Family Involvement in Practice: Issues and Attitudes

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The family occupies an important role in the lives of persons with a physical, developmental, or mental disability; however, the extent and manner in which occupational therapists work with families is not known. A questionnaire concerning family-therapist involvement was sent to occupational therapists. Responses of 340 occupational therapists with a primary practice area of physical disabilities, developmental disabilities, or mental health were compared. Results indicated that the amount of contact with families of clients, reasons for family-therapist interactions, and attitudes about the family's abilities and involvement were affected by the respondent's area of practice. Respondents in all three practice areas identified scheduling difficulties as the biggest issue affecting their involvement with families of their clients. Implications discussed include the need to obtain an understanding of families' desired level of involvement and the importance of continuing education opportunities for occupational therapists in changing attitudes about working with families. This study also suggests that the role of occupational therapists with families in mental health settings needs to be better articulated and shared with professional peers.

Families serve as socialization and change agents for family members and play a central role in the promotion of health, independence, psychological well-being, and disease prevention for each member (Doherty, 1985; Ell & Northen, 1990). As a result, families are an essential element in the rehabilitation process and in the lives of people with handicapping conditions (Bernheim & Switalski, 1988; Doane, 1991; McNeny & Wilcox, 1991; Moyers, 1992; Zoltan & Ryckman, 1990). The American Occupational Therapy Association's (AOTA) Standards of Practice identifies opportunities for family involvement in occupational therapy services (AOTA, 1992). The extent and manner in which occupational therapists in different practice areas work with families has not been documented. This article reports on a survey of occupational therapists practicing in three areas—physical disabilities, developmental disabilities, and mental health—conducted for better understanding of family involvement in the therapeutic intervention process.

Family Involvement

The contribution of a family toward a person's well-being is clearest at both ends of the life span. The natural dependency of childhood and the consequences of secondary aging among older persons result in caregiving needs that are frequently met by family members. At times, the role of the family as nurturer and change agent is so central that the family becomes the focus of intervention. Provision of family-centered services in occupational therapy is endorsed for pediatric and geriatric services (Baum, 1991; Hanft, 1989). Intervention at the family level in medical services is not new, but the range of application is increasing (Doherty, 1985). In the family-centered approach, the emphasis is on enabling the family to maximize function and social integration of a dependent family member.

The current Standards of Practice for Occupational Therapy (AOTA, 1992) reflect family involvement and, in comparison with the 1983 Standards (AOTA, 1983), suggest expanding family involvement in occupational therapy services. According to the 1992 Standards, contact with families starts with the occupational therapist sharing information during the assessment phase about its purpose and procedures. Family-therapist collaboration continues in the intervention planning process. Current Standards recognize that occupational therapy services may involve and educate family members about activities to support intervention. Finally, the family's goals are addressed as part of discharge planning.

The Standards of Practice (AOTA, 1992) suggest a range of professional activities while acknowledging that the nature of family-therapist interaction could vary considerably. Doherty (1985) outlined four potential levels of professional involvement with families. The level of pro-
fessional involvement is determined by the clinician's awareness of the purpose of interaction with the family and the effect he or she anticipates having on the family.

Doherty (1985) suggested that at the lowest level there is minimal emphasis on the family. The occupational therapist operating at the first level believes that the client is the focus of his or her services and is not concerned with the effect of the disability or services on the client's family. At the second level, the therapist retains the client focus but is open to engaging the family to obtain information about the client and educating the family about the disease. At the third level, the therapist recognizes that the client has an effect on the family and wants to address the family's feelings. The final level of family involvement reflects a systematic assessment of family needs and goals and family involvement in intervention planning. The clinician's attitudes and feelings about the family's abilities at the fourth level are consistent with those needed to engage in a family-centered approach. A collaborative family-therapist relationship is developed and the family's goals and intervention priorities are addressed.

Although suggested by the Standards of Practice (AOTA, 1992), the extent and nature of family-therapist involvement and issues surrounding family involvement in occupational therapy are not clear. Relatively little time in entry-level curricula is devoted to content on the family system and family assessment (Humphry & Link, 1990). Power struggles and friction between therapists and families do occur (Gans, 1983; McNeny & Wilcox, 1991). Professionals may feel that some families have contributed to the client's dysfunction or believe the family's desire to care for the member with special needs slows progress in the return of function. Stress between professionals and some families may lead to generalized beliefs about most families' roles and abilities to promote return of function when there is a member with a disability. Therapists who question the family's capabilities to select meaningful goals or set priorities for what occupational performance areas are most important to the client may find it difficult to implement a family-centered approach.

