Client-centred practice – an Indian occupational therapy perspective

Abstract

Background: Although client-centred practice is considered a vital part of occupational therapy practice in western countries, there has been little discussion of the applicability of this approach in non-western countries.

Purpose: The purpose of this project was to explore the applicability of client-centred practice as an approach in a medically oriented setting in an Indian cultural context, and the main question concerned Indian occupational therapists' perceptions of client-centred practice as an approach in a medically oriented setting in India.

Method: Qualitative methods were used and data were gathered from nine Indian occupational therapists through audio recorded focus group interviews. Content analysis was used to identify three themes: How the participants define client-centred practice, factors that influence client-centred practice in India, and the participants' description of how they use client-centred practice.

Conclusion: The results suggest that practicing this approach in this type of setting can be challenging due to many factors. The conflict between a medical model and client-centred practice, cultural impacts on practicing a client-centred approach in India, and the client's ability to understand information and communicate problems are highlighted. In the discussion it is indicated that there is a need for further investigations on the relevance of health literacy in client-centred practice, to find an appropriate way of using a client-centred approach in a medically oriented setting, and to explore the use of client-centred practice in non-western contexts.

Keywords: Client-centred, occupational therapy, India, culture

Av Oda Pettersen og Ingunn Svilaas

Introduction

The approach client-centred practice is a considerable part of the curriculum of the occupational therapy (OT) education at Oslo University College (Høgskolen i Oslo 2010). Our third year clinical placement was conducted at a hospital in India. Our impression from this was that the use of client-centred practice there is somewhat different from what we had experienced in Norway. We were therefore curious to find out whether this approach is equally important and applicable in a culture very different from ours, namely in India.

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Det er ingen interessekonflikter.

Aspects of client-centred practice are mentioned as a vital part of OT practice in several countries (Norsk Ergoterapeutforbund 2006, College of Occupational Therapists 2010, American Occupational Therapy Association 2010). According to a review by Awaad (2003), OT frameworks are mainly developed in western countries, and research on their relevance and applicability in other cultural settings is limited. A lot of research has been conducted on client-centred practice in western countries (Duggan 2005, Maitra & Erway 2006, Mortenson & Dyck 2006, Sumsion 2004, Sumsion & Law 2006, Sumsion & Smyth 2000, Wilkins, Pollock, Rochon & Law 2001, Wressle & Samuelsen 2004). Some research on this topic has also been conducted in non-western countries such as Taiwan, Singapore and Korea (Chen, Rodger & Polatajko 2002, Yang, Shek, Tsunaka & Lim 2006, Kang et al 2008). Chen et al. (2002) and Yang et al. (2006) suggest that there is a need for further research to explore cultural influences on client-centred practice. Hence there is a need to explore client-centred practice as an approach in a non-western OT setting.

The aim of our project was therefore to explore the applicability of client-centred practice as an approach in a medically oriented setting in an Indian cultural context. To explore this, our main question was: What are Indian occupational therapists' perceptions of client-centred prac-

tice as an approach in a medically-oriented setting in India? We narrowed our focus to a medically-oriented setting because the participants in this project work in a hospital strongly influenced by a medical model. The terms client-centred practice and client-centred approach will in this article be used interchangeably.

Same tractor, same purpose, different wrapping.

Methodology

Design

A qualitative method was chosen as this method is useful when the goal is to develop an understanding of individuals' views, attitudes and behaviours (Moore 2006). Focus group interviews were used as the method of data collection, as we wanted to bring forward different viewpoints of the topic client-centred practice. According to Kvale and Brinkmann (2009) this method is preferred to get such information.

Participants

A total number of nine occupational therapists divided into three groups contributed in the interviews. They were currently employed at a hospital in India. Their caseload consisted mainly of acute inpatients, but occasionally they were also seeing outpatients. OT took place at the hospital's OT department, and the therapists did not go on home visits.

Berg (2009) recommends a good range of respondents, as this may mirror a wider population. To ensure this, the occupational therapists we selected had their origins from different parts of India, were educated at different universities, had a varying amount of clinical experience, and were currently working in paediatrics, orthopaedics and neurology. Four of them were male and five were female. This type of sample is, according to Berg (2009), called a nonprobability purposive sample and cannot be considered representative for a wider population of occupational therapists in India. The participants are made anonymous, and the names used are pseudonyms. Since English is the second language for both the participants and the interviewers, quotations are used frequently to limit possible misunderstandings.

