

From Paternalism to Partnership:
Family and Professional Collaboration in
Children's Mental Health

by

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Over the past 15 years, many mental health professionals and family members of persons with emotional disorders have advocated for collaboration between the two groups. A number of key elements of collaborative practice have been identified (Bernheim, 1990; Dumt & Paget, 1991; Hayield, 1979; Lamb, 1983), and programs to train professionals in principles of collaboration have been developed (Edelman, Greenland, & Mills, 1992; Yosler-Hunter, 1989). Although the concept of family-professional collaboration has gained some acceptance, there has been little research to assess the concept or related factors.

LITERATURE REVIEW

Previous research indicates that, historically, families of persons with severe emotional disorders have been dissatisfied with the services provided to their family members. Families have reported feeling blamed by professionals for their relative's illness and that the services offered to them did not meet their needs (Grunebaum, 1984; Hatfield, 1982; McElroy, 1987; Spaniol, Jung, Zipple, & Fitzgerald, 1987). While such reports in the children's mental health field are limited in number, the findings are consistent with those in the adult field. (Collins & Collins, 1990; Friesen, 1989; Tarico, Low, Trupin, & Forsyth-Stephens, 1989).

Reports of family dissatisfaction, along with a number of other factors affecting service delivery to persons with severe emotional disorders (DeChillo, 1989), have aroused interest in the relationship between mental health professionals and their patients' family members. Four studies (Bernheim & Switalski, 1988; McElroy, 1987; Smets, 1982; Spaniol et al., 1987) compared the attitudes and beliefs of families and professionals in order to understand factors leading to family dissatisfaction. Overall, lack of agreement between families and professionals regarding family needs and lack of family involvement were identified as two major contributors to dissatisfaction. It has been suggested that collaboration between families of individuals with emotional disorders and the professionals with whom they work could produce more satisfying working relationships between families and professionals and that this would facilitate positive outcome for patients (Collins & Collins, 1990; DeChillo, 1993; Group for the Advancement of Psychiatry, 1986; Grunebaum, 1986; Hatfield & Lefey, 1987).

Collaboration is commonly understood as two or more parties working together in pursuit of a common goal. Specific qualities or components of collaborative family-professional relationships have been identified. These components have been derived from theoretical discussions (Bernheim, 1990; Dunst & Paget, 1991; Grunebaum, 1986; Hatfield, 1979; Lamb, 1983; Spaniol, Zipple, & Fitzgerald, 1984; VoslerHunter, 1989); surveys of family members (Cournoyer & Johnson, 1991; Friesen, 1989; Friesen, Koren, & Koroloff 1992; Petr & Barney, 1993); and a survey of families and professionals (Durst, Johanson, Rounds, Trivette, & Hamby, 1992). The number of proposed characteristics, or components of collaboration range from four to 26 (Durst, et al., 1992), but the five most consistently cited are: 1) a caring, non-blaming attitude toward the family; 2) sharing information; 3) recognition of the family as a key resource; 4) recognition of limits and of the existence of other responsibilities; and 5) shared responsibility and power in the relationship, including joint decision-making and problem-solving.

Throughout discussions of all aspects of collaboration, the commonly agreed essence of a collaborative helping relationship between families and professionals is reciprocity, with shared power and responsibility. Such a relationship is grounded in the belief that the family can be a resource for professionals. It is worth noting that there is a good deal of overlap among proposed characteristics (e.g., sharing power and responsibility necessitates sharing information and recognizing limits). Although the characteristics were identified to guide professionals in their collaborative efforts, they apply equally to the reciprocal role of the family.

Sources of family dissatisfaction, family and professional attitudes, and the characteristics of collaboration in general have been studied; however, little empirical research has specifically addressed family-professional collaboration. In a survey of family members and social workers on an adult inpatient psychiatric unit, DeChillo (1993) assessed collaboration, factors influencing it, and its effects on clinical outcome. The strongest predictor of collaboration was the social worker's attitude toward family involvement in treatment. Higher levels of collaboration were also found to relate to positive perception of

the social worker's skill, identification of a mutual goal of improvement in the patient's functioning, positive perception of the family's intelligence and psychological awareness, and a greater number of family-staff meetings. Of particular note is the fact that greater collaboration was associated with more family involvement in the patient's discharge planning and with greater family satisfaction.

