OBJECTIVE: The goal of this study was to determine whether pediatric occupational therapy practitioners implemented family-centered principles in their practice.

METHOD: Twenty-eight occupational therapy practitioners were interviewed in three practice settings: home based, clinic based, and school based. A grounded theory approach was used to analyze the results. Responses were compared across respondents and across practice settings.

RESULTS: Responses varied among practitioners and, more significantly, practice settings. A continuum of family-centered practice was demonstrated, with home-based practice as the most family centered, school-based practice as the least family centered, and clinic practice varying in between.

CONCLUSION: Occupational therapy practitioners are familiar with most principles of family-centered practice. However, implementation of those principles differs significantly across practice settings.


Occupational therapy is described in the Occupational Therapy Practice Framework: Domain and Process (2nd ed.; American Occupational Therapy Association [AOTA], 2008) as a client-centered approach to the end goal of supporting health and participation in life through engagement in occupations. When working with children, occupational therapy practitioners typically use the term family centered rather than client centered (Case-Smith, 2010; Dunn, 2011). This substitution reflects that a child with special needs is part of a family unit with reciprocal influence on one another’s ability to participate in life activities (Jaffe, Humphry, & Case-Smith, 2010). Families are the constant in a child’s life as he or she develops and participates in school and community programs (MacKean, Thurston, & Scott, 2005). Subsequently, intervention for a child requires the involvement of the entire family, most specifically the parents.

In the literature, this type of intervention is referred to as family-centered practice (FCP), in which the goal is to enhance the quality of life for the child and the family. The efficacy of FCP has been documented in improving child-related outcomes (Dunst, 2002; Morris & Taylor, 1998), parental satisfaction (Law et al., 2003; O’Neil, Palisano, & Westcott, 2001; Van Schie, Siebes, Ketelaar, & Vermeer, 2004), and parental participation (Dunst, Boyd, Trivette, & Hamby, 2002). The key elements of FCP, stated broadly, are as follows (Bailey et al., 2006; Dunn, 2011; Dunst, Trivette, & Hamby, 2007; MacKean et al., 2005; Rosenbaum, King, Law, King, & Evans, 1998):

- Families are essential members of the treatment team because they know their children best.
• Intervention needs to be flexible and tailored to the unique characteristics and identified needs of the family.
• Intervention needs to be focused on supporting and strengthening family functioning.

Occupational therapy practitioners work with children in a variety of settings, including homes, clinics, and schools. Griswold, Evenson, and Roberts (2009) described these settings and the type of service delivery most common to the setting. In their description, only early childhood intervention was labeled as family centered. Is this categorization a reflection of best practice or current practice? Are the two synonymous? How do therapists working with children in a variety of practice settings implement the principles of FCP?

The purpose of this study was to explore the phenomenon of FCP in a variety of pediatric occupational therapy settings. We used a grounded theory approach to describe the experience of occupational therapists working in home-based, clinic-based, and school-based settings in relation to FCP principles. Therapists were interviewed about their understanding of FCP and how its principles did or did not influence their practice.

Method

Design

We used a grounded theory approach to explore how FCP is implemented by occupational therapy practitioners providing intervention for children in a variety of practice settings. In this approach, the theory about the targeted phenomenon evolves from and is grounded in the data collected from the respondents (Creswell, 2007). Theoretical sampling of occupational therapy practitioners in home-based, clinic-based, and school-based settings allowed comparison of practice approaches among therapists and among settings.

Participants

Participants were occupational therapy practitioners from a large metropolitan area of the southern United States. Interviews continued with participants from each setting until saturation of data or a redundancy of themes and comments emerged. More variation was noted among clinic respondents, so more interviews were conducted there. Twenty-eight practitioners were interviewed: 9 school-based practitioners (SBP) from six school districts, 12 clinic practitioners from eight clinics, and 7 home practitioners from two home health agencies and four early childhood intervention (ECI) agencies. See Table 1 for participant demographics.

