

## Evolution of Family-Professional Partnerships: Collective Empowerment as the Model for the Early Twenty-First Century

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In this chapter we present four models of parent-professional partnerships, including a discussion of the power relationships within each. The approaches that we discuss include 1) parent counseling/psychotherapy, 2) family involvement, 3) family-centered services, and 4) collective empowerment. The research and professional literature upon which we base our analysis is drawn from the early childhood special education field. That literature has been constructed primarily since the 1950s with a focus on young children with developmental disabilities. Family-professional partnership trends in other areas of early childhood services have differed from those that we are presenting; however, it is beyond the scope of a single chapter to analyze partnership models within all early childhood fields.

We begin the chapter with a discussion of the type of power – power-over, power-with, and power-through – that are generally inherent in each of the four family-professional partnership models. The models are further portrayed through the use of a what-might-have-been vignette. We begin the chapter with a vignette of an imaginary family, one that prototypically might be known to any service provider. As we discuss each of the models and the power relationships within those models, we suggest how that model may have been brought to bear on that family.

Jeanette A. is a 37-year-old African American woman who lives in a community of approximately 65,000 people in an eastern state. Her daughter, Tisha, was born at 26 weeks gestation, weighing 1

pound, 12 ounces. Tisha has multiple disabilities including hydrocephaly, a heart defect, and cerebral palsy. Jeanette also has an older son, Lenny, who is a 19-year-old high school dropout and is intermittently employed. Jeanette's mother lives about 25 miles away but often is called upon for child care and is a source of emotional support for Jeanette.

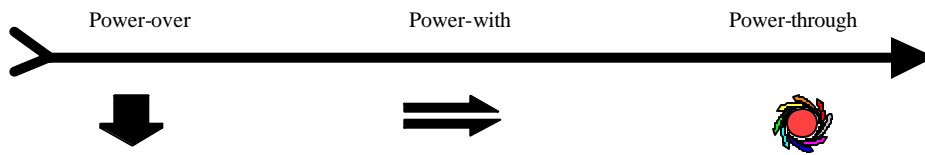
Jeanette and Tisha usually live by themselves in a two-bedroom duplex, but Jeanette's former husband, who is also Tisha's father, sometimes lives with her, as does Lenny. Jeanette works as a nurse's aide, 11:00 a.m. till 3:00 p.m., five days a week, at a nursing center in a community 30 miles away from her home.

Lenny and Jeanette have a stormy relationship, with frequent verbal and physical altercations over both relatively minor and significant issues. Lenny is a good care provider for his younger sister, Tisha, and is often called upon to provide child care for her.

Jeanette's relationship with her husband and her son have on occasion been physically abusive. Jeanette has some learning disabilities and requires medication for a bipolar disorder. She also regularly attends AA meetings because of her drug and alcohol addiction.

### **POWER AND FAMILY-PROFESSIONAL PARTNERSHIPS**

The evolution in developing and implementing family-professional partnerships within early childhood special education can be described as an evolution along a power continuum, as illustrated in Figure 27.1.



Forty years ago, the professionally driven parent counseling/psychotherapeutic model with the professionals in a power-over relationship with parents was most common (Wolfensberger, 1967). Today, an empowerment model, one that enables power to be generated and to grow through relationships, is emerging (Dunst, Trivette, Gordon, & Starnes, 1993; Turnbull & Turnbull, 1997).

*Power*, which is the "ability and willingness to affect the behavior, thoughts, physical well-being, and/or feelings of another" (Claus & Bailey, 1977, cited in Kisthardt, 1992, p. 76), is a critical element of all relationships. Natiello (1990) suggested that power in and of itself is neither good nor bad; it is how it is used that can lead to either destructive or creative growth. She further suggested that, traditionally, authoritarian power has been most common in human relationships.

The use of authoritarian power can result in feelings of distrust, competition, loss of control, and dependency by subordinates on those who are in the dominant role (Natiello, 1990). For the subordinates in authoritarian power relationships, there is often low self-esteem; loss of social and personal potential; and feelings of anger and unrest. In these relationships, there is little room for emotional expression, personal openness, intimacy, or interconnectedness (Crais, 1993; Natiello, 1990).

Parent-professional partnerships have been traditionally marked by the presence of these dominant-subordinate power structures, with the service provider in the dominant role and parents or family members in the subordinate role. Professionals most often have had control of information and resources that were needed by families in order to help their children. This power structure is referred to as a *power-over* relationship (Follett, 1924; Natiello, 1990; Turnbull & Turnbull, 1997). Power-over relationships are characterized by professionals exerting decision-making control over parents through perceived higher competence, professionalized communication, and control of environmental resources. The goal is often to define




**Figure 27.1.** Power Continuum

parental problems on the basis of the professional's "diagnosis" and to enforce compliance through authoritarian control with "treatment." Parent counseling/psychotherapy and parent training/involvement partnership models are built on these traditional authoritarian power relationships. Table 27.1 identifies the characteristics of power-over relationships.

In recent years, relationships and the power distribution between service providers and families have begun to change. Emerging partnerships began to reflect the principles of family-centered practice in which families are actively involved in decision making and services meet family and child needs (Bailey, Buysse, Edmondson, & Smith, 1992; Kjerland & Kovach, 1990; McBride, Brotherson, Joanning, Whiddon, & Demmitt, 1993; Turnbull & Summers, 1985).

Family-centered partnerships are marked by power-with relationship between providers and family members. Service providers and family members recognize the value of the knowledge and expertise each brings to the table. Ultimate decision making is a responsibility of the family, although the decision might be to avoid making a decision or to delegate decision making to the service provider (Turbiville, Turnbull, Garland, & Lee, 1996). *Power-with* partnerships arise when collaborative decision making is used among parents and professionals through perceived equal competence, contextual communication, and sharing of environmental resources. In family-centered partnerships, professionals respect family members' competence, listen to their perspectives, and are influenced by the knowledge and resources inherent in their family system and community ecology. Because they are not the primary decision makers in most instances, professionals in power-with relationships are collaborators with families through information sharing and problem solving (Crais, 1993). Table 27.1 highlights the characteristics of these partnerships.

**TABLE 27.1. Evolution of Relationships**

Type of power	Family-professional partnership model	Type of decision making	Participants	Communication	Resources
Power-over 	Parent counseling/psychotherapy; parent training involvement	Exerting control	Professionals, with parents (usually mothers)	Full of clinical jargon, maintenance of professional distance, and directive	Often limited to existing service-system resources within professionals' control
Power-with 	Family-centered services	Collaborating	Parents (usually mothers) and professionals	Courteous and candid	Existing service-system resources, plus family resources
Power-through 	Collective empowerment	Synergizing	Parents, family members, friends, community citizens and professionals	Insightful ("head"), caring ("heart"), and dynamic	Creation of new and preferred resources

One might presume that a balancing of power or power-with partnerships would be the desired outcome of any relationship. As knowledge about family/professional partnerships has progressed, however, an even more productive way for families and professionals to relate has emerged. That relationship, which we refer to as collective empowerment, is a *power-through* partnership. Power-through partnerships incorporate synergistic decision making among family members, professionals, friends, and community citizens through perceived group competence, "mind and heart" communication, and the creation of new and preferred environmental resources. Synergistic decision making infuses the traditional individual and dyadic decision making with group energy and creativity so that the combined effect is substantially greater than what individuals or dyads could have constructed. In more common vernacular language, it means "that the whole is greater than the sum of the parts."