The present investigation sought to identify elements of collaboration from the perspective of the family members of children with serious emotional disorders. In doing so, it addressed the following questions: 1) To what degree are those components of family-professional collaboration proposed in the literature empirically distinct when assessed from the perspective of family members? 2) Are specific characteristics of professionals (e.g., organizational affiliation, professional title, gender, and ethnicity) related to the degree of collaboration? 3) Are specific service delivery characteristics (e.g., duration of services, frequency of contacts, and the number and type of services) related to degree of collaboration? 4) Are specific characteristics of the family (e.g., household income, education, age of caretaker, family structure) related to degree of collaboration? 5) Is there a relationship between degree of collaboration and family satisfaction with services?

METHOD

Scale Construction

Following standard scale-construction techniques (Carmines & Zeller, 1979; Dawis, 1987; DeVellis, 1991), a measure was developed to assess collaboration. Item content was based on concepts from the literature, findings from a telephone survey of family members and professionals who had participated in collaboration training, and suggestions from staff of the Research and Training Center on Family Support and Children's Mental Health (RTC), some of whom were parents of children with disabilities.

Scale items were designed to measure the following key components of collaboration:

- 1) Joint decision-making and planning (e.g., How much has this person worked with you in making decisions about services for your child/asked you to approve a treatment or service plan for your child?).
- 2) Locating or developing services (e.g., How much has this person worked with you to find services/to develop new services?).
- 3) Funding services (e.g., How much has this person helped plan how you would pay for services for your child/worked with you to find ways of paying for services?).
- 4) Evaluation based on feedback from family (e.g., How much has this person specifically asked for your feedback about the way that he or she is working with you/ made changes in treatment or services based on your feedback?).
- 5) Conveying a caring attitude (e.g., Has this person really cared about your family/ understood the problems you and your family have had?).
- 6) Sharing information (e.g., How much has this person explained the process of information-gathering to you? How satisfied are you with the way this person has answered your questions?).
- 7) Recognizing the family as a resource (e.g., How much has this person asked your opinion about your child's problems and needs/encouraged you to contribute ideas about your child's treatment or service plan?).
- 8) Recognizing limits of the family (e.g., Has this person understood that you have other things to worry about in addition to caring for your child with emotional problems/helped you find a balance between caring for your child and taking care of other things you have to do?).

Although some items focused on specific aspects of service delivery (e.g., involvement in the treatment plan), most were designed to be general in focus. The questionnaire consisted of 40 items, each with four response alternatives ranging from "Not at All" (scored as 1) to "Very Much" (scored as 4).

A pilot test of the initial item pool was conducted with 94 parents of children with emotional disabilities. The families were contacted through local parent support groups and through a national conference attended by a large number of family members. Twenty-nine of the parents also participated in focus groups that addressed issues of readability, clarity, and content of items. Each focus group

consisted of approximately seven parents who received a fee for participation. Based on feedback from the focus groups and analyses of responses, minor revisions were made in item wording and format.

The final version of the questionnaire was included in a booklet that contained an instrument to measure family empowerment (Koren, DeChillo, & Friesen, 1992), as well as questions about the professional, the service delivery process, the family and child, satisfaction with services, and availability of resources..

Parents were asked to complete the items with respect to one professional with whom they had had a number of contacts during the past 12 months. Many families receive services from more than one professional, and a choice of one from among them by parents themselves raised the possibility of idiosyncratic and unknown bias in the selection process. For example (assuming that families would choose to work more with providers that they liked), selecting the provider with whom they had had the most contact might bias the sample in favor of more collaborative providers. Therefore, two versions of the questionnaire were developed. One version asked the parent to choose the person with whom they found it easiest to work; the other instructed the parent to choose the person with whom they found it the most difficult to work. In cases where the parent only worked with one professional, the instructions directed them to complete the questionnaire with respect to that person. Assignment of questionnaire versions was random, and each version was completed by approximately half of the sample.

