

**WEAVING PHENOMENOLOGY:
THE LIVED EXPERIENCE OF HOME-BASED CLIENT-CENTRED
OCCUPATIONAL THERAPY**

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Dedication

My work is dedicated to Rita Revenko
with her 95 years of living experience in her 100-year-old house.

Abstract

The metaphor of weaving and the methodology of phenomenology are used to expose eight ordinary people's lived experience of receiving client-centred occupational therapy at home. This qualitative study reveals the themes of Thread, Weave and Texture interlocking to create the phenomenological structure of the lived experience. The two threads of being acknowledged and being respected are used with the five weaves of listening, taking time, demonstrating, having knowledge, and projecting a positive attitude, building four simple textures. The four textures -- having opportunity for choice, receiving support, getting information, and being cared about -- blended to form the participants' lived experience. Their stories have inspired me to weave a tapestry of words, something that in its beauty celebrates the delivery of client-centred occupational therapy but also teaches these principles.

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Table of Contents

Dedication.....	iii
Abstract.....	iv
Acknowledgements.....	v
Table of Contents.....	vi
Chapter 1. Introduction.....	1
Basics of Weaving.....	2
The Evolution of my Occupational Therapy Practice.....	3
Definition of Client-Centred Practice.....	5
Importance of Client-Centred Practice to Occupational Therapy.....	6
Purpose of the Study.....	8
Musings on “Mastering”.....	9
Chapter 2: Building Client-Centred Practice.....	11
The Warp of Client-Centred Practice.....	11
The Founder: Carl Rogers.....	11
Occupational Therapy in Canada.....	14
The Weft: Health Professionals’ Perspectives on Client-Centred Practice.....	16
Family Therapy.....	16
Physiotherapy.....	18
Occupational Therapy in Canada.....	19
Occupational Therapy Outside Canada.....	21
The Weft: Clients’ Perspectives on Client-Centred Practice.....	25
Clients in Canada.....	25

Clients Outside Canada.....	30
Conclusion	32
Chapter 3: Building Phenomenology.....	36
The Warp: Phenomenology	36
The Founder: Edmund Husserl	37
Essential Threads of Descriptive Phenomenology	38
Summary	44
The Weft: My Research Process.....	44
Selection of Participants	44
Ethical Considerations	45
Interview Format.....	46
Data Analysis	48
Writing	51
Conclusion	52
Chapter 4: Building the Tapestry.....	53
The Warp: Meet the Participants	54
John.....	54
Sherry	57
Joan	60
Brenda.....	63
Martha.....	64
Jean	65
Brian.....	66

Sheila.....	67
The Weft: Meaning Units	68
The Thread.....	68
The Weave	69
The Texture.....	70
A Final Touch.....	73
Musings on Phenomenology.....	73
Musings on the Tapestry.....	74
Chapter 5: Displaying the Tapestry	75
Revisiting the Tapestry	75
The Thread.....	76
The Weave	78
The Texture.....	80
The Tapestry as a Whole.....	84
Limitations of the Study.....	85
Strengths of the Study.....	86
Implications of the Study	87
Directions for Future Research.....	89
Revisiting the Implicated Researcher	89
Conclusion	90
References.....	91
Appendix A. Screen for Client-Centred Principles of Practice	100
Appendix B. Guiding Principles for Enabling Occupation in Client-Centred Practice..	102

Appendix C. Consent to Participate for Occupational Therapists	103
Appendix D. Participant Selection Criteria	105
Appendix E. Ethical Considerations	106
Appendix F. Consent to Participate for Clients	107
Appendix G. Interview Format	109
Appendix H. Occupational Therapy Values and Beliefs	110

Chapter 1. Introduction

“One of the most important steps in approaching any craft is mastering the required skills” (Gonsalves, 1974, p. 6). Weaving, client-centred occupational therapy and phenomenology are ‘crafts’ that I have built skills in and continue to work on mastering. I am an occupational therapist trained in the late 1960s, a time when the biomedical approach to health was strong. My desire to help people led me into the Faculty of Rehabilitation Medicine at the University of British Columbia. My combined physiotherapy/ occupational therapy degree included a learning foundation of techniques for both practices. The focus in occupational therapy on activity analysis exposed me to the world of handicrafts and their application to disability. The art of weaving was my favorite handicraft; it required time and patience. The notion of client-centred practice emerged in the 1980’s and I have worked on weaving its principles into my daily practice. The opportunity to expand my formal learning in the Masters of Science program at the University of Lethbridge directed me to the life world of phenomenology. Weaving, client-centred occupational therapy and phenomenology have taken on new meaning for me in my “mastering.”

As I looked at the relationship between weaving, client-centred practice and phenomenology I was surprised. All three were about people; each had its own history and language; and to be successful, all three relied on the individual performing the task. Weaving connected to my research with its simplicity and its complexity. Being knowledgeable about the process and tools, being committed and patient to complete the task, and being creative and thoughtful during the work were all familiar to me as an

occupational therapist, a weaver, and now as a phenomenologist. Weaving would and could enlighten my study.

Basics of Weaving

Weaving has been performed for thousands of years by cultures all over the world. Woven cloth was made on basic looms using a wide variety of threads, and each country had its unique fabric. Understanding the fundamentals of weaving requires knowing the language. Basic weaving terms such as *warp*, *weft*, *loom*, and *tapestry* are important. *Warp* describes the lengthwise or vertical yarn that is wound onto the loom. The warp threads provide the working foundation for the weaving project. A *loom* can be a simple or complex structure. A simple loom created from a wooden picture frame is called a stretcher bar frame loom. Nails are placed along the top and bottom edges of the frame.

To begin a weaving project the weaver first chooses threads, deciding on weight and color, as well as the size of the finished project. Using the stretcher bar frame loom, the warp threads are wound back and forth on the nails. The *weft* threads are woven horizontally across the warp using a tapestry bobbin or needle. Different weaves are formed by the placement of the weft threads. Plain or tabby weave is created by moving the weft thread over one warp thread and then under the next thread, with the pattern being repeated across the full width of the warp. The weaver chooses the weave pattern to create a desired look in the completed project. A *tapestry* is a pictorial weaving technique using special methods for joining areas of color or texture to produce an overall surface design. “The beauties of design, color, and texture in weaving depend not on the loom itself but on the individual whose tool it is” (Gonsalves, 1974, p. 5).

The metaphor of weaving is a personal image and action for me. I see a connection to client-centred practice and phenomenology. All three concepts have their own unique vocabulary, history, and development. To understand each concept a review of terminology and definitions is useful. Examining client-centred practice and phenomenology from their history to today is like weaving the weft threads on the warp. The different weaves are created by the choices I make in whose perspective of client-centred practice and phenomenology to expose. Tapestry, “the art of joining together rows or sections of woven color to create a design” (Gonsalves, 1974, p. 42), is illustrated by the personal stories of my participants. Descriptive phenomenology will be used to expose the threads or the individuals, reveal the weave or actions of the occupational therapist, and build the texture or structure of their lived experience of receiving client-centred occupational therapy in their home. Finally, the tapestry will be displayed or positioned in the discourse.

The Evolution of my Occupational Therapy Practice

Learning is a journey. Learning is about mastering skills, it is about not knowing and then knowing, it is about building a foundation, and it is about living. I have followed a lifelong learning path with occupational therapy. My initial training with two service perspectives, physiotherapy and occupational therapy, helped me define how I wanted to work with people. I began as a physiotherapist in an acute hospital setting and found the focus of therapy too narrow. I found no challenge, for example, in strengthening the quadriceps muscles of the left knee. I enjoyed interacting with clients and discovering who they were outside their patient roles. Physiotherapy did not meet my expectations. I began to realize that I preferred an approach that looked at the client as a whole person

and that I needed to play a meaningful part of my client's rehabilitation. In my second position as an occupational therapist in a rehabilitation facility I saw the human side of the client: practice became "real."

Over the past thirty years I have worked in community care, mental health, long-term care, non-profit sector, administration and a First Nations community. These experiences have guided me to become a generalist specializing in the whole. Each role has further built my vision of work. The home/community environment enabled me to come close to clients and their needs. I strive to have a client focus in the present biomedical model of health. Marie Gage (1995) spoke about how the delivery of health care was based on the professional being the expert. The bureaucracy in the medical model is a daily challenge to addressing the needs of the client. The biomedical model is quick to suppress the human aspect of delivering health services. This suppression catalyzes me to work harder with and for my client. Whether it is a directive in policy or a prescriptive comment made by a colleague, I want to hear the voice of the client in the medical system.

Recently a client of mine within the palliative care service struggled not with his dying but with the medical system. How could this be? Is dying not an important step in one's life? People responsible for allocating medical equipment were unwilling to bend the rules for his personal situation. He was frustrated, the family felt helpless and so I encouraged them to voice their concerns in writing to the decision makers. The letter frustrated the people in the medical bureaucracy as they had no vehicle to deal with unique cases. The family felt they were not being valued nor heard. In my role as another voice for the client, I encouraged the decision makers to look for a place to review this

concern. Following my conversation, the person receiving the client's letter wrote a personal response to the client recognizing and acknowledging the client's position and need. The letter outlined that future decisions would be reviewed based on this new information. The initial resistance, the human side of the discussion, the value of dialogue, and the opportunity to have a voice were energizing for me. I see my work in health is just beginning. As the future of health care evolves I believe the change will have a human face.

Reflecting on the paths that I have followed in my career I became aware that my preferred manner of practice was client-centred. I was attracted to articles and studies that had some aspect of client-centred occupational therapy. I was most intrigued by the words of the clients and their perceptions of this form of practice. In my world of client-centred occupational therapy the client is the most important player. I believe the skilled therapist demonstrates qualities of respect and empathy. As an active listener, the therapist provides choices when possible and advocates for the client. In sharing my personal view of client-centred practice I have exposed a thread of my being. I want to be a better client-centred occupational therapist.

Definition of Client-Centred Practice

The foundation of occupational therapy practice in Canada is client-centred (Canadian Association of Occupational Therapists, 1991, 2002). Client-centred practice bases its principles on the clients having experience and knowledge that relates to them. The client and the occupational therapist participate together in identifying activities that will meet the client's needs. In 1995 Mary Law, Susan Baptiste and Jennifer Mills defined client-centred practice:

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

In 2002, the Canadian Association of Occupational Therapists (CAOT) further clarified the definition of client-centred practice: “Client-centred occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients’ needs, and otherwise recognize clients’ experience and knowledge” (p. 180).

These definitions emphasize the key characteristics of the therapist’s behaviors that create a dynamic relationship with the client. The framework of client-centred practice portrays the client as a valued person and the therapist enables the process.

Importance of Client-Centred Practice to Occupational Therapy

Occupational therapy has been shaped through therapists listening to the clients they have served. The profession aims to respect and seek client input to enlighten its philosophy of practice (Law, 1991). Occupational therapy services continue to evolve to best meet the needs of their clients. Upon entering the millennium, health care generally and occupational therapy specifically moved to building the “best practice” for their service delivery. Alison Kitson (2002) highlighted that the sources of finding proof of good medical care needs to be bigger and could include but not be limited to “expert knowledge, clinical experience, patient perspective” (p. 180). Valuing the perspective of

the patient enriches the knowledge of the clinician and in turn the clinician's contribution to effective practice. Occupational therapy has had a holistic perspective from its inception, and with the present willingness to listen to clients' wishes within health care, occupational therapists are strongly positioned to contribute to the overall mission of health care organizations.

Client-centred practice is an emerging force within health care. Consumers are asking to be involved in their health plans, people want a say in how the health system is delivered, the patient and family want to be heard (Gage, 1995; Gerteis, Edgman-Levitan, Daley, & Dellbanco, 1993). Today's challenge is that the present traditional medical model is objective, quantitative and technical. The client-centred model is subjective, qualitative and human. Client-centred practice looks at the human side of health, looking at the person and his or her issues. The focus to determine the needs of the person and enable a "non-directive" (Rogers, 1951) strategy of solutions for those needs is central to the model. The professional in partnership with the client enables the process to occur. "Knowledge of enabling is a contextual feature that supports giving, empowerment over dependence" (Townsend & Brintnell, 2002, p. 15). To enable the client to be the person he or she wants to be is a powerful and meaningful process.

Alison Kitson (2002) suggests that the strain between client-centred practice and evidence-based practice could be erased if the definition of what constitutes proof in research was broadened. The present narrow focus of logical positivism stops forward movement. The information gathered is useful but it does not tell the whole picture and restricts true best practice for the health system. "The almost complete neglect of qualitative methods" (p. 179) in the search of proof of worthiness in practice misses a

major perspective in the health care puzzle. How practice is reframed and how it continues to survive is seen as the responsibility of many. Research involving clients and their perspective is lacking. Two Canadian occupational therapy studies in the field of mental health asked clients to express their opinions on the meaning of client-centred care (Corring & Cook, 1999; Rebeiro, 2000). The results from these two studies were not flattering to what therapists were actually doing. Some of the negative comments included feelings of indifference from the providers, no confidence in the provider and hopelessness. The information helped inform the practice of occupational therapy (Corring & Cook, 1999; Rebeiro, 2000). Using such “mechanisms as talking to former clients to learn from their experiences with occupational therapy” (Law, 1991, p. 176) is expected to build capacity within the profession to continue to move towards the vision of excellence in occupational therapy.

Purpose of the Study

What is the lived experience of receiving client-centred occupational therapy in the home? Kevin Wood (2006) stated, “We seek to study that which is familiar in some sense, something we have ‘lived’ through, but the reason we inquire is we crave more understanding, more awareness and more meaning” (p. 12). I wanted to know more about what the client had to say about receiving client-centred occupational therapy. As a health profession, occupational therapy is quite young in its development. Even so, the profession is a leader in client-centred practice in Canada. I am proud to be a part of this focus on delivering services in a compassionate manner. This study explored the lived experience of receiving client-centred occupational therapy in the home. As phenomenology is the study of lived experience, I used descriptive phenomenology to

examine client stories about their time spent with a client-centred occupational therapist. This discovery occurred while I was with the client and as I reviewed my findings. During my conversations with my participants, I listened, watched and got a feeling for their lived experience. Through my findings, I discovered their lived experience and brought these findings into the whole of the structure of receiving client-centred occupational therapy in the home.

Expressing the results so that the reader can resonate with the findings is not done objectively. A sense of living needs to be created. Using metaphors brings the reader closer to the lived experience (Murray, 1975). I wove the testimonies of the participants with the structural warp of phenomenology to engage the reader in this human experience. Understanding weaving, client-centred practice and phenomenology assists the reader to see the ‘being’ of my participants’ lived experience. My exploration, discovery and building attempted to add another weave to the knowledge base of my profession (Creswell, 2003).

Musings on “Mastering”

To muse on something “means to gaze thoughtfully” at it (Jewell & Abate, 2001, p. 1125). Nancy Drew (2004) stated that a “researcher’s self-awareness is crucial to the validity of phenomenological research” (p. 215). My writings have provided a brief look at weaving, an exposed thread of me and client-centred practice, an overview of my profession’s involvement with client-centred practice and a beginning for the role of phenomenology. It is my writing that will bring you closer to how I see things, what I see and where I feel the “new look to me” should be. I want you to discover how my preparations for this tapestry, the building of client-centred practice and the methodology

of phenomenology have guided me. At purposeful places throughout this document I will share my musing to bring you closer to my personal weave.

Chapter 2: Building Client-Centred Practice

In this chapter I will examine the threads of information linked to client-centred practice. The theoretical root of client-centred practice begins with Carl Rogers. After considering his approach I will focus on the thread of how, as practitioners, occupational therapists became interested in embracing a client-centred approach. On my simple loom of discovery it is these threads, stretched lengthwise, that form the warp threads. The crosswise or weft threads, which are woven into the warp to create my tapestry, are two dye lots. The first, represent the health profession's experience of client-centred practice, and the second, the client's. Although used sparingly, the threads representing the client studies shine.

The Warp of Client-Centred Practice

The Founder: Carl Rogers

In *Client-Centred Therapy*, Carl Rogers (1951) describes the client's role in the therapeutic relationship, the characteristics that client-centred therapists need to possess, and the types of environments most conducive to this type of therapy. As a psychotherapist, Rogers continuously contemplated what worked and what did not work in therapy. His clinical work and personal reflection guided him to refine the philosophy of client-centred practice. His commitment to the "effective and consistent psychotherapy" (p. 482) has had a tremendous impact on the delivery of health services.

