No. 1, Vol. XIII /2012

G Y M N A S I U M

Scientific Journal of Education, Sports, and Health

FAMILY-CENTERED OCCUPATIONAL THERAPY; IS IT REALLY APPLIED?

Seppänen Ulla-Maija [1]*,
Rata Marinela[2],
[1]*MScOT Oulu University of Applied Sciences, Oulu, Finland*
[2]*"Vasile Alecsandri" University of Bacau, 157 Marasesti Av., Bacău, 600115, Romania*

Keywords: *family-centered, occupational therapy, competences*

Abstract

Over the years attitudes and believes about what is the role of parents in occupational therapy intervention has been changed. Family-centered occupational therapy is approach that is based on the believes, values and preferences of each family as a unit. Working with families is always context related and the aim is to empower the family system.
Purpose. Is to find out if there is connection between the principles of family centered occupational therapy and the competences for occupational therapist. Method. Analyzing the concepts connected with family centered occupational therapy and competences in practice according to literature. Comparing the information in order to identify the possible gaps and similarities.
Results. The concept of family-centered is wildly used, but it is more connected with client's needs than to focused on the dynamic and quality of life of family as a system. Competences for occupational therapy shouldn't only be focused on needs of individuals and groups.

1. Introduction

For years in pediatric occupational therapy and rehabilitation in general, the principles of family-centered approach has been recognize to be the basis when providing services. Family-based approach is focusing on the main principle that parents are the best experts of their children. (Hanna & Rogers, 2000.) It is also emphasized that the best way to promote the occupational performance of a child is to underpin the importance of family, immediate social network and their resources (Eglison, 2010).

It is well known fact that the home environment is a major source of stress and relapse. Even knowing that, mental health occupational therapists do not traditionally provide family work. Relapse is far more prevalent in environments with high expressed emotion. That is why the goal of family work is to reduce expressed emotion. Fitzgerald , Ratcliffe & Blythe (2012) found the occupational

* *E-mail*: ulla-maija.seppanen@oamk.fi

therapists suits well to provide family work because of unique skills in environmental modification and behavioral management. In order to enable successful discharge of the service user to the home could therefore be a valued service offered by occupational therapists. (Fitzgerald, Ratcliffe & Blythe, 2012.)

Definitions of professional competence are hard to define (Epstein & Hundert, 2002). It is perceived by occupational therapists to be difficult to assess and to have ill-defined standards (Courtney & Farnworth, 2003). In Europe TUNING Educational Structures started in 2000 as a project to link the political objectives of the Bologna Process and at a later stage the Lisbon Strategy to the higher educational sector. Tuning has developed into a Process, an approach to (re-)designing, develop, implement, evaluate and enhance quality first, second and third cycle degree programmes. The Tuning outcomes as well as its tools are presented in a range of Tuning publications, which institutions and their academics are invited to test and use in their own setting. The Tuning approach has been developed by and is meant for higher education institutions. (http://www.unideusto.org/tuningeu/ .)

2. Materials and methods

In different countries in Europe, there are standards, competences and guidelines used specially in one country. Code of ethics is a typical example of that, since most of countries have their own code of ethics for occupational therapists. In code of ethics it is also often defined what are the competences that occupational therapist should be able to follow. One of the competences that is found often is the capability to work autonomously. A study by Fawcett and Strickland (1998) indicated that occupational therapists thought that a key outcome of continued competence was the ability to practice autonomously. Safe practice is also a hallmark of competent practice (Allen, Oke, McKinstry & Courtney, 2005). Those occupational therapists that are probably the most autonomous of all, private practitioners, have identified that there are barriers to maintaining professional competence inherent in their role including professional isolation, time and finances (Courtney & Farnworth, 2003). Professional isolation has been identified as a risk factor for poor performance in other health fields, most notably medicine (St George, 2006).

Cultural competence promotes equity in health care outcomes and ensures that occupational therapists support clients in culturally relevant daily activities. Four major themes emerged from the data: (1) learning about culture; (2) applying cultural knowledge; (3) reflecting on culture; (4) family-centred partnerships. The first three themes occurred as a dynamic learning process within the context of family-centred partnerships (Wray EL & Mortensen PA, 2011).

After a mater research Case-Smith J. (2007), in the family practicum context, through qualitative analysis of the students and involved families, four themes emerged: (1) acknowledge that parenting a child with a disability is a 24/7 job; (2) recognize that internal and external resources are essential to

family adaptation; (3) respect parents as the experts on their child; and (4) accept the family's values. These themes were validated by the families' evaluation of the practicum and provide evidence that students grew in their appreciation of and competence in relationship-centered early intervention.

Klein S, et all., in 2011 researched about family-centered care within a tertiary care interdisciplinary neurodevelopment diagnostic assessment clinic by furthering an understanding of parent perceptions of the relevance of diagnostic information provision. Parents did not perceive the information in the way professionals expected. Parents acknowledged receipt of comprehensive information relevant to the diagnosis but indicated that not all their needs were met.

