Striving for Shared Understandings: Therapists' Perspectives of the Benefits and Dilemmas of Using a Child Self-Assessment

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ABSTRACT

Pediatric client-centered intervention planning is particularly complex because children, parents, and professionals must form a "tridactic" partnership and reach a shared understanding for therapy. Therapists may use child self-reports to facilitate children's involvement in this process. The purpose of this study was to understand how therapists used and interpreted a child self-report to achieve a shared understanding in the context of a tridactic relationship, using the Children's Occupational Self-Assessment (COSA) as an exemplar. Thirty-three pediatric therapists participated in five focus groups and qualitative analysis was conducted in four iterative phases. Therapists' decision to use the COSA led to either "good" responses or unexpected tensions between the therapist's, child's, and parent's perspectives. Therapists used demonstration, negotiation, or reflection to shift beliefs to achieve a shared understanding for therapy. Findings suggest that although therapists valued children's voices, professional knowledge usually took precedence over child and parent self-knowledge during intervention planning.

Client-centered practice is "an approach to services which embraces a philosophy of respect for, and partnership with, people receiving services" (Law, Babtiste, & Mills, 1995, p. 253). The profession of occupational therapy embraces these ideals (American Occupational Therapy Association, 2008) and the literature contains guidelines and strategies to support a client-centered approach to practice (Restall, Ripat, & Stern, 2003; Sumsion & Law, 2006). Even so, therapists report it is difficult to implement client-centered intervention planning. For instance, research indicates that resolving discrepancies between a therapist's and a client's preferred goal is a common barrier to client-centered practice (Mortenson & Dyck, 2006; Sumsion, 2004; Sumsion & Smyth, 2000; Wilkins, Pollock, Rochon, & Law, 2001).

In pediatric rehabilitation, the family-centered care model, which is similar to a client-centered approach, is cited as best practice (Hanna & Rodger, 2002; Lawlor & Mattingly, 1998). Intervention planning using a family-centered approach is particularly complex because children, their parents, and professionals must form a "tridactic" partner-

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ship (Gabe, Olumide, & Bury, 2004; Garth, Murphy, & Reddihough, 2009; Lawlor & Mattingly, 1998). Within this tridactic relationship, the child, parent, and therapist must collaborate to agree on the same vision for the outcome of intervention and the processes by which that vision will be achieved. Yet children often do not enter into the tridactic relationship with common goals. Several studies illustrate that children have unique needs and concerns that are not always recognized or shared by parents or other adults (Dunford, Missiuna, Street, & Sibert, 2005; McGavin, 1998; Missiuna & Pollock, 2000; O'Brien, Bergeron, Duprey, Olver, & Onge, 2009; Pollock & Stewart, 1998). In these instances, in addition to reconciling their professional goals with client-stated goals, therapists must be prepared to resolve discrepancies between children and their parents' goals for intervention.

Reaching a genuine "shared understanding" (Cohn, Tickle-Degnen, & Gavett, 1998) in a tridactic relationship would require all those involved to express their way of knowing, understand another's way of knowing, and negotiate between professional knowledge and "expert self-knowledge" (Sumsion & Law, 2006, p. 156). However, this negotiation requires professionals to share and even relinquish power when collaborating with children and parents to determine priorities for intervention (Lawlor & Mattingly, 1998). Relinquishing professional authority over decision-making may be especially difficult within the health care context, in which both clients and professionals are accustomed to deferring to professional expertise (Abberley, 1995; Sumsion, 2004; Sumsion & Law, 2006; Townsend, 2003). Further, children's stated needs and goals for therapy may not carry the same weight as those of adults when determining intervention priorities. Minimization of the child's perspective may be related to the developmental approach common in contemporary practice that views children, and especially children with disabilities, as less competent and dependent on adults (Mayall, 2004; Priestley, 2003). As a result, children's expert self-knowledge about their lived experience (James, Jenks, & Prout, 1998; Mayall, 2004) may be less valued than professional recommendations or parent priorities during intervention planning.

Few studies have examined the methods by which professionals, parents, and children achieve a shared understanding in health care planning. In one study, pediatricians indicated they often withheld information from children and let parents determine the degree to which children participated in medical decision-making (Garth et al., 2009). Charles, Gafni, and Whelan (1997) noted that pediatric service providers may corroborate with parents to persuade the child in one direction or form a coalition with the child to advocate for a course of action not endorsed by the parent. These service providers place themselves at the center of negotiation and, as a result, maintain their professional power (Gabe et al., 2004). However, these studies do not consider what happens when professionals use specific strategies to actively enable children's involvement in the intervention planning process. There is a need for a deeper understanding of how client- and family-centered strategies impact the process of achieving a shared understanding within tridactic partnerships.

