A review of evidence on the conceptual elements informing client-centred practice

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Key words
- Client-centred practice - Power - Occupational therapy practice, evidence-based

Mots clés
- Pratique centrée sur le client - Pouvoir - Pratique de l’ergothérapie, fondée sur les faits scientifiques

Abstract
Background. Client-centred practice is a central concept in occupational therapy in Canada. Since 1980, Canadian occupational therapy publications have discussed the elements of a client-centred practice approach. Purpose. The purpose of this paper is to enhance the understanding of key elements of a client-centred approach and to highlight the implications for practice that arise from this discussion. Method. Literature about client-centred practice in health care from 1990 – 2005 was reviewed regarding thoughts and ideas about client-centred practice. The content was analyzed for thematic focus about client-centred practice conceptual ideas and their influence on practice. Results. Thematic conceptual elements emerging from the review include an overarching theme of power, with important underpinning themes of listening and communicating, partnership, choice, and hope. Selected definitions of client-centred practice and the link to best practice provide the context for the presentation of the concepts and recommendations for the implementation of client-centred practice. Practice Implications. The paper concludes with a discussion of practice implications through the presentation of questions for therapists to consider as a quick reference tool and suggestions for further research and dialogue concerning client-centred practice.

Résumé

A client-centred approach is now clearly recommended as the foundation for occupational therapy practice in Canada. Conceptual and practice models, as well as outcome measures have formed the basis of this approach or have arisen from client-centred practice. These models and outcome measures include the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists (CAOT), 2002), the Canadian Occupational Performance Measure (Law et al., 1990; Law et al., 2005), the Occupational Performance Process Model (Fearing & Clark, 2000) and the Framework of Strategies for Client-centred Practice (Restall, Ripat, & Stern, 2003).

However, concerns remain about the day-to-day challenges in the implementation of this approach (Sumsong & Smyth, 2000; Townsend, 2003; Wilkins, Pollock, Rochon, & Law, 2001). The authors of this paper are also aware of continuing research in this area – discussions with students and clinicians, attendance at an interdisciplinary conference on client-centred practice and ongoing reviews of multi-disciplinary literature – that misconceptions remain about the key

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elements underpinning this approach and the therapist's role regarding implementation.

The purpose of this paper is to enhance the general understanding of key elements of client-centred practice through a literature review and discussion of the implications for practice with reference to occupational therapy. The elements reviewed within the paper include power, listening and communicating, partnership, choice, and hope. Questions for an occupational therapist to consider regarding practice implications are included to provide a reference tool for therapists who strive to practice from a client-centred perspective within the realities of a fast-paced and resource-stretched system.

**Method**

The process of a critical review of literature for this paper began with a search of the occupational therapy and general health services literature using key occupational therapy texts and the Medline, CINAHL, Ageline and Psychlit bibliographic databases. The initial search centred on articles and texts with definitions of client-centred practice and research/literature reviews providing evidence of the effectiveness of client-centred practice. Further literature searches were conducted by the authors, both for the purposes of this article as well as their ongoing teaching and research activities. Key words used for the second phase of the literature search included choice, communication, listening, partnership, power, hope, and barriers to client-centred practice. All searches were limited to English and the years 1990–2005. Reference lists from articles were also examined for identification of additional papers.

Abstracts of the identified articles and chapters in texts were reviewed regarding their focus on concepts and ideas related to client-centred practice. Since the literature on client-centred practice is very broad, including both theoretical and practical applications, the authors did not conduct a formal systematic review of the papers found through the literature search. The identified literature, consisting of approximately 120 papers, was analyzed for thematic content centred on ideas central to client-centred practice. This analysis was guided and informed by the work of Schon (1983) and Fish and Coles (1998). Specifically, the authors were interested in how the literature reflected the exchange of information between conceptual ideas and practice and the influence of each of these areas on the other. Initial analyses indicated the following content groups: choice, communication, hope, partnership, power, time and respect. Upon further reflection and analysis, these content groupings were consolidated into the following ideas for focus in this paper: an overarching thematic focus on power, with linked thematic groupings of listening and communicating, partnership, choice, and hope. The literature related to each of these conceptual groupings will be explored further in this paper.

