School of Occupational Therapy

A Trans-Cultural Study of Practice of Occupational Therapists in Thailand and Australia: Reframing Theories of Practice

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Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

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ABSTRACT

Culturally appropriate conceptual models for practice are of major interest to occupational therapists, an emerging health profession in Thailand. Currently in Thailand, occupational therapy education and practice derives its conceptual models from Western models. How these models are translated into practice in Thailand is unclear, as there are currently no research studies relating to the cultural and clinical practice demands of Thai occupational therapists and of service delivery in Thailand. In addition, how occupational therapists in Australia apply conceptual models in practice has also been given limited attention in the research literature. A comparison is made between Thai and Western Australian occupational therapists to examine the use of theoretical models in the Western cultural context and to investigate the influences of cultural differences on occupational therapy practice. The purpose of this study is to identify the conceptual models most frequently used by occupational therapists in Thailand and in Australia, to describe the application of these models to practice, and to explore the cultural influences impacting on the application to practice. The need for a derived but more culturally specific conceptual model for occupational therapy practice in Thailand was also investigated.

Focus group interviews were conducted as the initial stage of the study, to obtain in-depth background information about occupational therapy practice. Content analysis using transcript-based analysis and systematic coding was used to analyse the focus group data. The results demonstrated three main conceptual approaches: among both Western Australian and Thai occupational therapists. These three models were described as the Performance Model, the Whole Person Model, and the Medical Model. The findings from focus group interviews and related literature were used to develop a questionnaire. The questionnaire was designed as a self-report measure, using a 4 point scale ranging from 'strongly agree' to 'strongly disagree'. It was arranged in 4 parts: Part A-Background Information, Part B-Models of Occupational Therapy Practice, Part C-Occupational Therapy Practice, and Part D-Practice Comment. Parts A, B and C consisted of closed-ended questions, whereas Part D was constructed to elicit open-ended questions.

The survey data was collected from 138 Thai occupational therapists (ThaiOTs) and 155 Western Australian occupational therapists (WAOTs).

A Chi-square test result demonstrated that ThaiOTs favoured the Medical Model for practice whilst WAOTs used the Performance Model and the Whole Person Model ($p < 0.05$). Principal component factor analysis was used to identify significant factors differentiating the practice of WA and Thai occupational therapists and to guide the development of the model of practice for ThaiOTs. The Mann-Whitney U Test results showed clear differences of therapist practice between Australia and Thailand in relation to their views about Clients, Professional Perspective (Therapists), Intervention, Cultural Implications, and Health Care Systems due to the influence of the culture and socio-cultural environment ($p < 0.05$). The outcomes from all stages in the study were used to develop a model of practice for Thai occupational therapists. This model named the 'Samphan' Framework of Practice focuses on the client and family as an inseparable unit, which differs from an individual, or client focus central to most Western models.

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OPERATIONAL DEFINITIONS AND ABBREVIATIONS

The following section outlines the operational context of terms used in this thesis. The spelling conventions employed in this thesis follow Australian English.

Operational Definitions

'Conceptual' or 'theoretical models' for practice refer to a coherent conceptual basis or core concept for practice, derived from the organization of knowledge (Kielhofner, 1997a).

The concept of 'independence' refers to having adequate resources to accomplish everyday task which includes such dimensions as individualism, autonomy, competence, initiative, self-reliance and commitment to goals (Hasselkus, 1997).

The concept of 'interdependence' refers to the desirability of mutual dependencies among people as they live their daily lives or mutual dependencies of individuals within social groups (Hasselkus, 1997).

'Individualism' refers to liberalism, freedom, equality, equity, voluntary participation, self-reliance, self-improvement, independence, loose relationships, and expectation to look after oneself and one's nuclear immediate family (Hofstede, 2001; Triandis, 1995).

'Collectivism' refers to security, in group harmony, interdependence, family integrity, personalised relationship and close and cohesive relationship between individuals from birth onwards (Hofstede, 2001; Triandis, 1995).

In this study, Western cultures value individualism more than collectivism such as in the USA, Australia, and New Zealand, conversely; non-Western cultures value collectivism more than individualism such as in Thailand, Taiwan ,and ElSalvador (Hofstede, 1991).

'Activities of daily living' refer to the typical life tasks required for self-care and self-maintenance, such as eating, hygiene, grooming, bathing, dressing, transferring (Christiansen & Baum, 1997c).

'Occupational performance' is the unique term that occupational therapists use to express function that refers to an individual's ability to perform activities or tasks in their occupational roles or daily occupation (American Occupational Therapy Association, 1995b).

"Occupational therapy uses the word function interchangeably with performance and occupational performance because occupational therapy's domain is the function of the person in his or her occupational roles" (American Occupational Therapy Association, 1995b, p. 1019).

'Occupations' refer to the daily activities: self-care or self-maintenance, work, and play or leisure, performed by a person according to his or her occupational roles in an individual context, which require active participation (American Occupational Therapy Association, 1993b; Kielhofner, 1995; Meyer, 1982; Trombly, 1995).

'Purposeful activity' refers to "goal-directed behaviours or tasks that comprise occupations" (American Occupational Therapy Association, 1993b, p. 1081).

'Functional independence' refers to functional independence in performance areas: self-care or self-maintenance, work, play or leisure that are meaningful and purposeful for the individual (Crabtree, 2000).

Abbreviations

ADL	Activities of daily living
MOHO	Model of Human Occupation
OT	Occupational Therapy
ThaiOTs	Thai occupational therapists
WAOTs	Western Australian occupational therapists
ThaiOT	A Thai occupational therapist
WAOT	A Western Australian occupational therapist
OTs	Occupational therapists
WA	Western Australia

CHAPTER 1

Introduction

1.1 Background to the Study

Occupational therapy emerged in the beginning of twentieth century as a distinct health profession within Western societies to meet the needs of individuals with mental and physical illness and disabilities (Christiansen, 1991; College of Occupational Therapy, 1989; Hagedorn, 1995; Kielhofner, 1997b). Whilst occupational therapy has expanded to embrace health promotion and prevention (Diasio, 1971), the core concepts focus on facilitating people with disabilities to engage in daily activities that are meaningful (American Occupational Therapy Association, 1972; Baum & Baptiste, 2002).

The profession of occupational therapy has expanded globally, but always through the application of Western models to clients from different cultural backgrounds. This was resulted in questions of cultural relevance and transferability. One area of debate has centred on concepts of independence and interdependence. Phipps (1995) suggested that cultural difficulties in working with non-English speaking clients were related to an emphasis on clients achieving independence. The concept of independence is not comfortably aligned with values in many non-Western cultures (Kinebanian & Stomph, 1992). Jang (1995) found in Chinese society that the extended family system, which values interdependence, and accepts a passive role for patients were obstacles in developing patients' potential to achieve independence. Additionally, Dutch occupational therapists found that emphasising independence and an active role for patients in performing or engaging activities obstructed service delivery to immigrants from Indonesia, Vietnam, the Middle East, the Mediterranean, Suriname, the Caribbean, China, and Sri Lanka (Kinebanian & Stomph, 1992).

A qualitative study of a cohort of occupational therapy students working with clients from different social and cultural backgrounds in New Zealand was carried out over three years. The students noted that their clients placed less value on independence and engaging in meaningful occupation than those in Western cultures, where individualism is a key value. This was thought to be due to a stronger family

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and community orientation (Whiteford & Wilcock, 2000). Fitzgerald, O'Byrne and Clemson (1997) identified seven important areas of cultural concern from the occupational therapists' viewpoint. These included professional values, family roles and responsibilities, communication, social behaviour, gender, the sick role, and explanatory models.

Currently in Thailand, occupational therapy education and practice is based on Western models (Department of Occupational Therapy, 1975). Thai occupational therapists are providing services to an increasing number of clients with chronic disabilities and age-related problems, as well as adapting to the current policy of health prevention and promotion in Thailand. The theoretical model for occupational therapy of promoting independence by people with disabilities was developed in a Western cultural context (Paul, 1995; Phipps, 1995). Applying theories based on Western cultural values to practice in non-Western cultures is a contemporary challenge not only in Thailand, but also in other countries. Exactly how these models are translated into practice is unclear. For example, there is currently no research relating to the cultural and clinical practice demands of Thai occupational therapists and of their service delivery in Thailand. Nor are there studies that compare practice in Western countries such as Australia where the conceptual models have been developed, with Eastern cultures such as Thailand. Furthermore research is also limited on how occupational therapists in Australia actually apply conceptual models in practice. Collecting data on actual practice in Thailand and Western Australia would provide a valuable comparison.

1.2 Significance of the Study

Cultural differences are assumed to influence the way in which health care services are delivered and interpreted (Dyck, 1998; Groce, 1999; Hasselkus, 1997; Levine, 1987). Understanding the specific health environments in which occupational therapists practice, and the cultural influences impacting on the core of occupational therapy practice, will add to the limited knowledge base about the profession of occupational therapy in Thailand and Australia. Findings from this study will provide knowledge which may facilitate useful modification or adaptation of Western theories to practise with non-Western clients or in non-Western countries. By identifying the way such conceptual models for practice are described and applied, it is hoped to elicit information on differences as well as similarities between

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the two countries. Examining the evidence regarding the need for a new or adapted conceptual model for Thai occupational therapists based on cultural needs will further guide the profession. Information collected may also contribute to the enhancement of educational programs in Thai occupational therapy schools, the Occupational Therapists Association of Thailand, the Thai Government and relevant agencies, as well as to the practice of occupational therapists themselves. In addition, it is suggested that aspects of this knowledge may be relevant to the future of occupational therapy as an emerging profession in a range of developing countries of 'Eastern' culture.

1.3 Objectives of the Study

The major purpose of this study is to examine the need for a new or modified conceptual model of practice of occupational therapy in a developing country, specifically Thailand. The aim is to identify a culturally responsive model specific to the service delivery needs of clients in Thailand. In order to do this, the specific objectives of this study were to:

1) Examine existing conceptual models most frequently used by occupational therapists in Thailand and Australia;

2) Describe the application of these models in practice in Thailand and Australia;

3) Compare and contrast the identified models and their application by Thai occupational therapists (ThaiOTs) and Western Australian occupational therapists (WAOTs);

4) Examine the evidence to support the need for a new or modified, culturally specific model for occupational therapy practice in Thailand.

1.4 Overview of the Studies

The study that is the core of the thesis was carried out in the following stages: First, we carried out focus group interviews to explore theoretical models and their application to practice as employed by representative groups of occupational therapists from Thailand (as an example of Eastern countries) and from Western Australia (as an example of Western countries). The findings highlighed the importance of three theoretical models for practice: the Performance Model, the

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Whole Person Model, the Medical Model; as well as professional issues, and culture as an influential factor in practice.

Second, findings from the focus group interviews were used to develop a questionnaire in order to obtain information from a large number of occupational therapists in both WA and Thailand. The questionnaire includes close-ended and open-ended questions.

Third, questionnaires were administered to occupational therapists in WA and Thailand to compare the use of the three theoretical models and of specific occupational therapy models that emerged from focus group findings, and investigated the influence of culture on their practice. The results demonstrate ThaiOTs use the Medical Model and Model of Human Occupation (MOHO) most often, while WAOTs use the Performance Model and the Occupational Performance most often. The cultural context of practice emerges as the most important factor influencing practice of occupational therapists in both Thailand and WA. Thai occupational therapists identified a need to modify existing models or develope a new framework for practice appropriate to the Thai cultural context. All quotations from focus group interviews and responses to open-ended questions in the questionnaire were translated into English by the author.

Fourth, the framework of practice for ThaiOTs was developed from findings based on part C of the close-ended questions and on the third open-ended question. An hypothesized framework was verified with a subset of ThaiOTs who participated in the main survey. Finally, framework was developed, named the 'Samphan' framework. It focuses on the client and family as an inseparable unit. 'Samphan' is a Thai word for 'relationship'.

1.5 Overview of Thesis Structure

This investigation was completed in three stages.

In stage one, focus group interviews were conducted to obtain in-depth background information about occupational therapists' perceptions of conceptual models and of their clinical application. Emergent themes were used, in stage two, as a basis from which to create items for a self-report questionnaire used in a survey. The final stage presented the results of the survey to be used to develop a model for Thai therapists if sufficient evidence for this has been found.

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This dissertation includes ten chapters, beginning in chapter 2 with a discussion of the relevant background literature, major concepts of occupational therapy, theoretical models of practice, definitions of culture and cultural implications for occupational therapy practice and the health care system.

The first stage includes:

- Application of theory to practice in Western Australia and Thailand: An exploratory study using focus group interviews (Chapter 3);

- Findings of the exploratory study (Chapter 4).

The second stage includes:

- Questionnaire design (Chapter 5);

- Use of Conceptual Models in Thailand and Western Australia: Methods (Chapter 6).

The third stage includes:

- Use of Conceptual Models in Thailand and Western Australia: Results (Chapter 7);

- Discussion of use of Conceptual Models in Thailand and Western Australia: Results (Chapter 8);

- The 'Samphan' Framework of Practice (Chapter 9);

- Conclusions and recommendations (Chapter 10).

The specific objectives, methods, results and implication are discussed for each stage independently.

CHAPTER 2

Literature Review

Occupational therapy is a health care discipline that emerged in response to the needs of people with chronic illness and disabilities, in the belief that engaging in activities of daily living would support health and survival (American Occupational Therapy Association, 1972; Christiansen, 1991; Hagedorn, 1995). 'Occupation' was introduced to people with disabilities as a means to improve their physical and mental conditions, and hence the use of occupation in treatment became known as occupational therapy (Baum & Baptiste, 2002). The theoretical models for the profession of occupational therapy have historically been developed in Western countries. As occupational therapy in Thailand is a relatively new and emerging health profession, theoretical models have been adopted from Western countries. Thai occupational therapists have, to date, employed these Western theories in their education and practice according to their cultural understanding and interpretation.

With these historical developments in mind, it is appropriate in the literature review to present the evolution of occupational therapy both in developed countries such as America and in a developing country such as Thailand. In addition, the theoretical and cultural implications for occupational therapy practice, together with the overall health care systems of Thailand and Australia, will be discussed.

2.1 Occupational Therapy

Occupational therapy has evolved in accordance with the changing world environment since the First World War. It has developed from the philosophies of humanism, reductionism, and occupation (as discussed later in Section 2.2).

Occupational therapy has evolved from its initial focus on psychosocial dysfunction, to include applications on physical disability, and paediatrics, and has now expanded to include health promotion and community practice (Schwartz, 1998). In response, the definition of occupational therapy has continued to be modified in many ways, according to the development of the profession. Possibly the earliest accepted definition of occupational therapy stated "occupational therapy is any activity, mental or physical, medically prescribed and professionally guided to aid a patient in recovery from disease or injury" (McNary, 1947, p. 3). More

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recently, the definition of occupational therapy accepted by the World Federation of Occupational Therapists in 1993 was "a health discipline which is concerned with people who are physically and/or mentally impaired, disabled and/or handicapped, either temporarily or permanently. The professionally qualified occupational therapist involves the patients in activities designed to promote the restoration and maximum use of function with the aim of helping such people to meet the demands of their working, social, personal and domestic environments, and to participate in life in its fullest sense" (World Federation of Occupational Therapists, 2002, p. 1). Comparison of the two definitions, demonstrate the shift in focus from recovery to one of meaningful participation in life, and reduction of what the World Health Organization now calls 'activity limitation' and 'participation restrictions' (World Health Organization, 2001). It also emphasises the important contribution of environmental factors to human functioning (Madden, 2002, p. 3).

2.1.1 Evolution of Occupational Therapy

During the 18th and 19th centuries, ideas relating to the use of activity, work or occupation to improve mental health were beginning to take shape, although at that time they were not called 'occupational therapy'. The primary aim was to cure patients with mental illness (Hopkins, 1988). In 1786, Dr. Philippe Pinel introduced work as a form of treatment in the Bicetre Hospital in Paris for the insane and suggested this approach to all mental hospitals (Hopkins, 1988; Punwar, 1994b). His idea inspired the use of activity or occupation for people with mental illness in institutions both in Europe and in America (Punwar, 1994b). William Tuke, an English Quaker, who established an asylum for the insane at York in England believed that the mentally ill could be cured by encouraging them to learn self-control from working and recreation, and described his approach as 'moral treatment' (Punwar, 1994b; Turk, 1964). This moral treatment approach emphasised moral behaviour according to cultural norms, which "evolved from both a humanitarian and humanistic movement" (Reed, 1993, p. 27). Thomas Scattergood, a Quaker minister, visited the York retreat and, drawing from Tuke's approach, instigated the concept of 'occupation and non-restraint' when establishing a similar mental health institution in Philadelphia in 1800 (Hopkins, 1988; Punwar, 1994b; Reed, 1993). Benjamin Rush was the first physician who used the moral treatment and occupation approaches to treat people with mental illness in America, based on

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his belief that man was created to be active (Bynum, 1964). Finally, Dr. Thomas Kirkbride, superintendent of the Pennsylvania Hospital from 1840 to 1860, emphasised the use of moral treatment and occupation throughout his term and endorsed the use of activity (Punwar, 1994b; Reed, 1993).

About 1860, arts and crafts displaced the use of 'moral treatment' (Reed, 1993). "The arts and crafts movement suggested the potential of crafts for both their curative process and satisfying outcome" (Schwartz, 1998, p. 855) and were known as diversional therapy, manual training, vocational education, and occupational training (Reed, 1993). In 1904, Dr. Herbert James Hall, of Massachusetts, started using progressive and manual occupation to treat neurasthenia instead of the common 'rest cure' (Hall, 1910). He established a workshop for weaving, ceramics, and various crafts, and recommended his patients follow "a schedule of work, rest, and relaxation" (Reed, 1993, p. 29). The use of occupations and this treatment approach resulted in the improvement of his patients (Hall, 1910). At about the same time, Susan Tracy, a nurse, who taught nursing students at the Adams Nervine Hospital in Boston, began training nurses to use occupation in the treatment of patients (Licht, 1948 cited in Punwar, 1994a; Tracy, 1910 cited in Reed, 1993). She is probably to be considered the first occupational therapist, because she valued occupations as an important adjunct to drug regimes and focused on the process of occupation to improve the patient's condition, not on the products (Licht, 1948 cited in Punwar, 1994a; Tracy, 1910 cited in Hopkins, 1988). By this time, the term 'occupational therapy' was being used and gaining recognition. Although the concepts were used early, as noted, this period of time (early 20th century) is often considered the origin of the occupational therapy profession.

In 1911, Dr. William Rush Dunton, Jr. presented a lecture course on patient occupation for nurses including guidelines on the prescription and use of occupational therapy, which was published in a textbook in 1915. He expressed many of the early concepts of occupational therapy and supported the employment of occupational workers in army hospitals (Peloquin, 1991). Dr. Adolph Meyer, a Professor of Psychiatry at Johns Hopkin University in Baltimore, presented a lecture entitled 'The philosophy of occupational therapy'. Meyer viewed mental disorders as the disorganization of habits or behaviour which manifest problems in daily living rather than dysfunction of the body and brain (Meyer, 1922; Meyer, 1951 cited in

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Reed, 1993). He proposed patients' activity should be a balance of work, play and rest in their daily life (Meyer, 1922).

George Barton, an architect, who had tuberculosis and a left hemiplegia, valued the activities which helped him to recover from depression and physical limitations, and proposed the term occupational therapy rather than occupational work (Barton, 1915; Dunton, 1931; Licht, 1967). The purposes of occupational therapy, as Barton described, was to distract the patient's mind, to exercise muscles and limbs, or perhaps to relieve the boredom of convalescence (Hopkins, 1988). In March 1917, before the United States entered World War I, an association of workers who were interested in providing occupation for patients was established, with Barton as their president. The membership included medical doctors, social workers, teachers, nurses, and artists who saw the importance of occupational therapy to fulfil the treatment of the sick and disabled (Hopkins, 1988). The concept of occupational therapy created by early researchers and practitioners are summarised in Table 2.1.1.

Table 2.1.1

The Evolution of Concepts of Occupational Therapy

Duration	Researcher/Practitioner	New concepts
18-19 century	Dr.Philippe Pinel	Work treatment introduction
	William Tuke	Moral treatment: working and recreation
	Thomas Scattergood	Occupation and non-restraint
	Benjamin Rush	Moral treatment and occupation
	Dr.Thomas Kirkbride	The use of activity
	-	The art and craft approaches
20 century	Dr. Herbert James Hall	The progressive and manual occupation
		A schedule of work, rest, and relaxation
	Susan Tracy	The goal of occupation to improve the patient's condition
	George Barton	The term 'Occupational Therapy'
	Dr.William Rush Dunton, Jr.	Guidelines on the prescribing and the use of occupational therapy
	Dr.Adolph Meyer	The philosophy of occupational therapy A balance of work, play and rest

A significant event in the development of the profession was World War I, with many wounded men requiring rehabilitation. In 1918 the Medical Department

of the U.S. Army established training programs for two groups of reconstruction aides known as physiotherapists and occupational therapists (Hopkins, 1988; Punwar, 1994b). Occupational therapy aides were trained to provide occupation to patients during long convalescence from war injuries, including amputation, blindness, and head and nerve injuries (Hopkins, 1988; Reed, 1993). At that time, occupational therapy was perceived as women's' work and reconstruction aides were all female (Punwar, 1994b). During this period, occupational therapy, which had mainly focused on people with mental illness, introduced treatment for people with physical disabilities (Hopkins, 1988; Punwar, 1994b). The kinesiological analysis of activities and adaptive devices came into use to remedy specific physical limitation (Hopkins, 1988). Significant medical advances emerged in response to the increasing number of people with chronic disabilities requiring long-term care and rehabilitation. In addition, the new treatment approaches arising from the science of psychology - Freud's psychoanalytic theory and Skinner's Behavioural theory were introduced. Occupational therapy introduced the concept of remotivation for people with mental illness, through reactivating the mind, and restoring function of people with physical disabilities (Woodside, 1971).

After World War I, the training programs for Occupational Therapy was closed but reopened because of the demand for occupational therapists to work in civilian hospitals (Hopkins, 1988). Physicians who had experiences of occupational therapy during the war valued its services and established units in many general and children's hospitals (Principles of Occupational Therapy. AOTA Bulletin No. 4, 1923 cited in Hopkins, 1988). During the 1920s and 1930s, occupational therapy expanded to orthopaedic practice and to general hospitals and even to private practice (Punwar, 1994b). By 1930, occupational therapists were viewed as medical carers of the sick and injured, closely associated with medicine; however, a more scientific approach was needed to deal with the problems of people with mental illness and physical disabilities. Occupational therapy practice began to focus on the more limited "subcomponents of functional performance- muscular function, neurophysiology, biomechanical principles, and specific abnormal behaviours- rather than the holistic view of the individual," which had been accepted practice in the earlier stages of the occupational therapy profession (Punwar, 1994b, p.27).

Again as a result of war, this time World War II, there was an increased demand for occupational therapists to help people who were sick and wounded, and this created a greater recognition by the military of the role of occupational therapists (Messick, 1947). The therapeutic medium used by occupational therapists changed from an emphasis on crafts to more practical job-related skills, or what became known as functional occupation. Along with this shift, occupational therapists were in demand to treat people with physical impairments, not related to war wounds, and become a part of the interdisciplinary team approach in physical medicine and rehabilitation (Schwartz, 1998). In the USA, the need for therapists in both military and civilian hospitals increased, resulting in a number of new schools of occupational therapy being established from 1940 to 1945. By the end of World War II, there were more than 1,000 occupational therapists providing services in military hospitals in the United States and other countries. At that time, occupational therapists worked with persons with psychological and psychiatric impairments or disabilities, as well as with orthopaedic and neurological problems (Hopkins, 1988).

From 1942 to 1960 was the era of the rehabilitation movement, with extensive growth in development of new facilities and treatment methods for populations with disabilities (Punwar, 1994b). Occupational therapy became integral in the rehabilitation field and took roles in prosthetic use training, developing orthotic devices and adaptive equipment, activities of daily living training, work simplification, increasing muscle strength, evaluating patients' vocational aptitudes and abilities, and in the use of neuromuscular facilitation and inhibition (Semrad, 1956; West & McNary, 1956). In the psychiatric field, occupational therapists focused on "the therapeutic use of self" and used psychotherapeutic techniques to improve social adaptation of patients or clients so that they could return to function in their home and communities (Punwar, 1994b; Semrad, 1956). During the 1950s, in an attempt to make occupational therapy a more exact science, occupational therapists used rehabilitation techniques and more exact methods of measuring physical dysfunction (Spackman, 1968). West and McNary (1956) recommended that occupational therapists demonstrate and define their unique role within the rehabilitation setting, rather than align their role and definition in the teaching of arts and crafts. At this time, occupational therapy practice was focused at a technical

level and had not strongly associated practice with a theoretical model (Punwar, 1994b).

Following World War II, allied medical services grew rapidly in many countries throughout the world and along with this, occupational therapy advanced in knowledge and techniques, especially in the area of physical rehabilitation (Hopkins, 1988). To promote occupational therapy, the World Federation of Occupational Therapists (WFOT), which consisted of ten founding member countries, held the first congress in Edinburgh, Scotland, in 1954, and joined the World Health Organization in 1959. The WFOT organised a list of expert advisors for the countries where there was a need to develop occupational therapy programs and formulated a code of 'Ethics for Occupational Therapists' and documented the 'Functions of Occupational Therapy' (revised in 1962) (Spackman, 1967). Thailand first joined WFOT in 2002 at the Council Meeting (Sinclair, 2002).

From 1960 to 1980, advances in technology and new information affected health care generally and also occupational therapy practice (Diasio, 1971; Schwartz, 1998). There was a trend towards specialists in each field of medicine and also in occupational therapy (Diasio, 1971). To be accepted by physicians and to increase professional status, occupational therapists were prompted to specialise and strengthen treatment techniques (Higher Status Near, 1960 cited in Schwartz, 1998). For example, some therapists were identified as specialists in hand rehabilitation, spinal cord injury, or burns (Diasio, 1971).

With the development of effective vaccines, epidemic diseases such as polio declined; however, stress-related diseases and dysfunction increased. The number of elderly people increased, and more people with disabilities survived because of improvements in delivery, prenatal care, and health care in general. In addition, people began to take more responsibility for their own health. Medical systems began to encompass health prevention and health promotion through public education about disease, injury prevention, and the use of technology to protect the public's health. To align with the new policies, occupational therapists were involved in education, prevention, screening programs and health maintenance, as well as initiating new programs such as public school programs for children with handicaps, community mental health centres, and agencies promoting independent living for elderly people and those with disabilities (Diasio, 1971). During this time, there were leaders who

encouraged the occupational therapy profession to move in new directions in response to the changing health care environment (Schwartz, 1998). Yerxa (1967) encouraged the profession to move away from the Medical Model and become more autonomous (Yerxa, 1967). Likewise, when Wilma West delivered the Eleanor Clarke Slagle Lecture in 1968, she urged the profession to shift from an illness model towards a wellness and prevention model, and to take more roles in prevention as well as in treatment and rehabilitation (West, 1968).

During the 1970s and 1980s, health care moved from a solely hospital base to a community base, because of the high cost of hospitalisation and the belief that patients could have more normal and productive lives in community settings, rather than in residential institutions. In addition, in 1975 the Education of the Handicapped Act (PL 94-142) in the USA specified the need for children with handicaps to have access to occupational therapy in the school setting. This contributed to the rapid growth of the paediatric area of occupational therapy practice in the USA. At this time Jean Ayres's theory 'sensory integration' provided a rationale for occupational therapy treatment especially in paediatrics (Schwartz, 1998). To respond to this trend, increasing numbers of occupational therapists worked in public and private schools, outreach programs, community service agencies, and private practices. Occupational therapists believed that they played roles in the prevention of disability, and in the maintenance of health, as well as in the treatment of functional limitations. They perceived themselves as fitting better into an educational or a social model of practice than into a medical model (Reilly, 1971).

During the 1980s, in the USA, Acquired Immune Deficiency Syndrome (AIDS) emerged. There was no effective treatment, and diseases that had been well controlled for decades re-emerged, for example tuberculosis. Occupational therapy encountered the need to search for treatment approaches to meet the needs of terminally ill patients. During the 1980s and 1990s, quality of life was accepted as a main goal of occupational intervention to maintain a client's dignity, even in those with terminal illness. Occupational therapists began to use the clinical reasoning process in treating their clients and also applied theories to analyse clients' problems and to select an appropriate treatment approach. Occupational therapists also became concerned with the cultural backgrounds of clients, in order to work more effectively with them (Punwar, 1994b).

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2.1.2 Occupational Therapy in Australia

In Australia, occupational therapists were employed as early as 1939, primarily in the mental health sector. The first occupational therapy school was launched during the Second World War and since that time occupational therapists have become strongly identified as part of the multidisciplinary health team in a multiculural society (Anderson & Bell, 1988).

The Government of Western Australia has focused on health promotion/health education programs and community care as integral parts of the health care system. Community care services are in place to assist the frail aged, people with disabilities, and those with chronic illness to be rehabilitated and to maximise their independence (State Health Purchasing Authority, 1995). Under this policy, occupational therapists take roles in community services that are different from those they take in institutional settings. Occupational therapists provide services in various clinical work settings such as the general hospital, psychiatric hospital, pediatric hospital, rehabilitation centre, community centre, nursing home, industry and school (Lomma, 1997). According to competency standards for entry-level, occupational therapists are expected to apply various approach in their practice such as occupational performance, behavioural, biomechanical and rehabilitation frames of reference (Australian Association of Occupational Therapists, 1992). Health care issues are integral to the government's multicultural policy (Blackford, 2003), and it is recognised that culture influences values and ethical principles of patients, carers and health professionals (Lickiss, 2003). This has important implications for practice of health processional in Australia (Manderson, 1990). For this reason, as one of the health professions, occupational therapists are urged to take cultural competency into account in their education and practice (Fitzgerald, O'Byrne, & Clemson, 1997; Phipps, 1995).

2.1.3 Genesis of Occupational Therapy in Thailand

In Thailand, Occupational therapy, founded by Professor Phon Sangsingkaew in 1939, primarily emerged in the mental health sector by providing vocational work to psychiatric patients in institutions (Bunyaratavej, 1992; Occupational Therapy Association of Thailand, 1995). In 1946, an occupational therapy service was established for patients with physical disabilities by Professor Feung Satsanguan (Bunyaratavej, 1992). As the Ministry of Public Health required the services of

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occupational therapy for increasing numbers of people who had acquired physical disabilities through trauma, occupational therapy was also included as an integral health discipline and was identified as an emerging health profession in the middle of the twentieth century (Bunyaratavej, 1992; Occupational Therapy Association of Thailand, 1995).

In 1974 the first occupational therapy school was established at the Faculty of Associated Medical Science, Chiang Mai University, and began awarding a Bachelor Degree of Occupational Therapy (Occupational Therapy Association of Thailand, 1995). The first group of students graduated in 1984, and to date more than 350 students have graduated (Department of Occupational Therapy, 2002a). At present there are 206 occupational therapists working in Thailand, primarily located in larger cities and institutions. Most work with people with physical disabilities (Department of Occupational Therapy, 2002a) who live within the context of Thai culture. However, the education curriculum and practice of occupational therapy has been based on theoretical models developed in Western countries (Department of Occupational Therapy, 1975). The Model of Human Occupation has been taught as part of the occupational therapy curriculum since the school opened in 1975 (Department of Occupational Therapy, 1975).

2.1.4   The Occupation

2.1.4.1 Significance and definition of occupation

As it is evident from the preceding section, 'occupation' is the medium of treatment in occupational therapy (Townsend, 1997), and achievement in 'occupation' is the domain of concern of occupational therapy (Trombly, 1995).

There are numerous definitions of occupation to be found within the occupational therapy literature. "Occupation in occupational therapy refers to all of the activities that occupy people's time and gives meaning to their lives" (Neistadt & Crepeau, 1998, p. 5). Likewise, The Canadian Association of Occupational Therapists (CAOT) defines occupations as "activities or tasks which engage a person's resources of time and energy, specifically self-care, productivity and leisure" (Canadian Association of Occupational Therapists, 1995, p. 140). Christiansen (1991) defined occupation as all goal-oriented behaviour related to daily occupation, and activity as specific goal-oriented behaviour directed toward the

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performance of a task (Christiansen, 1991). A simple definition of occupation which appears in the consensus paper of occupation published by the American Occupational Therapy Association (AOTA) is the "ordinary and familiar things that people do every day" (Christiansen, Clark, Kielhofner, & Roger, 1995, p. 1015). Occupation is also defined as purposeful activity or function (Henderson et al., 1991; Wilcock, 1993). All definitions stress the participation in every-day events and explicitly or implicitly imply goal-oriented, meaningful participation.

Definitions provided by Kielhofner (1995) and Nelson (1988, 1996) link occupation to the environment in which they occur. Kielhofner describes human occupation as "doing culturally meaningful work, play or daily living tasks in the stream of time and in the contexts of one's physical and social world" (Kielhofner, 1995, p. 3). Nelson proposes the definition of occupation as "the relationship between an occupational form and occupational performance" (Nelson, 1988, p. 633). Occupational form refers to the objective context of occupation which includes a social and cultural reality, and performance norms or expectations as reflected in values, roles, symbols, and sanctions for interpreting the physical elements. Occupational performance, in contrast, refers to the doing of occupations in the context of that doing or that doing situation (Nelson, 1988, 1996). This context can influence the purpose and meaning of occupation. Consequently, any interpretation should be made in terms of all the elements comprising the context of the occupation. For example, socio-cultural norms could be one of the major factors affecting interpretation of purpose and meaning of occupation (Christiansen, 1991).

From the model of occupational science, a very recent theoretical model, occupations are defined as "chunks of daily activity that can be named in the lexicon of the culture" (Zemke & Clark, 1996, p. ix). Occupational science teaches that the most effective occupations should: "have meaning for the individual; are intrinsically motivated and fired by a drive for competence; are self-initiated, active, a result of an act of the will; are goal-directed, purposeful for the individual, and are the ordinary activity of everyday living" (Henderson, 1996, p. 422-423).

2.1.4.2 The nature of the occupation

Occupation is categorised into three common domains, which generally characterise the nature of human activities and have been used as the principal professional focus for occupational therapists (Golledge, 1998; Hagedorn, 1995;

Punwar, 1994c; Wilcock, 1993). However, depending on the theoretical model, the way the domains are labelled varies. Generally speaking, the three domains are work or productive activities, play or leisure activities, and self-maintenance or self-care activities. Collectively, the three domains of occupation are called occupational performance areas in the Uniform Terminology adopted by The American Occupational Therapy Association (American Occupational Therapy Association, 1994b). In the occupational performance model, the three are collectively referred to as simply occupational performance (Canadian Association of Occupational Therapists, 1991).

Within the third edition of the uniform terminology for occupational therapy, work refers to "purposeful activities for self-development, social contribution, and livelihood" (American Occupational Therapy Association, 1994b, p. 1052). Work is termed 'productivity' by the Canadian Association of Occupational Therapy (CAOT) (Canadian Association of Occupational Therapists, 1991), and is likewise defined as "those activities and tasks which are done to enable the person to provide support to the self, family and society through the production of goods and services" (Canadian Association of Occupational Therapists, 1991, p. 141). Stated another way, work/productivity refers to "skill and performance in purposeful and productive activities in the home, employment, school and community" (Jacobs, 1999, p. 158). Generally, an individual's work is organised into a major life role, which is recognised by the social environment and positioned within society. Therefore, the duties/activities/occupations of students, housewives, and volunteers are also considered as work (Kielhofner, 1988). Work/productivity is not only necessary for self-preservation, but also for contribution to the social group. Human society is characterised by the types of work/productivity which an individual performs. Adults who can contribute to society through working/productivity will have a sense of self-worth and a sense of association with the social group (Kielhofner, 1988).

Play constitutes the primary occupation of children and the term leisure is used to describe the non-work and self-care activities of adults (Christiansen & Baum, 1997a; Reilly, 1966). Both play and leisure involve characteristics of choice, expression and development activated by intrinsic motivation and pleasure (Christiansen & Baum, 1997a; Parham, 1996; Passmore, 1998). The occupation of play is required to develop the child's nervous system. For example doing jigsaw

puzzles is believed to contribute to the neurological programming of visual perception and problem solving (Kielhofner, 1988). From play experiences, children develop a sense of personal causation, learn a sense of time, and are able to be creative, flexible and adaptive to their environment. Work and play contribute to the creation or modification of behaviour in human beings (Kielhofner, 1988; Kielhofner, 1997c). Play, which is influenced by the special beliefs, values, ways of interacting, and technology of the social group, has been responsible for the development of new behaviours compatible with the cultural repertoire of a social group. The developing person adjusts to the socio-cultural group and prepares for adulthood through the play. For adults, play is also important to maintain morale and commitment, and to value structure of the social group (Kielhofner, 1988; Kielhofner, 1997c) as well as providing refreshment before return to work (Reilly, 1966). Leisure is useful to reduce stress, improve health (Kielhofner, 1988; Parham, 1996) and increase longevity both in adulthood and old age (Kielhofner, 1988).

Self-maintenance is also described as self-care and activities of daily living. The Canadian Occupational Performance Measure, an outcome measure commonly used in many countries, gives examples of self-care as: "personal care; dressing, bathing, feeding; functional mobility: stairs, bed, cars and community management; transportation, finances, services" (Law et al., 1990, p. 84). Self-care/self-maintenance occupation is necessary to maintain the self within the environment (Christiansen & Baum, 1997a). Apart from the necessity for survival, self-care occupations are also necessary for social acceptance, essential to a sense of self-worth and competence and to achievement in activities of daily life (Hogan, 1983; Hogan & Sloan, 1991; Punwar, 1994c).

Self-care/self-maintenance and work/productivity are required adult activities. These activities include for example, earning a living through employment, maintenance of a household, and rearing children. Work valued by society is a primary source for the development of self-esteem, self-control, and self-competence (Kielhofner, 1988). Participation in activities also provides an avenue for development of insight into abilities and limitations (Levine & Brayley, 1991), and provides the opportunity for the individual to become aware of his or her self-concept, which comprises sexual identification, body image, and self-esteem (Levine & Brayley, 1991).

Three categories of occupation: self-care, work ,and play/leisure are interrelated and create a dynamic balance in living throughout life (Kielhofner, 1988; Kielhofner, 1997c). However, the categorisation of specific activities by different occupations is difficult due to the meaning and context in specific situations. For example, hobbies or amateur pursuits can be viewed as both work and play (Kielhofner, 1988); making a meal for oneself is usually considered as self-care. However, making a meal for a family may be considered as work. Preparing a meal for invited friends may be considered leisure. Thus it is difficult to determine clear criteria to differentiate occupations into discrete categories.

Occupation has been proposed as necessary for the health and survival of human beings. Occupational therapists focus on the optimal balance of occupations in daily living including work, play, leisure, and self-maintenance or self-care for good health and well-being (Kielhofner, 1988; Wilcock, 1993). Human beings are viewed as active, capable, and self-directed agents able to manipulate health through the use of "hands, mind and will" (Burke, 1977; Reilly, 1962, p. 2). The active engagement of the person with their environment through occupation is believed to increase skills and competence, leading to health (Yerxa, 1992).

Occupational therapy considers that a balance of work, play, and self-care is required to maintain healthy functioning and in turn prevent dysfunction of an individual's occupations, which is believed to affect life satisfaction and competence of individuals (Kielhofner, 1988). When a person's normal occupations are affected though illness or trauma, occupational therapy considers that disintegration of normal occupation occurs. At this time, maintenance, restoration, or recreation of balance is fundamental to regaining health (Kielhofner, 1988). A well-known occupational scientist, Wilcock (1993), has proposed the major functions of occupation as meeting bodily, social, and personal needs.

Occupation has been proposed as central to human development in "biological, psychological, and social dimensions", (Kielhofner, 1988, p. 88). Occupation is also essential to maintain biological function in adulthood and in old age (Kielhofner, 1988).

Occupation is viewed by occupational therapists as "the organising model of a person's life, but activities are the focus of therapy" (Hagedorn, 1995, p. 118). Occupations or activities provide individual experiences to react to, adapt to, and/or

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master the environment. Therefore, occupation is important to the reorganization of behaviour and human adaptation (Hagedorn, 1995; Kielhofner, 1988) and meets occupational therapy's aim to develop or improve a sense of competency and satisfactory engagement in life roles (Trombly, 1995). If a person loses or has a disruption in occupations, personal well-being, self-satisfaction and quality of life may be threatened (Hagedorn, 1995; Kielhofner, 1988). Occupation provides the mechanism for learning, for self-maintenance, for gaining a sense of satisfaction and fulfilment, for social interaction, and societal development and growth (Christiansen, 1994; Wilcock, 1993). Levine and Brayley (1991) offers a similar view of occupation or activity emphasising that it improves human performance in self-care, work, and play/leisure and the links physical, psychological, physiological, cognitive, and emotional factors together in order to perform occupation in an individual's life roles. Activities are essential to enhance the competent performance of an individual during daily life and are also viewed as therapeutic media. Occupational analysis or activity analysis, which provides information about occupations' complexity, is used to determine the therapeutic components of an activity (Law, Polatajko, Baptiste, & Townsend, 1997a; Simon, 1993).

2.1.4.3. Meaning and purpose of the occupation

Why do people engage in occupation? According to Christiansen (1994) and Clark, Wood and Larson (1998) the answer is because they see occupation as necessary for their adaptation and survival or as meaningful within the context of their lives. It has been suggested that "only meaningful occupation remains in a person's life repertoire" (Trombly, 1995, p. 963). The reason why people select one activity over another appears to be explained by "motivation for goal-directed or purposive action" (Clark et al., 1998, p 19).

How occupations and their meaning influence performance, what people choose to actually do over time, has been studied by occupational scientists (Christiansen, 1994; Clark et al., 1998). Individuals rely on their past experience and subjective feelings to find meaning in occupation (Kielhofner & Burke, 1985). Meaning and purpose are subjective and are the experiential aspects of occupation, which are not directly observable (Nelson, 1996). In other words, meaning is the sense the individual makes of a situation (Nelson, 1996), which reflects the attitude or sentiment toward life events (Christiansen, 1994). Therefore, the meaning of

occupation can be defined as "the person's active interpretation of the occupational form" (Nelson, 1997, p. 13). The purpose of occupation is the outcome that the person desires to receive from engagement in the occupation (Nelson, 1996; Nelson, 1997). Once a person interprets or makes sense of things (determines the meaning of a situation), an experience of wanting or intending to do something about the situation (purpose in the situation) will result (Nelson, 1996; Nelson, 1997).

2.1.5   Issues of Using Occupation as a Therapeutic Method

The scope of occupation covers any human activity, task or activities people do to occupy, look after, and bring about satisfaction. The concept of occupation, then, is broadened to any work, or a part of a task, which, in turn, are parts of roles, formal jobs or day-to day activity or purposeful activity (Christiansen & Baum, 1997a; Fleming, 1994). Occupational therapists enable people to engage in the tasks of everyday life or participate in everyday activities for example dressing, cooking, shopping, work, play, creating, constructing (Fleming, 1994; Hagedorn, 2000). The common activities in daily life or simple activities provided to clients have complex reasons underlying those activities. Despite computers and environmental controls, occupational therapy is viewed as using low technology or common sense in the process of therapy. Therefore, it is hard for a person who does not use occupational therapy's services or a layperson to understand the complexity of intervention of occupational therapy (Hagedorn, 2000).

In Thailand, Occupational therapy is a newly emerging health profession, which is described and defined in complex language and in relation to services outside of those common in Thai culture. The translation of 'occupational therapy' in Thai is difficult for both workers in related professions and the public to understand, because the word 'occupation' misleads many people to vocation; hence, they understand occupational therapy refers to vocational therapy or training (Occupational Therapy Association of Thailand, 2002). Only one published study on occupation has been undertaken in Thailand. Apikomonkon and Bunrayong (2000) surveyed the use of media by Thai occupational therapists in a variety of settings and factors influencing their selection. It was found that specific techniques and activities of daily living were primarily used (i.e., both were used more than 80 percent of the time). Factors influencing their selection were models of practice such as the Medical Model.

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2.1.6 Summary

Occupational therapy was initially established mainly to care for patients with mental illness (in Europe, North America and Thailand) through the use of work and diversional activities. Occupational therapy has since evolved to focus on a balance of work, play, and rest in daily life and developed treatment approaches for people with both physical and mental disabilities. Over time, the roles of occupational therapy have expanded to include a role on interdisciplinary teams focusing on rehabilitation, community health care, health promotion/prevention, early intervention, and improving quality of life. In occupational therapy, occupation is used to meet the needs of people with disabilities and chronic illness to improve their functional performance in daily living in the areas of work, play, leisure, and self-maintenance. This is based on the tenet that people engage in occupations to respond to life contexts and to enhance their health and quality of life. Occupational therapists use meaningful occupation/activities to promote humans' participation in daily life, to achieve optimal performance. Subsequently, occupation is the core of occupational therapy, and is addressed in all occupational therapy theories and models.

2.2 Theoretical Models of Practice in Occupational Therapy

This section presents the major theoretical models underpinning occupational therapy. However, in occupational therapy literature, there are a number of terms used to describe theoretical models: models, frames of reference, paradigms and approaches (Kortman, 1994). In fact, the occupational therapy literature is filled with academic discussion and debate regarding such terminology (Baum & Christiansen, 1997; Kielhofner, 1997d; Mosey, 1985, 1989). This theoretical debate, while interesting, is not of significant importance in this research. Thus, for the purposes of this study, and supported by the Macquarie, Webster's Dictionary and Roget's Thesaurus, the terms model, frame of reference, paradigm and approach will be considered to have the same meaning (Kortman, 1994) and the term 'model' will be used throughout this study. The term 'model' will thus be defined as a way of thinking and practicing, which aims to explain a group of phenomena and which guides practice (Kielhofner, 1997d).

2.2.1 Development of Occupation-Based Models

Occupational therapy, as with other professions, developed from a set of values, beliefs, and principles that have influenced the identity and development of both the discipline and its models (Christiansen, 1991; Mosey, 1981). These values, beliefs, and principles allow the profession to articulate its rationale and goals and to determine its domain of concern and legitimate tools for service to society (Mosey, 1981). Values, beliefs, and principles are also used to develop models of practice for the profession (Mosey, 1981). Over time, three distinct sets of values and beliefs have influenced the development of occupational therapy models. These can be broadly defined as humanism, reductionism, and occupation.

Early occupational therapy was based on the ideas of humanitarianism of the 19th-20th century (Kielhofner, 1997b; Reed, 1993). Later humanism developed from the organismic view which perceives humans as active agents in determining and controlling their own behaviour, over which they have control. The organismic view also proposes that "a person is an integrated and organised entity that cannot be reduced to discrete parts" (Reed, 1993, p. 36). This is often labelled or conceptualised as 'holism.' Holism recognises the principle that the human being is viewed as the integration of the components of mind, body, spirit, emotions, and environment (Hemphill-Pearson & Hunter, 1997),and perceived as a whole person (Canadian Association of Occupational Therapists, 1991). According to holism, the causes of illness cannot be identified purely by environmental factors or the separate components of an individual such as body, mind, spirit, thoughts, feelings, and emotion. Even daily activities that are not consistent with a person's spiritual purpose such as attitude, meaning, will, and motivation, may contribute to illness (Bar, 1998). To maintain health, prevent illness, or recover from illness, holistic concepts focus on the integration of all internal factors of a person and his/ her environment (Bar, 1998; Gordon, 1980). Therefore, principles of holistic practice include encouraging and educating healthy life style: emphasis on self care and self-regulation, establishing good relationships and a partnership with clients to contribute to healing outcomes; consideration of the client's needs and culture; and emphasis on optimal health, not only the absence of sickness (Bar, 1998; Gordon, 1980; Stein & Cutler, 1998).

Based on humanistic values, early occupational therapy viewed a person as potentially active in enhancing his own or her own health and quality of life by actively engaging in occupations (activities) that were personally meaningful and purposeful. It was believed that, provided with an organised and structured environment that included routine and purposeful activity, people with mental illness or disability could return to more functional and healthy patterns of life (Kielhofner, 1997b). Today, these concepts are still apparent in the occupational therapy literature, with a focus on providing opportunities to improve quality of life relevant to one's sense of fulfilment and self-esteem (Baum & Christiansen, 1997). As holism has been considered important throughout occupational therapy's development (Dunning, 1973; Meyer, 1922; Reed, 1984), it is believed that therapists should treat the whole person according to his or her individual needs (Taylor, 1972). The concepts of holism are described in occupational therapy principles, methods, and techniques (Hemphill-Pearson & Hunter, 1997). In using the holistic approach in occupational therapy practice, basic principles include collaboration with the patient and/or family, and giving adequate attention to biological, psychological, social, and environmental factors (Slaymaker, 1986).

During the late 1940s and 1950s, when medical science flourished, humans were viewed from a more mechanistic and reductionist viewpoint (Kielhofner, 1997b). This viewpoint sees a person as the sum of his or her component parts (Hagedorn, 1997; Reed, 1993). This implies that function is based on the intricate balance displayed when all parts are individually functional – as a machine (Kielhofner, 1997b). According to the medical perspective, illness is the result of biological disorders, caused by organs, tissues, cells, and molecular structures of which living organisms are composed; hence, each single unit or measurable units can play a role in causing illness (Engel, 1977; Kielhofner, 1997b). The Medical Model is based on the medical perspective and reductionist approach, focusing on the application of scientific technical knowledge to identify and eliminate or control disease or trauma (Kielhofner, 1997b). The need to identify the root cause or diagnosis leads to an understanding of the professional as an 'expert', and the patient as a passive recipient of care (Kielhofner, 1997b). Illness of the patient is viewed as the damage of a machine's parts which requires repairs, replacements, and adjustments by the experts (Kielhofner, 1997b). External factors control the health of

the individual (Hagedorn, 1992), and it is the inner mechanism of body and mind that are of concern (Kielhofner, 1997b). Therefore, the patient does not need to take responsibility for his or her illness (Fleming, 1994; Kielhofner, 1997b). During the 1960s to the 1980s, the Medical Model had a profound influence on occupational therapy practice (Fleming & Mattingly, 1994) in pursuing a more scientific approach with the resultant use of a number of different models of practice: for example the Kinesiological, Psychoanalytic, Interpersonal, Sensory integrative, Cognitive-Perceptual, and the Neurological Models (Baum & Christiansen, 1997; Kielhofner, 1997b). The influence of the mechanistic era continued beyond the 1980s for example in influencing the development of the cognitive disabilities model of Allen. (Kielhofner, 1997e).

The original emphasis in the importance of occupation, based on humanism, occurred at the beginning of the twentieth century, during the foundation years of the profession. At that time, however, no formal models were developed. The original concepts of occupation have taken on renewed importance during the 1980s (Kielhofner, 1997b). The current understanding of occupation has developed to serve the occupational needs of human beings (Kielhofner, 1982), and focuses on ways to reduce the consequences of disease or injury that disrupt the individual's ability to participate in activities of daily living, work, and/or leisure, or to deal with functional problems (Fleming, 1994). Based on this philosophy, occupational therapy focuses on ways to enhance occupational performance rather than only correcting a disability or pathological orientation(Anonymous, 1974). In addition, occupational therapy views a person as able to master, or at least influence his or her environment via engagement in activities which contribute to a sense of being and contributing to a society (Shannnon, ____ cited in West, 1984). The term used uniquely by occupational therapy to explain functional competence is occupational performance (Baum & Christiansen, 1997), which reflects an individual's engagement in daily occupations within the environment (Law & Baum, 1994). Occupational performance can be described as the product of the dynamic and interconnected relationship among people, their occupations and roles, and the environments in which they live, work, and play (Law et al., 1996). Current occupational therapy theories believe that health is the result of the interplay of three major concepts:

person, environment, and occupation. Different theories focus more or less on one of the concept (Kielhofner, 1997b; Reed, 1998). Three such models will be discussed.

2.2.2 The Model of Human Occupation

Keilhofner, in 1980, proposed in his Model of Human Occupation (MOHO), asserting that humans are an open system embedded in the environment (Kielhofner, 1997f). This model explains how humans are motivated to engage in occupations, how they choose and organise occupations, and how they perform occupations in a range of environments (Kielhofner, 1995).

Kielhofner proposed that humans are occupational beings who are motivated to explore and master their world (Kielhofner & Burke, 1980; Kielhofner & Burke, 1985). Further, he claimed that occupation is a central aspect of human existence, and meaningful occupation is important for health (Kielhofner & Burke, 1985). The model teaches that occupational behaviour arises from the interaction of a human system with the environment (Kielhofner, 1997f). The human system is a dynamic, changing, open system made up of three subsystems: volition, habituation, and mind-brain-body performance subsystems that motivate, organise, and enable a human being to perform possible occupations (Kielhofner, 1997f; Law et al., 1997). These subsystems are arranged in a hierarchy according to general and open system theory, with volition the highest and mind-brain-body performance the lowest (Kielhofner, 1997f; Miller, 1993).

The volition subsystem emerges from innate and acquired urges or needs to act on the environment (Duncombe, Howe, & Schwartzberg, 1988; Kielhofner, 1997f) and includes the constructions of personal causation "(beliefs and feelings about one's capacity and control), values, and interests" (Kielhofner, 1997f, p. 188). The habituation subsystem arranges behaviour into predictable patterns and roles, which are regulated by the volition subsystem. The habituation subsystem comprises habits, the routine activities of daily life, and internalised roles defined as a particular social identity, with related obligations that a person is expected to behave and learn to behave in certain ways (Duncombe et al., 1988; Kielhofner, 1997f; Miller, 1993). The mind-brain-body performance subsystem or performance capacity subsystem is the lowest level of the system and governed by the other two subsystems. This system is made up of physical component such as musculoskeletal, neurological, and cardiopulmonary systems, and mental component such as memory, perception,

cognition including the corresponding learning experiences (Kielhofner, 1997f; Kielhofner, 2002).

The performance capacity of an individual can be explained by objective components and subjective experiences of the individual who performs such an occupation. The objective physical and mental components are combined with the subjective experience that the individual learn from performing occupations and his or her feeling about such a performance, both contributing to performance capacity and limitations of performance of the individual. Objective components and subjective experience are closely related, in that both are routinely used in everyday life. In fact, we experience both body and mental activities when we perform occupations, such as reading, and in effect paying attention in both body and mind during such a performance. Hence mind and body are inseparatable. Therefore, both the objective approach and subjective experience are indispensable for therapists to be able to diagnose a client's performance capacity, and provide a guideline for the client to modify the way to accomplish a task when necessary. In most cases, the clients are required to learn to do a task in a different way to increase their performance capacity (Kielhofner, 2002).

According to this model, occupational behaviour is also influenced by one's environment (the physical and social environments) (Kielhofner, 1997f). Each physical and/or social environment requires specific occupational behaviour (referred to as press) and provides opportunities for performing that behaviour (referred to as effort). An individual engages in occupational behaviour in accordance with the pathway created by environment (Kielhofner, 1997f).

2.2.3   The Canadian Model of Occupational Performance

The Canadian Model of Occupational Performance (CMOP) was first published in 1983 (Department of National Health and Welfare and Canadian Association of Occupational Therapists, 1983) as a result of a task force to "develop national consensus guidelines for the practice of occupational therapy"(Canadian Association of Occupational Therapists, 1991, p. 4.). This model emphasises the inter-relationships between people, their abilities and strengths, their environments and occupations, and proposes occupational therapy processes that assist clients to achieve optimal occupational performance as defined by the individual (Baum, 1998).

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The primary concept of the model is that engagement in self-care, productivity, and leisure occupations is fundamental to human existence and that all people, with or without disabilities, have a need to engage in a range of activities within these categories. Engagement in occupations is an interaction between the demands of the occupation, the performance components possessed by the individual, and the environmental context in which the occupation is to be performed (Canadian Association of Occupational Therapists, 1991). In other words, occupational performance refers to "the ability to choose and satisfactorily perform meaningful occupations that are culturally defined, and appropriate for looking after one's self, enjoyment of life, and contributes to the social and economic fabric in a community" (Law et al., 1997a, p. 45). The environment in which meaningful occupation occurs is comprised of cultural, institutional, physical and social components (Law, 1991; Law et al., 1997a,).

The third edition of the Uniform Terminology published in 1994 (American Occupational Therapy Association, 1994b; Pedretti, 1996) has been used to make the CMOP model more relevant to U.S. cultures. In this version, the occupational performance model is described as consisting of three performance areas, three performance components, and two performance contexts. The performance areas include activities of daily living, work and productive activities, and play or leisure activities. The performance components, which are: fundamental to the performance areas, comprise: the sensori-motor component, the cognitive/cognitive integration components, and the psychosocial/psychological components (Pedretti, 1996). The final elements are the temporal and environmental performance contexts (Breines, 1984). Temporal contexts encompass the individual's age, phase of maturation, and stage in important life processes (Breines, 1984). The environmental contexts consist of 1) the physical, including buildings and objects 2) the social, including significant others and social groups, and 3) the cultural environments, including customs, beliefs and behavioural standards.

Additional versions of the Canadian Model have been published in Australia (1997) and in Hong Kong, with the curriculum at the Hong Kong Polytechnic University based on the original version. Therefore, the occupational performance model is currently used in several countries.

Congruent with the Canadian Model, and published at much the same time, was the clinical approach known as 'the client-centred approach' to occupational therapy intervention. The client-centred approach assumes that clients are in the best position to make choices regarding engagement in occupations, as they themselves are most knowledgeable about their own needs and desires (Baum, 1998; Stein & Cutler, 1998). The person is viewed in an integrated, holistic manner, engaged in occupations within an environmental context (Strong et al., 1999). Client-centred practice responds to the individual's occupational needs in his or her specific environment (Law et al., 1997a). The individual is perceived as an active partner in occupational therapy services and making decisions about their lives (Law et al., 1997a; Stein & Cutler, 1998).

The CMOP regards occupational performance as the result of a dynamic relationship between the person, environment, and occupation over a person's lifespan (Law et al., 1997a). In this model the person is perceived as an "integrated whole who incorporates spirituality, social and cultural experiences, and observable occupational performance components" (Law et al., 1997a, p. 41-42). Social and cultural experiences, which are important subjective aspects of life, affect people's view of themselves and the meaning of their life (Law et al., 1997a). Spirituality is placed at the core and is the essence of self (Law et al., 1997a), and includes the "innate essence of self, quality of being uniquely and truly human, expression of will, drive, motivation, source of determination and personal control and guide for expressing choice" (Law et al., 1997a, p. 43). Occupational performance comprises an individual's capability in mental, physical, spiritual and socio-cultural components (Law et al., 1994). As social and cultural performance is shaped by the environment, the other three performance components are defined as affective, cognitive and physical performance, which are interdependent (Law et al., 1997a).

This model includes assessment and intervention guidelines for the client-centred practice of occupational therapy (Department of National Health and Welfare and Canadian Association of Occupational Therapists, 1983, 1986). According to these guidelines, the Task Force recommended a measure to evaluate occupational performance outcomes of a client (Department of National Health and Welfare and Canadian Association of Occupational Therapists, 1987). Therefore, the Canadian Occupational Performance Measure (COPM) was developed to assess occupational

performance outcomes of a client in the areas of self-care, productivity, and leisure (Department of National Health and Welfare and Canadian Association of Occupational Therapists, 1983), which assists occupational therapists in applying this model to practice (Law et al., 1990).

2.2.4   The Person-Environment-Occupation Model

The Person-Environment-Occupation Model (PEO) developed by Law, Copper, Strong, Stewart, Rigby, and Letts was built on concepts derived from environment-behaviour theories, theories of occupation, and client-centred practice (Strong et al., 1999). It is closely aligned with the Canadian Occupational Performance Model and in fact shares at least one author. In most aspects, there is little difference between the two models, although the PEO model is more descriptive of the relationship between components than the Canadian Model. The PEO model uses a transactional approach, assuming an interaction between person and his or her environment (Law et al., 1996). "In this approach, it is acknowledged that behaviour is influenced and cannot be separated from contextual influences, temporal factors, and physical and psychological characteristics" (Law et al., 1996, p. 10).

The PEO model is conceptualised as the dynamic interaction among the person, his or her environments, and occupation as developed over time. The three components: person, environment, and occupation, are represented by three inter-related circles transacting over the life span. The overlap in the centre of the three elements depicts occupational performance (Law et al., 1996; Strong et al., 1999). Occupational performance is described as "the product of a dynamic, interwoven relationship that exists among people, their occupations and roles, and the environments in which they live, work, and play" (Law et al., 1997). The definition of person, environment, and occupation are as follows. The 'person' refers to an individual client, a group of clients or an organization, who assumes various roles simultaneously. The 'environment' is conceptualised broadly as cultural, socio-economic, institutional, physical, and social factors affecting occupational performance and derived from the unique perspective of the person, household, neighbourhood, or community. 'Occupations' are defined as clusters of activities and tasks in which people engage over a lifespan in order to meet intrinsic needs for self-maintenance, expression, and fulfilment while they are carrying out various roles in

multiple environments (Law et al., 1997; Strong et al., 1999). A person's level of satisfaction and functioning is "the outcome of the fit between the person-environment-occupation transaction". That is, the more the three circles overlap, the greater the degree of harmony or fit (Strong et al., 1999, p. 124), therefore maximising occupational performance (Law et al., 1996).

