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The Family Therapy Engagement Model (FTEM)

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Abstract

Among pediatric Occupational Therapists' goals is to provide a holistic approach towards intervention planning which includes preparing the child's social environment, especially in facilitating the carry-over of tasks in the child's daily contexts. This model explores the factors contributing to the limited opportunities for family/caregiver participation during actual therapy sessions. It also discusses and integrates some of the best practice principles for family engagement that are based on the Phoenix Theory of Parent Attendance, Adlerian Play Therapy, and Discrimination model. This model was conceptualized in response to the growing need to increase family engagement during therapy in the Philippine setting, which could help them overcome barriers and strengthen their therapeutic skills and relationship with the child. Techniques and intervention processes that aim to engage the family during occupational therapy need to be further developed and studied. To fulfill this, this paper introduces a conceptual framework that maps out (1) five core elements, (2) five phases of family therapy engagement, and (3) a process checklist during the intervention process. The five core elements that affect family engagement are client, therapist, family, therapy-related, and environmental factors. This model explains how good collaboration between the family and therapists can be achieved if they undergo the preparation, consultation, planning, experiential activities, and re-education phase. The researchers suggest using this conceptual framework as a guide to understand and provide a systematic family engagement process during therapy sessions

Keywords: Occupational Therapy, Family Engagement, Factors affecting family engagement, Family

INTRODUCTION

Families provide a great influence on a child's progress. In educational settings, it has been well established that parental involvement is correlated with the academic success of children and adolescents.¹

In pediatric OT practice in the Philippines, families have been observed to assume a passive role during the therapy session. Active engagement occurs only during the feedback sessions wherein the therapist explains what transpired during the session. The effects of rehabilitation services are mostly effective when parents are consistently engaging and participative.² The rehabilitation services aim to combine principles of family-centered care that

require parent-service provider collaboration to promote child development.² Studies show that favorable family engagement was associated with improving parents' self-growth, parenting skills, increasing knowledge in promoting children's development and functional skills, enhancing the learning quality of children with developmental delay, improving parent-child relationship, and establishing a strong partnership between family and professionals.³

The child's therapeutic progress is largely dependent on parents' participation in the therapy process. Family-centered care is highly valued in OT when working with children and their families.¹⁰ The parents' contribution is well

recognized in family-centered practice, where a collaborative relationship between parents and health professionals is considered vital to achieving positive outcomes.⁴ In the Philippine context of a “family,” this may include extended family members such as a caregiver who accompanies the child during the session.

Family engagement is defined as the active engagement of the primary caregiver during the phases of therapy. Out of the five proposed phases in this model, the phases that allow the most opportunity for active participation are (1) Consultation Phase, (2) Experiential Phase, and (3) Re-education Phase. During these three phases, the family is directly involved in the therapy.

There is a lack of research that details the process of parent engagement during therapy sessions in OT. While engagement has been established in mental health settings and developing in the pediatric setting, its unique manifestation is still poorly described.⁴

The FTEM aims to serve as a guiding framework for therapists in engaging families in the service delivery, particularly during intervention sessions, and aims to influence positive intervention outcomes in the delivery of OT. With the use of the FTE Process Checklist, this model aims to help clinicians have a clear path in carrying out interventions that help parents become more engaged in reaching the child's full potential

DEVELOPMENTAL PROCESS

FTEM started by integrating key principles from two main studies: the Adlerian Play Therapy⁵ and the Phoenix Theory of Parent Attendance.² Furthermore, the authors gathered some evidence regarding family engagement in therapy sessions. These include Bernard & Goodyear's Discrimination Model, a published article titled ‘Influential factors on adherence to OT in parents of children with cerebral palsy.’⁷ The details of the studies are discussed in the next section. These aided in developing a comprehensive framework that will guide therapists' involvement in the therapy process.

After reviewing the literature, the authors identified concepts related to the phases and elements of family engagement. These ideas were then incorporated into ideas drawn from an analysis of the authors' clinical experience regarding family engagement in pediatric OT in the Philippines. Next, the authors identify relationships between concepts and principles by contrasting and integrating key keywords to develop a clearer transcription.

