational therapist.

Emancipatory Perspective and Reflexive Methodology

My training and early practice of occupational therapy was grounded in the scientific paradigm, which prescribes objectivity and standardization and therefore requires strict separation between therapist and client. However, through my subsequent experience in clinical practice and my Master's studies I became aware that my core values were not congruent with the values of objectivity and standardization that pervade modern health care delivery. Instead, I had learned that what I valued was attending to each individual and this required listening to their stories and trying to see the situation from their perspective. I needed a way to free myself from the strictures and limitations of the scientific paradigm while still adhering to the requirements for good practice grounded in this paradigm. What was needed was a means to emancipate my own approach to practice in order to encompass more than the scientific paradigm. This dissertation is a study of what has been entailed in accomplishing that emancipation. It is a study of how the scientific or dominant discourse and other discourses influence a collaborative therapist-client therapeutic relationship. This study is grounded in an emancipatory perspective which values egalitarian over hierarchical relations.

The methodology used to accomplish this emancipatory move was reflexivity. I was already a reflective practitioner in the habit of monitoring my practice moment by moment and also of looking back over daily incidents of practice. I was accustomed both to reflecting *in* action and reflecting *on* action (Schön, 1987). I honed these abilities in my Master's work and used them as my methodology in this present study.

Reflexivity as a methodology entailed looking critically at my daily practice of occupational therapy to identify personal and professional biases, theoretical predispositions and preferences that consciously and unconsciously directed and shaped my work as an occupational therapist. An insider perspective had the advantage of allowing a depth of analysis not yet present in the literature of occupational therapy. However, it was also important to me that my analysis pertains to more than just my own practice. Hence, as described in a subsequent section of the dissertation, I constructed practice narratives that would be recognizable to most occupational therapists as the site for my analysis. The reflexive methodology used in this study focused on discourses as the sociocultural process through which personal and professional biases, theoretical predispositions and preferences come into being and shape the work of occupational therapy. Employing the reflexive turn enabled me to explore critically and mindfully the therapeutic interactions and relationship between clinicians and clients. This exploration required an understanding of where and how I and by extension other therapists were positioned in and by the various discourses at work in the daily practice of occupational therapy.

The first step in this process was the construction of a collage through which I explored in detail my beliefs, assumptions, values, perspectives and ways of knowing

around client-centred practice. I had used collage as a vehicle for critical self-reflection many times before. In this case it produced a clarification and articulation of subconsciously held beliefs and values congruent with an emancipatory research methodology and a collaborative approach to therapist-client relationships.

Working with the data that originated in my own practice raised issues of credibility and trustworthiness. In an emancipatory framework, reflexivity and critical self-reflection are the primary means of addressing bias and ensuring trustworthiness of the data and the data analysis. Trustworthiness ultimately relies on the credibility of the researcher and her ability to be critically reflective. I have cultivated the capacity of reflexivity and critical self-reflection in practice over a number of years. Having become comfortable and proficient with reflexivity as a mode of practice I employed it as a research methodology. As the researcher in this study I have carefully and mindfully examined not only my own values, beliefs and theoretical predispositions using collage, but also my discursive positioning in the clinical narratives that serve as data for this study, and the manner which I generated the clinical narratives and the role played in these narratives by both clinician and client.

Personal Perspective on Client-Centred Practice.

In order to bring to the forefront the subtle nuances of issues that I was working on and to arrive at an articulation of them I used my already-established practice of collaging. This practice entails allowing the subconscious mind to choose and assemble visual images that relate to the topic of inquiry. The collage becomes an externalized representation of the unconscious contents of mind, which are then examined through the

lenses of reflexivity and critical self-reflection. Through continuous cycles of reflecting and writing complex levels of beliefs, values, assumptions and understandings are illuminated.

I created a collage on client-centred practice. Being a reflective practitioner and frequently using collage I use color and images instead of words and concepts to allow the subconscious to dictate what will appear in the collage and what is available for analysis by the conscious mind. By critically reflecting, writing, re-reflecting and re-writing working with the collage, I unearthed and articulated my beliefs, values and assumptions and multiple complex understandings around client-centred practice and a collaborative therapeutic relationship. This reflexive and critical self-reflective move furthered the process of emancipating me from the scientific paradigm.

The Clinical Narratives.

The origin of the narrative texts used in this study was personal debriefing notes that drew on three decades of clinical practice as an occupational therapist. These notes were developed as a regular part of my reflexive practice. They were recollections of my interactions with clients while striving to establish a collaborative therapeutic relationship and of debriefing sessions with colleagues where interactions with clients were critically examined and possibilities for improving future interactions were explored. These notes were developed not for research purposes, but in order for me as the clinician to become aware of what was happening in a given situation and to learn from the experience. The emphasis was on the clinician's perspective. The notes contain my memories and interpretations of what happened in developing a therapeutic relationship. As a researcher I am interested in these notes in order to examine how the dominant health care

discourses and the professional discourses shape therapist-client relations, particularly in reference to the collaborativeness of these relations. The narratives were assembled specifically to provide descriptions of situations in which I could explore the research questions, namely how do various competing discourses that are at work in the everyday practice of occupational therapists influence by inhibiting or enhancing a collaborative therapist-client therapeutic relationship and what are ways of strategizing a more client-centred collaborative approach in the midst of tensions and disjunctures of everyday clinical practice.

In the narratives three composite characters have been created, around each of whom has been constructed a clinical narrative, which details a specific critical incident that actually occurred in a practice setting. The incidents are described exactly as they happened. The focus of each narrative or story is the collaborative therapist-client therapeutic relationship and each incident describes some therapist-client interactions that are particularly problematic and some that are particularly successful. In examining these incidents, particular attention is paid to the language I used as a clinician, the non-verbal nuances of the client (gestures, postures, facial expressions) and the silences and pauses that occurred during the therapist-client interactions. By employing critical reflection I examine my actions, re-actions, lack of action and the responses of clients.

Composite characters of clients were created in order to ensure anonymity and confidentiality. Any words or references to any situations or events that could possibly identify any individual client, colleague or institution have been removed. A name for each client has been randomly chosen in order to guise any reference to an individual. The selected name does not relate in any manner to the individual's name. Other material

and information relating to individuals, events, situations, locations and institutions have been fictionalized. There is no reference to a specific timeframe and any reference that may have implicated a third party has been eliminated.

The clinical narrative is written in the first person while the clinical analysis of the clinical narrative is written in the third person. This way of writing and presenting the clinical narratives and the clinical analysis was deliberately chosen in order to make it clear to the reader which was the actual narrative and which was the analysis of the clinical story. This format also proved to be helpful for the clinician/researcher who was participating in both aspects, namely the story telling from the practice setting and the reflexive clinical analysis from an emancipatory research perspective.

Analysis of the Clinical Narratives

Each narrative is analyzed using the concepts of occupational therapy clinical reasoning and of discourse to identify the ways in which client-centred practice is enhanced or prevented. Clinical reasoning is a complex multidimensional process. It is about how and what occupational therapists think and perceive in the midst of their daily practice. The specific modes of clinical reason used in this research study were identified in an ethnographic and action research study of occupational therapists in a variety of clinical areas conducted by Cheryl Mattingly and Maureen Fleming in the United States over a period of four years (1986 – 1990). The modes of clinical reasoning are labeled procedural, interactive, conditional and narrative. An additional form of clinical reasoning not identified in the aforementioned clinical reasoning study but used in this study is pragmatic clinical reasoning (Schell & Cervero, 1994).

The term “discourse” is used in this study to refer to interconnected modes of thinking, acting and being including personal and professional biases, theoretical predispositions and preferences that both frame and construct experience. Because we are always immersed in discourse we are usually not consciously aware of how they work both on us and through us. Discourses can be difficult to identify through observation. However, the aforementioned clinical reasonings are clearly defined and easily observable in practice. In this study clinical reasoning provides access to discourse insofar as a particular mode of clinical reasoning signals a corresponding discourse by showing the mode of thinking characteristic of that discourse. The different modes of clinical reasoning are thus the interpretative lenses used to reveal and analyze the differing discourses that are at play at the practice site.

There is often an indirect relationship between clinical reasoning and discourse. That is, one type of clinical reasoning can be employed within more than one discourse usually to negotiate multiple discourses simultaneously. For example procedural clinical reasoning can be used to negotiate or maneuver in and between dominant health care discourses and client-centred discourses. Sometimes the relationship between clinical reasoning and discourse is more direct. For example interactive, conditional and narrative clinical reasonings are rarely used in the dominant health care discourses. However, these latter three clinical reasonings when used alongside procedural clinical reasoning can signal an attempt to balance the competing dominant and professional discourses.

Client-Centred Occupational Therapy

Occupational Therapy Client-Centred Practice: Canadian Historical Perspective

I am aware that a number of health care professions talk about practice as client-centred or patient centred or some similar name. However, in this research study when I name or write about client-centred practice or a client-centred approach I am referring to the concepts as they relate to the professional occupational therapy practice guidelines in Canada. A number of the terms associated with these concepts are outlined in Appendix A.

It is now over twenty years since the emergence of client-centred practice within the Canadian occupational therapy scene. “The orientation to client-centred practice grew out of government and professional concerns to evaluate health services and to make services more accountable through quality assessment and quality assurance” (Townsend, 1998, p.47). In keeping with the emphasis on quality assurance, the Canadian Association of Occupational Therapists spearheaded specific projects such as the development of a national statistical measurement, standards for occupational therapy services for explicit use in hospital accreditation, and an occupational therapy profile for use in academic and fieldwork education. The fourth project was the establishment of a national task force to develop occupational therapy practice guidelines.

Initially the terms of reference for the development of the practice guidelines were not orientated to client-centred practice. However:

After an extensive review of occupational therapy, quality assurance, professional evaluation, accreditation standards, health promotion, disability, sociology, psychology, professionalism and related literature

from the 1960s to the mid 1980s, the concept of client-centre practice was adopted and embedded in the forthcoming practice guidelines (Townsend, 1998b, p.48).

The result of this action was a shift to the generic guidelines being client-centred and not professional-centred. The purpose of the national consensus *Guidelines for the Client-Centred Practice of Occupational Therapy* (Department of National Health and Welfare [DNHW] & Canadian Association of Occupational Therapists [CAOT], 1983) was:

To foster cohesiveness, consistency, and a high standard across diverse areas of practice; form the bases of quality assurance and program evaluation in occupational therapy across Canada; articulate a generic conceptual framework for clinical, administrative and educational program planning and research; support a nationally consistent orientation to student occupational therapists and provide an important resource for public relations to inform those in government, other professions and the community about occupational therapy, (Townsend, 1998b, p. 49).

The use of the term guidelines rather than standards was a deliberate action by the Task Force so as not to impinge on the rights of “Canadian provinces [to] define and monitor standards through provincial organizations such as those that regulate occupational therapy practice” (p. 48). The guidelines present a vision of “reasonable as opposed to optimal or minimal” practice (DNHW & CAOT, 1983, p. 2).

Although when it was adopted client-centred practice was not explicitly defined, five theoretical and philosophical concepts of client-centred practice were presented and

discussed. These were the worth of the individual, the holistic view of mankind, the occupational performance model, the therapeutic use of activity and a developmental perspective (Townsend, 1998b). By looking at the next set of practice guidelines, the *Intervention Guidelines for the Client-Centred Practice of Occupational Therapy* (DNHW & CAOT, 1986), one can trace the increasing movement towards a client-centred approach. One example of this is the use of the word *intervention* rather than *treatment* in the title and throughout the text. This was a deliberate act by the authors to demonstrate that occupational therapists “were expanding rapidly outside medical contexts; and client-centred practice involves collaboration with, versus doing for people as is implied in treatment” (Townsend, 1998b, p. 50).

The commitment to a client-centred approach is further demonstrated in this 1986 document in the description of the orientating principles (professionalism, team approach, and adaptation), the five fundamental elements of client-centred interventions (spirituality, motivation, therapeutic relationship, teaching learning process and ethics), and the basic concepts of client-centred practice (process of practice was added to the concepts noted above).

Among the fundamental elements of client-centred intervention, spirituality was highlighted to give emphasis and importance to attending to the meaning in clients’ lives. Individuals were recognized as having a spirit as well as a body and a mind. As Townsend (1998b) noted, “spiritual malaise or anomie was differentiated from the psychological construct of motivation” (p.52). Motivation was seen as “a psychological process and related to self-concept, confidence, and a sense of control in problem solving and decision making” (p.52). The therapeutic relationship was recognized and described

in general terms, as a process of establishing and engaging in a collaborative interaction between the client and the therapist, where mutual teaching and learning enable and support risk-taking, problem-solving, decision-making, and skill acquisition. The importance of ethical elements was also highlighted. For example, it was acknowledged that therapists and clients might hold differing values and beliefs about goals and therapeutic priorities. In light of these possible differences, this document emphasized the “importance of occupational therapists upholding their professional responsibility to both service the clients needs while also adhering to the professional code of ethics to ensure that potential harm to clients is minimized” (p. 52). This is not always easy or straightforward. Conflicts can arise. The dilemma for occupational therapists is identified by Sumsion and Smyth (2000): “This ethical dilemma of trying to simultaneously preserve autonomy and beneficence may result in therapists wishing to support the client’s autonomy, while fearing that the clients will choose unsafe or inappropriate goals” (p. 18).

The emphasis on client-centred practice was maintained in the third consensus guidelines document, *Towards Outcome Measures in Occupational Therapy* (DNHW & CAOT, 1987). Outcome measures were reviewed in relation to the professional client-centred model of occupational performance. The occupational performance areas of “self-care, productivity, and leisure are the primary outcomes of occupational therapy, while physical, mental, and socio-cultural performance components are secondary” (Townsend, 1998b, p.52). Townsend, Ryan and Law, (1990) noted that the occupational therapy approach to outcome measures was compatible with the *World Health Organization’s International Classification of Impairments, Disabilities and Handicaps*.

These 1987 outcome guidelines recommended the development of a specific assessment tool of occupational performance that would be compatible with the concepts of client-centred practice. The *Canadian Occupational Performance Measure (COPM)* was developed and implemented in 1991 to meet these recommendations and directions. (Law, Baptiste, Carswell, McCall, Polatajko & Pollock, 1994; Law, Baptiste, McCall, Opzoomer, Polatajko & Pollock, 1990; Pollock, 1993). In keeping with the emphasis on being client-centred, the COPM “does not measure occupational therapy outcomes, rather it focuses on the occupational performance outcomes in an individual client’s self-care, productivity and leisure” (Townsend, 1998b, p. 53). In this assessment tool the value of specific occupations or activities are defined and ranked by the client in terms of importance, performance and satisfaction. By taking into account client roles and role expectations and the client’s environment, the COPM ensured the relevance of the performance issue to each individual client and thereby re-enforced the profession’s commitment to client-centred practice through supporting and encouraging a shift in the client/therapist power dynamics. The professional was moving from being the expert who develops and directs the client’s care to becoming a facilitator who enables the client to be an active participant in determining the focus and direction of his/her goals, interventions and outcomes processes. While the occupational therapist’s professional expertise and judgments were recognized, the client was also recognized as being an expert in identifying his/her own specific issues and concerns. Thus, by the beginning of the 1990s Canadian occupational therapists had three core guideline documents and a specific outcome measure to promote quality client-centred practice (Townsend, Brintnell & Staisey, 1990).

In the 1990's the emphasis on client-centred practice continued to grow and develop through CAOT's promotion of five interrelated initiatives, namely "consolidating, clarifying, concentrating, classifying and creating" (Townsend, 1998b, p. 54). These initiatives related to consolidating the original guidelines into one document, clarifying the uses and usefulness of the guidelines, concentrating on mental health by developing guidelines for this practice area, clarifying professional competency in a national document and creating a new set of national client-centred guidelines. Each of these initiatives will be briefly reviewed in relation to the developing client-centred practice in Canada.

Supporting the profession's evolving concepts of client-centred practice the three previous consensus guidelines were consolidated into *The Occupational Therapy Guidelines for Client-Centred Practice* (CAOT, 1991). The preface of this document offered current perspectives on the original client-centred guidelines highlighting societal changes such as the growing focus on health promotion and consumer involvement, and it addressed the increased relevance of environment and spirituality to client-centred practice.

As a result of the decline in the number of occupational therapists entering the practice field of mental health in the late 1980's and early 1990's a national task force was struck to clarify occupational therapy client-centred practice in mental health. This resulted in the publication of *Occupational Therapy Guidelines for Client-Centred Mental Health Practice* (CAOT, 1993). In this document it was recognized that client-centred practice "does not negate the importance of professional expertise . . . which is guided by an ethical commitment to listen and respond to each client" (p.5). In this particular approach

to practice occupational therapists have an “ethical and moral responsibility to ensure that clients are as informed as possible of the options and risks associated with possible courses of action” as well as actively seeking and structuring “opportunities for clients to have real choices and authority commensurate with their skills and experience” (p.5). The guidelines support “an equalitarian client-professional relationship and an organizational system which acknowledges that clients, to the best of their ability, share in taking ethical, moral and legal responsibility” (p.6). These guidelines also have an emphasis on enabling, which is a “complex, wide-ranging set of methods and approaches through which occupational therapists help clients to reach their optimal occupational performance” (p. 13). Although enablement implies working with the client rather than doing for the client there remains a subtle imbalance between the client and the professional. Rather than collaborating where authority is more evenly distributed between the client and the clinician, helping implies that the professional has more to offer and therefore more authority than the client. It is not until later in the 1990’s that the concept of collaboration is emphasized in client-centred practice. It is my understanding that in some health professions such as counseling in a client-centred relationship the power balance remains in the clinician’s favor while in a collaborative relationship the client occupies the stronger power position. However, in occupational therapy the concepts of client-centredness and collaboration are virtually synonymous and both are seen as reducing but not eliminating the power difference between the client and the clinician. In both, the professional’s expertise and the client’s experience are recognized but not always given equality.

From this stronger stance in client-centred practice the national association and Human Resources Development Canada (HRDC) undertook the task to classify professional competence for client-centred practice. The 1996 *Profile of Occupational Therapy in Canada* (CAOT & HRDC) is based on the Canadian orientation to client-centred practice and emphasizes collaboration with clients, meaningful occupation and occupation performance. *The Profile* is used for developing academic standards and validating the blueprint for the CAOT national certificate examination, which all occupational therapists educated in Canada and foreign graduates wishing to work in Canada must successfully pass in order to be accepted by provincial credentialing colleges. Clinicians can also use it as a self-assessment tool. The aforementioned supports and emphasizes the national association's commitment to client-centred enabling practice.

In order to evaluate the usefulness of the client-centred guidelines and how they were being used the national association conducted an impact study. The findings of the evaluation indicated that the primary users of the guidelines were administrators involved in quality assurance, advocacy for clients or lobbying for professional interests and explaining occupational therapy to medical or other professionals. A major emphasis of client-centred practice is listening to and engaging the client in practice but the voices of the practitioners who ultimately facilitate this practice were missing from this study. In this time period there were also a number of articles written primarily by academics and researchers about the topic of client-centred practice. Interestingly, as in the impact study the voices of the front line practitioners were mostly silent. Hence, the authors of the study recommended and CAOT agreed that it was essential to “articulate a clear vision of

occupational therapy's own concepts, discourse and strategies based on ideas and experiences in trying to implement client-centred practice" (CAOT, 1991, p. 285).

Creating a new set of client-centred practice guidelines enacted this dictate. *Enabling Occupation: An Occupational Therapy Perspective* was introduced in 1997 (CAOT). In addition to the client-centred concepts this document introduced the emerging language of occupation, enablement and justice (see Appendix A). The now internationally acclaimed *Canadian Model of Occupational Performance (CMOP)* was also introduced in this text. This model was developed to "capture the dynamic interaction between people, their environment, and their occupations over the lifespan; and principles and ethical issues for being client-centred are highlighted for clients who may be individuals, groups, agencies, or organizations" (Townsend, 1998b, p. 58). Suggestions for using the guidelines and clinical vignettes provided practical examples of applications of client-centred practice. These guidelines are well known nationally and internationally and have succeeded in furthering the evolution of client-centred practice.

Fearing and Clark's (2000) book, *Individuals in Context: A Practical Guide to Client-Centered Practice*, is a collaborative effort by clients, clinicians, academics and administrators that produced an integrated approach to practice. The text uses a friendly practical approach to client-centred practice with an emphasis on partnership and collaboration. This document has been well acclaimed by occupational therapists and has done much to support and advance client-centred practice.

Client-Centred Practice in Occupational Therapy A Guide to Implementation (Sumsion, 1999, 2006) is another practical and highly respected book about everyday client-centred practice. Sumsion has been actively involved in the development of the

practice guidelines. She is committed to this practice approach and is continuing to advance and champion client-centred practice through her writings.

The core concepts in client-centredness of enablement, empowerment, collaboration, justice and occupation are further expanded in *Enabling Occupation II: Advancing An Occupational Therapy Vision for Health, Well-Being & Justice* (Townsend & Polatajko), the latest national practice guidelines document published in 2007. This book is a sequel and companion to *Enabling Occupation: An Occupational Therapy Perspective* (CAOT, 1997, 2002). Townsend and Polatajko, the primary authors of *Enabling II*, note that “the book advances the transformation of occupational therapy from being a profession focused on the therapeutic use of activity, to one dedicated to enabling all people to be engaged in meaningful occupations and to participate as fully as possible in society” (2007, p. 2). This shift to client-centred enablement in meaningful occupations is accomplished through working collaboratively with the client. The client is empowered to actively participate in decision-making and problem solving regarding the recovery process, which supports a client-centred approach to practice.