**Defining client-centred practice**


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

Subsequent definitions have appeared to enhance the understanding of client-centred practice. In 1997, the Canadian Association of Occupational Therapists offered the following explicit definition:

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

Sumion's (2000) definition is interesting to note given that she developed it based on interviews to determine how client-centred practice was defined by occupational therapists in Britain in the late 1990s. She concluded the following regarding the definition of client-centred practice:

Client-centred occupational therapy is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfill his or her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the clients' values, adapts the interventions to meet the client's needs and enables the client to make informed decisions. (p. 308)

These representative definitions share many similar components. There is a strong emphasis on a collaborative approach or partnership, respect for the client, facilitating choice and involving the client in determining the occupa-
tional goals that emerge from his or her choices. The subsequent sections of this paper will focus on several of these elements as well as contextual issues that enable these concepts to be realized.

**Link to evidence-based practice**

The development of literature regarding client-centred practice has paralleled the development of concepts related to evidence-based practice. There is now growing interest in including client values and experience as important aspects of evidence. Sackett, Strauss, Richardson, Rosenberg and Haynes (2000, p. 1) define evidence-based medicine as “the integration of best research evidence with clinical expertise and patient values.” Client values include “the unique preferences, concerns and expectations each patient brings to a clinical encounter” (p. 1). This definition provides a vehicle for clinicians, who are being urged to ensure their practice is evidence based, to link that approach to practice with the preferences and choices of the consumer. The link between client-centred and evidence-based practice is further supported by the 1999 Joint Position Statement on Evidence-based Occupational Therapy released by CAOT, the Association of Canadian Occupational Therapy University Programs, the Association of Canadian Occupational Therapy Regulatory Organizations and the President’s Advisory Group. These groups reiterated the role of the client as the provider of expert knowledge and the therapist’s role in providing current knowledge.

From a research evidence perspective, there is considerable evidence in the literature to support the use of client-centred practice as one of the fundamental underpinnings of occupational therapy practice (Law, 1998). Client-centred practice and family-centred service have been shown to improve satisfaction with services, increase adherence to therapy recommendations, and improve functional outcomes (Calnan et al., 1994; Greenfield, Kaplan, Ware, Yano, & Frank, 1998; Hasnatt & Graves, 2000; King, King, & Rosenbaum, 1996; Law et al., 2003; Sloper & Turner, 1993). Evidence-based practice supports the use of a client-centred approach. Therefore, it is important for practitioners, educators, researchers and students to continually update their knowledge about the conceptual development of client-centred practice.

**Literature review findings**

**Power**

Since 1990, power has emerged from the client-centred literature as a powerful organizing framework under which to think about all other key client-centred elements. Understanding the influence of power is fundamental to implementing authentic client-centred practice. Within the idea of power, the emphasis is often placed on strength, control and competitiveness, which supports the idea that health professionals do have power over clients, that power influences goal attainment and that clients are disempowered by the health system (Corring, 1996; Hugman, 1991). Avis (as cited in Law, 1998) found that this power differential was an important factor in lessening people’s ability to participate in their health care and hence to make choices.

To facilitate genuine client-centred practice, therapists need to address the balance of power between client and therapist, with a shift in that balance toward the client (Corring, 1996; Epstein, Campbell, Cohen-Cole, McWhinney & Smilkstein, 1993; Honey, 1999). Townsend (1998, p.48) stresses that “client-centred practice shifts the power in a client-therapist relationship from one of dependence to one of mutual interdependence and partnership.” Enhancing power for clients relates to their ability to set goals, achieve objectives and effect outcomes, which gives control to individuals (Raatikainen, 1994; Swaffield, 1990).

Townsend’s (2003) recent work also emphasizes the importance of understanding power and how policies readily disempower those they are designed to help. The clients and therapists in this study also spoke about the lack of power held by persons with disabilities. She discusses some of the developing views of a power relationship between clients and therapists and the factors involved in this process. The factors include the perspectives of the client and therapist as well as the impact on the client’s ability to engage in the client-centred process and the therapist’s ability to work in this way.