2.2.5   Sources for Developing the Occupational Therapy Model

Holism underlines the concept that active participation in occupation, such as daily living tasks, work, and play can contribute to recovery from illness, normalise inappropriate behaviour, and assist adjustment to disability (Bockoven, 1972; Kielhofner, 1997b). Historically, occupational therapy focused on meaningful and purposeful occupation for individuals and on the therapeutic processes. Occupation can be graded according to the individuals' capacity, and facilitate interaction of the body, mind, and environment in order to maintain normal function and well being. Therapeutic media used in early occupational therapy such as crafts, games, sports, recreation and work contributed to the individual's mind, body, and spirit, and underlined the importance of occupation in human life and health (Kielhofner, 1997b). The importance of occupation for normal function and healthy life patterns of the individual is emphasised in the current models such as the Model of Human Occupation, the Canadian Model of Occupational Performance, and The Person-Environment-Occupation Model.

Due to the influence of scientific and biomedical perspectives, the concepts of mechanism or reductionism urged occupational therapists to understand the inner mechanisms of function and dysfunction in term of underlying neurological, anatomical, and the intrapsychic dynamics. In other words, it is asserted that human performance is best described through the basic concepts of physiology, anatomy, and psychology. The understanding of the mechanisms underlying function and dysfunction are used to develop models or techniques of treatment in occupational therapy practice (Kielhofner, 1997b). To restore functional performance, activity, orthotic devices, and adaptive equipment, tasks, compensatory techniques, and modified environments are all used in treatment. The mechanistic or reductionistic perspective is reflected by models or techniques used in OT practice, such as kinesiological models, neurodevelopment techniques, ADL or skills training, psychodynamic approaches, work simplication, sensory integration, and cognitive-

perceptual models (Baum & Christiansen, 1997; Kielhofner, 1997b; Semrad, 1956; West & McNary, 1956). According to these models, understanding the components of the dysfunction is necessary to treat the specific dysfunctions of patients. Therefore, the components of performance are the domain of concern of mechanistic or reductionist approaches (Punwar, 1994a), which is termed the Medical Model. The components of performance are always included in OT models such as MOHO, CMOP, and PEO.

From a Medical Model perspective, occupational therapists give little attention to the participation of clients in meaningful occupation. Instead they mainly focus on the impact of occupation on performance components. 'Goal-directed' activity is used instead of 'meaningful' activity, without necessarily considering the personal or cultural relevance of the activity. An appreciation of the nature and role of occupation in the whole of human life, and the active participation of clients in occupation is omitted, which leads to the loss of identity of OT as a profession. The Medical Model cannot explain all of the potential of occupation with an effect on patients (Kielhofner, 1997b). Nor can't respond to many of the problems and needs of people with disabilities who are discharged into the community (Hagedorn, 2000; Kielhofner, 1997b). Therefore, to treat disability as it affects the patient's daily life, therapists must broaden the scope of clinical problems and address many real life issues. These focus on the quality in living, which may bring them into conflict with the values of the biomedical approach (Fleming & Mattingly, 1994).

Furthermore, there is support from professional leaders to develop an identity for occupational therapy that responds to the health care system by broadening the focus to include health promotion and prevention (Diasio, 1971; Schwartz, 1998; West, 1968). Service delivery of occupational therapy thus extends from the acute care setting into community based services and also from directive to client-centred approaches for caring (Hagedorn, 2000). Although the situation is changing rapidly, still a number of occupational therapists work in hospitals where their roles still focus on preparing people to function when they return to their expected environment (Fleming, 1994). Therapists use functional assessments to gather information that also includes patients' experience of disability. The clients' perspective is not normally included in biomedical assessment and treatment (Fleming & Mattingly, 1994). In reflecting this approach, occupational therapy has

changed to again reinforce the use of occupation, with in a holistic model, and to focus on occupation as both a therapeutic medium and aim of treatment (Kielhofner, 1997b).

To respond to this, current OT models include an emphasis on performance components underlying an occupation, meaningful and purposeful occupation, and a holistic model in order to achieve occupation or occupational performance of the individual. This includes in the Model of Human Occupation, the Canadian Model of Occupational Performance, and The Person-Environment-Occupation Model. However, each model focuses on those combined concepts to different degrees. The combined perspective from reductionism, humanism, and occupation reflected in current OT models implies that occupational therapy has tried to solve the conflict between the reductionistic and holistic approaches and focused on occupation, together with its related factors, in order to meet the occupational need of human beings. Figure 2.1 summarises this perspective.
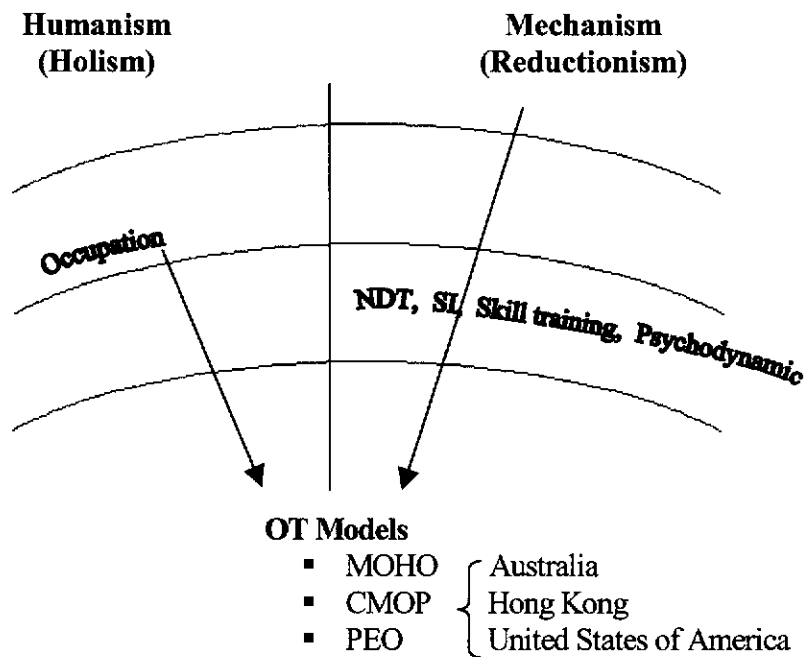
Figure 2.1 Model of synthesis of occupational therapy perspectives

2.2.6   Summary

Theoretical models guiding occupational therapy practice have been developed from three categories of values and beliefs: humanism, reductionism, and occupation. Humanism views the human being as a whole person. A whole person approach is applied when focusing on quality of life and all domain of spiritual concern affecting human. The influence of a reductionist approach on occupational therapy models of practice is reflected in the inclusion of performance components. The concept of occupation reflects the role of occupation and its relationship in maintaining health.

2.3   Culture and Cultural Implications for Occupational Therapy Practice

This section presents an overview of culture in relation to Western and Eastern societies, specifically Australia and Thailand, with a focus on health and illness. These perspectives are discussed to identify and assess a variety of influences on occupational therapy practice.

Culture is defined as shared meanings of ideas, concepts, knowledge, beliefs, values, norms, and symbols, passed from generation to generation within a society, through which members of a culture interact and communicate with each other (Dyck, 1998; Loveland, 1999). The learned, shared beliefs, values, attitudes, and

behaviours reflect the culture of a society or population (Fitzgerald et al., 1997). Some observers have asserted that the orientation embedded in the culture of Western societies such as Australia, and Eastern societies such as Thailand, are individualism and collectivism respectively (Hofstede, 1980, 1983; Triandis, 1995). Notwithstanding, their views, aspects of both individualism and collectivism can be found in both Western and Eastern countries, but vary to different degrees (Triandis, 1995).

2.3.1 Individualism Versus Collectivism

The dichotomous values of individualism and collectivism have an impact on health. Individualism embraces liberalism, freedom, equality, equity, voluntary participation, hedonism, competition, utilitarian pursuits, and open communication with the community, self-reliance, self-improvement, loneliness, and independence and separation from family according to Triandis (1995). In individualistic societies, the relationships between individuals are loose and the individual is expected to look after oneself and one's nuclear, immediate family. The individual is the 'smallest unit', whereas in collectivist societies the family is conceived as the smallest unit (Hofstede, 2001).

Collectivism embraces security, good social relationships, group harmony, interdependence, family integrity, and personalised relationships, social order, respect for tradition, honouring parents and elders, and politeness. Among other activities, collectivist is achieved through good deeds to assist the sick, the poor, relatives, teachers, and friends (Triandis, 1995). In collectivist cultures, children learn that their lives are involved with the lives of others, creating emotional dependency, interest in, and concern for the effects of decisions on others (Hui, 1984; Triandis, 1995). In contrast, individualism focuses on self-sufficiency, freedom, independence, having concerns for oneself and loved ones (e.g. nuclear family), as well as making independent decisions (Hui, 1984; Triandis, 1995).

In collectivist societies, people live closely together with family members including extended family members such as grandparents, uncles, aunts, and cousins, and sometimes also expand the relationship to include neighbours, co-villagers, and servants (Hofstede, 2001). In a collectivist culture, it is assumed that family resources, such as income, will be shared among family members, while in individualist families, parents are proud if their children can earn money to spend on

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what they want; privacy is also valued (Hofstede, 2001). The Far Eastern Economic Review surveyed business-persons in nine Southeast Asian countries, plus Australia, about living with parents and found that 6 percent of Australian respondents lived with their parents, whereas 47 percent of Thai respondents lived with their parents. In addition, 13 percent of Australian respondents reported their parents would prefer to live with them in the future, whilst this was reported by 57 percent of Thai respondents (Anonymous, 1996). It was reported that Australia has a level of individualism greater than Thailand, and the corollary is a level of collectivism less than Thailand (Hofstede, 1991). Thai people depend highly upon each other and find their security in dependence and support from other (Wichiarajote, 1975).

2.3.2   Culture and Health in Western Societies

Western societies value competence, independence, productivity, and mastery (Krefting & Krefting, 1991). Health care and rehabilitation has been influenced by these individualistic values (Leavitt, 1999). This means people aspire to look after themselves, and that their competence is the result of individual ability and personal effort (Triandis, 1995).

Since Western society values the virtues of independence and self–reliance (Baum & Christiansen, 1997; Christiansen, 1991), one goal of rehabilitation is to increase the patient's independence (Baum & Christiansen, 1997). Functional independence has long been a core concept of occupational therapy theories and a goal of the occupational therapy process, which requires that patients achieve competence and autonomy (Rogers, 1982a). Independence includes "initiative, self-reliance, and commitment to goals" by a motivated individual, a concept reportedly valued by occupational therapists (Hasselkus, 1997, p. 376), and has been reported as a step leading to an increase in human dignity and quality of life (Sabonis-Chafee, 1989; Sabonis-Chafee & Hussey, 1998).

In Western societies, mass media creates an image of a healthy population that values and rewards outward appearance of beauty and strength. Therefore, people with physical disabilities, whose conditions are visible, may see themselves as unwanted or rejected (Bates & Linder-Pelz, 1990). Chronic illness and disability; however, reminds healthy people that they too are vulnerable. It has been argued that people avoid what they fear, by putting people into institutions such as hospitals,

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hostels, nursing homes, retirement villages and sheltered workshops (Bates & Linder-Pelz, 1990).

Marini (1994) has found that the public's attitude toward people with disabilities is one of both admiration and pity, and views them as homogeneous group, perceived as different from those without disabilities. Furthermore, in the Medical Model view, persons with disabilities are sick, and therefore incapable of making independent decisions and playing an active social role. This is in contrast to the high value Western culture places on an individual who is productive, achievement oriented, and capable of risk taking (Young, Alfred, Rintala, Hart, & Fuhrer, 1994). Thus, in Western culture, persons with disabilities who live with their families and/or obtain a disability pension, are not typically perceived as successful (Marini, 1994). The elderly adult also perceives that maintaining independence is the ultimate personal contest, and loss of independence and autonomy is the beginning of the end (Watkins, 1998).

Rehabilitation programs aim to decrease impairment and increase functional capacity of people with disabilities, helping them manage continuing/chronic disability on their own (Bates & Linder-Pelz, 1990). Health professionals become consultants to those with disabilities, who make the major decisions themselves and often take an active role in their own treatment (Bates & Linder-Pelz, 1990).

2.3.3   Culture and Health in Thai Culture

Cultural themes of Thai behaviour include personal values that emphasise fun and merit accumulation. There is also an emphasis on personalism, which emphasises survival of self, by dependency on others for the same survival purpose. Fun-loving values include self-gratification of wishes such as taking/consuming time, eating and drinking excessively, detestation of hard work, and abundance in material generosity. Merit accumulation values include belief in one's karma and predestined fate (Smuckarn, 1980).

The core religion in Thailand is Buddhism, with 94 percent of the population in Buddhist (Anonymous, 2002). Thai society upholds the culture of mutual dependence or support, despite an expansion of ideas from foreign cultures (Thailand Junior Encyclopedia Project, 2002). The influence of Buddhism is still embedded

within the psyche of Thai people, although globalisation is impacting on Thai life style.

To describe more fully the values that underlie perspectives of health and illness in Thailand, a brief explanation of Buddhist views and related aspects of karma and earning of merit is needed. Buddhism focuses on the interdependence and inter-existence of all (Miles, 1999). That is no one can exist inherently alone, but needs to depend upon the existence of others (Chitsomboon, 2001). In other words, everyone is co-dependent, or inter-dependent with others. Buddhism teaches that life is filled with suffering from birth, disease, aging, and death, and only enlightenment can bring an end of these (Buddhadasa, 1989; Haglund, 1994). Buddhists can achieve enlightenment by three practical steps: morality, concentration (meditation), and insight (Buddhadasa, 1989). These teachings strongly influence the life and culture of Thai people. Haglund (1994) stated that, "by knowing that life is suffering, a Buddhist has an ability to accept suffering and misfortunes in a way that I believe few Westerners have" (p. 5). Desire is assumed to be at the origin of suffering.

Karma is the action or the law of cause and effect, that is, the results of one's actions cause one's own suffering or happiness (Keawkungwal, 1989). There are three kinds of karma: good or positive karma, evil or negative karma, and neutral karma. The three kinds of karma can be explained by examination of recovery from a disease and cooperation in treatment process.

Evil karma: people expect to recover from their diseases, but they do not totally cooperate in the treatment process. Therefore, they will suffer with the result that treatment fails because they have high expectations, but have chosen to not fully cooperate in recovering process.

Good karma: people expect that their diseases may be cured and that they fully cooperate in the treatment process, and therefore, the result of treatment tends to be successful. However, they may be disappointed as the outcomes may not be completely effective, because they still hold expectations of full recovery, but the degree of disappointment is not as great as that of the person performing the evil karma.

The evil karma brings a negative result; the good karma brings a positive result; however, the neutral karma brings about either positive nor negative results (Payutto, 1993).

Neutral karma: people do not necessarily expect to recover from their diseases, based on an understanding of the law of nature; some chronic diseases and ageing processes are inevitable. Due to this insight, the individual will fully cooperate in the treatment process but maintain peaceful mind. Therefore, they will not suffer nor be delighted in response to the failure or success of the treatment (Phra Rajsuddhinanamongkol, 2000). The core concept of Buddhism is in avoiding evil karma or evil deeds, performing good karma or good deeds, and purifying the mind (Chitsomboon, 2001). Following the Buddha's teachings and the laws of Karma is believed to create change. In line with Buddhist beliefs, in order to achieve a better life in this lifetime or future ones, a Thai needs to create good karma or perform as many good deeds as they can to earn merit (Haglund, 1994). Buddhism, therefore, influences Thai people to value interdependence in relationships, and influences their beliefs about karma and the need to earn merit in this life.

2.3.3.1 Interdependence, karma and earning merit in Thai culture

Thais believe that caring for sick members or older parents is a normal part of interdependent family relationships; they perceive it as a way to repay the goodness of their elders. This also earns merit according to Buddhist beliefs (Hatthakit, 1999). Helping the sick is valued as a good deed or a moral obligation (Triandis, 1995). Historically, in Asian nations or Eastern culture, children hold responsibilities and a strong obligation to care for and protect their elders. Caring for older parents is the way children show their respect, and dependency is expected whether or not the parents can look after themselves. Therefore, independence in later years is not necessarily valued by Asian people (Yeo, 1997). Likewise, in Thai culture, caring for parents in their old age is a primary responsibility of adult children. The elderly parents contribute their acquired wisdom to their children and grandchildren; thereby they have an accepted and honoured place in the household. The interdependent relationship between the elderly and other family members strengthens love and bonds within the family, an important foundation of caring for the elderly people who generally live in the same house (Chaoum, 1994; Trakulsithichoke, 1991). Apart from this, Buddhist teachings are the root of the Thais virtue known as namchai,

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"water of the heart", which encompasses "spontaneous warmth and compassion that allows families to make anonymous sacrifices for friends and to extend hospitality to strangers", which is a typical virtue in Thai villagers (Anonymous, 2001, p. 2). This virtue influences Thai people to help others, especially the sick, troubled, and disadvantaged.

Buddhism supports common expressions, such as mai pen rai (or "never mind, it doesn't matter") when unfortunate events happen. Thais will thus accept the effect of external forces which are beyond their control, such as the effects of past karma (Anonymous, 2001; Pongsapich, 1994). In other words, when something unexpected or uncontrollable happens, Thais interpret this as a consequence of accumulated karma (Hatthakit, 1999). Thus, Thai attitudes derived from the Buddhism emphasise the individual's working for his or her own karma, but also emphasise this must be accomplished through collectivist morality (for example, caring for the others) (Komin, 1990). Karma can also justify the status quo in Thai society in that power and wealth are thought to represent the rewards of former goodness (Redmond, 1999).

Thais believe that merit earning is all about long-term investments, not short-term profits, and "a matter of far-sighted sacrifices, deposits in bonds collectible after death, and insurance policies with no payment guaranteed in this world" (Redmond, 1999, p. 106). Compassion becomes a valuable state of mind to have, which contributes toward merit. Helping unfortunate persons now is equivalent to saving for the future. Based on these beliefs, Thais expect the individual doctor and health worker to have a character of compassion (Redmond, 1999).

2.3.3.2 Belief in illness, disabilities and rehabilitation

Thais' view about health and illness are currently derived from a largely un-analysed mix of Western medicine (national wisdom) and local wisdom from local cultural beliefs especially about karma and fate (Jungsatiansub, 1990). In general, it can be argued that Buddhism is still the fundamental basis from which Thais view health and illness.

According to Ratanakul and Than (1996), the Buddhist concepts of health and disease are formulated from claims that there is an interdependence of all phenomena, and a relationship between cause and effect. In health and disease, there

is a focus on interdependence of the body and mind, the relationship between health and the environment, and in nature and human deeds or karma. Buddhists view health holistically. The person is considered both physically and mentally in relation to social, familial, work, economic, and cultural environments where they live and which act on them. Good health is the harmony within oneself in those environments. In other words, good health means a state of balance among body, mind, spirit, and environment. On the other hand, illness refers to the state of imbalance among these elements. Hence, in Thais' view, healing is not only the treatment of physical symptoms, but a means to create harmony within the patients, in their relationship with others, and with the natural environment.

The individual has responsibility for his or her health and illness, because performing good deeds leads to good health, while performing bad deeds brings illness. Past deeds, present deeds, and environment are interwoven to generate health and illness. That is, the interrelationship among biological factors, environmental factors, and life style of the individual creates the causal matrix generating health and illness. The present karma is not totally the result of past karma, because the conditions or effects can be changed or dissolved by current deeds to some degree. Therefore, in Thailand, health also depends on an individual's current life style (i.e., the way one thinks, feels, and lives). A life style involving bad deeds or karma leads to illness, which can also be the effect of bad karma in a previous life. For practical purposes, in Thailand, even if the disease is the result of bad karma, it should be treated and undertaking good deeds will lessen the effects of the past bad karma. For a person with a terminal illness, the concept that illness is the legacy of past karma avoids blame in a person's present life, and enables one to accept the current situation. Therefore, the individuals' efforts and attitudes towards illness enable them to cope with the painful fact of life, without an unproductive struggle or negative mental states until the last day of their life. In other words, Buddhists believe the effort of the persons with terminal or chronic diseases to endure the suffering with a peaceful mind is itself good karma (Ratanakul & Than, 1996).

According to "three universal characteristics" in Buddhism, all things are characterised by impermanence, unsatisfactoriness (suffering), and non-selfhood. In other words, nothing and no condition is worth clinging to (Buddhadasa, 1989). To apply this Buddhist concept to the views on the nature of health and illness, Thais

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might perceive illness and disabilities as part of natural change like the aging process. Therefore, many Thais accept illness and disabilities with calm mind, and enabling them to live peacefully until the end of their life.

People with disabilities are seen as unfortunate and to be pitied, as disadvantaged people who need support. This attitude is compatible with the belief of bad karma, which views the individual as being responsible for the current situation based on previous lives. Based on this belief, some parents with children with disabilities feel ashamed and choose to keep these children away from the public and health care services (Phongphaew, 1992).

In Thailand, the public hold the view that people with disabilities or who have abnormal physical appearance are not able to work for a living. Conversely, if people with disabilities can work for a living, they are not viewed as the disabled. People with disabilities who are completely dependent in Activities of daily living (ADL) functioning, will be assisted by their family members in self-care activities (Wiboolpolprasert, Pradapmuk, Riewpaiboon, Rujakom, & Pengpaiboon, 1996). Those with mental health problems who manifest violent and poor behaviour receive no attention from the community. Thais believe the cause of disabilities could be the results of bad karma in previous life which are unknown and uncontrollable. Simultaneously, according to scientific reasoning, they believe the causes of disabilities derive from malnutrition, lack of vaccinations, abortion, and accidents. Therefore, the root causes of disabilities could derive from bad karma in previous life, while their interaction with the environment could be explained by scientific reasons. When disabilities persist, the overall perception of ordinary Thai people is that they cannot be solved or made better, because this issue is beyond human ability (Wiboolpolprasert et al., 1996).

Generally, though, physicians tend to direct and treat clients based on biomedical principles, rather than taking into account an individual's beliefs about health and illness. Thai patients and their families tend to integrate many concepts together about illness and health (Jungsatiansub, 1990), combining beliefs that embrace medical, religious, and cultural concepts.

2.3.3.3 Problems and needs of people with disabilities and their families

Approximately 80 percent of people with disabilities in Thailand live in rural areas (Phongphaew, 1992), where rehabilitation programs are unavailable. In addition, if they are poor or lack education, it is even more difficult to receive rehabilitation (Phongphaew, 1992). Currently, Thai society is moving towards industrialisation, and families are becoming smaller and more likely to be a nuclear composition. Economic conditions are entering people into the formal workforce, with the result that people with disabilities tend to have nobody to look after them at home. A family with a disabled member has the burden of caring for the disabled member, which affects the income of the family. The current challenge for people with disabilities is how to be part of daily life, possible making a financial contribution. For instance, how can they obtain education or training and careers suitable to their potential, instead of being a burden to their families? How can they participate in society? And how can they access public infrastructures and facilities? (Phongphaew, 1992).

People in Thai society, both ordinary people and officials of the government and private sectors generally have an attitude of giving, rather than helping people with disabilities to help themselves. For example, giving money or material goods, rather than skills or support for independent living. This attitude prevents persons with disabilities from developing their potential to help themselves. Moreover, people with disabilities have no opportunity to demonstrate their abilities in society. In addition, most people have negative attitudes toward employing disabled persons, because they are confused and uncertain about their abilities (Tawintarapakti, 1997).

Whilst the studies discussed above centre primarily on people with disabilities remaining interdependent, newer studies indicate a shift forward Western thinking. A study about independent living for spinal cord injury patients at Maharashnakorn-Chiang Mai hospital, Thailand found that 56 percent of patients interviewed expected to help themselves as much as possible, and 12 percent expected not to be a burden to others (Sitthigan, Intawong, Janwong, & Khowinta, 2000). Additionally, Samuktiya (2000) surveyed the expectations of relatives of people hospitalised with chronic schizophrenia, for those, and found that they expected these patients to go back to work in their community.

An ethnographic study by Hattakit (1999) on family-oriented self-care for stroke patients in Thailand, identified four factors affecting care for persons with chronic illness or disabilities: socio-environmental pressures, care workload, perception of care-receiving, and care-giving. These are described below:

Socio-environmental pressures: Thailand's socio-political structure and resulting health policy has not identified rehabilitative and geriatric services as a priority. Social-welfare for the elderly people, such as nursing homes, mainly focus on the poor who do not have adequate support at home. Hence, people view nursing homes as charitable institutions, rather than as a health service for the frail elderly. In addition, it is difficult for many patients to access existing hospital services, due to the perceived barriers created by poor communication and reluctant personnel, and through the overall lack of formal health services, especially in rural areas.

Care workload: caring for a person with chronic illness, who requires a significant amount of physical assistance, creates significant tension in the family. In addition, the attachment to the 'sick role' by both the individual and family caregivers, together with inadequate health support increases the care workload. For example, care after discharge from the hospital almost completely relies on the family, their social network and informal resources in the community. These factors affect the well being of both the sick person and other family members.

Perception of care receiving: the sick elders expect to receive support and be cared for their children as a part of family obligation. The expectation of receiving care can prevent elders from improving their potential abilities to look after themselves. Nevertheless, elderly people who are more self-reliant attempt to help themselves as much as possible, especially in Activities of daily living (ADL). They feel useless, frustrated, and uncomfortable in asking for help if they cannot perform ADL independently. However, if the tasks they have to perform are too difficult, or beyond their existing capability, they still expect assistance from family members.

Perception of care giving: caring for parents in their old age or when they are sick is considered a family obligation. In Thai culture, contributing to caring for the sick family members is grounded in Thais' belief in reciprocity and merit gained through care giving.

Reciprocity (Tob-Taan-Bunkhun) is achieved when one person benefits from the admirable actions of another such as love and care from a mother, or knowledge and wisdom from a teacher, repays those persons through appropriate action. A moral obligation is imposed on people to perform reciprocity through being grateful, showing recognition, and giving gifts and moral support. The unconditional support from parents for their children invites the children to provide help and care to their parents when they become old, ill, or dependent (Hatthakit, 1999).

Whilst these findings are embedded in Thai and Buddhist culture, there are some suggestions of variation in perception. For example, some individuals who are able to do so choose to remain self-reliant. And, despite their belief in service to others, tensions arise in some families who need care for disabled or ill members.

The Thai Government views people with disabilities as underprivileged persons who need support, and provides support and welfare to this group. In addition, people with disabilities are viewed by the public as suffering persons who need assistance and support. Thai people pity those with disabilities and would like to help them; however, these attitudes have the potential to obstruct development of competence of these people in the rehabilitation process (Wiboolpolprasert et al., 1996).

2.3.4 Cultural Implications in Occupational Therapy Practice

Cultural factors can influence a client's perception of illness, disability and therapy, and also influence the manner in which people learn to cope with difficult situations such as illness and disability. People favour treatments that match their view (Krefting & Krefting, 1991). In occupational therapy practice, a number of cultural factors have been postulated that can affect treatment outcomes. To achieve successful outcomes, the following cultural aspects appear to be useful for therapists in the occupational therapy process. They must access the cultural background of clients, in order to plan culturally appropriate intervention (Krefting & Krefting, 1991). They should plan treatment that meets the clients' goals, values, and interest as well as the goals of the occupational therapy program (Levine, 1987). Occupation assigned to clients should meet the clients' life roles and the meaning of their life (Levine, 1987). Therefore, self-care, work, and leisure should be assessed according to each client's perspective (Krefting & Krefting, 1991).

Krefting and Krefting (1991) proposed a list of important cultural factors that the therapists should consider in the occupational therapy assessment, such as "balance of work and play, role (s) assumed in the family, knowledge of disability and sources of information, beliefs about causality, sources of social support, amount and level of assistance from others they will accept, degree of importance attributed to independence/autonomy, sense of control over things that happen to them and typical or preferred coping strategies" (Krefting & Krefting, 1991, p.107).

Fitzgerald, O'Byne and Clemson (1997) proposed seven important categories of cultural issues in occupational therapy practice based on interviews with 86 therapists in Australia, including: 1) professional values, 2) family roles and responsibilities, 3) communication, 4) social behaviours, 5) gender, 6) sick role, and 7) explanatory models based on health and illness belief systems that influence client behaviour. Additionally, a survey of therapists in Australia who service clients from non-English speaking backgrounds (NESB) found that the majority of occupational therapists experienced obstacles to cross-cultural care within occupational therapy practice. The frequency of occurrence of different issues that arose in working with NESB clients was ranked as: cultural differences regarding the importance of achieving independence, communication barriers, lack of client commitment to home health programs, cultural differences regarding the value of purposeful activity, cultural limitations of standardised assessment instruments, difficulties building rapport, and difficulties assessing client living skills due to differences in customs and privacy standards (Phipps, 1995).

In Western societies, individual autonomy and independence are generally given more importance than interdependence (Phipps, 1995). Although there has not been a conscious decision on the part of model builders and theorists from Western societies to focus on independence, the unspoken value of individualism is inherent in concepts of independence and 'doing-it-yourself', concepts which are in turn embedded in occupational therapy models (Dyck, 1991; Kinebanian & Stomph, 1992). When individual clients are the focus of therapy, a major aim of occupational therapy is for the individual to make decisions regarding engagement in meaningful and purposeful activities. Most occupational therapy models, however, do acknowledge the client may not always be an individual. For example, there is much debate about who is the 'client' in a family with a child with a disability, or when

working with a patient with dementia and his or her caregivers. Additionally, most models recognise the importance of culture for both the individual and the community in which they live, with the belief that accommodation of different viewpoints is required.

Western society tends to value independence and self-reliance (Baum & Christiansen, 1997; Christiansen, 1991), and therefore the goal of rehabilitation is to increase the patient's independence (Baum & Christiansen, 1997). As one participant in the rehabilitation team, the occupational therapist has inculcated these values (Christiansen, 1991). In 1993, the Representative Assembly of The American Occupational Therapy Association endorsed seven core values, including altruism, equality, freedom, justice, dignity, truth, and prudence (American Occupational Therapy Association, 1993a). The concept of freedom was defined as the individual's ability to "exercise choice and to demonstrate independence, initiative, and self-direction" (American Occupational Therapy Association, 1993a, p. 1085).

Many scholars define independence for people with disabilities in term of self-determination, self-direction, and the experience of the efficacy of controlling their lives (Campbell, 1994, p. 89; DeJong, 1978; Mocellin, 1992). Independence requires competence, and autonomy in physical, social and temporal environments that facilitate independence (Rogers, 1982b). Competence involves effectiveness in interacting with the environment, and adaptability in organizing skills to respond to or master environmental demands (White, 1959). In occupational therapy, competence in self-care, work, and play activities is usually the focus of therapy (Crabtree, 2000; Rogers, 1982a). For example, self-care independence is often considered fundamental to daily survival (Rogers, 1982b). Autonomy brings self-confidence in regulating one's daily life, and is reflected in the ability to make choices compatible with one's needs, capabilities and, desires, and by resistance to control by the external forces of the environment (Rogers, 1982b).

Autonomy differs from independence. Independence is usually considered to include the physical ability to engage in activities (Crabtree, 2000; Jackson, 1996; Turnbull & Turnbull, 1985), whereas autonomy is more related to having the capacity to make decisions and choices, even if physically unable to undertake specific activities (Crabtree, 2000; Stephens & Yoshida, 1999). Occupational therapy is based on the belief that "the autonomy of disabled persons is determined by what

they want to do rather than what we think is in their best interest" (Rogers, 1982b, p. 710). Functional independence in performance areas of the client's choice seems to be taking on increased importance among practitioners. However, they have not entirely investigated the meaning and assumptions underlying the concept, or how to apply it during therapy (American Occupational Therapy Association, 1994a, 1994b, 1995a, 1995b; Crabtree, 2000).

Nevertheless, for people with disabilities, issues of autonomy, independence, and dependence are complex and not mutually exclusive. For example, clients can choose to be independent in some occupational performances areas, but to be dependent in others (e.g. a stroke patient can choose what to wear, but choose to have a family member physically assist with dressing). Therefore, the underlying meaning and assumptions of functional independence in performance areas are fluid and not uniformly applied within occupational therapy theory and practice (Crabtree, 2000). It appears that functional independence includes aspects of personal autonomy and wholeness (sense of well-being), as well as meaning and purpose. However, "the value of independence to the individual varies, depending on their social and cultural contexts" (Dunn et al., 1995). For example, independence that is valued in Western societies might not be desirable with the same potency in others (Whiteford & Wilcock, 2000). Therefore, "occupational therapy practitioners value the right of individuals to choose their preferred level of independence relative to their life role activities and the context in which they are performed" (Dunn et al., 1995, p. 1014). Current trends in occupational therapy, while still recognising the importance of independence, are emphasising "activities that are personally meaningful and necessary and client-centred" (Baum & Baptiste, 2002, p. 7) and focused on "the occupational needs and competencies of the individual" (Hagedorn, 1995, p. 11). Occupational therapy thus is coming to focus on occupation/activities compatible to clients' needs and autonomy.

Meaningful and purposeful activities also vary from one culture to another, because culture influences the perspective of self-care, work or productivity, and leisure (Hasselkus, 1997; Krefting & Krefting, 1991). For example, leisure might be interpreted as laziness or incompetence in a culture where only productivity is valued (Krefting & Krefting, 1991). The value of doing productive activities in Western cultures might not be valued in the same way in non-Western cultures (Whiteford &

Wilcock, 2000). Facilitating clients in performing activities themselves is the core of occupational therapy as currently practiced. However, facilitating persons with sickness or a disability to engage in purposeful activity contradicts the methods many non-Western cultures rely on to treat sick and disabled persons.

In those cultures people who are ill may readily give up much of their autonomy and independence (Kinebanian & Stomph, 1992). Thus, the family plays an important role in dealing on appropriate therapeutic activities for the patient and dominant family members take on the role of problem solver (Kinebanian & Stomph, 1992; Trafford, 1996). Occupational therapists also tend to take a direct or an active role in changing clients' situations, rather than encouraging clients to take responsibility for problem solving as in Western cultures (Trafford, 1996). Any purposeful activity must, not only be meaningful to the client, but also to the family (Kinebanian & Stomph, 1992). This in contrast to Western cultures where clients tend to choose their own occupation. In addition, a client's direction and degree of involvement in self-care, work, and leisure activity may be different between Western and Eastern cultures. Therefore, discussion of occupation, independence, autonomy, and interdependence, particularly in relation to cross-cultural contexts, is of importance (Whiteford & Wilcock, 2000).

The emphasis on independence in Western cultures can be contrasted with the choice of dependency in non-Western cultures (Kinebanian & Stomph, 1992). In many non-Western societies, bonds within a family, honouring the family, and accepting family members' decisions are more important than independence (Kinebanian & Stomph, 1992). For example, maximising independent functions may be in conflict with the sick or passive roles of clients in Chinese culture, where practitioners and family tend to do everything for clients (Jang, 1995). A passive recipient of treatment, reliant on others during sickness and old age, and interdependence within family and community units, may be inconsistent with concepts of client participation, self-help, and independence that are currently dominant in occupational therapy (Dyck, 1991). Westerners emphasise freedom of choice, making ones' own decisions, and self-direction, whereas many non-Westerners emphasise being a part of the family, honouring family, and accepting family members' decision (Kinebanian & Stomph, 1992). These values affect

independence and activism in purposeful activity, which are strongly embedded in occupational therapy practice.

In summary, current occupational therapy models are primarily based on concepts of client independence, autonomy, choice and self-determination, although recognition of different cultural perspective is included in the models. At this time, the application of the models in non-Western settings, and the unperceived barriers they may be encountering, have been questioned by researchers but not examined in any depth. In fact, there is a paucity of research regarding the application within Asian cultures in particular. It is possible that the continuing for occupational therapy in cross-cultural settings needs some modification, with less emphasis on independence in daily living and activism in occupation. Including provision for interdependence and family participation within the models, as well as difference in purposeful and meaningful activities as required by the client and his or her family, may increase cultural 'portability'.

As noted, in Thailand there is no relevant research or literature on cultural issues in occupational therapy practice. However, propositions about culture and occupational therapy practice can be drawn from Fitzgerald et al. (1997); Krefting and Krefting (1991); Levine (1987) and Phipps (1995). From the above literature review, cultural implications for practice in Thai culture may be proposed as follows:

• The cultural background (beliefs, values, and interest) of clients influence assessment, treatment planning, and intervention; therefore, the belief and values of Thai clients regarding interdependence, karma, and earning merit will very likely affect the occupational therapy process.

• When considering clients in the Thai cultural context, the roles of those clients and their families, their sources and level of social support, the amount and level of assistance from others clients, the degree of importance attributed to independence and autonomy, and typical coping strategies adapted are likely to be different from those in a Western cultural context.

• Given Thai cultural influence on the meaning and purpose of occupation; self-care, work, leisure, and degrees of participation in each area of occupation, Thai clients might be expected to react quite different from Western clients.

• Activities that are personally meaningful and necessary for the individual in a client-centred Western setting might be incongruent with family involvement in decision making and caring for the client in a Thai cultural setting.

2.3.5 Overview of Cultural Influences on Occupational Therapy Practice

Due to cultural influences on the practice of occupational therapists, they are supposed to consider cultural factors in order to achieve effective treatment outcomes. However, there is limited technical guidance on how to do this, and few cultural-specific models for non-Western settings that aim at effective delivery of occupational therapy. Consequently, this study aims at identifying incompatibilities between the dominant model and current practice in Thailand, and suggests the outline of a cultural-specific model for service delivery.

2.4 A comparison of Health Care Systems

This section discusses the health care systems in Thailand and Australia in order to present an overview of the broader settings in which occupational therapists practice. Discussion also touches on aspects of welfare policy that have relevance to health care delivery. Health care systems influence not only occupational therapy services, but also the clients who receive them.

2.4.1 The Australian Health Care System

2.4.1.1 Health policy and services

Health care in Australia is the responsibility of two levels of government, the Commonwealth and the states and territories. The Commonwealth has a leadership role in policy making and in financing health matters. The State and Territories are largely responsible for the delivery and management of public health services and the regulation of health workers in the public and private sectors (Department of Health and Aged Care, 1999, 2000).

The Commonwealth Government plays the major role in financing health by allocating public funding to health care in many areas, including subsidies for medical services under Medicare, Pharmaceutical Benefits, and Public Health Outcome Funding Agreements that support to states and territories in undertaking particular public health activities.

Under current arrangements, it is state and territory governments that decide on responses to more local health issues, such as funds available to the public hospital system and arrangements under which they are paid, the number and location of hospitals and community health services, the range of services available at each hospital, and the public health priorities within the state or territory (Department of Health and Aged Care, 1999)

The general population has access to many health care services at no or minimal cost (at the point of delivery), and can be treated free of charge in a public hospital under a universal health care system known as Medicare (Department of Health and Aged Care, 1999; Swerissen & Duckett, 1997). Policy prescribes that clients' needs be placed at the centre of the planning, funding, and delivery of services, and cooperation among providers, the bureaucracy, and clients is promoted (Department of Health and Aged Care, 1999). Health care focuses on primary care and prevention, especially at home and in the community, which is the preference of most Australians. Hence, "the Commonwealth Government had strongly supported initiatives in health and aged care that keep older people, and people managing chronic conditions, in their own homes as long as possible" (Bloom, 2000, p. 121). Clients who require hospitalisation will be assisted to return home as soon as practically possible and appropriate (Bloom, 2000).

Health care in Australia is financed by public funding at around 67 percent of the total cost, and private health sector around 33 percent (Department of Health and Aged Care, 1999). The Commonwealth, states, and territories jointly fund public hospitals and community care for aged and disabled persons, and also jointly administer community care (Department of Health and Aged Care, 2000). To reduce or eliminate the financial burden of illness experienced by an individual, the Commonwealth Government provides universal access to public health services to all Australian through national health insurance –Medicare–, and choices of health services for individuals, through private health insurance (Department of Health and Aged Care, 2000; Palmer & Short, 2000).

Health services delivery is provided by both public and private sectors, although the "public hospitals provide most of the more complex types of hospital care such as intensive care, major surgery, organ transplants, renal dialysis and specialist outpatient clinics" (Department of Health and Aged Care, 2000, p. 3). In

the rural areas, secondary services are provided so that people who live there can generally access the services closer to home (Health Department of Western Australia, 2002c).

Health policy in Western Australia (WA) promotes opportunities for all individuals to maintain their full health potential and to seek choices about the type of health care services they want. The policy focuses on working with people in partnership, securing healthy alliances, care closer to home, and the best use of available resources (Health Department of Western Australia, 2002a). Health prevention and promotion and community cares are emphasised, and those at high risk in the population are targeted. Community care services provide assistance to the frail aged, people with disabilities, and those with chronic illness (Health Department of Western Australia, 2002b).

Public and private sectors jointly provide public health services, hospitals, nursing home services, and community health services. Public health services refer to the activities provided by government for the population as a whole (Bloom, 2000; Palmer & Short, 2000), and includes "environmental health measures, health education, health promotion and other disease-prevention activities, including immunisation programs" (Palmer & Short, 2000, p. 9).

There are many types of hospitals such as acute-care public hospitals, private hospitals, mental hospitals, geriatric and rehabilitation hospitals, and hospitals under the responsibility of the defence forces that "provide inpatient accommodation together with medical, nursing and other services" (Palmer & Short, 2000, p. 6). Nursing homes cater for long-stay, chronically ill patients who are mostly in the elderly age groups, but also include people who are mentally and developmentally disabled (Palmer & Short, 2000).

Community health services refer to services provided outside hospitals and nursing homes, which include both private and public health services. Community programs aim to shift the emphasis of health care from "treatment to the prevention of disease, to provide an alternative to traditional general medical practice in the delivery of primary health care, and to reduce the dependence of the community on institutions" (Palmer & Short, 2000, p. 121). The community health program focuses on screening, immunisation and child health services, care to groups with special needs, such as people on low incomes and women, health education to individual

clients, and community health promotion at the local level (Health Department of Western Australia, 2002b).

Health services and public policy provide disadvantaged groups such as people with disabilities and older people with equal access to health care. The aim of current policy is to encourage disadvantaged groups to participate in decision-making in the health care system, thus shifting the power within the health care system towards the disadvantaged sectors of the community (Palmer & Short, 2000).

Rehabilitation policy for people with disabilities provides not only for income support, but also aims to provide opportunities for restoration of health and normal activity (Remenyi, 1997). Rehabilitation is defined as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness" (Remenyi, 1997, p. 172). The aim of rehabilitation is to "maximise an individual's ability to function independently after injury or illness and often involves the dedicated support of family members and carers as well as a wide range of health care professionals in a variety of settings" (Health Department of Western Australia, 2002b, p. 86). For Australian workers, an occupational rehabilitation program is also provided (Remenyi, 1997).

Results from the Australian Bureau of Statistics (1999) Disability, Ageing and Carers survey showed that "3.6 million people, or one in five Australians, had a disability in 1998, and most of this group identified physical conditions as the main cause of their disability (85 percent)" (Palmer & Short, 2000, p. 293). The majority of those with a disability (87 percent) have some limitation in performing certain activities or tasks in self-care, mobility, communication, schooling, or employment. In addition, due to an increasing ageing population, the proportion of Australians with a disability has increased (Palmer & Short, 2000).

People with disabilities include physical, intellectual, and psychiatric disabilities, or severe multiple disabilities, as well as specific disabilities such as hearing disability, and visual impairment. The Commonwealth Government provides programs and service delivery for persons with disabilities through direct cash payments, including the invalid pension, a rehabilitation allowance, and mobility allowance, as well as direct services. In addition, organizations conducting services for people with disabilities are provided subsidies (Palmer & Short, 2000). People

with disabilities have the right to make their own decisions and have equal access to educational and employment opportunities (Palmer & Short, 2000).

The state governments provide education, health, family, and community services, housing and transport for people with a disability. In addition, non-government organizations also provide a wide range of services for people with disabilities, including special schools, sheltered employment, residential accommodation, home care services, vocational training, social, sporting and recreational facilities, information services, publicity, advocacy, lobbying and representation (Palmer & Short, 2000).

Apart from the above services, people with disabilities and their families and supporters, can represent and express their views through state branches of umbrella disability organizations such as Disabled People's International (Australian) and the Australian Council for Rehabilitation of Disabled, and the National Association of Intellectual Disability (Palmer & Short, 2000).

The International Year of the Older Person in 1999 attempted to alter the view that the elderly are a burden requiring excessive attention and resources, to a recognition of the aged as independent and resourceful members of society who can contribute to family and community (Palmer & Short, 2000). A survey of 286 community dwelling elderly adults in Western Australia that focused on health-related values and attitudes to health, ageing and exercise found that respondents prioritised independence, and emphasised that independence must be maintained, as the loss of independence implied the beginning of the end to those surveyed (Watkins, 1998).

New policies for elderly people have been introduced. Elderly Australians are encouraged to stay at home, with assistance from carers, rather than in residential care, except those who are highly dependent. Multidisciplinary aged care assessment (ACAT) teams have been established nationally (Australian Institute of Health and Welfare, 1998). Those with less intensive needs are catered for in hostel-style accommodation. However, a means-tested, user-pays policy for care of older persons in nursing homes and hostels operates, but remains controversial.

Further surveys confirm that older Australians want government support to remain independent and at home (Minister for Aged Care, 1999). The Community

care program for the aged is divided into two elements: Community Aged Care Packages provide residential care for frail older people who are dependent and need complex services (Minister for Aged Care, 1999); The Home and Community Care (HACC) program is the mainstay program for the frail aged and for people with disabilities, who want to live at home. This program includes home nursing, allied health services, personal care, meals on wheels, home care services, assessment services, aged day care services, sitting services, respite care, and transport for aged people and people with disabilities (Minister for Aged Care, 1999; Palmer & Short, 2000).

2.4.1.2 *Australia's welfare system*

Welfare services in Australia include children's and family services, child protection, housing assistance, crisis accommodation and support services, aged care services and disability services (Australian Institute of Health and Welfare, 2001). Disability services are person-centred and focus on the individual's needs in the community. These include the needs of families and carers, with the main goal to support people with disabilities to participate in a broad range of life activities (Australian Institute of Health and Welfare, 2001). The Disability Service Commission is "responsible for policy and program development and service planning in all areas that affect the rights and needs of Western Australians with disabilities" (Disability Service Commission, 2001, p. 1). People with disabilities and the aged can receive pensions or allowances, and carers of people with disabilities or the aged may receive financial help such as Carer Payment or Child Disability Allowance (Centrelink, 1998; Duckett, 2000). Even though these people receive pensions and allowances from the government, family and friends are the main providers of assistance and the main focus of their social lives (Australian Institute of Health and Welfare, 2001). Therefore, to some extent, informal care has been a replacement for formal caring arrangements (Duckett, 2000). For elderly people, services and government welfare covers income support, medical services, hospital services, pharmaceutical services, and aged care services.

Australians with work-related injuries and illness are covered by compulsory workers' compensation insurance, and Australians who are injured in motor vehicle accidents are covered by compulsory third party insurance. Other groups, such as the

armed forces and veterans are also covered by Medicare and additional special arrangements (Department of Health and Aged Care, 2000).

Approximately 11 percent of the population is covered by private health insurance, with added benefits such as "choice of doctor, choice of hospital and choice of timing of procedure" (Department of Health and Aged Care, 2000. p. 11). Ancillary insurance is also available to meet all or part of the cost of private sector services which are not covered by Medicare, such as dental, optical, and allied health services (Department of Health and Aged Care, 2000; Palmer & Short, 2000). Private health insurance is also regulated, to ensure availability to a wide range of people in the community, including the aged or the chronically ill, who pay the same rate for private health insurance as a healthy younger person (Department of Health and Aged Care, 1999, 2000).

2.4.2 The Thai Health Care System

2.4.2.1 Health policy and services

Relevant information on the current health care system in Thailand is drawn from data collected and documented in the 8 th national economic and social development plan (1997-2001), and from the outcomes proposed in the 9 th national economic and social development plan (2002-2006). Just as in Australia, plans are detailed and well documented. However, actually achieving plan goals is challenging. Under the health development plan, the ultimate goal 'Health for all', proposes that all Thai people attain a minimum health status according to basic standards accepted by Thai society. Strategies to gain and maintain basic health include: health promotion/prevention, personal responsibility for health, community involvement in resolving local health problems, and systematic program to support health services and primary health care programmes that relies on appropriate health care technologies. People are expected to play a self-care role for their own health, take care of family members, and cooperate with the government, especially district public health services (Ministry of Public Health, 1997b).

The underlying premise of health care policies is that the community has to take part in health activities in order to achieve minimum health standards for the individual, family, and community. The community's role in health activities has two aspects: 1) in receiving and understanding basic health care knowledge, 2) in

participating as a caregiver and a preventer of basic health problems (Ministry of Public Health, 1997a, 1997b). However, the Health Ministry (1997) claims that the people are not responding to opportunities to participate in health development programmes, particularly, in organising themselves in self-help groups.

In fact, most health programmes are organised and directed by government health professionals, and emphasise a disease response medical model, as opposed to addressing health promotion, prevention, and self-responsibility for health as mentioned in the health plan. This in turn creates a dependency on government welfare services (Ministry of Public Health, 1997b). Moreover, there is a lack of serious and ongoing public health campaigns and strategies, other than those run by government health professionals. Furthermore, the potential of community citizens or organizations to promote public health strategies is low, as they lack ongoing support about health care information and education, and relevant funding (Ministry of Public Health, 1997a). Additionally, a health development plan for people with disabilities and the elderly people is also important.

People can access services within the Thai health system at four levels: village, subdistrict, districts and provincial levels (Ministry of Public Health, 1992).

1) The village (muban) level is the first to provide primary health care (PHC). Care is made possible by villages under the supervision of civil servants in the village. People are encouraged to look after their own health and also their immediate family. Public health volunteers are trained in medical skills and are available to train villagers.

2) The subdistrict (tambon) level of health care supports the village level, and includes such government services as community public health offices, and health centres. At this level, primary medical care (1°MC) is undertaken by public health officials, who examine villagers, general health and treat diseases as appropriate.

3) The district (amphoe) level supports the subdistrict and village levels by community hospitals. By providing secondary medical care (2°MC) with nurses, general practitioners and specialists, the area is provided for.

4) The province level provides general or regional hospitals. Such hospitals have tertiary medical care (3°MC) from highly skilled specialists (Ministry of Public Health, 1997a).

Thailand's public health system and the principal roles of each service level

are shown in Figure 2.1

Public Health system of Thailand

	Province level		Regional hospitals / General hospitals	3 °MC
District level		Community hospitals	2° MC
Subdistrict level		Health centres	1°MC
Village level		Public health volunteers/senders	PHC

BHS → HFA
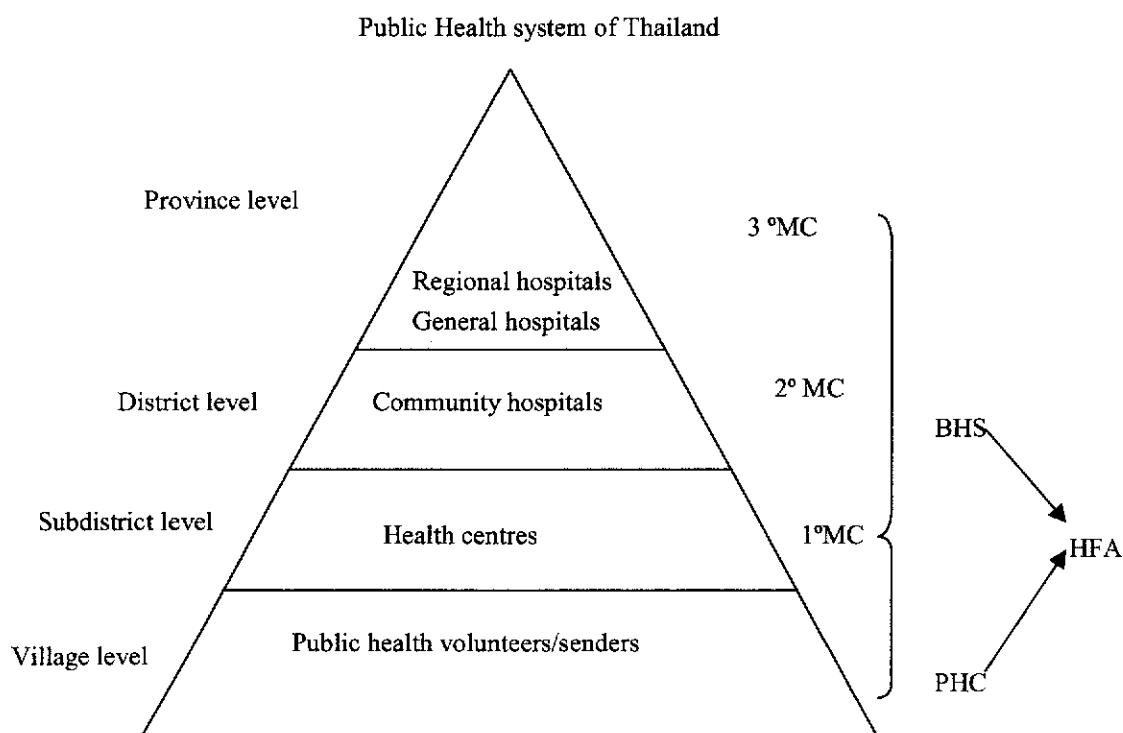
PHC = Primary health care, BHS = Basic health service, HFA = Health for all

Figure 2.2 The Projected Public Health System of Thailand (2000)

Source: Ministry of Public Health, (1992) p. 12

The Rehabilitation Act, promulgated by the Thai Government in 1994, addressed five types of disability: 1) hearing disability or communication disorder, 2) visual, 3) physical or movement, 4) psychiatric, 5) and mental disabilities (Ministry of Public Health, 1997a; Tawintarapakti, 1997). The definitions of disability, impairment, and handicap used in Thailand follow those of the World Health Organization (Wiboolpolprasert et al., 1996). However, this Act only applies to adults who become disabled during working age and who live in urban districts, rather than those disabled in childhood, or the elderly people who live in rural areas.

Rehabilitation aims to enhance the potential and competence of clients, so that they can have better living conditions, and work and live in society equally alongside normal people, using medical, educational, social and vocational training process

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(Tawintarapakti, 1997). People with disabilities have the right to receive medical rehabilitation free of charge, once classified as 'disabled' by a physician and registered with the Department of Public Welfare (Ministry of Public Health, 1997a).

Currently, the main causes of illness and mortality in Thailand are AIDS, accidents, and non-infectious diseases such as heart diseases, diabetes, hypertension, cancer, and diseases from pollution including these acquired in work settings. With economic and social development, and the advance of information technology, Thai society has given increased attention to people with disabilities and the elderly. More Thai people are acknowledging the importance of health and quality of life issues, as well as expecting better public health services. According to current population trends, the number of elderly is increasing; hence, chronic diseases, which need prolonged and complicated health services, are increasing (Ministry of Public Health, 1997a). In 2001, the most recent survey of national statistics recorded the incidence of disabilities as follows (National Statistics Institution, 2001):

Communication disorder	240,904
Visual disability	123,157
Physical and movement disability	512,989
Psychiatric disability	81,262
Mental disability	222,004

A study of medical rehabilitation services in 1995-1996 estimated that the percentage of the population with disabilities was 8.1 percent. Physical and movement disabilities were the major types identified (Wiboolpolprasert et al., 1996). The need for rehabilitation services increases in response to the increasing number of disabled and ageing people. Nevertheless, medical rehabilitation services remain very restricted, only 3 percent of the total health care budget in 1996 was allocated to medical rehabilitation, with about 80 percent of services aimed at preventing complications, rather than increasing functional ability (Wiboolpolprasert et al., 1996). In 1996, Sirindthorn National Medical Rehabilitation Centre surveyed rehabilitation services in 100 hospitals throughout Thailand. The results indicated that only three hospitals have separate medical rehabilitation units within the hospital, with a total of 227 beds allocated for medical rehabilitation. Apart from the restricted budget and insufficient in-patient units and beds for medical rehabilitation,

there are other factors affecting rehabilitation services (Wiboolpolprasert et al., 1996).

Factors affecting rehabilitation

Factors affecting rehabilitation include:

1) Rehabilitation of people with disabilities focuses on medical programs aimed at treatment, rather than fostering functional development for clients. This group is seen as disadvantaged and deserving of free treatment.

2) The laws relating to benefits for people with disabilities focus on monetary compensation for losing income and/or body parts or organs, rather than rehabilitation.

3) The main focus of rehabilitation is on physical and movement disabilities, not on developing the potential of those with disabilities.

4) Currently, there is a lack of clarity regarding roles, duties, and structure in providing rehabilitation services (Wiboolpolprasert et al., 1996). In community hospitals, medical rehabilitation is subsumed in health promotion services (Sribruchayanun, Saisypatpol, & Chantha, 1995). In addition, referral mechanisms for external sectors such as education, vocational training, and social rehabilitation are not systematic for people with disabilities.

5) Some groups of persons with disabilities are viewed as not even suitable for rehabilitation, and therefore it is the responsibility of the community and family to look after them. This attitude focuses on support, rather than rehabilitation, which obstructs undertaking rehabilitation programs.

6) Many persons with disabilities have no access to rehabilitation services especially the poor and disadvantaged, because they are isolated from facilities and lack information on how to access rehabilitation services.

7) Necessary resources for medical rehabilitation such as personnel, equipment, and rehabilitation units or wards are insufficient. Anecdotal evidence shows that in-patient wards do not have enough beds for rehabilitation of patients need after their disabilities are corrected. Since hospitals need to keep the limited available beds for acute treatment, patients with ongoing disabilities are often discharged early, and only a portion of them return to participate in rehabilitation

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programs, or continue rehabilitation programs at home. Rehabilitation programs are, therefore, not continuous, effective, and efficient in assisting clients in the transition from hospital to home (Wiboolpolprasert et al., 1996).

In summary, rehabilitation in Thailand focuses on improving movement and physical function of persons with disabilities, rather than developing the potential to return to living in the community. Referral to education, vocational services and social rehabilitation are not effective, and overall access to rehabilitation is not easily available due to lack of facilities and information. Even in medical rehabilitation which is the primary focus, necessary resources remain inadequate in relationship to demand and continuous rehabilitation program are generally ineffective and inefficient. Apart from this, the public emphasise support for patients, rather than enhancement of their potential to function effectively in society. Consequently, occupational therapists should consider steps needed to overcome these shortcomings of rehabilitation programs in providing occupational therapy for clients.

2.4.2.2 *Health insurance and social welfare*

Health insurance in Thailand can be divided into four types (Ministry of Public Health, 1990, 1997a):

1) Government employee scheme: this is a medical benefit for permanent government employees and state enterprise employees. Benefits also cover all expenses of government health services for the employee's parents, spouse, and up to three children under twenty years of age.

2) Public assistance: this is a medical benefit for disadvantaged groups throughout the country, and people who have the right to receive assistance include the poor, people over 60, primary school pupils (0-12 years), people with disabilities, monks, community leaders, volunteers, and veterans.

3) Compulsory health insurance: this includes three types: social security, labour compensation funds, and auto accident victim protection.

4) Voluntary health insurance: these optional health insurance schemes include private health insurance and the Ministry of Public Health Insurance Card Project. People who are not covered by any health benefits, or wish to ensure access to good private services, often choose to purchase health insurance. The percentage of people holding self-financed health insurance in 1998 was 15.9 percent, which includes 13.9

percent purchasing of Ministry of Public Health insurance, and 2 percent purchasing private health insurance (Ministry of Public Health, 2002). The Insurance Card Project is a voluntary program for people who are not eligible for other types of insurance. Cardholders are entitled to government health services in the provinces. Those with higher income pay annual fee. These with low income are given free insurance.

Despite these social welfare and insurance schemes, 30 percent of the population did not have any health insurance, or access to care until recently (Ministry of Public Health, 1997a). Due to these problems, the current (Thaksin) government established universal health insurance scheme that caps upto at 30 baht per hospital visit. The system was introduced on October 1, 2001. Therefore, a government provided universal health insurance, which caps medical cost is now in place for patients willing to use public facilities (Editors, 2001; Prime Minister Thaksin Shinawatra, 2001).

At least in theory, all Thai people are guaranteed access to a nationally acceptable standard of health care (Prime Minister Thaksin Shinawatra, 2001) with all citizen able to access core health services close to home. Health service policies aim to provide integrated care, holistic care, continuous care, and effective referrals, as well as community health care that deliver services to families at home when appropriate. Processes have been introduced to all health services to maintain quality of health care, quality assurance, and accreditation, (Editors, 2001).

Social welfare services provided to people with disabilities in Thailand include the following (Tawintarapakti, 1997):

1) Medical rehabilitation: Medical rehabilitation that is generally available at a basic level, includes services to enhance the potential of people with disabilities through medication, surgery, occupational therapy, speech and hearing therapy, behaviour therapy, the supply of orthosis and prosthesis or self-help aided devices, and social work services. People with disabilities have free access to government services at hospitals or institutions.

2) Educational rehabilitation: Educational rehabilitation is to be provided for school-aged children with disabilities in mainstream schools and special education schools. However, available programs lack sufficient publicity, and cooperation

among relevant sectors is inadequate, which affects access to education of children with disabilities.

3) Vocational rehabilitation: Vocational rehabilitation consists of vocational training, skill development (including employment of people with disabilities,) and a rehabilitation foundation for this group. However, the law is not effective. Most employers have a negative attitude towards employing people with disabilities, and are uncertain about their capacities to perform. The regulations of Social Welfare and Labour Ministry require that private sector firms with 200 or more employees are required to employ at least one disabled person per 200 employees. If the industry is unable to employ people with disabilities, the employer is required to make contributions to the rehabilitation foundation annually. Employers who employ disabled people can claim a tax rebate for themselves or for their company.