No single factor predicts professional attitudes or determines issues such as family involvement. Family-therapist involvement in habilitation services and educational programming for persons with mental retardation or developmental disabilities has been mandated through federal laws since the early 1970s. Most recently, the Individuals With Disabilities Education Act (Public Law 102-119) reaffirmed family-centered services in early intervention. Family involvement in other practice areas may not be as clearly outlined by external sources. Personal attitudes and perceived opinions of peers influence whether or not a person is inclined to engage in a behavior (Fishbein & Ajzen, 1975). Other factors, such as the occupational therapist's role, nature of work experience, amount of time in practice, type of employer, and level of education each explain some of the variation in attitudes about a family-centered approach (Humphry & Geissinger, 1993).

Experience with and attitudes about working with families probably have a reciprocal relationship. Positive attitudes about an activity increase the probability of engaging in the action which, if successful, leads to experience that further enhances positive opinions and the probability of repeated action (Bandura, 1982). Therapists who believe in family involvement may select work settings where families are encouraged to participate, build skills in collaborating with families, experience more successful contact with families, and thus express even stronger views about family involvement. On the other hand, therapists' lack of experience in interacting effectively with families could create a negative attitude about the family's potential contributions to occupational therapy services. Without open attitudes, therapists may not develop the necessary skills or experience successful family-therapist involvement.

The purposes of this study, therefore, were to (a) describe the frequency and reasons for therapists' contact with families; (b) identify what therapists thought were the most important issues in working with families; (c) explore the effect of specialty area on the amount of contact with families, reasons for family-therapist involvement and ranking of issues in working with families; and (d) examine the relationship between attitudes about families and practice area, experience with families, direct service role, years of practice, education, and personal experience of having a family member with special needs.

Method

Subjects

Six hundred occupational therapists were asked to complete a questionnaire. A stratified sample approach was used and 200 randomly identified occupational therapists each in physical disabilities, developmental disabilities, and mental health special interest sections of AOTA were the pool of potential subjects. A total of 361 (60%) occupational therapists responded. Seventeen persons were not working in occupational therapy, did not complete the questionnaire, or indicated that they did not fit into one of the practice areas. Four persons returned questionnaires after data analysis was completed. The response rate in physical disabilities was 66%, in developmental disabilities it was 54%, and in mental health it was 51%.

Instrument

The questionnaire developed for this study was pilot tested by participants at a state occupational therapy conference. The responses of 76 of these therapists were used to refine the items. The final instrument consisted of
three sections. The first section, Personal Background, had seven items that asked for information about the respondent’s professional background, current work setting, and whether the respondent had a family member with a disability. The second section, Nature of Contact With Families, had four items. The first item asked for the percentage of clients who had families that the therapist had met in the past 6 months. If the therapist reported meeting families, he or she was asked to estimate what percentage of time was spent on different activities. An open-ended question asked about the most important benefit of family–therapist interaction. Finally, the respondent was asked to rank, from a list of eight options, the three most important issues in working with families.

The third section, Working With Families, consisted of attitude items and used a 5-point Likert scale to measure the respondents’ feelings concerning families with a member with disabilities and how occupational therapists should work with families. There were 21 items that had been either adapted from a questionnaire on early interventionists’ attitudes about a family-centered approach (Humphry & Geissinger, 1993) or generated by discussion among ourselves. When appropriate, item scoring was reversed so that higher scores indicated more positive attitudes of a family’s ability and role in the rehabilitation process. The internal reliability (Cronbach alpha) for the attitude section of the questionnaire was .82.

We chose not to provide a definition of a family for participants as part of the questionnaire. It was assumed that responses would reflect the operational definition of family used by treatment teams. We thought that definitions should be allowed to vary as they might for the respondents. Imposed criteria might have excluded some persons whom respondents considered family members or created the false impression of family–therapist involvement with persons whom the respondents had never thought of as family members of their clients.

Procedure

Each subject was mailed a cover letter, the questionnaire, and a stamped self-addressed envelope. If the questionnaire had not been returned within 3 weeks, a follow-up reminder postcard was sent.

Results

Personal Background

The final respondents were 340 occupational therapists, 131 in physical disabilities, 107 in developmental disabilities, and 102 in mental health. Significant differences were found between the areas of practice for the number of years in occupational therapy ($F[2,357] = 11.22, p < .0001$). Respondents in developmental disabilities and 71% in mental health reported baccalaureate degrees; 77% in developmental disabilities and 71% in mental health reported baccalaureate as their highest degrees.