By defining power in terms of capacity rather than control, partnerships are moved to a different plane. On that plane, power becomes a synergistic resource for everyone who is involved in the partnership. No longer is control of communication, resources, decision making, or other people the issue. In these partnerships, there is a synergy that creates power

(and empowerment) for all participants. Power is not finite within collective empowerment partnerships; instead, it is generative and available to all (Wagner, 1992). This partnership creates the context in which all participants can access and influence the resources they need to achieve their goals (Kalyanpur & Rao, 1991; Katz, 1984; Kieffer, 1984).

Service providers sometimes fear the loss of control or power in power-with or power-through partnerships. In fact, particularly in power-through partnerships, power increases. Here, through the synergy of the relationships, more resources are made available to all members of the partnerships (Turnbull & Turnbull, 1997; Wagner, 1992). Power-through partnerships based on synergistic power are characterized by openness, responsiveness, dignity, personal empowerment for each member, alternating influence, and cooperation (Katz, 1984; Kieffer, 1984; Natiello, 1990). These partnerships generate win-win outcomes: each partner gains (Turnbull & Turnbull, 1997).

## MODELS OF FAMILY-PROFESSIONAL PARTNERSHIPS

As we stated at the outset, we want to reiterate that our focus is on family-professional partnerships within

**TABLE 27.2. Time periods of Primary Emphasis of Family-Professional Partnership Models within Early Childhood Special Education Field**

Time of primary emphasis	1950s-1960s	1960s-1970s	1980s	1990s and into 21st century
Models	Counseling/psychotherapy model	Parent training/involvement	Family-centered model	Collective empowerment

the early childhood special education field. The literature that we cite comes from the early childhood special education field with a primary emphasis on serving children with developmental disabilities and their families. We highlight each of the four family-professional partnership models (parent counseling/psychotherapy, family involvement, family-centered services, and collective empowerment) in a sequential order in terms of the period of time in which the model has had or continues to have most influence. Table 27.2 illustrates the four models and the general time period most associated with their primary emphasis within the field of early childhood special education.

We want to caution readers against generalizing our analysis of practices within the early childhood special education field to all applications of parent counseling-psychotherapy, family involvement, family-centered services, and collective empowerment in other fields and with other populations. We briefly highlight 1) an overview of the model, 2) the type of power that generally characterizes the model, 3) assumptions, 4) professional roles and perspectives, 5) parent perspectives, and 6) expected outcomes.

### **Overview of Parent Counseling-Psychotherapy Model**

Counseling-psychotherapy models were particularly prevalent with mothers of young children with mental retardation in the 1950s and 1960s (Beddie & Osmond, 1955; Bowlby, 1960; Dalton & Epstein, 1963; Emde & Brown, 1978; Goshen, 1963; Mandelbaum & Wheeler, 1960; Ross, 1964; Sieffert, 1978; Solnit & Stark, 1961; Wolfensberger, 1967). Wolfensberger's (1967) comprehensive review of the 300-plus articles that constituted the bulk of the

counseling/psychotherapy literature highlights the psychoanalytic framework and clinical orientations of this period. The literature primarily emphasizes 1) the impact of the child with mental retardation on the mother's "adjustment" and 2) clinically observed stages of grieving.

A passage from Solnit and Stark (1961), a frequently cited article illustrative of this model and time period, characterizes the model's psychoanalytic framework:

The theoretical approach to our work is founded on the psychoanalytic explanation of the process of the mourning as applied to the mother's reactions to the birth of a defective child (Bibring, 1959; Bibring, Dwer, Huntington, & Valenstein, 1961; Freud, 1917, 1923; Janis, 1958a,b). Freud's contributions to the understanding of narcissism and its vicissitudes (1914) are essential for the study of object loss – in our case, the loss of the longed-for healthy child. (Solnit & Stark, 1961, p. 524).

Parents frequently become the "cases" for counseling and psychotherapeutic treatment. This treatment focused almost exclusively on mothers.

Although the mother's reactions to her defective child are to a significant extent shaped by the type and degree of defect, they also are greatly influenced by her own past experiences with parents and siblings as well as by other significant life events. Conflicts in the woman's relationship to her own mother and in regard to her own femininity are often reawakened during the psychological work during the pregnancy...an awareness of the preparatory developments in the mother will heighten understanding of the impact of the disappointment, feeling of helplessness, and sense of failure that the individual woman experiences when the child she bears is obviously blighted. (Solnit & Stark, 1961, p. 525)

Grief models hypothesized a sequence of stages, beginning with initial shock and concluding with the final acceptance of reality (Wolfensberger, 1967). A pervading sense of pathology characterizes this literature. "Treatment" attempted to "fix" mothers' personal pathologies and their relationships with their child with mental retardation and other family members. Parent counseling/psychotherapy was often the sole intervention, with children with mental retardation receiving no or limited services.

Although this view of parents (i.e., mothers) as needing counseling or psychotherapy is less frequently seen in the 1990s than in the 1950s and 1960s, it is still cited today. Seitz and Provence (1990), in depicting caregiver-focused models of early intervention in the infant mental health field, described Fraiberg's work in which "the problem of the infant is seen to be a result of conflict between parent and infant arising from the mother's unresolved problems with her own past – the 'ghosts' that have invaded the nursery" (p. 404). Such caregiver models, however, are essentially absent from contemporary early childhood special education literature on family-professional partnerships (Odom & Karnes, 1988; Odom & McLean, 1996; Stayton & Karnes, 1994).

**TYPE OF POWER.** Skrtic (1995) suggested that one of the principal uses of professional power, so illustrative of the parent counseling-psychotherapy model, is the power to define "normalcy." Because of their expert knowledge, professionals have the power to decide who is normal and who is not. Once classified as abnormal, parents are then prescribed treatment, which can only be provided by professionals, according to the counseling/psychotherapy model. An example of the "diagnosis" and "prognosis" reflecting power relationships is exemplified in how Jeannette might have been characterized through the lens of a counseling/psychotherapeutic model.

Mrs. A. was referred to therapy by the child protective services agency. Early on, intensive counseling with this mother revealed a deeply disturbed personality. Her postnatal feelings of guilt, worthlessness, helplessness, hopelessness, and self-blame justify a finding of narcissistic disequilibrium. When I recommended that she place the child in foster care or put the child up for adoption, she manifested denial and

and avoidance of acceptance of the reality of Tisha's deviancy. Her vituperative response prompted her to engage in typical shopping-around behavior, evidencing her continued denial and incapacity for acceptance. Whatever the results of her shopping behavior, she returned to therapy only after our clinical social worker contacted her with the non-negotiable ultimatum that she resume therapy or else have to justify, in a child neglect/custody hearing, why her child should not be taken from her home and put into child protective services custody.

The power within this therapeutic relationship can be characterized as unequal, with the professional having power-over communication, resources, and outcomes.