4) Social rehabilitation: Social rehabilitation provides support to people with disabilities, so that they can adjust to independent living, enhance their quality of life, be involved in social activities, and be effective citizens. Under Ministry of Labour and Social Welfare rules, there are criteria for providing facilities, infrastructure, and public services for people with disabilities to promote their independence, social participation, living in society, and safety at level equal to the other citizens. This service also promotes community-based rehabilitation aimed at participation of family, community, and the broader society in caring and rehabilitating people with disabilities. However, people with disabilities cannot easily access public facilities, such as toilets, and use public services, such as public transport. Moreover, people with disabilities are often overprotected by their family members and other people in public, and do not have an opportunity to show their competence. Furthermore, they do not know about their basic rights, or about social welfare services. Therefore, it is difficult to improve their potential to live independently in society.

5) Support for people with disabilities in welfare institutions: this is the final approach to help all types of disabled people to obtain the basic minimum needs for living which are medical, educational, vocational, and social rehabilitation, before returning to live in society. This service is aimed at supporting people with disabilities who are abandoned, homeless, have no support, and cannot live with their families.

Despite the introduction of the Rehabilitation for the Disabled Act (1991), which focuses on the areas outlined above, and encourages all levels of government and the private sector to participate in rehabilitation, cooperation amongst these sectors is reported to be poor. The result is that rehabilitation services do not adequately serve those who need them (Tawintarapakti, 1997).

Achievement under the 8th Plan for Public Health Development have apparently remedied some problems, indicated by an increase in average lifespan, a decrease in malnutrition in children, and a decrease in mortality rates of mothers and infants. Nevertheless, diseases caused by inappropriate behaviour or lifestyles are increasing. In addition, approximately 80 percent of health dollars are used for curative medical services; only 10 percent for disease control, health promotion and rehabilitation; and the remainder for investments such as consumer protection, research, and health personnel development. In responding to issues arising from the 8th plan, the 9th plan (2002-2006) focuses on development of universal health insurance, health promotion and prevention, and community involvement. This includes regular evaluation of health policies, development of good governance, enhancing participation and networking of all health sectors in planning processes, and development of primary public health services in both rural and urban areas (The Planning Committees, 2002).

2.4.3   Comparison of Health Care Systems in Western Australia and in Thailand

In Australia, current government policies emphasise health care in the community and health promotion and prevention, although the bulk of funding is still directed to those with long-term illnesses. People with disabilities have ready access to rehabilitation services that enable them to function independently; and aged people are supported to remain independent and live at home. Apart from government support, individuals can still choose to rely on assistance and support from their informal network of families and friends. Disabled and elderly Australians, therefore, have a range of choices for maintaining their lifestyle and health.

To align with government policies, occupational therapists focus on supporting functional independence and quality of life for clients that includes supportive interventions at home and in the community, as well as in hospitals, rehabilitation settings, and clinics, that also take into account health prevention and promotion

aims. In contrast with Australia, most health care services in Thailand tend to be created and directed by the government. Thais are not involved in health promotion programs for the community. Moreover, community organizations do not have sufficient capacity to look after the health of individual and community. In addition, the disadvantaged groups have few opportunities to make decisions about their basic health care.

Disabled and elderly people have a right to receive free medical rehabilitation, but services are not available in more remote areas. Budgets are limited, and inpatient units for medical rehabilitation are scarce, and there is a focus on limited medical programs, rather than on development of the individual's full potential.

There are also limitations on educational, social, and vocational rehabilitation. For example, parents of children with disabilities lack information about the accessibility of education; public facilities and services are not provided for people with disabilities; and there is a negative attitude towards employing people with disabilities. Apart from this, cooperation among the government, private sector organizations, community organizations, and organizations of people with disabilities, is not effective. Hence, the aim of helping people with disabilities to become independent in daily living and participate in ordinary social activities is not met.

Most Thai occupational therapists work in hospitals and provide medical rehabilitation. Apart from home visits and outreach services provided by a few Thai therapists, they do not take other roles in the community (Occupational Therapy Association of Thailand, 2002). A role of Thai occupational therapists in health prevention and promotion has not been provided especially at the community level, and their roles remain restricted to institutions, and focused on treatment and rehabilitation. To respond to current health policies that focus on health prevention/promotion and community involvement, Thai occupational therapists need to expand their roles in the near future.

2.4.4   Summary

Health care systems influence the practice of occupational therapists both in Australia and Thailand. The participation of WAOTs and ThaiOTs in their respective health care systems will no doubt lead to differences in how they apply occupational

therapy models to their practice. Therefore, the health care system is an important factor that also requires investigation about the impact on the practice of occupational therapists in each country.

CHAPTER 3

Occupational Therapy from Theory to Practice in Western Australia and Thailand: An Exploratory Study

The preceeding literature review describes the evolution and the philosophy of occupational therapy and occupation, together with theoretical models of practice used in occupational therapy. It also addresses specific cultural issues and their cultural implications. Finally, the health care systems of Australia and Thailand, and their impact on service delivery for occupational therapy have been discussed.

The existing literature, however, offers only limited information about differences between occupational therapy practice in Western and Eastern cultures and little information about the application of theoretical models to practice within different cultures. There has been little research aimed at identifying culturally appropriate conceptual models for practice in non-Western cultures. What literature does exist has been based around sub cultural groups predominating Western cultures, for example Native Canadians (Wieringa & McColl, 1987) and Native (Maori) New Zealanders (Jungerson, 1992). Application of traditional Western occupational therapy models in clinical practice in developing countries such as Thailand have not yet been studied. Although concerns have been expressed about the adequacy of current models (Dyck, 1991; Kinebanian & Stomph, 1992; Whiteford & Wilcock, 2000), no straightforward theoretical basis has been offered to examine the cultural relevance of existing models. Therefore, theory building is required for the initial phase of this study. An exploratory, qualitative study has been undertaken to gather information from the experts themselves, the therapists, to identify the use of and influence of current theoretical models on occupational therapy practice. This chapter presents the methodology, using focus group interviews, as the first stage of the research process.

3.1 Objectives

The main objective of the study was to explore the theoretical models and their application to practice employed by representative groups of occupational therapists from Thailand and Western Australia. This phase addressed main objectives 1-3 of this research as identified in Section 1.3 of the dissertation from a qualitative

perspective. It was expected that, based on these findings, a quantitative measurement tool could be developed to further explore cultural issues in applying primarily Western occupational therapy theoretical models within Thailand.

The specific objectives were to:

1) identify the conceptual models that underpin occupational therapy practice in Thailand and Australia;

2) describe the application of these models in practice in Thailand and Western Australia;

3) qualitatively compare similarities and differences between Thai and Western Australian occupational therapists;

4) provide basic information for formulating the hypotheses used in the main survey;

5) develop a measurement instrument for the main survey.

3.2 Methods

3.2.1 Study Design

Due to the limited available research and the need to gather preliminary data regarding cross-cultural application of models, a qualitative study was considered appropriate. Focus group methods were selected to obtain initial data for this study, as they are known to provide rich, in depth data for exploratory studies. Results can be used later for item for developing the elements of the measurement instrument (Stewart & Shamdasani, 1990). The major strength of focus groups is that they provide an opportunity to collect data from group discussion on a topic of interest (Morgan, 1988). The researcher and respondents interact directly in focus groups, allowing the researcher to clarify responses given and in turn, respondents are able to qualify and clarify their responses (Stewart & Shamdasani, 1990). Additionally, focus groups have the flexibility to adjust to group process and dynamics in various groups of people and settings (Morgan, 1988; Stewart & Shamdasani, 1990). Finally, the researcher can collect the data from focus groups much more quickly and cheaply than from other qualitative methods (Morgan, 1988; Stewart & Shamdasani, 1990).

There are many reasons for the use of focus group methods in this research. First, focus group methods are useful for exploratory research where the

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phenomenon of interest is only partially known (Stewart & Shamdasani, 1990). Second, focus groups provide general background information from which hypotheses about the research topic can be formulated. The proposed hypotheses can then be tested or verified using quantitative methods such as surveys (Murphy, Cockburn, & Murphy, 1992; Stewart & Shamdasani, 1990). Third, focus group data can suggest research topics related to attitudes and cognitive perceptions of the participants themselves, (Morgan, 1988) from which new ideas and creative concepts can be generated (Morgan, 1988; Stewart & Shamdasani, 1990), including model development. Use of self-contained focus groups means that," the results of the research can stand on their own," and be reported without further data collection (Morgan, 1988, p. 25). Finally, focus group methods are useful to learn about participants' experiences, perspectives and what and how they think about the topic of interest (Morgan, 1988), including providing "insights into the attitudes, perceptions, and opinion of participants" (Krueger, 1994).

3.3 Sample Participants

Focus group participants were occupational therapists who were currently working across a range of settings in Western Australia and Thailand, including work with: physical disabilities, mental illness, developmental disabilities, occupational health, and the aged, all participated voluntarily in focus group interviews. In Western Australia, occupational therapists currently working in the metropolitan area of Perth were the main focus, whereas Thai occupational therapists work at various locations around Thailand were the main focus.

3.3.1   Participant Recruitment

A purposive sample of occupational therapists was drawn, in order to provide baseline evidence on how occupational therapists view and apply theoretical models in their respective countries. A purposive sample of participants was recruited from a representative range of occupational therapy settings within the metropolitan area of Perth, Western Australia (WA). Participants in the focus groups were recruited through distribution of 52 letters informing the Heads of Occupational Therapy Departments about the nature of the study, and requesting support in recruiting therapists from their staff to be involved in the focus groups on two proposed dates (Appendix A). Names and addresses were obtained from the Curtin University

School of Occupational Therapy database of WA Occupational Therapy Departments. Heads of departments forwarded names of volunteering staff members to the researcher. Nineteen therapists volunteered to participate.

Letters of invitation, including a description of the topic, the main objectives of the focus groups, the schedule and place, as well as participant's consent forms (Appendix B) were posted to the volunteer occupational therapists individually. A reminder telephone call was made to each participant two days prior to the focus group discussion.

Recruitment of participants in Thailand was undertaken through several different sources. The first source of participants was from the annual Thai Seminar at Chiang Mai University, which a majority of therapists in Thailand attend. Volunteers were recruited by advertisement, and provided information about the study, including the need for therapists with differing years and types of work experience. Additional therapists were recruited via advertisement in psychiatric occupational therapy departments, as insufficient numbers working in this field were available from the Seminar. Prior to inclusion, participants were provided with information and a consent form. Twenty participants agreed to participate. Prior to the focus group interviews, the participants were contacted face to face or by telephone, one day before the focus group interview was scheduled.

The data was collected first in Western Australia, and results will be presented in the same order:

In Western Australia, 15 participants attended the scheduled focus group sessions for a response rate of 78.95 percent. There were one male and 14 females from the metropolitan region. Therapists ranged in age from 20 to 59 years; however, most were 20 to 39 years old (Table 3.1). Therapists had been working an average of 10.9 years (10.9 ± 7.75 years; range = 2.5 to 27 years). Work areas of participating therapists are reported in Table 3.2. As some therapists listed more than one work area, the number of therapists and work areas are not equal.

In Thailand, 16 participants attended for a response rate of 80 percent; one male and 15 females were recruited from many parts of Thailand. Therapists ranged in age from 20 to 39 years and most commonly included therapists from 20 to 29 years. They had been working for an average of 4.66 years (4.66 ± 4.05 years; range

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= 1.67 to 14 years). Age ranges and clinical work areas nominated by therapists themselves are reported in Table 3.1 and Table 3.2 respectively. The relative youth and shorter work experience of Thai participants reflects the corresponding 'youth' of the profession in Thailand. The larger number of work areas repeated by Thai participants (despite fewer years in the profession), probably also reflect a profession with fewer specialised facilities and fewer opportunities to specialise.

Table 3.1

Reported Age of WA and Thai Participants in Focus Groups

Age (years)	Total WAOTs	Total ThaiOTs
20-29	7	12
30-39	5	4
40-49	2	0
50-59	1	0

Table 3.2

Reported Work Areas of WA and Thai Participants in Focus Groups

Clinical work areas	WAOTs		ThaiOTs	
	Total	%	Total	%
Paediatric	5	33.33	13	81.25
Neurology	5	33.33	14	87.50
Orthopaedics plus Hand Therapy	7	46.67	9	56.25
Aged care	6	40.00	1	0.06
Clinical medicine	4	26.67	3	18.25
Psychiatry	2	13.33	5	31.25
Vocational rehabilitation	1	0.07	1	0.06
Community	1	0.07	0	0

3.3.2   Data Collection

Focus groups are group interviews in which interaction within the group is based on the topics supplied by the researcher, who typically takes the role of a moderator (Morgan, 1988). In focus groups, discussion is elicited from homogeneous

participants on topics related to the purpose of the study (Krueger, 1994). Discussion is designed to gain perceptions on the topic of interest in supportive and non-threatening environment (Krueger, 1994). The process should move from the general to the specific, using a 'funnel' approach to interviewing (Stewart & Shamdasani, 1990).Whilst the aim is for participants to share ideas and perceptions in an atmosphere of comfortable discussion, the response to the ideas and comment in the discussion can also be affected by each of the group members (Krueger, 1994). The recommended size of focus groups is 6 to 12 participants (Krueger, 1994).

Focus groups were conducted in the rooms at the School of Occupational Therapy in WA, and at Chiang Mai University, each for a period of two hours. These were natural settings: quiet, comfortable, and well known to the participants. Four focus group interviews were conducted: two groups each in WA and Thailand. Four groups were estimated to be sufficient to reach theoretical saturation. The interviews were conducted on 28 April and 5 May, 1999 in WA and on 18 and 19 May, 1999 in Thailand. Each focus group interview was audiotaped and later transcribed verbatim.

Prior to the commencement of the study, Human ethics approval was sought and given by Curtin University of Technology (See Section 3.5: Ethical Considerations).

At the commencement of the focus group, each participant was asked to complete a questionnaire of 8 items comprising demographic characteristics, clinical work history and experience, and identification of the key tasks and roles undertaken at work (See Appendix C). The researcher adopted the role of facilitator of the group. Each group had an assistant facilitator (a professional colleague) to take responsibility for all equipment and refreshments, as well as record field notes and support the group process. At the beginning of each session, the researcher reiterated the procedures outlined in the letter: (i) that confidentiality would be guaranteed in any of the research published or presented orally; (ii) the interview would be audiotaped and field notes would be recorded; (iii) following transcription, the audiotapes would be erased and no name would appear on the transcript or research report; and finally (iv) results of the focus group interviews would be used to develop items for the questionnaire used in the main survey.

In the interview, the researcher used a semi-structured group interview format based on probe questions. The questions (Appendix D) were developed from the

literature and from the theoretical focus of the study, to facilitate the sharing of participants' thoughts and experiences on each topic, according to the objectives of the study. For the focus group interview process in Thailand, probe questions were translated to Thai by the researcher, who was also the facilitator, in order to maintain consistency in facilitating the groups.

The group interview initially invited discussion about conceptual models for practice. The key areas of discussion included: specific models used by the therapists that underpinned clinical practice; a description of the broad or overall conceptual models the participants used in practice; interpretation and adaptation of these models to practice; and the perceived constraints/benefits of the conceptual models the therapists used in clinical practice. Other areas of concern evolved around the expectations of occupational therapists in service delivery to their clients, the needs of clients from the therapists' perspective, the demands of employers as well as that of their clients, and their understanding of occupational therapy. Finally, participants were invited to describes what factors contributed to their overall job satisfaction/dissatisfaction (See Appendix D).

3.3.3   Data Analysis

3.3.3.1   Accuracy and rigour in analysis

To determine the accuracy and credibility of an investigator's interpretation of field data and of its representation in a final report, six basic approaches are identified in the literature (De Poy & Gitlin, 1998). They are: triangulation, saturation, member checks, reflection, audit trail, and peer debriefing. They are designed to check whether the investigator used adequate strategies to enhance the accuracy of representation of data, credibility of interpretation, and reliability (De Poy & Gitlin, 1998; Merriam, 1998). Internal validity in this form of research means, "how research findings match reality, how congruent are the findings with reality" (Merriam, 1998, p. 201). Reliability refers to "the extent to which research findings can be replicated" (Merriam, 1998, p. 205). In this study, the researcher validated her finding (Merriam, 1998) by using saturation (refer to Section 3.3.2: Data collection) and member checks (refer to Section 3.3.3.2: Content analysis). Saturation refers to undertaking as many focus group interviews as are required, up to the point where little additional insight or new understanding is forthcoming (De Poy & Gitlin, 1998; Krueger, 1994).

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3.3.3.2 *Content analysis*

Content analysis using transcript-based analysis and systematic coding was used to analyse the focus group data, following the methods of Krueger (1994) and Morgan (1988).

Manual methods were used for data analysis, relying on the tread and true methods using cut and paste technique and frequent comparative discussions with a researcher experienced in this technique. As the researcher speaks English as a second language, this facilitated meaningful understanding of the data through verification and explanation by the other researchers.

The first phase was to code the major points and significant meanings or emerging themes based on each probe question. These formed the first categories, and relevant key quotes and/or statements relating to each category were recorded under each probe question. The researcher selected quotes, which were within mainstream perspectives, and in line with the objectives of the study (Krueger, 1994).

In the second phase, the emerging categories from all questions were coded, and the number of times that key categories were reported was counted. The codes were written in the margin of the transcript. The coding method enabled the researcher to recognise the most frequent words, phrases, themes or concepts within the data (Field & Morse, 1985). A label was attributed to each new idea or phenomenon, with the same label being used each time the concept/phenomena reappeared, even if it was presented in different words and styles (Krueger, 1994).

In the third phase, the researcher identified the themes from the major categories that have been developed. Quotes and statements attributed to each theme were assembled, using the cut and paste technique. Each theme was named according to the significant content and meaning. In the final phase, the researcher summarised findings according to the objectives of the study, and then wrote draft reports, starting with the most important question or major theme. An independent reviewer who is an expert in focus group interviews validated these themes through reviewing raw data and identifying categories that supported the logic of the research and development of themes (De Poy & Gitlin, 1998).

After data analysis was complete, the researcher sent the draft reports back to some focus group participants to check the summaries, or particular understandings, or variations in reporting, for verification. Member checks are a technique of checking an assumption or tentative interpretation with one or more informants to verify if the findings are plausible (De Poy & Gitlin, 1998; Merriam, 1998). This process can reaffirm a particular revelation from research participants, thus strengthening the credibility of the interpretation, and decreasing the bias of investigators (De Poy & Gitlin, 1998). Participant member checking was used to ensure that "the researcher has adequately understood the intent of participants", and the summary of focus groups is accurate and complete (Krueger, 1994, p. 128). This process of member checking enhances reliability of the collected data (Krueger, 1994).

Draft reports were mailed to approximately half of the original participants for verification. The participants were recruited to ensure at least one representative from each area of practice of the original focus group participants. Eight WA participants were chosen and six responded. Nine Thai participants were also chosen and six responded. The participants were invited to provide feedback by writing on the draft focus group summary. Comments from the respondents confirmed the research's analytic scheme, no additional insight was gained, and no modifications were required.

3.4 Ethical Consideration

Focus group participants were informed about the purpose of the study, its procedures, the utilisation of the data gathered, and the amount of time required for attendance at the focus group. Whilst anonymity cannot be assured in a focus group, rules regarding confidentiality were provided. Written informed consent (Appendix B) was obtained from all the participants regarding the research process, based on the National Health and Medical Research Council Guidelines. Each group was audiotaped and discussion was later transcribed verbatim. Participants were assured that no names would be identified, and extracts of interviews were used in the research report, thesis and academic articles only, ensuring confidentiality of responses. Interview/audio tapes were only identifiable by a code number, and were erased following the completion of data analysis. Any enquiries about this study could be directed to the researcher and the researcher's supervisor via the contact

phone numbers on the consent form. The research protocol was approved by the University's Human Research Ethics Committee.

CHAPTER 4

Findings of the Exploratory Study

4.1 Introduction

This chapter presents findings from content analysis of the focus group data and discusses the meanings and significance of the findings by investigating relevant literature to support the discussion. The focus groups were conducted to identify important themes about occupational therapy theoretical models and their possible application to practice in Australia and Thailand, as well as other related themes. Analysis of the data reveals five emergent themes based around culture, three generic conceptual models, and a variety of professional issues. The findings expose the similarities and differences of theoretical models, and their application to practice in WA and Thailand, as well as the significance of culture as an influential factor.

4.2 Findings

Five major themes emerged: three generic conceptual models; professional issues; and culture. The three generic conceptual models arising from the discussion were labelled the Performance Model, the Whole Person Model, and the Medical Model. Culture also emerged as an overarching theme, as did professional issues based on work experiences. Culture and its influence at many levels was described frequently by participants, including its impact on each identified generic treatment model. It is therefore reported both generally, under the heading of culture, as well as in the discussion of each generic model.

The naming of the models was based on the underlying description provided by participants, but could also identified in the occupational therapy literature and in broader health-related writings. The three models were labelled according to the essence of the most distinct, yet commonly described characteristics of each of the three clusters. The models are not mutually exclusive. For example, all focus on clients' performance, albeit from varied perspectives. Thus, they share commonalities, as well as manifesting differences.

The secondary themes that were discovered for each conceptual model evolved from: 1) the main concepts; 2) location and generalisation – (with whom and how

broadly the models could be applied); 3) considerations of culture; and 4) additional discussion and conclusions regarding the reported model.

The findings are supported by quotations extracted from the transcript. The use of notation such as (Group 1, p. 5) are used following a direct quotation, to indicate the focus group in which the statement originated and the page of the numbered transcript from which the statement was drawn. In addition, all themes are presented in relation to the literature.

4.2.1 The Performance Model

According to participants in the four focus groups, one theoretical model frequently referred to in occupational therapy practice is focused on performance or functional outcomes for their clients. Whilst most group participants used the term 'function' rather than 'performance', further discussion revealed their meaning of the term function actually referred to outcome performance. That is, how well an individual can perform certain skills. Hence the term 'performance' has been used in the findings to describe functional outcomes. Thus the model is labelled as the Performance Model. However, the Performance Model described by participants, whilst including aspects of the occupational therapy models identified with the term 'performance' either in the title name or as part of its construct, did not coincide exactly with more comprehensive descriptions reported in the literature. The following sub-themes elaborated what was evident from the participants' discussion.

4.2.1.1. Main concepts of the Performance Model

The Performance Model was described in all four groups as having a focus on how clients performed in different functional areas, such as work, self-care, and leisure. Participants' described components of performance as including the sensori-motor and cognitive/cognitive integration components, and the psychosocial components underpinning specific performance demands.

"I think I'd look at the performance components for a problem like handwriting. ...Often I offer functional training such as specific handwriting training because that is the issue that is causing the problem for the child" (WAOT, Group 1, p. 24)

"I expect them to go back home and they can perform functional skills needed to survive within their living situation" (ThaiOT, Group 1, p. 5)

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"Educated clients (in particular) would like to be trained functionally because they will feel proud if they can do (perform) voluntary movement and ADL" (ThaiOT, Group 1, p. 2)

The Performance Model as described by informants focuses on maximising and maintaining the clients' independence in performance. Western Australian therapists included a wider range of functional capacities in their discussion, such as being able to perform functional skills to undertake their broader life roles in the areas of interpersonal, work, and leisure skills. Thai occupational therapists reported they tended to focus on issues around independent performance of ADL, rather than taking into consideration more complex life roles and performance abilities. Independence in the broader aspects of the clients' life role or in the clients' environment such as at home, school, or daycare seems to be considered by WAOTs, while ADL independence becomes the major focus of ThaiOTs.

"I suppose a more functional idea is (about considering) functional roles, and typically OT is about maximising the independence of clients' life roles - that is important" (WAOT, Group 2, p. 5)

"I think another model is certainly occupational performance ... (with some children) ... with regard to maximising their independent functioning at home, school, day care, wherever they are situated" (WAOT, Group 2, p. 2)

"(Therapy aims for) independence according to the clients' abilities, ... at least (so) they can perform ADL independently" (ThaiOT, Group 1, p. 5)

"... the first goal is ADL independence ... as much as possible" (ThaiOT, Group 1, p. 3)

"I expect clients to have the motivation to perform ADL like 'normal' people and depend on themselves as required" (ThaiOT, Group 2, p. 5)

Both Western Australian and Thai therapists agreed that the Performance Model focused on occupational performance, or occupation required to support the daily living skills necessary for the individual with functional problems. This is consistent with the views of Baum and Christiansen (1997) and Fleming (1994). Independent performance was the overall aim of the Performance Model as reported by participants from both countries. Participants viewed the focus as independent

performance of the individual. However, Thai participants noted this focus conflicted with the values of interdependence within the Thai family, and the cultural context of performing occupational demands appears to be different in WA and Thailand.

The Performance Model discussed by the focus groups used similar terminology and definitions of performance components and areas, as those of the CMOP, although the participants did not offer a clearly articulated understanding of the principles of this model, and only focused on limited aspects of it. In the CMOP, occupational performance is described as the inter-relationships between people, their environment, and occupation that assist clients to achieve optimal occupational performance, as defined by the individual (Baum, 1998; Stein & Cutler, 1998). The literature underlying the CMOP, however, does not focus so much on independence in occupational performance. However, this issue was emphasised by the participants in discussing their approach to the Performance Model. The difference between the concept described in the theory, and that reported by participants in focus groups, provides interesting perspectives for further discussion.

Assumptions regarding functional independence in performance areas are reported as fluid and related to the condition of clients and their environment (Crabtree, 2000), or are thought vary with the clients' social and cultural context (Dunn et al., 1995). Western society values independence and self-reliance (Baum & Christiansen, 1997; Christiansen, 1991), and one goal of rehabilitation is thus to increase the patient's independence (Baum & Christiansen, 1997). The value of independence and individualism in Western culture (Hofstede, 1991; Triandis, 1995) might influence Western Australian therapists to emphasise maximising clients' functional independence as the aim of the Performance Model. As most participants mentioned *function* as outcome performance, rather than using the term *performance*, they, therefore, may link their views to concepts of functional independence. Independence is frequently considered to include the physical ability to engage in activities (Crabtree, 2000; Jackson, 1996; Turnbull & Turnbull, 1985), and is a term particularly used by Thai therapists who work mainly with people with physical disabilities (Department of Occupational Therapy, 2002a). Perhaps, for this reason, Thai therapists, and to a lesser extent WAOTs, reported independence as the aim of the Performance Model, reflecting both the relative importance of working with people with disabilities, and an historic view of what occupational therapists aimed

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for in working with clients. In other words, the Western cultural value of individualism is inherent in concepts of independence and 'doing it yourself', which are concept embedded in the prevailing occupational therapy model (Dyck, 1991; Kinebanian & Stomph, 1992).

4.2.1.2. Location and generalisation

Participants from the WA focus group reported that the activities that were used to intervene to change clients' functioning should here application in the clients' home, or some other expected environment (e.g. a hostel). In addition, compensatory approaches such as environmental adaptation, providing self-help devices, and adapting a person's ways of doing things, were applied, so that clients could manage practical affairs such as self care and home management tasks in order to survive in their environment. Compensatory approaches assist a client in adapting, but Western Australian therapists also emphasised the role of task analysis in assisting clients to relearn old skills or learn new ways of performing daily activities.

"You can see someone's not performing, we break it down into the work level that they are able to generalise to their environment ... ... the broader concept of whether or not they can still do it at home" (WAOT, Group 1, p. 25)

"Maybe we tend to try to shift the focus to be more compensatory or what's this person going to do to actually survive out there ...and this particular person wants to make practical things like making a sandwich" (WAOT, Group 1, p. 14)

Thai occupational therapists claimed that they focused mainly on the functional skills necessary for survival in daily life, especially self-care activities such as feeding, hygiene, and dressing, and that the focus of these skills were mostly chosen by the therapists. They focus on ADL independence as the main aim of this model, especially self-care which Roger (1982b) argues is fundamental to daily survival.

Thai participants emphasised that in hospitals or institutions, clients are always trained in these basic ADL skills. They also provide self-help devices and equipment, and use at least one-step task analysis to assist the clients achieve satisfactory ADL performance. Thai occupational therapists from both groups reported that ADL independence is often performed successfully in a hospital or an institutional environment, but is infrequently transferred to a client's home environment because of the family's insistence an 'helping' their family member with health problems.

They reported that family involvement in taking care of a family member with illness or disability appears to be considered a fundamental family role and responsibility, a finding which is compatible with a study of Fitzgerald, et al. (1997). Nevertheless, most Thai therapists do not visit clients at home (Department of Occupational Therapy, 2002b); hence, they do not have information about the clients' way of living, nor their interaction with their families at home, nor their level of ADL skills. However, some research has shown that families actually modify and create new techniques and self-help devices to assist their relative in ADL achievement (Hirunchunha, 1999), and it is suggested that ADL performance which clients learn from hospitals might not be applicable to the clients' home.

ThaiOTs stated, *"Mostly the general hospital will focus on ADL independence, and train clients to improve that function, we can't look at clients' vocation in detail" (ThaiOT, Group 1, p. 5)*

"We focus on function and at least they can do one - step tasks. Therapists focus on providing at least one - step task analysis for functioning, such as fastening a strap" (ThaiOT, Group 1, p. 2)

"Occupational therapy is (a) very important aspect of functioning ADL, (as well as) self-help devices and equipment" (ThaiOT, Group 1, p. 5)

"Most patients can perform ADL independently when they were in hospital, however, when they go back home, they haven't done (so). Their relatives decided to do ADL, for them because they feel sympathetic and don't want to wait until the patients finish performing ADL by themselves" (ThaiOT, Group 1, p. 10)

Western Australian occupational therapists reported that the Performance Model was broad in scope, addressed a variety of issues, and there were many techniques that can be used after undertaking an assessment. However, actual application was limited by time and hospital/health policy, which focuses on early discharge rather than on achieving functional performance outcomes prior to returning home.

A WAOT stated, *"I think often with the time limit or with the broader things that constrain..., for example, the Occupational Performance Model is quite broad...you are limited by the hospital policy..., for example in the acute setting you've lots of people to see" (WAOT, Group 1, p. 20)*

From such finding it appears that therapists in both cultures lack a strong knowledge base about the formal occupational therapy performance models, or have a comprehensive basis for applying them in a variety of occupational therapy settings and cultures.

4.2.1.3. Considerations of culture

Both WA and Thai occupational therapists suggested that the clients' cultural background and rehabilitation needs might be in conflict with the underlying purpose of this model, which they reported is to maintain or maximise independent performance. However, Western Australian participants claimed that the Performance Model was generally useful in contributing to independence in performance or functional areas, which generally fits in with the goals and values of clients in Western society. Limitation came in situations from the need to release clients from hospitals quickly.

In contrast, Thai participants implied that this model might be culturally inappropriate. They reported that Thai clients, especially the elderly, would often prefer to depend on their families. The high value that Thai place on caring for family members with illness and disabilities might be viewed as a deterrent for some Thai clients to actively pursue satisfactory performance outcomes. Nevertheless, according to Buddhist teaching on the role of individual in family, each member has to take responsibilities for his/her own roles and duties, and share other responsibilities with other members of the family unit (Payutto, 2003). As Thailand is interdependent society (Thailand Junior Encyclopedia Project, 2002; Wasri, Samuthwanich, Roauthammathadhs, & Boonmee, 1996; Wongsit, 1992), family level members are obliged to look after one another and share responsibilities to maintain family function (Hatthakit, 1999; Payutto, 2003). Therefore, adult clients of working age may need to achieve considerable autonomy in ADL so that they can perform their prescribed interdependent role, and enjoy their lives within the family context. In effect those who can work will not be regarded as disabled. Perhaps the most important point is that the desired level of client autonomy must be negotiated and worked out within the family.

"Maintaining their independence, safety and comfort achieving their goals is the outcome I am looking for in client intervention" (WAOT, Group 1, p. 21)

"We are looking at working on the performance components and building those all up into a person who is functioning at what we hope is his or her optimum level in all areas" (WAOT, Group 1. p. 33)

"Some clients resist performing ADL when they stay at home with family members, because their family always takes care of them" (ThaiOT, Group 2, p. 4)

"The clients with low self-esteem, for example the elderly, don't value doing activities during treatment. They think their children should show gratitude by caring for them and it is time for them to rest" (ThaiOT, Group 2, p. 4)

"Western people value independence more than Eastern people do. So values and culture will be the first factor to consider" (ThaiOT, Group 2, p. 4)

Western Australian therapists reported that they actively considered cultural values that may impact on clients and their families. This increased awareness of cultural issues by Australian therapists may arise from working with clients in a multicultural context.

"Culturally, if the person and their families don't want them to be independent, then there is no point for us doing independence programs, because it is not going to achieve anything. But actually, see what they want to work on, and do that" (WAOT, Group 1, p. 41).

"Independence is also what we aim for, but being careful not to make it the only point" (WAOT, Group 1. p. 41)

Thai participants commented that in Western societies people appeared to value the concept of independence more than Thai or Eastern people. Hence, the perceived aim of clients' independence that participants believed related to the Performance Model was viewed as compatible with the value of Westerners, but less compatible with that of Thai or Eastern people. As Thai people uphold the value of caring for people with illness or disabilities, they will assume the care for family members or people in the community who are elderly, chronically ill, or have disabilities. The Thai value of mutual dependence (Thailand Junior Encyclopedia Project, 2002; Wasri et al., 1996; Wongsit, 1992) does not fit comfortably with the described purpose of the Performance Model as focusing on maximising or maintaining a clients' independence. In support of such findings, Jang (1995) in studying Chinese culture found that practitioners and family "have a tendency to do

everything for the patients – even to the extent of discouraging chronically ill persons from physical self-help" (Jang, 1995, p. 105).

Alternatively, the value placed on caring for a family member may be have a positive role, one that matches the family's need to help with a treatment program that recognises the clients live in circumstances where there are limited resources, public facilities, and infrastructures such as specialised toilets and ramps (Tawintarapakti, 1997; Wiboolpolprasert et al., 1996). Apart from this, in collective societies, the family is conceived as the smallest unit (Hofstede, 2001). Therefore, the family is a very important part in collective or interdependent societies in assisting clients to be able to perform their occupation.

In Thai culture, this point is important for ThaiOTs, who consider that the aim of the Performance Model could be shifted from independence of the individual client to independence of the family unit, which assumes to collaboration between the client and family to perform occupation within the cultural context of family unit. Thai therapists do not tend to explicitly reformulate the aim of the model appropriately, to take into account the values of caring for family members with illness and disabilities. When Thai therapists focus on independent performance of individual clients; hence, they may under value the role of family members of caring for those with illness and disabilities, even regarding them as an obstacle to efforts to enhance the client's potential.

Alternatively, we still need to promote independence of an individual as required by clients and their families especially for adult clients who need to work outside or inside the home, and play interdependent role in the family as mentioned previously. This statement is compatible with the study of Sittigan, et al., (2000) which found that spinal cord injury patients expect to help themselves, and the study of Samuktiya (2000) which found that relatives expect schizophenia patients to go back to work in their community.

Conversely, Western society emphasises the values of competence, independence, productivity, and mastery (Krefting & Krefting, 1991), and the individual's ability and competence in performance is valued (Triandis, 1995). Western Australian therapists felt this model required consideration of cultural issues and could accommodate for different cultures, and modified the intervention to match the clients' culture. Western Australian occupational therapists also described

clearer views about the place of independence as related to occupational therapy practice than Thai therapists, whose cultural context of practice does not really value independence.

4.2.1.4. Conclusion and discussion of the Performance Model

Both WA and Thai occupational therapists agreed that this model focused primarily on independence in performance in accordance with the functional capacity of the client. Nevertheless, Thai therapists primarily focused on ADL independence and applications that assist the clients to progress in this area, especially in hospitals or institutional settings. Alternatively, Western Australian therapists focused on broader areas than ADL, and on performance applicable for participation in their homes and environment. With a different focus of therapists in the two countries, in practice the application of the Performance Model differs. Western Australian therapists focus on independence when they work with the clients from Western backgrounds, who are the majority group in the population. But they modify their approach when working with clients of a different culture. By contrast, Thai therapists reported a conflict when attempting to reinforce the aims of ADL independence in their practice particularly if they focus on independence of the individual client, rather than independence of the family unit.

In analysing the frequency of reference to the Performance Model, the terms 'functional focus', or 'performance focus', and 'occupational performance model', and the terms 'function' or 'performance' when applied as the aim of practice, were counted. It was found that Western Australian therapists applied this model most often in their practice, whereas Thai therapists applied it least often. Thai therapists perceived that the value of caring for disabled or elderly family members might actually prevent clients from achieving independence in performance; thus, Thai therapists used this model least in their practice. In contrast, Western Australian therapists perceived that the aim of independence of the individual client is compatible with the emphasis on individualism among Western people.

The general aims and concepts of the Performance Model as discussed in the focus groups seemed to derive from a combination of the reductionist and occupational perspectives. This therapists' model emphasised performance components, goal-directed activities, self-help devices and equipment, compensatory techniques, and adapting skills needed to perform occupations in order to meet the

aim of independent performance consistent with the functional capacity of each client. Western Australian therapists focused on performance areas that were applicable to the clients' broader life roles and environment, whereas Thai therapists focused only on ADL. Western Australian therapists used task analysis to assist clients to learn or relearn necessary skills for life roles and managing their environment, whilst Thai therapists used simple task analysis for a focus on self-care activities. Additionally, Western Australian therapists also considered the clients' culture in using the Performance Model. This implied that Western Australian therapists are concerned about the clients' cultural context, and that possibly they adopt a more holistic way of reflecting upon the areas of clients' needs, reflections that are also relevant to the following model as described by focus group participants.

4.2.2 The Whole Person Model

The next model reported by focus group participants encompassed many factors that impact upon a client's capacity to engage in meaningful occupation in relation to his or her or individual needs and choices, family, cultural and environmental contexts, and quality of life. This model viewed clients in a 'whole of person' context, and hence was named the Whole Person Model. It is theoretically most compatible with the holistic model of occupational therapy theorists. Again; however, this model does not exactly coincide with holistic models as described in the wider literature.

4.2.2.1. The main concept of the Whole Person Model

The Whole Person Model was described by participants as focusing in daily patterns of living of individuals, including the clients' performance, roles, habits, and the contextual environment, as well as recognising clients' and families' needs in relation to quality of life concerns.

Participants reported that this model focused on the person as a whole. Within this model, occupational therapists considered all factors relating to clients' quality of life, and performance areas affecting the clients' ability to fulfil life roles, within their environmental context. The occupational therapists' role in collaboration with the client was identified as focusing on functions and skills important for the client in performing meaningful life roles, i.e., roles the client perceives as being of personal

value. In addition, the needs of the client within their family, together with individual cultural concerns, were cited by participants as important aspects of the model. Nevertheless, Western Australian therapists focused primarily on individual client's choices in order to achieve individual goals. In contrast, Thai therapists focused on the needs of both the client and family, in order to achieve the goals of both.

Thai participants reported the MOHO model as the approach they used most to understand clients from a holistic perspective, although it can be argued that this model is somewhat limited in this respect, and actually focuses on systems of an individual rather than the whole person. That is, the system of the whole person which includes family and relevant others to a client are not explained through the subsystem dynamic of MOHO. According to the value of interdependence within family unit in Thai culture, the family is the most important factor influencing each client subsystem, and leads to success in performing each occupation and attaining a satisfactory quality of life. Even though family is described as part of the environment, this approach does not explain the influence of the family on the motivation, habits, and mind-body performance areas of the client. That is, as the needs of the client are integrated with needs of the family success in performance requires collaboration between the client and family. These details are not included in MOHO.

The following statements by therapists support a more comprehensive whole person approach to working with clients.

WAOTs stated, *"be careful not to focus on one particular disability, but the person as a whole" (WAOT, Group 1, p. 4)*

"You look into performance, their environment and culture and all that surrounds it, you then do treatment that's related to what they desire or may need" (WAOT, Group 1, p. 8)

"It's (a whole person approach) a good basis to start - that you are looking at all areas of the clients' life" (WAOT, Group 1, p. 2)

"Reducing the person's needs to come back to hospital, ...and improve quality of life" (WAOT, Group 1, p. 21)

"To make sure that where they choose to be and what sort of lifestyle they want to lead, we are assisting them to try and achieve that lifestyle if possible. So it's real

quality of life and peoples' choices that we are dealing with ... " *(WAOT, Group 2, p. 3)*

"*I am focused on the true quality of life so I mean that I'm focused on the whole person and their goals*" *(WAOT, Group 2, p. 16)*

ThaiOTs stated, "*We used MOHO to get the patients to achieve success in their quality of life, both in children and adults*" *(ThaiOT, Group 2, p. 1)*

"*MOHO will be used to consider the performance ability of the patient and the needs of clients, to plan the treatment program according to the goals set by occupational therapists and patients, together with what their families concerns about the patients*" *(ThaiOT, Group 2, p. 2)*

"*Occupational therapists should look at the whole person and understand clients in their expected environment, which is very different from the environment in rehabilitation*" *(ThaiOT, Group 1, p. 2)*

Participants, although labelling working with the whole person as different from a focus solely on performance, considered all performance areas - the clients' life roles, quality of life, the environment, and culture-, and not only the skill requirements. They therefore described a model somewhat differed from the perspective of Performance Models. However, Western Australian therapists preferred this approach in relationship to the unique needs of the individual, whereas Thai therapists included the needs of the client and family together. Essentially, this generic model is compatible with the MOHO and CMOP, that focus on occupational performance or performance areas of individuals using a client-centred approach (Baum, 1998; Kielhofner, 1997f; Stein & Cutler, 1998). The client-centred approach derives from humanistic values, and emphasises the importance of meaningful occupation of clients, which enhances health and quality of life (Kielhofner, 1997b; Reed, 1993).

In practice, the client-centred approach assists occupational therapists to provide more effective services (Stein & Cutler, 1998). Therapists treat the whole person according to his or her individual needs (Taylor, 1972). For this reason, focusing on the whole person was applied in practice in order to enhance clients' quality of life and success in meaningful performance areas. Nevertheless, focus group participants tended to report an emphasis on the whole person, derived from a

broader, holistic approach which is familiar to all health disciplines. It appears that integrating occupational therapy models with the broader health models may facilitate communication with other health professionals. Based on a holistic perspective, quality of life and related factors becomes the major concern of participants in the Whole Person Model.

Thai therapists supported use of MOHO when emphasising the model's value in enabling them to understand clients from a holistic perspective, even though this model focused on the client as an individual, they found its emphasis on the client's relationship to the environment was also considered, as were motivation and personal interests as described by Kielhofner (1995). As Thai therapists had learned about the MOHO during occupational therapy training, it is possible that familiarity with that approach permits a gradual broadening of its application in practice.

4.2.2.2. Location and generalisation

In discussing how this model was applied, participants in all focus groups focused on the reported needs of the clients' and their contextual environment, especially the family. Therapists used this model to determine specific requirements of the client, and in which areas to design interventions. Western Australian therapists designed interventions that were appropriate to the individual clients' needs and roles. Alternatively, Thai therapists applied activities that were appropriate to roles and needs of clients, together with the needs of their families. Additionally, all groups described that they worked closely with families; however, Western Australian and Thai therapists had a different target for their interventions. Collaboration between Western Australian therapists and family members focused on assisting the clients to achieve their goals, but that between Thai therapists and family members assisted clients and their families to achieve the goals of both clients and families.

Western Australian participants also reported they were concerned about the social needs and cultural contexts of clients, and offered resources for self-management such as recommendations of libraries and self-help groups so that the clients and carers could make changes and develop strategies to cope with difficulties.

WAOTs stated, *"As you're trying to find out about a person, you want to know about their roles and habits were prior to coming into the hospital"* (WAOT, Group 1, p. 3)

"It is looking at them in terms of their social needs and cultural context" (WAOT, Group 1, p. 5)

"Initially look at clients in their environment and work closely with the family and everyone involved in order to encourage the client to achieve their goals," (WAOT, Group 2, p. 23)

"We (Therapists) are looking at empowering the parents to be able to ... look at where the gaps are... what's right for the kids and themselves within the family context" (WAOT, Group 1, p. 6)

"I'd be working on parent strategies and the parent/child relationship ... Trying to get some links for that family if they need it within the community so it can be used in play groups and toy libraries, and getting them into-" (WAOT, Group 2, p. 23)

ThaiOTs stated, *"We use the Model of Human Occupation in the process of assessment and for searching their history and background"* (ThaiOT, Group 2, p. 3)

"MOHO, which considers the roles and needs of each patient, including family's need (i.e., what do the family need the clients to be able to do), then link to the problems and apply appropriate activities" (ThaiOT, Group 2, p. 1)

"Apply MOHO to have a balance of work and leisure, and consider social roles as well. Focus on what they need more than what occupational therapists need. What would the parents like their child to be? What would the parents like OTs to help with?" (ThaiOT, Group 2, p. 1).

Both Western Australian and Thai occupational therapists used the Whole Person Model to understand the occupational background and needs of clients and their families. Thai occupational therapists from one group also linked the needs of the clients and their families to set goal in designing appropriate activities for clients, focused on the needs of parents when children cannot express their needs. This, in both countries therapists emphasised that providing adequate services to children

requires close collaboration with parents. Western Australian occupational therapists recommended a broad assessment of clients needs, including social and cultural context, and working with the family. They also reported that they focus on the needs of parents and children, including the parent-child relationship, and that they also provide appropriate intervention for both clients and their families when working with children. Both Thai and WA groups reported that they work with clients' families in order to enable intervention to be more effective. This is compatible with a therapeutic relationship approach in occupational therapy that emphasises collaboration with clients and/or their families (Slaymaker, 1986).

All focus groups reported this model was useful for gathering comprehensive information about clients, setting goals of treatment, and implementing appropriate activities. The process begins at the first admission, and the approach can be used in evaluation at the end of treatment, even if all aspects could not be pursued.

Whilst some participants felt the Whole Person Model, based on the holistic viewpoint, is a fundamental occupational therapy philosophy, it was also suggested by all groups that it requires considerable time and resources to meet the needs of an individual. Therefore, resources limit use of this model and competing demands of the health system, the institution, and duration of hospitalisation. In other words, this model cannot deal with the clients' problems within a limited time. Griffin (1993) found that "therapists in short-stay environments are not able to implement the holistic, long-term approach that they have been taught"(p. 1090). Focus group participants noted that this model is limited by the short duration of hospitalisation, by the large number of clients currently being seen in occupational therapy programs, and by the time-consuming process required in applying this model to numerous aspects of a clients' life. Thai participants also claimed the language used in relation to the MOHO model, for example, which they claim reflects a holistic approach, was complex and difficult to understand in the Thai context. Thai participants implied that this language is troublesome in communicating with medical staff, who mostly rely on the Medical Model.

WAOTs stated, *"Models of OT are very holistic and broad" (WAOT, Group 2, p. 20)*

"We know our intervention is not meeting clients' expectation, because the clients can only stay in hospitals within a limited time" (WAOT, Group 1, p. 33)

ThaiOTs stated, *"Some models that consider many aspects of a client consume a long time to be effective" (ThaiOT, Group 1, p. 3)*

"Because of the long and detailed evaluative tests, other staff are wondering why we treat fewer patients than they expected" (ThaiOT, Group 2, p. 4)

"Some terms in MOHO are difficult to communicate with others" (ThaiOT, Group 1, p. 3)

4.2.2.3. Considerations of culture

Western Australian therapists primarily focused on the needs and choices of clients. However, when clients make unrealistic or inappropriate decisions, WAOTs reported they occasionally approach family members to make decisions for the clients. Thus, family participation in decision-making may be necessary when the clients cannot express their needs or choices appropriately.

Thai participants emphasised that, due to the value of interdependence among family members in Thai culture, families are (almost) invariably involved in decision making for disabled members.

A WAOT stated, *"On many occasions our patients perceive their wanted outcome, something which is quite unrealistic..., and yet they don't need an Aussie daughter or whatever it might be (to tell them what to do). It is not really appropriate, so as much as they are able to make appropriate decisions regarding discharge outcomes and having their wishes met, but sometimes you do have to step in and talk to the relatives who make those decisions for them" (WAOT, Group 2, p. 22)*

A ThaiOT stated, *"One of the family members always accompanies the client and participates in treatment programs, including often in decision-making in these programs for the client" (ThaiOT, Group 2, p. 3)*

The Whole Person Model is most concerned with the needs and choices of clients, which is compatible with the need of clients in Western culture, who are encouraged to make their own decisions in order to support their dignity and autonomy (Phipps, 1995; Young et al., 1994). Therefore, the focus of needs and choices of clients in the Whole Person Model supports autonomy of clients, presumably a satisfactory approach for the majority of the population.

In Thai culture, family members tend to be involved in decision-making on behalf of the client. Kinebanian and Stomph (1992) and Trafford (1996) support this viewpoint in study findings that demonstrate the family was always involved in treatment decision and programs in non-Western culture. Therefore, Thai occupational therapists perceived that the rights of autonomy of clients, and their individual needs and choices might not be a major concern in Thai culture. There are many factors affecting decision-making of clients. When clients have some limitation in performance or in physical abilities, they are also likely to lose their authority or power. Thus, decisions relating to treatment and rehabilitation programs will be mainly made by family members. That is, clients need to rely on family members, who care for them and bring them to receive treatment and attend rehabilitation programs (Hatthakit, 1999).

This is also true in WA in some cases, when patients are particularly weak or ill. They may authorise their families to make decisions, communicate with health professionals, and receive useful information for them. The compliance of family members with advice from health professionals, and their collaboration in the treatment program help clients to receive effective health care services and achieve recovery.

Generally speaking, the most important need of the Thai client and family is almost always to maintain the functioning of the family; hence, the needs of the client may be defined in a way that is in accordance with family resources and potential (Hatthakit, 1999). Family members as caregivers have the authority to convey their views about condition and needs of the client to health professionals, and the client may feel constrained in expressing his or her true needs and feelings. Family members generally regard their participation as assisting clients in performing activities that they cannot undertake themselves, and as contributing significantly to the recovery of clients (Potaya, 2001). Alternatively, some clients like to express their real needs and choices, but they do not have the opportunity because family members take over these roles. In this case, therapists should provide useful information to clients and their family members and may be able to mediate between them.

4.2.2.4. Conclusion and discussion of the Whole Person Model

WA and Thai therapists reported the same focus in applying this model. Both reported the model assisted them to understand the client as a whole, including the family and surrounding environment, thus helping to define interventions appropriate to the individual client, his or her family, and the context. Western Australian therapists focused initially on the needs and choices of individual clients, and later approached family members in order to assist the clients achieve their goals. Alternatively, Thai therapists focused from the beginning on the needs of clients together with their families, and approached family members at the outset in order to achieve shared goals. Therapists in both location agreed that the limitation of this model was in relation to the time frame available to offer services. Therapists in both countries approach families when clients cannot express their needs or cannot express them appropriately. Nevertheless, based on the value of family interdependence in Thai culture, the separate needs and goals of clients and families may often need to be compromised, to take into account the limited the resources and potential of each family to undertake a treatment program while maintaining normal family function. Therefore, focusing only on the clients' needs and choices will seldom be appropriate in Thai culture. Thai therapists may usefully take a mediating role to assist clients and families to meet the needs of both, especially if family members take a leading role in making decisions. However, clients also need the opportunity to express their preferences.

How often therapists actually apply the Whole Person Model was determined by counting the number of times the terms relating to quality of life and performance of clients within their family and cultural contexts were mentioned by focus group participants. Based on these frequencies, it was found that both WA and Thai participants cited the Whole Person Model as the second most often mentioned in relation to clinical practice. The Whole Person Model was concerned with the clients' needs, choices, and opportunities within their cultural context, which vary from Western to non-Western culture. Thus, Western Australian therapists focused on the needs of individual clients, whereas Thai therapists focused on the needs of both clients and families. The flexibility and encompassing nature of this model could be applied in both Western and Thai culture.

The Whole Person Model as discussed in focus group interviews, appeared to be derived from combination of holistic and occupation perspectives (Bockhoven, 1971; Kielhofner, 1997b). According to a holistic perspective, therapists can use this model to understand beliefs, values, and cultural backgrounds, as well as the needs of clients in relation to quality of life in their family and environment. Collaboration with clients and their families is a major concern in assisting clients to achieve their goals. According to the occupation perspective, therapists consider all performance areas in the clients' life, but emphasise meaningful and purposeful occupation for the individual (Kielhofner, 1997b). The client's needs and choices relating to occupation are the major concern, even though these might not be supported in Thai culture, due to family involvement.

When the two perspectives are combined, all factors relating to quality of life, the occupation of the individual, and success in performing occupations, in accordance with the individual's needs and choices, are the domain of concern. The model is used to improve occupation and quality of life for clients within a wider family and environmental context.

4.2.3   The Medical Model

The last model discussed by participants in the four focus groups included specific techniques based on a scientific or biomedical rationale, which they viewed as being suitable for treating specific symptoms and conditions of clients, or leading to solutions of client problem within a short term thus supporting early discharge from hospital. This model was called the Medical Model, and participants included the following elements:

4.2.3.1. The main concept of the Medical Model

This implicit model served as the umbrella for a range of medically aligned models described by participants from both cultures, and included neurodevelopmental, sensory integration, biomechanical, rehabilitation, and cognitive-behavioural models.

In all four groups, participants described this model as emphasising basic functional skills for clients, to be able to return to a safe environment with adequate support. It is compatible with the study of Russell, Fitzgerald, Williamson, Manor and Whybrow (2002) on independence as a practice issue in occupational therapy,

The safety clause, which found that safety of clients is the primary professional responsibility of OTs. Hence, the main purpose of this model was not to achieve maximum independence or to focus on quality of life issues for the client, but to sufficiently improve clients' condition so they can be discharged safely. In other words, it was to assist clients to improve or maintain their basic functional potential.

The underlying emphasis for Western Australian occupational therapists was on safe and successful discharge for clients, and this approach tended to create a discharge-focus rather than a client-focus, and was generally reported in the context of acute-care hospital settings. Thai participants claimed their focus was to support clients in making some degree of recovery, or assisting them to achieve sufficient health to perform basic self-care or be able to return home.

WAOTs stated, *"The Medical Model has a discharge focus" (WAOT, Group 2, p. 16)*

"The employers still very much focus on the Medical Model, this is the problem, fix it, send them(clients) home. And they don't have a broad understanding of the whole person" (WAOT, Group 1, p. 34)

"They (the hospital system) can do the minimal for them to be able to go home" (WAOT, Group 2, p. 17)

"Well, everyone's discharged fairly quickly from hospital. So the occupational therapist will do what he or she can to set things up for safe and successful discharge, but where they feel that this and further involvement is required just to make sure that either everything's going to work all right or there 's further rehab for clients after discharge" (WAOT, Group 2, p. 14)

"I think the acute care system is not so much client focused, it's discharge focused, that is the priority of everyone's intervention, the client's personal goals, independence or whatever it is, are not really a significant consideration in discharge" (WAOT, Group 2, p. 10-11)

ThaiOTs stated, *"The patients expect occupational therapists to help them to be better or feel better so that they can do basic self care or return home" (ThaiOT, Group 2, p. 6)*

"I'll provide intervention for each problem (of performance components) such as motor, sensory and perception first. After that, I'll increase social interaction and improve behaviour of clients by using Developmental groups and the Behavioural model" (ThaiOT, Group 1, p. 3)

The Medical Model as described by participants, is aligned with the reductionist viewpoint, which emphasises an objective and utilitarian view of reality, and is an approach that the majority of medical practitioners operate within (Hagedorn, 1997; Kielhofner, 1997b). The strength of the Medical Model is that it identifies and eliminates or controls disease or trauma, and views a person as the sum of his or her component parts (Hagedorn, 1997; Reed, 1993). It is also the main approach used in acute physical rehabilitation (Hagedorn, 2000).

4.2.3.2. Location and generalisation

Thai participants provided detailed reports about the frequent use of neurodevelopmental and sensory integration models in their practice. They observed that these approaches could best serve patients with a physical problem, who are in fact the largest group of clients in Thailand. Behavioural and developmental models were reported to increase social interaction and to modify the behaviour of their clients.

Thai therapists apply the Medical Model to respond to the demands of employers and external policies for work in acute settings. Often this leads to application of biomechanics and rehabilitation techniques according to ThaiOTs who often prescribe splints, train in compensation technique for hand function and for shifting body weight in bed.

In contrast even with a major focus on early discharge, Western Australian occupational therapists reported they listen to what clients say, and observe interactive behaviours between clients and their families in order to collect as much information as possible to prepare the most appropriate intervention for clients returning to their home environment, despite limited time. In contrast given limited time, Thai occupational therapists reported they used their professional experience in OT clinic, and medical reports, to lay out an occupational therapy program. That is, Thai therapists identify problems or needs of clients largely from their own clinical experience and medical reports, and undertake OT programs, which generally

emphasise performance components that facilitate basic self-care, according to their own judgment.

WAOTs stated, *"In the acute stage, the basics are the requirements for the discharge and the environment they're going to"* (WAOT, Group 2, p. 17)

"In case time is limited for intervention, pick up any cues that the person mentions, listen to what the person says, and observe what they do, how they interact with others and the environment" (WAOT, Group 1, p. 8)

ThaiOTs stated, *"In an acute setting, occupational therapists have to get many things done in the limited time"* (ThaiOT, Group 2, p. 2)

"I consider the state of patients and use my own occupational therapy experience to provide an intervention program for the patients" (ThaiOT, Group 2, p. 3)

"Biomechanics and rehabilitation model don't take much time to be effective; the patients can see the result faster than other models" (ThaiOT, Group 1, p. 3)

Application of this model by Western Australian therapists is associated with interventions based on input from clients or their families, albeit within a limited time. This approach does not exclude incorporation of a range of models, such as biomechanics or sensory integration. For Thai therapists, application of this model led to provide interventions based largely on their own clinical experience. This approach, for example, often included biomechanics and rehabilitation models to achieve immediate results that made the clients feel better. This emphasis on interventions with rapid results was viewed by ThaiOTs as appropriate since they view themselves as the experts, and the patients as passive recipients of care who should accept the authority of therapists (Fleming & Mattingly, 1994; Kielhofner, 1997b).

Thai therapists focused on outcomes within short period of time that also met the demands of employers. Under these circumstances, they are not so concerned about the clients' functional areas apart from basic self-care at home. They assume that family members will take care of clients on returning home. However, Thai participants reported that they provided instructions for home programs, which encouraged collaboration between clients and their families. It was found that even though families looked after ADL for clients at home, they needed professional

information and instruction in order to care effectively for clients after discharge (Somnuk, 1997).

Member of all focus groups reported using theories from the Medical Model to help clients solve their specific problems in short periods of time, and noted that this responded to employers' and clients' demands. However, this mechanistic approach is not a comfortable fit with the generally accepted philosophy of occupational therapy. Therapists reported that they are under pressure to provided services within limited time periods to a large number of patients and that documents they prepare reflect this approach. Thai occupational therapists also emphasised that in using this model, outcomes could be concretely measured, such as the increased number of clients treated and discharged, and the improvement of motor and feeding activities. This concrete outcome responded to the demands of employers and/or doctors.

WAOTs stated, *"Clients want to be fixed in a week" (WAOT, Group 1, p. 29)*

"Parents will think you are going to fix everything over a very short period of time" (WAOT, Group 2, p. 25)

"The people who run hospitals are interested in time management" (WAOT, Group 1, p. 32)

"The employers would like to see as many as soon as you can in the least amount of time" (WAOT, Group 2, p. 27)

"The medical mode is very medically focused and I think that's not OT" (WAOT, Group 1, p. 34)

ThaiOTs stated *"Patients would like to depend on occupational therapists because they believe occupational therapists can run the program or train them better than they do by themselves" (ThaiOT, Group 2, p. 4)*

"The director would like to see concrete outcomes, he is not aware of the limitation of space and the shortage of staff" (ThaiOT, Group 1, p. 8)

The benefits of this model in the view of both Western Australian and Thai participants was associated with underlying beliefs that they could manage clients' problems within a short period of time, and while meeting the basic demand of clients and employers. However, Thai occupational therapists were more focused on the benefits of concrete outcomes, such as improvement of motor or basic self-care

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activities, which can be objectively presented to the medical profession. This focus can, no doubt, affect quality of life, and meet some needs of clients.

The traditional approach of medical practitioners is that an external agent repairs the patient. In contrast, the dominant occupational therapy viewpoint emphasise active involvement of the patient (i.e., "using occupation as a means of self-regulation") (Kielhofner, 1997b, p. 39-40), even when applying medical model principles. Although the Medical Model is generally viewed as controversial within occupational therapy, which values holistic approach (Hagedorn, 1997), this approach was given evidence by participants from both countries because it is practical to use, particularly in acute settings where a response is required to a medical crisis. Furthermore, it is also consistent with employers' and clients' demands to deal with problem in a limited time. In Thailand, most occupational therapists work in hospitals in acute medical settings, mainly with people with physical disabilities, and necessarily practice under the Medical Model umbrella (Department of Occupational Therapy, 2002a; Occupational Therapy Association of Thailand, 2002). Thus, both authority of medical practitioners and the demands of clients in acute settings influence the practice of ThaiOTs.

4.2.3.3. Considerations of culture

Western Australian participants reported this model does not attempt to deal with cultural issues, nor with the key needs of clients and their families. Thai participants did not specifically mention cultural implications.

"You cannot just work from a totally developmental model if there are cultural aspects. You will need to look at your family-centred approach, and what is important for the family. So you need to see from a cultural perspective what is important, and what are their expectations". (WAOT, Group 2, p. 8)

Western Australian occupational therapists are concerned that the Medical Model does not consider the needs and cultural context of clients and their families. It does not treat the disability as it affects the client's daily life (Fleming & Mattingly, 1994), nor fully satisfy the needs of people with disabilities who are discharged into the community (Hagedorn, 2000). This is a tension in occupational therapy, which has been described as "a health discipline rather than a medical discipline because occupational therapy's focus is on the effects of disease or injury

on everyday living and has a uniquely non-medical focus" (Christiansen, 1991, p. 4). In addition, the Medical Model does not provide an opportunity for active participation or engagement for clients, nor let them attempt things for themselves, which is more consistent with the activist approach prefer by Western people (Parry, 1984).

