How occupational therapists engage adults with cognitive impairments in assessments

Amanda White,1 Clare Hocking,2 and Heleen Reid3

Introduction: There is little discussion in the multidisciplinary literature about how to engage adults with cognitive impairments in health-related assessments. This qualitative descriptive study used semi-structured interviews to explore how nine occupational therapists working across a range of practice settings addressed this issue.

Method: Interviews were digitally recorded and transcribed verbatim. Inductive analysis revealed themes, which were refined through an iterative process.

Findings: The findings showed that the participants used individually developed strategies to engage clients in assessments. The first theme, 'Managing a complex process', described the steps used with clients and families to obtain informed consent, prepare for the assessment, and consider the impact of having a third party present. The second theme, 'Recruiting cooperation', addressed how the participants used their relationship with clients to recruit them to engage in the assessment.

Conclusion: The findings provided a snapshot of processes employed in practice to determine the needs and capabilities of clients with cognitive impairments, and the compromises therapists make in relation to eliciting informed consent and the integrity of formal assessment tools. The findings have implications for the profession and further research.

Introduction

Clients with cognitive impairments are at risk of not being able to manage everyday activities because of functional limitations related to sensory processing, memory, task sequencing, and decision making (Bossen et al 2009). Assessments of this client group inform goal setting and intervention plans that will support the clients’ choice about their living situations. To protect the clients’ interests and safety, therapists need to explain the assessment process and how the information generated will be used, so that clients can make informed decisions about the provision of services. The principle underpinning this requirement is that occupational therapy should be based on client choice and participation in planning, including allowing clients to take risks and fail (Canadian Association of Occupational Therapists 1997, Clemens et al 1994, Law et al 1995). Enacting that principle, however, is complicated when clients have cognitive impairments affecting their capacity to understand the risks they face, the choices available to them, and the potential consequences of the decisions they make. The importance of this issue is heightened by the increasing prevalence of cognitive impairment that is associated with increasing rates of dementia, stroke, multiple sclerosis, and Parkinson’s disease as populations age worldwide (United Nations 2007). Therefore, the goal of this study was to inform professional debate about how therapists ought to respond to these issues, by exploring what occupational therapists actually do when they conduct assessments with clients with cognitive impairments.

Key words: Cognitive impairment, assessment, therapeutic strategies, informed consent.

1 Occupational Therapist, Waitemata District Health Board, Occupational Therapy, Auckland, New Zealand.
2 Professor, Occupational Therapy, Auckland University of Technology, Auckland, New Zealand.
3 Senior Lecturer, Auckland University of Technology, Occupational Science and Therapy, Auckland, New Zealand.

Corresponding author:
Professor Clare Hocking, AUT University, Private Bag 92 006, Auckland 1142, New Zealand.
Email: clare.hocking@aut.ac.nz


DOI: 10.4276/030802214X13887685335427

© The College of Occupational Therapists Ltd.
Submitted: 6 November 2012.
Accepted: 11 July 2013.
A search for relevant literature was completed using the Auckland University of Technology library catalogue and databases OVID, EBSCO, Medline and PubMed. As there was limited occupational therapy research directly addressing the topic, the search included literature dating from 1990, as well as that of other allied health disciplines, medicine, and psychology. The search encompassed professional issues of client-centred practice and ethical practice.

The search identified multiple textbooks describing a range of occupational therapy cognitive assessments, including those focused on cognitive impairments and observational evaluations of task performance. Texts typically included the rationale for each assessment, what aspect of cognition each assessed, and a description of the assessment task(s) (for example, McHugh Pendleton and Schultz-Krohn 2006, Trombly 1995). The reliability and validity of 32 standardized assessment tools was comprehensively reviewed to support assessment selection (Douglas et al 2008). A decision-making process to systematically build an understanding of the client's cognitive status and its impact on his or her activities of daily living was also made available (Hartman-Maeir et al 2009). None, however, proposed strategies to support clients in making an informed choice about being assessed.