**ASSUMPTIONS.** Assumptions of the counseling/psychotherapy model (Darling, 1989; Saleebey, 1992) include the following:

1. Children with disabilities create family pathology and counseling/psychotherapy is the appropriate treatment.
2. The professional refers to the child and family as "my case."
3. Diagnostic categorizations and clinical judgment result in an expert diagnosis that serves as the basis of treatment.
4. The professional's treatment consists of working to change the mother's reaction to the child and the child's diagnosis, with negligible attention to changing the family's environmental ecology by building on strengths and enhancing preferred formal and informal resources.
5. Emphasis is placed on finding "an optimal distance" (Foley, Hochman, & Miller, 1994, p. 19) in the therapeutic relationship through focusing on problems associated with managing transference and countertransference.

By transference, we mean the feelings, impulses and behaviors repeatedly experienced by the client in relation to the psychotherapist, which arise not out of the "real" but out of recapitulations of earlier relationships (Freud, 1912; Sander, 1993). By countertransference, we mean the unconscious reactions directed toward their clients in the present that are experienced by the psychotherapists and which have their origins in the past. (Foley et al., 1994, p. 19)

**PROFESSIONAL PERSPECTIVE.** The counseling/psychotherapy model assigns professionals, particularly those with medical backgrounds, the role as experts. Not surprisingly, the term *medical model* – which frequently refers to an expert making a diagnosis; and providing treatment to a patient or case – pervades the professional literature describing the counseling/psychotherapy model (Weick, 1983). Interactions with professionals typically occur within their clinics or offices, with few community resources.

Kanner (1953) described the challenge of providing counseling/psychotherapy to parents:

Whenever parents are given an opportunity to express themselves, they invariably air their emotional involvement in the form of questions, utterances of guilt, open and sometimes impatient rebellion against destiny, stories of frantic search for causes, pathetic accounts of matrimonial dissensions about the child's condition, regret about the course that has been taken so far, anxious appraisals of the child's future, and tearful pleas for reassurance. It takes a considerable amount of cold, hard-boiled, pseudo-professional detachment to turn a deaf ear on the anxieties, self-incriminations, and concerns about past, present, and future contained in such remarks. (p. 375)

In a description of the clinical interviewing process, Hirshberg (1996) stressed the importance of building a relationship between the provider and the family members. "[T]he critical point is that what is learned about the infant and family is a picture or account which is constructed in the course of an active, dynamic exchange between family members and evaluator" (p. 91).

Although parents are encouraged to participate in the process by telling their story, the purpose of hearing the story is to enable the provider to identify and address the family's problems and underlying issues. The provider uses his or her relationship with the family as a context for assessment and diagnosis of problems (no mention is made of strengths as well), not as a context for collaboration.

It is important to assess how the parents perceive, experience, and interpret the infant's behavior....This usually opens up for exploration the parents' own early experiences and how they may be involved in the problems of the baby. Here again, it is crucial not to pass by

or gloss over any areas of anxiety or conflict which may emerge, but instead to focus incisively on them in a persistent but respectful manner. (Hirshberg, 1996, pp. 116-17)

**PARENT PERSPECTIVES.** Families have frequently described the traumatic way that the diagnosis of mental retardation (Roos, 1985) and autism (Akerley, 1985) was delivered to them by professionals – particularly during the height of the counseling/psychotherapeutic model in the 1950s and 1960s. One parent of a child with Down syndrome described the following situation:

About 8 p.m. the doctor came in and said abruptly: "Read the numbers of the baby's ID bracelet, and the one on your wrist. See, it's the same. This baby is yours. This happens to women your age. You may want genetic counseling, and you'll probably want to put it in a home." (Turnbull & Turnbull, 1997, p. 137)

Paradoxically, there is very little in the research literature of this period concerning the impact of the professional's diagnosis on parent perspectives.

Parents of children with autism were particularly subject to a counseling-psychotherapeutic orientation (Bettelheim, 1950, 1967). Mary Akerley (1985), a parent of a son with autism, describes in some detail the ordeal that she and her husband encountered in their "enforced" therapy (i.e., for their son to receive treatment in the late 1960s, they were required to be recipients of psychotherapy).

One of Eddy's favorite play things was a set of wooden dowels that were part of a construction-type toy. His way of enjoying them was to stand them on end, lie down, and move his head back and forth behind them.... I chose to see his little game, after trying it myself, as an independent discovery of the theory of relativity. Not so. The learned doctor, who patiently explained to me that I had clearly kept Eddie in his crib and play pen too much because he was now reliving the behind-bars trauma! My response was really more innocent than sarcastic, although it was not perceived that way. "If it was so awful, why is he reliving it with such obvious pleasure?" No answer came. (Akerley, 1985, p. 28)

Another parent told of her interactions with the psychologist sent to her home. This parent describes how her concerns about her two young children were

addressed. Her older child had autism, and her younger child had microcephaly, and had begun to projectile vomit.

A psychologist..began visiting my house. [He] told me [he] could find nothing physically wrong with my child. Then [he] said I wasn't bonding properly, and I had given my child infantile depression....During one of the psychologist's visits, my son started acting up, pushing the baby. When I corrected him before comforting my baby, the psychologist said, "That's a perfect example. You paid attention to the older child and neglected the baby." (Autism National Committee, 1996, p. xviii)

**EXPECTED OUTCOMES.** The primary outcome of counseling/psychotherapy model was for mothers to reach the final stage of adjustment, namely, acceptance of and adaptation to their child with a disability (Wolfensberger, 1967). To reach that result, mothers had to be helped by treatment to pass through the sequential stages of shock, denial, anger, guilt, or depression so that they could reach acceptance (Grays, 1963; Koegler, 1963; Rosen, 1955). Obviously, in this model, power remained in the hands of the professionals. Because professionals frequently recommended institutionalization of children with mental retardation or other obvious disabilities (Farrell, 1957; Gordon & Ullman, 1956; Koch, Graliker, Sands, & Parmelee, 1959), professional intervention sought the parental outcome of making the institutional placement without suffering negative reactions.

Little emphasis in the parent counseling/ psychotherapeutic literature of the 1950s and 1960s was given to any kind of outcome for the infants and toddlers with disabilities. Because this model was particularly prevalent before the time children with developmental disabilities acquired a legal right to early childhood services or elementary-secondary education, it was often assumed that children were not educable and that services and intervention for children was relatively futile.

### Parent Training/Involvement Model

**OVERVIEW.** Two perspectives on parent training and involvement were evidenced in the compen-

satory education programs for disadvantaged children (a term used in the 1960s and 1970s that today is considered to be culturally insensitive) of the 1960s (Zigler & Valentine, 1979). These parent involvement perspectives, in turn, strongly influenced early intervention for children with disabilities. Based on evidence that family environment influences children's intelligence (Hunt, 1972), the first perspective viewed parents as being in need of remediation to improve their child's development. This is a *parent-deficit model*. This model leads to parent involvement activities that "adopt a primary, didactic, instructional role as a part of the intervention program" (Guralnick, 1989, p. 12) and treat parents as learners so that, in turn, they could be their children's teachers.

The second perspective, based in President the Kennedy's New Frontier and President Johnson's Great Society programs and characterized as a *political model*, regarded parents as disenfranchised and in need of an opportunity to increase their decision making power. Accordingly, parent involvement elements of early Head Start programs gave parents opportunities to be decision makers, not just recipients of services.