Occupational therapists are encouraged to reflect on doing, being, and becoming not only as it relates to the development of their profession but also in their own lives (Wilcock 1999).

Occupation-centered practices with infants and children necessarily involve parents. Although the importance of parent–therapist collaboration is recognized and through the therapeutic strategies occupational therapist facilitate the development of competence and confidence in achieving performance in daily life activities. The therapeutic use of self (parent and occupational therapist) is a central aspect of occupation-based practice. These data strongly support understanding family patterns and perspectives through treating the infant as a developing occupational being within the context of co-occupations with the parents. The therapists must see parents as clients who must learn to nurture and manage their infant's ongoing medical and social needs as a member of the nuclear and human family. These findings provide therapists with an example on which to reflect on their own practices with infants and families and evidence-based theory through which to articulate and practice from an occupation-based approach (Price MP, Miner S, 2009).

In the Netherlands, Nijhuis B.J.G. et all (2007), within the article Family-centred care in family-specific teams, concludes that the family-specific team analysis of importance ratings yielded significant differences ($P < 0.05$) on all domains between parents, rehabilitation professionals and special education professionals. For Enabling and partnership ($P < 0.01$) and Specific information about the child ($P < 0.01$), parents considered the behaviours to be significantly more important than rehabilitation professionals. The problem-score analyses showed that in all domains a considerable number of parents (19—38%) did not receive the care they deemed important.

Also, working with family, the therapists experienced significantly less stress and higher levels of parenting. According to Broggi MB, Sabatelli R (2010) the family-centered approach may provide guidance to clinicians seeking to develop more collaborative relationships with families.

The occupational therapist role is to promote information exchange, communication among parents and therapists, approaches toward child and

family care, supporting social and emotional needs, perceptions of therapists' roles, and understanding service delivery systems to improve care coordination. It is recommended training for therapy service providers and pediatricians in the areas of child development, and not only, team building, and service systems. Family-centered strategies emphasizing systems of care are recommended to improve therapists' role in care coordination (Ideishi RI, O'Neil ME, Chiarello LA, Nixon-Cave K, 2010).

Occupational performance coaching may be a useful intervention for therapists seeking to achieve occupational performance outcomes with children and parents in home and community contexts (Graham F, Rodger S, Ziviani J, 2010).

Forhan M., 2010 reflects on the problematic of family situation through perinatal loss. The article is a form of self-narrative that places the family in social context through the lens of an occupational therapist. This article aims to convey the meanings attached to the experience of grief and loss in the context of participation in everyday occupations.

3. Resullts and discutions

According to the analyses of the literature we may say that the concept of family-centered is wildly used, but it is more connected with client's needs than to focus on the dynamic and quality of life of family as a system. Competences for occupational therapy shouldn't only be focused on needs of individuals and groups. Although we have to take into account the family-centered approach holistically (figure 1). Three major components frame the client (part of the family) needs within the family context:

- the family which is represented by parents, sibilants, grandparents, relatives; they are the main resources with whom the occupational therapist create a team in decision making and planning occupational process;
- contextual influences are connected to the level of educational, cultural, socio-financial, spiritual, traditional of families and their beliefs;
- Environmental Settings are described according with occupational habits, routine and needs of the family and client.

Occupational competences results from the analyses of these major aspects and drives the occupational therapist in the therapy.

