

Client-Centered Practice in Spinal Cord Injury Rehabilitation: A Field Guide

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This Field Guide was developed with two purposes in mind; to facilitate an understanding of the model of client-centered practice and the common language used when discussing this model as reflected in the current literature and, more importantly, to recommend specific strategies to facilitate client-centered practice in spinal cord injury rehabilitation.

It is primarily intended for rehabilitation health professionals, educators, and supervisors (referred to in this guide as rehabilitation professionals or therapists) who work in rehabilitation settings with adults with spinal cord injury (SCI). Our hope is that this guide will encourage readers to reflect on their current practice and use the strategies in their interactions with clients and in working with other disciplines. This guide may also prove useful as a focus for discussions with clients, team members, colleagues, and supervisors.

The strategies recommended are based on the findings of a qualitative study conducted by Dr. Christina Papadimitriou in one spinal cord unit in the Midwestern United States. However, the principles and strategies of client-centered practice can be adapted and applied in other neuro-rehabilitation contexts.

How was the Field Guide developed?

This guide is the result of collaboration between Christina Papadimitriou and Christine Carpenter, based mostly on data from a 12-month research grant awarded by the United States Department of Education, National Institute on Disability and Rehabilitation Research (NIDRR) to Christina Papadimitriou and a research and artistry completion grant by Northern Illinois University, Graduate Division (2011–12). Please see About the Authors (page 38) for their biographical sketches. For more information on the empirical bases of this guide, see the Appendix (page 32).

During the twelve months of this research project, we collected pilot data from one spinal cord unit in the Midwestern United States. During the five-month collection of data, we observed the unit's day-to-day activities, including team meetings, lunch hours, group physical therapy and occupational therapy sessions, individual physical therapy and occupational therapy sessions, community outings, and assessments. We interviewed inpatients, therapists, unit managers, nurse managers, and medical directors multiple times. In preparing this guide, we discussed ideas with physical therapists (PT) and occupational therapists (OT) of the spinal cord unit, community advisors and disability experts, and research advisors to this project. We also conducted systematic reviews of the current literature on client-centered care in inpatient rehabilitation in major medical databases and journals. Our focus has been on understanding client-centered practices of rehabilitation professionals (primarily PT and OT) in SCI rehabilitation in order to outline possible strategies for increased client-centered practice.

What is Client-Centered Practice?

While the terms client-centered, patient-centered, and person-centered are generally used synonymously in the health research literature, client-centered is the most commonly used in rehabilitation scholarly literature. This approach has emerged in recent years as an important theoretical model for the delivery of health and rehabilitation services (Picker Institute, 2000). Yet despite its growing influence, there is little consensus as to its meaning or how it is defined (MacLeod & McPherson, 2007). The definitions of client-centered practice vary according to the professions developing them. However, common characteristics are reflected in most of the published definitions. For example, five dimensions are identified in medicine: bio-psychological perspective; patient-as-person; sharing power and responsibility; therapeutic alliance; and ‘doctor-as-person’ (Mead & Bower, 2000). In occupational therapy, the emphasis is on patient-therapist collaboration and partnership, client autonomy and control, and respect for the client’s values and right to make choices (Sumsion & Law, 2006). Leplege et al., (2007) emphasize the multi-dimensional nature of person-centered care including: holistic assessment, interventions reflecting the patient’s needs, empowering patients through decisional autonomy, treating people with a disability with respect, and avoiding stigmatization.



We feel that Hammell (2006) captures the core elements of client-centered practice when she describes it as being “characterized by collaborative approaches to practice that encourage and respect clients’ autonomy, and that support and advocate for clients’ rights to make and enact choices” (p. 154). Engaging in client-centered practice requires a fundamental realignment of power and for rehabilitation professionals to “work collaboratively towards the client’s goals and assess the achievement of outcomes that matter [are useful and relevant] to the client” (p. 155).

Although the differences in meaning of the terms ‘client’ and ‘patient’ can be debated, in this guide we will use the terms interchangeably; however, ‘patient’ is used most commonly in rehabilitation settings.

Why is client-centered practice important?

There is limited research reporting the outcomes of client-centered practice. Research does suggest that clients place more importance in their relationship and communication with health professionals than the nature of their interventions or their technical skill (French, 2004), and a client-centered approach is found to contribute positively to clients' sense of confidence, self-worth, and self-esteem (Blank, 2004). Studies have also shown that the active engagement of clients in rehabilitation leads to improved functional outcomes and blood pressure control, better client-practitioner communication, and increased client comfort and satisfaction (Cott, Teare, McGilton & Linecker, 2006). There is also some evidence to suggest that "reorganization of services based on client-centred theory can increase efficiency and cost-effectiveness and decreased length of stay" (Cott, Teare, McGilton & Linecker, 2006, p. 1396). More research, however, is required that evaluates the outcome of client-centered services from the client and practitioner perspectives.



Examples of Effective and Problematic Client-Centered Practice

In this section, we will present examples of best and problematic practices of client centeredness drawn from our data and experiences in spinal cord injury rehabilitation. These examples were chosen to facilitate reflection on what client-centered practice looks like in the clinical setting. All names are pseudonyms. As you read these examples, consider:

- How collaborative was this patient-provider interaction?
- Was the patient involved in goal setting? Was he/she appearing to direct his/her care?
- Was the patient's experience and knowledge of his/her body and disability recognized?
- Were therapeutic services delivered in a flexible, individualized manner?
- How are the providers in these examples advocating with and for patients to meet patients' needs?

Positive Example 1

The following vignette reflects a positive communication exchange between Mary (OT) and Tim (client) and during an OT session. Mary has been working in spinal cord injury for 1.5 years and is a recent graduate. Tim is 45 years old and injured his spine in a motorcycle accident during a recreational event. He has sustained an incomplete injury. This is his first experience of inpatient rehabilitation. Staff in the unit perceived Tim to be quiet, motivated, and polite.

The session begins in the client's room. Tim is sitting in his wheelchair getting ready to put on an ankle-foot orthosis (AFO) to practice walking and standing.

Mary: Now, I know for some people it's a little bit harder [to put these on]. Now, are you able to try and bring your leg up to the opposite knee?

Tim: Yeah; it doesn't go as good.

Mary: It doesn't go as well. The reason I ask is because I'm concerned as far as you having to bend down all the time, I'm just a little bit concerned with your back and body mechanics. So, if you start to feel a little sore or tired or something like that, you may want to try and start bringing your feet up across your knee. Even though it's a little bit harder, and, you know, it's kind of is a strengthening activity in and of itself, getting your leg up there. But it can save your back too.

Tim: It stretches too.

Mary: It does stretch. I always tell guys, you're going to leave here a lot more flexible than you came in here.

Tim's father: You guys want to do some walking?

Mary: Um, probably a little bit of walking and some strengthening—actually try and do some of the machines from standing instead of sitting. So we try (inaudible) strengthening and the flow.

Tim: Let's go outside.

Mary: Okay. Now he changed his mind. [laughing/joking tone]

Tim: I like that. [smiles]

Mary: Can I—let me try one thing before you try and get it up to here. Just to make it work.

Tim: Okay. [Mary uses Dyson to fix the orthotic.]

Mary: This is the stuff that they all use here. The amount of times that Dyson has helped you guys with rubber bands?

Mary: If you just throw it up here that could help keep it from sliding. So, that, you know—you're all ready. Try to focus on getting up there in the first place and trying to have strength to keep it up there. So, if it slides and you can get up, this will help keep it there. And, if you can get your foot far enough over it to hang off your leg, then you can work on the (inaudible)?

Tim: Okay.

Mary: If it doesn't work, it doesn't work. At least we can say we tried it. (Inaudible) in there?

Tim: Yeah.

Continued...

Mary: All right, nice. I'm trying to get it to stretch.

Tim: Ah.

Mary: I'm sorry, I'm sorry. Hello hamstrings. Making it harder?

Tim: No.

Mary: Well, it's always gets harder before it gets easier. We're trying to preserve your back here. It's just something good to try and bring you to the fourth floor, the Ortho floor, has these things called foot funnels and it slides it's this little thing that slides over the back heel, and it's around in circles so you don't have to worry about that going down. And your foot is supposed to just slide in it from there.

Tim: Yeah, with these shoes, it's not too bad. But with a low back it's...

Mary: Um hmm; that's where it gets a little moist.

Tim: In the shoe?

Mary: Um hmm. So, it's obviously too hard right now at this point for you to keep your leg up there on your own, but it's just something to think about?

Tim: I have to stretch more. Like...

Mary: It is.

Tim: Otherwise...

Mary: And, you know, if we want to think about keeping you from bending over all the time... [there are] other ways that we can do it. Or just pull, like if you want to pull right up to here. Just prop it up here, or on the bed or something, so you don't have to keep it held on top of your knee and worry about it sliding, but at least you'll be on a higher surface and you wouldn't have to put that leg all the way down. Just things to think about.

Tim: Enjoying the headrest.

Mary: What's that?

Tim: Enjoying the headrest.