Data Collection

To obtain a sufficiently large sample for analysis, data were collected from several sources. Organizations for parents whose children have emotional, behavioral, or mental disorders in three states plus the District of Columbia were asked to distribute questionnaire booklets to their members. These organizations provide services to families whose children have mental health problems; however, membership may include families whose children have multiple disabilities. The participating organizations were given postage-paid questionnaire packets to be addressed and mailed to their members. Approximately two weeks later, they sent a followup postcard as a reminder. Questionnaires were completed anonymously and were returned directly to the RTC in business-reply envelopes included in the packet. Respondents were offered two complimentary RTC publications for participation; their anonymity was maintained by return of the order form in a separate envelope.

Questionnaires were distributed in June and July of 1992; 369 in Oregon, 820 in Wisconsin, 231 in Mississippi, and 50 in Washington, D.C. The number returned was 398 (an overall return rate of 27%). Using the same incentive and follow-up procedure, questionnaires were sent directly to participants in a previous RTC survey in 31 states and the Virgin Islands who had indicated a willingness to participate in additional research. Of the 283 questionnaires mailed, 117 were returned (a return rate of 41 %). For purposes of the present study, all data were merged into one sample. Thus, the effective overall return rate for the sample was 29%.

Sample

The analyses reported here are based on the responses of 455 parents who had a child under the age of 21 and who reported having had at least six contacts (arbitrarily chosen as the minimum number necessary for a reasonable impression of collaborative practice) with the chosen professional. To keep the analytic focus on issues relevant to minors, parents of children aged 21 and older were excluded from the sample. The majority of parents were female (93%), white (91%), and the biological or adoptive parent of the child (95%). The mean age was 40.2 (± 6.6) years. Almost all (96%) had completed high school and 34% had completed college. Just over one quarter (27%) lived in single-parent households. Annual gross household income was below \$10,000 for 13%, and greater than \$50,000 for 21 %.

The children were predominantly white (85%), male (74%), and had a mean age of 13.1 (± 3.9) years. Three-quarters lived with their biological or adoptive family at the time of the survey, 7% lived with an extended or foster family, and the remainder lived in non-family situations (e.g., residential treatment, psychiatric hospitals, group homes, or juvenile justice settings). The majority of the children were in the custody of the survey respondent (84%), the remainder were in state custody (8%) or in the custody of a person other than the respondent (8%). The most frequently reported diagnoses were attention-deficit hy-

peractivity disorder (55%), developmental disability (51%), emotional disorder not further specified (35%), mood disorder (24%), conduct disorder (21%), and oppositional disorder (16%). Many children (77%) had multiple diagnoses or conditions.

A little more than half (55%) of the professionals with whom the family members worked were female. Over one-quarter (27%) were teachers, 20% were social workers, 17% were psychologists, and 17% psychiatrists. The remaining 19% of professionals were divided among case managers, physicians, nurses, and lawyers. One-third of the professionals worked in educational settings, one-quarter in mental health agencies, 14% in private practice, and the remainder in other settings (e.g., medical, child welfare, and juvenile justice). From a checklist of 11 possible services, parents reported that professionals provided the following to their children: individual counseling (40%), assessment or testing (37%), educational services (35%), family counseling (29%), information and referral (29%), case management (25%), medication (24%), advocacy (15%), group counseling (8%), recreational services (7%), and vocational services (7%). Most professionals provided more than one type of service, averaging between two and three types of services to each child.