Twenty-two percent of all respondents indicated that they had a family member with special needs and there were no significant differences between the groups. For those respondents who reported having a family member with special needs, the relationship with the respondent was parent (23%), child (19%), sibling (19%), or more distant relative such as niece or nephew (12%) or aunt or uncle (9%).

Nature of Contact With Families

Analysis of variance was used to compare respondents in the practice areas for the percentage of families met and the percentage of time used for different purposes (see Table 1). Post hoc analysis (least squared differences) was used to compare respondents in the practice areas for the percentage of families met and the percentage of time used for different purposes (see Table 1). Post hoc analysis (least squared differences) was

<table>
<thead>
<tr>
<th>Variable</th>
<th>Physical Disability ($n = 131$) (%)</th>
<th>Developmental Disability ($n = 107$) (%)</th>
<th>Mental Health ($n = 102$) (%)</th>
<th>$F$</th>
<th>$p^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean percent of families met$^b$</td>
<td>63</td>
<td>63</td>
<td>21</td>
<td>75.6</td>
<td>.0001</td>
</tr>
<tr>
<td>Time spent in different activities</td>
<td>Casual/informal$^b$</td>
<td>16</td>
<td>5</td>
<td>40</td>
<td>41.2</td>
</tr>
<tr>
<td>Give family information</td>
<td>28</td>
<td>31</td>
<td>20</td>
<td>2.2</td>
<td>ns</td>
</tr>
<tr>
<td>Get information from family</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>1.1</td>
<td>ns</td>
</tr>
<tr>
<td>Instruct family in how to do things$^b$</td>
<td>31</td>
<td>22</td>
<td>12</td>
<td>20.8</td>
<td>.0001</td>
</tr>
<tr>
<td>Develop treatment plan$^b$</td>
<td>13</td>
<td>25</td>
<td>14</td>
<td>11.1</td>
<td>.0001</td>
</tr>
</tbody>
</table>

Note. ns = not significant.

$^a$Mental health significantly different from other two groups.

$^b$All 3 practice areas were significantly different from each other.

$^c$Develop mental disabilities significantly different from other two.

$^d$Sources of significant differences were established with post hoc analysis ($p < .05$).

Table 1: Percentage of Families of Clients That Respondents Met and Percentage of Family-Therapist Interaction Time Spent in Different Activities

There was a significant practice area difference in the percentage of respondents who were direct service providers ($\chi^2[2, N = 334] = 10.5, p < .005$). The largest percentage of direct service providers (88%) were in physical disabilities. Eighty-two percent of the respondents in developmental disabilities were direct service providers; 70% of the mental health respondents indicated that they were direct service providers. Respondents in the other role category for each practice area included administrators, educators, and consultants. There was a significant effect for practice area for the respondent’s level of education ($\chi^2[2, N = 340] = 7.7, p < .02$). Eighty-six percent of the respondents in physical disabilities had baccalaureate degrees; 77% in developmental disabilities and 71% in mental health reported baccalaureate as their highest degrees.

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Table 2
**Ranking of Issues That Most Affected Therapists’ Work With Families**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Physical Disability (n = 124)*</th>
<th>Developmental Disability (n = 104)</th>
<th>Mental Health (n = 69)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families lack time to meet</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapist’s schedule not flexible to meet</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Needs of families with different cultural/ethnic backgrounds</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Work with families from different socioeconomic backgrounds</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Agency’s stress on productivity limits meeting</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Reimbursement for time with families</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Administration policy does not support occupational therapy with families</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Professional peers do not expect occupational therapist to work with family</td>
<td>8</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

*Subjects who never met family members of their clients did not respond to this item; this explains changes in sample sizes.

used to compare the three practice areas when a significant difference was found. The alpha level for post hoc comparisons was set at .05. The results of these comparisons are presented in Table 1.

In all three practice areas, similar percentages of family–therapist time were spent in giving and receiving information about the client. Respondents in mental health estimated that 40% of their contact with families was unplanned or casual. Respondents working in physical disabilities spent the most time instructing families on how to work with their members with special needs. Respondents in developmental disabilities spent a larger percentage of their interaction time on treatment planning than did the respondents in the other two practice areas.

Each respondent’s ranking of issues that affected their work with families were weighted so the first choice was given a value of three, the second a value of two, and the third a value of one. The sums of the weights were used to identify the most important issues (see Table 2). In all three practice areas, the issues most affecting work with families involved scheduling. The mental health group assigned different weights to other issues compared to the physical disabilities and developmental disabilities groups.

