Professional Tensions in Client-Centered Practice: Using Institutional Ethnography to Generate Understanding and Transformation

Elizabeth Townsend, Lynn Langille, Debra Ripley

Do you wonder why client-centered practice is so challenging? The purpose of this paper is to illustrate the theory and method of institutional ethnography as a research approach for explicating professional tensions in occupational therapy's client-centered practice. Two questions sparked the paper: What produces professional tensions in client-centered practice? and What understanding and change might be generated using institutional ethnography? The sociological theory and method of institutional ethnography are described using data from an ongoing investigation of mental health services as a social institution. Illustrated are the research aim, research questions, and institutional analysis that distinguish institutional ethnography from conventional ethnography. Two professional tensions are associated with attempts to fulfill client-centered practice in mental health. One is that of working at cross-purposes with the prevailing hierarchical structure; the other tension is that of being celebrated yet subordinated in the medical and management hierarchies of health services. Although client-centered practice is difficult to do, the authors recommend institutional ethnography as a research approach to generate understanding and transformation of the context and practice of occupational therapy.

The Research Aim of Institutional Ethnography

Institutional ethnography is a theory and method for explicating the ways in which people know and do in the everyday world (Smith, 1987). The aim is to develop generalizable, thick, rich description of human experience in a cultural context. These ethnographic accounts can be extremely powerful, whether or not the results are representative of or generalizable to the experiences and meanings of anyone beyond the persons or situations portrayed.

In contrast, conventional ethnography (Glaser & Strauss, 1967; Strauss & Corbin, 1990) draws on ontological values and beliefs about subjective experience and on epistemological knowledge frames, such as critical theory (Claire & Strauss, 1967) or phenomenology. The methods and analysis of conventional ethnography are generally to portray and interpret human experience and on epistemological knowledge frames, such as critical theory (Claire & Strauss, 1967) or phenomenology. The methods and analysis of conventional ethnography are generally to portray and interpret human experience.

Occupational therapists have been attracted for some time to occupational therapy and occupational performance as described by people who know their own local experience (Depoy & Girardin, 1990). The research aim of conventional ethnography is generally to portray and interpret human experiences and meanings as described by people who know their own local experience (Depoy & Girardin, 1990). The research aim of conventional ethnography is generally to portray and interpret human experiences and meanings as described by people who know their own local experience (Depoy & Girardin, 1990). The research aim of conventional ethnography is generally to portray and interpret human experiences and meanings as described by people who know their own local experience (Depoy & Girardin, 1990). The research aim of conventional ethnography is generally to portray and interpret human experiences and meanings as described by people who know their own local experience (Depoy & Girardin, 1990).
interest to those who work with critical social science and critical feminist paradigms of research. Initially developed as a feminist theory and methodology, institutional ethnography has been used broadly to investigate professional dominance and other questions of power that may or may not be explicitly about gender. Strictly speaking, institutional ethnography does not fit into the division between quantitative and qualitative research. Its critical interests are in generating and analyzing quantitative and qualitative data in order to map relations of ruling. A point in common with other critical paradigms is a belief that human existence is essentially social. Although humans are biological beings, biology and occupational experience exist in a social context of structures and organization.

Dorothy Smith, a Canadian sociologist who spent her formative academic years at the University of Southern California in the United States, pioneered the development of institutional ethnography as a new form of feminist sociology, as described in her three milestone texts (1987, 1990a, 1990b). Institutional ethnography was a theoretical and methodological shift from doing sociology “from the top down,” as it were. In the 1970s when institutional ethnography was emerging, mainstream sociology typically looked at social policy as a disembodied object of inquiry extracted from real experience. Smith was prompted through her own personal and academic experiences to generate a sociology for women. She sought a research approach that took into account women's lived, bodily experience. Her own and other women's experiences were at odds with social theories developed either by men or without reference to the everyday realities of the home, workplace, or community (Campbell & Gregor, 2002; Smith, 1987).

