The Use of Standardized Assessment in Occupational Therapy: The BaFPE-R as an Example

Mary F. Managh, Joanne Valiant Cook

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Before 1970, most assessments administered by occupational therapists were informal and nonstandardized. Since the 1970s, the use of scientifically sound instruments has increased. One such standardized assessment, the Bay Area Functional Performance Evaluation (BaFPE), was developed to measure the functional performance of psychiatric clients. This study was designed to explore the use of a revised version of BaFPE as an example of standardized assessment in occupational therapy.

The BaFPE was selected as an example of an assessment extensively used in psychiatric occupational therapy practice. A qualitative study that used in-depth semistructured interviews was conducted with a convenience sample of occupational therapists.

The occupational therapists who were interviewed described and explained making several adaptations and modifications to the recommended administration and scoring of the BaFPE. An analysis of the interview data suggested that standardized assessments are valued as indicators of professional status. However, the interview responses also suggested that the demands of test standardization were incongruent with the values that guide occupational therapy practice.

The findings of this study suggest that the future development and use of standardized instruments should be consistent with the values of the profession. In particular, assessments that recognize the diverse nature and needs of individual clients are required.

A person’s ability to perform the tasks required to function successfully in his or her daily life is of fundamental concern to occupational therapists (Kielhofner, 1992). Traditionally, many occupational therapists have used homemade assessment tools such as checklists to assess function (Leonardelli Haertlein, 1992; Smith, 1992; Stein, 1988). Before 1970, most assessments administered by occupational therapists were informal and nonstandardized (Stein, 1988). Since the 1970s, however, scientifically sound instruments have been developed in an attempt to document client status and change more accurately, as well as to demonstrate treatment effectiveness (Watts, Brollier, & Schmidt, 1988).

The trend in the profession toward the use of standardized assessment has been followed by occupational therapists specializing in mental health (Hemphill, 1980; Moyer, 1984; Thibeault & Blackmer, 1987; Watts et al., 1988). The Bay Area Functional Performance Evaluation (BaFPE) was one of the first standardized instruments developed by occupational therapists for use with psychiatric clients (Bloomer & Williams, 1978; Watts et al., 1988). According to the test developers, the BaFPE was designed to measure some behaviors that persons must exhibit to carry out activities of daily living (Bloomer &
The original version of the BaFPE was revised and a second edition (BaFPE-R) was published in 1987 in an attempt to improve its standardization and clinical utility (Houston, Williams, Bloomer, & Mann, 1989). This revised version is widely used by occupational therapists in psychiatry (Mann, Klyczek, & Fiedler, 1989). For the purposes of clarity, the revised BaFPE will be referred to as the BaFPE-R in this paper.

The BaFPE-R consists of two subtests, the Task-Oriented Assessment (TOA) and the Social Interaction Scale (SIS). The TOA is designed to assess general ability to act on the environment in specific goal-directed ways, and the SIS is designed to assess general ability to relate appropriately to people within the environment. Interrater reliability and internal consistency of the BaFPE-R has been established and some evidence of the validity of the instrument has been published (Williams & Bloomer, 1987).

Leonardelli Haertlein (1992) and Smith (1992) in the United States, Eakin (1989) in Britain, and Fricke and Unsworth (1992) in Australia have reported that the modification of standardized assessments in occupational therapy practice is widespread. During discussions with clinicians about the clinical use of the BaFPE-R, the principal investigator learned that there were often variations in the purposes for assessment use, methods of administration, and interpretation of the results. In an article dealing with current issues in occupational therapy assessment, Smith (1992) asserted that "we have not addressed the most critical questions pertaining to how occupational therapists collect data and what occupational therapists do with it" (p. 3). With these issues in mind, an exploratory study examining the clinical use of the BaFPE-R by an available sample of occupational therapists was conducted in 1991. The selection of the BaFPE-R as an example of standardized assessments was based on its reputation in the literature. Mann et al. (1989) have documented its extensive use and Leonardelli Haertlein (1992) described it as one of the assessments "setting the current standard for occupational therapy evaluation" (p. 952).