ANALYSIS AND RESULTS

Components of Collaboration

Exploratory factor analysis was performed on item responses in order to identify distinct latent dimensions of collaboration (Loehlin, 1987). The analysis was based on the principle axis method using squared multiple correlations as communality estimates and a scree test to determine the number of factors to rotate. Since there was no reason to assume that different dimensions of collaboration would be orthogonal, or independent, the direct oblimin method of factor rotation was used, a method that allows rotated factors to be correlated. Four factors with eigenvalues of 25.17, 1.64, 0.97, and 0.74 were obtained, collectively accounting for 71% of the variance. Both the pattern and structure matrices were used to interpret factors.

Factor I was principally defined by items that measured the relationship component of collaboration, as well as activities reflecting a fundamental spirit of partnership, e.g., professionals conveying a caring attitude, taking parents' opinions and concerns seriously, treating the family as a key resource, recognizing parents' limitations and competing responsibilities, and including parents in the decision-making process. Of the 40 items, 21 had pattern matrix loadings above .40 on this factor, and the order of loadings suggested that there were few empirical differences among key concepts often identified in the literature as important facets of collaboration. This does not mean that distinctions among such concepts are not worth making, but rather that many of these distinguishing activities tend to occur in tandem and thus may be viewed as collectively defining the general tenor of a collaborative relationship.

Factor II was largely defined by instrumental items concerned with paying for, finding, developing, and coordinating services. The emergence of this factor reflects the importance of attention to practical aspects of service delivery aside from the relationship itself. The underlying issue is accessibility to services in cases where access is impeded by lack of finances, information, or sufficient linkage with resources.

Factor III was defined by items concerning information and explanations provided by professionals on such matters as service options, why certain information is needed in the service delivery process, and how parents can become involved in planning. Implied here is the role of information in the maintenance of reciprocity; the open, exchange of information makes possible a partnership between parents and professionals, while the withholding of information can become a barrier to achieving partnership.

Factor IV was defined by items measuring the flexibility of the professional in changing services based on parental feedback. It reflected professionals' openness to the possibility of change, how much they encouraged parents to make suggestions, and a general approach to service delivery that

emphasizes the need for feedback and monitoring. While evaluation is not often listed as a distinguishing feature of collaboration, the results of the factor analysis suggest that it carries some importance.

The correlations among factors were moderately strong, particularly those between the first factor and the other three between .60 and .61. All remaining correlations among factors were between .44 and .45. This pattern suggests that even though distinctions could be made among different components of collaboration, all components were functionally related.

Professional Characteristics of Service Providers

To assess whether collaboration varied by characteristics of service providers, multivariate analysis of variance (MANOVA) was used to examine the relationship of collaboration factor scores to professional title, organizational affiliation, and gender. The factor scores were derived from the preceding factor analysis using the regression method and are referred to as Supportive Understanding, Accessing Services, Sharing Information, and Utilizing Feedback, corresponding to the four factors. Following the detection of a significant multivariate effect, mean differences among individual factor scores were identified with univariate analysis of variance (Barker & Barker, 1984; Hummel & Sligo, 1971). Sheffe post-hoc comparison tests were performed to examine mean differences between each category and the mean of all other categories combined. For the analyses focusing on professional title and organization, only those categories with a relatively large number of cases were included. For professional title, analyses were limited to social workers, psychiatrists, psychologists, and educators; together these four groups accounted for 82% of the sample. For organizational affiliation, analyses were limited to medical organizations, mental health agencies, schools, and private practice settings, which collectively accounted for 81 % of the sample. Table 1 presents the results of these analyses.

Significant multivariate effects were found with respect to all three professional characteristics. With respect to professional title, significant univariate effects were found with three of the four factor scores: Supportive Understanding, Accessing Services, and Utilizing Feedback. Post-hoc comparisons revealed that educators were significantly lower on Accessing Services compared to the average level of other professionals, and social workers were significantly lower on utilizing feedback compared to the average level of other professionals. With respect to professional affiliation, significant univariate effects were found with two of the factor scores, Supportive Understanding and Accessing Services. Post-hoc comparisons revealed that parents viewed private practice settings as significantly higher than other organizations on Supportive Understanding. However, compared to other professional settings, they tended to view educational settings as significantly lower on both Supportive Understanding and Accessing Services.