Smith (1987) acknowledges that she was influenced by a great number of philosophers and social scientists, three of whom are noteworthy here. Smith incorporated the philosophical ideas about ordinary language championed by Wittgenstein (1953) who recognized inconsistencies between the ways in which people talked about their lives and the ways in which they actually lived. Her experiences with Garfinkel's (1967) use of ethnomethodology prompted ideas of challenging the automatic, taken-for-granted ways in which people live. Garfinkel's work contributed to the sociological position that the routine organization of social structures is a human creation, and thus can be altered by humans who decide that a different routine organization is desirable. Smith's interest in researching how everyday life actually works also led her to Karl Marx and Frederick Engels. In their German ideology, Marx and Engels (1939) explicated the interconnectedness of micro and macro social relations. Smith was attracted by their recognition that the relationship between employees and employers is invisibly embedded in broad, extralocal social relations that shape the particular local social relations between workers and bosses. Her interest in a sociology for women also found support in Marx and Engels' recognition that workers are active agents who can develop awareness of forces beyond their individual situations, such as policies, funding, and laws, which influence what they can do. She adopted their position on humans as active, social agents who consciously or unconsciously choose to comply with or resist the conditions of work and everyday life.

Research Questions Appropriate to Institutional Ethnography

The aim of explicating tensions grounded in the social organization of knowledge is expressed by raising research questions about experiences that are problematic in that they cannot be fully explained by studying the experiences themselves. These are experiences characterized by underlying tensions, contradictions, disjunctures, lines of fault (Smith's terms throughout her writing), or other puzzles (Campbell & Gregor's term) that seem to be generated beyond the individuals involved. In essence, the research questions addressed by institutional ethnography are about common experiences of powerlessness that persists without the use of force, and without full awareness of the sources of tension.

Although questions of gender are often raised, institutional ethnography has also been used broadly to display power in professional and managerial practices. Examples cited in Campbell and Manicom (1995), the most comprehensive anthology of studies by Smith's students or colleagues, include tensions or puzzles associated with poverty and exclusion experienced by women and children who have been battered (Walker, pp. 65–79), social exclusion experienced by gay men (Kinsman, pp. 80–95), marginalization and poverty experienced by women living in Peru (Mueller, pp. 96–107), intensification of work experienced by elementary school teachers (Manicom, pp. 135–148). Also included are studies of exclusion and harassment experienced by lesbian students (Khayatt, pp. 149–163), exploitation and work intensification experienced by clerical workers (Reimer, pp. 193–208), work intensification and policing required by social workers employed in child protection (de Montigny, pp. 209–220), and managerial control of nurses' work (Campbell, pp. 221–233).

Townsend encountered institutional ethnography as a doctoral student in the late 1980s (Townsend, 1996, 1998b). Langille and Ripley have participated with Townsend in an ongoing explication of mental health services (Townsend, Birch, Langille, & Langley, 2000;
Townsend & Ripley, 2001). The tensions explored here lie in the disjunction or puzzling dilemma in occupational therapy of finding client-centered practice and occupational performance celebrated yet subordinated in institutional priorities. A number of studies have identified barriers to client-centered practice in occupational therapy, in programs, and in systems (Lane, 2000; Spiers, 1995; Sumision & Smyth, 2000; Wilkins, Pollock, Rochon, & Law, 2001). The partnership and practical orientation of occupational therapy’s client-centered practice are congruent with trends in health services and society overall. However, professions do not historically work collaboratively. Rather they have operated historically through hierarchical dominance and elitism (Coburn, 2000; Freidson, 1986; Freire, 1985; Illich, Zola, McNight, Caplan, & Shaiken, 1977). From a management perspective, client-centered practice is a customer service within an integrated system for managing human and financial resources (Campbell, Copeland, & Tate, 1998; Cervaro & Wilson, 1999). Client-centered practice is also one of those concepts of health reform that can have the effect of transferring both the responsibility and burden of health services from the state to individuals (Brandis, 2000; Lefley, 1997).