The study consisted of chart audits of occupational therapy department records and semistructured interviews with occupational therapists who used the BaFPE-R. The purposes of the research were to describe the demographic characteristics of both the clinicians who used the BaFPE-R and the assessed clients, to explore why and how the assessment was administered, and to determine how the assessment results were interpreted and used.

This paper focuses on three aspects of the study to provide (a) a classification of the therapists’ descriptions of their administration of the BaFPE-R and their analysis and use of the assessment results, (b) an interpretive analysis of the therapists’ descriptions, and (c) a discussion of the implications for the development and use of standardized assessment in occupational therapy.

Method
Sample
Thirty occupational therapists in four cities were interviewed. Each therapist was practicing in psychiatry and had used the BaFPE-R during the previous 2 years. The interviewees were graduates of nine different occupational therapy programs, both domestic and foreign. The sample included 18 (60%) therapists who were graduates of the same university program. Twenty-one (70%) of the therapists were employed at provincial psychiatric hospitals and 9 (30%) were employed in psychiatric units of general hospitals. On average, the therapists had been practicing occupational therapy for 7.5 years and had been practicing in psychiatry for almost 6 years. The mean length of employment at the therapists’ current facility was 4.4 years.

Procedure and Instrument
Face-to-face, in-depth, semistructured interviews were used because of the exploratory nature of the study. This research method allows the interviewer to establish a “peer” relationship with the respondents (Lincoln & Guba, 1985, p. 269) and provides opportunities to ask questions relating to context and meaning (Schutzman & Strauss, 1973; Spradley, 1979). All interviews were conducted at the therapists’ place of employment and recorded on audiotape by the first author. The length of the interviews ranged from 30 to 80 min. Typically, the interviews were more like conversations than formally structured interviews” (Marshall & Rossman, 1989, p. 82). Using this technique, “the researcher explores a few general topics to help uncover the participant’s meaning perspective, but otherwise respects how the participant frames and structures the responses” (Marshall & Rossman, 1989, p. 82).

The interview questions were based on the first author’s personal use of the BaFPE-R and on a review of the literature about standardized assessments, including the BaFPE-R. The interview guide was elaborated and refined after pilot trials. Eight topic areas were covered in the interview: demographic and clinical information, use of the assessment, perceptions of the purposes of the BaFPE-R, administration of the assessment and analysis of the assessment results, assessment of clients’ reactions to the BaFPE-R, therapists’ knowledge of the BaFPE-R, evaluation of the strengths and weaknesses of the assessment, and attitudes toward standardized assessments in general (see Appendix).

Analytic Procedures
The taped interviews were transcribed by the first author and analyzed according to the methods described by Marshall and Rossman, who stated that
analytic procedures fall into five modes: organizing the data; generating categories, themes, and patterns; testing the emergent hypotheses against the data; searching for alternative explanations of the data; and writing the report. Each phase of data analysis entails data reduction as the means of collected data are brought into manageable chunks and interpretation as the researcher brings meaning and insight to the words and acts of the participants in the study (1989, p. 114).

In accord with these conventions of qualitative data analysis, the therapists' responses were organized into categories of patterns and themes. Sets of interrelated responses were compared logically, theoretically, and empirically with other findings (Polgar & Thomas, 1988). The interpretation of the patterns and themes was derived from the literature on the profession of occupational therapy and its values (Kielhofner, 1992; Shannon, 1977; Yerxa, 1985).

The emergent analysis and interpretation of the study results were examined by academic peers and members of the occupational therapy profession, including some who were involved in the study. The purpose of this examination was to assess the trustworthiness of the research (Guba, 1981; Krefting, 1990; Lincoln & Guba, 1985).

Results

Reasons for the Use of the BaFPE-R

The categories of reasons that therapists provided for using the BaFPE-R, in order of frequency of responses, were (a) departmental procedure, (b) time efficiency, (c) screening function, (d) attitudes of multidisciplinary teams, (e) support for other assessments, (f) therapeutic medium, and (g) evaluation of task performance. Examples of these reasons, selected from the interview transcripts, follow.