Service Delivery

In addition to inherent characteristics of professionals providing services to families, other characteristics of the service delivery process may influence collaboration. In this study, three such characteristics were examined: number of services provided, frequency of contacts, and length of time with the professional. Categorical representation of these characteristics were examined with MANOVA using the four collaboration factor scores as a multivariate dependent variable. Following an overall multivariate effect, univariate tests were performed on individual scores, supplemented by *F*-tests for linearity to identify linear relationships among the means. The results of these analyses are presented in Table 2.

Table 1
Summary of MANOVA Results:
Factor Score Means by Professional Characteristics

PROFESSIONAL CHARACTERISTIC	FACTORa				MULTIVARIATE
	I	II	III	IV	Fb
Title					
Social Worker (N=90)	-0.11	0.18	0.00	-0.24	6.22***
Psychiatrist (N=76)	0.14	0.12	0.02	0.14	
Psychologist (N=78)	0.27	-0.04	0.02	-0.01	
Educator (N=128)	-0.16	-0.24	0.03	0.13	
F ^c	4.13**	4.63**	0.03	3.47*	
Organizational Affiliation					
Medical (N=43)	-0.01	-0.06	-0.18	0.01	5.08***
Mental Health (N=111)	0.14	0.20	0.04	-0.05	
Educational (N=150)	-0.14	-0.23	0.07	0.12	
Private Practice (N=63)	0.36	0.22	-0.02	0.23	
F ^c	4.56**	5.99**	0.77**	1.37*	
Gender					
Women.(N=250)	0.02	0.04	0.13	0.03	3.93**
Men (N=200)	0.00	-0.04	-0.15	-0.03	
F ^c	0.03	0.73	9.77**	0.47	

Note: Values are mean factor scores.

^aFactor I=Supportive Understanding; II=Accessing Services; III=Sharing Information; IV=Utilizing Feedback.

^bApproximation of Wilks' Lambda.

^cUnivariate tests of each subscore.

*p<.05; **p<.01; ***p<.001.

Significant multivariate effects were found with respect to all three characteristics of service delivery. For number of services, significant univariate effects were found with all four collaboration factor scores such that a higher number of services was associated with more collaborative activity. For frequency of contacts and length of time with the professional, generally similar patterns were found linking more collaboration with increased contact. Two of the four factor scores, Supportive Understanding and Sharing Information, were significantly associated with higher frequency of contact, and two other factor scores, Accessing Services and Utilizing Feedback, were associated with longer length of time working with the professional. In both instances, the linear trend among means was significant.

Family Variables

The reciprocal nature of collaboration raises the possibility that certain family characteristics are associated with different facets of collaboration. This may reflect either differential treatment of families based on certain characteristics (e.g., a professional who feels that collaboration can only be achieved with educated families), or the contributions of family members to the collaborative relationship (e.g., a family that is sufficiently assertive to demand involvement in service decisions). To address this issue, the relationship was examined between the four collaboration factor scores and a series of family and child variables: parent's age, education, and marital status; family income, child's age and gender, and length of time that the child or family had received services for the child's condition. All variables were treated in a categorical manner and analyzed with MANOVA supplemented by univariate tests.

No significant effects were found with respect to parental age or education, child age or gender, family income, or length of time that the child had received services. Only marital status (spouse vs no spouse) was associated with a significant multivariate effect ($F=3.22$, $p<.05$), and here only one factor score, Accessing Services, appeared to be significantly different across the two conditions ($F=10.33$, $p<.01$). Parents who did not have a spouse or partner were more likely to report that their professional helped them to find, develop, and arrange payments for services than were parents who had a spouse or partner.

Satisfaction With Services

The questionnaire asked parents to rate their satisfaction with professionals in the areas of assessment, planning, providing services, and evaluation using five-point scales ranging from "Very Dissatisfied" to "Very Satisfied." A composite score formed from these item responses was used as an overall indicator of parental satisfaction with the professional's services. The reliability of this score, estimated by an alpha coefficient, was .96. Stepwise multiple regression was used to examine the relationship of this score to the four collaboration factor scores.