**Developing an Institutional Analysis**

As Campbell and Gregor (2002) state:

“The notion of explication is important—it is the analytic core of the research process in institutional ethnography….Data collection has to expand beyond what people in the local setting know and do. There is always something missing from even very good experiential accounts made by people who live in the events in question. Some aspects of their lives are organized outside what they can know about from being there in the everyday world of experience. (pp. 59–61)

Whereas a conventional ethnography develops themes and theories about what is subjectively known and experienced, an institutional ethnography seeks to describe how social relations are organized beyond a local setting. The analysis uncovers what informants do not know explicitly about the world. Although the concepts and language of an institutional analysis are specific to its theory and method, the practical steps to develop a proposal, gain ethical approval, gather and handle data, write an analysis, and disseminate results resonate in many ways with conventional ethnography. Ethical approval depends on explaining for reviewers the ontology and epistemology that drive the collection of diverse data that cannot be specified at the outset. One seeks ethical approval for a fair and open process that generates knowledge for use not only by professional researchers, but also by the community of people whose experiences of powerlessness are being explicated (noting that this is not participatory action research unless these people are full research partners). As with conventional ethnography, the initial investigation develops an account of everyday experience, ideally by observing it and asking about it first hand. Quantitative data may also be gathered, either in the form of existing statistics and quantitative reports or through surveys or other measures. Quantitative data are gathered as evidence for critical rather than for empirical analysis. Interviews may also be used, although interviewing in institutional ethnography is more like “talking to people” (Devault & McCoy, 2002, p. 756).

As with conventional ethnography, multiple forms of data are collected. The data may offer what is described in interpretative qualitative research as triangulation, (i.e., confirmation from diverse perspectives) (Depoy & Gitlin, 1998). In institutional ethnography, the purpose of gathering diverse data in an institutional ethnography is to extend the explication of how the local, everyday world works and is governed by a textually mediated ruling apparatus. As data are gathered and managed, the institutional ethnographer needs to ensure that the account documents experience without interpretation of meanings or motives. Universality and generalizability are not matters of sampling or research design. Rather the institutional analysis describes and maps nationally or internationally consistent social relations. While local differences may be observed, the institutional analysis shows how local differences are variations in generalized ruling practices, for instance in the generalized use of the international *Diagnostic and Statistical Manual of Mental Disorders* to control and organize admission to psychiatric services.

To manage the data collected on everyday experiences and textually mediated practices in the two studies of mental health services, data were coded and sorted using the software program Ethnograph (Qualis Research Associates, 1988). Coding was merely to sort the data that described components of the work of mental health services: admission, discharge, program planning, hourly or daily programming, record keeping, member attendance keeping at research meetings, policy writing, budgeting and financial management, and so forth. Since the aim is to critically describe/map the conceptual practices of power, no further coding was done to interpret this work under thematic categories as would be done in interpretive approaches such as Grounded Theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

With the aim of explicating the social organization of knowledge in puzzling situations of tension or disjuncture, the institutional analysis is driven by a particular understanding of social relations (key terms are italicized). The
description of everyday experience identifies typical, local work processes. Work processes refer to what Smith, drawing from Marx and Engel's German philosophy (1939), calls the material practices of life. Material practices are what people actually do in the real, material, everyday world. The analysis of work processes examines the conceptual practices of power. The conceptual practices of power refer to concepts, such as client-centered, occupation-focused, accountability, efficiency, effectiveness, liability, quality management, professional competence, risk, safety, and so on. The investigation reveals how governance works in everyday work processes and also through various texts such as records, statistics, marketing information, policies, legislation, and more. Smith describes this as an investigation of discursively organized settings and textually mediated social organization, contrasted with settings that are organized through the use of military or other direct force. Mental health programs are discursively organized since control and coordination are done through policies and other texts that determine what staff and patients will do without using face-to-face supervision or overt force.

A conceptual practice of central interest is that of objectification. Texts, such as statistics or reports, provide objectified accounts of everyday life by extracting pieces of information that form conceptual facts. For example, statistics that report the numbers of persons admitted and discharged from mental health services objectify persons as cases whose experiences of mental illness are categorized diagnostically. Statistics are reported as objective facts, even though the process of psychiatric diagnosis is highly subjective and diagnostic categories are clusters of symptoms reported subjectively by real people who are living real lives with a myriad of diverse experiences of difficulty (Smith & David, 1975).