4.2.3.4. Conclusion and discussion of the Medical Model

Both Western Australian and Thai therapists reported this model focuses on giving clients basic functional skills to facilitate safe early discharge. Both agreed that the Medical Model can solve clients' specific problems in short period of time, and thus is suitable for acute settings. Both groups also applied this model regularly to respond to demands of employers and established policies within an acute setting. However, given limited time, Western Australian therapists paid some attention to the concerns of clients, their families, and their mutual interaction in planning occupational therapy interventions. WAOTs are also concerned that the Medical Model does not consider cultural implications, nor is it consistent with the overall philosophy of occupational therapy.

In contrast, given limited time, Thai therapists design intervention's based on their own professional experience, their own assessment of the situation, and medical reports, and regularly apply techniques that are aligned with the Medical Models, specifically biomechanics and rehabilitation models for short term results. Thai therapists are also concerned with demonstrating the benefit of treatment through concrete outcomes, such as improvement of motor and basic self-care activities, which can be presented to the others. Both the Performance Model and the Medical Model address function, but the scope or level of function described in each model is different. The Medical Model focuses on minimum self-care functions, which in Thailand mainly refers to feeding and bed mobility training, so that clients can return to a home environment with adequate support in other functions. In addition, the Medical Model emphasises discharge readiness, rather than achieving functional outcomes or independence.

To learn how often participants actually use the Medical Model, the specific names of particular techniques or models that occurred during discussion were counted. It was found that the Medical Model was the major model actually mentioned in relation to clinical practice in Thailand. In contrast, in discussions

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Australian participants implied they were attempting to move away from reliance on the Medical Model, and to distance themselves from its authoritarian structure. Hence, they reported they used this model least. ThaiOTs implied the Medical Model best suits their cultural context. Despite limited time, most Thai therapists are not concerned about the limitation of the Medical Model, because they know the clients will receives supporting in an array of functions or issues from their families after discharge, based on their understanding of the values of interdependence and family participation in Thai culture. Conversely, Western Australian therapists are concerned with limitations of the Medical Model. That is, this model relies only on specific occupational therapy technical skills, and does not encompass the wider health-oriented perspectives of the profession -*(active participation, health promotion and prevention)*- and does not consider other needs and cultural requirements of clients. For this reason, Western Australian therapists use the Medical Model least in their practice.

The Medical Model, as described in focus groups, mainly derives from a reductionist perspective. This approach focuses on the basic self-care necessary for safe discharge, and solves clients' specific performance problems in a short period of time. Techniques or models that can readily treat the problems of each performance component underlying a particular dysfunction, especially in basic self-care, are used to assist clients to improve or maintain their basic function (Baum & Christiansen, 1997; Kielhofner, 1997b; Semrad, 1956; West & McNary, 1956). Approach based on therapists' clinical knowledge are the main component of interventions without considering clients' needs, choices, and cultural contexts (Kielhofner, 1997b). Thai therapists are likely to respond from the Medical Model perspective and adopt a role of a professional 'expert' in servicing clients. Alternatively, Western Australian therapists also at least briefly consider the concern of clients and their families, in order to provide interventions that are likely to meet the needs of clients when they return home.

4.2.4   Professional Issues

In addition to discussion of professional models, focus group participants were encouraged to discuss a range of professional issues. This discussion covered factors contributing to job satisfaction and dissatisfaction, and therapists' views on occupational therapy as a satisfying or unsatisfying career. The findings of Western

Australian and Thai therapists are reported separately, under the broad themes of job satisfaction and dissatisfaction, and sub themes of each.

4.2.4.1 Sources of job satisfaction of Western Australian therapists--
Exciting, interesting, flexible, and valuable

When asked about job satisfaction, Western Australian occupational therapists reported that they viewed occupational therapy as a satisfying career because it is exciting, interesting, and flexible. In addition, they viewed their work as valuable. The following statements supported these views.

"It is exciting ... and in order for it to be successful, it is taking a lot of energy and a lot of my personal to really see it blossom. But it is starting to ... it is rewarding" (WAOT, Group 1, p. 38)

"It is very exciting to work on new things" (WAOT, Group 1, p. 38)

"Having the contact with many interesting people" (WAOT, Group 1, p. 39)

"The profession is flexible, there are so many areas we can work in, you have got some choice within the profession. (WAOT, Group 1, p. 40)

"I really value what I have learnt as in how I see people and how I see the world through being an occupational therapist" (WAOT, Group 1, p. 39)

"The profession is really valuable, and I think every job within the profession has its limitations and dissatisfactions" (WAOT, Group 1, p. 39)

The job satisfaction for Western Australian occupational therapists appeared to be associated with four main underlying views which emerged from the data. Occupational therapy is: exciting, interesting, flexible and valuable. The data suggest these ideas are interrelated, and significantly affected Western Australian therapists' vision of their profession and its success.

4.2.4.2 Sources of job satisfaction of Thai therapists--*A holistic approach and contribution*

Thai occupational therapists reported that they views occupational therapy as a satisfying career, in which people can be understood from a holistic approach, even if they generally apply the holistic approach only part of the time in the assessment process. The following statements supported these perceptions.

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"Occupational therapy relates to the need of a person both physical and mental aspects" (ThaiOT, Group 1, p. 9)

"I am proud of the content of profession which see a person as a holistic" (ThaiOT, Group 1, p. 9)

"I am happy that we can help patients" (ThaiOT, Group 1, p. 9)

"I am proud of being an occupational therapist. I can contribute to others" (ThaiOT, Group 2, p. 10)

"The scope of occupational therapy is broad, we can do many things" (ThaiOT, Group 1, p. 9)

"Occupational therapists can do many things and occupational therapy is useful for living skills, I appreciate that occupational therapy is creative and unique" (ThaiOT, Group 1, p. 9)

"Occupational therapy is different from the other (health professional) and patients need this" (ThaiOT, Group 1, p. 9)

Thai therapists seemed satisfied with occupational therapy's broad scope in covering all aspects of a client's life, and with contributions it can make in responding to clients' needs, for example, in living skills. By these successes the profession is able to show its identity.

4.2.4.3 Discussion of job satisfaction

Both Western Australian and Thai therapists agreed that occupational therapy contributes to an understanding of people from many different viewpoints. Therapists from both countries recognise the benefit of occupation in supporting health, and value occupational therapy's contributions not only to clients, but also to the broader public. Thus, they are satisfied with what OT can contribute to society. These views were supported in a study by Davis and Bordieri, (1987) regarding perceived autonomy and job satisfaction among occupational therapists. The study showed that job satisfaction was highly positively correlated to the perceived autonomy of the profession. Furthermore, the nature of the work itself was perceived as an incentive (Davis & Bordieri, 1987). Western Australian therapists express satisfaction during the focus groups that occupational therapy is a flexible profession in which they can make choices to work in many different areas. This result concurs with a study by

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Wright (2001) on occupational therapy, that asked "what makes you stay in the profession". This study found that occupational therapy provided flexibility in career choice, allowing therapists to work with various groups of people (Wright, 2001).

4.2.4.4 Sources of job dissatisfaction of Western Australian therapists-- Broad scope, lack of acceptance, and limitations of time and system management

In describing job dissatisfaction, Western Australian occupational therapists reported the following:

"I will never get to the end, I just never see I will have time to complete things. I know it is partly my own lack of time and management planning, but there are many things. I guess in my job too" (WAOT, Group 1, p. 38)

"In mental health, OT is so broad that one of the difficulties is to get standing and respect from the other professions; we actually aren't expert in that area but we are actually trained broader" (WAOT, Group 1, p. 39)

"People don't give you a free way to do all that you know and you can do" (WAOT, Group 1, p. 39)

"Occupational therapy was very very low on the list of all other professions. We are not in this for the money, but in a way that shows you how society values it" (WAOT, Group 1, p. 40)

"They pay us the same as the check out in the supermarkets (clerks). And we have much more responsibility than them" (WAOT, Group 1, p. 40)

The job dissatisfaction of Western Australian therapists appeared to be associated with concerns that the scope of the profession can be almost too broad, that there is a lack of acceptance or understanding from other professions and society, and that limited time, and overall health system management are problems. Additionally, they feel they are not treated as true professionals, with their value to society not fully recognised, despite the responsibility they undertake.

4.2.4.5 Sources of job dissatisfaction of Thai therapists--Salary, unclear roles, non-recognition, and non-specialisation

On this issue, Thai therapists reported they were also dissatisfied with their salaries, their unclear roles, lack of understanding and recognition by other

professionals about their contribution to the health of society, and lack of respect as a specialised professional entity. The contribution of occupational therapy in returning patients to active participation in society is not widely recognised, despite success in rehabilitating people with severe disabilities. In addition, the level of education of clients and Thai culture has an impact on occupational therapy practice. The following statements support these categories.

"I am not satisfied with my salary" (ThaiOT, Group 1, p. 9)

"The other professions do not understand occupational therapy roles, and think they can do the same things as occupational therapists do, such as nurses" (ThaiOT, Group 1, p. 10)

"The higher executives do not understand occupational therapy roles" (ThaiOT, Group 1, p. 10)

"I am frustrated that those colleagues and patients do not understand occupational therapy roles" (ThaiOT, Group 1, p. 9)

"Occupational therapy is not well-known and not accepted in society" (ThaiOT, Group 1, p. 9)

"Many people do not know there is occupational therapy in Thailand" (ThaiOT, Group 2, p. 9)

"The Government has not treated occupational therapists as equal to the other professions" (ThaiOT, Group 2, p. 10)

"The words 'occupation' make others think it means vocation" (ThaiOT, Group 2, p. 10)

"I am not quite impressed with the characteristics of occupational therapy. The potential of the profession is not outstanding. It is not clear and too broad. We capture everything" (ThaiOT, Group 2, p. 10)

"Their relatives feel ashamed to bring the disabled to get services. We have the culture to take care of people with disabilities"(ThaiOT, Group 1, p.10)

"The value of people with low education is that anything they get free of charge is not worthy" (ThaiOT, Group 1, p. 10)

"Most people with disabilities in rural areas would like to depend on the People with Disabilities Act" (ThaiOT, Group 1, p. 10)

4.2.4.6   Discussion of job dissatisfaction

Both cultural groups expressed dissatisfaction with the lack of acceptance and recognition from other professions and society in general. Western Australian therapists complained that the scope of OT is too broad. Thai therapists complained that the roles of occupational therapists are unclear. Within the literature, the definition and scope of occupational therapy does indeed cover a wide range of services and clients. It includes daily living skills such as self-care, work, and leisure, for people who have limited ability to perform these skills. Occupation, which is the medium of treatment, is often perceived by others as common activities of everyday life that possibly anybody can apply in a common sense manner (Hagedorn, 2000). This view may lead other health professionals and employers to view occupational therapy as simplistic and lacking a significant professional status within the disability sector, due to its, scope and complexity of intervention that are not easily understood by others (Hagedorn, 2000). Even though therapists themselves understand the benefits of occupational therapy for the daily lives of clients, the public is unlikely to understand the profession unless better knowledge is actively promoted. Acceptance and recognition remain an issue for the OT profession in both countries.

Thai focus group participants seemed dissatisfied with several features of the occupational therapy profession. They complained about: lack of understanding and acceptance from related professions, health executives and society; unclear job descriptions; inadequate public relations on behalf of the profession; negative influences of Thai culture; and frequent misconceptions on the part of clients. These underlying conceptual problems are likely to be major obstacles to effective development of occupational therapy in Thailand. Therefore, Thai therapists need not only apply theoretical models appropriately in their practice, but must also promote their profession through education, research, and best practice examples, in order to be accepted by other professions, government, and society.

In Thailand, where occupational therapy is a new health profession, the terms 'occupational therapy' and 'vocational therapy' are often mistakenly assumed to be the same. In large part this is due to the complexity and broad scope of OT services, and to its introduction in Thailand only over the last 20 years on so. In addition,

caring for people with illness and disabilities is usually perceived as a normal part of interdependent family relationships and as a 'good deed' in Thai culture rather than as a professional activity (Hatthakit, 1999; Triandis, 1995) further hindering effective provision of services. These perceptions have their effect on the performance of Thai therapists and very likely contribute to their job dissatisfaction. The tension between the professional ideal of being a flexible, holistic, client-centred service provider, and working within very limited economic resources, leads to ambivalence about what should be the focus of the profession. At a simpler level, this perhaps reflects a conflict between technical competence and the broader patient-centred philosophy about client intervention.

4.2.4.7 Conclusion

Both Western Australian and Thai therapists are satisfied with the inherent contribution of occupational therapy to everyday health of people. However, lack of recognition from the public and relevant organizations is an issue in both countries. This lack is thought to hinder the development of occupational therapy, especially in Thailand where the profession is still new and has yet to find a clear position within the health care system. Compared with Western Australian therapists, Thai therapists were dissatisfied with many aspects of occupational therapy, which has among other things led them to try to find and apply frameworks more appropriate to Thai culture, and to promote their profession within the medical system and within the broader society.

4.2.5 Culture

Culture influences the practice of both WA and Thai occupational therapists, as reported by all focus groups. In applying the theoretical or generic models in practice, participants reported routinely modifying the aims of each model: for example: How can they be applied? With what kind of clients can they be applied? and Under what cultural circumstances can they be usefully applied? In addition, they reported on how constraints as well as the benefits within their cultural contexts affected application of each model. The following themes and statements describe the perceived influence of culture in applying models to practice.

4.2.5.1 Individualism and autonomy

WAOTs stated, "Letting people have the dignity of risk, being able to take the risks and try things out for themselves" (WAOT, Group 2, p. 16)

"In Western society, culture is very much you go out and you do it yourself, very individualised" (WAOT, Group 1, p. 19)

These statements by Western Australian therapists assume the value of individualism and autonomy, a view well supported in the literature (Krefting & Krefting, 1991; Phipps, 1995; Triandis, 1995). The value of individualism is closely associated with the perceived aim of the Performance Model, in which is to focus on independent performance. Independence is reported as contributing to human dignity (Sabonis-Chafee, 1989; Sabonis-Chafee & Hussey, 1998), and seems to suit people in Western societies. The value of individualism and autonomy is also very compatible with the Whole Person Model, which focuses on enhancing and maintaining performance outcomes in accordance with individuals' needs and choices, within their environmental context. Hence, the Whole Person Model is also appropriate to people in Western cultural contexts. Autonomy is embedded in occupational therapy philosophy (Rogers, 1982b), and become focus for measuring the effectiveness in client performance of life roles (Dunn et al., 1995). Autonomy refers to the ability to make choices compatible with one's needs (Rogers, 1982b). Therefore, autonomy is the basic aim of the Whole Person Model in OT practice.

4.2.5.2 Family-centred approach and value of interdependence

In non-Western, Thai culture, focus group participants noted that a family-centred approach together with an emphasis in interdependence, as seen in Thai culture necessarily influences the practice of occupational therapists. The following statements support this theme.

A Western Australian therapist suggested that *"In Asian communities, it is very much a family-centred approach; they look after their own family and have extended family" (WAOT, Group 1, p. 19)*

Thai therapists noted that, *" In Thai culture, we uphold the value of caring for people with illness or disabilities" (ThaiOT, Group 1, p. 10)*

"In Thai culture, we have extended family and the value of gratitude, so we take care of family members with illness or disabilities" (ThaiOT, Group 1, p. 10).

WAOTs have noted that clients in Australia from Asian communities tend to focus on the family. Thai therapists, in turn, emphasise widely-held cultural values that favor family care for people with illness or disabilities.

These findings are compatible with studies of occupational therapy in Chinese culture by Jang (1995) and in different cultural and language speaking backgrounds by Fitzgerald, et al. (1997), which posit that cultural issues affect health beliefs and behaviour significantly in that sick people from non-Western communities may take on passive roles and depend on families and others to care of them.

In Thailand, the dynamic system of families with a sick member, must adjust their roles as needed, for example taking over the sick person's normal responsibility and allocating specific care responsibilities to family members within the extended family (Hatthakit, 1999; Hirunchunha, 1999; Pradapmuk, 1999). In addition, the sick can choose to perform some self-care activities within the range of his or her physical ability, and ask family to perform other activities beyond those abilities (Hatthakit, 1999). The boundary of responsibility in tasks, financial support, and caring tend to be shared among family members (Potaya, 2001), or might be interchangeable among the client, caregivers, and other family members in order to maintain family functioning (Hatthakit, 1999). This is the essence of interdependence within the family.

From the literature, 94 percent of Thais are Buddhists (Anonymous, 2002), who generally believe that caring for the sick or people with disabilities infer religious merit, and thus it is a family responsibility to look after a family member who is sick, frail or disabled, especially caring for elderly parents, which is perceived as conferring particularly abundant merit (Chaoum, 1994; Hatthakit, 1999; Triandis, 1995). The values of interdependence within the family and caring for a family member who is sick or disabled in Thai culture may be seen contradict to the value of independence in Western culture. This point is noted in the studies of Dyck (1991), Kinebanian and Stomph (1992), and Jang (1995). Placing a high value on interdependence is likely to deter Thai therapists from effectively applying the Performance Model, with its focus gaining independence for clients.

Logically, the Medical Model is more likely to be more concrete in application, because it is based on mechanistic and reductionist values (Kielhofner, 1997b). And in fact, the Model does not focus on the impacts of disease, injury, and disability on the clients' daily life (Baum & Christiansen, 1997; Fleming & Mattingly, 1994). Nevertheless, the Medical Model was viewed by Thai focus group participants as most appropriate to Thai culture. This seems to be because most Thai therapists work in acute medical settings which are doctor-oriented structures (Department of Occupational Therapy, 2002a; Occupational Therapy Association of Thailand, 2002), and because family support is generally available after clients are discharged to their homes. Additionally, most ThaiOTs work in acute care setting, so that they do not have enough time to train clients to maximise or maintain ADL independence, even though they accept that this should be the focus in the hospital. Thai culture influenced not only the application and use of the generic models identified by Thai participants, but also their job satisfaction, as noted previously.

Western Australian occupational therapists noted that therapists should be competent to understand differences in clients' cultural backgrounds and able to accept each client's cultural values as directly relevant planned interventions. This is reflected in their consideration of the importance of culture in their discussion of all practice models. In addition, they suggested that beliefs about independence need to be considered in deciding whether independence should be a goal pursued on behalf of clients, their families, or any significant others.

Thus, Western Australian occupational therapists seem to apply culturally sensitive practices more readily than Thai occupational therapists. In the focus groups, Thai therapists did not acknowledge the need for culturally competent therapy, whereas Western Australian therapists often did so. It is possible this is because Thailand is less consciously a multicultural country than Australia, and that cultural diversity issues are seldom given public attention. In fact, that majority of Thai people share a similar cultural background. Although a few groups in Thailand originate from different races or religions, most come from Asian countries whose cultures emphasise family duties and interdependence, and therefore have something in common with Thai culture. For this reason, it is easy for these groups of Thai people to assimilate with some aspects of Thai culture. It is also possible that Thai occupational therapists might not have enough experience of applying cultural

analysis even though they readily identify the cultural shortcoming of action models that are not compatible with interdependence between clients and their families in Thai culture.

Western Australian therapists have found ways to apply their models with Asian clients, but ironically Thai therapists have not. Thai therapists seem more comfortable in an expert role, generally providing therapist-defined services in hospitals or institutional settings and almost always choosing to focus on performance components and ADL. However, they have found that in focusing on ADL, and only a sub-set of self-care activities are directly applicable to clients' homes. Therefore, Thai therapists might do well to consider the requirements and solicit the agreement of both clients and families, taking into account their ability to undertake key tasks, and their cultural context in order to provide appropriate interventions.

4.3 Discussion and Conclusion

From the focus group findings, it is important to note that the models named and identified are drawn from the perceptions of group participants, and reflect their level of integration of theory to practice. Ambiguity is evident from the participants' descriptions of the models, their philosophy, clinical application, and relationship to established occupational therapy-specific models or wider health models. It was apparent from discussion that many participants were eclectic in their use of theoretical models, or had only limited knowledge of the specific occupational therapy models reported in the literature. For example, many Western Australian therapists reported using the Canadian Model of Occupational Performance. However, with more in-depth discussion, it was revealed that they were referring to the Canadian Occupational Performance Measure (COPM), which they used to evaluate performance of their clients. They knew little about the overall theoretical model it is derived from. Thai therapists reported the MOHO, which integrates body and mind in interaction with occupation in the environment in order to maintain normal functioning (Kielhofner, 1997b), as the Whole Person Model based on the holistic approach. In fact, the MOHO is only one of a number of occupational therapy models that emphasises the holistic approach. However, according to the perception and knowledge that they might have about MOHO in the Thai context of

education and practice, participants quoted only the MOHO with the Whole Person Model.

Occupational performance is a unique term that occupational therapists use to express function (American Occupational Therapy Association, 1995b), or explain functional competence (Baum & Christiansen, 1997). Hence, the word 'function' is used interchangeably with occupational performance or performance by occupational therapists (American Occupational Therapy Association, 1995b). However, the word 'function' is often used in medicine to refer to the specific operation of human organs (Christiansen, 1991), and in the medical literature to describe "the ability of an individual to accomplish tasks of daily living" (Christiansen & Baum, 1997a, p. 5). Therefore, function is more familiar to health professionals than performance. It is possible that occupational therapists in this study use 'function' to mean 'performance', which is more understandable to the other health disciplines. In addition, many therapists appeared pragmatic in actually applying theory, letting the clinical setting determine the parameters for practice, which are frequently restrictive and therefore limit the scope for applying comprehensive theoretical models clinically.

Hence, the descriptors used to categorise the 'real' use of theory in occupational therapy practice, as reported by participants, are not solely derived from occupational therapy models, but include the incorporation of broader health models such as the Medical Model and holistic model. For example, the identified Performance Model, whilst aligned with those identified in the occupational therapy literature, does not precisely reflect theorists. Based on participants' reported perceptions, there appears to be some discord or tension between the perspectives of occupational therapy theorists and how their theories are actually applied by clinicians in practice. This raises interesting questions about the philosophical viability of theory application in a range of practice settings in occupational therapy that need to be addressed. Many of the perceived methods of working appeared to be limited to technical interventions, rather than wider health-oriented involvement based on more comprehensive professional reasoning.

For the above reasons, in order to question occupational therapists about actual application of models currently used in practice, questions needed to be built around perceptions therapists hold about theory and conceptual models, and not only on the

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theoretical literature. Models, based on the findings and discussion in focus group interviews, and actually used in OT practice, will be useful understanding application of OT theories in practice, and provide useful guidelines for modifying the theories to better-fit actual practice.

It is also important to note that, whilst participants were selected from representative areas of practice within their own cultures, most Thai therapists work within medically oriented institutions, largely in acute care settings. In Australia, occupational therapists are mostly based in rehabilitation or clinic settings, but with a growing trend to community-based practice.

The study indicates that occupational therapists' cultural backgrounds are reflected in tradeoffs between meeting clients' needs and taking into account their environmental context. Contexts include not only the family and social setting, but also the service delivery setting. Moreover, service delivery models in health care systems influenced occupational therapists in selecting and applying conceptual models to their practice. These influences may create a tension between limited, and more comprehensive interventions. Furthermore, the perceptions and interpretations that occupational therapists hold about theories and conceptual models and cultural context of practice, also affect what and how they select and apply conceptual models to practice. In addition, occupational therapists emphasised the need to understand, and potentially meet cultural expectations. Overall, the conceptual models selected by occupational therapists for practice were based on their own knowledge, understanding, skills and attitudes; the contexts of their services; the specific needs of the clients and environment, the family and significant others; and their culture. Theoretical occupational therapy models developed by scholars and taught in occupational therapy schools are not the only basis for determining the theory of practice. To survey models actually applied in practice, occupational therapy practitioners must be relied on to provide information for developing a questionnaire and in turn be the target group the survey.

Thai occupational therapists in particular, who have adopted models of practice developed in Western culture to their practice, may need to adopt a more critical appraisal of the relevance of these models. Specifically, more analysis about cultures not only their beliefs and values, but also how the current health care system and government policies affect occupational therapy practice is needed. Eventually, the

practical theoretical models for practice can be further developed, modified, or extended by Thai occupational therapy practitioners, themselves, in order to more appropriately meet the demands of Thailand.

4.4 Preliminary Recommendations for Occupational Therapy Practice and Education and Health Care Policy in Thailand

In occupational therapy practice in Thailand, the relative importance of interdependence within the client's family should be carefully considered. The conventional Western aim of achieving independence in an *individual client's performance* can be usefully shifted to independence of *a family unit's performance* emphasising collaboration between the client and family in order to achieve a satisfactory performance outcome for the client. Moreover, therapists should consider needs of both the client and family in setting goals of the intervention and undertaking intervention programs. Furthermore, therapists should be concerned about the client's way of living, his or her interactions with family, the cultural and environmental context of the client and family, and potential and resources of the family unit to provide useful information and interventions within the home. In addition, therapists should enhance the potential of the client and family, and empower them to look after themselves at home, through education and training programs, and making appropriate home modifications and introducing self-help devices. Collaboration among therapists, clients, and family should be a concern throughout the OT process, to ensure interventions are effective for the client and family, and maintain the effective functioning of the family. Therefore, therapists should visit clients at home and expand their roles into the community. These concepts should be incorporated into OT education, so that OT students have broader vision for viewing and understanding clients and families in their cultural and environmental context.

Extending occupational therapy services into the community should be proposed to the government, thus strengthening a health care policy that promotes health prevention/promotion and community participation. The Occupational Therapy Association and representatives of the occupational therapy profession at the Ministry of Public Health should point out that OT services restricted to hospitals

or similar institutions are not effective for clients after they are discharged to live at home and in their communities.

CHAPTER 5

Questionnaire Design

5.1 Introduction

The findings from the focus group interviews provided information about practices of occupational therapists in Western Australia (WA) and Thailand. Therapists' perceptions about applications of theoretical models to practice were also examined. Then, in order to obtain information from a large number of occupational therapists in both WA and Thailand, a questionnaire was developed. The questionnaire probed similarities and differences in practice in an Eastern and a Western culture. Thailand was again selected to explore therapists' perception about the application of conceptual models for practice in an Eastern, developing country setting. Australia provided an example of a Western, multicultural country.

Data from the Australian context was considered critical for establishing a point of reference for understanding the application of the same models in Thailand, where a relatively young occupational therapy workforce applies the models in a culture different from that of their theoretical origin. This reference point was required to avoid bias in drawing conclusions about the application of conceptual models in Thai culture.

This chapter outlines the draft questionnaire development process (Section 5.2), finalisation of that questionnaire (MCPQ) (Section 5.3), preparation of the Thai version (Section 5.4), and carrying out normality and reliability testing after the main survey was completed (Section 5.5).

5.2 Draft Questionnaire Development

The purposes of using any questionnaire can be generally summarised as:

• to collect data from a large number of people;

• to obtain information from people dispersed geographically, such as in Western Australia and Thailand (Deschamp & Tognolini, 1983);

• to minimise social bias and interviewer distortion and assure the anonymity of respondents (Deschamp & Tognolini, 1983; Woodward & Chambers, 1991);

• to save time and resources (Deschamp & Tognolini, 1983).

The reasons for including a questionnaire in this study were to validate findings from focus group interviews, to expand the findings from focus group interviews, and to provide valid observation on cultural difference between Thai and Western Australian OTs.

The themes emerging from the focus group interviews (Chapter 4) become the main components of the questionnaire. Part A gathers demographic data used to describe the sample. Parts B, C, and D are based on key themes that emerged in the preliminary study (See Appendix F). The four parts were:

Part A: Background and Demographic Information,

Part B: Models of Occupational Therapy Practice,

Part C: Occupational Therapy Practice,

Part D: Practice comments: Open-ended questions.

Parts A, B, and C was composed of closed-ended questions, whereas part D sought elaborated information and was therefore constructed as open-ended questions. Parts A and B were constructed so that the respondents were required to select from a range of possible responses. Part C required respondents to choose a response from a four-point Likert scale that ranged from strongly agree (4) to strongly disagree (1). A four-point scale was used to avoid a mid-point value because people have a tendency to choose the mid-point rather than positive or negative responses (Deschamp & Tognolini, 1983). The original questionnaire included 111 items, 10 in Part A, two in Part B, 96 in Part C, and three open-ended questions in Section D (See Appendix F).

5.2.1   Part A: Background Information

Part A, Background Information, covered ten demographic characteristics; gender, age, marital status, highest level of education, place of graduation (state or country), number of years working as an occupational therapist, type of work, current position, clinical work area, and the clients mainly worked with. In last three items, respondents could select more than one choice.

5.2.2 Part B: Models of Occupational Therapy Practice

Part B, Models of Occupational Therapy Practice consists of three generic occupational therapy models and more specific models. The definition of each generic model, as well as the names of the models, mainly derived from the findings of the focus groups analysis. The three generic conceptual models were: the Medical Model, the Performance Model, and the Whole Person Model. Respondents were asked to select the one of these three models they most applied to practice. The three generic occupational therapy models were defined as follows:

From the draft questionnaire, The Medical Model is described as solving each part of the patient's problems under the supervision of health professionals and/or developing minimum function to permit discharge. This model consists of the Neurodevelopmental Approach, Sensory Integration, Biomechanical Model, Rehabilitation Model, Behavioural-Cognitive Model, and Psychoeducational Approach.

The Performance Model includes acknowledging the performance of clients in different functional areas, components of performance, functional skills for survival in daily life especially self-care and maximising the clients' independent functioning in their life roles.

The Whole Person Model includes the clients' performance, roles, habits, and the environment of clients as well as the clients and their families' needs relative to quality of life which focus on what are important for cleints and their families as well as on their satisfaction.

The more specific occupational therapy models referred to in the questionnaire included the Model of Human Occupation (MOHO), the Canadian Occupational Performance Model, the Occupational Performance model, the The Person-Environment-Occupation Model, Allen's Model of Cognitive Disabilities, and a model which could be described and labelled by the respondents. The mentioned models were provided in a checklist form in which respondents could select more than one.

5.2.3   Part C: Occupational Therapy Practice

Part C provided the main data collection tool and consisted of five subsections as derived and related to the focus group analysis, and included Clients, Therapists, Intervention, Cultural Implications, and Health Care Systems.

Section 1 of Part C, labelled '*Clients*' has 13 items (1- 13) designed to obtain an understanding of how therapists perceive clients' expectation of them and their services.

Section 2, labelled '*Therapists*' included 20 items (14- 33) designed to obtain the respondents' views of their theoretical and practical focus as professionals. Items examine clinical experiences and practice approaches as well as perceptions of recognised models and practice.

Section 3, '*Intervention*', contains 37 items (34- 70) designed to obtain respondents' views on application of the conceptual models and their relationship to practice; interventions; and outcome expectations.

Section 4, '*Cultural Implications*' has 18 items (71- 88) designed to obtain respondents' views on culture and cultural implications for their practice. Culture is defined for the respondents as all knowledge that humans learn as members of social groups that includes values, beliefs, and customs of family, community, and society (Christiansen & Baum, 1997b; Hasselkus, 1997). Item 58 consists of two parts: item 58A requires a response from Thai (Eastern culture) therapists or Australian therapists who had experience with clients from Eastern cultures, and item 58B is for Australian therapists with no experience with clients from Eastern cultures. Item 58A was included in the Thai version and both items 58A and 58B were included in the English version.

Section 5, '*Health Care Systems*' includes 8 items (89- 96) to obtain views on systems in which respondents work, including policies of health institutions, community, and government; budgets; facilities; and resources.

In summary, Part C, Occupational Therapy Practice is divided into 5 sections: Clients, Therapists, Intervention, Cultural Implications, and Health Care Systems. *Clients* examines the therapists' view of clients, *Therapists* refers to the therapists' views about themselves as professionals, *Cultural Implications* refers to how

therapists incorporate culture in their practice; and finally *Health Care Systems* refers to policies, budgets, facilities, and resources.

5.2.4   Part D: Practice comments (Open-Ended Questions)

To allow therapists to add any additional information, three open-ended questions were included as Part D. The questions were:

1) Have the theoretical frameworks, which underpin practice assisted you in client interventions? This item provided both for Yes/No answer and blank space for providing reasons.

2) What are the limitations of current frameworks for application in your country?

3) Make a list of what you would like to include in a new framework for practice.

The open-ended format required respondents to create their own answers and state them in their own words (Aiken, 1997; Woodward & Chambers, 1991). Open-ended questions are valuable when more details of the respondents' attitudes, beliefs, and thoughts are desired, and when closed-ended questions cannot define the concerned variables clearly enough for assessment (Aiken, 1997). The main purposes of open-ended questions in this study were to clarify the answers from closed-ended questions, solicit suggestions, and find the most prominent aspects of occupational therapy practice (Woodward & Chambers, 1991).

5.2.5   Developing the Questionnaire from the Findings of Focus Group Interviews

Part B (Models of Occupational Therapy Practice) included two sections. The first was based on the three generic models of practice and included a definition of each model as determined from focus group findings. The second section identified more specific occupational therapy models described in the focus groups and from the experience of the researcher in recognising specific models discussed by participants, but were not necessarily named by participants.

In Part C: (Occupational Therapy Practice), all subsections are based on themes drawn from the focus group findings, which explain how to apply each generic model in occupational therapy practice. The main concept or aims of each model, location and generalisation which includes their application, constraints, and benefits of the model, and the effects of culture and professional issues, were reorganised

under the headings: Clients, Therapists, Culture, and Health Care Systems, in order to further clarify a number of factors in a larger sample of occupational therapists. Any content that was not directly related to Clients, Therapists, Culture, and Health Care Systems, but related to how to apply the models to practice, together with the reported outcome expectations of therapists and clients, were included in an additional section labelled 'Intervention'. Culture was relabelled 'Cultural Implications', as this label was more relevant to those aspects of culture being investigated in relation to occupational therapy practice. Finally, the relevant statements about Clients, Therapists, Intervention, Culture, and Health Care Systems created items for each of the five subscales.

In part D: Practice comments (open-ended questions), the first and second questions were derived from the concepts generated about constraints and benefits of each model as identified in the focus group findings. The third question was derived from discussion of professional issues in the groups.

5.2.6 Validating the English Questionnaire

Face validity (content and construct validity) of the questionnaire was examined in two steps. First, a preliminary review was undertaken by six experts in questionnaire design and occupational therapy theory, and then, after modification, by a further 10 experienced clinicians who were identified as within the target population of the survey.

The first six reviewers included five senior occupational therapy academic staff and a senior clinician. All were identified as either experts in questionnaire design or as having extensive knowledge of theory and clinical practice. This portion of the validation process was aimed at production of a first draft suitable for further testing. Each expert was asked to read the questionnaire and then provide verbal and written feedback on content, format, and design. All comments were reviewed and changes made accordingly. Feedback from the experts led to modification of the questionnaire presentation, constructs, and content, as well as the wording of some items.

The modified questionnaire was then further evaluated for face validity by 10 clinical occupational therapists currently working at teaching hospitals in the metropolitan region of Western Australia. Occupational therapists were selected

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through purposive sampling. Each Head of an occupational therapy department from a teaching hospital nominated one clinical occupational therapist to participate in this evaluation. The draft questionnaire was mailed to them. The main purposes were to

- verify the questions;

- define the main headings of subscales;

- clarify the statements;

- evaluate the adequacy of the instructions;

- perceive the relevance of the items in each subscale;

- determine average completion time; (Woodward & Chambers, 1991).

Therapists were asked to complete the sample questionnaire and provide written comments on items that were not clear or not relevant. Additional or overall comments were also welcomed. All written comments were reviewed.

5.2.7   Outcomes of Questionnaire Review

The response rate from Western Australian occupational therapists reviewing the questionnaire was 80 percent, as eight therapists provided feedback on the questionnaire. Each therapist contributed information of a unique nature, with little overlap in comments. Thus, each comment was individually considered and changes were made based on the comments, and in light of findings of the focus groups. Two respondents reported that the time spent on filling out the questionnaire was too long and that this might affect the response rate. A third respondent suggested reducing the number of items due to the length of time for completion, but did not elaborate further.

Therapists reported high levels of agreement on Parts A, B, and D. Only minor changes were made in Part A and B; no changes were suggested for Part D (See Table 5.1). In Part A, the changes were made in the content of items 3 and 8 but there was no change to the original number of items.

In Part C, most comments were related to the Likert scale items. Resulting modifications included removing redundant items, rewording unclear statements, and removing/rewording items that suggested a positive ('agree') response. Changes to each of the five sections are detailed below.

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Prior to the review, the section labelled 'Client' comprised 13 items. Based on the evaluation of the experts, the wording on one item was changed to improve clarity and three items were removed because they were reported as redundant and/or unclear, leaving 10 items.

In the 'Therapist' section of 20 items, two items were deleted as they were reported as not relevant; four redundant and unclear items were removed; one item was shortened; one item was moved to the section on Cultural Implications; and three items were combined to create one concise and clear item. In all 11 items remained.

In the 'Intervention' section of 37 original items, eight items were modified for clarity and to make them more concise. For example the item "I should begin with client's issues and then use the model or frame of reference which is relevant" was modified to "I begin with the client's issues and then use the appropriate model". Six items were removed as they were reported as redundant or lacking clarity, leaving 31 items.

In the 'Cultural Implications' section comprising 18 original items, five redundant and unclear items were deleted, and nine items were modified to increase their clarity. For example "I need to meet cultural expectations", was modified to "I consider clients' cultural expectations". In all, there were 14 items left, including one item from the therapist section.

In the 'Health Care Systems' section (originally eight items), two redundant and unclear items were removed, two items were modified, and one item was divided into three items for specific and clearer meaning. For example, " I work in conjunction with doctors, insurance companies, employment and referring agencies" was divided into three items as follows: "I work in conjunction with Government and/or private insurance agencies or the private sector", "I work with other Government departments/agencies in addition to the health sector", "Quality assurance standards promote better outcomes in occupational therapy". In all, eight items remained.

The changes to the questionnaire are summarised in Table 5.1.

Table 5.1

Summary of the Changes to the Questionnaire Following Expert Panel Review

	Number of items prior to validation	Number of items in final questionnaire	Reason for changes
Part A Demographics	10	10	-
Part B Models of OT Practice	2	2	Redundant words were removed
Part C Occupational Therapy Practice			
1. Clients	13	10	Items 8, 11, 12 were removed because they were reported as redundant and/or unclear. Item 5 was reworded for clarity.
2. Therapists	20	11	Items 14, 15 were deleted as they were not relevant. Items 17, 21, 25, 29 were removed as they were redundant and unclear. Item 31 was reduced due to the lengthy wording. Item 26 was moved to the section on Cultural Implications as it was more relevant. Items 30, 32, 33 were combined to create one concise and clear item.
3. Intervention	37	31	Items 43, 44, 48, 59, 62, 65, 67, 69 were modified to make them more concise and clearer.
3. Intervention	37	31	Items 49, 51, 52, 53, 54, 60 were removed as they were redundant or lacking clarity.
4. Cultural implications	18	14	Items 71, 73, 84, 85, 86 were deleted as they were redundant and unclear.
5. Health Care System	8	8	Items 72, 74, 76, 77, 79, 80, 81, 83, 88 were modified to increase their clarity. Item 26 was moved to add in this section. Items 92, 93 were deleted, as they were redundant and unclear. Items 91, 95 were modified for specific and clearer meaning. Item 89 was divided into 3 items for specific and clearer meaning.
Part D Practice comments	4	4	No change. No comment from respondents.

Note: see Appendix F for original questionnaire and Appendix G for validated questionnaire.

5.3 Finalisation of the questionnaire

After modification, the questionnaire was again reviewed by three senior occupational therapy academics who are experts in questionnaire development. The wordings of some items were further modified for clarity, and changes to the actual presentation and format of the items were made. The final questionnaire, requiring approximately 30 minutes to complete, was called The Models for Clinical Practice Questionnaire (MCPQ) – English Version (See Appendix G).

5.4 Preparation of the Models for Clinical Practice Questionnaire (MCPQ) - Thai Version

The questionnaire to be used in Thailand with Thai occupational therapists was translated into Thai by two bilingual speakers. Two former univerisity lecturers, one in nursing, the other in economics, who have resided in Australia for more than 10 years, undertook this work. The author made final corrections and edits on that version. Due to the small total population of occupational therapists in Thailand (170), it was decided not to conduct full validity testing with Thai therapists, as it would ultimately reduce the available sample population. Instead it was pre-tested with a small group of five Thai occupational therapists to assure the full understanding of the language and instructions. The wording of a few items was modified for clarity, with no change to the original meaning. The Thai version is presented in Appendix H.

5.5 Normality and Reliability Testing of Part C of the final Questionnaire (MCPQ)

After the questionnaires were administered to WA and Thai occupational therapists, the normality of Part C of the MCPQ was tested in order to select appropriate statistical analyses, and reliability was checked (See Table 5.2).

All items of Part C of the questionnaire were tested for normal distribution using The Kolmogorov-Smirnov statistic with a Lilliefors significance level. If the significance level was greater than .05, then normality was assumed (Coakes & Steed, 2001). It was found that the significance level of each item of the whole questionnaire was less than .05, which therefore meant that normality was not

assumed. This result is frequently found in social sciences research on smaller samples.

As each section of the questionnaire addressed discrete areas, reliability of each subscale of part C was tested using a Cronbach's alpha, in both English and Thai version independently. The results the Coefficients of Cronbach's alphas are presented in Table 5.2.

Table 5.2

Reliability of the Questionnaire (Both English and Thai Versions) Using a Cronbach's Alpha

Subscales	English version	Thai version
Clients	0.43	0.61
Therapists	0.58	0.61
Intervention	0.89	0.84
Cultural Implications	0.71	0.56
Health Care Systems	0.53	0.43

In the Clients subscale of the English version, the reliability is lower than other sections at 0.43. This may indicate that Western Australian occupational therapists, who frequently work with clients from various multicultural backgrounds, interpret that their clients needs and expectations will be diverse. In the Health Care Systems section of the Thai version, the reliability is lower than the other sections at 0.43. This may reflect the ongoing process of health system reform. Standards for acute care are relatively clear at this time. But, procedures and performance standards for chronic care and rehabilitation are not yet well established and vary from institution to institution. Since most occupational therapists work with patients with chronic illness, this lower level of reliability may be expected. On the other hand, the Intervention section has high reliability in both the English and Thai versions. It is proposed this is because it encompasses occupational therapy intervention that is based on theories and a process, which although it may vary, has fundamental principles that are universal.

CHAPTER 6

Use of Conceptual Models in Thailand and Western Australia: Methods

Data was collected from a representative sample of practicing occupational therapists to describe and compare the use of conceptual models (both general health care models and specific occupational therapy models) in Thailand and Western Australia. The purpose was to empirically examine the major objectives as identified in Section 1.3.

This chapter describes the research design, sampling method, instrument, and data collection procedures and the statistical analysis approach used. Ethical considerations are also discussed.

6.1 Study Design

The study design was descriptive, and used a structured survey to collect data on a cross-sectional sample of participants.

6.2 Sample

The target population consisted of occupational therapists in Thailand or Western Australia who were employed in a position designated as an occupational therapy position (either full-time or part-time) at the time of completing the survey (March 16-June 10, 2000). No database was identified that could provide an accurate source of the numbers of therapists who were working in either Thailand or WA. Various sources were reviewed to provide crude estimates of number of therapists employed. Based on the records of the Department of Occupational Therapy, Chiang Mai University (the only School of Occupational Therapy in Thailand) in March 2000, 190 Thai occupational therapists had graduated since 1984, when the School began awarding a Bachelor Degree of Occupational Therapy. However, numbers remaining in the workforce were not available. In WA two sources were accessed: 950 Western Australian therapists were registered with the Occupational Therapy Registration Board of Western Australia in 1999, but again did not discriminate between those who were and were not practicing. According to a workforce study (Lomma, 1997), 381 therapists were recorded as working in both metropolitan and

rural areas. Again, these figures could not be substantiated, and only provided rough estimates of the total population of occupational therapists in each location, and do not reflect accurate numbers in the workforce.

Due to the small number of therapists in Thailand, it was felt that, as far as possible, all therapists should be included in the study sample. Participants in Thailand were recruited via the Occupational Therapists Association of Thailand. Thai occupational therapists who held current membership in the Occupational Therapists Association of Thailand in the year 2000 and had a contact address were included in the study sample.

As estimating the number of therapists currently employed in WA was difficult and no comprehensive database existed, two strategies (one for metropolitan therapists and one for rural therapists) were used to collect data from as many therapists as possible. Heads of each of the urban occupational therapy departments were contacted, provided with information about the nature of the research, and invited to distribute information about the proposed study to their staff (See Appendix E). All departments contacted were willing to forward information to their staff for potential recruitment. Rural therapists were recruited via addresses recorded by the Occupational Therapy Registration Board (WA). Therapists were contacted by mail. It was recognised that a number of these therapists would not be currently working clinically, and thus not meet the specified criteria; however, with limited avenues open for contact, this was seen as the most prudent approach to recruit participants.

6.3 Data Collection

The Thai or English versions of the MCPQ and a cover letter were distributed to therapists in each location. The purpose of the survey, the areas of interest in the questionnaire, and the time required to complete the questionnaire were explained in the cover letter (See Appendix G&H). Confidentiality and anonymity were emphasised and guaranteed. Return of the survey was considered implied consent. The surveys were mailed to the workplaces via the Heads of Department in Thailand and urban WA, and to the addresses of individual therapists in rural areas in WA.

In Thailand 160 questionnaires, consent forms, and covering letters were mailed. In Western Australian 500 survey questionnaires were distributed to

occupational therapists. Of these 148 were sent to occupational therapists in rural settings, and the rest distributed via Heads of Departments. Questionnaires were collected over a six-week period during April-May, 2000 in WA and Thailand. This allowed collection of data at very similar times, eliminating any impact of time of the year. After this time, a reminder telephone call was made, or a reminder letter sent to the Heads of workplaces. However, as participation was voluntary, Heads were requested only to remind and not to force participants to return completed questionnaires.

In Western Australia, of the 500 questionnaires distributed, six questionnaires were returned as undeliverable; and two questionnaires from the rural areas were excluded because they were not currently working, or not working in Australia.

6.4 Instrumentation

The MCPQ as outlined in Chapter 5 was self-administered by participants. A rigorous pilot study to test for reliability and validity of this developed instrument was not possible, due to the limited number of subjects available in the target population. It was also not possible to check for criterion validity, due to the uniqueness of the variables identified in the instrument. As the main focus, however, was the exploration and description of the perceptions of therapists regarding the use of theoretical models in two distinct cultures, the MCPQ questionnaire provided an appropriate means for collection of data across two countries.

Upon checking the questionnaires on their return, it was found that the Thai version of the questionnaire Part C (Section 1, Item 8) contained a typing error, which altered the meaning, so that it was no longer consistent with the English version. Therefore, this item was removed from both the Thai and English questionnaires for data analysis. Section 1 then contained nine items; numbers 1-7 and 9-10 and the final instrument contained 73 items.

6.5 Data Analysis

Both quantitative and qualitative methods were employed to describe and explain the data obtained. A quantitative method was used to present data from parts A to C of the questionnaire, whereas content analysis was used to analyse the open-ended questions.

All data were entered and analysed using SPSS (version 10.0) for Windows (SPSS Australasia, North Sydney, NSW, Australia) by the researcher, to reduce the possibility of error that may occur with operators unfamiliar with the format of the questionnaire. The data were checked for missing responses and entry errors through the examination of frequency outputs and logical data checks. In the case of missing data from incomplete questionnaires, they were entered as missing values.

6.5.1   Statistical Analysis

Objective 1 (See Section 1.3)

Frequency distributions were performed to describe the demographic information (Part A) and models of occupational therapy practice (Part B), which were assigned nominal number codes to designate categorical variables. Data in Part A and B are nominal scale because they described qualitative characteristics of variables and their values can be categorised and counted as frequencies (Dawson & Trapp, 2001). Frequency distributions were also used to check missing values of these parts.

Objective 2 and 3 (See Section 1.3)

The specific null hypotheses tested were:

1) There is no difference in the type and frequency of conceptual models used by therapists in Thailand and WA

2) There is no difference in the application of conceptual models used by therapists in Thailand and WA.

A Chi-square was employed to test the association between the countries where the occupational therapists work (WA and Thailand) and models of practice. Chi-square tests were used as data were nominal, to compare the actual number observed in each group, and the expected number (Blalock, 1979). Chi-square also tested the association between selected demographic variables (highest level of education, ages of therapists, and numbers of years of working) and models of practice. A significance level of .05 was chosen as a 5 percent error is typically identified as appropriate in social research (Weinbach & Grinnell, 2001). A two-tailed test was used if the contingency table of observations is greater than 2 × 2 because there was no clear indication available to test the hypothesised direction, as required for a one-

tailed test. Afterwards the Chi-square test for 2 × 2 contingency tables was performed at .05 level of significance using a one-tailed test because the hypothesised direction had been identified from the first Chi-square test for a greater than 2 × 2 contingency table (Indrayan & Sarmukaddam, 2001).

Principal component (PC) analysis was used to determine component structures of the MCPQ and for data reduction of Part C of the questionnaire, as well as to obtain relevant factors to compare the application of models to practice between Thai and Western Australian occupational therapists. Reduction of a large number of variables from item responses can be summarised through PC to create a smaller number of hypothetical or observed variables that have common underlying dimensions or factors (Hair, Anderson, Tatham, & Black, 1998; Kim & Mueller, 1978; Tabachnick & Findell, 1989). This process was guided by a priori theory and statistical criteria. Principal Components analysis was conducted to examine the factors of each subscale of the questionnaire from Part C separately, based on the assumption that each created subscale dealt with very different concepts made up of a number of discrete underlying dimensionalities. The internal consistency of each subscale was tested using Cronbach's alpha, which provides a conservative estimate of a measure's reliability. The minimum acceptable number for factor analysis is 100 subjects (Coakes & Steed, 2001), and this criteria is met by the two samples.

The composite variables of each obtained factor in Part C of the questionnaire were used to compare the practice of WAOTs and ThaiOTs. This comparison was analysed by a Mann-Whitney U Test examined at .05 level of significance, using a two-tailed test. A two-tailed test was used instead of one-tailed test because there was insufficient initial theory, and no research in this area to predict the direction for setting an alternate hypothesis. The Mann-Whitney U test was employed in this comparison, because the values of composite variables of each obtained factor were not normally distributed (See Section 7.4).

Power effects of the non-parametric tests were a consideration, as it was assumed that many of the variables would depart substantially from normality. With equal sample sizes and the same data set under the same conditions, parametric tests are more powerful than nonparametric tests (Portney & Watkins, 2000; Weinbach & Grinnell, 2001). However, nonparametric tests are most practical for nominal and ordinal data that are not normally distributed, and are reported to achieve

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approximately 65-95 percent power-efficiency of parametric tests (Portney & Watkins, 2000).

Objective 4 (See Section 1.3)

The results of comparing practice between Thai and Western Australian occupational therapists using Mann-Whitney U test, as mentioned above, were also used to determine if significant differences appeared that were relevant to the cultural influence on the practice of Thai and Western Australian occupational therapists. In addition, responses from the third open-ended question of ThaiOTs were used to determine the need for a new or modified culturally-specific model for practice in Thailand.

6.5.2   Content Analysis

Systematic coding was used to analyse the written responses of the open-ended questions. Firstly, categories from each question were coded and counted systematically. Secondly, the researcher identified the themes from the categories of each question and the typical quotes and statements. Thirdly, each theme was named according to significant content and meaning. Finally, the researcher summarised the findings and wrote a draft report. Triangulation of the draft reports was undertaken by two additional experts in qualitative research.

6.6   Ethical Consideration

This study was approved by the Human Research Ethics Committee of Curtin University of Technology (HR 24/99), in accordance with National Health and Medical Research Council guidelines. Since the research was not associated with any one institution or agency in Thailand, ethical approval from Curtin University of Technology was considered adequate for both WA and Thailand.

All survey participants in Thailand and WA were volunteers. Participants were informed of the purpose of the study, the components of the questionnaire, and the time required for completion of the questionnaire. There were no inherent risks to any participant. Confidentiality and anonymity were guaranteed. Therapists themselves made a conscious decision whether or not to return the questionnaire.

No identifying information appeared on the questionnaire. Questionnaires were numerically coded, simply to identify the recipient for purpose of reminder notices.

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The key to personal identity and code number was stored in a locked cabinet separate from the data. All data will be stored at Curtin University of Technology for a period of five years and then will be destroyed.

CHAPTER 7

Use of Conceptual Models in Thailand and Western Australia: Results

7.1 Introduction

The main survey was conducted to verify the initial theoretical assumption derived from focus group findings, and investigate the influence of culture on the practice of Thai occupational therapists (ThaiOTs) and Western Australian occupational therapists (WAOTs). In addition, the survey sought to confirm the type and frequency of conceptual models used by therapists in Thailand and WA, and differences in application of conceptual models by the therapists. This chapter presents descriptive and inferential statistical results, as well as the findings from open-ended questions obtained from the survey.

The response rate from the Thai occupational therapists was 86.25 percent ($n =$ 138), assuming an available population of 160. No questionnaires were excluded from the Thai sample, as all met the inclusion criteria.

The response rate from the Western Australian occupational therapists in rural areas was 21.13 percent and from metropolitan areas 35.71 percent. It should be remembered that this response rate was only approximate. In the rural areas, it was not known what percentage of recipients was currently working and thus eligible to participate. In urban areas, questionnaires were distributed through the workplace, rather than to individual working therapists. It was not known how many individual therapists actually received questionnaires.

7.2 Descriptive Analysis

This section describes characteristics of the samples: personal demographics, occupational backgrounds, and generic models of occupational therapy practice reported by WAOTs and ThaiOTs. It also discusses the relative importance of the generic models of occupational therapy practice in each country, the clinical practice areas where occupational therapists work, and selected demographic variables.

7.2.1 Sample Characteristics

The sample consisted of 155 WAOTs and 138 ThaiOTs. Table 7.1 shows the demographic variables of the sample, and Table 7.2 presents the employment status of participants.

Table 7.1

Demographic Characteristics of Participants

Characteristics	WAOTs		ThaiOTs	
	N	%	N	%
Gender				
Male	10.00	6.50	32 .00	23.20
Female	145.00	93.50	106.00	76.80
Marital Status				
Single	48.00	31.00	98.00	71.00
Partnered/married	102.00	65.80	38.00	27.50
Widow	1.00	0.60	-	-
Divorced	-	-	2.00	1.40
Age (in Year)				
20-29	58.00	37.40	90.00	65.20
30-39	50.00	32.30	44.00	31.90
40-49	31.00	20.00	1.00	0.70
50-59	16.00	10.30	3.00	2.20
Highest Level of Education				
Diploma	14.00	9.00	-	-
Bachelor	114.00	73.55	113.00	81.90
Graduate Diploma	20.00	12.90	3.00	2.20
Master	5.00	3.23	22.00	15.90
Missing	2.00	1.29	-	-
Place of Qualification				
Thailand			132.00	95.70
Australia	139.00	89.67	1.00	0.70
Germany	-	-	3.00	2.20
New Zealand	3.00	1.94	-	-
India, South Africa	3.00	1.94	-	-
United Kingdom	8.00	5.16	-	-
USA	-	-	2.00	1.40
Missing	2.00	1.29	-	-

Table 7.2

Employment Status of Participants

Characteristic	WAOTs		ThaiOTs	
	N	%	N	%
Number of Years of Working				
0-5	50.00	32.26	85.00	61.59
6-10	31.00	20.00	19.00	13.77
11-15	35.00	22.58	26.00	18.84
16-20	22.00	14.19	4.00	2.90
21-25	6.00	3.87	4.00	2.90
26-up	11.00	7.10	0.00	0.00
Current Work				
Full time	104.00	67.10	136.00	98.55
Part time	49.00	31.61	2.00	1.45
Missing	2.00	1.29	0.00	0.00
Position				
Manager (WAOTs)/Head of OT (ThaiOTs)	11.00	7.10	37.00	26.81
Clinical specialist (WAOTs)/OT Lecturer (ThaiOTs)	46.00	29.68	18.00	13.04
Senior Clinician	56.00	36.13	0.00	0.00
Base Grade Clinician	61.00	39.36	92.00	66.67
(The respondent can tick more than one box)				

Table 7.3

Clinician Expertise of Participants

Characteristic	WAOTs		ThaiOTs	
	N	%	N	%
Clinical Work Areas*				
Neurology	33.00	21.29	106.00	76.81
Paediatrics	37.00	23.87	107.00	77.54
Occupational Health	20.00	12.90	4.00	2.90
Aged Care	59.00	38.07	30.00	21.74
Community Practice	22.00	14.19	32.00	23.19
Hand and Upper Limb Rehab	21.00	13.55	94.00	68.12
Health Promotion	11.00	7.10	29.00	21.01
Mental Health	33.00	21.29	0.00	0.00
Orthopaedics	23.00	14.84	87.00	63.04
Psychiatry	17.00	10.97	27.00	19.57
Clinical Medicine	10.00	6.45	30.00	21.74
Education	8.00	5.16	20.00	14.49
Private Practice	10.00	6.45	6.00	4.35
Chronic Pain	7.00	4.52	6.00	4.35
Early Intervention	17.00	10.97	31.00	22.46
Vocational Rehabilitation	18.00	11.61	0.00	0.00
Developmental Disability	22.00	14.19	100.00	72.46
Other	26.00	16.77	9.00	6.52
The Client Groups*				
Children	38.00	24.52	101.00	73.19
Adult	95.00	61.29	111.00	80.43
The elderly	66.00	42.58	41.00	29.71

* The respondent can tick more than one box

The participants in the Western Australia sample included 155 WAOTs: 10 males and 145 females. The largest group was in the 20–29 year old category. The majority were married or partnered. There were 14 respondents with diploma certificates, 114 with a bachelor's degree, 20 with a graduate diploma, and 5 with a master's degree. Of the Australian respondents, 90 percent graduated in Australia. Almost one third of the respondents had been working as an occupational therapist for 0-5 years. In addition, most of them worked full time, and in the clinical work areas of Aged Care (38 percent), Paediatrics (24 percent), Neurology (21 percent), and Mental Health (21 percent). Over one third (39 percent) held a position as a base

grade therapist, 36 percent as a senior therapist, 30 percent as a clinical specialist, and 7 percent as a manager. The clients they mainly worked with were adult, the elderly, and children respectively.

In the Thai sample of 138 ThaiOTs, 32 were males and 106 were females, aged mainly in the range of 20 to 29 years (65 percent). The majority were single. There were 113 respondents with a bachelor's degree, 3 with graduate diplomas, and 22 with a master's degree. Of the respondents, 96 percent graduated from Thailand. Almost two-thirds of the respondents had been working as occupational therapists for 0-5 years. There was no occupational therapist working more than 25 years, because formal occupational therapy training began only 22 years ago in Thailand. Most worked full time and in the clinical work areas of Paediatrics (78 percent), Neurology (77 percent), Hand and Upper Limb (68 percent), and Orthopaedics (63 percent). No therapists from Thailand checked the mental health area of practice, although 20 percent checked the psychiatry box. It is possible that Thai therapists are not familiar with the term mental health as used in Western practice. It was also reported by Thai therapists that their occupational therapy programs in psychiatry focused on acute treatment only, rather than on prevention, promotion, or longer-term management. Hence, they had no opportunity to work with a broader range of people or in managing mental health problems other than acute manifestations.

Neither did therapists in Thailand check the box about vocational rehabilitation practice. They apparently misunderstand this phrase assuming it refers to vocational training. Thai occupational therapists did select the occupational health category that includes rehabilitation programs for work-injured people, instead of vocational rehabilitation.

Two-thirds (67 percent) held a position as an occupational therapist, 27 percent were Heads of Occupational Therapy Departments, and 13 percent were occupational therapy lecturers. Thai occupational therapy lecturers were included in this survey because they supervise students in clinical practice, and also consult with medical doctors and related disciplines such as physiotherapists, speech pathologists, and teachers, regarding clients. This differs somewhat from Western Australian occupational therapy academics, who mainly focus on teaching programs and research, although some maintain clinical roles. Thai therapists' main clients were adults, children, and the elderly, respectively (See Table 7.1-7.3).

7.2.2 Generic and Specific Models of Practice

Table 7.4 and Figure 7.1 present generic and specific models of occupational therapy practice used by WAOTs and ThaiOTs.

Table 7.4

Generic and Specific Models of Practice Used by WAOTs and ThaiOTs

Characteristics	WAOTs		ThaiOTs	
	N	%	N	%
The Medical Model	36.00	24.66	86.00	66.67
The Performance Model	56.00	38.35	17.00	13.18
The Whole Person Model	54.00	36.99	26.00	20.15
Specific Models of Practice				
(Respondents could select more than one model)				
	N	%	N	%
The Model of Human Occupation (MOHO)	57.00	36.77	111.00	80.43
The Canadian Occupational Performance Model	29.00	18.71	11.00	7.97
Occupational Performance Model	63.00	40.65	30.00	21.74
The Person-Environment-Occupation Model	31.00	20.00	33.00	23.91
Allen's Model of Cognitive Disability	4.00	2.58	22.00	15.94
Other	18.00	11.61	9.00	6.52

Western Australian occupational therapists used the Performance Model, the Whole Person Model, and the Medical Model in their practice with no one model dominant. The specific model identified as most common to practice in WA was the Occupational Performance Model, with the Model of Human Occupation (MOHO) as the second most reported model, and Allen's Model of Cognitive Disability applied least in practice. Other models were also reported, including use of an eclectic approach, as reported by six respondents. Sensory Integration, the Neurodevelopmental, and the Biomechanical Approach were reported twice. The following models were reported by one respondent: The Functional Practical Approach, Biopsychosocial Approach, Developmental Approach, and Rehabilitation Model. One Western Australian occupational therapist who worked in mental health also named various psychological models or methods, such as Rational Emotional Therapy, Cognitive Behavioural Techniques and Emotional Freedom Techniques as providing models for practice.