It has been argued that the client-centred process is no longer therapist led and therefore the power is no longer assigned to the therapist (Crepeau, 1991). Once this power is understood and accepted by the therapist and the client, clients become equal partners in health care and can foster their own health rather than always seeking professional help (Sumison, 1999).

While the concept of power is vital to the understanding and implementation of client-centred practice, the consideration of other key thematic groupings in the literature will enhance our application of this approach. Important thematic groupings identified in our literature review include listening and communicating, partnership, choice, and hope.

**Listening and communicating**

Issues related to power can be addressed through effective listening and communicating. Law and Mills (1998), following a review of six client-centred frameworks, concluded that the provision of information and an emphasis on client-centred communication were common to all models. Effective communication, through the use of appropriate language, is an important element in ensuring the success of the therapist-client partnership or collaboration (Boumbulian, et al., 1991; Corring, 1996; Delbanco, 1992; Edgman-Levitan, 1997; Ellis, 1997; Townsend, 1998). Communication should occur between all members of the treatment team, the client and
his/her family (Matheis-Kraft, George, Olinger, & York, 1990). Communication skills are essential to enable all those involved to discuss issues openly in an atmosphere of mutual decision-making (Logan, 1997; Pesznecker, Zerwekh, & Horn, 1989). However, professionals need to be trained how to use information with clients to promote informed decision-making (College of Health, 1999).

Listening is an important aspect of communication and hence of effective client-centred practice (Webster, 2001). Sometimes, this listening means simply being silent and allowing the clients to explore the issues they are facing (Harrison, 2001). At other times, it means listening to fears, worries and concerns so appropriate actions can be taken (Maxmin, 2002). Therapists must take the time to listen even if they have trouble dealing with what is expressed. Otherwise, clients will feel that their opinions are not respected or valued and that their expert self-knowledge is not recognized (Corring & Cook, 1999; Darragh, Sample, & Krieger, 2000; Hanman, 2001; Stewart, Brown, Levenstein, McCracken, & McWhinney, 1986). There are times when clinical teams do not listen as it may be easier for them to do what they feel is best for the client (Harrison, 2001). Barry, Stevenson, Britten, Barber and Bradley (2001) investigated the importance of listening to the life world of the client. They found that this life world is often ignored as clients try very hard to get someone to listen but ultimately retreat to following what the medical voice is saying. They also found that medical consultations were more effective when the client's voice was heard.

If clients are to be recognized as consumers of and active participants in health care, it is essential that they receive the information that is appropriate to their needs (Coulter cited in Kennedy & Rogers, 2001; Rycroft-Malone, Latter, Yerrill, & Shaw, 2001). In fact, the communication of information is the central focus of a client-centred approach (Coulter & Dunn, 2002). Communication is often completed less satisfactorily than other aspects of client-centred practice (King et al., 1996). For example, early information related to medication or its side effects and to mental illness has been found to facilitate understanding and symptom management (Crowe, O'Malley & Gordon, 2001; Rycroft-Malone et al., 2001).

Information is also required about clinical status, progress, prognosis and processes of care (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993a). Such information will enable clients to make decisions about and take responsibility for their own health (Baum & Law, 1997; CAOT, 1997; Grol, DeMaeseneer, Whitfield, & Mokkink, 1990; Laine & Davidoff, 1996) and also facilitates autonomy and self-care (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993b). Information is also needed to understand how people felt about the intervention and whether or not the outcome was good from their perspective (College of Health, 1999). Informed individuals can determine whether or not the ben-

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efits outweigh the risks (Thomas & Lindow, 1993). Coyle and Williams (2001) found that receiving information from doctors in a range of areas of care was important and that more women than men were concerned that they did not receive sufficient information. This sharing of information has also been found to be a predictor of satisfaction with medical consultations (Little et al., 2001).