Occupational Therapy Client-Centred Practice: Underpinnings

The underpinnings of the construct of client-centredness are found in the works of Carl Rogers. The term client-centred practice arose in his book *The Clinical Treatment of the Problem Child* (1939) where “he described a practice that was non-directive and focused on concerns as expressed by the client receiving the service” (cited in Law & Mills, 1998, p.4). In his writings Rogers emphasized the importance of cultural values, the dynamic nature of the therapist-client relationship and interactions, the need for

openness, sharing and honesty in the clinical therapeutic relationship, the nondirective/nonjudgmental approach of the therapist, and the client's active role in defining and solving problems. In looking at the roots of client-centred practice, Law and Mills (1998) identified an important assumption arising from the phenomenological nature of Roger's client-centred therapy, namely, "that clients are the best individuals to describe their experiences and their reality" (p.5). Therefore, it is important to spend time to listen and be able to learn about clients' life experience.

While they have continued to evolve, the concepts of occupational therapy client-centred practice are similar and reflect the contributions of Roger's thinking, as can be seen in the next section.

Occupational Therapy Client-Centred Practice: Concepts

Over the past ten years the occupational therapy literature has highlighted a philosophy of practice built on the concepts of client-centredness, where the client-therapist relationship is defined by trust, caring and competence (Doble, 1988; Law et al., 1995; Mattingly & Fleming, 1994; Peloguin, 1991). After a review of available models of client-centred practice Law and Mills (1998) identified in the book entitled, *Client-Centered Occupational Therapy*, the following concepts:

- Respect for the clients and their families, and choices they make
- Provision of information, physical comfort and emotional support
- Facilitation of client participation in all aspects of occupational therapy services
- Client and families have the ultimate responsibility for decisions about daily occupations and occupational therapy services
- Flexible, individualized occupational therapy service delivery

- Enabling clients to solve occupational performance issues
- Focus on the person-environment-occupation relationship (p.9).

Respect is one of the basic concepts in a client-centred approach and is the foundation of any therapist-client relationship. A fundamental concept in client-centred occupational therapy is that occupational therapists show respect for the choices that a client has made, will make, and his/her personal method of coping (Law & Mills, 1998). The client's opinions must be sought, their values and beliefs respected and the individual must be treated with dignity and integrity throughout the therapy process.

A therapeutic relationship in this particular approach supports, encourages and facilitates the client taking control and making informed choices. Polatajko (1992) asserts that a client-centred approach where the client defines the primary issues and concerns for occupational therapy supports a shift from a deficit model of intervention to an enablement model.

To be congruent with a client-centred approach/discourse it is imperative that clients feel safe and comfortable in the occupational therapy setting. Both comfort level and understanding information provided about therapy are factors which can impact clients' everyday living and influence how individuals make decisions about their therapeutic intervention process. Hence, clients need to be provided with information in a manner that they can understand and that will enable them to make informed decisions about their needs. Law and Mills (1998) note:

The relationship and interactions between clients and occupational therapists deserve much more attention than they have received in the past. An open, caring relationship in which the occupational therapist hears the story that

the person has to tell and listens to the description of his or her needs can only enhance the ability of the person and the therapist to work together to solve occupational therapy performance issues (p. 12).

Facilitation of a collaborative partnership between the client and the therapist is another fundamental concept. This alliance requires a conscious shift in power dynamics within the therapeutic relationship. This move in power happens when it is the client who is identifying the occupational performance issues and is actively involved in the decisions and problem solving around outcomes. (Law & Mills, 1998; Law et al., 1995; Sumsion, 1993). The occupational therapist becomes the collaborator and the facilitator rather than the person choosing the direction to be followed (Townsend, et al., 1990). The goal of client-centred occupational therapy is to ensure that the relationship between the therapist and the client is one of mutual participation. The collaborative partnership is different from the traditional client-therapist rapport, where the professional is the expert who directs the clients' occupational therapy services.

Ideally in a client-centred approach the service delivery system should be flexible, provided in a timely and accessible manner and the services constructed to meet the needs of the client rather than the client fitting into the service model. Law and Mills (1998) note that in a client-centred approach the occupational therapist has a responsibility to strive to enable the client's access to the services and intervention opportunities with a minimum of bureaucratic red tape. However, the practice site can be filled with conflicts for the occupational therapist, who in the majority of situations has limited or no control in this area.

Inherent in client-centred occupational therapy is the focus on enabling and facilitating client involvement in the therapy process and client-defined outcomes. In this client-centred environment therapists work with client's to empower and enable clients to generate and implement solutions to their identified goals. Enablement is facilitated through the process of listening to the client's illness experience and life story using language that is understood by the client and providing information to support the client to problem solve and make informed decisions. The emphasis is on actively engaging the client in occupations that are important and meaningful to them. Thus, the concepts of enabling and facilitating encourage and support "the possibility for client independence, a sense of internal control and a purposeful existence" (Townsend, et al., 1990, p. 72).

Recognition of the client's roles and lives (interests, environment and culture) within the larger community context is an important consideration in all aspects of client-centred practice. As Law and Mills (1998) point out "a unique concept within client-centred occupational therapy is the acknowledgement that clients are not divorced from the environments and community in which they live, work and play" (p.15).

Occupational Therapy Client-Centred Practice: Client Perspective

Not until the late 1990's did the client's perspective on client-centred practice become more visible in occupational therapy literature and research. With the increase in the use of qualitative research methods in occupational therapy has come a shift to include the client's voice and opinions in the clinical research being conducted. However, only a few therapists have conducted studies that have sought the views and opinions of clients on occupational therapy client-centred practice.

Corring and Cook (1999) were the first researchers to involve clients as participants in their research study. They noted that the absence of the client's perspective in the earlier research was "puzzling when partnership, client involvement in decision-making and client empowerment is thought to be fundamental elements of this approach to practice" (p.71).

The qualitative studies by Corring and Cook (1999) and Rebeiro (2000) sought the perspectives of clients with experience in the mental health delivery system. Through focus groups, the former researchers asked clients about the meaning of a client-centred approach to practice, while the latter researcher used in-depth interviews to gather material from clients regarding practice and occupation. The following issues were identified as important client perspectives in Corring and Cook's 1999 study:

- The importance of the therapeutic relationship
- A specific focus on recovery
- Advocacy for a more humane care responsive to client need
- Respect and value of the client's knowledge of themselves
- Valued, fulfilling lives for clients
- Therapists and students understanding the significance and importance of the client's life experience and expectations.

The primary message from this research was "the need for individuals with mental illness to be viewed as valuable human beings by service providers and society" (p. 71).

Unfortunately, in many communities this issue remains unaddressed.

Prescription of specific activities, lack of client choice and a focus by therapists on illness rather than on the individual client were viewed by the client participants of

Rebeiro's (2000) study as the primary causes leading to exclusion of the client in the therapeutic intervention decision-making process thereby precluding the possibility of a collaborative client-therapist partnership. Greater focus upon choice, consideration of the individual, providing accepting and supportive environments, and using professional expertise to guide the client towards active participation in meaningful occupations were the recommendations to therapists from the client participants in this research study. These recommendations are similar to the practice guidelines, which strongly indicates that there is a major gap between the principles and the implementation of a client-centred approach to occupational therapy practice.

The results from Darragh, Sample and Krieger's (2000) research support the claim that the client-centred approach the profession strives for is not always forthcoming. In voicing their understanding of the meaning and characteristics of client-centredness, study participants spoke to the inadequacies of the care they received. Rebeiro (2000) noted, "in general, the philosophical assumptions and beliefs of the profession have been largely affirmed by the participants. However, these same beliefs were not perceived to be an integral aspect of the occupational therapy care they received" (p. 13). Corring and Cook (1999) stated the results of their study painted "a very honest, but far from flattering picture of a service delivery system and service providers" (p. 80). For example, "the participants in this study referred often to not being believed, and stated their opinions and perspectives were not respected by service providers" (p.78). Again this speaks to a major gap between the intentions and the actual doing of client-centred practice.

Collectively, individuals living with a psychiatric illness have often been excluded from society as actively participating citizens deserving respect, dignity and value as human beings. They are marginalized with sometimes devastating effects. Therefore, it is important to pay close attention to their voices and, in particular, to the issues of being valued as a human being. This aspect had been primarily absent from the writings and discussions about client-centred practice. Corring and Cook (1999) maintain, “if we are able to meet the challenges of the client-generated principles of client-centred care, then perhaps clients can begin to feel like valuable beings and enjoy the love, respect, and fulfillment they deserve” (p. 80).

In her article, Carpenter (1999), a mental health client, discussed the importance of the relationship between the client and the therapist. She noted that this relationship must remain relaxed, offer trust, be respectful and understanding, and provide open and honest communication.

Klein (1995, 1998), a film maker, broadcaster, writer and a survivor of strokes caused by a rupture to a brain stem malformation, addressed the profession as the keynote speaker at the 1995 national occupational therapy conference, where she spoke to the conference theme, “Partners in Practice”. Aspects of this address have been included in a CAOT journal article (1995) and in the forward of guidelines, *Enabling Occupation: An Occupational Therapy Perspective* (CAOT, 1997). She was invited to update her comments for the reprint of the above document, which was published in 2002. Klein called upon occupational therapists not to lose focus on occupations that have meaning for people, to listen to clients’ needs, to learn and pay attention to laws and local services in order to fully understand how these will impact the lives of disabled persons, and to

know clients, “not just as clients but as fellow human beings” (1997, p. x). Furthermore, she urged occupational therapists, “because of their unique body of knowledge and skill, to become partners, and even more importantly, allies with their clients” (1995, p. 283). I support her premise that the profession needs to become truly inclusive and representative and to take actions to bridge the power gap between the profession, the professional and clients where we seek collaborative partnership. I also believe that, as therapists, we have to reflect and act upon Klein’s request that we be client allies. “Just as I needed an ally to support my personal vision for complete rehabilitation . . . I needed an ally for adapting to the wide world . . . I needed an ally for the rehabilitation of society itself (p. 285).

Occupational Therapy Client-Centred Practice: Tensions and Challenges

As the chairperson of the task force that designed the guidelines model, Sumsion wrote in 1993, “I am not convinced that we truly understand, even ten years later, what the implications of this model are for practice” (p.7). She acknowledged that through reading, attending conferences, and discussing with colleagues, the majority of Canadian occupational therapists have heard of the model. However, she questioned whether therapists had truly integrated the client-centred concept into their everyday practice. Is the client the primary decision maker in establishing goals and treatment direction? Has the therapist become the collaborator in the process rather than the one directing the treatment?

It is interesting that almost ten years after Sumsion’s questioning, occupational therapists still had questions about this approach. For example Corring and Cook in 1999

asked, What does client-centred practice mean? Rebeiro in 2000 asked, Are we truly client-centred? Also in 2000 Hong, Pearce and Withers asked, How client-centred can occupational therapy assessment be? And in 2001 Wilkins, Pollock, Rochon, and Law asked, Why is it so difficult to do?

A partial answer to this last question was provided in the studies of Clark, Scott and Krupa (1993), Law et al., (1995), Toomey et al., (1995) and Sumsion and Smyth (2000), all of whom found that therapists and clients having different goals regarding interventions was a primary challenge and often a major barrier to facilitating and implementing a client-centred approach to practice. In this vein, Law et al. (1995) and Toomey et al. (1995) found that professionals often assume that the clients' goals and their own are the same when, in fact, they are not. Clarke et al. (1993) found that disagreement between clients and occupational therapists on the importance of clinical issues often led to incongruence between the goals of the professional and those of the client. Gage and Polatajko (1995), Law et al. (1995), Sumsion and Smyth (2000), Townsend (1993) and Woodside (1991) all suggested that therapists may be uncomfortable with the shift in power from the therapist to the client and with the client's willingness and ability to make decisions and exercise power. This power dynamic was further illuminated by Law et al. (1995) when they stated, "there may be situations when a therapist is uncomfortable with the client's choice, more because of a difference in values than the fact that the client is not competent to make that choice" (p. 252).

Occupational therapists may also find using client-centred evaluations such as the COPM unsettling because they believe that letting the client choose the goals for

interventions gives the balance of power to the client. These often hidden imbalances of power prevent partnerships based on mutual trust, collaboration and acceptance. This shift in power from the occupational therapist to the client can result in much tension and difficulty for the occupational therapist educated in and / or practicing in the rehabilitation model within the dominant health care discourse. In this dominant medical discourse the professional is the knowledgeable expert and the client is seen as having limited or no experience or knowledge to contribute to the intervention process. In this environment, limited or no value is given to the client's knowledge of their illness experience and desires for interventions or outcomes.

Wilkins et al. (2001) analyzed barriers at three levels. At the system level issues were primarily around funding and team work. At the occupational therapist level there were difficulties involving time and resources and their knowledge of client-centred practice and at the client level the issues related to power sharing and partnership.

Having difficulty facilitating clients' goal identification and hence intervention direction is another tension that therapists may experience when first trying to implement a client-centred approach to practice. As Sumsion (1993) noted, "it takes far more skill to facilitate the clients' identification of their problem than it does to simply make that decision for them." (p. 7). In order to facilitate decision making and enablement there is a need for an emphasis on therapists listening to clients' needs and desires and a necessity to use language that clients can understand (Clarke et al., 1993; Law et al., 1995; Sumsion & Smyth, 2000). Also for some clients there is a need for occupational therapists to develop the ability to make clients feel comfortable with client-centred practice and to teach them how to take control (Toomey et al., 1995).

Over the years there has been a change not only in the profession's approach to practice but also in the disciplinary knowledge base underlying practice. In the relatively new client-centred approach the emphasis is on facilitating, collaborating, coaching and enabling the client to make informed decisions about their intervention process. In the long-standing medical model, however, occupational therapists are the experts who make the decisions, prescribe the modalities to be used and set the direction for the occupational therapy treatment. It is understandable then, that the occupational therapists shifting from the latter approach to the former approach often encounter frustrations, tensions, challenges and difficulties in adapting styles and approaches and in learning and gaining new skills. As more occupational therapists graduate from university programs versed in client-centred enabling and the core competencies relating to this practice there may a further shift toward a client-centred enabling approach.

Contextual issues are also an important aspect to consider when examining a client-centred approach. Often health care routines and technologies require that the client be passive, and client attempts at assertiveness and control are considered to be “disruptive” by health care providers. This “disruptive behavior” often results in the client being labeled as “noncompliant” or “resistive”. In order to enable a change in approach it may be necessary to educate both clients and staff. There is a need for organizations to be both staff –and-client-centred. It has to be remembered that organizational culture:

includes a philosophy that shapes relationships among employees and clients, norms that govern behavior, values that members share, rules of the game and the climate or feel of the organization. Culture is hard to change: it evolves over time. Being client-centred requires more than a

declaration from administration. It must be [a] genuine part of the values held by everyone within the organization (Wilkins, Pollock, Rochon, & Law, 2001, p. 73).

Personal Perspective on Client-Centred Practice

Introduction

Much has been written about client or patient-centred practice in the various fields of health care. In my profession, occupational therapy, the material has been accumulating for more than two decades resulting in numerous publications, the development of the *Canadian Model of Occupational Performance* in 1997 and expanded in 2007 to the *Canadian Model of Occupational Performance and Engagement*, the *Canadian Model of Client-Centred Enablement*, the *Canadian Practice Process Framework* (Townsend & Polatajko, 2007) and specific evaluation tools such as the *Canadian Occupational Performance Measure* (Law, Baptiste, Carswell, McCall, Polatajko, & Pollock, 2005).

Client-centred practice is a core tenet of occupational therapy in Canada. As an occupational therapy administrator, educator and practitioner I immersed myself in these texts seeking to further understand this material in relation to institutional policies and procedures and the development of my own and others' everyday practice. Now as a researcher I have the unique opportunity to review the literature through more critical lenses and to ponder my clinical reflections.

The occupational therapy professional texts on client-centred practice are specifically described as guidelines rather than hard and fast rules. These guidelines provide the foundation for the development of client-centred practice. However, professional literature and research and personal observations in courses and workshops related to occupational therapy client-centred practice indicate that individual professional interpretations and understandings of the concept of occupational therapy client-centred

practice vary considerably and many occupational therapists are ambivalent or remain unclear as to how to take up client-centred practice.

I believe that each professional has a responsibility (response-ability) to be aware and understand what client-centred practice means to him or her as a practicing occupational therapist and as a person. Both my professional and my research focus on client-centred practice require that I further explore and examine my beliefs, values, assumptions and understanding around client-centred practice. What do the concepts of client-centredness mean to me? What does it mean to practice in a client-centred manner? What aspects of this practice approach are important to me and why? What tensions and challenges enter into my everyday practice? How do I handle these tensions?

I have found visual images and color helpful in uncovering awareness, increasing understanding and creating meaning. In this situation I believed that my established practice of collaging would be extremely useful and informative in mining this topic. Collage is to me what free writing is to many writers and scholars. Collage enables me to proceed in a spontaneous non-judgmental manner. As I create the visual image there is no censoring, no editing and no interpretation. The images, symbols and colors emerge from the inner core of my being. Having developed the collage, I am ready to explore and critically reflect upon the images created. Interpretation, analysis, understanding, awareness and meaning making are possible through reiterative cycles of critical reflection.

I made the decision to use this particular process to explore my understanding of client-centred practice. I purposefully did not wish to refer only to my interpretations and understandings of the professional literature. I was especially interested in my

assumptions, beliefs and values around client-centred practice and what I was experiencing and learning in my everyday clinical practice. My hope was that in addition to social, economic and historical influences I would unearth my specific integration of theoretical knowledge and practical experience. I assembled a collage and critically reflected on it. Please refer to Appendix C for a copy of the complete collage.

The Collage: My Perspective on Client-Centred Practice

As I began to reflect on the collage I found myself interpreting the images from the scientific paradigm, which admittedly has been a very strong influence in my professional life. Like the well-schooled occupational therapist that I am, I noted that as occupational therapists we are actively involved in all aspects of the occupational life course – through birth to death. In my years of clinical practice I have worked with babies, toddlers, children, adolescents, young adults, adults and seniors. This picture of the man with the baby in the foreground and the vast expanse of sky and mountains in the background take into consideration aspects of spirituality, gender and the cultural, institutional, physical and social elements of a dynamic environment. The images also hint at the scope of occupation, that is everything a person does to occupy themselves: self-care (looking after daily tasks such as bathing, hygiene, grooming, medications); leisure (enjoying life) and productivity (contributing to the social and economic fabric of the person's community). The images also suggest the many performance components of a person: affective (feeling), cognitive (thinking) and physical (doing) (CAOT, 1997 & 2002).

As I re-read these interpretations I became increasingly aware that I was analyzing the images in terms of the material in the professional texts on client-centred practice. At one level I found this exciting and re-assuring. Subconsciously I had chosen images that reflected client-centred concepts as defined by the profession. Yes, it is important to be committed to these concepts that include the developmental process, the occupational life span, gender, environmental issues, occupations, enabling and performance issues and components. But at a deeper level I wondered where was my voice, my values and beliefs with regard to occupational therapy client-centred practice. This was the urge to emancipate myself from my theoretical predispositions that were restricting my visions of client-centred practice.

I looked again and further reflected on the collage to find my own particular meanings. I began to pay close attention to the details of the visual images at the centre of the collage. Please refer to Appendix B for a copy of the centre of the collage. Eventually through this critical re-reflection I found an articulation that was more congruent with my core beliefs and values.

I became more aware of the man's outstretched arm and hand, his facial expression and the way the baby was held in his arm. I also began to pay attention to the bubbles, the mountain range and the wide-open sky. The man blowing bubbles with outstretched arm and hand represented, for me, openness. This is an invitation, a willingness, to enter into and accept the possibility of a relationship. In a collaborative therapeutic relationship the interactions and communication are two ways. Both parties, the occupational therapist and the client, must be willing to provide an invitation into and be accepting of an invitation into an interpersonal and a therapeutic relationship. The baby appears happy,

content, accepting and trusting of being held, safely, in the adult's arm. However, the adult must be aware of the child's possible vulnerabilities in such a trusting relationship. Likewise the occupational therapist must be aware of possible client vulnerabilities as they build a therapeutic rapport. Again this aspect of the image signifies openness, trust and responsibility, qualities that are important to developing respectful and balanced relationships.

The bubbles then become a metaphor for relationship, particularly a collaborative therapist-client therapeutic relationship. The bubbles and their multiple colors represent the possibilities in the client's recovery process. The unpredictability of the bubbles represents the unknown in the building of a therapeutic relationship on the unfolding path of recovery. What shape and direction does the future hold? Like the bubbles, therapeutic relationships move and change while connectedness persists. Some bubbles remain separate while others connect and float in tandem on a specific journey. Each bubble is unique. There are different colors, sizes and shapes. Similarly, the therapist-client therapeutic relationship is unique and varied. The therapeutic alliance is built upon each person's characteristics, values, beliefs and visions. The client and the occupational therapist remain as separate individuals while at the same time each has specific strengths and issues, which can influence the therapeutic relationship and the recovery process. Each has a responsibility to and within the collaborative relationship.