Table 1. Demographics of Occupational Therapy Practitioner Respondents

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Home Based (ECI; n = 5; HH; n = 2)</th>
<th>Clinic Based (n = 12)</th>
<th>School Based (n = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, yr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25–35</td>
<td>2</td>
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<tr>
<td>35–50</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>&gt;50</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Years practiced</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>2</td>
<td>7</td>
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</tr>
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<tr>
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</tr>
<tr>
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<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>OT or COTA, n</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>OT</td>
<td>7</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>COTA</td>
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<td>1</td>
<td>1</td>
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<tr>
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<td>7</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. COTA = certified occupational therapy assistant; ECI = early childhood intervention; HH = home based; OT = occupational therapist.

Data Collection

Participants were notified of the study through direct contact or program directors. Volunteers were interviewed in either a face-to-face or a telephone format using a series of questions with a variety of probes for elaboration. Participants were asked about (1) communication with parents, (2) definition of FCP, (3) elements of FCP incorporated in their practice, (4) elements of FCP not incorporated in their practice, (5) observed family outcomes, and (6) how a questionnaire describing parental challenges to life participation might influence their practice. Institutional review board approval was obtained from the appropriate institution, and all respondents provided informed consent.

Data Analysis

All interviews were audio recorded and transcribed verbatim. To assist with coding of the data, we used the Nvivo 9 software program (QSR International, Burlington, MA), which allowed axial coding from the initial categories to explore causal relationships and contexts relevant to the phenomenon of FCP (Creswell, 2007). All transcripts were coded by the first author (Patricia E. Fingerhut) and independently coded by another author for triangulation of the data.

Results

Interview responses showed a continuum of FCP, with home-based practice the most family centered, school-based
practice the least family centered, and private practice falling in between.

**Communication With Parents**

Respondents practicing in home-based settings reported regular and extensive communication with parents, including verbal communication, modeling, and written documentation. Sherri (ECI) stated that she interacted with parents “throughout the 45 minutes or 1 hour that you may be out in the home . . . it’s a very active process with the parent.”

Most clinic therapists reported a quick conversation with parents after therapy sessions, although some parents were active participants in the session. Ashley (clinic), stated, “Well, some of the parents will come into the session and stay with us, so during the session I’m communicating with them, and then some parents tend to stay in the waiting room.” Laura (clinic) had a similar answer: “Typically after the session I will go out and give a summary of what happened. Sometimes that doesn’t get to happen if they have [occupational therapy] and then transition into another discipline.”

School therapists reported far less communication with parents. Although all therapists reported attempting to contact parents at the time of the initial evaluation, regular contact was very rare. Michelle (SBP) described the variance in her practice with apparent frustration: “I have parents who I communicate with probably once a month, and I have parents who I haven’t spoken with.” Jeri (SBP) responded, “I talk to all parents at least once a year. . . . It really depends on how much they’re interested in contacting me.”

**Therapists’ Definition of Family-Centered Practice**

All participants were able to identify aspects of FCP, including parents being part of the intervention team and the need to listen to parents’ goals for their child. The differences among settings were primarily related to the level of collaboration with the parents and the recognition of addressing family outcomes. Those therapists practicing in ECI more frequently included the elements of enhancing family quality of life, integrating goals and interventions into daily routines, and teaming with and empowering parents. Mary (ECI) described FCP as meaning “taking the whole family’s needs and concerns into consideration whenever you write up your plan of care or decide on your treatment.” Joyce (ECI) stated, “It’s also really consistent with ECI philosophy in terms of trying to integrate our goals and our interventions in the daily routines of not just the child but the family as a whole.”

The clinic therapists described FCP in terms of having a relationship with the parents to provide support and resources and to improve family involvement and carryover. Ashley (clinic) said, “Well, to me FCP is looking at what the parents’ goals are for that child and [making] the practice or our treatment plan [include] the parents involved in that because they really are the ones who are going to follow through with their kids at home.”

The school therapists were also able to identify many elements of FCP, such as the parents being part of the team, the importance of carryover at home, and the evaluation needing to address the child’s performance across settings.

**Incorporating Elements of Family-Centered Practice**

After the respondents had defined FCP in their own words, they were given a list of five elements commonly associated with FCP to provide them with a common framework on which to base their reflections on what they did and did not incorporate into their practice. Follow-up discussion included what the therapists perceived as barriers to FCP. Therapists working in home-based practice generally thought that they incorporated all the elements of FCP presented to them. Karen (ECI) stated, “I would say every single one of those. They’re very important to me; it guides everything that I do.”