Mary: Okay.

What makes this encounter a positive example of client-centered practice?

- Tim is able to choose what he focuses on during the session. This choice is given to him by the therapist who waits for him to choose.
- Tim is actively engaged in making these choices.
- Mary adapts to Tim's choices and reasoning.
- The atmosphere of the interaction is friendly and comfortable for both client and therapist.
- Mary explains her reasoning for the use of the orthotics and for focusing on how Tim can put it on and take it off. Mary presents and shares her reasoning in an informative, collaborative, and flexible way that encourages Tim to be fully involved.
- The interaction reflects Mary's genuine interest in Tim's unique circumstances and the dialogue between them.

Positive Example 2

This vignette reflects a positive exchange between Bettina (OT) and Charlie (client) during an OT session. Charlie is a 68-year-old man, a former middle school teacher and principal, who became an incomplete tetraplegic after back surgery five years ago. He lives with his wife in his own home. This is his third inpatient admission. The goals of this admission are to improve sitting and mobility, improve his wheelchair skills, and explore some new technologies. The rehabilitation professionals perceive him to be motivated and his assertiveness to be positive. Charlie is a knowledgeable and experienced patient, and he understands organizational demands and limitations. He is vocal yet polite about his needs, and is self-directed and energetic. Bettina is an experienced OT who has been working in the field of SCI for twelve years, teaches at a local OT department, is a mentor to many new graduates, and engages outside the clinic in sports and foundations for persons with SCI.

This session initially takes place in Charlie's room then, moves to the common area in the unit.

Bettina begins by greeting him and asking about his previous day. Charlie is in the process of putting on his hand splint in anticipation of the OT session.

Bettina: So what I have today is some computer stuff. You need to—you want to try that USB? You want to see how it works in the computer? We can do that.

Charlie: Yeah.

Bettina: Okay. Those are my two agenda items and then we'll stretch. [...] We're trying to think of things you can do to take some of the work, so that Jane (Charlie's wife) doesn't do as much. So that was the one thing I thought—that would be the other thing.

Charlie: It's very important for me to be in as much control of things as I can. For me.

Bettina: I can understand.

Charlie: That's very important.

Bettina: Can you get the underarm, over here? So now you can lift that arm up a little bit. Aw, and now let's see it. I knew you could lift that arm more.

Charlie: Yeah, I can. Barney (technician) stopped in this morning.

Bettina: He did?

Charlie: So I showed him that.

Bettina: Good. And what did he say?

Charlie: He said he'd take care of it. He was more concerned about...

Bettina: That's what I was concerned about all right. So, do I keep it...how do I put it on you? I, um, you know, put it in a position of comfort, right?

Charlie: Sure.

Bettina: I keep it on lock. So, it's on the unlock portion. Okay.

Charlie: When you put it in you put it on lock. Then you screw it down after you put the...

Continued...

Charlie: Yeah.

Bettina: So, he thinks the thumb is best to put in first. You're still going to watch that spot because the more I can give information about that redness today again...

Charlie: Yeah.

Bettina: The better he's going to be able to adjust. It's a big raise but...

Charlie: It's a bit cumbersome.

Bettina: I know. But you still have an opportunity to...

Charlie: Uh-un, there's my thumb.

Bettina: Now you...do you just like to do it like that? Or can you relax it or...? Because I wonder if that's causing the pressure on the bone.

Charlie: No, it's not up yet. Once you crank it up, I think it will. Yeah.

Bettina: So, you would recommend—I'd recommend using the back pieces first. Okay. This is the part your wife is going to really like. She gets to adjust the angle. Angle of torture, I would say. [laughter] I can get it to—well, what are we going for today because right there is neutral, zero. Actually it's a little past that.

Charlie: Let's start at zero.

Bettina: Okay. Now when you get to where you like it, lock it, half an hour—that's it. So it makes it very hard to use this very much. I can stretch it.

What makes this encounter a positive example of client-centered practice?

- There is a reciprocal interaction between Bettina and Charlie. Bettina listens to Charlie, and he contributes ideas throughout the session.
- Their exchanges show a relationship built on trust and rapport. There is an appropriate use of humor and joking. Both are appraising the work Charlie has done to date, exchanging views and making suggestions.
- Bettina's goals are informed by Charlie's interests (to use the computer as independently as possible).
- Bettina and Charlie problem-solve issues related to Charlie's wife assisting with his care. By making these issues part of the session, Bettina addresses one of Charlie's main goals which is 'to be in as much control as I can.' Bettina illustrates her respect for Charlie's goals by incorporating them into the session.
- Bettina asks Charlie to show her how he does things and offers suggestions in non-patronizing ways.

Problematic Practice Example 1

This example reflects problematic interactions between Barry and the PT and OT over the course of six outpatient sessions. Barry sustained a C6 complete spinal cord injury when he was 19 years old. Since that time he has lived independently and is working full time as a learning resources counselor at a major university. He uses a manual wheelchair, owns his own home, and drives a van with hand controls. His primary passion is music and playing the drums. With a friend he founded an adapted music society in the city. He does his own transfers (wheelchair to bed, toilet, car seat) using a small transfer board. He is now 50 years old and experiencing some of the consequences of aging with a disability, including repetitive strain shoulder injuries and collapsed thoracic vertebral bodies causing back muscle spasms. His health is generally excellent. He has not been hospitalized since his injury and has returned to the rehabilitation center only once. He has obtained an outpatient referral to the rehabilitation center with the primary aim of seeking advice on exercises and stretches to address the repetitive strain injuries, positioning in the wheelchair, and assessing possible new manual wheelchair alternatives and bathroom hoists. He is also beginning to think about acquiring daily assistance at home with his morning self-care routine.

Overall, Barry felt he gained little of value from attending the rehabilitation center.

When asked about his experience as an outpatient, these are some of the things he described. He had no medical problems but was required to be assessed by the doctor at the center who focused primarily on the possible need for back surgery and a long list of complications that could result. He was separately physically assessed (and asked the same questions) by the PT and OT. On almost every occasion he was kept waiting for 20 to 30 minutes beyond his appointment time.

When physically examined by the PT and OT, they chose to transfer him with another person's help because it was quicker than letting him transfer himself. To facilitate their moving around the treatment mat, his wheelchair was moved and, on one occasion, he was left on the treatment mat for 30 minutes unable to get off and leave. Most conversation and information provision occurred when he was lying on the treatment mat.

He had hoped to have the opportunity to try out different newer manual wheelchairs, but only one type was available. The OTs seemed intent on persuading him to use a power wheelchair, and while he recognized the logic of their advice, he was not at that time prepared to make that lifestyle change.

There seemed to be no acknowledgement that he was attending these appointments within the context of full-time employment. The staff did not seem to know much about the effects of aging with a spinal cord injury. He felt generally demoralized by the experience and has since accessed information and services through a diversity of other sources including massage therapy, medical equipment suppliers, private community occupational therapy, and a personal exercise trainer at the university gym.

Why does this encounter not represent client-centered practice?

- Barry's extensive (and successful) experience of living independently with a SCI is not acknowledged or used to advantage in these interactions.
- The sessions focus on what is convenient for the therapists; e.g., late for the sessions, controlling transfers, and leaving him stranded on the mat. These actions disempower Barry and reflect a basic lack of respect.
- Barry articulated specific goals for the rehabilitation sessions, and these were not addressed. A joint OT and PT assessment focused on Barry's stated goals would have been preferable.
- Implicit in the therapists' approach is a focus on Barry's disabilities rather than his abilities.
- The effects of aging combined with SCI have major implications for physical independence and require significant lifestyle changes—which in turn require major psychosocial adjustments that were not addressed by the rehabilitation professionals.
- Barry was not given the option to make equipment choices.



Problematic Practice Example 2

This example also describes problematic interactions between Azim and rehabilitation professionals in an inpatient rehabilitation setting. Azim sustained a T8 complete spinal cord injury and a left below-knee amputation from a motorcycle accident when he was 22 years old. He had left high school at age 16 and trained as a welder. He was employed and shared an apartment with two friends. He was healthy, tall, and his main pre-injury interests were various sports and going to the local gym.

In the rehabilitation center Azim was generally found to rebel against the routines imposed on him, such as getting up at a certain time, eating at specific times, appointments with professionals, etc. The nurses described him as ‘angry’ and ‘difficult to manage’. His parents were horrified at the change in their son and could not reconcile the idea that Azim would not be able to walk. Azim did seem to establish an effective relationship with the PT (who shared a similar sense of humor) and identified how depressed he was about his physical appearance and was scared about his future.

On one occasion Azim, intending it as a joke, pretended to hang himself while sitting in bed, but the nurses and doctor took it seriously and the episode did little to improve his relationship with them. Azim had requested a non-weight bearing prosthesis “to fill out my trouser leg and to put a shoe on” but the doctor did not consider it useful or necessary and refused to make the referral. After the requisite ten weeks he was considered independent in self care and functional activities and he was discharged to his parents’ home with minimal follow up and no further rehabilitation at that time.