A very strong relationship was found between satisfaction and collaboration. Collectively, the four factor scores accounted for 86% of the variance in parents' satisfaction with professionals ($R=.93$, $p<.001$). All four factor scores provided unique and significant contributions to the equation, although their importance varied. Supportive Understanding provided the strongest contribution ($\beta=.67$, $p<.001$), accounting for approximately 45% of the variance in satisfaction. Lesser contributions were provided by Accessing Services ($\beta=.16$, $p<.041$), Sharing Information ($\beta=.11$, $p<.001$), and Utilizing Feedback ($\beta=.09$, $p<.001$). The results of this analysis suggest that each of the components of collaboration influence how parents feel about professionals but that Supportive Understanding is the most important of the factors.

Conceivably, the availability of services in a community could influence the relative importance of different collaborative activities. In the questionnaire, parents were asked, "At the time you were working with this person, were services available for your child in the community?" The same 4-point scale used in other items was provided for responses. To further examine the contribution of collaborative activities to satisfaction with services, similar stepwise multiple regression analyses were repeated under conditions of high availability of resources—i.e., for those who answered "Very much" to the above question ($N=81$)—and low availability of resources—i.e., for those who answered "Not at all" to the above question ($N=121$).

While each equation accounted for approximately 83% of the variance in satisfaction ratings ($R's=.91$, $p<.001$), the contributions of individual factor scores varied. For the very low resource condition, the Supportive Understanding, Utilizing Feedback, and Accessing Services factor scores provided significant contributions. Their standardized regression coefficients were .73, .16, and .12, respectively

Table 2
Summary of MANOVA Results:
Factor Score Means by Service Delivery Characteristics

SERVICE DELIVERY CHARACTERISTIC	FACTOR ^a				MULTIVARIATE
	I	II	III	IV	F ^b
Number of Services					
1 (N=133)	-0.51	-0.38	-0.46	-0.26	6.93***
2 (N=124)	-0.03	-0.12	-0.09	-0.13	
3 (N=180)	0.26	0.22	0.28	0.04	
4(N=58)	0.46	0.36	0.46	0.40	
5(N=58)	0.49	0.50	0.44	0.44	
F ^c	19.89***	14.40***	19.69***	9.72***	
F for Linearity	59.81***	49.36***	59.18	36.64***	
Frequency of Contacts					
<Once a Month (N=79)	-0.29	-0.21	-0.27	-0.11	1.78*
Once a Month (N=80)	-0.17	-0.08	-0.15	-0.17	
Few Times a Month (N=137)	0.11	0.04	0.13	0.10	
Once a Week (N=86)	0.21	0.18	0.11	-0.03	
>Once a Week (N=69)	0.07	0.03	0.14	0.15	
F ^c	3.81**	1.95	3.58**	1.78	
F for Linearity	9.50**	4.54*	10.19**	3.84	
Time With Professional					
Under 1 Year (N=99)	-0.06	-0.21	-0.19	-0.20	2.04*
1 Year Up to 2 Years (N=142)	-0.11	-0.04	-0.03	-0.03	
2 Years Up to 3 Years (N=104)	0.10	0.01	0.08	0.07	
3 Years and Over (N=110)	0.10	0.23	0.14	0.16	
F ^c	1.43	3.80*	2.50	2.85*	
F for Linearity	2.61	10.90*	7.35**	8.48**	

Note. Values are mean factor scores.

^aFactor I=Supportive Understanding; II=Assessing Services; III=Sharing Information; IV =Utilizing Feedback.

^bApproximation of Wilks' Lambda.

^cUnivariate tests of each subscore.

p<.05; *p*<.01; *p*<.001.