Procedure and data analysis

The participants were asked questions under three topics: (1) The definition of client-centred practice; (2) The applicability of client-centred practice in India; and (3) The use of client-centred practice.

In the interviews the topics were introduced, and the participants were encouraged to discuss the topics with each other. The interviewer intervened as little as possible as recommended by Kvale and Brinkmann (2009). The interviews were audio recorded.

We wanted to explore client-centred practice from the viewpoint of the participants as they experience it in their context. The analysis is therefore based on phenomenological philosophy (Kvale & Brinkmann 2009). The data was analysed stepwise using content analysis as this method helps to identify patterns, themes, biases and meanings in materials such as interviews (Berg 2009).

Limitations

According to Larsen (2008) there is a risk that the participants will say what they think the interviewer wants to hear. This is particularly relevant in this project, as the concept client-centred practice is developed in our part of the world. This risk was limited by encouraging the participants to be honest when expressing their opinions.

The participants and the interviewers had different cultural backgrounds. This makes it important to be aware of how *«foreign cultures may involve different norms for interaction concerning initiative, directness, modes of questioning and the like»* (Kvale & Brinkmann 2009, p. 144). We had clinical placement in India eight weeks prior to the interviews, and this enabled us to establish familiarity to the

culture as recommended by Kvale and Brinkmann (2009).

Theory

Client-centred practice

Client-centred practice has become a fundamental part of OT practice during the last decades (Parker 2006). Carl Rogers was the first to use the term client-centred in 1939. At that time a medical model dominated the health care system, and a client-centred way of thinking was quite contrary to this with its emphasis on active listening and understanding in the client-therapist relationship (Rogers 1939 cited in Falardeau & Durand 2002).

In The Ottawa Charter for Health Promotion (World Health Organization 1986) clients' involvement in health care and their opportunity to take control of their own health and wellbeing were stated as essential for achieving «Health for All by the year 2000». In 1983 Canadian Association of Occupational Therapists defined the client-centred approach for the first time for occupational therapists. Since then several definitions of client-centred practice have been published in OT literature (Sumsion & Law 2006). The definition used in this project is developed by Sumsion (1999, 2000): *«Client-centred OT is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfil his or her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client's values, adapts the interventions to meet the client's needs and enables the client to make informed decisions.»* (Sumsion 2000, p. 308)

According to a review by Sumsion and Law (2006) client-centred practice is a partnership between the client and the therapist which enables the client to set and achieve goals and to gain control over his/her situation. The clients participate actively throughout the intervention and supply information about their goals, wishes and perspectives. The therapist provides relevant information and possesses knowledge about the condition and its treatment. Research shows that client-centred practice may improve satisfaction with services, increase adherence to therapy recommendations, and improve functional outcomes (ibid.).

Medical model

According to Mattingly (1994) occupational therapists work within two different discourses. In the medical discourse the focus is on the «body as a machine», and in a phenomenological discourse the focus is on the «lived body». A medical model separates disease from illness experience and it focuses on diagnoses and treatment of disease. It has a strong emphasis in modern health care services, especially in institutional settings (ibid.). In a study by Mortenson and Dyck (2006) occupational therapists described that they were strongly influenced by both these discourses, and that the client-centred discourse was experienced as less powerful than the medical discourse. Falardeau and Durand (2002) compare the medical model to a client-centred approach. They find that these are quite opposite in many aspects. One of these aspects is the emphasis on illness in a medical model versus focus on occupational performance in a client-centred approach. Another aspect is the power balance in the client-therapist relationship. In a medical model the therapist holds the power, is the expert, and is expected to cure the patient. The therapist controls the situation and may not give the client's requirements much space. The client´s experience is sometimes be ignored and the client becomes passive in therapy (ibid.).

Culture and client-centred practice

Culture can be defined as: *«patterns of values, beliefs, symbols, perceptions, and learned behaviours shared by members of a group and passed from one generation to the next»* (Has - selkus 2002 cited in Lim 2008, p. 252). This means that OT core concepts can mean different things for different people depending on their cultural background. A consequence of this is that evidence of the applicability and effectiveness of OT models in one particular cultural context is not necessarily transferable to another cultural context. A western perspective emphasises doing, individualism, analysis and problem-solving as opposed to being, collectivism, acceptance and contemplation in a non-western perspective (Lim & Iwama 2006). Yang et al. (2006) conducted a study about cultural influences on OT in Singapore, where they discovered that some patients did not see independence as a valuable goal. They mention a collectivistic family system where the family members are expected to help each other as a reason for this. Chen et al. (2002) studied experiences with client-centred practice in adult neuro-rehabilitation in Taiwan. They suggest that cultural barriers to client-centred practice might be client's perceptions of the sick role as a passive role, and clients expecting a cure. Sumsion (2004) found that such a passive role can make it difficult for patients to define goals. Different beliefs and values held by the therapist and the patient can also create a barrier (ibid.).