Why does this interaction not reflect effective client-centered practice?

- Physical independence was not an issue in this case, but Azim was clearly having emotional and psychological difficulties. These were not addressed by staff.
- Little understanding of Azim as a person or the context of his family and social life was reflected in the rehabilitation program and discharge decisions made by rehabilitation professionals.
- Azim was not encouraged to develop goals or discuss choices.
- The label of being difficult to manage undermined the development of a collaborative relationship with staff.

Case Study

This case study represents the reality of the patient experience in rehabilitation where, within one day or the same week, there are multiple encounters with different rehabilitation professions. One of these encounters reflects client-centered practice; the other quite the opposite. In addition to coping with the SCI and the radical life changes that accompany it, patients also have to manage the expectations of a diversity of professionals. This aspect of the patient experience is rarely acknowledged.

Irving is a 54-year-old African American male whose injury, resulting in tetraplegia, occurred more than 20 years ago. He lives in a nursing home and was admitted to inpatient rehabilitation for treatment of ischial pressure sores and an ulcer; he is experiencing decreased function and increased pain in this right arm. Some therapists described Irving as 'difficult' because he did not appear to be self-motivated. Irving stayed in the inpatient unit for almost five weeks. The first ten days he had very low energy, was often dizzy, had his eyes closed during the OT sessions, did not engage much in eye contact, and spoke very softly and very little. Gradually he became less dizzy and more energetic, more talkative and interactive with staff, and appeared more engaged in his therapy sessions. Maggie, a seasoned PT who has worked in SCI for six years, is working with Irving.

The following excerpt occurred in Irving's room during the second week of his admission and was described as 'typical' by Maggie.

Irving is reclining in bed, it is 10:00 am, he has not eaten his breakfast or taken his medication. Maggie comes in with a new motorized wheelchair for him to try. This new chair is supposed to improve his posture and driving ability to negotiate uneven surfaces. The new chair also has a control system that Maggie thinks might be better than his previous wheelchair. Irving does not appear excited about trying the new chair and he is dizzy. A nurse comes in to give him his medicine during their interaction. Maggie wants Irving to try the new wheelchair, so she transfers him into the chair despite his being dizzy, not having eaten breakfast or taking his medications, and without his explicit agreement.

Most of the hour session, in reality, was spent on addressing Irving's dizziness and providing information about the new chair. Once Irving was transferred into the chair, there were twenty minutes left to 'try it'. In spite of his dizziness, Irving began to use this new chair in the hallway and gym area of the unit following Maggie's suggestions to try maneuvering figure eights, and an obstacle course as other patients observed. Irving says little, seems to listen to Maggie, but does not establish much eye contact. Maggie observes for fifteen minutes but offers little or no feedback or comment and ends the session saying, "Thank you for trying it today, did you like it? Do you want to keep it?" to which Irving responded with a hesitant "Uummm. [pause] I can tolerate it."

Irving: Getting dizzy.

Nurse: Do you have your binder on?

Irving: Getting dizzy. I don't know what's happening.

Maggie: We can't have you getting dizzy now. You need to practice in your new chair there. [silence] Do you want to try? It just kind of goes...so I can explain it. You hit the mode button right there. So that's the foot rest. And then you can move it. Typically so you use a joystick. And when you have them both, seat & the back rest, that's when you're going to get the tilt, and the toggle is going to turn into the tilt mechanism. Ok? So just to go over this again. You've got the mode button. And even though this is just a one-day demo for you, you may not be able to hit all these buttons, so we might get a different set of buttons for you, where you could tap to go through the cycle. So you just hit the button to go through it. This one actually will just have the foot rest. Okay the foot rests go out, the foot rests come down. And then we just did the tilt. And then the back rest will go out. You know, just like you recline the back rest.

Maggie: I'll get you in and then we can try all the buttons. How's that sound? Is that good? Are you feeling a little better? Are you still dizzy? You were okay though when you are sitting up and eating your breakfast, correct?

Irving: Well, I wasn't really eating breakfast. Just trying to get some fluids in me.

Maggie: Did you need some more to drink?

Irving: Yeah I'm going to try to drink something. Mighty shake.

Maggie: Can you reach it?

Irving: Yes

Maggie: You got strawberry today.

Irving: Strawberry every day.

Maggie: I'll let you finish that before I get you up. Better? Ok. [begin transfer] Sitting position.

Irving: Oh, boy.

Maggie: What, dizzy?

Irving: Yeah, unusually dizzy.

Maggie: So do you want to lay flat? You want to sit up? Usually when people are dizzy, they want to lay back down. Do you want me to recline the bed?

Irving: Yes. see what that does.

Nurse: I'm going to take your blood pressure, going to go get a machine.

This session is also an example of the constraints imposed on rehabilitation professionals by the organizational and health care system contexts within which they practice.

These constraints are frequently identified as barriers to client-centered practice and will be discussed in more detail in the section on organizational components that affect client-centered practice (page 25).

The following interaction between Irving and Judith (an Occupational Therapist Assistant with 22 years of experience) occurred in the same week as the previous one but is clearly very different

Irving is more energetic, talkative, and upbeat. This change in affect, according to Judith, can be partly attributed to his medications being properly adjusted. His expectations of the rehabilitation admission also seem more realistic; as Judith said, “He now understands better why he is here.” However, in spite of these positive changes he was still perceived by the staff as ‘not trying hard enough.’ He acknowledged this perception and expressed a desire to change this.

In this excerpt, Irving and Judith are working on problem solving how he can squeeze bottles of saline and apply it for his contact lens and dry eyes. Irving explains to Judith where the gauze and wash clothes are and how he had been applying the drops before his arm function deteriorated and necessitated the use of a sling.

Irving: So, the next time this comes up, when they say, ‘he doesn’t try’, you tell them different.

[Judith brings a shirt that he needs to put on as part of his session.]

Judith: Hum?

Irving: Now I will take the gauze off my eye. After I finish [with the drops] I feel like I have taken a dip in the lake.

Irving: A lot of people want you to do it their way. As long as the end result is the same, it doesn’t make a difference of how I do it, is that right?

Judith: Oh, do you?

Judith: Most of the time.

Irving: Yeah. [pauses for a few seconds] How am I doing Judith?

Irving: Why do you say ‘most of the time’?

Judith: You are doing great.

Judith: Well, I agree with you. I guess you can kind of agree to disagree along the way. The end result might be the same, but, you know, as long as...

Author/CP: What do you think?

Irving: It’s okay for what we are doing, yeah.

Irving: No, because that would offend me, too. I am not ready to go out like that, that is not in the plan. Never, ever, and never will it ever will be.

Judith: I think you did that perfectly.

Irving: Oh, thank you.

Judith: Okay.

Judith: Yeah.

Irving: God is not done with me yet.

[Irving now focuses on putting on his shirt. The session is ending. The following exchange speaks to Irving’s understandings of his circumstances.]

Continued...

Judith: All right. Well, that is all we will do for right now then. I will see you at 1:00 pm. Great job on your shirt.

Irving: Thank you.

Judith: And with your splint, cleaning your splint, and the eye drops. Very good session today.

Irving: Thank you.

Judith: Do you think so? I mean, do you feel the same way? Because I know I didn't do a thing. I was over here, you did it all.

Irving: You know something? I am just now starting to get to do this stuff together all the time. You know, I was so sick and so medicated I could barely raise my hand up, and talking about picking up my shoulder off the bed, I was too weak...

Judith: Yeah, your body has been through a whole lot and you've come a long way, so you are doing very well.

Irving: By the grace of God for sure. So, I think that even when Dr. Xing [his doc] said, you know, he didn't think that I was accomplishing as much as I can because the arm was in this condition, you know, and something else he said, I can't remember right off the top. But I told him what I gained from rehab is the strengthening and conditioning. I mean, I'm in a place that's not giving me the adequate exercise sessions, in terms of therapy, and then I'm not getting stronger. I have to wait until the food kicks in on me and that takes a long time, especially when I don't get the protein I need. So I will tell anybody, rehab is a great place to be in terms of trying to get your life in order if you have an accident or surgery or whatever.

What makes this encounter a positive example of client-centered practice?

- Irving is given a full explanation of what Judith hopes to achieve in the session thus enabling him to contribute and understand the therapy provided.
- Judith consistently offers feedback and positive comments.
- Judith provides examples of why the session was “very good today” and commending him for what he has accomplished and the progress he has made since his admission.
- Irving is able to share information about his circumstances and Judith clearly listens carefully, and does not interrupt or challenge his account.
- Irving's engagement in the session is illustrated by his willingness to share his feelings about his progress.

Rehabilitation Professionals' Engagement in Client-Centered Practice

Rehabilitation professionals' engagement in client-centered practice requires them to assume multiple roles; e.g., therapist, educator, consultant, and advocate. These roles reflect the complex nature of spinal cord rehabilitation, and the literature suggests that practitioners frequently feel ill-prepared by their education for this multiplicity of roles (Higgs & Titchen, 2001). These feelings of inadequacy are a reality of practice and can motivate us to learn, critique, and validate our practice knowledge in our interactions with colleagues, other disciplines, and clients. The acquisition of confidence and expertise is not a static process; it requires continual personal growth, reflection, and lifelong learning. These professional values are re-lected in the model of client-centered care, which offers an approach that promotes best practice in rehabilitation and supports our ongoing development as practitioners.