**Attitudes in Working With Families**

Regarding respondents’ attitudes about the abilities and role of families of clients, an initial analysis of variance resulted in a significant difference in the total scores of the attitude questionnaire between the respondents in the three practice areas ($F[2, 341] = 30.14, p < .0001$). Post hoc analysis revealed that respondents in the developmental disabilities area scored significantly higher than the other two groups. Multiple linear regression was used to explore the relative contribution of respondents’ area of practice, percentage of clients with families met, whether the respondent had a direct service role, years of experience, education, and whether respondents had a member with special needs in their own families. A hierarchical regression approach was used because there were significant group differences in the area of practice for other variables of interest (see Table 3). Respondents who were not in direct service and those with degrees beyond a baccalaureate tended to have more positive attitudes about working with families. There was no relationship between the respondent’s personal experience of having a family member with special needs and his or her attitudes about families.

To further clarify the relationship between the percentage of families met and respondents’ attitudes, groups of low (less than 25%), medium (25% to 80%), and high (more than 80%) family contact were created. The two-way analysis of variance using practice area and family contact grouping as independent variables was significant for the attitude score ($F[4, 334] = 18.37, p < .0001$). The post hoc analysis revealed that respondents in the high family contact group held significantly ($p < .05$) more positive attitudes than respondents in the medium or low family contact groups.

**Discussion**

**Nature of Contact with Families**

The survey of occupational therapists identified considerable variation in the number of clients’ families whom the respondents met. Respondents in physical disabilities and developmental disabilities met similar percentages of families; respondents in mental health met significantly fewer families of clients. The low rankings of some issues (i.e., productivity, professional peer expectations, and administrative support) suggests minimal systems barriers to working with families in physical disabilities and developmental disabilities. In mental health, emphasis on productivity and peer expectations, both of which exclude working with families, suggests major systems barriers to working with families. Perhaps the role of occupational therapists with families of clients with mental health problems is not considered essential by peers in other disciplines and thus occupational therapists are excluded from family services. Clarification of the range of occupational therapy services in mental health and education of team members is needed to affect these issues.

This study also examined the nature of family contact and found the percentage of time spent in giving families information or receiving information from them was simi-
lar across the three practice areas. The finding that therapists in physical disabilities spent a greater amount of time training families to work with the client than did the other two practice areas may reflect the fact that families must learn technical motor skills to provide care for the client who is going to live at home. It is not clear why a greater percentage of family-therapist interaction in the physical disabilities setting does not involve treatment planning. The extent to which clients themselves are involved in selecting and prioritizing goals needs to be investigated before the lack of family involvement can be viewed as a concern.

Family involvement with therapists for goal writing in developmental disabilities is not surprising. Most of the respondents in this group worked in school systems or developmental centers where the family representative’s participation is strongly encouraged in the educational or habilitation program planning process. Administrative support to include family members is part of the whole service provision system. In addition, although the percentage was less than that reported in physical disabilities, respondents in developmental disabilities were found to spend more than 20% of their contact time instructing families.

For respondents in mental health, the possible lack of a perceived role for occupational therapy in family involvement could also explain the small proportion of family-therapist involvement in treatment planning and training of family members. In the mental health group, a large percentage of family-therapist contact was casual. It is assumed that with an understanding of the occupational therapist’s potential role with families and administrative support, therapists would become more involved with family goal planning, education, and training.

Another aspect of family-therapist involvement examined in this study was the therapists’ perceptions of issues surrounding family involvement. The most consistently identified issues for therapists in all practice areas dealt with time. Respondents indicated that both the family and therapist had schedule flexibility problems. As a resource, time is allocated according to perceived value. Reasons that finding time to meet was a problem may differ for therapists and families. For all clinicians, making time to involve families means giving other activities in the clinic a lower priority.

More study will be needed to see why a therapist’s schedule flexibility is a problem. Do therapists expect families to come in only during the day? Are they placing a higher priority for time in client-therapist contact and do they feel, due to heavy treatment loads, that meeting with family members is a luxury they cannot afford? If the family is seen as the major factor in reaching intervention goals of enhanced occupational function, then client-therapist treatment sessions may need to be reduced to make time to meet with families.

Scheduling is a mutual issue. Are families as involved in occupational therapy as they would like to be? If they are not, what are family-identified barriers to increased family-therapist involvement? One barrier to family-therapist involvement may be the implied role of families. In hospitals, family members may be referred to as visitors, which communicates that their status is external to the rehabilitation process. Families may want a more involved role but not know how to indicate their desire.