**Departmental procedure.** The most commonly reported rationale for use of the BaFPE-R was that it was the standardized assessment that the occupational therapy department had decided therapists would routinely use.

Respondent 2: It is our standard tool . . . we made the decision that it was the tool we were going to use as a standard assessment for assessing task skills.

Respondent 1: All our patients, other than those with dementia or those who are illiterate or have poor English, get the test because it's part of our assessment process.

**Time efficiency.** The second most frequently cited reason for using the BaFPE-R rather than alternate assessments was that the BaFPE-R could be administered and scored in less time.

Respondent 17: It's a very quick turnover [on the unit]. They're allowed to stay 6 weeks, but they don't stay that long. And this is why the BaFPE-R is very useful. Because you do a quick one-shot assessment. That's why I'd use it, because time is a factor on admission units.

Respondent 9: It [the BaFPE-R] was probably meeting my needs, because I had to have something done quickly with [patients], because they likely weren't going to be in that long and at least this gave me some quick and dirty observations that I could get into a clinical note.

**Screening function.** Therapists reported that the BaFPE-R was often used for two screening purposes. As the following statements suggest, therapists found the BaFPE-R helpful in establishing the clients' level of functional performance to determine whether occupational therapy intervention was required:

Respondent 13: It can also be an indicator of [whether] OT is required . . . if they do super well [on the BaFPE-R], there may not be a need for extensive OT involvement.

Respondent 17: Sometimes they're very functional so I don't want them in OT because I don't feel they need it.

The second screening function was to identify difficulties in specific functional performance component areas. The recognition of these impairments then justified placement of the client in a particular occupational therapy group.

Respondent 18: I find it's very good as far as highlighting organization, memory, kinds of activities they do best on; structured versus unstructured . . . it helps me to pick the kind of activity that I would probably give them.

**Attitudes of multidisciplinary teams.** Many of the therapists interviewed indicated that their use of the BaFPE-R was influenced by the multidisciplinary team with which they were affiliated. Most explained, in some way, that their multidisciplinary team preferred standardized assessments to nonstandardized assessments.

Respondent 15: For the initial assessment, they prefer that it be a standardized test . . . if they didn't know about it [the BaFPE-R], and if they didn't want me to use standardized tests, I might not tend to use it as much.

Respondent 2: Our psychiatrists challenge the OTs about the test [BaFPE-R]. They place a lot of importance on traditional standardized psychological tests such as the MMPI . . . they always felt we [OTs] didn't have a lot of basis in scientific method because we didn't have a standardized assessment . . . The main expectation that psychiatrists have of the OT on the team is providing information about the patient's functioning. Psychiatrists are concerned with pathology, while the OT is the team member that accentuates the strengths of the patient. The OTs' initial concern, when the test was first used, was that it reflected the medical model of psychiatrists, rather than the client-centered model [of occupational therapy] . . . Psychology is particularly interested in the BaFPE-R results. OT and psychology [testing] results often correlate . . . Nursing has focused more on subjective information, while OT now has objective information instead of relying on observation.

Several of the therapists interviewed reported publicizing the BaFPE-R in grand rounds or inservices at their facilities. One respondent explained as follows:

Respondent 17: Most of them [the team] are familiar with the BaFPE-R because I've done an inservice on it. In fact, we flung it around here.

**Supportive purposes.** Therapists reported that the BaFPE-R was used to support clinical observations and to complement other life skills assessments.
of Assessment Results
theses of deviation from the guidelines described in the
specific actions rather than merely respond to verbal or
Therapists interviewed in this study reported varying de­
results were consistent with the assessment guide­
ary team, its usefulness as an adjunct to other assess­
sed that the feedback clients received from the BaFPE­R results often improved client self-esteem and
self-confidence.

The BaFPE-R as a therapeutic medium. In addition
to evaluating clients’ current level of functioning, the
BaFPE-R was used as a therapeutic medium. Therapists
recounted that the feedback clients received from the
BaFPE-R often improved client self-esteem and
self-confidence.