Strategies

Reflect on why you chose to work in spinal cord injury and not some other area of practice. Our interest in a specific type of work and client group can for example, originate from our personal experiences, a desire to practice holistically, or the influence of a mentor. It is important to understand what motivates us and what we hope to gain from our practice.

Reflect on your attitudes and beliefs about living with a disability.

We need to recognize that our understanding and interpretation of what it is like to live with the consequences of spinal cord injury over the long term is limited and influenced by our experience of working with patients who are newly injured or who experience health difficulties requiring re-admission to rehabilitation. Strategies that help to expand our perceptions of what it is like to live with a disability include:

- Work closely with and learn from peer mentors (old hands).
- Get involved with people with disabilities in other areas of life; e.g., making music or participating in sports or organizations that provide services and are directed by people with spinal cord injury.
- Be open to clients staying in touch with you over time. In this way you will gain a long-term perspective and a sense that the majority of clients lead productive lives after injury.
- Discuss with colleagues (particularly those with more expertise) patient trajectories and post-rehabilitation potential.
- Read biographies written by people with first-hand experience of living with a disability, watch movies, and explore disability culture and arts.

In spinal cord injury rehabilitation the therapeutic relationship can be perceived as a 'one-way street', that is, the therapist giving to the client without expecting or getting anything back, rather like the role of a parent is portrayed. This perception disempowers the client and leads to burn out on the part of the professional. It does not reflect a reciprocal and collaborative partnership between clients and professional that is at the heart of client-centered practice. Some strategies have been shown to better support the professional's role in this partnership:

- View patients as unique individuals and stay open to learning from them. Challenges inherent in the therapeutic relationships can be great learning opportunities.
- Working full time may deplete you emotionally and/or physically or not provide you with the professional challenges you need. Consider working part-time in spinal cord injury rehabilitation and part-time in a different practice area or in administrative role.
- Consistently explore the evidence that can support your practice. Over the last fifteen years the definition of 'evidence' has expanded beyond the traditional focus on randomized clinical trials to include other forms of research and scholarship; e.g., qualitative articles and metasynteses (Hammell, 2007a, 2007b) that capture the client perspective on their experiences of disability (Carpenter, 1994), their health care provision and the nature of client-centered practice (Cott, 2004).
- Develop your communication skills. We do not develop these essential skills automatically; they need to be learned and practiced. However, no amount of courses or training can make a person a good communicator unless it comes from the heart. This means having an ongoing dialogue with clients; being genuinely interested in the other person; asking open-ended questions; actively listening; being authentic; offering choices; and being honest about expectations what can be offered in rehabilitation and the constraints of practice and the organizational context.
- Develop stress management strategies that suit you, such as keeping a journal; doing Tai Chi, yoga, or meditation; or exercising regularly.
- Establish a formal or informal peer support system within the unit or interdisciplinary team.



If you are frustrated with your work environment, develop strategies to resolve them or diffuse your irritation with them. For example, prioritize your concerns to determine what can be changed and what cannot, think of possible solutions, discuss these with peers and your manager, and ensure that you get feedback from management on your concerns and suggestions.

Take responsibility for what you are finding difficult. Ask yourself:

- How am I contributing to the situation?
- How can it be improved or changed?
- What will it take?
- Am I willing to try?
- How will you evaluate your success in making a change?

Make a plan and share it with others who share your concerns. How will you evaluate your success in making a change?



Client-Professional Interaction in Client-Centered Practice

The central issue in the professional-client relationship is the allocation of authority and decision-making, and it has been characterized in a variety of ways. A partnership implies a close relationship of mutual trust and cooperation; the professional and client are involved in a mutual collaborative venture. Although the professional may be doing things for a client and to a client, the overriding principle is that of doing things with a client (Cain, 2002). This type of relationship assumes the professional and client are fundamentally equal. Other types of professional-client relationships privilege the professional's knowledge and skills, and assume that the professional is, to some extent, in a superior position to the client. Such relationships can be labeled, in varying degrees, as benevolent or authoritative and raise issues of power and paternalism. To be perceived as an authority, as professionals frequently are, and to expect clients to willingly comply with the professional's recommendation are clearly to exercise power in the relationship. Paternalism is doing something to someone because it is perceived as being of benefit or good for them, regardless of whether they are fully informed or have given consent.

This type of approach is difficult to justify, as it denies people the freedom to make choices affecting their lives. This type of relationship undermines the over-arching goals of rehabilitation: to promote self-responsibility and independence, self-management, and quality of life, and it is incompatible with the concepts of partnership and collaboration that are fundamental to a client-centered model of practice.

However, in reality, it is difficult to consistently counteract the power imbalance in the professional-client relationship, particularly when the client is newly injured and lacks knowledge of his or her situation; i.e., when they don't know what they need to know. This is the argument frequently used to support the more authoritative relationship, and as such, engenders the use of strategies to persuade clients to comply and adhere to their professional decisions (Kirschner, et al., 2001). Such strategies, if not used mindfully, can lead to client disempowerment early in the rehabilitation process. Professionals are encouraged to observe clients' abilities to collaborate and increasingly engage them in collaborative decision making. In addition, when patients' and rehabilitation professionals' expectations of therapy and perceptions of their respective roles within the relationship are congruent, communication between them is likely to be better—with fewer misunderstandings taking place and increased acceptance of each other's contributions and strengths. It is often difficult to achieve this congruence.

In summary, the relationship between the rehabilitation professional and client is the foundation of the client-centered model of practice and is based on mutual respect, joint decision making to achieve commonly shared goals, and where both parties share decisions and responsibility (Hammell, 2006; Cott, 2004; Sumsion, 1999).

Strategies

- Consider yourself as a consultant or information resource for clients and provide them with as much information and evidence, derived from your reading of the research and scholarly literature, as possible about their injury and your understanding of their future capabilities as possible.
- Share information derived from your work with clients that might be relevant or perceived as helpful; for example, share other clients' stories to illustrate effective treatment approaches, alternative ways of doing things, management of complications, and their trajectories.
- Acknowledge your expertise in diagnosis, prognosis, treatment options, preventive strategies, and explain the constraints inherent in insurance policies and procedures and the organizational structure that can impact the therapy process.
- Incorporate time within therapy sessions to establish rapport, build trust, and allow negotiation between you and the client.



- Involve peer mentors (or old hands) in the therapy sessions and encourage clients to meet with peer mentors to discuss life after rehabilitation with them. [See box to the right.]
- Involve trained peer mentors support to help exemplify how smaller goals in therapy can lead to accomplishing larger goals in real life.

John described how he learned to do a car transfer by observing and talking with a peer mentor. "I was sitting in my chair in my hospital room looking out my window down at the parking lot and I saw a man in a wheelchair, I think he was paraplegic, going into his car with ease. He just transferred quickly, lifted his chair in and off he went, and I was like 'wow, look at that' and I remember realizing that I can do that too. I can drive and I can be independent again. ... And you know, I didn't know that at the time, but that was one of the peer mentors 'cause I met them later in the unit."



- Share information with and explain to clients how you see them progressing in their rehabilitation program and what you hope they will achieve by the time they are discharged. [See box to the right.]

In this interaction between Judith (OT Assistant) and Irving (client) Judith provides positive feedback and the fact that he has achieved independence in this activity.

Judith: Great job on putting on your shirt

Irving: *Thank you.*

Judith: And with your splint, cleaning your splint.

Irving: *Thank you.*

Judith: Do you think so? I mean, do you feel the same way? Because I know I didn't do a thing. I was over here, you did it all.

- Encourage clients to get involved with meaningful activities, such as sports, art, or music that relate to their interests before they were injured. Recreation and vocational therapists can be a great resource. [See box to the right.]
- Consistently ask clients (particularly those who have lived with a disability over the long term) to share their experiences of their bodies, the management strategies they have developed, and what resources and equipment support their abilities. Treat this information as expertise in the same way that you perceive your technical knowledge and work experience as expertise. [See box to the right.]
- Solicit information about clients' attitudes, values, preferences, and pre-injury experiences to gain an understanding of who they are as a person and the context of their lives. This information is invaluable in capitalizing on their capabilities and in planning therapeutic goals and tasks.

Jennifer talks about how important being introduced to rock climbing was for her as a wheelchair user and how it enhanced her self-esteem.

“I went to the adaptive sports program, and he mentioned rock climbing. I wanted to try this before my accident. And that was of of those things when I found out that I could still rock climb, I get it! I can still do a lot of stuff. So once you realize it, that you can do things, it makes it a little easier.”

As Allie said about her acute rehabilitation experience:

“Don't tell me what to do because you don't know how my life was and don't know how much has changed. You don't know anything...let me learn my own way.”