Clinic-based therapists gave a much wider range of responses. All the therapists thought they listened well to parents and that parents knew their children best. However, many considered their practice less than optimal in tailoring intervention to the family’s unique characteristics and community contexts for carryover, and few identified consistent consideration of family outcomes. Jocelyn (clinic) stated,

> I think I really try and listen to parents’ needs and concerns and try to make goals to help address their concerns. Because I’ve learned that if you make goals that aren’t important to family there will be little to no carryover.

Ashley and Christie (clinic) were less sure of their FCP: “I think often we get caught up with treating the child, but we often forget that we are treating the family, too.” “When you have patients back to back, you don’t have time to really spend with the family.”

No school-based therapist described her practice as family centered. Therapists in this group acknowledged the family-centered principles discussed as critical to the child’s and family’s quality of life but articulated numerous barriers to implementing FCP in the schools. Tara (SBP) stated,
That’s one of the areas [in which] I think schools are particularly lacking. . . . I think that there are a lot of things that are lacking that [occupational therapists] could help with but maybe just can’t because of limitations of practice in the schools.

Discussing elements of FCP that therapists were not incorporating naturally led to a discussion of barriers.

**Barriers to Family-Centered Practice**

The barriers to FCP articulated by the respondents fell into two themes: (1) characteristics of the family and (2) characteristics of the practice setting. Barriers that were based on individual family characteristics were common to therapists across all three settings and included family issues of language, socioeconomic status, culture, and personal stressors. Nicole (clinic) described family barriers in this way: “Sometimes parents have major issues themselves; they may be going through separation, divorce, or I also see some younger single moms with their kids, and they’re just trying to get on their feet.” Teresa (clinic) spoke about language barriers: “Also there is a language barrier at times, and sometimes parents aren’t inclined to listen.” Laura (clinic) identified a common theme of the parents’ need for respite: “A lot of times kids have therapy sessions back to back. A lot of parents use that time as parents’ need for respite: “A lot of times kids have therapy sessions back to back. A lot of parents use that time as a respite time or go run errands.”

System or practice setting barriers were different among the three settings. Home-based practitioners identified budget cuts, high caseloads, and changes in eligibility guidelines for enrolling children in ECI as impediments to providing FCP. Blanche (ECI) said, “Yeah, we used to be able to address a need if the family had a need that may have specifically impacted a childhood role. . . . We don’t write those outcomes any more.” Carol (ECI) described her frustration with high caseloads:

I’ve had such a high caseload that it has been very difficult for me to also be the case manager, which is really the go-to person for the family. . . . I don’t feel I can get to the meat of being a therapist, which is what I want to do.

The variety of responses in private therapy clinics reflected the differences between practice culture and guidelines among clinics and among therapists within clinics. Christie (clinic) stated, “I was in home health, and that was easier because you are right there with them in their home and you can see what is going on. It is difficult in the clinic to get at what they really need.” Louise (clinic) reflected,

You only have 1 hour to do an evaluation, so you are really focused on the child, what he can do and, yeah, you might get some information from the parents about their life, but you don’t get that until there’s a relationship with the parents. . . . It usually takes a little while.

Robert (clinic) described the discrepancy between the therapy ideal and reality:

We’re moving towards more of a model as a company [in which parent in session] becomes the culture and the norm for treatment sessions. We don’t want the session to be, Drop your child off and come back to get them in an hour. [However,] for some people it is literally the only hour they have without their child.

Some practitioners described constraints resulting from the perceived focus of the funding source. Nicole (clinic) stated, “We also see kids from Medicaid; they want to see that it’s all about the child. But in my head and in my heart, I’m always thinking about the holistic approach and how’s it affecting the whole family.” Teresa (clinic) described difficulty in documentation: “Well, I think one of the first tricks is to figure out how to document a parent outcome because from a documentation point of view, it has to be about the child.”