Technology can be used to access information for both professionals and clients and therefore enhance the discussions that are central to a client-centred approach. Ready access to information can be a significant time factor as easier and more efficient access saves time (Glick & Moore, 2001). Consumers want to be more informed and to discuss the options for care and to be more involved in decision-making (College of Health, 1999; Law & Mills, 1998; Matheis-Kraft et al., 1990; Phillips, 1999). Increased awareness has resulted in consumers who are more sophisticated and who are demanding more influence over the future of health care (Robinson, 1991). Information is also more readily available through the popular press where treatment procedures and options are discussed (Logan, 1997). CD ROMs, interactive videos, touch screen kiosks and the internet provide access to a wide range of information (Fivesh, 1998; Richards, 1998; Shepperd, Charnock, & Gann, 1999).

However, there is concern about the quality of the information that is available (Jadad, 1999; Richards, 1998). Jadad (1999) further states that there is no evidence that consumers and health care providers are working together to put information on the internet. He cautions that the “clinician patient relationship can be undermined if clinicians are not prepared to deal with patients who come armed with information from the internet” (p. 762). Health professionals must work with clients to put this information to the best possible use (Richards, 1998) and recognize that informed consumers have a better chance of getting their needs met but are also more likely to refuse treatment (Fivesh, 1998).

In summary, Hall, Roter and Katz (1988, p. 665) found that client satisfaction was “most dramatically predicted by the amount of information imparted by providers.” This view is further supported by a survey of clients in four countries regarding their satisfaction with primary care, which reported that clients received insufficient information (Calnan et al., 1994).

**Partnership**

Listening and communicating are important elements within an effective partnership. Therefore, health professionals are being challenged to change the way they traditionally relate to clients and to make the shift from “authoritarianism to partnership” (Rosenbaum, King, Law, King, & Evans, 1998, p. 3). An effective professional client partnership is required to ensure that the best care is provided as it adds to the strength and effectiveness of that care (Edgman-Levitan, 1997; Ellers,
enhancing the relationship with the client will have
term benefits and potentially save time (Brown, McWilliam,
& Weston, 1995; Delbanco, 1992; Jones et al., 2004). In fact,
therapists may spend too little time gaining accurate data and
learning about the clients and their lifestyle and what is
important to them prior to setting goals (Elwyn, Edwards,
Gwyn, & Grol, 1999; Kramer, 1997). A more positive perspec-
tive on this barrier is presented by Brown et al. (1995)
who found that the time spent understanding the whole
person and forming the client/doctor relationship did not have
to be lengthy and was the best use of resources in the long
term. Time spent on these issues saved the client from having
to return for a more accurate response to his/her concerns.
Nurses have also found that when time is spent reviewing
plans with clients then less time has to be spent in explaining
basic tasks such as the importance of walking (Powers,
Goldstein, Plank, Thomas, & Conkright, 2000).

Choice

Choice is an important ingredient in an effective part-
nership and has been identified as a key element of client-
centred practice since the inception of this concept within
Canadian occupational therapy (CAOT, 1983, 1991). This
element is also closely tied to the provision of relevant infor-
mation and is central to the client-centred process. As iden-
tified in the Canadian Model of Occupational Performance
(CAOT, 2002) and the Occupational Performance Process
Model (Fearing & Clark, 2000), the values and preferences of
clients and their families fundamentally inform the identifi-
cation of occupational performance issues for intervention.
Thus, choice begins the occupational therapy encounter, and
is continued throughout assessment and intervention.

Choice is influenced by the stage of an illness/disability
and the capabilities of the client. Fallowfield (2001, p. 1144)
cautions that “a clear distinction needs to be made between
a desire for information and a wish to assume responsibility
for decision-making.” This issue is discussed in relation to med-
ication management where interactions related to simple
information about medications enabled clients to make
informed decisions, although the agendas determining the
time of these interactions were often set by the nursing staff
(Rycroft-Malone et al., 2001). Patients receiving palliative
care and treatment for cancer have also stressed the impor-
tance of staff respecting their ability to make decisions
(Harrison, 2001; McKinlay, 2001). If therapists fail to respect
these abilities then they are demonstrating the concept of
power over another person which influences behavior and
decisions of others to obey or conform and “encompasses
control, competitiveness, authority and leadership”
(Raatikainen, 1994, p. 424).