Respondent 7: One lady said “I can’t concentrate, I can’t do any­
thing.” I had something to show her. [I said that] “even though
you’re feeling that way, you scored 20 out of 20 on Attention Span,
and your Memory for Instructions was 20.” I can show her that,
when she did this formal test . . . [her attention span] wasn’t a
problem area.

Respondent 6: [If the patient has] functional difficulties, [if he is]
unable to cope with dependency and his world has become very
small because of his illness, I might do the BaFPE-R to give [him]
some concrete feedback.

Evaluation of task performance. Five therapists
stated that the principal strength of the assessment was
that it is task-based. They reported that they preferred
the BaFPE-R because it requires the client to “perform”
specific actions rather than merely respond to verbal or
written questions. The following quotation represents
this view:

Respondent 13: The biggest strength, as far as I’m concerned, is
that it’s task based. That is, to me, tremendously significant. As
opposed to other standardized interviews, self-report ques­tionnaires, [that ask] “how do you do in . . . ?” [the BaFPE-R] is task based . . . I believe, certainly for the population that we deal with
in the provincial system, I question the validity of self-report ques­tionnaires [that ask] “do you have problems with . . . ?”

In summary, the clinicians who used the BaFPE-R
provided numerous rationales for their use of the
assessment. These rationales included the influence of de­
partmental policy, the time efficiency of the assessment,
its screening function, the influence of the multidisciplin­
tary team, its usefulness as an adjunct to other assess­
ments, its therapeutic value, and its emphasis on task
performance.

Variations in Assessment Administration and Analysis
of Assessment Results
The developers of the BaFPE-R provided specific guide­
lines for the administration of the assessment and for the
interpretation of the results (Williams & Bloomer, 1987).
Therapists interviewed in this study reported varying de­
grees of deviation from the guidelines described in the
assessment manual. Some of these variations in the ad­
ministration of the assessment and in the interpretation
of the results were consistent with the assessment guide­
lines. Conversely, some of the adaptations and modifica­
tions described did not conform to the developers’ spe­
cifications. Many of these adaptations were explained in
terms of the value therapists placed upon the therapeutic
alliance and what they considered to be in their clients’
best interests. The interview responses indicated three
main areas where variations in therapists’ use of the
BaFPE-R were common: (a) exclusion of the Social Inter­
action Scale (SIS), (b) exclusion of the Qualitative Signs
and Referral Indicators Section (QSRIS), and (c) modifica­
tions to the administration and scoring of the Task Ori­
tented Assessment (TOA).

Exclusion of Social Interaction Scale. The most
common form of variation in the administration of the
BaFPE-R was the exclusion of the SIS. Twenty-six (86.7%)
of the clinicians interviewed stated they had not used the
SIS in the past 6 months. The assessment developers
emphasized that the evaluation of functional perform­
ance should include both the task performance and social
interaction scales (Williams & Bloomer, 1987). Therefore,
clinicians who had only used the TOA can be said to have
assessed task performance rather than functional per­
formance using the BaFPE-R.

Therapists offered various reasons for not using the
SIS. One frequently cited reason was that other therapists
were not observed using the scale. Others reported that
the SIS was not used because social interaction was rou­
tinely assessed by the observation of clients in therapy
groups. Of most concern to therapists was the length of
time required to rate the SIS. As one therapist stated:

Respondent 27: I used the SIS once, some time ago, but it just
found that the amount of time that I had to put into the paper
work wasn’t conducive. As far as I can remember, I think that
the areas that it covered were quite relevant. It’s just that I felt I had an
awareness of that sort of summary through my observations. It
was more of a paper task that wasn’t revealing something unusual
to me that I wasn’t aware of (already).

Exclusion of the Qualitative Signs and Referral
Indicators Section. According to the assessment develop­
ers, the QSRIS is an optional component of the TOA that
may provide information about possible organic involve­
ment (Williams & Bloomer, 1987). Six of the therapists
interviewed stated they had not used the QSRIS at all. Of
those therapists who reported that they had used the
section occasionally, 11 therapists said that the QSRIS was
only used if the client had previously exhibited organic
signs. Some therapists who had not used the QSRIS state­
ed that, with experience, they had learned to identify
signs of organic involvement independently through ob­
servation of the client in other situations.