The practitioners working in schools consistently stated that the parents were integral to the child’s success but did not describe their interaction as family-centered. Jeri (SBP) sighed when she said, “I’m there for the families, but my role is predominantly contact with the teacher, and sometimes I don’t think I have as much interaction with the parents [as] maybe I could or I should.” Tara (SBP) stated, “You’re looking at how the student is doing within the educational environment . . . there’s not really a whole lot of input from the parent as far as driving practice or driving goals.” Michelle (SBP) and Rebecca (SBP) described some confusion and wistfulness in their role as related services in the schools:

I think my interventions, like it says, need to be designed for family carryover. When I’m doing stuff, my laser beam is on that teacher and less on the family. I think that the families should be more involved, but how that’s supposed to look—I’m completely unclear about that one, for sure.

You have so many kids on the caseload, so I think some of that’s slipping. We’re not having that access in the home as we used to.

**Family Outcomes**

All participants were able to describe examples of when they thought their intervention had resulted in positive family outcomes. Commonly described themes included improved child independence resulting in reduced caregiver burden, improved child skill or behavior resulting in...
increased opportunity for participation with the child in the community or accessing a sitter, and increased parental empowerment and quality of life through parent education and provision of resources and equipment. Tara (SBP) reported,

We’re working with our students on increasing their independence, especially as related to self-care tasks . . . [and helping] the parents both in their parental role and also in freeing up their time to do whatever else they need to do around the house.

Carol (ECI) focused on the sensory issues affecting a child’s, and consequently parents’, ability to participate:

Those children are not going to do well in a community, in a mother’s day out or a church nursery. They don’t play well with things that move, like balls and swings, so [occupational therapy] could help enormously with that. He’s so much more willing and happier to go out into the world, and that changes everything for the family.

Monique (clinic) recalled a happy interaction with a mother:

You can see it in her face when she says, “He put his shirt on by himself this morning.” “Oh yes, you got your cup of coffee, too, this morning cause you had time, huh?” You can see it in her eyes—oh, the best morning ever.

Abigail (clinic) summed up by saying, “When the child is being successful and able to function throughout the day, it trickles down to the whole family.”

Respondents were then asked how they measured and documented these outcomes. The consistent response in all practice settings was that they did not. With further reflection, Rachel (ECI) stated,

Probably one of the big things is, “Oh, the child’s sleeping through the night, so now I’m getting adequate rest” or if the parent says, “We’re able to go to Chuck E. Cheese as a family,” or “I can go into Wal-Mart now, I can take him with me when I do my grocery shopping.” So those kinds of things are usually noted in the SOAP note.

How Might Therapists Use a Parent Participation Questionnaire?

The final question asked the therapists whether or how they might use a questionnaire that provided information on the parents’ ability to engage in life activities. Home-based therapists described this type of information as integral to their practice. Mary (home health) and Rachel (ECI) thought this would be very valuable in a home-based practice:

That would be huge. Especially if I had something the parent could fill out, because there is only so much time in each treatment session.

I think that would be helpful if we had a form to address that. . . . There’s not really anything we are giving to the parent to look at ahead of time so they have time to think about it and consider it.

Carol (ECI) thought that ECI already had this information covered: “I think we actually do that. It is the ‘family story,’ we’ve called it in the past, and we’ve called it three or four different things, but it does kind of get to those questions.”

Clinic therapists generally thought the information would be very valuable if they could collect it in an efficient manner such as a self-report questionnaire. Teresa (clinic) said,

It might help to know if there were underlying issues with the parents; that way I would be able to know what his or her expectations were for that child. I would incorporate more of the parents’ goals into the therapy session.

Maria (clinic) noted that sometimes parents raising children with special needs are so focused on their child that they do not stop to consider their own participation:

I think it would be very beneficial as far as knowing what the client’s needs [are] in real life. A lot of times you’re asking about the developmental milestones and other things that a child needs to function, but at the same time there are community settings such as working, doing errands that a person would be expected to participate in.

Nicole (clinic) highlighted the frequently voiced theme of a therapist’s lack of time: “If it’s a quick checklist or something like that, then that’s something that I would use. . . . You get a lot of other information that you might not get otherwise about the child.” None of the clinic therapists could describe a specific instrument or questionnaire that they used to assess family-centered issues. However, many reported asking about what type of concerns and goals parents had for their child.