In this respect, Carl Rogers was a visionary (Anderson, 2001). His gift was his philosophy of living, his belief that in all aspects of life, we need to be human. According to Rogerian therapy, "philosophy is not about finding scientific truths but [rather]

involves ongoing analysis, inquiry and reflection” (Anderson, 2001, p. 347). The client-centred philosophy is alive when

The therapist invites, respects and acknowledges the client’s expertise; the therapist trusts and believes the client; the therapist is a learner; the therapist is always on the way to understanding; and the therapist is fully present as another human being. Emphasis is placed on the client’s expertise regarding his or her life, and the therapist’s expertise on how a client should live his or her life is de-emphasized. (Anderson, 2001 p. 348)

In working with clients, Rogers (1951) primarily focused on personality development and personality change. He responded cautiously to the client’s medical diagnosis feeling that this label drew more attention to the problems rather than the individual. He believed that the key to working with people was relationship building, not in being limited to the exploration of a specific diagnosis. His caution about diagnosis also reflected his position of avoiding the traditional approach of the therapist controlling the therapy, instead placing the power of the relationship with the client.

Because he felt the client should not be directed or led by the therapist, Rogers (1951) initially referred to his approach as being “non-directive” (p. 5). In fact, he envisioned the client directing the therapeutic relationship. No matter how the relationship was developed, however, Rogers found the client consistently sought the therapist’s guidance. Rogers chose to rename his therapy “client-centred” to emphasize his philosophy of the client being central to the process of therapy (Boeree, 2000).

While not convinced that the conventional empirical science was the only means of studying human behaviour, Rogers (1951) was a strong supporter of research. He

sought a more human approach, one in which researchers would “consider, for instance, human beings as subjective, a person’s meanings, and the client as a research partner” (Anderson, 2001, p. 342). In fact, Rogerian therapy asserts that the client has the internal capacity and ability to address his own life.

Christopher Green (2001) discusses the unique characteristics of client-centred therapy. According to his observations, there are three distinct stages that set it apart from other therapeutic approaches. First, the client moves through a process of expression, exploration, realization and then to choice. Second, the therapist acknowledges that it is the client who has the capacity to truly know himself or herself and consequently, has the ultimate ability to create his or her own lifestyle. Third, it is the therapist’s “way of being” that catalyzes the client-centred process (Anderson, 2001, p. 354). In other words, the quality of the therapeutic relationship is dependent on the manner in which the therapist encourages client conversations.

Carl Rogers (1951) identified that all life has the ability to “actualize, maintain, and enhance the experiencing organism” (p. 487), a behaviour he referred to as the actualizing tendency. For this reason, the therapist plays a vital role in developing a client-centred environment. Qualities of being genuine, empathetic and having positive regard towards the client are essential. Interestingly, the client’s internal drive to become and move to a better place of being is what drives the client-centred therapist. When engaging in client-centred practice, therefore, the therapist and client will both grow and develop their talents (Anderson, 2001).

Occupational Therapy in Canada

The history of occupational therapy in Canada forms another of the warp threads. According to Judith Friedland, Isobel Robinson and Thelma Cardwell (2001), “The nucleus of our discipline only began to take form with World War I” (p. 1), when wounded soldiers returning to Canada needed assistance to enable them to return to their previous occupations or to retrain for other employment possibilities. Training programs were quickly put in place for “Ward Aides” who were also known as “Occupation” Aides (p. 1). These aides were the beginning of the “occupational” therapy profession.

By 1926 the Canadian Association of Occupational Therapy was formed to support and promote the development of the profession. This national body assisted the provinces in developing educational programs in order to train people as occupational therapists. The educational focus for occupational therapy was on occupation, assisting soldiers to re-enter their work world and their other life responsibilities. By the 1940s a transition of curriculum occurred and activity as therapy became the norm. Analyzing the activity, particularly handicrafts, and matching that to a diagnosis was the foundation of occupational therapy training programs. “This shift [to activity based training] effectively removed the client from the decision-making process and placed them under the auspices and control of knowledge and authority” (Rebeiro, 2000, p. 8). From the 1940s to the 1980s, occupational therapy continued to adopt activity analysis using handicrafts, expanded the activity focus to include those of daily living tasks, and introduced the use of specialized equipment and techniques in their provision of services to the public. The therapist was the expert in assessing functional, purposeful and practical abilities of the individual and then prescribing the most appropriate treatment program. Aligning with

the evolution of the biomedical model this prescriptive educational model remained in place for forty years.

In the 1980s the profession returned to its roots, so to speak, with a renewed focus on occupation and client-centred practice. This change was in response to the increasing awareness in client-centred practice facilitated by the national organization, the Canadian Association of Occupational Therapists (CAOT). As well, there was a rising consumer voice with clients wanting to have a say in their health process. Responding to this awareness and the consumer voice, CAOT sought government support to establish a task force of occupational therapists to examine ways to prepare therapists for the shift from activity based practice to client-centred practice. The task force created foundation documents to stimulate, support and lead the profession into being client-centred.

The first document, *Guidelines for the Client-Centred Practice of Occupational Therapy* (Department of National Health and Welfare, 1983), established a foundation of a client-centred philosophy for the delivery of occupational therapy services. The second complementary manuscript, *Occupational Therapy Guidelines for Client-Centred Practice* (CAOT, 1991), expanded the idea. According to Barry Trentham (2001), these documents “reflected a return to the profession’s historical emphasis on a holistic, mind-body-spirit perspective guided by the central organizing concepts of occupation and client-centred practice” (p. 2). In 1997 CAOT published the first edition of *Enabling Occupation: An Occupational Therapy Perspective* and merged the work of client-centred practice with occupation. Occupation today is described 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

(productivity)” (CAOT, 2002, p. 3). The enabling approach to achieve occupation is client-centred practice.

Returning to the journey of client-centred practice, it was the commitment and efforts of the task force of occupational therapists established by CAOT to establish guidelines of practice that also stimulated research. As Harlene Anderson (2001) indicates, “Ideas and practices do not spring forth in a vacuum but develop within a context, a history and an era, being influenced by the personalities and passions of their originators” (p. 340). Karen Rebeiro (2000) poses that what was happening in research impacted the human side of health. At the same time as client-centred practice was developing in occupational therapy, the world of science was recognizing the contribution of qualitative research practices. The qualitative movement aimed to examine the subjective, human feature in life. Both client-centred practice and qualitative research reflect and expose the livelihood of the person.

The Weft: Health Professionals’ Perspectives on Client-Centred Practice

Other sectors of the health professions have also threaded the warps of their looms with Rogerian yarns. From family therapy to psychology to physiotherapy, each profession has processed and woven a variety of colors, designs and textures of Rogerian practice into its own tapestry. The opinions and experiences of these health professionals are what makes up the weft; altering their designs by retaining, discarding or expanding the components of Rogerian therapy.

Family Therapy

Family therapy can be divided into two main delivery approaches: one that supports the “science of intervention,” known as first-order family therapy, and a second-

order family therapy that supports the “art of conversation” (Bott, 2001, p. 362). The existing tension between these two groups led David Bott to rediscover the fundamental role that client-centred therapy played in the origins of family therapy. He claims that the actualizing tendency of individuals, expressed by Rogers (1951), compares to the formative tendency where the family naturally seeks to achieve and reach its healthy possibilities. David Bott challenges his family therapy colleagues to revisit the work of Rogers and see that this “existential-phenomenological framework” (p. 363) works within family therapy. Harlene Anderson’s (2001) positive description of Rogers’ contributions to the world of therapy concludes that family therapists “may have taken him for granted” (p. 358).

Continuing, David Bott (2001) suggests that second-order family- and client-centred therapies were created due to “reactions to disrespectful practice... both place the client at the centre of therapy, challenging the power of the therapist as expert” (p. 363). Carl Rogers’ writings do not speak to therapy for families or couples. However, both David Bott and Harlene Anderson (2001) see Rogers’ philosophy as embedded in second-order family therapy practice. As the individual successfully makes personal changes, “clients are able to transfer the therapeutic experience to family relationships” (Bott, p. 366). This was as close as Carl Rogers came to working with families.

The collaborative approach in second order family therapy has principles both similar to and different from client-centred therapy. Some of the similarities are: therapists’ taking time to reflect on their practice and its relationship to theory; therapists having a positive view of people; clients having the ability to be the expert in their lives; and the personhood of therapists which influences the client-therapist relationship. The

significant differences present in collaborative therapy are the “therapist intention, goal of therapy and the process of therapy” (Anderson, 2001, p. 356). The classic work of Carl Rogers, revisited by practitioners fifty years later within the realm of family therapy, reflects the foundation he created. David Bott (2001) invites family therapists to re-examine Rogers’ work especially “if we are seeking to humanize our practice and respond respectfully to families” (p. 375).

In the 1990s a third approach to delivery, narrative therapy, was introduced to the world of family therapy. Narrative therapy asks clients to share their present life stories and then to choose their preferred new script or story. In narrative therapy, the therapist uses a questioning technique to help the client separate himself from the problem. The founder of narrative therapy, Michael White, borrowed from the principles of client-centred therapy and the collaborative approach. The “relative influence questioning” that is employed in the therapeutic process is also used to enable the client to assemble new outcomes to begin a different life story (Carr, 1998, p. 492). In other words, the client is the main actor, the person responsible for his life journey, and the narrative therapist plays a supporting role in the process.

Physiotherapy

Jayne Dalley (1999) attempted to use client-centred evaluation “in the light of the need for establishing the effectiveness of physiotherapy practice” (p. 491). Her evaluation occurred in a multidisciplinary rehabilitation hospital. Dalley first reviewed literature on research tools and client-centred measurements leading her to question whether there was a relationship between professional competency and client needs. Attempts to isolate the contributions of physiotherapy within a team environment were impossible. The

physiotherapy outcome evaluation is blurred and made difficult when introducing client needs and the contributions of a rehabilitation team. The tension between using quantitative versus qualitative measures inhibited the evaluation. Dalley surmised that “part of the identification of unique physiotherapy expertise may lie in discovering the clients’ priorities and perceptions of the benefits of therapy” (p. 496).

Alison Christie and Vinette Cross (2003) undertook a quantitative study of undergraduate physiotherapy students in England to determine a preferred working practice that was “client-centred or a professional-powered model of working” (p. 100). A self-reporting questionnaire was used to establish their “ethos” or philosophy of practice. The survey found just under half of the students would choose to work in a client-centred setting. This study suggests a strong component of control is important to the physiotherapist. Adding a qualitative component may have clarified this assumption.

Occupational Therapy in Canada

In Canada, the term client-centred practice “is well recognized as an important part of occupational therapy” (Falardeau & Durand, 2002, p. 136). Although therapists are generally knowledgeable about the theory of client-centred practice, an obvious tension exists between its acceptance and practice (Townsend, Langille & Ripley, 2003). The differences and difficulties in implementing client-centred practice is a challenge to occupational therapists (Falardeau & Durand, 2002; Townsend et al., 2003; Wilkins, Pollock, Rochon & Law, 2001). While many occupational therapists readily describe their service delivery as being client-centred, they may not be “walking the talk.” In fact, the delivery of occupational therapy may be a very different experience for the client.

Many of these barriers are embedded in the very fabric of the healthcare system. Seanne Wilkins et al. (2001) identified three layers that impede the process of client-centred practice: 1) the system or organization, 2) the therapist, and 3) the client. Using the results derived from three qualitative studies which exposed the barriers from the therapists' perspective, they first considered the organizational layer. At this level they noted four loose threads: a lack of commitment to the philosophy at all levels of administration, a lack of practical steps to introduce the concept into daily service, a lack of all team members "living the philosophy," and a lack of time and resources (p. 75).

Similarly, the occupational therapist layer indicated a lack of knowledge, a limiting attitude, and a lack of ability to deal with the shift of power from therapist to client. Finally, the client layer revealed a lack of clarity in knowing who the client is, the lack of "the 'right' client" (p. 77), and a lack of ability to deal with the shift of power from therapist to client; that is, the client wanting the therapist to make the decisions. Seanne Wilkins et al. (2001) concluded that "organizations, therapists and clients must work together to facilitate these changes" (p. 78).

Continuing the research to examine client-centred practice, Marlene Falardeau and Marie Jose Durand (2002) reviewed the literature in order to closely look at the aspect of power and respect in the client-therapist relationship. Their findings led them to identify two types of client-centred models, one "led by the client" (p. 137) and the other "led by the interaction" (p. 137). Where "the therapist's power can be strong, not for controlling but for helping," the researchers used the term "negotiation" (p. 140). Their inference that, in cases where the client guided the therapeutic relationship, the "power of the therapist was weak" (p. 140) is precisely why Carl Rogers (1951) chose to rename his

model “client-centred” as opposed to “non-directive.” This article challenges the client-centred approach, questioning the power position of the therapist.

Using institutional ethnography (identifying the tensions embedded in the social organization of institutions), Elizabeth Townsend, Lynn Langille, and Debra Ripley (2003) wanted to expose the “invisible, management ceiling that confines possibilities for collaboration and choice” (p. 22). In a mental health setting, they studied two processes, the professionals’ work to admit clients to their program and the policy on consumer driven research. Both processes were found to be limited as they played a secondary role, the occupational therapist to the centralized decision-making model of service, and the consumer group in having to compete with funding sources and community priorities. Townsend et al. felt that “partnerships between clients and therapists could generate an important collective voice to move beyond compliance with systems that disempower clients as well as occupational therapists” (p. 26). They urged occupational therapists to reflect on their professional struggle with the client-centred approach and through conversations expose the tension intrinsic in the profession about client-centred practice. Finally, they implied that occupational therapists are either part of the problem or part of the solution in bringing about institutional change regarding client-centred practice. It is our choice. Weaving principles into practice requires work and commitment by all.

Occupational Therapy Outside Canada

According to Ron Carson (1999), Gudrun Palmadottir (2003), and Thelma Sumsion (1999b), Canada is considered a leader in the level of commitment to the philosophy of client-centred work. The activities of Canadian occupational therapists have sparked occupational therapists and their professional organizations, in countries

such as the United States, England and Iceland, to address the potential benefits of client-centred practice. Consequently, the building of the client-centred experience by occupational therapists in other countries exhibits a weave similar to the Canadian tapestry.

For example, Thelma Sumsion (1999a) initiated research to develop a “British occupational therapy definition of client-centred practice” (p. 52). The purpose of her study was to provide guidelines to support the Code of Ethics and Professional Conduct established in 1995 by the College of Occupational Therapists. The code identified that occupational therapists will practice using a client-centred approach. Using the Delphi technique, Sumsion set out to develop a draft definition of client-centred practice. The Delphi technique surveys experts, in this case occupational therapists, about an issue (client-centred practice). The technique compiles the initial responses provided by the expert group and then through a series of formal feedback and further responses the expert group comes to consensus. Sumsion successfully facilitated the creation of a draft definition for client-centred practice.

A year later, Sumsion (2000a) embarked on a second phase of her research, to review and revise this draft definition. Using focus groups of occupational therapists, 67 in total, she asked, “What are the important components of client-centred practice?” (p. 305). Each therapist was later asked to rank the group comments. These focus groups also reviewed the initial draft definition, indicating what they liked, what matters were of concern to them, and what changes they would like to make. The individual participants again ranked the information collected in importance. This is the final definition:

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 assessments, intervention and evaluation. Throughout the process the therapist listens to and respects the client's values, adapts the interventions to meet the client's needs and enables the client to make informed decisions. (p. 308)

Thelma Sumsion's commitment to client-centred practice has provided a working foundation for occupational therapists in the United Kingdom. Thelma Sumsion and Genevieve Smyth (2000) went on to examine the insights British occupational therapists had regarding the already identified obstacles that prevented therapists from practicing in a client-centred manner as well as the suggested ways of eliminating them. A questionnaire was developed from their literature review of barriers, and methods to resolve barriers, to client-centred practice. One section of the quantitative questionnaire used a 5-point Likert-type scale to rate the relative intensity the barrier had in preventing practice. A second section listed methods of removing barriers and were to be rated in their perceived effectiveness. The most commonly cited barrier was the absence of common goals between therapist and client. Therapists felt, however, that by having an opportunity to review case studies of practicing in a client-centred manner, this barrier could easily be eliminated.