Self-report assessments are one strategy that can be used to facilitate collaborative intervention planning. In the context of tridactic relationships, child self-reports offer a concrete means to solicit and potentially to understand the child's self-knowledge. Child self-reports facilitate children's expression by asking questions that are meaningful to children and by enabling children to communicate in ways that are more developmentally appropriate. By eliciting children's input, self-reports may help children negotiate power differentials inherent in child–adult interactions (James et al., 1998). The purpose of this study was to understand how therapists used and interpreted a child self-report to achieve a shared understanding in the context of a tridactic relationship. Attending to the extent to which professional power and ways of knowing are privileged or relinquished during this process may help us better understand how and why therapists report difficulties with client-centered intervention planning. This process was explored using one self-report as an exemplar, the Children's Occupational Self-Assessment (COSA) (Keller, Kafkes, Basu, Federico, & Kielhofner, 2005).

Methods

This study used focus groups to explore therapists' perspectives regarding the COSA and collaborative intervention planning. A major strength of the focus group approach is the ability to use multiple narrative types such as jokes, clinical stories, and interactions between members as informational sources that are dynamic and contextualized (Kitzinger, 1995). A resulting benefit is that these group dynamics can be used to describe not merely what people think, but to investigate how they think and why, offering a richer understanding of a phenomenon (Frank & Polkinghorne, 2010; Kitzinger, 1995).

The COSA measures the self-perceptions of children with disabilities (ages 6 to 17 years) regarding

Table 1
Participant Demographics (*N* = 33)

Characteristic	Frequency
Location of therapist	
UK	10 (30.3%)
US	23 (69.7%)
Discipline	
Occupational therapy	28 (84.8%)
Physical therapy	5 (15.2%)
Primary setting	
Inpatient hospital	1 (3%)
Outpatient hospital	3 (9.1%)
School-center	12 (36.4%)
School-mainstream	16 (48.5%)
Other	1 (3%)
Female gender	32 (97%)
Highest academic degree	
Trade certification	1 (3%)
Associate's	3 (9.1%)
Bachelor's	16 (48.5%)
Master's	13 (39.4%)

the importance of and their competence with 25 everyday activities related to self-care, social interaction, learning, and playing. The COSA guides therapists to explore items for which children report high importance but low competence as potential activities to address during intervention. The administration of the COSA may be modified to ensure a child understands and can access the content. Previous research suggests that the COSA has good psychometric properties when used with children with a range of disabilities and ages (Kramer, Kielhofner, & Smith, 2010; Kramer, Smith, & Kielhofner, 2009).

Participants

Convenience sampling was used to recruit professionals using the COSA in practice for at least 3 months. The first author invited individuals contributing COSA data for another study and also recruited through supervisors supporting (but not mandating) the use of the COSA through flyers, e-mail, and in-person invitations. A total of 33 therapists participated in five focus groups (Table 1). Therapists had 1 to 33 years of experience working in their practice discipline (mean = 18.6 years, standard deviation = 10.7 years) and on average used the COSA for 9 months prior to the focus group (mean = 9.4 months, standard deviation = 8 months). Three focus groups in the United States were held with teams of therapists, two groups included professionals employed by a large school district, and a third focus group included professionals employed by a private mental health service agency offering a range of services. In the United Kingdom, focus groups included teams of therapists and individual therapists held during 1-day workshops conducted on the COSA. All participants volunteered to use the COSA.

Procedures

Recruitment and data collection occurred after institutional review board approval was secured from the University of Illinois at Chicago, the primary research site. All focus groups were facilitated by the first author. The facilitator obtained consent and reviewed ground rules before each focus group. A semi-structured interview guide included specific questions about the COSA and related to barriers to client- and family-centered practice as identified in the literature. After each focus group, questions and probes were refined based on information shared in the previous group. Focus groups were approximately 60 to 90 minutes and were audio recorded. After each focus group, the recorded conversation was transcribed verbatim without identifying information.

Analysis

Formal analysis of transcribed data occurred after all focus groups were held. The data analysis process for this study took place over a period of a year and a half, and was hallmarked by periods of data immersion, removal, and return, and the inclusion of additional researchers (Fig. 1). Dickie (2003) noted the value of making explicit the many legitimate ways of analyzing qualitative data, particularly the questions and "confusions" (p. 52) that guide the analytical process. The first author and her collaborators engaged in four iterative phases of data analysis, each guided by a new research question. Throughout these phases of data analysis, codes were refined or interspersed with codes from other periods, and reorganized to move from a structure that represented descriptive content to a structure that represented both process and meaning (Kearney, 2001).