School therapists had difficulty visualizing how this information would influence their intervention beyond giving them a more complete picture of the child. Rebecca (SBP) mused,

There are probably many, many things that these parents are going through that we don’t always get all the information. We’d definitely get a more well-rounded picture and possible strategies that we could work on that correlate to the school setting but also [that correlate] to more independence out in the community.
Karen’s (SBP) response highlighted a common theme from the school-based therapists: “I like to know what their issues are at home, but again, I feel it’s a place I’m not supposed to walk.”

Discussion

The occupational therapy participants described three very different practice experiences in relation to being family centered. All the participants acknowledged the importance of including family-centered principles to achieve the best outcomes for the child; however, many did not think they were currently doing so. All could define FCP, recognize the importance of stated FCP elements, and identify positive outcomes of occupational therapy intervention for the child and the family. However, when describing their practice, many restricted interactions with the family to obtaining information about the child and achieving carryover of intervention at home. This gap between family-centered language and actions was described by Bezdek, Summers, and Turnbull (2010) as being able to talk the talk but not walk the walk.

Brown, Humphry, and Taylor (1997) classified seven levels of family centeredness derived from interviews with occupational therapists. Only Levels 6 and 7 were labeled as family-centered practice (Table 2). All levels of practice, except Level 1, were recognizable in the interviews in this study. Although there was variance within practice settings, the most notable variance was between practice settings. The home-based respondents described a practice rooted in family-centered principles. Families were central to services, were involved in all decision making, collaborated in intervention, and frequently served as team leaders or service coordinators. The Individuals With Disabilities Education Improvement Act of 2004 (IDEA), Part C (Pub. L. 108–446), which proclaims a family-centered model, guides early intervention. Intervention focuses on the individual family service plan, described as a “family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family’s capacity to meet the developmental needs of the infant or toddler” (IDEA, Sec. 636[a][2]).

Many respondents described attempts in clinic practice to increase family involvement in intervention, suggesting a perceived need and increasing awareness of Level 6 as the therapists’ goal for best practice. However, when articulating how they implemented family-centered elements, most respondents described consulting with parents for direction on goals, asking for information on home and community context, and focusing on the need for the parent to carry over intervention in the home. With the exception of 1 respondent who came from an ECI background, clinic therapists described their practice as somewhere between Levels 2 and 5.

The school-based therapists interviewed mostly described therapist–family interactions as being at Level 2, family as informant. Again, these therapists were able to articulate FCP and perceived benefits from a more collaborative approach with families, but they could not reconcile this knowledge with their current practice situation. One therapist, however, described creative and persistent ways in which she attempted to connect with the parents, such as communication books, e-mail, and text messaging (Rene, SBP). Respondents in SBP frequently referred to the need for educationally relevant outcomes as the reason families were not more involved. However, inclusion of the family appears to be embedded in the legislation that initiated occupational therapy as a related service in the school system. One of the priorities in the 2004 IDEA amendment was to provide funding for excellence in personnel preparation, including “effectively working with and involving parents in the education of their children” (Sec. 662[b][2]). Family collaboration is also documented in the teaching literature (Morris & Taylor, 1998) and in the AOTA

Table 2. Levels of Family Involvement

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No family involvement</td>
<td>Interaction occurs only if essential or by accident.</td>
</tr>
<tr>
<td>2. Family as informant</td>
<td>Family interview is used to obtain information about client’s history or current functioning.</td>
</tr>
<tr>
<td>3. Family as therapist’s assistant</td>
<td>Family is about disability and how to follow through on occupational therapist’s directed intervention.</td>
</tr>
<tr>
<td>4. Family as coclient</td>
<td>Occupational therapist’s concern includes how well family copes or adapts so therapist can assist in stabilizing family.</td>
</tr>
<tr>
<td>5. Family as consultant</td>
<td>Family input into goals and intervention is solicited; family is not a team member but invited guest.</td>
</tr>
<tr>
<td>6. Family as team collaborator</td>
<td>Occupational therapist includes family in evaluation, goals, and intervention planning.</td>
</tr>
<tr>
<td>7. Family as director of service</td>
<td>Family members decide whether occupational therapist is involved on the basis of which disciplines can help them achieve family goals. Family is team leader or selects service coordinator.</td>
</tr>
</tbody>
</table>

statement on occupational therapy in school settings as being crucial for student success. Nevertheless, implementation of family-centered principles appeared minimal for the therapists in this study providing occupational therapy services in educational settings.