Thelma Sumsion (2000a) also offered her personal insights on client-centred practice. To begin with, she exposed her own bias that she saw the client as a team member. Curiously, this core element to her perspective on client-centred practice had

been discarded by therapists in her study. Consequently, she challenged therapists “to ensure that they are not looking for a ready reason to say it [client-centred practice] won’t work” (p. 2). Finally, in asserting that individual therapists can make a difference in ensuring client-centred practice is present in their service, she takes another step forward.

In the United States, rehabilitation facilities complete accreditation processes for national recognition of their services. One small step in the review process identifies that documentation of client goals is required, reinforcing the importance of client involvement in their treatment (Neistadt, 1995). Maureen Neistadt’s study set out to identify how occupational therapists met this requirement. Her review of the literature indicated positive outcomes were achieved when clients were involved in goal setting and that “the concept of working collaboratively with clients is basic to occupational therapy” (p. 429). She also reviewed ways of common goal setting; these included admission interview of client; using formal assessment tools such as: Goal Attainment Guide and Canadian Occupational Performance Measure. She then designed a survey asking department directors of occupational therapy services in physical disability settings to identify: 1) if occupational therapists were stating client goals on admission; 2) what methods were being used to identify client goals; and 3) were client goals specific enough to determine treatment. The 70% response to her survey identified that 99% of occupational therapists identified client goals through informal interviews. Her findings also revealed that the client goals could not be linked to treatment plans. Effectively then, occupational therapists obtained client goals but used the biomedical or expert model of practice to decide treatment. Neistadt concluded, that the “client-therapist collaboration”

in goal setting would be more effective if the therapist was trained in using a formal set of procedures” (p. 435).

The Weft: Clients’ Perspectives on Client-Centred Practice

Research on the client’s perspective of client-centred practice in occupational therapy is scarce. In the 1990s two Canadian studies were conducted in mental health settings (Corring & Cook, 1999; Rebeiro, 2000). The researchers’ work and findings will be discussed. To further reinforce and support the client perspective, comments from articles written by clients connected to investigator Karen Rebeiro will be shared. It appears that only two other studies, from Iceland and England, have attempted to address this approach from the viewpoint of the client (Palmadottir, 2003; Sumsion, 2005). The former was conducted in a rehabilitation facility and the latter in a community mental health service. These findings will be woven following the discussion of clients in Canada.

Clients in Canada

Corring and Cook. Deborah Corring and Joanne Cook (1999) set out “to explore the opinions and perspectives of individuals” (p. 71) within the mental health service in Ontario. The researchers were motivated to look at a client-centred approach through the eyes of the clients themselves, a first in Canadian research. Prior to this the literature had presented the principles and characteristics of client-centred practice as defined by the therapist. In their study they discussed two health service models with similarities to the client-centred philosophy.

The Planetree model, for example, encourages patients to play an active role in their health care by deciding what will take place in their care plans. Patients are

encouraged to schedule times for eating, bathing and sleeping, to spend time conversing with staff and to access educational materials relevant to their condition. Similarly, the second model, known as psychosocial rehabilitation, values “client empowerment” (p. 73), focusing on choice, flexibility of services and support for client needs. This last model involves clients in its refinement and improvement of service delivery.

Corring and Cook’s (1999) study was intended to compare and contrast the client’s perspective with the therapists’ definition of client-centred practice. Using a qualitative frame of enquiry, the researchers had clients participate in focus groups to discuss their opinion of “what client-centred care would look like” (p. 73). The 17 participants were adults, all with a history of mental illness who had received services from the mental health system. Initial discussion centred on the personal health experiences of each participant and their experiences with accessing mental health services. From there the groups were asked to speculate on four questions:

- 1) What does client-centred care mean to you?
 - 2) If mental health services revolved around you and your needs, what would they look like?
 - 3) What sort of things in a hospital or community agency help or hinder a person with your kind of needs to achieve their goals in life?
 - 4) If you were asked by people who decide what and how mental health services are provided to you as a mental health client, what would you suggest is the number one priority?
- (p. 73)

Corring and Cook (1999) expressed their findings using three themes: “1) the client in the client/service provider relationship; 2) the client in the social and mental health system; and 3) client-centred care means I am a valued human being” (p. 74).

They indicated that clients described very depressing experiences with service providers

and the system. Some of these experiences included: negative attitudes by providers; indifference to clients as human beings; superficial knowledge of clients; the provider-as-expert; client needs not met; lack of trust; and providers stigmatizing the clients. All of this represented a marked contrast to the fundamental principles of client-centred practice.

Fortunately, the participants also offered a number of suggestions, not only for improving the client-therapist relationship but also in terms of service delivery. Corring and Cook (1999) indicated that these ideas reflected many of the unique qualities of client-centred care found in the literature, including the following: 1) the providers display an appreciation for the client's life experience; 2) the providers get up close and personal with clients; 3) the providers have and take time for conversations with the client, to listen and get to know the client; and 4) the provider and client work together as partners. Their findings provided further evidence of the value of client-centred philosophy. Not surprisingly they concluded that it is the human side of client-centred practice that means the most to clients. Consequently, Corring and Cook stated that their findings would "be a useful addition to the knowledge base in occupational therapy's conception of client-centred care" (p. 73).

Rebeiro. Karen Rebeiro (2000) attempted to take "a snapshot of occupational therapy practice through the eyes of two clients" (p. 13) receiving occupational therapy services in a hospital-based mental health setting. In her study, the participants' expressed their opinions of client-centred practice and shared how they had not found it in their occupational therapy experience. In analyzing these results Rebeiro organized participants' responses into four themes.

Firstly, “the provision of an accepting, supportive environment” (p. 10) was seen as meaningful to their occupation and motivated their involvement. While the institutional setting of the occupational therapy department was described as being artificial and limited to client participation, the volunteer opportunity outside of the hospital was considered to be more open, thereby promoting the growth of the individual.

Secondly, “the provision of choice” was seen as critical to achieving “client-centred occupational needs” (p. 10). The clients perceived the formal delivery of occupational therapy as being prescriptive and authoritarian. They spoke of feelings of dependence and lack of hope.

Thirdly, the clients believed that “the provision of personally meaningful occupation” (p. 11) was thought to create a sense of self worth and hope. Finally, “recognition of the individual within the client” (p. 12) was deemed essential; looking at the person and hearing their needs would create opportunities for wellness. Although these themes closely mirror the theoretical definition of client-centred practice, the participants had not experienced the delivery of client-centred service in their occupational therapy sessions. Rebeiro (2000) sees client-centred practice as integral to the future livelihood of occupational therapists.

Client writings. Remarkably, however, the participants of Rebeiro’s (2000) study were able to share their opinions on client-centred occupational therapy practice in the Canadian newsletter, *Occupational Therapy NOW*. The following observations are presented as further testimony to ensuring that the client’s perspective of client-centred practice is considered in any future research.

A study by Bibyk, Day, Morris, O'Brien, Rebeiro, Seguin, et al. (2001) focuses on the experience of individuals who have received occupational therapy. These researchers responded to the question, "What does a client-centred therapist look like, act like, and feel like to the client?" (p. 2). The responses indicated that the following characteristics were valued: welcoming, non-threatening, non-authoritarian, and non-judgmental. Similarly, they indicated that the art of conversation enables a process of caring, sharing and learning to take place between the client and therapist. Therefore, a client-centred environment can be described as fostering the importance of the individual, being open to conversation, and values the client-therapist relationship. These clients further described the actions of a client-centred occupational therapist as: genuine, heartfelt, emotionally and intellectually connected to the client, as well as able to interact with humor. Their comments reinforce the worthiness of client-centred practice.

Starke, Andrews, Griffin and Rebeiro (2001) explored occupational therapists' personal experiences with disabilities and their experiences of client-centred care. Three themes emerged: "1) client-centred care must acknowledge, respect and value the client's knowledge; 2) client-centred care is an equal status partnership; and 3) occupational therapy was often perceived to be the most client-centred caregiver within an otherwise non-client-centred system" (p. 1). However, these professionals' experience in occupational therapy was neither positive nor flattering to the profession. They spoke of not being recognized for knowing themselves as persons and for not being seen or valued as qualified occupational therapists. Their primary recommendation was for therapists to treat clients the way they treat themselves, with dignity and respect.

Clients Outside Canada

In studies based in Iceland and in Britain respectively, Gudrun Palmadottir (2003) and Thelma Sumsion (2005) examined the experience of clients in occupational therapy to add knowledge to their profession. Palmadottir identified specifically the benefits of occupational therapy as described by clients. Sumsion helped to refine the newly defined practice of being client-centred.

Iceland. Gudrun Palmadottir (2003) set out “to explore clients’ perspectives on the outcome of occupational therapy practice in rehabilitation” (p. 157). Using a qualitative method involving twenty adults, discharged from an institutional rehabilitation program, he examined their “lived experience with occupational therapy” (p. 158). Interviewing each participant in his or her home, he made the following enquiries: “What happened during therapy sessions, how decisions were made, how therapy was organized, the relationship with the therapist, and the overall experience and satisfaction with occupational therapy” (p. 158). In compiling the data, Palmadottir organized the results into three interwoven themes: “1) balance and enjoyment; 2) enabling everyday life; and 3) building a new future” (p. 159). In general, the participants described their time in occupational therapy as a comfortable change of pace within their rehabilitation program. Similarly, they made positive comments about the opportunities they had to connect with others on a social level. The most striking result, however, was the importance they placed on the implementation of new techniques as well as altering the physical situation to perform daily occupations. “Through occupational participation people learned about themselves and became aware of their own habits, abilities and limitations, which helped them to come to terms with reality” (p. 160). In the course of building their new identities

the participants' spoke about having a partnership with the therapist. Palmadottir's findings, therefore, support the role of occupational therapy in the rehabilitation team, affirming the positive impact of art and craftwork and recognition of a "philosophy of meaningful occupation" (p. 163).

England. The purpose of Thelma Sumsion's (2005) research was to "determine the opportunities for, and barriers to, the application of" (p. 14) the British definition of client-centred practice. In her qualitative study, she interviewed nine clients in a community mental health setting. Sample questions included the following:

How was the decision made about the goals you would work on in this program?

Please describe a situation when you thought this program met your needs.

Please describe a situation when you thought this program did not meet your needs.

Are you given a chance to make choices? (p. 15)

Sumsion (2005) created three themes: 1) Initiating client-centred practice; 2) Therapist responds to client issues; 3) Knowledge of client-centred practice (p. 16). She argues that the process of enabling client-centred practice means providing clients with information that will give them choice in their decisions as they work towards achieving their goals. Compassionate staff and flexible service plans helped clients to conquer fear of new experiences and deal with severe health issues. Clients identified that it was important that staff listened to their conversations. Finally, although Sumsion indicated the concept of client-centred practice was not familiar, once defined, clients could relate to most of the principles. She concluded that clients responded positively towards the client-centred approach and "the opportunities outnumbered the barriers" (p. 19).

Conclusion

The notion of client-centred practice was founded by people who were passionate about the human side of health (CAOT, 2002; Rogers, 1951). Carl Rogers' principles of client-centred care have been valued, embraced and embedded into practice by many health care professionals. The recent examination of these principles by family therapists highlighted their positive impact on service development. Client-centred principles are so intrinsic to human nature that they are understood, experienced, and valued even in the absence of a theoretical foundation. That is, clients are able to speak about the principles and yet are not familiar with the term "client-centred".

Occupational therapists in Canada have laid a strong foundation for promoting and supporting client-centred practice. In winding these warp or vertical threads on the loom, were all the important steps considered and included? The present tension between theory and implementation of theory suggests not. The exclusion of client participation in the early steps of developing the model is puzzling. In fact, the lack of any major client voice is perplexing. It appears the client-centred model was in fact established using a biomedical approach. The expert perspective has predominantly influenced the development and I have found no evidence of a strong movement to include the client in the journey. For example, in preparing the preface for the CAOT's revised publication of *Enabling Occupation: An occupational therapy perspective* (2002), Elizabeth Townsend contacted over 58 occupational therapists and only 5 clients. As an occupational therapist, I see five different clients in one day of work: The continued imbalance between the expert perspective and client views disturbs me.

This warp tension continues in the writings of family therapists (Anderson, 2001; Bott, 2001) and psychologists (Boeree, 2000; Green, 2001). Both disciplines have professional members who have struggled to establish the client in the centre of their services. The expert model has a strong presence and both disciplines would do well to listen to the voice of the client. It appears that narrative therapy is trying to do that (Carr, 1998).

The tension really came to the surface when physiotherapy tried to evaluate their services from the human perspective (Dalley, 1999). I applaud Jayne Dalley for attempting to step out of the constraints of structured therapy evaluations. I believe her work was successful when she asked, “To what extent is it necessary to identify individual skills, and the contributions of physiotherapists?” (p. 495). I was elated when she suggested that looking at client goals and viewpoints would enlighten physiotherapy practice. Her study is a first step for physiotherapy to actively participate in client-centred practice.

Identifying barriers to practicing in a client-centred manner repeatedly appear in current occupational therapy literature (Falardeau & Durand, 2002; Townsend et al., 2003; Wilkins et al., 2001). As a practicing occupational therapist I have experienced these limitations. I personally find that this focus on barriers enables therapists to justify why they are not using the principles. In the expert model accountability and justification are the founding principles of knowing. The opportunities provided by a client-centred approach have been overshadowed by the discussion of barriers. Although the researchers all support and encourage the use of client-centred principles, this strategy of identifying obstacles has backfired.

Lessons from the Canadian experience have not been used to successfully implement client-centred practice in other countries. The bold step of embedding client-centred principles in the Code of Ethics and Professional Conduct of the British College of Occupational Therapists without guidelines both affirms and demeans the value. The lack of recognition for the powerful influence of the biomedical approach on practice rendered this step as futile. Thankfully, Thelma Sumsion (2000b) rectified the situation by establishing a definition of client-centred practice. However, her predominantly quantitative process using only the contributions of occupational therapists mirrors the Canadian approach. History repeats itself as further research built on the presence of barriers to practice (Sumsion & Smyth, 2000). Although, Sumsion (2000a) personally supports clients as team members, she did not involve clients in her research. Hearing her personal insights provided me with hope, as did her study in 2005 asking for clients' viewpoints. Client-centred practice is such a human, natural way of being for me that I reacted to all the research as being too academic and expert based. The private thoughts of other occupational therapists that support client-centred practice may generate a positive movement towards its successful implementation.

Finally, the work of Maureen Neistadt (1995) demonstrates the intricacy that occurs when looking closely at a biomedical process, accreditation. Highlighting that client goal setting always occurred and in contrast no link could be made to meaningful treatment programs, exposes the superficial participation in client-centred practice. I am disappointed that her conclusions lead to education on formal assessment tools versus an acknowledgement of the importance of the client's knowledge and expertise.

The majority of the studies on client-centred practice are presented through the eyes of therapists. Studies that ask clients to describe their opinion of client-centred practice are written by therapists. Is the strong involvement of occupational therapists in all the studies creating a bias towards the viewpoint of therapists? I struggle with this question as I attempt to complete my research. As an occupational therapist, will I hear the words of the client?

Additionally, I perceive a tension between quantitative and qualitative research approaches. The authors write using quantitative information and then readily describe their findings with qualitative language. I surmise that the authors are building their skills to work and write qualitatively. This strain assisted me to look differently at my writing therefore; I have worked at being personal, thoughtful in my expressions and connected with the emotions of the client. For the current research project, I want my writing to be client-centred.

Clients described their preferred model of client-centred practice as appreciating the client's life experience, recognizing the client as expert, and creating a close partnership with the client. Clients want to work in an environment that provides choice and is accepting, supportive, and meaningful to their personal occupation. Client opinions were valued in the research and clients should have opportunities to experience this model all the time. The emergence of qualitative methodology specifically phenomenology, enables research to examine the human experience of client-centred practice, a missing link in the evolution of client-centred occupational therapy.

Chapter 3: Building Phenomenology

Chapter 3 describes the research methodology used in this study. The qualitative philosophic and scientific framework used to inform the inquiry will be discussed. The chapter concludes with my specific research methods.