Barriers to client-centred practice

Research also shows other factors that influence client-centred practice. Policies and structures such as time limits and documentation can lead the OT intervention in a direction that is not client-centred (Sumsion 2004, Wilkins et al. 2001). Sumsion and Smyth (2000) and Wressle and Samuelsson (2004) found that a dominance of the medical model in OT intervention can be a barrier. If the referral for OT is restricted to the patient´s medical problems, this may conflict with the patient's functional complaints (Duggan 2005, Sumsion 2004). Maitra and Erway (2006) and Wilkins et al. (2001) say that aspects connected to patients´ willingness and ability to involve actively in therapy can make it difficult to work client-centred. Maitra and Erway (2006) also found that therapists in hospitals tend not to use client-centred practice because patients in hospitals have difficulties setting goals. Patients with little education as well as low income can have diffi-

culties participating actively in decision-making because they are used to being told what to do (Sumsion 2004, Yang et al. 2006). In a study by Wilkins et al. (2001) the participants described the ideal client for client-centred therapy as a client with good cognition, insight and ability to solve problems. Few patients fulfil these criteria, but it is the therapist's responsibility to find a way to work client-centred with all clients (ibid).

Results

How the participants define client-centred practice

In all the interviews the participants emphasised focus on the client as a significant factor in client-centred practice. The participants also discussed the importance of providing information for the patient to be able to make informed decisions and set goals. The participants argued how there need to be a collaboration between the client and the therapist when using a client-centred approach. The client has information about himself and what he wants, and the therapist has knowledge about the client's condition. The client and the therapist negotiate, and the client participates actively in the decision-making process.

Vegetables at the market in Mysore India.

Factors that influence client-centred practice in India

The context in which the therapy occurs can have an influence on whether or not the therapist can work client-centred according to the participants. It is difficult to work client-centred if the patient has wishes that cannot be fulfilled with available resources, or if time available is lacking. Praveen said: *«A patient may want to be independent. ... If to make that person functional I suggest we can make a ramp at the entrance of his home, it is not that simple. We don't have resources to deliver it.»* Namita mentioned time: *«…client-centred practice requires a lot of time…really understanding the client's needs, demands, setting, I don't think we have it [time] in this setup.»* The participants said that it might be difficult to use a client-centred practice because of time constraints if the patient gets discharged fast and if the therapist's case load is too big. Some of the participants said that client-centred practice is more suitable in the client's own environment in a community health setup than in a hospital setup. Lakshmi said: *«Therapy is left at the hospital; it is not extended into his actual living setup. So … if it is actually serving the purpose in his real setup is not known to us most of the time.»* Namita mentioned difficulties connected with a body-oriented system: *«The patients themselves are very body-oriented, the physicians are also very body-oriented. Everybody seems to be towards the body, whereas client-centred therapy in OT practice is basically function-based. The whole system is seeing the body or symptom, when we are seeing function.»*

The participants discussed how the patient's condition can influence the use of client-centred practice. As Praveen said: *«…client-centred cannot be applicable to all. … Because from the client perspective, his understanding, his cognitive abilities, his insight with the disease, all this will create a barrier.»*

In all the interviews the participants are discussing how patients in an acute phase of a disease or injury have difficulties identifying possible functional problems. Namita said: *«In the acute phase nobody feels a need yet, it has not really hit them.»* Manu explained it like this: *«They don't know what their problem exactly is. They just know «I am not able to move my hand or leg.» … Even if you ask them, they will say; «No, I don't have a problem», or they'll say: «My wife is there to help me out right now». So only once they go back, and they come as outpatient, that is the time when actually they say: «These are the problems, I have problem with eating» … That is the time they come with a functional problem. In such condition we'll use client-centred practice. Whereas in acute it's very difficult.»*

They also argued how patients in an acute phase do not realise they have a chronic condition, they think they will get cured either by traditional measures or by medicine. Manu stated: *«They feel that once they take medicine, after 10 - 15 days they'll be fine. When they go back home they'll be fine. ... they don't see the problems which can occur in the future.»*