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Two third of Thai occupational therapists reported applying one generic approach, the Medical Model, in their practice. The Whole Person Model and the Performance Model were applied by fewer respondents, 20 percent and 13 percent respectively. The specific occupational therapy model reported as applied in practice most frequently was MOHO (80 percent). Small percentages (8 percent and 7 percent) applied the Canadian Occupational Performance Model and 'other models' identified by therapists. The other models, which ThaiOTs mainly specified were the Medical Model and eclectic approach, each reported on three occasions. The Biomechanical Model, Behavioural-Cognitive Model, Biopsychosocial Model, and the Neurodevelopmental Techniques (NDT) were each reported twice. The remaining models named only once were the Developmental Approach, Sensory Integration, Behavioural Model, and the Human Occupation Model of Reed and Sanderson.

Figures 7.2 and 7.3 show the frequency distribution of Generic Models of Occupational Therapy Practice by Clinical Work Areas reported by Western Australian and Thai therapists.

144
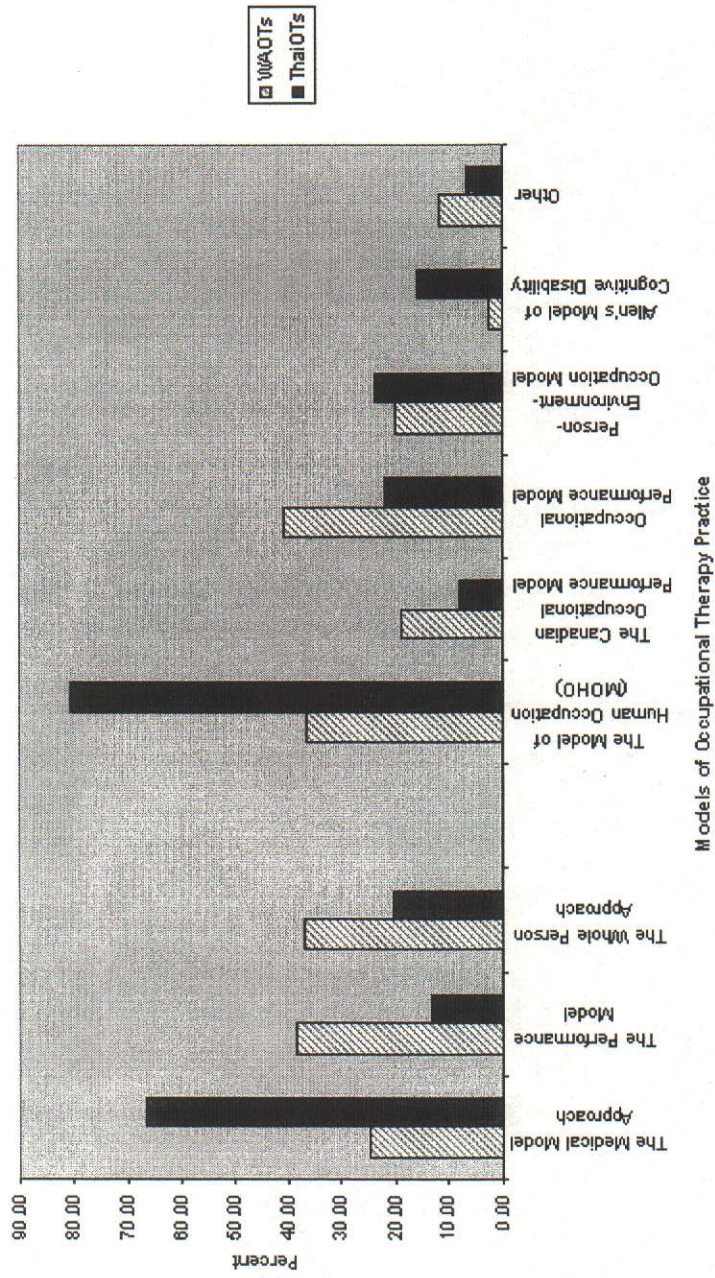
Figure 7.1

Models of Occupational Therapy Practice used by WAOTs and ThaiOTs

145
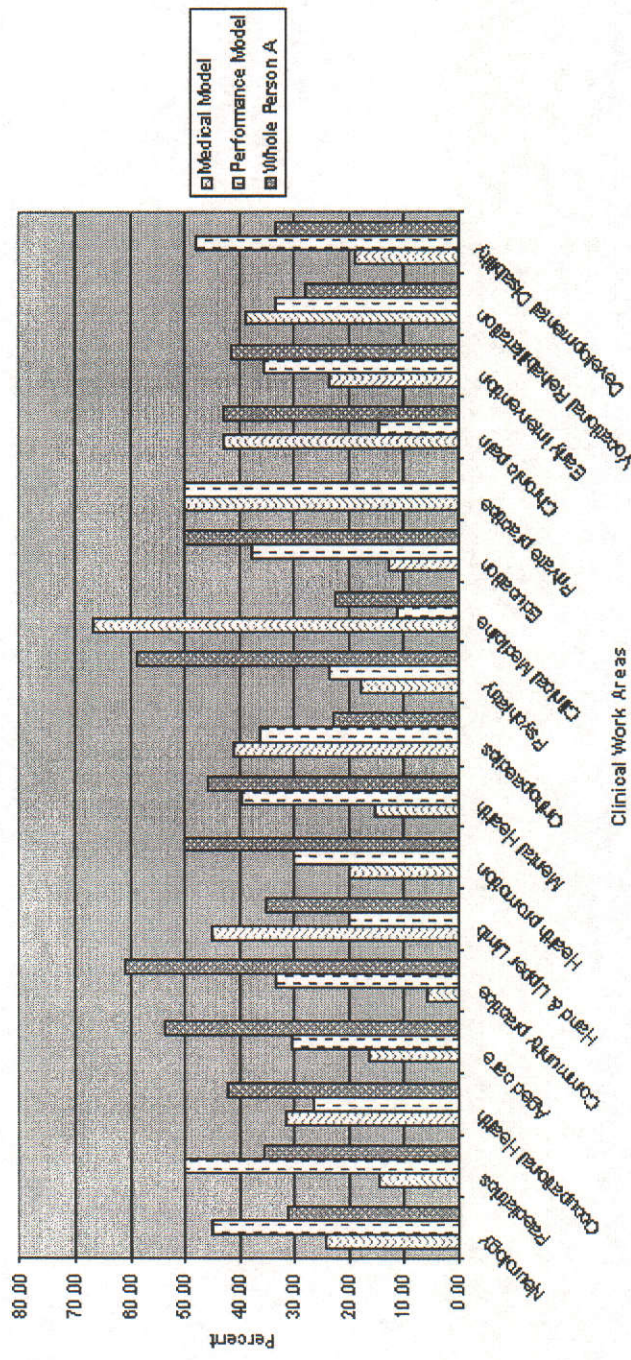
Figure 7.2

Frequency of Models by Clinical Work Areas of WAOTs

146
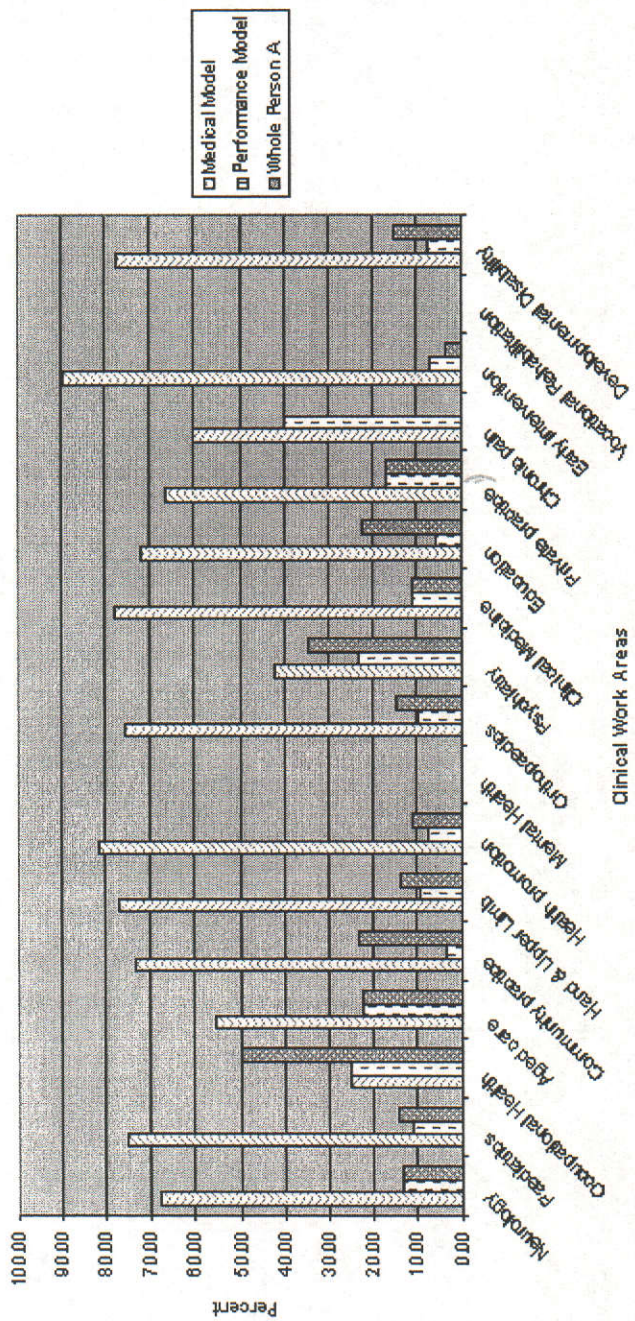
Figure 7.3

Frequency of Models by Clinical Works Areas of ThaiOTs

Table 7.5

Frequently Used Generic Models in Each Clinical Area in Ranked Order

Therapists	Medical Model	Performance Model	Whole Person Model
ThaiOTs	All clinical work areas except Occupational Health	-	-
WAOTs	Clinical Medicine	Private Practice	Psychiatry
	Private Practice	Paediatrics	Aged Care
	Hand & Upper Limb Rehabilitation	Developmental Disability	Community Practice
	Chronic Pain	Neurology	Education
	Orthopaedics		Health Promotion
	Vocational Rehabilitation		Mental Health
			Chronic Pain
			Early Intervention
			Occupational Health

The Medical Model was mostly used (See Table 7.5 and Appendix I) by WAOTs in Clinical Medicine, Private Practice, Hand and Upper Limb Rehabilitation, Chronic Pain, Orthopaedics and Vocational Rehabilitation. The Performance Model was mainly applied in Paediatrics, Developmental Disability, Neurology and Community Practice. Finally, the Whole Person Model was largely employed in Psychiatry, Aged care, Community Practice, Education, Health Promotion, Mental Health, Early Intervention, and Occupational Health. WAOTs mainly used the Medical Model in Clinical Medicine (67 percent) and in Private Practice (50 percent) but in the other clinical work areas less than 50 percent.

Thai occupational therapists applied in all clinical work areas except in Occupational Health (See Table 7.5 and Appendix I). The Medical Model was used 50 percent of the time or more in every clinical field except Psychiatry. The most frequent application of the Medical Model was in Early Intervention (83.9 percent), and the least frequent application was in Psychiatry (41percent). The Whole Person Model was used most often in Occupational Health, compared with other models. ThaiOTs apply the Medical Model in most clinical areas of practice, whereas WAOTs apply all generic models in various areas of practice.

Table 7.6

Models of Occupational Therapy Practice by Clients Groups

| Clients | Medical M | | | | Performance M | | | | Whole Person A | | | |
| | WAOTs | | ThaiOTs | | WAOTs | | ThaiOTs | | WAOTs | | ThaiOTs | |
	N	%	N	%	N	%	N	%	N	%	N	%
Children	6.00	17.14	71.00	74.74	17.00	48.57	11.00	11.58	12.00	34.29	13.00	13.68
Adult	28.00	30.77	70.00	67.31	37.00	40.66	13.00	12.50	26.00	28.57	21.00	20.19
Elderly	15.00	24.20	26.00	68.42	18.00	29.03	3.00	7.90	29.00	46.77	9.00	23.68
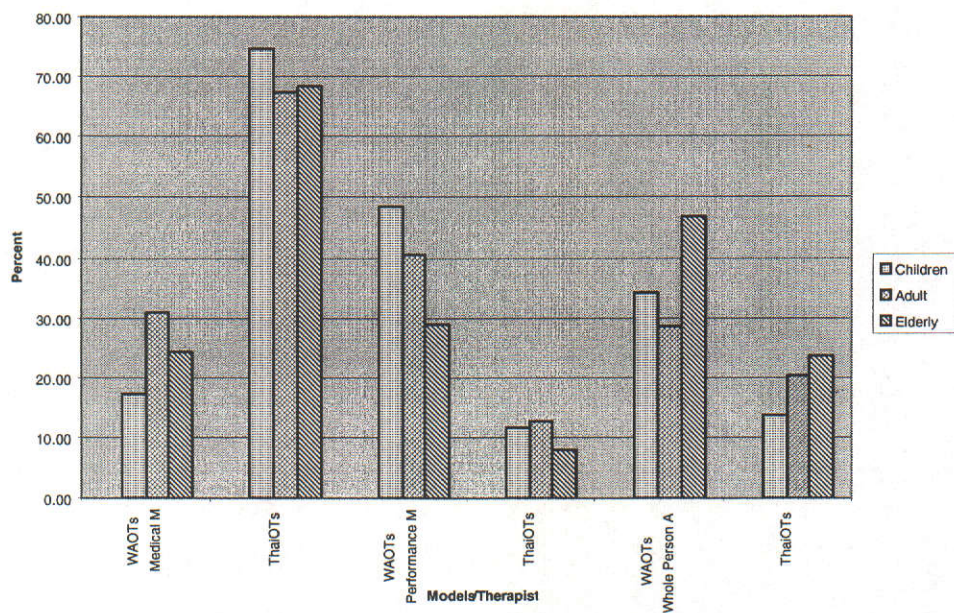
Figure 7.4

Frequency Distribution of Models of Occupational Therapy Practice by the Clients WAOTs and ThaiOTs Mainly Work With

Western Australian therapists mostly used the Performance Model with children and adult clients. For the elderly clients, the Whole Person Model was largely used (46.77 percent). The Medical Model was used least with children and the elderly clients, whereas the Whole Person Model was used least for adult clients (See Table 7.6 and Figure 7.4).

With Thai occupational therapists, the Medical Model was, by far, most frequently reported and applied to all types of clients. The Performance Model was used least. The Performance Model was used least often with elderly clients (7.9

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percent). With children, ThaiOTs used the Performance Model slightly less often than the Whole Person Model (See Table 7.6 and Figure 7.4).

7.3 Comparison of Selected Demographic Variables and Generic Models of Practice (Inferential Analysis)

Selected demographic variables for WA and Thai occupational therapists such as where they practice, highest level of education, ages, and numbers of years worked were compared. Countries where therapists practised were selected to investigate whether or not the context of each country (Australia and Thailand) influenced selecting generic model of practice. Highest level of education, therapists ages and numbers of years worked were selected to examine whether or not therapists backgrounds influenced their selection of generic models of practice, and whether finding matched research. Selected demographic variables (independent variables) and generic models of occupational therapy practice (dependent variables) were compared by using a cross-tabs analysis, a type of Chi-square test. The Chi-square test for contingency tables larger than 2×2 was performed using a two-tailed test as the first step, as demonstrated in the following tables (Table 7.7, 7.8, 7.9 and 7.10). Then the Chi-quare test for 2×2 contingency tables was performed, using a one-tailed test as the second step, as shown in the equations below (See *). The outputs of the first step Chi-quare were used to hypothesise the appropriate direction for a one-tailed test.

7.3.1 Association Between Countries Where Therapists Practice and Generic Models of Practice

This association was performed to compare the influence of Western Australia and Thailand (independent variable) on selecting generic models of practice (dependent variable) as presented in Table 7.7.

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Table 7.7

The Association Between Country and Generic Models of Occupational Therapy Practice

Country		Medical M	Performance M	Whole Person M	Total
Western Australia	Observed values	36	56	54	146
	Expected values	64.80	38.80	42.50	
Thailand	Observed values	86	17	26	129
	Expected values	57.20	34.20	37.50	
Chi-Square		Value	DF	Significance	
Pearson		50.27	2	0.00	

Minimum Expected Frequency = 34.24

There was a strong association between country and the preferred generic model of practice (χ^2 (2, N = 275) = 50.27, p = .000), and a significant difference in the use of these practice models between the two countries. Since significant differences have been demonstrated through Chi-square analysis, therefore, power effect of the non-parametric tests is not a matter concerns (Portney & Watkins, 2000). From a 2 × 3 table, Thai occupational therapists reported applying the Medical Model most and the Performance Model least, whereas Western Australian therapists applied the Performance Model most and the Medical Model least of all. There is no marked preference between the Performance Model and the Whole Person Model among Western Australian therapists. In examining the observed cell frequencies of 2 × 2 tables, Chi-square using a one-tailed test indicated that ThaiOTs preferred the Medical Model for their practice (χ^2 (1, N = 275) = 48.97, p = .000)*, in strong contrast to Western Australian therapists, who preferred the Performance Model (χ^2 (1, N = 275) = 22.27, p = .000)* and the Whole Person Model (χ^2 (1, N = 275) = 9.41, p = .001)*.

7.3.2 Association Between the Selected Demographic Variables (SDV) and Generic Models of Occupational Therapy Practice (WAOTs)

To investigate whether or not levels of education, years of work experience, and age influence selection of generic models of practice, data from WA and Thai therapists were analysed separately with results for the former discussed first.

Associations between the years of work experience, level of education, and age could not be tested by using the categories reflected in table 7.1 and 7.2 because the minimum cell frequency was too low in some cells and violated the main

assumptions of Chi-square (i.e. the minimum expected cell size is less than 5) (Dawson & Trapp, 2001).

Cells for number of years worked, highest level of education, and age of therapists reach the appropriate cell frequency, when fewer categories were used, which is an appropriate procedure (Blalock, 1979). Years of work experience were collapsed into 4 levels: 0-5 years, 6-10 years, 11-15 years and 16-up. Levels of education, originally represented by 4 levels, were collapsed into two combinations, each including two sub-levels. In one combination, the first sub-level included those with Diploma or Bachelor's degree, and the second contained those with Graduate Diploma or Master's degree. In the other combination, the first sub-level included Diploma and the second included the higher degrees (Bachelor's, Graduate Diploma, and Master's). Ages of therapists were categorised into 3 levels: 20-29 years, 30-39 years, and 40-49 years.

The χ^2 test found that there was an association between age and generic model of occupational therapy chosen among WAOTs (χ^2 (4, $N = 146$) = 9.78, $p = .044$), as shown in Table 7.8. There was no association between number of years of experience and preferred generic model or level of education and generic models at a .05 level of significance.

Table 7.8

Association Between Ages of Occupational Therapists and Generic Models of Occupational Therapy Practice (WAOTs)

Age		Medical M	Performance M	Whole Person M	Total
20-29 years	Observed values	11	27	18	56
	Expected values	13.80	21.50	20.70	
30-39 years	Observed values	17	17	14	48
	Expected values	11.80	18.40	17.80	
40-up	Observed values	8	12	22	42
	Expected values	10.40	16.10	15.50	
Chi-Square		Value	DF	Significance	
Pearson		9.78	4	0.044	

Minimum Expected Frequency = 10.356

The following can be concluded from Table 7.8. There was a significant difference in application of generic Models of Practice among the three age groups of

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therapists. From a 3 × 3 table, there was no clear for preference the Medical Model or the Performance Model in the 30-39 years group.

Examination of observed cell frequencies in the 2 × 2 tables, using a one-tailed Chi-square test indicates that the Medical Model was used more by WAOTs aged 30-39 years than among those aged 20-29 years and those 40 years and above (χ^2 (1, N = 146) = 4.46, p = .0175)*. The Performance Model was used more by WAOTs aged 20-29 years than those aged 30 years and above (χ^2 (1, N = 146) = 3.734, p = .0265)*, and the Whole Person Model was used more by WAOTs aged 40 years and over in comparison with their younger colleagues (χ^2 (1, N = 146) = 6.0, p = .007)*.

7.3.3 Association Between the Selected Demographic Variables (SDV) and Generic Models of Occupational Therapy Practice (ThaiOTs)

Associations between years of experience, levels of education, and ages could not be tested by using the categories in the earlier tables because the minimum expected cell frequency was too small to meet the main assumptions of Chi-square.

Current work (full time or part time) could not be tested by Chi-square at all, because the proportion between full time and part time was greater than 50:1, as only 1.6 percent of Thai occupational therapists worked part time.

To meet the main assumptions of Chi-square, categories for number of years worked, highest level of education achieved, and age of therapists were reduced. Combining into larger categories was not expected to alter the outcome sought in determining associations. Years of work experience were collapsed into two groupings: 0-5 years and 6 years and more. Level of education was also collapsed into two levels: Bachelor's degree and postgraduate qualifications (Graduate Diploma and Master's). Ages were also collapsed into two levels: 20-29 years and 30 years and above. The χ^2 test found that there were association between number of years of work experience and generic models of practice applied (χ^2 (2, N = 129) = 7.73, p = .021) and between ages of occupational therapists and generic models of practice (χ^2 (2, N = 129) = 6.62, p = .037). The association between the level of education and preferred model could not be tested by Chi-square, because the minimum expected frequency was still less than 5.

Table 7.9

Association Between Years of Experience and Generic Models of Practice (ThaiOTs)

Working		Medical M	Performance M	Whole Person M	Total
0-5 years	Observed values	52	15	12	79
	Expected values	52.70	10.40	15.90	
6-up	Observed values	34	2	14	50
	Expected values	33.30	6.60	10.10	
Chi-Square		Value	DF	Significance	
Pearson		7.73	2	0.021	

Minimum Expected Frequency = 6.589

The following can be concluded from Table 7.9. There was a significant difference in application of generic Models of Occupational Therapy Practice between Thai therapists (ThaiOTs) with working experience of 0-5 years and those working more than 5 years. The observed cell frequencies in 2 × 2 tables using a one-tailed Chi-square test, indicate that the Performance Model is used more frequently by ThaiOTs who have worked 0-5 years, than those working more than 5 years (χ^2 $(1, N = 129) = 6.01, p = .007)^*$. The Whole Person Model was more used by ThaiOTs who had worked for more than 5 years than those who had worked for fewer years (χ^2 $(1, N = 129) = 3.12, p = .039)^*$. Both age group prefer the Medical Model overall.

Table 7.10

Association Between Ages of Occupational Therapists and Generic Models of Occupational Therapy Practice (ThaiOTs)

Age		Medical M	Performance M	Whole Person M	Total
20-29 years	Observed values	56	15	13	84
	Expected values	56.00	11.10	16.90	
30-up	Observed values	30	2	13	45
	Expected values	30.00	5.90	9.10	
Chi-Square		Value	DF	Significance	
Pearson		6.62	2	0.037	

Minimum Expected Frequency = 5.930

There was also a significant difference in application of generic Models of Practice between Thai therapists aged 20-29 years and their older colleagues (Table 7.10). In examining observed cell frequencies in 2 × 2 tables using Chi-square, a one-tailed test shows the Performance Model is applied more frequently by Thai therapists aged 20-29 years than by their older peers (χ^2 $(1, N = 129) = 4.35, p =$

.0185)*. The Whole Person Model is used more by older ThaiOTs (χ^2 (1, N = 129) = 3.66, p = .028)*. However, both age groups preferred the Medical Model.

7.4. Exploratory Factor Analysis

Exploratory factor analysis is employed to identify underlying constructs from a number of original items (Hair et al., 1998; Kline, 1994). In this study the original items are therapists responses to the questionnaire. Factor analysis techniques can be used to: 1) identify the structure of interrelationships among large data sets through data summarisation; or 2) for data reduction (Hair et al., 1998). Both techniques were used in this study, in order to identify items relationships in each subscale of Part C of the questionnaire, and reduce the number of items in each subscale. Part C of the questionnaire included 5 subscales: Clients, Therapists, Intervention, Cultural Implications, and Health care systems, which derived from the themes of focus group findings.

Principal component factor analysis extracts factors from the data matrix by identifying sets of variables that are linearly correlated (Portney & Watkins, 2000; Stevens, 1992). Analysis starts with the covariance matrix or correlation matrix, and then principal components are retained to represent new sets of variables (Johnson & Wichern, 1998). Thus a large number of variables are reduced to a smaller number of factors, their relationships are summarised. Assumptions regarding the normal distribution of variables are not required for this analysis (SPSS, 1997; Tabachnick & Findell, 1989).

As mentioned above, each subscale of the questionnaire focused on different concepts. Thus, exploratory factor analysis was independently employed with each subscale to assess the underlying dimensions. As the questionnaire was over inclusive in the number of items asked of therapists, data reduction and summarisation of data relationships were undertaken by employing principal component factor analysis. Each subscale covered in Part C of the questionnaire was independently analysed to obtain distinct factors supporting models of practice. Subsequent analysis then compared the values of the retained factors of the two samples (WAOTs and ThaiOTs). Numerical results in most analyses are reported to two decimal places, unless the probability approximated .05, in which case three decimal places were reported. Analysis was divided into two phases as follows:

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7.4.1. Sample

Principal component analysis was employed with the entire sample [WAOTs plus ThaiOTs ($N = 293$)] to identify components to be retained and compared in subsequent analysis. In addition the construct validity in each subscale of the questionnaire was tested from data summarisation, and a new structure for the questionnaire was gained from data reduction.

7.4.1.1 Process of principal component analysis and interpretation

Principal component analysis and interpretation was applied to the entire sample of therapists in (See section 7.4.1), specifically to the Thai therapists (See section 7.6). The Term 'component' is used for the first factor matrix solution, while after rotation 'factor' is used.

Principal component analysis (PCA) (in sections 7.4.1 and 7.6) was performed using a covariance matrix as input for component analysis of items of the questionnaire, using an ordinal scale. Ordinal scales can be categorised and ranked, even through the magnitude of difference between two adjacent categories is not necessarily equal throughout the scale (Dawson & Trapp, 2001). It is recommended however, that variables be measured in the same metric unit where possible, and in the scale of rank order (Gorsuch, 1983), or in a 'reasonably commensurable' scale (Stevens, 1992), "Performing a components analysis on the covariance matrix is preferable for statistical reasons" (Morrison, 1976, p. 222). The alternatives of performing PCA on a correlation matrix often yields the values of factor loading with a minus power for many levels of maximum iteration for convergence, and retained factors are not logical according to theoretical models.

The Kaiser-Meyer-Olkin (KMO) Measure of sampling, sets the level of 0.5 as sufficiently high to allow PCA on a covariance matrix to proceed. The Bartlett's test of sphericity was also used to test the overall significance of all interrelationships within the covariance matrix (Hair et al., 1998). Coakes and Steed (2001) suggest that a sample of 100 cases is acceptable, but sample sizes of ≥ 200 are preferable to perform PC analysis. An Eigenvalue greater than 1, or 50- 75 percent of the total variance [or 50-75 percent cumulative explained variance (cumulative percentage)] was used as the criterian to retain factors. Diekhoff (1992) judges this percentage of variance as sufficient to explain the original variables in the social and behavioural

sciences (Diekhoff, 1992). In addition, only factors with eigenvalues greater than 1 are considered to be significant (Diekhoff, 1992; Hair et al., 1998). Varimax rotation was performed to simplify the factors, by maximising the loading variance within factors (Tabachnick & Findell, 1989). The loadings were rotated to achieve a simpler and interpretable structure (Johnson & Wichern, 1998).

Pairwise deletion of cases with missing values was used to minimise the effects of missing data (De Vaus, 1995; SPSS, 1997). An item-loading criterion of ≥ 0.5 was selected, because a 0.5 loading is reported as contributing 25 percent of the variance accounted for by the factor. This level has a relationship to original variables that can be assumed to be 'fair' or 'good' (Tabachnick & Findell, 1989), although other sources report loadings > 0.30 or 0.40 indicate some evidence of a relationship (Portney & Watkins, 2000).

Finally, the reliability of each retained factor based on at least three variables was tested using Cronbach's alpha. The reliability coefficient of Cronbach's alpha is reported as the most widely used measure to assess internal consistency of the entire scale (Hair et al., 1998). In this case, it relates to each subscale section. Descriptive analysis for scale if item deleted is checked for each factor including at least 3 variables in order to increase alpha if the item is deleted. Since the cut off size for interpretation purposes is a matter of researcher preference (Tabachnick & Findell, 1989), the factors were selected according to factor loadings (≥ 0.5), theoretical models and the reliability coefficient of Cronbach's alpha. Factors were named based on the final factor analysis solution, reflecting higher loading (Hair et al., 1998), common themes, and theoretical constructs (Portney & Watkins, 2000). The process of analysis can be summarised in Figure 7.5.

Covariance matrix

Principal component analysis

Extract Eigenvalue greater than 1 or

50-75% cumulative explained variance

↓

Rotation method: Varimax

↓

Missing values: Exclude case pairwise

↓

Factor loading ≥ 0.5

↓

Reliability coefficient of Cronbach's alpha

↓

Retained factors according to

-factor loadings

-theoretical models

-the reliability coefficient of Cronbach's alpha

↓

Factors named based on higher loading,

common themes, and theoretical constructs

Figure 7.5 Summary of the process of principal component analysis in phases 7.4.1 and 7.6

In analysis of the covariance matrix, Eigenvalues of the rescaled solution (standardised scale solution) were selected to explain the total variance and used to report factor loadings.

7.4.1.2 Clients subscale: occupational therapists' views on clients

The first analysis included nine observed variables that were considered to underpin the occupational therapists' view on their clients, represented by items 1-7, 9, and 10 of the questionnaire [See Appendix G (a questionnaire)].

In the rotated factor solution that provided the basis for interpretation, items 2, 5, and 10 were removed; six items were retained.

A three factors solution accounted for 52.05 percent of the total variance. Factor I (items 4, 3, and 1) was labelled 'Client-Centred', and produced a reliability coefficient using Cronbach's alpha of 0.56. Factor II (items 7and 6) was labelled 'Dependent Expectations', and Factor III (one item: 9) was retained as 'Clients' Expectations of Cure'.

Factor III, containing only item 9, was included in order to meet the need for a 50 percent or greater cumulative percentage. In addition, based on theoretical models, Factor III is highly applicable to the study as an important criterion, as well as essential for achieving statistical significance (Hair et al., 1998) (Table 7.11).

Table 7.11

Results of Principal Component Analysis with Varimax Rotation of Clients Subscale (Combined Sample)

Items	Wording	Factor loading		
		I	II	III
4	A conceptual model for practice needs to integrate all aspects of my clients' life	0.80		
3	All of my clients' roles are considered	0.76		
1	My client's needs guide the treatment plan	0.54		
7	My clients expect to remain dependent upon health professionals		0.89	
6	My clients to remain dependent upon their families		0.84	
9	Clients (or their relatives) expect I am going to "fix everything" in a short period of time			0.98
	Eigenvalue	1.85	1.73	1.10
Total variance = 52.05 %	% of variance	20.59	19.21	12.25
KMO = 0.63	Bartlett's test of sphericity p = .000			

I = Client- Centred
II = Dependent Expectations
III = Clients' Expectations of Cure

7.4.1.3 Therapists subscale: occupational therapists' views about themselves as professionals

The first analysis included 11 variables that underpin occupational therapists' view of themselves as professionals (items 11-21). Three factors, accounting for

50.61 percent of the total variance, were retained. Factor I (items 20, 21, and 19) was labelled 'Community Orientation'; Factor II (items 12 and 13) was labelled 'Reductionist Orientation', and Factor III (items 11, 18, and 16) was labelled 'Clients Orientation'.

From the rotated factor solution, items 14, 15, and 17 were removed, leaving eight items representing professionalism (Table 7.12). The reliability coefficients of Cronbach's alpha for Factors I and III were 0.77 and 0.36 respectively. The low figure for the latter indicated that items included had high variance. Factor III was labelled 'Clients Orientation', the context of clients tended to vary between clients in Australia and Thailand due to the cultural context.

Table 7.12

Results of Principal Component Analysis with Varimax Rotation of Therapists Subscale (Combined Sample)

Items	Wording	Factor loading		
		I	II	III
20	I provide programs in the community to promote independent living	0.86		
21	I promote community members to participate in the clients' community rehabilitation program	0.81		
19	I use transition programs for transferring clients from hospital to home/community	0.74		
12	I focus on developing minimum functional skills to permit safe discharge		0.89	
13	Occupational therapy models should sit under the umbrella of the Medical Model		0.75	
11	I have to deal with a variety of clients and their families who may not hold the same belief and values			0.68
18	I believe in extended rehabilitation for clients whose return to functional independence take longer to resolve			0.62
16	I use a model which emphasises the client's ability to perform roles relating to the clients' need and to their family's needs			0.57
	Eigenvalue	2.39	1.63	1.55
	Total variance = 50.61% % of variance	21.77	14.78	14.06
	KMO = 0.69 Bartlett's test of sphericity p = .000			

I   = Community Orientation
II = Reductionist Orientation
III = Clients Orientation

7.4.1.4 Intervention subscale: therapists' views on how best to proceed

The first analysis included 31 observed variables that underpin the intervention role of occupational therapists (items 22-52). A nine factors solution accounted for 53.16 percent of the total variance as listed below.

Factor	Item	Label
I	30, 31, 32,22	Occupational Guided
II	35, 36, 25	Therapist-Guided
III	47, 39	Treatment-Focused
IV	40,41, 42	Client-Family Guided
V	28, 27	Activities of Daily Living Guided
VI	50, 51	Clients' Support
VII	45, 46	Acute Setting
VIII	37	Demands of Employers
IX	24	Reductionist Approach

Table 7.13

Results of Principal Component Analysis with Varimax Rotation of Intervention Subscale (Combined Sample)

Items	Wording	Factor loading								
		I	II	III	IV	V	IV	IIV	IIIV	IX
30	A client's occupational history enables me to assign and propose occupation that are meaningful	0.65								
31	I use activity analysis in designing treatment programs	0.61								
32	Occupations provided to my clients should be applicable to their home, work and leisure environments	0.61								
22	Occupational performance outcomes of my clients are considered in their environmental context	0.55								
35	I take the role of directing and setting goals for treatment programs		0.77							
36	I provide prescribed interventions and then implement with my client's cooperation		0.64							
25	Rehabilitation of a specific performance area is guided by my clients' choice		-0.53							
47	I have clearly defined the treatment outcomes for my clients			0.80						
39	I identify clients' specific requirements and the related skills to survive in society			0.53						
40	I work closely with clients' families to achieve clients' goals				0.82					
41	Despite the limited time, I observe and listen to what the clients and their families report				0.61					
42	I begin with client's issues and then use the appropriate model				0.56					
28	My focus is on development of functional ADL skills					0.88				
27	I focus on developing everyday life skills in my clients					0.68				
50	I expect clients to return to a safe environment with adequate supports						0.72			
51	After discharge continuing support should be provided/required						0.64			
45	In an acute setting I primarily focus on requirements for discharge							0.84		
46	In an acute setting I focus on the client's personal goals for lifestyle adaptation							0.51		
37	I carry out treatment programs to respond to the demands of my employer								0.93	
24	I believe a reductionist approach is required to work on specific performance enhancement									0.87
	Eigenvalue	3.27	2.29	2.21	2.05	1.98	0.51	0.47	0.46	0.43
	Total variance = 53.16% % of variance	10.54	7.40	7.11	6.60	6.40	4.10	3.82	3.69	3.50

KMO = .84   Bartlett's test of sphericity p = .000

I=	Occupational Guided	VI =	Clients' Support
II =	Therapist-Guided	VII =	Acute Setting
III =	Treatment-Focused	VIII =	Demands of Employers
IV =	Client-Family Guided	IX =	Reductionist Approach
V =	Activities of Daily Living Guided		

From the rotated factor solution, items 23, 26, 29, 33, 34, 38, 43, 45, 48, 49, and 52 were removed, leaving 20 items in the subscale on Intervention. (Table 7.14)

In Factor II (Therapist-Guided), item 25 had a negative sign, which means it moves in a direction opposite to other items, or has an opposite meaning vis-a-vis the others. The reliability coefficient of Cronbach's alpha for Factors I, II, and IV were 0.65, 0.57, and 0.65 respectively.

7.4.1.5 Cultural Implications subscale

The first analysis included 14 observed variables that were considered to underpin culture (items 53-66).

Five factors accounting for 55.85 percent of the total variance were retained. Factor I (items 63, 64, 62, 65, and 66) was labelled 'Cultural Values and Independence'. The reliability coefficient of Cronbach's alpha of Factor I was 0.77. Factor II (items 60, and 59) was labelled 'Societal Perception of Disabilities'. Factor III (item 61) was labelled 'Workplace Discrimination'. Factor IV (items 56 and 57) was labelled 'Mutual Dependence'. And Factor V (item 53) was labelled 'Changing Societal Attitudes Toward Disabilities'. From the rotated factor solution, Items 54, 55, and 58 were removed; hence, 11 items were retained in the subscale on Cultural Implications (Table 7.14).

Table 7.14

Results of Principal Component Analysis with Varimax Rotation of Cultural Implications Subscale (Combined Sample)

Items	Wording	Factor loading				
		I	II	III	IV	V
63	I consider whether independence is valued by their cultural groups	0.83				
64	I consider clients' cultural expectations	0.79				
62	In treatment, I consider whether independence is valued by clients and their families	0.73				
65	Clients are used as a resource in understanding cultural beliefs, family dynamics and clients' views of illness	0.63				
66	I encourage clients to utilise resources common within their own culture	0.50				
60	Families with relatives with handicaps still have the burden of stigma			0.83		
59	I do not believe people with physical disability and /or people with mental illness are seen as a valued part of society			0.80		
61	There are limited workplaces to accept clients with disability			0.90		
56	I believe clients prefer to depend on their families and relatives for care				0.85	
57	Thai or Eastern families uphold a culture that aspires to take care of sick or handicapped people				0.70	
53	I can influence society in changing social attitudes to disability					0.88
	Eigenvalue	2.64	1.46	1.44	1.43	1.40
	Total variance = 55.85% % of variance	17.61	9.75	9.59	9.55	9.35
	KMO = 0.67 Bartlett's test of sphericity p = .000					

I = Cultural Values and Independence
II = Societal Perception of Disabilities
III = Workplace Discrimination
IV = Mutual Dependence
V = Changing Societal Attitudes Toward Disabilities

7.4.1.6 Health Care Systems subscale

The first analysis included eight observed variables that were considered to underpin the Health Care Systems (items 67-74). Four factors accounting for 67.37 percent of the total variance were retained. Factor I (items 67, 70, and 71) was labelled 'Legislation and Policy Impact'. Factor II (item 72) was labelled 'Funding Impact'. Factor III (item 69) was labelled 'Priorities in Health Care'. And Factor IV (item 68) was labelled 'Interagency Cooperation'. From the rotated factor solution, items 73 and 74 were removed; hence, six items were retained in the subscale on Health Care Systems (Table 7.15). Factor I: Legislation and Policy Impact had the

lowest Cronbach's alpha coefficient at 0.38. The variance of data may be due to the different effects of this factor on the practice of WAOTs and ThaiOTs.

Table 7.15

Results of Principal Component Analysis with Varimax Rotation of Health Care Systems Subscale (Combined Sample)

Items	Wording	Factor loading			
		I	II	III	IV
67	I work in conjunction with Government and/or private insurance agencies or private sector	0.72			
70	Registration and Government policies have direct impact on my practice	0.60			
70	Quality assurance standards promote better outcomes in occupational therapy	0.52			
72	I have to admit and discharge clients quickly because the occupational therapy service is dictated by the funding		0.88		
69	I have a long waiting list affected by the priorities within the health system			0.96	
68	I work with other Government department/agencies in addition to heatlh sectors				0.99
	Initial Eigenvalue	1.11	0.76	0.75	0.65
	Total variance = 67.37% % of variance	22.97	15.64	15.38	13.38
	KMO = 0.58 Bartlett's test of sphericity p = .000				

I = Legislation and Policy Impact

II = Funding Impact

III = Priorities in Health Care or Waiting List Impact

IV = Interagency Cooperation

7.5 Comparison of Samples

Comparison of practices of Western Australian and Thai therapists was performed as a subsequent analysis of retained factors resulting from PCA as described before so that hypothesis two (Section 6.5) could be tested.

The composite variables of the retained factors in each subscale were computed, and the mean obtained to create summated scales for this comparison (Hair et al., 1998). A modified summated scale method was used to accommodate missing values of the retained factors, and modified values of missing variables were used in subsequent analysis.

A Mann-Whitney U test was used to compare summated scales of WAOTs and ThaiOTs, as the summated scales of this data were not normally distributed as required by Kolmogorov-Smirnov (See Appendix L).

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Comparisons were made, using inferential statistics, between the two samples on five subscales of the Models for Clinical Practice Questionnaire. These included: Clients, Therapists, Intervention, Cultural Implications, and Health care systems, which measured different dimensions of therapists professional values and behaviour (See Section 5.2). The comparison was conducted to examine whether or not culture influences practices of therapists in the two countries.

The summated scales (the average score of the variables) for each retained factor in each of the five subscales were used to make group comparisons. The comparison of summated scales was analysed by a Mann-Whitney U Test, examined at .05 level of significance, using a two-tailed test. Since there is insufficient theoretical evidence and no empirical studies to compare the practice of WA and Thai occupational therapists, the hypotheses of this comparison are set up to demonstrate either a difference or no difference, and a two-tailed test was used.

In this study, a summated scale was used to compute a composite score, instead of using a factor score. This was done for the following reasons. A summated scale is a composite value for a set of variables (a factor), in which all of the variables that have height loadings on a factor (in this study the loadings were assumed to be 1) are combined, and the average score of the variables is used as a replacement variable (Hair et al., 1998). This means the loading of each variable is assumed to be equal in all processes of computing the average (Hair et al., 1998). Factor scores are "linear combinations of the original variables, and the sizes of the coefficients correspond to the sizes of the loadings" (SPSS, 1997, p. 303). The key difference between a factor score and a summated scale is that the factor score derives from the factor loadings of all variables on the factors, whereas the summated scales derive from the height loadings of selected variables (Hair et al., 1998).

However, in this study, 97.30 percent of the variables contained one or more missing values, which were randomly distributed across all variables, affecting factor scores and summated scales. For summated scales, all variables that have height loadings on a factor are computed to obtain the mean score that represents a composite value (Hair et al., 1998). Hence, many missing values affect this computation, even though the effect is less than that on computing factor scores. To manage the problem, the modified summated scale method was used to accommodate missing data and used for subsequent analysis and comparison. In the

process of using the modified summated scale method, only values of variables or items presented in each retained factor were computed to obtain a mean score for further analysis. In other words, the average of non-missing values was used to analyse the Mann-Whitney U Test between WAOTs and ThaiOTs. The modified summated scale method is assumed as an acceptable method to manage missing values, because retained factors do not include many variables, and are therefore unlikely to affect the variation (See 7.4.1). An example of average scores using the modified summated scale method for Factor I: Client-Centred is shown below.

Factor 1: Client-Centred (items 4, 3, and 1).

Cases	Item 4	Item 3	Item 1	Average
1	2	3	4	3.00
2		4	2	2.00
3	4	3		2.33

The average scores of cases 1, 2, and 3 were 3.00, 2.00, and 2.33 respectively. These average scores were used for comparison using the Mann-Whitney U Test.

The modified summated scales for each subscale were tested and are presented below.

In the *Clients* subscale (Table 7.16), significant differences were demonstrated between therapists in Australia and Thailand in all factors, at the .05 level of significance. That is ThaiOTs hold different views from WAOTs about the elements of a Client-Centred Approach, Dependent Expectations, and Cure Expectations of Clients. This indicates that ThaiOTs view the role and expectations of clients in treatment differently from WAOTs.

Table 7.16

Comparison of Composite Variables in the Clients Subscale

Factors (names)	Country	Case	Mean Rank	Corrected Z	For ties 2 tailed Sig
I. Client-Centred	Australia	154	155.84	-2.04	.041*
	Thailand	138	136.08		
II. Dependent Expectations	Australia	153	119.9	-5.76	.000*
	Thailand	138	174.93		
III. Clients' Expectations of Cure	Australia	149	116.58	-6.14	.000*
	Thailand	138	173.61		

*$p < .05$

In the *Therapists* subscale (Table 7.17), again there were differences between therapists in Australia and Thailand on all factors, at the .05 level of significance. ThaiOTs differ from WAOTs on their professional views/roles in relation to Community Orientation, Reductionist Orientation for Discharge, and Client Orientation.

Table 7.17

Comparison of Composite Variables in the Therapists Subscale

Factors (names)	Country	Case	Mean Rank	Corrected Z	For ties 2 tailed Sig
I. Community Orientation	Australia	148	129.29	-3.08	.002*
	Thailand	138	158.74		
II. Reductionist Orientation	Australia	153	95.60	-10.98	.000*
	Thailand	138	201.88		
III. Clients Orientation	Australia	155	177.05	-6.61	.000*
	Thailand	138	113.25		

*$p < .05$

In the *Intervention* subscale (Table 7.18), there were differences between therapists in Australia and Thailand on seven factors (I, II, III, IV, V, VII, and IX) at the .05 level of significance. This indicates that ThaiOTs and WAOTs differ significantly in their focus on Occupational Guided, Therapists-guided, Treatment-

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Focused, Client-Family Guided, ADL Guided, Client Support, Acute Setting, Demand of Employer, and Reductionist approaches. That meant therapists from each country view these seven factors guided their interventions differently.

There was no significant difference between the two groups of therapists in Factors VI and VIII. This indicated that ThaiOTs agree with WAOTs regarding the importance of Client Support and Demands of the Employer. Both ThaiOTs and WAOTs reported that Client Support should be promoted, so that clients can return to a safe environment after discharge, and that interventions should also take into account the demands of employers.

Table 7.18

Comparison of Composite Variables in the Intervention Subscale

Factors (names)	Country	Case	Mean Rank	Corrected Z	For ties2tailed Sig
The comparison of the composite variables in Section 3: Intervention					
I. Occupational Guided	Australia	155	130.08		
				-3.68	.000*
	Thailand	138	166.01		
II. Therapist-Guided	Australia	155	118.42		
				-6.13	.000*
	Thailand	135	176.59		
III. Treatment-Focused	Australia	155	157.37		
				-2.50	.012*
	Thailand	137	134.2		
IV. Client-Family Guided	Australia	155	127.02		
				-4.27	.000*
	Thailand	137	168.54		
V. ADL guided	Australia	152	129.63		
				-3.25	.001*
	Thailand	135	160.18		
VI. Clients' Support	Australia	150	140.79		
				-0.72	.472
	Thailand	137	147.51		
VII. Acute Setting	Australia	118	104.08		
				-5.03	.000*
	Thailand	137	148.6		
VIII. Demands of Employers	Australia	146	136.21		
				-1.32	.186
	Thailand	137	148.17		
IX. Reductionist Approach	Australia	121	90.21		
				-8.47	.000*
	Thailand	135	162.81		

*$p < .05$

In the *Cultural Implications* subscale (Table 7.19), differences between therapists in Australia and Thailand in Factors II, III, IV, and V were noted at the .05 level of significance. Thai therapists differed from WAOTs about Societal Perception of Disabilities, Workplace Discrimination, Mutual Dependence, and Changing Societal Attitudes Toward Disabilities.

On the other hand, there was no difference between the two groups of therapists on Factor I at the .05 level of significance. Thai therapists generally agreed

with WAOTs about Cultural Values and Independence. This implies that both groups are equally likely to consider cultural values and whether independence is valued by their clients, families, and cultural groups, as an important factor in intervention.

Table 7.19

Comparison of Composite Variables in the Cultural Implications Subscale

Factors (names)	Country	Case	Mean Rank	Corrected Z	For ties 2tailed Sig
I. Culture Values and Independence	Australia	154	141.49		
				-1.1	.273
	Thailand	138	152.09		
II. Societal Perception of Disabilities	Australia	152	177.47		
				-7.18	.000*
	Thailand	137	108.98		
III. Workplace Discrimination	Australia	153	108.43		
				-8.47	.000*
	Thailand	137	186.89		
IV. Mutual Dependence	Australia	147	116.24		
				-5.79	.000*
	Thailand	137	170.67		
V. Changing Societal Attitude Toward Disabilities	Australia	149	164.56		
				-5.25	.000*
	Thailand	137	120.6		

* $p < .05$

In the *Health Care Systems* subscale (Table 7.20), there were differences between therapists in Australia and Thailand on Factors I, III, and IV at the .05 level of significance. This indicates Legislation and Government Policies, Priorities in Health Care, and Interagency Cooperation affect Thai and Western Australian occupational therapists differently.

On the other hand, there was no difference between the two groups in Factor II at the .05 level of significance. Funding appeared to impact on admission and discharge systems similarly in the Thai and Australian settings, as judges by the therapists.

Table 7.20

Comparison of Composite Variables in the Health Care Systems Subscale

Factors (names)	Country	Case	Mean Rank	Corrected Z	For ties 2tailed Sig
I. Legislation and Policy Impact	Australia	155	133.16		
				-3.02	.002*
	Thailand	138	162.54		
II. Funding Impact	Australia	142	145.49		
				-1.13	.259
	Thailand	138	135.37		
III. Priorities in Health Care	Australia	150	133.27		
				-2.47	.013*
	Thailand	137	155.75		
IV. Interagency Cooperation	Australia	151	158.25		
				-3.05	.002*
	Thailand	138	130.51		

$*\ p < .05$

7.6 Principal Component Factor Analysis of Thai Sample

Analysis in Section 7.2 indicated that the context of each country influences the practice of occupational therapists. Additionally, comparison of occupational therapy practice of WA and Thai occupational therapists in the subscales for Clients, Therapists, Intervention, Cultural Implications, and Health Care Systems in Section 7.5 showed significant differences in these attributes, due to the influence of culture. Therefore, there is evidence that the cultural context of practice influence both WA and Thai occupational therapists in selecting and applying models of practice. To ascertain the most important factors in the practice of Thai occupational therapists, the reduced items questionnaire developed in section 7.4.1 was used. PCA was undertaken to clearly identify specific factors that hold most relevance within Thai culture. This approach was employed to examine specifically the questionnaire responses of Thai occupational therapists ($N = 138$), using the same process of analysis applied in section 7.4.1.1 to all of the therapists. The criterion to retain factors in this phase was based on an Eigenvalue greater than 1 or 50–75 percent of the total variance or cumulative percentage, just as before. Given that the data analysed in this section are a subset of those analysed above, it can be expected that they will yield similar but not identical factors.

7.6.1 Clients subscale: the occupational therapists' view on clients

The first analysis included six observed variables considered to underpin Thai therapists' views on clients (items 1, 3, 4, 6, 7, and 9).

Three factors accounting for 71.81 percent of the total variance were retained. Factor I (items 7 and 6) was labelled 'Dependent Expectations'; Factor II (items 4, 3, and 1) was summarised as 'Client-Centred', and produced a reliability coefficient using Cronbach's alpha of 0.56, and Factor III (item 9) was labelled 'Clients' Expectations of Cure'. From the rotated factor solution, no item was removed (Table 7.21).

Table 7.21

Results of Principal Component Analysis with Varimax Rotation of Clients Subscale (Thai Sample)

Items	Wording	Factor loading		
		I	II	III
7	My clients expect to remain dependent upon health professionals	0.92		
6	My clients expect to remain dependent upon their families	0.87		
4	A conceptual model for practice needs to integrate all aspects of my clients' life		0.82	
3	All of my clients' roles are considered		0.75	
1	My client's needs guide the treatment plan		0.62	
9	Clients (or their relatives) expect I am going to "fix everything" in a short period of time			0.99
	Eigenvalue	1.67	1.63	1.01
Total variance = 71.81%	% of variance	27.84	27.12	16.85
KMO = 0.58	Bartlett's test of sphericity $p = .000$			

I = Dependent Expectations

II = Client-Centred

III = Clients' Expectations of Cure

7.6.2 Therapists subscale: occupational therapists' views about themselves as professionals

The first analysis included eight observed variables considered to underpin the occupational therapists' view of themselves as therapists (items 11-13, 16, 18, and 19-21).

Three factors accounting for 60.28 percent of the total variance were retained. Factor I (items 20, 21, and 19) was summarised as 'Community Orientation', and produced a reliability coefficient using Cronbach's alpha of 0.77. Factor II (items 12 and 11) was labelled 'Client Approach'. And Factor III (item 18) was labelled 'Extended Rehabilitation'. From the rotated factor solution, items 13 and 16 were removed. Hence, six items were retained in the subscale for therapists (Table 7.22).

Table 7.22

Results of Principal Component Analysis with Varimax Rotation of Therapists Subscale (Thai Sample)

Items	Wording	Factor loading		
		I	II	III
20	I provide programs in the community to promote independent living	0.91		
21	I promote community members to participate in the clients' community rehabilitation	0.87		
19	I use transition programs for transferring clients from hospital to home/community	0.80		
12	I focus on developing minimum functional skills to permit safe discharge		0.88	
11	I have to deal with a variety of clients and their families who may not hold the same belief and values		0.59	
18	I believe in extended rehabilitation for clients whose return to functional independence takes longer to resolve			0.99
	Eigenvalue	2.44	1.38	1.02
Total variance = 60.28%	% of variance	30.52	17.24	12.52
KMO = 0.68	Bartlett's test of sphericity p = .000			

I = Community Orientation
II = Client Approach
III = Extended Rehabilitation

7.6.3 Intervention Subscale: Therapists' Views on How Best to Proceed

The first analysis included 20 variables considered to underpin the intervention of occupational therapists (items 22, 24, 25, 27, 30-32, 35-37, 40-42, 45-47, 50, and 51).

Seven factors accounting for 58.37 percent of the total variance were retained. Factor I (items 30, 22, 32, and 39) was summarised as 'Occupational Guided', and produced a reliability coefficient using Cronbach's alpha of 0.64. Factor II (items 50 and 41) was labelled 'Therapeutic Support'. Factor III (items: 28 and 27) was labelled 'Activities of Daily Living Guided'. Factor IV (item 40) was labelled 'Family guide'. Factor V (item 37) was labelled 'Demands of Employers'. Factor VI (items 45 and 46) was summarised as 'Acute Setting'. And Factor VII (items 24 and 47) was labelled 'Reductionist Approach'.

Factor II had originally comprised three items: 35, 50, and 41. However, item 35 was removed to increase the reliability from 0.36 to 0.45, and furthermore it was determined that item 35 was not compatible with this factor according to theory (See rotated factor matrix in Appendix M). From the rotated factor solution, items 25, 31,

35, 36, 42, and 51 were removed; hence, 14 items and seven factors were retained in the Intervention subscale (Table 7.23).

Table 7.23

Results of Principal Component Analysis with Varimax Rotation of Intervention Subscale (Thai sample)

Items	Wording	Factor loading						
		I	II	III	IV	V	VI	VII
30	A client's occupational history enables me to assign and propose occupation that are meaningful	0.78						
22	Occupational performance outcomes of my clients are considered in their environmental context	0.64						
32	Occupations provided to my clients should be applicable to their home, work and leisure environments	0.58						
39	I identify clients' specific requirements and the related skills to survive in society	0.53						
50	I expect clients to return to a safe environment with adequate supports		0.69					
41	Despite the limited time I observe and listen to what the clients and their families report		0.51					
28	My focus is on development of functional ADL skills			0.89				
27	I focus on developing everyday life skills in my clients			0.63				
40	I work closely with clients' families to achieve clients' goals				0.93			
37	I carry out treatment programs to respond to the demands of my employer					0.89		
45	In an acute setting I primarily focus on requirements for discharge						0.89	
46	In an acute setting I focus on the client's personal goals for lifestyle adaptation						0.52	
24	I believe a reductionist approach is required to work on specific performance enhancement							0.75
47	I have clearly defined the treatment outcomes for my clients							0.59
	Eigenvalue	2.77	2.08	1.70	1.45	1.30	1.25	1.14
Total variance = 58.37%	% of variance	13.84	10.39	8.49	7.24	6.48	6.23	5.70

KMO = 0.70   Bartlett's test of sphericity p = .000

I   = Occupational Guided   IV = Family-Guided   VII = Reductionist Approach
II = Therapeutic Support   V = Demands of Employers
III = Activities of Daily Living Guided VI = Acute Setting

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7.6.4   Cultural Implications Subscale

The first analysis included 11 observed variables that were considered to underpin Cultural Implications (items 53, 56, 57, 59, and 60-66).

Five factors, accounting for 67.33 percent of the total variance, were retained. Factor I (items 63, 62, 64, 65, and 66) was summarised as 'Cultural Values and Independence', and produced a reliability coefficient using Cronbach's alpha of 0.77. Factor II (items: 56 and 57) was labelled 'Mutual Dependence'. Factor III (item 53) was labelled 'Changing Societal Attitudes Toward Disabilities'. Factor IV (item: 59) was labelled 'Societal Perception of Disabilities', and Factor V (item 60) was labelled 'Family Stigma'. From the rotated factor solution, item 54, 55, and 58 were removed; hence, 11 items were retained in the Cultural Implications subscale. From rotated factor matrix, Factor I originally comprised item 61-66, but item 61 was removed to increase reliability from 0.72 to 0.77. In addition, item 61 was not compatible with this factor according to the theoretical model (See rotated factor matrix in Appendix N). After item 61 was removed, 10 items were retained in the Cultural Implications subscale (Table 7.24).

Table 7.24

Results of Principal Component Analysis with Varimax Rotation of Cultural Implications Subscale (Thai sample)

Items	Wording	Factor loading				
		I	II	III	IV	V
63	I consider whether independence is valued by their cultural groups	0.73				
62	In treatment, I consider whether independence is valued by clients and their family	0.72				
64	I consider clients' cultural expectations	0.68				
65	Clients are used as a resource in understanding cultural beliefs, family dynamics and clients' views of illness	0.63				
66	I encourage clients to utilise resource common within their own culture	0.53				
56	I believe clients prefer to depend on their families and relatives for care		0.86			
57	Thai or Eastern families uphold a culture that aspires to take care of sick or handicapped people		0.83			
53	I can influence society in changing social attitudes to disability			0.91		
59	I do not believe people with physical disability and /or people with mental illness are seen as a valued part of society				0.91	
60	Families with relatives with handicaps still have the burden of stigma					0.98
	Eigenvalue	2.54	1.47	1.28	1.07	1.04
Total variance = 67.33 %	% of variance	23.13	13.35	11.63	9.74	9.48
KMO = 0. 62	Bartlett's test of sphericity p = .000					

I =Cultural Values and Independence   III = Changing Societal Attitudes Toward Disabilities

II =Mutual Dependence   IV = Societal Perception of Disabilities

V = Family Stigma

7.6.5 Health Care Systems Subscale

The first analysis included six observed variables that were considered to underpin Thai therapists' assessment of the Health Care Systems (items 67-69 and 70-72).

Three factors accounting for 58.11 percent of the total variance were retained. Factor I (items 70 and 72) was summarised as 'Legislation, Policies, and Funding'. Factor II (item 69) was labelled 'Priorities in Health Care'. Factor III (item 68) was labelled 'Interagency Cooperation'. From the rotated factor solution, items 67 and 71 were removed. Hence, four items were retained in Health Care Systems subscale (Table 7.25).

Table 7.25

Results of Principal Component Analysis with Varimax Rotation of Health Care Systems Subscale (Thai Sample)

Items	Wording	Factor loading		
		I	II	III
70	Registration and Government policies have direct impact on my practice	0.8		
72	I have to admit and discharge clients quickly because The occupational therapy service is dictated by the funding	0.66		
69	I have a long waiting list affected by the priorities within the health care system		0.99	
68	I work with other Government department/agencies in addition to health sectors			0.999
	Eigenvalue	1.39	1.10	1.04
	Total variance = 58.11% % of variance	23.08	18.30	16.73
	KMO = 0.59 Bartlett's test of sphericity p = .000			
	I = Legislation, Policies and Funding			
	II = Priorities in Health Care or Waiting List Impact			
	III = Interagency Cooperation			

7.7 Summary of Factor Analysis and the Comparison of Factors

Principal component factor analysis was used to reduce data and form new sets of variables called factors as well as to reduce items of the questionnaire to be used for the final analysis. The reduced-item questionnaire can be assumed to be a better survey instrument for use in assessing occupational therapy theory and practice in Australia and Thailand. Factors derived from the entire sample were used to compare practices of WA and Thai occupational therapists. Comparison of the retained factors identified significant differences in practice between WA and Thai therapists, which are assumed to result from the influence of their respective cultures. Given this evidence regarding cultural influences on practice, the reduced item questionnaire was used in principal component factor analysis of data on Thai occupational therapists so that the retained factors can be used developing the action framework for ThaiOTs presented in Chapter 9.

7.8 Findings from the Open-Ended Questions

This section presents qualitative findings based on the open-ended question responses of 155 Western Australian and 138 Thai occupational therapists. These findings reflect the ideas, concepts and opinions of the questionnaire respondents, and are used to elaborate on responses to the closed-ended questions, and contribute

to development of a theoretical framework for practice. The first part examines Western Australian therapists' responses, and the second findings regarding Thai therapists.