The Warp: Phenomenology

Phenomenology is the study of the lived experience. It looks for the structure of this lived experience. Phenomenology seeks to describe and make clear the phenomena being studied. “Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences” (van Manen, 2003, p. 9). Client-centred occupational therapy focuses on the needs of clients in their everyday lives. Van Hesteren (1986) stated that there is a growing readiness to allow the nature of the subject under study to determine which research methodology. The descriptive phenomenological approach was used to expose the client’s perspective on home-based client-centred occupational therapy. I was guided by the works of Amedeo Giorgi (1975, 1985, 1988), a contemporary phenomenologist, to bear witness to the lived experience of home-based client centred occupational therapy.

Before beginning the exploration of this methodology, I need to identify that I am an occupational therapist. I have provided services in the community. Therefore, I too am implicated in this research (Nixon, 1992). “The problem of phenomenological inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much” (van Manen, 2003, p. 46). I have supported the development of client-centred principles in occupational therapy from its beginning. The Masters of Science; Health Science program has provided me the opportunity to look closely at how

client-centred practice has impacted me personally and professionally. Current research has not addressed the voice of clients of client-centred occupational therapists; their viewpoint is missing. I used phenomenological reduction to openly see the lived experience of my participants. Temporarily suspending, or bracketing my biases brought clarity to their point of view and to the data collected.

The Founder: Edmund Husserl

Edmund Husserl (1859-1938) had his professional beginnings in mathematics (Gearing, 2004). His interest in philosophy led him to seek different ways of evaluating human issues. He found fault in the empirical ways of the natural sciences. He worked to be more subjective in his pursuits (Lavery, 2003). Husserl “thought of it [phenomenology] as supporting and clarifying science in its fullest sense” (Moran, 2000, p. 14). He supported the philosophical assumption “that experience as perceived by human consciousness has value and should be an object of scientific study” (Lopez & Willis, 2004, p. 727). Husserl (1970, first published in 1900) felt that human beings lived their daily lives without any particular thought (known as natural attitude). A scientific approach could specify the important or essential parts of that commonplace activity. The concept “back to the things themselves” (Husserl, 1970, p. 252) guides phenomenology. Going to the everyday world, where people live, builds on the origins of this idea. In the beginning, Husserl (1973) talks of “changing its total style, philosophy takes a radical turn: from naïve objectivism to transcendental subjectivism” (p. 4). In his search for a meaningful way to look at the human side of life, he moved from the objective-subjective dual observation to the subjective position. “Subjectivity means that one needs to be as perceptive, insightful, and discerning as one can be in order to show or disclose the object

in its full richness and in its greatest depth” (van Manen, 2003, p. 20). Like Amedeo Giorgi (2003), Husserl committed his energies to the pursuit of this new way of seeing life using the qualitative approach of phenomenology.

Phenomenology is fluid and continues to evolve and change. Much is written in the literature regarding the use of philosophical phenomenology versus scientific phenomenology. Giorgi (2000c) steadfastly speaks about acknowledging the philosophical foundations at the same time as honoring the scientific rigor phenomenology provides. He encourages embarking on the research project scientifically using the perspective of the professional discipline.

Susan Kleiman’s (2004) article title, “*Phenomenology: To Wonder and Search for Meanings*” speaks to the basis of the approach as a discovery. Phenomenology focuses on the descriptions of human experience (Polkinghorne, 1989). To begin phenomenological work one needs to “understand the meaning of phenomenology as a whole by learning to recognize its essential components” (Munhall, 1994, p. xv) or structure.

Essential Threads of Descriptive Phenomenology

Life-world. The world as experienced by a person is known as the “life-world.” The life-world is the starting point for phenomenology: “No assumptions are made to as what might be behind or cause the life-world” (Valle, King & Halling, 1989, p. 9). The life-world is co-constituted or co-created in the dialogue of that person and the world. It is prior to or before reflective thought therefore it is known as pre-reflective. This is the starting point of all knowledge. “Human life needs knowledge, reflection, and thought to make itself knowable to itself” (van Manen, 2003, p. 17). Phenomenology “affirms the primacy of the life-world as a point of departure for research” (Giorgi, 1975, p. 99). Just

as Giorgi urges psychology to stay close to this limitless and valuable source of data, I urge occupational therapy to do the same.

Consciousness. Valle et al. (1989) state that there is no world without the consciousness to recognize it and, there is no consciousness without a world to be aware of. Consciousness is “the window of the world” (Falk, 2005, p. 26). To understand humans, one needs to understand consciousness. It is through the realm of consciousness that the phenomenon is exposed. That is how we access the world and it is through this awareness that we relate to the world. “Thus all we can ever know must present itself to consciousness” (van Manen, 2003, p. 9).

Intentionality. Intentionality refers to the fact that consciousness is always directed toward something other than our selves; “it is the essential feature of consciousness” (Giorgi, 1997, p. 237). This concept moves away from Cartesian traditions that initially saw consciousness directed to us, unrelated to anything outside our own space. A person’s thoughts are directed to the world and they are then related to the world (Giorgi, 1985). Intentionality is a “process where the mind is directed toward objects of study” (Lavery, 2003, p. 5). “The lived experience themselves are as such intentional” (Moran, 2002, p. 260).

Essence. Essence as a noun is defined as “the intrinsic nature or indispensable quality of something” (Jewell & Abate, 2001, p. 580). Discovering essence or “eidae” (LeVasseur, 2003, p. 412) is a fundamental component of descriptive phenomenology. “We want to know that which is most essential to being” (van Manen, 2003, p. 5). Regardless of what is revealed about a phenomenon at any given time, the phenomenon is seen to have the same critical features when it is observed over time in a variety of

situations. It is this premise that drives this study to see how it will place itself with the existing work to date. The understanding of intentionality and essence is important to grasp the texture of lived experience. Max van Manen (2003) explains essence this way:

When we speak about the essence of poetry, for example, all we mean to say is that in some respects poetry has certain qualities or properties that make it distinguishable from other literary forms such as novels, plays, or essays. In other words, without these qualities or properties poetry would no longer be experienced as poetry. (p. xiv)

These concepts called me to pursue the fundamental nature of home-based, client-centred occupational therapy. Phenomenology differs from other sciences in that it focuses on gathering “insightful descriptions” (van Manen, 2003, p. 9) of how someone experiences the world pre-reflectively. This stance enables all to be in closer contact with life.

Intuition. Intuition is a characteristic of consciousness that “presents objects to us” (Giorgi, 1997, p. 236). Intuition reflects a broad perspective, whereas experience expresses a restricted perspective. Phenomenology is an inductive stance where the evidence is discovered in the essential descriptions. This evidence is revealed through rigorous effort. “Intuition - a kind of immediate intellectual ‘seeing’” (LeVasseur, 2003, p. 412) is used to identify the stand-alone evidence.

Free imaginative variation. “Free imaginative variation is a natural method for discovering essences” (Giorgi, 1997, p. 242). This method changes one or more aspects of the phenomenon to see if the phenomenon remains constant. The process relies on the researcher to be as creative as possible. Researchers need to remain open to a variety of perceptions of the same phenomenon. Once it is recognized which features cannot be

removed identifies the essential parts needed to reach consciousness, commonly referred to as essences. “The researcher then describes the invariant characteristics and their relationship to each other, and that becomes the structure of the phenomena” (Giorgi, 1994, pp. 206-207).

Phenomenological reduction. Phenomenological reduction is the method of achieving an original state of awareness about an experience (Wall, Glenn, Mitchinson & Poole, 2004). Bracketing describes the process used to achieve this original state of awareness or attitude. The researcher attempts to temporarily suspend any previous or past knowledge of the phenomenon. “The problem of phenomenological inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much” (van Manen, 2003, p. 46). The purpose of bracketing is to allow a fresh, impartial position to view the situation (Giorgi, 1997). Nixon (1992) stated that Husserl formulated phenomenological reduction to give voice to how we are already in the middle of things.

The controversy over bracketing. Bracketing is controversial (Gearing, 2004; LeVasseur, 2003). How can the researcher be completely removed from the study? In qualitative studies, the researcher is the instrument to see the world. Phenomenological reduction or bracketing is a “temporary” suspension not a complete removal. It is the “task of sorting out the qualities that belong to the researcher’s experience of the phenomenon” (Drew, 2004, p. 215). The process of bracketing can occur through out the research process to enable the most accurate picture of the experience to develop. Whatever it is that we carry with us, our prior ideas, biases, or preferences, we need to understand and make explicit. Husserl (1970) felt that human beings live their daily lives

without any particular thought (known as natural attitude). “In the natural attitude we are too much absorbed by our mundane pursuits” (Giorgi, 1975, p. 148) and therefore require a change of attitude to be open to what is presented. Expressing our biases allows us to move away from the natural attitude; it may not be possible to completely remove our bias. Bracketing assists in reducing our bias (Gearing, 2004).

Bracketing only the natural attitude. Jeanne LeVasseur (2003) proposes that using bracketing with only the natural attitude could potentially satisfy those researchers in hermeneutic phenomenology who so strongly oppose its use. Le Vasseur uses the analogy of being curious where one does not know nor presuppose knowledge on an event or situation. She urges “persistent curiosity” (p. 419). It is like having an unknown object placed in a brown paper bag and the bag is a temporary bracket. Initially as you reach into the bag, your thoughts are open without any presupposition. It is at this point in time that your descriptions of the object are most pure to its natural form. LeVasseur contends that this experience best describes bracketing. Munhall (1994) describes the bracketing process of qualitative research as freeing the researcher from their prior knowledge of reality. Giorgi (1994) presents bracketing this way: “stand back attitudinally and discover one’s own ‘taken-for-granted’ assumptions” (p. 214).

The importance of bracketing. “Positively speaking, the motivation for the reduction is because of the concern for proper evidence” (Giorgi, 1988, p. 172). If the researcher in pursuit of the phenomena looks at the information from his place of “knowing,” it is likely that he will not see all the features. It is also possible that features that do not exist may be gathered into the data. The researcher wants to get it right. As Giorgi (1994) states, “Reduction [bracketing] is a means of rendering oneself as

noninfluential as possible during the process of research (neutral) in order to come up with valuable (value) findings” (p. 205). The researcher is able to organize his analysis based on self-evaluation and reflection.

Validity and reliability? The tension between quantitative and qualitative research surfaces when looking for the rigor of both approaches. As I read how to evaluate my phenomenological work, I found that the process is evolving. The empirical sciences continue to reinforce the need to measure accurately and consistently. The empirical viewpoint comfortably carries itself into phenomenology. “Most researchers have encountered the question of validity within the context of empirical science, but validity does not have the same role within phenomenological philosophy of science” (Giorgi, 2002, p. 1).

Giorgi (2002) supports the need of accuracy and consistency in research. However, a different viewpoint is needed to evaluate a phenomenological study. “If the essential description truly captures the intuited essence, one has validity in a phenomenological sense” (Giorgi, 1988, p. 173). If a researcher has aptly described the information given to him and “can use this essential description consistently, [the researcher] has reliability” (p. 173).

Giorgi (1988) goes on to describe other ways of disputing and confirming the need of using the concepts validity and reliability in phenomenological research. This discussion continues to attempt to reduce the tension between the quantitative and qualitative worlds. Giorgi concludes that the words validity and reliability do not mean the same in these two paradigms. He suggests taking a small step towards clarity by calling the evaluative process *phenomenological* validity and *phenomenological*

reliability; that is, “for something to be valid is to see it as self-evidently true within the conditions he describes” (p. 174), and if this description routinely occurs, it is reliable.

Summary

Phenomenology is the study of the lived experience. Descriptive phenomenology enables the reader to understand the “things as they are” for that person. Using descriptive phenomenology answers the question “what is the lived experience of receiving client-centred occupational therapy in the home?” Using phenomenological reduction or bracketing assists the researcher in seeing the experience of the client in “a clear and unaltered manner” (Wall et al., 2004). Seeking the client’s point of view is the essence of this study; these findings will further shape the framework of client-centred occupational therapy.

Bracketing provides an opportunity for researchers to awaken to the world and possibly see themselves for the first time. Discovering “me” has enriched my own career and life journey. “The approach itself, however, is clarified in the very process of investigating specific phenomena by specific methods” (Giorgi, 1985, p. 177); in the next section, I share my research steps. Selection of the participants is reviewed, ethical considerations are addressed and the interview process is outlined. Data analysis is described followed by an introduction to my writing of the results.

The Weft: My Research Process

Selection of Participants

Selection of participants was based on purposive sampling. A presentation was made to all occupational therapists working in a particular provincial health region in Canada outlining the intended study. Therapists were provided with, and asked to

complete, a questionnaire (Appendix A). The questionnaire was based on the principles of client-centred practice developed by the Canadian Association of Occupational Therapists (2002). The principles are presented in Appendix B. If they scored 7/10 or greater on the questionnaire, the therapists were invited to contact the researcher. This invitation was voluntary, based on their score and interest in participating in the study.

Three weeks after the initial presentation I had no replies. I was nervous: what if occupational therapists did not want to participate? I contacted one occupational therapist to determine her experience with the questionnaire. She stated she had scored herself less than 7 and that she did not see herself as practicing in a client-centred manner. Now I was anxious: would other therapists rate themselves in a similar fashion? It was one month after the initial presentation that I was contacted by two occupational therapists. Their self-score was greater than 7 and they were interested in participating. I met with each therapist individually to review the intent of the study, to complete the consent to participate form (Appendix C), and to review the criteria for participant selection (Appendix D).

The two occupational therapists agreed to review their caseload for appropriate clients. The therapists would contact the clients to ask if they would be interested in participating in my research. If the client agreed the therapist would give the client's telephone number to me. I then called the clients and arranged a time to meet. Eight clients agreed to participate in the study.

Ethical Considerations

This study complied with the ethical standards required when human subjects are involved (Appendix E). The Ethics Committee of Chinook Health provided the first

research proposal approval. The Ethics Committee at the University of Lethbridge granted second approval.

Confidentiality can be a problem because of the small sample size, the relatively small size of the community and the rich description obtained from the participants. Therefore, I used pseudonyms and was careful not to use quotations that would reveal information on where they lived or what other health professionals worked with them. These efforts were made to preserve the confidentiality and the identity of the participants (Streubert & Carpenter, 1999). I am the only one who knows their identity.

Interview Format

The researcher is the sensitive instrument in scientific phenomenology. In-depth interviewing is used to collect spoken data using broad and open-ended questions. The interview is an opportunity for the participants to fully explain their lived human experience of receiving home-based client-centred occupational therapy services. The interviews were face to face and occurred in the participants' homes. The interview began by describing the purpose of the study. The consent to participate form was reviewed and signed (see Appendix F).

Following Seidman (1991) the interview was structured into three stages: the context of the interviewees' experience, a construction of the experience and finally a reflection on the meaning of the experience. To enable the participants to focus on their time with occupational therapy the qualities of client-centred practice were presented (see Appendix F). The researcher asked the participant to speak about a time or provide an example for each of the qualities implemented by the occupational therapist.

Ray (1994) identified that after the initial open-ended question of the lived experience the researcher facilitates the flow of information in seeking further description and does not use predetermined questions. The process of answering by the participant continues until the “the thing itself” is described and seen. The interviews were tape-recorded to ensure the stories and experiences were accurately collected. Following the interview the researcher made notes to further assist in capturing the lived experience of the participant. Munhall (1994) stated that phenomenology calls upon us to do the following:

Listen to the experience.

Feel the experience.

Be unknowing.

Become with the experience.

Raise our consciousness: the ordinary now becomes wondrous and extraordinary.

Feel amazed.

Feel puzzled.

Begin to understand differences as “real.” (p. 23)

Each interview was a conversation. Bibyk et al. (1999) describe true conversation as an art that is caring and respectful of the individuals involved. It is open and interactive. The conversation allowed the participants to express themselves. Values were discussed but not imposed. I used techniques such as paraphrasing, pausing and affirmation to encourage an easy flow of information from the participant. Colaizzi (1978) speaks about the dialogical research as the participant and researcher connecting “as persons” and takes place in the context of trust.