Some of the participants pointed out that patients in an acute phase have expectations that are not suitable for client-centred practice. Praveen explained: *«Acute phase, yes, even I would try to be a passive recipient … When somebody comes to the doctor or a therapist he expects them to know better about the disease and come with a solution.»* Sherin said: *«Here the patients are more into things like «you give me a medicine» and «I need to get better».»*

The participants described how patients may have vague expectations regarding therapy for different reasons. Sherin mentioned literacy: *«Here in India most of the time patients really don't know what they need. … It may be because of understanding of words, literacy. So I think for a client-centred practice to be very effective, the patient should have a good knowledge about their condition and should be educated.»*

Namita talked about education level: *«Most of the patients we see are lower education class, they are also low socioeconomic class. They are something like: «You tell me what to do». Most of the time we say they are passive recipients … First of all they are not so demanding, and sometimes it is difficult for them to comprehend when we ask them what they wish. … in fact they say everything is fine.»*

Lakshmi added: *«They just see us as another doctor. They just say, «I have pain, I have this, I have that. So for the patient to understand what the therapist is capable of doing is necessary.»*

Another challenge the participants identified was that patients in India tend to have a lack of motivation to become independent. Namita explained: *«In India there is someone to help you anyway. We don't even mind taking help; it's a part of our culture. In fact if the mother doesn't help, she feels bad. If we don't help, we feel guilty.»* Sandeep declared that *«the patient plays the sick role»*. Sachin said that patients accept their condition and their dependence on others very fast; *«I have to live with it, it's fortunate or unfortunate this thing.»*

Several of the participants talked about a connection between client-centred practice and independence. Padma stated: *«If the patient doesn't have that motivation to be independent, we don't have any role for the patient, we motivate that issue, that's where we start from then.»* Lakshmi, in answer to this, asked: *«If there is no need for that [independence] in the patient, then how do we use client-centred?»* Namita revealed a different opinion to this: *«According to client-centred practice you're supposed to accept that.»*

The participants' description of how they use client-centred practice

The participants discussed how they use parts of a client-centred approach in therapy. Some of them stated that they use it in goal setting, but not in the rest of the therapy process. One reason they gave is that they use a medical treatment model where goals focus on performance areas and treatment focuses on performance components. Lakshmi explained: *«I think when we assess the patient we do [use a client-centred approach]. But when it comes to the treatment, we don't. So when I am asking the patient what his problems are and all, I think, there is a touch of client-centred in it. … I think that the cycle of client-centred is not complete. I feel it's just at the assessment, and then the outcome.»*

Namita partly agreed with the others: *«as for goal we use it [client-centred approach]. Our goal is always for the client»*. She also gave an example of how she can be client-centred in the intervention when resources are available. One of her patients was interested in needlework, but had difficulties with her dexterity. Instead of using usual department activities, Namita used activities that matched the patient's interest: *«So with this particular patient I can say I was client-centred. Because the therapy was designed towards her interests.»* Praveen said therapy is not client-centred unless the client takes part in the decision making process: *«Why I say that I don't give client-centred therapy is because it is passively … it's me who take the decision, it's from my perspective. The patient is not involved actively in the decision-making process. That's why technically speaking I would not follow strictly the client-centred therapy.»*

Through the interviews they discussed different ways of using this approach depending on the context and the patient. Namita said she uses client-centred practice with educated patients who are able to communicate. In these cases she would explain the therapy to the patient and ask about his view. *«That is when I'm client-centred, right, I'm asking his wish, but that is not possible every time. For educated patients I can explain.»* Further she said: *«We are almost a variety to client-centred.»* Manu gave an example of how he would approach a patient with a low education-level: *«People who are very poor and illiterate, they'll like; «Okay, no, we don't want [therapy]». And their understanding will also be very poor. So in that condition we'll use more of, we only say: «If you do this, you'll get better».»* This is how Sandeep said he would meet patients with difficulties identifying problems: *«...therapist has to find out the problem as well as the solutions. So automatically the client-centred is not there. … Their complaints will be few … The decision will finally be taken by the therapist.»* Some of the other participants indicated that they can still be client-centred by using repeated probing and questioning, as Sherin said: *«...we need to really look into and have an on-sight evaluation, how he's doing it and asking him 'do you think it's a problem?» and if he says «yes», then we should address it. So it's indirect.»*

In cases where the patient is not motivated for therapy Lakshmi explained how they do it: *«…convincing the patient that it is important to be independent, that he can be independent and that this is going to facilitate his quality of life and his sense of wellbeing in life. So getting the patient to understand that, and then look into what he really aims at in life. … If they are motivated we automatically can use client-centred, but if they are going to accept the fact that «yes, my*

wife is going to do this for me, or my husband will do this for me», then, I think we start with facilitating the need to be independent, and then getting to address his needs.»