Family barriers to successful implementation of FCP are real and challenging. Professionals working with families need education in cultural awareness, access to interpreters and interpreted materials for communication, opportunities to refer families to other professional resources, and flexibility and creativity in methods of accessing and collaborating with parents. Acknowledging the unique preferences and capacities of different families is inherent in FCP. One family may desire empowerment to guide all aspects of their child’s care, whereas another family may find this approach overwhelming and more a source of stress than benefit. FCP is definitely not a one-size-fits-all service delivery model (Edwards, Millard, Praskac, & Wisniewski, 2003; Egilson, 2011).

Occupational therapists and program administrators also need to reflect on internal and system barriers to FCP. Although evidence of the benefits of FCP is strong, studies have shown that many therapists are still unlikely to adopt FCP principles (Campbell & Halbert, 2002). Bruder (2000) identified the following reasons for nonadoption:
- A gap between research and practice
- Lack of therapist education in FCP
- Federal and state rules and regulations
- Limited support from administrators and colleagues
- Professional attitudes about the therapist’s and the parent’s roles.

In the current study, the therapist respondents identified some of the same barriers to FCP, and some were implied in discussion of their personal expectations of families and perceived barriers to family involvement. The respondents frequently described their biggest barrier to FCP as a lack of time. Similarly, Edwards et al. (2003) identified lack of time as the primary barrier to FCP for both therapists and parents.

The therapist respondents in this study were familiar with and able to articulate FCP principles. Nevertheless, their experiences with implementing FCP principles varied among therapists and, most significantly, among practice settings. Barriers to FCP, described by the therapists interviewed, appeared related to individual therapist characteristics; families’ unique and diverse needs; and the setting’s system, culture, and structure.

Limitations

Respondents were recruited from a limited geographic area using convenience sampling, so their experience may not be representative of that of therapists practicing in other areas of the United States or in other countries. Volunteering to be interviewed may have created sampling bias. Although many respondents gave information about the typical socioeconomic and diagnostic characteristics of their child clients, we did not collect specific demographic information on these variables to determine how well the families matched the general population of families raising children with special needs.

Future Research

Replication of these results using a larger sample of therapists from other parts of the country would provide information indicating the possibility of regional differences as well as practice setting variation. Further investigation of barriers to FCP in relation to both client and setting variables could provide therapists with increased awareness and opportunity to investigate solutions. All the respondents were able to identify principles of FCP, suggesting this topic was covered in basic occupational therapy education. However, educational research regarding how students are taught to operationalize these principles in specific practice settings might reveal opportunities for improved professional education.

Implications for Occupational Therapy Practice

Occupational therapy practitioners need to consider the following issues when working with children and their families:
- Do I understand the principles of FCP and what the literature says about effective implementation of these principles?
- Am I comfortable in a collaborative role with families?
- How am I facilitating communication with families? How can I make this communication more efficient and effective?
- What are the unique needs of this family? With what level of involvement are they comfortable? How can I facilitate involvement that is more effective?
- What are the systematic and cultural barriers to FCP in my practice setting? How can these barriers be modified to facilitate best practice?

Conclusion

We used a grounded-theory approach to analyze how occupational therapy practitioners working with children in a variety of settings implemented family-centered principles. All the therapists were familiar with the concept of FCP and could articulate how elements of FCP were or were not implemented in their current practice. Although
therapist responses varied slightly within a practice setting, the level of family centeredness was significantly different between settings. Therapists practicing in a home-based setting such as early intervention professed FCP as central to their service delivery. Clinic therapists acknowledged a desire for FCP but had numerous barriers to best practice related to their own experience and comfort level; unique situations of their client families; and temporal, spatial, and cultural practices within their specific clinic. The school-based respondents in this study generally did not see their practice as family centered. Although they described the importance of family involvement, achieving it appeared difficult and not central to the expectations of their practice setting.

Acknowledgments

We thank all the occupational therapists who participated in the study interviews.

References