**TYPE OF POWER.** The parent training/involvement model usually continued the power-over relationship of the parent counseling/psychotherapy model. Professionals still had control of communication and resources. In the parent training/involvement model, the parents, primarily mothers, were not necessarily viewed as emotionally deficient but as lacking the specific skills needed to raise their child with a disability.

Professionals used their expert power (Kisthardt, 1992; Skrtic, 1995) to make and prescribe the intervention for children who had disabilities. More significantly, this exercise of power by the providers had an impact on the family system. Family functions and interactions could be interrupted by the demands of intervention activities that parents were expected to complete. Jeannette, for example, might find herself making a choice between working with Tisha to practice picking up puzzle pieces and going to an AA meeting scheduled in the evening. Jeannette would be caught in the dilemma of doing the intervention program that she had been told to do to help Tisha's fine motor skills or working to keep her commitment to long-term sobriety.

**ASSUMPTIONS.** The assumptions of the parent training/involvement model are as follows:

1. Children with disabilities will learn more and will be more likely to minimize or overcome their disability if their parents teach them at home, supplementing professionals' teaching. Parents need training to be effective teachers.
2. Because parents are viewed as being disenfranchised from program input, they need explicit opportunities to be decision makers regarding program operation. Parents who learn to be effective decision makers within the program will be more effective decision makers at home, and their children will benefit from this enhanced parental skill.
3. Parents have time and energy to be involved in their child's training and educational program.
4. Parent involvement is oriented toward enhancing program and child outcomes, as contrasted to parental outcomes (e.g., helping parents get a job or access to economic resources) or system outcomes (e.g., creating greater access to community participation on the part of children with disabilities).
5. Parent training/involvement typically is mother training/involvement, with little evidence in the literature that fathers have been highly involved in these kinds of activities.
6. Parents should act as agents of professionals, which will result in children receiving the benefit of educational programs that are delivered by professionals, as well as their parents. When parents carry out professional roles at home, it should not interfere with their parenting role, so this approach is additive for the child as contrasted to the child "losing a parent" to "gain another teacher."

**PROFESSIONAL PERSPECTIVES.** With compensatory education programs as a precursor, Congress authorized the Handicapped Children's Early Education Program (HCEEP) in 1968 for children from birth to 8. HCEEP projects were expected to demonstrate methods and techniques for enhancing the development of preschoolers with disabilities (Harvey, 1977). In addition, they were expected to enlist parents as allies of early intervention specialists, as the chairman of the Select Committee on Education, Congressman Dominick V. Daniels, made clear:

Few parents are prepared to take care of a child who looks different, behaves in grossly unacceptable

ways or fails to respond even to the sound of a mother's voice. Parents of handicapped children have fears and are often frustrated and bewildered. They need help in understanding their child's disability. They need help in working with their handicapped child.

This bill will bring us into a new era of educating handicapped children. In addition, it is anticipated that this legislation will enlist the help of the parents as allies and associates of educators to provide a total program. (Lavor & Krivit, 1969, p. 381)

Federal regulations implementing the HCEEP network specified four parent involvement modes:

1. parent assistance in project planning, development, operation, and evaluation;
2. parent training;
3. parent participation in educational and therapeutic project components; and
4. parent participation in advising and assisting in information dissemination related to the project.

A major impetus for parent involvement came from P.L. 94-142, now titled the Individuals with Disabilities Education Act (IDEA). P.L. 94-142 required that parents be invited to attend their child's IEP conference. Comprehensive reviews of research on the nature of parent involvement in the IEP process is beyond the scope of this chapter and can be found in other sources (Smith, 1990; Turnbull & Turnbull, 1997; Wood, 1995). In brief, however, research reveals that the IEP process is a passive experience for most parents: parents, such as Jeannette, typically listen to professionals describe to them an already developed IEP. The professionals still hold the power over the family to determine the child's needs and to prescribe the best approach to addressing those needs. Notwithstanding this fact, the IEP model served as a precursor for the IFSP, which was implemented with the intention of incorporating a family-centered approach (which is discussed in the next section).

**PARENT PERSPECTIVES.** Jeannette was no longer targeted for intervention because of deficiencies as a parent or person; she now was recognized as "extra hands for the provider. She and other parents were enlisted as assistants to the teacher or therapist. Jeannette often heard the phrase, "We can only teach her five hours of the day; you have her the rest of the time. You have more opportunity to teach her than we." So each time Jeannette met with a provider, she went

home with a list of discrete therapy or teaching activities. These activities often included a sheet for keeping "data" as she worked with Tisha.

For Jeannette, the parent involvement model meant that most activities with Tisha had a teaching component designed by the teacher or therapist to work on deficit areas. Jeannette was given training to incorporate speech and language skills into the family dinner hour and to teach Tisha to stack blocks during the time Jeannette had in her schedule for playing with Tisha. Jeannette did not see these as priorities for Tisha. She thought that Tisha's learning to entertain herself so that she could be less dependent on parental attention was a higher priority, given their family style. The teacher, however, said "home therapy" had to be done, so Jeannette was trying valiantly to follow through with the program.

For many parents the parent training/involvement model presented a conflict in role expectations. Often, parents did not want to take on a pedagogical role but instead wanted to be "just" parents, not teachers (Seligman & Darling, 1997). Martha Blue-Banning, whose son Ryan is 20 years old and has Down syndrome, often relates her regret at the loss of Ryan's toddler years. Martha remembers that everything she did with Ryan was "therapy"; there was not even a recognition that he was a baby and then a toddler who could be played with and enjoyed for himself (M. J. Blue-Banning, personal communication).

**EXPECTED OUTCOMES.** There has been a strong expectation within the early childhood special education field that higher quantity and quality of parent training/involvement result in better outcomes for children. There has been some disagreement over whether this outcome has been actualized, however. Casto and Lewis (1984) reported that programs involving parents were not necessarily more effective than programs that did not involve parents. Others, however, found benefits to parents and children from parent involvement. Shonkoff, Hauser-Cram, Krauss, and Upshur (1992) reported positive outcomes in the Early Intervention Collaborative Study for both parent and child as a result of the mother's involvement in early intervention. In one stage of this study, mother-child interactive skills were correlated positively with the cognitive performance and adaptive behavior of their

children (Krauss, 1993). During this period of the study, the children demonstrated "relatively accelerated growth in adaptive behavior and play skills" (Krauss, 1997, p. 615). It is important to note that parent involvement was a means to achieving child outcomes – not a means for achieving parent or family outcomes. Jeannette's role was to help remediate Tisha's deficits. That role was dictated to her without regard for other family demands or circumstances. Service providers still maintained a position of power over Jeannette and the rest of the family.

### Family-Centered Model

**MODEL OVERVIEW.** At the core of the family-centered approaches is the recognition of the centrality of the family – not just the mother – in the life of the child (Bailey & McWilliam, 1993; Shelton, Jeppson, & Johnson, 1989). Conceptually, family-centered intervention, also recognizes the relationships between individual family members, the nuclear family, the extended family, and community as factors affecting the functioning of the family and the development of the child. The goal of family-centered intervention is one of improving the wellbeing of the family as a whole (Bailey & McWilliam, 1993). Family-centered models became more prevalent in the mid-to-late 1980s.