Overall, occupational therapists can ensure a range of
choices for clients at each stage of the occupational therapy
intervention process. Examples of choices might include
number of treatment sessions to attend, type of wheelchair to purchase, amount of support needed to assist with independent living and what the ultimate goal of the client/therapist partnership will be.

Hope

It is important for the client to maintain hope throughout any client-centred interaction. The literature search completed for this paper identified a plethora of references about hope that address a broad spectrum of client groups. An even larger number of articles emerged from the reference lists of the resources included in this section. No attempt has been made to incorporate all of this literature but the abundance of this information reinforces the importance of hope in the health care process and client-centred practice. Readers are referred to the work of Bays (2001) and Lohne (2001) for a comprehensive overview of the current literature on hope.

Hope for clients can be either global or focused on a specific goal. For example, there are six major themes which clients undergoing bone marrow transplants identified to foster hope. These include feeling connected to God, affirming relationships, staying positive, anticipating survival, living in the present and fostering ongoing accomplishments (Saleh & Brockopp, 2001). This view is supported by Bays (2001) who also sees spiritual inner strength as a central concept of hope as well as an orientation toward the future and positive views of outcomes. These concepts speak to occupational therapists who work in a client-centred way. Occupational therapy acknowledges the importance of spirituality in each person’s journey towards wellness and in the determination of the occupations they choose to perform on a day-to-day basis (McCull, 2003).

Further support for the importance of this concept came from a young man who had sustained a spinal cord injury and was on a panel at a conference addressing client-centred practice. He was asked to convey the one important message that an educator should take back to her students. His answer was simply “don’t ever take my hope away” (P. Athanasopoulos, personal communication, November, 2002). Indeed, that is exactly what client-centred practice represents. An article by Greek (2000) reinforces this view. She published her story, which related to her diagnosis of stage IV cancer, to emphasize the importance of hope, encouragement and optimistic words from staff. The first person she saw was the oncologist who left her with no hope. She had difficulty getting over this first message in spite of subsequent attempts by other team members to alter this view. Overall, her message was that health professionals should be optimistic and sell life and hope so their clients can learn to hope. Kubler Ross (2000) also emphasizes that staff can help the most by eliciting and supporting hope. “Hope is the expectation that something good will happen in the future” and that a client cannot live without it (von Gunten, 2002, p. 1421).

It is important to recognize that hope is not directly connected to a person’s illness or the severity of his/her symptoms and will be impacted by other changes such as plans for discharge (Landeen, Pawlack, Woodside, Kirkpatrick, & Byrne, 2000). These authors also found that there was no connection between the length of the person’s illness and the level of hope the clients experienced. Elliott and Olver (2002) found that there were many different definitions of hope. Therefore, health professionals cannot assume that clients are using the term consistently and must also be aware that any information given can be interpreted as hope. Hope is a very important issue for clients and in the words of one of the clients in a study by Bays (2001, p.26) “If you didn’t have the hope then you would be totally lost.”

Implications for practice

Over the past two decades, knowledge about the concepts and implementation of client-centred practice has grown considerably. However, development of knowledge does not guarantee that this information will move into practice. For client-centred practice, this is particularly relevant since barriers within organizations and lack of clear strategies for use by therapists and clients create challenges for implementation. In his theory of diffusion of innovations, Rogers described different types of individuals and how quickly they embrace and use new knowledge (Rogers, 1995). He particularly focuses on one user group, the early adopters, as the key to initially moving knowledge and information to practice. According to Rogers, early adopters are well-connected individuals who are regarded with respect by their colleagues. They actively search for new knowledge and are eager to implement ideas perceived by them to be beneficial. While not as quick to adopt changes, another group described by Rogers (1995), the early majority, learn about changes locally but also display a readiness to implement new information. In the area of client-centred practice over the past 20 years, client-centred concepts have likely been implemented by those occupational therapists that were early adopters or part of the early majority. For other therapists, the systemic challenges to implementation may appear greater with fewer perceived benefits.