Content analysis was used to analyse open-ended responses, as mentioned in Section 6.5. Interpretative schemes were proposed in terms of themes and categories underpinning each theme. Summarised statements were grouped by common theme, then categorised. The original statements, however, have been quoted directly here, to clarify the findings. The coding of each question was performed separately. However, the method of coding was the same, and can be outlined as follows:

1) Major points and significant meanings were highlighted with colours or marked with symbols. Use of the same colour or symbol referred to the same major points or significant meanings.

2) Points with the same highlight or mark were grouped in categories, then coded by number for counting, and then given appropriate names to reflect their content.

3) Categories having similar meanings or referring to the same concept were grouped together to form a theme.

4) Each theme was labelled according to the significant content and meaning of the component categories.

5) Quotes and statements that are typical of each category were recorded and reported under the theme.

7.8.1 Responses from Western Australian Occupational Therapists

7.8.1.1 Question1: Have the theoretical frameworks which underpin practice assisted you in client interventions?

It was found that 92 Western Australian therapists (59.35 percent) agreed that theoretical frameworks assisted them in client intervention, whereas 23 Western Australian therapists did not agree.

Several reasons for why theoretical frameworks have a useful role in practice were provided by respondents. The overarching reason given by 55 Western Australian therapists, was that they assist in implementation of the occupational therapy process. They also commented that the occupational therapy process provides a mechanism for assessing and viewing their clients in a particular way, and

in structuring required documentation. Conceptual frameworks provide a mechanism for assessing and viewing their clients as a whole, or from multiple perspectives. Additionally, theoretical frameworks are seen as providing a valid and scientific basis for guiding assessment and intervention.

In contrast, those therapists who opined that theoretical frameworks do not assist in their practice provided the following reasons. First, theoretical frameworks are restrictive and too inflexible for application to reality, and do not account adequately for the influences of government policy, insurance companies, and limited time and funding. Second, this group of therapists reported that they use experience, 'common sense', or an eclectic approach to respond to clients' needs and plan interventions. Finally, they perceived that such frameworks conflict with the Medical Model and focus on individual, not population based approaches.

Most Western Australian therapists supported the claim that theoretical frameworks assist in client intervention. However, their impact is limited by the health care system and policy, as well as the limited understanding that therapists, themselves, have about specific conceptual frameworks. Many claimed that they had not been educated or trained adequately, and lacked a good knowledge of occupational therapy theoretical frameworks, so that they were forced to rely on their experience, common sense, or use of eclectic approaches. In addition, the conflict between Occupational Therapy models and the Medical Model was seen as an obstacle for effective application.

7.8.1.2 Question 2: What are the limitations of current frameworks for application in your country?

It was found that 91 Western Australian therapists (58.71 percent) reported restrictions in effective application of current frameworks to their practice, whereas 12 therapists (7.74 percent) reported that they perceived no such restrictions in applying theory to their practice.

Based on the frequency of responses the following explanations were offered for why theoretical frameworks are limited in application: 1) resource limitations, 2) lack of cultural and contextual relevance, 3) adverse impacts of government policy and legislation, 4) heavy workloads, 5) need for adherence to the Medical Model, 6) difficulties in interpretation and application of current frameworks, 7) working in

multidisciplinary teams, 8) lack of specific frameworks to meet the needs of specific client groups, and 9) accountability demands and the reliability of frameworks. Themes 4 to 9 were reported by less than 5 percent of Western Australian therapists. Hence, they are not presented in detail in these findings. Western Australian therapists mainly reported that limitations of time and money limit effective application of current frameworks to practice, more so than the cultural context or any of the seven categories.

The most commom observation (42 therapists or 27.10 percent) was that theoretical frameworks do not take into account resource limitations, which include time, funding, and ongoing institutions support. Time and funding were considered as the major limits on application of current frameworks.

1.1 Statements about time:

"Usually it is not the model, but the lack of time and resources to address (issues) properly, and as a result this is reflected in intervention"

"Limited time in the hospital environment to consider all aspects represented in theoretical models"

1.2 Statements about funding

"Models can not be completely adhered to when you have financial limitations"

"Funding in each area limits the access of direct and indirect interventions possible"

"Financial limitation so people are discharged from hospital too early. Models don't address this issue"

1.3 Statements about ongoing support

"There is limited ability to provide the ongoing support in the community i.e., a coordinated scheme to cover all aspects of an individual life role"

Sixteen Western Australian therapists (10.32 percent) reported that theoretical frameworks had limited application in a narrow range of cultural contexts. The following typical statements provide evidence for this viewpoint.

"Many of the current models appear to be well suited to Western culture; however, I find working with clients of a variety of cultures, they sometimes are difficult to apply when the clients' beliefs and values are markedly different from those of Western clients"

"Most are very Westernised and reductionist, not much recognition for ecology and community"

"Some models are underinclusive of some aspects of the client's lifestyle e.g. religion and cultural expectations"

"Community/culture thinks elderly people should be looked after if it's an effort to be independent, even if capable of performing ADL's themselves"

"In Australia, the cultures are now so diverse that we need to expand the model and become more creative"

"Little relevance to indigenous population"

"Not as significant generally for this country but certainly there are limitations of current models for Eastern culture. Within this country-the Western value of maintaining independence in the aged does not correlate with values of people from Asian/Eastern European culture"

Western Australian therapists stated clearly, or implied that most of the current frameworks tend to be Westernised in their emphasis on of maintaining independence, and might not apply to diverse cultures, especially Eastern cultures.

Of the other issues reported by respondents, the most common, suggested by 10 therapists (6.45 percent), was that government policy and legislation affect employers and insurance companies, which in turn impact on current frameworks for practice.

"Sometimes the restraints of policy and organization limitations restrict how well you can use some models"

"Limited models for different areas of work that fit within the Government policies/procedures in place"

"There is minimal scope to consider alternative models, due to constraints of legislation and support from the insurance companies"

"Difficult to apply them with current job in vocational rehabilitation, with so many parties involved and agendas"

It can be concluded that many Western Australian therapists believe that inadequate resources are a major limitation, and that other concerns include the cultural context and the impact of government policy and legislation. These factors are seen to have considerable impact on application of the current frameworks to their practice.

In contrast, 12 Western Australian therapists (7.74 percent) said there were no limitation in using theoretical frameworks in practice. They made the following statements to support this view:

"I see models as being more as a tool to enhance ideas and solutions for client's issues"

"You can not take an 'all or none' approach. We need to be flexible with our approach, particularly with the ever-increasing diversity of cultures in Australia"

"None as long as it's applied as models on which treatments/plans are based"

7.8.1.3 Question 3: Make a list of what you would like to include in a new framework for practice

Western Australian therapists provided numerous ideas that they believe should be included in a new framework. However, only three categories, based on the highest response rates, are described here. The first focuses on the need for an individual client-centred approach within their specific context. The second emphasises the need to be practical in application when practice is affected by limited resources. The third underlines the importance of cultural dimensions and the need to focus on community, wellness, and health promotion. Additional categories were reported, but as less than 10 responses were recorded against each, they are not elaborated here.

There were fifteen (9.67 percent) who suggested that a new framework should include a focus on an individual client-centred approach within their specific context. Typical suggestions include:

"The model should include how to work with the whole person in all settings of daily life eg. at school and home"

"More holistic, less regard for health department concerns"

"Client needs (which are not always what they want)"

"Client expectations and client doing the goal setting"

"Clients perception and motivation for treatment"

"Client-focused and family-focused"

"Meet the client's individual and group needs"

Thirteen respondents (8.34 percent) underlined the importance of resource constraints, as discussed above in section 7.8.1.2 by suggesting that a new model should provide guidance on dealing effectively with resource constraints.

Western Australian therapists suggested that a new framework needs to be practical in application, as clinical work is inevitably affected by external factors such as personnel levels, funding, policy, and systems. The following suggestions reflect concerns about accommodating external demands with ideals solutions as laid out in the models.

"Policies/procedural issues that affect intervention (state, ideal, national policy)"

"Consideration of other parties involved in discharge system"

"More consideration for resources and service available in immediate environment eg. Rural town versus city suburb"

"Deduction/lack of funding does not allow for the luxury (of) following through in the most ideal way as promoted by many of its models"

"The reality is that the minimum intervention is required to suit the health dollar"

Concerns with culture, community, wellness, and health promotion were also suggested as sources of a difficulty. Twelve Western Australian therapists (7.74 percent), reported that a new framework should take into account cultural dimensions, noting for example:

"Sensitivity to cultural differences"

"Minority group consider cultural differences and limitations"

"Expanding on cultural issues/impact on independence"

"Cross cultural reference-a model which takes into account cultural background"

"Ideas of usage with particular cultures"

Also, 12 Western Australian therapists (7.74 percent) suggested that a new framework should focus on community, wellness, and health promotion as noted in the following typical suggestions.

"Promotion of community integration/enhancement of lifestyle"

"Focus on community integration to decrease dependency on hospital, outpatients services and increase normality"

"Wellness and health promotion models"

"Community based models to be provided on a population basis"

"Health promotion models for occupational therapists"

7.8.1.4 Summary of responses from Western Australian occupational therapists

Most Western Australian therapists agreed that theoretical frameworks assist their practice, especially in implementation of the occupational therapy process. Nevertheless, application of the current frameworks is limited by a lack of resources, cultural and contextual relevance, and impact of government policy and legislation. Even though most Western Australian therapists complained about limitation of resources as the primary limiting factors, they emphasised the importance of a client-centred approach as the most important area for improvement; and being practical in application that could be supported by minimal resources as the second most important. In thinking about a new improved framework, Western Australian therapists are most concerned about being able to follow an individual client-centred approach that is practical to the individual cultural context; and also one that is applicable under limited resources, and consistent with current health policy and systems; and take into account cultural dimensions, wellness, and health promotion.

7.8.2 Responses from Thai Occupational Therapists

7.8.2.1 Question1: Have the theoretical frameworks which underpin practice assisted you in client interventions?

All Thai therapists who responded to this open-ended question (*n* = 138) agreed that the current theoretical frameworks assist them in client interventions, by ticking the yes option.

Most Thai occupational therapists (*n* = 106) (76.81 percent) suggested that the primary value of theoretical frameworks is for clarifying the occupational therapy process to be used. As secondary reason they are useful as reported by Thai therapists is that they give a rationale and scientific basis for intervention. In addition, Thai occupational therapists suggested theoretical frameworks can be useful in meeting the particular demands of the clients' contexts.

The therapists also noted that the model help in implementing the occupational therapy process by laying out all steps in the process, resulting in a systematic program from assessment to evaluation that can be accomplished within a limited time frame. They also noted that the occupational therapy process prescribed by the models include structures for reporting that are useful to inform other professions and clients' relatives. Additionally, they ensure that viewing and understanding clients from a whole person perspective are incorporated in the occupational therapy process.

Theoretical frameworks built on a scientific basis are useful in establishing a clear rationale for the process of intervention, for provision of effective and clear outcomes, and for assisting in promotion of the occupational therapy profession to other professions and employers.

Apart from these, typical statements, Thai occupational therapists suggested that the theoretical frameworks should be adapted appropriately to meet the demands of the clients' context, including the following:

"Adapt the frame of reference appropriately for clinical practice in Thailand"

"They should be applied and modified appropriately to meet the clients' condition and their context"

Even though all Thai therapists agreed that theoretical frameworks assisted in their practice, especially in occupational therapy process, some argued that there is a need for a theoretical framework that is appropriate to the clients' Thai context.

7.8.2.2 Question 2: What are the limitations of current frameworks for application in your country?

Most Thai therapists (n = 88) (63.77 percent) claimed that effective application of current frameworks for practice is limited by Thai culture. They also perceived their own limitations in applying current frameworks to practice. In addition, they reported that the structure of the health care system limits effective application of those frameworks. Other specific factors that limit effective application of these frameworks were reported by only a small number of respondents.

Based on frequency of responses, the major reasons theoretical frameworks find limited application in practice in Thailand are: 1) lack of relevance to Thai culture, 2) limitations of therapists, 3) limitations in the structure of the health care system, 4) financial constraints, 5) not being practical for application in real situations, 6) inappropriate policies of government and the public health ministry, 7) unhelpful content and requirements of the frameworks and the environment in which they are applied, and 8) insufficient accountability and reliability. Themes 4 to 8 were reported by fewer than 6 percent of Thai occupational therapists. Hence, they are not presented in detail in the findings. The themes one to three can be further elaborated as follows:

Eighty-eight therapists (63.77 percent) ventured opinions on limitations of the theoretical frameworks for direct application in the Thai culture, and also in providing relevant information. Currently, attitudes within Thai culture toward disabled clients are based on the premises that disabled members of the society need to be treated with compassion. This translates into having families, health care professionals, and relevant others looking after their needs. This also implies that clients have no requirements to become independent and take care of themselves. This may be because they view people with disabilities as having no potential to take care of themselves and the people are willing to help them because of their sympathy and generosity. Specifically, in relation to care of the elderly, younger family members readily take on the role of caregiver, and the elder expects to be taken care of. There is no overall acceptance that people with disabilities can contribute

positively to mainstream society, as this is inconsistent with the belief that they should be cared for. This is controversial with the study of Sitthigan, et al., (2000) and Samuktiya (2000), which study with spinal cord injury patients, and relatives of schizophenia patients that they emphasise helping themselves. This newer studies indicate a shift toward independence and can be the aim to promote independence of an individual within interdependent family in near future. These may be at least two differing interpretations of why most ThaiOTs have this view. First, they may have relatively little concern for the independence of their clients. Or, alternatively, it may be that their work in institutional services limits their time and discourages them from undertaking the demanding home visits that would be required to support client self-sufficiency. Examples of typical statements describing this attitude include:

"General attitudes toward the handicapped in the Thai culture are that they have no potential to take care themselves, or they should be overprotected (Social Attitude)"

"In Thai culture people take care of the disabled; they have no chance to help themselves"

"Thai people feel sympathetic toward the ill or disabled, and then they have to help them"

"Thai people view that the handicapped can not help themselves"

"Thais uphold the value of compassion to take care the ill and handicapped"

"Thai's habit is to take care and help the ill and handicapped"

"Most concepts come from Western countries, whose culture is different from Thai culture"

"To apply to Thai culture, we have to understand clients' families"

"There are different motivations of each human race to take part in treatment program and help themselves"

"Values, beliefs, and culture that don't accept clients abilities"

Several respondents made specific references to independence:

"Thai belief and value is not independence"

"The emphasis on independence does not fit to Thai culture. They believe in gratitude and compassion"

"The goals of treatment of Thai people are not independence"

"Thai people do not accept the concept of independence"

"Attitude toward the handicapped e.g. they should depend on others for the rest of their life"

"The patients, themselves, would like to depend on the others as well"

"They prefer to rely on their families"

Within Thai culture, inherent beliefs are based on external control more than internal control. This implies that clients and their relatives should rely on health professionals to treat diseases, rather than to manage on their own with consequences as reported in the following typical statements:

"Thais believe in external control more than internal control. They don't have motivation to take care of themselves, and they always rely on health professionals, superstitious things, and monks"

"Clients and their relatives focus on recovery from diseases, rather than helping themselves"

"Clients believe in health professionals so they don't express their needs"

"No cooperation from clients and their relatives; they expect only medical treatment"

"Clients expect occupational therapists to fix their problems, and they don't cooperate in treatment programs"

"Thai people don't express their needs and the exact problem"

In general, the Thai community is not well informed about the possibilities of rehabilitation, because it is contrary to cultural concerns, as reflected in the following typical statements:

"Level of education of clients"

"Their relatives don't understand or value intervention programs"

"The level of knowledge and understanding of clients"

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The second most important category of limitation, as reported by 18 Thai occupational therapists (13.04 percent), is limitations imposed by 18 therapists' own conceptualisation of the common theoretical frameworks, and their application in practice, as supported by the following typical statements:

"ThaiOTs do not have a clear understanding of theoretical models"

"ThaiOTs can not appropriately apply theoretical models for practice"

"ThaiOTs lacks clear understanding of how to apply models for practice"

"Don't understand models deeply, and have not followed the new ones"

"They don't maintain contact with new information"

"Don't understand models deeply, lack experience, and are weak in integration and appropriate application"

"ThaiOTs lack skills in practice"

The third most important category of limitation reported by 12 Thai occupational therapists (8.70 percent), is limitations imposed by the structure of the health care system, lack of collaboration of health teams, and limited acceptance of occupational therapy in the health care system, as confirmed by the following typical statements:

"Rehabilitation is based almost solely within an institution, apart from a limited Community Based Rehabilitation program"

"Decisions about clients are not often made collaboratively"

"The work system and cooperation among different organizations are not effective"

"Patients are discharged quickly"

"The transition program from hospital to home is limited"

"The health insurance system of Thailand does not cover rehabilitation programs, it focuses on compensation for loss of body parts and of income"

"Occupational therapy is not essential for life and death decisions, it is more focused on the quality of life, which is not well promoted"

"Occupational therapists have to build up more understanding to overcome many problems and obstacles"

It is readily apparent that Thai occupational therapists are more concerned about the influence of Thai culture on effective application of current frameworks to their practice, than with the effect of other factors.

7.8.2.3 Question 3: Make a list of what you would like to include in a new framework for practice

Many Thai occupational therapists proposed a new framework that includes cultural concerns, a client-family focus, and an inclusive occupational therapy process as major elements. Other ideas for a new framework were suggested by fewer than seven therapists, and thus are not elaborated upon here. For the record, these less common suggestion included: devising conceptual frameworks that are easy to comprehend and explain; build a combined framework (an eclectic approach); emphasise community, health prevention and promotion; and include concrete concepts and outcomes:

Twenty-nine Thai occupational therapists (21.01 percent) suggested a new framework that emphasises cultural concerns, and most emphasised it should be applicable specifically to Thai culture. Examples of typical suggestions:

"How to apply models suit to each culture"

"To be relevant to Thai culture"

"To be concerned to Thai culture, general Thai lifestyle and lifestyle of the handicapped, relevant to performance of Thai people"

"Based on the belief and culture of each group"

"The standardised model for use throughout Thailand and relevant to culture in each part of Thailand"

"Applicable to Thai culture"

"Modified the current models to suit Thai values and the real context of Thai people"

"Modify the process and theories suitable to Thai culture"

"Suit to Thai view, lifestyle and culture"

"Change the attitude and vision to the handicapped, who are supposed to be viewed that they can live in the same society as the normal, and give them the opportunity to help themselves"

"Cultivate the value of independence"

Fourteen Thai occupational therapists (10.14 percent) proposed that a new theoretical framework should support an approach that includes a broader client-family focus, and takes into account the entire family's quality of life concerns, as is applicable to their specific cultural context. Examples of typical statements:

"Quality of life of clients and family members (caregivers)"

"Focus broadly on the lifestyle of clients in the future"

"Focus on all aspects of clients"

"Status and role of clients in family"

"Family's expectation for a client"

"Needs of clients"

"The whole person approach, including family"

"Clients and family members participate in decision making"

"Accept that the decision of clients is the most important in rehabilitation program"

Nine therapists (6.52 percent) proposed that a new framework should cover the occupational therapy process in detail, have a clear approach to each problem, and identify the target group of clients.

"Include counselling and guiding client approach correctly"

"Therapeutic approach for each kind of clients"

"The model should identify the group of clients suitable to this model"

"Clear approach to each problem which is different from medical treatment"

"Clear procedure and approach relevant to clients' problems"

"Clear and covering the treatment process"

"Specify therapeutic media according to pathology and occupational dysfunction"

7.8.2.4 Summary of responses from Thai occupational therapists

All Thai occupational therapists agreed that current theoretical frameworks assist them in practice, especially in the occupational therapy process; although it is evident they lack information and understanding about some newer frameworks that might meet some of the points they identified for a new framework for Thailand. Overall, the lack of a clear 'fit' with Thai culture is seen as the main limitation in applying the current frameworks for practice. The value placed on caring for people with disabilities and elderly people, is opposed to the value placed on maximising independence of people with disabilities and elderly people in the current frameworks. Thai occupational therapists are concerned that cultural dimensions, a client-family focus, and an inclusive occupational therapy process respectively should be included in a new framework, while other issues are less important. In other words, Thai occupational therapists primarily emphasised that a new framework should meet the demands of the client-family and harmonise with Thai culture.

7.8.3   Summary and Discussion

7.8.3.1   Question1

Most Western Australian occupational therapists (WAOTs) agreed that current theoretical frameworks assist them in client-intervention. However, 23 WAOTs did not agree that the theoretical frameworks assisted them in client intervention. Most of these complained that the frameworks are restrictive and too inflexible for application to reality. Hence, this minority argue that a common sense or eclectic approach might be more useful in responding to clients' needs. All Thai occupational therapists expressed the opinion that current frameworks are relevant to their work.

Western Australian and Thai occupational therapists generally provided the same explanation for why the theoretical frameworks are useful in occupational therapy, noting that they help in viewing and understanding clients, in structuring reporting, and in providing a rationale and scientific basis for intervention. Notwithstanding, these points in favor of existing frameworks, Thai occupational

therapists overwhelming expressed a need for a framework more appropriate to a client in Thai culture.

7.8.3.2 Question 2

Most Western Australian and all Thai occupational therapists agreed that the current frameworks have limits to effective application in their countries. However, 12 WAOTs reported they found no such restriction on application in their practice, noting that the frameworks guide their thinking and enhance ideas for solutions in practice.

Most Thai occupational therapists reported that a poor fit between the frameworks and Thai culture as the first limitation in applying current frameworks to their practice, whereas most of WAOTs reported a lack of financial and human resources as the major limitation. Thai occupational therapists considered that limitations of therapists in applying frameworks is the second most important limitation, and problems caused by structure of the health care system as the final major concern. However, WAOTs identified culture and context the second limitation, and government and policy as the final concern.

7.8.3.3. Question 3

Most Thai therapists proposed that a new framework should include: greater cultural relevance, a more explicit client-family focus, and a more inclusive occupational therapy process, in that order. Most Western Australian occupational therapists proposed that a new framework should include: first, an individual client-centred approach; second, guidance on dealing with resourcing limitations, and third; dealing with cultural dimensions and community, wellness, and health promotion concern. ThaiOTs primarily focused on the importance of the client-family, embedded within the Thai culture, while WAOTs are mainly concerned with individuals and their needs.

Most Western Australian and Thai occupational therapists agreed that the current theoretical frameworks assist them in practice; however, they could not apply the full occupational therapy program in their clinical settings due to limitations of resources, time, and policy and contextual issues including the cultural contexts of practice. Thai occupational therapists also reported that there are limitations in

applying Western models to their practice due to cultural factors which affect their interpretation of the Western models.

Thai occupational therapists reported they do not have a clear understanding of a number of concepts that underlie current occupational therapy models. These appear to clusters around issues kf independence, autonomy, and activism in occupational therapy philosophy that underlie Western-oriented models. ThaiOTs lack of clarity in translating these concepts into practice, for example in relationship to the occupation of individual in occupational therapy models, appears related to Thai culture. Therefore, it is difficult for ThaiOTs to apply Western occupational therapy models to Thai culture, which value interdependence and caring for people with disabilities and elderly people. In contrast, Western Australian therapists appear to have clearer understanding and greater sympathy with an emphasis on independence, autonomy, and activism in occupational therapy philosophy. However, due to expansion of multicultural societies in Australia, Western Australian occupational therapists also acknowledge the importance of application of occupational therapy models to a range of cultural contexts, when they work with clients from different cultural backgrounds.

Even though the holistic model has been incorporated into occupational therapy practice by using the client-centred approach and the clients' environment approach, the two approaches focus on the client as an individual. This means the needs and choices of individual client are the primary concern and the client must be encouraged to express his or her needs appropriately. For this reason, Western Australian occupational therapists emphasised that an individual client focus should be included in a new framework, whereas Thai occupational therapists proposed a client-family focus that is more relevant to Thai culture. In addition, due to a lack of clear understanding of occupational therapy philosophy and models, and of experience in applying traditional occupational therapy models to practice in the Thai cultural context, Thai therapists recommended that a new framework should introduce greater specifically by identifying specific techniques in the occupational therapy process in relation to specific diagnostic problems within specific targeted groups. This implies that a very structured, step-by-step, technical approach to problems should be adopted.

However, while structured solutions may appear to provide a clearer method of practice in Thailand, this proposed approach does not take into account the individual requirements of clients and their families, nor does it reflect the current direction of WHO guidelines, or the underlying philosophy of current occupational therapy practice. Aligning occupational therapy more closely with Thai culture may offer a more progressive solution than a highly structured technical approach to occupational therapy. These ideas will be further elaborated in chapter 8.

CHAPTER 8

Discussion of Use of Conceptual Models in Thailand and Western Australia: Results

8.1 Introduction

This chapter discusses outcomes of the survey and includes findings from the open-ended questions. These are discussed in relation to current literature in the field. The survey provided an overview of the actual application of conceptual models of practice, as well as illuminating differences in practice in occupational therapy between Western Australian and Thai occupational therapists. Western Australian and Thai occupational therapists are compared in: use of conceptual models in practice; cultural influences on models for practice; and occupational therapy practice in the subscales of Clients, Therapists, Intervention, Cultural Implications, and Health Care Systems. This discussion addresses the objectives of the study, which were introduced in chapter 1, and are repeated below:

1) Examine the existing conceptual models most frequently used by occupational therapists in Thailand and Australia;

2) Describe the application of these models in practice in Thailand and Australia;

3) Compare and contrast the identified models and their application by Thai occupational therapists (ThaiOTs) and Western Australian occupational therapists (WAOTs);

4) Examine the evidence of the need for a new or modified culturally specific model for occupational therapy practice in Thailand

In discussion, the three conceptual models: the Performance Model, the Whole Person Model, the Medical Model were emphasises because they were emphasised as the most important models during analysis of focus group discussion transcripts.

The discussion examines the significance of age and work experience of therapists in relationship to preferred models of practice (Section 8.2), and then the relative overall importance of models that guide the practice of WA and Thai occupational therapists (Section 8.3). Since culture emerges as the major factor

impacting on practice in Section 8.3, Section 8.4 probes the relationship of culture to occupation; roles of clients, their families, and therapists; values of independence/autonomy versus interdependence; attitudes toward illness and disabilities; social support; levels of assistance that are acceptable and related coping strategies; and systems (e.g. rehabilitation) of health care.

8.2 Association of Age and Work Experience of Therapists, and Choices of Models of Practice

It is evident from statistical analysis that the age of WAOTs does influence the model of practice chosen and most frequently used (See Table 7.8 and *). This may, in part, reflect shifts in context of undergraduate occupational therapy education over time. Thus, therapists in the younger age group (20–29 years) were more likely to use a performance model, a framework that has been highlighted in the literature and in education during the past decade. Older therapists (over 40+ years) in WA, reported that they use a whole person model more often than younger groups. The reason for this may lie in Adamson's (1994) claim that a greater emphasis on using a humanistic approach and promoting the clients' resources is to be found in therapists with greater age and professional experience (Adamson, Sinclair-Legg, Cusick, & Nordholm, 1994). It may be that rather than having to focus on technical skill requirements, with maturing professional confidence and competence, together with developed clinical reasoning skills, there is an increased ability to take into account multiple levels of client requirements. This is in contrast to younger graduates who are still developing skill competencies and attempting to adhere to the system demands of the environment in which they work.

It was also found that Thai therapists who graduated recently (0-5years) are more likely to use a performance model (See Table 7.9 and *), reflecting current thinking in the occupational therapy literature. Again it is the older and more experienced therapists who were more likely to report using a whole person model (See Table 7.10 and *). It has also been noted in the literature that "experienced therapists demonstrated more interpersonal skills than did non-experienced therapists" (Adamson et al., 1994, p. 479). This observation is in line with those in WA, but for Thailand, professionals rely largely on the Medical Model.

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The strong influence of the Medical Model is most readily apparent in the acute care systems in which Thai occupational therapists currently work (Department of Occupational Therapy, 2002a). These do not generally support the new health policies favouring greater consumer collaboration.

Thai therapists with work experience of 0-5 years and aged 20-29 years, had a preference for the Performance Model and primarily worked in paediatric and neurology settings. Those working in paediatric clinical settings (79.1 percent) focused on areas such as play performance, whilst those treating adult neurological clients (81.3 percent) focused on performance, specifically in self-care and pre-vocational training. In addition, as the occupational therapy curriculum is evaluated and modified every four years to include new knowledge and the latest theories, like young WAOTs, it can be assumed that this group of Thai therapists has learned more about performance models and their application to practice.

In sum, age and years of work experience of therapists influence selection of models of practice. This result implies that the age and work experience might contribute to wisdom and interpersonal skills that enable therapists to interpret models of practice more clearly in relation to the context, and develop relationships with clients more readily. Furthermore, the content of education programs influence therapists' choice and application of models to practice. Finally, health care policy that drives change and guides practice, such as in new areas of health promotion and prevention, has the potential to shift occupational therapy practice toward more a consistent focus on a whole person perspective. Therefore, in addition to the culture in which therapists practice, their education and level of competence and confidence also appear to influence the interpretation and selection of models for practice.

8.3 Models that Guide Practice

Models that guide practice were investigated to respond to study objectives 1 and 2, to compare and contrast the identified models. As most Thai therapists work in acute health settings, they are considered to be under the umbrella of the medical profession (Department of Occupational Therapy, 2002a; Wiboolpolprasert et al., 1996). Hence, the Medical Model approach is extremely powerful within the practice of Thai therapists, and is identified as the most popular choice as an alternative model of practice other than models specific to occupational therapy practice. This

reductionist viewpoint has brought three treatment models to the forefront: the kinesiological, psychoanalytic, and the sensory integrative or neurological models (Baum & Christiansen, 1997). Thai occupational therapists mainly work in clinical areas of neurology, paediatrics, developmental disability, hand and upper limb rehabilitation, and orthopaedics, where it is viewed as appropriate to use such models, and rather than demonstrating their value as techniques to be used in conjunction with an occupational therapy model, these 'models' become the focus of intervention. Notwithstanding, the Medical Model approach has demonstrated effectiveness in addressing deficits of clients (Mattingly, 1994), and in meeting the needs of clients and employers within a limited time frame. As found in the results from open-ended question 2, the Medical Model is also perceived as suitable for accommodating to the limitations imposed by the structure of the health care system and by the need for collaboration and cooperation with medical professionals, particularly in rehabilitation programs based within institutions directed by medical doctors.

Thai occupational therapists cited the use of Kielhofner's (1985; 1995) Model of Human Occupation as the theoretical occupational therapy model most drawn from in practice. MOHO is based on an integrative systems perspective that takes into account client motivation, habits, and interests (Kielhofner, 1995; Kielhofner, 1997f), as well as the more reductionist performance components incorporated under an integrated mind-brain-body performance subsystem and the relationship to the environment (Kielhofner, 1995).

Of the five specific occupational therapy models, the Canadian Model of Occupational Performance, like other holistic models, was least used in practice in Thailand. This model views clients as active partners in the occupational therapy process able to collaborate and make decisions about their life (Stein & Cutler, 1998), as opposed to adopting the sick, more passive role that is common in non-Western cultures (Kinebanian & Stomph, 1992). From the therapist's responses to the second-open ended question, it appears that Thai clients in treatment programs place a high value on interdependence, rather than working towards independence. This would, in turn, discourage Thai clients from taking personal responsibility for directing and making decisions about their life.

Western Australian occupational therapists noted that they mainly applied the Performance Models to their practice, and to some extent a whole person model, quite different from responses given by Thai occupational therapists. The Performance Model adheres to the values of independence and individualism, which promote individual's dignity and self-esteem in Western culture (Triandis, 1995), and is therefore more aligned with values of Western Australian therapists that measure the worth and dignity of an individual through achievement of performance outcomes (Kielhofner, 1997b).

Whilst in both countries current health policies are focused on health promotion, education, and community based programs, these views have been embedded within Australian culture for a greater period of time than in Thailand (Health Department of Western Australia, 2002b; The Planning Committees, 2002). In WA, policy suggests that local community care providers be facilitated to provide holistic care for people with multiple and complex care needs (Health Department of Western Australia, 2002b). It appears that these external guiding principles also encourage Western Australian therapists to focus on the whole person, as this approach is aligned with the attitudes, values, and orientation of Australian occupational therapists (Adamson et al., 1994). Occupational therapists were found to endorse a humanistic approach in their delivery of health care, which is congruent with a de-emphasis on the biomedical model in current health service delivery (Adamson et al., 1994).

In practice, the Performance Model was used mostly in paediatrics and developmental disability (45.9 and 45.5 percent respectively), focusing on children from infancy to 18 years, and covering key developmental stages leading to young adulthood, which Western society associate with gaining independence. This performance framework (as reported) relies largely upon performing not only in self-care, but also in school and work and leisure environments. The latter is a particularly important component of adolescent development (Passmore, 1998).

The Whole Person Model was mostly used in psychiatry and aged care (58.8 and 50.8 percent respectively) in WA. It can be argued that the Medical Model fails to solve the full range of problems of people with chronic disabilities and whose problems are usually more extensive than internal mechanism deficits (Kielhofner, 1997b), and requires a more comprehensive understanding of their life contexts. The

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Whole Person Model was reported by WAOTs to be a better alternative to solve the wide range of problems of these clients.

Both Thai and Western Australian occupational therapists often used the Medical Model in clinical medicine, private practice, chronic pain, hand and upper limb rehabilitation, and orthopaedics. This tendency to use the Medical Model in the same areas of practice might respond to the reductionist approach that the contexts of practice in those areas align with.

Survey results on how frequently the various practice models are used in WA and Thailand are compatible with findings of the initial focus groups, and demonstrate that: 1) Thai therapists used the Medical Model more than WAOTs, and the Medical Model is the most popular model in practice among Thai therapists; 2) Western Australian therapists used the Performance Model more than Thai therapists, and the Occupational Performance Model is the most favoured model of practice among WAOTs; and 3) Western Australian therapists used the Whole Person Model more than Thai therapists, a result that does not support the focus group findings that indicated both countries use this model equally.

In responding to the open-ended questions, Western Australian and Thai therapists agreed that models of practice assist them in shaping and carrying out the occupational therapy process. But they noted application is limited by the cultural contexts in which they practice. Varied aspects of culture influenced therapists' application of theory to practice. However, the major findings at the professional level were that WAOTs focus on meeting the needs of individual clients, whereas Thai therapists focus on meeting the needs of both clients and their families as one unit of concern. Both demonstrated concerns about cultural implications in practice. However, Thai occupational therapists proposed the need for a new, more culturally sensitive model of practice as their primary concern. From overall findings from the survey, it is concluded that it is the cultural contexts of practice that most influence WA and Thai occupational therapists in perceiving, interpreting, selecting and applying models of practice in each country, rather than other factors.

These differences seem to arise primarily from cultural influences that vary between Western and Eastern cultures. This comparison between the practice of Thai and Western Australian occupational therapists has been undertaken to determine the extent and quality of the differences and similarities in use of conceptual practice

models, and the impact of cultural influences. The results of this comparison, discussion, and recommendations, can usefully reflect on: 1) whether or not there is sufficient evidence for the need for a new conceptual framework; 2) or on the need to modify existing models of occupational therapy practice for Thai culture; and 3) what mechanisms can be adopted to support the occupational therapy practices in Thailand that are aligned with both the philosophy of World Federation of Occupational Therapists (WFOT), and the cultural needs of Thai people. And new or revised model should also adhere to current and future health policies of Thailand that are now guided by the WHO.

To help understand the influence of culture on the practice of WA and Thai occupational therapists, a comparison is discussed according to the conceptual domains that were developed from both documentary research and field survey. Some of these domains are compatible with the postulates of Krefting and Krefting (1991, p. 107) (See 2.3.4).

8.4 Cultural Influence on the Practice

8.4.1 Occupation

In line with the reductionist or medical model mainly used by Thai occupational therapists, biomechanical and neurodevelopmental rehabilitation techniques are combined with ADL or self-care activities in training (Baum & Christiansen, 1997; Kielhofner, 1997b; Semrad, 1956; West & McNary, 1956). Self-care is considered fundamental to daily survival (Rogers, 1982b), particularly in rehabilitation programs in Thailand. A survey undertaken by Apikomonkon and Bunrayong (2000) showed activities of daily living were primarily used as the therapeutic medium by Thai occupational therapists, and factors influencing their selection were models of practice such as the Medical Model. It was also found that self-care activities were the major services that Australian occupational therapists provided to meet the needs of clients in acute settings (Griffin & McConnell, 2001).

As presented in Section 8.3 above, ThaiOTs mostly used the Medical Model, presumably because most of them work in acute health settings; hence, self-care activities or ADL is the occupation they apply most to practice, to meet the survival needs of clients, and to align with the Medical Model. Studies about caring for people with disabilities in Thailand showed that ADL was the most important

occupation that the family take a responsibility for in looking after clients post discharge (Hirunchunha, 1999; Somnuk, 1997). However, even though, family members modify and create techniques and self-help devices to assist clients in ADL achievement (Hirunchunha, 1999), they still need information and instruction in order to successfully care for clients at home (Somnuk, 1997). Therefore, ADL should be the key occupation of concern for ThaiOTs in providing to clients and family in both institutions and communities.

Alternatively, Western therapists use the Performance Model mostly in their practice that includes areas of self-care but also the domains of work and leisure (American Occupational Therapy Association, 1994b). In Western societies, people believe in activism (Parry, 1984) and value independence (Hofstede, 1991; Triandis, 1995), that assumes the need for therapists support to achieve competence and autonomy (Rogers, 1982b). The characteristics of occupation that are self-initiated, active and contribute to self-competence tend to have meaning for clients in Western culture (Henderson, 1996). Therefore, therapists tend to focus on occupation, including broader areas than self-care activities. In comparing the frequency of 'Occupational Guided', and 'ADL Guided' approach between WA and Thai therapists, it was found that therapists applied these two approaches in a significantly different manner ($p = .000$ for 'Occupational Guided' and $p = .001$ for 'ADL Guided' respectively) (See Table 7.18).

8.4.2 Roles of Clients and Their Families

In non-Western cultures (or 'interdependent societies'), clients tend to adopt sick or passive roles in treatment. A passivity during treatment, and reliance on others during sickness and old age, is accepted (Dyck, 1991; Jang, 1995). In their responses to the second open-ended question, Thai therapists report that their clients are not required to be independent, because their families, health professionals, and relevant others all look after all their needs. Specifically, in relation to care of the elderly, younger family members readily take on the role of caregiver, and the elder expects to be taken care of. In addition, Thai clients believe in health professionals, readily rely on them to treat diseases, assume they know the best way to manage the problem, and therefore do not express their own views about their problems. According to the Medical Model that most Thai therapists work under, clients expect to be treated or rehabilitated and rely on health professionals to help them improve or

recover. In the non-Western or Thai cultural context, the family is always involved in treatment decisions and programs (Kinebanian & Stomph, 1992; Trafford, 1996). The family in non-Western culture takes part in choosing appropriate occupations for the client, and dominant family members take the role of problem solver (Kinebanian & Stomph, 1992; Trafford, 1996). Thus it is to be expected that in non-Western culture, the degree to which clients are involved in self-care, work, and leisure activities will be substantially different from level in Western culture.

In Thai society, it was found that the family not only assists in ADL for clients, but also in mobility rehabilitation of clients' extremities, or in encouraging clients to perform mobility rehabilitation (Somnuk, 1997). The family has the most important role in caring for a family member with a chronic illness or disability (Pradapmuk, 1999), and is expected to take care of the health of all members (Ministry of Public Health, 1997b). Therefore, the family should have knowledge on how to take care of clients, and become independent caregivers for family member at home (Pradapmuk, 1999). On the other hand, caring for family members with chronic illness or a disability may be a major burden for the family (Hatthakit, 1999), and it is often difficult to predict how long the family will be able to take on the caregiver role (Pallet, 1990). It was found that the capability of clients in performing ADL was negatively correlated with the caregiving burden of caregivers (Kenchaiwong, 1996; Somnuk, 1997). Based on previous research and result of focus groups, to maintain family functioning, the responsibilities in caring, tasks, and financial support need to be shared among family members, and the needs of the client are also supposed to be compromised with the needs of the family according to the resources and potential of the family. In addition, family members need to be encouraged to provide opportunities for the client to enhance his or her potential. It is suggested that clients take a greater role in caring for themselves, in order to enhance their occupational potential, especially in ADL and in so doing decrease the burden on families.

In the Western context, clients usually direct their life and make their own decisions (Bates & Linder-Pelz, 1990; Kinebanian & Stomph, 1992). This may be with some formal consultation (Bates & Linder-Pelz, 1990), but clients generally expect to take an active role and participate in treatment. Additionally, the clients' needs are placed at the centre of the planning, funding, and delivery of service (Department of Health and Aged Care, 1999). People with disabilities and older

people have readily access to health care services, which are appropriate to their needs, and have the potential to participate in decision-making at many levels in the health care system (Palmer & Short, 2000). Therefore, the roles of clients in Western culture tend to be different from those in non-Western culture, a view which is supported by the results of the clients subscale comparison (See Table 7.16). This table shows that Thai therapists view the factors of the client subscale differently from WAOTs. In addition, from the comparison of the factor: 'Client-Family Guided', in the Intervention subscale, it was found that the participation of a client and family in intervention in Australia and Thailand was different ($p = .000$) (See Table 7.18).

8.4.3   Roles of Therapists

In non-Western cultures, occupational therapists take a direct role in changing clients' situations, rather than facilitating clients in solving their problems (Trafford, 1996). From the response of Thai therapists to the second open-ended question, families and health professionals and relevant others look after all of the clients' needs, which is compatible to the passive roles of clients in non-Western cultures (Dyck, 1991; Jang, 1995; Kinebanian & Stomph, 1992). According to the Medical Model that Thai therapists work under, therapists are often seen as the 'expert' with a high degree of authority over patients, and view themselves as having the required knowledge for direct treatment of the patients (Fleming & Mattingly, 1994; Kielhofner, 1997b). Alternatively, in Western societies, health professionals take the role of 'consultant' to clients, who often take an active role in decision-making (Bates & Linder-Pelz, 1990). These difference are supported by results of comparing factors in the subscales, which show Thai therapists emphasis a 'Reductionist Approach' and 'Therapist-Guided' intervention, significantly different from those emphasised by WAOTs ($p = .000$) (See Table 7.18).

In line with the Medical Model, Thai therapists take a directive role in solving problems of clients, with clients as passive recipient. Nevertheless, according to government policy, clients and families are expected to play a self-care role for their own health, and take care of family members (Ministry of Public Health, 1997b), and to be responsible in looking after themselves and family members (The Planning Committees, 2002). Despite this expectation, clients and families need appropriate information to ensure that appropriate care is given, as mentioned previously.

Therefore, Thai therapists should be involved in educating both clients and families about intervention programs, so they can transfer these programs to homecare. Effective intervention programs need collaboration between clients, families, and therapists in order to meet the needs of clients and families.

The Australian health care system focuses on community care and service close to clients' homes (Health Department of Western Australia, 2002a, 2002b). Occupational therapy takes a number of roles in community care (OT Australian Association of Occupational Therapists, 2001). In contrast, most Thai occupational therapists work in hospitals or institutions, not in the community (Department of Occupational Therapy, 2002a), and their practice has a medical focus (Wiboolpolprasert et al., 1996). In Thailand, ordinary community members are not involved in health development programs, which are generally organised and directed by health professionals who work for government (Ministry of Public Health, 1997b). Community organizations are not viewed as having sufficient capacity (e.g. knowledge, budget, etc) to look after the health of either their own members or other in the community (Ministry of Public Health, 1997a). Currently, most Thai occupational therapists do not work in the community. Even if some of them do undertake work in the community, they mainly take roles in screening and educating community members (Department of Occupational Therapy, 2002b). Comparison of viewpoints of WA and Thai occupational therapists on 'Community Orientation' demonstrated a significant difference at $p = .002$ (See Table 7.17), which supports the above views.

In Thailand, nevertheless, according to current government policy community members and organizations are expected to participate in caring for members and families with illness and disability in the community (Pradapmuk, 1999; The Planning Committees, 2002). This clearly implies that Thai therapists should take more roles in community health, including screening, assessment, intervention, and evaluation, and should began seeing clients and families at home. In addition, Thai therapists should use resources in the community and engage community members to participate in relevant OT programs, including prevention, promotion, intervention, and education and training. These health-related programs should be provided to community leaders, folk healers, and volunteers in the community as priority groups so that they can more effectively look after themselves and community members.

Finally, Thai therapists need to learn to empower clients, families, and community members to look after themselves and members of their communities.

8.4.4 Value of Independence/Autonomy Versus Interdependence

Thai people value interdependence and care for people who are ill or disabled. This is perceived as a good deed or a moral obligation and earns merit according to Buddhists' beliefs (Hatthakit, 1999; Triandis, 1995). Thais depend upon each other, and find their security in dependence and support, rather than individualism (Wichiarajote, 1975). They value dependency on others for the same survival purpose (Smuckarn, 1980). Alternatively, in Western societies, individual autonomy and independence are valued over interdependence (Phipps, 1995). The concept of independence includes autonomy and self-determination and loss of independence implies "the beginning of the end" for elderly patients (Watkins, 1998).

In comparing the importance attached to 'Mutual Dependence' among Thai and Australian therapists, a significant difference was found ($p = .000$) (See Table 7.19), and supported evidence in the literature. Notwithstanding, this difference, both Thai and Western Australian occupational therapists focused on clients' cultural values, and no-significant difference ($p = .273$) (See Table 7.19) was found in comparing this attribute between therapists in the two countries. Both are aware of the cultural context of clients and consider whether independence is valued by clients, their families, and their cultural groups. Western Australian therapists also work with clients from non-Western backgrounds and are obliged to take clients' cultural contexts into account. Findings from the open-ended questions indicate that Western Australian occupational therapists are aware that most of the current frameworks tend to be Westernised in their emphasis on independence, and might not suit diverse cultures, especially Eastern cultures. Thai occupational therapists have to take the values of interdependence and family participation into account in their practice. Thus results demonstrate that all therapists report concern about their clients' culture and values around independence.

Due to interdependence within the Thai family, members are supposed to take care of one another and members with illness and a disability. Family members support one another both financially and change labour or work when a member become sick or disabled (Somnuk, 1997). The Thais emphasis on interdependence is useful to encourage clients and family members to share these responsibilities in

order to maintain family function. This value may enable families to become independent in caring for themselves and family members with an illness or a disability. In addition, based on the value of interdependence of community members, self-help groups and networks for providing care and promoting health should be established within the community, which then contributes to independence of both the family and community.

8.4.5   Attitude Toward Illness and Disabilities

Based on the belief of bad karma from a previous life, Thais perceive that causes of disabilities are unknown and uncontrollable, and that intervention cannot solve or improve the existing condition (Wiboolpolprasert et al., 1996). They generally have an attitude of giving to people with disabilities rather than helping them to help themselves for independent living (Tawintarapakti, 1997). They assume people with physical disabilities will be unable to work for a living and need to be cared for. People with mental health problems who manifest violent and inappropriate behaviour (e.g. aggressiveness to others) receive no attention from the community, because this behaviour frightens community members (Wiboolpolprasert et al., 1996). Most people in society also have a negative attitude toward employing persons with disabilities, because they are uncertain about their abilities. Apart from this, the society does not provide an opportunity for those with disabilities to show their abilities (Tawintarapakti, 1997).

In the open-ended questions, Thai therapists indicate that people with disabilities need to be treated with compassion within the society, which currently translates into having families, health care professionals, and relevant others look after all their needs. In addition, there is no overall acceptance that people with disabilities can contribute to mainstream society, as there is a belief that they should be cared for in order to gain 'merit'. Thais expect people with disabilities to depend on their families and the compassion of others. This emphasis on giving, coupled with negative attitude towards employing persons with a disability, may be a deterrent for clients' families to enhance their potential and help them become more independent. Families and the community tend to carry the burden of caring for and supporting members with disabilities, which may obstruct the developing potential of clients and families, and in maintaining family function. It is also difficult for the family to become independent. Therefore, the attitudes of the following groups might

usefully be changed through OT education using a community-based approach in order to contribute to greater understanding of the need of people with disabilities. Furthermore, attitudes of clients should be changed from dependence on others, toward greater dependence on themselves within the family context. Attitudes of the public need to be changed, from giving materials and money, to helping people with disabilities to enhance their potential and help themselves. Attitudes of employers should be changed, from avoiding employment of people with disabilities, to providing a chance for them to have a job. In addition, according to the Thai Constitution of 1997: Section 30, unjust discrimination against persons based on physical or health conditions (Constitution of the Kingdom of Thailand, 1997a) should be counteracted in public information campaigns undertaken by government and non-government organizations.

In Western societies, the beliefs about the causes of disabilities are generally based on the Medical Model, which separates illness and health condition from social and spiritual phenomena, as well as religious concerns (Jungerson, 1992; Kinebanian & Stomph, 1992). From the Medical Model perspective, "disability is seen as a deficit, loss or sickness" (Neufeldt, 1999) or physiological impairment which can be a chronic condition, and physical environment or social attitudes can contribute to maintain an impairment or its treatment (Neufeldt, 1999). People with disabilities are viewed as a homogeneous group, basically different from those without disabilities. The public's attitude toward people with disabilities is ambivalent, and includes both admiration and pity. Persons with disabilities who live with their families or obtain a disability pension are not typically perceived as successful (Marini, 1994). An individual who is productive and take risks is rewarded (Young et al., 1994). According to the independent living movement, people with disabilities must have opportunities for life choices equal to those of people without disabilities, and can function as full citizens (Neufeldt, 1999). Therefore, attitudes toward disabilities between Western and Thai societies tend to be different, an outcome supported by the comparison of therapists description of 'Societal Perception of Disabilities', 'Workplace Discrimination', and 'Changing Societal Attitudes Toward Disabilities', showing a significant difference (p = .000) (See Table 7.19).

8.4.6 Social Support

According to the value of interdependence and accumulation of good karma and merit, Thais help others in need, and show their compassion to the ill, the disabled, and disadvantaged (Jumsai, 2000; Redmond, 1999). If people with illness or disabilities are their family member or an older parent, caring is a normal part of interdependent family relationships and will gain great merit according to Buddhist beliefs (Chaoum, 1994; Hatthakit, 1999). Alternatively, in Western societies, the individual is expected to look after himself or herself and the immediate nuclear family (Hofstede, 2001). Even though people with disabilities and the aged have support from the social welfare system, informal care from family and friends remain the main source of assistance, and the main focus of their social lives (Australian Institute of Health and Welfare, 2001). This seems to be broadly similar to the social support system in Thailand, which includes a social welfare system and a family and community network. Social support of clients is a domain of concern for both WA and Thai occupational therapists. Through comparison of results, Client Support from therapists in both countries found no-significant difference ($p = .472$) (See Table 7.18).

Due to limitation of resources, public facilities, and infrastructure for people with disabilities (Tawintarapakti, 1997; Wiboolpolprasert et al., 1996), informal support from family and community appear to be very important in Thai society. Thais believe that the family and the community should support people with disabilities, and this might be a deterrent to the development of an effective client-family working relationship as discussed previously, and to empowering clients and families to look after themselves. Presumably, there should be a balance between support from the family and the community, and from the self-support of the client and family working together. According to the Thai constitution of 1997, the state shall provide assistance to the elderly, the indigent, the disabled or handicapped, and the underprivileged to ensure a good quality of life, and enable them to depend on themselves (Constitution of the Kingdom of Thailand, 1997b). This policy is implemented through government and non-government organizations, and broadly expands to communities and the public. In addition, citizen attitudes toward social support should be changed from giving to helping people with disabilities, and

helping families to help themselves, and achievement of independence of the family unit.

8.4.7 Level of Assistance that is Acceptable and Coping Strategies

In non-Western societies, people value bonds within the family, being part of the family, the honour of family, honouring the family, choosing dependency, interdependence within the family and community unit, and accepting family members' decisions (Dyck, 1991; Kinebanian & Stomph, 1992). From interpretation of responses to the second open-ended question, Thai therapists believe their clients have no motivation to become independent and take care of themselves, because families, health professionals, and relevant others are expected to look after all their needs. However, study regarding independent living for spinal cord injury patients in a Chiang Mai teaching hospital (Sitthigan et al., 2000), and a survey about expectations of relatives of people with chronic schizophrenia in regional hospital in Chiang Mai, found that patients with spinal cord injuries expect to help themselves, and that relatives expect patients with schizophrenia to go back to work in their community (Samuktiya, 2000). These new studies indicate there may be ongoing shift from dependent expectations to independent expectations.

According beliefs of Thai people about karma, if people regularly become ill and unhappy at some stage of their life, they must accept that their illness or unhappiness is the result of bad karma (doing bad deeds) from a previous life (Hatthakit, 1999; Ratanakul & Than, 1996), while this may lead to attitude of resignation and dependency on the part of clients. Apart from this, they may also apply the "three universal characteristics: impermanence, unsatisfactoriness (suffering) and non-selfhood", to interpretation of illness and disabilities. It may also enable people with disabilities to accept their situation with a peaceful mind because they need to acknowledge and accept their own karma (Komin, 1990), and "three universal characteristics". Another role of Buddhism in occupational therapy practice is that people with disabilities are encouraged to perform mental training procedures, or meditation, and behave themselves according to Buddhist teaching, in order to maintain their "quality of life" as perceived in Thailand (i.e., a peaceful mind, motivation for living, adapting to survive in society, and being accepted as a good citizen) (Tawintarapakti, 1997). In the view of Thais, the quality of life for people with disabilities might be better viewed as a quality of mind, rather than in term of

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physical status. This might be a major coping strategy for people with disabilities in Thailand.

Interdependence within family and community can be used to encourage clients and families to look after themselves, and can empower family units to become independent, as discussed previously. If quality of life concerns focus on 'quality of mind' rather than on physical well being, it may be possible for people with disabilities to live in the community without unnecessary struggling and depression. Acceptance of disabilities with a peaceful mind, but with a firm motivation for living, may be useful for encouraging active participation in OT and health programs, enabling client and family to follow the program more effectively. A successful program may contribute to an increased sense of responsibility of clients and families, ensuring sustained health prevention/promotion. The sense of responsibility should be promoted continuously, so that clients, families and community generally feel responsibility to look after them. This concept is compatible with the government's current emphasis on an active role for citizen in health prevention/promotion, and family and community participation (The Planning Committees, 2002), as well as the law of karma that everybody must take responsibility for his or her own karma (Komin, 1990).

In Western societies, people value individual autonomy and independence rather than interdependence (Phipps, 1995), and Australia has a level of individualism greater than Thailand (Hofstede, 1991). The value of individualism to Western culture is further emphasised in complementary concepts such freedom, equality, self-reliance, independence, and separation from family (Triandis, 1995). In Western culture, a persons' competence is the result of individual ability and personal effort (Triandis, 1995), and persons with disabilities who depend on families and disabilities pensions are not perceived as productive members of society (Marini, 1994). From previous discussion, Westerners are assumed to take active roles in decision-making and coping with stress and problems. They also generally expected to direct their own lives, and take responsibility for their own problems, and tend to believe in internal controls for dealing with themselves and their problems. Using questionnaire responses, regarding clients' 'Dependent Expectations' and 'Expectations of Cure' as reported by WA and Thai occupational therapists, there were significant differences in both attributes ($p = .000$) (See Table 7.16). This result

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support the assumption that the level of assistance that is acceptable is highly different between clients in Western culture and those in Thai culture.

8.4.8   Systems of Health Care

Although the health care policies of both Australian and Thailand follow WHO guidelines that now emphasise health prevention and promotion, in Thailand only 10 percent of the fiscal health budget supports this area because most of health dollars are used for curative medical services (The Planning Committees, 2002). Therefore, actual health care resources are likely to affect the practice of occupational therapists in both countries, more than official policies that follow WHO guidelines.

From the current literature, it appear that Australia and Thailand have similar concern for rehabilitation and enhancing the potential of people with a range of disabilities, in order to return them to live equally in society, including physical, mental, social, and vocational rehabilitation. In Australia, this stated goal seems to be actively pursued. The first priority of rehabilitation, based on a broad consensus, is to return people with disabilities to useful activities in order to foster their abilities, not disabilities (Bates & Linder-Pelz, 1990). People with disabilities are assisted to maximise their abilities to function independently (Health Department of Western Australia, 2002b), and the aged are also encouraged to remain independent and live at home with assistance from caregivers, if necessary (Australian Institute of Health and Welfare, 1998; Minister for Aged Care, 1999). The Australian Government promotes cooperation among providers, the bureaucracy, and clients (Department of Health and Aged Care, 1999), and encourages community members to participate in directing health service delivery within the community (Palmer & Short, 2000; State Health Purchasing Authority, 1995), although this may not always occur at the grass roots level. The Commonwealth Rehabilitation Service is also reported to provide a wide regional network, enabling client to access health and welfare services that cooperate together (Remenyi, 1997). Therefore, it can be assumed that cooperation related services to meet the aims of rehabilitation are quite systematic.

In Thailand, actual practice are less in line with WHO guidelines. The priority is medical rehabilitation, which aims at treatment rather than fostering functional development for people with disabilities. The main focus of functional development is physical and movement disabilities, not on developing the full potential of those with disabilities, and enabling them to participate fully in society. Moreover, the law

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relating to benefits for people with disabilities focuses more on compensation for loss of income or body parts than rehabilitation programs; hence, rehabilitation programs are limited (Wiboolpolprasert et al., 1996). Even though cash benefits are not large, when combined with the support from family and community, they enable beneficiaries to survive, lessen motivation of beneficiaries to improve and develop their potential in the full range of occupations. Furthermore, cooperation among various health and welfare service providers is not efficient (Wiboolpolprasert et al.,1996;Tawintarapakti, 1997). In addition, it has been argued that rehabilitation in Thailand has not received enough support from government (Wiboolpolprasert et al., 1996). In responding to the questionnaire, Thai occupational therapists argues with these points, noting in particular that limitations due to the lack of collaboration between health teams, affected application of current frameworks of practice.

In Thailand, rehabilitation focuses on medical treatment programs and physical function, not on developing the potential of people with disabilities. Furthermore, there are limited resources, facilities, infrastructures, and cooperation among sectors related to rehabilitation (Tawintarapakti, 1997; Wiboolpolprasert et al., 1996). In addition, universal health insurance and quality assurance have just been introduced (Editors, 2001). Therefore, clients, families, and the community are expected to look after themselves and use their own resources (Pradapmuk, 1999). However, clients, families, and communities need health care information and knowledge, including knowledge of methods and techniques to look after themselves (Ministry of Public Health, 1997a; Pradapmuk, 1999).

Recent studies on caring for people with disabilities, also found that travel or transportation in bringing clients to receive rehabilitation is a major burden for families (Somnuk, 1997). Caring for people with disabilities at home and in community is likely to be the primary locale for providing health care and rehabilitation services. For this reason, health professional should provide knowledge, about appropriate health care and rehabilitation methods to clients, their families and communities through widespread education and training programs. Human resources in the community, such as folk healers and volunteers, should be encouraged to attend education and training programs on caring for people with disabilities, so they can play a role in taking care of people with disabilities in the community, and collaborate with health professionals. Self-help devices and

equipment for people with disabilities should be made available by using resources in the community, and be appropriate for use by clients and their families in their homes.

Quality assurance monitors the quality of care provided by occupational therapy services, which links to accountability as well as careful systematic documentation (Stein & Cutler, 1998). Documentation is required for reimbursement under the health insurance system (Chisholm, Dolhi, & Schreiber, 2000). Quality assurance is also an area of concern for occupational therapy practice in Australia. In developed countries, quality assurance procedures are well established both for health insurance and for quality health care services. In contrast, in Thailand introduction of universal health insurance and quality assurance evaluation has just begun (Editors, 2001). Only two percent of the Thai population hold private insurance, and more extensive and detailed documentation is needed to update the health insurance scheme (Ministry of Public Health, 2002). Hence, systems for health insurance and quality assurance are currently being developed, especially in the area of rehabilitation, which requires long-term care, and more complicated treatment to be undertaken. Thus lesser emphasis on quality assurance by Thai occupational therapists is understandable and might be remain different from that of Western Australian therapists for some time.

It can be assumed that policies and operations of health care systems in Australia and Thailand are different, due to the cultural contexts of practice of each country, although, as noted above the more recent introduction of health insurance is also a factor. An emphasis on culture is supported by comparison of the impact of Legislation and Government Policy, which have emphasised quality assurance, and therapists working in conjunction with government and insurance agencies or the private sector; and of Interagency Cooperation. Results found that the impact of such policies on the practice of Thai and Western Australian therapists was significantly different ($p = .002$) (See Table 7.20).

8.5 Conclusion

Cultural influences, associated health care practices, and attitudes toward disabilities and health care are the results of evolution within Thailand. Thai therapists apply models in practice differently from Western Australian therapists.

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The cultural context of practice is a very important factor affecting occupational therapy practice of both Thai and Western Australian occupational therapists in perceiving, interpreting, selecting, and applying models of practice. It has been demonstrated that the culture of each country influences practices of occupational therapists related to occupation, roles of clients, their families, and therapists; the value placed on independence/autonomy; attitudes toward illness and disabilities; focus of social support; the level of assistance that is acceptable and coping strategies, and the system of health care (e.g. for rehabilitation).

Views of WA and Thai therapists, and results of the literature review, suggest that the practices of Thai occupational therapists diverge from Western practice in ways that possibly meet the needs of the Thai culture. If we juxtapose the influence of Thai culture with current government policy [the 9th plan (2002-2006)], it is reasonable to assume that any new model of occupational therapy practice for Thailand should include: 1) enhancing clients' and families' ability to look after themselves, especially for ADL; 2) providing intervention programs that clients and families can use at home; 3) approaching communities and empowering community members to look after one another; 4) changing attitudes of clients, the public, and employers to emphasise the importance of clients' enhancing potential; 5) promoting a balance of support among the family, community and client 6) encouraging use of available human resources such as folk healers and volunteers for caring people with disabilities, and greater use of self-help devices and equipment. All of these contribute to greater independence of families, which are interdependent in relations between healthy members and clients.