Despite considerable, inherent subjectivity in the diagnostic process, the statistics used to coordinate and control mental health services are generated using the discursive organization of psychiatric categories of diagnosis. Statistics on the number of cases admitted in diagnostic categories such as schizophrenia or anxiety disorder are the conceptual facts used to administer admission and discharge policies in mental health services. Facts on cases defined by psychiatric categories are used also to calculate staffing needs, programs, and other policies. Psychiatric treatment (medication, psychotherapy, etc.) and other programming (including occupational therapy) are the methods used to address issues in relation to those same categories. Objectified facts, not subjective experience, inform managerial decision making about the financial and programming parameters of mental health services. In addition, objectified facts about psychiatric diagnoses are used to organize professional education. Based on educational and professional facts about qualifications and liability insurance, not subjective reports from clients or direct observation, professionals are licensed to practice by their regulatory bodies and the state. Textual facts, such as liability insurance and professional licensing, are used to coordinate and control the broad social relations and the ruling apparatus that governs the social organization of knowledge of an institutional function, such as mental health services.

**Professional Admission Work Processes in a Mental Health Day Program**

One research example of institutional analysis flows from Townsend's (1998b) observation of an occupational therapist, code named Pat. Pat asked a person attending a day program: “Would it help if I gave you a bit of information on the program and how it works? Then maybe you can decide from there whether you want to take part.” On being asked by Townsend about the apparent choice being offered through this statement, Pat replied:

…I suppose if you want to look at it in black and white, this is a voluntary program. So they’ve made the choice whether or not to come. If they’ve come, then we expect them to participate. And if they’re not participating in the types of things we have, we find out why not. And if it’s not something we want to change, we do suggest that they leave the program. People, theoretically, once they choose to come to the program, choose to be in all parts of the program. It’s not, I’m going to take Parts A & B and leave the rest alone. …You’re not deciding what group therapy is. You are, in that you’re one of eight or nine people who has some impact on what the discussion is or what happens or whatever. But you don’t decide that—instead of group therapy, we’re going to have an outing, or learning group, or whatever. (pp. 75–79)

A few weeks later, Townsend met with people who attended the same day program and asked them for suggestions for program changes. The suggestions a group member recorded on a flip chart were:

1. Groups in the morning and activity in the afternoon, with one-to-one time available in the afternoon.
2. More explanation [from staff and people attending] so we know why we are doing things.
3. Staff and patients [act] more [as] a unit not two separate groups (e.g., lunch).
4. More groups which actually teach you something.
5. More organization of physical space.

Pat’s initial statement looks quite congruent with being client-centered. She provided information on which the person could choose whether or not to participate in the program. Suppose that the person listens to Pat’s explanation and, based on everyday experience in living with a
mental illness, decides that participating in groups is not likely to help. What are the alternative choices? Individual counseling? Medication alone? Living in a boarding house with no community support? On the surface, there is an attempt to collaborate and offer choice. But as Pat says, “you’re not deciding what group therapy is.” And, once in the program, clients implicitly learn the boundaries of choice. The suggestions for program change are all minor adjustments in the taken-for-granted schedule of daily groups and interviews. No one suggested setting up a farm or a business. No one asked for more occupational therapists to visit their homes and coach them in dealing with mental illness as they engage in the daily farming practices that are the economic base of the community of this day program. The day program was set down by hospital policy in which neither Pat nor the clients were participating writers. Pat may observe and interpret that this person is or is not suitable. But neither the person nor Pat hold the power to decide to “take Parts A & B and leave the rest alone...” Nor could they collaborate in choosing to “decide that—instead of group therapy, we’re going to have an outing, or learning group, or whatever.”

Pat is attempting to be client-centered beneath an invisible, management ceiling that confines possibilities for collaboration and choice. Pat’s statement can be traced to a standard program policy that guides professionals through the orientation of new clients. This piece of Pat’s work is invisibly interconnected with and embedded in the institutional management of admissions. The work processes required for admissions to a mental health program are interconnected with the institutional management of patient consent and liability. Pat’s orientation comprises the verbal component of the documentary, legal requirements for the institution to confirm consent by inviting people to choose whether or not to participate in the programs offered by mental health services in this setting. In the state coordination and control of mental health services, the occupational therapist, along with other professionals, is allocated the work of confirming whether a case, the object of these services, will or will not comply with the psychiatrist’s assessment of suitability and with the program’s mandate and funding.