When initiating cognitive assessments, occupational therapists were advised to act on the presumption that clients are competent to make an informed choice unless they have been through the legal proceedings and assessments required to declare them incompetent (Grebe 2007, Great Britain. Parliament 2005). They were also advised that to ensure individuals are able to understand the decision-making process, ‘greater care will be required when explanations are made to those with a disability’ (Johnson 2004, pp.121–122). With increasing demand for occupational therapists to respond to conditions affecting a client’s competence, obtaining informed consent to treatment is important. Accordingly, it was recommended that therapists be aware of the factors influencing the legal standards for determining someone's competence (Grebe 2007). Addressing a related issue, Foye et al (2002) completed a descriptive ethics study using surveys conducted in large rehabilitation hospitals in the United States. The study yielded a 68% response rate, and concluded that occupational therapists were not well prepared to manage ethical issues.

Several strategies used by occupational therapists when working with adults with a cognitive impairment have been documented in the literature. Hobson (1996) proposed graded decision making and advocacy on the client's behalf, thus fulfilling expectations for client-centred practice, which was characterized as using a collaborative approach, demonstrating respect for the client through facilitating client choice, and involving the client in intervention planning (Sumson and Smyth 2000, Wilkins et al 2001). The models Hobson (1996) proposed were similar to the negotiated model of decision making proposed by Moats (2007), who considered client-defined decision making to be impossible if clients were cognitively impaired or putting others at risk. However, there has been limited research into the practical strategies therapists use to put this philosophy into practice. An analysis of three studies that discussed the challenges and barriers to client-centred practice concluded that it depends on the client’s ability to participate and ‘take control of the situation’ (Wilkins et al 2001, p.78). A later study of the specific strategies used to facilitate client-centred practice with clients who have a cognitive impairment illustrated how therapists need to be knowledgeable of, and sensitive to, the issues with different client groups (Restall et al 2003).

Choice is an important component of client-centred practice. There is an expectation that, within a consumer orientated service, clients would be offered choices about timing and interventions, with options put before them in an objective manner that provided adequate information to make an informed choice (Fallowfield 2001). Choice begins with the ‘occupational therapy encounter, and is continued throughout the assessment and intervention’ (Sumson and Law 2006, p.157). The idea that occupational therapists must ensure they provide clients with all the information necessary to make a choice, including choosing whether to participate in assessments, has been supported by research (Marteau et al 2001).

To create opportunities for client choice, communication directed towards developing the client-therapist relationship is necessary. To effectively interact with clients, occupational therapists used clinical reasoning and read the verbal and non-verbal cues in a complex interpretive process (Boy Schell and Schell 2008, Crepeau 1991). Appropriate communication and therapeutic interaction, building rapport, and empathy have been identified as examples of both interactive and conditional reasoning, and as professional skills (Roberts 1996). Underpinning these skills was the ‘process of problem solving based on acquiring cues, processing these and proposing a solution’ (Roberts 1996, p.236). Whether considered to be modes of reasoning or professional skills, being able to engage the client in the therapeutic process was identified as a central aspect of occupational therapy practice. However, it is under researched (Lawlor 2012), particularly with clients with cognitive impairments.

The study reported here explored how occupational therapists engage adult clients with cognitive impairments in assessments, within the New Zealand context. This included the therapists’ accounts of the processes they used leading up to assessments, the use of formal and informal functional and cognitive assessments, and how the participants developed and used the therapeutic relationship.

Method

To address the research topic, a qualitative descriptive approach was selected, using semi-structured interviews. Qualitative descriptive research is not predetermined and the findings,
in this case the perceptions and inclinations of the participants, are reported in everyday language. Informed by Maxwell (cited in Sandelowski 2000), the intent was to elicit descriptions that accurately convey events, in order to achieve descriptive and interpretative validity.