Sachin explained that in the prescription from the physician the focus is on body components in a terminology the patient does not understand: *«Please mobilize and improve their [patients] ranges.»* Further he said: *«…what he [the patient] understands is: On day one he could not eat, after ten days he still cannot eat. This is the language that he understands. So we keep juggling between these two tracks.»* Sandeep gave an example where the patient's goal was to ride a bike (performance area) but the focus in therapy sessions became increased wrist extension (performance component). Padma pointed out: *«You have to explain to the clients that this will help them in their performance areas. You have to explain them, it's not visible.»*

Discussion

It is evident from the results that the participants' definition of client-centred practice contains many of the same components as Sumsion's (2000) definition. They mentioned collaboration and negotiation between the therapist and the client, informed decision, client's active participation and the importance of prioritising client's needs and values in goal setting. This indicates a common knowledge base when it comes to client-centred practice.

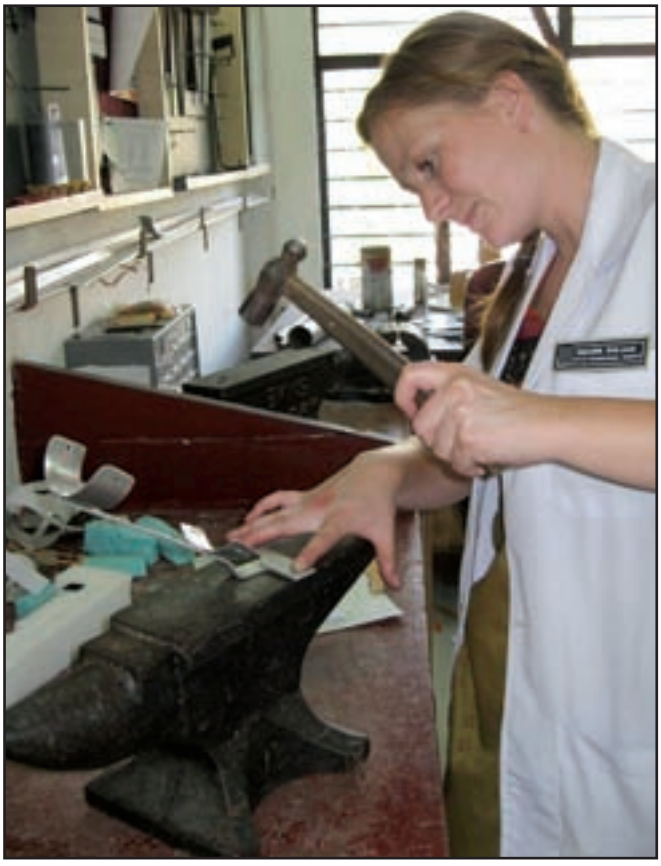
According to the participants in this project, there are many factors that can influence the ability to use client-centred practice:

a Practice context such as type of clinical setting, the structure of the health services, working within a body oriented system, resources and time. Duggan (2005), Maitra and Erway (2006), Mortenson and Dyck (2006), Sumsion (2004), Sumsion and Smyth (2000), Wilkins et al. (2001) and Wressle and Samuelsson (2004) all mention different factors related to the context that have an impact on client-centred practice. The participants also described factors related to the client:
b Client's condition such as cognition and insight,
c client's difficulties seeing performance problems,
d client's expectations such as expectations to get well fast or to be cured, either by the therapist or by medicine, and
e client's lack of motivation to become independent. Chen et al. (2002), Maitra and Erway (2006), Sumsion (2004), Wilkins et al. (2001) and Yang et al. (2006) all found barriers for application of a client-centred approach at the level of the client in their studies.

In this project the aim was particularly to look at client-centred practice in a medically oriented setting within an Indian cultural context. The following discussion will focus on these aspects.