A second barrier for family-therapist involvement may be the family members’ sense that they need to distance themselves from the negative consequences of a disability. Time in occupational therapy may focus too much attention on lost functional abilities of the family member, threatening the family’s ability to maintain hope. A third possible barrier for why time to meet with therapists is not allocated by some families is the family members’ desire to get on with more positive aspects of their lives. After the acute crisis period of a disease or disability, families of persons with chronic problems face the challenge of carrying on a normal family life under abnormal circumstances (Roland, 1987). Finally, geographic proximity and other family responsibilities may prevent adult children from participating in occupational therapy services for the elderly parent.

A step to understanding the family’s perspective of scheduling may be consumer satisfaction surveys. By systematically asking for feedback from all families, not just those families the therapist meets, the occupational therapist can learn whether and how families wish to be involved.

**Attitudes in Working With Families**

The finding that respondents working in developmental disabilities had more positive attitudes about a family’s abilities and role in intervention is not surprising. The effect of the family on a child’s life is widely acknowledged, so family-therapist involvement may be seen as a natural part of services. Increased understanding of family systems theory and how families function may lead therapists in other practice areas to recognize the interdependent influences between the family and a member with special needs, regardless of age.

The regression analysis (see Table 3) also suggested a small but positive relationship between attitude and percentage of clients’ families met. The study reveals that the attitudes of respondents, regardless of practice area, who met 80% or more of their client’s families were significantly more positive than the attitudes of those meeting fewer families. A causal relationship between attitudes and frequency of family contact is not necessarily suggested by the association. However, the possibility of an interrelationship between opinions about families’ roles and ability to work with families and increased experience with families is supported by this finding. If, as Doherty (1985) suggested, attitudes define the type of family-
professional involvement, some therapists may find it difficult to work in a family-centered approach.

Although family-therapist involvement may not be needed in all occupational therapy practice areas, it is difficult to imagine a setting where family input would not enhance services. Family-centered occupational therapy services may be especially important when a person's recovery includes lifestyle changes or there are residual limitations in function. The person and family will need to manage normal family tasks along with activities associated with the illness or limited occupational performance of the member. Life satisfaction rather than the person's level of independence may be a better definition of success for rehabilitation specialists (Levine, 1987).

Maintaining the psychological well-being of all members is a major family task, and for members of a family, individual life satisfaction will depend to some degree on how well the family functions for all family members. It is not realistic to anticipate compliance with discharge recommendations or home programs if the family and client have not participated in goal development and intervention planning. Families may be in the best position to help the rehabilitation team identify family priorities regarding time and energy use. Hasselkus's (1991) study illustrates how the caregiver may choose to not push for independence, which most occupational therapists see as the primary outcome of rehabilitation. A family-centered approach may assist therapists in making treatment goals more realistic, pragmatic, and consistent with the needs of the entire family.

Study Limitations

This study presents an initial description of family involvement in occupational therapy as seen by a limited number of therapists in physical disabilities, developmental disabilities, and mental health and therefore can not be generalized to all therapists in these or other practice areas. In addition, the level of family involvement and attitudes of nonrespondents are not known.

Family involvement in occupational therapy may not always be feasible, such as in acute care, in services that follow a traditional medical model, or when family pathology is identified. This study also did not ask respondents how many clients had families or how they determine who constituted their clients' families. Some clients may not have family members who wish to be involved, and institutional care or other social networks may replace the family in the long-term caregiving role.

Implications for Occupational Therapy

This study offers an initial description of family-therapist involvement and suggests that scheduling is a major issue in family-therapist involvement. Further study is needed to clarify scheduling problems and how therapists prioritize their time. Program evaluation will need to seek the views of family members regarding their desired level of involvement and to determine system changes needed to enable participation in occupational therapy services. Another area of study may be how therapists and their employers determine who is identified as a family of the person with special needs.

The low contact with families and the casual nature of family-therapist involvement in mental health practice suggests that the role of occupational therapists with families in this practice area needs to be better articulated. One example of how therapists in a mental health settings may work with families was presented by Moyers (1992).

The need to address families' goals for members with chronic disability and increase family involvement in health care systems has been stated (Baurt, 1991; Straus & Corbin, 1988). If attitudes about families' roles and abilities are related to the amount of contact with families, one step to maximize the level of family-therapist involvement is to challenge therapists' attitudes about families. Continuing education may be helpful to change attitudes of therapists in different practice areas. In 1990, AOTA provided workshops about family-centered services in early intervention; this form of continuing education has been effective in changing participants' attitudes about families (Geissinger, Humphry, Hank, & Keyes, 1993). Similar opportunities may be needed for occupational therapists in other areas of practice.

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References