Data Analysis

A sense of the whole. Analysis is the process of making sense of the information collected. Initially I personally transcribed verbatim the interviews recorded digitally. The first eight interviews were read through in their entirety to get a sense of whole (Giorgi, 1985). The entire description is read to get a grasp and a general sense of the complete transcript. By listening to the audiotapes while doing my first read of the transcripts and by personally transcribing the interviews I got a “feel” for the “data” (Rich, 2004, p. 243). Listening and reading helped me to get a “tone of the ideas” (Creswell, 2003, p. 191).

Information lacking. The interviews were then read looking for a change of meaning. At each change of meaning, notes were made in the margins using the words of the participants. The interviews were then presented to my advisor, who identified that the content in the first few interviews did not speak about the experience of client-centred occupational therapy. I needed to improve my interview techniques. Role-playing was used to refine and build my interview skills. In the role-play I focused on not hurrying the interview, encouraging a conversation, refraining from introducing new topics and paying attention to what the interviewee was saying. I listened for key words and reflected these words back to enable further conversation. I asked for concrete examples of what the occupational therapist said or did when the interviewee was vague about their experience. I did a lot of thinking ‘hard.’ I developed a structured format to focus the participants on the qualities of client-centred practice. I piloted the format in two mock interviews to refine the structure. Appendix G presents the final structure that was used in subsequent

interviews. I transcribed these interviews verbatim. Again, the interviews were read completely to get a sense of the whole.

Description with the reduction. I returned to the beginning of the text and read through the descriptions looking to identify “meaning units” (Giorgi, 1985, p10). In the margin of the transcribed text, I noted the participants’ own words each time there was a change of meaning. According to Giorgi (1994) “the phenomena are described precisely as they present themselves, neither adding to nor subtracting from what is given” (p. 206). I consciously took on the attitude of phenomenological reduction to be open to these descriptions. By temporarily suspending my “past theories and knowledge” (p. 206) I encountered the experiences as presented. All the interviews were read in this manner.

Creating meaning units. I wrote each brief descriptor (in the participants’ words) on to notes. Once this task was completed the notes were organized into similar ideas or themes. This organization task was done on the kitchen wall, a patchwork of words and thoughts. I reflected on the notes looking for “meaning units” (Giorgi, 1989a, p. 49). Twelve major meaning units were initially discovered. As I spent more time with the meaning units or themes I saw there was a natural fit between some of the themes. Three major themes emerged with sub themes.

I re-read the interviews. On the transcribed text of description, I began to mark each theme and section with a different colored highlighter. Highlighting the words of the participants to separate the meaning units preserved the perspective of the interviewee. It was difficult to analyze the whole text. It made sense to break the text into sections that were more manageable. As Giorgi (1985) stated, “Here is the practice of science within the ‘context of discovery’” (p. 14). What is discovered in the text depends largely on the

perspective of the researcher and “transforms the interviewee’s words into language that echoes the researcher’s own beliefs as well as those of the professional discipline” (Drew, 2004, p. 217). Giorgi (1989b) also supports the researcher analyzing the data from the perspective of his or her particular discipline. I looked at my data from an occupational therapy perspective. A perspective is founded on the values and beliefs of that individual or profession. I have shared and embedded my beliefs in my writing. The values and beliefs of occupational therapy are outlined in Appendix H.

Using weaving to describe the meaning units. I reviewed the meaning units once more. This review called for reflection and free imaginative variation. Imagining alternative ways of expressing the meaning units were used to see if the experience remained clear. Having identified three themes and sub themes, I used quotes from the participants that projected the richness found in the interviews. The essences or experiences were then described with a variety of metaphors, a work in progress.

The clustered themes were shared with three occupational therapists. Giorgi (1994) suggests this technique where members of the same “disciplinary community” (p. 209) confirm the researcher’s perspective. The therapists were asked to review the information “to critique or verify the expression” (p. 209). Our conversation about the themes was dynamic and thought provoking. The quotes expressed in each of the themes and sub themes were supported. Our discussion was lively when looking at the linguistic descriptors or metaphorical choice for each theme. Experience, past and present, influenced how each of us responded to the metaphor. At this point in my journey, I presented my work to my advisory committee. Their response to the grouping of quotes was affirming. Our conversation was again thought provoking. What is the best

metaphorical descriptor of the themes? I was left with the task to find “the right look.” The linguistic expression of phenomenology is the research. “Intuiting disciplinary meanings” (p. 209) is the task of the researcher.

An arts and crafts metaphor emerged through the process, much to my surprise. Discussion with my advisor led me to choose weaving as a metaphor to help frame my research. Working with the metaphor of weaving I presented the work again to the occupational therapists: The metaphor resonated.

Writing

The final step in the research process is writing. As Max van Manen (2003) notes, “Human science research as writing is an original activity” (p. 173). He questions whether language can represent lived experience. Can the uniqueness of the participant be described in words of my choosing? No, I must use their words. Are the words themselves able to reflect the intent? As van Manen concludes, “it may still be possible and worthwhile to try to emulate our pre-reflective life by means of life-world sensitive texts” (p. xiii). Giorgi (1994) points out that “One of the most difficult tasks in qualitative research is the expression of findings on the part of the researcher” (p. 208).

It was my task to express my results so that a sense of living was created. Metaphors generate a bigger picture, create energy and expose emotions. Metaphor is phenomenology. I began to weave the testimonies of the participants with the structural warp of phenomenology to engage the reader into this human experience. The relationship between my findings and the metaphor of weaving helped me build the story of the lived experience of home-based client-centred occupational therapy.

I prepared my research loom with accurate transcriptions of the participants' stories. Quotations, of varied length, were chosen to best describe their stories and experiences. I continued to expose my own biases through field notes and musings on particular aspects of my project. Phenomenological validity was created in the writing of the findings. Reassembling the parts of the analysis into the whole captured the lived experience. I hoped the experiences would resonate with my readers. "Phenomenological descriptions, if done well, are compelling and insightful" (van Manen, 2003, p. 8).

Conclusion

I am inspired by the work of Amedeo Giorgi, who has dedicated forty years to advancing the world of phenomenology. My three years of study have been guided by his work and words. Giorgi's (2000c) support for making mistakes in the pursuit of phenomenology motivates me to keep trying. "The solution is not to chase researchers away from phenomenology, but rather to have them understand it better" (p. 3). His publications, critiques and reviews (2000b, 2000c) have helped and challenged me to see and practice phenomenology.

"Lived experience is the starting point and end point of phenomenological research" (van Manen, 2003, p. 36). Husserl's descriptive phenomenology with the accompanying phenomenological reduction aims to capture the "description of the research participant's life-world" (Ashworth, 1999, p. 3). Phenomenology is the perfect fit for determining what is the lived experience of receiving client-centred occupational therapy in the home.

Chapter 4: Building the Tapestry

It is because of my early roots in occupational therapy that I have chosen to discuss my research using the metaphor of weaving. I began my training learning a variety of crafts. Of these, my most intensive and creative project was learning to weave using a loom. My recent academic project, this master's thesis, offers a number of parallel experiences. My early mornings have passed working with the warp threads, reading the literature and reviewing the results of my own research.

As Murray (1975) indicates, "The metaphor can be seen as a matter of teaching an old word new tricks, of applying an old label in a new way" (p. 286). For me, being able to connect my early training in weaving with today's phenomenological approach is like bringing an old and a new friend together for the first time. Under the eyes of an experienced artisan, I recall many early mornings spent on the loom weaving, only to have to pull the sections that were not quite right, even as I neared the completion of the project. As with weaving, the planning, preparation and doing of various tasks required for the completion of a thesis results in an extensive amount of time. During this process I have, similarly, received steady support, this time from my academic advisor.

Weaving has its own terminology and intricacies, just as qualitative research has a language and complexity. This metaphor provides a thread between my original learning to today's focus on phenomenology, bracketing, free imaginative variation and essence. Having an opportunity to reflect on these two ways of knowing has deepened my understanding and appreciation of my profession. As with learning to weave, my purpose in studying and conducting phenomenological research has been driven by my need to help others live fuller lives.

My research has focused on the human experience of everyday people who have received client-centred occupational therapy services in their home. Participant comments have been used to describe and intensify this phenomenon. As Halling (2002) notes, “At its best, phenomenology deepens peoples’ appreciation for the depth and nuances of the experience” (p. 35). Although phenomenology can be applied to a multitude of disciplines, it is generally understood that the results will be expressed from the perspective of the researcher’s own discipline (Giorgi, 1994). Using an occupational phenomenological influence will make these stories most powerful for my colleagues in occupational therapy. The stories may also ring true for other health professionals in community settings.

The Warp: Meet the Participants

As described elsewhere, *warp* refers to the foundation, the vertical threads on a loom. The weaving is done across the warp; the process creates a colorful and meaningful tapestry. In the course of preparing to thread the loom of my research project, I interviewed eight ordinary people who shared the experience of receiving occupational therapy services in their homes. All of the participants had changes in their health and willingly shared their story. Due to newfound physical limitations, each had difficulties with self-care. An occupational therapist visited each participant at least three times.

John

John is a 45-year-old married man. He has a close relationship with his wife and children. He and his wife live in a split-level house in a bedroom community. John worked as a long haul truck driver and enjoyed the camaraderie with his fellow drivers. His income was such that his wife did not need to work to meet their household expenses.

Two years ago John became ill over Christmas. He experienced splitting headaches, blurred vision and was unable to drive his truck. He entered the medical system seeking a quick answer and anxious to get back to work. Although his presenting symptoms led to a series of tests, the results did not lead to a specific diagnosis or treatment. John had never been seriously ill; however, four months later he was diagnosed as having multiple sclerosis.

John has been involved with two occupational therapists, one in the hospital setting and the second in his home. He has limited energy and requires assistance to stand and move about. An occupational therapist has assessed his home environment for accessibility, and reviewed his transfers from bed to wheelchair, wheelchair to recliner and wheelchair to toilet. Therapy has primarily focused on increasing his ability to perform self-care activities. John has not been able to return to work.

Creating and spinning the thread. As I sat in John and Sally's newly renovated basement, I was grateful for their willingness to talk about their occupational therapist, Karen. Our conversation began with John sharing his loss of health; he was devastated. He had never before been so involved with the health system and he was depressed by the experience. Recognizing how he felt I moved forward gently with my probing questions.

As John focused on his time with Karen his mood lightened, his responses came quickly and he readily entered into our conversation. John described Karen as talking to "me" and asking him, "What do you think? What will this help? Can you reach?" He went further to say, "Karen was always thinking of me." I sensed the importance of being recognized as a person, an individual; John came alive as he spoke in this manner. He repeated, "Karen was talking to me" and then emphasized that "She truly believed in

you.” I heard the feeling of being treated as a person rather than a disability and that this feeling came as a surprise to him.

John and Sally discussed how with his physical limitations they had to look at renovating their home to allow room for his wheelchair. Karen had participated in their review of what physically needed to be changed. Describing her participation, John stated, “*Karen respects our needs, our feelings and our privacy.*” Karen demonstrated her respect by her way of acknowledging and supporting them as well as honoring their personal space.

John talked about what he felt Karen did that made him feel important and respected as a person. He said, “*Just the way Karen listens. [She] pays attention.*” He knew she was listening to him by her appropriate responses and suggestions following their conversation. He observed that she always came in and sat down; Sally added, “*Just like you are doing, sitting down with us.*” I sensed that sitting demonstrated listening; a readiness to listen is established. Karen had spent a lot of time with them; at least that was John’s perception. He never felt hurried, nor did he feel that she was pressed for time. He stated “*Just the way she came in. Karen was just so, let’s do this you know like it wasn’t I have to be here. I have somewhere else to be. I have another appointment in ten minutes. Hurry up already.*” The giving of time supports the experience of active listening.

John expressed he has had moments of despair adjusting to his changed physical condition. He found his time with Karen was different, “*Karen was a burst of sunshine in all this negativeness we had had.*” Both he and his wife felt good about themselves. John

again said, *“Karen makes your days brighter.”* He went further to say, *“She probably brings out the best in people.”*

As John struggled with how he personally managed every day, not walking as he did before nor having the energy to easily start a new day, he found Karen to be very supportive. Sally echoed her husband’s point that the occupational therapist was positive and offered a great deal of support. *“Karen definitely encourages. Always encouraging him to do as much on his own as he can without aids.”*

As we ended our conversation about being with Karen the following comments by John brought tears to Sally’s eyes, *“Karen knew exactly who you were. You’re not just another client. When Karen leaves your house, she does not leave you. You know Karen cares.”* John explained, *“I would say Karen was very connected with us.”*

Sherry

Sherry is 55 years old. Prior to moving to a bedroom community a year ago, she and her husband lived in the city. She has worked as an insurance adjuster and as a personal caregiver. Over the years she has cared for 14 foster children and who remain very much a part of her extended family.

Ten years ago she became ill and went into a coma. She was in the hospital for five years. Upon discharge, she could not easily move her arms and legs and had lost her short-term memory. She now walks independently and performs her own self-care. At the time of my first interview, she had been given the dual diagnoses of multiple sclerosis and Parkinson’s. Sherry and her husband do not work; they live on her disability income as her husband plays a care giving role when needed.

Sherry has worked with two occupational therapists. The first therapist focused on improving the fine motor abilities of her hands, as well as helping her to carry out self care skills. Once home, the second therapist evaluated her home for accessibility. She continues to have days when she experiences weakness and pain.

Creating and spinning the thread. Sherry and I began our conversation sitting at her kitchen table. Sherry was having a good day, where she felt full of energy and walked using only a cane. Sherry had spent a lot of time in the health system; she had many stories, positive and negative, to share with me. Initially I was overwhelmed by the depth of her health history; thankfully, I was able to focus myself and eventually Sherry, on her time spent with Jill, the occupational therapist that had worked with her at home.

Sherry started her story by emphatically saying, “*Not once, not even once, not even a feeling of, did Jill ever make me feel incomplete. She always left you feeling like you were a whole person.*” According to Sherry, Jill recognized Sherry as an individual person in all their interactions. Sherry valued this relationship and went on to say, “*Jill makes me feel like a regular person. She doesn’t treat me any differently than the next-door neighbor. Okay she doesn’t see the wheelchair.*” Sherry had spent many years in a wheelchair; she felt that people initially responded to the chair and not to her. Jill demonstrated an ability to communicate to Sherry on a human level.

As our conversation continued Sherry became more passionate as she shared her experience about being respected. She asserted, “*Jill sees me as a regular person; as a human being that is entitled to respect and dignity no matter what.*” Sherry recounted another time when she had been unavoidably late for her appointment with a medical specialist; the rude response from the receptionist left her angry and frustrated.

Sherry, just like John, was able to identify specific actions that Jill took to build their relationship. *“Jill listened. She didn’t interrupt while you were talking. When Jill had questions about what you were saying she would wait until you were finished and then she would ask some questions.”* Sherry was very matter of fact in her descriptions of Jill’s behaviour and there seemed to be a hint of surprise that I could not describe them myself. Sherry also spoke about her perception of time, *“Jill never makes you feel like she is hard pressed for time. Jill will spend all the time in the world with you.”* Although time is a precious commodity, it’s something we are all capable of giving.

Sherry had worked with Jill learning how to independently get out of bed on the days she was weaker. Sherry’s response to this process was, *“Jill has taken care of all my needs before I knew I needed them.”* Jill’s knowledge and experience enabled Sherry to be successful in living in her home. Recalling her interactions with her therapist, Sherry indicated that *“Jill was always just bubbly and interested and that meant a lot to me.”* Additionally, she mentioned that *“You can truly tell Jill likes her job and her clients. Jill likes what she does and it shows how we are treated.”* Sherry quickly reinforced this feeling of optimism by saying, *“Okay, Jill loves what she does and because she loves what she does you like being with her.”* People will generally respond to a positive presentation; being positive has a contagious effect.