Mutual goal setting is an important component of the professional-client interaction

The concept of goal setting may be alien or new to clients. They are often overwhelmed in the early rehabilitation phase and may require help prioritizing. Goals established by rehabilitation professionals, usually related to physical impairment, may not be important, relevant, or a priority at that time to the client. Also the literature suggests that goals achieved in rehabilitation are not practical or comprehensive enough in the real world outside rehabilitation (Hammell, 2006). Rehabilitation professionals, on the other hand, frequently feel that client goals are too big or unrealistic; e.g., wanting to walk again and have difficulty aligning these goals with what they of the client's future potential.

- Be prepared to discuss clients' goals and use your imagination to break down the larger goals by developing acceptable smaller tasks that clearly relate to the client's overall goal. Be honest about your reservations about the possibility that the larger goal can be achieved, but avoid shutting the door.
- Teach more than one way to do something; e.g., dress or transfer onto the toilet or floor. Clients tell us that learning only one way does not prepare them to manage the different environments and situations they can potentially experience once re-engaged with their real life. It assumes that they will not be travelling or staying in different places and with different people.

This exchange, between an occupational therapist and patient demonstrates collaborative goal setting.

OT: Today I thought we would work on some things you can do when you are home helping with chores. Do you help out with chores?

Mike: Well, yes, I am the breakfast guy. I make breakfast.

OT: Great. Well, do you want to work on that? I thought we could also do some strengthening exercise too. What do you think?

Mike: Well, let's start with strengthening. I will need that in order to do breakfast, don't I?

Jennifer describes how the opportunity to address her big goal was missed by some rehabilitation professionals.

Jennifer's goal during rehabilitation was to have a good life. So she perceived rehab as being about helping her build a foundation to achieve that and to move forward.

She shared these big goals with the nurse, but she says that they were never explored in physical therapy, occupational therapy, or with her psychologist—and were only treated conversationally by her nurse and other staff.

As she said: "I did not focus on the micro-goals of physical therapy or occupational therapy. I just showed up and did what I was told. The micro goals of my therapists were focused on the practicalities of getting me home."

Peer mentoring within inpatient rehabilitation

Peer mentoring is an individually designed service that seeks to support newly disabled persons during their inpatient stay. A peer mentor offers education, shares personal experiences, and informs clients in various areas such as accessible transportation, personal attendant services, social services, equipment tips, behavioral or emotional concerns of being newly disabled, accessible sports or fitness options, and so forth.



Peer mentoring can be a successful peer-to-peer support service. It is based on the belief that often people with disabilities who are struggling to regain a satisfying life may best benefit from relating to another person with a disability who has been successful in this effort. Individuals with disabilities often experience attitudinal and physical barriers; a peer mentor is able to examine these barriers and assist disabled patients to overcome them. This service is not intended to meet clients' needs for or act as a substitute for professional mental health services.

There are various models that support use of peer mentoring and peer mentors. From our research, we conclude that successful peer support programs screen their mentors using specific selection criteria, utilize a standard process for orientation and training that includes shadowing and routine coaching, and engage mentors in regular communication and advocacy (at least annual) in-services to ensure continued competency. Integrating these components facilitates effective coordination of the program; respect, value, and trust of the peer team by clinical staff; and a systematic method for continuous quality improvement and evaluation.

Contribution of Interdisciplinary Teams to Client-Centered Practice

Working together on interdisciplinary teams is an integral component of rehabilitation that is not reflected in research or education programs. There are multiple definitions of team. We have chosen to use the term interdisciplinary team as we believe best relates to client-centered practice described in this guide: an understanding of the everyday practices, values, and beliefs of colleagues from various disciplines and a recognition of the organizational constraints shared by all team members that shape not only individual clinical practices but also the institutional environment, are learned by professionals through experience in a serendipitous fashion.

Dysfunctional teams are not uncommon: teams that are characterized by, for example, a hierarchical structure, turf wars between team members, fragmented communication, perceived alignment of one team member with the client and their family, disparate values, and conflicts over scarce therapy hours (Caplan & Reidy, 1996). It is often asserted that the client is the most important member of the team; however, most rehabilitation professionals are well aware that the ideals of effective team functioning and client-centered care are fraught with difficulties. Clients, for example, may be excluded, often unintentionally, from assuming an active role in the team process.

Members of a successfully functioning team develop feelings of collegiality towards each other. They frequently share common values and beliefs upon which their practice is based and have an understanding of the role each discipline plays in the larger rehabilitation context. In contrast, the clients find themselves 'outsiders' within the team dynamics, in unfamiliar territory, and unable to contribute in a meaningful way.

What is an interdisciplinary team?

An interdisciplinary team is characterised by collaboration reinforced by continuous and multilateral communication. (Korner 2010).

When are interdisciplinary teams client-centered?

Interdisciplinary teams that are client-centred are characterized by members who are involved in problem solving beyond the scope of their own discipline to meet client goals. (Kumar, 2000).

What does a client-centered professional look like?

A client-centred professional who is part of an interdisciplinary team is willing to share and indeed give up exclusive claims to specialized knowledge and authority, if the needs of clients can be met more effectively by other disciplines. (Molyneux, 2001).

Organizational Components that Affect Client-Centered Practices

Strategies

- Work with your colleagues to ensure that patients and/or their advocates are authentically involved in team discussions and decisions; e.g., ask them to share their progress and frustrations, review their smaller and larger goals, and provide information about their discharge destinations.
- If formal team meetings are held consider rotating the leadership or chair each time and include patients in assuming this role.
- Ensure that the relevant team members establish the client's goals and work together in a coordinated fashion to achieve them (see suggestions about use of client-centered outcome measures on page 29) to avoid working at cross-purposes or repeating tasks and information.
- Work with selected team members on joint problem solving sessions with patients.
- Sharing a common office area and treatment space has been shown to foster understanding and respect of each other's roles and to enhance informal communication. If possible, propose or influence this arrangement within the organization. If not, establish clear lines of communication, including emails, medical records, notice boards, etc., and value the time spent sharing information with your interdisciplinary colleagues.
- Negotiate with relevant interdisciplinary colleagues how your work and roles will be differentiated in terms of helping clients achieve their goals and how grey areas will be managed.
- Discuss difficult situations with colleagues, particularly potential areas of interdisciplinary conflict and organizational constraints, and together try to develop possible solutions.

As discussed in the previous section, rehabilitation of persons with SCI is typically provided in a team context within a program or service unit. The organization's culture, mission, system design, and operation all influence the extent to which client-centeredness is supported and facilitated. Endorsing a model of client-centeredness requires a significant level of commitment and adjustments in organizational structures (Ponte, 2003). Unfortunately there are few studies that focus on understanding the effect that organizational structure can have on client-centered practice. In



acute care and stroke rehabilitation, studies show that organizational culture may be related to quality of care, performance, and client-centeredness and that better patient outcomes can be observed when care was provided by interdisciplinary teams (Campbell et al., 2001; Meterko, et al., 2004; Shortell et al., 2001; Hagenow, 2003; Strasser, 2008; Opie, 2000). However, how organizational components facilitate or hinder client-centered practice remains unclear and further research is needed to understand these relationships (Papadimitriou & Cott, 2012).

In this section we outline some organizational factors that rehabilitation professionals, administrators, and educators could consider to promote and facilitate client-centered practice within their organizations. In this section, unlike other sections of this guide, we do not recommend specific strategies because the system changes required are often too complex for rehabilitation professionals to address or for us to discuss in this context.

Questions to consider in discussions with patients and their families are:

- What existing mechanisms assist therapists to ‘work around’ or adapt policies to better serve the clients?
- How are reimbursement policy decisions that affect rehabilitation practice communicated to rehabilitation professionals by administration leaders?
- How are policies and their impact communicated to patients and their families?

Post-acute care policies

These policies change and are often poorly communicated to staff and patients, making them unclear and difficult to accommodate in day-to-day practice and decision-making. In the current United States healthcare context, reimbursement for rehabilitation therapies in inpatient rehabilitation facilities (IRF) mandates a three hours per day therapy program per patient. If patients are unable to adhere to this requirement, they are discharged to other post-acute care environments such as nursing homes, skilled nursing homes, etc. Rehabilitation therapists are required to provide proof that:

- Patients are getting three hours of therapy per day (PT, OT, and speech).
- The patient is improving.

Improvement is customarily evaluated using Functional Independence Measure (FIM)TM scores. Often, reimbursement policies are difficult to reconcile with therapists’ recommendations in relation to goal setting or discharge planning.

Earlier we presented a vignette of Maggie (PT) and Irving (client) as an example of problematic client-centered practice. Maggie needed Irving to transfer to and try out a new wheelchair, but Irving was struggling with dizziness and appeared disinterested in the new chair. Maggie was reacting to the constraints on practice imposed by the post-acute care insurance reimbursement, organization productivity, and billable hour's policies. She was focused on ensuring that the session "counted" for Irving because she was concerned about him potentially losing his insurance coverage as a result of not participating in therapy.