Analytical phases one and two used line-by-line coding following a constant comparison approach (Miles & Huberman, 1994). Descriptive codes were identified first and described the action or content occurring in the data. Transcripts were read a second time to generate interpretative codes. Interpretive codes required the researcher to interpret the meaning, assumptions, and values underlying a clinical story or expressed viewpoint. As each consecutive

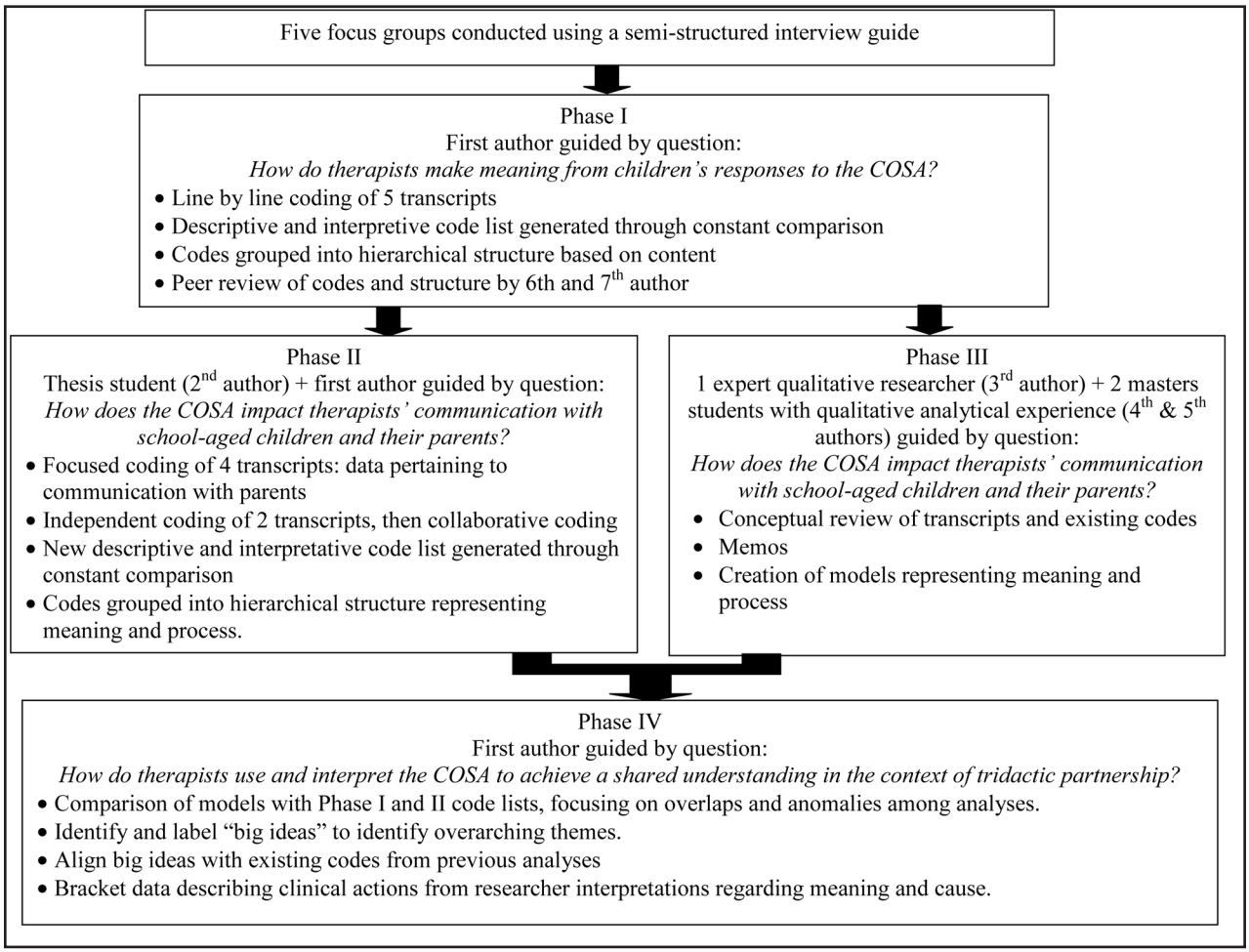

Figure 1. Process of data analysis. COSA = Children's Occupational Self-Assessment.

transcript was read, an iterative process of code refinement occurred by comparing new information with the existing code list and considering whether new codes needed to be developed or whether previously generated codes were adequate.