It is difficult to define the specific characteristics of family-centered services. Despite varying definitions, however, two elements are consistently included as nonnegotiable in the delivery of family-centered services: family choice and a family strengths perspective (Allen & Petr, 1996).

**Family Choice.** Support for family decision making is central to definitions of family-centered services (Allen & Petr, 1996; McBride, Brotherson, Joanning, Whiddon, & Demmitt, 1993; Raver & Kilgo, 1991). The family choice component of family-centered services is expressed in many different ways but has at its core the concept that a family is the final decision maker when it comes to issues related to their child or family. It is Jeannette's decision to include issues related to her participation in AA in her IFSP, not the service provider's. Some definitions refer to this as *consumer-driven services* (Dunst, Johnson, Trivette, & Hamby,

1991) or as responsiveness to families' priorities and choices (Lee, 1993; Leviton, Mueller, & Kauffman, 1992). The role of the professional in this decision-making process is to be the agent or instrument of the family in the promotion of family decision making (Dunst et al., 1991).

Choices for Jeannette and other families begin with their decision to participate in the process and their level of participation (Simeonsson & Bailey, 1990). Other choices include but are not limited to: 1) family membership; 2) decision maker; 3) unit of attention; 4) nature of the family-professional relationship; 5) sharing of information; 6) identification of needs, goals, and intervention; and 7) limits of choice (Allen & Petr, 1996). The choice-making component recognizes that the decisions families make may vary from opportunity to opportunity and depend on their perceptions of their resources, concerns, and priorities and on the resources, concerns, and priorities of those around them.

**Family Strengths Perspective.** The second constant in family-centered intervention is the adoption of a strengths perspective in working with families (Allen & Petr, 1996). Family-centered intervention includes the belief that every family has strengths (Bailey & McWilliam, 1993) that arise from the family's capacities, talents, possibilities, visions, values, and hopes that have survived circumstance, oppression, and trauma (Saleebey, 1996). Often, the environment around the individual or family is such that their strengths cannot be used effectively to address a problem. One professional role is to facilitate the availability of environments where those strengths can be recognized and used (Dunst, Trivette, & Deal, 1988). Another role is to focus on the strengths and resources of the family rather than on their pathology, deficits, or needs (Bailey & McWilliam, 1993).

Focusing on the family's strengths and resources requires the professional to look at those things that will enable the family to carry out their responsibilities effectively. Building on family strengths also mandates that services enhance families' knowledge, skills, and abilities to make decisions about their child; mobilize social resources and supports; protect the family from unwarranted intrusion; and enable parents to make choices by providing a variety of information and options (Dokecki & Heflinger, 1989).

**POWER AND THE FAMILY-CENTERED MODEL.** The move to family-centered services also marks a change in the power relationships between families and service providers. Its emergence is accompanied by a power realignment. In a shift from a power-over relationship to a power-with partnership, parents and service providers each have some power to determine what issues should be included and addressed and what resources should be provided.

For Jeanette, this means that she chooses the team members who can contribute the most to the outcomes she wishes. She requested parenting help, and efforts were made to move her to the top of the list for the local Parents as Teachers program. With the shared power of family-centered services, she also took a role in identifying sources of funding for the medications she needed. She called several agencies with which she was familiar while her service coordinator called those she knew.

In family-centered services, parents share power with providers while maintaining their role as ultimate decision maker by determining outcomes, resources, and allocation (Turbiville et al., 1996). Some providers oppose sharing power because they view it as a loss of power on their part (Ross, 1995).

Although power is shared with families in this model, this model still assumes a limited amount of power available in a partnership. In previous models, in which the service providers had power over families, the providers had all the power. With the implementation of a family-centered model, service providers and families share power – service providers have power with families.

**ASSUMPTIONS.** The assumptions underlying family-centered service delivery were first articulated by Shelton, Jeppson, and Johnson in 1989 as principles of family-centered care and were later modified in recognition of the racial, ethnic, cultural, and economic diversity of families (Johnson, 1990). Although other people have suggested different principles, most formulations have their foundation in those listed here (Johnson, 1990).

1. The family is a constant in the child's life, whereas the service systems and personnel within those systems fluctuate.
2. Family-professional collaboration at all levels of care is facilitated.

3. The racial, ethnic, cultural, and socioeconomic diversity of families is honored.
4. Family strengths, individuality, and methods of coping are recognized and respected.
5. Complete and unbiased information is shared with families on a continuing basis and in a supportive manner.
6. Family-to-family support and networking are encouraged and facilitated.
7. Systems of care understand and include the developmental needs of infants, children, and adolescents and their families.
8. Comprehensive policies and programs are implemented that provide emotional and financial support to meet their family needs.
9. Accessible systems of care are designed that are flexible, culturally competent, and responsive to family identified strengths and needs.

**PROFESSIONAL PERSPECTIVES.** For some professionals, the shift to family-centered services has been difficult. Because most were trained to provide services to children, providing services to the children within the family system framework presents numerous challenges. These challenges include a lack of familiarity, experience, and training in including families in early intervention (Bailey et al., 1992) and time to pursue a holistic, family-centered approach (McWilliam, Tocci, & Harbin, 1995).

The movement toward the family-centered model requires professionals not only to expand their resource knowledge from child-focused to family-focused priorities but it also requires them to change their decision-making approaches (Bailey et al., 1992; Dunst et al., 1993; Seligman & Darling, 1997; Turnbull & Turnbull, 1997). Because professionals have traditionally been the primary decision makers concerning any intervention, implementing a family-centered model requires that decision-making power reside with the family. Collaboration becomes the operating mode in identifying and achieving child and family outcomes (Turbiville et al., 1996).

A challenge for professionals working in the family-centered model is answering satisfactorily the question "What's in it for me?" Family-centered services are values based; if professionals do not value collaborative partnerships and mutual responsibility, the answer to this question is problematic.

**FAMILY PERSPECTIVES.** For families, the shift to family-centered services has also been challenging. Families have been conditioned by professionals to be the recipients of professional expertise, particularly when they first learn of their child's disability (Seligman & Darling, 1997). McWilliam, Tocci, and Harbin (1995) reported that services to infants and toddlers continue to be far more child- than family-oriented, perhaps because of parent preferences for this emphasis. Families, however, are now expecting their preferences and expertise to be respected as services are made available to their children and family. For families such as Jeannette's, the implementation of the family-centered model means that issues such as getting to AA meetings, finding housing for Lenny, and securing money for her medications could be part of the intervention effort.

Parents report a greater sense of control and direction when services are family centered (Turbiville, Schaffer, Schaffer, & Brammel, 1997). Families find that sharing information and decision making helps them maintain equal footing- in the partnership:

The staff at the early intervention center knew we wanted Aric to attend a regular kindergarten class...They gave us ideas to get him into the setting. They never took control out of our hands, and we always did the steps ourselves. They were there as a resource and support. (Leifield & Murray, 1995, cited in Seligman & Darling, 1997)

**EXPECTED OUTCOMES.** Family-centered early intervention services are expected to generate outcomes for both the child and the family. The family outcomes include an increase in their abilities to meet the needs of their children (McGonigel, Kaufmann, & Johnson, 1991; Pearl, 1993) and an increase in their sense of competence in meeting those needs (Allen & Petr, 1996). Although family-centered services are designed to address family and child issues, the family issues to be addressed relate to those that would increase the family's ability to meet the child's needs. For Jeannette, family-centered services meant she could choose the professionals with whom she wanted to work most closely without being "accused" of shopping around. Furthermore, when she was not interested in placing her child in foster care or adoption, her preference for providing care herself is respected.