Administrative policies and overall culture

Whether, and how, rehabilitation institutions and administration leaders promote client-centeredness is important and reflects the organizational culture and the value attributed to this model of practice.

Consider whether the organization or service units engages in strategies that facilitate client-centered practice, such as:

- Enlisting the assistance of a facilitator to promote client-centered practice.
- Providing interdisciplinary continuing education workshops.
- Soliciting client assessment of the provision of client-centered practice within the organization.
- Encouraging continuous professional development.
- Involving rehabilitation professionals and patient representatives in strategic planning.
- Supporting or promoting innovation, new ways of doing things, encourage rehabilitation professionals to review, and make recommendations to improve service delivery.
- Providing joint PT and OT assessment and treatment sessions.
- Facilitating peer mentor led workshops.
- Providing community outings.
- Encouraging participation in adapted sports.
- Providing non-allopathic therapies.
- Supporting and valuing peer mentoring as an important component of the rehabilitation service.



Productivity

Increasingly, health service organizations focus on employee productivity based on direct patient care hours. Patient care hours are defined within each organization and based on post-acute care insurance policies and can be constraining and inflexible, thus hindering therapists' efforts to be client-centered. Consider:

- Are there mechanisms in place to ensure that therapists' practice is appreciated and valued by senior administration in spite of insurance and financial pressures? Such as an employee performance appraisal process that consistently and fairly evaluates professionals' practice and provides constructive feedback.
- Are rehabilitation professionals consulted about service development and changes?
- Are therapists rewarded for being client-centered?

Staffing

The issues of adequate staffing, how staff are assigned to different service units, the use of casual or float staff, and staff retention can be problematic in providing a consistent standard of patient care and make effective interdisciplinary team functioning more difficult. Questions that need to be addressed in staff planning include:

- How is staffing of the units managed? Does staff provide input on what is required to provide a high standard of practice?
- How are decisions about the type and complement of different disciplines made? For example, does the speech-language pathologist have to cover more than one unit? Are there more PTs than OTs on the unit? Are rehabilitation professionals involved in making these decisions?
- What kind of formal and informal mechanisms does the organization and unit have in place to support the well-being of the staff? For example, hot topics lunches, a meeting place, staff-to-staff mentoring and support, psychological support, and informal peer gatherings.
- When the hospital or unit experience low staffing, are there fair and equitable mechanisms in place by which existing staff can provide patient services?



Evaluating Client-Centered Practice

Evaluating practice can take place at two levels; measuring achievement of client rehabilitation goals (outcomes) and assessment of the client's experience of rehabilitation. In client-centered practice the aim of assessment and treatment is to position the patient at the center of the process, with different professionals seeking to understand the patient's experience of illness from a psychological, social, and biomedical perspective. Based on this holistic assessment, specific goals identified by the client as important to them; for example, activities of daily living, return to work, or social participation, are developed, and these form the focus for each of the disciplines working with that patient.



The choice of appropriate outcome measures can support client-centered practice and encourage rehabilitation professionals to collaborate with each other and the patient. Examples of two such outcome measures are the Goal Attainment Scale (GAS) and the Canadian Occupational Performance Measure (COPM)[®].

These outcome measures help patients formulate and discuss their rehabilitation goals as well as gain insight into their rehabilitation potential and focus on what is meaningful to them in the context

of their lives. GAS is a method of scoring the extent to which patients' individual goals are achieved in the course of intervention. In effect, each patient has their own outcome measure, but this is scored in a standardized way to allow statistical analysis. Generic measures include a standard set of tasks (items) and a standard set of levels. In GAS, tasks are individually identified to suit the patient and the levels set around their current and expected levels of performance (Turner-Stokes, 2009a, 2009b).

The COPM is an individualized outcome measure designed for use primarily by occupational therapists, but has been shown to be useful as a focus for the interdisciplinary team. (McColl, Paterson, Davies, Doubt, and Law, 2000). The measure is designed to detect change in a client's self-perception of occupational performance over time. The COPM is a standardized instrument, in that there are specific instructions and methods for administering and scoring the test. It is designed as an outcome measure, with a semi-structured interview format and structured scoring method (Law et al., 2005). These client-centered outcome measures offer some benefits relative to other standardized global measures, such as the Functional Independence Measure (FIM) now often used in conjunction with the Functional Assessment Measure (FAM) and the Barthel Index, the use of which are commonly required by rehabilitation organizations.

These problems include floor and ceiling effects and a lack of sensitivity. Patients can demonstrate change in one or two important items, but this change is lost in the overall scores where a large number of irrelevant items do not change.

It is not common for patients to be asked to assess their rehabilitation experience. If the rehabilitation team and the organization are committed to client-centered practice, this needs rectifying. Cott, Teare, McGilton and Lineker (2006) developed and tested the validity and reliability of the Client Centred Rehabilitation Questionnaire (CCRQ). The CCRQ is a publicly available measure of client-centered rehabilitation based on a literature review, focus groups with clients, and review by content experts.

The seven domains of client-centered rehabilitation that are important from the client's perspective are:

- Participation in decision-making and goal setting.
- Client-centered education.
- Evaluation of outcomes from the client's perspective.
- Family involvement.
- Emotional support.
- Coordination and continuity.
- Physical comfort.

Client-centered practice does not occur in a vacuum. It takes place within a complex environment affected by factors such as professionalism, disciplinary models and theories, team organization and functioning, institutional culture, post-acute care reimbursement and insurance policies, and market trends regarding health service delivery. This guide has focused on several components of client-centered practice, derived from our research, with the purpose of suggesting strategies that rehabilitation professionals could use to support client-centered practice in spinal cord injury rehabilitation. We have not expanded our recommendations to the policy or system levels, though we are cognizant that future work is needed in this area.

What is a client-centered partnership?

A partnership implies a close relationship of mutual trust and cooperation the professional and client are involved in a mutual collaborative venture. Although the professional may be doing things for a client, and to a client, the overriding principle of client-centeredness is that of doing things with a client. (Cain, 2002).

What is client-centered practice?

Client-centered practice is a collaborative practice aimed at enabling cooperation with clients by demonstrating respect, involving clients and empowering them in decision-making, advocating with and for clients to meet their needs, and recognizing clients' experiences and knowledge. (Sumsion, 1999).

What is rehabilitation?

Rehabilitation is a process of enabling someone to live well with an impairment in the context of his or her own environment and, as such, requires a complex, individually tailored approach. (Hammell, 2006).

Summary of Recommendations

When we reviewed the literature on client-centered practice in rehabilitation, we realized that in spite of twenty years of professional debate on this topic, it is still difficult for rehabilitation therapists to implement client-centeredness into their practice (Maitra et al., 2006; Law et al., 1995; Moats, 2007). Ironically, in our view, the clients' perspectives on client-centered practice are still poorly researched and understood (Cott, 2004). Furthermore, little research has been conducted that investigates the relationship between client-centered practice and spinal cord injury rehabilitation (Cohen & Schemm, 2007; Donnelly et al., 2004).

In this final section, we draw from the literature as well as our clinical and research experiences to summarize some recommendations for rehabilitation professionals interested in providing client-centered care.

To achieve client-centeredness in practice, we recommend that you, the rehabilitation professional:

- Consistently engage in reflecting on your practice and your relationship with clients.
- Expand your knowledge and understanding of disability by accessing the perspectives of those who are the 'experts' in living with a disability.
- Be open to exploring possibilities with clients after spinal cord injury. They, and we as rehabilitation professionals, are often limited only by a lack of imagination. Actively involve trained peer mentors in your practice.
- Acknowledge client experiences and knowledge of their abilities as expertise.
- Develop your communication skills.
- Be determined to think outside the box.
- Access and incorporate current evidence to support your practice and inform clients, including relevant alternative sources of evidence, such as, narratives of people living with disabilities.
- Develop self-care strategies to avoid burn out.
- Collaborate with other rehabilitation disciplines to meet the needs of your clients. For example, work with therapeutic recreation and vocational rehabilitation counselors and psychologists to integrate and develop client-centered goals.
- Actively engage patient advocates (friends and family) for teaching and goal setting.
- Develop peer-based support systems that can enhance and support your efforts to be client-centered.
- Choose ways that you can advocate with clients. Those can be within, but also outside, the boundaries of the work environment.

This field guide was based on a 12-month qualitative research study funded by the National Institute on Disability and Rehabilitation Research (NIDRR). The study employed a combination of in-depth ethnographic field methodology and elements of participatory action research (PAR) that involved clients (patients and families), rehabilitation professionals and administrators, and community residents with SCI in understanding and improving the care they receive, provide, and support. Because the first objective of this study was to understand how client-centered concepts are practiced in the day-to-day activities of physical and occupational therapists with their inpatients with SCI, the study employed an ethnographic field-work methodology. This type of methodology is particularly useful for investigating phenomena in their real-life context and securing rich and detailed descriptions of them (Strauss & Corbin, 1998; Hammell & Carpenter, 2004). It is a methodology that is now readily used to study rehabilitation and evidence-based practice (Hammell & Carpenter, 2004). Both authors of this guide are experts in this methodology (see About the Authors on page 38).