While in hospital, Sherry constantly wished to return home to be with her family. Her short term memory may have been poor but her memories of family kept her striving to get healthy to go home. As Jill assessed Sherry’s home environment, Sherry commented, *“Jill always gives you a choice. She doesn’t say you have to do this or you gotta [sic] do that. Jill says what do you think we can do? Do you think we can handle*

this or try it another way? Or forget it altogether; it's up to you." It was important to Sherry to have options on how to meet her needs in her own home. Sherry did not want to be pressured into making her decisions and put it this way, "*Jill doesn't walk into the house and say do this and this."*

As Sherry reflected on her time with Jill she said this, "*Jill always made sure I understood what she was saying. Always."* Understanding the information is critical to learning. Sherry spoke of her sessions with Jill as one of exploration and said it this way, "*If you can't work one way, you work another way and Jill finds it."*

Joan

Joan is 52 years old and lives with her retired husband in a rural community. She worked in the health care field for over 25 years, as a social worker. Her children, who live in other communities, maintain weekly contact. Although Joan has never been seriously ill, two years ago she began having pain in her joints. As the pain and reduced movement became unbearable, she was hospitalized and had to stop working. Joan was diagnosed as having rheumatoid arthritis and began working with an occupational therapist in her home. Taking great pride in being an active mother and career woman, she initially returned to work. Her abilities to care for herself have continued to change and recently she has suffered heart complications. On the day of my last interview, she had just resigned from her position at work due to her medical condition.

Creating and spinning the thread. As I sat with Joan in her living room I felt welcomed and comfortable. Joan reclined in her lazy boy armchair with a soft woolen comforter over her thin body; she smiled as she signed the consent form to participate in my research project. Joan recaptured her two-year journey with her loss of health. To her

it seemed like an eternity, impossibility and a looming reality. She frequently compared herself to her aging mother whose health was perfect.

My list of client-centred qualities helped Joan to attend to her time with Karen, her occupational therapist. Joan spoke slowly and reflectively as she said, *“Karen didn’t make me feel like a fool. She asked my opinion and she valued my opinion. We worked together.”* Karen had visited her at home looking at how Joan managed herself in her bathroom. Continuing, she added *“Karen gave me choices on things to do and that shows respect. It shows you are included. It demonstrates her appreciation of my input and hers.”* When Karen affirmed her wishes, perspectives and opinions, it indicated that she had ‘heard’ Joan, demonstrating respect. Being present in a conversation enables understanding and subsequently builds rapport. Joan addresses this in her comment, *“Karen said things that demonstrated that she knew and appreciated where I was coming from.”* She reinforced this concept by saying, *“I felt she understood what I was saying about work.”* For Joan, conversing with Karen enabled her to better understand herself in the context of the present as well as envisioning her future self.

Joan was also able to describe Karen’s behaviors during their sessions together. *“Karen sat down face to face with me. If there is something I don’t like its, and I know people don’t really mean it, but they are often standing up there and you are down here.”*

This description has been mentioned before, sitting demonstrated active listening, being present in the conversation encouraged people to share.

Joan spoke with surprise when she said, *“Karen would actually demonstrate. We actually went into the kitchen.”* She went on to describe looking at her kitchen utensils and experimenting with how to hold them with comfort and ease. Joan explained, *“Karen*

actually saw what I could and couldn't do rather than just asking." Relating learning to the present is meaningful, as well as seeing how a task is done reinforces the learning.

Karen offered alternate ways of learning when she demonstrated skills in Joan's kitchen.

Joan identified that she had seen many different health professionals as she gathered information on her disease, rheumatoid arthritis. She commented that, "*Often in the medical field you feel that people are telling you to do this and telling you not to do that.*" She emphasized that, "*Karen helped normalize things.*" When your health changes there are decisions to be made on what you can or cannot do. Without choice, people felt out of the ordinary. Joan became comfortable with her abilities as she continued to work and talk with Karen.

Joan and Karen's conversations moved towards what was really important in Joan's life. Joan expressed, "*I needed at that time somebody to support my visions of going back to work.*" As Joan struggled with her changing body she hung on to the idea of working. She saw this aspect of her life as the place where she could still be herself. Her conversations with Karen led her to realize that there was more left in her life than she thought. Joan went further to say, "*Talking about visions 'cause I thought I would have to stop all that I am doing. But I didn't have to.*"

The support that Karen provided to Joan was critical to Joan's self esteem. Joan saw the relationship this way:

Hear what my interests were not just what I could and couldn't do but my interests. What I wanted to do and together we would explore ways around that I could do parts of things. I didn't have to give up. I didn't have to give up being

with my grandchildren. I can't run and play hide and seek but I can read and they can sit on my knee. They can still have fun doing things like that or I can.

Joan's comments changed from "I can't" to "I can," she experienced client-centred care as enabling.

Joan found that the information and ideas that Karen brought forward helped her to make changes in her life. She was surprised at how raising the height of the toilet seat could make it so much easier on her knees. She repeatedly returned to the idea of how a raised toilet seat was so simple and yet had such an impact. She shared, "*Karen offered her expertise and then we could make the decisions together about things.*" She expanded her comment by saying, "*Sometimes you don't think of it [ideas], putting it out there, I guess makes you think of it.*" Joan appreciated how Karen facilitated her to think more broadly, increasing her knowledge base.

Brenda

Brenda, aged 70, worked as an elementary school teacher while her husband farmed. A year ago they were retired, living on their savings and pension plans, when his health changed. Over the past year and a half, she has had heart problems and suffered a mild stroke. Brenda attempted to provide care for her husband. She worked with an occupational therapist in supporting her husband and had therapy sessions for her own needs. However, she was not able to physically manage the care for her husband and he was admitted to a long-term care facility. Brenda's occupational therapy program focused on energy conservation skills as well as reinforcing exercises for clear speech. Brenda continues to be active with friends and family. Sadly though, in the time period between my two interviews her husband died.

Creating and spinning the thread. Brenda and I sat at her kitchen table, a warm and comfortable place in her home. Brenda easily spoke about her time with Jill. She described times when her husband needed help in managing at home and then how she needed help to recover from her stroke. I was struck by her emotions when she said, “*Jill encouraged me not to give up.*”

Brenda referred to her background as a teacher and how important learning was to her. She highlighted that when working with Jill she had felt a confidence and strength in her actions, she explained, “*Jill knew what she was doing. Everything is in the right place; we have got all the right equipment you know. It’s all been because of her comments or her acting.*” Brenda expressed “*Jill has given us so much information.*” Knowing more about how to help her husband and herself was very important to Brenda. She did not appreciate being pressured into making quick decisions and described Jill’s behaviour as “*Never pushy, never. Always just suggestions.*” She repeatedly stated, “*Jill was an excellent listener.*”

“*Jill never looked at her watch.*” Brenda found this action affirming and supporting as she and her husband valued the time Jill spent with them. Brenda felt a bond with her therapist, she described it this way, “*Caring. Just trying to always look out for my best interests in what she was doing here.*” The thoughtful actions of Jill made Brenda say, “*Jill made me feel she really wanted me to get better.*”

Martha

Martha is 83 years old and has been a widow for over 15 years and until recently she had been living in her own home. When Martha was employed, she worked in the kitchen of the local hospital. She is able to support herself on her pension and savings.

She spent a number of years taking care of her ailing mother and then her husband.

Martha has had heart problems and one year ago, she fell. Following surgery to repair a broken hip, she returned home. An occupational therapist visited Martha at home to assess her needs for a wheelchair. Martha learned how to perform her self-care skills and kitchen tasks from sitting in a wheelchair. Over the year, Martha's abilities weakened so it was unsafe to live alone. She decided to move into a seniors lodge setting. Martha worked with the occupational therapist on becoming self sufficient from the wheelchair in the lodge.

Creating and spinning the thread. Martha and I talked in her room at the lodge, she sat in her wheelchair and I sat next to her on her bed. Martha started talking by stressing that "*Jill had talked to me*" when she visited. She remembered feeling positive about Jill's visits both to her previous home and to her new home, the lodge. When she described working with Jill in her old kitchen, she said, "*Jill knew what she was doing.*" Her most poignant comment was, "*It's almost like as if Jill opened the door to everything; to a whole new thing or to everything.*" Martha had many challenges in her life; but her ability to face the physical changes in her life was enabled by her conversations with Jill.

Jean

Jean is a 74-year-old widow who has recently moved a single dwelling home to a one-bedroom apartment. She has breathing and heart issues and although she worked with an occupational therapist to make her home wheelchair accessible, she did not have the stamina to continue managing in her home. Having never worked outside the home, she now lives on her savings and her husband's pension.

At the time of my interview, she had been in an apartment for two months. She walks in her apartment using a wheeled walker. As she tires very easily, the one-hour interview left her exhausted. Jean continues to work with the occupational therapist on energy conservation skills. Her three adult children provide support when they can.

Creating and spinning the thread. Jean and I sat together in her living room; she reclined in her lazy boy chair, taking deliberate, slow breaths. She was concerned that her quiet voice would not be heard on the tape recorder, so I placed the recorder close to her. Jean described a session where she showed Karen, her occupational therapist, how she walked about her house and had to sit down a number of times to catch her breath. Karen had helped her choose a wheelchair, she said, “*Karen gave me information on how to use the chair. She answered my questions.*” Jean reinforced that “*Karen was very helpful, she explained everything so I could understand everything,*” she added, “*If I looked a little bit puzzled she would try again.*” Jean closed with saying, “*I believe Karen is really trying hard to help a person at least that is what she did with me.*”

Brian

Brian is a single 53-year-old man with multiple sclerosis. Although he has always lived in low-cost housing, for the last ten years he has lived on a disability income. Over the past year, his ability to walk has steadily decreased. Although he has been using a power scooter for outside mobility, the scooter is too large to use inside his studio suite.

He was able to stand and move slowly from one seated surface to another but he does have difficulty walking safely within his apartment. He made contact with the health region in order to have an occupational therapist assess his need for a power wheelchair

for use within his home. At the time of my interview he had received notice that his application was successful and he was awaiting delivery from the factory.

Creating and spinning the thread. Brian sat in his manual wheelchair while I perched on a kitchen stool. Brian did not make a lot of eye contact while we talked but he was comfortable sharing comments about working with his occupational therapist, Jill. He opened by expressing, “*Jill was always there for me.*” He felt she was “*very concerned*” about getting all the right information for him about power wheelchairs. He identified that it was her work that “*got it [power wheelchair] approved the first time around.*”

Sheila

Sheila is a 75-year-old widow living in a new home in a bedroom community. When she was twenty she emigrated from Europe with her husband to Canada and has never worked outside of the home. She experiences chronic discomfort from osteoarthritis, causing her hips and knees not to move easily.

Although, Sheila was having difficulty getting in and out of the bathtub safely and comfortably, she refused personal assistance from home care staff to bathe. Sheila did, however, work with one occupational therapist to evaluate her options for independence in the bathtub. She successfully bathed using a special water-powered bath lift. Sheila looked forward to her weekly contact from her daughter, a teacher.

Creating and spinning the thread. As I sat across from Sheila in her sun lit living room, she seemed uncomfortable about our conversation about working with Karen. Sheila became more at ease the longer we talked. Sheila felt that “*Karen had suggestions of what to do and what would work best for me*” and that “*Karen’s suggestions give me a*

chance to live in my own house.” Sheila laughed when she described Karen, “*She’s bubbly, (more laughter), bubbly.*”

The Weft: Meaning Units

Phenomenology, the study of the lived experience of people, brings a deeper understanding of the phenomena. Occupational therapy looks at the lived experience of people to better understand how to enable them to live in their life-world. Seeing the “humanness” of people, appreciating their feelings, and their experiences builds relationships. Health is about relationships. As Virginia Fearing and Jo Clark (2000) state, “Because client-centred practice is all about human relationships, it is important to know ourselves and to appreciate the differences among us” (p. 4).

The participants’ lived experience of receiving client-centred occupational therapy in their home has been woven into three main thematic clusters: 1) The Thread, 2) The Weave, and 3) The Texture. Each theme contributes to exposing the experience of home-based client-centred occupational therapy.

The Thread

The qualities of the threads are important in designing a tapestry. A tapestry is created using a strong warp and has weft threads that are stiff and yet soft enough to fully cover the warp. In building the client-centred tapestry, the participants exposed two important traits of their personhood. They described two distinctive threads: being acknowledged and being respected.

Being acknowledged. The loss of health was expressed as being harsh on some participants therefore it is important to see the person and not his or her disability. My conversations with the participants about their time with a client-centred occupational

therapist caused an aliveness to appear in their voices. As each individual was recognized for their personhood; they came alive. The feeling of being a person first was almost a surprise. The participants felt overshadowed in the medical system, yet when they felt acknowledged as people there was a sense of hope.

Being respected. Respect was demonstrated by inclusion, giving of information, and supporting choice. The participants felt they were listened to when the therapist affirmed their wishes, perspectives and opinions. Appreciating their feelings and experiences built a relationship with their therapist. Their conversations with their occupational therapist allowed an expression of self and developed an awareness of their personal future.

The Weave

Different types of weave are used to build a tapestry. The most basic weave has the horizontal threads alternately crossing over and under the warp threads; known as a plain weave. Other basic weaves produce a diagonal pattern or a luster on the surface. The weave choice highlights the threads as they are brought to the surface. I found five different weaves in the client-centred experience: she listens, she took time, she shows me, she knows what she is doing, and she projects a positive attitude. The participants saw these weaves in their experience and each weave interlocked forming a dynamic and powerful tapestry.

She listens. She took time. Listening allowed a conversation to happen and physically sitting down supported active listening. When the therapist was actively present in the conversation, the participants were encouraged to share. Listening to and

taking time with clients enabled the delivery of client-centred therapy. All participants valued being able to spend time with their therapist.

She shows me. Demonstrating a skill was an effective teaching method, as described by Joan and breaking the task into parts more readily matched her ability. Having the participants perform activities provided a precise picture to the therapist. Seeing a task done allowed the therapists to make their own evaluation. According to Brenda, experience was a good teacher.

She knows what she is doing. “To be experienced, we must understand that which we experience” (Wood, 2006, p. 15). Providing a successful service required knowledge and experience, this was echoed by John. Having knowledge allows for opportunities to gather more information as Brian found out learning about power wheelchairs. As Sherry experienced, being familiar with the big picture enabled anticipation of the next step. The therapists abilities to deliver this knowledge in a timely, and sometimes faster than expected, fashion was appreciated.

She projects a positive attitude. All the participants responded to a positive presentation and readily engaged in the therapy. As the occupational therapists enjoyed their work, the participants also felt good about themselves and showed that the consistency of a positive attitude can spill over to others.

The Texture

The nature of the texture depends on the qualities of the threads and how they are arranged. The participants spoke about several sides of their lived experience. Just as you gaze at a tapestry or turn it over you will see that the parts change and duplicate. The participants saw actions stand out and behaviors repeated. A tapestry has parts that

engage people and parts that do not. Personal conversations can feel positive or negative. The experiences of occupational therapy can vary; therapy sessions can be constructive or depressing (Corring & Cook, 1999; Rebeiro, 2000). Four simple textures surfaced in building the tapestry: choices, support, informed decision making, and caring.

Choices. The participants repeatedly spoke of being given choices or options. The interviews affirmed these opportunities. Participants felt that when they were given choices they wanted an element of control over these choices. Having control over their decisions was valued. In comparison, choice was not given as an option with other medical personnel. How the choices were presented would influence the participants' response. Both Sherry and John had been searching for an answer to their health problems in the medical world for a while before being diagnosed properly. The state of being in limbo was isolating, frustrating and negative. They could not or would not make choices when they did not know their diagnosis. Sherry and John were not healthy but wanted choice. Having choice is healthy though being healthy speaks of choice. When your health changes there are decisions to be made on what you can or cannot do. Without choice, people felt out of the ordinary. Choice became an exploration. The therapist facilitated a search for solutions. All the participants had a change in physical ability and yet they became aware of choice through their interactions with their occupational therapist.

Support. As the participants shared their health history they identified needing support. The experience of being unwell caused a sense of inability, loss of control and loss of direction in their lives. The texture of their lives became loose and disconnected.

Having the conversation on how to continue daily activities became the engine to living. Participants' lives became bearable.

Promoting and reinforcing the achievement of skills encouraged the participants to continue their efforts. Support is built on knowing and seeing. Support has an understanding of passions and interests. Support is enabling. As Joan discovered, facilitating abilities promotes positive self-esteem.

Informed decision making. The participants found that getting the information is the first step, followed by understanding what is received, leading to actually using the information. Sheila's experience with her therapist enabled an informed decision on her wheelchair choice.

Information does not have to be new; it can be stopping to have a second look or reflecting on what is already known, as Joan expressed. The therapist challenged Joan's thinking. Additionally, information can be new; it may help us to see things more clearly and provides the platform to make decisions. John and Sally found this to be true when renovating their basement.