Participants
Nine participants were recruited using convenience sampling. Three recruitment strategies were used. The first author outlined the study to a regular meeting of community occupational therapists. Another person not associated with the study verbally advertised it to therapists employed in a large, government-funded health service and followed up with written information. Snowball sampling was also used. The participants were required to be registered occupational therapists working with adults (defined in this context as aged 16 years and above) who complete assessments with clients who have a cognitive impairment: for example, due to dementia, stroke, multiple sclerosis, or traumatic brain injury. There was a preference for participants with a depth of experience and those working in community settings, where assessments are frequently conducted on the initial home visit. Of the nine participants, there were three males and six females. All of them worked in the public health sector, with six employed in physical and three employed in mental health settings. The participants’ practice experience varied from 3 to 29 years (average 7 years). Four participants had originally qualified in the United Kingdom and the others were New Zealand graduates. Five participants worked predominantly in inpatient settings, and four worked in the community.

Ethics
The Auckland University of Technology Ethics Committee approved the study, and consent was obtained from each therapist who indicated willingness to participate. Confidentiality and anonymity have been addressed by using pseudonyms and aggregating demographic data. It was not anticipated that there would be any risks or discomforts associated with participation in the study. As with any interview where people’s thoughts, feelings, and experiences are open for discussion (Patton 2002), however, there was a possibility the participants might discover things they did not know prior to the interview. Appropriate measures were put in place in case participants experienced distress, or the researcher felt that a breach of the Occupational Therapy Board’s Code of Ethics had been uncovered.

Data collection and analysis
Semi-structured interviews of 30 to 60 minutes in duration were conducted by the first author at the participants’ workplaces, apart from one that was held at the university. The interviews were audio-recorded and transcribed. The interview guide included the following questions: Can you tell me about a time when an assessment did not go according to plan? Can you tell me about a time that you had difficulty engaging a person who has a cognitive impairment? What did you do?

In qualitative research, data are analysed by interpreting words rather than numbers and understanding meanings, processes, people and their thoughts (Lysack et al 2006). Thomas’ (2006) five-stage general inductive approach was used as a guide. First, the interview transcripts were checked for accuracy by the participants. The second stage was close reading of the text, when phrases and meanings in the raw data were coded. Placing the 22 initial codes into logical and meaningful categories formed the third stage (Hoepli 1997). Overlapping categories and un-coded text were reviewed, and where excerpts could have fitted two different categories, they were sorted into the one with which they most strongly aligned. Through ongoing discussion between the three authors, the categories were refined in the fourth stage, with similar categories merged into themes and subthemes were identified. The fifth stage was continued revision and refinement of themes. Each theme included a contradictory point of view, which strengthened and demonstrated its meaning.

Rigour in data collection and analysis
The credibility of the findings was enhanced using member checking to ensure the information was accurately captured. Data interpretation was enriched by having multiple researchers (Hammell et al 1997). The three authors met regularly to share their different perspectives, which stimulated deeper reflexive analysis. Transferability has been addressed by providing information about the participants’ demographics and the setting. An enquiry audit was used to enhance dependability and confirmability of the study by keeping a trail of the raw data, analysis processes, and documentation from member checking.

Findings
The analysis generated two main themes: (1) Managing a complex process, and (2) Recruiting cooperation. There were a number of subthemes within each. Each theme is illustrated with participant quotes, reported anonymously in order to protect the identity of the participants.

Managing a complex process
Engaging clients with cognitive impairment in assessment processes emerged as a complex process that therapists had learned to actively manage. As the analysis progressed, a high level of consistency between the therapists’ descriptions of and rationale for their actions and the procedural and interactive reasoning proposed by Mattingly and Fleming (1994) was recognized. Accordingly, that terminology is employed in presenting the findings.

Informed consent
This subtheme captures examples of the difficulties encountered and practical steps therapists take when they think the client is not fully capable of giving consent. The participants were aware of the need for a consent process; however, their
enactment of the process varied in its formality. One therapist explained how:

I introduce myself to the patient and we talk about the fact that … my role is about looking at what needs to happen to help them do normal things that they want to do.