In outlining the qualitative methodology employed in this study, the following aligns the methods to be used with the objectives they sought to address.

Objective 1

Understand how client-centered concepts are practiced by physical and occupational therapists in inpatient spinal cord injury (SCI) rehabilitation.

Methods:

- Key Informant interviews with PT, OT, SLP, and SW.
- Structured Observations of PT & OT private and group sessions.
- Debriefing interviews with patients and therapists after observations.
- Focus groups with PT and OT.

Objective 2

Identify critical barriers and facilitators to client-centered practice implementation in inpatient spinal cord injury (SCI) rehabilitation.

Methods:

- Interviews with administration staff (unit leader, medical director, nurse manager).
- Focus groups with PT and OT.
- Client-Centered Rehabilitation Questionnaire (to clients post discharge).
- Phone interviews with former patients.

We used a PAR framework to ensure that the choices of participants and observations were informed, that the interview and focus group questions were properly oriented and directed, and that the data and preliminary findings were given sufficient contextual understanding and review. To achieve this, we used a Community Advisory Board (CAB) whose members included representatives from key local disability advocacy organizations, community residents with SCI, and rehabilitation professionals with experience in SCI. The CAB met four times in 2010–11.

Sample and Recruitment

All data were generated from one spinal cord (SCI) unit at a large Midwestern rehabilitation hospital. The SCI unit typically employs 12 to 15 physical and occupational therapists and treats approximately 165 inpatients per year, roughly 12 to 14 new inpatients per month. Patients on the SCI unit are adults (most between the ages of 18 to 55, mean age is approximately 35), roughly 70 percent are male, and about 40 percent are ethnic minorities.

We studied all physical and occupational therapists of the unit and approximately 20 inpatients with SCI.

Inclusion criteria for the inpatients with SCI included:

- Have sustained a (traumatic or non-traumatic) spinal cord injury.
- Functional English.
- Cognitively able to provide informed consent.
- Between the ages of 18 to 60.

All inpatients received informational letters on admission and were approached during their first four days in the unit. The SCI floor nurse approached patients, explained the study, and ascertained their willingness to participate. Inpatients who agreed to participate met with Christina Papadimitriou to complete the informed consent protocol and be enrolled in the study. For inpatients, enrollment in the study meant agreeing to:

- The release of demographic and background data.
- Be observed and audio-taped by applicant during their physical and occupational therapy sessions.
- Participate in short debriefing interviews following some therapy sessions.
- Be contacted after discharge to complete a questionnaire (CCRQ) and answer brief questions regarding their overall care.

Physical and Occupational therapists on the SCI unit were informed about the objectives and procedures of the study during team meetings and agreed to participate. All PT and OT on the SCI unit were eligible to participate regardless of years of service and full or part-time status. For them, enrollment in the study meant agreeing to:

- Release demographic and background information data.
- Be observed and audio-taped during their sessions with inpatients and in short debriefing interviews.
- Participate in focus groups. Administration and management staff (such as nurse director, medical director, unit leader) were also interviewed.

Data Analysis

Interviews, focus groups, and audio-recorded observations were professionally transcribed. All data were de-identified and transferred into Microsoft Word files. Initial thematic analysis was conducted by Christina Papadimitriou (CP). Themes from interviews, observations, and focus groups were organized initially in broad descriptive categories such as client views, therapist views, etc. Subsequent analyses focused on identifying effective and problematic interactions among therapists and clients based on topics such as respectful communication, shared goal setting, therapist's descriptions of client interactions, client's descriptions of rehabilitation experiences, and so on.

Themes and categories were shared with a Research Advisory Board of qualitative and rehabilitation researchers for validation and feedback. They were refined by CP into four general themes of concerns toward achieving client-centered practice in inpatient SCI rehabilitation: therapists concerns, team or unit level concerns, organizational and policy level concerns, and patient characteristics. Analyses were then shared with the Community Advisory Board who offered validation, criticism, and suggestions. This process allowed for disagreement, validation, and constructive criticism, which are important in qualitative analyses for increased accuracy of complex phenomena such as understanding client-centered practice. This process increases the trustworthiness of qualitative findings because it offers mechanisms for challenging analyses. An audit trail was kept recording these procedures.

Finally, for this guide, Dr. Christine Carpenter's expertise on client-centeredness and SCI was solicited as an analytic consultant. Dr. Carpenter reviewed all data, preliminary analysis, and codes, and developed more nuanced categories of effective and problematic professional practices of client-centeredness. The Field Guide reflects the iterative process of developing strategies to aid rehabilitation professional to engage in client-centeredness.

- Blank, A. (2004). Clients' experiences of partnership with occupational therapists in community mental health. *British Journal of Occupational Therapy*, 67 (3): 118–124.
- Cain, P. (2002). "Partnership" is not enough: Professional-client relations revisited. In: Fulford, K.W.M., Dickenson, D.L., & Murray, T.H. (Eds.) *Healthcare ethics and human values* (pp. 278–281). Oxford: Blackwell.
- Campbell, S.M., Hann, M., Hacker, J., et al. (2001). Identifying predictors of high quality care in English general practice: Observational study. *BMJ*, 323: 784–792.
- Caplan, B. & Reidy, K. (1996). Staff-patient-family conflicts in rehabilitation: sources and solutions. *Topics in Spinal Cord Injury Rehabilitation*, 2 (2): 21–33.
- Carpenter, C. (2004). Dilemmas of Practice as Experienced by Physical Therapists in Rehabilitation Settings. *Physiotherapy Canada* 57 (1): 63–74.
- Cohen, M.E., Schemm, R.L. (2007). Client-centered occupational therapy for individuals with spinal cord injury. *Occupational Therapy in Health Care*, 21: 1–15
- Cott, C.A., Teare, G., McGilton, K.S., & Lineker, S. (2006). Reliability and construct validity of the client-centred rehabilitation questionnaire. *Disability and Rehabilitation* 28 (22): 1387–1397.
- Cott, C.A. (2004). Client-centred rehabilitation: Client perspectives. *Disability and Rehabilitation* 26 (24): 1411–1422.
- Donnelly, C., Eng, J.J., Hall, J., Alford, L., Giachino, R., Norton, K., & Kerr, D.S. (2004). Client-centered assessment and the identification of meaningful treatment goals for individuals with a spinal cord injury. *Spinal Cord*, 42: 302–7.
- Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196 (4286): 129–134.
- French, S. (2004). Enabling relationships in therapy practice. In: Swain, J., Clark, J., Parry, K. et al. *Enabling relationships in health and social care* (pp. 95–107). Oxford: Butterworth-Heinemann.
- Gzil, F., Lefevre, C., Cammelli, M., Pachoud, B., Ravaud, J.F., & Leplege, A. (2007). Why is rehabilitation not yet fully person-centred and should it be more person-centred? *Disability and Rehabilitation*, 29 (20–21): 1616–1624.
- Hagenow, N. R. (2003). Why not person-centered care? The challenges of implementation. *Nurs Adm Q*, 27 (3): 203–207.

- Hammell, K.W. (2007a). Quality of life after spinal cord injury: A meta-synthesis of qualitative findings. *Spinal Cord*, 45: 124–139.
- Hammell, K.W. (2007b). Experience of rehabilitation following spinal cord injury: A meta-synthesis of qualitative findings. *Spinal Cord*, 45: 260–274.
- Hammell, K. (2006). *Perspectives on disability and rehabilitation contesting assumptions; challenging practice*. Edinburgh: Churchill Livingstone Elsevier.
- Hammell, K.W., Carpenter, C. (Eds.) (2004). *Qualitative Research in Evidence-Based Rehabilitation*. Churchill: Livingstone.
- Higgs, J. & Titchen, A. (2001). *Practice knowledge and expertise in the health professions*. Oxford: Butterworth-Heinemann.
- Johnstone, D. (2001). *An introduction to disability studies* (2nd ed). London: David Fulton Publishers.
- Kirschner, K., Stocking, C., Wagner, L.B., Foye, S., & Siegler, M. (2001). Ethical Issues identified by rehabilitation clinicians. *Archives of Physical Medicine & Rehabilitation*, 82 (Suppl. 2): S2–8.
- Korner, M. (2010). Interprofessional teamwork in medical rehabilitation: A comparison of multidisciplinary and interdisciplinary team approach. *Clinical Rehabilitation*, 24: 745–755.
- Kumar, S. (2000). *Multidisciplinary Approaches to Rehabilitation*. Boston: Butterworth-Heinemann.
- Law, M., Baptiste, S., Carswell, A., McColl, M.A., Polatajko, H., & Pollock, N. (2005). *Canadian Occupational Performance Measure* (4th ed). Ottawa, ON: CAOT Publications.
- Law, M., Baptiste, S., & Mills, J. (1995). Client-centred practice: what does it mean and does it make a difference? *Canadian Journal of Occupational Therapy*; 62 (5): 250–257.
- Lepège, P.A., Gzil, F., Cammelli, M., Lefève, C., Pachoud, B., & Ville, I. (2007). Person centeredness: conceptual and historical perspective. *Disability and Rehabilitation* 29 (20–21): 1555–1565.
- Maitra, K.K., Erway F. (2006). Perception of client-centered practice in occupational therapists and their clients. *American Journal of Occupational Therapy*, 60: 298–310.
- MacLeod, R. & McPherson, K.M. (2007). Care and compassion: Part of person-centred rehabilitation, inappropriate response or a forgotten art? *Disability and Rehabilitation*, 29 (20–21): 1589–1595.