Finally, the FTE process checklist was created. It describes the therapist's tasks in each phase of the model, inspired by Terry Kottman's Adlerian Play Therapy, where four phases have been designated as one of the Adlerian techniques that strengthen the therapist's relationship with the child and parents. Based on the foregoing theory and the authors' clinical experience, they were able to develop five steps in the FTE process checklist.

THEORETICAL BASES

Phoenix Theory of Parent Attendance, Participation, and Engagement.² The Phoenix Theory of Parent Attendance offers a conceptual understanding of parents' participation and engagement in children's therapy services that can be used by service providers, policymakers, organizational leaders, and researchers to increase engagement in children's developmental rehabilitation services.

The theory is symbolically described as a journey to child health and happiness comprising six components: parent feelings, skills, knowledge, logistics, values, beliefs, and parent-professional interaction. It explains that the child, parents, and organizational elements influence engagement. Parent engagement is influenced by the parent, child, and organization elements, including the therapist, program, and institution. By assessing and addressing these factors, parent engagement is increased. This principle serves as the primary basis for the development of the factors making up the Family Therapy Engagement Model (FTEM). The authors changed the term *parent engagement* into *family engagement* to include different family and caregiving set-ups. Family engagement involves parents, caregivers, relatives, or guardians who

directly take care of the child.

Adlerian Play Therapy.⁵ Adlerian play therapists are guided by the concept that everyone is socially embedded, goal-directed, and creative. This outlines the four phases of child therapy and parent consultation: (a) developing an egalitarian rapport with the kid, (b) exploring the child's lifestyle, (c) assisting the child in gaining insight into his or her lifestyle, and (d) giving reorientation and reeducation for the child when needed.⁵ Parent consultation proceeds similarly, focusing on the relationship between the parent and his lifestyle and the parent-child lifestyle.

The therapist's role in four phases highlighted in Adlerian play therapy was re-described in the Triadic model by Jeon and Myers.⁸ First, the therapist gathers information and provides consultation on building relationships with parents. The therapist then helps parents establish themselves through experiential activities (i.e., family games), which help parents become aware of the inter- and intrapersonal dynamics surrounding their child's concerns. Toward the end of the reeducation process, the therapist actively incorporates teaching approaches via discussion, modeling, and behavioral rehearsal. The above processes described by the Adlerian Play Therapy and the Triadic Model served as the basis for FTEM's 5-stage process: 1.) Preparation 2.) Consultation 3.) Planning 4.) Experiential Activities 5.) Re-education. These are further explained in the next section.

Discrimination Theory. Bernard proposed the Discrimination Model in the mid-1970s as a theoretical framework for clinical supervision.⁶ This Discrimination theory suggested three main focuses for teaching/supervising:

1. Intervention skills to enable parents to cope with their child's symptoms and concerns.
2. Conceptualization skills which can help parents grasp their child's case, identify contributing factors and therapeutic elements in child therapy sessions.
3. Personalization skills to aid parents in understanding how personal or relationship issues may affect their child's symptoms.

This theory also highlighted the tripartite role of the therapist: counselor, consultant, and teacher. As a counselor, the therapist supports parents in gaining insight into the dynamics between their child's existing problems and their individual issues. As a consultant, the therapist helps parents conceptualize their child's case through a wider perspective by considering holistic aspects from both the child and parents. As a teacher, the therapist educates parents about coping techniques, interventions, and psycho-education to increase awareness of child development and help improve their parenting skills.

These roles were matched with each of the phases of Adlerian play to describe the therapist's tasks at every stage of the FTE process. This was the primary basis for creating the comprehensive FTEM and Process Checklist.

Influential Factors on Adherence to Occupational Therapy in Parents of Children with Cerebral Palsy.⁷

As non-compliance with treatment is prevalent, Rezaie and Kendi conducted a study to gain OT's perspective on the factors that influence parental adherence to OT interventions for children with cerebral palsy. Adherence was shown to be affected by four primary categories. First, *child and family factors* included variables such as child health and family composition. These variables could improve or hinder treatment adherence. Second, *therapist-related factors* included clinical competence, interpersonal skills, and job fulfillment. Third, *environmental factors* covered sociocultural perspectives' influence on disability and access to OT interventions. The category focused on environmental challenges to treatment adherence. The fourth category, *therapy-related factors*, described barriers such as type of therapy and duration.