Another participant routinely referred to functional tasks at home in an attempt to show the purpose of the assessment and how it relates to everyday life, so that:

… the patient knew what I was doing, why I was doing it, and how it related to this specific situation.

In an effort to ensure their explanation is understood, therapists used interactive reasoning to get to know the client as a person, rather than just their disability, and tailored their explanations accordingly. One therapist would ask the client to:

Tell me what this is like for you, I want to know your experience.

explaining that:

I’m hoping this will help me to advocate for you and work with you.

The language that therapists used played a role in creating a sense of shared understanding and partnership, and minimizing the anxiety that being assessed might provoke. A contrasting and ethically marginal example is the therapist who used the words ‘test’ and ‘pass/fail’ (which most therapists avoided), saying that:

I can just say, ‘I have come to give you some exciting tests and if you pass you get to go home’, and they don’t mind. But it depends on the level of formality and how you judge it.

Developing rapport by spending time in developing a relationship was a key strategy both in situations where clients voluntarily consented and within psychiatric liaison services, where the requirement for assessment is enforced by the judicial system. As one therapist put it:

We have patients who are no longer competent to make decisions for themselves and who don’t have an enduring power of attorney, and we [have] to take action through the court … [It is] quite a challenge to get the standardized assessment necessary for the courts to be able to make their decision. I have had more success to some extent than psych[atric] liaison, simply because we have had to do practical stuff and have got more time to develop rapport with somebody.

Preparing assessment tools and clients

The participants reported two important considerations in preparing to conduct an assessment. First, the difference in formality makes to whether the client will agree to engage; second, the difference preparation makes to how smoothly the process goes for the therapist. Preparation starts with selecting assessments appropriate to both the client and the context, a consideration of particular salience to therapists who would meet the client for the first time when they went to assess them in their homes. To help the process go smoothly, therapists spend time with their clients to elicit information about the occupations they need to perform. The participants described how important it is to individualize the process, getting background information about clients from multiple sources, including key workers, to ensure the assessment aligns with their clients’ lifestyles and goals. One participant described his procedural reasoning in the preparation stages:

Making sure I am all prepared and making sure the assessment I am conducting with those people is relevant, rather than just an assessment.

Therapists made decisions about whether to use standardized or non-standardized assessments based on their impression of whether clients are:

… that bad and really worried about [being assessed] reasoning that:

some of the tests and questions [in formal assessments] are quite hard.

Commonalities across the inpatient therapists included the risk that assessments might be terminated by the client, inconclusive due to insufficient time to establish whether the client was medically stable, or interrupted for medical rounds.

Initiating the assessment process

The participants took many factors into consideration when initiating the assessment process, in order to give clients an opportunity to perform at their best. Primary concerns were the client’s diagnosis and comfort with being assessed. Amongst therapists working in acute medical settings, improvements in the client’s medical status were also actively monitored. Therapists were careful not to ask for abilities that they judged that clients would never have developed and that were not relevant to their lives, because of the risk that posed to the client’s engagement in and completion of the assessment process. Therapists addressed that concern by inquiring into the person’s occupational history and matching that information to the type of assessment selected. Participants emphasized the importance of using a holistic approach, which included gaining an appreciation of the client’s current occupations. For example, when explaining her choice of assessment strategies to use with a particular client, one participant explained that:

… her identity is in occupations of traditional family values like the cooking and housekeeping. She is still very much a wife who attends to her occupations in her own home.

There was a sense that therapists experienced increased difficulty engaging clients in assessments that were not specific to occupational therapy, and greater success when using occupation-based assessments. At times, this resulted in therapists using only the more functional components of standardized assessments.
One therapist said that:
I use the practical elements like the functional screens, like the following instructions of the COTNAB, that's quite [concrete].

Illustrating her point, the same therapist named items she used in administering the COTNAB, as 'screws, plates, bolts, those sorts of things'.