Other anticipated outcomes of family-centered services include the involvement of family and kin and the coordination of service delivery (Dokecki & Heflinger, 1989). These outcomes can be achieved through the utilization of a systems approach in planning and implementing intervention services, primarily at the micro- and meso-system levels or in the immediate setting and environment of the child and family members (Bronfenbrenner, 1979).

Although rhetoric within the family-centered model focuses on family outcomes, the actual outcomes of family-centered intervention have been primarily child-centered (Boone, Moore, & Coulter, 1995; Guralnick, 1989; Mahoney & O'Sullivan, 1990; McWilliam et al., 1995). That is, the outcomes written most often are for child skill development. In spite of family-centered assumptions, providers are still trained to work with children rather than with their families and have found it very difficult to shift their focus from the individual child to the child within a family (Bailey et al., 1992).

Moreover, family-centered services still primarily include the mother (Able-Boone, 1993). Turnbull (1993) reported that even in research on parents and families, twelve times as many mothers as contrasted to fathers were involved as participants. Only two percent of outcomes written for the IFSP address paternal issues (Sparling, Berger, & Billing, 1992). Grandparents or brothers and sisters are also usually absent from the early intervention process (Able-Boone, 1993). Most services and support to families come from the formal rather than informal support network (Boone et al., 1995; Crnic & Stormshak, 1997) and from agencies charged with early intervention service delivery rather than from resources throughout the community ecology (Polrnanteer & Turbiville, 1997).

Another outcome has been the extra effort made by service providers to provide family-centered intervention when families represent diverse cultural groups. Each family must dictate its membership (Brinker, 1992) and its way of performing family functions (Turnbull & Turnbull, 1997). The assumptions underlying family-centered approaches must be individually tailored for families in a manner that is consistent with their culture and family traditions.

### Collective Empowerment Model

**OVERVIEW.** Definitions of empowerment vary across disciplines, including sociology (Alinsky, 1969; Freire, 1973); psychology (Rappaport, 1987; Zimmerman, 1990, 1992); social work (Gottlieb, 1992; Gutierrez & Nurius, 1994; Kaplan & Girard, 1994; Pinderhughes, 1994); and education (Turnbull & Turnbull, 1997). The central element in the many definitions, however, is the process of taking action to get what one wants and needs. The outcome of the empowerment process is gaining mastery or control over the challenges that one faces on a daily basis.

Early views of empowerment in early intervention addressed the empowerment of families. Families were viewed as lacking the competence to achieve the outcomes they desired for their child or family. Service providers were assumed to have this competence and therefore were already regarded as empowered. They needed to use their own skills and power to facilitate or enable the empowerment of the family. Unfortunately, it appears that many service providers perceive that they, too, are unable to access the resources they need (Epstein, 1995; Mlawer, 1993; Skrtic, 1991). It would seem to be difficult for service providers who perceive themselves to be unable to access the resources they need to achieve the desired outcomes of actively facilitating or enabling family empowerment. This realization of the sense of disempowerment by service providers has provoked a revision of the thinking on family empowerment. Currently, the contemporary focus is on collective empowerment, in which all participants (i.e., professionals and families) increase their capacity and mastery over the resources needed to achieve mutually desired outcomes (Epstein, 1995; Gutierrez & Nurius, 1994; Pinderhughes, 1994; Turnbull & Turnbull, 1997).

Indeed, there are three elements of a collective empowerment program philosophy that surpass a singular family focus. One element relates to the families; they represent one group of beneficiaries of an empowerment approach. Another element relates to the professionals; they too are beneficiaries of an empowerment approach. The third element relates to the context in which the families and professionals interact and collaborate. The context is also a beneficiary, because

collective empowerment has the outcome of making contexts more responsive.

**TYPE OF POWER.** The essence of the collective empowerment model is synergistic power, not monopolized power (Bond & Keys, 1993; Epstein, 1995; Katz, 1984; Turnbull & Turnbull, 1997). The new model assumes power-through family-professional partnerships. The collaboration itself creates its own power and then radiates that power synergistically throughout the contexts of community ecology. By contrast, some of the previous models assume power-over in which professionals control the relationship for the purpose of fixing the patient or a power-with situation in which the available power is shared.

In the collective empowerment model, not only is power gained for all participants through the partnerships but the very nature of the power generated is also transformed. Power is no longer only to control events and resources. Power has become capacity building, with participants gaining in competence, abilities, resource acquisition, and capability without taking any power from others (Wagner, 1992). Kanter (cited in Wagner, 1992) stated that power is the ability to get things done and is not domination or control over others. With the collective empowerment model, power or capacity also becomes a limitless resource for everyone in the partnership (Katz, 1984). It is not a scarcity to be hoarded by any member; there is power, as capacity, for all.

**ASSUMPTIONS.** Many of the assumptions of the collective empowerment model are consistent with the previously discussed assumptions of the family-centered model. As applied to early intervention, the collective empowerment model assumes 1) centrality of the family, 2) family choices as the basis of decision making, and 3) family strengths and capabilities as the focus of intervention. The major additional assumptions within a collective empowerment model focus on 1) access to resources, 2) participation, and 3) changing community ecology.