The evidence cited above demonstrates the need to modify existing models or create an entirely new framework for practice of Thai therapists in the Thai cultural context in order to meet needs of clients and families, and align occupational therapy practice with current and future health care policy. A new framework can built based on questionnaire responses of Thai occupational therapists, specifically findings from factor analysis of Part C (occupational therapy practice) of the questionnaire and answers to the third open-ended question "Make a list of what you would like to include in a new framework for practice". Development of this framework also needs to take into account-updated directions of Thai health care policy (the 9th national economic and social development plan) and promotion of holistic health.

CHAPTER 9

The 'Samphan' Framework of Practice

9.1 Introduction

Evidence from focus groups and the survey shows that Thai occupational therapists depend on current conceptual frameworks to assist them in practice. However, they claim that effective application of those models to practice is restricted by multiple factors, including Thai culture, limitations of therapists themselves in applying current frameworks due to lack of understanding of how to apply such frameworks to their cultural setting, and the structure of the Thai health care system. Based on these limitations, Thai therapists contributed to a list of ideas for inclusion in a new framework of practice.

In comparing occupational therapy practice (See Chapter 8), there was strong evidence that Thai culture influences Thai therapists to view factors in practice differently from WAOTs. For this reason, a new framework of practice that is appropriate to Thai culture, practical in the socio-cultural environment, and aligned to the newly formulated health policy, has been developed, using the results of the survey.

Qualitative information from the retained factors of the PC analysis of questionnaire data (Part C), as answered by Thai therapists was used to develop domains for a framework for practice in Thailand. Qualitative themes generated from the open-ended question asking therapists to "Make a list of what you would like to include in a new framework for practice" were integrated with factors from PC analysis, to create domains and definitions for a model of occupational therapy practice. Based on these quantitative and qualitative findings, an original framework is offered below (See Figure 9.2). This tentative framework will then be subject to verification by a subset group of Thai occupational therapists who participated in the main survey. As appropriate the framework will be modified to make it a practical framework for application in Thailand. The final framework, called the 'Samphan Framework" is based on the main survey, contextual and experiential information, and related literature in this area (Figure 9.3: The 'Samphan' Framework of Practice).

environment, even within limited time. The third factor- *Activities of Daily Living Guided*- refers to the degree that therapists focus on developing activities of daily living skills, including the typical life tasks required for self-care and self-maintenance. The fourth factor, labelled '*Family-Guided*', explores therapists' willingness to work closely with clients' families to achieve client goals. The fifth factor labelled '*Demands of Employers*', explores how therapists undertake treatment programs within the confines of employer's expectations. The sixth factor- *Acute Setting*- explores whether therapists can focus on the need for timely discharge, whilst taking into account their personal goals for lifestyle adaptation even in an acute setting. The last factor- *Reductionist Approach*-probes why therapists often apply this medically oriented approach.

9.2.4 Cultural Implications Subscale

There were five factors in this subscale. The first - *Cultural Values and Independence* – probes beliefs, values and expectations of clients and their families about independence, illness, and available resources within their own culture. The second factor- *Mutual Dependence*- refers to the extent to which clients value dependence on their families and relatives, and the extent to which Thai families' value taking care of ill or disabled relatives. The third factor labelled '*Changing Societal Attitudes Toward Disabilities*', probes therapists' thoughts on influencing society to changing attitudes toward disabilities. The fourth factor labelled '*Societal Perception of Disabilities*', examines why people with a physical disability or with mental illness are not valued in Thailand as members of society. The last factor labelled '*Family Stigma*' considers why families with a relative with a disability are sometimes stigmatised.

9.2.5 Health Care Systems Subscale

There are three factors in this subscale. The first – *Legislation, Policies and Funding* –explores the influence of legislation, government policies, and funding on occupational therapy services, admission, and discharge. The second, labelled '*Priorities in Health Care or Waiting List Impact*', examine how long waiting lists, arranged according to priorities within the health care system, affect occupational therapy practice, especially in-patient services. The last factor labelled '*Interagency Cooperation*', explores how therapists worked with other government departments/agencies such as social security and social welfare.

9.3 Qualitative Themes Derived from Content Analysis of the Question

Themes derived from responses to the open-ended question: "Make a list of what you would like to include in a new framework for practice" were examined earlier in defining the scope for a new framework of practice (See Chapter 7). Thai occupational therapists did focus primarily upon Cultural Concerns, secondarily the Client - Family Focus, and lastly on the need for an Inclusive Occupational Therapy Process.

Cultural Concerns raised by Thai therapists suggest that a new framework of practice should be developed specifically for Thai culture. Given the high value placed on interdependence within family and community, Thai people readily look after family members with illness and disabilities. The new framework should be applicable to the values, lifestyles, and occupation of Thai people.

Client-Family Focus considers all aspects of clients-family interaction and takes into account the quality of life of both client and family. In addition, this focus should be specifically relevant to Thai culture, which values interdependence and a family/community focus.

In emphasising the need for an Inclusive Occupational Therapy Process, Thai therapists implied that a new framework of practice should cover occupational therapy process from initial assessment to evaluation, have a clear approach to each problem based on the new model domains, and identify target groups of clients who need particular occupational therapy services. Specifically, a new model for Thailand should include therapeutic media and methods, interpretation and application of knowledge about the diagnosis and pathology, and developmental stages to occupational dysfunction.

9.4 Integration of Quantitative and Qualitative Results to Create New Domains

The retained factors from the PC analysis of part C of the questionnaire and themes emerging from responses to the open-ended questions (using content analysis) were integrated to create new domains for occupational therapy practice in Thailand, as presented in the Figure 9.1.

Factors derived from quantitative data (Construct A) and the themes derived from qualitative data (Construct B) were integrated using an inductive thinking process, in order to create the new domains in constructs C and D. Integration of construct A, including subscales and factors for each subscale, and construct B, including three themes was based on definitions of each subscale, factor, and theme. The process of integration can be step-by-step as follows:

Step 1: The 'Client-Family Unit' domain was created based on the whole key concept of 'client' (A1), integrating definitions of the Clients subscale, including definitions of factors A3.4, A4.1, and A4.2, and definition of the 'Client-Family Focus' (B2). These were integrated because both emphasise aspects of the client or family, or their interaction.

Step 2: The 'Therapists' domain was created from all concepts relating to therapists (A2) and also encompassed definitions of all factors included in the Therapists subscale. To provide relevant and practical occupational therapy programs, therapists should focus on these factors. Therapist's subscale was not integrated with factors in other subscales or themes because this subscale had nothing in common with the others. However, definitions of A2.1 and A2.2 in the 'Therapists' subscale, can be integrated with some factors in other subscales, or with a theme in construct B (because of the similar definitions). For example, the definition of A2.2 can be integrated with the definition of A3.6 as described in step 3.

Step 3: The 'Occupational Therapy Process' domain was created from the whole concept of intervention (A3), together with the definition of A2.2 and the definition of an Inclusive Occupational Therapy Process (B3). The definition of A2.2 was first combined with the definition of A3.6, and then the key concept of 'Intervention' (A3) was added to the Inclusive Occupational Therapy Process (B3), and become a part of the Occupational Therapy Process.

Step 4: The 'Health Care System' domain was created from the concepts of the 'Health Care System' (A5). The 'Health Care System' subscale was not integrated with factors in other sections or themes, because they did not have anything in common.
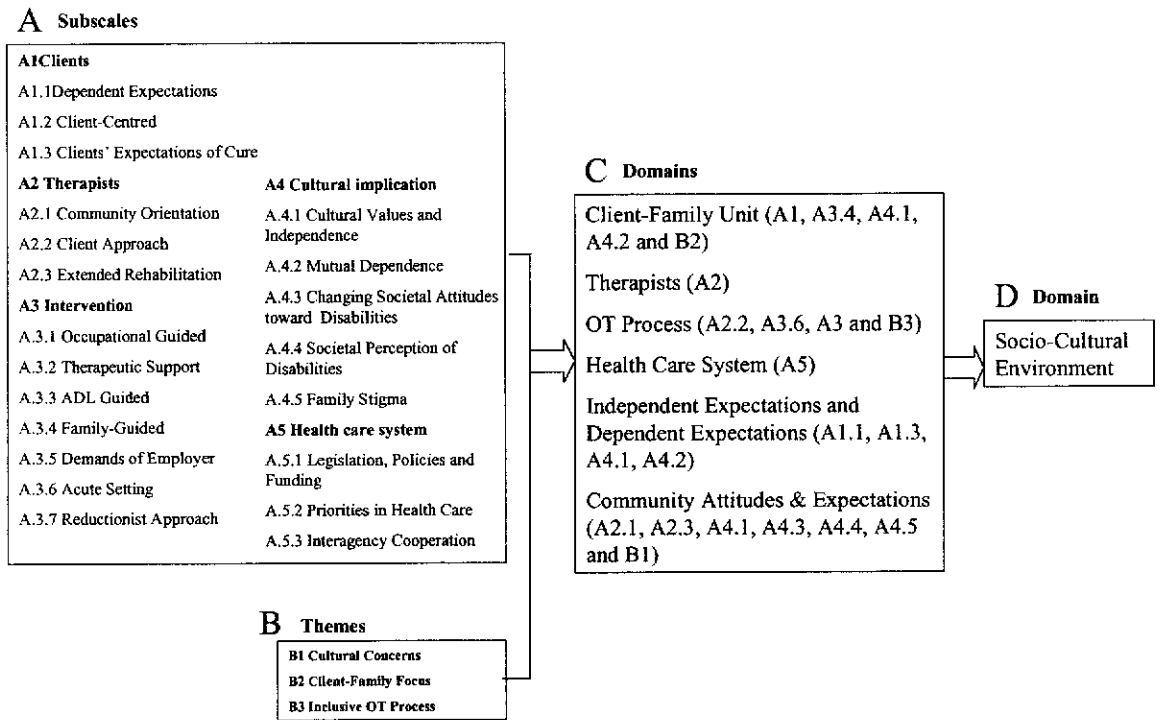
Step 5: The 'Independent Expectations and Dependent Expectations' domain was created from definitions of 'Dependent Expectations' (A1.1), 'Clients' Expectation of Cure' (A1.3), 'Cultural Values and Independence' (A4.1) and 'Mutual Dependence' (A4.2). These were integrated because they refer to the value of independence and dependence of the clients, their families, and their cultural groups, as well as their culture. 'Independent Expectations and Dependent Expectations' are a crucial part of the cultural contexts of clients and their families, because widely varying levels of emphasis on independence in Western and non-Western cultures are found as a key influence on the practice of occupational therapists.

Step 6: The 'Community Attitudes and the Expectations' domain was created from definitions of 'Community Orientation' (A2.1), 'Extended Rehabilitation' (A2.3), 'Cultural Values and Independence' (A4.1), 'Changing Societal Attitudes Toward Disabilities' (A4.3), 'Societal Perception of Disabilities' (A4.4), 'Family Stigma' (A4.5) together with 'Cultural Concern' (B1). These were integrated because they all refer to the overall cultural context of the clients, their families, and their cultural groups within their community. The community where clients, families, and therapists live has an impact on them and on occupational therapy programs.
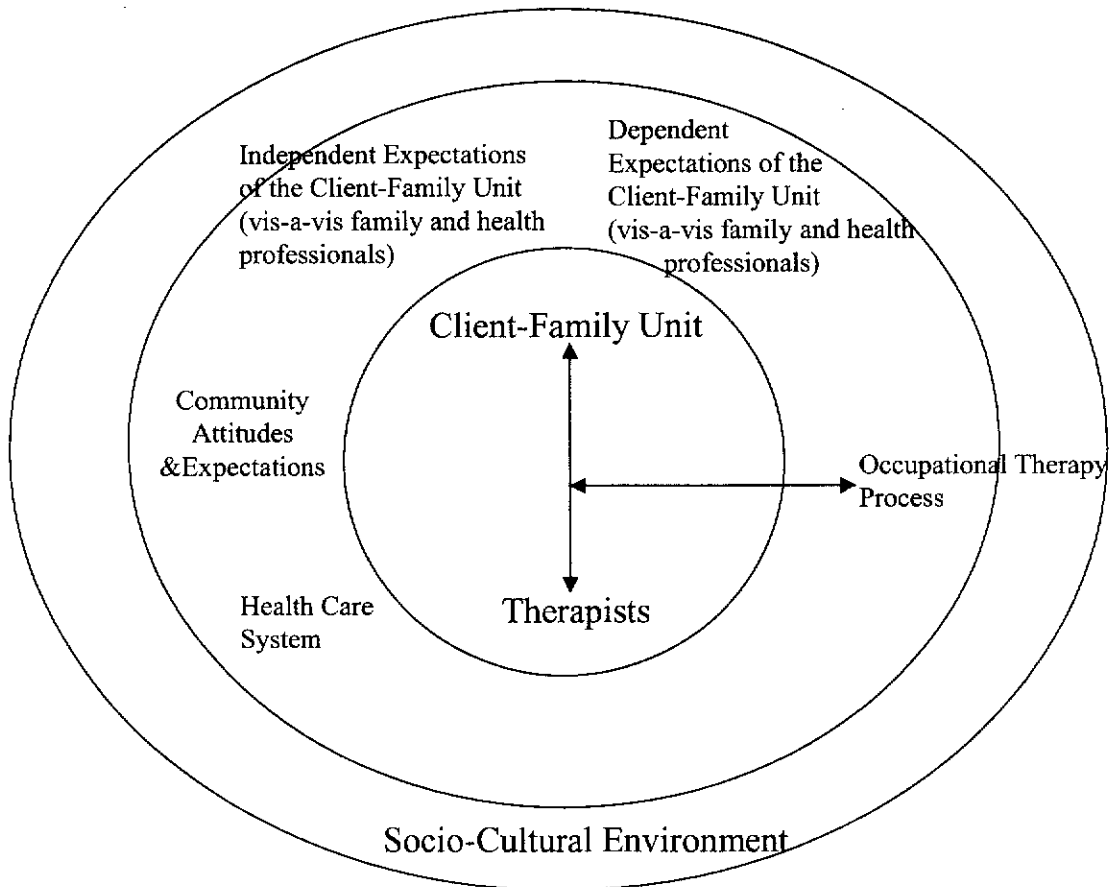
Step 7: Each new domain in constructs C (described above), therefore, was derived from integration of constructs A and B, combined with postulates regarding the Thai cultural context.

Step 8: Definitions of all new domains in construct C were integrated to form a broad domain called 'Socio-Cultural Environment', which is construct D (See Figure 9.1).

Relationships among all the domains were analysed and assigned to three levels- inner, middle, and outer- according to interrelationships among definitions and the assumed relevance of each domain, in order to formulate the new framework. This framework, labelled a 'hypothesised' framework, is presented in Figure 9.2. The interaction between the Client-Family Unit and Therapists was identified as the core relationship for creating an effective occupational therapy process, and was placed in the inner circle.

A Subscales

A1Clients	
A1.1Dependent Expectations	
A1.2 Client-Centred	
A1.3 Clients' Expectations of Cure	

A2 Therapists	A4 Cultural implication
A2.1 Community Orientation	A.4.1 Cultural Values and Independence
A2.2 Client Approach	
A2.3 Extended Rehabilitation	A.4.2 Mutual Dependence
A3 Intervention	A.4.3 Changing Societal Attitudes toward Disabilities
A.3.1 Occupational Guided	A.4.4 Societal Perception of Disabilities
A.3.2 Therapeutic Support	
A.3.3 ADL Guided	A.4.5 Family Stigma
A.3.4 Family-Guided	A5 Health care system
A.3.5 Demands of Employer	A.5.1 Legislation, Policies and Funding
A.3.6 Acute Setting	
A.3.7 Reductionist Approach	A.5.2 Priorities in Health Care
	A.5.3 Interagency Cooperation

C Domains

Client-Family Unit (A1, A3.4, A4.1, A4.2 and B2)

Therapists (A2)

OT Process (A2.2, A3.6, A3 and B3)

Health Care System (A5)

Independent Expectations and Dependent Expectations (A1.1, A1.3, A4.1, A4.2)

Community Attitudes & Expectations (A2.1, A2.3, A4.1, A4.3, A4.4, A4.5 and B1)

D Domain

Socio-Cultural Environment

B Themes

B1 Cultural Concerns
B2 Client-Family Focus
B3 Inclusive OT Process

Figure 9.1 Creating the new domains for OT practice in Thailand

Figure 9.2 Hypothesised framework of practice for Thai occupational therapists

9.5   Verification and Refinement of the Framework

The hypothesised framework (Figure 9.2) was verified through a focus group interview. The focus group included 12 occupational therapists who participated in the main survey and were recruited from a range of clinical settings in Thailand. The focus group interview was held at the Department of Occupational Therapy, Chiang Mai University. The hypothesised framework consisted of Client-Family Unit together with Therapists grouped within an inner circle; Independent Expectations of Client-Family, and Dependent Expectations of Client-Family vis-à-vis the Family and Health Professionals; Community Attitudes and Expectations; and the Health Care System clustered in a middle circle; with the socio-cultural environment in an outer circle. In the hypothesised framework, the relationship between the Client-Family Unit and Therapists interact to create the occupational therapy process in the middle and outer circles (represented with arrows).

In the focus group interview, participants nominated that 'Social Support' as an important domain with significant influence on client-family daily living. They stressed that occupational therapy services provided by therapists such as the range of activities of daily living necessary for individuals, will be influenced by the kinds and levels of social support provided by the family to the client. For example, relearning cooking may not be necessary for all clients. Focus group participants also provided feedback that clarified occupational therapy process, and suggested that the 'Occupational Therapy Process' in the framework should span all three levels of circles.

The researcher then refined the framework by adding 'Social Support', and changed the position of 'Occupational Therapy Process' to span all three circles (Figure 9.3). 'Outcomes' were added at the end of the occupational therapy process continuum. The 'Independent' and 'Dependent Expectations of the Client-Family', were further clarified and combined to be 'Independent/Dependent Expectations of the Client-Family vis-a-vis the client, his or her family, and health professionals. The two domains were combined because Independent and Dependent Expectations measure the same domain, but are different poles of the continuum. Furthermore, 'Client-Family' constitutes an inseparable unit.

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In summary, the value of hypothesised framework was generally verified but was refined in response to feedback about specific requirement of a practical framework for service delivery in Thai culture. The diagram of the final framework named the 'Samphan' Framework can be seen in Figure 9.3. 'Samphan' is a Thai word for 'relationship'.
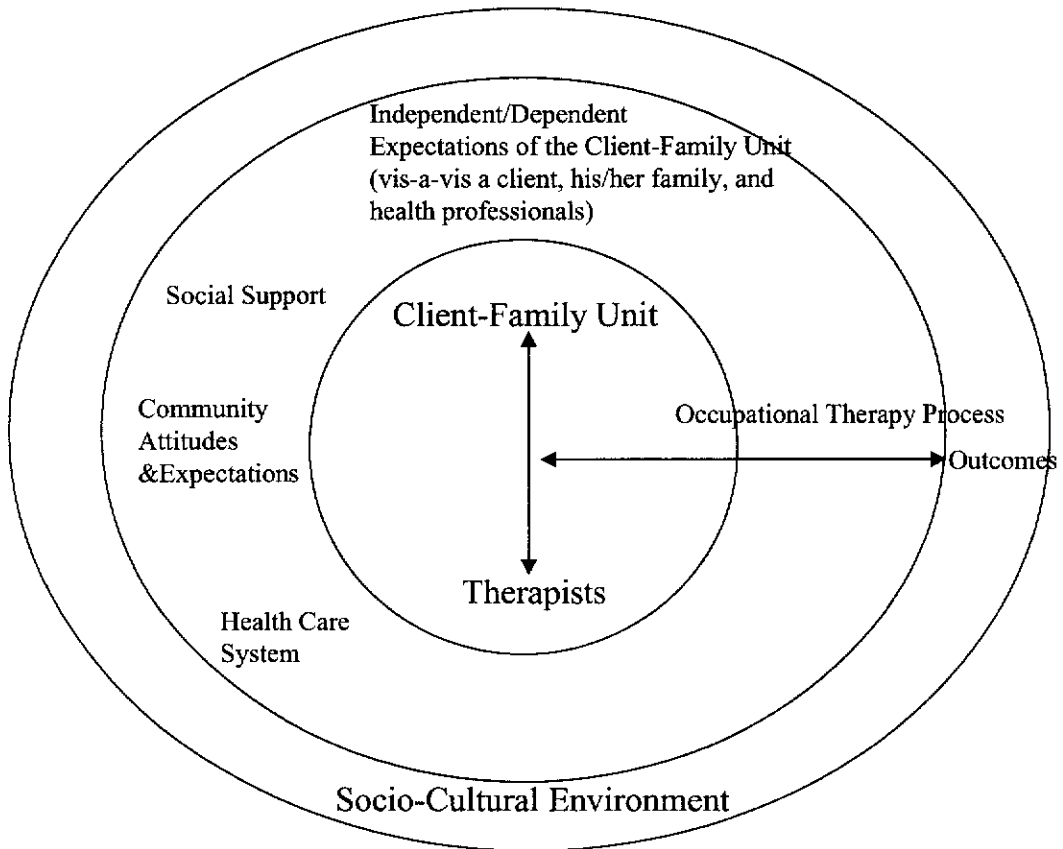
Figure 9.3 The 'Samphan' framework of practice

9.6 Definitions and Relationships among Domains in the 'Samphan' Framework

9.6.1 The Inner Circle

In the inner circle, there are two domains: 'Client-Family Unit' and 'Therapists'.

9.6.1.1. Client-Family Unit

This domain focuses on the client, his or her family, and the client-family's context, building upon the holistic approach that encompasses all related aspects of a client and his or her family, such as clients' needs, beliefs, and roles, in order to promote quality of life. The client and family are conceptualised as a single unit, which cannot be easily separated. The Client-Family Unit has an interaction with Therapists. It may have relatively Independent or Dependent Expectations for the client vis-à-vis his or her family and health professionals, the Health Care System, Social Support, and Community Attitudes and Expectations.

9.6.1.2. Therapists

This domain refers to the therapists' degree of professionalism in providing relevant and practical occupational therapy programs. It is affected by the Client-Family Unit, Independent/Dependent Expectations of the Client-Family, the Health Care System, and interactions between Social Support and Community Attitudes and Expectations (middle circle). Both the Client-Family Unit and Therapists (in the inner circle) are influenced by all domains in the middle circle.

9.6.2 The Middle Circle

In the middle circle, there are four domains: Independent/Dependent Expectations of the Client-Family, the Health Care System, Social Support, and Community Attitudes and Expectations. Each domain is equally important and there is no assumption of hierarchy.

9.6.2.1. Independent/Dependent Expectations of a Client-Family

This domain refers to the level of expectation a client and his or her family have regarding the level of independent that can be achieved in daily living tasks such as self-care, transfers, transport, work, and leisure. This also includes

expectations between the client and family, and among family members. All involved have these expectations of each other including the expectation of the client to the family of the client, the expectation of the client to therapists, and self-expectation of (each person) or the client. In Thailand, these expectations that people hold about any health professional can be generalised to all of the disciplines of the health professions (industries).

9.6.2.2. Health Care System

This domain encompasses government policy in health and rehabilitation, policies of hospitals, health institutions, and rehabilitation sectors; the government budget for rehabilitation and occupational therapy services; the number of clients and priorities within the health care system, and level of cooperation with other government departments and health sectors. The health care system influences the Client-Family Unit and Therapists to comply with the health care system requirement in receiving or in the provision of health care.

9.6.2.3. Social Support

This domain includes financial, emotional, informational and material support for a client and his or her family. This may include support from the formal system including social welfare and charity organizations, and the informal system, including support by the client himself or herself, his or her family, more distant relatives or neighbour. In Thailand, financial, emotional, and material support is provided primarily within the client-family system. Social support influences interactions between Client-Family Unit and Therapists. The structure of Thai society is patron-client oriented. Reciprocal relationships are based on exchanges between a patron and a client. There are many kinds of exchanges: tangible and intangible, accountable and unaccountable (Pongsapich & Kuwinpan, 1996). In rural Thailand, people value interdependence and mutual help as significantly more than people in cities (Komin, 1990).

9.6.2.4. Community Attitudes and Expectations

This domain refers to the influence of cultural beliefs, values, expectations, and attitudes of people in Thai communities vis-à-vis the client-family and therapists. These include beliefs, values, and expectations of the overall community regarding independence, using resources in the community, views about illness, chronic illness

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and disabilities, and attitudes towards people with disabilities, including stigmatising families with members with a disability. In Thai culture, the concept of interdependence and family/community focus is valued, but is stronger in rural areas (Komin, 1990; Pongsapich, 1994). All domains in the middle circle are influenced by the outer circle.

9.6.3 The Outer Circle

9.6.3.1 Socio-Cultural Environment

The socio-cultural environment is the only domain is in the outer circle and influences all other domains in the framework. It includes all social and cultural factors, which affect the daily living of a client and his or her family, and also the practice of therapists, and interaction among the client, family, and therapist. An example of an element of this domain is government policies for health and rehabilitation, social welfare services, social security, health insurance, and any other benefits for people with disabilities, as well as the inherent values of interdependence and family/community focus in Thai culture. It also takes into account the strong influence of Buddhist teachings and beliefs pertaining to the need to earn merit (This could be a deterrent to effective treatment. That is, an emphasis on earning merit by looking after people with disabilities might obstruct the potential of client to achieve significant independence in daily life). This domain covers all social and cultural factors influencing clients, families, and therapists, and suggested a need for community-based education and a community-based rehabilitation approach.

9.6.4 The 'Bridging' Domain

9.6.4.1 Occupational Therapy Process

Occupational Therapy Process spans three circles and provides a final outcome. This domain refers to the process focusing on a Client-Family Unit to provide occupational therapy services or outcomes, which include screening, assessment, setting outcome goals for occupational therapy programs, actual intervention, and evaluation. In each step of this process, target groups of clients, defined on the basis of diagnosis, related symptoms, pathology, and occupational dysfunctions, should be identified in order to receive appropriate occupational therapy services. The Occupational Therapy Process should also incorporate 'Occupational Guided interventions' that suggest appropriate mechanisms to

implement or facilitate occupational performance, Therapeutic Support in providing adequate guidance and information to clients and families, appropriate activity of daily living, and allow for Family - Guided interventions, Demands of Employers, Acute Setting which is characteristic in Thailand, and Reductionist Approaches of ThaiOTs. The 'Occupational Guided interventions' should be able to shape the occupational therapy process from the initial assessment through final evaluation.

9.7 The Dynamics and Function of the 'Samphan' Framework of Practice

The 'Samphan' Framework of Practice (Figure 9.3) can be perceived as dynamic when viewed as a series of interactions between Client-Family and Therapists interaction that underpin the Occupational Therapy Process. Successive interactions take place along a continuum from the inner to the outer circle, so that the required/identified outcome is eventually achieved. This process is of course in a specific socio-cultural environment, and should lead to outcomes appropriate to the Thai client, family, and community.

The domains in the inner circle are influenced by domains in the middle and the outer circles that are broader than those in the inner circle. Likewise, domains in the middle circle are influenced by domains in the outer circle, which is the broadest of all. All domains in the inner, middle, and outer circles interact and influence one another. The level of influence, however, depends on the scope of each domain, as defined previously. Consequently, at the start of the Occupational Therapy Process, therapists focus on the Client-Family as a unit, then integrate this unit with the main concerns of therapists, which are in turn influenced by expectations of the Client-Family regarding the client, and by the actions of other professionals, the Health Care System, Social Support networks, and Community Attitudes and Expectations with in a context of Thai culture in order to achieve desired outcomes (from inner to outer circle). The outcomes also provide feedback to the process, which should lead to regular adjustment to the process, notably in interaction between Client-Family and Therapists.

9.8 Discussion

Discussion in this section is mainly based on findings of this study. However, relevant literature, most of which has been presented in Section 2.2.2, 2.2.3, and 2.2.4, is also considered.

The 'Samphan' Framework of Practice is a structural frame that focuses on the interdependent relationship between a client and family, and between community members and the Client-Family Unit. 'Samphan' is the Thai word for 'relationship'. The 'Samphan' Framework of Practice is meant to function as a filter for Thai therapists, enabling them to understand occupational therapy models developed in Western cultures, and where appropriate to adjust them to the Thai cultural context. This framework is not a fall-blown conceptual model of practice, but is a structural frame to help Thai therapists apply current occupational therapy models to service delivery for Thai clients.

The most important focus of the 'Samphan' Framework of Practice is the Client-Family as a unit, reflecting to Thai values in which a client and his or her family are inseparable. This focus is different from most models in Western culture, which emphasise an individual client as the centre of service delivery, for example, the Model of Human Occupation, the Canadian Model of Occupational Performance, and the Person-Environment-Occupation Model.

Success within most Western models is a significant achievement of the client in occupational performance. In other words, the expected outcome of most Western models is autonomy. Occupational function and dysfunction of individuals is the domain of concern in practice. Individuals who are occupationally functional achieve performance levels that meet their needs and expectations, whereas individuals who are occupationally dysfunctional do not.

Thai occupational therapists believe service delivery requires considerable time, generally more than the system allows to achieve independence in performance for clients. Hence, they focus on minimum skills in performance, to permit safe discharge in accordance with the assumption that their clients will be looked after by the family and community. Thai therapists' emphasis on reaching minimum skills in performance is not congruent with that of Western therapists, who aim to produce optimal performance based on the individual's need for autonomy and competence.

Western therapists do apply a family-centred approach to practise with children, which is more congruent with the approach Thai therapists use with a full range of clients. Thai clients, in general, cannot express their needs, and thus, are very dependent, according to focus group responses.

Even though Western therapists approach clients' families to obtain useful information that may shape interventions overall, they aim to meet the individual client's needs. In the practice of Western therapists, the amount of assistance clients will accept from others is considered in the initial occupational therapy assessment, and considering this issue early in the process is useful in planning culturally sensitive interventions (Krefting & Krefting, 1991). Where culturally appropriate (e.g. in working with Asian clients), immediate family members might be fully involved, and make important decisions regarding interventions. Nevertheless, the clients are assumed to be a source of essential information, and are expected to decide whether or not the involvement and decision-making of the family is necessary (Krefting & Krefting, 1991). This concept is different from role of a Client-Family Unit in the 'Samphan' Framework of Practice, in that the Client-Family Unit is assumed to have collaborative partnership role. Thus, in general, Western therapists focus on the needs of a client as the primary concerns and do not necessarily aim to meet the needs and goals of family. Alternatively, Thai therapists focus on the needs and goals of a Client-Family Unit, which are viewed as inseparable. In addition, Thai therapists aim at regular interaction between themselves and the Client-Family Unit, under influences of other domains in the middle and outer circles as represented in the framework.

Western theoretical models have not been totally appropriate to Thai culture and there is no widespread use of Western models in Thailand, because these models are reported as difficult for Thai therapists to understand and apply in the Thai cultural context. This difficulty may derive from the abstract meanings of terms in Western models that are hard to translate into Thai terms. There have been no concerted efforts by academics or researchers who work in this area and provide clear definitions of these terms in Thai. Thai therapists complained that due to their lack of clear understanding of Western occupational therapy models, they could not appropriately apply these models to practise in Thai cultural context (See findings from the second open-ended question in section 7.8.2.2). Accordingly, the

'Samphan' Framework of Practice provides a structure and concept for Thai therapists to integrate Western occupational therapy models into the Thai context.

The key feature of the 'Samphan' Framework of Practice is that it better reflects the relationship between Thai Client-Family Units and Therapists. After substituting Client-Family Unit / Therapist relationship instead of the client / therapist relationship as the core, therapists then should be able to apply Western models within the 'Samphan' Framework of Practice. This combination of the 'Samphan' Framework and a Western model, and emphasis on Thai occupational performance and occupational roles, or on occupational performance areas according to individual occupational roles in Thailand is required to devise effective treatment in Thai culture.

In combining the Western models with the 'Samphan' Framework of Practice, those models will need to be modified as follows:

The main focus of MOHO will need to be shifted from the volition and habituation subsystem focused on the individual client to a focus on the Client-Family Unit, and from setting achievement goals in occupational performance and related roles with the client alone, to inclusion of Therapists and the Client-Family Unit.

The main focus of the Canadian Model of Occupational Performance requires a change from a client-centred to a client-family centred approach in which the client and his or her family make decisions together about their lives. Achieving congruence between a Client-Family Unit, the environment, and occupation assists the Client-Family Unit to achieve goals according to the client-family's needs in their environment. The client-family centred approach may be similar to the client-centred approach, in that the client needs and desires to include the family to participate and collaborate in decision-making and performing occupation. This approach may also occur in some Western families that have very close and interdependent relationships. Thus, it is possible that the core concept of the 'Samphan' Framework of Practice, focusing on interactions between Therapists and the Client-Family Unit, can also be applied to some Western clients.

The main focus of the Person-Environment-Occupation Model must also be changed, to support the wishes and functioning of a Client-Family Unit. With this in

place, analysis based on the transaction between the client-family, environment, and occupation unit should be fit well with the model.

When using any Western model combined with the 'Samphan' Framework of Practice, therapists should also consider Occupational Guided, Therapeutic Support, ADL-guided, Family-Guided interventions, as well as Demands of Employers, the Acute Setting, and the presence of the Reductionist Approach in the occupational process, and then select the methods that are appropriate to each clinical setting.

Based on findings in the present study, MOHO is most utilised by ThaiOTs. Therefore, this model can be employed as an example to explore how the 'Samphan' Framework can be combined with a current model to shape OT practice in Thailand. The following issues need to be considered.

Occupational Function versus Dysfunction

'Occupational function versus dysfunction' cover a continuum of capability levels within the Client-Family Unit, that enable it perform, organise, and choose occupations to meet the needs both the client and the family, with support from their community. In Thai culture, interdependence between the client and the family can be a positive force in planning programs and meeting client needs.

Therapeutic Intervention

The purpose of therapeutic intervention is to maintain a satisfying and productive life for the Client-Family Unit. Effective collaboration between client and family can adjust for any client shortcoming in volition, habituation, and performance capacity, and maximise achievements of the client in occupational performance and roles. Appropriate interdependence with community members can enhance occupational achievements of the Client-Family Unit. The 'volition' subsystem' assesses the motivation of both the client and his or her family. The 'habituation' subsystem focuses on how a client and his or her family collaborate on daily routines within the Client-Family Unit. The 'performance capacity' subsystem emphasises the overall performance of the Client-Family Unit. Information on 'volition' and 'habituation' is received from the Client-Family Unit during interaction with Therapists. Information regarding the 'performance capacity' subsystem is based on performance of occupational areas by the Client-Family Unit. The client and the family may change roles that were performed previously, to new

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ones as agreed between client and family, so that both sides can perform occupations successfully. Agreements between the client and his or her family, as well as the potential of the Client-Family Unit to perform various occupations, will shape decisions about treatment.

Assessment

Therapists are supposed to gather data on a Client-Family Unit through structured approaches to assessing the situation. Examples of those methods include role and interest checklists, to facilitate collaboration between client and family in making joint decisions on which roles or interests should be reserved for the client alone, for the family alone, or for both client and family as a unit. The 'situational' method is useful for observing performance of the Client-Family Unit and better understanding their concerns. In addition, the performance capacity of the Client-Family Unit can be assessed from objective components and subjective experiences regarding the unit.

Intervention Methods

Setting outcome goals for intervention is based on agreement between the client and family, together with useful information provided by ThaiOTs.

Intervention should be selected based on the assumption there can be effective collaboration between the client and his or her family, and their potential to meet their own needs and aims should be carefully assessed. For example, a client who is a housewife does not need to do shopping, but can make the shopping list for one of the family members to do shopping for the whole family. Intervention methods help the Client-Family Unit to successfully perform occupations that maintain, restore, reorganise or develop capacities, motives, and lifestyle of the Client-Family Unit. This unit should participate in therapeutic occupations that meet the needs and life circumstances of both client and family, and so that the Client-Family Unit can become more adaptive healthy beings while maintaining the function of the family. To provide appropriate interventions for the Client-Family Unit, therapists need to consider all domains that influence 'volition', 'habituation' , and 'mind-brain-body performance' as presented in the 'Samphan' Framework of Practice.

Outcomes of the OT process

Based on the present study, outcomes of the OT process should be evaluated based on accomplishments in occupational performance and roles of the client and the family. Some occupations, such as shopping, may have to be performed by both the client and other family members to reach goals. Feedback on such outcomes should be received from the client and family as a unit.

9.8.1 Comparison of this Framework with Related Research

The results of this study (the Samphan Framework of Practice) are compatible with results of related research, in such attributes as 'Occupational Guided', 'Activity of Daily Living Guided', 'Family-Guided intervention' and 'Social Support', as follows:

9.8.1.1 *Occupational Guided and Activity of Daily Living Guided intervention*

'Occupational Guided' and 'Activity of Daily Living Guided' approaches in occupational therapy are congruent with the discussion of Thibeault in 2002 regarding her experience in Sierra Leone. Through introduction of appropriate occupations and commencement of simple activities of daily living, such occupation were found to be useful for recovery from war trauma (Thibeault, 2002).

The value of activities of daily living or self-care activities is discussed in a parallel study by Packer (1997) in China on identifying needs of people with disabilities, and a study by Packer, Yun, and He (1999) on families and family-based rehabilitation, also in China. These two studies found that Chinese identified self-care as the most important area that requires occupational therapy intervention, which is compatible with results in this study.

9.8.1.2 *Family-Guided intervention*

A 'Family-Guided' approach to occupational therapy, an emphasis that has emerged from this study, is consistent with both the discussion of Packer (1997) on needs of people with disabilities in China and the discussion of Packer et al. (1999) on families and family-based rehabilitation. That is, the family accepts responsibility in caring for the member who has an illness or a disability (Packer, 1997), and

family-based rehabilitation can be utilised effectively in enhancing occupational performance of family members with disabilities (Packer et al., 1999).

The 'family-guided' approach is also compatible with a study in Australia by Fitzgerald et al., (1997), which considers cultural issues in occupational therapy practice with people from different cultural and linguistic backgrounds. It was found that the roles and responsibilities of the client and his or her family members were mentioned as important by most therapists.

In a study by Hatthakit (1999) on family-oriented self care of stroke patients in Thailand, the use of a family-oriented self-care model for nursing practice, education, and research was proposed. This model focuses on the family as a whole, as they play a vital role in contributing to the well being of family members through health promotion for well families and health restoration for families with a sick member.

9.8.1.3   Social Support

Hoffmann and McKenna (2001) reviewed the literature on prediction of outcomes after strokes and implications for clinical practice, and found that social support was an important predictor of positive outcomes in such functional status (fewer functional limitations), discharge setting (discharge home), and quality of life (higher quality of life).

Anderson, Madill, Warren, and Vargo (1996) studied the role of social support in relationship to existing barriers to post-secondary education of students with physical disabilities in Canada. They found that social support was a significant factor in helping students with physical disabilities to overcome barriers to University access, by providing emotional support, and facilitating ongoing adjustment to disability. Students with physical disabilities who received social support developed skills in social relationships, and built social networks. The authors also recommended that occupational therapists should consider intervention for clients who need to improve their social networking capabilities, and that social support be considered in the process of assessment and programme planning.

In Thailand, Singhakumfu (1989) studied the relationship among self-care agencies, social support mechanism, and quality of life of hemiplegic patients, and found that social support was significantly positively correlated with quality of life,

and a predictor of quality of life. Most social support came from the families of hemiplegic patients. In another study, Saewan (1993) found social support was significantly negatively related with burnout syndrome of caregivers of stroke patients, and also a predictor of this syndrome.

Consequently, 'relationship' and 'social networks in the community' as well as appropriate occupations are crucial factors for applying the 'Samphan' Framework of Practice for service delivery in Thailand.

9.9 Implications of the 'Samphan' Framework of Practice for Service Delivery

The 'Samphan' Framework of Practice will provide a structural frame for occupational therapists conducting occupational therapy programs for Thai clients, and for clinical reasoning processes in combination with occupational therapy models. Occupational therapists will focus on the Client-Family as a unit and as the primary concern in occupational therapy process for service delivery in institutions and in the community. Occupational therapists can apply this framework to encourage a sense of responsibility of people in the community, including people with and without disabilities, and facilitate community participation by focusing on each domain of the framework. Community involvement in health care can facilitate health prevention and promotion efforts, which accords with the current health care policy of Thailand as discussed in Section 9.9.2 and 9.9.3. To ensure the 'Samphan' Framework of Practice is practical in occupational therapy practice, the implications of this framework for service delivery in hospitals and institutions, for the family, and community, and the health care system and policy, the various 'domains' of the framework are explored here:

9.9.1 Implications of the 'Samphan' Framework of Practice for Service Delivery in Hospitals and Institutions

The framework focuses on 'Occupational Guided' and 'Activity of Daily Living Guided' interventions, within the needs of clients and families, under a safe environment with adequate supports, so that minimum functional skills can be acquired and the patient can be discharged. For acute settings, the Reductionist Approach is used to intervene in specific performance enhancement areas with clear identification of treatment outcomes sought. Moreover, 'Family-Guided intervention'

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is essential. Treatment should focus on the needs of clients and their families, as well as specific agreements with those clients and the families, after they have received guidance sufficient to enable them to look after themselves upon their return to home and community. In addition, therapists should consider the level of Independent/Dependent Expectations of the Client-Family vis-à-vis client, his or her family, and the therapists themselves.

9.9.2   Implications for the Families

The concept that everybody takes responsibility for his or her own karma can be used to develop a sense of responsibility, and improve the potential of the client and his or her family. That is, the client and his or her family can learn to accept the illness or conditions with 'a peaceful mind' and then focus their efforts on improving their potential, or improving their conditions. Therapists should approach the Client-Family Unit at home and learn more about client-family life. They should understand the needs of the Client-Family Unit relating to degrees of Independent/Dependent Expectation vis-à-vis the client, his or her family, and health professionals, and consider all factors affecting a Client-Family Unit. They should also search information about interaction between the client and family, about how responsibility is shared between client and family, and about the overall potential of the Client-Family Unit.

The client, family and therapists should collaborate in setting goals of intervention programs after therapists provide appropriate guidance about potentials and limitations of the clients. The client, family, and therapists should collaborate in the intervention programs in order to meet goals of intervention and needs of a Client-Family Unit. Moreover, needed information about formal (e.g., social welfare) and informal (self-help groups, folk healers) support and health care services in the community should be provided to the Client-Family Unit. Furthermore, therapists should advise and instruct the Client-Family Unit on using resources in the community, on making self-help devices, and equipment, and on modifying the home, and surroundings for clients. In addition, therapists should search for sources of community support families, so they can take care of clients and themselves longer, and do their job effectively.

9.9.3 Implications for Communities

Initially, therapists should learn about the community in order to understand people's way of life, culture and belief systems, as well as existing resources. They can then use this information and identified resources to support and provide health care and rehabilitation programs to the Client-Family Unit. Examples of this approach follow:

Community resources can be used to facilitate community participation in treatment programs. For example, volunteers can take a health messenger role by providing information, surveying people with disabilities, and screening disabilities. Proactive programs in the community, such as educational programs, establishing self-help groups, and community-based rehabilitation will have the additional benefit of changing attitudes towards people with disabilities, and develop further community participation. Information on causes of disabilities and on the challenges of living with people with disabilities should be shared with people in the community, so they can understand more about these disabilities as well as the potential of people with disabilities to recover and become more self-sufficient.

Due to the interdependent nature of society, people with disabilities need to be valued as capable and productive members of their community. For example, educational programs about the competence and assets of people with disabilities can be organised. Persons with disabilities can be encouraged to participate in cultural activities such as the Thai New Year festival, religious ceremonies, and ritual activities in the community, so they can show their competence and assets.

Social support systems can be organised, so that people in the community can help people with disabilities to meet their basic needs in daily living, and encourage them to further improve their potential so that they can live in the community as equal members. Well-organised reciprocal relationships allow family members and community residents to show their gratitude to their senior members by caring for them and let the seniors have opportunity to improve their potential and participate in occupations that are appropriate to them.

Earning merit motivates members in the family and community to encourage people with disabilities to help themselves within their family unit. Apart from cultural or social activities, the community provides opportunities and creates

occupations for people with disabilities, so that they can participate and resume normal life, such as joining vocational development groups. An example of a group of this type can be found in the Thai Government's One Tambon One Product program (Committees of one Tambon one product project, 2001). One Tambon One Product means "one product per subdistrict through out Kingdom of Thailand denoted as OTOP and known as otop in Thailand, thai product, otop's products or single words 'otop', handmade, handicrafts as well" (Anonymous, 2004). According to the law of karma and merit making, members of the family and community should accept people with disabilities and be willing to contribute to people with disabilities. Through organised family and community participation, these religious values can be used to increase the potential of the client and his or her family to live harmoniously with others in society. Although, the Constitution of the Kingdom of Thailand in 1997: Section 30 supports equal human rights, and opposes unjust discrimination against a people on physical or health grounds (Constitution of the Kingdom of Thailand, 1997a), people with disabilities are currently labelled too often as dependent and hopeless persons, and their families are viewed as having the stigma of bad karma. Therefore, education programs and community programs to support clients and their family can play a valuable role in decreasing these negative labels, as well as the stigma.

To improve support to Client-Family Units, therapists can provide information and training to folk healers about health care and rehabilitation, so that they have appropriate knowledge and skills to take care of the Client-Family Unit. In addition, therapists can collaborate with folk healers, so they can refer clients to health care services when it is necessary to do so.

To support family with a member with a disability, therapists should collaborate with community leaders and volunteers to encourage community members to support the family as well. For instance, therapists can provide training programs for school leavers and housewife groups in taking care of clients so they can sometimes relieve family members, allowing them to rest and release tensions.

All of these suggested approaches support WHO policy, which focuses on encouraging community involvement, participation of people with disabilities in their society, community education, developing support systems, and promoting and

protecting the right and dignity of people with disabilities (World Health Organization, 2004). They also promote a holistic health approach.

9.9.4 Implications for the Health Care System and Impact on Health Policy

Major implications are as follows:

9.9.4.1. Occupational therapy services in community

An expansion of the role of occupational therapy in Thailand from a focus on rehabilitation in acute care hospitals and institutions to a community-based, the Occupational Therapists Association of Thailand should initiate health promotion and prevention approach. The Association should demonstrate how establishing services in communities can develop the potential of the Client-Family Unit, and promote independence of the Client-Family Unit after discharge through organised home and community care. This approach should be proposed to the Thai Health Promotion Foundation, the state agency responsible for encouraging, supporting, and funding projects that promote public health with the aim of reducing sickness and premature death rates. This agency also encourages changing behavioural patterns, and believes that beneficial environmental changes will contribute to an improved quality of life for Thais (Thai Health Promotion Foundation, 2003).

9.9.4.2. Education and training programs

The Occupational Therapists Association of Thailand should propose education and training programs for clients, families, and community members and request financial support from the Thai Health Promotion Foundation.

9.9.4.3. Awareness of a sense of responsibility

The Occupational Therapists Association of Thailand and Thai Health Promotion Foundation should join in promoting awareness of a sense of responsibility in clients, families, and community members through the Thai Health Promotion Foundation's network all over Thailand, which work with organizations in the community. A greater sense of responsibility of the client, family, and community can lead to active participation in occupational therapy and health care programs, and then lead to active efforts to solve problems of individual client-families, as well as broader community problems. People in the community can then

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take more active roles in health promotion and prevention, as envisioned in the current health care policy.

9.9.4.4. Promoting rights of people with disabilities

Associations of health professionals, association of people with disabilities, association of families of people with disabilities, and civil society organizations working at the community level can cooperate to ensure laws and policies supporting the rights of people with disabilities are effectively implemented by the government.

9.9.4.5. Support for families with a member with a disability

Government should provide incentives for families with a member with a disability, such as tax reductions or allowances for caregivers. Associations of health professionals, people with disabilities, families of people with disabilities, and civil society groups should join such an advocacy campaign, initially approaching the Ministry of Public Health.

9.9.4.6. Promotion of the 'Samphan' Framework of Practice for use in Thailand

9.9.4.6.1 Promotion of the 'Samphan' Framework of Practice for use in education

The 'Samphan' Framework of Practice should be promoted for use in universities that have curriculums of occupational therapy, as well as curriculums for heath care education and training. This should be undertaken by the Occupational Therapy Association of Thailand, associations of health professionals, and associations of related disciplines.

9.9.4.6.2 Promotion of the 'Samphan' Framework of Practice for use in the health care system

Promotion of the 'Samphan' Framework can be undertaken in all practice settings through the Occupational Therapists Association, using advertising and discussion programs in the mass media, and with through therapists who sit on health policy-making committees. These strategies can have an impact at the ministerial level, facilitating application of the 'Samphan' Framework across the health care system.

9.9.5   Implications for Occupational Therapy Education System in
Thailand

Academics teaching occupational therapy courses in Thailand will need to develop further knowledge, in conjunction with clinician, about conceptual models in OT, thus providing a more informed basis to undergraduate students for occupational therapy education, that is also culturally relevant.

Education institutions in Thailand should also begin to provide graduate programs in occupational therapy, in order that therapists can obtain more sophisticated knowledge through conducting research. Findings from research can provide clearer concepts about current occupational therapy models, so that academics and researchers can bring these clearer concepts into teaching about occupational therapy. Thai therapists will be able to apply current models in combination with the 'Samphan' Framework enabling them to better serve a range of Client-Family Units in a manner that is practical in Thai culture.

9.10 Conclusion

The 'Samphan' Framework of Practice has been developed as a structural frame for Thai occupational therapists to combine with appropriate occupational therapy models in order to provide effective service delivery for Thai clients. This is accomplished by appropriately modifying or harmonising those models with Thai culture. As a result of appropriate modifications, client and family as a single unit, in which an appropriate sense of responsibility can be instilled and the potential of the individual to look after himself or herself, in sharing responsibilities and receiving support from the community and the nascent social welfare system of Thailand. The relationships among client, family, and among community members is used as the key entry point to promote effective collaboration and sharing of responsibilities.

Finally, the active participation of the client-family and community members leads to health prevention and promotion, which in turn further enhance the role of occupational therapy. That is, an active participation is a common goal in both health promotion and occupational therapy (Thibeault & Hebert, 1997). Therefore, there should be a balance of individual (client-family) and collective (community and country) responsibilities in performing occupation for the Client-Family Unit, and in

implementing a framework such as the 'Samphan' Framework of Practice in accordance with Thai culture.

CHAPTER 10

Conclusions and Recommendations

Application of conceptual models of occupational therapy practice was investigated in a representative Western country-Australia, and a representative Eastern country-Thailand. Research was conducted using both qualitative (focus group interviews) and quantitative methods (a survey).

Findings from the focus group interviews demonstrated there was a difference in interpretation and application of current conceptual models to practice, between Western Australian and Thai occupational therapists, and it can be assumed this is primarily due to cultural influences. These findings were used to develop a questionnaire surveying opinions of a larger number of therapists from the two countries, regarding their understanding and use of theoretical models.

To investigate cultural differences between the West and the East and how they influence interpretation and application of the conceptual models in practice, the survey was administered to both WA and Thai occupational therapists. Survey results demonstrated differences in applying the models, and identified the cultural context of practice as the most influential factor in creating those differences.

The typical practice of Thai occupational therapists and their implicit claim that a new framework of practice needs to be developed to meet the cultural demands on ThaiOTs has been addressed by this research. A new hypothesised framework of practice for ThaiOTs was developed, based on responses and comments to the survey by ThaiOTs, and also on relevant contextual and experiential information, as well as related literature. The hypothesised framework was verified with a group of ThaiOTs, to enable the framework to be more practical in real situations. The final model, labelled the 'Samphan' Framework of Practice, focuses on a client-family unit as the key domain of concern in occupational therapy practice in Thailand. The 'Samphan' Framework, in combination with Western occupational therapy models, can provide a structural frame for Thai occupational therapists to provide service delivery that is appropriate to Thai culture and current health care policy in Thailand. ThaiOTs can combine an appropriate occupational therapy model with the 'Samphan' Framework, to adapt the Western model to Thai culture. This combination will then shape the OT process, following the dynamics and functions

presented in 'Samphan' Framework. The Framework assumes repeated interaction between the Client-Family Unit and Therapists, influenced by the expectations of the client-family regarding the dependence of the client, the potential for involvement by the family and health professionals, the Health Care System, Social Support, Community Attitudes and Expectations within Socio-Cultural Environment.

10.1 Recommendations for Occupational Therapy Practice

10.1.1 Implication of the 'Samphan' Framework for Therapists

Thai therapists' should shift from a focus on independence in individual client's performance to independence of the family unit so that the client can look after him or herself as appropriate within the family, and family can take care of the client and themselves appropriately at home. Effective collaboration among therapists, the client and family should be the initial domain of concern in occupational therapy practice for Thai therapists, who should seek to expand their roles to the community, in order to provide intervention programs that meet the needs of the client and family.

Based on the value of interdependence within family, the client and family should be encouraged to share responsibility in maintaining family functioning, and to enhancing the potential of the client, especially in activities of daily living.

Given the positive value placed on interdependence in the community, clients, families, and community members should be encouraged to look after themselves, at the community level, in effective achieving 'independent interdependence'. Thai therapists should provide education and training programs to communities and use resources available in the community to empower clients, families and community members to look after one another.

10.1.2 Implications of the 'Samphan' Framework for Other Parts of the Service Delivery System

The Framework implies that hospitals and similar institutions should emphasise developing adequate functional skills, such as self-care to meet the needs of clients and their families, and should provide useful information to help them look after themselves at home.

The Framework implies that communities should be encouraged to collaborate with therapists, and through community leaders, folk healers, and volunteers.

10.2 Recommendations for Health Policy

The following strategies are proposed to government organizations, such as Ministry of Public Health, in order to improve the health care system and ensure effective implementation of current health policies:

- provide occupational therapy services in communities;

- provide education and training programs to clients, families, and community members;

- promote and encourage awareness of a sense of responsibility among clients, families, and community members;

- promote the rights of people with disabilities to communities and the public;

- support families with a member with a disability;

- promote the 'Samphan' Framework of Practice for use in the education and health care systems in Thailand.

Implementing these strategies will require cooperation among the Occupational Therapy Association, associations of health professionals, associations of people with disabilities, associations of families of people with disabilities, civil society, and government organizations such as the Thai Health Promotion Foundation and Ministry of Public Health.

10.3 Recommendations for Further Study

Although, generally, Thailand and other Eastern countries have similar value of collectivism and interdependence, the degree of emphasis may differ. Moreover, health care systems in each country are different. These differences are derived from many causes, for example, different political systems and economic status. These differences could impact significantly on occupational therapy practice in each country. Therefore, there should be further studies, country-by-country, in order to obtain information on how Western models are interpreted and applied in practice by Eastern occupational therapists. If results are similar, this will confirm the need for

adjustments similar to the 'Sampham' Framework developed here. Some version of the 'Samphan' Framework of Practice might be applicable to OT practice in other Eastern countries. If results of studies in other countries are significantly different, they would in any case, provide information relevant application in OT practice, and may provide a basis for frameworks equivalent to the 'Sampham' Framework.

Whether studies lead to modification of the 'Sampham' Framework or completely new approaches, they imply the need for changes of education programs and health care policies, which will result in changes of the contexts of practice. For example, Thai therapists might expand their roles to practise in community. Therefore, this survey should be conducted again, perhaps in three to five years to investigate any possible needed changes of model application for occupational therapy practice in Thailand.

It is recommended that the 'Samphan' Framework of Practice be applied to service delivery in both institutions and community settings as discussed in Chapter 9. In addition, strengths and limitations of the framework should be investigated, and feedback should be given by relevant agencies on modifying and improving the framework, to ensure it will be practical in reality. That is, this Framework, in combination with a western occupational therapy model such as Model of Human Occupation, should be tested in the real context of Thailand, to investigate whether or not it is applicable to real situations of practice. If it proves effective, it should be incorporated into occupational therapy education. This Framework may also, with or without modification, be applicable to occupational therapy practice in the other Eastern developing countries that are broadly similar to Thailand.

In addition, future studies should collect data from clients, family members, and employers, using a more concise version of questionnaire, which have been modified to suit the target group. This will provided needed information on the needs and perspectives of the clients, family members, and employers vis-a-vis occupational therapy services. This information can be used to improve service delivery, as well as the professional status and security of therapists. Comments and feedbacks from clients and employers can also be used to improve and modify this Framework, to make it more suitable to these relevant groups.

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APPENDIX A

Invitation Letter

School of Occupational Therapy

Curtin University of Technology

8 Selby Street, Shenton Park. WA., 6008

April 12, 1999

Dear

My name is Arisa Pongsaksri, I am an occupational therapist currently enrolled to complete my doctoral studies at Curtin University of Technology. I graduated with a BSc. of occupational therapy and Master of Science in psychology from Chiang Mai University, Thailand. I am going to conduct a doctoral research project entitled **"A trans-cultural study of the practice of occupational therapists in Thailand and Australia: Reframing theories of practice to enhance job satisfaction in Thailand."** The purpose of this research project is to identify the conceptual models underpinning practice, determine the application of these models and based upon these findings develop a culturally appropriate conceptual models for practice in Thailand. The knowledge gained from this study will be important as it will provide occupational therapists with information which will help occupational therapists to improve their practice and service delivery to meet the cultural and job demands as well as to promote retention of occupational therapy professionals in a developing country.

I invite occupational therapy practitioners to participate in this study which will be conducted by using focus group interviews and later a survey. The interviews will be conducted <u>only one evening after work on 28th April or 5th May at Occupational therapy school and will take approximately one hour. You can select to attend either session.</u> Each focus group will comprises 6-8 participants. As occupational therapy practitioners are viewed as the experts regarding occupational therapy practice, the group will be a general discussion around the practice of occupational therapy.

The interviews and discussion will be tape-recorded; however, participants can be sure of absolute anonymity and guaranteed confidentiality.

I also attached the abstract of the research with this letter. If you have any queries or require further clarification or information please contact me at the School of Occupational Therapy, Curtin University of Technology, WA. The phone number is 92663660 between 9 a.m. to 6 p.m. Otherwise, if you have any concerns about this project you can contact my supervisor, Dr. Anne Passmore on 92663637

If you feel able to support this project could you please make a list of the names of therapists in your department who are willing to participate in the initial focus interviews. I will follow up with you shortly and organise to collect their names.

I should be most grateful, if you could pass this letter to occupational therapy practitioners working in your department.

Thank you for your assistance.

Your sincerely,

Arisa Pongsaksri

APPENDIX B

Informed Consent Form

Thesis title: A trans-cultural study of the practice of occupational therapists in Thailand and Australia

My name is Arisa Pongsaksri, I am an occupational therapist currently enrolled to complete my doctoral studies at Curtin University of Technology. The purpose of this research project is to identify the conceptual models underpinning practice, determine the application of these models and develop culturally appropriate conceptual models for practice. The knowledge gained from this study will be important as it will provide occupational therapists with information which will help occupational therapists to improve their practice and service delivery to meet the cultural and job demand as well as to promote retention of occupational therapy professionals in a developing country.

I invite you to participate in this study, which will be conducted by using focus group interviews and a survey. As you are viewed as the experts regarding occupational therapy practice, the group will be a general discussion around the practice of occupational therapy. The interviews and discussion will be tape-recorded. Interview/audio tapes will be only identifiable by code number and will be erased after transcription. No name will appear on the transcribed interviews. Extracts of interviews may be used in the research report, but you will not be identified in any way. Participants can be sure of absolute anonymity and guaranteed confidentiality.

Focus group interviews will be conducted: 2 groups in Thailand and 2 groups in Australia, with occupational therapists currently working from a representative range of occupational therapy setting. Each of the group interviews will take approximately 1 hour and involve up to 8 participants in each group. The focus group interviews in Thailand will be arranged during annual occupational therapy conference after working hours, which is convenient for most participants. However, the focus group interviews in Australia will be arranged during lunchtime or after work.

If you require further clarification or information, please contact me at the School of Occupational Therapy, Curtin University of Technology, WA 6008, Phone no: 61892663660 between 9 a.m. to 6 p.m. In Thailand, Please contact me at the Department of Occupational Therapy, Faculty of Associated Medical Sciences, Chiang Mai University, Phone no: 6653945084 between 8.30 a.m. to 4.30 p.m. Otherwise, if you have any concern about this project you may contact my supervisor, Dr. Anne Passmore on +61 892663637.

I look forward to your response to this request at your earliest convenience.

Yours sincerely

Arisa Pongsaksri

Participant's consent

I,_____, have read the above information on the study. I understand the purpose of this study, which has been explained in the information above, and understand that my participation is voluntary. I hereby give permission to be interviewed and for the interviews to be tape recorded.

I agree to participate in this study by joining in a group discussion.

Signature of Participant_____Date: / /1999

APPENDIX C

Information Form

1. First name _____ Surname _____

2. Age: 20-29, 30-39, 40-49, 50-59   Sex   F   M   (Please circle)

3. Highest level of Education _____

4. The number of years of working as an occupational therapist _____

5. Clinical work area: _____

_____

6. List the clients you mainly work with (e.g. neurological patients)_____

_____

7. What ages ranges do you primarily work with? _____

_____

8. List the key tasks or common roles you usually perform in daily clinical practice or in your working environment.

1. _____

2. _____

3. _____

4. _____

5. _____

others _____

_____

APPENDIX D

Probe Questions

The probe questions are for seeking the respondents' view of the subject area with regard to the following aspects:

1. Job roles as the professional requirement of profession

Describe the key tasks you usually perform in your working environment or identify common roles you perform in daily clinical practice.