Concurrent with the second analytical phase, a team conducted a conceptual review of the transcripts and existing codes. This team provided written memos and generated draft models illustrating relationships between codes. In the final phase of analysis, the first author compared conceptual models and existing code structures to answer the final research question. The final thematic structure was generated by identifying patterns in the relationships between concepts (Miles & Huberman, 1994). The researcher interpreted this thematic structure by examining discrepancies or concordances between the descriptions of what therapists said and the meanings, values, and assumptions inherent in their clinical stories (Frank & Polkinghorne, 2010). This final interpretation was reviewed by the full analytical team.

Findings

The findings describe how the therapists' decision to use the COSA led to either "good" responses ("good" was a term used by therapists across groups to describe children's COSA responses) or unexpected tensions between the therapist, child, or parent perspective in the process of collaborative intervention planning (Fig. 2). When unexpected tensions emerged, therapists used demonstration, negotiation, or reflection to shift children's, parents', or therapists' beliefs. This shift in beliefs was essential to achieving a shared understanding of therapy priorities and goals within the tridactic relationship.

Therapists' Decision to Use the COSA

Value for the Child's Voice. Therapists purposefully sought to elicit the child's point of view about needs and goals. The COSA was a tool that enabled therapists to demonstrate their value for children's

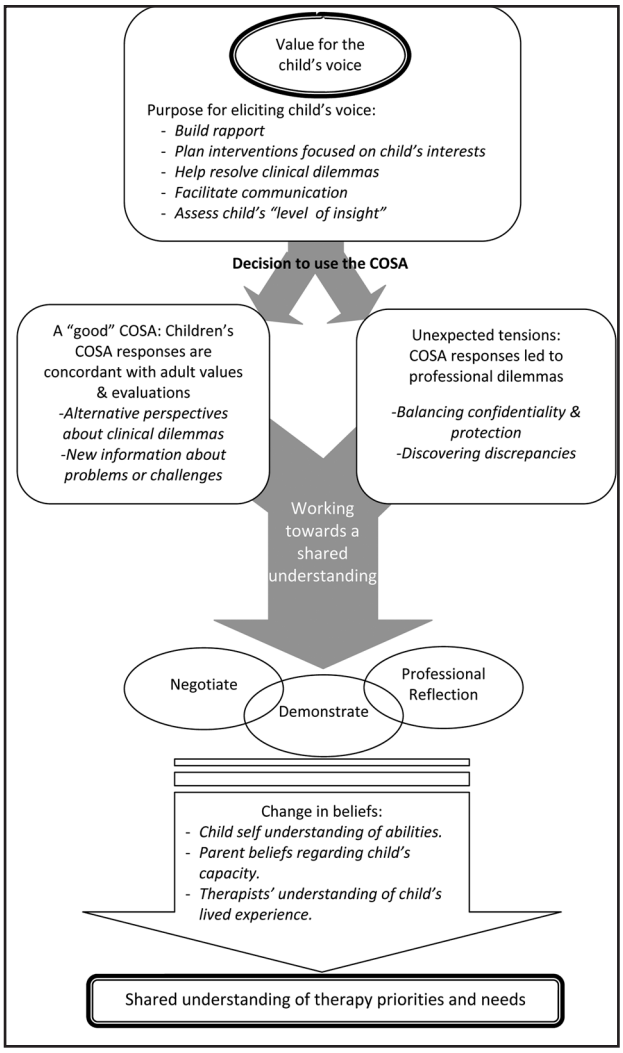

Figure 2. Therapists' perspectives of the process of achieving a shared understanding within the tridactic relationship using the Children's Occupational Self-Assessment (COSA).

involvement in the intervention planning process. This was a common theme across focus groups, as represented by the following quote (brackets added by authors): "This [the COSA] actually gives [children] a voice" (Focus group 4). The COSA provided therapists the opportunity to elicit the child's voice in situations where it had not previously been considered: ". . .no one ever really asked the kids what they wanted to do. They came in with all the problems from parents, and school" (Focus group 1). The COSA became a mechanism for therapists to operationalize and demonstrate to the child and others their respect for the child's perspective.

Purposes for Eliciting the Child's Voice. Therapists had five common purposes for eliciting a child's perspective by means of using a self-report. Table 2 contains clinical stories illustrating each purpose: build rapport, discover children's interests, resolve clinical dilemmas, facilitate communication among multiple team members, and assess each child's "level of insight."