(all $p < .001$). For the very high resource condition only the Supportive Understanding and Sharing Information factor scores provided significant contributions to the prediction of satisfaction. Their standardized regression coefficients were .72 and .26, respectively (both $p < .001$). While the supportive quality of collaboration was clearly a major contributor to satisfaction under both conditions, the differences in the two equations suggests that, when community resources are low, activities related to finding and developing services, as well as flexibility in evaluating services, are particularly important. When community resources are high, however, these activities become less important in favor of information sharing, e.g., explaining the process of information gathering and discussions about planning and service delivery.

DISCUSSION

The results of the present study have important implications about how professionals conceptualize, measure, operationalize, and promote collaboration. The findings highlight the importance of four key elements of collaboration—supportive relationships, practical service arrangements, forthright information exchange, and a flexible, shared approach to gauging failure or success. These four elements appear to be empirically distinguishable in a factor analytic framework and substantively meaningful in relation to various professional, service delivery, and family characteristics. From a methodological standpoint, the findings provide some support for using these constructs and their associated items as reliable measures of family-professional collaboration. For example, if all the items with loadings above .40 on their respective factors are simply formed into four corresponding composite scores, the alpha coefficient for each subscore meets or exceeds .90. Although more research is needed with this item pool before a definitive measure of collaboration can be established, the initial results are promising.

Professional Characteristics

The substantive findings linking different components of collaboration to various professional, service delivery, and family characteristics are particularly relevant to professional education and training. Educators, for example, were perceived as less likely than other professionals to assist families in accessing services, and educational settings were seen as less supportive than other settings. Similarly, social workers were seen as less likely to seek and utilize feedback compared to other professionals.

With respect to both professional title and organization, some of the findings may be attributable to traditional roles. Compared to other service providers, educators may be less likely to provide a range of services and thus understandably fall lower on the Accessing Services factor. However, the comparatively lower rating on Supportive Understanding in the educational sector suggests that this key facet of collaboration may require more attention by teachers, principals, and other school personnel. Moreover, the lower rating on Utilizing Feedback with respect to social workers suggests the need for more attention to evaluative activities that actively involve parents' appraisals of services.

In interpreting the findings, it should be noted that professional title and organization were measured from the standpoint of parents who may not have known the specific discipline of the professional. For example, a case worker in a social service setting may have been identified as a social worker, although that person may not have possessed a formal affiliation or degree in the field of social work. Nevertheless, the findings indicate broad differences in practice that have implications for training and management.

Although all children with emotional disorders are involved with the educational system at one time or another, and many families whose children have disabilities interact with social workers, it is possible that educators and social workers do not receive sufficient training and support in these key areas of collaboration. Training programs in family-professional collaboration have been developed and successfully implemented (Edelman et al., 1992; Kelker, 1987; Vosler-Hunter, 1989), and there are promising signs that collaboration principles are being incorporated into professional training curricula (Friesen & Schultze, 1992; Johnson, 1993). The present findings suggest that these efforts are both timely and deserving of wider application.

Gender of the professional also showed an overall multivariate effect, and this appeared to stem largely from a significant difference in information sharing between men and women. Female professionals were generally seen as more open about sharing information than were male professionals, although this finding must be qualified by the fact that the vast majority of parental respondents (96%) were women. An adequate test of gender-based professional differences controlling for gender of the respondent, i.e., matching parents and professionals on gender, was not feasible because of the low number of males in the sample. However, the finding does suggest that male professionals could benefit by paying more attention to both the quality and the quantity of information that they share with family members, especially with females. This finding may also reflect the strong association between gender and authority in society, with the implication that male professionals need to be especially attuned to power differentials in helping relationships.

The fact that parents were asked to rate the easiest or most difficult professional, while effective as a methodological procedure, may have introduced a degree of polarization in the total sample. The procedure did not direct family members to assess their experiences with all professionals with whom they had worked, and therefore the data cannot be viewed as representative of the average professional. Nevertheless, the range of professional qualities tapped in this study is consistent with anecdotal accounts from parents who collectively reported an array of very positive and very negative experiences with professionals and the service system.