Although relatively strong, the bubbles have delicateness, fragility. The therapeutic relationship also has a delicateness and fragility of which the occupational therapist must always be mindful. Like the bubbles the relationship can 'pop' prematurely if not handled with care, respect, trust and dignity. As with the journey of the bubbles there may be

elements of risk for the client on the path of recovery. The journey may not always be smooth sailing. Just as the wind or other environmental elements may impact the path of the bubbles, there may be currents, issues and discourses that influence the therapeutic relationship and in turn the recovery process.

The mountains in the centre of the collage represent an invitation to further explore the therapeutic relationship and unearth the meaning in the therapeutic relationship and the recovery process. Mountain climbing offers the climber many exciting and exhilarating opportunities and possibilities. Active engagement in the climb can be awe inspiring, inspirational and rewarding. However, as a climber, I am also aware that challenges and difficulties can be encountered en route. Rarely is a climber on their own; there are usually other team members involved and each has a responsibility to listen, communicate and collaborate with the others regarding the route and handling the dangers and unforeseen events that can and do occur on the journey. Collaboration and co-operation can conquer difficulties and overcome challenges. Each person has particular strengths and offers solutions to the specific issues as they arise or are anticipated.

I see that there are many similarities between mountain climbing and developing and maintaining a collaborative therapist-client therapeutic relationship. Developing, building and maintaining a collaborative therapeutic relationship offer many opportunities, possibilities and challenges. Like the bubbles, the mountains are a metaphor for relationship, which reinforces the importance of a collaborative therapeutic relationship in the recovery process and my interest in this specific type of relationship. The following

interpretation of the mountain metaphor is a brief description of what opportunities, possibilities and challenges in a collaborative relationship can look like.

In order to develop an authentic collaborative therapeutic relationship the therapist and the client must work together in partnership to ensure a process of genuine enablement, each person respecting and trusting the other so that responsibilities, problem solving, decision making and engagement in the therapeutic process can be shared appropriately. The appropriateness comes from the recognition and acceptance that each person may have different yet specific and valuable contributions to make to the process of the relationship, rehabilitation plan, intervention process and therapeutic outcomes. Just as the climber must understand the mountain environment and the climatic conditions, so must the occupational therapist be aware of the different contexts and the client's lived experience of their illness/disability. Contexts can change just as the mountain terrain and weather can change. Like the climber, the occupational therapist must be ever vigilant.

The mountains looming into the expansive sky represents freedom of movement for both the client and the occupational therapist in the therapeutic rapport and the recovery process. In a client-centred practice environment a collaborative therapeutic relationship is neither static nor linear. Just as the clouds move across the sky in ever changing patterns, so does the collaborative therapeutic relationship change and grow. Growth, change and difference are accepted. At times, this may not be easy for either partner. At times rain clouds may darken the sky. Ideally, through two-way communication these dark clouds can be displaced and the relationship can move into a deeper dimension of understanding. A collaborative therapeutic alliance becomes a relationship that encourages and supports sharing and openness in communication, problem solving,

decision-making and choice. The client's and the occupational therapist's values, beliefs and assumptions are recognized and valued. However, it must also be recognized that just as a climb may have to be aborted due to weather conditions, a developing relationship may have to be discontinued by either party. As in the mountain climb this decision is best made through assessment, analysis and communication. The therapeutic relationship may terminate for a variety of reasons. For example the closure may be due to a personality clash or belief differences that cannot be overcome. For both parties it is preferable that these insurmountable differences are discovered early in the developing relationship.

In looking at the centre of the collage I have a feeling of serenity, a sense of awe and inspiration, a sense of spirituality. I find this interesting as the *Canadian Model of Occupational Performance* "places spirituality as a central core, as the essence of self" (CAOT, 1997, p. 42). With the publication of the latest occupational therapy practice guidelines spirituality remains in the centre of the revised *Canadian Model of Occupational Performance and Engagement* (Townsend & Polatajko, 2007). Spirituality for some is traditional religious beliefs and visions, while for others it may be a feeling, or the provision of a sense of meaning, direction or purpose to everyday life. It may also be described as the capacity for self-determination. I agree with Pelquim (1994) that in the collaborative therapeutic relationship consideration of spirituality is a way of developing an appreciation for the uniqueness of each person.

Viewing laterally from the centre of the collage, the images I see relate to the client's everyday occupations, defined by Townsend and Polatajko, (2007) as "groups of activities and tasks named, organized, and given value and meaning by individuals and a

culture” (p. 369). Please refer to Appendix C for a copy of the complete collage.

Occupational therapists consider occupation as “everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure) and contributing to the social and economic fabric of their communities” (p. 369).

Occupation is the “domain of concern and the therapeutic medium of occupational therapy” (p. 369). The national association in 1983 first classified the three main purposes of occupation as self-care, productivity and leisure. Examples of a variety of occupations can be seen around the collage: parenting, play, gardening, school work, life long learning, socializing, communication, sports, outdoor activities, homemaking, personal care, personal responsibility, volunteering, and other work related occupations. I believe the images also capture the idea that in different contexts, occupations take on diverse purposes. At this point in my reflections I became aware that my interpretations of the collage incorporated values from both my own collaborative client-centred values and from the professional literature grounded in the scientific paradigm. Here I had achieved an integration of elements of two competing discourses.

I continued my reflective interpretation focusing on the words that appear around the images. The words represent and describe what happens within the therapeutic relationship as the occupational therapist and the client work together towards common goals and direction in the recovery process. These include words such as invitation, communication, inspiration, support, hope, sharing, difference, similarities, trust, respect, encouragement, caring, acceptance, and possibilities.

The diversity of chairs represents the uniqueness of clients, occupational therapists and therapeutic relationships. Each occupational therapist and client is a person who has

specific values, beliefs, assumptions, knowledge, expertise, strengths and challenges that may impact the collaborative therapist-client therapeutic relationship. There may be similarities but there are also differences. The diverse qualities, cultures and life styles of individuals influence relationships and therefore warrant awareness and consideration when attending to establishing a collaborative therapist-client therapeutic relationship. The occupational therapist's knowledge and understanding of self is advantageous in developing and building the therapeutic alliance.

Both the chairs and the gates in the collage represent the invitation, the openness and the possibilities for dwelling within a collaborative therapist-client therapeutic relationship.

Naming What is Going On: Participatory Consciousness

As the clinician I have found it difficult to express either verbally or in writing what was 'happening' within a developing and deepening therapeutic relationship. I was aware of paying particular attention to the other and I knew that somehow this paying attention opened up access to further develop therapeutic rapport for both the occupational therapist and the client. I liken this non-describable occurrence to Polanyi's (1966) concept of tacit knowledge: "The knowing that we know but cannot tell" (p. 4). There was also a feeling of a Heideggerian sense of dwelling with/in possibilities. However, as the researcher reflecting on the clinician's reflections and also re-reflecting on the core aspect of the collage, I started to become aware of a deeper sense of a collaborative therapist-client therapeutic relationship. These re-reflections brought to consciousness the clinician's enchantment with the prospect of entering into a collaborative therapeutic

relationship and her somatic and emotional participation in it. I began to realize that my involvement in a collaborative therapist-client therapeutic relationship entailed “a mode of consciousness” or a way of being with the other in which there is “an attitude of profound openness and receptivity” (Heshusius, 1994, p. 16). Heshusius likens this mode of consciousness to Schachtel’s allocentric knowing, which is concerned with both “*the totality of the interest*” and with “participation of the total person” (of the knower) (1959, p.225). This type of knowing requires a “*total turning to*” (p. 225) the other, which leads “not to a loss of self but to a heightened feeling of aliveness and awareness” (p.181). Heshusius’ (1994) term for this way of knowing is “participatory consciousness”, and she says that it “involves a somatic, non-verbal quality of attention that necessitates letting go of the focus of self” (p. 15). This description of participatory consciousness resonates with my (clinician) way of being with the client in the practice setting as I have been articulating it while reflecting on the collage. The creation of the collage enabled a conscious awareness and articulation of a way of knowing, learning and meaning making not mentioned in the literature on collaborative therapist-client therapeutic relationship in client-centred practice. Heshusius provided a language to express my understanding, beliefs and experiences of the collaborative therapist-client therapeutic relationship.

Illustrating Participatory Consciousness: A Vignette

The following vignette illustrates my clinical experience as I, the clinician, move into participatory consciousness.

Shona had been attending the outpatient department where I had been working with her on a specific rehabilitation plan, with mutually developed goals for re-integration into

community activities. This particular interaction commenced with Shona approaching me to ask if she could meet to give an update and discuss the plans she had for approaching two organizations regarding volunteer work she was pursuing as part of her intervention plan. We sat down to talk in a small quiet room, which was filled with light from the surrounding windows. As we were discussing her interests and plans around volunteering I was surprised to hear Shona comment that she was unsure about sharing this information with me and the other members of her treatment team, as we might not approve. Up until this point I had thought that our therapeutic interactions and her relationships with her other health care workers had been of a collaborative nature. What was of particular interest to me was the client's comment that this was of concern because she knew that a health care professional had and could exert more power than a patient. Again, I was surprised. I realized that there are power differences between the professional and the client, which cannot be completely diluted. However, I had not fully understood how strongly Shona saw this power difference. In our therapist-client therapeutic relationship I believed that I had always included her in the decision-making and problem solving process. This was my attempt at making the interactions as evenly balanced as possible.

Having shared this concern, Shona continued to share information about her interests around her proposed volunteer work. In connecting with Shona I became aware of defensiveness in her voice tone and her guarded body movements. I wondered was this reaction also from a need for her voice to be heard? Was this her way of trying to overcome the power difference? Little or no space was left in Shona's conversation for me to respond or provide feedback. What I found interesting was that it appeared as if

Shona could or would not hear the other. As I recognized this in the client, I also became aware of the somatic and emotional responses such as annoyance and impatience beginning to rise in my body and mind. I began to wonder. Were my reactions also a type of defensiveness? Why was Shona not listening? Why was she taking this particular stance – not being open to hearing another point of view - particularly from someone from whom in the past she had sought feedback, someone who was aware of her previous patterns of behavior and responses? In professional terms I considered that the type of feedback I had to offer was from a reflective listening perspective rather than an advisory expert opinion. Why was this interaction so different from our previous discussions?

Reflecting on my reactions I realized that I was unknowingly moving from an initial mode of openness and collaboration into one of judgment and authority – the professional as expert. Shona had earlier shared that this was her greatest concern and fear. I became aware that something in this interaction had to change.

As the researcher later reflecting from a distance on the interaction I noted that this self-awareness of the client's dis-ease helped the clinician move from preoccupation with self into a state of attention which in turn enabled the clinician to begin to move into a mode of consciousness which enabled a "*total turning to*" the other (Schachtel, 1959, p. 225). By being mindful of her own somatic reactions and emotions and simultaneously reflecting on the client's responses, the clinician had a heightened awareness of the client's dis-ease and her own part in it. Although the clinician did not agree with the client's perception, she gave it credibility and was willing to act as if it were true thereby supporting a turn to "an attitude of profound openness and receptivity" (Heshusius, 1994, p. 16). Through this willingness to move into and be in this space of open non-

judgmental attentiveness the clinician experienced a feeling of calm and peace. In this space the clinician did not lose sense of herself, but rather she let go of the focus on self. In order for this to happen it was essential that all judgments were suspended. In this open space any feelings of 'stand off' or power struggles between self and other were let go. They slipped off into oblivion. There was an increased "feeling of aliveness and awareness"(Schachtel, 1959, p. 181). By the clinician entering into and dwelling comfortably in this open space, aspects of this particular interaction that may have been unclear or even invisible became clear. Access to this open space was not available to the clinician early in the interaction with Shona. Only when the clinician entered the space of attentiveness, openness and receptivity was there a possibility for a deep sense of trust, respect, co-operation, fairness and collaboration.

Although Shona did not comment, it appeared from her non-verbal language that simultaneous with the clinician's move to a state of participatory consciousness, Shona became aware of the opening up of this unique space. Her facial expression lightened, a pleasant smile slowly appeared, her eyes brightened and her speech became less intensive and pressured. She knew her voice was being heard. She continued to tell her story but she was now open to asking for and hearing feedback, which was interpreted as indicating that she was feeling more relaxed in the interaction. She slowly began to explore her behavior and her responsibilities in the situation that she had been describing. In turn she actively began to formulate problem-solving solutions and to develop plans to assist her in following up on her decision.

In interactions such as the one just described, the clinician moves into a special space of being with other, the client. In this space the clinician is in tune with the client and has

a deep sense of kinship and of being authentically present. I believe that in this collaborative dwelling the clinician moves into what Heshusius describes as participatory consciousness. As a clinician, like Heshusius, “I had to completely and non evaluatively observe my personal reactions and *in* that attentiveness, *dissolve* (rather than manage or restrain) them, which opened up a mode of access that was not there before” (Heshusius, 1994, p. 19).

From reiterative reflections on the collage I became more aware of my intense interest in and passion about the collaborative therapist-client therapeutic relationship and by revisiting Lous Heshusius’ article (1994) on a participatory mode of consciousness I found a way of articulating and theorizing client-centredness within my everyday practice.

Occupational Therapy Clinical Reasoning

The Clinical Reasoning Study

For more than two decades researchers, educators and clinicians in the field of occupational therapy have been interested in the kinds of reasoning used by occupational therapy professionals in a clinical setting. Jean Rodgers, an American occupational therapist, initially kindled an interest in this topic when she made clinical reasoning the theme of the 1983 Eleanor Clarke Slagle lectureship. In 1984 Donald Schön presented his work on the reflective practitioner at the annual conference of the American Occupational Therapy Association. This further fueled the interest in clinical reasoning and a group of well known and respected theorists and researchers in occupational therapy met to discuss the possibility of conducting an extensive study of clinical reasoning in the profession (Mattingly & Fleming, 1994; Mattingly & Gillette, 1991).

After two years of planning, the Clinical Reasoning Study commenced in October 1986, a co-funded venture of the American Occupational Therapy Association (AOTA) and the American Occupational Therapy Foundation (AOTF). This study “was designed to examine how therapists reason, what features characterize expert as compared to novice reasoning, and how students and experienced clinicians might most effectively be guided in the development of their reasoning” (Mattingly & Gillette, 1991, p. 972).

In addition to the funding, the project was collaborative in a variety of aspects. There was collaboration between disciplines as the core research team consisted of three occupational therapists (Maureen Fleming, Ellen Cohn and Nedra Gillette) and an anthropologist (Cheryl Mattingly), with consultation from a philosopher who was an expert on professional reasoning (Donald Schön). Initially funded for two years, the

project was expanded in 1988 for a further two years, enabling the development of educational materials based on the research findings.

The Clinical Reasoning Study was conducted in a large acute care hospital that included a number of rehabilitation beds and two outpatient clinics. The occupational therapists that participated in the study worked in a variety of clinical areas, namely acute cardiology, acute neurology, spinal cord injury, hand therapy, pediatrics, oncology and psychiatry. The study was based on the every day activities of occupational therapists and their clients (Mattingly & Fleming, 1994).

The study had two innovative features. One was its ethnographic approach. Prior to this study the majority of clinical reasoning studies in the health professions relied on “quantitative methods rather than on the extended naturalistic investigation of the practice that characterizes ethnographic research” (Mattingly & Fleming, 1994, p. 5). The second was that ethnography was combined with action research. Originally the intent was to conduct a two-year ethnographic study focusing on discovering and describing clinical reasoning as it was revealed in a practice setting. Data collection was to consist of the more traditional anthropological techniques of participant observation, in-depth interviewing and videotaping treatment sessions. However, as the research progressed the researchers invited the occupational therapists to examine their practice alongside the research team. As the occupational therapists became increasingly involved and committed to the project, they became research partners. This differed from a more common mode of action research where the research subjects work with the researchers from the beginning in defining the problems to be investigated and the study is directed to solving specific practical issues.

The Clinical Reasoning Study was the first in-depth investigation into occupational therapists' reasoning in everyday practice. Hence the majority of the investigations into occupational therapy clinical reasoning stem directly from the Clinical Reasoning Study or from issues arising from this study. Publication of this material stimulated much interest on the topic and further research projects by occupational therapists, not only in North America but also in Britain, Europe, South Africa, New Zealand and Australia.

What is Occupational Therapy Clinical Reasoning?

Clinical reasoning in occupational therapy is described as:

a largely tacit, highly imagistic, and deeply phenomenological mode of thinking.

It is argued that clinical reasoning involves more than the ability to offer

explicit reasons that justify clinical decisions because it is also based

on tacit understanding and habitual knowledge gained through experience.

Clinical reasoning also involves more than a simple application of theory,

particularly theory as understood in the natural sciences, because complex

clinical tasks often require that the therapist improvise a treatment approach

that addresses the unique meaning of disability as it relates to a particular

patient (Mattingly 1991b, p. 979)

In occupational therapy professional practice the notion of clinical reasoning is very complex and multidimensional. It involves several ways of thinking, perceiving, seeing, and practicing:

Clinical reasoning is not reducible to a method (or even several methods) of

thinking, it is also, a way of perceiving. . . . [It includes] what therapists think

about, what they focus on as the central problem, what they ignore, how they describe what is physiologically problematic for the client, and even their view of who the client is as a person (Mattingly & Fleming, 1994, p. 9).

According to the Clinical Reasoning Study, the above processes of thinking, perceiving, seeing and practicing happen over time. They are unfolding processes that occur through interactions with clients. The mental process is always placed in the social context that triggers it, namely working with clients in a particular clinical setting. An occupational therapist in the midst of a treatment session might shift therapeutic interventions in response to client cues. In the practice setting this type of clinical judgment is often invisible to the occupational therapist at that moment.

“Clinical reasoning in occupational therapy is directed not only to the biological world of disease but to the human world of motives and values and beliefs - a world of human meaning” (Mattingly & Fleming, 1994, p. 12). By attending to the client’s medical conditions and personal illness experience, the occupational therapist is using and integrating both theoretical knowledge and practical wisdom. Practitioners, academics and researchers in the field of occupational therapy often talk about the art and science of the profession. It is my opinion that this captures theoretical knowledge, tacit knowledge, practical clinical experience and clinical judgment all of which are used in occupational therapy clinical reasoning. When therapists speak of individualizing the client’s treatment to best suit the client’s rehabilitation needs they are addressing and using all the aforementioned experience, knowledge and judgment.

“Clinical reasoning in practice means reasoning not only about what is wrong and how to fix it but also about how to engage the patient in that fixing process” (Mattingly,

1991b, p. 984). In order to work collaboratively with the client the occupational therapist must have the awareness of the client as a whole person not just their specific disability or condition. Knowing what the client desires as their rehabilitation goals and having an “understanding of the uniqueness of the person’s response to disability is integral to effective therapy” (p. 985). Knowledge of the client’s conditions, understanding the illness from the client’s perspective, collaborating with the client on rehabilitation goals and interventions, reading and interpreting the context, and as necessary tailoring and modifying therapeutic interventions to the life situation of the client are all aspects of the occupational therapist’s clinical reasoning.

Based on the findings of the Clinical Reasoning Study, Mattingly advocated an “interpretive, or meaning-centered model that focuses on how patients make sense of their disability and its meaning for their individual lives” and she “claimed that such a model of clinical reasoning is more appropriate than the traditional medical model, which is built on the biological sciences” and focuses on impairments and disability (p. 985).

The collection of occupational therapy clinical reasoning strategies that follow I believe take into consideration both the biological scientific aspect of the client’s condition and also the meaning-centered nature of occupational therapy (Mattingly, 1991b).

Occupational Therapy Clinical Reasoning Strategies

The work of researchers and theorists Cheryl Mattingly and Maureen Fleming (1991 & 1994), who were the co-investigators in the Clinical Reasoning Study, showed that occupational therapists used a variety of different types of reasoning depending upon

which aspect of the client's therapy they were addressing at any given moment - assessment, interventions or discharge processes. Fleming (1991 & Fleming in Mattingly and Fleming, 1994) identified three distinct types of reasoning or "tracks" along which occupational therapists quickly and frequently, sometimes even simultaneously, moved. In her writings she refers to this as "the therapist with the three track mind" (1991b, p. 1007). These "tracks" or modes of reasoning are called procedural, interactive and conditional. They are employed "for different purposes or in response to particular features of the clinical problem" (p. 1007).

Procedural clinical reasoning.

Procedural reasoning is "the therapist's dual search...for problem definition and treatment selection" (Fleming, 1991, p. 1008). Occupational therapists used this mode of clinical reasoning when problem identification was the primary issue and they were thinking about the client's disabilities and what procedures or modalities would assist in improving the client's functional performance. Occupational therapists knowledge of clinical conditions is usually acquired through their academic education and continuing professional education and is almost always presented and taught within the philosophical framework of the medical model.

Interactive clinical reasoning.

Fleming (in Mattingly & Fleming, 1994) states "interactive reasoning took place during face-to-face encounters between the therapist and the patient" (p. 121). Therapists use this mode of reasoning to better understand the client as a social being, their views, beliefs and perspectives on their illness or disability. Fleming points to the complexity of

interactive clinical reasoning and lists a number of particular ways this reasoning is employed in the clinical setting:

To engage the person in the treatment session.

To know the person as a person.

To understand the disability from the patients' own point of view.

To communicate a sense of acceptance, trust and hope to the patient.

To construct a shared language of actions and meanings. (p. 122).