A "Good" COSA: Children's Responses Are Concordant With Adult Values and Evaluations

Sometimes the child's responses on the COSA aligned with adult values and evaluations of the child's needs and abilities. Therapists referred to these self-reports as "good" COSAs. Although the child's conceptualization of the situation might differ slightly from the adult's, the child's perspective was ultimately used to make progress toward a therapeutic outcome endorsed by adults. For example, one therapist explained how she received a referral to evaluate a child who only ate Coco-Puffs™. The child's parents and other adults wanted to expand his food repertoire. However, the child's alternative perspective on the situation quickly changed the therapist's approach to dealing with this clinical dilemma:

> We did the COSA and he thought his eating skills were awesome. And so this team was sort of relying on me to come up with some strategies to figure out how to get him to eat other things. . .but he was just not interested. . .and what I did discover is that he values healthiness. So what we were able to do was put together a whole nutritional education program that the whole team is working on with him to teach him about having a healthy body. (Focus group 3)

In this story, the child's value for "healthiness" was in concert with the adults' concerns surrounding his restricted diet. The adults and child quickly achieved a shared understanding; they shifted from a focus on increasing the number of foods eaten to a focus on health.

In other instances, children shared information about problems or challenges that were unknown to adults. In this instance, information from the COSA enabled the team to provide the child with the needed support. Sleep emerged as an example of a problem that children faced but of which adults were unaware. Children's sleep is important due to the connection between sleep and well-being (American Occupational Therapy Association, 2008). Therefore, the information obtained from the child about sleep was then used by the team to identify a new shared priority for intervention.

In both of these instances, the information obtained using the COSA did not conflict with adults' perceptions of the child's needs or abilities. Rather, children's responses provided adults with an explanation or bet-

Table 2
Therapist Purposes for Eliciting Children's Voice

Stated Purpose	Illustrative Quotes[a]
Build rapport	"I really used the COSA to start with to kind of build rapport with the children." (Focus group 1)
	"I explained to [the child] why we were doing what we were doing, and how it was in their best interest…it was something that they were gonna gain from it." (Focus group 3)
Plan interventions focused on children's interests	"I also used it to try and motivate, to find a way to motivate a child to engage." (Focus group 2)
	"In open ended questions…it leads into conversation about what their likes and dislikes are, so again, as you are working you can pair it back to something that's of interest for them." (Focus group 3)
Help resolve clinical dilemmas	"The team has been just battling…the kid's declining and they're kind of wondering 'Is he cycling, is this what he does every couple of years?' And the team is really struggling…we're going to give [the COSA] to him so that we can try to help see if we can figure out some of those questions." (Focus group 5)
Facilitate communication among parents, children, and other professionals	"[The child] was being overburdened with homework, and so that conversation was able to come out between home and the teacher…. I was just able to spark someone else to take care of the problem." (Focus group 3)
	"I really I feel like I've gotten so much valuable information to share with students, parents, teachers, and everyone within the IEP [Individualized Educational Plan] team so far has been very pleased to hear the child's viewpoint. It's like, we didn't think of this before?" (Focus group 4)
Assess child's "level of insight"	"I was surprised that one person didn't have the insight I thought they would have…that, in itself, is useful information." (Focus group 2)
	"Now another student…his [COSA] came out so good, in terms of him being right on target with what his problems were." (Focus group 4)

[a]*Brackets added by authors.*

ter understanding of the difficulties children faced in their day-to-day lives and provided information to support adult-identified intervention priorities.

Unexpected Tensions: COSA Responses Lead to Professional Dilemmas

Balancing Child Confidentiality and Protection. During the COSA, children sometimes shared sensitive information that revealed they were at risk and vulnerable to potential harm. Therapists then needed to decide whether they would honor the child's confidentiality or take steps to protect a child by sharing the information with other professionals or parents. One therapist shared:

> [The young man] didn't realize he was in a situation that was potentially an abusive situation. . . . [H]e disclosed that he was having under-aged sex, but he didn't realize that was a problem 'cause the woman involved was 18. . . . [The COSA] was a way of actually helping him to understand his rights and responsibilities (Focus group 2).

In this scenario, the therapist made the decision to not report the information to other professionals. However, some therapists reported situations in which they felt compelled to share children's reports with other professionals. Usually this occurred when the information shared by the child suggested he or she was in imminent bodily harm as required by law. For example, one therapist in Focus group 4 reported passing on information to a social worker when a child said he wanted to kill himself.

In other situations, children were concerned about the confidentiality of their responses while completing the COSA. This often occurred when children told therapists negative stories about their parents or other family members. Therapists also reported that children did not want therapists to share information with other professionals out of fear that the information would be used to increase their time in intervention, take away things that they cared about, or result in disciplinary action. For example, one therapist described: "I had an eighth grader I gave it to, he was actually concerned about how [responses] might be used against him—so I had to use it more for. . .my information at that point. . . . I mean, I've honored it" (Focus group 4). For this therapist, the benefits of the trust and rapport outweighed any po-

tential risk posed to the child or to herself as a professional for withholding his information.