Respondent 15: Organicity is something . . . you can just tell, and
yet the screening factors [in the QSRIS] wouldn’t pick it up any
more than with any schizophrenic who has the same kinds of
problems of inability to abstract . . . it was usually with clinical
observation that you [could] say “there’s something wrong here.”

Adaptations and modifications in the administra­
tion and scoring of the TOA. When asked during the
interview if they had ever adapted or modified the assess­
ment administration, most therapists said they had not.
However, in explaining their experience and use of the

assessments, 21 therapists (70%) described some modifications they had made and their reasons for doing so. The majority of reasons given for the adaptations related to therapists’ perceptions of clients’ needs. Although therapists provided many examples of deviations from the assessment protocol of the TOA, three variations were most commonly described: (a) alteration of task completion time, (b) deviation from the protocols for scoring and analysis of results, and (c) modification of the verbatim instructions.

With regard to the first variation, 19 therapists (63%) stated that the guidelines for task completion time on the TOA were not always followed. Five therapists reported that additional important information about clients’ task functioning could be gained if the client was permitted to complete the task rather than stop when the allotted time had expired. Several therapists explained that clients were allowed to complete tasks on the TOA to maintain their self-esteem. One of these therapists reported as follows:

Respondent 6: I don’t want them to think I’m setting them up for failure. They get a certain satisfaction from completing it.

Other therapists were concerned about the negative effect that timing the task had on client performance.

Respondent 9: It puts pressure on them that they can’t tolerate, knowing that they’re timed, so they probably don’t function as well as they can. It affects performance.

With regard to the second variation, deviations from the TOA scoring protocol and the guidelines for analysis of the results were made almost as often as the time allotted for assessment completion was altered. Nineteen therapists (63%) reported that they did not use the norms published in the BaFPE-R manual (Williams & Bloomer, 1987). Some of the therapists interviewed had never used the norms published by Mann et al. (1989) and Mann and Klyczek (1991). Therapists at one provincial psychiatric hospital reported that neither the scoring format nor the norms for the TOA were used. Conversely, therapists at a general hospital stated that they used the scoring protocol outlined in the manual. However, instead of comparing these scores to the norms, they used other methods of interpreting the scores.

Many therapists provided more than one reason for their decision to alter the scoring or the protocols used for analysis of the assessment results. Some reported that the length of time taken to score the assessment decreased them from using the formal scoring protocol. Other therapists made observations of performance while the client was completing the TOA. These observations were described as more useful than the actual task scores. Ten therapists (33%) expressed concerns with the scoring criteria for the TOA. Some said that they questioned the reliability of the scoring procedures. Three therapists did not score the TOA because of these concerns.

Therapists discussed their differing reservations about comparing clients’ scores on the TOA to the normative scores. Some therapists chose not to use the normative data at all; others continued to persevere with their use of the norms despite misgivings. Six therapists stated that they believed the norms for the TOA were not applicable to their client population. The small sample size of the normative group was a concern to two therapists interviewed. Another two therapists considered the use of norms for the TOA to be unimportant. Some therapists stated that they decided not to use the norms for the TOA after observing that other therapists were not using them. Others explained that they believed the use of the TOA norms would not be fair to the client. They were particularly concerned that the client might be labelled as a result of the performance scores. One therapist exemplified the hesitation expressed by many therapists about the use of the standardized scoring and norms in the following words:

Respondent 6: I think there must have been some reason why I didn’t think it was fair to document those [scores in comparison to the norms]. I must have compared them to some psychology test and felt that it’s not fair to write this judgment down, to be in someone’s file forever. . . . I report everything as being my own impression, not absolute. Sometimes the things you put in the notes have a lot of power. They can make long-standing impressions on future people who are involved with the client.