Third party involvement
There were different perspectives on whether to allow a third party, either family or other staff, to be present during the assessment phase of occupational therapy intervention. Some participants described it as distracting to have family members present, lowering the client's concentration levels and negatively affecting the outcome of the assessment. Clients are:

... a little more relaxed and they are not as focused on the assessment that you are trying to do. It can take away their concentration, attention, or involvement.

In contrast, other participants reported that having family members who were involved in the care of the client present during the assessment meant that the family members were able to observe the assessment first hand and discuss the results. That was thought to be beneficial:

... because it is the most marvelous method of them learning what is actually the problem and when discussing the result:

... it gives me [the therapist] excellent corroborating evidence of what is actually happening.

Additionally, there were some suggestions that when in the presence of family, clients tried to perform at their best in order to hide changes in functioning and cognitive decline from family.

Recruiting cooperation
The second theme turns to the ways occupational therapists draw on their relationship with the clients to recruit their cooperation with assessment processes. There were a variety of techniques used to develop or draw on the client–therapist relationship to engage the client in an assessment.

Building rapport: recruiting the client
Developing rapport is one of the key components of developing the client–therapist relationship, and one that therapists are mindful of when they encounter clients who need to be assessed. By listening and taking time, participants worked to develop a deeper understanding and strengthened relationship, which were felt to be useful in recruiting the client to engage in an assessment. Participants working in mental health services who had a key worker role spent time finding out about the client's interests and then 'doing something nice' based on those interests and occupations: 'The trick is to find that lever.'

Some participants recruited clients to cooperate with assessments by creating a sense of shared understanding of what is important to the client. For example, a participant who worked in a hospital setting reported asking:

Can you tell me what you think is going to be a problem at home? Are you worried about anything at home?

This strategy was intended to create a sense of partnership, and shared the power with the client by asking about perceived challenges. Presenting information as solution focused when interacting with clients and their families was also perceived to enhance rapport and pave the way to the assessment process:

You are not telling them what to do; you are asking them what you need to do for them.

The occupational therapists' attributes were also described as playing a role in developing rapport:

So, my people skills, I believe, are good; probably because I am dyslexic, so I am [inclined to be] verbal rather than writing.

Other attributes included having an open personality and 'being cheerful', as 'I always find the way that they react to me in that first sentence' determined whether the therapist could have a 'chat' or needed a formal discussion. Keeping things pleasant and informal was thought to ease a client's way to consenting to an assessment.

Offering enticing occupation-based assessments
In considering how to make an assessment attractive, participants reported the benefits of focusing on clients' roles and 'culture as well'. One participant explained how:

... we have a few Maori clients who really see food as an integral part of their lives and customs.

That knowledge enabled the therapist to draw the client into cooking a meal — a meaningful occupation that also served as an effective assessment of functional living skills. Another account involved a mental health client who was reported to have been a chef but who had 'no insight into his illness'. Despite the client's initial reluctance to engage in a trip to the supermarket, once he:

... started cooking, he was amazing. He looked like he was a chef and he was cooking steak, but he was using herbs and things that I had never heard of.

One therapist choose an assessment that was attractive to the client and offered a pleasurable reward:

... thought we would just go for a coffee, and you know go from there.

This approach requires knowledge of what is meaningful and familiar to clients, to achieve the right occupation–assessment match, but also raises questions about the client's awareness that he or she was being assessed while engaging in an occupation.

Understanding the person
Participants employed in physical health settings had access to pen and paper assessments but reported how those assessments, in particular, can have an adverse effect on some clients,
changing how willing they are to engage in the process. One instance of that related to the Middlesex Elderly Assessment of Mental State, which asks clients to remember information about a fictional individual, ‘Mary Carter’. A therapist remarked that a client was reported to respond:

‘Well she [Mary Carter] is nothing to me, I don’t even like her’.

Going on to say that:

They don’t see the concept and they just try and say, ‘No I am not going to remember her name, I don’t even know her’.