**Consumer Research Work Processes in the Mental Health Action Research Connection (MHARC)**

The Mental Health Action Research Connection (MHARC) offers a second example of institutional analysis. MHARC is a consumer-led, participatory action research group that eventually became incorporated as an independent nonprofit community organization. MHARC was organized as a vehicle for active consumer involvement in research and the development of consumer leadership. Projects involve quantitative or qualitative methods using Participatory Action Research (PAR) as a framework to involve mental health consumers. Since its creation, MHARC has received numerous grants and professional contracts relating to research, evaluation, and community action.

MHARC was established as a client-centered organization. Its aims and community actions are both client-centered and client operated. While still being managed as a program that is staffed by mental health services, MHARC has achieved considerable autonomy for consumers to be meaningfully occupied. For the most part, research grants and contracts are designed to be self-supporting, providing limited honoraria and resources to support the consumer-led administrative structure. For many, the MHARC group provides an environment that is not found in many other work settings and that provides supportive, flexible, meaningful occupations.

The everyday experience of MHARC participants is of entering the world of research through small projects that press at the edges of formal, professional research ruling practices. To explicate how mental health services is or is not enabling this client-centered organization, one policy document of interest is “Community Mental Health Supports for Adults” (Nova Scotia Department of Health, 2000). This is the newest policy that speaks in favor of client-centered initiatives. It opens with a statement on “Health Promotion” that concludes with the sentence “Principles of mental health promotion—empowerment, personal dignity, meaningful participation, capacity building, holistic approaches, partnerships, cultural sensitivity and responsiveness—must be reflected throughout the mental health system” (p. 7). There is recognition here of the need to develop mental health services, such as MHARC, that favor consumer empowerment. This policy offers a framework for inviting consumers, such as Pat’s client, to participate in defining programs and priorities, even though it is unclear what decisions would or would not be open to consumer participation. A “Service System Alignment Initiative” is defined, with three objectives (p. 14) to: a) harmonize policies within the mental health system and across departments, b) help service providers take best practices approach to delivering services, and c) make sure that the service delivery system is effective and efficient.

Since this policy is part of the discursive organization of mental health services, one needs also to recognize the language of management. Read the four objectives again. This document expresses an interest to further “harmonize policies and practices,” “ensure consistency with best practice evidence,” and “help service providers take a best practices...
approach” that is “effective and efficient.” The policy functions as public relations, a statement of vision, and what Townsend (1998b) has called “good intentions.” Advertised together in one policy are the ideal product of citizen empowerment and the ideal concept of total quality management. The promise of this policy is large. Yet MHARC struggles to develop through small, project-funded initiatives. No MHARC members with a mental illness receive salary funds for their work since they would lose their disability or other social support funding, which is worth far more than any beginner researcher salary given medication, transportation, and other benefits provided to those who remain dependent on state assistance. Business development funds may be available, but applications by mental health consumers to develop a research business would require considerable creativity and support.

This brief analysis of one policy shows the disjuncture between promise and reality. To continue with the analysis, one could examine documents that govern funding priorities, staff workload allocations, mental health program priorities, admission, and accountability criteria. The aim throughout the analysis would be to show how micro experiences of mental health consumers are embedded in an interconnected, taken-for-granted web of invisible, macro policies or other discursive organization that determines whether or not mental health consumers are fully included as citizens.

Mapping Conceptual Practices of Power

What produces professional tensions in occupational therapy’s client-centered practice? and What understanding and change might be generated using institutional ethnography? To return to the research questions posed in this paper, the final step is to visually map the analysis of institutional social relations. While not every institutional ethnography is portrayed graphically, two graphic maps are offered to display how and why professional tensions are produced and persist in occupational therapy’s client-centered practice. The institutional analysis (written or graphic) is what institutional ethnographers call the blueprint. The notion of creating an analytic blueprint reflects the ontological belief that humans organize social institutions and humans perpetuate the unconscious, routine, taken-for-granted ways of living and working in the everyday world. Societies are organized through broad social relations that determine whose ideas and actions prevail and how they will be enforced through a ruling apparatus. The blueprint, then, is not only an explication of analytic data. It describes critically the social relations and social practices that humans can change.