She notes that “monitoring the patient’s feelings about the treatment and yet managing that treatment” requires what Gardener (1985) calls “interpersonal intelligence” (p. 124):

On the one side, there is the development of the internal aspects of a person . The core capacity at work here is *access to one’s own feeling life* . . . The other personal intelligence turns outward, to other individuals.

The core capacity here is *the ability to notice and make distinctions among other individuals* and, in particular, among their moods, temperaments, motivations and intentions (Gardener, 1985, p. 239).

Interactive clinical reasoning requires that occupational therapists be able to assess and interpret the client’s subtle cues regarding interests, intentions and mood. Furthermore, therapists have to “convey this interpretation” to the client and interpret the client’s response “to that interpretation” (Fleming in Mattingly & Fleming, 1994, p. 124). As might be expected, Fleming also found that interactive clinical reasoning relates to occupational therapists’ values, specifically, “their sense of the importance of patients as individuals and the degree to which practice was guided by a complex set of deeply held

humanistic values”. This led her “to draw parallels to work on ethical and moral decision making” by such authors as Gilligan (1982) and Kegan (1982) (p. 124).

Interactive clinical reasoning supports and enables collaboration so that the client is enabled to actively contribute to therapeutic interventions. Thus, this “complex, sophisticated, and essential” form of clinical reasoning not only encourages “participation in therapy, it is, in many instances, a therapeutic process” (Fleming in Mattingly & Fleming, 1994, p. 196).

Conditional clinical reasoning.

As found in the Clinical Reasoning Study, occupational therapists used conditional clinical reasoning to assist clients to adapt or reconstruct their lives following an injury or disease which had permanently changed their lives. This clinical reasoning style moved beyond the specific concern about clients and their problem and encompassed the broader social context of family, home, community, and future events following clients’ discharge from treatment. Occupational therapists considered physical/psychiatric conditions, the meaning of the illness to the client and the family, and social, cultural, environmental and physical contexts. Clients were actively involved in the whole rehabilitative process including assessments, goal setting, therapeutic interventions and understanding and setting possible outcomes. Because it included speculation and prognosis, Fleming concluded, “conditional reasoning seems to be a multidimensional process involving complicated, but not strictly logical, forms of thinking” (Fleming, 1991b, p. 1012). Fleming postulated, “that in using conditional reasoning, the therapist reflects upon the success or failure of the clinical encounter from both the procedural and interactive standpoints and attempts to integrate the two” (Mattingly & Fleming, 1994, p.

133). This reflection then moved the occupational therapist's thinking to a "deeper level of interpretation" of the complete problem from the context of a possible future for the client (p. 143). The whole process included imagination as well as interpretation.

Mattingly and Fleming (1994) use the term conditional in three different ways:

One is that therapists think about the whole condition: this includes the person, the illness, the meaning of the illness has for the person, the family, and the social and physical contexts in which the person lives. A second is that therapists need to imagine how the condition could change and become a revised condition. The imagined new state is conditional, that is, a proposed state, which may or may not be achieved. The third sense is that the success or failure of reaching a point in life that approximates that future image is very much contingent upon (or conditional upon) the patient's participation. The patient must participate, not only in the therapeutic activities themselves, but also in the construction of the image of the possible outcome, the revised condition. (p.133).

As Schell and Cervero (1994) note Fleming "effectively synthesized several aspects of clinical reasoning to allow for therapists' attention to the individual biomedical situation and the meaning of that situation to the person" (p. 608).

Following is a brief vignette to illustrate an occupational therapist's three track mind – procedural, interactive and conditional clinical reasoning.

Isla was a single woman of slender build in her early thirties who following a manic episode approximately three years ago had been given a diagnosis of bipolar affective disorder. She was having some difficulty accepting and coming to terms with this

diagnosis. I first met Isla when she was hospitalized for a severe depressive phase of her bipolar condition.

Calling upon academic theoretical knowledge and employing procedural clinical reasoning I observed and described the depressive phase of Isla's bipolar illness. Her affect was flat, she had difficulty concentrating and focusing, she had difficulties making even simple decisions, her movements were slow and labored indicating motor retardation, and she was tending to isolate from family and friends. She also reported that her sleep pattern was interrupted. She had difficulty falling asleep and during the night she would wake up and have difficulty falling asleep again. Her appetite was markedly reduced and she had lost interest in and motivation to prepare regular meals. Isla also suffered from diabetes. From a formal occupational assessment it was evident that she would benefit from involvement in everyday life skills such as nutrition, meal planning and budgeting and increasing activation and social skills. Following the medical discourse within the dominant health care discourse this plan appears clear, logical and therapeutic but Isla was ambivalent and therefore not fully committed to this therapeutic plan. This resulted in her engagement and follow through being limited. I was keen to have Isla actively engage in her rehabilitative process. After reflecting on the situation I shifted into using interactive and conditional clinical reasoning. I gently probed to find out Isla's perspective on her illness, and suddenly the complexities of Isla's life became evident. I became aware of how the bipolar illness had affected her every day life: the dismay she felt at being shunned by her family and friends because of their lack of knowledge, understanding and acceptance of her psychiatric condition; the guilt she felt because she lacked the interest, motivation and energy to participate in everyday tasks at

home and at work; the shame she felt because during a recent manic phase of the illness she had incurred much credit card debt; and the frustration she felt at the degree of complexity that diabetes added to her life. Through knowing her better as a social being, understanding and accepting her current life situation and having a greater awareness of her family and community life Isla and I began to develop a therapeutic alliance. She became actively involved and more committed to the therapeutic rehabilitation process. She could now begin to look towards the future. I believe that using the three tracks of procedural, interactive and conditional reasoning helped me as an occupational therapist have a fuller understanding of Isla's psychiatric and physical conditions. These three tracks of clinical reasoning provided the opportunity to shift into the phenomenological approach, which enabled an increased understanding and awareness of Isla as a human being and also opened new possibilities for Isla.

Narrative clinical reasoning.

In contrast to the explicit, objective, logical scientific perspective, Mattingly (1991b, 1991c, 1994) suggested that clinical reasoning in all its forms is a “largely tacit, highly imagistic and deeply phenomenological mode of thinking” (1991b, p.979). It is no surprise therefore that she found “that a narrative model of reasoning, as opposed to scientific reasoning in the traditional sense, is fundamental to the thinking of occupational therapists” (1991c, p. 998). Occupational therapists construct stories about patients' illness experiences and how these influence their lives. Through story telling, or narrative reasoning, they seek to discover the human motivations for actions and the relationship between events. This includes understanding the patients' pasts, the effect of

the disability or condition on the patients, foreseeing possible futures for patients and how to approach problematic patients. (Mattingly in Mattingly & Fleming, 1994).

Mattingly (1991c, 1994) identified two distinct and equally important ways that occupational therapists think with stories: storytelling and story making. “Telling stories is always retrospective, a way of considering past events, whereas story making is largely prospective, playing out images that therapists have of what they would like to happen in therapy” (Mattingly in Mattingly & Fleming, 1994, pp. 268-269).

Noting how therapists combined narrative and other forms of reasoning, Mattingly (1991c) observed “in moving between chart talk and storytelling, therapists present the clinical problem in different ways” (p. 1000). In chart talk, formal objective reporting which can be either verbal, written or both, the occupational therapists present problems primarily related to the condition in an abstract objective manner, while in storytelling the narrative comes alive with real live actors and the client’s specific situation or their experience of the illness. The condition and the therapeutic interventions are not ignored; however, the client’s subjective view and the unique features of the client’s situation are now included.

Interestingly, the Clinical Reasoning Study found that story telling was evident not in the therapists’ interactions with patients but rather in the ways therapists informally thought and talked about their clients with colleagues in occupational therapy departmental clinical rounds or staff meetings or when sitting in the departmental office.

Story making or “therapeutic emplotment” (Mattingly, 1991c, p. 998) “concerns the way therapists work to structure therapy as a coherent plot, as an event and not just a sense of treatment activities, thus creating dramatic therapeutic events that connect

therapy to a patient's life" (Mattingly in Mattingly & Fleming, 1994, p. 269). "Therapists are in a quest to transform their actions and the actions of their patients into as yet untold stories" (Mattingly, 1991c, p. 1002). Mattingly (1994) noted that this narrative clinical reasoning is often triggered by the client not fully engaging in the therapeutic occupations and the occupational therapist searching for a significant event for the client in the therapeutic intervention. The intent is to make therapy a "meaningful short story in the larger story of the patient" (p. 269). However, "for a therapeutic story to be set in motion, both therapists and clients must have something they desire" (p. 265).

Mattingly (1994) also pointed out that clients, too, create stories about their illness experiences, which she refers to as life stories. Through listening to a client's story, the occupational therapist gains valuable information about how the client views self, current life circumstances and prospects for the future. Therapists can work collaboratively with the client to incorporate this information and the insights it generates into the client's rehabilitation process. Thus, the client and the therapist can see themselves in the same story and this will, hopefully, reduce conflicts or mismatches in therapist-client rehabilitation goals and interventions.

The following vignette is an example of narrative clinical reasoning – story telling from the clinical practice site. Story telling usually occurs through informal confidential discussions between colleagues in order to work through a difficult or disturbing event. The client is not present.

It had been a particularly difficult and frustrating therapeutic group session in which Isla had been a member. My co-facilitator and I walked back to our office and once inside decided that we needed to talk about the group session. We were particularly

concerned about Isla's lack of engagement and her negative approach and responses. It appeared as though Isla was stuck, as she gave no sense of what was going on. Was this her depression? Were the medications taking longer than usual to "kick in"? Was there an issue with the control of her diabetes that had somehow been missed? What could we do to assist in facilitating a change or at least a spark or some sense of willingness to initiate change? We talked at length about her lack of participation and wondered whether it was due to her depression but intuitively we felt that there was more to this issue. She did look sad and depressed, she had limited range of affect, her interactions with the other group members were scant and when she did interact her responses were negative and critical. Then we started to think more of Isla as a person and began a new story about her. From a collateral history from a close family member we learned that she worked at a job she enjoyed and had a fair amount of responsibility in this position. She was also active in lots of community activities. She was concerned about having been labeled with the diagnosis of a bipolar condition. When first admitted to the inpatient unit she had shared that many of her family members did not understand this psychiatric illness and she felt shunned and rejected. This helped bring Isla, the woman, alive in our minds and discussions. We decided to bring our concerns regarding medications and diabetes to the attention of her medical team. We also decided that we needed to think of alternative approaches to the group content and process that might help Isla and the other group members feel more like valued individuals rather than just clients. We began to talk about changes we could make to the group topics and how we could help the members, including Isla begin to be involved in suggesting and making decisions around

the topics. We hoped that this would help Isla and others feel part of their recovery process and begin to envision their futures in the community.

Pragmatic clinical reasoning.

There is one additional form of clinical reasoning worth mentioning that did not come out of the Clinical Reasoning Study. Schell and Cervero (1994) identified aspects of clinical reasoning alluded to by a number of authors namely, Barris (1987); Fisher (1997); Fondiller, Rosage, & Neuhaus (1990); Fortune & Ryan (1996); Hooper (1997); Kuler-Hutchison (1988); Steward (1996) but not specifically named. They noted that these authors “have raised concerns about the effect of various organizational, political, and economical realities on the practice of occupational therapy” (p. 608). In addition, the research on values influencing clinical interactions, therapists’ worldviews, ethical considerations, the impact of technology and cost containment, and professional and institutional constraints are contextual issues directly and indirectly impacting upon the practice of occupational therapy. Hence, “it seems logical that contextual factors that inhibit or facilitate therapy are themselves part of the clinical reasoning process” (p. 608). This particular form of clinical reasoning Schell and Cervero, called pragmatic reasoning.

In discussing their concept of pragmatic reasoning they conceded that aspects of this clinical reasoning may parallel Fleming’s (1991b, Fleming in Mattingly & Fleming, 1994) conditional reasoning. However, they argued that the focus of pragmatic reasoning is broader as “it is not only concerned with contextual issues affecting the patient now and in the future; it is also concerned with the personal and professional context of the therapist and the culture of the practice environment” (Schell & Cervero, 1994 p. 609).

Clinical Reasoning as an Analytical Tool

When analyzing the clinical practice narratives that constitute the data of this dissertation study, the forms of occupational therapy clinical reasoning described above are used as analytical tools or interpretive lenses for seeing how at the practice site the occupational therapist, in relation with the client, negotiates the multiple discursive presses that converge at the practice site. The specific clinical reasonings described in this chapter signal which discourse(s) the occupational therapist is subject to and how she acquiesces or resists. Clinical reasoning also signals when there is a move into or out of particular discourses. In sum, clinical reasoning is used in this study to illuminate the collision of differing discourses in routine daily practice, and to show how occupational therapists negotiate these conflicts in their effort to develop a collaborative therapist-client therapeutic relationship.

Discourses

Competing Discourses

Discourse is a rich and complex notion that makes it possible to talk about the ways in which linguistic practices both carry and produce values, cultural norms, institutional expectations, and relations of power. Discourse includes body language, non-verbal as well as verbal utterances and written texts. Discourses give rise to awarenesses and understandings and ways of making sense. Discourses pervade the entire context or environment. While discourses are socially constructed, as individuals we are immersed in discourses, in spite of ourselves. Without our being aware of it, discourses shape our thinking and ways of being as we grow up in a particular culture, making us who we are. As Davies (2000) says, “Subjectivity is constructed through those *discourses* in which the person is being positioned at any one point in time, both through their own and others’ acts of speaking/writing” (p. 57).

It is important to note that through discourses we are both subjugated and empowered. Davies (2000) describes this paradox succinctly, saying, “We are simultaneously constituted through discourse . . . and yet we become at the same time and through those same processes a speaking subject, a ‘signifier,’ one who can *appear* as separate and independent of those processes, who can even, potentially, go beyond those processes” (p. 14 – 15). Thus, it is possible to resist dominating discourses and to reconstitute ourselves in alternative, non-dominant discourses. In my case, as an occupational therapist encapsulated by and participating in the dominant health care discourse, I have values that are contradictory to the values on which the dominant discourse is built that give me the bases for resisting some aspects of the dominant discourse at any given

moment and for seeking ways of acting, expressing, relating or communicating that are more congruent with the values I hold. At those times I call in a non-dominant discourse, for example professional client-centred discourse or participatory consciousness discourse.

In this study, discourse has served as a powerful tool to draw attention to the complexity of what goes on between therapist and client to produce certain kinds of feelings, reactions, responses, understandings, actions and social positionings. As recounted in this research, reflexive awareness of my patterns of speaking and interacting and my embodied understanding of my actions and responses have helped me find ways of making my discursive practices as a therapist both visible and revisable (Davies, 2000). It is for this purpose that I centred my research on my own clinical experience: “not to produce an autobiographical account of a particular life (though of course it can be read that way), but because . . . an embodied being provides an immediate and vivid resource for examining the constitutive power of discourse” (p. 10).

Through my research I have become aware of a number of conflicting discourses at play in my work contexts. As a clinician working in this environment I was initially unaware of how these discourses operated. Their influence on everyday practice was invisible, particularly their effect on the therapist-client therapeutic collaborative relationship. However, as a researcher studying clinical practice, I have become aware of how insidious, powerful and socially condoned but rarely mentioned shaping forces operate through verbal and written language and social institutions including family, medicine and other professions.

Each sector of a society has a dominant discourse into which its members are inducted. Like other occupational therapists who work in large organizations and who were educated within the medical model I have been immersed in humanistic, medical, legal and ethical discourses. These dominant authoritative discourses have had a major influence on my professional language, behavior, being and hence my daily practice. However, less authoritative discourses, namely professional client-centred discourse and participatory consciousness discourse, are also major shapers of my everyday professional life, especially in the therapist-client therapeutic collaborative relationship.

My research is situated in the point at which multiple rich and complex discourses collide but also overlap each other. Each influences the other, impacting and complicating the situation. As a researcher of this “complex tangle of experience”, my task is to distinguish how these different discourses operate at any given time: how the clinician is maneuvering among them, resisting or taking them on, and balancing or negotiating among them (Davies, 2000, p.4).

The following are the various discourses that I have identified as having a particular influence on the therapist-client therapeutic collaborative relationship.

Legal discourse.

This discourse is a dominant authoritative legalistic discourse of government that governs organizations and professions in Canada through acts, laws and regulations. For example the provincial legislation and regulations regarding patient confidentiality and privacy result in the health care organization developing and implementing policies, procedures and rules that in turn impact each professional department within the organization of the hospital by regulating the conduct of professional employees’

everyday practice. For example only health care professionals who are working directly with a client have access to that client's health care record. Also if a health care professional is using a computer where there is confidential information and they wish to leave the computer for a few moments they must "lock" the computer so that no one else can access the computer in their absence. Only the professional who "locked" the computer has the appropriate password for re-entry into that particular computer file.

Another legal discourse that operates at the provincial level is the Health Professionals Act, which has led to the creation of a provincial regulatory body that determines and regulates professional competencies and standards in order to protect the public. In British Columbia for example, the College of Occupational Therapists is responsible for overseeing the regulations and each occupational therapist that works in the province must meet the set requirements in order to register with the College. Without this approved registration the occupational therapist is unable to work in the province. Legal discourse permeates professional behavior, expectations, ways of being and how professionals implement the work they have been trained/educated to perform. Researchers too must submit their research proposals for acceptance and approval by the appropriate ethical and research committees. Primarily these rules and regulations are intended to protect research participants and prevent any legal action against the organization or the researcher.

Ethical discourse.

Ethical discourse is also dominant and authoritative with respect to occupational therapy in Canada. Ethical and legal discourses intersect and have a marked influence on how professionals conduct their daily practice. There is an expectation and a

responsibility to be moral and ethical. Governing professional organizations such as the national and provincial professional associations have codes of ethics, which each professional must sign and adhere to.

In addition to the written professional and organizational texts regarding rules of conduct and regulations, policies and procedures regarding education, professional competency and standards of practice, there are also unwritten expectations regarding behavior that exist verbally and within the custom of the organization and/or profession. It is as if one should know how to behave and conduct business as a responsible and good professional. These authoritative ethical and legal discourses permeate the lived experience of occupational therapists.

Dominant health care discourse.

Supportive of and congruent with legal and ethical discourses are the overarching dominant health care discourses, which include the medical, the clinical and the administrative discourses. Together these establish and hold in place a network of expertise, power and authority that privileges medical practitioners over clients.

Medical Discourse.

The medical discourse is a particularly authoritative discourse within the dominant health care discourse due partly to the expertise, knowledge and power it assigns to its members. In this discourse the members have the particular privilege and authority to diagnose illness and prescribe medications and treatment. Within medical discourse there are numerous areas of specialty that require additional knowledge leading to a specific expertise, authority and often a superior power base.

In medical discourse the client is positioned as an object. It is not the uniqueness of the individual client that is important, but the uniqueness of the diagnosis and the medical or psychiatric prescription. The language of the diagnosis, medications and treatment is considered to be objective and true.

Professional Clinical Discourse.

Although the professional clinical discourse within the dominant health care discourse involves professionals with specific expert theoretical and practical knowledge, this discourse has less authority and power than the medical discourse. Most of the clinical professionals are educated following the medical model and consequently most accept without question the power and authority of medical discourse.

In the professional clinical discourse the position of the client is very similar to that in the medical discourse. The professional is viewed as the expert with the objective knowledge to determine what the client needs. The expertise and language of this discourse relates specifically to each clinical profession.

Administrative Discourse.

Administrative discourse includes documents regarding staff, equipment and other materials. The administrative institutional texts include the rules, regulations, policies, procedures, statistics, financial budgets and practices regarding the everyday administrative running of the institution. Important sub discourses arising from this administrative institutional discourse are the sub discourses of efficiency, effectiveness and timeliness. Also within this administrative institutional discourse is the sub discourse of the professional clinical texts which includes referral forms, formal assessment formats, protocols, templates, patient admission and discharge criteria and the official

patient charts or records. Arising from the professional clinical text discourse is the biomedical clinical chart talk. In this discourse the clinician typically outlines a list of clinical problems and characteristically treatment is described as a collection of isolated actions and a linear sequence of events. “ The particular experience of the patient is downplayed or left out altogether” (Mattingly & Fleming, 1994, p. 60). The chart talk discourse, like the medical discourse, is seen as objective, factual and true and the subjective experience of the client is downplayed or completely ignored.

Professional and administrative experts keeping in mind the ethical and legislative requirements develop the clinical and institutional texts within the organization. The relations of power set up by those texts can over-rule the intentions and the decisions of the medical personnel and the clinical professionals working within the organization. (Smith, 1987; Townsend, 1993). Therefore in certain situations, particularly administrative contexts, medical personnel may not be as autonomous as they think or believe they are. Clinical professionals lower in the hierarchy than the medical personnel have an awareness of the importance of the clinical and administrative texts but may not fully realize or be aware of the full influence on their daily practice, particularly with clients.

All the discourses and the sub discourses and the practices they author(ize) are authoritative and powerful within the overarching dominant health care discourse.

Professional client-centred discourse.

Although “[s]ince its inception occupational therapy has been located and found within the health system, which operates primarily within the medical model” (Townsend & Polatajko, 2007, p.33), more recently there is a move in the profession toward a more

client-centred discourse. In the most recent practice guidelines it is noted that there is a need to shift the thinking of occupational therapists from a “medical perspective to an occupation perspective” and from a “treatment perspective to an enabling perspective of collaborating with clients” (p. 197).