The FTEM borrowed the concept of *Therapy-related factors* from the said study as one of the factors affecting family engagement. It represents the properties of the therapy session itself. Family adherence is influenced by the nature of OT and its interventions. Under therapy-related factors are assessment tools, intervention types, and treatment duration. When assessment tools are scarce, therapists have difficulty tracking their patients' progress,

leaving parents unaware if there is a need for their increased engagement in therapy. Parents' attitudes toward play-based therapy, a common form of intervention, may be unfavorable, resulting in their lack of a collaborative attitude

towards the therapist. Pediatric OT is often long-term; this demand from families may discourage them from seeking and being actively involved in therapy sessions.

CONCEPTUAL FRAMEWORK

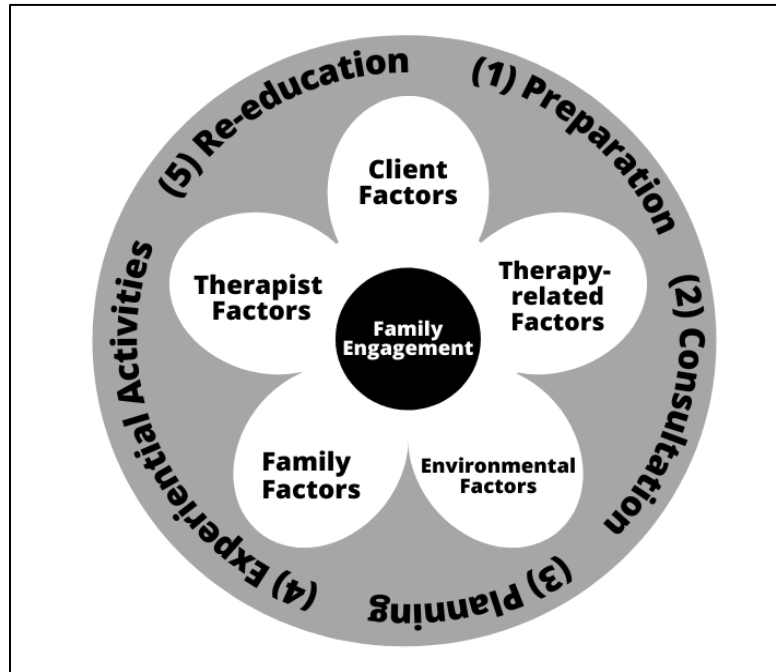


Figure 1. The Family Engagement Therapy Model

The FTEM serves as a guiding framework for therapists to engage the family in service delivery. OT practitioners strive to collaborate with the child's family during service delivery to obtain expected goals. The flower representation symbolized the "blooming" of the child's potential. The petals represent the factors that affect parent engagement.

The FTEM depicts the interrelatedness of Therapist Factors, Therapy-related Factors, Parent Factors, Client Factors, and Environment Factors adapted from the Adlerian Play Therapy and Phoenix Theory. Each factor affects the level of family therapy engagement in the pediatric OT sessions and must be closely identified and appreciated by the therapist.

Therapist factors. These pertain to therapists' competency, communication skills, knowledge, and attitudes toward the child's family during service delivery, contributing to poor family engagement.

Family factors. Poor therapy engagement may result from the family's motivation, cultural beliefs, economic capability, cognitions towards the therapy intervention, and other personal circumstances. The presence of issues in these factors can be manifested by poor compliance to home instructions, passive stance during feedback time, and overall low engagement in the therapeutic relationship.

Therapy-Related Factors. These factors mainly account for the characteristics of the given therapy session itself. Therapy programs that are too technical and that demand too much of the family's time, physical and financial resources may lower the family's engagement.

Child factors. The child with family and the therapy process mutually affect each other. The behaviors, abilities, and nature of the child's limitations can affect the family's motivation to engage in therapy. A child might dislike having their family present during therapy and could

interfere in the therapy process and aggravate an already disengaged family from therapy. Another issue is when the child has developed a transference towards the therapist, causing the child to only listen to the therapist's instructions, not the family. This will affect the level of family engagement and disrupt the parent-therapist rapport.⁹

Environmental factors. Environmental factors can be controllable or uncontrollable, and support or barriers. Distance issues and family schedule conflicts are beyond the therapist's and family's control. However, it is still important to discuss this during the consultation to work on a resolution together.