- Meterko, M., Mohr, D.C., & Young, G.J. (2004). Teamwork culture and patient satisfaction in hospitals. *Medical Care*, 42: 492–498.
- Moats, G. (2007). Discharge decision-making, enabling occupations, and client-centered practice. *Canadian Journal of Occupational Therapy*, 74: 91–101.
- Molyneux, J. (2001). Interprofessional teamworking: What makes teams work well? *Journal of Interprofessional Care*, 15 (1): 29–35.
- Opie, A. (2000). *Thinking Teams/Thinking Clients: Knowledge Based Teamwork*. New York: Columbia University Press.
- Papadimitriou, C. & Cott, C. Team functioning and client-centered care in inpatient rehabilitation. *8th International Organizational Behavior in Healthcare Conference Proceedings*, Trinity College, Dublin, Ireland, April 2012.
- Ponte, P.R., et al. (2003). Making patient-centered care come alive: achieving full integration of the patient's perspective. *J Nurs Adm*, 33 (2): 82–90.
- Shortell, S.M., Zazzali, J.L., Burns, L.R., Jeffery, A.J., Gillies, R., Budetti, P.P., et al. (2001). Implementing evidence based medicine: the role of market pressures, compensation incentives, and culture in physician organizations. *Med Care*, 39 (7): 62–78.
- Strasser, D.C., Falconer, J.A., Stevens, A.B., Uomoto, J., Herrin, J., Bowen, S.E., & Burrige, A.B. (2008). Team Training and Stroke Rehabilitation Outcomes: A Cluster Randomized Trial. *Archives of Physical Medicine and Rehabilitation*, 89 (1): 10–15.
- Strauss, A., Corbin, J (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed). London: Sage Publications Ltd.

Biographical note for Christina Papadimitriou

Dr. Papadimitriou is a qualitative sociologist who uses qualitative research to study inpatient rehabilitation practices in the areas of disability and spinal cord injury. She was funded by NIDRR (Mary Switzer fellowship, 2009–10) to conduct a qualitative study of client-centered practices in inpatient rehabilitation for spinal cord injured adults. In Fall 2011, she was awarded a small research grant to study pressure ulcers in veterans with spinal injuries from Hines, VA Hospital.

She has published articles in the areas of rehabilitation, disability and qualitative research. She has recently (2010, 2011) co-authored two articles with David A. Stone exploring Heidegger's notion of existential temporality and the experience of traumatic spinal injury.

Christina is also exploring how organizational factors affect client-centeredness in rehabilitation. Her work with Dr. Cheryl Cott at the University of Toronto explores this little researched area in a recent publication (2012).

She is currently working on her first book, *Uncovering the Experience of Re-Embodiment: Studies in Disability and Rehabilitation after Spinal Cord Injury*.

Her articles appear in *Disability & Rehabilitation*, *Disability & Society*, and *Physical Therapy Reviews*.

Her research interests include: Client-centered care in inpatient rehabilitation; Clinical Encounters in Rehabilitation; Peer mentoring in Rehabilitation; Disability Ethics; Health Disparities; Phenomenological Research; Qualitative Health Research.

Dr. Papadimitriou is currently an Associate Professor at Northern Illinois University, College of Health and Human Sciences, School of Nursing and Health Studies. She studied Sociology at Boston University for both her Bachelors (1990) and Ph.D. (2000). In 2009, Christina completed an interdisciplinary healthcare studies post-doctoral program at Northwestern University, Institute of Healthcare Studies.



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Selected Publications:

- Papadimitriou, C. & Stone, D.A. (2011) Addressing existential disruption in traumatic spinal cord injury: a new approach to human temporality in inpatient rehabilitation. *Disability and Rehabilitation* 33, (21–22): 2121–2133.
- D. A. Stone & Papadimitriou, C. (2010) Exploring Heidegger’s Ecstatic Temporality in the Context of Embodied Breakdown.Schutzian Research. *A Yearbook of Worldly Phenomenology and Qualitative Social Science* 2: 137–154.
- Papadimitriou, C. (2008). The ‘I’ of the beholder: Phenomenological ‘seeing’ in the context of disability. *Sports, Ethics and Philosophy*, 2: 216–233.
- Papadimitriou, C. (2008). Becoming En-wheeled: Re-embodiment as a wheelchair user after Spinal Cord Injury. *Disability and Society*, 23: 691–704.
- Papadimitriou, C. (2008). “It was hard but you did it”: Work in a Clinical Context among Physical Therapists and Spinal Cord Injured Adults. *Disability and Rehabilitation*, 30: 365–774.
- Papadimitriou, C. & Cott, C. Team functioning and client-centered care in inpatient rehabilitation. *8th International Organizational Behavior in Healthcare Conference Proceedings*, Trinity College, Dublin, Ireland, April 2012.
- Papadimitriou, C., et al. (to be published in 2013). Testing Quality Measures for Rehabilitation: Results from Cognitive Interviews. *Rehabilitation Nursing*.
- Papadimitriou, C., Magasi, S., Frank G. (2012). Current thinking in qualitative research: Evidence-based practice, moral philosophies and political struggle. *OTJR* 32 (1S): 2–5.

Biographical note for Christine Carpenter

Christine Carpenter was educated as a physical therapist in Liverpool, England, and attained her graduate degrees in Educational Studies at the University of British Columbia (UBC), Canada. Before joining the School of Rehabilitation Sciences at UBC she worked for over twenty years in rehabilitation settings primarily with individuals who had sustained spinal cord injury. In 2004 she relocated to the United Kingdom and is currently a Reader in Physiotherapy in the Faculty of Health and Life Sciences, Coventry University. She has extensive experience teaching at both graduate and undergraduate levels (including qualitative research methodologies and methods) and has received several university teaching awards. Dr. Carpenter is also involved in providing dissertation supervision for graduate (Masters and Doctoral) students in the United Kingdom and Canada. Her research initiatives have focused on the long-term experience and quality of life issues, and participation in the community following spinal cord injury, client-centered practice, and ethical dilemmas in rehabilitation settings.



She has co-authored three books *Using qualitative research: A practical introduction for occupational and physical therapists* (2000) and *Qualitative research in evidence-based rehabilitation* (2004) with Karen Hammell and *Qualitative research for occupational and physical therapists: A practical guide* (2008) with Melinda Suto.

Selected Publications:

Mir, S. & Carpenter, C. (in press) Implementing a person-centred model of service delivery and practice in neurological rehabilitation: Theoretical and practical considerations. *International Journal of Person Centred Medicine* (accepted August 12, 2011)

Hurtubise, K. & Carpenter, C. (in press) Parents' Experiences in Role Negotiation in the Family Centered Model of the Infant Services Program
Parents' experiences in role negotiation within an Infant Services program. *Infants and Young Children* (accepted for publication October 2010)

Carpenter, C. (2010) Moral distress in physiotherapy practice. *Physiotherapy Theory and Practice*, 26 (2): 69–78.

- Carpenter, C., Forwell, S., Jongbloed, L. & Backman, C. (2007). Community participation after spinal cord injury. *Archives of Physical Medicine and Rehabilitation*, 88 (April): 427–433.
- Jongbloed, L., Forwell, S., Backman, C. & Carpenter, C. (2007). Employment after spinal cord injury: the impact of government policies in Canada, *Work: A Journal of Prevention, Assessment & Rehabilitation*, 29 (2):145–154.
- Carpenter, C., Ericksen, J., Hill, D. & Purves, B. (2004). Evaluation of the impact of an interdisciplinary health care ethics course on clinical practice. *Learning in Health and Social Care*, 3 (4): 223–236.
- Carpenter, C. (2004). Dilemmas of Practice as Experienced by Physical Therapists in Rehabilitation Settings. *Physiotherapy Canada*, 57 (1): 63–74.
- Price, D. & Carpenter, C. (2004). The phenomenon of snowboarder's ankle: A literature review. *Physiotherapy Canada*, 55 (4): 110–115.
- Carpenter, C. & Forman, B. (2004). Provision of community programs for clients with spinal cord injury: Using qualitative research to evaluate the role of the British Columbia Paraplegic Association. *Topics in Spinal Cord Injury Rehabilitation*, 9 (4): 57–72.
- Carpenter, C. (1997). Conducting Qualitative Research in Physiotherapy: A Methodological Example. *Physiotherapy*, 83 (10): 547–559.