Caring. Caring is a catalyst to health. Being both cared for and cared about was positively expressed and is a powerful relationship builder. These caring moments were personal for the participants. Caring is about knowing the person and sharing their lives. Caring formed a bond to meet the participants' needs. This texture was soft and warm. These thoughtful actions focused the participants' awareness on their abilities instead of their limitations.

A Final Touch

Eight ordinary people have shared their points of view about their lived experience of receiving client-centred occupational therapy in their home. The threads of being seen and being respected were strongly supported. The five weaves of listening, taking time, demonstrating, having knowledge, and projecting a positive attitude built four simple textures. These textures of having opportunity for choice, receiving support, getting information, and being cared about, blend to form their lived experience. These three themes -- The Thread, The Weave and The Texture -- interlocked to create the phenomenological structure or tapestry of the lived experience of receiving client-centred occupational therapy in the home.

Musings on Phenomenology

I have sat with my results and mulled over how to present and write about them. Amedeo Giorgi (1994) promotes living with one's data. Yes, I have lived with my data. I have had bright "Aha!" moments that quickly turned to not knowing. I have experienced not being able to say the word phenomenology and then seeing the 'being' of my results. I tenaciously stayed with the phenomenological approach, trying it again and again. This was the key to my success.

The support of my colleagues, their encouragement and questioning also allowed me to stay with descriptive phenomenology. Initially descriptive phenomenology was a 'gut' feeling. It was that 'the given' was the fit. As I continued to read, write and attend educational opportunities related to phenomenology I began to 'see' descriptive phenomenology as the method of inquiry. I became comfortable using the words. I did

not always understand everything. There were moments of clarity and moments of confusion. Both these moments continue.

I am always excited and passionate about hearing the point of view of the clients. I am learning about learning. I am sharing and receiving. The path of my learning is always a step ahead of me and then the information that I find just seems to fit. Is this destiny or coincidence or do I make my own path blindly? I have more to learn, it is hard to believe that I know what I know now about weaving, client-centred practice, and phenomenology. Tomorrow I will know more.

Musings on the Tapestry

The present buzzwords for occupational therapy practice include “evidence based” and “best practice.” The testimonies of these participants are the evidence. Their conversations show “strong” practice. Chapter 5 displays the tapestry where it can be easily seen, where it can be related to other works, where it can be evaluated, and where it can be mused upon.

Chapter 5: Displaying the Tapestry

This study examines the threads of the lived experience of receiving client-centred occupational therapy in the home. The results of this study are the voices of eight individuals sharing their experience; it is their conversations that bring the life-world of home-based client-centred occupational therapy to the surface of our everyday understanding.

Revisiting the Tapestry

Reflecting on my findings, I saw that although my participants may not have known the definition of client-centred practice, in relating their experiences they described this very practice. Guided by my question of ‘tell me a time when this quality happened’ allowed their pre-reflective moments to surface. Their conversations described their lived experience highlighting the meaningful threads of client-centred practice. Although each participant’s circumstance was unique, they shared many similar experiences. In discovering the meaning units and bringing these parts back into the whole, an identifiable structure emerged. Like an artisan who weaves a fine tapestry, the creative process is as much a part of the art as is the tangible outcome.

In other words, like Maria Piantanida and Noreen Garman (1999), “I am claiming to portray the essence of my experience with an understanding of the phenomenon. If I have inquired into the phenomenon with sensitivity, rigor and integrity, then the way I understand the phenomenon, the way I have made sense of it, may have utility for others who are struggling with phenomenon in similar contexts” (p. 145). My participants’ stories have inspired me to weave a tapestry of words, something that in its beauty

celebrates the delivery of client-centred occupational therapy, but also teach these principles.

The results of my research have been expressed as 1) The Thread, 2) The Weave, and 3) The Texture. The first step to embarking on weaving a tapestry is to choose the threads that will create the desired look. Next the weaver must determine the type of weave to employ in order to highlight these threads. It is not until the project is completed, however, that the overall texture of the tapestry is revealed. I will begin my display by discussing 'The Thread.'

The Thread

Being acknowledged. Each participant spoke positively about the relationship that each of them had with their occupational therapist. The participants felt they were acknowledged as persons. This affirmation was expressed by the clients mentioned in Deborah Corring and Joanne Cook's (1999) study of clients' perspective on occupational therapy services in a mental health setting. One of the clients stressed how being valued was personally important and poignantly stated "I am a valued human being" (p. 71). The science of 'social neuroscience' offers biological significance and evidence supporting the positive effects of being valued. Daniel Goleman (2006) refers to this as a "people prescription" (p. 250) where the medical professional refrains from focusing on a specific disease and instead approaches the client as an individual person. This concept is supported by Townsend et al. (2003): "Client-centred practice involves working *with* people" (p. 18). The word "with" suggests a relationship based on mutual respect.

In describing the principles of client-centred practice, Law et al. (1995) began by addressing the uniqueness of each client, with an emphasis on the importance of clients

knowing themselves best. This latter idea, of the client as ‘expert’ was not specifically discussed in the course of administering my study. It was in knowing that they felt recognized and accepted as individuals; the participants became the authority of their needs and desires.

Client-centred practice is all about people: understanding who they are, how they feel, what they do, why they are here, where they want to go, and when they want to do things. The clients who took part in my study all spoke glowingly about their time with occupational therapy. In Corring and Cook’s (1999) study, however, a client stated that “I want some kind of response – an emotional response that I exist as an [sic] human being...” (p. 78).

Being respected. Boeree (2004) defines respect as “acceptance, unconditional positive regard towards the client” (p. 7). Being accepting of others is what builds positive relationships. Marlene Falardeau and Marie Jose Durand (2002) found that respect was a core element. They reviewed many concepts of respect settling for the understanding that respect is present when someone is “paying attention” (p. 138) to another in order to be aware of their way of thinking and wishes. In her assessment of frameworks that centred on the client, patient and family, Mary Law (1998) discovered that these approaches stressed the importance of respect for clients and families. Respect is the thread that all conversations and interventions build upon, something that those who participated in my study experienced. “*She respects our needs, our feelings and our privacy*” said John. These threads of acknowledgement and respect, therefore, represent the strength and spirit of client-centred practice.

The Weave

As suggested earlier, many different types of weaves may be used in the process of creating a tapestry. Weavers make a weave selection that will complement their desired pattern. Occupational therapists also dictate the pattern of client responses that they will elicit. It is the occupational therapist's choice to exhibit behaviours that convey to the client they are acknowledged and respected. The definition of client-centred practice uses these words: "demonstrate, involve, advocate and recognize" (CAOT, 2002, p. 180). The participants went one layer deeper to pick out the exact behaviours the therapist had when working with them. In their interactions with occupational therapists, my participants highlighted a number of behaviours that were of particular importance to them in the treatment process: listening, taking time, projecting a positive attitude, demonstrating and having professional knowledge.

She listens. She took time. She projects a positive attitude. In facilitating the College of Occupational Therapists' (UK) definition of client-centred practice, Sumsion (2000b) includes "the therapist listens to" (p. 308). Discussing the historical roots of client-centred practice, Mary Law (1998) refers to Carl Rogers', the founder of client-centred practice. Probing further, Law emphasizes the importance of taking the time to listen to the lived experience of the client. Indeed, the perception of a therapist's ability to spend time with them was something that was valued and remembered by the participants in my study. The presence of having time builds a relationship; the opportunity to listen as well as to offer our total attention is what establishes a connection with the client.

A therapist by a projection of their attitude establishes a positive or negative milieu. Being able to project a positive attitude not only builds rapport but is contagious.

Nonetheless, much of the existing literature pertaining to client-centred practice has paid little attention to this skill. In explaining the process of building rapport, however, Daniel Goleman (2006) does refer to positive feelings. In outlining the first step he suggests that paying attention to others and making them feel good is critical. A good feeling can be evoked “through tone of voice and facial expression” (p. 30). One of my participants commented, “*She’s always so bubbly.*” I chose to describe her comment as the ‘champagne effect,’ the positive feeling needed in establishing rapport between therapist and client.

Linda Tickle-Degnen and Robert Rosenthal (1990) sought to describe the appearance of rapport and how one experiences rapport. They identified three essential elements to creating rapport: mutual attentiveness, positivity and coordination between individuals. The initial stage of building rapport requires a higher balance of mutual interest and friendliness, higher than once rapport is established. Together these two qualities will enable rapport to emerge. One of my participants stated, “*She was always just bubbly and interested. That meant a lot to me.*” Building rapport is a vital step in client-centred practice.

Similarly, the use of humour is a factor that can serve to speed up the process of rapport building. Clients responding to what a client-centred therapist acts like listed having a sense of humour as an action (Bibyk et al., 1999). “Humour is a familiar and informal form of communication,” stated Virginia Fearing (2000), in a very brief overview of the use of humour, as she discussed being present in the client-therapist process (p. 18).

She shows me. She knows what she is doing. A client-centred therapist is a skilled educator and an excellent communicator (Gerteis et al., 1993). These two skills are implicit in the definitions of client-centred practice (CAOT, 2002; Sumsion, 2000b) and are essential if the clients are to master skills they value and are likely to use (Hammel, 1998). Skills that are important to the client go without saying in client-centred practice. The therapist's academic and practical knowledge plays a major role in assisting the client to achieve their goals. Educating clients "to discover a new way of living" includes words, written and verbal, as well as demonstrating tasks, movements or skills (CAOT, 2002, p. 50). Using language that is familiar to clients facilitates their learning. Communication is critical to client-centred practice.

The language of occupational therapy has been influenced by the biomedical model and the client-centred model. Like all health professions there has been the evolution of "expert" words that are used in our work and exclude others from understanding. The meaning units I discovered in the testimonies of my participants were simple. A simple weave presents itself in the definition of client-centred practice. As I reflect on the conversations with my participants I return to this weave of simplicity. Using simple, humanistic words could position occupational therapy close to the client.

The Texture

The warp or vertical threads are initially wound on to the loom forming the foundation for the project. As the weft threads are woven horizontally across the warp, the chosen weave will build and expose the design and texture. Using only two different threads as well as varying the weave produces "unique statements of style and personal vision" (Gonsalves, 1974, p. 40). As my participants shared their feelings of

acknowledgement and respect created by the actions of their occupational therapist a deeper understanding of the experience surfaced. The chosen actions or weaves produced the texture of the lived experience of receiving client-centred occupational therapy in the home. These textures: choices, support, informed decision making, and caring were revealed in the completed project. These four textures are also components of the definition of client-centred occupational therapy (CAOT, 2002; Corring & Cook, 1999; Law et al., 1995; Rebeiro, 2000; Sumsion, 2000b; Wilkins et al., 2001).

Texture in weaving results from a pleasant combination of thread quality, color relationships and pattern. A good design comes from using a simple, direct approach. Texture is created as the weft threads are woven on the warp; these separate elements unite to form a new and exciting presentation. As the threads of acknowledgement and respect were woven, using the weaves of: listening, taking time, projecting a positive attitude, demonstrating and having professional knowledge, these individual parts mix, join, and blend defining client-centred practice. From a client's perspective, the possibility of choice is largely dependent on having access to support and information. A caring environment provides the milieu for receiving the information, seeing the support and instilling the process of making choices. The *Ottawa Charter for Health Promotion* (1986) states, "Health promotion is the process of enabling people to increase control over, and to improve, their health" (p. 1). The charter goes on to say that supportive surroundings, right to obtain information and "opportunities for making healthy choices" enable each person to determine their own health. This Charter continues to be the foundation for wellness initiatives today.

Choices. In the biomedical world routines provide stability and predictability. The quantitative perspective of treating disease thrives on standard processes. The antithesis of this is the concept of choice, generally understood to refer to the possibility of having opportunities and options for living. Being able to make choices eliminates the rigidity of routine; a humanistic way of treating disease by offering individuals unique, flexible, and meaningful services. Karen Rebeiro (2000) discovered from her clients that choice was critical, both in their environment and their occupation. Her clients felt they relied on the health system for direction and expressed that having choice gave them hope for independent living. One client believed “that choice should be foremost in the provision of occupational therapy services” (p. 11). Not surprisingly, Gudrun Palmadottir (2003) found that “limited choice of occupations reduced the potential of occupational therapy” (p. 162).

Support. Two of my participants felt they needed information to have choice. When Brenda spoke about her efforts to improve her speech, for instance, the support and encouragement offered to her provided her with hope. In fact, several participants described situations with their occupational therapist that made things possible. Karen Rebeiro (2000), a researcher who has also studied this concept, indicated that an accepting, supportive environment facilitates discovery, understanding of the individual and is determined by individual desires. Her participants acknowledged that they were motivated to participate and had positive self-esteem when supported.

Informed decision-making. Mary Law et al. (1995) stated, “Clients have the right to receive information” (p. 252). My participants confidently spoke about their journeys with their health; they were knowledgeable about themselves and their experiences. It

was at the point of ‘not knowing’ that I heard them struggle. Their occupational therapist provided facts that related to their needs and provided information that enabled decision making. Seanne Wilkins et al. (2001) pointed to the importance of information in facilitating client-centred practice. She further urged therapists to reflect on how they provide information to their clients to ensure it is understood. Therapists were specifically asked to review the literacy level of their information handouts. One of my participants stressed that her occupational therapist made sure that she understood the information. Client-centred occupational therapy builds a milieu for clients to make their own decisions.

Decisions are often based on the information at hand. Therefore, the new life-world of individuals with disease requires fresh, reframed information that will assist in their decision-making processes. An occupational therapist has the knowledge and experience to provide that information. The value of occupational therapy services is increased when the occupational needs of the clients are identified. Activities that are meaningful to the client will have the greatest success (Carson, 1999).

Caring. Caring is defined as “displaying kindness and concern for others” (Jewell & Abate, 2001, p. 261). Deborah Corring and Joanne Cook (1999) called for occupational therapists to personally and professionally care for their clients; to be advocates for the human side of health delivery. My participants felt the kindness and concern; this warm connection to their therapist built hope. Bibyk et al. (1999) described a client-centred therapist as caring and connected “emotionally and intellectually with the client, where the client is at, not where the therapist believes the client should be” (p. 3). Deborah Corring (1999) identifies caring as the root of occupational therapy.

The Tapestry as a Whole

Much like building a tapestry, I see that all the work performed by occupational therapists to develop a model of practice can be energizing, exhausting, overwhelming and in the end rewarding. Starting with a basic structure, the works of Carl Rogers (1951) and CAOT (1991; 2002), occupational therapy has built a solid, strong foundation of client-centred practice. Choosing threads with just the right characteristics for client-centred practice has required the willingness to explore and seek knowledge, as well as a commitment to planning; patiently waiting for the threads to surface. Taking a look at the work of other professions, I saw a building interest and support for client-centred principles. Family therapists felt the presence of client-centred principles in their practice and were inviting their colleagues to acknowledge its place in their work (Anderson, 2001; Bott, 2001). Physiotherapy stepped briefly into the world of client-centred practice recognizing its value yet uncertain of how to place it within practice (Dalley, 1999). Examining the weft threads of occupational therapists in Canada there was a definite awareness of the definition of client-centred practice with an increasing effort to identify and eliminate barriers to enable practice (Falardeau & Durand, 2002; Law et al., 1995; Sumsion, 2000a; Sumsion & Smyth, 2000; Townsend, 1999; Wilkins et al., 2001). Occupational therapists have woven these threads on to their individual looms; some more successfully than others. Weaving takes practice; so does using the principles of client-centred occupational therapy.

The studies of Corring and Cook (1999) and Rebeiro (2000) highlighted the clients' preferred client-centred service which parallels my participants' stories. The works of Palmadottir (2003) and Sumsion (2005) reinforced the worth of client-centred

practice, as expressed in my study. My study celebrates those occupational therapists practicing in a client-centred manner. Client-centred occupational therapists are individually contributing to the evolution of the client-centred model. Returning to listening to clients, seeing their lived experience promotes a further growth of client-centred practice in occupational therapy. Positive experiences influence the process to change. The art gallery of client-centred occupational therapy presents a new display “the lived experience of receiving client-centred occupational therapy in the home.”