This model proposes five steps adapted from Adlerian Play Therapy to enhance the above factors to facilitate family engagement during therapy sessions. In each step, the therapist can assume the role of a (1) Teacher, (2) Counselor, and (3) Consultant.

1. Preparation

Therapist's role: Consultant

The first phase is mainly concerned with acknowledging the need to increase family engagement in a child's therapy process. It is the period for ensuring that all parties (i.e., child, family, professionals, institution) involved are well-oriented about the process. This phase aims to align the interests of each participant and prepare necessary therapy materials before the process of collaboration.

2. Consultation

Therapist's roles: Consultant and Counselor

This phase is mainly concerned with establishing a good family-therapist relationship. The therapist's main task is to gather information from the family to understand the family's situation better and assess the factors affecting their level of engagement. The therapist must communicate the importance of family engagement during therapy sessions, help the family understand the therapy process, assess their readiness, decide which family members can join in the therapy, and provide emotional support to the family before partaking in actual therapy engagement.

3. Planning

Therapist's role: Consultant

This phase gives the therapist time to prepare for the sessions wherein the family will be involved. The therapist must plan a structured therapy session that will facilitate a therapeutic experience for the child and for the family member who will be involved. Tasks include: planning the flow of activities, therapeutic use of self (TUS) that will be compatible with the family member, delineation of roles between the family member and therapist, time management, specifying outcomes for the session, and preparing necessary materials for the session.

4. Experiential Activities

Therapist's roles: Teacher and Consultant

This phase is the first step for family engagement in actual therapy sessions. It requires the child, family members, and therapist to be in the same space and time to achieve an optimal setting for interaction. This doesn't necessarily mean that this stage can only occur in face-to-face sessions. It can also be used in virtual and remote set-ups, where the therapist is distant from the family and child but is present through virtual space.

At this stage, the therapist teaches family members techniques and strategies used in the treatment and enables the child and family members to have healthy therapeutic interactions. The goal is to impart enough skill to family members so that they can replicate activities at home by allowing them to experience how it is done. Immediate feedback is also of importance at this point.

5. Re-education

Therapist's roles: Teacher, Consultant, and Counselor

In the last phase, the therapist employs all three roles. Here, the family has reached an active position in the therapy session. The family member continuously trains and applies the techniques taught by the therapist, with lesser dependence in initiating therapeutic activities with the child. Provision of a Home Instruction Program may be given, providing a clear set of activities that the family member can follow when engaging in therapy with the child at home.

The therapist accommodates new concerns, reviews the family member’s performance and the child’s progress, modifies the current treatment plan, teaches new skills, and supports the family. This doesn't necessarily mean that the therapist cessates direct patient handling; rather, the family has already achieved a level of engagement where they can perform some therapist roles under supervision.

The Process Checklist. This checklist was adapted from Adlerian’s Play Therapy Phases, originally composed of four phases. The FTEM results identified five sequential steps, namely, (1) Preparation, (2) Consultation, (3) Planning, (4) Experiential Activities, and (5) Re-education.

The checklist was synthesized to present a quick visual guide for the therapist in identifying tasks at each phase of the process. To use this checklist, the therapist must first determine how each factor supports or hinders family engagement during therapy sessions. Then, identify breakdowns in each factor in the preparation phase. These breakdowns are further assessed in the consultation phase. Lastly, the therapist attempts to address issues associated with the factors at the planning and experiential phases. During the final phase, the therapist works to improve or maintain the family's level of commitment.