Berwick (2003), in analyzing Roger’s work, discusses knowledge transfer as the social process taking place within a specific context. He provides the following recommendations and guidelines to improve knowledge transfer within health care:

1. Identify changes that are supported by evidence and by the values of the therapist and consumers.
2. Provide support to innovators to develop new changes.
3. Provide support to enable early adopters to test out solutions to current issues.
4. Disseminate information about early changes so all practitioners are aware of these developments.
**TABLE 1**
Practice questions.

<table>
<thead>
<tr>
<th>Component</th>
<th>Practice Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power</td>
<td>Do I use language that is easy for clients to understand? Do I use language that conveys my goal to work in partnership with the client? Do I advocate for systems and policies to be changed so clients can assume power for their program?</td>
</tr>
<tr>
<td>Listening and Communicating</td>
<td>Do I provide quality information at a level my clients can truly understand? What are the most important pieces of information my clients need? What is the best format in which to provide this information? Do I check that they have understood the information I provided? Do I tailor information to the specific needs of the clients and their family? Are my clients able to apply the information I have provided? Do I leave enough time so that clients are able to tell me about their occupational performance issues? Do I develop an understanding of a person’s values after talking to them? Do I let an interview unfold naturally, rather than structuring each question that I ask of the client? Do I share my perceptions of what the client said with them to confirm if I am interpreting their information correctly? Do I take the time to listen and truly hear their stories? Do I facilitate a process of ensuring my client’s voice is heard?</td>
</tr>
<tr>
<td>Partnership</td>
<td>Do I work in partnership with my clients to obtain the required information? What does the concept of partnership mean to me? Do I truly work in partnership with my clients? What contribution do we both bring to this partnership? What is the connection between a partnership and power?</td>
</tr>
<tr>
<td>Choice</td>
<td>Do I enable choice through the occupational therapy process? Am I able to facilitate small choices if larger ones are not possible for the client to make? Do I apply my occupational analysis skills to create opportunities for choice? Am I prepared to facilitate the process by empowering the client?</td>
</tr>
<tr>
<td>Hope</td>
<td>Do I understand and accept the importance of hope for my clients? Do I provide opportunities for clients to express their hope to me? Do differences in opinion between myself and the client represent different values rather than different goals? How can I incorporate their hope into the intervention plans?</td>
</tr>
</tbody>
</table>

5. When implementing changes, adapt processes to fit the local context.

6. Knowledge transfer requires time and investment on the part of therapists and leadership.

While general knowledge and awareness can be increased through mass media dissemination such as web sites, articles and practice magazines, decisions to use and implement new practices require a local commitment (Rogers, 1995).

These recommendations, along with available resources, can guide occupational therapy practice in Canada as we seek to implement this concept of client-centred practice on a day-to-day basis. For example, Restall et al. (2003) have developed the Client-centred Strategies Framework with specific implementation ideas and actions to facilitate client-centred practice. Therapists can design such actions to fit within their geographical and practice context, thus improving the knowledge transfer about client-centred practice.

This paper has highlighted key elements of client-centred practice that arose from a detailed literature review. Within the overarching ideas regarding power, the thematic elements of listening and communicating, partnership, choice, and hope are fundamental. To assist in information about each of these elements being applied in clinical environments, we pose the questions outlined in Table 1 for occupational therapists to consider when implementing a client-centred approach. These questions encourage reflection about both the art and science of practice as their application facilitates a review of personal and technical approaches. As well, the questions can be used to facilitate discussion in educational and practice environments to enhance the application of evidence-based practice.
Summary

This literature review has highlighted both key elements of client-centred practice and questions for therapists to consider as they enhance their application of this concept. The definitions that were presented indicate there is considerable agreement as to the components of this approach. The subsequent sections provided further evidence of the complexity of these issues and offered some probing questions to assist both the application of the components as well as a personal reality check to ensure the approach being used is truly client-centred.

The complexity of a client-centred approach necessitates ongoing investigation of the elements and the barriers to implementation. Research is needed in all areas of occupational therapy practice to provide therapists with an in-depth opportunity to evaluate whether or not they are being truly client-centred. Over the past 20 years, Canadian occupational therapists have consistently stated that client-centred practice forms the basis of their interventions. Therefore, research must continue to ensure these claims are grounded in a very strong foundation.

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