Client-centred practice is now entrenched in the values and beliefs found in the recent national guidelines, namely *Enabling Occupation: An Occupational Therapy Perspective* (CAOT, 1991 & 2002) and *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-Being, & Justice through Occupation* (Townsend & Polatajko, 2007). These values and beliefs are about the person, the environment, health, well-being and justice, occupation and client-centred practice:

The Canadian Model of Occupational Performance and Engagement (CMOP-E) locates the focus of practice in occupation, occupational performance and beyond. *The Canadian Model of Client-Centred Enablement* (CMCE) defines the key skills for enabling individual and social change. *The Canadian Practice Process Framework* (CPPF) is for use with various clients in diverse settings (p. 8).

The professional client-centred discourse promotes empowerment and enablement in occupations that are important and meaningful for the client. The client is encouraged to be an active participant in decision making and problem solving regarding their specific rehabilitation goals and direction. There is the notion that both the client’s and the therapist’s expertise are important and recognized, which empowers and guides the development of a collaborative partnership within the practice of client-centred enablement.

Client-centred practice also takes into consideration Canada's socio-cultural diversity. "Our diversity in Canada calls on us to enact an occupational therapy that is inclusive, equitable, just and truly enabling, and to develop a more progressive mandate in the broader global context" (Townsend & Polatajko, 2007, p. 5). Also, Iwama (2003) notes that it is important "to pay attention to the existence of diverse world views, and the fundamental effect of such views on the understandings of the form, function, and meaning of occupation"(cited in Townsend & Polatajko, 2007, p. 5).

Although the professional client-centred discourse has national models and a framework that relate specifically to occupation and enablement, it remains less authoritative than the dominant health care discourses.

Professional Competency Discourse.

The sub discourse of professional competency is very influential within professional client-centred discourse through its emphasis on regulation regarding professional competency and accountability. Occupational therapists exercise autonomy as professionals through knowledge and clinical expertise. However, with this professional autonomy it is essential to demonstrate accountability. As professionals, occupational therapists, "must be responsible to uphold specified values and the competent, discretionary use of expert knowledge and skills" (Townsend & Polatajko, 2007, p. 308). Townsend and Polatajko (2007) outline three forces that converge to "bring accountability to the forefront for occupational therapists: standards of practice stipulated by regulatory colleges; administrative benchmarks and limits set by managers; and escalating demands for accountability by consumers " (p. 307). The Canadian occupational therapy regulatory bodies refer to the competency framework called

Essential Competences of Practice for Occupational Therapists in Canada (Association of Canadian Occupational Therapy Regulatory Organizations ACOTRO, 2003) when establishing standards of practice. The units of essential competency identified by ACOTRO have been mapped with the units of competence established in the *Profile of Occupational Therapy Practice in Canada* (CAOT, 2007). Furthermore, the Profile competencies have been mapped with the ten enabling skills identified in the most recent enabling guidelines document. The provincial regulatory colleges utilize the competency framework for quality assurance and to develop educational materials regarding professional accountability for self-regulation, while the national and provincial association's mandate is to promote excellence in professional practice. Both life long learning and critical reflection are encouraged by the national competency framework and practice guidelines (p. 307-308). In addition, occupational therapists make an ethical and moral commitment to base practice decisions on scholarship, multiple forms of evidence including client experience, program evaluation and quality assurance in order to avoid unnecessary or irrelevant services that consume a client's time and energy as well as private or public funds (p. 309).

While the degree of scholarship, lifelong learning and critical reflection may vary among occupational therapist practitioners, the practice of all occupational therapists is strongly shaped by the standards of practice and the units of essential competencies.

Participatory Consciousness Discourse.

I have used the prefix "professional" with the client-centred discourse described above to distinguish it from another deeper form of client-centred discourse, which I call, after Heshusius (1994), participatory consciousness. Participatory consciousness discourse

signifies particular understandings, desires, motivations, capacities and ways of being that are different from those signaled by the dominant health care discourse and even the professional client-centred discourse. Participatory consciousness discourse is characterized by an attitude of profound openness and receptivity, which opens access to a unique non-threatening and non-intrusive space for both the client and the clinician. In the particular way of being signified by participatory consciousness the need for both personal and professional expert control on the part of the clinician are relinquished. Judgments are suspended. The boundaries habitually drawn between self and other in order to keep ourselves separate and distinct dissolve. When these boundaries melt and blur, I find, like Heshusius (1994, 1995), that I may come to understand and know the other and paradoxically myself more fully. Although all egocentric concerns are temporarily suspended, there is no loss of self. The clinician is simultaneously standing “out there” holding the space for the client-therapist relationship and also standing in the midst of the space. The clinician is cognizant of the bigger context and how to maneuver within it. The clinician retains the capacity to fully utilize professional knowledge and clinical experience while making a safe, secure and comfortable space for the client. Dwelling in this space the client and the clinician are positioned as equals. Each person is respected for who they are, their uniqueness, their experience and their own particular expertise. The client and the clinician communicate openly and work collaboratively. While dwelling in this space there is an unqualified willingness to listen. This is a listening without wanting or expecting anything from it. There is an increased understanding that leads a to deeper level of kinship. In this dwelling the clinician is

passive yet alert and vigilant without being intrusive (Heshusius, 1995). The clinician has a deeper and stronger sense of what it means to be client-centred.

As the clinician creates this particular space, she issues either a verbal or a non-verbal invitation to the client. Only when client accepts the invitation can client and clinician enter into and dwell within this space. Once the space has been entered, client and clinician are aware of dwelling collaboratively within an environment of mutual respect, trust, caring and equality.

In this study I use the notion of participatory consciousness discourse to enable me to speak about a way of being that is not easy to put into words or to bring to awareness, “a knowing that we know but cannot tell” (Polanyi, 1966, p. 4). Other people who recognize what I am trying to describe with the term participatory consciousness use different terminology. For example, Belenky, Clinchy, Goldberger and Tarules’s (1986) connected knowing highlights empathy and caring as lenses that permit viewing and understanding another’s life-world. Buber’s (1958) I-thou and Noddings’ (1984) engrossment both call upon reciprocity in a relationship and attentiveness to the uniqueness of the other. Noddings also speaks of being “totally and nonselectively present” (p. 10) with another, an attitude that is crucial in participatory consciousness. Schachtel (1959) uses the term a “total turning to” (p. 225) the other to designate this elusive state, and Thayer-Bacon (2003) refers to reaching out and attending to other by listening intently and temporarily suspending doubts and judgments. Doane (2005) relies on self-awareness and bodily knowing to “cultivate conscious participation” (p. 151) with another.

Discourse Analysis

In this inquiry, discourse is seen as the primary shaper of occupational therapy clinical practice. The clinician is seen to be in a context where there are dominant health care discourses and sub dominant discourses all of which compete, collide, and overlap. The intricate details of a clinician's practice are described and analyzed in terms of which discourses are primary at any given moment. The impetus for resisting a dominant discourse arises within the clinician in the form of a somatic signal that indicates to the clinician, not always on a conscious level, that something is amiss in the therapist-client interaction. "Something" is happening that makes her feel uncomfortable, or she "picks up" on the client's unease. This somatic signal prompts the clinician to change the nature of the client-therapist interaction. The clinician changes the protocol for the interaction and thereby changes the distribution of power in the therapist-client relationship.

There are two distinct levels with which I, as the researcher, can describe the shift the clinician makes in response to her somatic reactions. One is discourse and the other is clinical reasoning. While discourse is a large and sometimes elusive concept, the different clinical reasonings are clearly and distinctly defined and are more observable and evident in practice. Hence, clinical reasoning is a way of operationalizing and seeing specifically what discourses are at work, how they shape what is happening at the practice site and how they restrict or create possibilities for a collaborative client-centred therapeutic relationship.

The Relationship Between Clinical Reasoning and Discourse

The research analysis focuses on the shifts the clinician initiates in the mode of interaction with the client. These shifts are described very precisely in terms of clinical reasonings, of which there may be one or more in use at any given time. Clinical reasoning gives access to discourse. By identifying the clinical reasonings being used, it is possible to say whether the clinician is in between discourses, negotiating conflicting discourses or has made a shift from one discourse to another.

Although there is not a one-to-one correspondence between each form of clinical reasoning and a particular discourse, it is possible to map out a set of relationships. For example, procedural clinical reasoning can be used to negotiate or maneuver between the dominant health care discourses and the professional client-centred discourses.

Interactive clinical reasoning, conditional clinical reasoning and narrative clinical reasoning are rarely if ever used in the dominant health care discourses. However interactive, conditional and narrative clinical reasoning when used alongside procedural reasoning can assist in balancing the competing professional and dominant discourses. Interactive, conditional and narrative clinical reasonings are utilized primarily with the professional client-centred discourse and the discourse of participatory consciousness.

Clinical Narratives and Analyses

Disengagement and Re-engagement

Fiona: Clinical narrative.

Fiona is a tall slender young professional woman in her mid twenties who recently completed her university undergraduate degree. She had just commenced work in a large busy office in her specific area of expertise. She was excited about her work and enthusiastic about her promising career. In her work setting she dressed fashionably and displayed much confidence. However, underlying this outward appearance there was much apprehension. Prior to completing her education she had been experiencing periodic breaks with reality. Her perception of everyday situations was distorted. She misinterpreted conversations and she was suspicious of friends and colleagues. Friends began to notice that she appeared to be listening to and responding to stimuli, which they did not see or hear. She had been seen by her family physician, who had referred her to a psychiatrist. She had been prescribed anti-psychotic medication. Fiona initially took her medication but as she began to feel better she told friends that she felt it was no longer necessary. She stopped her medications. With the pressures of her new position she was again experiencing breaks with reality. As the episodes intensified Fiona was hospitalized. This was her first experience within the psychiatric health care system. She was unfamiliar with this system and she found the environment unnerving.

I met Fiona while she was a patient on the acute psychiatric inpatient unit. Her psychiatrist had referred her for assessment and treatment. We initially met in the lounge area on the ward where I introduced myself and briefly explained that I wished to have a meeting with her to discuss the purpose of the referral and to involve her in identifying

and developing specific rehabilitation goals and exploring possible treatment options.

While I was talking Fiona looked at me directly. She smiled and nodded her agreement to meet in the small interview room off the main lounge area, where we could continue our conversation with more privacy. Fiona was attentive to my words, and her direct eye contact, friendly facial expression and acceptance of my invitation suggested that she was interested in furthering our discussion.

The interview room was pleasantly decorated with light sage green walls and a darker sage green carpet. Landscapes of woods and meadows hung on the walls. There were two comfortable armchairs each with an end table. The chairs were positioned at an angle where eye contact was still possible and conversationalists could easily hear each other.

Fiona settled into the armchair and she waited for me to continue the conversation. She appeared calm and relaxed. She sat back in the chair with her arms resting on the padded arms and her legs crossed. She was well groomed, wearing a light T-shirt, blue jeans and a pair of hospital issue slippers. She looked at me while I was speaking. She was attentive to the information I provided. When I asked a question she answered quietly but within a reasonable period of time, which supported my observation that she was following and understanding the interaction. However, as the discussion progressed I began to sense that Fiona was beginning to disengage from our interaction. Fiona's responses were now becoming stilted and vague. There was hesitancy in her voice and she paused before responding. She seemed restless, moving her arms and legs and shifting her body position in the chair. Her facial expression seemed to be one of boredom or distraction. I found it difficult to clearly interpret her expression. I also began

to feel uncomfortable. I wondered what was happening in our interaction to cause Fiona to disengage.

My past experience and my observations during this particular interaction told me that Fiona's disengagement was more than her psychiatric illness causing lack of concentration, difficulty focusing on the topic at hand or disconnection with the current reality. Also I did not believe that her behavior or lack of engagement was a result of non-compliance. I could see that there was some resistance and hesitancy in remaining involved in the interaction and I was puzzled about the reasons for Fiona's reluctance to stay actively involved.

As the conversation lurched forward I became more and more uncomfortable. There was a tension building not only in Fiona and in me but also between us. Attending to the signals of my physical reactions and emotions I began to reflect on this tension and my communication in this interaction. I became aware that my primary aim was to set specific rehabilitation goals and to develop future treatment interventions. I was beginning to lose sight of Fiona as a person and her wishes. Had I been asking too many questions? Had I been so involved in my priorities that I missed a response from Fiona that indicated her priority? I knew Fiona was a bright, astute and sensitive person. Had she picked up something in my behavior or presentation, which lead her to change her interest in engaging in the discussion?

My intent was to actively engage Fiona in sharing her concerns and exploring how her illness was affecting her daily activities. I felt that it was imperative that I be respectful of Fiona's perspective. I wished first and foremost to invite Fiona to re-engage more fully. This clarification of my intentions had the desired effect. From the depth of my

unconscious clinical experience, I intuitively asked Fiona an open-ended question about her hospital experience. Her response was immediate and direct. Fiona was again alert, bright, interested and eager to engage. There was an edge of urgency in her voice. She had a story she wished to tell. The invitation had been accepted and this was the glimpse of opportunity for re-engagement.

The story Fiona wished to tell was about her illness experience. Because her behavior was considered bizarre and inappropriate the police had brought Fiona to the hospital and she had been admitted through certification under the Mental Health Act. Fiona's recollection of this procedure was not clear, but she did remember her feelings of fear and her apprehension over losing her sense of choice and control. She also remembered that while hospitalized she continued to feel a loss of control and choice as well as lack of trust. She felt that no one listened. No one appeared to be interested in her opinion, values and wishes. She felt devalued as a person. She expressed anger at the way she perceived she had been treated.

Although I could not alter her previous health care experiences, I could offer her an opportunity to let her know her story was being heard and understood and that she was a valued human being. I listened attentively as she told her story, occasionally paraphrasing her words for further understanding and clarification. The tension between Fiona and me began to dissipate. Sharing her previous experiences provided the opportunity to re-visit her desires and wishes regarding future treatment. She felt she needed more information about her illness and medications. I offered Fiona the opportunity to attend a group where she could obtain the information she wanted. I consciously offered this possibility as an invitation because I wished Fiona to have a choice and a sense of control in the treatment

process. Initially when the invitation was offered she stared at me in silence. Then hesitantly she asked a few questions about the nature of the group and some practical questions regarding time, location and duration of the group. Again she sat quietly, looking at me intently as I provided the information she requested. Slowly the tension in her face subsided as she said in a friendly way that she was interested in accepting the opportunity to attend this particular group. She thanked me for giving her a choice to attend the group and said that she was looking forward to obtaining more information about the illness and medications. From the discussion that followed I realized that part of the reason she wished to attend the group was that she was looking for and hoped to find evidence which would support her not taking the prescribed medications. However, I sensed that she was again open to hearing the information and making an informed decision.

Fiona did attend the group sessions where she heard not only from professionals but also from other clients. The clients spoke freely of their everyday experiences of living with a psychiatric illness. They spoke about why they may have stopped taking their medications. They shared in detail what happened and what it was like once they stopped and why after these experiences they choose to take their medications on a regular basis. Later Fiona expressed that she found this group therapeutic experience meaningful. She felt that she had made an informed decision and choice about attending the group sessions. Fiona used the group setting to gain information and ask questions from her particular perspective. Following attending these sessions she felt empowered to seek medical/psychiatric advice in order to obtain further information to assist her in other choices and decision-making regarding her recovery process.

As the clinician reflecting at a distance, I am glad that I was sufficiently mindful of my somatic reactions to take a moment in the thick of the clinical tension to notice what I felt and to reflect on what was happening to our interaction. This reflective turn enabled me to move into a more collaborative and respectful interaction. By changing gears I was able to communicate to Fiona a sense of acceptance, trust and hope. The invitation offered to Fiona was a different approach to the one she felt she had previously experienced in the health care system.

Fiona: Analysis.

As the researcher analyzing the narrative of Fiona, I am trying to understand what discourses were at play and what effect they were having on the therapist-client interactions and the collaborative therapeutic relationship.

Some discourses described in the Discourses Chapter, although always present, are mentioned in the analysis only when they occasion a change in the course of the therapist-client relationship. These are the ethical and legal discourses, which are a constant force within the constellation of the dominant health care discourse, and the professional competency discourse, which is part of the professional client-centred discourse. The clinician constantly negotiates these discourses; she is never outside their ken. However, it is only when the force of these discourses makes a difference to the direction of the narratives that they are addressed in the analysis.

At the beginning of the narrative the clinician was working simultaneously in the dominant health care discourse and the professional client-centred discourse. As prescribed by the dominant health care discourse, one of the first actions the clinician took was to meet with Fiona to review the institution's referral document, which provided

basic demographic information, the details of diagnosis, medications and prescription regarding possible assessment and treatment. This discourse provides ways of talking objectively about medications, diagnosis, treatment, prescription and programming. As required by the institution and the clinician's professional department, it focuses attention on a document rather than on the client as a person. At the same time, however, the clinician was also engaged in a less dominant discourse, that of professional client-centredness. By inviting rather than demanding a meeting and by offering Fiona the opportunity to be actively involved in the goal setting process and treatment direction, the clinician was looking past the referral document and seeing Fiona as a person. At this initial stage of the interaction the interview was going smoothly and the clinician was comfortably dwelling simultaneously in two disparate discourses.

This balancing act between two discourses was accomplished by the clinician's use of procedural clinical reasoning. Procedural clinical reasoning deals with the clinical conditions having to do with diagnosis, assessment and treatment planning. These processes must be carried out to fulfill institutional requirements. However in procedural clinical reasoning, the focus can shift back and forth between these processes and the client for whom these processes are designed. When the clinician was imparting specific clinical information to Fiona about the assessment and proposed treatment as well as asking Fiona relevant questions from the intake assessment document she was participating in the dominant, objectifying discourse. Similarly, the clinician was in the dominant discourse while carefully observing Fiona in this acute care clinical environment to assess her mental status, specifically, whether or not Fiona was misinterpreting information or displaying any behavior that would indicate psychosis or

disconnection from reality. However, the focus began to shift when the clinician provided Fiona with the opportunity to identify her personal perspective on her rehabilitation needs, goals and preferred treatment direction. At this point the clinician used procedural clinical reasoning in an enabling client-centred discourse, thereby successfully maneuvering both the dominant health care discourse and the professional client-centred discourse simultaneously.

This tenuous balance of normally incompatible discourses was soon upset. A disjuncture between the professional client-centred discourse and the dominant health care discourse was signaled by Fiona's disengagement and restlessness and the clinician's tension and uncomfortableness. This disjuncture was precipitated by a shift in the clinician's emphasis to the demands of the dominant health care discourse, namely the collection of data to ensure that Fiona met all the criteria for appropriate admission to the client treatment program. The dominant health care discourse necessitated that the clinician obtain in an efficient, effective and timely manner information from the client and also provide her with specific material about the program services to ensure her readiness and appropriateness for admission. This move resulted in the clinician no longer using procedural clinical reasoning to directly involve Fiona in problem solving, decision-making and providing her perspective to the assessment interview process. The sub discourses of efficiency, effectiveness and timeliness characteristic of the more authoritative dominant health care discourse over-ruled (Townsend, 1998) the clinician's intention of developing a collaborative therapist-client therapeutic relationship for which a professional client-centred discourse was necessary.

The clinician's role was now one of professional as expert. Using procedural clinical reasoning only within the dominant health care discourse supported the primary direction of gathering the information required by the institution for formulating treatment goals, plans and future direction. This subtle shift of emphasis to the professional as expert detracted from the client as a person and over-rode the establishment of a collaborative therapeutic partnership. In the reflective narrative the clinician noted that she was losing sight of Fiona as a person and of her own intention of involving Fiona in the decisions surrounding her health care. However, in the real-time practice setting the clinician was not consciously aware that there was a disjuncture between the discourses and a corresponding diminution of the professional client-centred discourse.

By following the dominant institutional health care intake texts, the clinician had unintentionally increased the power difference between herself and the client. As long as she was not noticing the client's disengagement, the clinician was unaware of the undermining effect of the discursive practices in which she was caught up and the effect on the developing therapeutic rapport. At this point the clinician was not consciously aware of the client's withdrawal and restlessness as signals of the client's unease with the authoritative discourse. In fact, the client's voice was being lost in the discourse of hierarchical systems and the inequalities of power relations between clinician and client were exacerbated. This move was accomplished primarily through the use of the dominant health care discourse that establishes the authority of the clinician and subjugates the client within the health care system.

However, somewhere deep in the clinician's subconscious she was aware that something was amiss. At the same time that she used these terms, the clinician was

reluctant to label the client as “non-compliant” and “resistant”. Labeling the client in this manner was contradictory to the clinician’s desire to dwell in a non-judgmental client-centred relationship. Reflecting on this reluctance and questioning her own actions led the clinician to shift to interactive reasoning. She began using a more personal interaction style with Fiona to better understand her and her experiences of how her psychiatric condition impacted her everyday life. (Mattingly & Fleming, 1994). Procedural clinical reasoning became secondary to the clinician’s use of interactive clinical reasoning and the clinician was able to re-direct her attention to the client as a person. This move assisted the clinician in bringing forward her own wish to follow her professional model of practice grounded in the discourses of client-centredness and enablement. The clinician’s interactive clinical reasoning and her intuitive questioning of Fiona about her hospital experience re-engaged the professional client-centred discourse.