Discovering Discrepancies. Discrepancies occurred when the child's self-report or parent's beliefs about his or her child did not "match" the therapist's evaluation of a child's abilities or limitations. Therapists frequently described instances in which children's responses on the COSA were "incorrect" or "lacking insight." For example, one therapist explained how her initial expectations for how the COSA would be used by a child were not met, causing her to question the meaning underlying the child's reaction:

> I was surprised that he didn't have as much insight as I expected. . . . 'Cause there was one question about attention. . .he ticks it that he is really good at it. . .and I did actually go "really?!" And he looked at me, and he gave me such a cheeky smile and carried on. . .but it's just the way he kind of looked at me and gave me the smile, I thought, I wonder what's going on there then? (Focus group 2)

This therapist assumed that the child shared her professional evaluation of his difficultly maintaining attention. However, his responses required her to question her previous understanding about the child.

Sometimes the process of completing the COSA with a child revealed discrepancies between the therapists' and parents' beliefs about a child's capacity for skill development. For example, based on a discussion following a child's response to an item about chores a therapist discovered: "One of the girls who said she hadn't done chores [because] the mother was fearful of her using knifes in the kitchen. . . . So she couldn't even make herself a peanut butter and jam sandwich if she got hungry. . . ." (Focus group 3)

However, the therapist believed that the child had the capacity to learn to fix simple meals and that it was an important skill to develop. In this story, the therapist encountered an unexpected response on the COSA because the parent's belief about the child's capacity did not match the therapist's evaluation of the child's potential. When the child's responses to the COSA revealed discrepancies within the tridactic partnership, therapists had to take additional steps to reach a shared vision for therapy.

Working Toward a Shared Understanding

Negotiate. Therapists negotiated with children and their parents regarding the process and goals of therapy. In some instances, the therapist had to act as a mediator between the parent's desired goals for therapy and the child's interests or concerns. For example, one therapist told a story in which she negotiated between a child's goal to make friends and his parent's concerns about his motor skills: "So it was looking at finding community-based things, and suggesting some things that the family could do together that work on the social aspect as well as motor skills" (Focus group 2). This negotiation required the therapist to identify therapeutic activities that achieved the child's and the parents' desired outcomes for intervention.

At other times, therapists negotiated directly with children. In one school setting, where a student had been working on handwriting for several years, the therapist described how she and the child negotiated a new goal for therapy while discussing his COSA responses:

> I said, 'I'll make a deal with you—if you can read cursive, you don't have to write it.' He picked up a book immediately, and one of the cursive books—he read every sentence in there—I said 'end of statement, we'll go someplace else now'. . . . We made a deal, we talked to mom, [who] said it's fine. (Focus group 4)

Negotiation was also used with children to determine activities for therapy: the child was provided with the opportunity to work on something he or she cared about as long as that child agreed to also work on something important to the therapist or parent. These examples illustrate that therapists often required children to first demonstrate or agree to an adult-endorsed goal before the child's goal was incorporated into therapy.

Demonstrate. Another way that therapists worked to reach a shared understanding was through the process of demonstration. Therapists often used "doing" as a way to demonstrate to parents the child's capacity to learn the skills needed to do an activity. Therapists created scenarios in which the child received the support needed to complete an activity that a parent had previously thought not possible. For example, one therapist discovered a young girl wanted to be able to make her own drink and snack but her mother wanted to avoid the risk of harm in the kitchen:

> [The girl] did cooking a healthy snack group with me in school time. . .then mom was like, 'well, she can't do that', and it's like I've seen her doing it. . . . And I ended up going home with her over the summer holiday, and did some cooking sessions with her, and actually made a ham and cheese toasty and a cup of tea for mom. And mom was in tears 'cause it's the first cup of tea she made for her. And I said, 'You know, it's gonna take her time, and she's gonna need to be guided and have supervision and support—but she can do it.' (Focus group 1)

This demonstration was only a starting point in what the therapist believed were this girl's capaci-

ties if provided with support and opportunities to practice. The end of this story also reveals that the demonstration changed this mother's beliefs regarding her daughter's capacity for cooking.

Therapists also used demonstration to enable children's self-reflection of their current ability to perform specific tasks. Therapists used this approach when they believed children's responses on the COSA reflected limited insight. One therapist explained how she used demonstration with a 17-year-old client who was in residential treatment:

> I said, 'Why don't you show me how you do your laundry. . . . You say you're really good at this'. . . . And he walked into the [laundry] room and I thought he was going to cry. . . . And what that told me was, he doesn't have the skills. . .I was challenging him in his answer. . . I basically said, 'Well, you sound like you really want to know how to do your laundry. . . . Come on over here, let me show you. . . .' And we made it kind of into a game. (Focus group 5)

This therapist's story illustrates that the demonstration was also a starting point for a shared vision in which the young man would work to acquire skills needed to successfully perform this new activity.