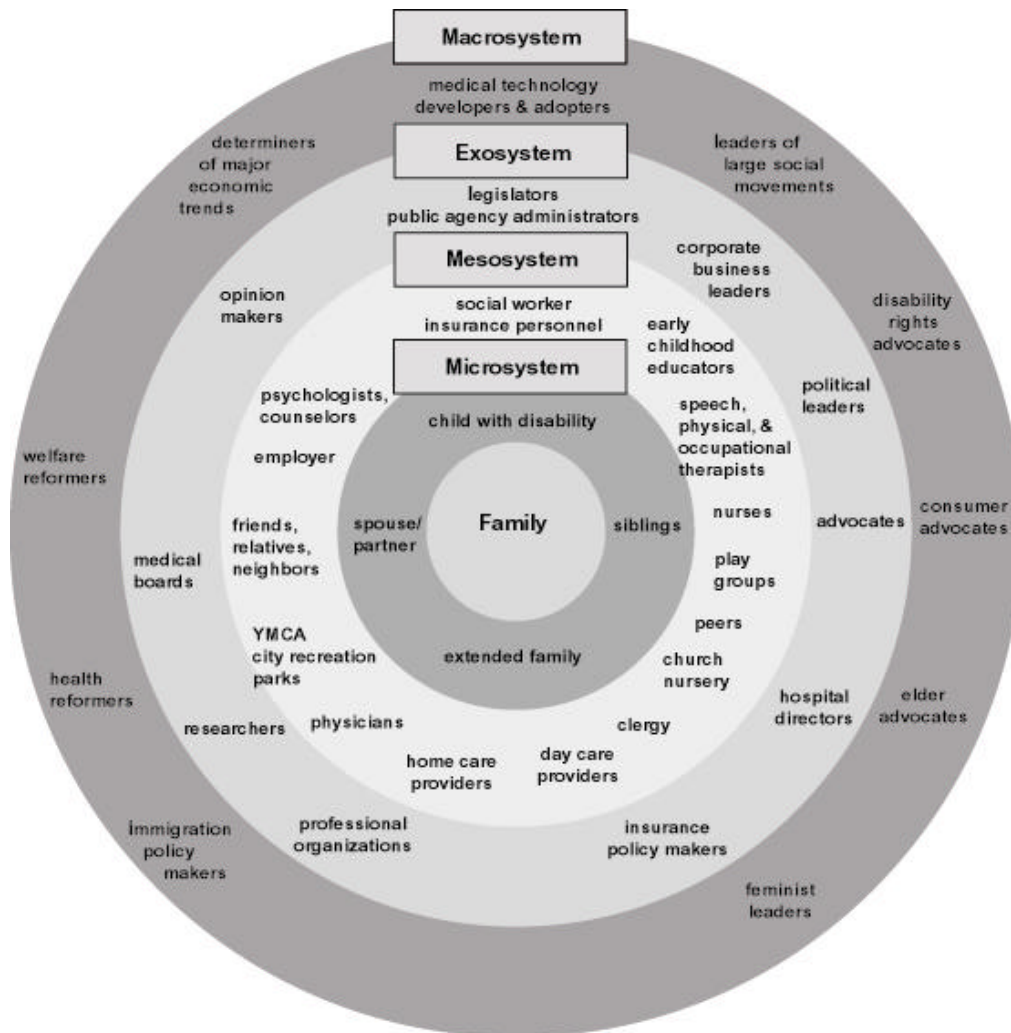
**Access to Resources.** Taking action to achieve what one wants and needs requires that families and professionals have access to resources. Two key components of the collective empowerment approach are that 1) participants must be knowledgeable about the

resources that would make the most substantial difference to them in gaining a sense of control in their lives and 2) they should participate in the decision-making process about the nature and extent of resources allocated to them. For example, family support programs provide monetary resources to families that they may spend to meet a wide variety of needs; their choices are not limited by the restrictions of the service agency or professional (Agosta & Melda, 1995; Bradley, Knoll, & Agosta, 1993; Garlow, Turnbull, & Schnase, 1991). The role of the professional is to facilitate or guide the family in the process of obtaining preferred resources within both formal and informal systems (see Figure 27.2).

Although the traditional view of service delivery has been that families primarily need formal services (e.g., counseling, psychotherapy, and training) delivered by professionals, a collective empowerment approach focuses on resources available from the informal system as well. Families are encouraged to network with other family members, friends, neighbors, and community providers in gaining resources in the least restrictive environment of their family life.

Jeannette would determine preferred resources in an empowerment model. Working with her providers and friends, who also know the system, she would decide where best to obtain those resources that would work for her. The timing and the use of these resources would also be her decision to make or delegate. Through this collaboration and dialogue about the resources, her service providers and friends gain information about and access to new assets. Thus, all involved increase their capacity and therefore their power.

**Participation.** A key element of a collective empowerment approach is opportunities for families and providers to participate in a decision-making process in which power is shared and family roles vis-à-vis professionals are characterized as being equal rather subordinate or hierarchical (Kieffer, 1984; Prestby, Wandersman, Florin, Rich, & Chavis, 1990). If, for example, a preschool program advisory board consists almost entirely of professionals and only one or two parents, then the parents are deemed to have unequal participation. Similarly, if an early childhood organization assembles a training manual in which all chapters are written by professionals with the



sole exception of one that is written by a mother, it cannot be assumed by the professionals that they have collaborated with families in writing their manual. Participation in an empowerment approach recognizes that power in these types of activities is inherently unequal and that genuine participation requires that there is a sufficient presence of families so that the numbers and respective contributions of families and professionals are roughly equal. Thus, in the development of a training manual, all chapters might be coauthored by a professional and family member (e.g., mothers, fathers, siblings, grandparents). Families thus fully participate in

**Figure 27.2.** Bronfenbrenner's (1979) Ecological Model Applied to Families of Young Children

Adapted from: Singer, G. H. S. (1996). Introduction: Trends affecting home and community care for people with chronic conditions in the United States. In G. H. S. Singer, L. E. Powers, & A. I. Olson (Eds.), *Redefining family support: Innovation in public/private partnerships* (pp. 3-38). Baltimore: Paul H. Brookes Publishing Company.

the development of the product, and their views are pervading rather than segmented. (We do not mean to imply here that all products should be developed equally by professionals and families. Our point is that

many professionals dominate the writing of products and then "claim" that the products were written in collaboration with families. This claim should only be made when there has been equal participation.)

Moreover, equal participation should occur from the initiation of project planning through project completion (Turnbull, Friesen, & Ramirez, 1995; Whitney-Thomas, 1997; Whyte, 1991). It is insufficient to bring parents into a project after the project has already been conceptualized and key decisions have been made by professionals. Genuine participation means being at an even table (Kritek, 1994) from the outset so that the nature of the project can be shaped from a family as well as a professional perspective.

Finally, because families choose to participate at different levels, at different times, and in different ways, participatory involvement in a collective empowerment model means that family choice pervades the process and decisions about family participation are made by families rather than professionals.

**Changes in Community Ecology.** The parent counseling-psychotherapy model assumes that the mother is broken and needs to be "fixed" within the mother-child microsystem relationship. Functioning competently at all levels of community ecology (see Figure 27.2) is largely ignored. Rather than viewing the "problem" as solely residing within the mother-child relationship, however, the collective empowerment model views "needs" as largely residing within all four levels of ecological context (see Table 27.2).

**PROFESSIONAL PERSPECTIVES.** Within the collective empowerment approach, professionals primarily assume the roles of facilitator, collaborator, or partner rather than expert or specialist (Gutierrez & Nurius, 1994; Turnbull, Turbiville, Schaffer, & Schaffer, 1996; Turnbull & Turnbull, 1997). Bailey (1994) described the concept of dialogue within an empowerment approach, on the basis of the work of Paulo Freire (1981), a Brazilian educator whose work focuses on overcoming oppression.

Briefly, Freire conceives a dialogue is more than a conversation between two people. Dialogue is truly an act of creation. For example, you and I come together and discuss a certain topic. I have opinions "B," and you have opinions "A." In true dialogue, we both are willing to *share* our opinions and simultaneously be *open* to the

opinions of the other. In true dialogue, there is mutuality of *respect* (of self and other), *trust* (in self and other), and *caring* (of self and other). Freire talks about these as elements of dialogue – humility, faith, hope, and love. So in true dialogue, we risk being changed as we take on some of the opinions of the other. We are transformed; we have engaged in critical thinking and mutually created an opinion "C" on this topic. (Bailey, 1994, pp. 38-9)

According to Freire (1981), this type of exchange can take place only when there is equality among the parties involved. This equality must be established by working to counterbalance the natural imbalance that often occurs between the professionals and families, the powerful and the powerless.