Looking more closely at the clinician’s question to Fiona about her hospitalization, it is important to note that this did not stem from logical analytical reasoning. In this instance, responding to the multifaceted issues that this situation was representing, the clinician was “picking up” on a number of clues from a variety of different sources: Fiona’s non-verbal responses, Fiona’s hesitant verbal interactions, her own past clinical experience in similar situations, her academic knowledge and her somatic feelings in the moment. This intuitive mode of knowing, which operates beneath the conscious level was signaled in the real-time practice setting primarily by the clinician’s increased tension and somatic feelings. This particular way of knowing may be said to have a ghost-like quality in that the clinician became aware of a need to pay attention to what she was observing non-verbally about the client, to listen more intently to the client’s limited verbal

expressions and to her own physical feelings. This attentive pull was strong and arose from a sense that something was absent from the therapist-client communication and the developing therapeutic relationship. Staying in the moment, responding to this increased awareness and simultaneously calling upon her past experiences in similar situations, the clinician asked Fiona specifically about her hospital experience. The clinician's use of her tacit knowledge and interactive clinical reasoning and reflections strengthened her stance in the less authoritative client-centred discourse and empowered Fiona to find her voice.

The clinician's critical reflections on Fiona's disengagement and her own reactions, attending to her somatic feelings and her use of her intuitive/tacit knowing, led to the crucial reflective turn, which remedied the imbalance between the dominant health care discourse and the professional client-centred discourse. Employing a connected way of knowing within the now more forceful professional client-centred discourse, the clinician moved into a state of heightened attention to the other. This was a special and unique way of being and knowing, a deeper and more complex mode of authentic client-centredness that I call a participatory consciousness discourse.

Participatory consciousness entailed suspending judgments about Fiona and/or the situation and moving into an "attitude of profound openness and receptivity" (Heshusius, 1994, p. 16). From this great depth of openness there was an unqualified willingness to listen to and hear the other, which enabled a "deeper level of kinship" (p. 16) between the clinician and the client. This was a deeper and stronger sense of client-centredness and collaboration that had not been present earlier in this interaction. Dwelling in this mode of participatory consciousness the clinician was completely attentive to Fiona's story.

Any egocentric concerns were temporarily suspended and the need for the control characteristic of the expert was relinquished. Thus, for a limited time, while in the participatory consciousness discourse, power relations between the clinician and the client were equalized and the clinician and Fiona could develop a greater awareness and understanding of each other. This understanding was further facilitated through the use of conditional clinical reasoning, which the clinician now used along with interactive clinical reasoning. Conditional clinical reasoning focuses on the client's social and environmental community. Employed within a discourse of participatory consciousness, it entails a "*total turning to*" (Schachtel, 1959, p. 225) the other. In this case, it provided the space for the clinician to invite Fiona in a non-threatening, non-intrusive way to make her own decision about participating in a group where she could obtain the clinical information she wanted. Fiona was empowered and able to accept the invitation offered.

In issuing the invitation to Fiona in this open, attentive manner the clinician was maneuvering within and between the discourses of participatory consciousness, professional client-centredness and the dominant health care discourse. Davies (2000) suggests, "the speaking/writing subject can move within and between discourses . . . [and] can use the terms of one discourse to counteract, modify, refuse or go beyond the other" (p. 60). Through interactive clinical reasoning in the professional client-centred discourse and the participatory consciousness discourse the clinician unearthed what was important to Fiona and what information and/or treatment she was seeking. In the participatory consciousness discourse she discovered that it was essential that Fiona have a sense of choice and control in her health care and that she was interested in finding out more about psychiatric conditions and medications. Using procedural clinical reasoning

the clinician was aware that Fiona's attendance at the group on psychiatric illness education would provide relevant research information and perspectives from both the professionals facilitating the group sessions and from the practical personal experiences and perspectives of the clients attending the sessions. Use of this procedural clinical reasoning enabled the clinician to keep simultaneously within the requirements of her professional client-centred discourse and of the institutional dominant health care discourse.

The source of the clinician's inclination to maneuver among contradictory discourses is seen in the clinician's closing reflections on her intentions to develop a collaborative therapist-client therapeutic relationship while practicing within the legal, ethical and professional competency parameters of the health care organization and her professional association and regulatory body. This collaborative therapeutic partnership was realized when she engaged in the professional client-centred discourse and was further enhanced by being mindful of somatic responses that enabled her to enter into the participatory consciousness discourse.

Although at the local practice site many of the subtle nuances revealed through the researcher's detailed analysis were invisible to the clinician, never the less she did appreciate the values of being mindful of her somatic reactions, which prompted critical reflection as she worked towards developing a collaborative therapist-client therapeutic relationship.

Disaster Prevented

Morag: Clinical narrative.

Morag, a small heavysset woman in her late thirties, has been a patient within the health care system since her early teens. Appearing older than her stated age, her skin was pale and she had a drained and weary look. Although her clothes were well worn, they were clean and she was neatly groomed. Over the past two decades she had experienced numerous encounters with various aspects of the health care system, including some lengthy hospitalizations. Initially she had been able to work in between episodes of her illness. However, as the depressive episodes became longer and more severe, she found that it became more and more difficult to meet the full requirements of her job. An additional challenge was the stigma that Morag began to encounter with her work colleagues who did not understand her psychiatric condition or accept the necessary absences from the work place due to her severe and persistent mental health condition. In recent years there has been an increase in the duration and severity of her illness, resulting in Morag being unable to remain in her paid employment. Now she is trying hard to survive on her provincial disability pension benefits. The change in her financial status has lead to her having to move from her two-bedroom rented suite to a small single room in a shared accommodation. She also found it necessary to move from an inner city dwelling to a more suburban environment, which meant that friends were left behind, and her support system changed. These challenges eroded the foundations of her confidence and her sense of self.

I first met Morag at an assessment interview I conducted regarding her admission to an outpatient rehabilitation day program. Morag was wearing a blue blouse, a light beige

jacket, dark brown slacks and flat brown shoes. I introduced myself. Morag smiled shyly, politely introduced herself and shook my outstretched hand. When invited to sit, she sat down across the table from me, occasionally glancing up with otherwise downcast eyes though not making eye contact with me. She constantly fidgeted with the large brown purse that she grasped tightly with both hands on her lap. Following the guidelines for the formal intake assessment I began to ask questions related to demographics, her medical and psychiatric history and her present rehabilitation needs. She gave each question much consideration before answering, as if trying to read my mind for the answers I expected. I felt that she was looking for the answers that would ensure her acceptance into the program.

I became increasingly aware of Morag's extreme anxiety through her quiet, hesitant voice and the constant nervous shifting of her feet and fidgeting of her fingers. Not once since the formal part of the assessment began did she look at me. I decided to abandon the formal interview questionnaire. I made this decision based on my past clinical experience where I found that with a less structured format clients became more relaxed and talkative. I was sure that I could still obtain the information I required to complete the formal assessment. I began to ask more informal open-ended questions, which I hoped would encourage Morag to start sharing information more spontaneously. I asked about her current life style, the effect of her illness on her everyday activities, what in her life she would like to change and her hopes and dreams for the future. With this change in the content of the questions and my more informal relaxed style, Morag for the first time looked directly at me. Her look was quizzical. She smiled somewhat nervously but she also appeared somewhat bemused. I felt that she was surprised by the questions I was

asking and that she was unsure of what to say. For a few moments there was silence. I did not interrupt this silence as I could see that Morag was slowly beginning to relax. Her shoulders were no longer hunched in tension, her smile was no longer forced and her fidgeting was decreasing. She looked at me, her eyes bright with anticipation. She now appeared relieved and pleased that someone was asking questions she knew how to answer about her everyday life, hopes and dreams. When she began to speak her voice tone was strong, friendly and confident. Slowly and cautiously she began to answer my questions and share the specific things she was interested in changing in her life. The most important issue she talked about and wished to address was her housing. She felt that obtaining safe and affordable housing and retrieving her belongings from storage in another part of the province would help her feel more settled and provide a sense of belonging. She expressed interest in exploring possible volunteer jobs in order to recapture the earlier sense of purpose, meaning and fulfillment that she had felt in her life. She also talked about how her involvement in physical and social recreation activities had decreased. She felt that this was contributing to her feelings of loneliness and physical lethargy. She was excited about finding out about the local recreation centres and their programs as she expressed interest in re-engaging in aspects of her previous leisure pursuits.

Over the next few weeks much emphasis and effort was placed on building our budding collaborative relationship. Morag had clearly told me what areas in her life she wished to work on. Therefore, I felt that she was ready to be involved in the development of her specific formal day program goal setting and intervention plan. We worked together negotiating, developing and mutually agreeing upon the treatment goals and

direction. Morag was actively involved in breaking the treatment goals down into smaller achievable steps, thus helping her work towards obtaining her goals and dreams. My professional intent was to assist Morag by enabling her to begin accepting responsibility in decision-making, which in turn would help build her confidence and actively engage her in the planning and implementation of her rehabilitation.

However, when Morag started to attend her group program it was almost as if she had forgotten our latest collaborative working sessions. She was apprehensive and anxious. Her behavior and interactions in the first few weeks of the program were not conducive to making her transitions into this therapeutic environment smooth sailing. When approached by me or other staff members she did not look directly at us. I observed that in trying to hide her apprehension and nervousness her speech was quite abrupt and abrasive, often to the extent of rudeness. While rocking from one foot to the other she would fidget with her fingers, rubbing her thumb across the top of her fingers on her right hand. I suspected that she saw the staff as more knowledgeable and superior and hence, she felt intimidated and did not know how to handle the situation. I also believed that her previous work environment validated Morag's understanding of the clinical environment. At her last place of employment her superiors, like her work colleagues, had not understood her psychiatric condition and had not been supportive.

When she was talking about the problems she had experienced in her work environment and social interactions she spoke in a very negative and self-deprecating way. Although she tended to blame others for her current hardships she also constantly put herself down in a most derogatory manner. She continually repeated her stories about her work, blaming all her work issues on her co-workers. She talked about how they

ignored her at coffee and lunch breaks and blamed errors and slow responses on her, attributing them to her because she had a psychiatric illness. She talked about how they made her feel stupid and worthless. Also, she shared how losing her job had made a major impact on her finances, living conditions and social contacts. She ruminated about her past life. At first her fellow patients listened patiently to her stories. They were supportive and understanding of her experiences as many of them had had similar experiences. However, eventually the rolling eyes and lack of attending when she began to speak made it clear that group members were tiring of hearing the same stories and of Morag's constant asking for advice and then not appearing to hear or act upon the advice offered. Morag's aggressive voice tone and abrupt mannerism were at times scary and off putting, even for staff.

With our recent experience of working together on her rehabilitation action plan I felt comfortable about discussing with Morag the negative impact her attitude and behavior were having on others. When we met she listened carefully to what I had to say. There was a period of silence and then Morag started to discuss what she could do, with support, to change the situation. She talked about concentrating on doing things that would bring her success and more pleasant interactions. With my assistance and support Morag was enabled to look more closely at her behavior and to see how her actions and quick negative re-actions affected individual group members and the group as a whole. She was able to discuss ways she could change her behavior. We discussed how stopping to take time to think before responding or reacting could be helpful. We discussed how silence when feeling defensive could give her some time to breathe and recover her composure. We reviewed and practiced how to turn negative feelings, thoughts and

behavior into positive ones. Following these discussions Morag developed a plan supported with strategies she could practice at home prior to implementing them in the group environment. Through collaboration we developed a series of non-verbal signals we could use in the group setting to help her and support her with the implementation of her plan.

The success and achievements she experienced in the group settings seemed to give her a new sense of confidence. With increased confidence her social interactions became less aggressive. Her speech was softer and her mannerisms less threatening. She was friendlier, warmer and hence more approachable. The group members began to reach out to her and invite her into their conversations more and more frequently. Also she had the courage to initiate conversations with her peers, who were no longer shying away from her. It appeared to me that she no longer felt she had to be on the defensive in order to protect and guard her.

Our therapeutic relationship also continued to grow and develop. We met regularly to review and discuss her progress. Where previously she would have waited for permission to sit, now she walked confidently into the room and chose and sat in the chair she wished. Her smile was no longer nervous; she looked directly at me and often started the discussion. She was no longer afraid to ask questions and I noticed that she no longer appeared to be second-guessing the answers to my questions. Her openness in our conversations also helped me be more spontaneous. I no longer felt that I had to be overly careful how I worded the question I was asking. I found that with this increased openness and spontaneity came mutual respect and increased collaboration. I felt comfortable inviting Morag to share her thoughts, ideas and opinions of what was important to her

and how these desires could be carried out. Also with her newfound confidence she was asking for my opinions and my professional input. I could see from her decisions and actions that she was considering all points of view. I was pleased that our therapeutic relationship was one of collaboration based on mutual respect and trust. However, one day to my surprise I found myself in a totally different type of interaction with Morag.

It was almost lunchtime and I was in the reception office surrounded by a pile of official forms and documents. I knew that it was essential that this work be completed within the next two hours. It seemed like an almost impossible task. I was working on this project when out of the corner of my eye I caught a glimpse of Morag approaching the reception area. As she reached the reception desk she noticed me working at the rear of the office. She smiled at the receptionist and looking past her, asked in a loud voice if she could talk to me for a few moments. I rose from the desk where I had been working and quickly walked towards the reception area. Upon seeing me move towards her Morag smiled and immediately started talking about an issue that we had discussed earlier that morning. She was anxious about a specific matter she had to deal with on the weekend, even though we had previously discussed how to handle the issue. My initial verbal response was pleasant but to the point. I started the conversation by saying that at the moment I was too busy to discuss her issue of concern. Almost immediately Morag's smile was replaced by a pout, her eyes were downcast and her voice became slow, whining and barely audible. Her whole appearance was one of helplessness, which implied to me, at this time, that she wished to be told exactly what to do to solve her perceived dilemma.

My response to her presentation and communication style was quick and precise. I said curtly that we had just finished a lengthy discussion on this issue and that she had made a definitive decision on how she would handle the situation. Morag ignored my response and said, "I don't know what to do". I repeated my response, adding that we had even role-played what she would do. Again Morag presented her issues stating, "I've tired before to let people know my feelings". There was a brief pause. "I've tried to set boundaries about what I'm able to do and what I'm willing to do. It didn't work! I don't want....." Morag did not complete her sentence. There was another brief pause. "I'm not able to take all the responsibility for looking after other people's things, other people's animals, even if it's only for a few days. Something always goes wrong. Then it's my fault. I get the blame. I know, because it has happened many times before and it will happen again. It always happens." With each telling her voice became more whining and childlike. I found myself pulling myself up to my full height behind the desk and stating that we had previously discussed the matter, her concerns had been addressed, a decision had been made and an action plan developed. Unfortunately, this did little to re-assure or satisfy Morag. She continued to repeat her concerns. I was thinking I wish this conversation were over. So, I told her the discussion had to stop, that she should have lunch and then go on to her planned group session. After making the pronouncement I turned away from the reception desk and walked briskly to the rear of the office to continue my work on the administrative assignments.

When walking away I felt a certain amount of relief that this conversation was over. But as I reflected on the discussion a few minutes later I became more and more aware of physical feelings of unease. In my mind's eye I remembered Morag's look of surprise,

hurt, embarrassment and possibly humiliation at my responses as I turned my back on her and walked away. I imagined how I would have felt if I had been in her position. I pictured her shocked look as she gazed at me, her increasing restlessness as she repeated her concerns, and her downcast look and posture as she finally left the desk and slowly shuffled her way towards the lunchroom.

Upon further reflection I found that I had become reactive not only to the content and repetition of Morag's conversation, but also to her voice tone and physical posture. In trying to understand what had happened in this particular interaction I recalled discussions with her other health care workers. I remembered one conversation in which they had described Morag as dependent. They supported their judgment by pointing out situations where they felt she was asking for help and expecting them or others to rescue her from situations that either she did not wish to deal with or felt were too difficult for her to solve. Prior to this incident I had always stated that I did not see her behavior in this way. I felt that she was making progress and taking responsibility for decision making and following through on her action plans. But now some doubt was creeping in. I began to question whether this behavior I had just witnessed was a demonstration of dependency. I myself had once described Morag as helpless, implying that she wished to be told what to do to overcome her problem. This uncertainty about the significance of Morag's behavior felt very uncomfortable. I was uneasy with the thoughts and feelings that arose when I reflected on this issue of dependency. I was aware that labeling a client dependent, especially in the clinical setting, tends to predispose situations and issues and can set up negative reactions towards clients. I had to think more about our interaction. I

did not wish to set in motion a destructive cycle that my experience told me could be extremely difficult to stop.

As I continued to reflect in on this interaction I realized that what bothered me was not Morag's reaction to me but my approach to her. Whereas previously I had engaged her in collaborative discussions, this time I had become controlling and dogmatic.

While I sat completing the administrative assignments, I became more and more aware of strong physical feelings of unease in my body. As I paid attention to these somatic feelings and reflected on my latest conversation with Morag I began to realize that although I had been aware of a physical unease during the interaction, cognitively I had been unable to alter my approach or change the direction of the interaction. The path had been set. I slowly began to accept that I could not ignore this interaction. I began to wonder if this particular dialogue could have a major negative impact on our developing collaborative therapeutic relationship.

I made the decision to accept responsibility for my behavior in this interaction and to meet with Morag to apologize. Later that afternoon as Morag was leaving her group session I stopped by and asked if she was willing to meet again as I would like to discuss our lunch time conversation. She appeared apprehensive, looking at me in a quizzical fashion, but she stated hesitantly that she would be willing to get together. Like Morag I was feeling apprehensive. However, I had decided to apologize for my earlier behavior and I intended to follow through.

We met in a small interview room, which had a round table, two comfortable armchairs and pleasant colorful photographs of provincial wildflowers on the walls. A round green teapot filled with jasmine tea, the aroma seeping out from the spout, two

china mugs and a plate filled with chocolate chip cookies sat in the centre of the table. Morag sat quietly waiting for me to start the conversation. She maintained eye contact but her look was cool and piercing.

As I began to apologize for my previous abrupt approach, curt manner and apparent difficulty in fully listening and responding to her concerns, Morag's eyes opened wide in amazement. She remained silent. She watched me intently, paying careful attention to my every word and move. As we sipped our jasmine tea and munched on the chocolate chip cookies there were pauses that seemed like an eternity. I was aware of trying to keep my body posture and facial expression open and welcoming. I invited her to share how she had felt during the lunchtime interaction. Slowly and very cautiously she began to talk. I smiled and nodded in encouragement as she shared how she had felt. She said that her biggest disappointment was that her concerns had not been heard. She felt that her concerns, which were of great importance to her, had been minimized and that she was being ignored. I listened carefully to her understanding and interpretation of the event. I paraphrased what I heard to ensure that I understood Morag's perspective and also to help validate her feelings and interpretation of the situation. I could see Morag's apprehensive look begin to fade. Her hunched shoulders fell, her tight grasp on the personal bags she carried loosened and her body visibly began to relax. Sitting in the chair across the table from me she appeared more comfortable and a smile was brightening her face. I could feel my own body begin to relax as the tension faded.

I felt and could see that our discussions were once more moving towards a more collaborative exchange. Restoring the openness, respect, trust and collaboration of our therapeutic relationship, we were able to start looking at some of Morag's behaviors. I

explained that just as some of my behaviors had upset her, some of her mannerisms and reactions had affected me and influenced my responses to her. We were both willing to listen to the other and were sufficiently comfortable in sharing our perspectives. In our meetings, prior to the lunchtime incident, Morag had shared her thinking style, particularly her self-depreciating perceptions, her tendency to blame others and to ruminate about the past and measure herself against external variables that negatively affected her self-esteem. Morag was willing and now able to examine her behaviors in our most recent interaction and to explore how her style of thinking, ruminations and self-judgments was again influencing her self-esteem and therefore her abilities to handle everyday situations such as the one she would be facing on the weekend. Our shared verbal interactions continued and the session ended with our mutual agreement to meet the following day to further practice the role-playing, which Morag felt would help her address more constructively and confidently the problems she would be dealing with on the weekend.

I was delighted that our collaborative therapeutic relationship had been salvaged from possible disaster.

Morag: Analysis.

As the researcher analyzing this narrative of Morag, I am trying to understand what discourses were at play and what effect they were having on the therapist-client interactions and the collaborative therapeutic relationship.

Some discourses described in the Discourses Chapter, although always present, are mentioned in the analysis only when they occasion a change in the course of the therapist-client relationship. These are the ethical and legal discourses, which are a

constant force within the constellation of the dominant health care discourse, and the professional competency discourse, which is part of the professional client-centred discourse. The clinician constantly negotiates these discourses; she is never outside their ken. However, it is only when the force of these discourses makes a difference to the direction of the narrative that they are addressed in the analysis.

At the beginning of this narrative the clinician was using procedural clinical reasoning, which deals with the clinical conditions having to do with diagnosis, goals and treatment. The use of procedural reasoning signaled the presence of the dominant health care discourse. In keeping with the prescription of this discourse, the clinician met with the client in a formal interview setting in order to gather information required by the health care organization and the government funding agency for admission to the outpatient rehabilitation day program. This dominant administrative discourse required that the clinician obtain and clarify information on the client's demographics, medical and psychiatric history, rehabilitation goals and treatment programming through a formal intake assessment questionnaire. As required by the government funding agency and the health care organization, this discourse focuses on the intake assessment document rather than on the client as a person. It objectifies the client for the sake of determining the client's appropriateness and readiness for admission to various outpatient programs.