In addition to making judgments about which clients would respond more positively to occupation-based assessments, the participants conveyed the need to understand the implications of the client’s medical condition and the person’s worldview. One strategy from therapists to elicit that knowledge was:

… giving a bit about myself and my background and sharing with her and finding those commonalities.

Another strategy described by participants in mental health settings was to explain the assessment as ‘something he would enjoy doing, something that he was capable of’, presenting the information in a positive light and emphasizing how it would impact the client in the future by getting him ‘what he wanted’.

A further strategy involved the therapist determining that it would not be in the best interests of the client to be fully informed of the reason for the assessment. Instead, the therapist explained:

I was a bit naughty and used the excuse [that] I was trying to train up one of the new members of staff to use it.

In this case, the adverse affects on the client’s ‘confidence because of the depression and anxiety’ were judged to outweigh ensuring that she was fully aware of the rationale behind the assessment.

**Prompting, support, and humour**

A variety of communication strategies were used to support the client to engage in and complete the assessment process. Participants reported providing verbal ‘prompting, support, and time’ as well as saying things to support, motivate, and coach clients to complete the assessment. While such techniques may have a place during informal assessments, they may invalidate standardized assessments that require adherence to a standardized protocol. Some participants described endeavouring to remain neutral during the assessment, which was described as:

… being respectful, and not showing any irritation about the repeated things.

They tried to read non-verbal communication, including body language and tone of voice, and to use a collaborative approach by giving the client a:

… protective environment where they can say that this is a problem, rather than having to be defensive about it.

This approach was especially challenging when using interpreters to facilitate assessments. Humour was also used to engage clients in assessments, particularly to ‘release some of the energy’ during a stressful situation. One participant explained:

This person came up with the most amazing words that I had to think to spell properly and then they exhausted themselves … I said ‘Wow those are really clever words, can you think of some easy ones?’ and the person just laughed, as if [acknowledging their] desperate need to perform, and their anxiety.

**Discussion**

The study provides a snapshot of the complex processes involved in engaging clients with cognitive impairments in assessments. There are a number of factors that influence the process. Clients bring their medical history, roles, culture, and history of occupational performance, while therapists need to consider the available time, assessment resources, workplace schedules, their own interactional style, and the person’s current medical status. The broad areas therapists need to consider prior to engaging a client in an assessment are: communicating and building rapport, eliciting informed consent, controlling third party presence, matching the client to the assessment, and managing the assessment process. Therapists bring these complex areas together to collaborate with clients and recruit them to engage in an assessment.

There were distinct differences between mental and physical health settings. Within physical health services, time constraints and needing to choose assessments that require minimal preparation for use in community settings were more evident. Therapists in inpatient physical settings described having opportunities to gauge when clients are medically stable and cognitively able to engage in assessments. Within mental health settings, there was more emphasis on doing things that were pleasurable and taking the time to listen to and build rapport with clients. These differences, however, did not appreciably alter the things therapists considered and the strategies they used to engage clients in assessments.

Where standardized assessments were used, participants at times knowingly selected only those sections thought to better align with the client’s strengths, avoiding sections expected to be overly challenging because that might cause the client to refuse to continue. Sections of standardized assessments might also be mixed with non-standardized functional assessments, to moderate the challenge clients experienced or the length of time spent on assessment tasks perceived as less directly relevant. Again, the goal was to encourage clients to continue to engage in the assessment process. The considerations shed some light on Holmqvist et al’s (2009) report that occupational therapists are reluctant to use standardized assessments and uncertain about using them. They are also consistent with previous reports that therapists rely more on clinical observations than standardized assessments (Koh et al 2009).
The participants’ emphasis on maintaining the therapeutic relationship included shifting the responsibility for needing the assessment results away from the therapist. This appeared to relate more to assessments that evaluate performance components rather than occupations. Taking action to protect the therapeutic relationship is supported by Taylor et al’s (2009) finding that the relationship between clients and therapists is perceived to be vital to engagement in activities and the outcome of therapy. The participants’ description of the therapeutic use of self, and the emphasis others have given to using one’s personal attributes, focusing on the client as a person (Eriksson and Dahlin Ivanoff 2002, Mattingly and Fleming 1994), and using humour to build rapport and improve clients’ responses to therapy (Leber and Vanoli 2000, Vergeer and MacRae 1993) also align with the findings of this study. Creating opportunities for enhanced engagement and participation based on doing occupations was a strategy used by the participants, and recently reported in the literature (Lawlor 2012). Finally, the tacit knowledge that Fleming (1991) described as the basis of practice is evident in the participants reflecting on and describing their practices to engage people with cognitive impairments in assessments.