With regard to the third variation, 18 therapists (60%) reported that they modified the provision of the written and verbatim instructions for the TOA. Some therapists paraphrased the instructions; others used verbal prompting. They offered several reasons for choosing to adapt the provision of the verbatim or written instructions. Some stated that more information about clients’ performance could be obtained if the verbatim instructions were modified. Others believed that presenting the TOA instructions in a standardized form was demeaning to clients. Several therapists emphasized that the method by which the assessment instructions are delivered should be individualized for each client. Four therapists reported that the provision of assessment instructions was altered to ensure that the client achieved success during the therapy session. One therapist explained as follows:

Respondent 11: Occasionally, I paraphrase the instructions to meet the needs of an individual patient. It’s difficult not to try and explain the instructions in another way and see if they can understand if you rephrase it. . . . The abstraction question, in the second edition, is poorly worded. I often need to rephrase it. “Skills” is a word word. Patients don’t think of the specific things we do. I might reword the question to say, “what do you need to be able to do in order to do this task?”

The information gleaned from the interviews with therapists who used the BaFPE-R indicated that there were perceived positive influences on the decision to use this assessment. Simultaneously, however, perceived needs and contingencies to alter its standardized admin-

The American Journal of Occupational Therapy

881

Interpretative Understanding

The results of this exploratory study support the assertions of other authors on the widespread practice of modifying standardized assessments in occupational therapy (Eakin, 1989; Fricke & Unsworth, 1992; Leonardelli Haertlein, 1992; Smith, 1992). The content of therapists’ explanations provides some suggestions as to why assessment adaptation is occurring. Professional issues and values appeared to permeate the responses of most interviewees. The responses centered on the therapists’ values and beliefs about clients’ needs and the perceived obligations of occupational therapy practice.

Most therapists interviewed directly expressed or indirectly indicated an ambivalence toward standardized assessments. They expressed a need to use standardized assessments, such as the BaFPE-R, yet they were concerned about the incompatibility of the assessment with the therapeutic aims of their practice. Many stated that their decision to use the assessment was influenced by their professional image that their multidisciplinary team colleagues, especially psychiatrists and psychologists, associated with the use of standardized assessments. It appears that they used the reporting of the BaFPE-R results in team meetings as an indicator of professional status. These therapists described their use of the BaFPE-R as a means to developing a professional identity and improving the recognition and credibility afforded their profession. The BaFPE-R seemed to serve as an outward manifestation of the scientific base of occupational therapy.

This commitment to the use of a standardized assessment was often constrained by the perceived inability of the BaFPE-R to identify and address the specific needs of individual clients. Most therapists alluded to a desire to address the unique needs of each client rather than merely the manifestations or symptoms of the disease. Many reported that the guidelines of the standardized procedures inhibited their ability to attend to persons’ needs. Although they did aspire to gain the acceptance and recognition of the multidisciplinary team, it appeared that following the administration protocol was incongruent with the therapists’ inclination to treat clients as individuals.

Kielhofner (1992), Shannon (1977), and Yerxa (1983), among many others, have examined the relationship between the core values of occupational therapists and the influence of science, scientific methods, and the reductionistic approach to health and illness. These authors provide possible reasons for the ambivalence reported by the therapists interviewed in this study.

The education of occupational therapists includes instruction in the administration of standardized assessments and the necessity for the reliability and validity of such instruments. Additionally, through their education and socialization to practice, occupational therapists tend to adopt the core values and assumptions of the profession (Department of Health and Welfare Canada and Canadian Association of Occupational Therapists, 1983; Kielhofner, 1992; Yerxa, 1983). These values reflect a strong tendency “to focus on the assets of individuals and to emphasize the therapeutic process” (Kielhofner, 1992, p. 73). According to Kielhofner, “another deeply ingrained value of occupational therapy is the belief in capacity and the therapist’s obligation to tease out that capacity” (1992, p. 73). The findings of this study illustrate the continuing commitment to those core values and beliefs that have underpinned the profession of occupational therapy since its inception. As Kielhofner stated, values “are very important guides to action” (1992, p. 73).

Knowledge of the values expressed by the therapists in this study contributes to an understanding of the manner of using and modifying assessments such as the BaFPE-R.