Juggling between two tracks

Within a medical model the emphasis is on illness while in client-centred practice the focus is on occupational performance (Falardeau & Durand 2002). Juggling between these two tracks means that occupational therapists have to see patients' problems from two different angles (Mattingly 1994). This is similar to findings in this project, where the participants explained that from a medical point of view they are seeing performance components, whilst from a client-centred point of view they are focusing on performance areas. The participants suggested that working in the community in the patient's own environment would make it easier to recognise the patient's performance problems for the patient as well as for the therapist. Participants described inpatients in an acute phase as having difficulties identifying functional problems. This is similar to findings in Maitra and Erways' (2006) study, where patients in hospitals had difficulties participating in the goal setting process. Falardeau and Durand (2002) observed the therapist's power as stronger than the client's; the client's role being passive, and the therapist's being the expert role in a medical model. The way the participants in this project described patients taking the sick role, being passive recipients and having expectations that the therapist would cure them, can this way be seen partly as the result of a medically oriented system. They say that even the patients consider their condition from a medical point of view. The participants find working client-centred in a medically-oriented setting difficult. They try to use the client-centred approach as much as possible, but end up using only elements of it. As Falardeau and Durand (2002) say, a medical model and a client-centred approach can be seen as contrasts in many ways. This may indicate that the use of a client-centred approach the way it is defi-



Oda Pettersen making splints.

ned by Sumsion (2000) in this type of medical setting, may be an unrealistic expectation. This is supported by Duggan (2005) who suggests that applying an ideal client-centred practice might not be attainable in an institutional setting. Wilkins et al. (2001) stated that occupational therapists should find ways to work client-centred with all clients. Considering the above, there may be a need for a customised version of client-centred practice so that occupational therapists in medically oriented settings do not constantly have to strive for something that may not be achievable.

Cultural impacts

Lim and Iwama (2006) explain that Asian clients' lack of initiative and passive behaviour may be due to a culture where stillness in «being» is more valued than actively «doing». The way the participants described patients taking the sick role and being passive recipients, this can also be seen as a result of cultural factors. Chen et al. (2002) also mention this phenomenon in their study. In addition to this the participants described that some patients do not have the drive to be independent. This is similar to the findings in Yang et al. (2006). The participants explained that this is because of a culture where the family helps out when the person falls ill. In western parts of the world independence is considered a central concept in rehabilitation (Tamaru, McColl & Yamasaki 2007). The participants raised the question of how to be client-centred when the patient does not want to become independent. Awaad (2003) says that western oriented models in OT need to be adjusted to better suit patients from non-western cultures, and that the goal for rehabilitation could focus on interdependence as well as independence. This indicates a need for further research on client-centred practice as an approach in non-western OT settings. This may benefit occupational therapists and patients in non-western countries as well as in a growing multicultural context in western countries.

Health literacy

Part of Sumsion's (2000) definition of client-centred practice is that the therapist *«enables the client to make informed decisions»*. Sumsion and Law (2006) say that clients must be given sufficient information to be able to take control and participate in a partnership with the therapist. The participants described how patients with a low education level and belonging to a low socioeconomic class have difficulties understanding such information. They also expressed difficulties in facilitating patients to come up with their problems. Health literacy is defined as *«the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course»* (Rootman & Gordon-El-Bihbety 2008 cited in Levasseur & Carrier 2010, p. 757). Patients' difficulties understanding information given by the occupational therapist and patients' difficulties expressing their needs, can be related to the aspects of understanding and communicating information in health literacy. Health literacy fosters partnership, mutual learning and a common understanding regarding solutions in the client-therapist relationship (Levasseur & Carrier 2010). These elements are important requirements for client-centred practice as described by Sumsion and Law (2006). Therefore to reflect on the patient's level of health literacy and give information that the patient understands can be considered important when applying a client-centred approach to practice. This is supported by Levasseur and Carrier (2010), who suggest that in order to enable the client to understand health information, rehabilitation professionals need to consider their client's level of health literacy. They also state that a low level of health literacy is a wide-spread problem in western countries. Health literacy may therefore be a relevant element to consider when using a client-centred approach not only in India, but also in other parts of the world.

Conclusion

We used a qualitative method to explore the applicability of client-centred practice in a medically-oriented setting in an Indian cultural context. By interviewing nine Indian occupational therapists, we found that they define client-centred practice in a similar way to Sumsion (2000). They find practicing this approach challenging, due to many factors. Despite these challenges they try to use client-centred practice as much as possible, but end up using only elements of it. Through our discussion we suggest that there is a need for further research to investigate the relevance of health literacy in client-centred practice, to find an appropriate way of using client-centred practice in medically oriented settings, and to explore the use of client-centred practice in non-western contexts. This may contribute to enhance the quality of OT services and client-centred practice. ❑

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