Professional Reflection. Therapists' clinical stories suggest that they used negotiation and demonstration to change the perspective of the child or parent. In contrast, some therapists noted that unexpected tensions provided them with the opportunity to reflect on professional values and assumptions and question the limits of "professional" knowledge:

> It's a tool that makes you very reflective of yourself and your own value base. (Focus group 2)

> It kind of puts you in that kid's shoes. . . . [W]e often color everything with our perspective. . .we're saying with these kids with physical disabilities who can't do certain things with their bodies. . .they may see it from a different point of view. (Focus group 4)

Therapists' clinical stories suggest that self-reports such as the COSA reminded them what was important in a therapeutic relationship. This included being client-centered and creating a relationship that was positive and encouraging to the children. In some cases, engaging in reflection and re-connecting with the values of client-centered practice led therapists to change their own beliefs about a child to achieve a shared understanding of the therapy goal.

Shared Understanding

A shared understanding of the child's needs and priorities of therapy was achieved when one or more partners in the tridactic relationship understood another individual's way of knowing and shifted their beliefs accordingly. A therapist working in a school context shared a clinical story that illustrates the process of achieving a shared understanding:

> This is a second grader who had been working on fine motor kinds of things forever. And I did the COSA and. . .she recognized where her weaknesses were but at the same time it didn't align with her values at all. . . . [O]ne of the things that she talked about was that really all she wanted to learn to do was to put her clothing on her Barbie™ dolls. . . . I shared the results with the family, and the mom was initially kind of skeptical about it, and eventually we sort of designed this to be a home program around some of the. . .the Barbie™ doll stuff. And within. . .a very short period of time, the mom called me, she was tearful, and saying that her daughter had her first play-date with other girls, that they played Barbies™. . . . And then since then, there has just been remarkable change in what I see in the classroom around her [activities of daily living] skills and her written output. . . . (Focus group 3)

This story illustrates how the therapists' use of the COSA to resolve a clinical dilemma revealed new information about the child's lived experience. The therapist then negotiated with the child's mother to advocate for a new focus of therapy that aligned with the child's values and interests. The child, parent, and therapist then achieved a shared understanding of both the priorities for intervention and the child's ability.

Discussion

In occupational therapy, the professional commitment to client- and family-centered practice puts forth collaborative intervention planning as best practice (American Occupational Therapy Association, 2008). In the ideal collaborative relationship, therapists, parents, and the child all contribute expertise that shapes the course of intervention. However, the stories shared by therapists in this study suggest that even when therapists valued children's voices and used self-reports to facilitate children's participation in the intervention planning process, professionals were not always receptive to understanding the child's or parent's way of knowing (Sumsion & Law, 2006). As a result, professional knowledge usually took precedence over child and parent expert self-knowledge during intervention planning. These findings raise questions about professional power and when professional or expert self-knowledge should be privileged during the decision-making process in therapy.

In this study, therapists' use of the COSA was driven by a core value to consider children's perspectives. In keeping with the tenets of client-centered practice (Law et al., 1995), therapists thought that self-reports helped them to better understand a child's lived experience and provided an opportunity to build rapport. However, therapists' stories suggest that children's self-knowledge was most easily integrated into intervention planning when it provided therapists with information that augmented and supported their professional knowledge. As in previous studies exploring the challenges of client-centered practice, therapists in this study found it difficult to resolve discrepancies between the child's, parents', or therapist's beliefs about the child's current abilities and capacity for future activity performance (Mortenson & Dyck, 2006; Sumsion & Smyth, 2000; Wilkins et al., 2001). Therapists handled these discrepancies in one of two ways.

The first approach was to operate under the assumption that professional expertise provided the most appropriate assessment of the situation and to use professional knowledge to resolve the discrepancies (Abberley, 1995; Lawlor & Mattingly, 1998; Mortenson & Dyck, 2006). For example, therapists' descriptions of children's responses as more or less insightful illustrate one way in which professional evaluation was maintained as the most "correct" evaluation. Another example of therapists' value for professional knowledge occurred when therapists constructed clinical activity scenarios to demonstrate that a child's performance aligned with the therapists' evaluation, rather than the child's or the parent's beliefs. Therapists used professional skills such as task equivalence, task analysis, and supported performance to help children complete new activities therapists believed were possible and developmentally appropriate, such as make a cup of tea. In other instances, therapists withheld support to make an activity more difficult and to demonstrate a child's lack of ability to complete an activity, such as doing laundry. Demonstrations often provided the "proof" parents or children needed to shift their beliefs about the child's current ability or future capacity for an activity. As a result, these demonstrations validated professional expertise and understanding of a child's needs. This allowed therapists to encourage parents and children to take a "professionalized" view (Allan, 1996; James et al., 1998) that valued professional ways of knowing over the lived experience.