The therapists modified the administration and scoring of the BaFPE-R to “tease out” their clients’ capacities at the expense of the standardized protocol. It appears that the values of a humanistic, client-centered practice outweighed the values of a reductionistic, scientific approach to practice. Their desire to maintain and enhance client strengths rather than to focus on deficits appeared to guide the therapists’ modified use of the standardized instrument.

Implications

The results of this study raise several questions in regard to occupational therapy research and practice. Most current research in the profession relies on the use of standardized assessments to measure the variables of concern. As this was an exploratory study, the findings described cannot be generalized to the use of other standardized assessments. Similar studies to the one reported here, examining the use of other standardized instruments are, therefore, required. Such research needs to address questions regarding the extent to which the non-standardized administration of assessments influences the reliability and validity of research based on these assessment results.

The implications for clinical practice appear to be as salient as the implications for research. The results of this study were interpreted in terms of the strength of occupational therapists’ commitment to approaches that emphasize each client’s unique strengths. This interpretation challenges the profession to develop assessments that recognize the importance of that therapeutic goal, that is, to develop assessments that meet our clinical responsibilities, our values, and our clients’ needs. Such instruments must demonstrate acceptable psychometric properties without diminishing our recognition of the capacities and holistic nature of our clients. The incon-
gruity between professional values and the demands of standardization, as currently professed, require careful examination and, ultimately, resolution.

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Appendix

Clinician Interview Guide: Revised

Demographic and Clinical Information

1.1 When did you get your occupational therapy qualification?
1.2 At which university?
1.3 How long have you practiced here, at this facility?
1.4 And how long in psychiatry?
1.5 What clinical team are you affiliated with?
1.6 What is the average length of stay of patients on your unit?
1.7 What are your main duties?

Use of the Instrument

2.1 Are you using the first or second edition of the BaFPE? [Have you ever used the (other) edition?]
2.2 How often do you use it?
2.3 Which patients do you use the BaFPE with [describe age, diagnosis, acute or chronic]?

Purpose of the BaFPE

3.1 What do you think the purpose of the BaFPE is?
3.2 What do you think the developers of the BaFPE intended it for?

Administration of the BaFPE and Analysis of Results

4.1 Which of the subtests do you administer? [Why do you not use (__) subtest/component?]
4.2 Have you ever made any adaptations to the BaFPE?
4.3 How do you interpret patients’ scores? [If norms not used, elaborate]
4.4 What do you use the results from the BaFPE for?
4.5 How much does the patient’s performance on the BaFPE affect your planning?
4.6 Who do you discuss the evaluation results with?
4.7 Are other members of your multidisciplinary team familiar with the BaFPE?

Patient Reaction to the BaFPE

5.1 How do your patients react to the BaFPE?
5.2 How often are you unable to complete it in one session?
5.3 How often are you unable to complete it at all?
5.4 How long does it usually take you to administer the BaFPE?
5.5 And to write up the results?
5.6 Do you think a shortened version of the BaFPE would be useful to you?

Knowledge of the BaFPE

6.1 How did you first learn about the BaFPE?
6.2 How were you trained to use it?
6.3 Are you familiar with the BaFPE manual?
6.4 Are you familiar with any studies that examine the BaFPE?

Evaluation of the Assessment

7.1 How much do you think the results on the BaFPE reflect the patients’ actual functional status?
7.2 Do you think the BaFPE is reliable?
7.3 And valid?
7.4 What do you think are the strengths of the BaFPE?
7.5 And its weaknesses or shortcomings?
7.6 Do you think any of the items are inappropriate for cultural or other reasons?
7.7 Have you ever taught or trained another occupational therapist or occupational therapy student to use the BaFPE?
7.8 Have you ever recommended it to other occupational therapists or occupational therapy students?

Standardized Tests

8.1 How important do you think it is that we as occupational therapists in psychiatry use standardized tests?

Note: These questions guided the interview and were not asked verbatim. Probe questions, not shown here, were used to elicit salient points raised by interviewees.

References


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