Working Against the Grain

As Figure 1 illustrates, professional tensions are produced in the disjuncture produced by sharing power horizontally with clients while being located bodily in a single time and place in which power is hierarchically controlled by management and professions that are socially organized to make decisions about the best programs and services for clients. This is the tension of working against the grain. Occupational therapists who want to be client-centered are torn and do not fit the system because they are trying to work horizontally and hierarchically while located bodily in the same time and place.

Pat’s interaction with a new client seems client-centered in offering choice about attending a program, but the statement is organized as part of the managerial and professional work of admission and patient consent—part of a management and legal relationship with the client. MHARC participants’ experiences are still those of dependent patients within the mental health system, although they have liberated themselves in their local, everyday work by renaming themselves as participants rather than patients. They are also participating in the public work of research without restricting their daily experiences to those of a dependent patient waiting for professional treatment. The lack of collaborative decision making is not mandated by individual policies or legislation. Nor is lack of collaboration the fault of individual occupational therapists failing to
be client-centered. Moreover, the tensions in client-centered practice are more than barriers. Barriers imply that individuals can choose to overcome them if only they are enlightened through case examples or trained to be more assertive in everyday situations. At stake in making change is the hierarchical organization of mental health and other public services.

**Celebrated Yet Subordinated—Talk With Little Action**

As Figure 2 illustrates, professional tensions are also produced by occupational therapists’ lack of power to fully implement client-centered practice beyond goal setting with individuals. Client-centered practice is celebrated as congruent with the World Health Organization definition of health for all (WHO, 1986). Occupational therapy looks like the ideal profession to implement policies such as the Community Mental Health Supports for Adults policy examined above.

Tension arises in holding a vision of client quality of life and empowerment while also attempting to meet accountability criteria that favor efficient, acute, medical treatments with individuals while located bodily in the same time and space. Occupational therapy operates as a cultural minority in a dominant managerial culture of efficiency and a dominant professional culture of psychiatry and psychology. Those who attempt to follow client-centered, occupation-focused values, beliefs, and approaches experience too little time, restricted risk-taking for working in real home and job settings, and restricted funds, such as for the travel costs of practice in real life settings. As well, the professional team is expected by management to hold and act on “expert” opinions, and to use “expert” approaches in assessment, program planning, implementation of programs, and evaluation. Client decision-making competes with professional decision-making on teams that are dominated by professionals. The real difficulty for occupational therapists and clients is not lack of time management skills or assertiveness. Rather, the real difficulty lies in organizing services with hierarchical, centralized decision-making in which occupational therapy is a subordinate player. Pat must comply with the job description and performance norms set out for a generic mental health worker, not for client-centered

---

**Figure 2. Professional Tensions in Client-Centered Practice “Celebrated yet Invisible, Misunderstood, and Narrowed.”**
practice. MHARC must compete with acute psychiatric services for funding, and with general community priorities that still subordinate the needs of mental health consumers.

Local funding policies for community services and an institutional funding formula per psychiatric case are driven by the public and private funding that is currently made available largely for acute professional services. These policies and practices form the discursive ruling practices of mental health services. State practices such as these are further embedded in a global economy in which economic interests generally prevail over the social interests that could be addressed through occupational therapy's client-centered practice and mental health consumers’ participatory research. The interconnections between policies, legislation, and the rest of the ruling apparatus form an invisible and subconscious web of forces that sustain the subordinate location of occupational therapy's client-centered practice despite calls for this type of work within governments’ own policies. Client-centered and consumer voices are what Hall (1992) describes as voices from the margins that press for equality and fairness. Occupational therapy's client-centered practice challenges what Janice Gross Stein (2001) calls “the cult of efficiency.” Inherent in client-centered practice is a commitment to change around what Michael Ignatieff (2000) terms a “rights revolution.”

Concluding Implications for Occupational Therapists

In conclusion, institutional ethnography has been presented as a theory and method for addressing the question: What produces professional tensions in occupational therapy's client-centered practice? The paper has shown briefly how two professional tensions work. These are extralocal tensions that are generated beyond individual occupational therapists yet are embedded in and experienced in various ways in the everyday world of practice. One tension is that of working against the grain because horizontal collaboration with clients is at cross-purposes with the vertical hierarchy of mental health services. The other tension is that of being celebrated yet subordinated—talk with little action. Occupational therapy's client-centered practice is celebrated yet located as secondary, subordinate priorities in the vertical hierarchy that privileges acute psychiatric and psychological services.