2. Conceptual model for practice

What occupational therapy conceptual model assist you in practice?

Identify the specific model or model which underpins clinical practice you constantly use.

How would you describe the broad of over all conceptual models for your practice?

How do you interpret and apply this model to your practice?

What are the constraints/benefits of the conceptual models you use in your practice?

For example:

The value of people in your country has a big impact on the way of your practice.

The government policy has a big impact on the way of your practice

3. The expectation of occupational therapists in delivery service to their clients.

What kind of outcome are you looking for in client intervention?

What do you believe are the major interventions you can offer your clients?

From the answers to the above questions, the researcher intends to distinguish between the therapists' aim to clients as one of independence or interdependence.

4. The perception of occupational therapists about the need of clients?

What do you believe your clients gain or benefit from occupational therapy?

Do you believe you perform the role requirement in meeting the demands of clients?

If yes, what are they?

If no, what do you perceive as the limitation in performance those roles?

5. The perception of occupational therapists about the employers' demand.

Do you believe you perform the role requirements in meeting the demands of your employer?

If yes, what are they?

If no, what do you perceive as the limitation in performance those roles?

4+5 Do you see clients and employers are having a clear understanding of occupational therapy?

If yes, what are they?

If no, what do you perceive as the limitation in performance those roles?

6. What contribute to your job satisfaction/dissatisfaction?

What are your views on occupational therapy as a satisfying career?

What are the factors which limit your job satisfaction?

APPENDIX E

Points for Phone Calls

When advertising the study and seeking voluntary recruitment from practising therapists, the researcher discussed the aspects of the study on the telephone with the Heads of Occupational Therapy Departments. These aspects were presented as follows:

The purpose of the study was to investigate the conceptual models for practice used in Australia and Thailand and their application in relation to developing a model of practice in Thailand.

The subjects in the survey were occupational therapists currently working at your departments.

The subjects who participated in the survey were volunteers.

The time required to complete the questionnaire was approximately 30 minutes.

The permission for conducting the survey and the cooperation for distributing questionnaires to the volunteer therapists was requested from the heads requested.

APPENDIX F

Draft Questionnaire

Models for Clinical Practice Questionnaire

Part A
Personal Data Form Please tick the box, which represents your responses
(except where otherwise indicated)

1. Gender   Female   ☐   Male   ☐

2. Age   20-29   ☐   30-39   ☐
                    40-49   ☐   50-59   ☐

3. Marital Status
Single ☐   Married ☐   Defacto ☐   Widowed ☐   Divorced/
                                                    Separated ☐

4. Highest level of education
Diploma ☐   B.Sc.(OT) ☐   Grad. Diploma ☐   Masters ☐   Ph.D. ☐

Year of Graduation to practise Occupational Therapy   19 ___

5. Place of graduation (state or country)_____

6. The number of years of working as an occupational therapist _____

7. Type of work   Full time ☐   Part time ☐

8. Position :   Manager ☐   Clinical specialist ☐   Senior ☐   Base grade clinicia ☐

9. Clinical work area (you can tick more than one)
Neurology   ☐   Orthopaedics   ☐
Paediatrics (0-18 years)   ☐   Psychiatry   ☐
Occupational Health   ☐   Clinical Medicine   ☐
Aged care   ☐   Education   ☐
Community practice   ☐   Private practice   ☐
Hand & Upper Limb   ☐   Chronic pain   ☐
Health Promotion   ☐   Early intervention   ☐
Mental Health   ☐   Vocational Rehabilitation ☐
Other (please indicate)   ☐

10. The clients you mainly work with (you can tick more than one)
Children   ☐   Adult ☐   The elderly ☐

1

Part B

This questionnaire is based on information derived from focus group interviews and the literature. The questions cover a number of aspects of clinical practice. The first section is about conceptual models and their application and the later section covers service delivery.

Models of Occupational Therapy Practice

From the conceptual models for practice discussed by a number of clinician presented the following these broad models were identified below. Which one mostly do you apply to your practice? Note that the models are not mutually exclusive but are clustered into the following broad areas. (Please tick only one model)

☐ 1. **The Medical Model Approach** is described as solving each part of the patient's problems under the supervision of health professionals and/or developing minimum function to permit discharge. This model consists of the Neurodevelopmental Approach, Sensory Integration, Biomechanical Model, Rehabilitation Model, Behavioral-Cognitive Model and Psychoeducational Approach.

☐ 2. **The Performance Model or Functional Approach** includes acknowledging the performance of clients in different functional areas, compojents of performance, functional skills for survival in daily life especially self-care and maximising the clients' independent functioning in their life roles.

☐ 3. **The Whole Person Approach** includes the clients' performance, roles, habits and the environment of client as well as the clients and their families' needs relative to quality of life which focus on what are important for the clients and their families as well as on their satisfaction.

86. Name the occupational therapy model you use in practice (you can tick more than one)
   ☐ The Model of Human Occupation (MOHO)
   ☐ The Canadian Occupational Performance Model
   ☐ Occupational Performance (Australia)
   ☐ Occupational Adaptation Model
   ☐ Allen's Model of Cognitive Disabilities
       Other (Please indicate)

_____
_____
_____
_____

Note: Occupations include Work (productivity), Leisure (play), and Self-care (self-maintenance; activities of daily living)

Part C

Please respond to the following statements and select the category, which best describes your view. There are no right or wrong responses.

Clients referred to therapists' view of clients

Items	Strongly agree	Agree	Disagree	Strongly disagree
1.My client's needs guide the treatment plan.	☐	☐	☐	☐
2.My clients has a right to a good quality of life	☐	☐	☐	☐
3.All of my clients' roles are considered.	☐	☐	☐	☐
4.A conceptual model for practice needs to integrate all aspects of my clients' life.	☐	☐	☐	☐
5.My clients needs occupational therapy input to and maximise their condition.	☐	☐	☐	☐
6. My clients expect to remain dependent upon their families.	☐	☐	☐	☐
7. My clients expect to remain dependent upon health professionals	☐	☐	☐	☐
8. My clients' performance outcome is considered in relation to their needs.	☐	☐	☐	☐
9.My clients expect my service to be free service as part of rehabilitation.	☐	☐	☐	☐
10.Clients (or their relatives) expect I am going to fix everything" in a short period of time.	☐	☐	☐	☐
11.My clients expect to return to their own homes to live.	☐	☐	☐	☐
12.My clients expect to remain as independent as possible.	☐	☐	☐	☐
13. My clients are acknowledged as equal partners in the therapeutic process.	☐	☐	☐	☐

Therapists referred to therapists' views about themselves as therapists

	Strongly agree	Agree	Disagree	Strongly disagree
14. I believe clients need to be educated about retaining maximum independence	☐	☐	☐	☐

Items	Strongly agree	Agree	Disagree	Strongly disagree
15.I believe families should support their disabled members but acknowledge their needs to make decision to be independent.	☐	☐	☐	☐
16.I have to deal with a variety of clients and their families who may not hold the same belief and values.	☐	☐	☐	☐
17.The frame of reference I apply meets the clients' needs	☐	☐	☐	☐
18. I focus on developing minimum functional skills to permit safe discharge.	☐	☐	☐	☐
19.Occupational therapy models should sit under theumbrella of the medical model.	☐	☐	☐	☐
20.I focus on solving clients problem in specific areas	☐	☐	☐	☐
21.I use a model to encourage clients to perform their occupations independently as possible.	☐	☐	☐	☐
22.I use a model, which considers the quality of life and the needs and performance outcomes of that client.	☐	☐	☐	☐
23.I use a model, which emphasises the client's ability to perform roles relating to the client's need and to his/her family's needs.	☐	☐	☐	☐
24.I use a model, which looks at the whole person and understands clients in their contextual environment.	☐	☐	☐	☐
25.I belief that we can change the way people cope with their life through therapeutic intervention.	☐	☐	☐	☐
26.I can influence society in changing society attitudes to disability.	☐	☐	☐	☐
27. I believe in extended rehabilitation for clients whose return to functional independence takes longer to resolve.	☐	☐	☐	☐
28.I use transition programs from hospital home/community to support the rehabilitation outcomes gained in hospital.	☐	☐	☐	☐
29.I visit clients in their home to provide program/equipment, which will assist clients adapting to their environment.	☐	☐	☐	☐
30.Community based programs, which I run provide cost-effective prevention and maintenance for my clients' management.	☐	☐	☐	☐
31.I provide the programs in the community to promote independent living for disabled persons eg. self-help group, training in living skills.	☐	☐	☐	☐

4

A questionnaire/20/12/99

Items	Strongly agree	Agree	Disagree	Strongly disagree
32.I encourage and educate people in the community to participate in clients' intervention program.	☐	☐	☐	☐
33.Occupational therapy programs in the community should focus on preventing disability and encourage people in community to take roles in community care.	☐	☐	☐	☐

Intervention

	Strongly agree	Agree	Disagree	Strongly disagree
34.Occupational performance outcomes of my clients are considered in their environmental context.	☐	☐	☐	☐
35.My clients' performance outcome is considered in relation to their needs.	☐	☐	☐	☐
36.I believe a reductionist approach is required to work on specific performance enhancement.	☐	☐	☐	☐
37.Rehabilitation of a specific performance area is guided by my clients' choice.	☐	☐	☐	☐
38.I assist clients to develop skills to reach their personal goals.	☐	☐	☐	☐
39.I focus on developing everyday life skills in my clients.	☐	☐	☐	☐
40.My focus is on development of functional ADL skills.	☐	☐	☐	☐
41.Occupation/activities enable my clients to reach their potential and gain mastery to perform their occupational roles.	☐	☐	☐	☐
42.Client's occupational history enables me to assign and propose occupations that are meaningful.	☐	☐	☐	☐
43.I use activity analysis to develop adaptive responses through occupations.	☐	☐	☐	☐
44.Occupations provided to my clients should be applicable to their home environment.	☐	☐	☐	☐
45.I collaborate with my clients to help them achieve their goals.	☐	☐	☐	☐
46.The model I use should be based on the expressed needs of clients	☐	☐	☐	☐
47.I take the role of directing and setting goals for treatment programs.	☐	☐	☐	☐
48.I provide prescribed interventions with my clients'cooperation.	☐	☐	☐	☐

5

A questionnaire/20/12/99

Items	Strongly agree	Agree	Disagree	Strongly disagree
49.I acknowledge the impact of illness/disability to my clients.	☐	☐	☐	☐
50.I carry out treatment programs to respond to the demands of my employer.	☐	☐	☐	☐
51.I use compensatory approaches such as environmental adaptation in adapting a person's performance	☐	☐	☐	☐
52.Where a client cannot function independently, I will locate relevant resources or support.	☐	☐	☐	☐
53.I apply a functional approach to maximise clients' abilities in order that they can perform ADL.	☐	☐	☐	☐
54.I apply the occupation (ie. Work, self-care, and leisure) as the media for treatment.	☐	☐	☐	☐
55.I aim for independence, but am inclusive of the clients' priorities	☐	☐	☐	☐
56.I identify clients' specific requirements and the related skills to survive in society.	☐	☐	☐	☐
57.I work closely with clients' families to achieve clients' goals.	☐	☐	☐	☐
58.Despite the limited time, I observe and listen to what the clients and their families' report.	☐	☐	☐	☐
59.I should begin with client's issues and then use the model or frame of reference, which is relevant.	☐	☐	☐	☐
60.I am flexible in working with clients.	☐	☐	☐	☐
61.I integrate the clients' goals with those of the health setting and current government policies.	☐	☐	☐	☐
62.I communicate clearly the aims of treatment to the clients.	☐	☐	☐	☐
63.In an acute setting, I primarily focus on requirements for discharge.	☐	☐	☐	☐
64.In an acute setting, I focus on the client's personal goals for lifestyle adaptation.	☐	☐	☐	☐
65.I expect treatment outcomes to be clearly identified	☐	☐	☐	☐
66.I expect treatment outcome should meet the demands of health providers.	☐	☐	☐	☐
67.I expect clients to be able to perform self-care activities and participate in activities within their environment.	☐	☐	☐	☐

6

Items	Strongly agree	Agree	Disagree	Strongly disagree
68.I expect clients to return to a safe environment with adequate supports	☐	☐	☐	☐
69.After discharge, families/clients I see support continuing programs.	☐	☐	☐	☐
70.I aim to meet the needs of both client and family members	☐	☐	☐	☐

Cultural implications

(**Culture** refers to as all knowledge that human being learn as members of social groups which include their values, beliefs and customs of family, community and society)

71.I have been taught to push for my client's independence without considering other viewpoints.	☐	☐	☐	☐
72.I believe Western people value the concept of independence and individualism more than Thai or Eastern.	☐	☐	☐	☐
73.I believe extended families from eastern cultural backgrounds take responsibility f or caring for ill/handicapped relative more than those from western cultural backgrounds	☐	☐	☐	☐
74.I believe clients do not desire or wish to take care of themselves and would prefer to depend on their families and relatives.	☐	☐	☐	☐
75.Thai or Eastern people uphold a culture that aspires to take care of sick or handicapped people.	☐	☐	☐	☐
76.I am not sure that I can apply theoretical frameworks from Western culture for practice in Thai or Eastern cultures.	☐	☐	☐	☐
77.I am not sure that I can apply theoretical frameworks from Western culture for practice in Australian culture.	☐	☐	☐	☐
78.I don't believe people with physical disables and /or people with the mental illness are seen as a valued part of the society.	☐	☐	☐	☐
79.Families with handicapped relatives still have the burden of stigma.	☐	☐	☐	☐
80.After clients have finished a prevocational training program, there is no workplace to accept them because of the socio-cultural factors.	☐	☐	☐	☐

7

Items	Strongly agree	Agree	Disagree	Strongly disagree
81.I consider whether independence is valued by clients and their families.	☐	☐	☐	☐
82.I consider whether independence is valued by their culture groups.	☐	☐	☐	☐
83.I need to meet cultural expectations.	☐	☐	☐	☐
84.I believe the clients are aware that their goals are societally based.	☐	☐	☐	☐
85.If the client's family does not want them to be independent, I will alter the treatment plan to incorporate this.	☐	☐	☐	☐
86.I aim for the clients' families' goals in working with clients.	☐	☐	☐	☐
87.Clients are used as a resource in understanding cultural beliefs, family dynamics and clients' views of illness.	☐	☐	☐	☐
88.I encourage the clients to utilise resources commonly used within their own culture.	☐	☐	☐	☐

Health care Systems

(refers to policy of health institute, community and government and budgets, facilities and resources)

Items	Strongly agree	Agree	Disagree	Strongly disagree
89.I work in conjunction with doctors, insurance, companies, employment and referring agencies.	☐	☐	☐	☐
90.I have a long waiting list affected by the priorities within the health system.	☐	☐	☐	☐
91.I am affected by policies (ie. Government, Public or Private hospital policy).	☐	☐	☐	☐
92.My employer would like me to see as many clients as possible.	☐	☐	☐	☐
93.Employers are concerned with outcomes, not the quality.	☐	☐	☐	☐
94.I have to admit and discharge clients quickly because the occupational therapy service is dictated by the hospital funding.	☐	☐	☐	☐
95.I need to be outcome focused	☐	☐	☐	☐
96.Transition programs from hospital to community need to be more effective	☐	☐	☐	☐

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A questionnaire/20/12/99

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Part D

1. Have the theoretical frameworks, which underpin practice assisted you in client interventions ?

Yes ☐
because _____

No ☐
because _____

2. What are the limitations of current frameworks for application in Thailand/ Australia? Please tick

Thailand ☐

_____
_____

Australia ☐

_____
_____

3. What would you like to include in a new framework for practice?

Please list

_____
_____
_____
_____
_____

Thank you for assistance

APPENDIX G

Models for Clinical Practice Questionnaire (MCPQ)

(English version)

Curtin

UNIVERSITY OF TECHNOLOGY

School of occupational therapy
The modes for Clinical Practice Questionnaire

Thank you for your contribution to this important study in occupational therapy. The result will provide information that will generate a better understanding of conceptual models required for in both Australia and Thailand.

The questionnaire should take about 30 minute to complete and include the following sections:

Part A	Background Information
Part B	Models of Occupational Therapy Practice
Part C	Occupational Therapy Practice
Part D	The Practice Comment

The information will be treated confidentially and your anonymity is guaranteed.

This questionnaire has been developed from a source of focus groups held in both Australia and Thailand.
The researcher is interested in justify out about conceptual models used in the practice of occupational therapy and their relevance and application in developing countries.

If you have any queries about any aspect of this questionnaire please feel free to ring the number below or email your concerns or questions.

Arisa Pongsaksri   Dr. Anne Passmore
Doctoral Student   ph (08) 92663637 (office)
Ph (08) 93552907 (home)   Ph (08) 93863009 (home)
Email: ppongsaksri@cc.curtin.edu.au   Email: ipassmor@info.curtin.edu.au

Please return the completed questionnaire by 28 of April, 2000 to
Arisa   Pongsaksri
School of Occupational Therapy
Curtin University of Technology
Kent Street. Bentley
WA. 6101

Models for Clinical Practice Questionnaire
(MCPQ)

Part A
Background Information
Please tick the box, which represents your responses (except where otherwise indicated)

1. Gender   Female ☐   Male ☐

2. Age   20-29 ☐   30-39 ☐
          40-49 ☐   50-59 ☐

3. Marital Status

Single ☐   Partnered /Married ☐

4. Highest level of education

Diploma ☐   Bachelors ☐   Grad. Diploma ☐   Masters ☐   Ph.D ☐

Year of Graduation to practise Occupational Therapy   19 ___

5. Place of graduation (state or country)_____

6. The number of years of working as an occupational therapist

   0-5 ☐   6-10 ☐   11-15 ☐

   16-20 ☐   21-25 ☐   26- up ☐

7. current work   Full time ☐   Part time ☐

8. Position :   Manager ☐   Clinical specialist ☐   Senior ☐   Base grade clinician ☐
          (you can tick more than one box)

9. Clinical work area *(you can tick more than one box)*
   ☐ Neurology   ☐ Orthopaedics
   ☐ Paediatrics   ☐ Psychiatry
   ☐ Occupational Health   ☐ Clinical Medicine
   ☐ Aged care   ☐ Education
   ☐ Community practice   ☐ Private practice
   ☐ Hand & Upper Limb   ☐ Chronic pain
   ☐ Health Promotion   ☐ Early intervention
   ☐ Mental Health   ☐ Vocational Rehabilitation
   ☐ Other (please indicate)   ☐ Developmental Disability

---

10. The clients you mainly work with *(you can tick more than one box)*
   ☐ Children   ☐ Adult   ☐ The elderly

1

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Part B
Models of Occupational Therapy Practice

1. From the conceptual models for practice discussed by a number of clinicians the following broad models were identified. Which one mostly do you apply to your practice? Note that the models are not mutually exclusive but are clustered into the following broad areas. (Please tick only one model)

☐ **The Medical Model Approach** is described as solving each part of the patient's problems under the supervision of health professionals and/or developing minimum function to permit discharge. This model consists of the neurodevelopmental approach, sensory integration, biomechanical model, rehabilitation model, behavioral-cognitive model and psychoeducational approach.

☐ **The Performance Model or Functional Approach** includes acknowledging the performance of clients in different functional areas, components of performance, functional skills for survival in daily life especially self-care and maximising clients' independent functioning.

☐ **The Whole Person Approach** encompasses the clients' performance, roles, habits and environment of the clients, including the needs of the clients and their families relative to life satisfaction and quality of life issues.

2. Name the occupational therapy model you use in practice (you can tick more than one)

    ☐ The Model of Human Occupation (MOHO)
    ☐ The Canadian Occupational Performance Model
    ☐ Occupational Performance
    ☐ Person-Environment-Occupation Model
    ☐ Allen's Model of Cognitive Disabilities
    ☐ Other (Please indicate in the space below)

    _____

    _____

    _____

    _____

2

Part C
Occupational Therapy Practice

Please respond to the following statements and select the category, which best describes your view. There are no right or wrong responses.

Clients (my view on my clients)	Strongly agree	Agree	Disagree	Strongly disagree
1. My client's needs guide the treatment plan.	4	3	2	1
2. My clients have a right to a good quality of life.	4	3	2	1
3. All of my clients' roles are considered.	4	3	2	1
4. A conceptual model for practice needs to integrate all aspects of my clients' life.	4	3	2	1
5. My clients need occupational therapy input to maximise their existing condition.	4	3	2	1
6. My clients expect to remain dependent upon their families.	4	3	2	1
7. My clients expect to remain dependent upon health professionals.	4	3	2	1
8. My clients expect my service to be a free service as part of rehabilitation.	4	3	2	1
9. Clients (or their relatives) expect I am going to "fix everything" in a short period of time.	4	3	2	1
10. My clients expect to remain as independent as possible.	4	3	2	1

Therapists (my views on myself as a therapist)				
11. I have to deal with a variety of clients and their families who may not hold the same belief and values.	4	3	2	1
12. I focus on developing minimum functional skills to permit safe discharge.	4	3	2	1
13. Occupational therapy models should sit under the umbrella of the medical model.	4	3	2	1
14. I focus on solving clients' problem in specific areas.	4	3	2	1
15. I use a model which considers the quality of life and the needs and performance outcomes of that client.	4	3	2	1

3

Therapists (my views on myself as a therapist)	Strongly agree	Agree	Disagree	Strongly disagree
16. I use a model which emphasises the client's ability to perform roles relating to the client's needs and to his/her family's needs.	4	3	2	1
17. I use a model, which looks at the whole person and understands clients in their contextual environment.	4	3	2	1
18. I believe in extended rehabilitation for clients whose return to functional independence takes longer to resolve.	4	3	2	1
19. I use transition programs for transferring clients from hospital to home/community.	4	3	2	1
20. I provide programs in the community to promote independent living.	4	3	2	1
21. I promote community members to participate in the clients' community rehabilitation program.	4	3	2	1

Intervention

Occupations include Work (productivity), Leisure (play), and Self-care (self-maintenance; activities of daily living)

	Strongly agree	Agree	Disagree	Strongly disagree
22. Occupational performance outcomes of my clients are considered in their environmental context.	4	3	2	1
23. My clients' performance outcome is considered in relation to their needs.	4	3	2	1
24. I believe a reductionist approach is required to work on specific performance enhancement.	4	3	2	1
25. Rehabilitation of a specific performance area is guided by my clients' choice.	4	3	2	1
26. I assist clients to develop skills to reach their personal goals.	4	3	2	1
27. I focus on developing everyday life skills in my clients.	4	3	2	1
28. My focus is on development of functional ADL skills.	4	3	2	1
29. Occupations/activities enable my clients to reach their potential and gain mastery to perform their occupational roles.	4	3	2	1
30. A client's occupational history enables me to assign and propose occupations that are meaningful.	4	3	2	1

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Intervention	Strongly agree	Agree	Disagree	Strongly disagree
31. I use activity analysis in designing treatment programs.	4	3	2	1
32. Occupations provided to my clients should be applicable to their home, work and leisure environments.	4	3	2	1
33. I collaborate with my clients to assist them achieve their goals.	4	3	2	1
34. The model I use should be based on the expressed needs of clients.	4	3	2	1
35. I take the role of directing and setting goals for treatment programs.	4	3	2	1
36. I provide prescribed interventions and then implement with my client's cooperation.	4	3	2	1
37. I carry out treatment programs to respond to the demands of my employer.	4	3	2	1
38. I aim for independence but am inclusive of the clients' priorities.	4	3	2	1
39. I identify clients' specific requirements and the related skills to survive in society.	4	3	2	1
40. I work closely with clients' families to achieve clients' goals.	4	3	2	1
41. Despite the limited time I observe and listen to what the clients and their families report.	4	3	2	1
42. I begin with client's issues and then use the appropriate model.	4	3	2	1
43. I integrate the clients' goals with those of the health setting and current government policies.	4	3	2	1
44. My clients understand the aims of treatment.	4	3	2	1
45. In an acute setting I primarily focus on requirements for discharge.	4	3	2	1
46. In an acute setting I focus on the client's personal goals for lifestyle adaptation.	4	3	2	1
47. I have clearly defined the treatment outcomes for my clients.	4	3	2	1
48. I expect treatment outcomes should meet the demands of health providers.	4	3	2	1

5

Intervention	Strongly agree	Agree	Disagree	Strongly disagree
49. I expect clients to be able to participate in activities within their environment at their ability levels.	4	3	2	1
50. I expect clients to return to a safe environment with adequate supports.	4	3	2	1
51. After discharge continuing support should be provided/required.	4	3	2	1
52. I aim to meet the needs of both client and family members.	4	3	2	1

Cultural implications

(Culture refers to as all knowledge that human beings learn as members of social groups which include their values, beliefs and customs of family, community and society)

	Strongly agree	Agree	Disagree	Strongly disagree
53. I can influence society in changing social attitudes to disability.	4	3	2	1
54. I believe clients should remain as independent as possible.	4	3	2	1
55. I believe Western people value the concept of independence and individualism.	4	3	2	1
56. I believe clients prefer to depend on their families and relatives for care.	4	3	2	1
57. Thai or Eastern families uphold a culture that aspires to take care of sick or handicapped people.	4	3	2	1
58a. I can apply theoretical frameworks from Western culture for practice in Thai or Eastern cultures. (OR)	4	3	2	1
58b. I can apply theoretical frameworks from Western culture for practice in Australian culture.	4	3	2	1
59. I do not believe people with physical disability and/or people with mental illness are seen as a valued part of society.	4	3	2	1
60. Families with relatives with handicaps still have the burden of stigma.	4	3	2	1
61. There are limited workplaces to accept clients with disability.	4	3	2	1
62. In treatment, I consider whether independence is valued by clients and their families.	4	3	2	1

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Cultural implications	Strongly agree	Agree	Disagree	Strongly disagree
(Culture refers to as all knowledge that human beings learn as members of social groups which include their values, beliefs and customs of family, community and society)				
63. I consider whether independence is valued by their cultural groups.	4	3	2	1
64. I consider clients' cultural expectations.	4	3	2	1
65. Clients are used as a resource in understanding cultural beliefs, family dynamics and clients' views of illness.	4	3	2	1
66. I encourage clients to utilise resources common within their own culture.	4	3	2	1

Health care Systems

(refers to policies of health institutions, community and government; budgets, facilities and resources)

	Strongly agree	Agree	Disagree	Strongly disagree
67. I work in conjunction with Government and/or private insurance agencies or private sectors.	4	3	2	1
68. I work with other Government departments/agencies in addition to health sectors.	4	3	2	1
69. I have a long waiting list affected by the priorities within the health system.	4	3	2	1
70. Registration and Government policies have direct impact on my practice.	4	3	2	1
71. Quality assurance standards promote better outcomes in occupational therapy.	4	3	2	1
72. I have to admit and discharge clients quickly because the occupational therapy service is dictated by the funding.	4	3	2	1
73. I am outcome focused.	4	3	2	1
74. Transition programs from hospital to community need to be more effective.	4	3	2	1

7

Part D
The practice comment

1. Have the theoretical frameworks, which underpin practice assisted you in client interventions?

Yes ☐
because _____

_____

_____

_____

_____

_____

No ☐
because _____

_____

_____

_____

_____

_____

2. What are the limitations of current frameworks for application in your country?

_____

_____

_____

_____

_____

_____

3. Make a list of what you would like to include in a new framework for practice

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.
Your assistance in this important study is greatly appreciated.

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APPENDIX H

Models for Clinical Practice Questionnaire (MCPQ)

(Thai version)

แบบสอบถามรูปแบบการปฏิบัติงานทางคลินิก

เรียน

    ขอขอบพระคุณสำหรับความช่วยเหลือของท่านต่อการศึกษาทางกิจกรรมบำบัดที่สำคัญครั้งนี้ ผลการศึกษาจะใช้เป็นข้อมูลสำหรับเสริมสร้างความเข้าใจรูปแบบการปฏิบัติงานทางคลินิก   ซึ่งจำเป็น สำหรับประเทศไทย และประเทศออสเตรเลีย

    แบบสอบถามนี้ใช้เวลาประมาณ 30 นาที ซึ่งประกอบด้วยหัวข้อต่อไปนี้

ส่วนที่ 1	ข้อมูลพื้นฐาน
ส่วนที่ 2	รูปแบบการปฏิบัติงานทางคลินิกกิจกรรมบำบัด
ส่วนที่ 3	การปฏิบัติงานทางคลินิกกิจกรรมบำบัด
ส่วนที่ 4	คำแนะนำสำหรับการปฏิบัติงานทางคลินิก

    ข้อมูลและความคิดเห็นอย่างอิสระของท่านจะได้รับการเก็บเป็นความลับ   โดยไม่มีการระบุชื่อ หรือข้อความใดๆ เกี่ยวกับตัวท่าน หรือที่ทำงานของท่านทั้งสิ้น

    แบบสอบถามนี้พัฒนาจากข้อมูลในการประชุมกลุ่มทั้งในประเทศไทย และ ออสเตรเลีย โดยผู้ วิจัยต้องการศึกษารูปแบบการปฏิบัติงานทางคลินิกกิจกรรมบำบัดที่สอดคล้องกับวัฒนธรรมไทย   และ นำไปใช้ได้อย่างเหมาะสม

    ถ้าท่านมีข้อคำถามใด ๆ เกี่ยวกับแบบสอบถาม โปรดกรุณาติดต่อผู้วิจัยทางหมายเลข โทรศัพท์ หรือทางจดหมายอิเลคโทรนิค (E-mail address) ที่ระบุข้างล่างนี้

อริสา พงษ์ศักดิ์ศรี	อริสา พงษ์ศักดิ์ศรี
นักศึกษาปริญญาเอก	ภาควิชากิจกรรมบำบัด
Curtin University of Technology	คณะเทคนิคการแพทย์
Western Australia	มหาวิทยาลัยเชียงใหม่
E-mail: ppongsaksri@cc.curtin.edu.au	โทร. 053-945084, 02-7536684-5
E-mail: arisa@mail.ams.cmu.ac.th	โทรสาร 02-7536685

<u>หมายเหตุ</u> ขอความกรุณาส่งแบบสอบถามกลับมาตามที่อยู่ที่แนบมาด้วย ภายใน <u>วันที่ 5 พฤษภาคม 2543</u> เพื่อผู้วิจัยจะได้นำไปวิเคราะห์ที่ประเทศออสเตรเลีย จักเป็นพระคุณยิ่ง

<div align="right">

นส. อริสา พงษ์ศักดิ์ศรี

</div>

แบบสอบถามรูปแบบการปฏิบัติงานทางคลินิก
ส่วนที่ 1 ข้อมูลส่วนตัว

โปรดทำเครื่องหมาย √ ในช่อง ☐ ซึ่งแสดงถึงคำตอบของท่าน (ยกเว้นในช่องว่างที่ให้เติมคำ)

1. เพศ ☐ หญิง ☐ ชาย

2. อายุ ☐ 20-29 ปี ☐ 30-39 ปี
   ☐ 40-49 ปี ☐ 50-59 ปี

3. สถานภาพสมรส ☐ โสด ☐ สมรส
   ☐ หม้าย ☐ หย่าหรือแยกกัน

4. ระดับการศึกษาสูงสุด ☐ ปริญญาตรี ☐ ประกาศนียบัตรหลังปริญญาตรี
   ☐ ปริญญาโท ☐ ปริญญาเอก

   ปีที่สำเร็จการศึกษาเพื่อปฏิบัติงานกิจกรรมบำบัด 25...... (อาจไม่ใช่ปีที่สำเร็จการศึกษาสูงสุด)

5. สถานที่สำเร็จการศึกษา (จังหวัด หรือประเทศ) ....

6. จำนวนปีของการปฏิบัติงานกิจกรรมบำบัด.........................ปี.............เดือน

7. ประเภทของงาน ☐ ทำงานเต็มเวลา ☐ ทำงานไม่เต็มเวลา

8. ตำแหน่งงาน ☐ หัวหน้าแผนก OT ระดับ ....
   ☐ นักกิจกรรมบำบัด/อาชีวบำบัด ระดับ ....
   ☐ อาจารย์กิจกรรมบำบัด ระดับ ....

   (ท่านสามารถตอบได้มากกว่า 1 ตัวเลือก)

9. ท่านปฏิบัติงานคลินิกด้านใด (สามารถเลือกได้มากกว่า 1 ด้าน)

   ☐ ระบบประสาทวิทยา ☐ ระบบกระดูก และข้อ
   ☐ เด็ก ☐ จิตเวช
   ☐ อาชีวอนามัย (Occupational Health) ☐ อายุรกรรม
   ☐ ผู้สูงอายุ ☐ การศึกษา
   ☐ ชุมชน ☐ คลินิกส่วนตัว
   ☐ มือ และระยางค์ส่วนบน ☐ ปวดเรื้อรัง
   ☐ การส่งเสริมสุขภาพ (Health Promotion) ☐ โปรแกรมการช่วยเหลือแรกเริ่ม
   (Early Intervention)

   ☐ พัฒนาการช้า (Developmental Disability)

   ☐ อื่นๆ (โปรดระบุ) ....

10. ประเภทของผู้ป่วย หรือผู้รับบริการที่ท่านทำงานด้วยส่วนใหญ่ (สามารถเลือกได้มากกว่า 1
    ประเภท)

    ☐ ผู้ป่วยเด็ก ☐ ผู้ป่วยผู้ใหญ่ ☐ ผู้สูงอายุ

ส่วนที่ 2
รูปแบบการปฏิบัติงานทางคลินิกกิจกรรมบำบัด

1. จากการอภิปรายกลุ่มของนักกิจกรรมบำบัดได้เสนอรูปแบบการปฏิบัติงานทางคลินิกอย่างกว้างๆ ขึ้น รูปแบบใดที่ท่านประยุกต์ใช้ในการปฏิบัติงานทางคลินิกมากสุดโปรดเลือกเพียงรูปแบบเดียว โดยคำนึงด้วยว่ารูปแบบเหล่านี้ไม่ได้แยกออกมาเป็นรูปแบบอิสระ แต่เป็นการรวมกลุ่มตามขอบเขตกว้างๆดังนี้

   1.1 วิธีการภายใต้รูปแบบทางการแพทย์ (The Medical Model Approach) หมายถึงการแก้ปัญหาแต่ละส่วนของผู้ป่วยภายใต้คำแนะนำของบุคลากรด้านสุขภาพ และ/หรือ การพัฒนาความสามารถขั้นต่ำสุดในการจำหน่ายผู้ป่วย รูปแบบนี้ประกอบด้วย the neurodevelopment approach, sensory integration, biomechnanic model, rehabilitation model, behavioral-cognitive model and psychoeducational approach.

   1.2 วิธีการภายใต้รูปแบบการประกอบกิจกรรม (The Performance Model or Functional Approach) หมายถึง การให้ความสำคัญต่อการประกอบกิจกรรมของผู้ป่วยในแต่ละขอบเขตหน้าที่ต่างๆ องค์ประกอบของการประกอบกิจกรรม ทักษะการทำหน้าที่เพื่อความอยู่รอดในชีวิตประจำวัน โดยเฉพาะการดูแลตนเอง และการเพิ่มการทำหน้าที่ในชีวิตประจำวันให้มีประสิทธิภาพสูงสุด

   1.3 วิธีการภายใต้รูปแบบองค์รวมของมนุษย์ (The Whole Person Approach) หมายถึง การประกอบกิจกรรมของผู้ป่วย บทบาท นิสัย และสิ่งแวดล้อมของผู้ป่วยรวมทั้งความต้องการของผู้ป่วยและครอบครัว ซึ่งเกี่ยวข้องกับคุณภาพชีวิตและความพึงพอใจของผู้ป่วย

2. โปรดเลือกรูปแบบทางกิจกรรมบำบัด (The Occupational Therapy Model) ที่ใช้ในการปฏิบัติการทางคลินิก (ท่านสามารถเลือกได้มากกว่า 1 รูปแบบ)

   ☐ The Model of Human Occupation (MOHO)

   ☐ The Canadian Occupational Performance Model

   ☐ Occupational Performance (Australia)

   ☐ Person-Environment-Occupation Model

   ☐ Allen's Model of Cognitive Disabilities

   ☐ อื่นๆ (โปรดระบุ)

   ....

   ....

   ....

การปฏิบัติงานทางกิจกรรมบำบัด

โปรดอ่านข้อความต่อไปนี้แล้วเลือกข้อความที่อธิบายความคิดเห็นของท่านได้ตรงมากที่สุด ไม่มีคำตอบใดผิด หรือถูก

__ผู้ป่วย/ผู้รับบริการ__ (ผู้ป่วย/ผู้รับบริการในความคิดเห็นของท่าน)	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
1. ความต้องการของผู้ป่วยชี้นำการวางแผนรักษาของท่าน	4	3	2	1
2. ผู้ป่วยของท่านมีสิทธิที่จะมีคุณภาพชีวิตที่ดี	4	3	2	1
3. ท่านคำนึงถึงบทบาททั้งหมดของผู้ป่วย	4	3	2	1
4. รูปแบบการปฏิบัติงานทางคลินิกจำเป็นต้องผสมผสานทุกอย่างในชีวิตของผู้ป่วย	4	3	2	1
5. ผู้ป่วยของท่านต้องการบริการทางกิจกรรมบำบัดเพื่อทำให้สภาพที่เป็นอยู่ในขณะนี้ดีที่สุด	4	3	2	1
6. ผู้ป่วยของท่านคาดหวังที่จะคงสภาวะการพึ่งพาครอบครัวของเขา	4	3	2	1
7. ผู้ป่วยของท่านคาดหวังที่จะคงสภาวะการพึ่งพาบุคลากรด้านสุขภาพ	4	3	2	1
8. ผู้ป่วยของท่านคาดหวังจะได้รับบริการทาง OT โดยถือเป็นส่วนหนึ่งของโปรแกรมการฟื้นฟูสมรรถภาพ	4	3	2	1
9. ผู้ป่วยหรือญาติคาดหวังว่าท่านจะแก้ไขปัญหาทุกอย่างได้ในช่วงเวลาสั้นๆ	4	3	2	1
10. ผู้ป่วยของท่านคาดหวังที่จะคงสภาวะพึ่งพาตนเองให้ได้มากที่สุด	4	3	2	1
__ผู้บำบัด__ (ความคิดเห็นของท่านเมื่อท่านเป็นผู้บำบัด)				
11. ท่านต้องจัดการกับความเชื่อและค่านิยมที่หลากหลายของผู้ป่วยและครอบครัว ซึ่งอาจไม่สอดคล้องกับท่าน	4	3	2	1
12. ท่านเน้นการพัฒนาทักษะความสามารถขั้นต่ำสุดเพื่อการจำหน่ายผู้ป่วยอย่างปลอดภัย	4	3	2	1

<u>ผู้บำบัด (ต่อ)</u>

	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
13. รูปแบบทางกิจกรรมบำบัดควรอยู่ภายใต้รูปแบบทางการแพทย์	4	3	2	1
14. ท่านเน้นการแก้ปัญหาที่เจาะจงของผู้ป่วย	4	3	2	1
15. ท่านใช้รูปแบบที่พิจารณาถึงคุณภาพชีวิต ความต้องการและผลของการทำกิจกรรมในชีวิตประจำวันของผู้ป่วย	4	3	2	1
16. ท่านใช้รูปแบบซึ่งเน้นความสามารถของผู้ป่วยในการแสดงบทบาทที่ผู้ป่วยและครอบครัวต้องการ	4	3	2	1
17. ท่านใช้รูปแบบที่มองมนุษย์โดยภาพรวมและเข้าใจผู้ป่วยในสิ่งแวดล้อมของเขา	4	3	2	1
18. ท่านเชื่อว่าการฟื้นฟูสมรรถภาพเพื่อให้ผู้ป่วยสามารถพึ่งพาตนเองในการทำหน้าที่ต่าง ๆ (Functions) ต้องใช้เวลานาน	4	3	2	1
19. ท่านใช้โปรแกรมการถ่ายโอนการรักษาจากโรงพยาบาลไปสู่บ้านและชุมชน	4	3	2	1
20. ท่านเตรียมโปรแกรมในชุมชนเพื่อส่งเสริมการดำรงชีวิตอย่างพึ่งตนเอง	4	3	2	1
21. ท่านส่งเสริมให้สมาชิกในชุมชนมีส่วนร่วมในโปรแกรมการฟื้นฟูสมรรถภาพในชุมชนของผู้ป่วย	4	3	2	1

<u>โปรแกรมการช่วยเหลือ</u>

กิจกรรม (Occupation) มีความหมายรวมถึง การทำงาน (work, productivity) กิจกรรมยามว่างหรือการเล่น (leisure, play) การดูแลตนเอง (self care: self maintenance; activity of daily living)

22. ท่านพิจารณาผลการทำกิจกรรมของผู้ป่วยตามสภาพแวดล้อมของเขา	4	3	2	1
23. ท่านพิจารณาผลการทำกิจกรรมของผู้ป่วยตามความต้องการของเขา	4	3	2	1

โปรแกรมการช่วยเหลือ (ต่อ)	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
24. ท่านเชื่อว่าการรักษาที่เน้นการแก้ปัญหาในแต่ละส่วนของผู้ป่วยจำเป็นต่อการเพิ่มการทำกิจกรรมที่เฉพาะเจาะจง	4	3	2	1
25. ผู้ป่วยเลือกที่จะชี้นำการฟื้นฟูสมรรถภาพของการทำกิจกรรมที่เฉพาะเจาะจง	4	3	2	1
26. ท่านช่วยผู้ป่วยพัฒนาทักษะที่จะบรรลุถึงเป้าหมายส่วนบุคคลของผู้ป่วย	4	3	2	1
27. ท่านเน้นการพัฒนาทักษะในชีวิตประจำวันของผู้ป่วย	4	3	2	1
28. ความสนใจของท่านมุ่งไปที่การพัฒนาทักษะในการทำ ADL	4	3	2	1
29. กิจกรรม (Occupation/Activity) ทำให้ผู้ป่วยของท่านสามารถบรรลุถึงศักยภาพของตนเองและสามารถกระทำบทบาทในกิจกรรมต่างๆ ของตนได้เป็นอย่างดี	4	3	2	1
30. ประวัติในการทำกิจกรรมของผู้ป่วยช่วยให้ท่านสามารถกำหนดและเสนอกิจกรรมที่มีความหมายได้	4	3	2	1
31. ท่านใช้การวิเคราะห์กิจกรรมในการออกแบบโปรแกรมการรักษา	4	3	2	1
32. กิจกรรมที่จัดเตรียมให้ผู้ป่วยควรสามารถนำไปใช้ในสภาพแวดล้อมที่บ้าน ที่ทำงาน และกิจกรรมยามว่าง หรือการเล่น	4	3	2	1
33. ท่านร่วมมือกับผู้ป่วยเพื่อช่วยให้เขาบรรลุถึงเป้าหมายของเขา	4	3	2	1
34. รูปแบบที่ท่านใช้ควรอยู่บนพื้นฐานของความต้องการที่ผู้ป่วยแสดงออกมา	4	3	2	1
35. ท่านมีบทบาทในการชี้นำและกำหนดเป้าหมายโปรแกรมการรักษา	4	3	2	1
36. ท่านเตรียมโปรแกรมการรักษาและทำตามโปรแกรมนั้นโดยอาศัยการความร่วมมือจากผู้ป่วย	4	3	2	1

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โปรแกรมการช่วยเหลือ(ต่อ)	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
37. ท่านดำเนินโปรแกรมการรักษาที่ตอบสนองต่อนโยบายของนายจ้าง (เช่น ผู้บริหารโรงพยาบาล, เจ้าของกิจการ เป็นต้น)	4	3	2	1
38. ท่านมุ่งเน้นการพึ่งพาตนเอง แต่ก็คำนึงถึงลำดับของสิ่งที่ผู้ป่วยให้ความสำคัญด้วย	4	3	2	1
39. ท่านระบุความต้องการที่เจาะจงของผู้ป่วย และทักษะที่เกี่ยวข้องกับการอยู่รอดในสังคม	4	3	2	1
40. ท่านทำงานอย่างใกล้ชิดกับครอบครัวของผู้ป่วยเพื่อให้บรรลุถึงเป้าหมายของผู้ป่วย	4	3	2	1
41. ถึงแม้เวลาจะมีจำกัดก็จะสังเกตและฟังสิ่งที่ผู้ป่วยและครอบครัวรายงาน	4	3	2	1
42. ท่านเริ่มต้นด้วยปัญหาของผู้ป่วยแล้วจึงเลือกใช้รูปแบบที่เหมาะสม	4	3	2	1
43. ท่านผสมผสานเป้าหมายของผู้ป่วยร่วมกับเป้าหมายของสถานบำบัดที่ท่านทำงานและนโยบายปัจจุบันของรัฐบาล	4	3	2	1
44. ผู้ป่วยของท่านเข้าใจเป้าหมายการรักษา	4	3	2	1
45. ในสถานบำบัดระยะเฉียบพลันท่านเน้นที่ความต้องการพื้นฐานที่จำเป็นสำหรับการจำหน่ายผู้ป่วย	4	3	2	1
46. ในสถานบำบัดระยะเฉียบพลันท่านเน้นที่เป้าหมายส่วนบุคคลของผู้ป่วยสำหรับการปรับตัวต่อรูปแบบการดำเนินชีวิต (life style)	4	3	2	1
47. ท่านกำหนดผลการรักษาอย่างชัดเจนสำหรับผู้ป่วย	4	3	2	1
48. ท่านคาดหวังว่าผลการรักษาควรสนองความต้องการของผู้ให้บริการด้านสุขภาพ (Health Providers)	4	3	2	1
49. ท่านคาดหวังให้ผู้ป่วยสามารถร่วมกิจกรรมภายในสิ่งแวดล้อมของเขา ตามระดับความสามารถที่มีอยู่	4	3	2	1
50. ท่านคาดหวังให้ผู้ป่วยกลับไปสู่สิ่งแวดล้อมที่ปลอดภัยโดยได้รับการช่วยเหลืออย่างเพียงพอ	4	3	2	1

โปรแกรมการช่วยเหลือ (ต่อ)	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
51. ท่านคิดว่าต้องมีการจัดเตรียมโปรแกรมให้ความช่วยเหลืออย่างต่อเนื่อง หลังจากจำหน่ายผู้ป่วย	4	3	2	1
52. ท่านเน้นการตอบสนองความต้องการของทั้งผู้ป่วย และสมาชิกในครอบครัวของผู้ป่วย	4	3	2	1
วัฒนธรรมและการนำไปใช้ หมายถึงความรู้ทั้งหมดที่มนุษย์เรียนรู้ในฐานะเป็นสมาชิกของสังคม ซึ่งรวมถึงค่านิยม ความเชื่อ และขนบธรรมเนียมประเพณีของครอบครัว ชุมชน และสังคม				
53. ท่านมีอิทธิพลต่อการเปลี่ยนแปลงทัศนคติของสังคมที่มีต่อภาวะความพิการ	4	3	2	1
54. ท่านเชื่อว่าผู้ป่วยควรคงสภาวะพึ่งพาตนเองให้ได้มากที่สุดเท่าที่เป็นไปได้	4	3	2	1
55. ท่านเชื่อว่าชาวตะวันตกให้คุณค่าต่อแนวคิดของการพึ่งพาตนเอง และการคำนึงถึงตนเองเป็นสำคัญ	4	3	2	1
56. ท่านเชื่อว่าผู้ป่วยพึงพอใจที่จะให้ครอบครัว และญาติดูแล	4	3	2	1
57. ท่านคิดว่าครอบครัวชาวตะวันออก และชาวไทยยึดถือวัฒนธรรมที่อยากจะดูแลผู้ป่วย หรือผู้พิการ	4	3	2	1
58. ท่านสามารถประยุกต์แนวคิดทางทฤษฎีจากวัฒนธรรมตะวันตกมาใช้ปฏิบัติการทางคลินิกในวัฒนธรรมตะวันออก หรือวัฒนธรรมไทยได้	4	3	2	1
59. ท่านไม่เชื่อว่าบุคคลที่พิการทางกาย หรือเจ็บป่วยทางจิตจะได้รับการมองว่ามีคุณค่าเป็นส่วนหนึ่งของสังคม	4	3	2	1
60. ท่านคิดว่าครอบครัวที่มีญาติพิการ ยังคงประสบกับความอับอายขายหน้า	4	3	2	1
61. ท่านคิดว่าสถานที่รับผู้พิการเข้าทำงานมีจำนวนน้อย หรือจำกัด	4	3	2	1
62. ในสถานบำบัดรักษา ท่านพิจารณาว่าผู้ป่วย และญาติให้คุณค่าต่อสภาวะการพึ่งตนเองอย่างไร	4	3	2	1

วัฒนธรรมและการนำไปใช้ (ต่อ)	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
63. ท่านพิจารณาถึงกลุ่มสังคม หรือวัฒนธรรมของผู้ป่วยว่าให้คุณค่าต่อสภาวะพึ่งตนเองอย่างไร	4	3	2	1
64. ท่านพิจารณาถึงความคาดหวังทางวัฒนธรรมของผู้ป่วย	4	3	2	1
65. ผู้ป่วยเป็นผู้ให้ข้อมูลในด้านความเชื่อทางวัฒนธรรม พลวัตของครอบครัว และความคิดเห็นของผู้ป่วยเองที่มีต่อความเจ็บป่วย	4	3	2	1
66. ท่านสนับสนุนให้ผู้ป่วยใช้ประโยชน์จากแหล่งข้อมูลและอุปกรณ์เครื่องใช้ที่มีอยู่แล้วในวัฒนธรรมของผู้ป่วย	4	3	2	1

ระบบ หมายถึง นโยบายของสถานบำบัดสุขภาพ ชุมชน และรัฐบาล รวมทั้งงบประมาณ สิ่งอำนวยความสะดวก และแหล่งข้อมูลต่างๆ

	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
67. ท่านทำงานร่วมกับรัฐบาล และ/หรือบริษัทประกันสุขภาพ หรือองค์กรเอกชน	4	3	2	1
68. ท่านทำงานร่วมกับองค์กรอื่นๆ ของรัฐบาล นอกเหนือจากองค์กรด้านสุขภาพ	4	3	2	1
69. ท่านมีผู้ป่วยเข้าคิวรออยู่ยาวเหยียด เนื่องจากการจัดลำดับความสำคัญภายในระบบองค์กรสุขภาพ	4	3	2	1
70. นโยบายของรัฐบาล และการขึ้นทะเบียนประกอบโรคศิลป์ มีผลกระทบโดยตรงต่อการทำงานของท่าน	4	3	2	1
71. มาตรฐานของการประกันสุขภาพที่มีคุณภาพส่งเสริมให้ผลการรักษาทางกิจกรรมบำบัดดีขึ้น	4	3	2	1
72. ท่านต้องรับ และจำหน่ายผู้ป่วยอย่างรวดเร็ว เพราะว่าบริการทางกิจกรรมบำบัดขึ้นอยู่กับเงินงบประมาณ	4	3	2	1
73. ท่านมุ่งความสนใจที่ผลลัพธ์ของโปรแกรมการรักษา	4	3	2	1
74. การถ่ายโอนโปรแกรมจากโรงพยาบาลไปชุมชนจำเป็นจะต้องทำให้ได้ผลอย่างจริงจังมากกว่านี้	4	3	2	1

คำแนะนำสำหรับการปฏิบัติงานทางคลินิก

1. กรอบแนวคิดทางทฤษฎีที่นำมาใช้ในการปฏิบัติงานทางคลินิกช่วย หรือเป็นประโยชน์ต่อท่าน สำหรับโปรแกรมการรักษาผู้ป่วย หรือไม่

   ☐ ช่วยเหลือ หรือเป็นประโยชน์

       เพราะว่า..

   ....

   ☐ ไม่ช่วยเหลือ หรือไม่เป็นประโยชน์

       เพราะว่า..

   ....

2. อะไรเป็นข้อจำกัด สำหรับการนำกรอบแนวคิดทางทฤษฎีที่มีอยู่ปัจจุบันมาประยุกต์ใช้ในประเทศไทย

   ....

   ....

   ....

3. โปรดระบุสิ่งที่คุณต้องการให้รวมอยู่ในกรอบแนวคิดใหม่สำหรับการปฏิบัติงานทางคลินิก

   ....

   ....

   ....

      ขอขอบพระคุณที่ท่านสละเวลาตอบแบบสอบภาพ ความช่วยเหลือของท่านมีประโยชน์อย่างยิ่งต่อการวิจัยครั้งนี้

APPENDIX I

Frequency Distribution of Generic Models of Practice by Clinical Work Areas.

Clinical work areas	Medical Model				Performance Model				Whole Person Model			
	WAOTs	%	ThaiOTs	%	WAOTs	%	ThaiOTs	%	WAOTs	%	ThaiOTs	%
Neurology	7.00	24.14	72.00	67.90	13.00	44.83	13.00	13.27	9.00	31.03	13.00	13.27
Paediatrics	5.00	14.71	75.00	75.00	17.00	50.00	11.00	11.00	12.00	35.29	14.00	14.00
Occupational Health	6.00	31.58	1.00	25.00	5.00	26.32	1.00	25.00	8.00	42.10	2.00	50.00
Aged Care	9.00	16.07	15.00	55.56	17.00	30.36	6.00	22.22	30.00	53.57	6.00	22.22
Community Practice	1.00	5.56	22.00	73.33	6.00	33.33	1.00	3.33	11.00	61.11	7.00	23.34
Hand & Upper Limb Rehabilitation	9.00	45.00	67.00	77.01	4.00	20.00	8.00	9.20	7.00	35.00	12.00	13.79
Health Promotion	2.00	20.00	22.00	81.48	3.00	30.00	2.00	7.41	5.00	50.00	3.00	11.11
Mental Health	5.00	15.15	0.00	0.00	13.00	39.39	0.00	0.00	15.00	45.46	0.00	0.00
Orthopaedics	9.00	40.91	62.00	75.61	8.00	36.36	8.00	9.76	5.00	22.73	12.00	14.63
Psychiatry	3.00	17.65	11.00	42.31	4.00	23.53	6.00	23.08	10.00	58.82	9.00	34.61
Clinical Medicine	6.00	66.67	21.00	77.78	1.00	11.11	3.00	11.11	2.00	22.22	3.00	11.11
Education	1.00	12.50	13.00	72.22	3.00	37.50	1.00	5.56	4.00	50.00	4.00	22.22
Private Practice	5.00	50.00	4.00	66.66	5.00	50.00	1.00	16.67	0.00	0.00	1.00	16.67
Chronic Pain	3.00	42.86	3.00	60.00	1.00	14.28	2.00	40.00	3.00	42.86	0.00	0.00
Early Intervention	4.00	23.53	26.00	89.65	6.00	35.29	2.00	6.90	7.00	41.18	1.00	3.45
Vocational Rehabilitation	7.00	38.89	0.00	0.00	6.00	33.33	0.00	0.00	5.00	27.78	0.00	0.00
Developmental Disability	4.00	19.05	72.00	77.42	10.00	47.62	7.00	7.53	7.00	33.33	14.00	15.05

APPENDIX J

Example of a Transcript of Western Australian Occupational Therapists (Group 2, Page 23)

I suppose mine would be to perhaps initially look at the environment and adapt it if possible. With necessary support to encourage the client to achieve their goals. Working closely with the family and everyone involved. Liaising closely with the team members and everyone else included that's required to try and support ---?--- support. And then at the end of the intervention referring that person on to other community (?) agencies ---------?---------.

Probably there are 3 sorts of interventions in the pediatric area at the skills of a child. So you're going to direct there and what the child can do within the ---?--- of different areas of developments. So you work through ADL (?), play and fine gross motor, motor skills, and social areas. So you're working on one level with child and the other things that I'd be working on would be parent strategies and parent/child relationship and above all that sort of hoping to have an impact in there somewhere. And then the other thing I do that is community based is then trying to get some links for that family if they need it within the community so it can be used in play groups and toy libraries, and getting them into ---?--- daycare or liaising with whoever to sort of set up a community base if that's something they want to and haven't been able to set up. So they would be major theories of intervention.

I'd probably say assessment and diagnosis related treatment and what that diagnosis necessarily is, the equipment prescription and the environmental adaptation. Home visiting and modifications in our setting.

In a pediatric setting I suppose it's very much addressing problems that the referral's based on. They're trying to improve those skills to the extent that they can click in a normal environment. That they could be home from school without losing esteem or you can just improve, or help them improve their skills--?--- I'll have a go at skills at a certain norm. Hopefully, that will make an impact on other areas such as their social confidence --?--- stresses and teacher stresses and all sorts of things. So I think of what we have and it reaches a wider audience.

Well that's actually led us very neatly onto the next question, which is what do you believe your clients gain or benefit from our team? And I think you've covered that in answers to the previous question. Would the others of you like to consider that question: what do you believe your clients gain or benefit from our team?

I think pediatrics nearly always, well certainly in the area that we're in now, which is perhaps multiple disabilities, certainly mild to moderate disabilities. You always see an improvement you know and so it's good to see people improving and getting better and being able to do more things. So that's one big area. The area is sort of working with the parents. It's usually more difficult to see sometimes whether you've made a shift in that. Very often you do and you see them using different strategies and being more positive about the child and understanding exactly what the cause of the problem is. So sometimes you do see a shifts in that, but it certainly is a harder area I find to work and get change and see change in. But you hope that there will be some changes in the parental attitude to child and the child's difficulties.

APPENDIX K

Example of a Transcript of Thai Occupational Therapists (Group 2, Page 4)

What are the constraints/benefits of the conceptual model you use in your practice?

The constraints might come from value, belief, culture and social environment. These constraints might be the barrier to get to the goal of treatment. In addition, these may obstruct the treatment program. So we should have the strategy to meet in the middle way between their benefit and the things we would like them to do.

Familiarity or good relationship makes the patients to depend on Occupational therapists. They believe that occupational therapists can run the treatment program for them better than they do by themselves. So they do not want to practice at home.

There are a lot of patiens, so only an occupational therapists cannot assess the big number of patients. Furthermore, the evaluative tests are quite detailed and take time. The other staffs in hospital are wondering why we can treat the number of patients less than they expected. In addition, if we run the prevocational training program, there is no place to accept patient to work because of the socio-cultural factors.

The patients believe that occupational therapists can run the program and train them better than they practise by themselves. They do not practise at home, so they get worse and worse. The program that we have already done for them, it is useless and waste time.

Patients respect occupational therapy so they will do as we taught them while they were staying in hospital. In contrast, they deny taking care themselves when they stay at home with their family members.

The benefit of models is to guide occupational therapists how to solve the children's problem. However, the program cannot be ongoing during vacation. During this time, the children are staying at home and their parents have no time to teach them.

What kind of outcome are you looking for in client intervention?

One of the constraints comes from the non-cooperation of clients in treatment program especially the clients who have low self-esteem. For example the elderly people do not value doing activities of treatment. They think their children should show gratitude by caring for them and it is time for them to rest.

The value and culture of Western people are independence. They have the value of independence more than Eastern people. The other thing is the social insurance system of ministry of public health. The clients will receive free service; hence they do not value the program of treatment.

One more thing, the policies of institutions have impacts on the treatment program.

APPENDIX L

Normality Test of Summated Scale

Tests of Normality	Kolmogorov-Smirnov		
	Statistic	df	Sig.
Client-Centred	0.167	292.000	0.000
Dependent Expectations	0.207	291.000	0.000
Clients' Expectations of Cure	0.224	287.000	0.000
Community Orientation	0.193	286.000	0.000
Reductionist Orientation	0.129	291.000	0.000
Clients' Orientation	0.168	293.000	0.000
Occupational-Guided	0.131	293.000	0.000
Therapist-Guided	0.219	290.000	0.000
Treatment-Focused	0.254	292.000	0.000
Client-Family Guided	0.160	292.000	0.000
Activities of Daily Living Guide	0.210	287.000	0.000
Clients' Support	0.205	287.000	0.000
Acute Setting	0.218	255.000	0.000
Demands of Employers	0.247	283.000	0.000
Reductionist Approach	0.261	256.000	0.000
Cultural Values and Independence	0.220	292.000	0.000
Societal Perception of Disabilities	0.174	289.000	0.000
Workplace Discrimination	0.264	290.000	0.000
Mutual Dependence	0.200	284.000	0.000
Changing Societal Attitudes Toward Disabilities	0.338	286.000	0.000
Legislation and Policy Impact	0.174	293.000	0.000
Funding Impact	0.285	280.000	0.000
Priorities in Health Care orWaiting List Impact	0.286	287.000	0.000
Interagency Cooperation	0.292	289.000	0.000

APPENDIX M

Factor Loading of Intervention Subscale

Results of Principal Component Analysis with Varimax Rotation of Intervention Subscale (Thai sample)

Items	Wording	Factor loading	
		I	II
35	I take the role of directing and setting goals for treatment programs		0.76
50	I expect clients to return to a safe environment with adequate supports		0.69
41	Despite the limited time I observe and listen to what the clients and their families report		0.51

APPENDIX N

Factor Loading of Cultural Implication Subscale

Results of Principal Component Analysis with Varimax Rotation of Cultural Implications Subscale (Thai sample)

Items	Wording	Factor loading I
63	I consider whether independence is valued by their cultural groups	0.73
62	In treatment, I consider whether independence is valued by clients and their family	0.72
64	I consider clients' cultural expectations	0.68
65	Clients are used as a resource in understanding cultural beliefs, family dynamics and clients' views of illness	0.63
61	There are limited workplaces to accept clients with disability	0.57
66	I encourage clients to utilise resource common within their own culture	0.53