When in response to the client's limited and stilted replies to the intake questionnaire the clinician drew on her tacit knowledge gleaned from her clinical experience, and aborted the formal intake assessment, she moved from the dominant discourse of health care to the less dominant discourse of professional client-centredness. It is important to note that in the practice setting the clinician was not consciously aware of the influence

the dominant discourse was having on her interaction with the client. She was aware, however, as noted in the clinical narrative, that a more open and less structured style of questioning would be preferable to the one she had been using. From her past clinical experience she knew that a less structured approach helped clients feel more comfortable and responsive. Accordingly she moved into interactive clinical reasoning. By introducing interactive clinical reasoning the clinician shifted her emphasis to a more personal interactive approach. This occurred through a subtle style change in offering Morag the invitation to share her personal perspective on her rehabilitation needs rather than having to answer the very specific questions from the intake questionnaire.

The continued use of procedural clinical reasoning enabled the clinician to still address the requisite issues of assessment, goal setting and treatment planning although in a less formal manner, thus shifting to the professional client-centred discourse. Interactive clinical reasoning provided a clearer understanding of Morag as a person and of the impact of her psychiatric illness on her everyday life. In using interactive clinical reasoning, not only was the clinician fulfilling her desire to work within her professional model of enablement and collaboration in the professional discourse of client-centredness, but the client Morag was empowered and enabled to talk informally about and share concerns that were important to her and to her recovery process.

Feeling comfortable with her developing collaborative therapeutic relationship with Morag, built up through the use of interactive clinical reasoning in the professional client-centred discourse, the clinician now felt she could afford to respond to the necessity of fulfilling the day program's formal administrative requirement of goal setting and intervention planning. Procedural clinical reasoning was once again present. However

this time, the clinician used procedural clinical reasoning to balance and negotiate both the dominant health care discourse and the professional client-centred discourse simultaneously. This negotiation was accomplished by shifting the focus back and forth between the processes of goal setting and treatment planning, which are the institutional requirements of the dominant discourse, and the client's personal perspective, which is the focus in the client-centred discourse. Using procedural clinical reasoning in a manner dictated by professional client-centred discourse rather than in the style of the dominant discourse, the clinician was able to incorporate Morag's personal perspective in developing rehabilitation goals and a treatment plan while at the same time ensuring that the health care organization's clinical documents were completed with the appropriate information.

This tenuous balance of usually incompatible discourses was soon disrupted however. In the clinical narrative when the clinician noted that Morag was experiencing numerous problems transitioning into her rehabilitation group program the clinician suspected that Morag saw the staff as more knowledgeable and therefore superior to her. Without being consciously aware of it, the clinician was observing the effects of the dominant discourse on Morag's behavior in the clinical setting. The expectations and the requirements of the dominant discourse emphasized the inequalities of power relations between the client and representatives of the institution, namely, the clinician and her colleagues. Moreover, expectations bred by the dominant health care discourse around active participation in the clinical program were also influencing Morag's behavior in the clinical setting. The client's abrasive manner was a signal of Morag's unease with the position of inferiority assigned her by the authoritative dominant discourse. The therapist-client relationship

once again fell under the sway of the dominant health care discourse and the collaborative rapport newly developed between client and therapist disappeared.

The clinician responded to this situation intuitively by once again introducing the more personal mode of interactive clinical reasoning in an effort to neutralize the client's fears and anxiety, thereby shifting into the less dominant discourse of professional client-centred enablement. This move changed the situation significantly. In this collaborative and enabling discourse Morag was empowered to accept and take responsibility for her behavior and to develop and implement strategies that would assist her recovery process.

However, this professional collaborative and enabling discourse was soon upset a second time. This time, the clinician precipitated the disruption when she acceded to the administrative demands of the dominant health care discourse to gather statistical data and demographic information. This material was related to funding and staffing ratios and it was essential that the information be provided to the organization's administration by their set deadline so that in turn the organization could meet the deadline set by the government-funding agency. The clinician was very aware of this strong external pressure to meet a fast-approaching deadline. Time was now very precious. When she told the client that she was too busy to talk she was reacting to the tensions and struggle she felt in trying to adhere to the organization's requirements. At this point the force of the dominant health care discourse was so strong that it over ruled (Townsend, 1998a) her desire to be client-centred. This shift back into the dominant health care discourse resulted in the clinician discarding the professional client-centred discourse of collaboration and enablement in favor of the dominant discourse. This move was evident

in her use of pragmatic clinical reasoning and its sub discourses of efficiency, effectiveness and timeliness.

At this point in the interaction the clinician's role had changed from professional as collaborator to professional as expert. In fact, the clinician was now caught up and stuck in two roles. One was the role of collector of data. The second was the role of expert who told the client what to do. In this role of professional as expert the clinician lost sight of the client as a person and also of her own desire for a collaborative therapeutic alliance with the client. By unintentionally giving priority to the administrative requirements of the dominant discourse and shifting to professional as expert the clinician had unknowingly increased the power difference between herself and the client. The clinician was unaware of her own behavior and the unfavorable effect of the discursive practices in which she was caught. Nor was she consciously aware that Morag's restlessness and the escalation of her behavior were signals of Morag's unease with the authoritative discourse. The client's voice and needs were being lost in the discourse of hierarchical systems that were created mainly through the use of the dominant health care discourse that establishes the authority of the clinician and subjugates the client within the health care system. By paying attention to her own physical unease and the client's restlessness the clinician was aware that something was amiss. But now she was caught and struggling within and between the discourse of the dominant health care and the professional client-centredness discourse.

Remaining in the dominant health care discourse and using procedural clinical reasoning the clinician contemplated the terms 'dependency' and 'helplessness' as a way of explaining the client's role in the lunchtime interaction. However, as seen in the

clinical narrative, the clinician was reluctant to label the client. She was aware that such terms as 'dependent', 'dependency' and 'helplessness' have negative connotations, objectifying the client and most often leading to negative judgments. She was also aware that labeling the client in this way was contradictory to her values and to her desire to be non-judgmental in a collaborative therapeutic relationship.

Attending to her somatic feelings and her speculation about how the client felt led the clinician to reflect on the lunchtime interaction and to shift into the professional discourse of client-centredness. Critical reflection, questioning her own behavior and actions, and paying attention to her somatic feelings triggered the clinician's concern and desire for the collaborative therapeutic relationship. Thus, she was enabled to re-direct her attention back to seeing the client as a person. This strong force to re-connect collaboratively with the client arose from the sense that the collaborative therapeutic relationship may have been hindered or even damaged by the lunchtime interaction. This critical reflective turn led the clinician to make the decision to apologize to Morag by meeting with her later that same afternoon. With this decision the struggle ceased and a sense of balance was achieved between the conflicting discourses.

Meeting with Morag following completion of the administrative assignments, the clinician moved beyond the professional client-centred discourse into a heightened awareness of the other. In addition to interactive clinical reasoning, the clinician now took up conditional clinical reasoning in which she gained a greater awareness of Morag's broader social, cultural, political and physical environments. This non-intrusive turning of attention to the other moved the clinician into the participatory consciousness discourse, a unique and special way of being with and knowing the other. The clinician's

apology and the informal setting within the clinical environment provided the invitation to the client to join with the clinician in this unique mode of participatory consciousness. Merging into this discourse with an “attitude of profound professional openness and receptivity” made possible a “deeper level of kinship” between the client and the clinician, which enabled a stronger and more meaningful sense of collaboration and client-centredness (Heshusius, 1994, p. 16). The clinician had an “inner desire to let go of perceived boundaries that constitute ‘self’- and that construct the perception of distance between self and other” (p. 16), thereby enabling a temporary suspension of judgments, a letting go of any ego concerns and an abandonment of control characteristic of the professional expert. Dwelling in this discourse the clinician was totally attentive to Morag and her concerns. Hence, while in the participatory consciousness discourse the power relations between the clinician and the client were equalized providing the opportunity for Morag and the clinician to have a greater understanding of each other. Even the pauses and silences on the part of the clinician helped in furthering the collaborative therapeutic partnership, for, as Heshusius (1994) points out, “one can come to know even in silence” (p. 18). Being in this non-threatening and non-intrusive space power imbalances were neutralized, the need for control was relinquished and Morag was again actively involved in her recovery process.

Dwelling in the participatory consciousness discourse and this unique way of knowing had successfully re-engaged the collaborative therapist-client therapeutic relationship. This move was accomplished through the clinician’s simultaneous use of interactive clinical reasoning and conditional clinical reasoning. Once again, the clinician was deftly negotiating multiple contradictory discourses, ostensibly complying with the dominant

health care discourses, which required her to develop treatment goals and plans, while at the same time engaging the participatory consciousness discourse in which she built an understanding of Morag as a person through a “*total turning to*” the other (Schachtel, 1959, p. 225).

Thanksgiving Dinner

Katrina: Clinical narrative.

Katrina was a small middle-aged woman who suffered from a chronic and persistent psychiatric illness. She had been diagnosed in her middle twenties as having a bipolar condition. She had suffered numerous bouts of depression and mania, many of which resulted in her being hospitalized. Following a recent manic phase of her illness Katrina had plummeted into a severe depressive episode where she had made a serious suicidal attempt. She had been hospitalized for a number of weeks and released. Since her discharge from the hospital a community-based team had been caring for her. The prescribed medications were stabilizing her symptoms but she was continuing to experience major difficulties in everyday functioning, particularly in the performance areas of productivity and leisure. This was why she had been referred to the outpatient clinic.

Prior to attending an interview for admission to the outpatient clinic, her community treatment team had advised me that Katrina was now able to handle the majority of her self-care activities independently. The community treatment team’s specific recommendations were that Katrina would benefit from developing such skills as budgeting and increasing her social skills and contacts, which they thought would come

from attending the psychiatric outpatient clinic. They had explained these specific recommendations to Katrina.

I first met Katrina on a warm summer's day in July. Katrina had an appointment for an interview in the outpatient clinic where I worked. The interview room was sparsely decorated with— cream colored walls, two blue upright armchairs, a small square table and a non-descript clock on the wall. The sun streaming through the wide bank of windows on two sides of the room gave a sense of warmth and light to this otherwise cool and clinical environment.

After checking in at the reception area and having the interview room pointed out to her, Katrina slowly made her way to the room. She shuffled slowly through the open door of the interview room. She briefly scanned the furnishings in the room and then looked at me and smiled. Katrina was a small obese woman in her middle fifties who looked older than her years. She was tidily dressed in a pair of dark pants, an oversized flowing purple colored top and a pair of black shoes. Her graying hair was pulled back in a bun, which gave her quite a severe and somber appearance. She wore no make-up. I smiled as I walked towards her, moving my hand to indicate the seating area, inviting her to join me. She hesitated for a few seconds and it appeared to me as if she was waiting to see which chair I would choose or which chair she would be advised to take. Eventually she chose a chair, sat down and drew it into the table. She then carefully placed her large black purse on the floor beside her and placed her hands on her lap. In this interview environment I felt that Katrina's slow paced movements and her downcast eyes indicated feelings of apprehension about what was in store as well as being signs of her depression. Since entering the room she had not spoken. As she sat waiting for me to begin the interview I

noticed that her initial smile faded, and her eyes were dull as she gazed down at the table. Her arms were crossed at her wrists, one hand lying on top of the other. Her fingers were constantly moving and her pale drawn face was now expressionless. I introduced myself. She looked up at me for a brief moment, then cast her eyes down again as she waited for the formal interview to begin.

Once the social introductions were over I began to ask questions intended to elicit the essential demographic information that I was required to gather for both the organization and the government. Having obtained this necessary information I carefully continued to follow the outpatient clinic's intake assessment guidelines document. Katrina was cooperative in answering the questions being asked; however, her responses seemed to me to be measured and minimal. Rarely did she provide any additional information or details. It was as if she was trying to anticipate the correct answers and/or provide just sufficient information to ensure her acceptance into the clinic. Throughout this information gathering session Katrina made little direct eye contact with me, although occasionally she would glance up and look out the window. As I watched Katrina sitting by the table I remember thinking how her demeanor reminded me of other clients who had on numerous occasions gone through similar situations. Her way of being, her appearance of compliance and her almost guarded answers to the interview questions indicated that she was familiar, yet not comfortable, with this formal interview procedure.

I ignored these fleeting reflections and continued on with the formal intake assessment. Following this format I ascertained that Katrina was feeling depressed and because she was feeling low it was an effort to do housework, shopping and to keep in touch with her family and friends. However, although still in the depressed phase of her

illness she was now successfully managing her personal hygiene and grooming, and taking her medication. Since her suicide attempt her medications were being carefully monitored. Following discharge from hospital her medications were limited to a few days supply and provided by the pharmacist in blister packs. She did express having some difficulties sleeping and eating regularly but she did not see these self-care activities as serious issues.

Having gathered the information necessary to complete the assessment and having confirmed that Katrina met the clinic's admission criteria, my next step was to start looking at goals and developing a rehabilitation treatment plan. Katrina looked surprised, almost astonished, when I invited her to be involved in setting her treatment goals and plan. After a few moments of silence where she looked either at the floor or out the window Katrina broke her silence by quietly repeating the problems identified by her community treatment team. When I asked her if she had any issues or problems she wished to add to her proposed treatment goals and plan she emphatically answered "No! My treatment team wants me to come to this program". She looked away and pausing for a moment added, "They know what's best for me". When reviewing her specific treatment program identified by her community treatment team Katrina appeared somewhat interested and as she shuffled out of the interview room she emphasized that she planned to attend the outpatient clinic. However, when later reflecting on this conversation I did wonder whether her agreement to attend was due to her own interest and commitment or because she felt that she had to please her treatment team. I also wondered if she would actually attend the clinic as planned. Time would tell.

Over the first few weeks following her interview, Katrina's attendance at the outpatient clinic was irregular and as the weeks progressed her follow-through became sporadic. It appeared as if my original concerns might be correct. I began to wonder whether her lack of commitment to her treatment plan was due to her decreased motivation, lack of energy and poor concentration or to something else? Had she agreed to her treatment plan because it would please her treatment team and keep them "off her back"? I had heard this explanation from other clients, particularly those who had no direct contribution to their treatment goals and plans and those who truly did not wish to attend the clinic. Or did Katrina have other priorities in her life that she would rather be working on?

When I reported to her community treatment team that Katrina's attendance and engagement in her treatment program was becoming more sporadic and limited they were surprised. They immediately responded that her medications were "kicking in" and that her affect appeared brighter and her symptoms were now more stable – indicating that they saw no reasons why she should not be attending as planned. After further discussion they acknowledged that they were aware that she was not attending daily as planned but they were astonished that her attendance was diminishing because when she met with the team she reported that she was attending and finding the groups useful. They therefore had assumed that she was attending more regularly than was the case. What did this mean? I now felt that it was necessary to hear from Katrina about what was going on.

As it would happen, Katrina arrived at the clinic the following day. I approached her and asked if we could meet to review and discuss her treatment program. She looked straight at me, her eyes had a haunted look and her brow was furrowed. She appeared

anxious and apprehensive. We moved into a small interview room and even before she sat down she asked worriedly, “Are you going to discharge me from the clinic?” I reassured her that at this time my intention was not to discharge her. However, I was interested in knowing what she was thinking and how she felt. Many thoughts and questions were swirling in my head. Did she wish to discontinue her attendance at the clinic? What things, if any, made it difficult for her to attend regularly? How did she find the groups she was scheduled to attend? Were the groups meeting her needs? Did she wish to make any changes to her program? Before I was able to ask any of my questions she volunteered quickly that she did not wish to be discharged and although she did not attend every day she did find the groups she attended helpful. She found it difficult to be more explicit. I felt that it was important not to pressure Katrina into answering a barrage of questions but I was also interested in understanding her apparent desire to attend. Furthermore, I wished to understand why she was finding it so difficult to attend regularly. By now she had begun to slowly relax into the chair and the worried expression on her face was also fading. This time I listened to the uncomfortable feeling in my chest and stomach and made the decision not to press the issue around rehabilitation goals and therapeutic plans. Instead I chose to gently move into inquiring about issues that would help me begin to understand Katrina as a person. I was interested in hearing directly from Katrina rather than relying on the images created by the health care records and the opinions of other health care professionals. I was interested in Katrina’s personal thoughts, feelings and description of her illness condition. I was particularly interested in experiences and situations she may have encountered because of her bipolar illness and asked her specifically how her psychiatric condition impacted her daily life. How did her

fluctuations in mood influence her participation in her daily routine? I also expressed interest in understanding what it had been like for her to raise her children on her own and at the same time hold down a job. I also recognized that at present because of her depression she might not always feel like doing things or encounter much pleasure. However, I was interested in knowing what she enjoyed doing or found pleasure in either now or in the past. I also asked her what in her life she would like to change. It was important to me to demonstrate my genuine interest and caring about her as a person and her current situation. I wished Katrina to feel sufficiently comfortable to be open and genuinely disclose her interests, concerns, issues, wishes and desires. It was my intentions that by helping Katrina feel more comfortable and respected she would begin to share everyday issues that mattered and were important to her.

My change to a more informal less clinical approach seemed to work. Over the next few weeks Katrina and I began to work more collaboratively. Slowly the picture of Katrina was developing from the original snapshot I had seen into a color movie full of action and surround sound.

Through talking with Katrina and paying attention to the details in her conversation I became aware of how her psychiatric conditions had had a major impact on her life. She talked about the alienation she felt from her immediate and extended family because of their fears and lack of knowledge, understanding and acceptance of her psychiatric illness. Also there were the complexities from diabetes and hypothyroidism that added to an already difficult situation. She suffered much anguish and guilt because she no longer had the interest, motivation or energy to care for her home the way she wished. Furthermore, during a number of manic phases in her bipolar condition she had “eaten”

into her savings. As our therapeutic relationship steadily moved into one of partnership and collaboration Katrina began to feel comfortable enough to talk about the issues in her life where she wished to make improvements and change.

One such example was the issue of Katrina hosting Thanksgiving dinner in her home. Due to her psychiatric and physical illnesses and particularly her family's negative reaction to these conditions, she had been unable to or prevented from carrying on this tradition for a number of years. This year her dream was that it would be different. She would once again host the celebration in her home. This was an ideal opportunity to put all Katrina's treatment goals and more into action – menu planning, budgeting, shopping, cooking, house keeping and socialization would all be taken into consideration. In addition to Katrina's wishes I could see how her community treatment team issues could also be addressed. I met with Katrina to review the potential of bringing her dream to fruition and also discussed what this would involve. For the first time since meeting Katrina I could see both from her facial expression and verbal interactions that she was excited and enthusiastic about making this event happen. Working collaboratively we drew up a schedule for the project that Katrina simply called "Thanksgiving". Over the weeks before the event Katrina with support from me, drew up plans for what exactly Thanksgiving would entail - deciding whom to invite and providing invitations, setting the menu, budgeting for the event, shopping, tidying her home, setting the table, cooking the meal, serving the meal and tidying up after the meal. We carefully looked at the list and with support from me Katrina decided what she felt she could handle independently and where she required help. We then discussed who could help her in this regard and precisely what their jobs would entail. Friends and support personnel from the

community team were enlisted to assist and their specific roles and jobs were assigned. As the event drew closer Katrina became quite anxious, yet she remained determined to follow through with the celebration. However, I felt that it would be important to have a backup plan in place should Katrina for any reason be unable to follow through on the tasks she had agreed to do independently. I also felt that having an alternative plan in place would help alleviate some of Katrina's nervousness and apprehension. I discussed with Katrina the possibility of developing a backup plan, to provide her with further help if and when required. She was in agreement with this suggestion and a backup plan, with Katrina's input, was developed. This action plan did help to alleviate most of Katrina's fears and anxiety.

Katrina was able to follow through on the tasks she had agreed to do independently, and with assistance from her friends and the community support staff the Thanksgiving dinner was an outstanding success. At the end of Thanksgiving Day Katrina had met her dream of organizing and providing dinner for her immediate family. When I met with Katrina the following day she was tired but very proud of her achievement. She remarked that she "had much to be thankful about".

Katrina: Analysis.

As the researcher analyzing the narrative of Katrina, I am trying to understand what discourses were at play and what effect they were having on the therapist-client interactions and the collaborative therapeutic relationship.

Some discourses described in the Discourses Chapter, although always present, are mentioned in the analysis only when they occasion a change in the course of the therapist-client relationship. These are the ethical and legal discourses, and the

professional competency discourse, which is part of the professional client-centred discourse. The clinician constantly negotiates these discourses; she never is never outside their ken. However, it is only when the forces of these discourses makes a difference to the direction of the narrative that they are addressed in the analysis.