Family Therapy Engagement Process Checklist (Therapist's Tasks)				
1	2	3	4	5
PREPARATION	CONSULTATION	PLANNING	EXPERIENTIAL ACTIVITIES	RE-EDUCATION
<ol style="list-style-type: none"> 1. Screen if the child needs increased family engagement during therapy sessions 2. Discuss with the family and the multidisciplinary team the child's need for increased family engagement during actual sessions 3. Ensure family is oriented about the therapy center's rules, policies, and confidentiality agreements. 4. Family agrees to have an active engagement during therapy. 5. Prepare necessary tools/ materials for consultation 	<ul style="list-style-type: none"> • Discuss the case of the child • Establish rapport with the family • Assess the family's lifestyle • Identify the family's attitudes toward the child • Identify the family's values • Determine the parenting methods • Assess marital relationships • Assess parent's readiness • Assess parent's insight into themselves, the child, and the dynamic of the two • Identify external issues affecting family's involvement • Set prioritized problem list • Set goals • Discuss the intervention plan with the family 	<ul style="list-style-type: none"> • Plan the structure of the treatment session <ul style="list-style-type: none"> ◦ The flow of activity/-ies to be accomplished during the session ◦ The appropriate therapeutic attitudes and approaches for the family ◦ The delineation of roles between parents and therapists ◦ Time management ◦ Specify outcomes for the session • Prepare necessary materials for the session 	<ul style="list-style-type: none"> • Establish expectations • Engage family in actual therapy sessions • Educate the family about the approaches, skills, and helpful attitudes during engagement in therapy • Allow the family member to apply the techniques and facilitate return demonstration • Strengthen the Family-Child relationship by allowing time for the family members to explore with their child 	<ul style="list-style-type: none"> • Review parent/caregiver performance during actual therapy sessions • Add/Modify techniques as necessary • Provide Home Instruction Program • Train parents/ caregivers on how to execute HIP at home • Monitor adherence to Home Instruction Program • Review intervention and outcomes

Figure 2. The Family Therapy Engagement Process Checklist

Limitations. The model was developed mainly for the use of pediatric OTs. The conceptualization of the model was inspired by the experiences of OTs working in the

Philippines. Thus, it may not account for therapists practicing elsewhere. Other professionals working with children, such as physical and speech therapists, may benefit from

this model. This model serves as a guide in understanding the factors which affect families. Furthermore, the process checklist is only meant to be a guide, not a protocol for addressing family engagement.

CONCLUSION AND RECOMMENDATIONS

Family engagement in therapy sessions is influenced by the transactions between the five core elements of this model: family, therapist, child, therapy-related factors, and environmental factors. Family engagement is an indicator of a child's potential for successful occupational performance. Professionals should intervene early so that family members can participate directly in therapy sessions while helping them overcome barriers and strengthen therapeutic skills and relationships with the child. Additionally, FTEM can be applied in face-to-face or virtual therapy set-ups. The OTs can draw on principles based on this conceptual model to guide selecting strategies for the child's family engagement in the therapy process.

Further research is needed to understand how parental engagement increases over time. A study focusing on personal and environmental circumstances is recommended. The child's multidisciplinary team should also be aware of the value and availability of family involvement in therapy. Recommendations from other professionals should include participation in family therapy to encourage family involvement in the child's therapy.

Individual author's contributions

C.N.A.: conception of paper, acquisition, analysis, and interpretation of journals, drafting the work and revising critically, approval of the version to be submitted for publication, and accountable for most aspects of the work; G.L.: conception of paper, acquisition, analysis, and interpretation of journals, drafting the work and revising critically, approval of the version to be submitted for publication, and accountable for most aspects of the work; C.V.C.: conception of paper, acquisition, analysis, and interpretation of journals, drafting the work and revising critically, approval of the version to be submitted

for publication, and accountable for most aspects of the work; M.A.: conception of paper, acquisition, analysis, and interpretation of journals, drafting the work and revising critically, approval of the version to be submitted for publication, and accountable for most aspects of the work; S.J.E.: conception of paper, acquisition, analysis, and interpretation of journals, drafting the work and revising critically, approval of the version to be submitted for publication, and accountable for most aspects of the work

Disclosure statement

The first author is the founder and executive director at Independent Living Learning Center, Academia Progresiva de Manila, the founder and president of REACH Foundation, Inc. and the program director of Mandaluyong CARES - Project Teach. The rest of the authors are graduate students of Master of Science in Occupational Therapy in the University of Santo Tomas.

Conflicts of interest

The authors whose names are listed in this paper certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

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