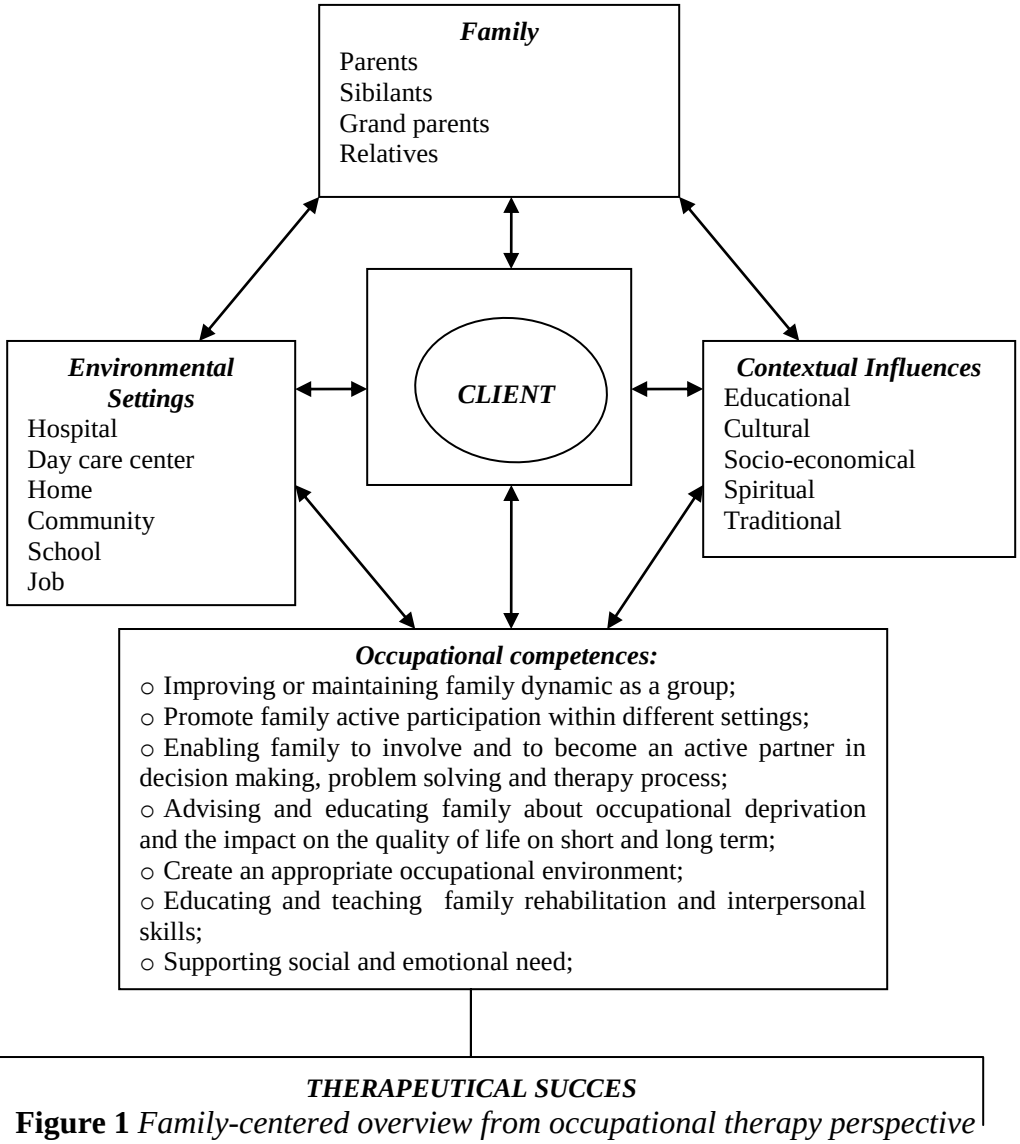

Figure 1 *Family-centered overview from occupational therapy perspective*

4. Conclusion

The capability to work autonomously enables the occupational therapists to develop standards, competences and guidelines according with different needs and context from one single geographic aria according with the national code of ethics.

Occupational therapists could develop cultural competence by engaging in reflexive practice and taking actions to promote equity in healthcare outcomes (Wray EL & Mortensen PA, 2011).

Results underscore the need for professionals to be attentive to parents' individualized needs. A strength-based approach and a focus on parental competency would support their coping efforts (Klein S, et all., 2011).

When providing family-centered services, the goal is to empower parents, siblings to take control of their child's (adult) therapy, to become an active partner and to explore the dimensions of occupational functionality within different settings.

The family-centered approach has to take into account in the same time the grief, life change events, narration, perinatal mortality and the occupational therapist has to focus on daily life activities participation.

After analyzing the literature we propose a schema for a better understanding of the role of occupational therapist within family-centered practice.

References:

1. CASE-SMITH, J., et al. (2007), Preparing Therapists to Provide Best Practice Early Intervention Services**,** Physical & Occupational Therapy in Pediatrics, Vol. 27, No. 3 , Pages 73-90
2. DUNSTAN E, GRIFFITHS, S., (2008), Sensory strategies: Practical support to empower families, Journal: NZJOT Year: 2008 Vol: 55 No: 1 Pp: 5-13
3. FITZGERALD, MARTIN; RATCLIFFE, GEMMA; BLYTHE, CHERELLE (2012), Family work in occupational therapy: a case study from a forensic service, The British Journal of Occupational Therapy, Volume 75, Number 3, March 2012 , pp. 152-155(4)
4. GRAHAM, F., RODGER, S., ZIVIANI, J., (2010), Enabling Occupational Performance of Children Through Coaching Parents: Three Case Reports, Physical & Occupational Therapy in Pediatrics, Vol: 30 No: 1 Pp: 4-15
5. IDEISHI, R.I., et al. (2010), Perspectives of Therapist's Role in Care Coordination between Medical and Early Intervention Services, Physical & Occupational Therapy in Pediatrics, Vol. 30, No. 1 , Pages 28-42
6. NIJHUIS, BJG, REINDERS-MESSELINK, HA., HITTERS, WMG., et al. (2007), Family-centred care in family-specific teams. Clinical Rehabilitation 21*:660-71*
7. PRICE MP, MINER S MOTHER BECOMING (2009) Learning to read Mikala's signs, SJOT, Vol: 16, No: 3, Pp: 68-77
8. WRAY, ELEANOR L., MORTENSON, PATRICIA, A., (2011), Cultural competence in occupational therapists working in early intervention therapy programs Canadian Journal of Occupational Therapy, Volume 78, Number 3, June 2011 , pp. 180-186(7)