Limitations of the Study

The human influence creates the research situation; this process in it self is a limitation even though science does not happen spontaneously. Giorgi (1989a) identifies that “One can never get a research situation that actually matches the way things are lived spontaneously” (p. 42). “Slippage” happens (p. 42). In other words, making an assumption that the gathered data reflects everything about the situation can be an incredible mistake.

Similarly, the research methodology should also be questioned, as it is only one way of examining the human experience. My choice of a phenomenological method, for example, placed boundaries on my research. The element of descriptive phenomenology that connected well with my research question was the ability to identify the basic or essential parts of the lived human experience. I accepted the challenges of phenomenological reduction or bracketing and made my best attempt to achieve the process. I recognize this limitation of phenomenology and acknowledge that another method could have addressed this study, for instance, hermeneutic phenomenology. My process of understanding the data and expressing the findings is only one way. As a

novice in the field of phenomenology I have committed to and completed my study recognizing the choices I made in this journey.

This study was based on eight individuals; this small sample size may not accurately represent the larger general population nor is it expected to in phenomenology. Identifying this fact does not reduce the lived experience of my participants. The intent was to place their experiences in a bigger context that may or may not hold true for others. However, the literature does show that if the process of client-centred practice is catalyzed the process will occur with one or more clients (Rogers, 1951). Of the eight participants, six were women, which may reflect a gender bias in the findings. As well all the participants were Caucasian; therefore the results are not sensitive to ethnic diversity. Having now identified the parameters of my study I feel that it is more important to note that these live participants were able to contribute to the concept of client-centred occupational therapy. In today's world of diversity, Carl Rogers' (1951) following comments support a common thread among mankind:

It has been the experience of many, counselors and clients alike, that when the counselor has adopted in a genuine way the function which he understands to be characteristic of a client-centred counselor, the client tends to have a vital and releasing experience which has many similarities from one client to another. A recognizable phenomenon, one that can be described, seems to exist. (p. 49)

Strengths of the Study

The simplicity of Carl Rogers' (1951) philosophy of practice may be universal. Using phenomenology to capture the lived experience sheds light on the humanness of client-centred practice. "In contrast to the more positivistic and behavioral empirical

sciences, human science does not see theory as something that stands before practice in order to ‘inform’ it. Rather theory enlightens practice” (van Manen, 2003, p. 15).

Weaving clients’ comments with the occupational therapists’ perspectives is a pleasing combination. As stated previously, the individuals receiving home-based client-centred occupational therapy were able to describe their experience. Their perspective brings an unbiased, naïve voice to the description of client-centred practice in the home. The client voices in my study try to balance the other studies of client-centred practice that were administered from the point of view of the therapist.

Strength of using phenomenology is that it “is self critical in the sense that it continually examines its own goals and methods in an attempt to come to terms with the strengths and short comings of its approach and achievements” (van Manen, 2003, p. 11). I have consistently evaluated my research steps; reviewing the phenomenological process, re-reading my transcripts, and returning to evaluate the current literature. It is the discovery of seeing that is phenomenological.

Implications of the Study

Bott (2001) and Anderson (2001) described tensions in family therapy that produced two orders of practice – one that used empirical foundations and the second human. First order family therapy bases its practice on the medical model, identifying a diagnosis and prescribed treatment by the expert, where as it is through the art of conversation with the client that second order family therapy is successful. Will occupational therapy settle for more than one way to provide service?

Studying phenomenology and its development I saw similarities to the building of client-centred practice. The tenacity, perseverance, belief, and continued conversations of

the followers have kept both philosophies alive. Giorgi (2003) sees himself as a minority in the field of psychology and after 40 years of work he continues to represent the phenomenological position. For 25 years, occupational therapists have continued the building of client-centred practice and now are merging this philosophy with occupation. In comparison to phenomenology, client-centred practice is still youthful. Today, after three years of study, seeing the accomplishments achieved in such a short timeframe, I applaud my occupational therapy colleagues in their determined pursuit of a strong foundation for practice.

My participants voiced an understanding of client-centred practice that echoed what has been written by and taught to occupational therapists. This study affirms the positive effects of practicing in a client-centred manner. The literature has focused largely on the barriers to performing client-centred practice and has made suggestions for how to eliminate the obstacles. Even though it can be overwhelming at first, especially if one only sees the barriers, I urge occupational therapists to build their skills of providing a client-centred approach to their clients. The positive reinforcement and successful outcomes of clients' involvement in the process, the human spirit, are compelling to stay committed. Directing CAOT's principles of client-centred practice towards ourselves (occupational therapists) would enable therapists to take the "risks" of practicing in a client-centred manner. As Townsend et al. (2003) state, "The place to start is in everyday practice" (p. 25).

Similarly, I see occupational therapy poised to provide leadership in promoting client-centred practice in health care. The solid history, development and research on client-centred practice within the field of occupational therapy provide a strong teaching

platform. As we commit to our principles of practice there are opportunities to advocate for a client-centred philosophy beyond our discipline. I challenge those of us who are there to step out of our boundaries and share our perspective to build client-centred practice with fellow health team members.

Directions for Future Research

This study was situated in the homes of clients; other Canadian research settings were in mental health services (Corring & Cook, 1999; Rebeiro, 2000). Occupational therapy services are found in acute hospitals, continuing care facilities, assisted living environments, community health and social services, and educational and vocational programs. I invite research in occupational therapy services in these diverse environments to see what is happening with their clients. Additionally, are there different responses from clients based on their gender and ethnicity? What role does humor play in client-centred practice? More importantly, I strongly urge a study on the lived experience of occupational therapists who believe they practice in a client-centred manner. The voice of experience leads others.

Revisiting the Implicated Researcher

This study is ultimately about me. My passion for hearing the voice of the client has heralded me to continue the task of the research. The reading and writing enriched my knowledge about client-centred practice, about phenomenology and about me. I am awed by seeing the learning that happens over time. Revisiting my initial writing has demonstrated the growth in my knowledge base. It stands to reason that in one year's time I will see even more threads of knowledge. I get excited living with my readings and data, there continues to be a movement in knowing and not knowing. I am moved by the

relationship between weaving and phenomenology and how these two partners have worked together to expose the life world of client-centred practice. Even though one says this is enough information to complete a thesis, I know there could be more to gather. Is this daunting or energizing? In my present quest of finalizing my thesis it is both. I want to include “good” information; I do not want to leave something out. I will complete the concrete task of my thesis but in many ways my journey in research and client-centred practice has just begun.

Conclusion

Hearing the voice of the client is a missing component in a model that focuses on clients. Participants spoke positively about the qualities of client-centred occupational therapy. A strong future for occupational therapy rests on the collective efforts of many to experience, reflect and refine client-centred practice.

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Appendix A. Screen for Client-Centred Principles of Practice

Dear Colleague,

I am beginning a study to complete my Masters of Science at the University of Lethbridge. I wish to look at the experience of receiving occupational therapy services in the community.

I am looking for occupational therapists that work with people in their homes and attempt to provide these services using client-centred principles. I will be asking these therapists to provide a list of clients (meeting certain criteria) who I will invite to be part of the study. Six clients will be asked to describe receiving occupational therapy services. *If you are interested in being part of this study please answer the following questions with YES or NO.*

- Do you listen to your client's visions?
- Do you support clients to look at risks and consequences?
- Do you support clients to succeed, but also to risk and fail?
- Do you respect clients' own styles of coping or bringing about change?
- Do you guide clients to identify needs from their own perspective?
- Do you facilitate clients to choose outcomes that they define as meaningful even if you do not agree?
- Do you encourage and actively facilitate clients to participate in decision-making partnerships in therapy, programme planning, and policy formation?
- Do you provide information that will answer clients' questions in making choices?
- Do you offer services that do not overwhelm clients with bureaucracy?

- Do you foster open, clear communication with clients?

If you have 7 or more YES answers, please contact me at. Thank you for your time on this request.

Sincerely,

Judy Lee, BSR, OT, ©

Appendix B. Guiding Principles for Enabling Occupation in Client-Centred Practice

- Base practice on client values, meaning and choice as much as possible.
- Listen to client visions.
- Facilitate processes for clients envisioning what might be possible.
- Support clients to examine risks and consequences.
- Support clients to succeed, but also to risk and fail.
- Respect clients' own styles of coping or bringing about change.
- Guide clients to identify needs from their own perspective.
- Facilitate clients to choose outcomes that they define as meaningful even if occupational therapist does not agree.
- Encourage and actively facilitate clients to participate in decision-making partnerships in therapy, programme planning, and policy formation.
- Provide information that will answer clients' questions in making choices.
- Offer services that do not overwhelm clients with bureaucracy.
- Foster open, clear communication.
- Invite clients to use their strengths and natural community supports. (Law, Polatajko, Baptiste & Townsend, 1999)

Appendix C. Consent to Participate for Occupational Therapists

Research Project Title: A Voice for Choice

Investigator: Judy Lee, BSR, OT

This form tells you what the research project is about and what you will be asked to do. If you would like more detail, please feel free to ask. Take the time to read this carefully.

A Voice for Choice is a study to discover a home client's experience with occupational therapy services. Six clients will be asked to describe a time with occupational therapy that made an impression. There will be two personal interviews that may last up to 1 hour each. Interviews will most likely be in the client's home. All interviews will be recorded and transcribed.

You are being invited to participate in the study by assisting with the identifying of potential clients. Not all occupational therapists use client-centred principles in their practice. You will be asked to self-identify your client-centred focus by answering a screening tool. If you answer YES to 7 or more questions, you are then invited to contact the researcher to assist with identifying potential participants. The researcher will share the criteria for client selection; this session will be tape-recorded. The tapes will be erased on completion of the study. You will be asked to contact potential clients to determine if they would be interested in participating in the study. The researcher will contact the clients who have responded positively.

You have the right to withdraw from the study at any time. Likewise, the researcher has the same right to ask for your withdrawal. Your sharing in this study is voluntary. You will not be paid for your time. Possible benefits to you may include: 1)

time to reflect on your style/method of service delivery, and 2) being part of adding to the knowledge of this topic.

Your identity, as part of this study, will be kept confidential. Any writing will not identify you.

Your signature on this form indicates that you agree to your role in the research project *A Voice for Choice*. In no way does this waive your legal rights nor release the investigator, or involved institutions from their legal and professional responsibilities. Y

You should feel free to ask questions at any time. If you have concerns related to this research, please contact:

Investigator: Judy Lee

Academic Supervisor: Dr. Brad Hagen
Faculty of Health Sciences
University of Lethbridge

If you have any questions concerning this project that are not related to the research, you may contact the Issues Management Director, Chinook Health Region or the Office of Research Services at the University of Lethbridge.

Participant Name: _____ Witness Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Appendix D. Participant Selection Criteria

The participants will be selected using the following criteria:

1. Articulate and willing to share their story.
2. Adults with varying ages.
3. Living in the community in their home – rented or owned.
4. Varying health issues, potential conditions are: neurological, orthopedic, rheumatoid and palliative.
5. Able to concentrate and focus for a minimum of 30 minutes.
6. Have had an initial assessment from Occupational Therapy plus one or more follow-up visits.

Clients will not be considered for the study if they are receiving or have received occupational therapy services from the researcher.

Appendix E. Ethical Considerations

The following ethical considerations were included in this study:

- Before participating, all participants, occupational therapists and clients, were informed of the aims and methods of the research. The nature and commitment of their involvement, the roles of both the participant and the researcher, and any possible risks to which they may be exposed during the study were outlined.
- Consent to Participate was obtained from the occupational therapists (Appendix C) and participants (Appendix F).
- The occupational therapists and participants were given the opportunity to ask questions and discuss any concerns at any phase of the study.
- Anonymity of participants was preserved by using a coding system to label audiotapes and transcripts. Pseudonyms were used in the transcripts and the final written text so that the participants could not be identified.
- Keeping the audiotapes under lock safeguarded confidentiality of information provided by the participants.

These precautions to protect both anonymity and confidentiality ensure that records are not traceable to any given participant.

Appendix F. Consent to Participate for Clients

Research Project Title: A Voice for Choice

Investigator: Judy Lee, BSR, OT

This form tells you what the research project is about and what you will be asked to do. If you would like more detail, please feel free to ask. Take the time to read this carefully.

A Voice for Choice is a study to understand your experience with occupational therapy services. You will be asked to describe a time with occupational therapy that made an impression. There will be two personal interviews with you that may last up to 1 hour each. Interviews will be at a time and place good for you, most likely your home. All interviews will be recorded and transcribed.

You have the right to withdraw from the study at any time. Likewise, the researcher has the same right to ask for your withdrawal. Your sharing in this study is voluntary. You will not be paid for your time. Possible benefits to you may include: 1) the time to share your story of receiving occupational therapy services, and 2) being part of adding to the knowledge about this topic.

The researcher will review the transcripts from the first interview and identify themes about the research topic. In the second interview, you will be asked to read and discuss the original transcript and identified themes. You will be invited to add, delete or confirm information.

Your identity, as part of the study, will be kept confidential. All tapes and transcripts will be coded and your name will not be used. The tapes will be locked in a filing container that only the researcher can open. After you have read the transcripts, the tapes will be erased. The results of the study will be written as a Master's Thesis and will

be presented to Judy Lee's Masters Committee and colleagues. However, at no time will your name or identifying information be disclosed. Any information that will possibly identify you will be removed from all written and verbal presentation of results.

There are no major risks for you to be involved in this research. However, if in the rare instance you feel emotional distress in re-telling your story, and are interested in counseling to assist you with this, the researcher will make available the names of some affordable counseling services.

Your signature on this form indicates that you agree to your role in the research project *A Voice for Choice*. In no way does this waive your legal rights nor release the investigator, or involved institutions from their legal and professional responsibilities. You should feel free to ask questions at any time. If you have concerns related to this research, please contact:

Investigator: Judy Lee
Academic Supervisor: Dr. Brad Hagen
Faculty of Health Sciences
University of Lethbridge

If you have any questions concerning this project that are not related to the research, you may contact the Issues Management Director, Chinook Health Region or the Office of Research Services at the University of Lethbridge.

Participant Name: _____ Witness Name: _____
Signature: _____ Signature: _____
Date: _____ Date: _____

A copy of this consent form will be given to you for your records and reference.

Appendix G. Interview Format

The participants were provided with the following information. The information was intended to focus their comments on client-centred qualities.

“You were chosen because you have worked with Karen (pseudonym). Karen displays, demonstrates certain qualities in her work that are client-centred. I want to talk to you about the things she did or said that built a relationship with you using these qualities.”

The participants were provided with the following hand printed pages one at a time. I asked them to think of examples when Karen demonstrated these qualities.

Page 1. A client-centred occupational therapist

- respects clients
- listens to client visions
- guides client to identify needs from their own perspective

Page 2. A client-centred occupational therapist

- involves client in decision making
- provides information for client choice in decisions
- recognizes client’s experience and knowledge

Page 3. A client-centred occupational therapist

- supports client to succeed, but also to risk and fail
- recognizes the client’s individual self
- creates a partnership with client focused on therapy
- advocates with and for client needs

Appendix H. Occupational Therapy Values and Beliefs

About occupation, we believe that

- occupation gives meaning to life
- occupation is an important determinant of health and wellbeing
- occupation organizes behaviour
- occupation develops and changes over a lifetime
- occupation shapes and is shaped by environments
- occupation has therapeutic effectiveness

About the person, we believe that

- humans are occupational beings
- every person is unique
- every person has intrinsic dignity and worth
- every person can make choices about life
- every person has some capacity for self-determination
- every person has some ability to participate in occupations
- every person has some potential to change
- persons are social and spiritual beings
- persons have diverse abilities for participating in occupations
- persons shape and are shaped by their environment

About the environment, we believe that

- environment is a broad term including cultural, institutional, physical and social components

- Performance, organization, choice and satisfaction in occupations are determined by the relationship between persons and their environment

About health, we believe that

- health is more than the absence of disease
- health is strongly influenced by having choice and control in everyday occupations
- health has personal dimensions associated with spiritual meaning and life satisfaction in occupations and social dimensions associated with fairness and equal opportunity in occupations

About client-centred practice, we believe that

- clients have experience and knowledge about their occupations
- clients are active partners in the occupational therapy process
- risk-taking is necessary for positive change
- client-centred practice in occupational therapy focuses on enabling occupation

(CAOT, 2002)