[P]ractitioners' readiness to empower clients, to value strengths, to respect cultural meaning, to take one – down positions when appropriate, and to engineer larger system change is heavily dependent on practitioner capacity to manage personal power need. Knowledge of how power operates in the helping encounter and how it influences personal motivation and behavior is key. This is so because the power differential that exists between practitioners and their clients is such that it can be and has too often been exploited by practitioners who intend to engage clients but who instead meet their own needs for personal power and esteem through the intervention process (Pinderhughes, 1989; Heller, 1985). (Pinderhughes, 1994, p. 27)

**PARENT PERSPECTIVES.** Because the collective empowerment model is relatively new in the evolution of family-professional partnership approaches and is being presented here as a direction for the future, there are few published reports from parents who have participated in early intervention programs with this orientation. One such report describes the perspectives of Hortense Walker and the early intervention services she received for her son. Eric in south-central Los Angeles. She characterizes her best experience in an early intervention program as being provided by a teacher, Marlene, who visited her home when Eric was 18 months old. Asked how Marlene was encouraging, Hortense responded:

We came to see Marlene as a person whose first objective was to meet the needs of our family as a whole. She emphasized the positives of the program for us and for Eric. We just ate up her time and her knowledge.

She felt appreciated by us, and she was. That made the difference.

Synergy occurs in collective empowerment when parents feel appreciated by professionals, and professionals feel appreciated by parents. The positive energy can enhance capacities for all participants. Susan Rocco, the mother of a young adolescent with autism, compares and contrasts other models of parent-professional partnerships with the empowerment approach as follows:

As the parent of a teenager with both medical and educational challenges, I had experienced most points on the power continuum. The unequal power relationship with Jason's teachers and therapists generally put the burden on me to wheedle, cajole, threaten, flatter – in essence, work harder at the relationship than anyone else – to get the desired outcome. The few times I have experienced true synergy, when we partners are working from our strengths and shared values, the burden has fallen away. The beauty of the synergistic model is that there is no more "them" and "us." "We" pool our resources and our creative juices, and "we" all celebrate in the success.

**EXPECTED OUTCOMES.** A number of outcomes have been identified as resulting from collective empowerment (Bond & Keys, 1993; Katz, 1984; Kieffer, 1984; Natiello, 1990; Saleebey, 1992); Three of these seem particularly relevant as outcomes of collective empowerment in family-professional partnerships. These include 1) synergy (Bond & Keys, 1993), 2) creation of renewable and expandable resources (Saleebey, 1992), and 3) increased satisfaction by participants (Natiello, 1990). Although these outcomes are separate, they are also strongly linked.

Synergy is commonly discussed as the outcome of collective empowerment (Bond & Keys, 1993; Katz, 1984; Kieffer, 1984; Saleebey, 1992). The synergy in collective empowerment results in the effectiveness of the group being greater than the sum of the individual parts (Bond & Keys, 1993). Synergy is an outcome of collective empowerment through the interaction of the empowerment of the individuals and their collaboration with each other (Bond & Keys, 1993). When only individuals are empowered, without collaboration, there can be little agreement on direction and united effort. Each empowered individual proceeds in his or her own manner and course. On the other

hand, if there is collaboration without empowerment, collaboration can become co-option by the strongest individual or group (Bond & Keys, 1993). Synergy, therefore, can be an outcome only when there is both collaboration and empowerment, as in collective empowerment. A second outcome of collective empowerment is the accessibility of new and renewable resources. These resources are created from the synergy of the partnership. Traditionally, we have viewed resources as scarce and, in many instances, unavailable (Katz, 1984). Through the implementation of collective empowerment, however, resources are constantly being created and re-created by the interaction and synergy of the group members.

Finally, collective empowerment results in an increase in satisfaction for all who participate. Because individuals feel able to meet their needs and are more self-efficient, self-satisfaction increases (Swick, 1988). The increased energy and creativity released through the collective empowerment process may also contribute to the increased sense of satisfaction (Turbiville et al., 1997).

For Jeannette, the collective empowerment of Tisha's intervention group and her family has meant more creative solutions to old problems. These solutions are more stable because of the support of all concerned. Tisha is attending a community preschool as a result of group action planning (Turnbull, Turnbull, & Blue-Banning, 1994; Turnbull, Turbiville, Schaffer, & Schaffer, 1996) by Jeannette, her family, and the intervention team to put together an intervention program that is not overwhelming to the preschool staff or to the early childhood staff. The two staffs believe they share the responsibilities of Tisha's participation in the preschool. The occupational therapist implements the speech-language pathologist's goals two days a week, and they reverse roles the other two days (Rainforth & York-Barr, 1997). Consequently, Tisha receives both services four days a week without adding to either therapy schedule. The preschool staff observes all of the sessions and use the same approaches, and they also take responsibility for sharing those strategies with Jeannette on a daily basis. Tisha's consistent participation in the program allows Jeannette to get to her AA meetings and also to spend time with her mother and Lenny. Jeannette and her group have recently begun to discuss the possibility of applying for a place on the Habitat for Humanity housing list in the community.

They plan to share in the "sweat equity" that Jeannette will be required to contribute. Everyone thinks it will open a whole new set of available resources for each of them.

## CONCLUSION

In this chapter, we presented four different models of interaction and power distribution in parent – professional partnerships. Through the vision and advocacy of many, primarily family members and advocates, the partnership orientation of service providers and families has evolved along a developmental continuum from a psychotherapeutic/counseling partnership to parent involvement, family-centeredness, and finally, collective empowerment.

In reality, all four models continue to be used in early intervention. Possibly because their needs and resources change, family preferences for their relationship with early intervention providers change. If family choice is indeed the reason for the continued use of the various models, this continued usage may indicate that the partnerships are based on the principles of family-centeredness or collective empowerment. As Allen and Petr (1996) suggested, one of the choices available to families in family-centered service delivery is that of the relationship between the family and the service providers.

Unfortunately, more often than not, the decision on the partnership model is probably made unilaterally by the service provider. If queried, the provider may respond that the family is satisfied with the partnership. This satisfaction, however, may be similar to the findings regarding the family's preferences for child outcomes (McWilliam et al., 1995). McWilliam et al. suggested that the family may not be aware of other approaches and options. Applied to partnership decisions, the family may not know that models other than the provider as the expert are available. Providers need to reflect on their partnerships with families and ensure that families truly have choices in how these critical relationships evolve.

The evolution of family-professional partnerships from an emphasis on parent (mother) counseling/psychotherapy to an emphasis on the collective empowerment of families and professionals has

represented change and challenge to the field of early childhood special education since the 1950s. Continued change and challenge are inevitable and welcome as we move into the new millennium. We invite the reader to stand in Jeannette's shoes and experience the life she lives. How does she develop the resources, the motivation, and the supportive environment she needs in order to participate in a collective empowerment model? Similarly, how do her providers learn to embrace the inherent values of a collective empowerment approach and the associated skills? Must her service providers first subscribe to collective empowerment and facilitate the development of her philosophy and skills? Can Jeannette facilitate the development in her providers? What is the impact on Jeannette, Tisha, Lenny, other family members and on providers of the partnership model?

The field of early intervention and early childhood special education has an opportunity to answer these questions and to continue to create even more responsive contexts for families and service providers. For now, and into the twenty-first century, we believe the model of collective empowerment holds the best promise for growth for infants, toddlers, and young children who have disabilities, their families, and their providers.

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