Strengths and limitations
The aim of this study was to create a description of one aspect of practice, which was achieved using a qualitative descriptive approach. The analytic approach was rigorous and the findings are grounded in the words of the participants. The methods were described in a step-by-step process, making them transparent. The participants were from a range of practice settings, which brought a breadth of perspectives, however the sample was small and all participants were based in urban settings. Further insights might have been generated from therapists working in more remote settings or by inclusion of observational data collection methods. A larger sample might also have revealed differences between recent graduates and therapists with extensive experience, and allowed investigation of any influence arising from the therapists’ cultural backgrounds.

Conclusion
This study set out to explore how occupational therapists engage adult clients with cognitive impairments in assessments, while acknowledging that the professional literature is largely silent on how to achieve this. The findings reveal that therapists employ their personal attributes and abilities to build relationships in order to engage individuals in assessment processes. In doing so, they prioritize their relationship with the client at the expense of clear consent processes and the integrity of formal assessments. This was especially the case when therapists were evaluating clients’ impairments, rather than their occupational performance abilities. The findings point to challenges at the interface of the profession’s commitment to client-centred, occupation-based enablement and its requirement for clear consent processes and the need to preserve the integrity of standardized assessment processes. Navigating this challenge is an issue requiring the urgent attention of the profession. As this issue is wider than occupational therapists, it is also of concern to healthcare services, which need to have a clear clinical pathway for obtaining informed consent from this vulnerable client group. Further research is recommended, using an observational component with a larger sample size to elicit the subtle cues and unspoken strategies that therapists use to engage clients with cognitive impairments in assessments.

Key findings
- To support the assessment process, some therapists may nurture the therapeutic relationship but compromise informed consent.
- To avert refusal to continue, some therapists knowingly omit sections of standardized assessments.

What the study has added
A snapshot of the complex process employed to engage clients with a cognitive impairment in assessments, which provides a basis for debate of best practice and further investigation.

Conflict of interest: None declared.
Funding: This research received partial funding from the Auckland University of Technology.
Research ethics: The Auckland University of Technology Ethics Committee approved the study (Ref no. 09/290).

References
Thesis abstracts

Theses donated to the COT Library are available for loan, but are not downloadable. Please contact the Library for details.

Davina Margaret Parker
University of Birmingham, 2013. PhD.

Client-centred practice underpins occupational therapy and is defined as a partnership between the client and therapist that empowers a client to fulfil his or her occupational roles in a variety of environments.

A mixed method design examining client-centred practice from the view of both client and therapist was undertaken using a systematic review to examine worldwide evidence of a client-centred outcome measure, a survey of a sample of therapists’ experiences, and individual client and therapist interviews.

Findings indicated that clients placed value on the attitude and behaviour of the therapist, in communicating respect and treating them as equals, while therapists valued partnership but were challenged in establishing a relationship with the client and could fail to negotiate goals. Using a client-centred outcomes measure (the COPM) reinforced partnership, demonstrated joint goal setting, and evaluated client satisfaction.

Implications for practice were that training is needed in client-centred practice, theoretical models, interviewing, risk assessment, goal negotiation and use of outcome measures. [Author Abstract]