At the commencement of this clinical narrative the clinician was using procedural clinical reasoning that relates to clinical conditions such as diagnosis, goals and treatment. This clinical reasoning signaled the presence of the dominant health care discourse. As required by the health care organization and government services for admission to the outpatient clinic the clinician met with the client to conduct a formal intake interview to collect specific information on demographics, the client's medical background, treatment objectives and program direction. This authoritative discourse through the formal clinical texts provided an objective way of talking about clinical conditions, goals and treatment planning and also determined the client's readiness and appropriateness for admission to the outpatient clinic. The focus of this dominant discourse is the objective formal clinical texts and not the client as a person. In the clinical narrative the clinician wrote about Katrina's behavior and how it reminded her of other clients who had felt uncomfortable during the formal interview. However, being caught up in the discursive practices of this discourse the clinician dismissed her brief reflections on the client's unease in the formal setting and her tacit knowledge which stemmed from recollections of clinical experiences of clients' reactions in similar situations. Therefore she continued to administer and follow the organization's formal intake document. In the practice environment the clinician was not conscious of the influence of the dominant discourse on the intake interview process and the therapist-

client relationship. Through her use of procedural clinical reasoning the clinician accomplished the requirements of this authoritative discourse, namely the gathering of information on the client's psychiatric condition, medical and psychiatric history, rehabilitation goals and treatment planning.

The clinician inviting the client to be active in decision making around her rehabilitation goals rather than the clinician as the professional expert telling her what the treatment goals would be initiated a shift to the professional client-centred discourse, a less dominant discourse. The clinician addressing both the professional client-centred discourse and the dominant health care discourse through procedural clinical reasoning succeeded in balancing two usually competing discourses. In procedural clinical reasoning the focus can move back and forth between the formal clinical assessment and treatment planning processes and the client for whom these processes are developed. When the clinician was asking Katrina questions from the intake assessment document she was participating in the dominant objectifying discourse. The focus began to change when the clinician invited Katrina to provide her personal perspective on her rehabilitation needs, goals and treatment plan. At this point the clinician used procedural clinical reasoning in the client-centred enabling discourse. Thus, she simultaneously negotiated both the dominant health care discourse and the professional discourse of enablement and client-centred practice. But when the client did not accept the clinician's client-centred enabling invitation the clinician abandoned her attempt at developing a collaborative rapport within the professional client-centred discourse. The clinician was once more recruited by the authoritative dominant discourse where the emphasis was on the role of professional as expert and she accepted the responsibility for developing and

formulating the goals and treatment direction. This move to clinician as expert increased the power difference between clinician and client. In the practice setting the clinician was not consciously aware of the impact and influence the dominant discourse had on her behavior and her desire to be client-centred.

In the narrative the clinician notes that she was concerned about Katrina's sporadic attendance and her possible lack of commitment to the outpatient program, therefore the clinician made the decision to meet with Katrina's community treatment team to discuss these issues. In this communication the emphasis on professional as expert was further demonstrated by the community treatment team's "chart talk" (Mattingly and Fleming, 1994, p. 59) that followed the medical discourse of diagnostic signs, symptoms and medications. However, the clinician's interest in her professional model of client-centredness and enablement continued to lurk in the shadows of the dominant discourse. This was seen as she reflected on her past clinical experience and tacit knowledge while pondering the reasons for the client's sporadic attendance and possible lack of motivation. In the clinical practice setting the clinician was not consciously aware of the subtle nuances of the dominant discourse and how this was impacting the client, the therapeutic rapport and her own desire to develop a collaborative therapist-client therapeutic partnership.

However, a shift in discourses was imminent. Reflecting on the client's behavior and the possible reasons for Katrina's limited engagement in treatment led the clinician to initiate meeting face to face with the client to review and discuss the above issues. This shift to the professional client-centred discourse was achieved through the use of interactive clinical reasoning. The clinician was relating with the client as a social being.

Hence, she had a greater understanding of the client as a person and her personal illness experience. The professional client-centred discourse was now the primary discourse with a focus on client-centredness and enablement. The clinician's critical reflections and questioning of Katrina's behavior, motivation and actions, her use of tacit knowledge and interactive clinical reasoning strengthened her stance in the less authoritative professional client-centred discourse. This in turn empowered Katrina to find her own voice through sharing her illness experience and issues relating to her recovery process. The collaborative therapist-client therapeutic relationship was emerging and growing and the clinician's wish to work in her professional client-centred approach of enablement and collaboration was coming to fruition.

Working within the now stronger professional discourse of enablement and client-centredness encouraged the clinician to pay close attention to the details of the client's verbal communication and non-verbal language. The clinician also noted in the clinical narrative that she began to attend to her own feelings of discomfort. Integrating the client's verbal and non-verbal cues and her own bodily ways of knowing the clinician experienced an increased awareness and heightened attention to the other. Listening to the strong attentive pull and weaving together those practical cues and experiences the clinician moved into a special and unique way of being with the other, namely the discourse of participatory consciousness. Dwelling comfortably in this discourse the clinician was totally attentive to the client and her therapeutic wishes. Being with the other with this authentic sense of caring and genuine "profound openness and receptivity" (Heshusius, 1994, p. 16) created a "deeper level of kinship" (p. 16) with the client. This powerful and meaningful sense of collaboration and client-centredness was not present

earlier in their therapeutic interactions. A temporary letting go of judgments, suspending any egocentric concerns and relinquishing the need for control enabled the power relations between the clinician and the client to be equalized while staying present in this particular discourse. In this presence there was an unqualified willingness to be mindful, listen and hear the other. Therefore, by being present and dwelling in this space both the client and the clinician had the opportunity to gain a deeper understanding of the other. This heightened awareness, ways of knowing and understanding characteristic of the participatory consciousness discourse was facilitated by the clinician's simultaneous use of interactive clinical reasoning and conditional clinical reasoning. In this discourse the interactive clinical reasoning was accomplished through a "*total turning to*" (Schachtel, 1959, p.225) the other with a deeper awareness of client as a person and her lived experiences, while conditional clinical reasoning enabled a greater understanding and awareness of the client's broader social, cultural, political and physical environments. Being with the client in this non-intrusive and non-threatening manner provided the space and the opportunity for Katrina to share her secret dream of once again hosting the traditional family celebration of Thanksgiving dinner.

When collaborating with Katrina to plan and organize this special Thanksgiving event the clinician moved out off the participatory consciousness discourse. It is possible to use a number of clinical reasonings almost simultaneously by moving one to the foreground as the other falls into the shadows for a short time. At this point in the interactions the clinician was using procedural, interactive and conditional clinical reasoning. She used procedural clinical reasoning to maneuver within and between the dominant health care discourse and the professional client-centred discourse. This negotiating was

accomplished by shifting the focus back and forth between the process of the clinician monitoring the client's psychiatric and medical conditions which are organizational requirements of the dominant discourse and the clinician inviting the client's perspective on her rehabilitation and medical needs which is the focus of the professional enabling client-centred discourse. The clinician was not consciously aware that through her use of procedural clinical reasoning she was successfully negotiating two normally incompatible discourses, namely the dominant health care discourse and professional client-centred discourse. Using a collaborative and enabling process with/in the professional client-centred discourse the clinician also employed the more personal approach of the interactive clinical reasoning and conditional clinical reasoning. The former increased the clinician's understanding and awareness of the client's social being and assisted in actively engaging Katrina in the planning, organization and implementation of this special social celebration. While the latter entailed the clinician looking at the client holistically, taking into consideration her past, her future and her everyday life world. Being mindful and attentive to the client's verbal language and her non-verbal cues the clinician assisted the client in clarifying what was meaningful for her and her future aspirations.

Remaining in the professional client-centred discourse, which was now the primary discourse the clinician, assisted the client in envisioning changes and future aspirations. The clinician "was beginning to envision a prospective story" in which the client could engage (Mattingly, in Mattingly & Fleming, 1994, p. 265). She enlisted the client in constructing images of what hosting a Thanksgiving meal would look like, who would be the guests at the dinner table and what hosting this event would entail. She then engaged

the client in the activities that would help make the Thanksgiving dinner a reality. Narrative clinical reasoning through story making or the “therapeutic emplotment” (Mattingly, 1991, p. 998) “concerns the way therapists work to structure therapy as a coherent plot, as an event and not just a sense of treatment activities, thus creating dramatic therapeutic events that connect therapy to a client’s life” (Mattingly in Mattingly & Fleming, 1994. P. 269). The intent is to make therapy a meaningful short story in the larger life story of the client.

In this clinical practice narrative through successfully negotiating the competing discourses of the dominant culture and professional enabling client-centredness and maneuvering in and between the dominant health care discourses, the professional discourse of client-centredness and the participatory consciousness discourse, the clinician established a collaborative therapist-client therapeutic relationship.

Reflections and Recommendations

This research study has illuminated a number of issues and topics that are of particular significance to clinicians, educators, students and the profession of occupational therapy. These issues and topics are expanded upon in the following discussions.

As I reflect on the years of working on my research study I am reminded of the value and importance of reflection and reflexivity to my research, practice and everyday life. This study has also demonstrated the importance and value of reflexivity and critical self-reflection to practice and research for clinicians, educators and the profession. The following writing is offered as further clarification of these tools to practice and research. Much has been written about reflection in the field of education, and the occupational therapy national practice guidelines and competency document support and encourage occupational therapists to be reflective practitioners. Reflecting on my clinical practice has been extremely helpful in furthering my understanding of daily lived experiences and my awareness of bodily ways of knowing. Critical reflection has assisted in unraveling unusual, complicated or difficult situations as well as what often appear as simple mundane daily events. It was my desire to know and understand the dynamics of these events that led me to write the clinical practice narratives, which in turn deepened my interest in client-centredness and initiated the call to further explore the meaning of a collaborative therapist-client therapeutic relationship.

In order to gain a deeper awareness, understanding and connection with the client-centred experience it was essential to peel back the multiple levels of reflection. Doing this I discovered that being mindful of subtle and often not so subtle emotions and somatic feelings can lead to the reflective turn that invites a unique way of being present

with a client. This deep and rich manner of dwelling with another opens up new possibilities with/in practice. Moving into this space and dwelling there requires thoughtfulness and openness. It requires that clinician learn to notice and examine honestly somatic feelings, emotions and actions. I am “not referring to surface feelings, to our predilections, likes and dislikes, but to the layers of affective-somatic knowing that guide the deeper course of our intellectual lives” (Heshusius & Ballard, 1994 p. 14). This is a bodily way of knowing. “Feelings *are* the direct connections between actual occasions of experience. . . . It is not just a matter of feeling the relations, but of feelings *as* relations. Feelings are what actualize the possible” (Keller, 1988 cited in Heshusius & Ballard, 1994, p. 171).

Because this critical reflection is an opportunity to look at mistakes and near misses as well as successes, this self-monitoring /assessment can be risky for clinicians: they can be perceived as not doing a good job. In order to reduce the clinician’s fear of being judged by others as incompetent it behooves regulatory bodies such as regulatory colleges and professional organizations to be aware that clinicians using critical reflection as a self monitoring/assessment tool are doing so because they are interested in learning by looking carefully and mindfully at what is happening in a given situation and wish to adapt or change to improve their practice. I agree with moral, ethical and legal dictates found in discourses such as the national occupational therapy *Code of Ethics* that practice “must not cause injury nor create and foster false expectations” (CAOT cited in Townsend & Polatajko, 2007, p. 309). However, the supervisory organizations whose texts support the reflective clinician have a responsibility to employ creative and non-threatening means to fulfill their mandate to monitor competence.

Shifting into a participatory mode of consciousness and knowing can move occupational therapists and the profession into exciting new directions regarding client-centredness and collaborative practice. While the move into participatory consciousness goes in the same direction as that of professional client-centredness it is the quality and the depth of the interaction between the individual clinician and the individual client that is different. In accessing this mode of being and dwelling in participatory consciousness clinicians have the opportunity of developing a deeper and richer understanding of what it means to work with/in an authentic collaborative relationship with clients. The move to this particular space is enabled through an unconditional willingness to be open to the possibility of authentic relatedness with other. One has to be comfortable with oneself in order to have the ability to stand back and let go of everyday judgments while simultaneously entering into and dwelling in a nonegocentric responsiveness to other. This unique kinship between therapist and client deepens the therapeutic relationship and also expands, opens up and strengthens the opportunities and possibilities in the therapeutic recovery process.

Like myself many occupational therapists were introduced only to the scientific worldview through our professional academic education and clinical training. We were embedded in this scientific discourse that re-enforced the importance of objective chart talk where clinicians recorded only objective factual data. Clear boundaries were set between what was perceived as intimate and personal interactions and what was seen as appropriate professional interactions and behavior. In the clinical environment the individual clinician's feelings were repressed or explained away in an objective manner. The research presented in the professional journals was primarily from the positivist or

scientific paradigm. Slowly over the years with the national association's thrust to a client-centered approach toward practice and the shift to more qualitative research in the professional texts there was a sense of trying to harmonize these differing and at times competing ways of knowing. For a few years there were articles written from each camp outlining the values and virtues of their specific bias. At present there is an acceptance that both qualitative and quantitative methods have much to offer the profession.

Nevertheless within the practice site the objective dominant health care discourse is given preference. Occupational therapy research and literature has shown that even years after the introduction of client-centredness, enablement and collaboration many clinicians have chosen to stay in the scientific objective paradigm because of their values, beliefs and assumptions or because it was easier and maybe even safer to remain in the objective dominant discourse. I would not anticipate those individuals making a move into a deeper mode of client-centredness because this would entail a major change in how they think about and carry out their daily practice. Also, the mode of participatory consciousness would be outside of their ken with respect to their value system and their ways of knowing and learning. As Poplin (1994) notes "the most difficult part of change is not learning new things, but shedding old ones" (p. 69). Other clinicians may be more comfortable, open and interested in shifting to this deeper and richer way of knowing because they have been educated in the newer curriculum of client-centredness and enablement and/or are familiar with the professional national practice guidelines. For a number of other individual clinicians, like me, this may mean moving into a way of being that they have been seeking, a way of practicing that just feels right and recognizes bodily and emotive ways of knowing.

This move into a participatory mode of consciousness and knowing would have potential theoretical and practice implications for the profession and the practice of occupational therapists. But how does one introduce and teach “knowing as nonegocentric responsiveness . . . (Heshusius & Ballard, 1994, p. 175)? Participatory consciousness cannot be taught by following a set of steps toward a predefined goal. The ability to enter a state of participatory consciousness comes only from experience. This move begins with an intention that emanates from values congruent with egalitarian collaborative relationship. Actions of daily practice come next. Then through reflection one realizes the possibility of temporarily setting aside judgments and need for control. It is only in retrospect through critical reflection that there is an awareness of having dwelt in a mode of participatory consciousness. The significance of this move into participatory consciousness is that the therapeutic relationship is more egalitarian. By moving into a different epistemology from that of which governs the scientific paradigm there is a freeing from the restrictions of the scientific paradigm. This move also signals that the vehicle of critical reflection is working effectively.

However, there are possibilities for developing the practice of participatory consciousness through multiple modes of learning. An example might be unearthing the deeper multiple layers of reflection that further meaning making, awareness, mindfulness and understanding about self, somatic reactions, emotions, other and the things that are taken for granted or dismissed as unimportant. Clinicians comfortable in using bodily ways of knowing could mentor students and colleagues less familiar with this process but open and responsive to developing this practice. For those clinicians who learn best through visual clues or bodily ways of knowing, the use of color, images and symbols,

for example through collage, could be a useful means of exploring practice. Critically reflecting and interpreting a collage can help clinicians clarify or identify differing aspects of practice or unveil aspects that previously were invisible at the practice site:

Living toward knowing as a nonegocentric responsiveness that takes as its starting point kinship and identification is at once a most hopeful and urgent development. For this to materialize, scholarship needs to develop a language that, as Patricia Williams (1991, p. 62) says, “encourages looking at others as part of ourselves”. It needs to attend, in Toni Morrison’s (1992, p. 4) words, to what makes possible “this process of entering what one is estranged from”. Given the intricate relatedness of intellectual, somatic, and emotive life, such development cannot but include all ways of knowing. (Heshusius & Ballard, 1994, p. 175-176).

As discussed earlier in this chapter it is necessary for the professional occupational therapy associations and regulatory colleges to support this move toward reflective practice without negative repercussions for practitioners.

The following account of my own experience of becoming a more reflective practitioner is intended to be informative for individual occupational therapists who wish to become more client-centred in a deep sense and for the profession, which might use this account as the basis for imagining creative ways to support such change throughout the profession. Over the years as the research has evolved and progressed I have found that, in practice, there has been a melding of my clinician self and my researcher self. In effect I have become a deeply reflective practitioner. This has led to my having a much

greater awareness and understanding of what is happening at any given time within my practice environment. I am now more aware of how I am positioned in and by discourse, and of how I am recruited or resist the discourse. In turn this has helped in developing strategies that reduce the tensions and struggles that occur when trying to live out client-centredness, enablement and collaboration in the deepest sense. I am now more in tune with the possible reasons for my somatic feelings, emotions and reactions and those of clients. In attending to these bodily reactions I am enabled to negotiate and maneuver in and between the various discourses in a way that supports and encourages enablement, collaboration and the building of a collaborative therapist client therapeutic relationship. Paying attention to somatic feelings and reflecting on these and my actions or lack of action led to the reflective turn that enabled me to move toward a mode of participatory consciousness every time I fell away from it. Having found a language from Heshusius to make this particular state explicit I can now talk and write about (as well as feel) what is being experienced. I am now aware of the importance of letting go of all egocentric concerns and judgments when accessing and moving into the non-intrusive and non-threatening space of participatory consciousness. The temporary suspension of egocentric responses also enables me to relinquish any professional or personal need I have for control, thus, equalizing the power relations between self and other. It is also important to note that in this place there is no loss of self. This dwelling place offers a unique opportunity for openness, listening, silence and collaboration that I have found moves the therapeutic relationship into a deeper and richer sense of client-centredness and enabling.

In addition to demonstrating the move to participatory consciousness, I have also developed a methodology for analyzing discourse that utilizes occupational therapy

clinical reasoning and discourse analysis as complementary analytical tools. The particular form of clinical reasoning being employed is the clue that there is a shift in discourse at the practice site, thus signaling the need for analysis of the various discourses at play and how they are influencing practice. This analytical tool could be used by other occupational therapists when looking at a professional setting to see how discourses are employed and how the clinician is struggling against or recruited by a particular discourse. This tool can also describe a non-dominant discourse that a clinician is resident in but cannot express because the discourse is over shadowed by the dominant health care discourse.

This research study has identified the various discourses at play at the clinical site and has shown how these discourses are employed to impede or enhance the collaborative therapist-client therapeutic relationship. The study also demonstrated how the clinician, by being mindful of and responding to somatic reactions of self and/or other, negotiated and maneuvered in and between the discourses. In this process, the research study has drawn attention to the fragile nature of the therapeutic relationship, particularly a collaborative one, and it has highlighted the challenges encountered at the practice site.

Reflecting upon this study I believe that I have unearthed a number of topics that would be useful to occupational therapy practitioners, educators and researchers in further enhancing daily practice. I hope that this study “will give heart to those who wish to consciously harmonize thought, reason, and intellect with tacit, somatic, and other nonrational ways of knowing” (Heshusius & Ballard, 1994, p. 172).

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Appendix A

Glossary of Occupational Therapy Client-Centred Terms

(Source: *Enabling Occupation 11: Advancing An Occupational Therapy Vision for Health, Well-Being, & Justice through Occupation*, Townsend & Polatajko, 2007)

Client-centred enablement is based on enablement foundations and employs enablement skills in a collaborative relationship with clients who may be individuals, families, groups, communities, organizations, and populations to advance a vision of health, well-being, and justice through occupation.

Collaborate is arguably *the* key enablement skill that involves power-sharing (Schaeffer, 2002) to work *with* clients, verses doing things to and for them in a joint intellectual effort or toward a common end (Answers.com) by sharing talents and abilities in mutual respect with genuine interest, acknowledgement of others, empathy, altruism, trust, and creative communication to achieve results that are greater than the sum of individual efforts (Linden, 2003), with awareness that professions, operate hierarchically in a top-down manner based on the priority given to the professional expertise over client experience (Freidson, 1970, 1986, 1994, 2001). In the *Profile of Occupational Therapy Practice in Canada* (CAOT, in press), collaborate is directly mirrored in the competency role of *collaborator*.

Empowerment refers to “personal and social processes that transform visible and invisible relationships so that power is shared more equally” (CAOT, 1997a, 2002, p. 180).

Enabling (verb) – Enablement (noun), focused on occupation, is the core competency of occupational therapy – what occupational therapists actually do – and draws on an interwoven spectrum of key and related enablement skills, which are value-based, collaborative, attentive to power inequities and diversity, and charged with visions of possibility for individual and/or social change.

Expert in enabling occupation. Occupational Therapy Practitioners use evidence-based processes that focus on occupation – including self care, productive pursuits, and leisure – as a medium for action. Practitioners take client perspectives and diversity into account. Expert in Enabling Occupation is the central role, expertise and competence of an occupational therapy practitioner.

Occupations are groups of activities and tasks of everyday life, named, organized and given value and meaning by individuals and a culture; occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity); the domain of concern and the therapeutic medium of occupational therapy (CAOT, 1997a, 2002); a set of activities that is performed with some consistency

and regularity; that brings structure and is given value and meaning by individuals and a culture (adapted from Polatajko et al., 2004, and Zimmerman et al., 2006)

Occupational performance is the “result of a dynamic, interwoven relationship between persons, environment, and occupation over a person’s lifespan; the ability to choose, organize, and satisfactorily perform meaningful occupations that are culturally defined and age appropriate for looking after oneself, enjoying life and contributing to the social and economic fabric of a community (CAOT, 1997a, 2002, p. 181).

Occupational therapy is the art and science of enabling engagement in everyday living through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate in their potential in the daily occupations of life.

Appendix B
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