Service Delivery

The significant multivariate effects found for all three characteristics of service delivery suggest that collaborative relationships are influenced by a higher level of involvement between families and professionals. This involvement may take the form of more time spent with families, more continuity of the relationship, or a more comprehensive approach to providing services. The findings also suggest that the occurrence of collaborative activities varies at different points of the family-professional relationship. Specifically, activities related to accessing services and evaluating the success of services are understandably more salient once the parent-professional relationship has been established and functionally focused on long-term progress.

Family Variables

The only significant association found between family variables and the four collaboration factors was that between single-parent status and Accessing Services. This may reflect efforts on the part of professionals to fill a perceived need for concrete support in arranging services—support that might otherwise be provided by a spouse. Implied here is the responsive quality of a collaborative relationship whereby the professional responds to the actual needs of the family rather than to preconceived notions of what is needed.

Variables such as education, income, and length of time receiving services are often viewed by service providers as indicators of a family's potential to collaborate effectively. While sampling limitations may restrict the generalizability of the present analysis, the findings provide no support for these notions.

The sampling strategy made predominant use of parent organizations, and the representativeness of such a sample with respect to the general population of parents of children with emotional disabilities is unknown. The sample varied widely on such characteristics as family income, parental education, service involvement, and diagnostic categories. However, families associated with parent organizations may also have a heightened awareness of certain issues pertaining to family-professional relationships, which may have influenced their responses. Ultimately, the issue of comparability of samples is a matter for future research.

Implications for Research and Practice

A number of issues warrant further research and refinement. The results of this study are based on perceptions of parents or other family members. Given its reciprocal nature, further research on collaboration should include a similar survey of professionals to assess not only self-perceptions but their perceptions of family members as well. Attention should also focus on gender differences of professionals and the interaction with both mothers and fathers. Investigation of issues related to cultural similarities

and differences between professionals and family members was not possible because of the limited diversity of the sample; however, these are areas that should be considered in future research.

In considering previous literature and the empirical verification of the four components of collaboration from this study, it appears that the overarching characteristic of a collaborative relationship is the sharing of power and responsibility by the family and the professional. This translates into professionals recognizing the valuable perspective and knowledge that families possess, seeking their input and involvement throughout the helping process, and involving them as partners in decision-making. With particular families, and under certain circumstances, the relationship may not always be a balanced one. During the focus groups held for construction of the scale, some family members reported that there had been times when they wanted a professional to assume the major role in a given decision or activity. In fact, such flexibility in responsibility and effort is more characteristic of true partnerships than of an artificial and rigid fifty-fifty split. To achieve this, professionals must be sensitive to the changing circumstances and needs of families. Since families have the primary interest in their child, they will be involved to as large an extent as possible, depending upon the attitude of the professionals with whom they work.

For some professionals, there is a dilemma inherent in the concept of collaboration. In traditional helping relationships, professionals exercise a good deal of power over the person seeking help, power that can take many forms, including knowledge, expertise, and access to resources. However, true recognition of reciprocity and mutuality in helping relationships (Hasenfeld, 1987; Par, 1988) carries profound and, to some, unsettling implications for traditional notions of professionalism. Advocates suggest that collaborative relationships do not threaten the value or status of professionals but rather transform their role to that of a facilitator who utilizes the client's perspective as a resource, ultimately empowering clients to help themselves.

Collaboration is not a simple and unitary concept; it is complex and multidimensional. It markedly expands our understanding of the nature of helping relationships with families and calls into question the professional's traditional role. Although the findings of this study are concerned with activities and behavior, the underlying subtext is one of values, and therein lies the challenge for the helping professions. It is one thing to prescribe techniques and types of behavior for ideal professional performance; it is quite another to promote a pervasive quality of partnership such that families' perspectives, ideas, and efforts are sincerely valued as an integral part of the service delivery process. The response of various helping professions toward this challenge will determine, in large measure, how much progress can be made in meeting the needs of children with serious emotional disorders and of their families.

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