What understanding and change might be generated using institutional ethnography? The second question posed in this paper prompts reference to three implications of this institutional analysis for occupational therapists: professional self-reflection and dialogue; partnership between clients and therapists; and actions for transformation.

Professional Self-Reflection and Dialogue. One implication for occupational therapists is that institutional ethnography might be used for professional self-reflection and dialogue about professional tensions inherent in occupational therapy’s client-centered practice (Kinsella, 2001). Drawing on the profession's literature, occupational therapists might ask whether the profession fully supports client-centered practice (Corring & Cook, 1999). In being client-centered with a focus on occupational performance, does this profession fully understand occupation, including the spiritual depths of occupation (Peloquin, 1997)? In the claim to be client-centered, does occupational therapy truly advocate for the recovery and empowerment of people with psychiatric disorders and other challenges (Deegan, 1997)? Are subjective well-being and health promotion the real goals of occupational therapy (Do Rozario, 1992)? Could sociopolitical models generate greater understanding by occupational therapists of daily routines and experiences (Dyck, 1992)? Is occupational therapy a profession that understands and works with individuals in context versus understanding and working with physical or mental function as entities on their own (Fearing & Clark, 2000)? How do clients experience the profession’s attempts to be client-centered, and can client perspectives provide a mirror for occupational therapy (Rebeiro, 2000)? Is occupational therapy language congruent with being client-centered, focused on occupation, and concerned with issues of justice related to health and quality of life (Townsend, 1998c)? How do professional tensions in client-centered practice reflect the gender composition and possibly the gendered practice of the profession (Frank, 1992; Litterst, 1992; Mathewson, 1975; Miller, 1993; Readman, 1992)?

Partnership Between Clients and Therapists. A second implication is that institutional ethnography might be used collectively by those who are partners in pressing for more client-centered institutions. Occupational therapists might situate this profession in partnership with agencies like MHARC to mediate change from hierarchy to collaboration. The potential power of occupational therapy's client-centered practice does not lie in rising higher in the professional hierarchy. Increased professional power would address the second tension (professional subordination) while aggravating the first tension (horizontal collaboration in a hierarchy). At the crossroads where clients and professionals interact, there is potential for enabling mutual, reciprocal social relations based on shared recognition and respect for diverse experience and expertise. The place to start is in everyday practice, as Pat did in describing options for participating in a mental health day program. MHARC is taking a similar initiative toward collaboration from its mental health consumer perspective. Gage (1997) describes
such new negotiated collaboration as establishing “synergistic relationships.” To be more client-centered, the profession would need to mediate accountability for client quality of life, empowerment, and equity (related to collaboration, partnership decision making and empowerment) with accountability for professional excellence and managerial control (related to professional standards and the sound management of liability and resources, human and financial). Partnerships between clients and therapists could generate an important collective voice to move beyond compliance with systems that disempower clients as well as occupational therapists.

**Actions for Transformation.** The third implication is to consider what actions are possible to transform social institutions. As active agents, occupational therapists are either compliant supporters of the system, or advocates and activists for transformation. Given the drive by people with disabilities to become more empowered in their everyday lives, does it make sense for occupational therapy to work for institutional change or to abandon client-centered practice as too idealistic and too unrealistic in the real world?

**References**


Occupational Therapy, 63, 310–315.


Now available!

Occupational Therapy in Community-Based Practice Settings
Marjorie E. Scaffa, PhD, OTR, FAOTA

Discusses theoretical frameworks for community-based practice in occupational therapy settings.

Chapter highlights include:
- legislation and policy issues
- program development
- accessibility issues
- adult day-care programs
- independent living programs
- home health
- early intervention programs
- mental health
- substance use disorders
- the future of community-based practice
- and implications for professional education and research

Order #1323-J
$30 AOTA members
$40 nonmembers

Call toll free: 877-404-AOTA
Shop online: www.aota.org