The second approach therapists took to resolve discrepancies was to embrace the opportunity to reflect on their professional assumptions about disability and rehabilitation. Identifying and solving problems in rehabilitation, such as resolving discrepancies within a tridactic relationship, is an inherently complex and socially constructed process (Cohn, Boyt Schell, & Crepeau, 2010). In this study, reflection provided therapists with the opportunity to critically evaluate the power underlying the decision-making process, and to take actions to shift power as needed to children. This was often as simple as remembering to ask what the child wanted to achieve, particularly in residential or long-term–care practice settings where the professional gaze permeates most facets of the child's life (Allan, 1996). As one therapist expressed, "we forget to ask them" (Focus group 5); the COSA was a reminder that each child possessed his or her own unique interests and desires. Reflective therapists were aware that children's lived experience was one type of knowledge that they, as professionals, could never achieve, and needed to respect and consider. For reflective therapists, the use of a self-report, in this instance the COSA, enabled an explicit evaluation of power and professional knowledge within the collaborative intervention planning process.

These findings suggest that self-reports such as the COSA, when used alongside professional reflection, may facilitate a shared understanding within the tridactic relationship that more authentically incorporates the voice and expert self-knowledge of the child. Yet the findings also contain a therapeutic "cautionary tale." That is, without professional reflection, the use of the COSA may enable therapists to construct a clinical story in which power appears to be shared with the child while the authority of professional knowledge is maintained.

Following a professional's recommendation for intervention does not inherently contradict a client-centered approach. In fact, one outcome of a client-centered approach is a client choosing to follow a professional's recommendations (Ballard-Reisch, 1990; Sumsion, 2004). In these instances, the client exercises his or her power within the relationship and makes an explicit decision to follow a professionally recommended course of action. However, if therapists assume that the use of a self-report automatically authenticates a child's power within the tridactic relationship, they may be less likely to explicitly discuss decision-making with children and more likely to assume their professional recommendation appropriately accounts for the goals and concerns of children. Without explicit discussion, children and parents are not given an opportunity to exercise their decision-making power to defer to professional knowledge over

self-knowledge; rather, using a self-report provides a semblance of shared power without engaging in the discussion and compromise necessary for collaboration (Cohn et al., 2010; Lawlor & Mattingly, 1998). Although self-reports are a vehicle by which collaborative intervention planning can occur, they do not, in and of themselves, ensure a collaborative process. These findings stress the importance of critical professional reflection throughout the intervention planning process, particularly in the context of a tridactic partnership.

Limitations and Future Research

During focus groups, therapists' comments and stories were sometimes truncated by other therapist's remarks, or not fully probed to their potential, which may have limited the depth and quality of the data used for this analysis. Due to their involvement in another study, the therapists who participated in this study were familiar with the researcher and participated in focus groups with their co-workers. One potential impact may have been that therapists recounted their stories in a way that highlighted their perceived successes. Alternatively, therapists may have focused on retelling stories that placed more of a demand on their clinical skills, regardless of the outcome. These possibilities may have influenced data by over-representing cases that required the more extreme examples of negotiation, reflection, or demonstration, or that had "successful" outcomes in terms of achieved a shared understanding.

Because this study did not interview children or conduct real-time observations of therapists, the extent to which therapists' shared stories reflect actual practice is unknown. Future research should complement therapist interviews with children and parent interviews and observations to better understand the nature of collaborative intervention planning in tridactic relationships. This research could also explore specific instances in which professional versus expert self-knowledge is privileged during therapy decisions to better understand the types of decisions for which different ways of knowing may be most appropriate. Further, the findings do not consider the influence of time, reimbursement requirements, or regulations on therapists' use and interpretation of the COSA. Descriptive survey research could be used to explore the external factors that influence the use of pediatric self-reports. Finally, this study only asked about the COSA; other self-reports may lead therapists to have different perspectives on collaborative intervention planning.

Conclusion

Child self-report assessments such as the COSA are one strategy that can be used to facilitate collaborative intervention planning with children and families. However, self-reports do not, in and of themselves, ensure a collaborative process. Strategies such as negotiation and demonstration may maintain professional authority during intervention planning. Professional reflection regarding the power of professional knowledge and the value of children and parents' self-knowledge may enable therapists, children, and parents to achieve a shared understanding that more authentically incorporates the voice and expert self-knowledge of the child.

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